Maternal and Child Health Services Title V Block Grant

New York

FY 2018 Application/ FY 2016 Annual Report

Created on 9/26/2017 at 12:17 PM

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 14, 2017

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 2018 Maternal and Child Health Services Block Grant Application and FFY 2016 Annual Report.

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

Sincerely,

Lauren J. Tobias
Director, NYS Title V Program and
Director, Division of Family Health

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

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

Section I.E. Application/Annual Report Executive Summary

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

Each year, states submit an application and report in accordance with MCHB guidance. This year's application from New York State (NYS) reflects continued leadership and commitment to promote the health of the MCH community within the context of a changing health care landscape, the continued adoption of a life course perspective and a focus on data-driven, evidence-based public health interventions. Building on the application submitted in Year 1 and 2, this FY 2018 application reflects a more in-depth analysis of State and National data, as well as evidence-based and promising strategies to address the identified State Priorities and move towards achievement of the 2020 State Objectives. The application submitted in this application reflects significant work over the past year to implement the strategies in the State Action Plan (SAP) as required for the eight core MCH priorities across six MCH population health domains: maternal and women's health, perinatal and infant health, child health, adolescent health, children with special health care needs and cross-cutting life course. NY's application reflects the ongoing commitment of NY's Title V program, NYS Department of Health (NYSDOH) and key MCH partners as well as significant input from families, providers and other key stakeholders across NYS.

The eight priorities selected by NYS include:

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

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

Under Title V leadership, a comprehensive process was convened to refine NY's MCH needs assessment and action plan for Year 1 and 2, building on extensive stakeholder engagement and needs assessment. As in Year 1 and 2, cross-functional teams from across the DFH were formed for each of NY's MCH priorities including Health Equity. The charge of the teams was to coordinate the implementation of the strategies and serve as a link to the Title V Program. All teams are comprised of a lead as well as staff with programmatic experience in the priority area, at least one staff with research/analytic skills and a representative from the Health Equity team to better ensure initiatives identify proactive ways to address equity. Over the past year, the teams continued their focus on the strategies within each priority area. The teams were guided by the DFH leadership and would periodically present updates to a larger DOH cross section of staff. Facilitated discussions informed implementation activities.

Input was also obtained from the MCHSBG Advisory Council, Parent to Parent of NYS and other key partners including the Schuyler Center for Advocacy and Analysis (Schuyler Center), American Academy of Pediatrics (AAP); Association of Regional Perinatal Programs and Networks, MCH Committee of the New York State Association of County Health Officials, New York State Perinatal Association and others providers and key stakeholders.

Key products of the process described above include a MCH Needs Assessment (NA) Summary Update, Public Input summary, accomplishments, emerging issues, challenges and plans as detailed in this application and highlighted below for each of the six MCH population domains.

Domain 1 – Maternal/Women's Health

Health care coverage is a significant factor in making health care accessible and available to women. Through the NY State of Health (NYSOH), the state's official health plan marketplace, NY continued its efforts to enroll all New Yorkers into comprehensive health care coverage. All Title V programs also prioritize engaging all women into health care coverage.

Title V leads efforts to improve the health of women in NYS with a key focus on women's ability to control their reproductive health. NYS has had a long-standing commitment to ensuring all women have access to comprehensive reproductive health care through the system of family planning services and generous health benefits, such as the Family Planning Benefit Program that includes presumptive eligibility. NY is a leader in increasing access to Long Acting Reversible Contraception (LARC), the most effective means of birth control through quality improvement efforts with family planning providers and over the past year has also engaged in opportunities to better understand the reproductive justice framework related to women's health.

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

Domain 2 – Perinatal/Infant's Health

Infant mortality has been steadily declining, but striking disparities remain. An ongoing concern for infant health is increasing rates of neonatal abstinence syndrome resulting from opiate abuse. In addition, developing strategies for new and emerging public health issues such as Zika virus challenges the system. Key accomplishments include a statewide system of regionalized perinatal care, strong community-based perinatal services including evidence-based home visiting, clinical quality improvement initiatives with birthing hospitals, involvement in the national Collaborative Improvement and Innovation Network (COIIN) initiative to decrease infant mortality and strong partnerships to promote improved health outcomes. NY's SAP includes updating and enhancing perinatal regionalization standards to enhance the quality of care provided in these facilities and ensuring the system is developed in synergy with the changing health care landscape in NYS, develop performance measures to promote quality improvement and ongoing assessment of levels of perinatal care, increasing retention of families in evidence-based home visiting programs, and promoting safe sleep practices. Collaborative efforts will continue to be enhanced or developed to improve important perinatal practices such as improving clinical quality of care, and to address new and emerging health issues such as maternal opioid use to improve perinatal outcomes.

Domain 3 – Child Health

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

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

Key accomplishments include extensive health insurance options, comprehensive early intervention services for infants and toddlers with developmental delays and disabilities, extensive engagement of Title V staff in developing and implementing Medicaid Health Home for children, family representation on key advisory groups, and funding for local health department-based services for families of CSHCN. However, parents have reported that the myriad of services available to CSHCN are at times challenging to understand and access, with significant gaps in some services or in specific areas of NYS. Although most of NY's children are insured, families of CSHCN continue to report lack of consistent services and inadequate health care coverage and lack of care coordination. In addition, adolescents with special needs remain challenged when transitioning from the pediatric to the adult care system. NY's SAP highlights plans for enhanced analysis of existing CSHCN data, continuation of a systems-mapping initiative to identify strengths, gaps and barriers to set future direction for Title V in this arena, continued strong engagement under Medicaid leadership to support successful implementation of Health Home for children, enhance family support practices within Early Intervention (EI) and disseminate best practices to other Title V programs, and supporting a structured quality improvement project to improve reporting and follow-up of newborn screening.

Domain 5 – Adolescent Health

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

Domain 6 – Cross-Cutting/Life Course

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

Throughout this application, racial, ethnic, economic and geographic disparities are highlighted for virtually all MCH outcomes and factors assessed. Disparities are not limited to race and ethnicity. Rather, economic status, geography, language, and other factors such as health literacy can have a significant impact on the health status of NY's MCH population.

NY's SAP outlines strategies for each of these cross-cutting priority areas. Strategies to address specific priority elements of preventive health care services across the life course, including preconception health care, developmental screening, and adolescent well care. The plan emphasizes the need for stronger collaborations with partners, and new efforts and approaches to develop and implement new strategies, including engaging partners at the community level to develop lasting changes to address home and community issues as well as promoting health equity to address NY's significant and long-standing health disparities.

II. Components of the Application/Annual Report

II.A. Overview of the State

II.A. Overview of the State

As of 2016, New York State (NYS) has the fourth largest population after California, Texas & Florida, with a population of 19.7 million. NYS is a very diverse state with a substantial portion of its population being members of racial & ethnic minorities. Compared to the national population, in 2015, a larger percentage of NYS' population is Black (17.6% NYS; 13.3% US); Asian (8.8% NYS; 5.6% US); and Hispanic (18.8% NYS: 17.6% US). NYS also has a significantly higher foreign-born population (22.5% NYS: 13.2% US-2011-2015 data), and larger population speaking a language other than English at home (30.4% State: 21% US-2011-2015 data). NYS's cultural diversity is both a strength and challenge. Racial and ethnic minorities often have poorer health than white Americans, even when they are able to access insurance. A priority for NYS is to ensure that health care systems meet the needs of diverse populations at all levels to promote equity in health care and eliminate disparities in health access & outcomes.

In 2011-15, the percent of New Yorkers who graduated from high school is slightly below the national level (85.6% versus 86.7% US), while the percentage with a bachelor's degree or higher is higher (34.2% versus 29.8%). NY's per capita income in the past 12 months (2015 dollars – 2011-15) is higher than the national average ($33,236 versus $28,930 US), & NY's median household income for 2011-15 is also higher ($59,269 versus $53,889). However, the State's percentage of persons below the poverty level percent during that same period is higher than the national percentage (15.4% versus 13.5%). Educational attainment has a major impact on income and is a significant factor in access & quality of health care. Poverty is also associated with poor health outcomes, especially for women & children. Racial& ethnic minorities are significantly impacted by lower educational attainment & poverty in NYS.

NYS' population is dense; in 2010 there were 411 persons per square mile in NYS, compared to 87 in the US. New Yorkers are more likely to live in urban areas than residents of other states. 64 % of NYS's population live in the NY Metropolitan area; 43% in New York City (NYC) alone. NYS is also geographically diverse; population density varies widely, from 69,467 persons per square mile in Manhattan to only three persons per square mile in Hamilton County in the Adirondack Mountain Range; NYC is 104 times more densely populated than the rest of the state. Population density often determines the number and types of health services in an area.
NYS has a rich system of health care. NYS has the fourth-highest ratio of physicians to residents in the nation, with approximately 325 physicians per 100,000 residents, compared to a national average of 271 per 100,000. NYS also has 40% more specialists per capita than other states and 22% more primary care physicians per capita than average. NYS is home to more than 2,500 outpatient hospital & free standing health clinics, including over 60 Federally Qualified Health Centers (FQHCs) with approximately 600 sites throughout NYS; 252 school-based health center clinics; 1,553 school-based health center-dental clinics; & 173 family planning clinic sites. In addition, NY has over 220 hospitals including 120 perinatal hospitals & 3 free-standing birthing centers. Despite the substantial health care resources, many areas of the state lack access to needed services due to a maldistribution of resources. As of January 2017, there were 93 primary care Health Professional Shortage Areas (HPSAs) in NYS, 38 dental HPSAs; & 54 mental health HPSAs. Of the total HPSAs, about 38% of HPSAs are located in metropolitan areas; 62% are in rural or mostly rural (non-metropolitan) areas. More than 4 million New Yorkers live in a primary Care HPSA.

The redesign of NY's Medicaid program to improve health care outcomes while containing costs continues as a priority. At the inception of the Medicaid Redesign efforts, NYS's Medicaid (MA) Program, once the nation's largest, was spending nearly $59 billion to serve 6.3 million people, which is twice the national average when compared on a per recipient basis. There was increasing recognition that payment reform was necessary to shift the payment incentives from expensive facility-based care to keeping people

healthy, including management of chronic diseases in ambulatory settings. To better serve patients in the right setting at the right price, NYS has invested in hospital programs, including outpatient clinics, ambulatory surgery, & emergency room; physicians' fees; primary care; freestanding programs;& mental hygiene enhancements.

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

As stated in the FY 2017 Application, the MRT plan includes:

- Care Management for All: NY is moving away from a fee-for-service payment structure that is volume driven to more value driven payment & coordination of care. As a result, the MRT has set NY on a multiyear path to "care management for all." The state has expanded enrollment in the MA Managed Care (MMC) by requiring many of the high need populations which were previously exempted or excluded, to enroll in managed care plans. The MMC provides an organized system of care, an accountable entity and the ability to coordinate and manage care. The Title V program has provided significant support to Office of Health Insurance Programs (OHIP) to plan for the transition of MCH services into managed care including MA waiver programs for children, medically fragile children, children in foster care and school-based health center services.
- Health Homes: a care management model that was initiated in 2016 to serve high-need/high-cost MA populations with expanded care coordination capabilities.
- Global MA Spending Cap: established a two-year state-share dollar cap and a four-year state-share spending cap, monitoring MA expenditures more closely than ever before. A global spending report is published to the MRT website monthly so the public can track performance.

Approximately 228 separate reform initiatives of MRT have been completed and 46 are still in progress. The Title V program developed several MRT proposals to enhance services for the MCH population and partners with OHIP to support MCH-related implementation issues, including an intensive collaboration to develop a children's health home initiative to provide enhanced care coordination for children with chronic physical and/or behavioral health needs.

Since the inception of MRT in 2011, per recipient spending has been reduced from $9,257 to $8,223, bringing spending in line with 2003 levels. Overall spending has been held virtually flat during a period of enrollment growth driven by a weak labor market and the Affordable Care Act. Savings have been reinvested into the health care system, thereby improving quality of care even as enrollment in Medicaid continues to grow. On April 14, 2014, the Governor announced that NY finalized terms and conditions with the federal government for a groundbreaking waiver that allows the state to reinvest $8 billion in federal savings generated by MRT reforms. The waiver amendment dollars address critical issues throughout the state and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program promotes community-level collaborations and focuses on system reform, specifically a goal to achieve a 25 % reduction in avoidable hospital use over five years. Safety net providers are required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement.

NY's Title V program continues to partner with OHIP to address the needs of the MCH population. As a result, increased support for community health navigators, clinical perinatal improvement projects, establishment or expansion of the evidence-based maternal-infant home visiting programs and Community Health Worker programs and population health projects to reduce preterm births, are part of the DSRIP initiative.

Changes in MA have proven they can drive the broader health care system-wide innovations. Building on previous successes, the Governor seeks to align the entire health care system to further improve quality, keep costs low, and improve the experience of care of all New Yorkers. NY was awarded a four-year, nearly $100 million State Innovations Model Testing (SIM) grant by the federal Center for Medicare and MA Innovation, which will support the Governor's State Health Innovation Plan (SHIP), a five-year strategic blueprint that works to give New Yorkers access to high quality, coordinated care. NY developed the SIM grant applications with the support of numerous stakeholders. The state grant began on February 1, 2015 and will continue for four years. In 2016, NY moved towards the integration several population health innovations to improve the health and wellness of all New Yorkers. This includes:

- Prevention Agenda (PA), developed in conjunction with the Public Health Committee of the NYS Public Health and Health Planning Council (PHHPC), and in partnership with more than 140 organizations across the state. The PA focuses on eliminating the profound health disparities across all priority areas including: preventing chronic diseases; promoting a healthy and safe environment; promoting healthy women, infants and children; promoting mental health and preventing substance abuse; and, preventing HIV, sexually transmitted diseases, vaccine-preventable diseases, and healthcare-associated infections.
- State Health Innovation Plan (SHIP) focused on improving access to care for all New Yorkers; integrating care to address patient needs seamlessly; make the cost and quality of care transparent; pay for healthcare value, not volume; promote population health; develop workforce strategy; maximize health information technology; and promote performance measurement and evaluation.
- Medicaid DSRIP Program focused on integrating delivery systems and creating Performing Provider Systems (PPS); performance-based payments; regulatory relief and capital funding; and long-term transformations and health systems sustainability.
- Population Health Improvement Program (PHIP) with regional PHIP contractors that identify, share, disseminate and help implement best practice and strategies to promote population health; support and advance the Prevention Agenda; support and advance the SHIP; and serve as a resource to DSRIP PPS.

Priorities of this integration include integrating behavioral health into primary care as well as addressing broad social determinants of health. This planning and integration also includes Value Based Payments (VBP) - a method to directly tie payment to providers with quality of care and health outcomes to incentivize providers through shared savings and financial risk. By DSRIP Year 5 (2020) all Managed Care Organizations must employ VBP systems that reward value over volume for at least 80-90% of their provider payments. Broad representation is included in VBP workgroups to ensure the standards and guidelines for these payments reflect broad input. Title V staff are involved in the Maternity Care workgroup as well as the Child Health workgroup in the development of the VBP system.

In order to access health care, New Yorkers must have access to health care coverage. Expanding access to health care by making affordable health insurance available is one of the critical accomplishments of the Governor's health care agenda. NYS has aggressively responded to implementation of the ACA. The NYS of Health (NYSOH), the state's official health plan marketplace, was created to assist New Yorkers to gain access to quality affordable health care coverage. As of January 2017, more than 3.5 million New Yorkers were enrolled in coverage and 92 % of those enrolled reported being uninsured at the time of application. Of those enrolled, 229,000 enrolled in private qualified health plans (QHPs); 643,000 enrolled in the state's new Essential Plan (described below); 293,000 enrolled in Child Health Plus (CHP); and, 2.3 million enrolled in Medicaid. New York's uninsured rate fell to 5% in 2015 - its lowest point in decades.

In 2016, NYSOH introduced an affordable health insurance option for New Yorkers. The Essential Plan is available to consumers under the age of 65, not eligible for Medicaid or CHIP, with income at or below 200 percent of the Federal Poverty Level (FPL) ($23,540 for a household of one; $48,500 for a household of four in 2016). Consumers with income at or below 150 percent of the

FPL ($17,655 for a household of one; $36,375 for a household of four in 2016) have no monthly premium. In accordance with Federal requirements, all plans cover essential health benefits including inpatient and outpatient care, physician services, diagnostic services and prescription drugs among others, with no annual deductible and low out of-pocket costs. Preventive care, such as routine office visits and recommended screenings, have no out-of-pocket cost to enrollees. This innovative Basic Health Program (BHP) is one of only two programs nationwide (Washington State is the other) to receive federal approval under the ACA.

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

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

NYS has benefitted from the receipt of ACA funding. Over $3 million in Personal Responsibility Education Program (PREP) funding supports programs designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections. Over $4.3 million in Abstinence Education Grant Program (AEGP) funds are available for an initiative to implement mentoring, counseling and adult-supervised activities, designed to delay the initiation of sexual activity in young people ages 9-12 residing in high-need communities. Over $7.6 million in Maternal, Infant and Early Childhood (MIECHV) funding is being used to implement evidence-based home visiting programs. Over $5 million in Support for Expectant and Parenting Teens, Women, Fathers and Their Families supports high schools and community colleges to help expectant and parenting teens succeed through health and education. Over $12 million in ACA funds have been used to support chronic disease prevention programs, including smoking cessation; evidence-based cancer screening and detection programs; implementation of comprehensive population-based strategies in community and health systems setting to prevent obesity, diabetes, heart disease and stroke, and to reduce health disparities among adults. Overall, ACA funding has provided NYS with tremendous opportunities to improve and enhance NY's MCH services and eliminate disparities. NY will continue to monitor the actions on the federal level to assess the impact of "Repeal and Replace" on the health care of New Yorkers in general, and the MCH population in particular.

The Governor continues to support significant legal, economic and health efforts that will have a positive impact upon the MCH population. This is evident in the 2017-18 Enacted Budget and legislative enactments that include:

- An expansion of Medicaid coverage for donor breast milk and certain infertility services.
- New York is now home to the nation's first accessible college program - The Excelsior Scholarship. Under this groundbreaking program, more than 940,000 middle-class families and individuals making up to $125,000 per year will qualify to attend college tuition-free at all CUNY and SUNY two- and four-year colleges in NYS. The new program begins in the fall of 2017 and will be phased in over three years
- Many direct service professionals (DSPs) serving individuals with disabilities in NYS earn an average of $10-$13 per hour – just above the state's minimum wage. In 2016, NYS implemented minimum wage increases that did not provide funding to account for the "compression factor" - the need to increase the salaries for more experienced DSPs and supervisors in order to maintain the current salary gap with minimum wage workers. This year's budget included funding to address this inequity to decrease the existing high turnover rate among those providing these critical services.
- The Governor signed the Clean Water Infrastructure Act – a $2.5 billion investment in drinking water infrastructure, clean water infrastructure and water quality protection across New York. This investment will help local governments pay for local infrastructure construction projects, address water emergencies, and investigate and mitigate emerging contaminants to ensure access to clean, drinkable water for all New Yorkers.
- Passage of Raise the Age ended decades-long injustice by raising the age of criminal responsibility, ensuring that 16- and 17-year-olds who commit non-violent crimes are processed as juveniles in the State's justice system. As part of the budget agreement, young people will now receive the intervention and evidence-based treatment they need and will no longer be permitted to be housed in adult facilities or jails.
- With the Liberty Defense Project, NYS launches the first-in-the-nation, state-led public-private project to assist immigrants, regardless of status, in obtaining access to legal services and process. The Liberty Defense Project will be administered by the state's Office for New Americans and will be run in partnership with law firms, legal associations, advocacy organizations, major colleges and universities, and bar associations.
- The budget also included significant support for education including investing in prekindergarten to expand high-quality half-day and full-day prekindergarten for three- and four-year-old children in high-need school districts; Community Schools to support the continued transformation of high-need schools into community hubs. Funding supports services that are unique to each school's individual needs, including before-and-after school programs, summer learning activities, medical and dental care, and other social services; and the Empire State After-School Program that increases NYS's after-school investment for public after-school programs in the state's 16 Empire State Poverty Reduction Initiative.
- The Governor remains deeply committed to women's rights. Under Governor Cuomo's leadership, New York is taking action to secure and guarantee access to reproductive health care for all women in the State. Access to reproductive health care is a fundamental pillar of women's equality and NY will continue to stand tall with all women by safeguarding their most basic rights.
- In order to protect New Yorkers' job security and earnings during new and unexpected life events, the Paid Family Leave Act was passed in 2016 that provides 12 weeks of job protected leave when caring for an infant, a family member with a serious health condition or to relieve family pressures when someone is called to active military service and cover all employees, regardless of business size.
- In 2016, the Governor issued a new directive to ensure that insurers do not unfairly discriminate against pregnant and postpartum women. Under New York Insurance Law, insurers cannot refuse to issue, renew, or cancel any insurance policy because of any past treatment for a mental disability, including maternal depression and are prohibited from limiting the amount, type of coverage, or charging a different rate for the same coverage solely because of a previous diagnosis of depression. Insurers offering group or individual health coverage must provide, with no copayment, coinsurance or deductible, preventative services such as depression screenings for pregnant and postpartum women.
- The Middle Class Recovery Act proposes a Child Care Tax Credit as well as the creation of 22,000 new after school program slots in high need areas across the state where children do not have a safe and supportive place to go after school.
- Implementing a plan to decrease new HIV infections to end the AIDS epidemic in NY including linking populations at greatest risk for HIV/AIDS to PrEP and a statewide public awareness campaign related to HIV Prevention.

Addressing the needs of the MCH population in NYS is complex and requires strong partnerships and collaborations. Analysis of data from a wide variety of sources, including MCH Program data, provides a substantial window into the needs of the MCH population. DFH works very closely with the other Divisions within CCH, as well as with the major organizational segments of DOH whose work complements that of DFH, to identify and address MCH priorities especially related to elimination of health disparities. A priority of the DFH is to promote performance-based, evidence-based practice with a clear understanding of DFH priorities and outcomes.

The DFH communicates regularly with the MCHSBG Advisory Council, the MCH committee of the New York State Association of County Health Officials, the NYC Department of Health and Mental Hygiene (NYCDHMH), Parent to Parent of NYS, with various stakeholders and MCH contractors, and through consumer surveys and forums. This communication has helped to identify global MCH priorities, as well as specific priorities at a regional level, for example, a lack of prenatal or obstetric services, strategies to improve access to Long Acting Reversible Contraception (LARC), among others. These regular communication mechanisms have also been useful vehicles to convey important information to the MCH community, for example, information regarding addressing health outbreaks affecting the MCH population such as Zika.

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

The functions, powers and duties of DOH, the Commissioner of Health and other DOH officers and employees are detailed in PHL Article 2. Some important powers granted by the legislature to DOH and the Commissioner include: supervision and funding of local health activities; the ability to receive and expend funds for public health purposes; reporting and control of disease; control and supervision of abatement of nuisances affecting public health; and to serve as the single state agency for the federal Title XIX (MA) program. Article 2 also provides that DOH shall exercise all functions that, "…hereafter may be conferred and imposed on it by law." Law governing the organization and operation of NY's local public health infrastructure, which includes the health departments of 57 counties and the City of NY, is contained in PHL Article 3, Local Health Organization. Local health departments are supported by millions of state local assistance dollars, which the DOH administers under the provisions of PHL Article VI, State Aid to Cities and Counties, providing further support for services targeting NY's MCH population.
A key determinant of DOH's capacity to serve mothers, infants and children is PHL Article 7, Federal Grants-in-Aid, which specifically authorizes DOH to "…administer the provisions of the federal social security act or any other act of congress which relate to maternal and child health services, the care of children with physical disabilities and other public health work and to co-operate with the duly constituted federal authorities charged with the administration thereof." This provision not only empowers DOH to obtain and distribute Title V funds, but also those from Title X of the PHS Act, WIC, and other federal resources essential to the health of the MCH population.

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

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

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

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

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

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

.

II.B. Five Year Needs Assessment Summary and Updates

FY 2018 Application/FY 2016 Annual Report Update

II B. Five Year Needs Assessment (NA) Summary
2017 Five Year Needs Assessment Summary
II. B. 1. Process

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

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

II.B.2 Findings
II.B.2.a MCH Population Needs

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

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

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

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

Title V continued to assess other factors impacting women's health. Although maternal depression screening has increased in the Medicaid Prenatal Care Program (36% during the initial prenatal care visit and 51.4% in the postpartum visit in 2014 – to 84.9% and 84.4% respectively), there is much work to be done to promote screening as well as services for women who screen positive for

depression. Effective in 2016 the NYS Medicaid program allows providers of infant healthcare to bill for postpartum maternal depression screening under the infant's Medicaid number. NY continues to address the opioid epidemic. As stated in the Annual Report section, significant interagency efforts are underway to implement a coordinated effort to address this public health priority.

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

Domain 2: Perinatal and Infant Health

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

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

Domain 3: Child Health

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

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

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

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

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

Domain 5: Adolescent Health

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

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

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

Domain 6: Cross-Cutting & Life Course

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

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

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

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

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

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

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

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

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

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

Domain 1: Women's & Maternal Health

No updates

Domain 2: Perinatal & Infant Health

No updates

Domain 3: Child Health

No updates

Domain 4: Children with Special Health Care Needs

No updates

Domain 5: Adolescent Health

No updates

Domain 6: Cross-cutting & Life Course

No updates

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

Included in Supporting Documents

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

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

II.B.1.

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

II.B.2

II.B.2.a

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

Domain 1: Maternal & Women's Health

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

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

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

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

Domain 2: Perinatal and Infant Health

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

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

within and outside of DOH.

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

Domain 3: Child Health

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

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

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

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

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

Domain 5: Adolescent Health

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

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

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

Domain 6: Cross-Cutting & Life Course

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

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

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

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

II.B.2.b. Program Capacity

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

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

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

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

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

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

Domain 3: Child Health No updates to this section.

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

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

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

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

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

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

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

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

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

II.B.1. Process

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

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

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

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

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

II.B.2. Findings

II.B.2.a. MCH Population Needs

Domain 1: Maternal & Women's Health

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

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

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

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

Key successes to build on in NYS include:

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

health and family planning practices.

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

"The family planning learning collaborative provided a platform

to engage in an educated discussion about how to improve

performance regarding contraceptives and LARC"

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

Domain 2: Perinatal and Infant Health

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

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

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

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

"Mothers need support to be healthy and to keep their

babies healthy; services like home visiting help families"

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

"We need to employ more people in front line

positions to reflect the communities we serve"

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

Domain 3: Child Health

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

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

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

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

They have more important things to deal with"

Key NYS successes to build on include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Domain 5: Adolescent Health

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

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

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

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

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

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

Key successes to build on in NYS include:

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

evidence- and theory-based youth programming.

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

Domain 6: Cross-Cutting & Life Course

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

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

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

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

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

"My kids would be healthier if they could

go out to play instead of watching TV"

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

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

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

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

II.B.2.b Title V Program Capacity

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

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

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

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

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

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

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

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

Domain 1: Women's & Maternal Health

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

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

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

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

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

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

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

Domain 2: Perinatal & Infant Health

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

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

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

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

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

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

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

Domain 3: Child Health

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

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

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

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

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

Domain 4: Children with Special Health Care Needs

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

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

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

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

Domain 5: Adolescent Health

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

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

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

Domain 6: Cross-cutting & Life Course

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rachel Gaul, MBA, Director, Bureau of Administration

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

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

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

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

II.C. State Selected Priorities

No.	Priority Need
1	Reduce maternal mortality and morbidity
2	Reduce infant mortality & morbidity
3	Support and enhance social-emotional development and relationships for children and adolescents
4	Increase supports to address the special health care needs of children and youth
5	Increase the use of preventive health care services across the life course.
6	Promote oral health and reduce tooth decay across the life course
7	Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course.
8	Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).

II.C. State Selected Priorities

As a result of the NA Summary contained in NY's Year 1 (FFY 2016) application, NYS selected eight MCH priorities for 2016-20:

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

The process to select and refine NY's Title V priorities was outlined in the FY 2016 and FY 2017 Application. Building on this model of collaboration and coordination, NY's Title V Program moved further into implementation of the strategies to advance the eight MCH priorities.

As stated in II.B. NA Process of this Application, cross functional teams were developed to move forward on the implementation of the strategies identified in NY's Title V SAP. The development of these teams was significant as it promoted not only cross-Division, but cross-agency collaboration. These cross-functional teams are comprised of professionals across the DFH (Bureaus of Child Health, Early Intervention, Women, Infant and Adolescent Health and Administration- Refer to NYSDOH Organizational charts in Section V. Supporting Documents) with varied skills, background and expertise, representing the breadth of MCH. These teams were developed for each State Priority (SP) area, including Health Equity. All teams are comprised of a lead as well as staff with programmatic experience in the priority area, at least one staff with research/analytic skills and a representative from the Health Equity team to better ensure a health equity lens is brought to each area.

The focus of NY's Title V Program over the past year was to work collaboratively to implement, or initiate implementation of the strategies contained in the SAP, and review and assess the validity of the State Performance Measures (SPM) and Evidence-Based Strategy Measures (ESMs) identified in NY's FY2017 Application. An important component of each SP is accessibility to quality data to determine MCH priorities, actions and to evaluate impact of those actions. This component was identified as essential early in the planning stages of the SAP not only for NY's Title V Program, but for partners on the state, regional and local level. As stated in the Annual Report section, the Title V Program is collaborating with the DOH Office of Public Health Practice (OPHP) to develop a MCH Dashboard modeled on the DOH Prevention Agenda (PA) Dashboard that will serve as a blueprint for state and local organizations to improve the health of the MCH population in the SPs identified in the SAP including to improve health equity. Tracking indicators are being developed to assess the current MCH population's health status and to monitor how the overarching goal and priority objectives are being met. It will serve as an interactive visual presentation of the Title V SAP tracking indicator data at national, state and county levels (where available). It will serve as a key source for monitoring progress that communities around the state have made with regards to meeting the SAP objectives.

Teams also continued their focus on promoting action in identified strategy areas or tracking progress when the action was focused outside of the DFH. As evidenced in the Annual Report and Application section of this document, progress was also made on fostering collaborative work to maximize existing resources in fulfillment of the objectives of the SAP.

Throughout the year, teams provided updates to the leadership staff and MCHSBG Advisory Council members at the Council's meetings to ensure the strategy and direction were clear and partnerships were identified and facilitated to better ensure achievement of the 2020 State Objectives. Discussions were also held with the entire DFH leadership to ensure comprehensive, collaborative approaches for each strategy and to refine SPMs and/or ESMs where necessary. The Title V Program also engaged in an extensive Public Input process (See IIF. Public Input) to guide implementation and future MCH priorities.

The Priority Results Table (Attachment 3) compares the eight priorities selected for 2016-20 to the previous 2011-2015 priorities (note that several priorities appear more than once in the table as they apply to more than one domain). The priorities reflect a comprehensive and systematic approach to improving the health of the MCH population based on NY's NA and public input. Many priorities have been expanded or refined from the previous 5-year cycle to reflect the key needs and opportunities identified in NY's state NA.

Overall, there was consensus among the leadership group, Council members and key stakeholders about the priority areas selected and strategies planned to address these priorities. Details of priorities by population health domain are presented below.

Domain 1: Maternal/Women Health

Priority 1: Reduce maternal mortality and morbidity

NY will continue its focus on maternal mortality. Although it appears to be improving, NY's maternal mortality rate continues to demonstrate significant racial disparity. This focus has been expanded to include maternal morbidity as well as maternal depression and opioid abuse. By examining severe maternal morbidity, NY's Title V Program can highlight aspects which need immediate consideration, such as hemorrhage and hypertension, to focus interventions for improvement. Maternal depression and increasing use of opioids were identified as key emerging issues with significant implications for both maternal health outcomes and infants' and children's health and social-emotional development (*Domains 2 & 3*). Addressing disparities will also continue specific to maternal mortality and through cross-cutting focus (*Domain 6*).

Also closely linked to this priority, NY will continue and expand work associated with the use of preventive services by women of reproductive age (*Domain 6)*. Previous work has focused primarily on prenatal care along with reducing and eliminating disparities in birth outcomes and unintended pregnancies. There is increasing recognition that further improvements in birth outcomes for both women and infants require focus on women's health before (preconception) and between (interconception) pregnancies, reinforced by NA findings demonstrating high rates of unintended pregnancy and the impact of chronic health conditions on maternal mortality.

While NY continues efforts to increase early enrollment in prenatal care and improve the quality and effectiveness of that care, there is an expanded focus on the use and quality of "well woman" preventive services, with particular focus on the integration of pregnancy planning and prevention in primary care for all women and especially for women with known risk factors. The development and expansion of the Partnership for Maternal Health (Refer to the Annual Report and Application for Maternal and Women's Health Domain) demonstrates a strong commitment to enhancing collaborative efforts to achieve the 2020 State Objectives. This priority also aligns with NYS's Infant Mortality (IM) CoIIN as well as major healthcare reform efforts in NYS, thus providing opportunities to leverage and strengthen collaborations with key external partners and internally with the NY SOH, Medicaid DSRIP, HH, and the SHIP/Advanced Primary Care initiative.

Domain 2: Perinatal/Infant Health

Priority 2: Reduce infant mortality and morbidity

NY will continue a priority focus on reducing infant mortality and morbidity. Within this priority, key focus areas include prevention of unintended pregnancy, preterm birth, perinatal regionalization, home visiting, and safe sleep, which align with the DOH's PA and national IM CoIIN Initiative as discussed in further detail in NY's Annual Report and Application for Perinatal and Infant Health Domain. Efforts have begun on revamping NY's system of perinatal regionalized care. New quality improvement efforts have begun on priority areas such as increasing the use of Antenatal Corticosteroid Treatment and Safe Sleep efforts will continue. Title V staff are pursuing efforts to increase recruitment and retention in evidence-based home visiting programs. NY will continue to focus on enrollment of infants in affordable health insurance and primary medical care and on reducing disparities in birth outcomes (*Domain 6*).

Domain 3 & 5: Child & Adolescent Health

Priority 3: Support and enhance social-emotional development and relationships for children and adolescents

NY's shared priority for child and adolescent health reflects consistent stakeholder input concerning the impact of poverty, toxic stress, critical periods of development and social-emotional relationships on lifelong health and well-being. These factors have profound influence on health outcomes across the life course including weight status/obesity, behavioral health, risk-taking behavior, school success and future birth outcomes and parenting practices. While there has been significant attention to social-emotional development for very young children, our NA highlighted the importance of continuing to support and nurture social-emotional development and healthy relationships throughout development. Moreover, a balanced approach is needed that supports population-based positive development and asset-building strategies with strategies to recognize and support specific behavioral health needs, adverse experiences and trauma. Work has begun to identify evidence-based and promising practice, and build awareness and capacity for measuring and addressing social-emotional wellness, behavioral health and trauma within clinical primary care and public health programs and services.

This priority is closely related to the *Domain 6* priorities to support healthy home and community environments, promote use of preventive health care services and reduce health disparities, and is linked to the *Domain 1* focus on addressing maternal depression. It also aligns with existing partnerships with the state Office of Mental Health, Early Childhood and Early Intervention Advisory Councils and the Office of Children and Family Services (OCFS). This priority will enable the Title V program to collaborate with other DOH programs as well as other state agencies to achieve collective impact.

Domain 4: Children and Adolescents with Special Health Care Needs

Priority 4: Increase supports to address the special health care needs of children and youth.

Supporting the health and well-being of the growing population of children and youth with special health care needs and their families remains a foundational priority for NY's Title V program. As discussed in NY's FY 2017 Application, efforts are underway to conduct a systematic analysis, including system mapping, of the current and emerging service system to identify specific gaps, barriers and ensure resources are fully leveraged. Key partners such as the MCHSBG Advisory Council, Parent to Parent of NYS, families, other key stakeholders will continue to be engaged through this process. NY's Title V Program will continue to emphasize previously identified priority areas that include strengthening family engagement and support, care management/care coordination and transition supports for youth and young adults with special health care needs. Further work will also continue on follow-up of newborn hearing screening results and developing a model of transition services for children and adolescents with sickle cell disease.

This priority closely aligns with NY's current work to implement a tailored Medicaid *HH* benefit for CSHCN pursuant to ACA, in which the Title V program has been extensively engaged. *HH* is a key strategy to improve care coordination and transition supports for CSHCN that will help meet medical and behavioral needs of CSHCN, improve health and school attendance and lessen the stress on families, all of which were voiced as priorities by our stakeholders. This priority also aligns with a major systems improvement initiative to strengthen family support and family outcomes within the EI program, which serves a key population of CSHCN and can be leveraged to identify effective practices to disseminate to additional public health programs. This priority also links to the *Domain 3 & 5* priority on supporting social-emotional well-being and the *Domain 6* life course priorities.

Domain 6: Cross-cutting Life Course

Priority 5: Increase the use of preventive health care services across the life course

Priority 6: Promote oral health and reduce tooth decay across the life course

Priority 7: Promote supports and opportunities that foster healthy home and community environments

Priority 8: Reduce racial, ethnic, economic and geographic disparities and promote health equity for the MCH population

The introduction of the life course framework for the Title V application has promoted and supported NY's Title V Program to re-frame many of NY's MCH priorities as needs that cut across all MCH populations and life course stages. It has also supported NY's efforts to specifically address health equity as a priority that encompasses all MCH populations throughout the lifespan. Differences in health outcomes are closely linked with social, economic, and environmental disadvantage and driven by the social conditions in which individuals and families live, learn, work and play. These "social determinants of health", beyond health insurance and health care, drive disparities in MCH health outcomes.

An emphasis will continue on educating all Title V staff to understand health disparities and health equity. Each SP also identifies and addresses a health equity component to ensure NY's Title V Program incrementally addresses health equity for the MCH population.

This cross-cutting, life course perspective was reaffirmed in the continued work over the past year. Efforts will continue to integrate oral health into all public health programs and practices as well as fostering healthy home and community environments for families to grow and learn. Finally, improving access to primary and preventive health care for all New Yorkers is key in addressing all SP and as well as health disparities.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

II.C. State Selected Priorities

As a result of the NA Summary contained in NY's Year 1 (FFY 2016) application, NYS selected eight MCH priorities for 2016-20:

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

The process to select and refine NY's Title V priorities was outlined in the FY 2016 and FY 2017 Application. Building on this model of collaboration and coordination, NY's Title V Program moved further into implementation of the strategies to advance the eight MCH priorities.

As stated in II.B. NA Process of this Application, cross functional teams were developed to move forward on the implementation of the strategies identified in NY's Title V SAP. The development of these teams was significant as it promoted not only cross-Division, but cross-agency collaboration. These cross-functional teams are comprised of professionals across the DFH (Bureaus of Child Health, Early Intervention, Women, Infant and Adolescent Health and Administration- Refer to NYSDOH Organizational charts in Section V. Supporting Documents) with varied skills, background and expertise, representing the breadth of MCH. These teams were developed for each State Priority (SP) area, including Health Equity. All teams are comprised of a lead as well as staff with programmatic experience in the priority area, at least one staff with research/analytic skills and a representative from the Health Equity team to better ensure a health equity lens is brought to each area.

The focus of NY's Title V Program over the past year was to work collaboratively to implement, or initiate implementation of the strategies contained in the SAP, and review and assess the validity of the State Performance Measures (SPM) and Evidence-Based Strategy Measures (ESMs) identified in NY's FY2017 Application. An important component of each SP is accessibility to quality data to determine MCH priorities, actions and to evaluate impact of those actions. This component was identified as essential early in the planning stages of the SAP not only for NY's Title V Program, but for partners on the state, regional and local level. As stated in the Annual Report section, the Title V Program is collaborating with the DOH Office of Public Health Practice (OPHP) to develop a MCH Dashboard modeled on the DOH Prevention Agenda (PA) Dashboard that will serve as a blueprint for state and local organizations to improve the health of the MCH population in the SPs identified in the SAP including to improve health equity. Tracking indicators are being developed to assess the current MCH population's health status and to monitor how the overarching goal and priority objectives are being met. It will serve as an interactive visual presentation of the Title V SAP tracking indicator data at national, state and county levels (where available). It will serve as a key source for monitoring progress that communities around the state have made with regards to meeting the SAP objectives.

Teams also continued their focus on promoting action in identified strategy areas or tracking progress when the action was focused outside of the DFH. As evidenced in the Annual Report and Application section of this document, progress was also made on fostering collaborative work to maximize existing resources in fulfillment of the objectives of the SAP.

Throughout the year, teams provided updates to the leadership staff and MCHSBG Advisory Council members at the Council's meetings to ensure the strategy and direction were clear and partnerships were identified and facilitated to better ensure achievement of the 2020 State Objectives. Discussions were also held with the entire DFH leadership to ensure comprehensive, collaborative approaches for each strategy and to refine SPMs and/or ESMs where necessary. The Title V Program also engaged in an extensive Public Input process (See IIF. Public Input) to guide implementation and future MCH priorities.

The Priority Results Table (Attachment 3) compares the eight priorities selected for 2016-20 to the previous 2011-2015 priorities (note that several priorities appear more than once in the table as they apply to more than one domain). The priorities reflect a comprehensive and systematic approach to improving the health of the MCH population based on NY's NA and public input. Many priorities have been expanded or refined from the previous 5-year cycle to reflect the key needs and opportunities identified in NY's state NA.

Overall, there was consensus among the leadership group, Council members and key stakeholders about the priority areas selected and strategies planned to address these priorities. Details of priorities by population health domain are presented below.

Domain 1: Maternal/Women Health

Priority 1: Reduce maternal mortality and morbidity

NY will continue its focus on maternal mortality. Although it appears to be improving, NY's maternal mortality rate continues to demonstrate significant racial disparity. This focus has been expanded to include maternal morbidity as well as maternal depression and opioid abuse. By examining severe maternal morbidity, NY's Title V Program can highlight aspects which need immediate consideration, such as hemorrhage and hypertension, to focus interventions for improvement. Maternal depression and increasing use of opioids were identified as key emerging issues with significant implications for both maternal health outcomes and infants' and children's health and social-emotional development (*Domains 2 & 3*). Addressing disparities will also continue specific to maternal mortality and through cross-cutting focus (*Domain 6*).

Also closely linked to this priority, NY will continue and expand work associated with the use of preventive services by women of reproductive age (*Domain 6)*. Previous work has focused primarily on prenatal care along with reducing and eliminating disparities in birth outcomes and unintended pregnancies. There is increasing recognition that further improvements in birth outcomes for both women and infants require focus on women's health before (preconception) and between (interconception) pregnancies, reinforced by NA findings demonstrating high rates of unintended pregnancy and the impact of chronic health conditions on maternal mortality.

While NY continues efforts to increase early enrollment in prenatal care and improve the quality and effectiveness of that care, there is an expanded focus on the use and quality of "well woman" preventive services, with particular focus on the integration of pregnancy planning and prevention in primary care for all women and especially for women with known risk factors. The development and expansion of the Partnership for Maternal Health (Refer to the Annual Report and Application for Maternal and Women's Health Domain) demonstrates a strong commitment to enhancing collaborative efforts to achieve the 2020 State Objectives. This priority also aligns with NYS's Infant Mortality (IM) CoIIN as well as major healthcare reform efforts in NYS, thus providing opportunities to leverage and strengthen collaborations with key external partners and internally with the NY SOH, Medicaid DSRIP, HH, and the SHIP/Advanced Primary Care initiative.

Domain 2: Perinatal/Infant Health

Priority 2: Reduce infant mortality and morbidity

NY will continue a priority focus on reducing infant mortality and morbidity. Within this priority, key focus areas include prevention of unintended pregnancy, preterm birth, perinatal regionalization, home visiting, and safe sleep, which align with the DOH's PA and national IM CoIIN Initiative as discussed in further detail in NY's Annual Report and Application for Perinatal and Infant Health Domain. Efforts have begun on revamping NY's system of perinatal regionalized care. New quality improvement efforts have begun on priority areas such as increasing the use of Antenatal Corticosteroid Treatment and Safe Sleep efforts will continue. Title V staff are pursuing efforts to increase recruitment and retention in evidence-based home visiting programs. NY will continue to focus on enrollment of infants in affordable health insurance and primary medical care and on reducing disparities in birth outcomes (*Domain 6*).

Domain 3 & 5: Child & Adolescent Health

Priority 3: Support and enhance social-emotional development and relationships for children and adolescents

NY's shared priority for child and adolescent health reflects consistent stakeholder input concerning the impact of poverty, toxic stress, critical periods of development and social-emotional relationships on lifelong health and well-being. These factors have profound influence on health outcomes across the life course including weight status/obesity, behavioral health, risk-taking behavior, school success and future birth outcomes and parenting practices. While there has been significant attention to social-emotional development for very young children, our NA highlighted the importance of continuing to support and nurture social-emotional development and healthy relationships throughout development. Moreover, a balanced approach is needed that supports population-based positive development and asset-building strategies with strategies to recognize and support specific behavioral health needs, adverse experiences and trauma. Work has begun to identify evidence-based and promising practice, and build awareness and capacity for measuring and addressing social-emotional wellness, behavioral health and trauma within clinical primary care and public health programs and services.

This priority is closely related to the *Domain 6* priorities to support healthy home and community environments, promote use of preventive health care services and reduce health disparities, and is linked to the *Domain 1* focus on addressing maternal depression. It also aligns with existing partnerships with the state Office of Mental Health, Early Childhood and Early Intervention Advisory Councils and the Office of Children and Family Services (OCFS). This priority will enable the Title V program to collaborate with other DOH programs as well as other state agencies to achieve collective impact.

Domain 4: Children and Adolescents with Special Health Care Needs

Priority 4: Increase supports to address the special health care needs of children and youth.

Supporting the health and well-being of the growing population of children and youth with special health care needs and their families remains a foundational priority for NY's Title V program. As discussed in NY's FY 2017 Application, efforts are underway to conduct a systematic analysis, including system mapping, of the current and emerging service system to identify specific gaps, barriers and ensure resources are fully leveraged. Key partners such as the MCHSBG Advisory Council, Parent to Parent of NYS, families, other key stakeholders will continue to be engaged through this process. NY's Title V Program will continue to emphasize previously identified priority areas that include strengthening family engagement and support, care management/care coordination and transition supports for youth and young adults with special health care needs. Further work will also continue on follow-up of newborn hearing screening results and developing a model of transition services for children and adolescents with sickle cell disease.

This priority closely aligns with NY's current work to implement a tailored Medicaid *HH* benefit for CSHCN pursuant to ACA, in which the Title V program has been extensively engaged. *HH* is a key strategy to improve care coordination and transition supports for CSHCN that will help meet medical and behavioral needs of CSHCN, improve health and school attendance and lessen the stress on families, all of which were voiced as priorities by our stakeholders. This priority also aligns with a major systems improvement initiative to strengthen family support and family outcomes within the EI program, which serves a key population of CSHCN and can be leveraged to identify effective practices to disseminate to additional public health programs. This priority also links to the *Domain 3 & 5* priority on supporting social-emotional well-being and the *Domain 6* life course priorities.

Domain 6: Cross-cutting Life Course

Priority 5: Increase the use of preventive health care services across the life course

Priority 6: Promote oral health and reduce tooth decay across the life course

Priority 7: Promote supports and opportunities that foster healthy home and community environments

Priority 8: Reduce racial, ethnic, economic and geographic disparities and promote health equity for the MCH population

The introduction of the life course framework for the Title V application has promoted and supported NY's Title V Program to re-frame many of NY's MCH priorities as needs that cut across all MCH populations and life course stages. It has also supported NY's efforts to specifically address health equity as a priority that encompasses all MCH populations throughout the lifespan. Differences in health outcomes are closely linked with social, economic, and environmental disadvantage and driven by the social conditions in which individuals and families live, learn, work and play. These "social determinants of health", beyond health insurance and health care, drive disparities in MCH health outcomes.

An emphasis will continue on educating all Title V staff to understand health disparities and health equity. Each SP also identifies and addresses a health equity component to ensure NY's Title V Program incrementally addresses health equity for the MCH population.

This cross-cutting, life course perspective was reaffirmed in the continued work over the past year. Efforts will continue to integrate oral health into all public health programs and practices as well as fostering healthy home and community environments for families to grow and learn. Finally, improving access to primary and preventive health care for all New Yorkers is key in addressing all SP and as well as health disparities.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy
- 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.
- SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets
- 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
- SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water

E. Linkage of State Selected Priorities with State Performance and Outcome Measures

SPMs for NY's MCH Action Plan were determined through the needs assessment conducted by NYS that consisted of extensive data analysis and evaluation, stakeholder input and discussion as well as the discussions related to selection of state priorities. The eight NPMs selected for focus are listed in the following table. Additional SPMs were then developed to further identify progress in State priorities where NPMs were insufficient to do so. Section II.F.1 State Action Plan Narrative clearly outlines the linkages of all performance measures contained in NYS's Action Plan. The information below summarizes the significance of the SPMs identified by NY in order to assess improvement in the selected MCH priorities. Alignment of selected SPMs with NY's priorities and federally-defined MCH population domains is contained in the table below.

MCH Priorities, State Performance Measures and Federal Population Domains

2016-2020 MCH Priority	National and State Performance Measure	Population Domain(s)
#1 Reduce maternal mortality and morbidity	NPM 1 - Percent of women with a past year preventive visit. **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.** **SPM 2 – The percentage of women age 15-44 years and enrolled in Medicaid using the most effective or moderately effective methods of contraception.**	Maternal / Women Health
#2 Reduce infant mortality and morbidity	NPM 3 -Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) NPM 5 - Percent of infants placed to sleep on their backs	Perinatal / Infant Health
#3 Support and enhance social-emotional development and relationships for children and adolescents	NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool NPM 10 - Percent of adolescents with a preventive services visit in the last year NPM 12 - Percent of children with special health care needs who received services necessary to make transitions to adult health care. **SPM 3 – Percent of children and adolescents surveyed who demonstrate 20 or more developmental assets.**	Child Health/ Adolescent Health
#4 Increase supports to address the special health care needs of children and youth	NPM 6 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool NPM 12 -Percent of children with special health care needs who received services necessary to make transitions to adult health care.	Children and Adolescents with Special Health Care Needs

	SPM 4 – Percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the NY Impact on Family Scale.	
#5 Increase use of preventive health care services across the life course.	NPM 1 -Percent of women with a past year preventive visit NPM 6 -Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool NPM 10 - Percent of adolescents with a preventive services visit in the last year. **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.** **SPM 2 – The percentage of women age 15-44 years and enrolled in Medicaid using the most effective or moderately effective methods of contraception.**	Cross-cutting Life Course Maternal/Women Health Perinatal/InfantHealth Child Health/ Adolescent Health
#6 Promote oral health and reduce tooth decay across the life course	NPM 13a - Percent of women who had a dental visit during pregnancy NPM 13b - Percent of infants and children, ages 1 to 17 years, who had a preventive dental visit in the last year. **SPM 5 – Percent of NYS residents served by community water systems that have optimally fluoridated water.**	Cross-cutting Life Course Maternal/Women Health Child Health Adolescent Health
#7 Promote home and community environments that support health, safety, physical activity and healthy food choices	NPM 8 - Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day	Cross-cutting Life Course Child Health/ Adolescent Health
#8 Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population	Use in stratifying measures	Cross-cutting Life Course All domains

Priority #1 Maternal mortality and morbidity will be followed by NPM1 percent of women with a past year preventive visit for all women as discussed in Section II.D. Progress toward achievement of objectives and outcomes associated with Priority #1 will be tracked through NPM #1. Due to the significant impact primary and preventive health care can have on maternal mortality and morbidity, two state performance measures (SPM) were identified: **SPM 1: The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy and SPM 2: The percentage of women age 15-44 years and enrolled in Medicaid using the most effective or moderately effective methods of contraception.** These SPMs address key elements of preconception health care and will build on collaborations that NY's Title V Program has developed with the DOH Division of Chronic Disease Prevention (DCDP)/BRFSS (SPM 1), and DOH OHIP and Office of Quality and Patient Safety (OQPS) for NY's IM CoIIN initiative and CDC-led 6|18 initiative (SPM 2).

Priority #2 Infant mortality and morbidity will be followed by multiple NPMs including: NPM 3: Percent of Very Low Birth Weight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) and NPM 5: Percent of infants placed to sleep on their backs. There have been no additional SPMs developed for this MCH priority.

Priority #3 Social-emotional development and relationships for children and adolescents will be followed by several NPMs. NMP6: Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool captures a critical (but not sufficient) aspect of supporting children's development. NPM10: Percent of adolescents with a preventive services visit in the last year and NPM12: Percent of adolescents who received services necessary to make transitions to adult health care capture selected elements of supporting adolescent development and relationships.

NY's SAP seeks to focus on a strength-based rather than a deficit model to address this extremely important priority for children and adolescents. Therefore, **SPM 3: Percentage of adolescents surveyed who demonstrate 20 or more developmental assets** has been added to NY's SAP. Significant effort is being devoted to the identification of tools and strategies to address this priority area. Title V staff will continue to work with the ACT for Youth Center of Excellence to develop or modify a tool that can be used by child and adolescent-serving MCH programs across age groups to support and enhance positive youth development to improve outcomes in this MCH priority.

Priority #4 Supports for children and youth with special health care needs will be followed by a series of measures including NPM6: Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool, NPM12: Percent of children with special health care needs who received services necessary to make transitions to adult health care, and a new **SPM 4: Percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the NY Impact on Family Scale.** Pursuant to a requirement of the U.S. Department of Education, Office of Special Education Programs (OSEP) for the Individuals with Disability Education Act (IDEA) Part C state programs, New York's EIP developed a State Systemic Improvement Plan (SSIP). OSEP required that the SSIP be focused on a child outcome, family outcome, or on a constellation of outcomes related to the child and family outcome indicators currently reported to OSEP. (Refer to Section II.F.1 State Action Plan Narrative for further detail.) NY is focusing on positive family outcomes for NY's State Identified Measurable Results with a goal to increase the percentage of families exiting the EIP who report that the EIP helped them achieve the level of positive family outcomes defined in conjunction with stakeholders as representing the State Standard. Lessons from this initiative will inform NY's efforts in enhancing supports for CSHCN and their families to improve efforts such as developing or improving supports for the transitions families and youth experience as they access the myriad of services and service systems throughout the child/young adult's life.

Priority #5 Use of preventive and primary health care services across the life course will be followed through several measures reflecting health care service utilization and quality for key life course periods including: NPM1: Percent of women with a past year preventive visit; NPM6: Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool measures a key recommended component of comprehensive well child care; and, NPM10: Percent of adolescents with a preventive services visit in the last year.

As stated in the State Action Plan Narrative, across the MCH life course, preventive health care services encompass well woman, preconception, prenatal, postpartum, interconception, well baby, well child and well teen care. Given the potential breadth of this priority, Title V staff considered fundamental cross-cutting needs to support use of preventive health care as well as specific populations and areas of clinical practice most in need of improvement, based on analysis of available data and stakeholder input. Important resources for development of this priority include the US Preventive Services Task Force (USPSTF) recommendations for preventive care; The American Academy of Pediatrics (AAP) *Bright Futures* Guidelines for Health Supervision of Infants, Children and Adolescents; and EPSDT guidelines for state Medicaid programs.

This priority is closely linked to other state priorities in all five other domains, reflecting the key importance of preventive health care services to promoting health across the life course. Therefore, NY has added two SPMs to more fully assess progress in this MCH priority area including: **SPM1: Percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy; and SPM 2: The percentage of women age 15-44 years and enrolled in Medicaid using the most effective or moderately effective methods of contraception.** These SPMs will support NY's ability to assess practices related to preconception/interconception care as well as use of effective, reversible methods of contraception, including Long Acting Reversible Contraception and continue focusing on strategies and processes to improve policies and practices.

Priority #6 Oral health and tooth decay will be followed with NPM13: a and b. NPM13a: Percent of women who had a dental visit during pregnancy, and NPM13b: percent of infants and children, ages 1 to 17 years, who had a preventive dental visit in the last year. NY also included a **SPM5: Percent of NYS residents served by community water systems that have optimally fluoridated water.**

Community Water Fluoridation (CWF) is an essential public health strategy to prevent dental caries and promote oral health for those individuals who are served by public water systems. As described in the 2016 Annual Report, Title V staff, in collaboration with colleagues from the DOH Center for Environmental Health (CEH) lead several key efforts to support CWF. These efforts include implementation of legislation and state funding for CWF enacted in 2015 and again in NY's current Enacted budget, providing $5 million in annual grant funding to support public community water systems for costs related to the construction, installation, repair, rehabilitation, replacement, or upgrade of drinking water fluoridation facilities. Title V and CEH also support onsite technical assistance to fluoridated public water systems, or those looking to start fluoridation. This SPM will enable NY's Title V program to more fully understand the success of the Title V program in promoting CWF and the potential to improve oral health of NY's MCH population.

Priority #8 Healthy home and community environments will be followed by: NPM8: Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day. There have been no additional SPMs developed for this MCH priority.

Priority #9 Racial, ethnic and economic disparities and health equity across all core MCH priorities and outcomes does not align with any specific NPM. Since NYS has diverse populations and noted disparities, all measures will be stratified by racial, ethnic, economic and geographic variables. In the development of NY's MCH Dashboard as discussed in the State Selected Priorities section of this Application, metrics will be included across Domains to provide identification of health equity issues on the state or local level (if available). It is a priority of NY's Title V program to assess all performance measures, wherever possible, by race and ethnicity to more fully understand the needs of the MCH population, develop improved strategies to address those needs and determine the level of success in reducing long-standing racial and other disparities to improve the health and wellness of NY's MCH population.

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

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

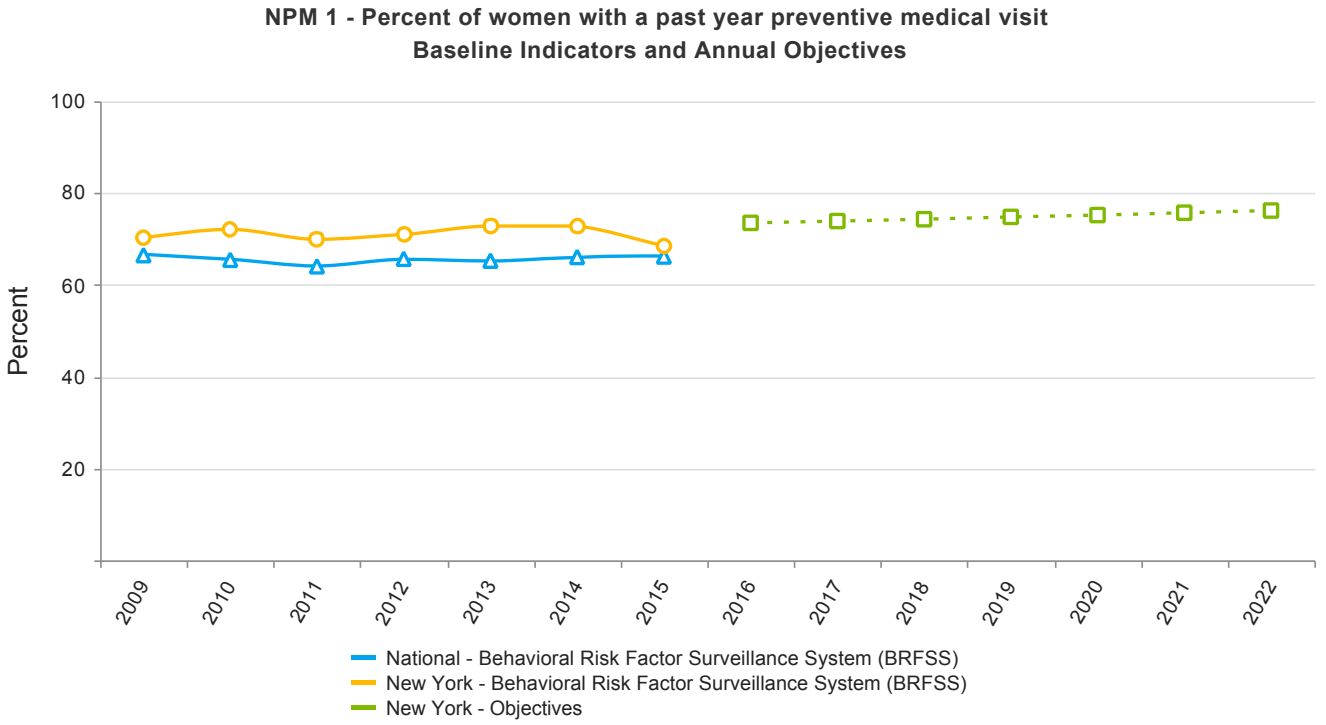
The Action Plan submitted with our Year 2 application established quantitative 2020 targets for objectives, refined strategies, and established state performance measures (SPM) and Evidence-Based/Informed Strategy Measures (ESM). This work was led by cross-programmatic Title V Staff Action Planning Teams. Targets were set based on analysis of data trends and projected impact of strategies. Key considerations for refining strategies included evidence base, feasibility and alignment with stakeholder priorities, with attention to advancing a balanced portfolio of population health surveillance, policy, workforce development, community-based prevention and clinical quality improvement strategies.

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-2014	238.5	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	20.6	NPM 1
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	7.8 %	NPM 1
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.4 %	NPM 1
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	6.5 %	NPM 1
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	8.7 %	NPM 1
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.6 %	NPM 1
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	6.1 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	22.8 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	5.5	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	4.6	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	3.2	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.4	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	175.9	NPM 1

National Performance Measures



Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	73.4
Annual Indicator	68.4
Numerator	2,471,455
Denominator	3,612,104
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	73.8	74.2	74.7	75.1	75.6	76.1

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Number of Title V programs for which health equity analyses are completed

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	5
Numerator	
Denominator	
Data Source	Title V Program Records
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	10.0	15.0	20.0	25.0	25.0

ESM 1.2 - a) Number of Equity Action Team meetings held; b) Number of DFH staff who have completed one or more Equity Learning Labs

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	50
Numerator	
Denominator	
Data Source	Title V Program recoDFH Personnel training records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	30.0	40.0	50.0	60.0	60.0

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
Annual Objective	
Annual Indicator	5
Numerator	
Denominator	
Data Source	Title V Program Records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	40.0	50.0	60.0	70.0	80.0	90.0

ESM 1.4 - Percentage of DFH procurements that demonstrate inclusion of evidence-based/-informed community engagement and collective impact strategies.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	47
Numerator	
Denominator	
Data Source	Title V Program records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	40.0	50.0	60.0	70.0	80.0	90.0

ESM 1.5 - The number of Title V programs with health insurance elements incorporated in program requirements.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	12.0	14.0	18.0	19.0	20.0

ESM 1.6 - The number of analytic reports developed and shared.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

ESM 1.8 - Maternal mortality report issued at least annually.

Measure Status:	Inactive - Completed

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 1.9 - Severe maternal morbidity surveillance initiated and operationalized by program.

Measure Status:	Inactive - Completed

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 1.10 - Number of policy, community prevention or clinical quality improvement strategies implemented in past year as a result of the Partnership collaboration.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1
Numerator	
Denominator	
Data Source	Partnership activity reports, meeting minutes.
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

ESM 1.11 - Percentage of managed care organizations that provide reimbursement for postpartum LARC insertion.

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	100
Numerator	
Denominator	
Data Source	Medicaid Managed Care Program
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	20.0	30.0	35.0	40.0	50.0	55.0

ESM 1.12 - Percentage of women enrolled in Medicaid Managed Care who are screened for maternal depression during a) prenatal care; b) postpartum care.

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	85
Numerator	
Denominator	
Data Source	Medicaid Prenatal Care Quality Improvement Project
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	87.0	89.0	90.0	92.0	94.0	94.0

ESM 1.13 - Title V staff participate in intra-and inter-agency groups developing response to opioid use.

Measure Status:	Inactive - Pursuant to a discussion at NY's HRSA Title V review, several ESMs that are more process oriented will be retired, however the information will be rep

State Provided Data	
	2016
Annual Objective	
Annual Indicator	4
Numerator	
Denominator	
Data Source	NYS Title V Programs Records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	5.0	5.0	5.0	5.0	5.0

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

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	87.0	89.0	90.0	92.0	94.0	94.0

State Performance Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	37.3
Numerator	
Denominator	
Data Source	BRFSS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	45.0	48.0	51.0	53.0	56.0	56.0

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
Annual Objective	
Annual Indicator	27
Numerator	
Denominator	
Data Source	Medicaid Claims
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	8.0	10.0	12.0	14.0	16.0	27.5

State Action Plan Table

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

Priority Need

Reduce maternal mortality and morbidity

NPM

Percent of women with a past year preventive medical visit

Objectives

Objective MWH-1: Reduce the maternal mortality rate in NYS by 10%, to 16.1 maternal deaths per 100,000 live births in 2020.

Objective MWH-2: Increase the percentage of women enrolled in Medicaid Managed Care who are screened for maternal depression during prenatal care by 10% to 94.2%, and during postpartum care by 10% to 90.9%.

Strategies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOMs

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

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

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 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

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

Priority Need

Reduce maternal mortality and morbidity

SPM

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

Objectives

Objective MWH-1: Reduce the maternal mortality rate in NYS by 10%, to 16.1 maternal deaths per 100,000 live births in 2020.

Objective MWH-2: Increase the percentage of women enrolled in Medicaid Managed Care who are screened for maternal depression during prenatal care by 10% to 94.2%, and during postpartum care by 10% to 90.9%.

Strategies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Need

Reduce maternal mortality and morbidity

SPM

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

Objectives

Objective MWH-1: Reduce the maternal mortality rate in NYS by 10%, to 16.1 maternal deaths per 100,000 live births in 2020. Objective MWH-2: Increase the percentage of women enrolled in Medicaid Managed Care who are screened for maternal depres-sion during prenatal care by 10% to 94.2%, and during postpartum care by 10% to 90.9%.

Strategies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FY2018 Application
Maternal/Women's Health

State Priority #1: Reduce maternal mortality and morbidity

2020 State Objectives:
Objective MWH-1: Reduce the maternal mortality rate in NYS by 10% to 16.1 maternal deaths per 100,000 live births in 2020.
Objective MWH-2: Increase the percentage of women enrolled in Medicaid Managed Care who are screened for maternal depression during prenatal care by 10% to 94.2%, and during postpartum care by 10% to 90.9%.

Maternal mortality and morbidity are critical indictors for maternal and women's health in NYS. In 2016, NYS ranked 30th among 50 states in maternal mortality. As measured by **MWH-1** - NYS's maternal mortality rate of 19.3 in 2014 and 22.3 in 2015 maternal deaths per 100,000 live births remains almost two times higher than the Healthy People 2020 objective of 11.4. NYS maternal mortality rate surpassed the US rate of 21.1 in 2015. Racial disparities in maternal deaths are significant; the statewide black to white mortality ratio peaked in 2006 at 6.3 to 1 and declined to 3.3 to 1 in 2013, has shown an increase to 5 to 1 in 2014. Geographic differences exist. In NYC, the Black to White ratio decreased from 7.4 to 4.5 to 1 while outside NYC the ratio reached 6.9 to 1 which represents a four time increase from previous year's ratio.

Leading causes of maternal death in NYS, based on the review of the 2012 – 2013 case cohort (n=59) completed this year, include: embolism (not cerebral) (31%, n=18), hemorrhage (19%, n=11), infection (15%, n=9), cardiomyopathy (11%, n=6) and hypertensive disorders (11%, n=6). Almost half the women who died were obese (34%) or overweight (12%). The majority of women who died were affected by risk factors including hypertension (15%), anemia (12%), asthma (12%), psychiatric disorders (12%), cardiac problems (12%).

As stated in the annual report section of this application, Severe Maternal Morbidity fundamentally affects the lives of mothers, newborns, families and health care provider teams, and can result in prolonged hospital stays, substantial medical costs, higher life-long burden of health problems, physical and emotional stress, and interference with maternal-newborn bonding, and is associated with an increased risk for maternal death, and therefore NY's Title V program will continue its focus on this important public health issue. The surveillance of SMM in NY showed a small increase among all deliveries from 264 cases in 2013 to 273 cases in 2014 per 10,000 deliveries. Among vaginal deliveries the number of SMM cases increased from 138 in 2013 to 155 in 2014 while among cesarean deliveries the number of cases decreased from 512 in 2013 to 507 in 2014. NY is in the process of publishing a manuscript summarizing the findings from the surveillance of SMM. The understanding gained from this work informs Title V efforts to address women's health before, during and beyond pregnancies.

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

While NY's SAP focuses on specific strategies and measures to promote preconception health, efforts will continue to build on the

extensive body of MCH public health programs and activities in place through NYS's Title V Program, including: Comprehensive Adolescent Pregnancy Prevention Program; Family Planning Program; School-Based Health Center Program; Maternal and Infant Community Health Collaborative; Maternal, Infant and Early Childhood Home Visiting (MIECHV); Perinatal Regionalization; Maternal Mortality Review; New York State Perinatal Quality Collaborative (NYSPQC); Text4Baby; and, the Growing Up Healthy Hotline (See Section II.B and 2016 Annual Report). Additionally, this work will leverage continued collaboration with NY's extensive network of partners including OHIP which administers NY's Medicaid program, including but not limited to Medicaid Managed Care, Health Homes, Family Planning Benefit Program, Family Planning Extension Program and Medicaid Prenatal Care Programs. This priority is closely linked to other state priorities including: Priority #2: Reduce infant mortality and morbidity; Priority #3: Support and enhance social-emotional development and relationships for children and adolescents; and all four Life Course priorities (#5-8). Strategies to address maternal mortality and morbidity are largely inextricable from those to address infant mortality and morbidity; thus, the strategies described for Domain 1 and Domain 2 should be considered part of the continuum of public health activities to improve both maternal and infant maternal mortality and morbidity.

Progress toward achievement of outcomes associated with Priority #1 *Reduce maternal mortality and morbidity* will be tracked through **NPM #1**: Percent of women with a past year preventive medical visit and two SPMs: **SPM 1**: The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy and **SPM 2**: The percentage of women age 15-44 years and enrolled in Medicaid using the most effective, or moderately effective methods of contraception. These SPMs address key elements of preconception health care and leverage important investments and collaborations that NY's Title V Program has developed with the DOH Division of Chronic Disease Prevention (DCDP)/Behavioral Risk Factor Surveillance System (SPM 1), DOH OHIP and Office of Quality and Patient Safety (OQPS) for NY's IM CoIIN initiative and CDC-led 6|18 initiative (SPM 2).

Strategy MWH-1: Continue maternal death case ascertainment and review process and issue reports of maternal death review findings and trends. As described in the 2016 annual report, NY has an established public health surveillance process in place to identify and review cases of maternal death through multiple sources of public health data and chart reviews. Title V will be releasing the 2012-2013 MMR later this year and will initiate the surveillance of the next cohort of maternal deaths – 2015 and 'early' reviews of 2016 deaths. Title V plans to continue this review process while aiming to release data reports annually to support prevention and clinical improvement strategies with partners. Title V will also be implementing the new review process with ACOG, described in the Annual Report section.
Through the updates to NYS's perinatal regionalization system and standards of care (see Priority #2) and the Title V Program's emerging collaboration with the PMH (See Strategy MWH-3), NY's Title V Program will continue to explore opportunities to streamline data analysis processes, and share lessons learned to improve maternity care practices. Implementation of this strategy will be tracked by **ESM MWH-1**: maternal mortality report issued at least annually.

Strategy MWH-2: Expand surveillance and reporting activities to include severe maternal morbidity. Studying SMM is critical both to preventing maternal morbidity and to strengthening Title V understanding of maternal death. Because SMM captures the most serious cases of maternal morbidity, analysis of SMM improves the opportunity to identify factors that are relevant to preventing future cases from progressing to the most serious stages of illness, disability or death. Building on the initial SMM data analysis work described above and in the 2016 annual report, Title V is working toward incorporating SMM case identification and analysis in annual surveillance reports to inform clinical and community prevention activities led by both Title V and partners. The first report on SMM is anticipated to be released later this year. Implementation of this strategy will be tracked by **ESM MWH-2**: severe maternal morbidity report issued at least annually.
NY's Title V program recognizes the importance of data access for all key partners and stakeholders. To that end, Title V staff are working with the NYSDOH's OPHP to develop a MCH dashboard, mirroring the objectives and outcomes reflected in NY's SAP. The dashboard, mirrored on the dashboard for NY's PA (link provided) will provide easy access to key data points reflected in NY's SAP and clearly show NY's progress in these priority outcomes, while also allowing partners to identify and

address priority MCH issues on the local level.
https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=sh

Strategy MWH-3: In collaboration with key partners, co-convene the NYS PMH to advance a comprehensive maternal health agenda that includes policy, community prevention and clinical quality improvement strategies. In NYS, heightened attention to the public health priority of maternal mortality – in particular the striking racial and economic disparities – has prompted significant work across several key organizations and settings, including the DOH Title V Program, ACOG-NY, state hospital associations including both the Health Care Association of New York State (HANYS) and Greater New York Hospital Association (GNYHA), the NYCDOHMH and the New York Academy of Medicine (NYAM). The PMH seeks to advance a comprehensive and collaborative agenda for improving maternal health across the life course and ensuring the quality and safety of maternity care in NYS. As discussed in the annual report section of this application, building on the Public Health Committee discussions and an initial review of shared goals resources and data, the partnership identified pre/interconception health as a starting point for collaboration and an initial focus of improving preconception care for women. During the work of this group over the past few months, it was recognized that, in order to better address the breadth of this issue, it is essential that the PMH include all health care providers and key stakeholders that intersect with women throughout the lifecourse. Therefore, the Title V program, in conjunction with the PMH, reached out to key groups to expand the scope including partners, such as the NYS Association of Licensed Midwives, NYS Psychological Association, Nurse Practitioner Association of NYS, Emergency Medicine, the NYS Society of Physician's Assistants among others and will be integrating these new members during the upcoming year.

Currently, the partnership is focused on increasing awareness and action among health care providers of women of reproductive age regarding preconception health. A first step is developing a webinar for health care providers on the importance of preconception health. Further work will be done in the upcoming year, incorporating recommendations from the expanded PMH to ensure the message resonates with and reaches the key health care providers it is intended to reach to impact practice. Title V staff have also been meeting with DOH Division of Chronic Disease Prevention (DCDP) staff to connect the hypertension prevention and treatment as well as diabetes prevention initiatives with the MICHC and MIECHV initiatives to improve pre/interconception health. The DCDP implements evidence-based, evidenced-informed, and innovative public health strategies in high need areas of the state to support New Yorkers to live healthier lives and eliminate health disparities by reducing the incidence and burden of chronic diseases and conditions (e.g., heart disease, stroke, cancer, obesity, diabetes, asthma, arthritis) and their associated risk factors (poor nutrition, tobacco use, and lack of physical activity). There is a tremendous overlap between the priorities and areas served by DCDP and the DFH. This will allow greater reach of these efforts by infusing practices and partnerships with organizations and individuals that may have not yet focused on Title V priority strategies and also those Title V programs and initiatives to improve interventions on those issues leading to poor birth outcomes through local partnership with DCDP initiatives. Implementation of this strategy will be tracked by **ESM MWH-3**: Number of policy, community prevention or clinical quality improvement strategies implemented in past year as a result of Partnership collaboration.

Title V will also continue its partnership efforts through the NYSPQC, a partnership with the NICHCQ, RPCs and affiliate obstetrical hospitals to improve birth outcomes. The NYSPQC, ACOG-NY, Greater New York Hospital Association (GNYHA) and the Healthcare Association of New York State (HANYS), will continue to work collaboratively to leverage skills and expertise to reduce maternal morbidity and mortality, specifically on issues identified by the NYS MMR. Together, the aforementioned organizations are developing an initiative to assist birthing hospitals across NYS with translating evidence-based guidelines into clinical practice to improve the assessment and management of maternal hemorrhage, one of the leading causes of maternal morbidity and mortality in NYS. This will be accomplished through: the implementation of a learning collaborative among NYS birthing hospitals to share and learn from one another; implementation of the Safe Motherhood Initiative (SMI) obstetric hemorrhage bundle; tailored clinical and quality improvement education (in-person and virtual, webinars, grand rounds, etc.) and

technical assistance; and ongoing data collection, analysis and feedback to track relevant measures. This initiative will align with the national ACOG Alliance for Innovation on Maternal Health (AIM). The purpose of the AIM program is to equip, empower and embolden every state, perinatal quality collaborative, hospital network/system, birth facility and maternity care provider in the U.S to significantly reduce severe maternal morbidity and maternal mortality through proven implementation of consistent maternity care practices that are outlined in maternal safety bundles (action systems). The AIM Program is designed to complement current maternal safety initiatives in progress, as well as drive continuous quality improvement on a state and birth facility level.

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

Building on the extensive work summarized in the 2016 Annual Report, including NY's IM CoIIN initiative and CDC-led 6|18 initiative, NY's Title V Program will continue to collaborate with NY's State Medicaid Program and other partners to educate providers on the policy change that provides reimbursement for immediate postpartum insertion of LARC and to address misconceptions about LARC among providers and women of reproductive age. Title V will also continue to participate in ASTHO's *Increasing Access to Contraception Learning Community* initiative with a team comprised of NYCDOHMH, CHCANYS, ACOG, OHIP, and hospitals. Implementation of this strategy will be tracked by **ESM MWH-4**: Percentage of managed care organizations that provide reimbursement for postpartum LARC insertion.

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

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

For the past few years, Title V staff have participated in a Prenatal Care workgroup with the OQPS to support implementation of Medicaid Prenatal Care standards and other related collaborative efforts. Part of the focus of this workgroup has been the development and implementation of a focused study on the quality of prenatal care provided through the Medicaid Prenatal Care Program. Title V staff will continue to work with OQPS focusing on the initiatives discussed below.
The 2017 – 2018 Perinatal Care Performance Improvement Project (PIP) is a two-year initiative with 15 NYS Medicaid Managed Care Plans. This PIP includes four priority areas of focus:

- Improving Access to 17-alpha hydroxyprogesterone caproate (17P) to reduce the risk of recurrent preterm birth
- Behavioral Health risk assessment and follow-up – depression
- Behavioral Health risk assessment and follow-up – tobacco use

- Improving utilization of Long-Acting Reversible Contraception (LARC) to support birth spacing that is optimal for maternal-fetal outcomes and patient choice.

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

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

Title V staff will continue to participate in monthly Prenatal Care Workgroup meetings to provide input into quality improvement activities and also provide updates on NY's participation in the national IM-CoIIN for focus area pre/interconception care (http://www.nichq.org/childrens-health/infant-health/coiin-to-reduce-infant-mortality), and the NYSPQC (http://www.albany.edu/sph/cphce/mch_nyspqc.shtml).
Several new initiatives began in 2016 that include a focus on maternal depression. Title V staff partner with the CCF on the implementation of a community-led project through the Early Childhood Comprehensive Systems (ECCS) Impact grant to improve maternal depression screening and follow-up as well as developmental screening and follow-up for young children through building partnerships and collaborative efforts. To support this initiative, Title V staff participate on a workgroup charged with implementation of developmental health promotion by increasing monitoring, screening, and follow up. The ECCS Impact grant is a community-led program that identifies community leaders to participate in local teams to identify ways to improve services including screening and services.

Similar to the ECCS initiative, Title V staff working in the Home Visiting Unit are leading a community-led program, Coordinated Intake (CI) and Referral System pilot project. DOH home visiting staff and CCF have submitted an abstract to co-present at HRSA's Annual Grantee Meeting for MIECHV in September 2017 on both community-led programs (ECCS and CI). This project complements NYS OMH's funding of the expansion of HealthySteps model to 17 additional pediatric health care practice settings as discussed in the annual report. Title V staff participate on a workgroup to support the HealthySteps initiative engage both the child and family during routine early-life doctor visits and provide screening services for the entire family, including screenings for maternal depression. These enhanced early-life visits will offer an opportunity for families to find support in an accessible and non-stigmatizing environment.
A NYS team including OMH, DOH, CCF, and the NYS Infant Mental Health Association was selected to participate in a Zero to Three community of practice on integrating mental health into home visiting. Through this six-month learning community (January – June 2017), the team will develop a plan for increasing mental health capacity in home visiting, including screening and referrals for maternal depression. Over the next year, the group will work with partners to help medical practices develop systems for referral and follow-up for positive screens, provide on-going technical assistance and use lessons learned in other maternal and infant health initiatives.

Additionally, the state's ECAC identified early identification, prevention and intervention for maternal depression as a current priority, and has convened a workgroup to develop and help advance relevant strategies. The group's current focus is ensuring payment for screening as a means of encouraging practices to screen. They are exploring barriers to billing as a first step. DFH

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

Strategy MWH-6: Participate in intra- and interagency groups developing response to increased opioid use to ensure maternal and child health perspectives and populations are addressed. The increase of opioid use among MCH population is a key concern of many stakeholders in NY. During the last five years for which data are available on opioid use, misuse, morbidity, and mortality in NYS, both heroin and opioid analgesic-related deaths have increased: 2,175 drug-related deaths were reported in 2013, 40 % more than in 2009; heroin was involved in 637 (29 %) of drug-related deaths in 2013 vs. 242 (16 %) in 2009; and opioid analgesic-related deaths increased 30 % from 2009 to 2013 (from 735 to 952).

For the MCH population specifically, the impact of this crisis is visible in the dramatic increase in rates of drug-related discharges for newborns over the last several years. While rates have increased across the state and among all racial/ethnic groups, the trend is especially pronounced outside of New York City, where the rate of NAS has doubled since 2008. In response to this rapidly emerging issue, Title V staff have been engaging with several key partners to assess needs, identify existing resources and participate in the development of additional strategies. Since spring 2016, Title V staff have been participating on an interagency work group, led by the NYS OASAS, to address pregnant and parenting women with opioid use disorders. Building on this work, 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 County. The is a two-year pilot program (6/2016 – 5/2018) and the core team, which includes Title V staff and agencies in Onondaga County, is developing a work plan to address objectives related to universal screening, treatment access, and developing peer services. Lessons learned will be disseminated across the state.

Title V staff are engaged in several efforts to contribute to and benefit from work related to surveillance and data for opioid use. The Title V Program is working collaboratively across NYS offices on a study of maternal opioid use and NAS. Study questions to be addressed for 2010 - 2014:

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

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

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

As more information about this significant public health issue becomes available, the Title V Program will incorporate the

information within relevant community-based prevention programs. Governor Cuomo's statewide task force to combat heroin and opioid abuse, comprised of experts in health care, drug policy, advocacy, education, parents and New Yorkers in recovery, will continue to build on the state's previous efforts and use members' expertise and experience to develop a comprehensive action plan. Title V staff will continue to identify opportunities to assure the needs of NYS's MCH population are included in statewide efforts to address this issue and make recommendations regarding opportunities to intervene. Implementation of this strategy will be tracked by **ESM MWH-6**: Title V staff participate in intra- and inter-agency groups developing response to opioid use.

II.F. FY 2016 Annual Report

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

The factors impacting women's health are complex and varied, ranging from social-emotional issues, environmental impact, health insurance status, access to health care, to birth spacing and any number of other factors. Improving women's health throughout the lifespan is an essential component to improving the health and wellness of NY's women. NY's Title V program promotes and supports a myriad of efforts to improve the health of all women. Over the past year pursuant to NYs SAP, the Title V program focused on improving access to health care, including access to the most effective forms of contraceptives; preconception health to promote women's health prior to pregnancy; and improving screening and treatment for maternal depression and substance use.

As stated previously, access to comprehensive health care coverage is a significant factor in ensuring health care is accessible and available to women. Through the NYSOH, the state's official health plan Marketplace, NY continued its efforts to enroll all New Yorkers into comprehensive health care coverage. There are now over 2.8 million New Yorkers with health insurance coverage through the NYSOH. There has been a reduction of 850,000 uninsured New Yorkers since the opening of the NYSOH. In 2015, 92% of women in NY had coverage. Rates differed by race and ethnicity, with whites having the highest coverage rate (94%) and Hispanic or Latino having the lowest (81.5%). Education also influenced rates. Those who had less than a high school education had much lower rates of insurance (80.3%) than those with a Bachelor's degree or higher (93.8%). To address this, NY has increased assistance to individuals seeking health care coverage through establishing over 13,200 navigators statewide and offering easier access to information including a NYSOH customer service center who responded to 1.3 million calls in the past year in over 94 different languages. Consumer educational materials are produced in 24 different languages. All Title V programs prioritize engaging all women into health care coverage and, for many programs overseen by the Title V program, enrollment into health insurance is a required performance measure, to promote outreach and engagement for all uninsured women, children and families.

Maternal mortality and morbidity are critical indictors for maternal and women's health in NYS and therefore a priority in NY's Title V SAP. Understanding those factors associated with maternal mortality and morbidity is essential for improving maternal health outcomes. Therefore, a strategy for this domain is 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 Review (MMR) process in 2010, which is a comprehensive review of all maternal deaths. In the MMR initiative, the DOH conducts comprehensive surveillance activities based on linked birth and death record data, hospital in-patient and emergency department data and a hospital-based adverse event reporting system to identify maternal deaths.

Through the MMR process, over the past year Title V staff completed 100% of the reviews for the 2012-2013 cohort of maternal deaths. A report summarizing findings from the surveillance of 2012-2013 cohort is to be released later this year. (**ESM MWH-1**: Maternal mortality report issued at least annually.) Leading causes of maternal deaths (N=59) included: embolism (not cerebral) (31%), hemorrhage (19%), infection (15%), cardiomyopathy (11%) and hypertensive disorders (11%). This is a change from the previous report when hypertensive disorders represented the top leading causes of death. Racial disparities in maternal deaths are significant; the statewide black to white mortality ratio peaked in 2006 at 6.3 to 1 and declined to 3.3 to 1 in 2013 and increased to 5 to 1 in 2014. Geographic differences exist as well. In NYC, the Black to White ratio decreased from 7.4 in 2013 to 4.5 to 1 in 2014 while outside NYC the ratio reached 6.9 to 1 in 2014 which represents a four time increase from the previous year's ratio (1.7 in 2013). However, the small number of deaths annually can significantly influence these figures.

Although DOH has successfully reached the Prevention Agenda 2013-2017: New York State's Health Improvement Plan goal to reduce maternal mortality (MM) to fewer than 21 maternal deaths for every 100,000 live births by 2018, much more work needs to be done to meet the Healthy People 2020 objective of 11.4 maternal deaths for every 100,000 live births. By continuing the comprehensive review of factors leading to maternal deaths through the Maternal Mortality Review Initiative (MMR) and designing strategies to address those factors, Title V aims to continue to improve outcomes for mothers and babies.

To that end, over the past year Title V staff, in collaboration with the American Congress of Obstetricians and Gynecologists (ACOG-NY) developed an enhanced process for maternal death reviews. The goal of these planning efforts was to develop a process that will not only address the population health approach which includes surveillance and planning on a statewide level, but to enrich the process to provide health care providers and others with information needed to improve and enhance health care standards and practices. This entailed a critical review of the current process and data collection forms, as well as the development of new forms to accommodate the additional review process with more specific deidentified case information to be reviewed by the MMR committee members. Materials and documentation from other states were used extensively for this endeavor. An extensive literature review of published maternal death processes from other states was also conducted. NY held conference calls with members of MMR committees in other states such as California, Colorado and Texas to learn from their experiences. The new process will integrate the MMR Committee into a more active role in the individual case review. The Committee will conduct a complete assessment of the causes of death, factors leading to death, preventability, and opportunities for intervention. The MMR findings on recent trends and issues will be translated into action through collaboration with ACOG-NY and other key stakeholders to develop Issue Briefs, Grand Rounds, and quality improvement projects through the NYSPQC with partners (e.g., hospital associations, regional perinatal centers and affiliate obstetrical hospitals). A maternal mortality report will also be issued to provide data and information that can be broadly used to improve maternal outcomes.

In addition to maternal deaths, those women who experience Severe Maternal Morbidity (SMM) or "near misses", defined as experiencing life threatening medical complications (e.g., sepsis, embolism, etc.) and/or the need for life saving interventions (e.g., assisted ventilation) during delivery-related hospitalizations, are 50 – 100 times more common than maternal mortality. To fully understand those factors that influence both outcomes, Title V staff have focused on identifying cases of SMM through linked birth and hospital discharge data to conduct an analysis to define the major causes of maternal morbidity. (**ESM-MWH-2**: Severe maternal morbidity surveillance initiated and operationalized by program.) MM fundamentally impacts the lives of mothers, newborns, families and health care provider teams, and can result in prolonged hospital stays, substantial medical costs, higher life-long burden of health problems, physical and emotional stress, and interference with maternal-newborn bonding, and is associated with an increased risk for maternal death. Initial analysis of SMM in NY completed in 2015 identified an increase in SMM from 2008 to 2013 – peaking in 2010 at 290 cases per 10,000 deliveries. SMM rates increased from 219 cases per 10,000 hospital deliveries in 2008 to 273 cases per 10,000 hospital deliveries in 2014. Among vaginal deliveries the SMM rates increased from 120 in 2008 to 155 cases per 10,000 hospital deliveries in 2014; among cesarean deliveries the rates increased from 413 in 2008 to 507 cases per 10,000 deliveries in 2014. The increase in SMM rates was almost three times larger among cesarean deliveries compared to vaginal deliveries (35 vs 94 cases per 10,000 hospital deliveries). Among delivery hospitalizations, the top six leading causes of maternal morbidity were: anemia (including sickle cell) (10.6%), hypertensive disorders (8.5%), hemorrhage (5.0%), chronic lung disease (4.5%), thrombocytopenia (all types) (1.6%), and uterine rupture (0.6%). Among severe maternal morbidity cases, the top 10 leading diagnoses were: hemorrhage (68.8%), anemia (including sickle cell) (64.4%), hypertensive disorders (26.0%), thrombocytopenia (all types) (7.7%), coagulation defects (7.3%), disseminated intravascular coagulation (7.3%), chronic lung disease (7.2%), heart complications (6.9%), heart failure (6.0%), and hysterectomy (4.5%). Higher risk for SMM during delivery was linked to women who did not receive prenatal care, women hospitalized during pregnancy, preterm labor, vaginal deliveries for first time mothers, those with breech position or multiple infants, and cesarean deliveries in general and for women with previous deliveries. Title V staff will continue to collaborate with partners and key stakeholders to understand those factors influencing birth outcomes and make improvements for all NY's women.

The Title V program is also working with the Public Health Committee of the NYS PHHPC to address this significant public health issue. The focus of this work is on the "pre-hospital" antecedents of maternal mortality, including: promotion of women's health and wellness across the reproductive life course; early identification and coordinated management of high-risk pregnancies; and, prevention of unintended pregnancies among women with known serious risk factors. The PHHPC in collaboration with Title V staff have explored opportunities to improve birth outcomes through program and policy improvements. A summary of this collaborative work is posted on the DOH web at http://www.health.ny.gov/facilities/public_health_and_health_planning_council/docs/prevention_of_maternal_mortality.pdf.

An outgrowth of the focus on maternal mortality and the PHHPC is the Partnership for Maternal Health (PMH), that was formed in 2015. The Partnership is comprised of various key stakeholders including Title V staff, ACOG-NY, NY's hospital associations, NYCDHMH and others with a common interest of identifying collaborative opportunities to decrease maternal mortality and morbidity. Recognizing that in order to improve maternal health outcomes, it is imperative for women to enter pregnancy in a healthy state, and that approximately 55% of the pregnancies in NYS are unintended, an initial priority of the Partnership is on preconception health. In September 2016, NYSDOH Commissioner Howard Zucker, MD, JD, issued a "call to action" to a wide range of health care providers highlighting NYS maternal mortality and morbidity rates and the importance of preconception care in improving maternal health outcomes to health care providers stressing that every time a woman intersects with the health care system, pregnancy intention should be assessed. In follow-up to this letter, PMH will conduct an instructional webinar on the importance of preconception care. The webinar is intended for healthcare providers caring for women of reproductive age, such as obstetricians, adolescent medicine specialists, internists, physician assistants, midwives, nurse practitioners, nurses and behavioral health providers. Its purpose is to increase the healthcare provider's understanding of the impact a woman's health care can have on pregnancy outcomes. (**ESM MWH-3**: Number of policy, community prevention or clinical quality improvement startegies implemented in the past year as a result of the Partnership collaboration.)

As stated previously, approximately 55% of pregnancies in NYS are unintended or mistimed. One strategy for improving maternal health is decreasing unplanned pregnancies through increasing access to and use of effective and highly effective contraceptives. Since one of the most effective means of birth control is long acting reversible contraception (LARC), Title V staff have been collaborating with OHIP to: reimburse providers for the full range of contraceptive services; reimburse providers or health systems for the actual cost of LARC or other contraceptive devices to provide the full range of contraceptive methods; reimburse for immediate postpartum LARC by unbundling payment for LARC insertion; and remove administrative and logistical barriers to LARC. The DOH obtained approval from the CMS to allow the cost of LARC to be paid to FQHCs separately from the Prospective Payment System rate. (**ESM MWH-4**: Percentage of managed care organizations that provide reimbursement for postpartum LARC.) This is significant as the acquisition cost of LARC can be prohibitive in many settings. Reimbursement for actual acquisition cost of LARC is available retroactively to April 1, 2016.

In addition, Title V staff and OHIP participated in CDC's 6|18 Initiative, targeting six common and costly health conditions – tobacco use, high blood pressure, healthcare associated infections, asthma, unintended pregnancies, and diabetes – and 18 proven specific interventions that formed the basis for discussions with purchasers, payers, and providers. This initiative offers proven interventions that prevent chronic and infectious diseases by increasing their coverage, access, utilization and quality of care. The goal is to improve health and control health care costs by providing these partners with rigorous evidence about high-burden health conditions and associated interventions to inform their decisions in order to have the greatest health and cost impact. Additionally, it aligns evidence-based preventive practices with emerging value-based payment and delivery models.

OHIP and DFH widely distributed the changes in postpartum LARC reimbursement through the monthly Medicaid Update as well as to DFH programs and external partners such as ACOG. The NYSDOH's participation in the Association of State and Territorial Health Officials (*ASTHO) Increasing Access to Contraception Learning Community* complements these efforts as

well as it is focused on removing administrative and logistical barriers to LARC. The Title V program continues to work with a number of partners including ACOG, NYCDHMH, and Community Healthcare Association of NYS (CHCANYS) on the following activities: educate primary care providers on full range of FDA-approved contraceptive methods, including LARC; educate, train and support family planning providers and providers interested in providing family planning services to the full range of contraceptive methods, including LARC.

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

Title V in NYS also continued to support and promote direct outreach to engage women into health care, promote health insurance enrollment and entry into prenatal care. Through the MICHC, community health workers (CHWs) focused on educating women on improved birth spacing, adherence to the postpartum visit, and use of an effective contraceptive method. Through CHW efforts, over the past year there was an increase from 76.2% to 77.3% in providing information to prenatal clients about the importance of the postpartum visit and an increase from 76.2% to 81.8% in providing information to clients about effective contraception methods. The percent of clients selecting an effective contraception method in the prenatal period to use in the postpartum period increased from 38.9% to 52.9%. For postpartum clients, both adherence of the postpartum visit (PPV) and use of an effective contraception (EC) method in the postpartum period improved: adherence to the PPV increased from 45.5% to 65.4%, and EC use increased from 31.8% to 65.4%.

The FQHC COIIN project discussed above demonstrated successes as well for 2016: 100% of clients were asked about pregnancy intention, up from 75.2% in 2015; the use of an effective or highly effective contraceptive method/LARC rates remained fairly stable for the cohort, averaging 48% throughout the reporting period; while the rates for client referrals for a highly effective/LARC method increased from 3.2% in 2015 to 8% in 2016.

In addition to addressing women's physical health, NY's Title V program is addressing women's social-emotional health. Maternal depression has a significant impact not only on mothers themselves but also on the social-emotional stability of their children. For the past few years, Title V staff have participated in a Prenatal Care workgroup with the OPQS to promote collaboration and maximize resources. Title V staff provided input into the development and implementation of a study on the quality of prenatal care provided through the Medicaid Prenatal Care Program.

Selected medical records from provider agencies are reviewed to determine compliance with comprehensive care requirements such as required education, laboratory testing and screening, including screening for maternal depression. The providers submit the information via a secure web-based data collection and reporting tool. In 2016, OQPS reviewed prenatal care providers from the 2014 birth year and were able to collect data for one Cohort (45 prenatal care practices). Plans are underway to add a second Cohort (50 prenatal care providers) for the 2014 birth year. IPRO recently completed development of a new data platform for the project, and have also launched a pilot of the project with three of the prenatal care providers from the first Cohort to test the platform before it is introduced to the rest of the Cohort (47 providers). The three pilot providers are initiating medical record reviews to test this data platform.

NYS specific data from the 2013 Medicaid Prenatal Care Study showed that 63% of women were assessed for depression during the initial prenatal visit, and 51.4% at postpartum visits, but among these only 7% of records documented using standardized

screening tools. Medicaid quality data from 2014 reviews suggest that depression assessment practices are improving for both prenatal (84.9%) and postpartum (84.4%) visits. Of the 5.3% of women who screened positive for depression during prenatal care visits, 90.2% were addressed in the practice or referred for care. During postpartum visits, 4.2% of women screened positive and 88% of those women who screened positive were addressed in the practice or referred for follow-up. (**ESM MWH-5**: Percentage of women enrolled in MMC who are screened for maternal depression during a) prenatal care and b) postpartum care.) While the screening rates have been improving, there is insufficient evidence to show that there has been an increase in the use of standardized screening tools and practitioners often identified a lack of treatment services as an issue for women who screen positive.

NYS is committed to addressing the comprehensive needs of women. In 2014, statute was passed requiring hospitals to educate patients about maternal depression, maternal depression screening and referral. The Title V program in collaboration with the Office of Primary Care and Health Systems Management (OPCHSM) notified all obstetric hospitals of this requirement. Staff also researched and updated resources on the DOH web site, an activity that is done regularly to keep resources current. In addition, the Title V program initiated discussions with the Office of Mental Health and other key stakeholders to discuss strategies to improve maternal depression screening and enhance resources for those women experiencing depression. Finally, legislation was passed mandating that, to the extent depression screening is already a covered benefit, insurers must pay regardless of which health care provider performs the screening.

Recognizing that women are more likely to seek health care for their infants than themselves in the postpartum period, in 2015 OHIP released guidance clarifying that pediatric providers could bill a mother's insurance if they screen her for depression and in 2016, released guidance that this can alternatively be billed to the child's insurance. OHIP provided two codes – one for a positive screen and referral and one for a negative screen. Pediatric providers began using the new screening codes in October 2016. OHIP is now able to provide data on the percent of providers submitting claims for depression screening and percent of positive and negatives screens.

NY's Title V program is committed to continued work to address this significant health issue for mothers and children. In addition to the programs and initiatives already discussed, several new strategies were initiated in the past year to address maternal depression. The NYS Early Childhood Advisory Council (ECAC) identified early identification, prevention and intervention for maternal depression as a current priority, and has convened a workgroup to develop and help advance relevant strategies. The group's current focus is to increase depression screening by pediatricians. Title V staff participate in this ongoing workgroup.

Addressing the complex needs of NY's women requires interagency partnerships and collaboration among key stakeholders. The NYS Office of Mental Health 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. These services include screening for maternal depression. This NYS initiative provides a full-time HealthySteps specialist in the medical practices resulting in expanded services available to identify and address maternal depression among NY's families.

To further enhance supports and services, the Title V program successfully collaborated on the development of an Early Childhood Comprehensive Systems Impact grant with the Council on Children and Families (CCF). The grant supports collaborative quality improvement projects in three high need counties (Erie, Niagara and Nassau) to improve maternal depression screening and follow-up as well as developmental screening and follow-up for young children. CCF is working closely with DOH on this grant which was initiated over the past year.

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. Under the Task Force, statewide initiatives such as training first responders to administer life-saving Naloxone, limiting opioid prescriptions to seven days, administering a statewide prescription monitoring program and mandated education for prescribers have been implemented to improve outcomes for the MCH population affected by opioid abuse.
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 monitors opioid overdose deaths in the state and regularly reports these deaths to counties for agencies on the local level to develop local intervention strategies. Furthermore, the workgroup developed a comprehensive website for opioid-related data in NYS (http://www.health.ny.gov/statistics/opioid). This site provides the most recent data and trends over time on opioid prevalence, healthcare utilization (emergency department visits, hospitalizations) and mortality at state, regional and county level, where available. Access to these data allows agencies and stakeholders to more easily identify priority areas to target in order to address the opioid epidemic in NYS.

NY's Title V Program is also working collaboratively with state agencies and stakeholders to increase understanding of, and develop strategies to address NY's growing opioid epidemic. In 2016, Title V staff participated on a team organized by NY's OASAS consisting of various state and local agencies and stakeholders involved in the child welfare system, to improve outcomes for families that are affected by substance use disorders. (**ESM MWH-6**: Title V staff participate in intra-and inter-agency groups developing response to opioid use.) Based on guidance from the Substance Abuse and Mental Health Services Administration the team will work to: facilitate cross-system collaboration, develop effective policy, practice and organizational changes, facilitate implementation in pilot sites, monitor implementation and initial outcomes and facilitate changes and adaptations as needed. As a follow-up to this team's initial work, OASAS applied for and was awarded an in-depth technical assistance grant from the National Center for Substance Abuse and Child Welfare to pilot a program in Onondaga County, NY to reduce the number of infants exposed to substances in utero. Title V staff are part of the core team and attended a training academy in Baltimore in February 2017 to learn about systems-level strategies to use in the pilot.

Two additional strategies employed by the Title V program to address the needs of NY's women and families are DOH's Growing Up Healthy Hotline (GUHH) and Text4Baby. GUHH is NY's Title V 24/7 phone line that provides information and referral in English and Spanish and in other languages via the AT&T language line. Any New Yorker can call the GUHH for information on a wide range of programs and services and is used in public health media campaigns. In 2016 GUHH responded to 17,481 calls including 346 calls requesting referral and information related to prenatal care, health insurance, primary and preventive health care and perinatal depression, among other priority MCH needs.

NY's Title V program also supports and promotes Text4baby to reach pregnant and parenting women across NYS. NYS promotes a customized version of Text4baby, a free text message service with messages delivered each week, timed to the woman's due date or baby's date of birth to provide new and expectant mothers with important health information to promote good health for their babies. Text4baby is available through a broad public-private partnership that includes the U.S. Department of Health and Human Services; the National Healthy Mothers, Healthy Babies Coalition; state and local governments; corporations; professional organizations; and community-based organizations. Messages focus on maternal and child health topics, including the prevention of birth defects, immunization, nutrition, seasonal flu, mental health, oral health, Zika virus, healthy behaviors, with a specific message addressing smoking cessation, and safe sleep as part of IM CoIIN initiative in NYS. Text4baby also connects women to prenatal and infant care, and other health services and resources. 8,795 NYS women enrolled in Text4baby during the last year.

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-2014	5.5	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	4.6	NPM 3 NPM 5
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	3.2	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.4	NPM 5
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	175.9	NPM 3
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	48.6	NPM 5

National Performance Measures

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

FAD for this measure is not available for the State.

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

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	91.0	92.0	93.0	94.0	94.5	94.9

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

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

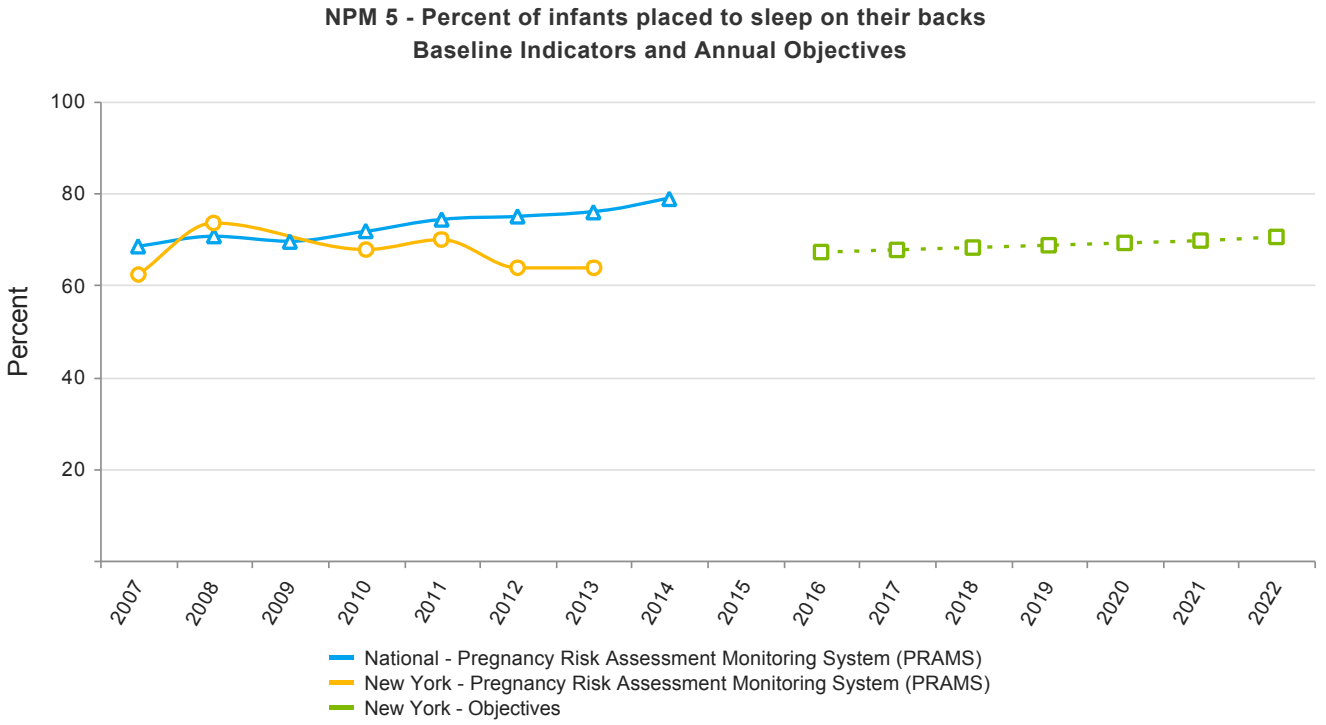
Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	50.0	100.0	100.0	100.0	100.0

ESM 3.2 - Number of home visiting and community health worker staff trained in the identified competencies.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	63.1
Numerator	
Denominator	
Data Source	MICHC and MIECHV
Data Source Year	FY 2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	75.0	80.0	85.0	90.0	95.0	100.0



Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	67.1
Annual Indicator	63.9
Numerator	135,686
Denominator	212,507
Data Source	PRAMS
Data Source Year	2013

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	67.6	68.1	68.6	69.1	69.6	70.4

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Initial infant mortality and morbidity data report published.

Measure Status:	Inactive - Completed

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 5.2 - Percentage of eligible birthing hospitals participating in a current QI activity.

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	66
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	15.0	15.0	30.0	30.0	40.0	40.0

ESM 5.3 - Capacity rates of local home visiting grantee projects (to be aligned with new MIEHCV performance measure, currently pending from HRSA MCHB).

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	65
Numerator	
Denominator	
Data Source	Nurse-Family PEO and HFNY database
Data Source Year	FY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	65.0	85.0	85.0	90.0	90.0	90.0

ESM 5.4 - Number of collaborative strategies implemented to reduce sleep-related infant death.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1
Numerator	
Denominator	
Data Source	NYS Title V Program data
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

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

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	90.0	90.0	90.0	90.0	90.0	90.0

State Action Plan Table

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

Priority Need

Reduce infant mortality & morbidity

NPM

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

Objectives

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

Objective PIH-2: Decrease the preterm birth rate by 12%, to 9.5% of live births

Objective PIH-3: Increase the percent of very low birthweight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) by 0.4%, to 91% of eligible infants.

Objective PIH-4: Decrease the SUID rate by 20%, to 0.3 per 1,000 live births

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

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

NOMs

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

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

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

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

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

Priority Need

Reduce infant mortality & morbidity

NPM

Percent of infants placed to sleep on their backs

Objectives

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

Objective PIH-2: Decrease the preterm birth rate by 12%, to 9.5% of live births

Objective PIH-3: Increase the percent of very low birthweight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) by 0.4%, to 91% of eligible infants.

Objective PIH-4: Decrease the SUID rate by 20%, to 0.3 per 1,000 live births

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

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

NOMs

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

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

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

FY 2018 Application

State Priority #2: Reduce infant mortality and morbidity

2020 State Objectives:

- **Objective PIH-1: Decrease the infant mortality rate by 18%, to 4.0 per 1,000 live births**
- **Objective PIH-2: Decrease the preterm birth rate by 12%, to 9.5% of live births**
- **Objective PIH-3: Increase the percent of very low birthweight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) by 0.4%, to 91% of eligible infants.**
- **Objective PIH-4: Decrease the SUID rate by 20%, to 0.3 per 1,000 live births**

IM, or the death of children under one year of age, is a fundamental indicator of the health of a population. In addition to being used as a measure of infant death, IM also serves as a proxy measure for the overall health and wellbeing of a community. In 2014, the United States (US) IM rate of 5.82 deaths per 1,000 live births lagged far behind other industrialized nations. In order to address this significant public health priority, the Title V program is promoting efforts to reduce infant deaths and decrease economic and racial/ethnic disparities in IM rates across NY through a variety of focused and collective evidence-based interventions.

Reducing IM is a longstanding, fundamental priority for NY's Title V Program. NY's IM rate is better than the HP2020 Goal and US rate, and has been improving over the last decade, driven primarily by reductions in New York City, where about half the births in NYS occur. As measured by **PIH-1**, NY's infant mortality rate was 4.5 per 1,000 births in 2014, down slightly from 4.9 in 2013. There are, however, persistent and marked racial, ethnic, and economic disparities in IM rates across NY. This priority is closely linked to other state priorities, including Priority #1: Reduce maternal mortality and morbidity, and all four life course priorities (#5-8). As noted for Priority #1 above, strategies to address IM are largely inextricable from those to address maternal mortality and morbidity; thus, the strategies and performance measures described above for Domain 1 should be considered part of the continuum of public health activities to address Priority #2.

Progress toward achievement of objectives and outcomes associated with Priority #2 will be tracked through **NPM 3:** Percent of Very Low Birth Weight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) and **NPM 5**: Percent of infants placed to sleep on their backs. **NPM 5** is viewed as a proxy for both sleep positioning and other safe sleep practices that are the focus of prevention strategies. While not selected for reporting purposes due to MCHB's limit on the number of NPMs per state, NY also will follow and focus on improving **NPM 4:** Percent of infants ever breastfed and exclusively breastfed for 6 months.

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

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

To combat the national crisis of IM, Title V leads a statewide collaboration of key stakeholders, agencies, partners, and providers to reduce infant deaths and decrease economic and racial/ethnic disparities in IM across NY through a variety of focused and collective evidence-based interventions. Title V continues to develop *NYS Infant Mortality Call to Action*, a document that describes trends in IM rates in NY between 2002 and 2014 and the action plan to reduce the number of infants who do not survive their first year of

life. Title V plans to revise and update the document periodically as new data become available to provide the most up-to-date information for the key stakeholders, partners, and providers.

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

Implementation of this strategy will be tracked by **ESM PIH-1**: Initial data report published.

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

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

Although NY exceeds the HP 2020 goals for delivery of VLBW infants in Level 3 or 4 perinatal hospitals, standards of perinatal care have evolved and the landscape of the perinatal hospital system, as well as health care coverage and systems, has changed. As measured by **PIH-3**, in 2014, 92.3% of VLBW infants in NYS were delivered at hospitals with a Level III or higher NICU, well above the HP 2020 target of 82.5%. NY will ensure all perinatal hospitals and birthing centers are functioning in accordance with current standards of care for both maternal and infant outcomes by continuing to lead efforts to update standards for perinatal regionalization in NYS, re-designate all birthing hospitals and birthing centers in the state, and engage RPCs and their affiliates in quality assurance and improvement activities to implement the updated standards, and monitor and improve performance and outcomes. This work will be jointly led by the DOH OPCHSM, which is responsible for regulatory oversight of hospitals, and will be accomplished in close partnership with IPRO and with other key partners including birthing hospitals, clinicians, hospital associations, professional organizations and other key stakeholders.

IPRO is currently researching standards of care for perinatal levels of regionalized care. Clinicians, advocates, and key stakeholders are being identified and solicited to assist in the development of standards and processes. Once the standards have been finalized, a survey process will be conducted among all NY obstetrical hospitals. The standards and process will be presented via webinars to ensure all are informed of the requirements. The surveys will be used to assign appropriate levels to all maternity hospitals in the state and identify RPCs as the hubs for networks of lower level facilities. Due to the complexity of the undertaking, it is anticipated that this will be a multi-year process with redesignations occurring in 2018.

Implementation of this strategy will be tracked by **ESM PIH-2**: Percentage of birthing hospitals re-designated with updated standards.

Strategy PIH 3:

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

NY's Title V Program leads the NYSPQC, a robust initiative comprising multiple structured projects to improve the quality of care and maternal and infant health outcomes in birthing hospitals. Building on the previously-completed projects to reduce early elective

deliveries, improve clinical practices related to assessment and education for maternal hemorrhage and hypertension, and reduce Central Line Associated Blood Stream Infections (CLABSIs) in the NICU, there are several NYSPQC projects currently underway related to IM reduction.

To reduce neonatal morbidity and mortality, the NYSPQC/MOD Big 5 State Prematurity Collaborative ACT Project is working toward improving hospital obstetric practices so all mothers of infants born between 23 0/7 and 34 0/7 weeks' gestation receive appropriate ACT. The NYSPQC Enteral Nutrition Improvement Project focuses on reducing the percentage of newborns <31 weeks' gestational age who are discharged from a NICU below the 10^{th} percentile on the Fenton growth scales. 38 NICUs are currently enrolled in the project. The project is expected to continue through December 2017.

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

NY's Title V program continuously considers focus areas for future initiatives through the NYSPQC. Potential projects that may be explored include: unplanned extubation in NICU patients; clinical care of infants identified as having NAS; antibiotic stewardship among patients in the NICU; and management of the obese obstetric patient. The NYSPQC project team is currently administering a survey of all NY birthing hospitals regarding toxicology screening practices during the perinatal period. The information obtained will inform potential work related to opioid use during the perinatal period and NAS.

Implementation of this strategy will be tracked by **ESM PIH-3:** Percentage of eligible birthing hospitals participating in a current QI activity. NYSPQC, which is convened and led by the DFH, continues to focus on providing the best and safest care for women and infants in NY by collaborating with birthing hospitals, perinatal care providers, and other key stakeholders to prevent and minimize harm through the translation of evidence-based guidelines to clinical practice. The current intervention projects of the NYSPQC are:

- Improving hospital obstetric practices so that all mothers of infants born between 23 0/7 and 34 0/7 weeks' gestation receive appropriate ACT to reduce neonatal morbidity and mortality;
- Reducing infant sleep related deaths by improving safe sleep practices; and
- Optimizing early enteral nutrition in newborns of <31 weeks gestational age to minimize discharge from a NICU below the 10th percentile on the Fenton growth scale.
-

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

The NYSPQC was offered the opportunity to partner with the MOD Big 5 State Prematurity Collaborative on the ACT project. The Big 5 State Prematurity Collaborative is comprised of perinatal leaders from five states with the highest number of births in the country, and includes New York, California, Florida, Illinois and Texas. As with NYS, the MOD Big 5 State Prematurity Collaborative fosters data driven perinatal quality improvement through the development and adoption of evidence-based interventions. The NYSPQC/MOD Big 5 State Prematurity Collaborative ACT Project aims to improve hospital obstetric practices so that all mothers of infants born between 23 0/7 and 34 0/7 weeks' gestation receive appropriate ACT to reduce neonatal morbidity and mortality. It is the recommendation of obstetric and pediatric societies to routinely administer ACT to pregnant women when delivery is expected prior to 34 weeks' gestation. However, this goal is often not achieved. In accordance with 2014 NY birth data, only 36% of mothers with infants born between 23 0/7and 34 0/7 weeks' gestation received ACT.

The Big 5 State Prematurity Collaborative, representing nearly 40% of the nation's births, chose ACT as its next topic of focus for 2015 and beyond. Hospitals were recruited to participate in the Big 5 State Prematurity Collaborative from the states listed above.

Participating NY RPCs, as recruited by the NYSPQC, can collaborate with hospitals from the other Big 5 states regarding ACT. This collaboration allows the NYSPQC to align goals and resources to bring more attention and energy to this effort. Our joint project addresses several objectives, two of which are the understanding and timing of ACT administration, and standardizing the assessment of imminent delivery.
The project's kick-off Learning Session was held on February 9, 2016, at the SUNY Albany School of Public Health. Participating NY RPCs came together for this in-person meeting to share ideas and opportunities, and begin working to increase utilization of ACT at their facilities, which will in turn improve outcomes for preterm infants. There have been several national and New York State specific webinars to date. On these monthly webinars, NY RPCs have had the opportunity to learn from national experts and hospital teams have shared their experiences with the project.
Participating facilities collected baseline data for the project and began prospective data collection in January 2016. The data collection form includes elements such as patient demographics, reason for preterm birth, if the patient received ACT, when and where ACT was administered, and how many courses were administered. Measures for the project include:
The percent of births at 23 0/7 – 33 6/7 weeks' gestation receiving any steroids;
The percent of births at 24 0/7 – 31 6/7 weeks' gestation receiving any steroids;
The percent of births at 23 0/7 – 33 6/7 weeks' gestation receiving a complete course of steroids;
The percent of births at 23 0/7 – 33 6/7 weeks' gestation receiving steroids between 24 hours and 7 days prior to delivery;
The percent of births at 23 0/7 – 33 6/7 weeks' gestation receiving steroids between 24 hours and 14 days prior to delivery;
The percent of births at 23 0/7 – 33 6/7 weeks' gestation receiving steroids less than 24 hours prior to delivery;
The percent of births at 23 0/7 – 33 6/7 weeks' gestation receiving steroids more than 7 days prior to delivery; and
The percent of births at 23 0/7 – 33 6/7 weeks' gestation for which the administration date of steroids cannot be determined.

The NYSPQC Safe Sleep Project focuses on improving safe sleep practices to reduce infant mortality in NYS. The project aligns with national and NY efforts pertaining to the IM-CoIIN. Through this project, the NYS DOH is working with 78 birthing hospitals across the state to improve safe sleep practices by:
Collaborating across hospital teams to share and learn;
Implementing hospital policies to support/facilitate safe sleep practices;
Educating health care professionals so they understand, actively endorse and model safe sleep practices; and
Providing infant caregivers education and opportunities so they have the knowledge, skills and self-efficacy to practice safe sleep for every sleep.

This project began in September 2015, and will continue through Summer 2017. To date, the project has held two in-person Learning Sessions, two Quality Improvement 101 webinars, a data training webinar, and nine Coaching Call webinars. As measured by **Objective PIH-4**, **t**he SUID rate in NYS for 2014 was 0.4 per 1,000 live births. **Objective PIH-3** addresses the rate of preterm births in NYS which was 10.7% in 2014.

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

As the designated lead agency for New York's MIECHV initiative, NY's Title V program plays a key leadership role in overseeing the implementation of both federal and state funds for evidence-based home visiting programs, specifically NFP projects and coordinated closely with partner agencies that implement other home visiting programs, including the HFNY led by the NY OCFS. As stated previously in this report, in addition to funding local home visiting programs, a MIH COE was established to provide training, technical assistance and evaluation support for both home visiting and other community-based maternal and infant health initiatives. See the Annual Report section of this Domain for further information.

As a key focal point for strengthening and increasing the impact of home visiting on MCH outcomes that aligns closely with federal

MIECHV priorities, NY's Title V program is collaborating with the MIH COE to provide training, technical assistance and evaluation for home visiting agencies on strategies to improve recruitment and retention of families in home visiting services to increase program capacity resulting in more families served through the program. In the first phase of the 2016-2017 CQI retention evaluation (as discussed in the Annual Report section of this Domain) the MIH COE identified best practices in client retention through a literate review and survey of the local evidence-based home visiting programs. Programs were offered two strategies to employ, with programs selecting one to implement and evaluate. Both strategies involved enhancing communication with families through more effective means based on families' needs (e.g., texting or other method chosen by the family) or more frequent contacts with the families served. The MIH COE provides training and technical assistance on implementation and evaluates results of the programs' efforts on retention to provide further guidance, as needed. As retention and, in a later phase, recruitment improve, programs will be able to maintain a higher level of program capacity thereby reaching more families. The overall capacity rate of all MIECHV grantees as of September 2016 was 64.7%. However, this includes artificially low capacity rates for three MIECHV grantees due to the timing at which they received MIECHV funding.

Strategy PIH-5:

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

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

Both MICHC and MIECHV are designed around defined sets of performance standards. Four performance standards define the goals of the MICHCs including: high-need women and infants are enrolled in health insurance; high-need women and infants are engaged in health care and other supportive services appropriate to their needs; the medical, behavioral, and psychological risk factors of high-need women and infants are identified and addressed through timely and coordinated counseling, management, referral, and follow-up; and, within the community there are supports and opportunities in place that help high-need women engage in and maintain healthy behaviors and reduce or eliminate risky behaviors. Five performance standards have been established for MIECHV programs including: recruitment, and training home visitors consistent with model-specific requirements; identifying high need families and screening for eligibility and enrollment in home visiting services; providing home visiting services with fidelity to the evidence based program selected; achieving measurable improvements across key benchmark areas (maternal and newborn health; improvements in family economic self-sufficiency; improvement in children's health and development; and, strengthen family functioning and life course); and, coordination and integrating with other maternal, infant and early childhood service systems. To ensure these initiatives were achieving the outcomes envisioned when they were created, the Title V program worked with the MIH COE to establish Performance Measures for both the MIECHV and MICHC Performance Standards.

As stated previously, the MIH COE supports MICHC and MIECHV grantees through the provision of guidance, training and technical support on numerous program elements including performance measure development, data collection and reporting systems, and quality improvement methodology. The MIH COE serves as a clearinghouse and resource for current research and is available to grantees for technical assistance. The MIH COE has developed a web site which provides grantees with access to technical

information, publications and other pertinent resources for the most current, research-based best practices in maternal and infant health and community-based interventions. In addition, the website posts a minimum of six original reports or publications annually. Annual training for MIH contractors includes statewide in-person trainings and webinars. Training topics are based on feedback from grantees and in collaboration with the DOH. An annual meeting addresses pertinent training needs for MIH grantees. An introductory training is provided for new MICHC home visitors, which includes all the above topics as well as other core competencies. Training logs, performance measures, quarterly reports, CQI and data analysis will all serve to evaluate progress and success in meeting training needs, competencies and desired outcomes with the target population.

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

In the coming year, the Title V program will be providing programmatic support and technical assistance to five pilot communities, with a plan to start a second cohort in late 2017. The pilot communities will be provided with technical assistance through webinars, in-person meetings and discussions and sample processes and tools to facilitate the development of the central intake system. The Title V program will also facilitate a learning collaborative to build systems that work for the target community and families served. Pilot programs will also be provided with sample triage tools/decision trees to adapt to their community's needs. Lessons learned from this pilot will help inform the development of standards of practice for coordinated intake and referral systems for home visiting in communities across NYS.

Both MICHC and MIECHV are part of NY's core Title V infrastructure for reaching, engaging and supporting MCH populations, high-need women, infants and families. Based on the NA and continued strategic planning process, several key priority areas have been identified as persistent or emerging priorities to be further strengthened through MICHC and MIECHV as well as other programs and initiatives. These include: pre- and interconception health including birth spacing and prevention of unintended pregnancy, well woman care, chronic disease management and other elements of pre-/interconception health; smoking cessation; substance abuse, including dramatic increase in opiate use; safe sleep practices; and initiation and continuation of breastfeeding. Information and skills-development on these topics will be incorporated within training and other QI strategies for local MIECHV home visitors and MICHC community health workers to strengthen their competency and skill to work directly with families in these areas.

Implementation of this strategy is tracked by **ESM PIH-5**: Number of home visiting and community health worker staff trained in the identified competencies.

Strategy PIH-6:

Lead collaborative strategies to reduce sleep-related infant death.

As described in the Annual Report for this Domain and other relevant NY SAP strategies, NY's Title V Program has been leading the state's work under the HRSA-led national IM-CoIIN. A major focus of this work in NY has been to promote safe sleep practices. SUID is among the leading causes of IM in the state, and a focus has been of increasing awareness and collaboration for stakeholders and including partners working in the child welfare system. The NY IM-CoIIN team focused on improving infant safe sleep includes partners from the NY OCFS, NY OASAS, NY OTDA, and the DON's Supplemental Nutrition for WIC programs. Several key projects have been developed due to this strong partnership, and, although the national IM-CoIIN is anticipated to end in July 2017, NY's Title V program will continue these efforts in the coming year. In partnership with OASAS and OTDA, DOH has

been working to develop and produce a webinar, presented by national expert Michael Goodstein, MD, for staff and providers of residence treatment facilities and homeless shelters focused on considerations for infant safe sleep for populations at risk of substance abuse and homelessness.

As part of the NY IM-CoIIN, a structured clinical quality improvement project to influence safe sleep practices within birthing hospitals has been implemented through the Title V NYSPQC infrastructure (see *Strategy PIH-3* above). The NYSPQC Safe Sleep Project will conclude in Summer 2017, and best practices will be shared with all NY birthing hospitals into 2018. In addition, Title V staff is coordinating a second core CoIIN safe sleep project as a structured statewide quality improvement initiative to promote safe sleep practices in community based organizations. Through this project, NY's Title V Program will continue to engage Local Health Departments and partnering community-based organizations (all of which are Title V MICHC grantees, see *Strategy PIH-5* above) in Orange, Onondaga, and Suffolk Counties to develop and implement safe sleep practices by providing safe sleep education to caregivers, 98% of whom are mothers. This project is expected to continue through July of 2017. Best practices will be distributed to MICHC projects and other partners across NY.

A third core project through NY's CoIIN initiative is focusing on collaboration with other state agencies as discussed previously to jointly develop and deliver infant safe sleep messages to individuals served through NY's respective agencies. This collaboration includes co-branded messaging and dissemination strategies that effectively reach their respective populations. These collaborations will continue, and infant safe sleep resources (e.g. pamphlets, mirror clings, magnets, crib cards) will continue to be distributed to all NY birthing hospitals. In addition to meeting the objectives of Title V, doing so will also fulfill newly implemented NY PHL mandating all birthing hospitals to provide women, upon registration for the birth hospitalization, with information related to infant safe sleep.

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

Implementation of this strategy will be tracked by **ESM PIH-6**: Number of collaborative strategies implemented to reduce sleep-related infant death.

FY 2016 Annual Report

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

Addressing factors that lead to IM continues to be at the forefront of all NY's maternal and child health initiatives. Overall, infant and neonatal mortality rates are declining in NY and are below the HP 2020 thresholds. NYS's infant mortality rate was 4.5 per 1,000 live births in 2014, down slightly from 4.9 per 1,000 births in 2013. The number of infant deaths was 1,068 in 2014, 291 fewer than in 2008. From 2008 to 2014, the IM rate declined 11.3% for non-Hispanic whites to 3.70 per 1,000 live births; 28.1% for non-Hispanic blacks to 8.5 per 1,000 live births; and 20.1% for Hispanics to 3.5 per 1,000 live births. Asian and Pacific Islanders had the lowest rate in 2014 at 2.2 per 1,000 live births; however, this represented a 6.9% increase since 2002 for this group. From 2008 to 2014, the neonatal mortality rate declined by 16.2% to 3.1 per 1,000 live births, while the post-neonatal mortality rate declined 22.2% to 1.4 per 1,000 live births.

Despite improvements, striking disparities exist. The ratio of black-to-white low birth weight rates was 1.6 in 2014, reflecting an improvement over the rates of 1.9 and 1.8 in 2010 and 2012, respectively. In 2012, the mortality rate for early term infants (37-38 weeks gestation) was more than twice the rate of full term infants (39-40 weeks gestation): 2.61 and 1.21 per 1,000 live births, respectively. The three leading causes of infant death in 2012 were prematurity, congenital malformation and cardiovascular disorders originating in the perinatal period. Title V is leading statewide efforts with key stakeholders, agencies, partners, and providers to reduce infant deaths and decrease economic and racial/ethnic disparities in IM rates across NY. Through a variety of focused and collective evidence-based interventions, NY's Title V program is improving the ability of new parents to raise healthy infants through the use of several strategies.

In order to address priorities such as infant mortality on a state, regional or local level, it is imperative to access comprehensive data for identification, implementation and evaluation of public health initiatives. Over the past year, NY's Title V program developed and began implementation of an expanded plan for analysis and reporting of infant mortality and selected morbidity data and began developing an initial data report, *NY IM Call to Action*, that highlights collaborations and describes trends in NY's IM rates between 2002 and 2014, the DOH's action plan to reduce IM, and where further efforts are needed to reduce IM. (**ESM PIH-1:** Initial infant mortality and morbidity data report published.)

To monitor progress of improving the health of woman, infants, and children and reducing health disparities, Title V staff are collaborating with the DOH's OPHP to develop a MCH dashboard (previously discussed in the Women Maternal Health section of the Annual Report), that will be comprised of National Performance and Outcome Measures as well as SPMs and Objectives. The dashboard will serve as an interactive visual presentation of the national, state and county data (where available). The most current data are compared to previous year data to monitor performance. Multiple partners within the NYSDOH are collaborating to support the data presentation and content of the dashboard for Phase I release. Title V staff have been engaged in discussions to finalize the list of indicators, determining state specific targets for the measures, and determining an outline of supporting documentation for the indicators.

An important factor in improving birth outcomes and reducing infant morbidity and mortality is ensuring access to comprehensive prenatal care. NYS has long supported access to comprehensive prenatal care for all women. Title V staff continued its collaborative efforts with the NY OHIP to ensure quality prenatal care services are available to NY's MA population. Services are available to women up to 223% of the Federal poverty level (FPL) and undocumented women, using State only funding. Supports are also provided to women to promote healthy behaviors and foster infant development. NY's Title V program is home to the MIECHV initiative that strives to improve the health and well-being of high risk families and reduce racial/ethnic disparities through 16 evidence-

based home visiting programs including seven Nurse-Family Partnership (NFP) and nine Healthy Families New York (HFNY) in nine high-risk counties. NY MIECHV grantees provided services to over 3,454 families in the FY15 (10/1/2015 to 9/30/2016) reporting period and showed improvement in the following infant construct measures:

- Percentage of clients enrolled prenatally who initiated breastfeeding from 78.5% in 2012 to 85.8% in 2016;
- Percentage of infants who received four or more well-child visits by age 12 months from 78.8% in 2014 to 81.8% in 2016; and
- Percentage of infants who received an Ages and Stages Questionnaire assessment at four months of age from 70.1% in 2014 to 82.4% in 2016.

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

Improving birth outcomes requires greater coordination of referrals and services on the local level. Home visiting grantees expressed some concerns and confusion about where to enroll women into home visiting, when different home visiting programs are operating in close proximity. In addition, the length of enrollment as well as the number of home visits otherwise known as "dosage" has an impact on outcomes. Therefore, in 2016 NY's Title V program invited all MICHC grantees to participate in the development of a coordinated intake and referral system pilot project in each MICHC community. (**ESM PIH-4:** Capacity rates of local home visiting programs.) Nine of the 23 MICHCs expressed interest in participating in this pilot project that aims to improve coordination and collaboration among home visiting programs, and ultimately improve community-level maternal and child health outcomes. Cohort one includes five teams and began in January 2017. Title V staff provides programmatic support through triannual in-person meetings, monthly coaching calls, sample tools, webinars, and ongoing technical assistance. Lessons learned 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 the NYS also served by federal Healthy Start (HS) grantees, namely in Queens, Brooklyn, Staten Island, Harlem, Bronx, Syracuse, and Rochester; five of the seven NY HS grantees are also MICHC grantees. Title V staff meet semi-annually with the HS grantees to discuss communication, collaboration, and coordination between the HS and MICHC programs to maximize existing resources, and improve community infrastructure. All NYS HS programs have been invited to trainings provided by the MIH COE (described in the next paragraph) and attend the annual MIE COE provider meeting to foster ongoing communication and collaborative efforts.

To enhance local systems building efforts through training, technical assistance data collection and analysis, and quality improvement for NY's Title V community-based MIH programs, including the MICHC and MIECHV, NY's Title V program began funding the MIH COE in July 2015. (**ESM PIH-5:** Number of home visiting and community health worker staff trained in identified competencies.) The MIH COE consists of two components: The University of Rochester provides training, technical assistance and evaluation and the University at Albany Center for Human Services Research develops, maintains, and manages a data management information system for the MICHC CHWs. The MIH COE held the first annual meeting of the MIH and Title V staff in 2016, provided training on a variety of topics (e.g., substance abuse, sexually transmitted diseases, maternal depression), and developed and began the MIECHV Continuous Quality Improvement (CQI) plan. The MIECHV CQI plan uses strategies to improve recruitment and retention of families in home visiting services. Both strategies involved enhancing communication with families through more effective means based on families' needs (e.g., texting or other method chosen by the family) or more frequent contacts with the families served. The MIH COE provides ongoing technical assistance to the programs and assesses the impact of selected strategies

on retention.

Title V staff continued to lead efforts to improve the health and well-being of young people and their newborns. Through the Pathways to Success initiative, Title V provided support for selected high schools and community colleges in Erie and Monroe counties and the Bronx to create and sustain supportive systems that assist pregnant and parenting teens/young adults to succeed through health, education, self-sufficiency, and strong families. Title V also contracts with three school districts and three community colleges which are also served by MICHC and MIECHV projects. These contractors focus on building collaborations with other Title V programs to strengthen support networks and referral systems for pregnant and parenting teens/young adults in these communities. Clients enrolled in the projects receive healthcare referrals for prenatal, interconception, and postpartum care, social referrals to Special Supplemental Nutrition Program for Women, Infants and Children and local Department of Social Services (DSS), and educational supports to better ensure academic success. Over the past year, the program served 1,097 students (423 high school and 674 community college) of which 148 were pregnant and 864 were parenting (85 students had an unknown status) and 462 children received health and supportive services. All six pilots are expected to sustain services for pregnant or parenting people and their children through integration of services into existing infrastructures (e.g. wellness programs) and maintain lactation rooms on community college campuses.

In addition to strong community supports and services, improving birth outcomes necessitates a strong system of perinatal hospital services, ensuring women, mothers, and newborns receive a comprehensive level of care to meet their needs. Perinatal regionalization is essential to improving the health of pregnant and postpartum women and infants. NY has achieved long-standing leadership in the field of perinatal regionalization by ensuring pregnant and postpartum women and their newborns receive care from, and deliver at, a perinatal hospital with the appropriate level of expertise. In 2014, 92.3% of VLBW infants were delivered at facilities for high risk deliveries and neonates, well above the HP 2020 target of 82.5%. NY's system of regionalized perinatal services includes a hierarchy of four levels of perinatal care provided by the hospitals within a region and led by a 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 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. NY's Title V program initiated a contract with the Island Peer Review Organization (IPRO) in late 2016 to assist in updating the standards for perinatal levels of care, develop the process to re-designate all obstetrical hospitals, and develop standard metrics to assess maternal and neonatal outcomes to identify opportunities for quality improvement. Over the past few months, IPRO has been researching current standards of care including ACOG/AAP Guidelines for Perinatal Care, other standards and literature. Title V staff worked with key stakeholders to identify an expert panel consisting of clinicians, hospital associations, health plans and others to work with the NYSDOH to finalize standards for the perinatal system of care. The system in NYS will also include a new component. In 2016, legislation was passed allowing mid-wife led birthing centers in NYS. The new standards will include birthing centers as the first level of care followed by Levels 1 through 3 and RPCs as the highest level of perinatal care. (**ESM PIH-2:** Percentage of birthing hospitals re-designated with updated standards.) The goal of this important initiative is to strengthen the perinatal regionalized system in NYS to ensure all birthing centers and obstetrical hospitals in NY meet current standards of care, and are affiliated with a strong RPC, in order for all pregnant and postpartum women and newborns to receive the best care possible at an appropriate level perinatal hospital.

To build on NY's rich system of perinatal care and aim to provide the best and safest care for pregnant and postpartum women and infants, Title V staff led the NYS NYSPQC initiative through collaboration with RPCs, RPC affiliate birthing hospitals, perinatal care providers, community-based organizations, NY's hospital associations, the National Institute for Children's Health Quality (NICHQ),

and other key stakeholders. The initiative aimed to prevent and minimize harm through the translation of evidence-based guidelines to clinical practice. Several initiatives under the scope of the NYSPQC focus on reducing infant mortality and morbidity including: the Safe Sleep Project, IM-CoIIN, Enteral Nutrition Improvement Project, and the NYSPQC/March of Dimes (MOD) Big 5 State Prematurity Collaborative Antenatal Corticosteroid Treatment (ACT) Project. (**ESM PIH-3:** Percentage of eligible birthing hospitals participating in a current QI activity.)

The NYSPQC Safe Sleep Project began in September 2015 and focuses on improving safe sleep practices to reduce IM in NY. The project aligns with national and NY efforts pertaining to the IM-CoIIN. NY's Title V program is working with 81 NY birthing hospitals, that had 183,605 (77.2%) statewide births in 2014, to improve infant safe sleep practices. Participating facilities collaborate across hospital teams to share and learn, implement hospital policies to support/facilitate safe sleep practices, educate health care professionals, endorse and model safe sleep practices, and provide infant caregivers education opportunities on safe sleep. All NY birthing hospitals assessed practices and variation across facilities in relation to infant safe sleep. Over the past year, Title V staff held two in-person Learning Sessions, two Quality Improvement 101 webinars, a data training webinar, and nine Coaching Call webinars. Project participants reported a 7% increase in medical records with documentation of safe sleep education; 40% increase in the percent of infants, sleeping or awake-and-unattended in crib in a safe sleep environment; 9% increase in the percent of caregivers who reported they received information on how to put their baby to sleep safely; and 18% increase in the percent of primary caregivers indicating they understood safe sleep practices between September 2015 and November 2016.

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

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

Under the HRSA-led national IM-CoIIN, Title V focused on increasing awareness and collaboration for stakeholders on one of the leading causes of IM in NY, Sudden Unexpected Infant Death (SUID). The NY IM-CoIIN develops key projects in partnership with the child welfare system including the NY OCFS, NY OASAS, NY Office of Temporary Disability Assistance (OTDA), and the Division of Nutrition's (DON) Women, Infants and Children (WIC) clinics, and NY Department of Motor Vehicles. In partnership with OCFS, patient education materials highlighting the ABCs of safe sleep (Alone, Back, Crib) were developed and distributed to all NY birthing hospitals in 2015 and 2016. These safe sleep materials include a brochure available in the seven most commonly spoken languages in NY, mirror clings, magnets, posters in English and Spanish, crib cards, and a one-minute video in English and Spanish. (**ESM PIH-6:** Number of collaborative strategies implemented to reduce sleep-related infant death.)

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

Growth Scale, difference in Z-scores for birth and discharge head circumferences, postmenstrual age at discharge (days), and median initial length of stay (days). All NY RPCs began participation in 2010 and the initiative was expanded in 2016 to include 20 Level III facilities. All facilities share efforts and results through monthly Coaching Calls and quarterly performance measure data reports. The initiative appears to have significantly increased the use of breast milk at all feeding junctures and improved growth as measured by decreases in weight and head circumference percentages below 10^{th} percentile at discharge. No increase in the incidences of nosocomial sepsis or NEC, nor an increase in the babies discharged more than the 75^{th} percentile for either growth measure indicate the interventions are safe. Through this work, an estimated 86 babies < 31 weeks in gestation at birth did not go home below the 10^{th} percentile for growth. A manuscript entitled, "*Variation in Enteral Feeding Practices and Growth Outcomes among Very Premature Infants: A Report from the NYS Perinatal Quality Collaborative,*" was published in the *American Journal of Perinatology* in January 2016 and seven abstracts have been published and presented at national meetings based on this project.

To reduce neonatal morbidity and mortality, the NYSPQC/MOD Big 5 State Prematurity Collaborative ACT Project has worked toward improving hospital obstetric practices so all pregnant women at risk for delivery between 23 0/7 and 34 0/7 weeks' gestation receive appropriate ACT. According to 2014 NY birth data, only 36% of mothers with infants born between 23 0/7and 34 0/7 weeks' gestation received ACT. Participating NY RPCs, recruited by the NYSPQC, can collaborate with hospitals from other Big 5 states regarding ACT to align goals and resources to bring more attention and energy to this effort. The joint project addresses the understanding and timing of ACT administration and standardization of assessment of imminent delivery. National and NY specific ACT Coaching Call webinars gave NY RPCs the opportunity to learn from national experts and hospital teams. Data collected through the Big 5 State Prematurity Collaborative shows that among participating hospitals, the percent of births between 23 0/7 and 34 0/7 weeks' gestation receiving any ACT increased from 90% in January 2016, to 94% in December 2016. Participating hospitals also reported an increase in the percent of births receiving ACT in the optimal period, 24 hours to seven days prior to delivery, from 51% of births in January 2016 to 57% in December 2016.

NY's Title V program has also been involved in discussions and plans related to DSRIP which include at least one project focusing on increasing the use of evidence-informed policies and evidence-based programs pertaining to the healthy development of children, youth, and adults. DSRIP providers are encouraged to collaborate with the community and other providers to address statewide public health priorities pursuant to NY's PA, namely Prevention of Chronic Diseases, Promoting a Healthy and Safe Environment, Promoting Healthy Women, Infants, and Children through the prevention of prematurity, Promoting Mental Health and Preventing Substance Abuse, Prevention of HIV/STDs, Vaccine-Preventable Disease and Healthcare-Associated Infections. Some of these projects are focused on increasing support for maternal and child health through expansion of NFP projects or the use of CHWs for community outreach and engaging women in prenatal care. Other projects focus on evidence-based models of care such as Centering Pregnancy, enhanced services, and the use of Health Information Technology (HIT) for communication to improve prenatal care. Through Medicaid Redesign, HIT projects were developed in four high need areas (Monroe, Onondaga, Westchester, and Kings counties) to demonstrate the effectiveness HIT to coordinate perinatal services, reduce costs by streamlining fragmented and redundant systems, increase patient access to medical records, and improve quality of care. These projects completed the development of HIT systems designed to identify the psycho-social risk factors of high-risk pregnant people and make referrals to needed services. National guidance and state legal counsel addressing system issues to centrally assess need and ensure appropriate referrals are made, while maintaining confidentiality.

Title V remains ready to address any public health issue impacting the maternal and child health population including new and emerging public health priorities such as the Zika virus and opioid epidemic. (Refer to the annual report and application section for Maternal and Women's Health for information related to NY's Title V role in the opioid epidemic.) This past year, Title V staff participated in various activities to address potential issues with the Zika virus. MICHC staff collaborated with the DOH Division of Epidemiology to improve communication from community-based organizations with women who may be at risk of contracting the virus. A training was conducted for all MICHC providers on Public Health Detailing (PHD) about Zika virus screening in impacted

areas. Following the training, MICHC providers conducted PHD to 157 area providers who serve at-risk women throughout the Fall of 2016. The PHD focused on connecting providers with DOH Zika virus resources including testing, materials (bilingual), and prevention kits. Title V staff engaged in interagency discussions to better ensure infants who test positive for the Zika virus are referred to the local EIP for potential follow-up and/or early intervention services as appropriate.

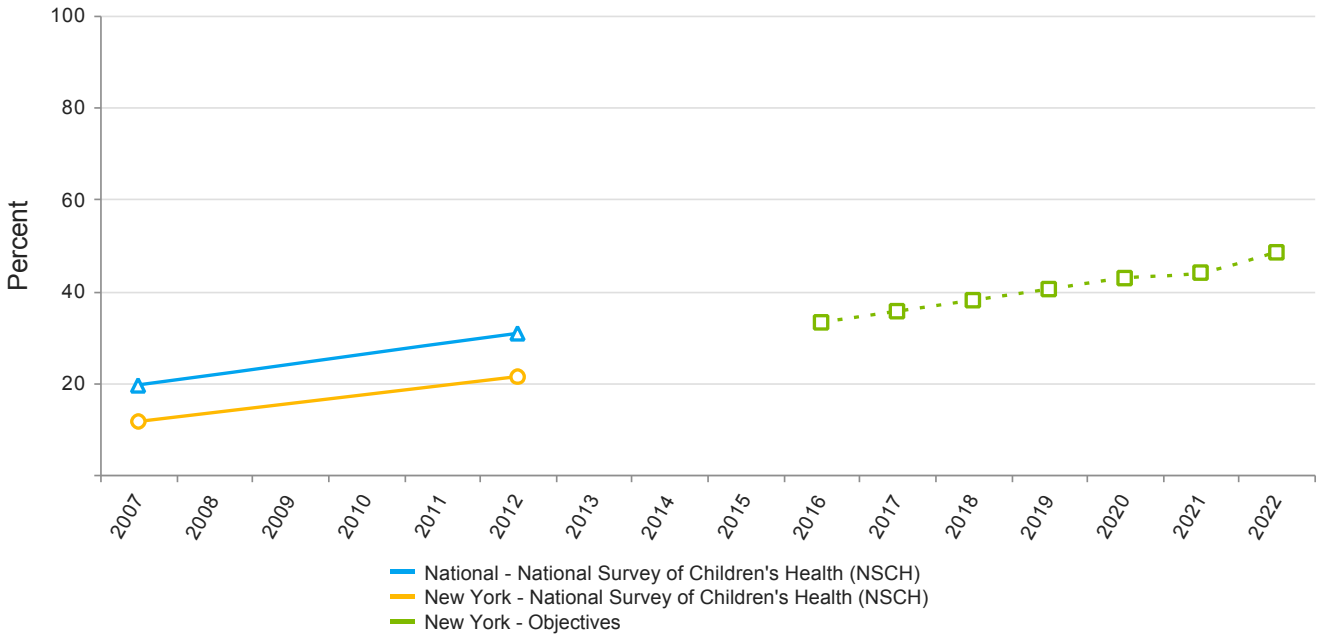
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	83.2 %	NPM 6 NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	32.4 %	NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	30.1 %	NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2015	27.0 %	NPM 8

National Performance Measures

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	33.2
Annual Indicator	21.3
Numerator	237,057
Denominator	1,115,288
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	35.6	38.0	40.4	42.8	44.0	48.4

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Initial data report is issued.

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 6.2 - Number of child-serving MCH programs implementing the asset profile tool.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	NYS Title V Program records.
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	1.0	1.0	1.0	1.0	1.0

ESM 6.3 - Number of DOH MCH staff and external partners trained on: a) social-emotional wellness and b) trauma-informed care practices.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	382
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2016-2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	400.0	450.0	500.0	550.0	600.0

ESM 6.4 - Number of child-serving MCH programs identified with an evidence-based social-emotional component.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	5
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	5.0	6.0	8.0	8.0	8.0

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
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	NYS Medicaid Health Home Data
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	4,000.0	5,000.0	6,000.0	7,000.0	10,000.0

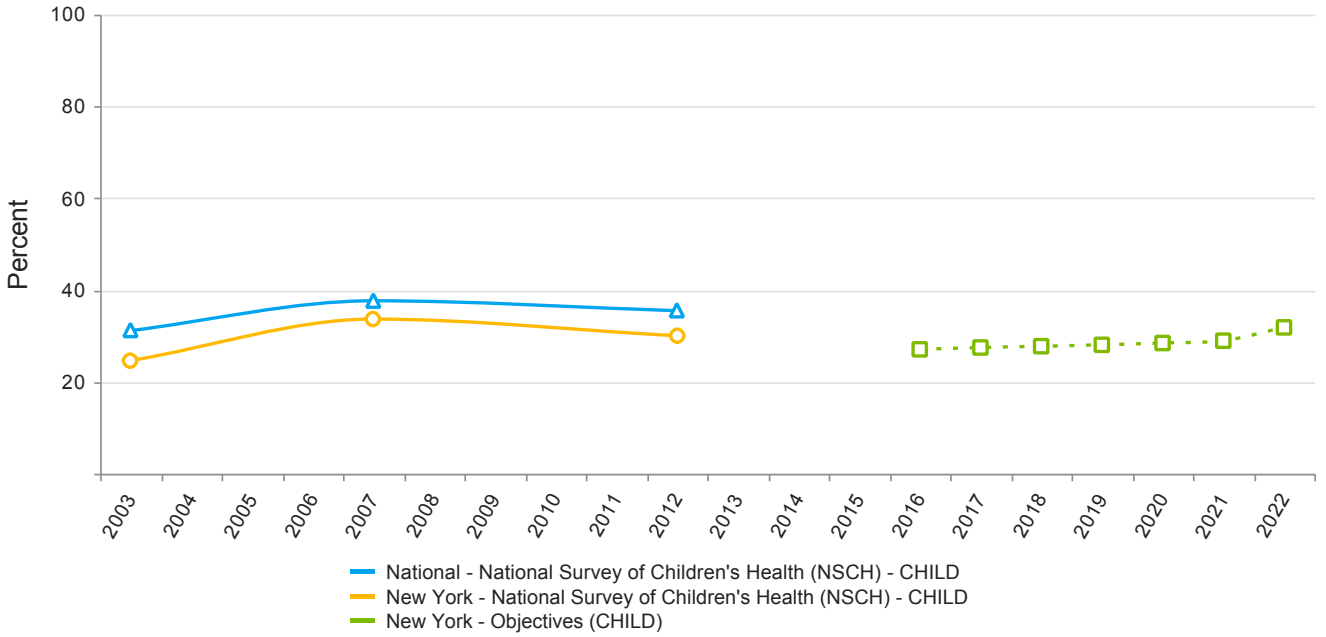
ESM 6.6 - Number of strategies implemented to improve developmental screening.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	5
Numerator	
Denominator	
Data Source	Title V Program Records
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
Baseline Indicators and Annual Objectives



NPM 8 - Child Health

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CHILD	
	2016
Annual Objective	27.1
Annual Indicator	30.0
Numerator	414,344
Denominator	1,379,538
Data Source	NSCH-CHILD
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	27.5	27.8	28.1	28.5	29.0	31.9

Evidence-Based or –Informed Strategy Measures

ESM 8.1 - a) Number PBI workgroup meetings held and attended by Title V staff; b) Number of resources are developed and disseminated based on PBI workgroup.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2
Numerator	
Denominator	
Data Source	Title V Program data
Data Source Year	7/16-6/17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

ESM 8.2 - Number of community environmental changes demonstrated as a result of enhanced collaborations.

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

ESM 8.3 - a) Evidence-informed framework to structure and measure collaborative efforts is established or identified; b) Number of internal partners trained; c)Number of external partners trained.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Title V Program data
Data Source Year	7/16-6/17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

State Performance Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	To Be Developed
Data Source Year	2017-2018
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	50.0	50.0	52.0	55.0	56.0

State Action Plan Table

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

Priority Need

Support and enhance social-emotional development and relationships for children and adolescents

NPM

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objectives

Objective CH-1: Increase the percentage of children surveyed who demonstrate 20 or more developmental assets by 10% from baseline (to be established in Years 2-3)

Objective CH-2 (Same as LC-2): Increase the percentage of children 10-71 months who whose parents report they have had a developmental screening using a parent-completed screening tool by 10% to 31.3%.

Strategies

Strategy CH-1: Develop and implement a plan for analysis and reporting of available data on children's social-emotional well-being and adverse childhood experiences (ACES).

Strategy CH-2: Identify, pilot test and implement validated tool for measuring positive developmental social-emotional assets among children and adolescents that can be used across MCH child-serving programs.

Strategy CH-3: Provide training for Title V staff and external partners, including local child-serving grantees, to increase: 1) awareness, knowledge, and skills to support children's social emotional development; and 2) trauma-informed care practices.

Strategy CH-4: Identify, support and integrate evidence-based/-informed strategies to promote children's social-emotional wellness and positive developmental assets through established Title V programs, including: Maternal and Infant Community Health Collaboratives (MICHC), Home Visiting, Infant/Child Mortality initiative, Early Intervention, Successfully Transitioning Youth to Adolescence (STYA) and School-Based Health Centers.

Strategy CH-5: Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for eligible children with serious emotional disturbance and complex trauma.
Strategy LC-1: Integrate performance standards, measures and improvement strategies related to health insurance enrollment across all Title V/ MCH programs.

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

Strategy LC-10: Continue and increase Title V staff leadership and participation in the DOH Place-Based Initiative (PBI) work group to: Adopt a shared definition and set of indicators to measure healthy communities; Review place-based initiatives to identify best practices for community environmental change; Develop a toolkit of data and evidence-based/-

informed practices for community change; and Incorporate requirements for healthy community practices within relevant MCH funding procurements.

Strategy LC-11: Enhance collaboration with key partners to advance changes in community environments that promote maternal & child health: increase access to healthy affordable foods & opportunities for physical activity in high-need communities through the Creating Healthy Schools & Communities program(with DOH Division of Chronic Disease Prevention)strengthen linkages between Title V programs and the Healthy Neighborhoods Program(with DOH Center for Environmental Health)support the Regional Centers for Sexual Violence Prevention to implement primary prevention environmental change strategies at the community and individual levels(with DOH Bureau of Injury Prevention) & incorporate selected health-related quality indicators in new quality improvement initiative for regulated child care programs(with Office of Children & Family Services)incorporate health promotion information & linkages within Community Schools initiative (State Education Department and Council on Children & Families

Strategy LC-12: Establish or adopt an evidence-informed framework for structuring, measuring and improving collaboration at state and community levels, and provide support to strengthen both internal and external partner capacity to implement the framework across MCH programs.

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

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

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

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

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

ESMs	Status
ESM 6.1 - Initial data report is issued.	Inactive
ESM 6.2 - Number of child-serving MCH programs implementing the asset profile tool.	Inactive
ESM 6.3 - Number of DOH MCH staff and external partners trained on:a) social-emotional wellness and b) trauma-informed care practices.	Inactive
ESM 6.4 - Number of child-serving MCH programs identified with an evidence-based social-emotional component.	Inactive
ESM 6.5 - Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.	Active
ESM 6.6 - Number of strategies implemented to improve developmental screening.	Inactive

NOMs

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

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (New York) - Child Health - Entry 2

Priority Need

Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course.

NPM

Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Objectives

* Objective LC-8: Increase the percentage of children and adolescents who are physically active at least 60 minutes daily by 10%, from 25.7% in 2013 to 28.5%.

* Objective LC-9: Increase the percentage of children and adolescents who live in supportive/ cohesive neighborhoods by 6%, from 79.2% in 2011/12 to 84%.

* Objective LC-10: Increase the percentage of children and adolescents who are usually or always safe in their community or neighborhood by 5%, from 79.9% in 2011/12 to 84%.

Strategies

Strategy LC-10: Continue and increase Title V staff leadership and participation in the DOH Place-Based Initiative (PBI) work group to: * Adopt a shared definition and set of indicators to measure healthy communities; * Review place-based initiatives to identify best practices for community environmental change; * Develop a toolkit of data and evidence-based/-informed practices for community change; * Incorporate requirements for healthy community practices within relevant MCH funding procurements.

Strategy LC-11: Enhance collaboration with key partners to advance changes in community environments that promote maternal and child health: * increase demand for and access to healthy, affordable foods and opportunities for daily physical activity in high-need communities through the Creating Healthy Schools and Communities program (with NYSDOH Division of Chronic Disease Prevention) * strengthen linkages between Title V programs and the Healthy Neighborhoods Program (with NYSDOH Center for Environmental Health) * support the Regional Centers for Sexual Violence Prevention to implement primary prevention environmental change strategies at the community and individual levels (with NYSDOH Bureau of Injury Prevention) * incorporate selected health-related quality indicators in new quality improvement initiative for regulated child care programs (with Office of Children & Family Services) * incorporate health promotion information and linkages within Community Schools initiative (with me

Strategy LC-12: Establish or adopt an evidence-informed framework for structuring, measuring and improving collaboration at state and community levels, and provide support to strengthen both internal and external partner capacity to implement the framework across MCH programs.

ESMs	Status
ESM 8.1 - a) Number PBI workgroup meetings held and attended by Title V staff;b) Number of resources are developed and disseminated based on PBI workgroup.	Inactive
ESM 8.2 - Number of community environmental changes demonstrated as a result of enhanced collaborations.	Active
ESM 8.3 - a) Evidence-informed framework to structure and measure collaborative efforts is established or identified;b) Number of internal partners trained; c)Number of external partners trained.	Inactive

NOMs
NOM 19 - Percent of children in excellent or very good health
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

State Action Plan Table (New York) - Child Health - Entry 3

Priority Need

Support and enhance social-emotional development and relationships for children and adolescents

SPM

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

Objectives

Objective CH-1: Increase the percentage of children surveyed who demonstrate 20 or more developmental assets by 10% from baseline (to be established in Years 2-3)

Objective CH-2 (Same as LC-2): Increase the percentage of children 10-71 months who whose parents report they have had a developmental screening using a parent-completed screening tool by 10% to 31.3%.

Strategies

Strategy CH-1: Develop and implement a plan for analysis and reporting of available data on children's social-emotional well-being and adverse childhood experiences (ACES).

Strategy CH-2: Identify, pilot test and implement validated tool for measuring positive developmental social-emotional assets among children and adolescents that can be used across MCH child-serving programs.

Strategy CH-3: Provide training for Title V staff and external partners, including local child-serving grantees, to increase: 1) awareness, knowledge, and skills to support children's social emotional development; and 2) trauma-informed care practices.

Strategy CH-4: Identify, support and integrate evidence-based/-informed strategies to promote children's social-emotional wellness and positive developmental assets through established Title V programs, including: Maternal and Infant Community Health Collaboratives (MICHC), Home Visiting, Infant/Child Mortality initiative, Early Intervention, Successfully Transitioning Youth to Adolescence (STYA) and School-Based Health Centers.

Strategy CH-5: Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for eligible children with serious emotional disturbance and complex trauma.

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

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

Strategy LC-10: Continue and increase Title V staff leadership and participation in the DOH Place-Based Initiative (PBI) work group to: Adopt a shared definition and set of indicators to measure healthy communities; Review place-based initiatives to identify best practices for community environmental change; Develop a toolkit of data and evidence-based/-informed practices for community change; and Incorporate requirements for healthy community practices within relevant MCH funding procurements.

Strategy LC-11: Enhance collaboration with key partners to advance changes in community environments that promote maternal & child health: increase access to healthy affordable foods & opportunities for physical activity in high-need communities through the Creating Healthy Schools & Communities program(with DOH Division of Chronic Disease Prevention)strengthen linkages between Title V programs and the Healthy Neighborhoods Program(with DOH Center for Environmental Health)support the Regional Centers for Sexual Violence Prevention to implement primary prevention environmental change strategies at the community and individual levels(with DOH Bureau of Injury Prevention) & incorporate selected health-related quality indicators in new quality improvement initiative for regulated child care programs(with Office of Children & Family Services)incorporate health promotion information & linkages within Community Schools initiative (State Education Department and Council on Children & Families

Strategy LC-12: Establish or adopt an evidence-informed framework for structuring, measuring and improving collaboration at state and community levels, and provide support to strengthen both internal and external partner capacity to implement the framework across MCH programs

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

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

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

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

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

FY 2018 Application

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

2020 State Objectives:

- **Objective CH-1: Increase the percentage of children surveyed who demonstrate 20 or more developmental assets by 10% from baseline.**
- **Objective CH-2: Increase the percentage of children 10-71 months who whose parents report they have had a developmental screening using a parent-completed screening tool by 10% to 31.3%.**

Due to the strong influence social-emotional development can have on children and adolescents throughout the lifespan, NY's Title V program selected the *Social-Emotional Development and Relationships for Children and Adolescents* as state priorities. Although work on these domains is closely intertwined, plans will be addressed separately for children and adolescents.

In the upcoming year, NY's Title V program will continue to focus efforts on the priority to support and enhance social-emotional development and relationships for both the child health and adolescent health domains. There is no specific data to report on State Objectives listed above (CH-1 and CH-2) as the past year has been devoted to the developmental work needed to implement the strategies needed to support these objectives. These data are also from the NSCH report to be released later in 2017.

Specific to child health, Title V will continue the work throughout the DFH as described in the Annual Report. These programs are strong public health initiatives that impact social-emotional development and relationships for children. Staff will continue to refine strategy areas, plan and further develop work that is already underway. Staff will focus on assessing progress, successes, barriers and challenges while evaluating progress on measures and reviewing further developments for this priority. A commitment to strengthen aspects of social-emotional developmental assets will continue to have positive effects beyond childhood and adolescents. As new procurements are released to provide funding for organizations that work with children and adolescents throughout NY communities, it is anticipated that language supporting evidence-based /evidence-informed strategies be adopted to include building social-emotional wellness for these domains. Additional specific actions based on the five strategies for this priority are listed below.

Strategy CH-1 – Develop and implement a plan for analysis and reporting of available data on children's social-emotional well-being and adverse childhood experiences (ACES).

During the upcoming period, the Title V program will seek to increase collaborative efforts with other NYSDOH initiatives, including continuing efforts with the Pyramid Model and Adverse Childhood Experiences. The Pyramid Model established by the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) focuses on the promotion of social, emotional, and behavioral developmental competencies for young children, aged 0-5. The workgroup will also focus on establishing partnerships with other state agencies, including the Council for Children and Families and the Office of Mental Health to continue to enhance the catalogue of emerging data and information as well as disseminate relevant information to staff and providers. Staff will continue to distribute the quarterly Social-Emotional Wellness Update to DFH staff and remain a source of content expertise within the DFH to specifically address and incorporate social-emotional evidence based /evidence-informed strategies into funding procurements. Next steps for this strategy measure include the sharing of dialogue and information with key staff members assigned to these collaborative efforts to determine what the opportunities for collaboration are. Title V staff may highlight these efforts through site sharing and will identify additional opportunities to bring these efforts into the work being done through the DFH on social-emotional wellness initiatives in communities.

Implementation of this strategy is measured by **ESM CH-1:** Initial data report is issued.

Strategy CH-2 – Identify, pilot test and implement validated tool for measuring positive developmental social-emotional assets among children and adolescents that can be used across MCH child-serving programs.

During the upcoming reporting period, NY's Title V program will obtain necessary approvals to administer an effective survey tool with the pilot programs and begin using the tool in a limited capacity to gather, analyze, and disseminate data on the state of social-emotional health for children throughout select populations across the state. This tool should be used to take a representative sample of the populations that DFH serves to provide a baseline of NYS's developmental assets. Title V staff will work with stakeholders to approve the tool before it is implemented. These stake-holders include program contractors and the Assets Coming Together for Youth Center of Excellence. (ACT COE). The ACT COE is a NYSDOH contract that brings research to practice in areas of positive youth development and adolescent health. They will provide resources to identify and review already accepted social-emotional wellness survey tools and have access to youth aged 9-21 across the State who can participate in reviewing the tool for content/age appropriateness. The staff will work with other DFH programs to adapt the tool for their specific age-group or priority population.

Implementation of this strategy is measured by **ESM CH-2:** Number of child-serving programs implementing the asset profile tool.

Strategy CH-3 – Provide training for Title V staff and external partners, including local child-serving grantees, to increase: 1) awareness, knowledge, and skills to support children's social emotional development: and 2) trauma-informed care practices.

NY's Title V program will develop an internal querying survey to identify the actual number of DFH staff who have participated in at least one related training. Efforts will continue to track the number of trainings, the intended audience and the actual audience for each training conducted within DFH as well as those done by our partners. Feedback will be provided to DFH staff and recommendations will be made to specific trainings that could benefit staff and community providers on specific trainings focusing on aspects specific to their programs and initiatives. Additionally, staff will continue to identify trainings within the realm of social-emotional wellness and inform DFH staff and/or providers of these training opportunities. Staff will continue to work with internal and external partners to recommend trainings and webinars on topics related to social-emotional development and relationships for young people. In the upcoming reporting year, the Title V program will identify and disseminate at minimum 2 training events per month across DFH, and have 200 staff members and 500 community providers attend these events (duplicated counts). This strategy is vital to the work being done by NY's Title V program as an increase in trained staff and community support will increase overall awareness of the NYSDOH's goal to increase positive youth development and trauma-informed care strategies throughout the state.
Implementation of this strategy is measured through **ESM CH-3**: Number of DOH MCH-staff and external partners trained on: a) social-emotional wellness and b) trauma-informed care practices.

Strategy CH-4 – Identify, support and integrate evidence-based/informed strategies to promote children's social-emotional wellness and positive developmental assets through established Title V programs, including: Maternal and Infant Community Health Collaboratives (MICHC), Home Visiting, Infant/Child Mortality Initiative, Early Intervention, Successfully Transitioning Youth to Adolescence (STYA) and, School-Based Health Centers.

During the upcoming reporting period, Title V staff will contact previously identified programs within DFH and gather additional information on how/if health equities and disparities are addressed. Through research-review, staff will analyze the responses and determine if the strategies are evidence-based, evidence-informed, or promising practices or if the initiatives need to incorporate these strategies into their program. Staff will explore how social-economic and other health disparities impacted overall social-emotional health and wellness for youth residing in communities throughout New York. Staff will highlight programs that are using sound methodology to incorporate social-emotional relationships and development while offering recommendations to the programs that can

benefit from incorporating these methodologies. Programs that are excelling in using these strategies will be emphasized in the quarterly Social Emotional Wellness Update that is distributed throughout DFH and to providers.

Implementation of this strategy is being measured through **ESM CH-4**: Number of child-serving MCH programs identified with an evidence-based social-emotional component.

Strategy CH-5 – Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for eligible children with serious emotional disturbance and complex trauma.

Title V staff will continue to provide subject matter and technical support to NY'S Medicaid HH program to implement enhanced care coordination for eligible children with serious emotional disturbance and complex trauma. The HH for Children will be implemented statewide during this period. DFH staff will work with colleagues in the OHIP to monitor enrollment and ensure children receive coordinated care across all the State's systems of care.

Implementation of this strategy is being measured through **ESM CH-5**: Number of children with documented serious emotional disturbances and/or complex trauma who are enrolled in Medicaid Health Home.

FY 2016 Annual Report

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

Social-emotional development is defined as a child's capacity for self-confidence, trust, and empathy and is a strong predictor of later academic, social and emotional success throughout life. Social-emotional development is impacted by a wide range of factors including but not limited to genetics, relationships, and the environment, all interacting and changing through life. Due to the strong influence social-emotional development can have on children and adolescents throughout the lifespan, NY's Title V program selected the *Social-Emotional Development and Relationships for Children and Adolescents* as state priorities. Although work on these domains is closely intertwined, it will be reported separately for children and adolescents.

One of the challenges identified for this priority focus is that the National Outcome Measures (NOMs) and National Performance Measures (NPMs) for the child health domain do not appear to comprehensively reflect social-emotional wellness for children. While the NOMs and NPMs are included for the Annual Report, the DFH established specific state measures to better reflect the work being done on this topic in the DFH. The aim of these strategies is to increase awareness of social-emotional wellness throughout DFH, promote evidence-based and informed strategies throughout community-based programs supported by Title V and to decrease disparities related to social-emotional wellness.

As with all NY's SAP priorities, each priority includes a strategy related to data analysis to ensure a clear understanding of the scope of the public health issue. Over the past year, staff identified several existing data sources, as well as relevant research findings, and evidence-based program resources, and made them available and accessible to all DFH staff by posting them on the DFH's internally shared website, as an important step in analyzing and reporting available data on children's social-emotional well-being. This includes current research, national and state-level statistics and indicators, registries of programs effective in reducing youth risk behaviors and resources for evidence-based programs. (**ESM CH-1:** Initial data report issued.) On a periodic basis, staff reviews the materials and discusses the information during unit and Division wide-meetings.

Staff also created an information publication, titled "Social Emotional Wellness Update". This publication was created to help highlight and disseminate information with internal and external 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. The workgroup will continue to publish the Social Emotional Wellness Update on a quarterly basis to keep Title V staff informed of information and developments related to this priority area.

As stated in NY's FY 2017 application, supporting children and adolescents' social-emotional development is an emerging field in maternal and child health and, as such, work on this priority for NY's Title V program continues to evolve. In order to provide a meaningful contribution, a priority over the past year was for Title V staff to increase their understanding of the complexities within this topic and to identify and embrace the evidence-based strategies associated with this work. Foundational work was conducted to develop a framework within which to address social-emotional development. The focus for some of the formative work in this area includes research and data for positive youth development strategies, ACEs, trauma informed care, well-child definitions and early intervention strategies as well as reviewing state and national-level data on specific measures that are considered to be within the scope of social-emotional development and relationships for the child health domain; including from the YRBS and the NSCH.

As stated previously, for Title V staff to address this priority area, it is essential that staff are well-informed regarding the issues and strategies to support social-emotional development. Over the past year, Title V staff identified relevant local, statewide and national

trainings offered to DFH staff, community providers and other external partners. Specifically, seventeen training opportunities were offered between July and December 2016. Staff determined that the majority of DFH staff and their respective program providers have participated in at least one related training, while many staff have attended three or more trainings (**ESM CH-3**: Number of DOH MCH staff and external partners trained on: a) social-emotional wellness and b) trauma-informed practices.) Information on training attendance was collected with the assistance of various community partners and contracted providers. Examples of DFH staff trainings included: Adverse Childhood Experiences (ACEs), the Impact of Domestic Violence on School-Aged Children and Trauma-Informed Care Approaches. Trainings for providers and community partners included: Supporting Adolescents' Self-Control, Trauma and Positive Youth Development: What is the Consequence and Sharing Evidence-Based Practices with Early Childhood Programs. Many of these trainings were attended by both staff and providers.

Over the past year work was initiated on identifying, testing and implementing a validated tool for measuring positive developmental social-emotional assets among children. During the reporting period, Title V staff identified programs that are suitable for a pilot and have continued to work with key partners to identify a proper validated tool that can measure social-emotional assets in children and adolescents. The first program that will implement the tool is the Comprehensive Adolescent Pregnancy Prevention (CAPP) initiative. This program has been chosen as a new five-year contract period commenced in January 2017 implementing evidence-informed multi-dimensional approaches with youth to increase positive youth development among participating adolescents and therefore was deemed "most ready" to implement this process. (**ESM CH-4:** Number of child-serving MCH programs identified with an evidence-based social-emotional component.) While the tool has yet to be chosen, it will encompass the developmental assets as defined by the Search Institute. The Search Institute is a public health research and policy organization that specializes in tools concentrating on social-emotional wellness and positive development for youth. The Search Institute developed the 40 developmental assets for specific age-ranges throughout childhood and adolescents; from newborns through adolescence, which is the framework for positive social-emotional development that has become a primary focus for this priority group. The tool is expected to take the form of validated surveys will be used within priority populations focusing on children and adolescents currently enrolled in DFH programs that use positive youth development approaches. This tool will be adapted for different age populations and will be implemented in additional DFH programs, including the Successfully Transitioning Youth to Adolescent (STYA) and EI programs. These programs were also selected as pilot groups as each program has a direct and specific impact on social-emotional wellbeing, in addition to focusing on different age groups which should provide rich data for the DFH: EI focuses on children aged 0-3, STYA focuses on pre-teens aged 9-12, and CAPP works with adolescents between the ages of 13-21.

Title V staff also assessed the capacity of existing DFH programs with a social-emotional component to adopt the use of a validated tool to measure this social-emotional development of children served. Title V staff reviewed the current list of programs that were identified as having a social emotional component through a process of interviews, and data synthesis. Within DFH, 21 community-based programs were identified and reviewed over the past year, which is the total number of community programs and initiatives within the DFH serving this population. Through in-person interviews and program reviews, 17 of these 21 programs were identified as addressing some aspect of social-emotional wellness within their programs, as identified in internal and external developmental asset categories, defined by The Search Institute. (**ESM CH-2:** Number of child-serving programs implementing the asset profile tool.) A table was developed identifying the DFH programs and developmental asset categories. Staff are compiling a list of the evidence-based, evidence-informed and promising strategies that each program uses to monitor the social emotional component on the program in which they work. Staff have reviewed the list to identify programs that also include an equity component within this context since many DFH programs are focused on socio-economic conditions and its impact regarding disadvantaged communities and populations.

NY's Title V program is also able to build on experiences learned through a long history of addressing social and emotional wellness in several key programs and initiatives. The EIP which is organizationally situated in the DFH, provides services to infants and toddlers 0-3 with developmental delay or disability and their families. Developmental delay means that a child has not attained developmental milestones expected for the child's chronological age adjusted for prematurity in one or more of the following areas of

development: cognitive, physical (including vision, hearing, oral-motor feeding and swallowing disorders), communication, social/emotional, or adaptive development. Disability means a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. Eligible children and their families receive a range of therapeutic and supportive services at no cost pursuant to an Individualized Family Services Plan. Services include family education, counseling, parent support groups, occupational and physical therapy, speech pathology and audiology, nursing, nutrition, social work, vision, psychological and service coordination services. The EIP provides over seven million service interactions to approximately 65,000 children every year. The EIP collects data on each child's social-emotional development and provides services that focus on all eight categories of social-emotional developmental assets as defined by the Search Institute.

Title V programs serving school-age children also include core strategies that address positive development and behavioral health. SBHC 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 and mental health services are provided by referral in sites that do not have in-clinic resources. Currently, in NYS there are over 250 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 181,569 students and provided 649,244 visits for health and supportive services.

NY's innovative STYA program, funded through the federal Abstinence Education Grant Program, supports 16 community-based organizations across the state to implement strategies to build protective factors for young people ages 9-12 living in high risk communities, including youth in foster care, youth with physical disabilities, and homeless and disconnected youth, to promote a transition to a healthy, productive, connected adolescence. Mentors provide youth with support and information on a wide range of topics framed in a youth development philosophy, focusing on the needs of youth and building on and nurturing the youth's individual strengths and needs. They provide adult-supervised activities to stimulate cognitive, social, physical and emotional growth. Group discussions occur to share information regarding topics of interest to pre-teen youth. Caring adults are available for more in-depth support and discussions. These programs also provide parent education to parents, guardians and adult caregivers to create a more nurturing environment for these youths. Over the past year, the STYA program reached 2,100 participants. Title V staff will continue to work with these providers to promote social emotional development of NY's pre-teen population.

The MICHC initiative aims to improve health outcomes for high need women and infants, by working with community partners and utilizing CHWs to assess women and their families and connect them with needed resources. There are currently 24 MICHC projects in priority communities across NYS. The MICHC initiative touches upon developmental assets in the following areas: support, empowerment, positive values, social competencies, and positive identity**.**

Similarly, the MIECHV works with families of infants through age-two to promote healthy behaviors and provide support for mothers. The MIECHV Initiative supports the NFP and the HFNY program; both evidence-based home visiting initiatives. NFP pairs first-time, low-income mothers with a nurse home visitor. The nurse helps to engage the mother in preventive health practices (e.g. prenatal care, healthier diet), empower parents to provide the best care for their children, and to become economically self-sufficient. Home visits occur from pregnancy through two years of age. The program is currently in the following counties: Bronx, Kings, Cayuga, Chautauqua, Chemung, Erie, New York, Monroe, Nassau, Onondaga, Queens and Richmond and served 3,454 pregnant women and caregivers of 2,702 young children between the ages of 0-5 in the past year.

HFNY pairs under-resourced families with home visitors from their own community (Family Support Workers) during the pregnancy or shortly after birth. Weekly visits occur until the child is six months old and occur less frequently until the child is enrolled in Head Start, kindergarten, or turns five years old. Visits are individualized to suit the family's needs. Programs aim to aid families struggling

with homelessness, mental health issues, substance abuse, domestic violence, teen pregnancy, unemployment and underemployment, child abuse and neglect, poverty, among other issues. HFNY is currently offered in 31 NYS counties. Both NFP and HFNY support the social-emotional development of infants and toddlers through support, positive values, social competencies and positive identity.

The Title V Keeping Kids Alive initiative aims to decrease abuse, maltreatment, and neglect as a method to reduce child mortality and morbidity among 0 to 18-year-olds. This initiative has a programmatic focus on building social support within families and communities. The initiative places an emphasis on building healthy families and healthy communities as an essential method to address child mortality including SIDS and SUID. Staff supported through this initiative attended 53 child fatality review team meetings where they reviewed 82 death records, attended 141 educational, outreach and public events to provide SIDS and SUIDS education to 6,874 professionals and parents and distributed over 18,700 educational materials concerning safe sleep and child safety and contacted 133 families who lost a child to offer bereavement services or linkages to support groups.

Title V staff also continued to collaborate with OHIP and other key partners on HH for Children initiative that launched in December 2016. There are sixteen HHs designated to serve children in NYS. Fourteen have initiated outreach and enrollment. Two will implement HH in March/April 2017. As of February 6, 2017, there were 4,889 children enrolled; 5,071 children are working with a HH care manager but have not yet enrolled; and 4,393 children have been assigned to a HH care manager; these initial numbers include children with serious emotional disturbance or complex trauma as well as other chronic medical needs, thus serving as an initial proxy (**ESM CH-5:** Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home) until more refined data by diagnosis are available. A number of webinar presentations have been jointly delivered to key stakeholders: the NYS Association of Counties (NYSAC) on November 3, 2016; the NYSACHO on November 3, 2016; the State's EIP on November 16, 2016; the HH and their Case Management Agencies (CMAs) on December 13, 2016; and the State's EICC, which is authorized in federal and state statute to advise the Department on the EIP, on December 3, 2015, September 17, 2016, and September 15, 2016. On January 24, 2017, a webinar presentation on Complex Trauma was delivered. Presentations were recorded and are available on the NYSDOH website: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_homes_and_children. Children who are in the EIP and who meet the HH eligibility criteria will transition to the HH in March/April 2017.

Finally, NY is committed to continued support and promotion of the social-emotional wellness of children and families. This is demonstrated through a joint effort of two NY Governor-appointed bodies - the EICC and the ECAC. The EICC is established in PHL and is a twenty-seven member Governor appointed body, charged with advising and assisting the NYSDOH as Lead Agency for the EIP Part C of the IDEA. IDEA requires that states establish an advisory group which must include parents of children with disabilities, public and private providers of early intervention services, an individual engaged in personnel preparation, a Head Start representative, and state governmental agencies. The ECAC was established in 2009 to provide advice to the Governor and the Commissioners of the state, health, education, and human service agencies on the development of a comprehensive system of supports and services for young children and their families. ECAC members include people with expertise in such issues as early childhood education, health and mental health care, child welfare services, home visiting, and parenting education and supports the state by monitoring and guiding the implementation of a range of strategies to achieve its vision -"All young children are healthy, learning, and thriving in families that are supported by a full complement of services and resources essential for successful development."

Over the past year, the two Councils collaborated on the development of 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*, aimed at service providers and families, due to the importance of the issue and the shared concerns for the large numbers of children and families who are struggling with social-emotional development issues and the need to strengthen the current system of services. This document contains guidance for early childhood professionals who deliver services to infants and toddlers and their families across a broad array of early childhood programs and services including the EIP, early education, child

welfare, health and mental health care, home visiting, and supportive services. There are four objectives for the guidance document: 1) ensure that the general population of young children receive routine and ongoing screening of children's development, including social emotional development; 2) identify children at risk of experiencing social emotional development delay or disability and ensure their families receive assistance from a wide array of early childhood programs and services; 3) improve the early identification of children who may already be experiencing developmental delays in social-emotional development; and, 4) ensure that evaluations. and assessments for all children in the EIP adequately address the area of social emotional development. The guidance has been approved by both Councils and plans are underway for its use and dissemination. This work will further advance NY's Title V strategic efforts to increase the number of child-serving MCH programs with evidence-based social-emotional components

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.

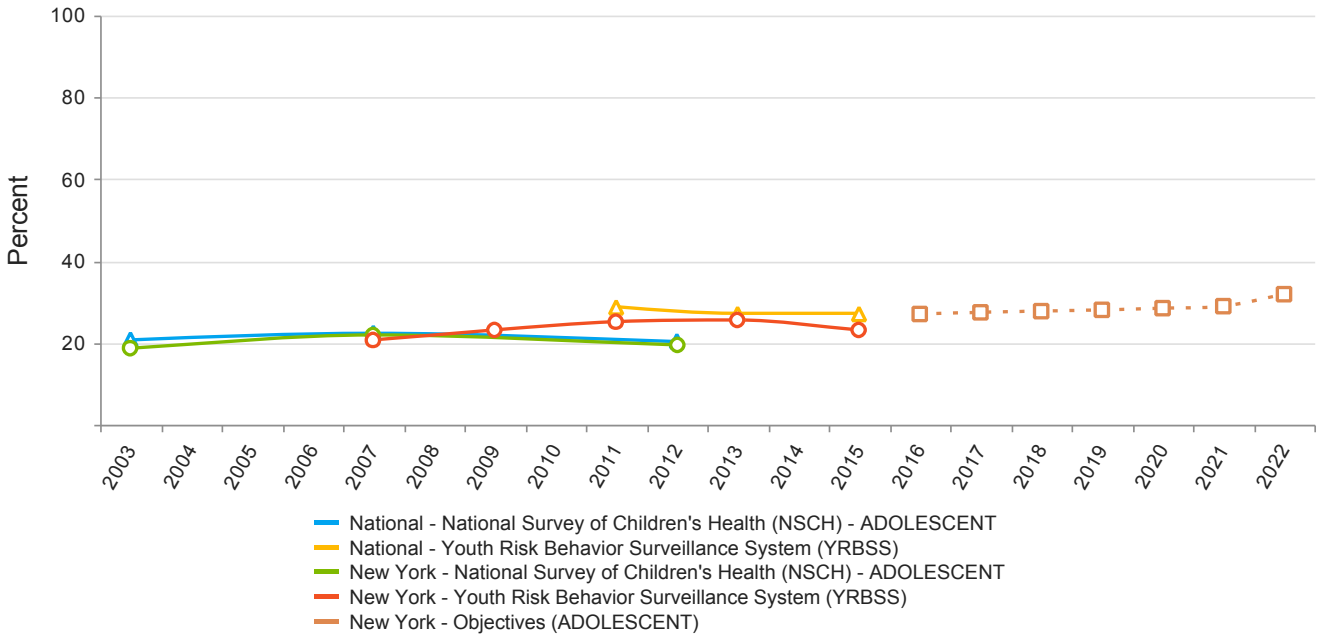
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	21.5	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	5.7	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	4.6	NPM 10
NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling	NSCH-2011_2012	65.2 %	NPM 10
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	83.2 %	NPM 8 NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	32.4 %	NPM 8 NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	30.1 %	NPM 8 NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2015	27.0 %	NPM 8 NPM 10
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	65.6 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	62.3 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	60.3 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	89.0 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	86.2 %	NPM 10

National Performance Measures

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
Baseline Indicators and Annual Objectives



NPM 8 - Adolescent Health

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	27.1
Annual Indicator	23.3
Numerator	161,704
Denominator	694,960
Data Source	YRBSS-ADOLESCENT
Data Source Year	2015

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT	
	2016
Annual Objective	27.1
Annual Indicator	19.6
Numerator	289,706
Denominator	1,477,307
Data Source	NSCH-ADOLESCENT
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	27.5	27.8	28.1	28.5	29.0	31.9

Evidence-Based or –Informed Strategy Measures

ESM 8.1 - a) Number PBI workgroup meetings held and attended by Title V staff; b) Number of resources are developed and disseminated based on PBI workgroup.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2
Numerator	
Denominator	
Data Source	Title V Program data
Data Source Year	7/16-6/17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

ESM 8.2 - Number of community environmental changes demonstrated as a result of enhanced collaborations.

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

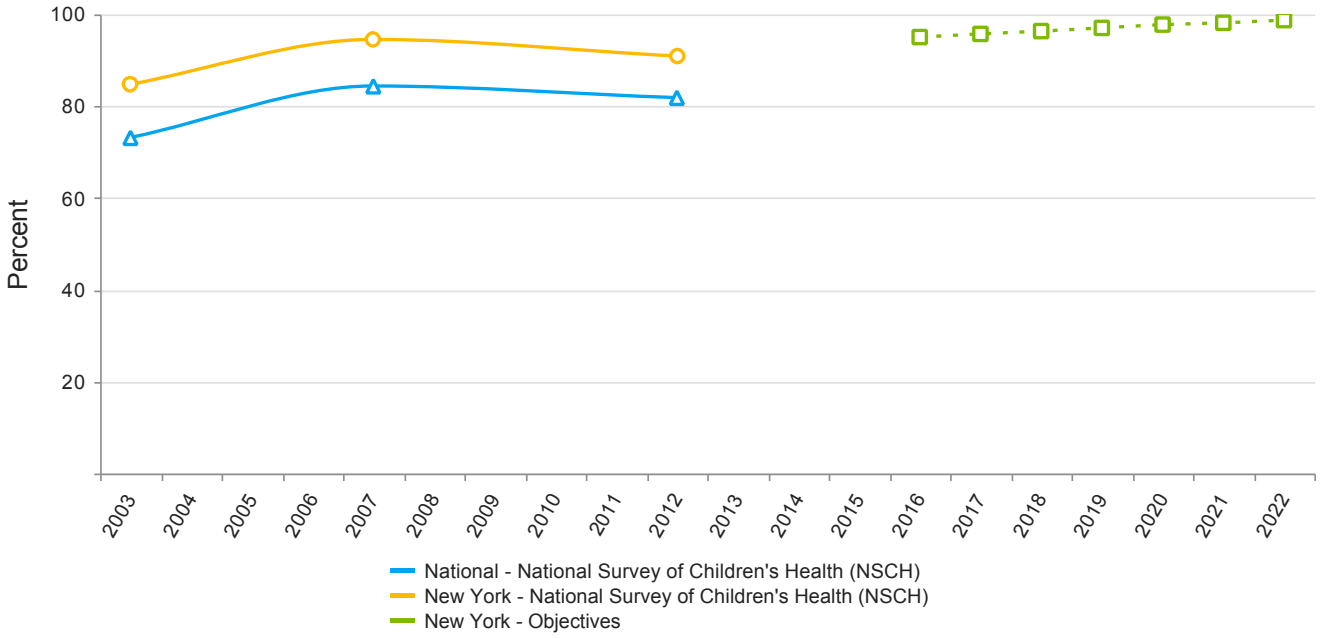
ESM 8.3 - a) Evidence-informed framework to structure and measure collaborative efforts is established or identified; b) Number of internal partners trained; c)Number of external partners trained.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Title V Program data
Data Source Year	7/16-6/17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

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



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	94.9
Annual Indicator	90.7
Numerator	1,346,186
Denominator	1,483,708
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	95.6	96.2	96.9	97.6	98.0	98.6

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - The number of focus groups conducted.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

ESM 10.2 - Initial data report is issued.

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	NYS Title V Program records.
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1,000.0	1,200.0	1,700.0	2,200.0	2,700.0	3,200.0

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

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

State Performance Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	To Be Developed
Data Source Year	2017-2018
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	50.0	50.0	52.0	55.0	56.0

State Action Plan Table

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

Priority Need

Support and enhance social-emotional development and relationships for children and adolescents

NPM

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

Objective AH-1: Increase the percentage of adolescents surveyed who demonstrate 20 or more developmental assets by 10% from baseline (to be established in Years 2-3)

Objective AH-2: Reduce the percentage of adolescents who feel sad or hopeless for two weeks or longer in the past year by 10%, to 21.6%.

Objective AH-3 (Same as LC-3): Increase the percentage of adolescents who receive a preventive health care visit in the last year by 6.5% to 97.7%.

Strategies

Strategy AH-1: Develop and implement a plan for analysis and reporting of available data on adolescent's social-emotional well-being and adverse childhood experiences (ACES), including Youth Risk Behavior Survey (YRBS) and forthcoming revised National Survey of Children's Health data.

Strategy AH-2: Identify, pilot test and implement a framework and validated tool for measuring developmental social-emotional assets among children and adolescents that can be used across MCH programs.

Strategy AH-3: Provide training for Title V staff and external partners, including local adolescent-serving grantees, to increase awareness, knowledge, and skills to support: 1) adolescents' social emotional development and 2) trauma-informed care practices.

Strategy AH-4: Identify, support and integrate evidence-based/-informed strategies to promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs, including: • Comprehensive Adolescent Pregnancy Prevention (CAPP) • Family Planning • Pathways to Success • Personal Responsibility Education Program (PREP) • School-Based Health Centers and • Sexual Violence Prevention.

Strategy AH-5: Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination and transition supports for eligible youth and young adults with serious emotional disturbance and complex trauma.

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

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

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

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

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

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

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

ESMs	Status
ESM 10.2 - Initial data report is issued.	Inactive
ESM 10.1 - The number of focus groups conducted.	Inactive
ESM 10.3 - Number of adolescents with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.	Active
ESM 10.4 - Number of strategies implemented to improve adolescent use of preventive health care services.	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000
NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children in excellent or very good health
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)
NOM 22.2 - Percent of children 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

State Action Plan Table (New York) - Adolescent Health - Entry 2

Priority Need

Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course.

NPM

Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Objectives

* Objective LC-8: Increase the percentage of children and adolescents who are physically active at least 60 minutes daily by 10%, from 25.7% in 2013 to 28.5%.

* Objective LC-9: Increase the percentage of children and adolescents who live in supportive/ cohesive neighborhoods by 6%, from 79.2% in 2011/12 to 84%.

* Objective LC-10: Increase the percentage of children and adolescents who are usually or always safe in their community or neighborhood by 5%, from 79.9% in 2011/12 to 84%.

Strategies

Strategy LC-10: Continue and increase Title V staff leadership and participation in the DOH Place-Based Initiative (PBI) work group to: * Adopt a shared definition and set of indicators to measure healthy communities; * Review place-based initiatives to identify best practices for community environmental change; * Develop a toolkit of data and evidence-based/-informed practices for community change; * Incorporate requirements for healthy community practices within relevant MCH funding procurements.

Strategy LC-11: Enhance collaboration with key partners to advance changes in community environments that promote maternal and child health: * increase demand for and access to healthy, affordable foods and opportunities for daily physical activity in high-need communities through the Creating Healthy Schools and Communities program (with NYSDOH Division of Chronic Disease Prevention) * strengthen linkages between Title V programs and the Healthy Neighborhoods Program (with NYSDOH Center for Environmental Health) * support the Regional Centers for Sexual Violence Prevention to implement primary prevention environmental change strategies at the community and individual levels (with NYSDOH Bureau of Injury Prevention) * incorporate selected health-related quality indicators in new quality improvement initiative for regulated child care programs (with Office of Children & Family Services) * incorporate health promotion information and linkages within Community Schools initiative (with me

Strategy LC-12: Establish or adopt an evidence-informed framework for structuring, measuring and improving collaboration at state and community levels, and provide support to strengthen both internal and external partner capacity to implement the framework across MCH programs.

ESMs	Status
ESM 8.1 - a) Number PBI workgroup meetings held and attended by Title V staff;b) Number of resources are developed and disseminated based on PBI workgroup.	Inactive
ESM 8.2 - Number of community environmental changes demonstrated as a result of enhanced collaborations.	Active
ESM 8.3 - a) Evidence-informed framework to structure and measure collaborative efforts is established or identified;b) Number of internal partners trained; c)Number of external partners trained.	Inactive

NOMs
NOM 19 - Percent of children in excellent or very good health
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

State Action Plan Table (New York) - Adolescent Health - Entry 3

SPM

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

Objectives

Objective AH-1: Increase the percentage of adolescents surveyed who demonstrate 20 or more developmental assets by 10% from baseline (to be established in Years 2-3)

Objective AH-2: Reduce the percentage of adolescents who feel sad or hopeless for two weeks or longer in the past year by 10%, to 21.6%.

Objective AH-3 (Same as LC-3): Increase the percentage of adolescents who receive a preventive health care visit in the last year by 6.5% to 97.7%.

Strategies

Strategy AH-1: Develop and implement a plan for analysis and reporting of available data on adolescent's social-emotional well-being and adverse childhood experiences (ACES), including Youth Risk Behavior Survey (YRBS) and forthcoming revised National Survey of Children's Health data.

Strategy AH-2: Identify, pilot test and implement a framework and validated tool for measuring developmental social-emotional assets among children and adolescents that can be used across MCH programs.

Strategy AH-3: Provide training for Title V staff and external partners, including local adolescent-serving grantees, to increase awareness, knowledge, and skills to support: 1) adolescents' social emotional development and 2) trauma-informed care practices.

Strategy AH-4: Identify, support and integrate evidence-based/-informed strategies to promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs, including: • Comprehensive Adolescent Pregnancy Prevention (CAPP) • Family Planning • Pathways to Success • Personal Responsibility Education Program (PREP) • School-Based Health Centers and • Sexual Violence Prevention.

Strategy AH-5: Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination and transition supports for eligible youth and young adults with serious emotional disturbance and complex trauma.

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

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

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

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

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

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

FY 2018 Application

Adolescent Health: State Priority #3: Support and enhance adolescents' social-emotional development and relationships

2020 State Objectives:

- **Objective AH-1: Increase the percentage of adolescents surveyed who demonstrate 20 or more developmental assets by 10% from baseline.**
- **Objective AH-2: Reduce the percentage of adolescents who feel sad or hopeless for two weeks or longer in the past year by 10%, to 21.6%.**
- **Objective AH-3: Increase the percentage of adolescents who receive a preventive health care visit in the last year by 6.5% to 97.7%.**

As noted in the Child Health Domain, due to the strong influence social-emotional development can have on children and adolescents throughout the lifespan, NY's Title V program selected the *Social-Emotional Development and Relationships for Children and Adolescents* as state priorities. There is no specific data to report on State Objectives listed above (AH-1 and AH-3) as the past year has been devoted to the developmental work needed to implement the strategies needed to support these objectives. These data are also from the NSCH report to be released later in 2017. Objective AH-2 reporting awaits release of current BRFSS data. Although work on these domains is closely intertwined, plans will be addressed separately for children and adolescents.

For the upcoming Title V MCHSBG period, the DFH will continue to focus efforts for the priority to support and enhance social-emotional development and relationships for the adolescent health domain and continue to support existing work as described in the Annual Report section of this Domain. These programs are strong public health initiatives that impact social-emotional development and relationships for adolescents. Staff will continue to discuss strategy areas, plan and further develop the work that is already underway. Staff will review progress, successes, barriers and challenges while evaluating progress on measures and reviewing further developments for this priority. A commitment to strengthen aspects of social-emotional development assets will continue to have positive effects beyond adolescents. While Title V staff focus on these efforts, it is imperative that the efforts are carried out through the DFH. As new procurements are released to provide funding for organizations that work with adolescents throughout NYS communities, it is anticipated that language supporting evidence-based/evidence-informed strategies will be adopted to include building social-emotional wellness for these domains. Additional specific actions based on the five strategies for this priority are listed below.

Strategy AH-1 – Develop and implement a plan for analysis and reporting of available data on adolescent's social-emotional well-being and adverse childhood experiences (ACES), including the Youth Risk Behavior Survey (YRBS) and forthcoming revised National Survey of Children's Health data.

During the upcoming period, the Title V program will seek to increase collaborative efforts with other NYSDOH initiatives, including continuing efforts with the Pyramid Model and Adverse Childhood Experiences. The Pyramid Model established by the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) focuses on the promotion of social, emotional, and behavioral developmental competencies for young children, aged 0-5. The workgroup will also focus on establishing partnerships with other state agencies, including the Council for Children and Families and the Office of Mental Health to continue to enhance the catalogue of emerging data and information as well as disseminate relevant information to staff and providers. Title V staff will continue to distribute the quarterly Social-Emotional Wellness Update to DFH staff and remain a source of content expertise within the DFH to specifically address and incorporate social-emotional evidence based /evidence-informed strategies into funding procurements. Next steps for this strategy measure include the sharing of dialogue and information with key staff members assigned to these collaborative efforts to determine opportunities for collaboration. Staff may highlight these efforts through site sharing and will determine if there are

additional opportunities to bring these efforts into the work being done through the DFH on social-emotional wellness initiatives. By the end of this 2017-18, it is expected that an initial data report will be drafted (**ESM CH-1**).

Strategy AH-2 – Identify, pilot test and implement validated tool for measuring positive developmental social-emotional assets among children and adolescents that can be used across MCH programs.

During the upcoming reporting period, Title V staff will obtain necessary approvals to administer an effective survey tool with the pilot programs and begin using the tool in a limited capacity to gather, analyze, and disseminate data on the state of social-emotional health for adolescents throughout select populations across the state. This tool should be used to take a representative sample of the populations that DFH serves to provide a baseline of NYS's developmental assets. NY's Title V program will work with stakeholders to approve the tool before it is implemented. These stakeholders include program contractors and the ACT COE. The ACT COE is a NYSDOH contractor that brings research to practice in areas of positive youth development and adolescent health. They will provide resources to identify and review already accepted social-emotional wellness survey tools and have access to youth aged 9-21 across the State who can participate in reviewing the tool for content/age appropriateness. The Title V program will work with other DFH programs to adapt the tool for their specific age group or priority population.

This strategy is measured through **ESM AH-2**: Number of adolescent-serving MCH programs implementing the asset profile tool.

Strategy AH-3 – Provide training for Title V staff and external partners, including local child-serving grantees, to increase:1) awareness, knowledge, and skills to support adolescent's social emotional development: and 2) trauma-informed care practices.

NY's Title V staff will develop an internal querying survey to identify the actual number of DFH staff who have participated in at least one related training. Efforts will continue to track the number of trainings, the intended audience and the actual audience for each training conducted within DFH as well as those done by our partners. Feedback will be provided to DFH staff and recommendations will be made to staff and community providers on specific trainings appropriate to their programs and initiatives. Additionally, staff will continue to identify trainings within the realm of social-emotional wellness and inform DFH staff and/or providers of these training opportunities. Staff will continue to work with internal and external partners to recommend trainings and webinars on topics related to social-emotional development and relationships for young people. In the upcoming reporting year, Title V staff will identify and disseminate at minimum 2 training events per month across DFH, and have 200 staff members and 500 community providers attend these events (duplicated counts). This strategy is vital to the work being done by this priority group as an increase in trained staff and community support will increase overall awareness of the NYSDOH goal to increase positive youth development and trauma-informed care strategies throughout the State.

This strategy is measured through **ESM AH-3**: Number of DOH MCH-staff and external partners trained on: a) social-emotional wellness and b) trauma-informed care practices.

Strategy AH-4 – Identify, support and integrate evidence-based/informed strategies to promote adolescent's social-emotional wellness and positive developmental assets through established Title V programs, including: Maternal and Infant Community Health Collaboratives (MICHCs), Home Visiting, Infant/Child Mortality Initiative, Early Intervention, Successfully Transitioning Youth to Adolescence (STYA) and, School-Based Health Centers.

During the upcoming reporting period, staff will contact previously identified programs within DFH and gather additional information on how/if health equities and disparities are addressed. Through research review, staff will analyze the responses and determine if the strategies are evidence-based, evidence-informed, promising practices or best practices or if the initiatives need to incorporate these strategies into their program. Staff will explore how social-economic and other health disparities impacted overall social-emotional

health and wellness for youth residing in communities throughout New York. The Title V program will highlight programs that are using sound methodology to incorporate social-emotional relationships and development while offering recommendations will to the programs that can benefit from incorporating these methodologies. Programs that are excelling in using these strategies will be emphasized in the quarterly Social Emotional Wellness Update that is distributed throughout DFH.

This strategy is measured through **ESM AH-4** – Number of adolescent-serving MCH programs identified with an evidence-based social-emotional component.

Strategy AH-5 – Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for eligible youth and young adults with serious emotional disturbance and complex trauma.

NY's Title V program will continue to provide subject matter and technical support to NY'S Medicaid HH to implement enhanced care coordination for eligible adolescents with serious emotional disturbance and complex trauma. The HH for Children will be implemented statewide during this period. DFH staff will work with colleagues in the OHIP to monitor enrollment and ensure adolescents receive coordinated care across all the State's systems of care.

This strategy is being measured through **ESM AH-5**: Number of children with documented serious emotional disturbances and/or complex trauma who are: a) enrolled in Medicaid Health Home; b) transitioned to adult-serving Health Homes.

FY 2016 Annual Report

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

As stated in the Child Health Domain of this report, a priority for NY's SAP is: *Social-Emotional Development and Relationships for Children and Adolescents*. Work on this priority is focused in both the Child Health and Adolescent Health domains and although there is a tremendous overlap of the strategies and activities, they will be reported separately in this report.

Over the past year, Title V staff identified many existing data sources as well as relevant research findings, and evidence-based program resources, and made them available and accessible to all DFH staff by posting them on the DFH's internally shared website, as an important step in analyzing and reporting available data on adolescent's social-emotional well-being. (**ESM AH-1:** Initial data report issued.) This includes current research, national and state-level statistics and indicators, registries of programs effective in reducing youth risk behaviors and resources for evidence-based programs. On a periodic basis, Title V staff reviews the materials and discusses the information during team and Division wide-meetings. Staff also created a preliminary information publication distributed throughout DFH, titled "Social Emotional Wellness Update". This publication was created to help highlight and disseminate information regarding social emotional development and relationships in children and adolescents by exploring relevant data, discussing available resources and addressing the importance of using these strategies while allowing for an opportunity to take an in-depth view on specific aspects related to the priority. Staff will continue to publish the Social Emotional Wellness Update on a quarterly basis.

As with the Child Health domain, in order to provide a meaningful contribution, a priority of the past year was to increase Title V staff's understanding of the complexities within this topic and to learn about the evidence-based strategies associated with this work. During the past year, foundational work was conducted to develop a framework within which to address social-emotional development. The focus for some of the formative work in this area includes research and data for positive youth development strategies, ACEs, trauma informed care, well-child definitions as well as reviewing state and national-level data on specific measures that are considered to be within the scope of social-emotional development and relationships for the adolescent health domain; including from the YRBS and the NSCH.

As discussed in the Annual Report for the Child Health Domain, during the reporting period, Title V staff identified programs suitable for a pilot and have worked with key partners to identify a proper validated tool that can measure social-emotional assets in children and adolescents. It is expected that validated surveys will be used within priority populations focusing on children and adolescents currently enrolled in DFH programs that use positive youth development approaches. The first pilot program for the survey tool is the Comprehensive Adolescent Pregnancy Prevention Program that recently made competitive awards to 18 community-based organizations to implement an optional program that adds a multi-dimensional opportunity for youth on multiple health and developmental related topics aimed at building developmental assets and increase social-emotional wellness for the enrolled youth. (**ESM AH-2:** Number of adolescent-serving MCH programs implementing the asset profile tool.)

Title V staff identified local, statewide and national trainings offered to DFH staff, community providers and other external partners. Specifically, the group identified seventeen different training opportunities that were offered between July and December 2016. Staff determined that the majority of DFH staff and their respective program providers have participated in at least one related training, while many staff have attended three or more trainings (**ESM AH-3**: Number of DOH MCH staff and external partners trained on: a) social-emotional wellness and b) trauma-informed care.) Information on training attendance was collected with the assistance of various community partners and contracted providers. Examples for DFH staff trainings included ACEs, the Impact of Domestic

Violence on School-Aged Children and Trauma-Informed Care Approaches. Trainings for providers and community partners included: Supporting Adolescents' Self-Control, Trauma and Positive Youth Development: What is the Consequence, and Trauma-Informed Techniques for Campus Police and Security. Many of these trainings were attended by both staff and providers.

Title V staff also reviewed the list of programs that were identified as having a social emotional component through a process of interviews, data synthesis and feedback for further revisions. Within DFH, twenty-one community-based programs were identified and reviewed. Of these, seventeen programs were identified as addressing some aspect of their programs focusing on social-emotional wellness, based on the previously identified internal and external developmental asset categories defined by The Search Institute. (**ESM AH-4:** Number of adolescent-serving MCH programs identified with an evidence-based social-emotional component.) A table was developed identifying the DFH programs and developmental asset categories. Members have reached out to the programs and are compiling a list of the evidence-based, evidence-informed and promising strategies that each program uses to monitor their social emotional component. Priority group members have also reviewed the list to identify programs that may include an equity component within the social emotional aspect since many DFH programs are focused on socio economic hardship, disadvantaged communities and populations.

The DFH has a long history of addressing social and emotional wellness in many programs that serve youth and adolescents, in fact, social and emotional wellness is at the heart of these programs. Programs focusing on both children and adolescents have been included in the Child Health Domain of the Annual Report. An additional Title V program focusing on adolescents and adults is the Rape Prevention and Education program, which has a central focus on social-emotional development and relationships. Programs are supported with Rape Prevention and Education (RPE) funds from the Centers for Disease Control and Prevention (CDC). Regional Centers for Sexual Violence Prevention implement interventions that focus on adolescents aged 10 to 24 years old and include community mobilization, coalition building, development or improvement of sexual violence prevention organizational policies, changing social norms, policy education, building social capital and additional educational sessions.

The Rape Crisis and Sexual Violence Prevention Program (RCSVPP) provides 24-hour crisis hotlines and intervention services, counseling, medical, forensic, and support services (e.g. accompaniment, advocacy, information, and referrals) to rape and sexual assault survivors. These programs also aim to build community support systems to improve prevention and response, provide community education and trainings for professionals who respond to victims, and provide outreach. The RCSVPP touches upon developmental assets in the following areas: support, empowerment, boundaries and expectations, positive values, social competencies, and positive identity. Over the past year, the six RPE regional centers conducted 495 community mobilization events, 211 coalition building events and 37 educations curriculum course sessions.

The Enough is Enough initiative combats sexual assault, dating violence, stalking, and domestic violence on college and university campuses. Funding was distributed to rape crisis programs to partner with colleges and universities to assist them in implementing requirements to prevent and respond to sexual assault, dating violence, domestic violence and stalking on their campuses. Some activities offered through this initiative are faculty, staff, and student training to prevent sexual violence and domestic violence, provision of victim services, referrals, and medical services. The social-emotional components of this program include the provision of crisis counseling and victim services provided to sexual assault survivors, in addition to education training on prevention of sexual and domestic violence throughout campus communities. The Enough is Enough program provided 17,468 direct services to campus sexual assault victims and that number continues to grow. Rape Crisis Programs have reached 43,677 individuals through awareness events, 3,642 through training and 21,794 through educational campaigns. These numbers include college/university students, faculty, staff and some parents. These numbers are expected to increase.

SBHCs are required to provide behavioral health screening for all patients (elementary, middle and high school age) as part of ongoing primary care, and most provide additional mental health services on-site within SBHC clinics; mental health services are provided by referral in sites that do not have in-clinic resources. Currently, in NYS there are over 250 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 181,569 students and provided 649,244 visits for health and supportive services.

The Pathways to Success program creates and sustains supportive systems that help pregnant and parenting teens and young adults travel pathways to success through health, education, self-sufficiency, and strong families with their infants and children. The partners in the Pathways to Success program are working towards strengthening community systems serving pregnant and parenting teens and young adults; improving the health, development, and well-being of young parents and their children; improving young parents' self-sufficiency through educational attainment; and increasing awareness of resources available to expectant and parenting teens and young adults in each community statewide. Pathways to Success utilizes an Asset and Risk Assessment Tool that assesses the student's financial, social, and educational support, as well as mental health, employment status, housing, food, clothing, health care, transportation, and parenting skills and touches upon developmental assets in all eight categories.

Adolescent Health initiatives, including the CAPP, PREP and STYA s all aim to promote healthy development, parent-child communication, relationship skills and healthy life skills through youth focused activities. The CAPP program recently awarded several contracts that will be specifically focusing on a multi-dimensional approach to adolescent health to support social-emotional well-being and strengthen community relationships to increase positive youth development and build developmental assets in youth. These programs reach approximately 33,000 adolescents aged 9-21 on an annual basis.

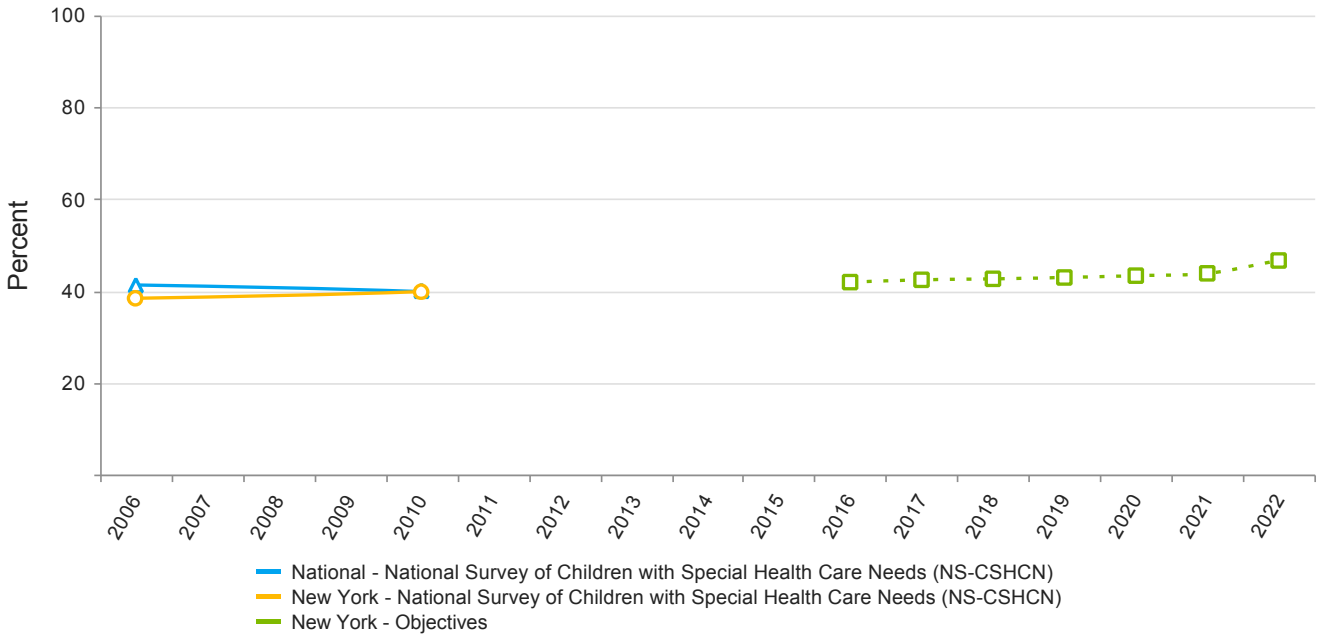
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	16.8 %	NPM 12
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	83.2 %	NPM 12

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	41.9
Annual Indicator	39.7
Numerator	100,326
Denominator	252,737
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	42.4	42.6	42.9	43.3	43.8	46.6

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Initial data report published.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Title V Record data.
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 12.2 - Number of partners engaged in system mapping.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	4
Numerator	
Denominator	
Data Source	Title V Program records
Data Source Year	2016-2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	200.0	650.0	650.0	650.0	650.0

ESM 12.3 - Number of CSHCN enrolled in Health Homes designated to serve children.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	3,905
Numerator	
Denominator	
Data Source	NYS Office of Health Insurance Programs Health Hom
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4,000.0	4,500.0	5,000.0	5,500.0	6,000.0	6,500.0

ESM 12.4 - Percent of Adolescents/ Young Adults with SCD age 12-21 years in the funded projects who have a transition readiness assessment completed and documented.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	28.1
Numerator	147
Denominator	524
Data Source	Sickle Cell Clinic
Data Source Year	CY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	25.0	50.0	90.0	100.0	100.0

ESM 12.5 - Number of best practice strategies for improving family outcomes that are documented through review and learning collaboratives.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	NYS Title V Program records.
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

ESM 12.6 - Percent of children transitioning from EIP to Special Education services who have a documented referral to LHD-based CSHCN Program.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0.7
Numerator	82
Denominator	12,000
Data Source	NYS CSHCN and EI
Data Source Year	2015-16
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.5	2.0	2.5	3.0	3.5

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
Annual Objective	
Annual Indicator	63.9
Numerator	4,275
Denominator	6,688
Data Source	NYEHDI
Data Source Year	CY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	45.0	60.0	70.0	75.0	78.0	80.0

ESM 12.8 - Number of DOH MCH staff and external partners trained on: a)social-emotional wellness b)trauma-informed care practices.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	382
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2016-2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	400.0	500.0	550.0	575.0	600.0

ESM 12.9 - Number of adolescent-serving MCH programs implementing the asset profile tool.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	1.0	1.0	1.0	1.0	1.0

ESM 12.10 - Number of adolescent-serving MCH programs identified with an evidence-based social-emotional component.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	15
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	15.0	16.0	18.0	18.0	18.0

ESM 12.11 - Number of adolescents with documented serious emotional disturbance and/or complex trauma who are: a) enrolled in Medicaid Health Home; b)transitioned to adult-serving Health Homes.

Measure Status:	Inactive - Replaced

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

State Performance Measures

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
Annual Objective	
Annual Indicator	61.6
Numerator	673
Denominator	1,092
Data Source	New York Family Survey
Data Source Year	2015-2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	65.0	65.5	66.0	66.5	67.0	67.5

State Action Plan Table

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

Priority Need

Increase supports to address the special health care needs of children and youth

NPM

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Objectives

Objective CSHCN-1: Increase the percentage of adolescents with special health care needs who receive services necessary to make to transitions to adult services by 10% to 44%.

Objective CSHCN-2: Increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale (> 576) by .50% to 66.5% (in 2018).

Objective CSHCN-3: Increase the percentage of CSHCN who need and receive care coordination services that meet their needs by 10% to 44%.

Objective CSHCN-4: Increase the percentage of infants who receive a follow-up hearing screenings after failing initial hearing screening by 45% to 50%

Strategies

Strategy CSHCN-1: Develop and implement a plan for analysis and reporting of CSCHN data for NYS, including forthcoming data from revised National Survey of Children's Health, and issue initial data report.

Strategy CSHCN-2: Engage parents, families and providers in a system mapping exercise to identify the gaps and barriers in the system of public health programs and services for CSHCN and their families

Strategy CSHCN-3: Provide subject matter and technical support to NYS Medicaid Program to implement enhanced care coordination and transition support services for CSHCN through Children's Health Homes.

Strategy CSHCN-4: Provide grant funding and technical assistance to support successful transition to adult services for young adults with Sickle Cell Disease (SCD), and evaluate projects to identify best practices for enhancing transition support to other key CSHCN populations.

Strategy CSHCN-5: In collaboration University Centers for Excellence in Developmental Disabilities Education, Research, & Service (UCEDD) and other stakeholders implement NY's IDEA Part C State Systemic Improvement Plan (SSIP) to: • create a repository of evidence-based practices for family centered services; • convene statewide learning collaboratives to improve family outcomes for children served in the state's Early Intervention Program; and, • evaluate projects to identify resources and best practices that can be extended to other CSHCN populations.

Strategy CSHCN-6: Use EI family survey data to inform CSHCN Program, of the needs of families transitioning from EI to CSHCN Program in order to better coordinate services.

Strategy CSHCN-7: Provide technical assistance and facilitate a structured quality improvement project to engage health care providers, hospital staff, parent representatives, audiologists to improve reporting of initial hearing screening and follow up results into the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS).

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

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

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

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

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

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

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

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

ESMs	Status
ESM 12.1 - Initial data report published.	Inactive
ESM 12.2 - Number of partners engaged in system mapping.	Inactive
ESM 12.3 - Number of CSHCN enrolled in Health Homes designated to serve children.	Inactive
ESM 12.4 - Percent of Adolescents/ Young Adults with SCD age 12-21 years in the funded projects who have a transition readiness assessment completed and documented.	Inactive
ESM 12.5 - Number of best practice strategies for improving family outcomes that are documented through review and learning collaboratives.	Inactive
ESM 12.6 - Percent of children transitioning from EIP to Special Education services who have a documented referral to LHD-based CSHCN Program.	Inactive
ESM 12.7 - Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.	Active
ESM 12.9 - Number of adolescent-serving MCH programs implementing the asset profile tool.	Inactive
ESM 12.8 - Number of DOH MCH staff and external partners trained on: a)social-emotional wellness b)trauma-informed care practices.	Inactive
ESM 12.10 - Number of adolescent-serving MCH programs identified with an evidence-based social-emotional component.	Inactive
ESM 12.11 - Number of adolescents with documented serious emotional disturbance and/or complex trauma whoare: a) enrolled in Medicaid Health Home; b)transitioned to adult-serving Health Homes.	Inactive

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 2

Priority Need

Increase supports to address the special health care needs of children and youth

SPM

The percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale

Objectives

Objective CSHCN-1: Increase the percentage of adolescents with special health care needs who receive services necessary to make to transitions to adult services by 10% to 44%.

Objective CSHCN-2: Increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale (> 576) by .50% to 66.5% (in 2018).

Objective CSHCN-3: Increase the percentage of CSHCN who need and receive care coordination services that meet their needs by 10% to 44%.

Objective CSHCN-4: Increase the percentage of infants who receive a follow-up hearing screenings after failing initial hearing screening by 45% to 50%

Strategies

Strategy CSHCN-1: Develop and implement a plan for analysis and reporting of CSCHN data for NYS, including forthcoming data from revised National Survey of Children's Health, and issue initial data report.

Strategy CSHCN-2: Engage parents, families and providers in a system mapping exercise to identify the gaps and barriers in the system of public health programs and services for CSHCN and their families

Strategy CSHCN-3: Provide subject matter and technical support to NYS Medicaid Program to implement enhanced care coordination and transition support services for CSHCN through Children's Health Homes.

Strategy CSHCN-4: Provide grant funding and technical assistance to support successful transition to adult services for young adults with Sickle Cell Disease (SCD), and evaluate projects to identify best practices for enhancing transition support to other key CSHCN populations.

Strategy CSHCN-5: In collaboration University Centers for Excellence in Developmental Disabilities Education, Research, & Service (UCEDD) and other stakeholders implement NY's IDEA Part C State Systemic Improvement Plan (SSIP) to: • create a repository of evidence-based practices for family centered services; • convene statewide learning collaboratives to improve family outcomes for children served in the state's Early Intervention Program; and, • evaluate projects to identify resources and best practices that can be extended to other CSHCN populations.

Strategy CSHCN-6: Use EI family survey data to inform CSHCN Program, of the needs of families transitioning from EI to CSHCN Program in order to better coordinate services

Strategy CSHCN-7: Provide technical assistance and facilitate a structured quality improvement project to engage health care providers, hospital staff, parent representatives, audiologists to improve reporting of initial hearing screening and follow up results into the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS).

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

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

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

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

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

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

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

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

FY 2018 Application
CSHCN Application

2020 State Objectives:

- **Objective CSHCN-1: Increase the percentage of adolescents with special health care needs who receive services necessary to make to transitions to adult services by 10% to 44%.**
- **Objective CSHCN-2: Increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale (≥ 576) by .50% to 66.5% (in 2018).**
- **Objective CSHCN-3: Increase the percentage of CSHCN who need and receive care coordination services that meet their needs by 10% to 44%.**
- **Objective CSHCN-4: Increase the percentage of infants who receive a follow-up hearing screenings after failing initial hearing screening by 45% to 50%**

A priority for NY's Title V Program is to promote and support a more coordinated, comprehensive system of supports and services for CSHCN and their families. The system mapping initiative will assist Title V to have a more comprehensive understanding of the complex needs of families across NYS. Building on this information, NY's Title V Program can promote partnerships, demonstrate leadership in policy and program development and engage in ongoing dialogue with parents and key stakeholders to improve outcomes for CSHCN. Objective CSHCN-1 and CSHCN-3 are based on data obtained through the NCHS that will be available later in 2017.

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

Title V staff has developed a formal plan for analyzing and reporting available data to provide staff with a better understanding of the CSHCN population and their needs and to inform program planning within NY's Title V CSHCN Program and with external partners. While this essential public health and MCH function has always been an essential element of the NY's Title V work, through this strategy the goal is to expand and formalize this process to include a data analysis plan and regular summary reports. As yet, the 2016 National Survey of Children's Health (NSCH) data that includes state level data has not been released. This NSCH will be a foundational component of this strategy. Staff have completed the review of 2009-2010 NY data and an initial report of the data analysis will be completed, though due to the age of the data, its utility may be less than optimal.

Upon receipt of the new NSCH data, Title V staff will utilize these data to inform CSHCN program planning. Coupled with the systems mapping exercise discussed in the annual report section of this Domain and discussed below, NY's Title V program will continue to develop strategies to improve and enhance supports and services. Title V staff will share data results with partners, including the OHIP and other State agencies and stakeholders. Title V staff will continue to review state level data to see if implementation of CHH improves results for care coordination. As stated earlier, further work needs to be done to understand the needs of CSHCN and their families and to develop supports and services to address those needs. This strategy is measured by **ESM CSHCN-**1: Initial data report will be drafted.

Strategy CSHCN-2: Engage parents, families and providers in a system mapping exercise to identify the gaps and barriers in the system of public health programs and services for CSHCN and their families.

Title V staff will continue to elicit parent maps from families of CSHCN and providers, professionals and clinicians who work with and support CSHCN and their families through March 2018. CSHCNs encompass a broad array of conditions ranging from allergies to behavioral health issues to complex medical, behavioral and educational needs. It is critical to the success of using systems mapping to understand the needs of families of CSHCNs, to ensure that the families who are engaged in the systems mapping

exercise represent the wide and diverse range of conditions that can impact CSHCNs. Family recruitment efforts targeted several groups that work with families of children who have physical issues, behavioral health issues, genetic conditions, as well as families from different socio-economic, racial, ethnic, and geographic backgrounds.

An email and instructions on how to access and complete a family systems support map was sent to approximately 350 graduates of the EI Parents as Partners in Training Program, which is a training initiative of the EIP. Parents of children receiving EI services apply and are selected to participate in this training to enhance their leadership skills, network with each other, and learn how to become better advocates for the care of their special needs child at the local, state and national levels. The request for these parents to complete an individual map was sent in March, 2017, with a follow-up reminder forwarded to the same parent group in April, 2017.

Title V staff continue to collaborate with Parent to Parent of NY to identify parents with CSHCN to develop aggregate system maps in five regions of NY. At least two of the five regional meetings will be conducted with Spanish as the primary language. A training webinar has been scheduled for Parent to Parent staff from across the state to introduce the systems support mapping project to them as well as to begin training their staff on assisting with facilitating the five in-person meetings with parents. This training is scheduled to take place in April, 2017. May and June of 2017 are targeted as the months to complete the in-person Regional Parent Meetings with Parent to Parent. In Spring 2017, there will also be an in-person training provided to the Capital District Parent to Parent Regional Coordinators during which a group systems map will be developed. It is important to note that Parent to Parent staff are themselves parents of children with special healthcare needs, so their input is essential to this project. This in-person training will serve as a pilot for the other Regional parent meetings. UNC Workforce Development Center staff will be present to provide oversight, support and coaching to Title V staff to help insure that the information is provided clearly and correctly to gather useful data at the in-person meetings.

Contact will also be made with the three UCEDDs and other family/child entities to engage their expertise in the mapping process. The UCEDDs work with people with disabilities, members of their families, state and local government agencies and community providers that focus on building the capacity of communities to sustain all their citizens. UCEDDs have played key roles in major disability initiatives involving issues such as early intervention, healthcare, community-based services, inclusive education, transition from school to work, employment, housing, assistive technology and transportation. UCEDDS will help Title V staff to connect with and engage professionals who would participate in the system mapping process. For example, the current class of Westchester Institute of Human Development (one of the UCEDDs) LEND fellows will learn about the systems support mapping process as well as participate in developing actual maps in April, 2017. Participants, including LEND fellows from Puerto Rico and the Virgin Islands, will be provided an overview of the Systems Support Mapping project and then will break into groups to discuss and develop a map in a small group before coming together to jointly develop a larger group family map and a workforce/provider map. The 22 LEND fellows are from multiple professional disciplines as well as at least two parent participants.

Local staff from both the CSHCN Program and the EIP participated in a webinar in March, 2017 to obtain an overview of the systems support mapping project and were asked to complete an on-line map. Title V staff requested that at least one CSHCN Program and one EIP staff complete a map. The Title V Program intends to share this expertise and the information with all Title V partners to collaborate and improve the systems of care for families with CSHCN across the State. Title V staff will review and analyze the data generated from the system maps provided by parents and providers to identify enhancements to further support families of CSHCN. This strategy is measured by **ESM CSHCN-2**: Number of partners engaged in system mapping.

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

Title V will continue to provide subject matter technical support to NY's Medicaid Program to implement enhanced care coordination and transition support services for CSHCN through CHH. Staff will participate in weekly conference calls and provide technical support to increase the number of EI eligible children who are referred to CHH. According to EIP data for 2015-2016, there are 38,649 Medicaid and EI eligible children that may be eligible for CHH, based on their EIP diagnosis. NY staff have worked with OHIP to develop a survey of EI providers to solicit readiness, capacity, linkages and identify training that may need to take place prior to dually enrolling children who would meet eligibility for both EIP and CHH Care Management services. The survey was issued to EIP providers in January 2017. As previously noted, 148 responses were received that reported interest in making connections with CHH agencies, becoming an approved EI provider and interested in training regarding EI Service Coordinator responsibilities

and requirements for EI eligible children when they are referred to CHH. Documents regarding Notice of Interest forms and EI provider applications have been distributed via state wide email distribution list. Work is being done to secure training for those providers interested in learning more about the responsibilities for providing EI service coordination through a recently procured Statewide Training Contract and extension of the previous contract to provide this mandated training. This strategy is measured by **ESM CSHCN-3**: Number of CSHCN enrolled in Health Homes designated to serve children.

Strategy CSHCN-4: Provide grant funding and technical assistance to support successful transition to adult services for young adults with Sickle Cell Disease (SCD), and evaluate projects to identify best practices for enhancing transition support to other key CSHCN populations.

Providing assistance and preparing AYA/SCD for transition to adult care has been shown to reduce emergency room usage, avoid pain crisis occurrence, and mortality. A transition readiness assessment and plan can help these children successfully move to adult care and improve their quality of life. Title V staff developed a Request for Applications (RFA) to seek providers who will provide supports and services for young adults with sickle cell disease and other hemoglobinopathies as they transition to adult medical care is in the approval process. It is anticipated that this RFA will be released in the upcoming year. These providers serve as "transition navigators," to assist adolescents to make a successful transition to an adult hematologist or other adult medical care provider and will also focus on providing adolescents with the skills they need to successfully transition to adult care. This will be assessed by evaluation of readiness and post transition for satisfaction with care. These transition services will have new emphasis on transition planning based on evidence based practices such as the "Got Transition" program and partnership with CHH. Many AYA/SCD are likely to be eligible for CCH based on Medicaid coverage in the AYA/SCD population and likelihood of two or more serious health conditions due to SCD.

Title V staff will also work to identify a SCD professional to provide information to HH care managers about SCD when working on transition plans. Children and AYA/SCD who do not meet the requirements for HHs will have transition services provided by the funded project. Several areas identified as in need of continuing focus include strengthening patient independence, making and keeping appointments, preparing questions for patient to ask their doctor, fear of the adult emergency room/adult admission and education about changes in healthcare privacy at age 18. Many AYA/SCD are lack the skill and, financial independence to transition to adult care without assistance from subject experts. Many patients have developed a strong emotional bond with their physician. Some patients are mature enough to transition and manage their own healthcare and do not wish to leave their doctor. The contracted experts will develop best practices and educational materials for replication of services by non-funded centers. Materials are to include transition readiness forms for use through the entire period of care, pre-transition evaluation and post transition survey to assess success of services.

It is anticipated awards will be made early in 2018. This strategy will be measured by **ESM CSHCN-4**: Percent of AYA with SCD age 12-21 years in the funded projects who have transition readiness assessment completed and documented.

Strategy CSHCN-5: In Collaboration with UCEDDs and other stakeholders, implement NY's IDEA Part C State Systemic Improvement Plan (SSIP) to: create a repository of evidence-based practices for family centered services; convene statewide learning collaboratives to improve family outcomes for children served in NY's Early Intervention Program (EIP); and evaluate best practices that can be extended to other CSHCN populations.

The UCEDDs will work with NY and other EI stakeholders, including county EI staff, EI providers and parents to implement learning collaboratives in regions of NY utilizing the Institute for Healthcare Improvement's Breakthrough Series. The learning collaboratives will be implemented for one year and are expected to begin in the summer and early fall and will provide technical assistance, training, mentorship and monthly coaching support to improve performance and collaboration with families within the community. Learning collaboratives are made up of 3-6 member teams, which include EI service coordinators, EI providers, local EI officials and parents of EI eligible children. It is expected that this work will enhance training opportunities in the EIP and improve the quality of EI service provision to children and families enrolled in the NY EIP. In addition to conducting learning collaboratives throughout NY, the

UCEDDs will identify evidence-based strategies relevant to improving EI performance and outcomes by research of the literature and developing and disseminating a repository of evidence-based or best practice strategies. Problem identification and utilization of small cycles of Plan, Do, Study, Act will lead to improvements in family/child EI outcomes.

The UCEDDs will convene the teams in their region, each month to discuss next steps in the process based on webinars presented by NY DOH staff. These meetings will consist of one to two in-person meetings, and conference calls. Recruitment documents have been issued to the Advisory Council and feedback expected by mid-April, will be compiled and documents revised based on feedback. Next steps include recruitment and formulation of teams for the summer 2017 and fall 2017 Learning Collaborative, which will continue for 12 months based on the execution of contracts with the three UCEDDs. The three regions targeted for this time frame include (1) New York City and Long Island, (2) Hudson Valley, Albany/Capital District and Northeast region, and the (3) Central and Western Region of NY. The Advisory Council will continue to meet to finalize the list of evidence based practices for EI services; review baseline data collected and data collection tools; and support the Learning Collaborative effort by participating in coaching calls, review ongoing data collected, provide support for teams especially with engaging families through increased participation in the annual family survey.
This strategy is measured by **ESM CSHCN-5**: Number of best practice strategies for improving family outcomes that are documented through review and learning collaboratives.

Strategy CSHCN-6: Use EI family survey data to inform the CSHCN Program of the needs of families transitioning from EI to CSHCN Program to better coordinate services.

The number of local programs making improvements in referrals from EIP to CSHCN will be monitored. The Title V Program will continue to stress to local programs the importance of documenting referrals between both programs. According to the 2015-2016 CSHCN data, 82 children, ages 1-5, were referred to CSHCN Program. The Title V Program will continue to monitor the data for the number of children that were referred from EIP to CSHCN in 2016-2017.

NY CSHCN Program staff conducted a webinar in October 2016 for the EI Officials and Managers to review this NY priority for the CSHCN domain. Ways to increase supports to address the special health care needs of children and youth were discussed throughout the webinar. The goal of the webinar was to educate the LHD EI staff on the importance of offering family support when children are aging out of EI and transitioning to preschool special education programs. This transition time is an opportunity for the LHD program to refer the child and family to the local CSHCN Program. Many questions were received from local EI programs about the specific referral process for CSHCN. An informational document has been developed and is undergoing the CCH approval process to provide information regarding collaboration between EI and CSHCN Programs.

Work is in progress for the upcoming year to update the current CSHCN database, coinciding with the beginning of a new five-year contract cycle for local CSHCN Programs. Title V staff have met with technical staff who will assist in the development of an updated system that will facilitate use of the system by the local programs and can create more detailed reports for DFH staff and the local CSHCN staff. A survey was conducted with local programs to determine the type of operating systems they use, to create a smooth transition to implementation of a new database. A new database will be developed in the coming year. This strategy is measured by **ESM CSHCN-6**: Percent of children transitioning from EIP to Special Education services who have a documented referral to the LHD-based CSHCN program.

Strategy CSHCN-7: Provide technical assistance and facilitate a quality improvement project to engage health care providers, hospital staff, parent representatives and audiologists to improve reporting of initial hearing screening and follow-up results into the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS).

This year, staff are working on enhancements to the NYEHDI-IS based on user feedback and available resources. A grant application was submitted for a CDC grant for funding starting July 1, 2017 for a five -year period to provide financial resources to further expand the NYEHDI- IS to be in alignment with the CDC Functional Standards Tool Kit to ensure complete, accurate and timely reporting of EHDI data. New data elements are being added to NYEHDI-IS to capture infants who transfer from the birth facility, referral providers, and referral to early intervention. Tracking infants after they leave the birth facility has been problematic since the information system does not currently have this functionality. The additional data fields will make it possible to direct inquiries

for missing results to the appropriate hospital/provider reducing the time to obtain this information. Additionally, the platform of the reporting system is being upgraded from an OpenMRS platform which was developed six years ago, to a Java based environment which will improve system performance and bring the application into current NYS Information Technology Services (ITS) standards for Health Commerce System compliance. A new reporting module is being added to allow the EHDI Program and providers to generate and download aggregate reports. Also, birthing facilities will have the capability to generate reports detailing children missing hearing screening and follow-up results. Having aggregate and individual reports will facilitate complete documentation to ensure resources are directed appropriately. Monthly coaching calls and provision of data reports will continue to be generated and provided to facilities to continue to improve loss to follow up to meet the goal of reducing loss to follow up by 5% each year.

Since December 2015-December 2016, the percentage of children receiving hearing screening increased from 94.6% up to 96.0%. NY staff will continue to provide technical assistance to support reporting of children with hearing loss and continuing to improve loss to follow up. The new five-year HRSA grant, starting April 1, 2017, will be utilized to continue quality improvement efforts. The NYEHDI Program will develop one state-based Learning Community for healthcare professionals and families each year for the three-year grant period, and embed evidence-based QI methodology to achieve the grant objectives to increase by 30% the number of newborns and infants who receive timely diagnosis and to increase by 25 percent from baseline the number of newborns and infants who receive timely referral to the EIP Program per the JCIH recommended practice guidelines. The NYEHDI Program will partner with staff from the DFH, BEI and NICHQ to convene and conduct the Learning Community. A MCH student intern will work with the NY EHDI staff to review and update SAS programs used to compile EHDI data reports. This strategy is measured by **ESM-CSHCN-7**: Percentage of infants with initial hearing screening results for whom follow-up is documented in NYEHDI-IS.

FY 2016 Annual Report

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

Population and program data are needed to help drive and evaluate work across all areas of MCH, including CSHCN. Title V staff continue to review data from the 2009-2010 NSCH, National Survey of Children with Special Health Care Needs (NSCSHCN) and data reported by NY's Title V Local Health Department-based CSHCN and EI programs. Access to updated National Survey of Children's Health including state level data, expected to be released in Spring 2017, is essential for States such as NY to assess current functioning in this and other Domains.

NY CSHCN data shows that 55.5 % of children have Medicaid; 22.5% have commercial insurance, 8.5% have CHP, and 2.8% have Social Security Income (SSI). Also, data shows that 53.2% are White, 9.6% are African American, 5.1% are Asian or Pacific Islander and .3% are American Indian or Alaska Native and 9.9% are Hispanic. The percent of children with a primary care provider is 71.5%. The percentage of children who report needing assistance for aspects of care are as follows: 59.2% need help paying for items that are not covered; 17.5% exceeds benefit amount; 10.2% premium; 3.5% deductible and 9.6% copays.

Review and analysis of data is an essential element of MCH work. To expand and formalize this process, a data analysis plan is being developed that includes regular summary reports. (**ESM CSHCN-1:** Initial data report published.) Since the new data is not yet available, data from the last national survey of CSHCN 2009-2010, were analyzed. Frequencies were run to evaluate data quality and identify prevalence of conditions within the NY CSHCN population. The data plan implemented a process of stratifying conditions by age and developed a methodology to identify frequency of groups of conditions. These exploratory exercises allowed for a better understanding of the population and help to identify associations most appropriate to run during later phases of the data analysis. Title V staff seek to increase understanding of the impact of having a child with special need on the child and family and the factors associated with the impact (i.e. presence of having insurance, medical home).

In developing NY's SAP, Title V staff recognized the challenges in NYS related to fragmentation of services and the need to fully understand the needs of NY's CSHCN and their families as well as their perception as to what is currently effective and where there are significant gaps and barriers to ensuring CSHCN and their families are fully supported and integrated into society. NY is estimated to be home to over 750,000 CSHCN. Families with CSHCN require health and supportive services from a complex and potentially fragmented network of public and private programs in health care, social service, and education systems in NY. Caring for CSHCN can be challenging for families, particularly with respect to meeting the complex and varied medical needs of these children. Consistent access to comprehensive health care and supportive community services is essential to ensuring positive health and developmental outcomes for CSHCN. Several NY agencies, including the NYSDOH, OCFS, Office of Mental Health and Office of Persons with Developmental Disabilities, support programs and services to aid CSHCN and their families. The Title V program recognizes that the current systems in place in the state vary tremendously, all with potentially differing eligibility criteria, processes, and their own language (i.e., acronyms) that can be confusing to fully understand and access.

Over the past year, Title V staff embarked on the development of a process to systemically assess how agencies and programs relate to each other and to the CSHCN and families served and to identify gaps in services. While systems and programs are in place for CSHCN, they may not be available in all locations, easy for families to understand or navigate, or are less than optimally coordinated. The same challenge may exist for professionals seeking to support the CSHCN and families they serve and support. System support maps offer a guided approach to help families and other stakeholders think about and document a system from their perspective. The map is a tool that will allow families/stakeholders to visually express their personal ongoing journey or "story" as they support the child(ren) they are responsible for. The process of creating a map will help families and stakeholders clarify, demonstrate and document the complex web of responsibilities, needs, resources, services and wish list involved in supporting their CSHCN. The information NY staff receives from these maps will help to answer questions, such as, "What supports and services

are needed to help providers, local DOH staff and others support families of CSHCN?"; "What can providers, local DOH staff and other do to support families?"; "What do families need to care for their CSHCN?"; "What is currently working that supports families?"; and, "What are the gaps and barriers to supports and services for CSHCN and their families?".

NY's Title V program, with assistance of the National MCH Workforce Development Center (WDC) initiated a systems mapping initiative to identify the connections/relationships that exist among programs and services and to identify specific issues, gaps and barriers in the system of public health programs and services for CSHCN and their families. This initiative includes engaging a variety of members representing different stakeholders involved with CSHCN, including parents, advocacy groups, health care systems and community based providers, academia, county officials and state agency staff to complete systems maps.

Instructions on how to complete a system map for an individual child or family were presented to a pilot cohort of twelve parents of CSHCN in December 2016 at an Early Intervention parent training session. The pilot cohort showed interest in participating in systems mapping and a desire to be involved in planning of future supports but only one parent of the twelve completed their map. According to the WDC, more parents made attempts to start a map but only one was successfully completed. Title V staff are reviewing the mapping tool and instructions to determine revisions that will gain improved participation. Additionally, the project coordinator of the parent training session agreed to reach out to the cohort of parents to encourage them to try again to complete their maps. Additionally, NY staff introduced the system mapping tool to local County EI managers in December 2016 during a call with all counties. A statewide webinar for local Title V CSHCN staff is scheduled for March, 2017 to introduce the system mapping tool and request that local Title V CSHCN staff create their own map using the WDC's online mapping tool.

Parents are essential and central partners in this mapping exercise. NY staff is working with local parent agencies to ensure that a diverse group of parents are engaged on a state-wide basis to complete maps. In March 2017, directions to the on-line parent mapping tool was sent to 350 parents of CSHCN asking them to create an individual family map. Demographic fields are being included in the system mapping tool for NY to capture information on race and ethnicity so that analysis can be conducted using a health equity lens. (**ESM CSHCN-2:** Number of partners engaged in system mapping.)

In addition to working with stakeholders, such as parents and local Title V staff, various provider and professional groups, such as pediatricians, medical specialists, therapists and others that care for and support CSHCN and their families will be contacted for their expertise. The Title V Program expects to gain a greater understanding of the strengths as well as gaps and barriers to care to improve access to appropriate and necessary services for families of CSHCN. The Title V program will share the results of the systems mapping with partners to help develop a more integrated, comprehensive, family centered and consistent system of care for families of CSHCN in NY.

Another Title V policy and program focus for CSHCN is the implementation of Children's HH. The enrollment of children in HH began in October 2016. In order to be eligible for CHH a child must be Medicaid eligible and have two or more chronic conditions including; alcohol or substance abuse, mental health condition, cardiovascular disease, metabolic disease, respiratory disease, BMI at or above 85% or other chronic conditions; or one single qualifying condition such as HIV/AIDS or serious mental illness, serious emotional disturbance or trauma and at risk for another chronic condition.

Title V staff participated in ongoing plans and efforts to develop and implement CHH including tailoring the Child and Adolescent Needs and Strengths (CANS) tool for NY and review of applications for CHH approval. Title V staff also participated in the Medicaid Analytics Performance Portal (MAPP) training. MAPP is the CHH data tracking system which records children who are referred to CHH. In November 2016, Title V and OHIP staff participated in site visits to three designated HH agencies prior to the program launch in December 2016. The three site visits included Kaleida (Buffalo), Collaborative Children and Families (NYC) and Children's Health Homes of Upstate NY (Rochester). The purpose of the visits was to assess each of the agency's organizational structure, governance model, readiness criteria, relations and connection to adult HH, planning for transitional youth, provider connection and training/knowledge of special populations (Medically Fragile, Early Intervention, specific geographical needs, among others) and their role in behavioral health. Care management agency staff and Title V staff shared information about pertinent programs.

Title V staff, as part of the CHH team, also collaborated to define policy elements related to comprehensive assessment of children enrolled in CHH. Title V staff contributed to the development of CHH indicators designed to assess process and outcomes related to

children receiving care management. DFH staff co-presented at three webinars for CHH and EI provider agencies to obtain input on supports and barriers to the CHH referral process for EI eligible children. A series of webinars were co-presented in November 2016, December 2016 and March 2017 by OHIP and NY Title V staff to provide information regarding EI eligible children who may benefit from referrals to CHH. The webinars also provided specific information regarding the responsibilities of CHH care managers for children who are receiving EI services. OHIP reports that as of January 2017, 3,905 children were enrolled in CHH. (**ESM CSHCN-3:** Number of CSHCN children enrolled in Health Homes designated to serve children.) Additionally, a readiness survey was developed and distributed to EI providers, municipalities, HH care management agencies, and CHHs to gain feedback on readiness and needs for additional training to receive referrals of EI eligible children. The survey returned 148 responses and determined that more than 50% of responders were interested in more training and establishing business agreements to work with CHHs and EI eligible children. It is anticipated that more EI children will be referred when additional training and EI approval of providers has been accomplished. The anticipated date for referral of EI children to CHH is September 2017.

Transition to adult services can be a challenge for youth with special health care needs. Local CSHCN programs provide adolescents with information about transitions to adult services and CHH can strengthen transition supports for eligible adolescents enrolled in Medicaid. Youth with sickle cell disease (SCD) are particularly vulnerable during this transition and require coordinated consistent support to develop the independent skills and knowledge they need to become healthy and productive adults. Research shows that adolescents and young adults (AYA) with SCD have a higher morbidity and mortality than their younger and older cohorts in the five years after transition. As individuals with SCD enter adolescence they are faced with the same options and challenges as their peers, but with the extra burden of SCD. They may experience challenges such as finding health care providers who are available and experienced in working with adults with SCD. Young adults with SCD can experience significant health problems and incur a higher use of emergency and inpatient medical care as compared to their younger and older cohorts.

For close to three decades NY has provided funding to qualified hemoglobinopathy centers to support transition navigation services. In 2016, four centers in NY were funded to provide transition services. In 2016, of the 510 children seen in these State-funded hemoglobinopathy centers, only 28% were reported as having an up-to-date transition plan and the percentage of transition readiness varies by center from a low of 7 % to a high of 81%. (**ESM CSHCN-4:** Percent of Adolescents/Young Adults with SCD age 12-21 years in the funded projects who have a transition readiness assessment completed and documented.) Although NYS supports best practices in transition planning, outcomes continue to vary among hemoglobinopathy centers. Through education and participation in systems mapping exercises, NYS hopes to identify and replicate the most successful transition plans. Partnering with both funded and non-funded centers will allow NYS to identify tools and activities that best support young adults with SCD during transitions years. Difficulty in transitioning to adult care is common in AYA/SCD. Research shows that AYASCD have a higher morbidity and mortality than their younger and older cohorts in the five years after transition. As individuals with SCD enter adolescence they are faced with the same options and challenges as their peers, but with the extra burden of SCD. They may experience challenges unknown to their peers, such as finding health care providers who are available and experienced in working with adults with SCD. Young adults with SCD experience significant health problems and incur a higher use of emergency and inpatient medical care as compared to their younger and older cohorts.

NY has established supports and services for CSHCNs and their families across the life course. Beginning at birth, NY's Newborn Screening Program (NBSP) performs blood testing for over 275,000 specimens annually for 49 diseases and conditions. Families and primary care providers are notified of any positive results. In addition, all birthing facilities in NY are required to conduct hearing screening on all newborns. If the result of a hearing screening test is abnormal, a referral is made to an appropriate specialized care center for hearing evaluation.

NY also supports several programs and initiatives to provide support for CSHCN and their families (CSHCN is further discussed later in this report). One of these programs is the Early Intervention Program (EIP), one of the largest EIPs in the nation. There are over 65,000 children enrolled in the EIP, of which over 12,000 are eligible to be referred annually to the SED Preschool Program for children 3-5 years of age who qualify for these educationally-oriented services. NY also supports 50 CSHCN programs in Local

Health Departments (LHDs) to provide information and referral services for families of CSHCN. These CSHCN programs worked to ensure that each child had a primary health care provider and appropriate health insurance. CSHCN contractors link families with facilitated enrollers, the NY Health Exchange and other community gap-filling programs. Current data (ESM CSHCN-6) show that only 82 children ages 1-5 were referred from the EIP to local CSHCN programs. Title V program staff are in the process of analyzing data from the EI survey to better understand the needs of families exiting the EIP, considering this low referral rate, so that patterns of insufficiency within a community can be identified that may be negatively impacting this transition process. One of the challenges for smooth transition from EIP to CSHCNs is that the EIP program provides families with a service coordinator, but SED Preschool Special Education Program does not. To fill this gap, CSHCN program staff and/or CHH (for children who are Medicaid eligible) provided brief or more systematic care coordination to manage this transition.

An important component of finalizing NY's SAP was addressing improved coordination and maximizing existing efforts to improve supports and services for CSHCN. A prime example of this is NY's SSIP, a comprehensive multi-year plan for improving results for infants and toddlers with special needs. The SSIP is a federal requirement, focused on improving family outcomes and is reported to the federal Office of Special Education Programs. The NY Family Survey was distributed to families when they exited the EIP. This survey captured feedback about outcomes for the family and child and the quality of EI services. In 2015-16, 61.6% of families participating in the EIP met or exceeded the state-established standard for the NY Impact on Family Scale (SPM-4). As part of the SSIP, NY identified three University Centers for Excellence for Developmental Disabilities (UCEDDs) to provide a team of experts to promote collaboration and utilization of best practices on topics specific to child and family outcomes in NY's EIP. Contracts with these identified UCEDDs were developed in this reporting year and will be executed in the upcoming year. See the application section of this Domain for further details.

Another important strategy of NY's SSIP is a Learning Collaborative (LC). A LC is a short term (6-15 month) system that brings together many teams to seek improvement in a focused topic area. Small teams focused on areas of improvement and change will be identified and successes will be shared statewide. The teams are made up of families, EI Officials, Designees or Managers, service coordinators and EI providers. Each team will have a Champion, who is a well-respected leader willing to devote time, who understands EI well and has a desire to drive system improvements. Each team will have a Key Contact who drives the project and cycles of change, coordinates communication and oversees data collection. Other team members participate as needed in the change cycles and project. The goal of the team is to make small changes to ensure family-centered practices are part of current interaction with families. In anticipation of the initiation of this LC, a SSIP State Advisory Group has been convened that consists of parents, EI providers, EI Officials, EICC members, ECAC members and members representing other NYS agencies, including Parent 2 Parent of NY. (**ESM CSHCN-5:** Number of best practice strategies for improving family outcomes that are documented through review and learning collaboratives.) The Advisory Group will provide advice and expertise to support to the learning collaborative efforts.

The first meeting of the advisory group was convened via WebEx in December 2016 and the group was provided with an overview of the SSIP, description of the Quality Improvement Framework and the advisory group's role in the process. A second meeting was held February 2017 to review relevant data and discuss the configuration of the member teams. A third meeting was held in March 2017 where the focus was on recruitment of teams. A draft recruitment packet which provides details of purpose, goals, expectations, schedules, what is required for pre-work, and detail of work of a learning collaborative has been developed and disseminated to the advisory group for feedback. Feedback on the recruitment packet was due back to NY in April 2017. A fourth meeting is planned for late April 2017 to discuss draft recruitment flyers that are specific to the three team member groups, including, parents, providers and EIO/EIMs and Service Coordinators. The one-page flyers were created with the State Advisory Group input. Outreach to stakeholders was initiated by NY through a presentation to NYSACHO in April 2017 during their monthly meeting. Additional outreach will be done through NY participation to Local Early Intervention Coordinating Councils (LEICCs) scheduled for late April 2017 in the Finger Lakes region for 11 counties and in July 2017 in NYC.

The NY Early Hearing Detection Intervention Information System (NYEHDI-IS), an online information system, is utilized to capture

inpatient hearing screening and allows for data entry of subsequent hearing screening and follow-up that occurs after birth. Data generated from this system helps to ensure that newborns with positive screenings receive appropriate follow-up supports and services and helps to identify those infants who did not pass a hearing screening and require follow-up, yet did not receive that follow-up. This is referred to as loss to follow-up (LTF).

To address those lost to follow-up, in 2014 NY applied for and received a three-year grant from HRSA to implement a quality improvement (QI) project to reduce loss to follow-up for newborn hearing screening. A collaborative was formed as part of the QI project, to work with obstetric hospitals to improve reporting of initial hearing screening that is entered NYEHDI-IS. Identification of a root cause for loss to follow-up and solutions to reduce it by 5% each year, is part of the QI project. Since 2014, a team of stakeholders, including parents, have participated in periodic calls to provide guidance and expertise to this initiative. Over the past year, monthly coaching calls were held to provide technical assistance and education on reporting follow-up results in NYEHDI-IS, and relate the importance of reporting follow-up results. The annual EHDI Advisory Workgroup, consisting of Title V staff, pediatricians, audiologists, Parent to Parent of NYS representatives, Hands and Voices of NY, hospital staff and speech language pathologists convened in November 2016, to share success, challenges and identify next steps for reducing loss to follow-up.

During the past year, Title V staff also created monthly data reports for program surveillance to identify missing results, which were shared with facility staff to improve reporting. A webinar series for Pediatric Audiologists was held in March 2017 by Title V EHDI staff. Additionally, site visits were conducted at birthing hospitals in the Rochester, Buffalo and Syracuse regions in March 2017 to provide guidance on the importance of follow-up with families. Staff participated in the annual EHDI Conference and provided several presentations regarding data match with EI eligible children, loss to follow-up, and NY's quality improvement achievements through a two- year learning collaborative.

Grant funding from HRSA was received for the period, April 1, 2017 through March 31, 2020, however, the grant was significantly reduced from previous years' funding amounts and future work will need to be adjusted accordingly. A grant application was submitted to the CDC for additional funding to provide support to the NYEHDI-IS for the period of July 1, 2017 through June 30, 2020. Funding from this grant will be used to develop enhancements to the NYEHDI-IS based on user feedback and available resources. Bi-weekly meetings were held with Title V staff to review system requirements, system enhancements and system modifications. As a reflection of these collective program activities, the percentage of children with a documented hearing screening increased from 94.6% in December 2015 to 96.0% in December 2016. Of these infants, 3,530 or 1.6% failed the screening and 539 or 15.3% received a documented follow-up screening. (**ESM CSHCN-7:** Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.)

Over the past year, it became increasingly apparent that on the local level, EIP staff in LHDs were not always aware of the LHD's CSHCN services even when they were in the same agency. Therefore, in the fall of 2016, Title V staff presented webinars to local EI and CSHCN programs to provide more detailed information regarding the CSHCN program, to discuss establishing improved linkages between these programs on the local level and increase documentation when referrals from the EIP are made to local CSHCN programs. (**ESM CSHCN-6:** Percent of children transitioning from EIP to Special Education services who have a documented referral to LHD-based CSHCN program.)

In order to more fully understand the needs of NY's CSHCN and their families, CSHCN information and referral programs have been required to distribute Family Satisfaction Surveys to all families served by the program the local level. This satisfaction tool provides data from the families served and assists with program planning to meet identified needs of families. Families of CSHCN were asked, as an example, "how easy is it to get information and help from staff ?" 84.2% of responses stated always easy, 13.8% stated sometimes easy and 2.1% stated never easy. When asked "what race would you consider your CSHCN", parental responses were: 14.6% Hispanic/Latino, 1.7% American Indian, 63% White, 2.5% Asian, 26.7% African American and 2.9% considered themselves as Other.

Since the number of families served by this program is limited, the number of completed Family Satisfaction Surveys statewide is low as well. The number submitted in a reporting year was even lower due to a limited number of surveys distributed by LHDs. Additional challenges included inconsistent timing of survey distribution: LHDs distributed the surveys at the end of the grant year, the end of the calendar year or when the outcomes of the intervention were completed. Survey response rates were inconsistent, i.e. had little return based on distribution for a month. To improve upon these challenges, technical assistance was sent to LHD to provide guidance on the correct and consistent method to obtain surveys.

Title V program staff, in collaboration with OPHP staff conducted a three-month pilot to improve survey performance. Six LHDs were selected for the pilot and five chose to participate. These LHDs had a family satisfaction survey return rate from good to poor. The LHDs participated in a webinar conducted by Title V staff and OPHP staff, that provided information on how to use a tracking tool to record details on performance. The tool tracked the following items: survey number that was assigned; status of the survey; date of visit; date the survey was sent out; method that the survey was delivered (mail, electronic, in person or by phone); and date that the survey response was received. Additionally, a section for notes and any follow up was included. The tool tracker includes a performance tab, which gives the LHD feedback on the status of the survey, method of the survey and follow up of the survey that was sent and received/completed.

At the end of the pilot, a conference call was conducted to review the results and get feedback on performance measures. The results of this pilot indicated that four of the five local CSHCN programs were compliant with providing each child's family a survey after their initial encounters although staff needed reminders, guidance and technical assistance due to staff turnover, in using the tracking tool. The goal of the pilot was to increase the return rate to 75%, and a 78.9% return rate was achieved. Based on the results of the survey, further state wide dissemination of the tracking tool is planned for the coming year.

While the majority of NY's children are insured, there still appears to be some gaps for CSHCN and their families. The Physically Handicapped Children's Program (PHCP) provided gap-filling services for those underinsured. In 2016, six children received an evaluation and 285 received treatment services. Service categories were orthodontia; medications, hearing aids, and medical equipment/supplies. The race of participants was reported as follows: 227 White, 6 African American, 3 Asian, 4 Pacific Islander,13 Other and 39 Unknown and ethnicity was: 13 Spanish, Hispanic or Latino, 88 considered themselves Other and 33 were Unknown.

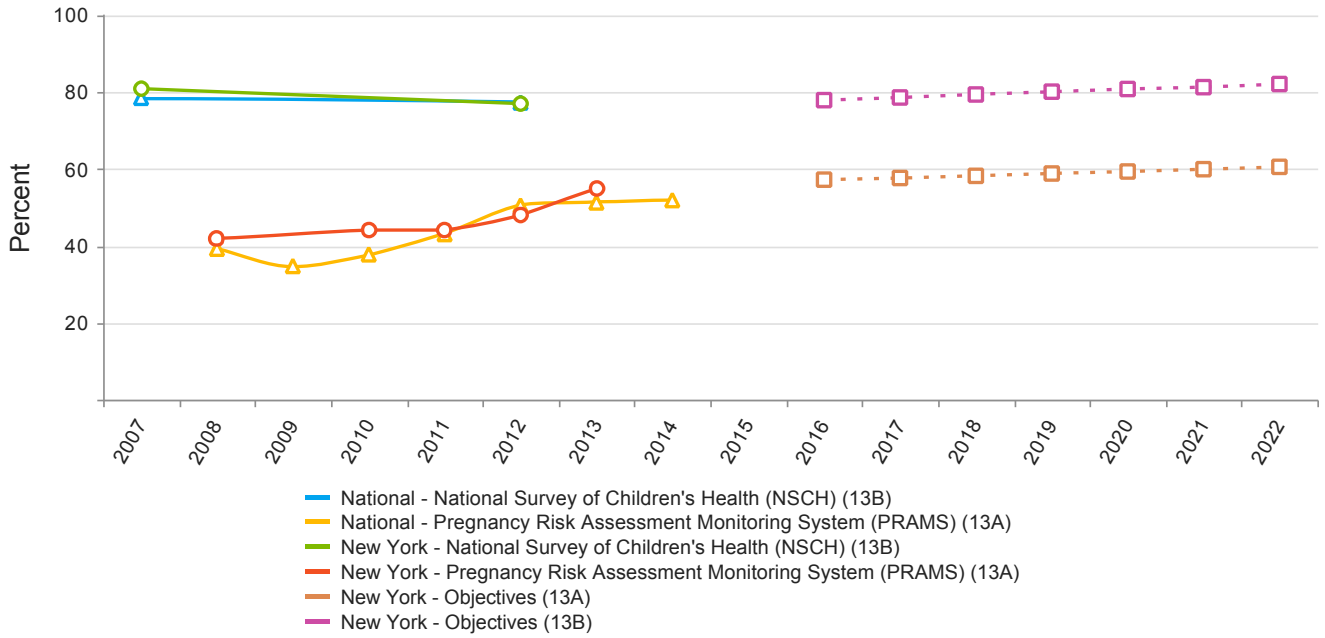
Cross-Cutting/Life Course

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 12 months	NSCH-2011_2012	19.4 %	NPM 13
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	83.2 %	NPM 13

National Performance Measures

NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year
Baseline Indicators and Annual Objectives



NPM 13 - A) Percent of women who had a dental visit during pregnancy

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	57.2
Annual Indicator	54.9
Numerator	117,570
Denominator	214,301
Data Source	PRAMS
Data Source Year	2013

State Provided Data	
	2016
Annual Objective	57.2
Annual Indicator	53.8
Numerator	
Denominator	
Data Source	PRAMS NYS
Data Source Year	2014
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	57.6	58.2	58.8	59.3	59.9	60.5

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	77.8
Annual Indicator	77.1
Numerator	3,075,807
Denominator	3,991,985
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	78.5	79.3	80.0	80.7	81.2	82.0

Evidence-Based or –Informed Strategy Measures

ESM 13.1 - 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
Annual Objective	
Annual Indicator	58
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	20.0	60.0	62.0	64.0	66.0	68.0

ESM 13.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	61.2
Numerator	
Denominator	
Data Source	SEALS (CDC Data)
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	40.0	41.0	44.0	47.0	50.0	53.0

ESM 13.3 - Number Medicaid claims submitted by primary care providers for application of fluoride varnish for children aged 0-5.

Measure Status:	Inactive - Challenge accessing all necessary data elements for this measure

State Provided Data	
	2016
Annual Objective	
Annual Indicator	9,447
Numerator	
Denominator	
Data Source	CMS Medicaid Claims Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10,000.0	10,000.0	10,000.0	10,000.0	10,000.0	10,000.0

ESM 13.4 - Plan adopted in collaboration with NYSDOH Division of Nutrition to promote integration of oral health strategies in at least one public health nutrition program.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 13.5 - 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
Annual Objective	
Annual Indicator	36.7
Numerator	
Denominator	
Data Source	MICHC reports
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	10.0	20.0	25.0	30.0	35.0

ESM 13.6 - Number of dental public health residents with completed residency projects utilizing data systems in the past year.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	10
Numerator	
Denominator	
Data Source	Preventive Dental Residents and NY Title V Records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	10.0

State Performance Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	37.3
Numerator	
Denominator	
Data Source	BRFSS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	45.0	48.0	51.0	53.0	56.0	56.0

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
Annual Objective	
Annual Indicator	27
Numerator	
Denominator	
Data Source	Medicaid Claims
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	8.0	10.0	12.0	14.0	16.0	27.5

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	72.0	73.0	75.0	77.0	78.5	78.5

State Action Plan Table

State Action Plan Table (New York) - Cross-Cutting/Life Course - Entry 1

Priority Need

Promote oral health and reduce tooth decay across the life course

NPM

A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Objectives

Objective LC-4: Increase the percentage of NYS residents served by community water systems that have optimally fluoridated water by 10% to 78.5%

Objective LC-5: Reduce the prevalence of dental caries among NYS children by 10% to 40.5%.

Objective LC-6: Increase the percentage of children and adolescents age 1-17 years who had a preventive dental visit in the past year by 5% to 80.9%

• Objective LC-7: Increase the percentage of pregnant women who had a dental visit during pregnancy by 10% to 54.6%.

Strategies

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

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

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

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

ESMs	Status
ESM 13.1 - Number of public water systems that receive financial and/or technical support from NYSDOH to maintainor initiate community water fluoridation.	Active
ESM 13.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.	Active
ESM 13.3 - Number Medicaid claims submitted by primary care providers for application of fluoride varnish for childrenaged 0-5.	Inactive
ESM 13.4 - Plan adopted in collaboration with NYSDOH Division of Nutrition to promote integration of oral healthstrategies in at least one public health nutrition program.	Inactive
ESM 13.5 - Percentage of pregnant women served by Title V community health workers that have a documentedscreening or referral for dental services.	Active
ESM 13.6 - Number of dental public health residents with completed residency projects utilizing data systems in thepast year.	Inactive

NOMs
NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months
NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (New York) - Cross-Cutting/Life Course - Entry 2

Priority Need

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

NPM

A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Objectives

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

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

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

Strategies

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

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

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

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

ESMs	Status
ESM 13.1 - Number of public water systems that receive financial and/or technical support from NYSDOH to maintainor initiate community water fluoridation.	Active
ESM 13.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.	Active
ESM 13.3 - Number Medicaid claims submitted by primary care providers for application of fluoride varnish for childrenaged 0-5.	Inactive
ESM 13.4 - Plan adopted in collaboration with NYSDOH Division of Nutrition to promote integration of oral healthstrategies in at least one public health nutrition program.	Inactive
ESM 13.5 - Percentage of pregnant women served by Title V community health workers that have a documentedscreening or referral for dental services.	Active
ESM 13.6 - Number of dental public health residents with completed residency projects utilizing data systems in thepast year.	Inactive

NOMs
NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months
NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (New York) - Cross-Cutting/Life Course - Entry 3

Priority Need

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

SPM

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

Objectives

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

Objective LC-2 (same as CH-2): Increase the percentage of children 10-71 months who whose parents report they have had a developmental screening using a parent-completed screening tool by 10% to 31.3%.

Objective LC-3 (same as AH-3): Increase the percentage of adolescents who received a preventive health care visit in the last year by 6.5% to 97.7%.

Strategies

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

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

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

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

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

State Action Plan Table (New York) - Cross-Cutting/Life Course - Entry 4

Priority Need

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

SPM

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

Objectives

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

Objective LC-2 (same as CH-2): Increase the percentage of children 10-71 months who whose parents report they have had a developmental screening using a parent-completed screening tool by 10% to 31.3%.

Objective LC-3 (same as AH-3): Increase the percentage of adolescents who received a preventive health care visit in the last year by 6.5% to 97.7%.

Strategies

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

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

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

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

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

State Action Plan Table (New York) - Cross-Cutting/Life Course - Entry 5

Priority Need

Promote oral health and reduce tooth decay across the life course

SPM

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

Objectives

Objective LC-4: Increase the percentage of NYS residents served by community water systems that have optimally fluoridated water by 10% to 78.5%

Objective LC-5: Reduce the prevalence of dental caries among NYS children by 10% to 40.5%.

Objective LC-6: Increase the percentage of children and adolescents age 1-17 years who had a preventive dental visit in the past year by 5% to 80.9%

Objective LC-7: Increase the percentage of pregnant women who had a dental visit during pregnancy by 10% to 54.6%.

Strategies

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

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

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

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

State Action Plan Table (New York) - Cross-Cutting/Life Course - Entry 6

Priority Need

Promote oral health and reduce tooth decay across the life course

SPM

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

Objectives

Objective LC-4: Increase the percentage of NYS residents served by community water systems that have optimally fluoridated water by 10% to 78.5%

Objective LC-5: Reduce the prevalence of dental caries among NYS children by 10% to 40.5%.

Objective LC-6: Increase the percentage of children and adolescents age 1-17 years who had a preventive dental visit in the past year by 5% to 80.9%

Objective LC-7: Increase the percentage of pregnant women who had a dental visit during pregnancy by 10% to 54.6%.

Strategies

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

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

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

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

FY 2018 Application
Cross Cutting/Life Course

State Priority #5: Increase use of primary and preventive health care services across the life course.

2020 State Objectives:

- **Objective LC-1: Increase the percentage of women 18-44 years old with a past year preventive medical visit by 10% to 79.4%.**
- **Objective LC-2: Increase the percentage of children 10-71 months who whose parents report they have had a developmental screening using a parent-completed screening tool by 10% to 31.3%.**
- **Objective LC-3*:* Increase the percentage of adolescents who received a preventive health care visit in the last year by 6.5% to 97.7%.**

Building on the established baseline of 11 of 19 DFH/Title V programs with health insurance requirements and an additional 11 of 17 programs with well-woman visit promotion requirements, staff will focus efforts during the upcoming year on increasing the number of DFH programs with preventive care components. Staff will continue to increase the number of Title V programs which include a focus on preventive health care. Further, work will begin to ensure that all strategies and activities promoting increased use of preventive care align with evidence based or informed best practices. This strategy is being measured by **ESM LC-1:** The number of Title V programs with health insurance elements incorporated in program requirements.

First steps will include initial assessment of current program standards, measures, and strategies being used across DFH/Title V programs to promote preventive health care. This assessment will enable staff to view all currently used performance standard, measure, or strategy language and associated data metrics within DFH. This assessment will coincide with a literature review to identify evidence based or evidence informed best practices to promote the use of preventive health care. Staff will analyze currently used program standards, measures, and strategies to determine whether they align with best practices.

A key focus of this work will be the development of Title V program wide language and measures for the promotion of preventive health care services in all programs. By working to adopt universal language and measures to promote health insurance enrollment and the use of well-woman care among all relevant Title V programs, DFH can ensure that programs are using best practices and have measures which allow for more meaningful comparisons among programs. Specifically, working to include universal measures in all DFH procurements released, thus enabling standard measures and collaborative activities between various programs. Through the adoption of universal data measures, staff will be better able to analyze successes and barriers, while identifying specific providers or programs who demonstrate a greater ability to promote preventive health care. Through this increased centralization of standards and measures, Title V programs and its contractors will be better supported in leveraging resources to achieve the best possible outcomes for their clients. Moving forward, performance goals and measures will be more clearly developed and assessed. This strategy is being measured by **ESM LC-3:** The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services.

In the upcoming program year, Title V staff will continue to support implementation of the preconception module in BRFSS and subsequent analysis of the results. This work will include analysis of the 2016 BRFSS data, which contained four questions from the preconception module. Once data is available later this year, an analytic report will be generated and reviewed to compare trends from 2014-2016. Further work will include advocacy for the inclusion of the Family Planning/Preconception Health module of questions in the even numbered years – the next being 2018. At least annually, DFH research scientists working on women's health

will review the most current data and produce recommendations for program staff about how these results should inform DFH work. Further, more in-depth analysis will be conducted to identify relationships between variables (e.g., is there any relation between women who say a doctor talked to them about planning a health pregnancy and women who report having particular chronic diseases). This work has already been initiated and has been presented at the Northeast Epidemiology Conference in October 2016. The goal is to develop a manuscript for publication using these data. This is being measured by **ESM LC- 2:** The number of analytic reports developed and shared.

As with previous years, DFH staff across programs will continue to support the improvement of developmental screenings for youth across NYS. This will include ongoing participation in the ECAC, support for the Albany Promise Initiative, collaboration on the ECSS, and regular internal efforts to improve developmental screenings within all Title V programs.

In the upcoming year, the NYSDOH MIECHV program will further emphasize developmental screenings among evidence based home visiting programs. Through the inclusion of two performance indicators defined by HRSA for the MIECHV program and implemented in October 2016, all home visiting programs receiving MIECHV funds must provide additional information and support for developmental screenings of all enrolled children. New MIECHV areas of focus include reporting on the following measures: the percent of children enrolled in home visiting programs with a timely screen for developmental delays using a validated parent completed tool; the percent of children enrolled in home visiting with positive screens for developmental delays (measured using a validated tool) who receive services in a timely manner; and the number of completed referrals which include a) individuals receiving developmental support from a home visitor; or b) individuals who were referred to EI services and received an evaluation within 45 days; or c) individuals who were connected to other community services and received those services within 30 days. These metrics will be tracked quarterly and used to provide targeted technical assistance to grantees based on their performance. This strategy is being measured by **ESM LC-4:** Number of strategies implemented to improve developmental screening.

Finally, staff will continue its focus on addressing the unique needs of adolescents. Following the recommendation of the Cornell ACT for Youth COE, the upcoming program year will begin with adoption of a new strategy and ESM for Strategy LC-5. Rather than convening focus groups before the development of intervention plans, in the next year, Title V staff will gather feedback on barriers and impediments to accessing preventive care through a series of surveys deployed by the ACT COE to current DFH funded adolescent health providers. This information, combined with a literature review of best practices to improve use of preventive care will help Title V staff in the development of proposed interventions to improve adolescent preventive health care use. Once proposed interventions are developed, Title V staff will work with ACT COE to convene focus groups and obtain feedback from adolescent participants on proposed changes. All strategies are aimed toward the goal that all programs within DFH, serving adolescent participants incorporate best practice strategies and begin to implement interventions designed to increase adolescent use of preventive health care services.

In conjunction with the Cornell ACT for Youth COE, DFH staff will work to develop strategies to improve preventive health care service delivery to adolescents, with a focus on reducing disparities.**ESM-5** has been updated to reflect this focus change: The number of strategies implemented to improve adolescent use of preventive health care services.

State Priority #6: Promote oral health and reduce tooth decay across the life course

2020 State Objectives:

- **Objective LC-4: Increase the percentage of NYS residents served by community water systems that have optimally fluoridated water by 10% to 78.5%**
- **Objective LC-5: Reduce the prevalence of dental caries among NYS children by 10% to 40.5%.**
- **Objective LC-6: Increase the percentage of children and adolescents age 1-17 years who had a preventive dental visit in the past year by 5% to 80.9%**

- **Objective LC-7: Increase the percentage of pregnant women who had a dental visit during pregnancy by 10% to 54.6%.**

Promoting oral health across the life span is an important priority for NY's Title V Program. Among children, tooth decay is the most common chronic disease, and receiving appropriate dental care is the greatest unmet service need. Access to dental care remains a challenge for many, especially low income individuals of all ages. In June 2014, there were 127 federally-designated dental health professional shortage areas in NY. As of January 1, 2017, this increased by over 9% to 139, impacting almost 2.2 million New Yorkers. Because of this, expanding access to evidence-based interventions, specifically CWF and dental sealants; delivery of preventative dental services across diverse settings including school-based clinics, primary care settings, and nutrition programs; and integrating oral health messaging and education within maternal and infant health programs, are all core strategies of the Title V Program and SAP.

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

NY's Title V program will continue to focus on activities to maintain and expand CWF across NY including providing financial and technical assistance to PWS. In the NY's 2017-18 Enacted Budget, $10 million was appropriated to support the Drinking Water Fluoridation (DWF) Grant Program. The next round of funding is expected to be released in the summer of 2017 with applications being accepted and reviewed on a rolling basis. DFH and its partners will work together to promote the DWF Grant Program, specifically in non-fluoridated communities, to increase the percent of NY communities on PWS receiving optimally fluoridated water. This includes providing direct outreach to municipalities to discuss eligibility, raising the level of awareness and empowering local CWF champions to work with their elected officials and PWS to submit applications, and providing a greater level of technical assistance to potential applicants in the application process. In addition to promoting DWF Round four, DFH will continue to manage and work with the 35 grantees awarded funding under DWF Rounds one through three. Staff will ensure completion of the projects and will provide technical assistance as needed.

DFH will continue to contract with the NYRWA to provide technical support for CWF to PWS through direct onsite visits and water operator trainings. The goal of this contract is to identify and address CWF operation issues and ensure a knowledgeable PWS workforce on CWF. NYRWA is expected to conduct 25 site visits in 2017-18. The locations of these visits will be selected based on specific criteria such as fluoride levels are trending high, low or vary greatly from day to day or an interest in initiating CWF. This strategy will be measured by **ESM LC-6:** Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.

Strategy LC-7: Increase the delivery of evidence-based preventive dental services across key settings:

- **school-based clinics**
- **primary care practices**
- **public health nutrition programs**

The SBHC-D Program targets high risk children from pre-kindergarten to high school who have limited access to a dental home or services. 25 SBHC-D programs received School-based dental sealant (SBSP) grants to ensure that children receive a highly effective dental prevention service through a proven community-based approach. SBSP are designed to maximize effectiveness by targeting schools with high-risk children (those vulnerable populations less likely to receive dental care) such as children eligible for free and reduced-cost meal programs. Starting July 2017, 25 SBSPs will implement a "package" of education and services to promote oral health in young children including applying sealants, providing education regarding oral health care, facilitating referral to needed oral health services and ensuring quality and continuity of care through retention checks, replacement of lost sealant material, and follow-up on any untreated dental disease.

As stated in the Annual Report section of this Domain, the NY Medical-Dental Integration (MDI) Project, begun in late Spring 2017 and built upon the work of the EC3 quality improvement project. The goal is to promote prevention of ECC by increasing access to quality preventive clinical dental services through the training and delivery of these services by pediatric medical providers. In fall 2017, DOH will transition the Medical-Dental Integration (MDI) Project into the Learning Collaborative phase to further engage the CHCs, and their primary care and dental providers, on medical-dental integration and build upon the work conducted during the initial training program. The aim of the Learning Collaborative will be to provide an opportunity for CHCs, that received an in-person training, to work on integrating oral health into primary care practice, as well as to build collaborative relationships between medical and dental colleagues and create/improve the infrastructure for dental referrals. MDI will hold three virtual Learning Sessions over a 12-month period to support CHCs to share their experience in integrating oral health into pediatric clinical workflow. Pediatric providers will work with their dental colleagues to address challenges/issues and create/improve the dental referral system to ensure children receive appropriate and timely dental care.

Activities to promote the evidence-based practice of fluoride varnish application to young children by medical providers will continue throughout the upcoming grant year. The DOH and NYSACHO will continue to work together to promote and provide technical assistance to LHDs on public health detailing for fluoride varnish. Title V staff will participate in monthly calls and provide additional support to counties developing plans to engage in this activity. In fall 2017, the DOH will continue to conduct in-person trainings at community health centers (CHC) on fluoride varnish. Title V staff and consultants will provide technical assistance and expertise on the MDI and fluoride varnish to CHCs throughout the performance period.

These efforts will be measured through **ESM LC-7b-** Number of Medicaid claims submitted by primary care providers for application of fluoride varnish for children 0-5 enrolled in Medicaid that receive fluoride varnish applications from their primary care providers.

DFH will continue to work with DON on oral health education and training through DON's CACFP's Steps to Excellence Program, which provides annual training to nursing home, adult day care, and child daycare settings staff, by region. In the fall of 2017, a student intern will assist DFH staff and dental residents in adapting existing dental resources, including the Oral Health Manual/Toolkit from the PIOHQI Program for an in-person training and to refine the focus of the training for child daycare staff. The initial plan is to adopt the "train the trainer" model, where CACFP staff will received training on oral health, and then will train the daycare staff. This will serve as a framework that can be used in building and measuring future collaborations. This is measured through **ESM LC-7c:** Plan adopted in collaboration with NYS DON to promote integration of oral health strategies in at least one public health nutrition program.

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

DFH will continue to integrate oral health services into the MICHC program infrastructure by facilitating oral health trainings and providing oral health resources to MICHC providers and their community partners. After the successful pilot of this initiative at Healthy Baby Network, DFH will expand the PIOHQI Program statewide and integrate oral health into the workflow of CHWs at all 23 MICHC sites. The Oral Health Manual/Toolkit and training materials developed by the pilot site will assist pre/perinatal health care providers and MICHC programs in incorporating greater oral health integration. DOH will begin facilitating trainings for all MICHC providers starting with a webinar and in-person regional training for four MICHCs in April 2017 and then expand to all MICHCs. The trainings will utilize successful strategies from the pilot site, ensuring that lessons learned are shared with all MICHCs and other home-visiting projects. Lessons from the NY PIOHQI Project are also being shared with the other HRSA-funded states through a PIOHQI National Learning Collaborative to develop best practice models for integrating oral health care into existing community-based pre/perinatal services. This is being measured through **ESM LC-8:** Percentage of pregnant women served by Title V CHWs that have a documented screening or referral for dental services.

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

The dental resident will continue to work collaboratively with DFH staff to provide support for MCH oral health programs. This will include an analysis of SBHC-D quarterly reports and recommend revisions to measures for more accurate evaluation of performance; assessment of EC3, including lessons learned, to develop performance measures and an evaluation plan for the MDI Learning Collaborative, which is expected to launch in fall 2017. The dental resident will further conduct an assessment of evidence-based interventions and best practices, particularly in nutrition, to help MCH promote integration of oral health strategies in at least one public health nutrition program in 2017. A search is underway to add an additional resident in 2017. This is being measured through **ESM LC-9:** Number of MCH oral health related projects and assignments completed by the dental residents and documented in the dental public health residency competency tracking sheet.

State Priority #7: Promote supports and opportunities that foster healthy home and community environments

2020 State Objectives:

- **Objective LC-8: Increase the percentage of children and adolescents who are physically active at least 60 minutes daily by 10%, from 25.7% in 2013 to 28.5%.**
- **Objective LC-9: Increase the percentage of children and adolescents who live in supportive/ cohesive neighborhoods by 6%, from 79.2% in 2011/12 to 84%.**
- **Objective LC-10: Increase the percentage of children and adolescents who are usually or always safe in their community or neighborhood by 5%, from 79.9% in 2011/12 to 84%.**

The significance of the selection of this as a State Priority in NYS cannot be underscored. As stated previously, safe and healthy environments including, but not limited to, safe places for families to walk and children to play, nearby access to fruits and vegetables and other healthy food options, housing free from hazards, all impact health throughout the life course. All the identified State objectives for this priority area are from national surveys (NSCH, YRBS) with updated data expected to be released later in 2017.

Strategy LC-10: Continue and increase Title V staff leadership and participation in the DOH Place-Based Initiative (PBI) work group to:

- **Adopt a shared definition and set of indicators to measure healthy communities;**
- **Review place-based initiatives to identify best practices for community environmental change;**
- **Develop a toolkit of data and evidence-based/-informed practices for community change;**
- **Incorporate requirements for healthy community practices within relevant MCH funding procurements.**

During the upcoming year, Title V leadership will continue to participate in the quarterly meetings of the DOH PBI Workgroup. Best practices, challenges and strategies for effecting community-level change identified from the PBI community contractor survey will be analyzed and presented during the upcoming year. Title V staff will share these results with all appropriate DFH programs to maintain alignment with partners and incorporate requirements for healthy community practices within relevant MCH procurements. In the 2016 State of the State, Governor Cuomo introduced the Empire State Poverty Reduction Initiative (ESPRI) which aims to combat extreme poverty and reduce inequality in 16 cities with the highest poverty rates in the state. ESPRI is modeled after NY's successful Rochester Anti-Poverty Task Force, part of a broad coalition of state and local government, business and nonprofit representatives working together to redesign and coordinate efforts to address extreme poverty. ESPRI will replicate this model to provide planning and implementation grants for the identification of specific, measurable objectives to improve residents' well-being and quality of life; to better align public and private resources with community-based interventions that are successful in improving outcomes for residents; to develop strategies that match promising practices to the challenges of each community; and to build partnerships among public and private, municipal and nonprofit organizations to provide a continuum of solutions.

Nora Yates, the new DOH Director of the CCH, worked previously with the City of Newburgh on their Community, Opportunity, Reinvestment initiative, the predecessor to ESPRI. Ms. Yates presented an overview of the ESPRI initiative to the PBI Workgroup. Ms. Yates proposed that the future of the PBI Workgroup may be to support these cities with their implementation projects through the identification and leveraging of opportunities to partner where appropriate.

This strategy will be measured through **ESM LC-10a**: Number of PBI workgroup meetings held and attended by Title V staff; and **ESM LC-10b**: Number of resources developed and disseminated based on PBI workgroup.

Strategy LC-11: Enhance collaboration with key partners to advance changes in community environments that promote maternal and child health:

- **increase demand for and access to healthy, affordable foods and opportunities for daily physical activity in high-need communities through the Creating Healthy Schools and Communities program *(with NYSDOH Division of Chronic Disease Prevention)***
- **strengthen linkages between Title V programs and the Healthy Neighborhoods Program (*with NYSDOH Center for Environmental Health)***
- **support the Regional Centers for Sexual Violence Prevention to implement primary prevention environmental change strategies at the community and individual levels *(with NYSDOH Bureau of Injury Prevention)***
- **incorporate selected health-related quality indicators in new quality improvement initiative for regulated child care programs *(with Office of Children & Family Services),* incorporate health promotion information and linkages within Community Schools initiative (*with State Education Department and Council on Children and Families.)***

Collaborative efforts to increase awareness and access to available resources at the local level without duplication of efforts will continue with key program partners: Creating Healthy Schools and Communities, HNP, the Regional Centers for Sexual Violence Prevention, Community Schools, Health Related Quality Indicators in New Quality Improvement for Regulated Child Care Programs, BRACE and the AIDS Institute's Faith Communities Project Program. For the collaborations established during the past year including Creating Healthy Schools and Communities, HNP, BRACE, and the Faith Based Communities Project Program, DFH staff will collaborate to identify services at the zip code level to better determine priority population overlap in DOH-funded communities. Title V program summaries and interactive community resources and asset maps will be created and distributed to the identified program partners and coordinators in communities funded through Creating Healthy Communities and HNP. Specific linkages will be made between: 1) Creating Healthy Schools and Communities and the Regional Centers for Sexual Violence Prevention as well as Title V adolescent pregnancy prevention programs and 2) HNP and MICHC and MIECHV. Title V staff will work with the key funded programs to assess if linkages already exist at the community level and if partner activities or cross-referral of services is already occurring. How to efficiently disseminate knowledge about available resources where service areas overlap as well as how to facilitate and track partnerships at the local level, will be determined through the utilization of the meaningful collaboration framework identified or developed. Additionally, data collection forms will be shared between specific key partner programs (HNP) to determine what data are collected with the goal of incorporating health equity indicators.

In addition, the Regional Centers for Sexual Violence Prevention under DFH will utilize a new coalition assessment tool to evaluate the effectiveness of the Centers' sexual violence prevention coalitions by determining how local coalitions engage in primary prevention and how the mission of coalitions relate to primary prevention. The Sexual Violence Prevention Statewide Training and Technical Assistance Center, Cicatelli Associates, Inc., provides the six regional centers guidance, training and technical assistance on community-level sexual violence prevention activities through needs assessments, online resources, conference calls, webinars and in-person meetings. The Sexual Violence Prevention Statewide Training and Technical Assistance Center will continue to support the six Regional Centers in these and their individual and community level change strategies.

As stated previously, Regional Centers are implementing primary prevention strategies that have been linked to their specific

population's focus. For example, the Center serving Onondaga and Broome counties is implementing the White Ribbon Campaign at the societal level to address social norms change while the Center for Nassau and Suffolk counties is working at the community level to form coalitions interested in policy change with local foster care agencies. In addition, at the individual level, the Center serving Dutchess, Orange and Westchester counties has been instrumental in implementing Safe Dates and Mentors in Violence Prevention programs to middle-school and college-aged students. It is the intention of the Regional Centers and their partners to implement these and other sexual primary prevention strategies to increase multi-level protective factors (e.g. problem solving skills, sense of self-efficacy, caring/respectful relationships, social support and availability of resources for their identified populations).

NYS' approach to supporting the Community Schools initiative continues to evolve. NY's Enacted budget increases support for Community Schools through the provision of $150 million to support the continued transformation of high-need schools into community hubs. This funding supports services that are unique to each school's individual needs, which may include before-and-after school programs, summer learning activities, social services and medical and dental care through school-based health centers. Title V staff will continue to provide information regarding SBHC services as a key component of the larger Community Schools model.

Following further internal DOH agency review, the 14 recommendations for new health-related quality indicators for child care programs developed by the workgroup of several DOH units and the Office of Mental Health will be presented to OCFS in the spring of 2017 for feedback, review and to determine next steps to support adoption and implementation. This project represents significant collaboration and has the potential for substantial impact on health promoting environments in child care including promoting safe sleep practices, providing age-appropriate physical activity, encouraging healthy food choices and breastfeeding, and providing supports for child development and CSHCNs.

Because of the new collaboration with the BRACE, the Text4baby messaging system will be utilized to develop ad hoc messages regarding the dangers of extreme heat exposure for pregnant women as well as where to find cooling centers. English and Spanish messages will be transmitted to over 15,000 Text4baby subscribers. During the upcoming year, enhanced collaboration with the AIDS Institute's Faith Based Community Project Program will result in the exploration of the town hall meeting process to serve as a strategy or blueprint for community engagement, which is a requirement to promote health equity as part of the DFH procurement process (Priority #8). Opportunities to collaborate or co-sponsor town hall meetings at the state and/or local level will be identified. This strategy will be measured by **ESM LC-11**: Number of community environmental changes demonstrated as a result of enhanced collaboration.

Strategy LC-12: Establish or adopt an evidence-informed framework for structuring, measuring and improving collaboration at state and community levels, and provide support to strengthen both internal and external partner capacity to implement the framework across MCH programs.

Strong collaboration is required to achieve community environmental change that results in positive outcomes, however, collaboration is often loosely structured or undefined. Many work plans include strategies to collaborate with partners, but the parameters or anticipated outcomes of that collaboration are not specified, making it difficult to identify the impact of the collaborative efforts. DFH will hire a graduate student intern from the SUNY Albany School of Public Health to specifically examine ways to improve the quality of the enhanced collaborations with key partners, identify an evidence-informed framework for structuring, measuring and improving collaboration at state and community levels. During summer 2017, the intern will conduct a literature review to identify a meaningful collaboration framework and/or gather the elements of best practices for collaboration to inform the development of a new framework. Results of this work will inform next steps to move this strategy forward in the coming year. One or more frameworks will be selected to pilot test with DFH staff, determine ease of use and impact of the framework(s), train DFH staff and partners on its use, and evaluate the effectiveness of the framework as it is disseminated. This strategy will be measured by **ESM LC-12a**: Evidence-informed framework to structure and measure collaborative efforts is established or identified; **ESM LC-12b**: Number of

internal partners trained; **ESM LC-12c**: Number of external partners trained.

State Priority #8: Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population

2020 State Objectives:

- **Objective LC-11: Increase the percentage of Title V staff that improve their knowledge of health equity concepts by 20% from baseline.**
- **Objective LC-12: Increase the percentage of DFH procurements that demonstrate application of health equity strategies listed by 20% from baseline.**
- **Objective LC-13: Reduce disparities for all selected national and state performance measures by 5% from baseline.**

To establish baseline data, DFH staff members reviewed the number of programs which indicated that they currently apply all three health equity activities now required by DFH. This includes; conducting an equity assessment, completing a CLF as part of the procurement development process, and including community engagement strategies in all programs. Based on this measure, there is currently one DFH program (MICHC) which meets that standard. Therefore, NY's Title V baseline measure is 5% (or 1 out of 19 programs). Data for Objective LC-11 and LC-12 will be reported in subsequent years as the strategies are further implemented. Objective LC-13 will cross all Domains and be further addressed under each Domain with key indicators incorporated into the newly developed MCH Dashboard.

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

During the coming year, Title V staff will continue building on the work of the past year to integrate a Health Equity framework into more aspects of the Title V work. Staff will collaborate among groups within DFH and DOH to support the 19 DFH Title V programs and their health disparity data needs. Currently 5 of 19 Title V programs have completed a health equity analysis. (**ESM LC-13**). Programs include: school based health and dental, sickle cell, family planning, and MICHCs and MIECHVs. As stated previously, plans are underway to develop an MCH dashboard as a public website for use by health planners and supporters of Title V program priorities. Age, race, ethnicity and geographic disparity, can be examined for the MCH measures on the dashboard. By increasing the availability of the health inequity data for all priority areas identified in the SAP, a greater focus on the efficacy of these programs within the communities of greatest need will be possible.

Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including:

- **creation of a cross-program DFH Equity Action Team;**
- **completion of an organizational assessment of equity practices, and**
- **facilitation of staff training and professional development through Equity Learning Labs.**

Title V staff will also continue to partner with the OPHP to complete the design and implementation of a new DFH Health Equity training program. As described in the annual report, this program will be comprised of several online course modules that have been evaluated and endorsed for appropriate and meaningful content. Staff will investigate the feasibility of collaborating with the Region 2 PHTC to develop a health equity training specifically focused on implementing health equity practices in the management of contracts. Recognizing the role that administrative and fiscal requirements play in shaping the type of providers with whom DFH typically contracts, this training will ensure all DFH staff, including those working primarily on administrative tasks, will be able to prioritize the role of health equity in their work. (Measured through **ESM LC-14a**) # of Equity Action Team meetings held; and **ESM LC - 14b**)

# of DFH staff who have completed one or more Equity Learning Labs).

In addition, work will continue to identify and promote non-traditional avenues of professional development; affording DFH staff the chance to learn, discuss, and model health equity principles through nontraditional learning experiences including book discussions and film screenings.

Title V staff will also serve on the OPH Culturally and Linguistically Appropriate Services (CLAS) assessment project to support an internal DOH assessment of CLAS compliance. The OMH-HDP and OPHP continue to lead the implementation of an internal organizational cultural competency assessment. Utilizing the USDHHS CLAS Standards, an internal assessment will be piloted within the OPH. Results will be analyzed, and division specific recommendations and best practices will be shared to correct for gaps and deficiencies identified by the assessment.

Conducting a CLAS assessment is an effective way to determine the NYDOH cultural competence and collective impact towards addressing health disparities which are key components of the DOH's National Accreditation, Strategic Plan, and PA. With support from DOH Executive Staff, efforts will be guided by a CLAS Steering Committee which is comprised of staff from divisions within OPH including the DFH. Steering Committee members will support distribution and completion of the assessment, and development and implementation of action plans to address deficiencies and share best practices.

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

Title V staff will disseminate a "DFH Community Listening Forum Toolkit" containing information, resources, and best practices for conducting forums as part of the procurement development process. Having a toolkit will enable staff to streamline planning and facilitation of listening forums to ensure that all upcoming procurements build in a focus on health equity, by insuring that the voice of the community is incorporated into the process. This approach should work to ensure that programs will successfully combine evidence based/informed best practices with unique program structures and activities specifically targeted to reflect the barriers and assets articulated by members of our priority populations. (**ESM LC-15**: Percentage of DFH procurements that complete community listening forums as part of concept development process.)

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

Finally, NY's Title V program will take additional steps to increase the number of DFH procurements that include an element of community engagement. This will be accomplished by continued research into best practices for community engagement, development of standardized performance measures, standards, and activities for community engagement inclusion, and the creation of DFH-wide measures of the success of community engagement activities. Going forward, all applicable procurements will be reviewed to ensure required health equity and preventative care activities (i.e. community listening forum, data analysis, health insurance activities, etc.) have been completed as a component of the approval process. Through this mechanism DFH will ensure increased inclusion of health equity principles in all DFH programs. (**ESM LC-16**: Percentage of DFH procurements that demonstrate inclusion of evidence-based/-informed community engagement and collective impact strategies.)

FY 2016 Annual Report

Cross Cutting/Life Course

A life course approach to preventive health care is essential to ensuring healthy families and healthy communities. Increases in chronic disease such as heart disease, diabetes and obesity impacts longevity and health outcomes. Racial and ethnic minority communities experience higher rates of obesity, cancer, diabetes and HIV/AIDS. Children are becoming increasingly vulnerable as an increase in overweight or obesity predisposes them to chronic disease and the numbers are even higher in African American and Hispanic communities. NY's Title V program selected this as a state priority since focusing on preventing disease and illness before they occur will create healthier homes, workplaces, schools and communities, so that New Yorkers can live long and productive lives and reduce healthcare costs.

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. Last year, NY's Title V program identified resources to further develop this scope of work that included: the USPSTF recommendation for preventive care, the AAP *Bright Futures* Guidelines for Health Supervision of Infants, Children and Adolescents, and EPSDT guidelines for state MA programs.

This priority is not only closely linked to other state priorities in all the Title V domain areas, but involves standards, measures, and improvement strategies across all Title V/MCH programs. Because of this common linkage, a necessary first step was to gather information from all DFH/Title V programs on the current scope of work related to preventive care services. To accomplish this, a survey was developed to ascertain these data, and staff were asked to submit responses for each DFH program. Responses were solicited from all DFH programs that administer grant contracts. Questions focused on obtaining information necessary to develop a baseline measure for many Title V MCHSBG measures and determining program structure, cycles, and opportunities to better align with Title V priority areas. During this process the idea to use this survey to inform strategies in other MCH domain areas was identified. Survey questions were added to gather information from programs relevant to the work of SP 7 - Healthy Communities and SP 8 - Health Equity. Final survey questions and collection methodology were approved by DFH leadership and 22 surveys were disseminated in January, 2017. 19 responses were received from DFH programs.

In further defining the questions on the survey, the number of programs involved with preventive medicine for children was identified. Participants were asked if the program used preventive health care for children, care including education on preventive health services, care coordination or referral for care, or assistance in finding primary care. This information was collected and will help in moving forward to assess which programs have measures to meet the national performance measures to improve the number of adolescents age 12-17 with a preventive medical visit in the last year. It also lays the foundation to gather on the number of adolescents receiving preventive health care visits in SBHCs and FP clinics. Of the 19 programs with completed surveys, 11 had a requirement for child preventive services.

To identify programs currently requiring a health insurance access component, respondents were asked, "Is enrollment in health insurance a performance standard, performance measure, an improvement strategy or not included at all as a component in your program?". Based on responses provided, Title V staff calculated the number of Title V programs with health insurance elements incorporated in their program requirements. This included programs that indicated any form of health insurance requirement; either performance standard, performance measure, or strategy. 58% of DFH programs indicated that they currently incorporated some form of health insurance requirement in their program. (**ESM LC-1:** The number of Title V programs with health insurance elements incorporated in program requirements.) Programs that responded affirmatively included; adolescent sexual health programs, including federal PREP and abstinence programs, maternal child home visiting programs, including federal MIECHV programs, family planning

programs, and school-based health and dental programs.

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 NYS unplanned, impacting the overall health of all women in NY is a key step in improving pregnancy and birth outcomes. To that end, improving access to health insurance and preventive health care is a major priority across the life course. By improving the overall health of NY women before pregnancy and concurrently working to improve the intendedness of pregnancies, Title V can be assured that this work will improve the health status and birth outcomes for all women.

Improving developmental screening for all children is also an important priority in NYS. Currently Title V staff from across DFH are participating in or leading five major initiatives aimed at improving developmental screenings in NYS. (**ESM-LC-4** – Number of strategies implemented to improve developmental screening.) These initiatives include the following collaborations/projects: supporting the inclusion of developmental screening in DFH's maternal and infant health initiatives and regulated child care; ongoing steps to promote early identification of potential developmental delays and referrals to EI; participation in the ECAC; ongoing work with the ECCS grant; and collaboration the Albany Promise Project.

The DFH remains committed to ongoing efforts to support the integration of improved developmental screenings in both Title V maternal child health work and within the EIP. Title V staff working in MICHC and MIECHV programs, have continued to make the inclusion of developmental screenings, either directly through program staff or via referrals to appropriate providers, a priority of their ongoing work. Current MIECHV activities include facilitation of a parent-completed developmental screening which is reviewed by home visitors and used to determine whether a referral to EI is necessary. In addition, EI staff continue to include increased developmental screening throughout their programming, especially the developmental surveillance that takes place in the Child Find component of the EIP.

An important element of these strategies has been the DFH's long standing commitment to the NYS ECAC workgroup. Convened by the NYS Governor's Office, this council is comprised of dozens of partners from all sectors of the early childhood community. ECAC has a longstanding priority interest in promoting children's development, and a specific focus on increasing rates of developmental screening. To further that goal, ECAC has recently convened a workgroup to advance developmental screening and follow-up, with a focus on policy-oriented interventions. Title V staff are members of this group and will remain in this capacity throughout the upcoming program year.

The work of the Early Childhood Comprehensive System (ECCS) represents another long-standing commitment of NYS Title V work focused on improving developmental screenings. Working in two place based communities, Nassau County (Docs for Tots) and Erie and Niagara Counties (Help Me Grown Western NY & CCRN of Western NY), the ECCS has recently begun work as part of a larger cohort to promote developmental health in both projects. Through a place based approach focusing on an "intentional effort to build, sustain and operationalize community capacity in improving systems around children's developmental health and family well-being" the project specifically aims to demonstrate a 25% increase from baseline in age appropriate developmental skills among 3-year-old children in selected NYS communities.

The recent work of the ECCS group has focused specifically, on increasing monitoring, screening and follow up of children's development, and have convened the first State Advisor Team, State Improvement Team, and local partners, to collaborate on a CoIIN Team. Each of the three teams has met at least once and is beginning the task of gathering community data related to developmental screening, referrals, and follow-up. Work has included participation of providers conducting developmental screens, as well as parent participants to ensure parent voice is a part of these projects. With members from both local teams attending a Learning Session supported by Council of Children and Families and NICHQ, initial work has focused on developing primarily drivers for their work and identifying next steps toward the development of PDSA cycles in their respective communities. Primary

drivers that communities work to include: a coordinated and community-wide system to promote developmental health and early identification of developmental needs of all children and families, especially those who are vulnerable, systems to promote and maintain family dignity and integrity by supporting active involvement in identifying, promoting, improving, and managing child developmental health in ways that are meaningful to them, and finally, linked and coordinated systems to promote continuity, collaboration, and cross-sector sharing in all aspects of monitoring, screening, referral, and service delivery while ensuring privacy and legal rights of families. Members of each CoIIN team broadly represent many of the local service based organizations who will work to implement and track small tests of change as part of their CoIIN project.

Another unique collaborative opportunity to promote developmental screenings can be seen through the DOH support of the Albany Promise Project. The Albany Promise Project is a regional cross sector partnership where community leaders in Albany, NY come together to support a shared cradle to career education vision. Focused on increasing school readiness among young children in the city of Albany, the Promise Program targets children under the age of five with a range of cross-sector multi-dimensional interventions. The DOH is partnering with Albany Promise, Medicaid managed care plans, and pediatricians to create a pilot program in Albany County that incentivizes pediatricians and health plans to help ensure all children enter school ready to learn. DFH staff participate on the Early Childhood Success Team that has focused on increasing enrollment in quality early childcare programs and increase the proportion of Albany children performing at or above benchmark upon entering pre-kindergarten while the NYS Medicaid Redesign Team is conducting a Pilot Program called All Albany Children Ready! - School Readiness.

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 understanding the system of child health care and how improved developmental screenings could improve subsequent outcomes for youth. Screening children at ages 0-4 and then addressing any needs that are present at that point in the child's life can significantly improve a child's outcomes as they grow.

Beginning with a process map of the current screening, referral, and treatment systems with the community, the Albany Promise Program worked through a collective impact framework. This work included development of mutually reinforcing activities to improve the identification of developmental delays, referral, and service provision systems. While this kind of collaboration is not without its challenges, this dynamic opportunity is working to better inform the DFH/Title V support for developmental screenings in ways that could be applicable in other communities across NYS.

Recognizing the unique barriers impacting the ability of adolescents to obtain preventive health care services, staff sought to collaborate with adolescent health experts to gain a better understanding of those barriers and how to best address them. To identify the key impediments to accessing preventive care use as well as the best strategies to improve use of preventive care by adolescents across NYS the DFH developed a strategy to facilitate focus groups with adolescents to obtain this information. Working with the Cornell ACT for Youth COE, staff investigated the most useful method to obtain feedback from adolescents on the issues. After first providing ACT staff background information on the issue, including publicly available rates of adolescent preventive care utilization, staff engaged in several discussions with ACT staff to plan next steps during the program reporting period. Through discussion, it was determined that in the absence of specific interventions, a focus group would likely not be the most effective way to proceed to obtain the adolescent feedback needed to develop new strategies to promote their use of preventive health care services. (**ESM LC5**; The number of focus groups conducted - has therefore been revised to **ESM LC-5:** The number of strategies implemented to improve adolescent use of preventive health care services.)

While decreased rates of adolescent utilization of preventive health care have been well documented, DOH recognizes the importance of getting feedback from adolescents to better understand the barriers and challenges to obtaining necessary health care services. Therefore, a focus of work in the coming year will be the creation of a plan to obtain first hand feedback from adolescents

on the major issues that keep them from accessing preventive care. ACT for Youth COE recommended a better initial step to obtain adolescent feedback would be a less intensive process of surveying adolescent already connected to DFH/Title V funded pregnancy prevention programs. Through this process, staff would be better able to identify the specific challenges, beliefs, and attitudes associated with low utilization of preventive care among adolescents. Following that initial data collection and analysis, staff will collaborate with ACT on a detailed literature review of evidence based best practices to improve preventive care utilization, and once strategies had been developed convene focus groups to obtain more specific feedback on planned interventions.

Another focus of feedback from the DFH program survey was to aid in gathering information on Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services which assessed current DFH program requirements promoting well-woman and preconception health care. Well-women care for women of reproductive age is touched upon by many of DFH's current programs and it remains a priority of the DFH to promote and improve women's health and well-being across the life course and further promote health equity.

Through use of the same survey, information was gathered on current DFH/Title V programs that a) served women of reproductive age and b) currently include an element promoting increased use of well-women or preconception health care. Beginning with the question, "Does your program serve women of reproductive age?" The number of programs targeting women of reproductive age (ages 11 through 44) was established as the denominator for this measure. Of the 19 programs who completed the survey, 17 indicated that women of reproductive age were a priority population, and of those 11 programs indicated that they currently require some emphasis on improving well-women care whether through performance standards, performance measures, or strategies. (**ESM LC-3:** The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services.)

Beyond ensuring preventive care is emphasized in Title V programs, staff also recognized the importance of assessing whether women of reproductive age received the preconception health care being advocated for. 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 and Surveillance System (BRFSS) sampling. This survey, which broadly represents the non-institutionalized civilian 18 years and older population of NYS, will be used to help Title V staff understand if women are getting these important health care services. The 2013-2014 BRFSS contains seven questions on pre-conception health as part of the family planning module, and these data have been analyzed and reports issued. The reports, were used to develop an abstract prepared and presented at the Northeast Epidemiology Conference in 2016. The Northeast Epidemiology Conference, a regional event hosted by the NYS DOH with support of the Council of State and Territorial Epidemiologists, is a key event during which a breadth of topics are covered, including a variety of communicable diseases, emerging infectious diseases, healthcare associated diseases, cross-cutting epidemiology practices, and occupational health/environmental health subjects. Topics include current disease surveillance and prevention trends, discuss findings from unique case studies, and offer guidance on epidemiological best practices with public health colleagues from state, county and local governmental agencies. (**ESM LC-2:** The number of analytic reports developed and shared.)

Oral health remains a key health indicator for women, infants, children and families throughout their lives. Poor oral health can impact learning, social-emotional wellness and overall health. While tooth decay remains the most common chronic disease for children, oral health disease is largely preventable and entirely treatable. NY's Title V Program is committed to promoting oral health through education, community based intervention and programming that benefits all NYS residents.

Over the past year, progress has been made in improving the oral health of NY's residents. The prevention of tooth decay remains a high priority area for the DFH because of the associated social and financial costs. According to the 2009-2011 DOH Oral Health Survey of Third Grade Children, 44.1% of third grade children have had a history of tooth decay and 22.1% had untreated tooth decay. The Guide to Community Preventive Services, re-released in April 2013 by the Community Preventive Services Task Force, recommends only two interventions as evidence-based practices to prevent dental caries: school-based dental sealant delivery

programs and community water fluoridation (CWF). CWF is an important intervention that communities can undertake to significantly address the problem of tooth decay. It has consistently been shown to reduce tooth decay by 25% across the lifespan regardless of age, race, income, and insurance status. CWF is considered by the CDC to be one of the 10 great public health achievements of the 20th century because of its role in the decline of tooth decay in children and tooth loss in adults.

In NY, more than 13 million people on public water systems (PWS) receive fluoridated water, representing 71.7% of residents served by community water systems. A priority of NY's Title V Program is to increase the percentage of NYS residents served by community water systems that have optimally fluoridated water by 10% to 78.5%. To achieve this, DOH must maintain its existing fluoridating PWS and several new communities (collective population size >1.23 million people) must vote to implement CWF. A primary strategy to accomplish this is to provide support, both financial and technical, directly to communities to maintain and expand CWF. Over the course of the 18-month reporting period, 60 different PWS received technical and/or financial support, with 12 PWS receiving both types of support (**ESM LC-6:** Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.) DOH has partnered with the NY Rural Water Association (NYRWA) since 2003 to provide technical assistance to PWS. The goal of DOH's contract with NYRWA is to provide technical assistance and guidance, in addition to raising operators' knowledge on CWF, to help ensure fluoridated PWS across NY are maintained and operated in compliance with all state laws, rules and regulations. Activities include conducting onsite visits at water treatment plants to provide guidance on operating issues; ensuring PWS are fluoridating at the optimal level; and organizing and holding continuing education trainings for water operators on the CWF-related topics, including public health, regulations, additives, equipment, laboratory analysis, personnel safety, operations, and management of CWF. During the 18-month reporting period, NYRWA completed 35 onsite technical assistance visits (33 unique PWS) and held 11 CWF trainings (training 257 water operators).

Financial assistance was provided to PWS through the Drinking Water Fluoridation (DWF) Grant Program, which was developed and authorized under the NY 2015-16 Enacted Budget. Two different types of projects were supported under the Program: 1) Planning & Feasibility Projects – support the development of an Engineering Report for feasibility, design or update purposes; and 2) Implementation & Maintenance Projects – support the upgrade, replacement, repair or purchase of equipment to maintain or initiate CWF. A total of 35 awards (benefitting 36 PWS), for a total of $2.9 million were made to support the maintenance of CWF. Because of the DWF Program, these PWS will be able to upgrade their equipment and infrastructure to ensure that the communities they serve will have continuous access to optimally fluoridated water for many years to come. To date, 33 contracts supporting CWF have been executed. (**ESM LC-6**: Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.)

The work outlined above was informed by and conducted in parallel with a DOH quality improvement initiative on CWF reporting. Title V staff worked with the DOH Bureau of Water Supply Protection (BWSP) to address: 1) consistent and timely access to CWF operation data from PWS; and 2) consistent delivery of optimally fluoridated water from PWS to residents. Two performance measures were created and monitored by Title V staff for this initiative. In addition, PDSA cycles were conducted. This work remains ongoing, as is the collaboration between Title V and BWSP staff. In April, 2017, the DOH collaborated with the Association of State and Territorial Dental Directors (ASTDD) for their "Adopting Performance Management Strategies to Improve Oral Health in Your State" webinar that provided an overview on performance management and quality improvement in state oral health programs. The DOH was one of only two states invited to present on how it has implemented performance management within its oral health program. DOH's presentation focused on CWF and its alignment within the priorities of NYS.

As discussed previously, fluoridated water and dental sealants are the evidence-based strategies that DFH has incorporated into program work. The SBHC-D Program targets high risk children from pre-kindergarten to high school who have limited access to a dental home or services. DOH continues to work across NY to provide preventive oral health services, including sealant application

on first year molars, to school age children. Use of dental sealants is an evidence based approach to combatting tooth decay. Currently, 61.2% of 2nd and 3rd graders served by SBHC-D programs receive sealants, which is a 20% increase from last year. The increase can be attributed to a more focused commitment by SBHC-D providers on the overall benefits of dental sealants. (**ESM LC-7a:** Percentage of 2nd and 3rd graders served by School Based Dental Programs who receive sealants.) In October 2016, DOH released an RFA aimed at increasing SBHC-D providers' use of dental sealants in high need 2nd and 3rd graders. It is anticipated that approximately 25 awards will be made for a contract period starting July 2017.
While the sealant RFA addresses dental caries in school age children, NY's Early Childhood Caries Collaborative (EC3) Initiative, launched in January 2016, addressed tooth decay in children under the age of five. EC3 was designed to accelerate improvement in priority strategy areas through collaborative learning, quality improvement and innovation. EC3 specifically focused on caries risk assessment (CRA) and increased follow-up for high risk children. Over the course of the year, four community health centers (CHCs) met monthly for shared learning, facilitated discussions, and coaching to improve the oral health status of young children in their communities. Through assessing children's risk for early childhood caries (ECC), adopting procedures to ensure timely follow-up services, and assisting caregivers in developing self-management goals for their children, CHC participants learned and applied key principles to improve care and implement the core interventions. As part of the improvement process, teams applied quality improvement strategies to their daily work. EC3 concluded in December 2016 and DFH is currently finalizing the dataset and overall findings. Preliminary data indicates that all four CHCs incorporated CRA into their clinical workflow to some degree. Two CHCs fully integrated CRA into practice, increasing the percent of children receiving CRA from 0% at baseline to consistently 75-100% throughout the Collaborative. The same collaborative approach was being utilized in the DFH's NY Medical-Dental Integration (MDI) Project, which began in late Spring 2017 and built upon the work of EC3. (See the Annual Application section of this Domain for further details.)

The Title V Program also partnered with NYSACHO on a public health detailing webinar series for local health departments (LHD). NYSACHO staff organized and facilitated Fluoride Varnish Technical Assistance Calls to discuss strategies for public health detailing in primary care practices regarding the application of fluoride varnish. (**ESM LC-7b-** Number of Medicaid claims submitted by primary care providers for application of fluoride varnish for children 0-5 enrolled in Medicaid that receive fluoride varnish applications from their primary care providers.)

Title V Program strives to identify ways to incorporate oral health education in diverse settings and has had initial discussions with DOH DON on possible areas for integration. Some of the initiatives NY's Title V program has explored include oral health education and products disbursement through food banks, addition of oral health screening questions on WIC questionnaires, and training Child and Adult Care Food Program (CACFP) staff on oral health education and messaging. MCH staff investigated the feasibility of these options. While the food banks/pantries would allow for a greater reach, they lack a consistent model and only basic information would be available to participants. CACFP provides nutritious meals to nursing home, adult day care, and child daycare settings and has the most potential for collaboration due to the ability to impact a wide range of high risk groups such as the elderly, the developmentally disabled, and young children birth-5 years. Title V staff will continue to discuss this potential integration with DON staff. (**ESM LC-7c**: Plan adopted in collaboration with NYS DON to promote integration of oral health strategies in at least one public health nutrition program.)
The Perinatal and Infant Oral Health Quality Improvement (PIOHQI) Project has continued its work with the MICHC Program to integrate oral health strategies into community-based maternal and infant health programs through care coordination, and public health detailing which entails training providers on best practices to promote preventive health interventions. Healthy Baby Network (HBN), the PIOHQI pilot program in Rochester, NY, partnered with Eastman Institute for Oral Health (EIOH) to develop the training materials and Oral Health Manual/Toolkit, recruit providers from the community for the trainings and solicit feedback. A total of 72 participants, ranging from dental care providers, perinatal care providers, and CHWs were trained via webinars and in-person meetings on use of the Toolkit and offered continuing education credits.

As part of the pilot, focus group discussions were conducted with healthcare providers in the community to identify topics of interest

in oral health, to determine level of importance, and to provide feedback on the draft of the Oral Health Manual/Toolkit. HBN's successes and lessons learned will guide implementation of oral health promotion and integration at the other 22 MICHC sites in NYS. The PIOHQI Project also addressed systems change at both the organizational and community level, providing MICHCs the ability to better link their clients to oral health services. Outreach and education was provided to MICHC clients and perinatal healthcare providers to build an effective referral network between MICHCs and dental healthcare providers. As part of this initiative, the pilot site incorporated two dental screening questions into their electronic care coordination system to better identify clients in need of oral health care referrals. In 2016, the percentage of pregnant/post-partum women served by MICHC that received an oral health screening was 36.7%; this is a marked improvement from the baseline of 16.6% in 2015 Quarter 3. In July-September 2016, 58.8% of the targeted population at the pilot site (all MICHC-eligible women, inclusive of pregnant women) received an oral health screening compared to 44.5% at baseline (April-June 2015). The heightened focus on oral health messaging by the MICHC program at HBN also led to a 32.1% increase in the number of prenatal and post-partum clients receiving an oral health screening conducted by CHWs. (**ESM LC-8**: Percentage of pregnant women served by Title V community health workers that have a documented screening or referral for dental services.) Overall, this effort has resulted in a higher number of high-need pre/perinatal women receiving oral healthcare.

The NYS Dental Public Health Residency Program (NYSDPHRP) is designed to support and build capacity for all MCH oral health programs through the utilization of dental residents' subject matter expertise in clinical dentistry and public health. Its 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 DFH staff on various MCH programs, the dental residents have a unique opportunity to apply concepts and tools in real public health settings, preparing them to assume critical roles in the practice of dental public health for improving health outcomes. Specifically, NY's strategy is to strengthen Title V internal capacity, dental public health core competencies and workforce development for oral health surveillance and evidence-based interventions through continued support for NYSDPHRP. Between 1998 and 2016, NYSDPHRP had 42 graduates, majority of whom are working as public health dentists in state government and academic and hospital institutions.

Since joining the NYSDPHRP in fall 2016, DOH's current dental resident has completed all 10 projects and activities and is on schedule to complete the training by fall 2017. The resident has been analyzing 2014-16 SBHC-D data to evaluate performance and impact, including increase in sealant application and dental caries reduction among 2nd and 3rd graders served by the program and has been conducting critical assessment of evidence-based preventive dental interventions and strategies in efforts to ensure best practices in all NY MCH oral health programs. (**ESM LC-9:** Number of MCH oral health related projects and assignments completed by the dental residents and documented in the dental public health residency competency tracking sheet.)

The objectives and measures in the healthy communities priority area address a variety of subjects, reflecting the broad scope of factors impacting MCH. This priority area aims to impact physical activity, obesity, wellness, safety, and community social cohesion. Title V programs cannot impact all of this alone, which is why collaboration is such a focus of this priority area's strategies. The source of these metrics is from national surveys (NSCH, YRBS) with updated data expected to be released later in 2017. For adolescents grades 9-12, slightly fewer adolescents perform at least 60 minutes of physical activity daily after years of increasing rates —a decrease from 25.7% in 2013 to 23.3% in 2015. This mirrors the increase in adolescent obesity following a steady downward trend—from 24.4% in 2013 to 27% in 2015. For children age 6-11, daily physical activity decreased in 2011/12 to 30% from 33.7% in 2007.

In the 2011/12 NSCH, parents reported that 79.2% of children live in supportive/cohesive neighborhoods, similar to past years' responses and similar to national levels. This includes parents' responses about whether people in the neighborhood help each other out, watch out for each other's children, can count on each other, and trust each other to help the children if they are injured or scared. Parents responded that 79.9% of children are usually or always safe in their neighborhood or community, which is similar to

past years, but slightly less than the 86.6% reported nationally.

Community environments and their impact on health behaviors and outcomes are a priority in NYS. Stakeholder input obtained in the preparation for this application identified factors including access to healthy affordable food, safe places to engage in physical activity, and social support as important elements of a desirable community in which to live and are believed to have significant impact on families' health and wellbeing. These perceptions are consistent with broader and longstanding public health approaches aimed at supporting "healthy communities," including strong commitments to community-driven change, fostering policy and environmental change strategies, and a focus on addressing social determinants of health rather than treating disease. Taking on these broad policy-level issues cannot be achieved by the health sector alone--strong collaboration with social service and other non-traditional partners is needed to efficiently make a positive impact in NY's communities.

As stated in the previous year's report, the Title V program prioritized a focus on Placed-Based Initiatives (PBI) as a multidisciplinary team based approach to achieve significant changes in a physical location. The PBI works to improve health equity by improving access to healthy lifestyle options, affordable and comprehensive healthcare, social services and quality housing. In September 2015, the DOH Commissioner established a workgroup to review all the PBIs sponsored by the DOH over the last ten years to 1) determine promising practices and strategies for current and future place-based efforts; 2) identify duplicative efforts and opportunity for synergy; and 3) develop collaborative efforts to address health inequities. The PBI Workgroup meets quarterly and is comprised of staff from the DFH, the DCDP, DON, CEH, Office of Minority Health, the AIDS Institute and the OPHP. During the reporting period, Title V staff attended two PBI workgroup meetings and increased its participation in PBI activities which included: the successful development and adoption of a shared definition for what a PBI is; a descriptive analysis of PBI health indicators; and the initiation of an online survey of PBI community contractors to identify best practices, challenges and strategies that resulted in sustained, environmental changes. This is reported under **ESM-LC 10a**: Number of PBI workgroup meetings held and attended by Title V staff; and **ESM-LC 10b**: Number of resources that are developed and disseminated based on the PBI workgroup.

In addition to PBIs, Title V staff have initiated and/or enhanced collaborative relationships with other key partners to advance changes in community environments that improve health outcomes for women, children and families. The broad scope of environmental-level issues impacting communities' health—physical activity, obesity, wellness, safety, and community social cohesion —require cross-sectorial involvement. During this reporting period, DFH staff identified several initiatives that are ongoing in other areas of the DOH that had potential for meaningful collaboration with DFH. Staff met to discuss opportunities for collaborative efforts with the following programs: Creating Healthy Schools and Communities, Healthy Neighborhoods Program, Regional Centers for Sexual Violence Prevention, Community Schools, Health Related Quality Indicators in New Quality Improvement for Regulated Child Care Programs, Building Resistance Against Climate Effects and the AIDS Institute's Faith Communities Project Program. Enhanced collaborations will offer opportunities to impact health outcomes of significance to MCH. (**ESM LC-11**: Number of collaborations related to community change fostered or strengthened by Title V program.)

During the reporting period, linkages with program contacts were established or strengthened and overlapping service areas and opportunities for collaboration were identified. The Healthy Neighborhoods Program (HNP) in the DOH CEH seeks to reduce the burden of housing related illness and injury through a healthy homes approach in selected high-risk areas. Through introductory meetings held during the reporting period, it was established that HNP and DFH programs target the same residents of high-need communities in the home setting, providing the opportunity to make cross-referrals and promote the services among both Title V and HNP programs. As a foundation for further collaboration, an initial cross-walk of services between programs was created at the county level.

Enhanced collaboration, demonstrating community environmental change, has resulted from activities of DFH's six Regional Centers for the Prevention of Sexual Violence (Regional Centers). Regional Centers implement primary prevention community-level activities including community mobilization, coalition-building, policy education and social norms change and individual-level sexual violence

prevention strategies with youth and young adults, ages 10-24, from six high-risk regions across NYS. Each Regional Center works with specific populations at increased risk for sexual violence perpetration or victimization based on data and/or sound theory. Specific priority populations include deaf youth and young adults, youth in foster care, youth identifying as lesbian, gay, bisexual, transgender or questioning (LGBTQ), young adults, middle, high-school, and college-age students which include non-traditional and trade school students. Regional Centers and their partners implement primary prevention strategies that link to their specific population focus: individual (e.g. being young), relationship (e.g. association with sexually aggressive peers), community (e.g. community social norms which tolerate sexual violence) and societal (e.g. poverty) risk factors. This past year, the Regional Centers and their community partners implemented over 400 sexual violence prevention community mobilization activities/events, and over 200 coalition-building events with youth, young adults and/or influential adults who work with youth and young adults from six high-need areas across the state.

Another initiative in which DFH enhanced collaboration resulting in community environmental change, is the Community Schools initiative. Established through Education Law and through initial funding and authorization in the state fiscal year budget 2013-14, the SED awards competitive grants to eligible school districts for plans that target school buildings as "community hubs to deliver co-located or school-linked academic, health, mental health, nutrition, counseling, legal and/or other services to students and their families in a manner that will lead to improved educational and other outcomes." Community Schools coordinate and maximize public, non-profit and private resources to deliver critical services to students and their families, thereby increasing student achievement and generating other positive outcomes. Title V staff provided input to the development of a Request for Proposals which resulted in grant funding for two cohorts of grantees for 2013-16 and 2014-17, respectively. Title V staff also contributed to the planning and implementation of statewide meetings for Community Schools grantees held in May 2014 and May 2015, including information about establishment/expansion of school-based health and dental care services as well as nutrition programs, community-based obesity prevention initiatives and other relevant public health resources. Building on this initial work, Title V staff from the SBHC Program provided leadership and worked extensively with the Community Schools program in the Schenectady City School District to establish two new SBHC sites which successfully opened in October 2016.

Over the past year, Title V staff led a collaborative process to develop recommendations for new health-related quality indicators for child care programs. This assistance was requested by the NYS OCFS as part of an initiative to incorporate quality measures in routine licensing visits for regulated child care programs, to augment the compliance monitoring system and engage a larger number of child care providers in quality improvement activities. Title V staff convened a workgroup with representatives across DOH programs including child health, CSHCN, oral health, injury prevention, immunization, chronic disease prevention, and nutrition programs and the Office of Mental Health. Through a structured planning process from February 2016-January 2017, the group developed and prioritized 14 recommendations for new health-related quality indicators that cover areas of health promotion in child care such as safe sleep, age-appropriate physical activity, healthy food choices, breastfeeding, child development, and supports for CSHCN. Recommendations were based on key references including QualityStarsNY (the state's tiered quality rating and improvement system) and national Caring for our Children standards. These recommendations will be presented to OCFS for their review, feedback and determination of next steps for adoption and implementation.

Because of increased collaboration across DOH, two new initiatives were successfully identified for inclusion in this strategy: Building Resistance Against Climate Effects (BRACE) and Faith Based Community Projects Program. One of the strategies of the BRACE initiative, in the OPHP, focuses on strategies to support and protect pregnant women and other vulnerable populations during periods of extreme heat exposure. BRACE has created a listing of cooling center locations across the state that individuals may seek out during periods of extreme heat. This was provided to Title V staff and a spreadsheet was created to indicate where centers are co-located within DFH-funded communities at the county level. The Faith Based Community Projects Program in the AIDS Institute has a goal of reaching out to churches, synagogues, mosques and other faith-based organizations to become partners in health in communities hardest-hit by the HIV epidemic. The program holds town hall meetings throughout the state several times a year to gain

knowledge of community needs and resources. It was determined that the town hall meeting process could serve as a strategy or blueprint for the DFH's work in community engagement.

Although strong collaborations are required to achieve community environmental change that result in positive outcomes, collaboration is often loosely structured or undefined. To provide support and evaluate enhanced collaborative efforts, Title V staff will establish or adopt an evidence-informed framework for structuring, measuring and improving collaboration at both the state and community levels. This strategy represents a new area of work for DFH. To move forward on this important work, a graduate student intern from the SUNY Albany School of Public Health will be hired in Summer 2017 to conduct a literature review and environmental scan to identify a meaningful collaboration framework or gather elements of or best practices for collaboration to inform development of a new framework. (**ESM LC-12a**: Evidence-informed framework to structure and measure collaborative efforts is established or identified; **ESM LC 12b**: number of internal partners trained; **ESM LC-12c**: number of external partners trained.)

While numerous interventions have positively impacted MCH health outcomes over the years, persistent health inequities, especially racial, ethnic and geographic, have continued to manifest. As stated in NY's FY 2017 application, NY's Title V program includes health equity as a life course priority to ensure a stronger concentration on improving access to quality, comprehensive health and supportive services across all Domains.

To fully address the needs of all New Yorkers, DFH has made a concerted effort to incorporate a Health Equity framework into all aspects of NY's Title V program. Since Fall 2016, DFH initiated the development and implementation of a series of strategies aimed at improving health equity across NYS as it relates to MCH. Title V staff worked collaboratively with support from the HRSA-funded University of North Carolina (UNC) WDC to identify existing resources and experts with whom staff could work to develop specific actionable strategies to promote health equity. A critical aspect of promoting and supporting health equity is a clear understanding of the concept and implementation strategies by all Title V staff. Therefore, a key focus of this work over the past year included an emphasis on increasing the internal capacity of DFH through staff development activities to promote and support health equity work, developing a procurement process that better reflected the needs and experience of priority populations, and ongoing community engagement activities within all DFH programs. (**ESM LC-14:** Number of Equity Action Team meetings held.)

As with all SPs across Domains, Title V staff focused on improving data collection and measurement throughout DFH to better identify and address existing health disparities. Coordination was established among the Title V staff and research groups within the CCH (Bureau of Chronic Disease Research and Evaluation and Minority Health) and DOH PHIG, to provide performance and outcome measures for each SP area. Health equity data disparity ratio methodology discussions have begun and sharing of reference materials from HP2020 and Surveillance, Epidemiology, and End Results (SEER) data tools. MCH data dashboard planning for phase 1 data elements has been established as previously discussed. Quantitative methods of providing the summary measures of health disparity will continue to be reviewed and discussed. Development planning and collection process has begun for SPMs related to health equity. These data support the assessments of specific populations served within Title V program areas.

Building on those efforts, Title V staff worked to address another key area of focus, improving the internal capacity of DFH staff to promote and support health equity in all aspects of work. An emphasis was placed on ensuring a health equity lens to each SP area, with at least one strategy or initiative focused on improving health equity. Title V staff investigated the disparities that exist, strategies and mechanisms that DFH programs are currently using to address identified disparities and/or health equity, possible additional areas for intervention and committed to at least one health equity area on which to focus for each SP.

While Title V staff possess a strong understanding of public health, there is increasing recognition in DFH that promotion of Health Equity requires a unique, often tailored, approach. Given the complex interplay of social determinants that impact health equity, it is imperative that staff develop a similarly complex understanding of the various, social, environmental, and systemic issues that often

manifest in health inequity. Additionally, DFH 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 DFH staff understanding of health equity, additional training and support beyond the typical onboarding process and education is being planned.

Over the past year, Title V staff investigated the options for training staff and identified an existing infrastructure within the NYSDOH, the Learning Management System (LMS). Plans were initiated to create a one-year comprehensive curriculum of health equity training to be developed and required for all staff working in the DFH. Using the LMS platform provides the opportunity to create and track completion of the training modules. The LMS can be used to generate Certificates of Completion for each individual course and for the full curriculum. Draft plans for component module areas were created. The learning experience is planned to span one year: an introductory course at the onset of hire with subsequent courses at 3 month intervals.

Staff catalogued existing modules to inventory content for applicability and quality. Content was reviewed for focus areas including health literacy, health equity, eliminating health disparities, and social determinants of health. Title V staff accessed resources from the HRSA-funded Region 2 Public Health Training Center (PHTC), a partnership of three Council on Education for Public Health accredited schools of public health, including Columbia University Mailman School of Public Health, Rutgers School of Public Health, and the University of Puerto Rico Graduate School of Public Health, along with the University of the Virgin Islands Community Engagement and Lifelong Learning Center, and NYSACHO. The Center's mission is to enhance the current and future public health workforce's ability to effectively deliver the Essential Public Health Services (EPHS) to the populations of NY, New Jersey, Puerto Rico, and the U.S. Virgin Islands. Using the "Training Program Evaluation Criteria" tool, developed by PHTC, the team evaluated courses and determined which merited inclusion in the curriculum. From this exercise the current courses under consideration are: "A Commitment to Advancing Health Equity", and "From Concept to Practice: Health Equity, Health Inequities, Health Disparities & Social Determinants of Health,". Objectives from seven courses were collected to help develop and finalize the curriculum. Gaps and needs for the curriculum have been identified and will be addressed in the final creation of the MCH Health Equity Training Curriculum. (**ESM LC-14b:** Number of DFH staff who have completed one or more Equity Learning Labs.)

Title V staff also identified several opportunities for professional development aimed at improving health equity competence of DFH staff. These included events, webinars, meetings and book clubs. The Epidemiology and Biostatistics Community of Practice (EBCoP), the Affirmative Action Advisory Committee, and the Office of Minority Health and Health Disparities Prevention (OMH-EHD) collaborated to present a series of events, from September 2016 to January 2017, to explore ways that staff can learn to effectively understand and address the factors that lead to disparities. The events included the screening of the acclaimed documentary series, "UNNATURAL CAUSES: Is Inequality Making Us Sick?". Monthly screening events were held featuring different episodes in the series including "In Sickness & In Wealth," "When the Bough Breaks," "Becoming American," "Bad Sugar" and "Collateral Damage." The screening series was promoted to all DFH staff and staff served as moderators for three of the sessions.

Title V staff also worked with the EBCoP to develop a health equity-focused book club. 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. The first meeting of the book club took place on March 9, 2017 and was attended by approximately 15 staff from various Divisions within the DOH and efforts are underway to further promote the equity book club to staff.

Title V staff continued to increase their knowledge and understanding by attending educational opportunities including "Building Community Partnerships to Address Social Determinants of Oral Health" and "Measuring Social Determinants of Health among Low-Income Populations: Early Insights from State Initiatives" from the Center for Health Care Strategies, Inc.; the National Academies Press of Sciences, Engineering, and Medicine's webcast, "Report Release for Communities in Action: Pathways to Health

Equity in the United States"; the National Academy of Medicine's webcast "Engaging Allies In the Culture of Health Movement"; and the National Partnership For Action webinar series: "Promoting Health Equity through Program & Policies by the College of Menominee nation."

Additionally, DFH and CCH had the opportunity to learn about incorporating health equity into MCH through a "Reproductive Justice" framework. Presented by the NYCDHMH, this interactive presentation allowed DFH staff to explore how this theoretical framework can be operationalized for use within a family planning setting. With its emphasis on involvement of members of key priority populations, the necessity of shared decision making, and focus on engaging nontraditional partners in promoting health equity, much of this work aligned with key concepts embraced by the DFH's life course approach outlined in NY's SAP.

An important component of health equity is ensuring a connection and understanding of the priorities, needs and opinions of the communities served. During this reporting period, Title V staff focused on the development and piloting of a Community Listening Forum (CLF) protocol for use in all DFH procurement development and program implementation and evaluation. Collaborating with staff from the OMH-EHD, DOH staff gained valuable insights from the OMH-EHD CLF process and adapted many of their resources for use in DFH. During the planning and development phase, collaborative staff meetings were held jointly with DFH and OMH-EHD staff. Staff obtained training materials, resources, marketing information, and findings from a series of large scale CLFs conducted across NYS.

With an anticipated release date of October 2017, the first Title V procurement selected to pilot this process was the MICHC program. (**ESM LC-15:** Percentage of DFH procurements that complete community listening forums as part of concept development process.) Title V staff began this process in August 2016 by hosting an informative webinar open to all MICHC providers. At this presentation, staff outlined the goals of the CLF and solicited interest for participation from among the 23 current MICHC providers. Aiming to elicit feedback from diverse participants who broadly represent priority populations for MICHC interventions, staff selected three current providers, from a total of 8 volunteer programs, to facilitate forums in Queens, Binghamton, and Rochester, NY. This selection represented both urban and rural communities with extremely diverse populations and one session was conducted entirely in Spanish.

Programs were provided with a web-based training, further outlining the scope of activities involved in CLF facilitation. This included a basic overview of health equity principles, how a CLF would serve to address issues of equity, the roles and responsibilities of volunteer organizations, and the basic expectations of all CLFs. Forums occurred in November 2016 and each had between 25-40 participants who could share ideas, and suggestions for improvement on key MCH topics areas. Participants selected from eight different topic areas to discuss including: family planning/pregnancy prevention, prenatal care, parenting, communities, mental health and substance abuse, social support, staying healthy over the lifespan, and looking toward the future. Discussions were recorded by and provided to MICHC staff for data analysis. Immediately following each forum, scribes engaged in a facilitated debrief.

Information gathered during each event was provided to the DFH for qualitative data analysis. Leading that effort was an MPH student intern hired to support this work from the SUNY Albany School of Public Health. The student developed a qualitative data analysis protocol, coded all information and feedback obtained, and developed written reports outlining key themes for each of the CLF sites. Among the major themes reported across the state were: increased desire for social supports, more opportunities for father engagement, frustrations with the health care system and health providers (including provider bias, lack of communication, limited time interacting with physicians), and opportunities for participants to be collaborative partners in improving the physical environments in which they live (e.g. creating more space for play, walkable communities, and improving safety).

Following the completion of the analysis, information gathered from forums was distributed to DFH staff working on the development of a new MICHC procurement so opportunities could be identified to incorporate insights gleaned into the next MICHC procurement, for release Fall 2017. Through the inclusion of community feedback, especially targeted at identified areas of need and

barriers to improved health outcomes, MICHC staff anticipates tailoring funding specifically to more closely meet the needs of individuals most impacted by health inequities in NYS. (**ESM LC-16:** Percentage of DFH procurements that demonstrate inclusion of evidence-based/informed community engagement and collective impact strategies.)

A final focus area is to work towards developing an internal culture that includes health equity work as a priority in every program. The Title V program recognizes the challenges presented with evaluating a program for health equity when the evaluation methodology and outcomes were not clearly established during project development. To address this issue, Title V staff members worked to identify key community engagement strategies best suited to support the health equity priorities of DFH. Through this review, staff determined that evidence based or best practice was a necessary component of any effort to promote health equity and must be included in all DFH programs and procurements moving forward. Title V staff is working to increase their knowledge of these practices and infuse them into procurements moving forward.

As a first step to create uniform community engagement requirements, all DFH programs were surveyed on the current requirements and their potential capacity to include elements of community engagement. Results were used to establish a baseline for compliance. Currently, 47% (9/19) of current DFH programs require some element of community engagement activities. It is important to note that elements of community engagement can vary widely among the included programs. Building on this baseline, NY's Title V program plans to increase the number of programs including community engagement elements and work to ensure community engagement activities are implemented consistently and in accordance with best practices.

Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

Section II.F.2. MCH Workforce Development and Capacity

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

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

MCH providers also use funds provided by the Title V program to access qualified and competent staff, participate in training and conferences and other activities to improve the quality of the workforce providing services. Title V advocates for staff to attend national conferences whenever possible to continue to build expertise in the MCH arena and make connections on the federal level as well as develop partnerships across state to continue to improve NY's approach to improving the health and wellness of the MCH population.

As previously discussed, NY's Title V program also leads various efforts with health care providers, hospitals and other professionals throughout NYS to enhance practice. These include, but are not limited to, the improvement initiatives through New York State Perinatal Quality Collaborative (NYSPQC), training and information provided to and through professional organizations such as the identification of children with Autism Spectrum Disorder (ASD), developmental screening, the identification and treatment of hypertension during pregnancy, screening and referral of children for oral health services and a range of other topics. The development of the NYS Partnership for Maternal Health further supports efforts to promote public awareness and clinical quality improvement efforts to improve maternal and infant mortality and morbidity.

Title V staff within DOH are the core of the Title V program and responsible to ensure the scope and mission of Title V is carried out in NYS. To ensure a strong focus on the needs of the Title V program staff, strong connections and linkages were maintained with resources supported through HRSA. The partnership continued with the HRSA-funded National MCH Workforce Development Center at the University of North Carolina that served as an invaluable resource to identify information, tools and resources such as assistance with the system mapping initiative for CSHCN. As discussed in the CSHCN Domain of this application, staff from the Center provided the system mapping tool and ongoing training and technical assistance to Title V staff as well as parents across NYS to support this significant undertaking to assess the needs, resources and priorities of families and professionals across the state related to CSHCN. The HRSA-funded *Strengthen the Evidence* site also 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 is also invited to present at the NYS MCHSBG Advisory Council to ensure NYS has the most current information from the federal level.

In an effort to build capacity for the dental public health workforce, the DOH has an accredited dental public health residency program to train residents to develop public health competencies and skills that can be applied in dental public health settings. The residency curriculum focuses on eight core competencies recognized by the American Association of Public Health Dentistry. They include : demonstrate the ability to incorporate ethical reasoning and actions that promote culturally competent oral health care to

individuals and populations: critique, synthesize and apply information from scientific and lay sources to improve the public's oral health; describe social and health care systems and determinants of health and their impact on the oral health of the individual and population; assess risk for oral diseases and select appropriate, evidence-based preventive interventions and strategies to promote health and control oral diseases at the individual and population level; demonstrate the ability to access and describe the use of population-based health data for health promotion, patient care, and quality improvement; demonstrate the ability to communicate and collaborate with relevant stakeholders to advocate for policies that impact oral and general health for individuals or populations; develop a capacity for lifelong learning and professional growth in order to provide leadership that utilizes principles of dental public health; and demonstrate the ability to participate in inter-professional care across the lifespan of people from diverse communities and cultures. The Title V program hosts up to two dental residents annually. Over the past year one dental resident participated in the program with the focus of her work being school-based dental care and NY's Third Grade Surveillance. A second dental resident is joining the program in Summer 2017 and will be focusing on community water fluoridation and dental workforce.

Residents are integrally involved in the analysis of the 3rd grade screening data. Their involvement often fosters interests in data projects that lead to additional projects that often lead to building and enhancing the evidence base to inform and improve prevention efforts in early childhood caries prevention, oral health and nutrition education and other oral health promotion activities. The residency program curriculum also includes monitoring programs for effectiveness, developing elements of interventions that assist in promoting and preventing dental diseases.

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

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

Title V will continue to make workforce development a priority and promote internal and external efforts to address these needs.

II.F.3. Family Consumer Partnership

As stated previously, at the community level, most services and programs are implemented by local partners including LHDs, universities and academic medical centers, hospitals and clinics, and community based organizations. When procuring services, efforts are made to locate services within communities served provided by individuals from the community or reflect the diversity of the community. Contractors are required to obtain consumer input from the MCH population served whether it is membership on a board to guide services, workgroups to provide input regarding education materials or outreach strategies, or direct input from families served. In a state the size of NY, obtaining input through provider organizations or other organizations representative of the population is the most practical, meaningful way to obtain input from the broad population that is MCH in NY. As stated in the state plan, a focus in the Early Intervention Program this coming year will be on assessment of family outcomes that will assist NY's Title V program to enhance the understanding of family input and disseminate this learning to other programs and services.

To further the DFH's goal of infusing meaningful community engagement into the procurement process so that the diverse voice of the community to be served is represented, the DFH hosted three community listening forums in different parts of the state, as part of the MICHC procurement process. Three distinct and diverse groups with over 100 participants participated in these listening forums, including one forum conducted entirely in Spanish. The information that was learned from these forums is being used to draft the latest procurement guidance so that the needs identified in the forums can be addressed by the contractors applying for the funding.

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 will continue. Parents are also members of the EI Coordinating Council as well as the MCHSBG Advisory Council and provide valuable input to guide policy and practice. Michelle Juda, executive director of Parent to Parent of NYS has been designated as a member of NY's MCHSBG Advisory Council and NY's family representation to AMCHP.

Title V also provides staff support to Hands & Voices of NY, a family support organization that provides support for families with children who are deaf or hard of hearing, regardless of communication modes the family selects. Hands & Voices is affiliated with and receives technical support from the National Hands and Voices, which is the leading parent support group in the country for these children. It is a parent driven non-profit organization providing families with the resources, networks, and information they need to improve communication access and educational outcomes for their children. Hands & Voices of New York has been an official non-profit 501(c)(3) organization for 3 years and currently has about 40 paid members. While the organization is based in the Capital District, there are satellites in Rochester, Buffalo, Utica, and Columbia Counties as well as Long Island. There are efforts underway to link more closely with Parent to Parent of NY in the coming year.

An essential component of NY's SAP is the system mapping efforts for CSHCN. The Title V program will further build supports and services as well as stronger connections with parents through the effort and promote strategies to support ongoing communication with parents of CSHCN throughout NYS. The Title V program will seek to develop standardized processes and measures to ensure all MCH providers obtain and use meaningful consumer input to improve the MCH system of services in NYS. This will be especially important in NY's upcoming plans to promote health equity across all NYS' families as well.

II.F.4. Health Reform

As stated throughout this report, Title V staff have been directly involved in NY's implementation of the Affordable Care Act. This includes input into the basic health plan, outreach and awareness and in keeping abreast of developments and the impact on the MCH population. Title V staff have facilitated information sharing with providers and consumers throughout NYS and requires all MCH programs to assess individuals for insurance status and facilitate enrollment into the Health Exchange. Work on this, Health Homes, DSRIP including SHIP/APC and others will remain a key part of the work of NY's Title V program to ensure the MCH population has ongoing access to comprehensive health care coverage and that Title V continues to build and maintain a leadership role in this arena. NY's Title V Program will continue to monitor any changes on the federal level that will impact the provisions of the ACA or federal funding that supports the MCH population in NYS.

II.F.5. Emerging Issues

All issues have been succinctly addressed in other sections of this application, including the SAP section. Title V staff in NY will continue to monitor the status of health insurance coverage for the MCH population, access to Health Home for Children, implementation of DSRIP, SHIP, including APC and other health care reform initiatives to advocate for supports and services for the MCH population. An enhanced focus will be placed on understanding and developing strategies to promote health equity, addressing the opioid epidemic particularly focused on the MCH population, increasing an understanding of the social-emotional needs of children and adolescents and developing a strength-based approach to supporting positive youth development. A major effort will be undertaken to update standards for perinatal regionalization as well as ensuring the structure of the perinatal regionalized system will be developed to align with the evolving health care system. Throughout the next year, Title V staff will also continue to implement the strategies identified in the SAP through evidence-based or evidence-informed practice to potentially update policy, program and other supports as new evidence emerges. Finally, Title V recognizes the need to strengthen internal and external partnerships, including formal and informal community leaders, in order to address some of the most challenging MCH issues faced across the Nation.

II.F.6. Public Input

NY's Title V Program fully embraces the vision of Title V that stresses that addressing the needs of women, children and families requires commitment and partnerships with families, health and human service providers and professionals, organizations and advocacy groups as well as other key stakeholders that support and promote improved outcomes for all NY's families. In line with this philosophy, NY's Title V Program implemented extensive public input over the course of this year to ensure NY's SAP reflected the needs, thoughts, and priorities of all MCH stakeholders and incorporated strong partnerships to build upon to coordinate efforts and maximize existing resources.

A key partner in NY's Title V Program is the MCHSBG Advisory Council (Council), that serves in an advisory capacity to the DOH with respect to the MCHSBG. In this capacity, the Council advises DOH in:

- determining program priorities consistent with MCHSBG principles;
- ensuring that services delivered under the MCHSBG are fairly allocated and directed to those most in need and are not duplicative of services provided through other sources of funds;
- the preparation of the annual performance report and application to HRSA;
- ensuring the public's ability to comment on MCH activities; and,
- ensuring a coordinated, statewide response to maternal and child health issues, including improved coordination among state agencies.

Since the inception of this five-year grant cycle, members of the Council (See Attachment for list of members) provided input into the identification of priorities, strategies, and provided recommendations on organizations and initiatives that could partner with NY's Title V Program to strengthen the approach to meet the needs of NY's MCH population. This input continued throughout the past year as the Council was engaged in discussions to inform and improve the implementation phase of NY's Title V SAP. Part of this discussion also focused on ensuring NY's Title V Program identified and connected with a wide range of MCH stakeholders during the public input process as well as in moving forward with implementation of the identified strategies.

In considering the process for this year's public input, attention was given to ensure broad input from families and other individuals, health care providers, human service providers and organizations with a special interest in MCH. Due to the extensive input in FY 2016 and 2017 Application in the development of the SAP, the focus of the input for this FY 2018 Application was on implementation of the identified strategies, including ideas for building partnerships and coordinating and maximizing existing resources. The discussions were tailored to the specific interests of each group and participants were asked to provide feedback on the appropriateness and completeness of the SAP. Each group, however, was presented with the same basic questions to initiate discussion including:

- What specific recommendations do you have for strengthening the work described?
- Are there key partners who are not represented in this plan that should be?
- Are there other initiatives that you know about that mesh with NY's Title V work that NY's Title V Program should be aware of/collaborate with?
- Is there any major issue you believe is missing?

The Title V SAP and associated strategies were presented to over 200 providers, health professionals and parents in a series of in-person meetings and/or webinars held between January and March 2017. Input was obtained from organizations including the Association of Perinatal Networks (APN), Association of Regional Perinatal Programs and Networks (ARPPN), NYS Perinatal Association (NYSPA), Maternal and Infant Community Health Collaborative (MICHC), MCH Committee of the NYS Association

of County Health Officials (NYSACHO), Schuyler Center for Analysis and Advocacy, oral health professionals, Parent to Parent of NYS, and the Early Intervention Coordinating Council (EICC) among others.

The public input strongly supported NY's plan for addressing the needs of NY's MCH population. Comments across all groups reaffirmed NY's SAP Cross Cutting /Life Course priorities. Addressing health disparities and promoting health equity was generally reflected through all discussions across all Domains. This mirrored the emphasis on ensuring access to health care coverage, understanding and adapting in the new era of health care (DSRIP, etc.), and promoting primary health care for all. All groups emphasized the influence social and community factors and environments have on health outcomes and the need to understand and address issues on the community level. It was stressed that communities need to "own" the process and solution in order to facilitate sustainable improvements.

Positive comments were also received regarding the inclusion and significance of the placement of oral health in NY's SAP. A number of health care providers from a variety of different sectors expressed strong support for increasing community water fluoridation and encouraged the development of an oral health education component in school-based health centers and school-based dental programs. There was discussion regarding the need for greater focus on children's oral health to better ensure access especially in rural areas as well as on the development of the oral health workforce, especially related to dental hygienists.

Broad support was expressed for efforts to decrease maternal mortality and morbidity including preconception health strategies and ensuring clinical standards of care are supported such as the use of long acting reversible contraception and promoting 17 Alpha-hydroxyprogesterone caproate to prevent prematurity. Several groups discussed the importance of addressing the use of opioids in the MCH population, pain management practices as well as the resulting neonatal abstinence syndrome (NAS). Discussions also centered on not only identifying pregnant and postpartum women with depression, but on ensuring there are supports and services to address these needs when identified.

Regarding perinatal and infant health, stakeholders such as NYSPA and the ARPPN (that represents NY"s Regional Perinatal Center hospitals) applauded NY's plan to update the system of regionalized care and also stressed the need to ensure alignment with the current health care system and systems of payment for health care. One group stressed the need for greater cultural sensitivity in the Safe Sleep campaign (e.g., co-sleeping) and indicated that families need to understand the reasons behind the recommendations and also suggested a greater emphasis on breastfeeding in the SAP.
Input obtained emphasized the significance of social-emotional development in children and adolescents and its life-long impact on health, wellness and functioning. The need to ensure behavioral health is addressed in all health care settings, including reproductive and perinatal health was also raised. One group specifically noted that health care providers need greater understanding of ACES and the impact on all areas of health and medical care. The inclusion of transition in the SAP was also strongly supported as often adolescents drop from care as they transition to adulthood.

Regional disparities were also raised as a consideration for implementation as certain evidence-based programs such as Nurse Family Partnership, Healthy Families NY or other models may not have broad applicability to more rural areas where burden is also less but the public health issue still exits.

Fiscal constraints were also discussed as funding on the federal or state level is decreased or reimbursement for certain interventions is not available. A couple of groups expressed the importance of electronic health records (EMRs) in care to ensure a comprehensive understanding of the health and medical information for pregnant women and expressed concerns with data compatibility issues between hospital EMRs and state data systems.

Families also provided valuable input into NY"s SAP. Some families expressed concern about vulnerability at times of transition e.g. service continuity for children between infants and adolescents. There was general consensus regarding the need to continue to

identify and coordinate supports and services for families. Emphasis on building capacity for diagnostic and support services for certain populations such as children with Fetal Alcohol Syndrome (FAS) was discussed. One noted concern was regarding the lack of dental providers who accept Medicaid making it difficult for children to be treated for dental caries and long waiting times to access treatment when a provider is found. Generally, the group expressed support for the system mapping effort and expressed a desire for ongoing input.

Overall, a comment that crossed many groups was the need for greater alignment of initiatives conducted by different groups/agencies across the state to ensure a more coordinated approach to the needs of NY's women, children and families.

II.F.7. Technical Assistance

As stated in previous year's Title V Application, travel restrictions impact the ability of NY's Title V staff to participate in State or National Conferences and in-person meetings. It would greatly benefit states such as NY if on the federal level, federal agencies would utilize technology to share and learn rather than in-person meetings or conferences. In addition, the inability to travel to National meetings can impact NYS sharing valuable experiences and showcasing accomplishments with federal and state representatives.

NY's Title V program also would welcome the opportunity to have periodic teleconferences with HRSA and other large states that may be experiencing similar challenges, discussing similar policy issues and developing and evaluating programs and initiatives to support Title V outcomes. Focused discussions on the impact of MCH in the climate of health care reform, and the role Title V can play to better influence those changes in a positive manner would be invaluable. Issues such as 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 examples of areas that may be of benefit to discuss in a forum with large states. Finally, discussions on strategies States have implemented pursuant to their State Action Plans in general, including strategies Title V in other states have taken to address disparities and improve health equity would be extremely helpful as NY's moves forward in addressing this high priority MCH issue.

III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$37,919,712	$37,919,712	$38,909,810	$38,909,810
Unobligated Balance	$0	$0	$0	$0
State Funds	$62,208,171	$78,841,785	$29,200,000	$58,908,173
Local Funds	$271,646,100	$224,894,104	$22,198,393	$317,759,172
Other Funds	$0	$0	$0	$0
Program Funds	$236,737,888	$292,856,562	$12,794,604	$274,679,941
SubTotal	$608,511,871	$634,512,163	$103,102,807	$690,257,096
Other Federal Funds	$62,905,602		$54,870,832	$41,545,988
Total	$671,417,473	$634,512,163	$157,973,639	$731,803,084

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$38,909,810	$38,909,810	$38,909,810	
Unobligated Balance	$0	$0	$0	
State Funds	$29,226,355	$65,501,510	$12,147,081	
Local Funds	$25,254,603	$85,526,375	$102,765,310	
Other Funds	$0	$0	$0	
Program Funds	$34,368,556	$26,095,730	$34,368,556	
SubTotal	$127,759,324	$216,033,425	$188,190,757	
Other Federal Funds	$72,809,819	$65,158,879	$57,096,314	
Total	$200,569,143	$281,192,304	$245,287,071	

	2018	
	Budgeted	Expended
Federal Allocation	$38,909,810	
Unobligated Balance	$0	
State Funds	$29,226,355	
Local Funds	$64,591,358	
Other Funds	$0	
Program Funds	$26,851,106	
SubTotal	$159,578,629	
Other Federal Funds	$68,845,166	
Total	$228,423,795	

III.A. Expenditures

A. FY 2016 Expenditures

As in previous years, FY 2016 Expenditures including Title V, State appropriations and other grant funding demonstrates NY's commitment to providing supports and services to NY's women, children and families. The State Allocation Plan is described in Section 504, Use of Allotment of Funds, and Section 505, Application for Block Grant Funds.

As evidenced in Form 2, NY has, once again, met the commitment to expend 30% Title V on Primary and Prevent services and 30% on CSHCN. The scope and comprehensiveness of services for NY's MCH population are fully outlined and described in the FY 2016 report and FY 2018 application. Title V funds supported primary and preventive health care services provided through initiatives such as School Based Health Centers, Family Planning and Reproductive Health clinics, School Based Dental clinics, Migrant Health programs and services, Lead Poisoning Prevention activities, Comprehensive Adolescent Pregnancy Prevention programs and other programs and initiatives focused on engaging NY's MCH population into primary and preventive health care.

Supports and services to NY's CSHCN and their families is an essential component of NY's Title V services. Although all primary and preventive health care programs provide services to CSHCN, NY's Title V program also oversees services specifically designed to serve CSHCN. For example, LHDs are supported with Title V funds to provide information and referral services to families of CSHCN. This funding supports staff in LHDs to respond to inquiries by families related to issues such as insurance coverage, assistance with services, support groups and needed items for their CSHCN. Title V funding also supports an extensive network of Article 28 clinics that provide genetic screening and counseling to parents of CSHCN, pregnant women and/or those planning pregnancies. NY's Lead Poisoning Prevention Program focuses on environmental changes as well as identifying and supporting potentially lead poisoned children and their families.

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

The Title V Administrative expenditures of $2 million slightly exceeds the budgeted figure of $1.8 million, however accounts for only 5.4% of NY's Title V expenditures and remains below the 10% limit for these costs.
NY's commitment to the MCH population is evidenced by the substantial State appropriation that is devoted to supports and services for NY's women, children, including CSHCN and families. Some differences in state and local contributions are evident as the State continues to maximize its public health funding, utilize state-based resources to match a large variety of public health grant programs, and recognize the growing effect of affordable health insurance. FY 2016 application reflected a budget of over $29 million in State MCH funds and over $25 million for Local funds. Expenditures in both categories far exceeded the budgeted figures from an increase in local public health policies and reformulated expenditure categories. This also applies to the Total State match and State Federal Partnership. Expenditures for State MCH funds exceeded the budgeted figures in the program areas of Child Lead Poisoning Prevention, Comprehensive

Adolescent Pregnancy Prevention, Family Planning, and American Indian Health. Expenditures for Local funds increased significantly in the areas of provision of primary and preventive care to uninsured children (<21 years) in a clinic setting, maternal and infant health, provision of prenatal/postpartum care in a home visiting setting, and reproductive health. Although NYS appropriates significantly more funding to services for the MCH population. NY's Title V program uses additional State funds to leverage other resources such as to obtain Federal Medicaid Assistance Program (FMAP) funding when possible.

Extensive efforts are also devoted to seeking other sources of funding to develop, improve and enhance supports for NY's MCH population. NY's Title V program has been very successful in accessing additional funding to develop the comprehensive system that currently exist in NYS. Grants such as MIECHV to support evidence-based home visiting, PREP to support adolescent programming, EHDI to augment the statewide newborn hearing screening program, and a myriad of other grants support NYS's efforts to improve outcomes of all women, children, including CSHCN and families across NYS.

III.B. Budget

B. Budget

This FY 2018 budget reflects NYS's commitment to Title V programs and services. NYS will use FY 2018 Title V funds to fully support the implementation of NY's State Action Plan. Title V funds, in addition to State appropriation, FMAP, and federal grant funds will continue to support programs and initiatives across all domains as described in the application section. This includes the development of substantial data analyses and reports to guide NY's services for the MCH population. Support for efforts such as maternal and infant mortality and morbidity surveillance and quality improvement efforts to avoid these devastating outcomes is a priority. Efforts will continue to provide supports and services for children and adolescents, with a significant focus on social-emotional development, school based health centers and school based-dental programs, evidence-based home visiting services, community health workers including CHWs serving Native Americans, oral health services, services for CSHCN and many other supports and services discussed throughout NY's application. CSHCN systems mapping efforts will assist NY's Title V Program to set a future course to enhance and strengthen efforts to support NY's CSHCN and their families. As stated in the application, promoting health equity remains a major priority of NY's Title V Program across all domains.

The Title V Administrative budget of $2.1 million increased slightly from prior years and remains below the 10% limit for these costs.

The state share for MCH services will continue to be considerable, and will more than meet the requirements for state match. Expenditures for FY18 are expected to utilize the full allocation of $38,909,810.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Title V State Agreement (003).pdf

V. Supporting Documents

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

Supporting Document #01 - Attachment MCH Collaborations - Final.pdf

Supporting Document #02 - Attach IIB2 Staff Quals 5-10-17.pdf

Supporting Document #03 - DOH-OPH-CCH-DFH Org Charts.pdf

VI. Appendix

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: New York

	FY18 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 38,909,810	
A. Preventive and Primary Care for Children	$ 12,965,080	(33.3%)
B. Children with Special Health Care Needs	$ 13,005,647	(33.4%)
C. Title V Administrative Costs	$ 2,157,838	(5.6%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 29,226,355	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 64,591,358	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 26,851,106	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 120,668,819	
A. Your State's FY 1989 Maintenance of Effort Amount $ 58,268,752		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 159,578,629	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 68,845,166	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 228,423,795	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 66,644
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 4,036,326
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement	$ 200,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 340,600
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 174,395
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 1,837,000
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 25,888,440
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 2,756,926
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 7,694,039
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 9,845,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 143,825
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 500,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Children's Oral Care Access Program	$ 175,000
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 1,508,763
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Strength Based Curriculum	$ 450,000

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Oral Health and Chronic Disease Collaboration	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match	$ 12,978,208

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 38,909,810		$ 38,909,810	
A. Preventive and Primary Care for Children	$ 12,598,789	(32.4%)	$ 11,769,605	(30.2%)
B. Children with Special Health Care Needs	$ 12,257,757	(31.5%)	$ 11,995,448	(30.8%)
C. Title V Administrative Costs	$ 1,815,301	(4.7%)	$ 2,084,419	(5.4%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 29,226,355		$ 65,501,510	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 25,254,603		$ 85,526,375	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 34,368,556		$ 26,095,730	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 88,849,514		$ 177,123,615	
A. Your State's FY 1989 Maintenance of Effort Amount $ 58,268,752				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 127,759,324		$ 216,033,425	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 72,809,819		$ 65,158,879	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 200,569,143		$ 281,192,304	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prevent Block Grant	$ 2,120,737	$ 2,061,057
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Part C - Early Inter	$ 24,971,913	$ 24,971,913
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Abstinence Education	$ 2,856,276	$ 2,144,052
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > MIECHV	$ 15,696,241	$ 5,370,042
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > PREP	$ 3,022,144	$ 2,653,020
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > SSDI	$ 77,054	$ 77,054
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Title X	$ 9,571,200	$ 9,762,000
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match	$ 13,461,825	$ 16,550,724
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Other HRSA	$ 1,032,429	$ 1,569,017

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**

Field Note:
The Title V Administrative budget of $2.1 million increased slightly from prior years and remains below the 10% limit for these costs.

Data Alerts:

1.	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.
2.	The value in Line 3, State 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.
3.	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.
4.	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	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 6,215,394	$ 8,504,738
2. Infants < 1 year	$ 1,070,067	$ 1,451,962
3. Children 1-22 years	$ 11,895,013	$ 10,317,642
4. CSHCN	$ 13,005,647	$ 11,995,448
5. All Others	$ 4,565,851	$ 4,555,601
Federal Total of Individuals Served	$ 36,751,972	$ 36,825,391

IB. Non Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 16,334,170	$ 21,748,437
2. Infants < 1 year	$ 8,542,850	$ 16,317,261
3. Children 1-22 years	$ 58,307,441	$ 86,539,522
4. CSHCN	$ 19,253,386	$ 31,453,225
5. All Others	$ 18,230,973	$ 21,065,169
Non Federal Total of Individuals Served	$ 120,668,820	$ 177,123,614
Federal State MCH Block Grant Partnership Total	$ 157,420,792	$ 213,949,005

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Form 2 line 1a includes infant under 1 year and children 1-22	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Form 2 line 1a includes infant under 1 year and children 1-22	

Form 3b
Budget and Expenditure Details by Types of Services

State: New York

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 37,500	$ 1,338
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	$ 37,500	$ 1,338
2. Enabling Services	$ 27,263,662	$ 27,330,538
3. Public Health Services and Systems	$ 11,608,648	$ 11,577,934
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		$ 1,338
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 1,338
Federal Total	$ 38,909,810	$ 38,909,810

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 4,338,266	$ 5,349,424
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 4,338,266	$ 5,349,424
2. Enabling Services	$ 48,384,660	$ 60,759,560
3. Public Health Services and Systems	$ 50,823,673	$ 89,765,901
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		$ 855,908
Physician/Office Services		$ 53,494
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 320,965
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 53,494
Laboratory Services		$ 0
Other		
Other		$ 4,065,563
Direct Services Line 4 Expended Total		$ 5,349,424
Non-Federal Total	$ 103,546,599	$ 155,874,885

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

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

State: New York

Total Births by Occurrence: 233,670

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	231,694 (99.2%)	2,246	331	331 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methyglutaric aciduria	Holocarboxylase synthase deficiency	ß-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, βeta-thalassemia	S,C disease
Biotinidase deficiency	Critical congenital heart disease	Cystic fibrosis	Hearing loss	Severe combined immunodeficiences
Classic galactosemia	Adrenoleukodystrophy	Mucopolysaccharidosis, type I		

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
Newborn Hearing Screening Program	222,944 (95.4%)	3,530	181	181 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

New York's Newborn Screening Program collects, analyzes and reports on approximately 275,000 specimens annually for 49 diseases and conditions including all core conditions recommended by the American College of Medical Genetics ad the March of Dimes. The Department also oversees mandatory screening for newborn hearing and critical congenital heart defects. Follow-up is provided through condition-specific Specialty Care Centers located throughout NYS.

Although there is no current mechanism to collect data on numbers regarding screening for Critical Congenital Heart Defects of the Newborn, NYS Public Health Law enacted in 2014 requires every obstetrical hospital to screen newborns for critical congenital heart defects using pulse oximetry.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Referred For Treatment**
	Fiscal Year:	**2016**
	Column Name:	**Core RUSP Conditions**
	Field Note: This figure includes all infants with presumptive positive test results for further testing and evaluation. All confirmed cases are then followed by specialty centers and other subspecialist providers.	
2.	**Field Name:**	**Newborn Hearing Screening Program - Receiving At Lease One Screen**
	Fiscal Year:	**2016**
	Column Name:	**Other Newborn**
	Field Note: NYS Public Health Law requires all maternity hospitals and birthing centers to administer newborn hearing screening programs. Parents are given information about newborn hearing screening prior to the screening. Shortly after birth, the infant's hearing is screened and parents are given the result. If the infant does not pass the screening, the parents are given a prescription for their infant to have an outpatient screening and a list of qualified infant hearing screeners. If the follow-up hearing screening is failed, the infant is referred for a full diagnostic hearing assessment. If hearing loss is detected, the infant is referred to the NYS Early Intervention Program (NYSEIP) for appropriate intervention services. If the birthing center cannot locate the parent after discharge, then a referral must be made to the NYSEIP Child Find to locate the family to assure follow-up occurs.	
3.	**Field Name:**	**Newborn Hearing Screening Program - Referred For Treatment**
	Fiscal Year:	**2016**
	Column Name:	**Other Newborn**
	Field Note: The confirmed 181 infants with hearing loss would be referred for care and are eligible for NY's Early Intervention Program. All presumptive positive infants are referred for further hearing evaluation. Out of the 3,530 referred for follow-up in 2016, only 539 have a documented diagnostic evaluation in the EHDI data system. As stated in the narrative section of this application, the Title V Program continues to work to decrease the loss to evaluation and care.	

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: New York

Reporting Year 2016

		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	68,890	45.8	0.0	51.4	1.7	1.1
2. Infants < 1 Year of Age	2,460	44.8	1.0	51.4	1.7	1.1
3. Children 1 to 22 Years of Age	627,391	30.8	6.9	54.4	7.9	0.0
4. Children with Special Health Care Needs	437,007	37.2	6.9	52.8	3.1	0.0
5. Others	84,882	21.4	0.0	61.9	16.7	0.0
Total	1,220,630					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2016**

Field Note:
These data reflect only those served through Title V funded programs approximated by individuals served and service category and does not represent an unduplicated count as NY has no mechanism to collect those data. The population served in these categories is far above these data reported supported through State funding and other sources but NY is unable to capture those data in the format requested.

Form 5b
Total Recipient Count of Individuals Served by Title V

State: New York

Reporting Year 2016

Types Of Individuals Served	Total Served
1. Pregnant Women	105,079
2. Infants < 1 Year of Age	19,650
3. Children 1 to 22 Years of Age	957,868
4. Children with Special Health Care Needs	665,710
5. Others	130,415
Total	1,878,722

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2016**
	Field Note: This figure does not represent the population of infants served in NYS. This figure reflects the approximate number of infants served by those programs receiving Title V funds. NY serves significantly more infants, women and children with State and other funding sources but is unable to collect those data in the format requested.	
2.	**Field Name:**	**Total Served**
	Fiscal Year:	**2016**
	Field Note: These data reflect only those served through Title V funded programs approximated by individuals served and service category and does not represent an unduplicated count as NY has no mechanism to collect those data. The population served in these categories is far above these data reported supported through State funding and other sources but NY is unable to capture those data in the format requested.	

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

State: New York

Reporting Year 2016

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	233,670	141,742	38,404	496	24,479	1,492	5,911	21,146
Title V Served	233,670	141,742	38,404	496	24,479	1,492	5,911	21,146
Eligible for Title XIX	123,600	61,166	27,056	331	13,838	377	3,623	17,209
2. Total Infants in State	238,025	144,537	39,181	505	24,836	1,517	6,029	21,420
Title V Served	238,025	144,537	39,181	505	24,836	1,517	6,029	21,420
Eligible for Title XIX	125,640	62,130	27,637	338	14,006	383	3,700	17,446

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	178,078	55,592	0	233,670
Title V Served	178,078	55,592	0	233,670
Eligible for Title XIX	81,253	42,347	0	123,600
2. Total Infants in State	181,650	56,375	0	238,025
Title V Served	181,650	56,375	0	238,025
Eligible for Title XIX	82,682	42,958	0	125,640

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Will update when Newborn Screening is inputted.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: These figures reflect deliveries served by perinatal hospitals as well as those served through Newborn Screening programs.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: These data reflect an approximation based on the percent of the NYS population eligible for Medicaid.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Total infant surpasses total number of deliveries due to multiple births.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: These figures reflect deliveries served by perinatal hospitals as well as those served through Newborn Screening programs.	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2016**

Column Name:	**Total All Races**

Field Note:
These data reflect potentially eligible infants based on data obtained from the NYS Certificate of Birth. This figure differs slightly from total deliveries in the state eligible for Title XIX due to multiple births.

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

State: New York

A. State MCH Toll-Free Telephone Lines	2018 Application Year	2016 Reporting 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) 474-6061	(518) 474-6061
5. Number of Calls Received on the State MCH "Hotline"		15,210

B. Other Appropriate Methods	2018 Application Year	2016 Reporting 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 J. Tobias
Title	Director, Division of Family Health
Address 1	Corning Tower, Room 890
Address 2	Empire State Plaza
City/State/Zip	Albany / NY / 12237
Telephone	(518) 474-6968
Extension	
Email	lauren.tobias@health.ny.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Susan Slade
Title	Director, Bureau of Child Health
Address 1	Corning Tower, Room 878
Address 2	Empire State Plaza
City/State/Zip	Albany / NY / 12237
Telephone	(518) 474-1961
Extension	
Email	susan.slade@health.ny.gov

3. State Family or Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: New York

Application Year 2018

No.	Priority Need
1.	Reduce maternal mortality and morbidity
2.	Reduce infant mortality & morbidity
3.	Support and enhance social-emotional development and relationships for children and adolescents
4.	Increase supports to address the special health care needs of children and youth
5.	Increase the use of preventive health care services across the life course.
6.	Promote oral health and reduce tooth decay across the life course
7.	Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course.
8.	Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Reduce maternal mortality and morbidity	New	
2.	Reduce infant mortality & morbidity	New	
3.	Support and enhance social-emotional development and relationships for children and adolescents	New	
4.	Increase supports to address the special health care needs of children and youth	New	
5.	Increase the use of preventive health care services across the life course.	New	
6.	Promote oral health and reduce tooth decay across the life course	New	
7.	Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course.	New	
8.	Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).	New	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 5

Field Note:
Including:
Preconception/ Interconception (“well woman”, including family planning)
Prenatal & Postpartum
Infants (“well baby”)
Children (“well child”)
Adolescents (“well teen”, including family planning)

Form 10a
National Outcome Measures (NOMs)

State: New York

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	80.3 %	0.1 %	184,418	229,561
2014	79.1 %	0.1 %	182,737	231,024
2013	75.4 %	0.1 %	173,442	230,047
2012	74.5 %	0.1 %	173,825	233,372
2011	73.7 %	0.1 %	172,588	234,324
2010	73.9 %	0.1 %	174,690	236,300
2009	74.1 %	0.1 %	174,327	235,200

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	238.5	3.3 %	5,431	227,749
2013	238.1	3.3 %	5,368	225,500
2012	233.5	3.2 %	5,396	231,131
2011	213.2	3.1 %	4,811	225,668
2010	216.5	3.1 %	4,907	226,617
2009	195.2	2.9 %	4,487	229,831
2008	172.7	2.8 %	4,018	232,716

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
2011_2015	20.6	1.3 %	246	1,195,255
2010_2014	20.9	1.3 %	251	1,202,356
2009_2013	20.6	1.3 %	250	1,211,693
2008_2012	22.2	1.4 %	272	1,225,096
2007_2011	21.2	1.3 %	262	1,237,631
2006_2010	20.5	1.3 %	256	1,246,423
2005_2009	19.9	1.3 %	248	1,248,399

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4.1 - 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
2015	7.8 %	0.1 %	18,507	236,941
2014	7.9 %	0.1 %	18,722	238,423
2013	8.0 %	0.1 %	18,847	236,671
2012	7.9 %	0.1 %	19,074	240,654
2011	8.1 %	0.1 %	19,557	241,031
2010	8.2 %	0.1 %	20,049	244,116
2009	8.2 %	0.1 %	20,341	247,850

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.1 - Notes:

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	1.4 %	0.0 %	3,188	236,941
2014	1.4 %	0.0 %	3,298	238,423
2013	1.4 %	0.0 %	3,210	236,671
2012	1.5 %	0.0 %	3,494	240,654
2011	1.5 %	0.0 %	3,533	241,031
2010	1.5 %	0.0 %	3,682	244,116
2009	1.5 %	0.0 %	3,767	247,850

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.2 - Notes:

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.5 %	0.1 %	15,319	236,941
2014	6.5 %	0.1 %	15,424	238,423
2013	6.6 %	0.1 %	15,637	236,671
2012	6.5 %	0.1 %	15,580	240,654
2011	6.7 %	0.1 %	16,024	241,031
2010	6.7 %	0.1 %	16,367	244,116
2009	6.7 %	0.1 %	16,574	247,850

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	8.7 %	0.1 %	20,531	236,998
2014	8.9 %	0.1 %	21,114	238,475
2013	8.9 %	0.1 %	21,052	236,558
2012	9.1 %	0.1 %	21,884	240,504
2011	9.2 %	0.1 %	22,117	240,932
2010	9.4 %	0.1 %	22,904	244,016
2009	9.5 %	0.1 %	23,527	247,770

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.1 - Notes:

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.6 %	0.0 %	6,067	236,998
2014	2.6 %	0.0 %	6,250	238,475
2013	2.6 %	0.0 %	6,213	236,558
2012	2.7 %	0.0 %	6,589	240,504
2011	2.7 %	0.0 %	6,601	240,932
2010	2.9 %	0.0 %	7,036	244,016
2009	2.9 %	0.0 %	7,052	247,770

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.2 - Notes:

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.1 %	0.1 %	14,464	236,998
2014	6.2 %	0.1 %	14,864	238,475
2013	6.3 %	0.1 %	14,839	236,558
2012	6.4 %	0.1 %	15,295	240,504
2011	6.4 %	0.1 %	15,516	240,932
2010	6.5 %	0.1 %	15,868	244,016
2009	6.7 %	0.1 %	16,475	247,770

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.3 - 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
2015	22.8 %	0.1 %	54,082	236,998
2014	22.7 %	0.1 %	54,104	238,475
2013	22.9 %	0.1 %	54,190	236,558
2012	23.4 %	0.1 %	56,356	240,504
2011	23.5 %	0.1 %	56,643	240,932
2010	24.2 %	0.1 %	59,001	244,016
2009	24.9 %	0.1 %	61,620	247,770

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	4.0 %			
2013/Q2-2014/Q1	5.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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
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
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
2014	175.9	8.6 %	420	238,773
2013	184.0	8.8 %	436	236,980
2012	188.5	8.9 %	454	240,916
2011	182.3	8.7 %	440	241,312
2010	191.9	8.9 %	469	244,375
2009	197.9	8.9 %	491	248,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
2013	9.5 %	0.8 %	20,516	216,615
2012	9.9 %	1.0 %	10,943	110,416
2011	8.4 %	0.7 %	18,417	218,407
2010	8.1 %	0.7 %	18,042	222,166
2008	7.3 %	1.0 %	8,464	115,245
2007	8.4 %	0.7 %	19,845	235,020

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.8	0.2 %	1,329	227,751
2013	5.5	0.2 %	1,233	225,503
2012	4.2	0.1 %	974	231,133
2011	4.3	0.1 %	975	225,668
2010	3.3	0.1 %	751	226,617
2009	3.1	0.1 %	705	229,831
2008	2.6	0.1 %	611	232,716

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.4 %	1.3 %	773,251	3,983,245

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% 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
2015	13.3	0.8 %	278	2,084,298
2014	14.7	0.8 %	306	2,084,950
2013	15.1	0.9 %	314	2,083,766
2012	14.5	0.8 %	303	2,084,583
2011	15.0	0.9 %	311	2,076,119
2010	13.9	0.8 %	291	2,087,905
2009	15.9	0.9 %	330	2,082,079

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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
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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	20.8 %	1.3 %	886,553	4,266,861
2007	18.5 %	1.3 %	817,664	4,420,982
2003	17.0 %	1.0 %	765,132	4,503,196

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% 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) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	16.8 %	1.6 %	100,137	597,820

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children 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
2011_2012	1.9 %	0.4 %	67,419	3,574,950
2007	0.7 %	0.2 %	27,641	3,741,722

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children 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
2011_2012	7.2 %	0.9 %	255,081	3,552,777
2007	7.0 %	1.0 %	261,777	3,737,898

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children 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
2011_2012	65.2 %	5.1 %	263,625	404,570
2007	61.4 %	6.6 %	144,514	235,493
2003	57.7 %	5.6 %	178,600	309,782

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children 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
2011_2012	83.2 %	1.3 %	3,547,871	4,266,077
2007	83.4 %	1.3 %	3,684,697	4,420,982
2003	83.2 %	1.1 %	3,742,722	4,498,836

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	32.4 %	2.2 %	595,108	1,835,215
2007	32.9 %	2.2 %	629,579	1,914,847
2003	30.9 %	1.9 %	611,888	1,978,692

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	30.1 %	0.1 %	58,788	195,413
2012	31.3 %	0.1 %	59,355	189,928
2010	33.3 %	0.1 %	62,211	186,760
2008	33.5 %	0.1 %	56,481	168,629

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	27.0 %	1.1 %	192,862	713,323
2013	24.4 %	0.9 %	173,389	711,539
2011	25.8 %	1.0 %	200,200	777,042
2009	26.1 %	1.2 %	166,963	639,137
2007	26.9 %	0.9 %	200,383	745,792
2005	27.1 %	1.1 %	207,294	765,158

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.5 %	0.1 %	105,108	4,203,284
2014	3.4 %	0.2 %	142,448	4,218,611
2013	4.1 %	0.2 %	172,518	4,229,729
2012	4.0 %	0.2 %	170,847	4,255,688
2011	4.4 %	0.2 %	188,067	4,276,363
2010	4.8 %	0.2 %	205,478	4,310,594
2009	4.8 %	0.2 %	211,576	4,422,300

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	71.9 %	2.3 %	240,896	334,940
2014	70.7 %	2.7 %	239,796	338,984
2013	72.2 %	2.6 %	246,514	341,428
2012	63.7 %	2.3 %	218,450	343,098
2011	61.3 %	2.7 %	213,239	347,888
2010	49.0 %	2.8 %	172,031	351,332
2009	47.8 %	2.7 %	175,404	367,087

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children 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
2015_2016	65.6 %	1.3 %	2,586,217	3,943,606
2014_2015	67.0 %	1.4 %	2,665,415	3,975,858
2013_2014	64.5 %	1.3 %	2,569,841	3,983,768
2012_2013	60.9 %	1.4 %	2,443,270	4,014,396
2011_2012	54.8 %	1.8 %	2,235,474	4,081,388
2010_2011	54.3 %	1.8 %	2,196,305	4,044,760
2009_2010	47.8 %	2.4 %	1,749,743	3,660,551

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	62.3 %	3.3 %	363,188	583,147
2014	58.8 %	3.8 %	346,257	588,802
2013	61.7 %	3.2 %	364,115	589,991
2012	56.0 %	3.6 %	333,275	595,307
2011	46.6 %	3.0 %	282,584	605,855
2010	56.2 %	3.4 %	345,502	614,347
2009	48.8 %	3.8 %	310,829	636,755

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	60.3 %	3.1 %	367,313	609,178
2014	49.8 %	3.5 %	306,506	615,513
2013	38.6 %	3.1 %	238,089	616,868
2012	17.9 %	2.6 %	111,455	621,393
2011	6.4 %	1.4 %	40,463	632,743

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	89.0 %	1.5 %	1,061,525	1,192,326
2014	91.5 %	1.5 %	1,101,490	1,204,315
2013	89.5 %	1.5 %	1,079,545	1,206,859
2012	90.3 %	1.5 %	1,098,346	1,216,701
2011	88.5 %	1.3 %	1,096,560	1,238,598
2010	82.9 %	1.8 %	1,041,143	1,255,446
2009	69.2 %	2.4 %	901,124	1,302,154

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	86.2 %	1.6 %	1,028,154	1,192,326
2014	79.6 %	2.1 %	958,880	1,204,315
2013	83.4 %	1.7 %	1,005,909	1,206,859
2012	78.5 %	2.1 %	954,645	1,216,701
2011	74.9 %	1.9 %	927,636	1,238,598
2010	71.2 %	2.3 %	893,640	1,255,446
2009	62.9 %	2.6 %	818,840	1,302,154

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: New York

NPM 1 - Percent of women with a past year preventive medical visit

Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	73.4
Annual Indicator	68.4
Numerator	2,471,455
Denominator	3,612,104
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	73.8	74.2	74.7	75.1	75.6	76.1

Field Level Notes for Form 10a NPMs:

None

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

FAD for this measure is not available for the State.

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	91.0	92.0	93.0	94.0	94.5	94.9

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	67.1
Annual Indicator	63.9
Numerator	135,686
Denominator	212,507
Data Source	PRAMS
Data Source Year	2013

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

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	67.6	68.1	68.6	69.1	69.6	70.4

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
NYS PRAMS 2014 preliminary data as of 5/22/2017
Annual Objectives based on statewide data:
2017 67.1
2018 67.8
2019 68.4
2020 69.1
2021 69.8

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	33.2
Annual Indicator	21.3
Numerator	237,057
Denominator	1,115,288
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	35.6	38.0	40.4	42.8	44.0	48.4

Field Level Notes for Form 10a NPMs:

None

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CHILD	
	2016
Annual Objective	27.1
Annual Indicator	30.0
Numerator	414,344
Denominator	1,379,538
Data Source	NSCH-CHILD
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	27.5	27.8	28.1	28.5	29.0	31.9

Field Level Notes for Form 10a NPMs:

None

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Adolescent Health)

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	27.1
Annual Indicator	23.3
Numerator	161,704
Denominator	694,960
Data Source	YRBSS-ADOLESCENT
Data Source Year	2015

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT	
	2016
Annual Objective	27.1
Annual Indicator	19.6
Numerator	289,706
Denominator	1,477,307
Data Source	NSCH-ADOLESCENT
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	27.5	27.8	28.1	28.5	29.0	31.9

Field Level Notes for Form 10a 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
Annual Objective	94.9
Annual Indicator	90.7
Numerator	1,346,186
Denominator	1,483,708
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	95.6	96.2	96.9	97.6	98.0	98.6

Field Level Notes for Form 10a NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	41.9
Annual Indicator	39.7
Numerator	100,326
Denominator	252,737
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	42.4	42.6	42.9	43.3	43.8	46.6

Field Level Notes for Form 10a NPMs:

None

NPM 13 - A) Percent of women who had a dental visit during pregnancy

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	57.2
Annual Indicator	54.9
Numerator	117,570
Denominator	214,301
Data Source	PRAMS
Data Source Year	2013

State Provided Data	
	2016
Annual Objective	57.2
Annual Indicator	53.8
Numerator	
Denominator	
Data Source	PRAMS NYS
Data Source Year	2014
Provisional or Final ?	Provisional

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	57.6	58.2	58.8	59.3	59.9	60.5

Field Level Notes for Form 10a NPMs:

None

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	77.8
Annual Indicator	77.1
Numerator	3,075,807
Denominator	3,991,985
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	78.5	79.3	80.0	80.7	81.2	82.0

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: New York

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	37.3
Numerator	
Denominator	
Data Source	BRFSS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	45.0	48.0	51.0	53.0	56.0	56.0

Field Level Notes for Form 10a SPMs:

None

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
Annual Objective	
Annual Indicator	27
Numerator	
Denominator	
Data Source	Medicaid Claims
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	8.0	10.0	12.0	14.0	16.0	27.5

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
NYSDOH OQPS created a CMS Developmental Measure of most and moderately effective contraception use in females 15-44 years of age.

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	To Be Developed
Data Source Year	2017-2018
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	50.0	50.0	52.0	55.0	56.0

Field Level Notes for Form 10a SPMs:

None

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
Annual Objective	
Annual Indicator	61.6
Numerator	673
Denominator	1,092
Data Source	New York Family Survey
Data Source Year	2015-2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	65.0	65.5	66.0	66.5	67.0	67.5

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Data collection: 7/1/2015-6/30/2016	

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	72.0	73.0	75.0	77.0	78.5	78.5

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)

State: New York

ESM 1.1 - Number of Title V programs for which health equity analyses are completed

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	5
Numerator	
Denominator	
Data Source	Title V Program Records
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	10.0	15.0	20.0	25.0	25.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.2 - a) Number of Equity Action Team meetings held; b) Number of DFH staff who have completed one or more Equity Learning Labs

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	50
Numerator	
Denominator	
Data Source	Title V Program recoDFH Personnel training records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	30.0	40.0	50.0	60.0	60.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
b. 6 staff completed learning equity labs

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
Annual Objective	
Annual Indicator	5
Numerator	
Denominator	
Data Source	Title V Program Records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	40.0	50.0	60.0	70.0	80.0	90.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.4 - Percentage of DFH procurements that demonstrate inclusion of evidence-based/-informed community engagement and collective impact strategies.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	47
Numerator	
Denominator	
Data Source	Title V Program records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	40.0	50.0	60.0	70.0	80.0	90.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.5 - The number of Title V programs with health insurance elements incorporated in program requirements.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	12.0	14.0	18.0	19.0	20.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
11 of 19 Title V programs incorporated health insurance elements in program requirements

ESM 1.6 - The number of analytic reports developed and shared.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
11 out of 17 Relevant Title V programs incorporated strategies to reinforce well-woman and preconception health care services.

ESM 1.8 - Maternal mortality report issued at least annually.

Measure Status:	Inactive - Completed

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 1.9 - Severe maternal morbidity surveillance initiated and operationalized by program.

Measure Status:	Inactive - Completed

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 1.10 - Number of policy, community prevention or clinical quality improvement strategies implemented in past year as a result of the Partnership collaboration.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1
Numerator	
Denominator	
Data Source	Partnership activity reports, meeting minutes.
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.11 - Percentage of managed care organizations that provide reimbursement for postpartum LARC insertion.

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	100
Numerator	
Denominator	
Data Source	Medicaid Managed Care Program
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	20.0	30.0	35.0	40.0	50.0	55.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
NYS policy is for all managed care organizations to provide reimbursement for postpartum LARC insertion.

ESM 1.12 - Percentage of women enrolled in Medicaid Managed Care who are screened for maternal depression during a) prenatal care; b) postpartum care.

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	85
Numerator	
Denominator	
Data Source	Medicaid Prenatal Care Quality Improvement Project
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	87.0	89.0	90.0	92.0	94.0	94.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: A. Prenatal Care Annual Indicator: 85.0 % B. Postpartum Care Annual Indicator: 84.4 % Annual Objective: 96.0 %	

ESM 1.13 - Title V staff participate in intra-and inter-agency groups developing response to opioid use.

Measure Status:	Inactive - Pursuant to a discussion at NY's HRSA Title V review, several ESMs that are more process oriented will be retired, however the information will be rep

State Provided Data	
	2016
Annual Objective	
Annual Indicator	4
Numerator	
Denominator	
Data Source	NYS Title V Programs Records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	5.0	5.0	5.0	5.0	5.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	87.0	89.0	90.0	92.0	94.0	94.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	50.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 3.2 - Number of home visiting and community health worker staff trained in the identified competencies.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	63.1
Numerator	
Denominator	
Data Source	MICHC and MIECHV
Data Source Year	FY 2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	75.0	80.0	85.0	90.0	95.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.1 - Initial infant mortality and morbidity data report published.

Measure Status:	Inactive - Completed

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 5.2 - Percentage of eligible birthing hospitals participating in a current QI activity.

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	66
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	15.0	15.0	30.0	30.0	40.0	40.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.3 - Capacity rates of local home visiting grantee projects (to be aligned with new MIEHCV performance measure, currently pending from HRSA MCHB).

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	65
Numerator	
Denominator	
Data Source	Nurse-Family PEO and HFNY database
Data Source Year	FY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	65.0	85.0	85.0	90.0	90.0	90.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.4 - Number of collaborative strategies implemented to reduce sleep-related infant death.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1
Numerator	
Denominator	
Data Source	NYS Title V Program data
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	90.0	90.0	90.0	90.0	90.0	90.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.1 - Initial data report is issued.

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: 1 report	

ESM 6.2 - Number of child-serving MCH programs implementing the asset profile tool.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	NYS Title V Program records.
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Data not available ye	

ESM 6.3 - Number of DOH MCH staff and external partners trained on: a) social-emotional wellness and b) trauma-informed care practices.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	382
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2016-2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	400.0	450.0	500.0	550.0	600.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
b. 218 trained on trauma-informed care practices.

ESM 6.4 - Number of child-serving MCH programs identified with an evidence-based social-emotional component.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	5
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	5.0	6.0	8.0	8.0	8.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
5 of 8 programs identified an evidence-based social-emotional component.

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
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	NYS Medicaid Health Home Data
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	4,000.0	5,000.0	6,000.0	7,000.0	10,000.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Not Available Yet	

ESM 6.6 - Number of strategies implemented to improve developmental screening.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	5
Numerator	
Denominator	
Data Source	Title V Program Records
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.1 - a) Number PBI workgroup meetings held and attended by Title V staff; b) Number of resources are developed and disseminated based on PBI workgroup.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2
Numerator	
Denominator	
Data Source	Title V Program data
Data Source Year	7/16-6/17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
a. 2 of 2 Place Based Initiative (PBI)
b. 0 resources developed 7/2016 - 6/2017

ESM 8.2 - Number of community environmental changes demonstrated as a result of enhanced collaborations.

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
6 collaborations during 7/2016 - 6/2017.

ESM 8.3 - a) Evidence-informed framework to structure and measure collaborative efforts is established or identified; b) Number of internal partners trained; c)Number of external partners trained.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Title V Program data
Data Source Year	7/16-6/17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: a. No b. Not Available c. Not Available	

ESM 10.1 - The number of focus groups conducted.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 10.2 - Initial data report is issued.

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	NYS Title V Program records.
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1,000.0	1,200.0	1,700.0	2,200.0	2,700.0	3,200.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.1 - Initial data report published.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Title V Record data.
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 12.2 - Number of partners engaged in system mapping.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	4
Numerator	
Denominator	
Data Source	Title V Program records
Data Source Year	2016-2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	200.0	650.0	650.0	650.0	650.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: dates: 12/01/2016-3/31/2017	

ESM 12.3 - Number of CSHCN enrolled in Health Homes designated to serve children.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	3,905
Numerator	
Denominator	
Data Source	NYS Office of Health Insurance Programs Health Hom
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4,000.0	4,500.0	5,000.0	5,500.0	6,000.0	6,500.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.4 - Percent of Adolescents/ Young Adults with SCD age 12-21 years in the funded projects who have a transition readiness assessment completed and documented.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	28.1
Numerator	147
Denominator	524
Data Source	Sickle Cell Clinic
Data Source Year	CY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	25.0	50.0	90.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Delay in new contract so future data not available.

ESM 12.5 - Number of best practice strategies for improving family outcomes that are documented through review and learning collaboratives.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	NYS Title V Program records.
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.6 - Percent of children transitioning from EIP to Special Education services who have a documented referral to LHD-based CSHCN Program.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0.7
Numerator	82
Denominator	12,000
Data Source	NYS CSHCN and EI
Data Source Year	2015-16
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.5	2.0	2.5	3.0	3.5

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Data time frame 10/1/2015 - 9/30/2016

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
Annual Objective	
Annual Indicator	63.9
Numerator	4,275
Denominator	6,688
Data Source	NYEHDI
Data Source Year	CY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	45.0	60.0	70.0	75.0	78.0	80.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.8 - Number of DOH MCH staff and external partners trained on: a)social-emotional wellness b)trauma-informed care practices.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	382
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2016-2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	400.0	500.0	550.0	575.0	600.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
a. 382 staff and partners trained on social emotional wellness.
b. 218 staff and partners trained on trauma-informed care.

ESM 12.9 - Number of adolescent-serving MCH programs implementing the asset profile tool.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Not Yet Available	

ESM 12.10 - Number of adolescent-serving MCH programs identified with an evidence-based social-emotional component.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

State Provided Data	
	2016
Annual Objective	
Annual Indicator	15
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	15.0	16.0	18.0	18.0	18.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
15 adolescent serving programs with evidence-based social and emotional component of 18 programs

ESM 12.11 - Number of adolescents with documented serious emotional disturbance and/or complex trauma who are: a) enrolled in Medicaid Health Home; b)transitioned to adult-serving Health Homes.

Measure Status:	Inactive - Replaced

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: a. Not Available Yet b. Not Available Yet	

ESM 13.1 - 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
Annual Objective	
Annual Indicator	58
Numerator	
Denominator	
Data Source	NYS Title V Program records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	20.0	60.0	62.0	64.0	66.0	68.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	61.2
Numerator	
Denominator	
Data Source	SEALS (CDC Data)
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	40.0	41.0	44.0	47.0	50.0	53.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.3 - Number Medicaid claims submitted by primary care providers for application of fluoride varnish for children aged 0-5.

Measure Status:	Inactive - Challenge accessing all necessary data elements for this measure

State Provided Data	
	2016
Annual Objective	
Annual Indicator	9,447
Numerator	
Denominator	
Data Source	CMS Medicaid Claims Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10,000.0	10,000.0	10,000.0	10,000.0	10,000.0	10,000.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.4 - Plan adopted in collaboration with NYSDOH Division of Nutrition to promote integration of oral health strategies in at least one public health nutrition program.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 13.5 - 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
Annual Objective	
Annual Indicator	36.7
Numerator	
Denominator	
Data Source	MICHC reports
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	10.0	20.0	25.0	30.0	35.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.6 - Number of dental public health residents with completed residency projects utilizing data systems in the past year.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	10
Numerator	
Denominator	
Data Source	Preventive Dental Residents and NY Title V Records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	10.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: New York

SPM 1 - The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy
Population Domain(s) – Women/Maternal Health, Cross-Cutting/Life Course

Measure Status:	Active
Goal:	Increase from baseline the percent of women aged 18 to 44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy.
Definition:	**Numerator:** Female BRFSS respondents 18 – 44 years old who are reproductively capable and who report ever talking with their health care provider about ways to prepare for a healthy pregnancy **Denominator:** All female BRFSS respondents 18-44 years old who are reproductively capable **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	N/A
Data Sources and Data Issues:	NYS BRFSS survey data In some survey years, number of respondents meeting criteria for this measure may be small.
Significance:	Incorporating preconception health care in routine health care for all women of reproductive age is critical to several NYS Title V priorities and strategies.

SPM 2 - The percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception.
Population Domain(s) – Women/Maternal Health, Cross-Cutting/Life Course

Measure Status:	Active
Goal:	Increase from baseline the percent of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception
Definition:	**Numerator:** Continuously enrolled female Medicaid recipients, 15-44 years of age, at risk for unintended pregnancy, initiating or continuing use of most or moderately effective contraception in the assessment period (year). **Denominator:** Continuously enrolled female Medicaid recipients, 15-44 years of age at risk for unintended pregnancy **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	FP – 16: Increase the percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception. HP2020 uses the National Survey of Family Health to measure.
Data Sources and Data Issues:	NYS proposes to use Medicaid claims data to measure. NYSDOH OQPS is creating a CMS Developmental Measure of most and moderately effective contraception use in females 15-44 years of age. Baseline to be established and targets for improvement to be determined as part of implementation
Significance:	Unplanned and closely spaced pregnancies have less healthy maternal and infant outcomes. Increased rate of use of most/moderately effective contraception will help improve birth spacing and pregnancy planning. This is a shared priority for Title V and Medicaid in NYS.

SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets
Population Domain(s) – Child Health, Adolescent Health

Measure Status:	Active
Goal:	Increase the percentage of children surveyed who demonstrate 20 or more developmental assets by 10% from baseline
Definition:	**Numerator:** Number of children and adolescents surveyed who demonstrate 20+ developmental assets **Denominator:** Number of children and adolescents surveyed **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	N/A
Data Sources and Data Issues:	Developmental assessment tool to be adopted/ established (tentative consideration for Search Institute tool)
Significance:	Positive social-emotional development and the presence of assets has been associated with positive health and wellbeing outcomes. Measurement of positive developmental assets among young people served by Title V Programs will provide a strong basis for informed youth development activities and interventions.

SPM 4 - The percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale
Definition:	**Numerator:** Number of respondent families participating in Early Intervention who meet the State's standard (person mean >=576) on the New York Impact on Family Scale **Denominator:** Number of respondent families **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	N/A
Data Sources and Data Issues:	Data will be collected using the New York Family Survey, which includes the NYS Impact on Family Scale and is conducted annually with a representative sample of families whose children exited the Part C Early Intervention Program in the year.
Significance:	Positive impact on families, including families of CSHCN, is central to the mission of our Title V Program. This measure is associated with New York's State Systemic Improvement Plan approved by the U.S. Department of Education, Office of Special Education Programs and thus aligns Title V and Early Intervention goals. New York is one of five states focusing on improved family outcomes as part of results-driven accountability for Part C early intervention program for infants and toddlers with disabilities and their families.

SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water
Population Domain(s) – Cross-Cutting/Life Course

Measure Status:	Active
Goal:	Increase the percentage of NYS residents served by community water systems that have optimally fluoridated water
Definition:	**Numerator:** Number of residents served by community water systems with optimal fluoride levels **Denominator:** Number of NYS residents served by community water systems **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	OH13- Increase the proportion of the US population served by community water systems with optimally fluoridated water
Data Sources and Data Issues:	CDC Water Fluoridated Reporting System
Significance:	Community water fluoridation reduces the prevalence and severity of tooth decay

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: New York

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: New York

ESM 1.1 - Number of Title V programs for which health equity analyses are completed
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.
Goal:	Develop and implement a data analysis plan to assess distribution of DFH/Title V resources and services through a health equity lens
Definition:	**Numerator:** Number of Title V programs with health equity analyses completed **Denominator:** N/A **Unit Type:** Count **Unit Number:** 25
Data Sources and Data Issues:	Title V Program records
Significance:	The Title V Program aims to enhance the visibility and application of these data to inform planning and decision-making across our programs. A review of best practice methods for data analysis, including consultation with partners in other program areas engaged in similar work, will be conducted to identify overall approaches to this strategy. Potential applications of resulting data include critical assessments of how distribution of MCH investments align with distribution of need as a factor in developing funding methodologies and review of characteristics of service recipients in relation to characteristics of communities to ensure services are provided equitably or prioritized to those most in need. (Please note: Health disparities will be analyzed for all NYS selected NPMs due to limitations of the system we are unable to reflect this on the form)

ESM 1.2 - a) Number of Equity Action Team meetings held; b) Number of DFH staff who have completed one or more Equity Learning Labs
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.
Goal:	Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs
Definition:	**Numerator:** A) Number of Equity Action Team meetings held; B) Number of DFH staff who completed Equity Learning Labs **Denominator:** N/A **Unit Type:** Count **Unit Number:** 60
Data Sources and Data Issues:	Title V Program records DFH Personnel training records
Significance:	The Title V Program aims to create a highly trained workforce capable of better supporting the MCH Title V funded programs through staff engagement in understanding the systemic inequities both internally and externally. This will enable DFH staff to apply a health equity approach in each aspect of their work ultimately leading to improved overall health disparities in New York State. (Please note: Health disparities will be analyzed for all NYS selected NPMs, due to limitations of the system we are unable to reflect this on the form)

ESM 1.3 - Percentage of DFH procurements that complete community listening forums as part of concept development process.
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	Integrate an equity framework into the development of all DFH/Title V procurements through community listening forums conducted as part of the concept development process.
Definition:	**Numerator:** Number of DFH procurements that include community listening forums as part of concept development process **Denominator:** Number of procurements released by DFH **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Title V Program records
Significance:	Understanding the myriad of social, political, and environmental factors that contribute to issues and factors that drive health disparities is a complex and ongoing task. By providing opportunities for that input in the earliest stages of program development, we will allow for the opportunity to refine the approach and scope of programs to better meet the needs of our priority populations while engaging and empowering affected populations.(Please note: Health disparities will be analyzed for all NYS selected NPMs, due to limitations of the system we are unable to reflect this on the form)

ESM 1.4 - Percentage of DFH procurements that demonstrate inclusion of evidence-based/-informed community engagement and collective impact strategies.
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.
Goal:	Incorporate evidence-based/-informed community engagement and collective impact strategies in all relevant DFH/Title V programs.
Definition:	**Numerator:** Number of DFH procurements that include evidence-based/-informed community engagement and collective impact strategies. **Denominator:** Number of procurements released by DFH **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Title V Program records
Significance:	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. This strategy aims to combine the strength of data-driven, evidence based programs and interventions with authentic community engagement opportunities in all DFH programs.(Please note: Health disparities will be analyzed for all NYS selected NPMs, due to limitations of the system we are unable to reflect this on the form)

ESM 1.5 - The number of Title V programs with health insurance elements incorporated in program requirements.
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Integrate performance standards, measures and improvement strategies related to health insurance enrollment across all Title V/ MCH programs.
Definition:	**Numerator:** Title V programs incorporate health insurance elements in program requirements **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Performance standards, measures and improvement strategies related to health insurance enrollment can be integrated across all Title V/ MCH programs.

ESM 1.6 - The number of analytic reports developed and shared.
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Continue to support preconception/ reproductive health module within state's Behavioral Risk Factor Surveillance System (BRFSS), and produce focused reports of results to inform Title V program and partner strategies.
Definition:	**Numerator:** Analytic reports developed and shared **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	NYS Title V Program records
Significance:	The preconception/ reproductive health module within state's Behavioral Risk Factor Surveillance System (BRFSS) can help produce focused reports of results to inform Title V program and partner strategies.

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 with a past year preventive medical visit

Measure Status:	Active
Goal:	Incorporate performance measures and strategies to reinforce use of well-woman care including pregnancy planning and prevention across core Title V programs serving women of reproductive age.
Definition:	**Numerator:** The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Incorporation of performance measures and strategies can reinforce use of well-woman care including pregnancy planning and prevention across core Title V programs serving women of reproductive age.

ESM 1.8 - Maternal mortality report issued at least annually.
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Inactive - Completed
Goal:	Continue maternal death case ascertainment and review process and issue reports of maternal death review findings and trends.
Definition:	**Numerator:** Maternal mortality report issued **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Mortality reports are needed to understand the causes of and contributing factors to maternal deaths to better focus prevention strategies.

ESM 1.9 - Severe maternal morbidity surveillance initiated and operationalized by program.
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Inactive - Completed
Goal:	Expand surveillance and reporting activities to include severe maternal morbidity
Definition:	**Numerator:** Maternal morbidity surveillance initiated **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Studying severe maternal morbidity (SMM) is critical both to preventing maternal morbidity and to strengthening our understanding of maternal death. Incorporating SMM case identification and analysis in surveillance activities will inform clinical and community prevention activities led by both Title V and our partners.

ESM 1.10 - Number of policy, community prevention or clinical quality improvement strategies implemented in past year as a result of the Partnership collaboration.
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	In collaboration with key partners, co-convene the New York State Partnership for Maternal Health to advance a comprehensive maternal health agenda that includes policy, community prevention and clinical quality improvement strategies.
Definition:	**Numerator:** Number of strategies implemented with the Partnership **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	Reports of Partnership activities, meeting minutes.
Significance:	Collaborative strategies in multiple settings must be implemented to improve the health of women of childbearing age.

ESM 1.11 - Percentage of managed care organizations that provide reimbursement for postpartum LARC insertion.
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Inactive - Completed
Goal:	Collaborate with Medicaid to institute reimbursement for immediate postpartum insertion of LARC
Definition:	**Numerator:** Medicaid managed care organizations providing reimbursement for postpartum LARC insertion **Denominator:** The total number of Medicaid managed care organizations **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Medicaid Managed Care Program
Significance:	Managed care organizations need to cover postpartum LARC insertion to increase the number of women receiving this service which would decrease the number of unintended pregnancies.

ESM 1.12 - Percentage of women enrolled in Medicaid Managed Care who are screened for maternal depression during a) prenatal care; b) postpartum care.
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Inactive - Replaced
Goal:	Collaborate with partners to increase screening and follow-up support for maternal depression.
Definition:	**Numerator:** Number of pregnant and postpartum women enrolled in Medicaid Managed Care who are screened for depression during prenatal and postpartum care. **Denominator:** The number of pregnant and postpartum women enrolled in Medicaid who are receiving postpartum care **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Medicaid Prenatal Care Quality Improvement Project data (annual survey of a sample of Medicaid Managed Care prenatal care practices and a sample of their Medicaid prenatal patient population).
Significance:	Increases in screening for perinatal depression will result in increased referral and treatment rates for depression. Nearly 50% of pregnant women are enrolled in Medicaid in NYS.

ESM 1.13 - Title V staff participate in intra-and inter-agency groups developing response to opioid use.
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Inactive - Pursuant to a discussion at NY's HRSA Title V review, several ESMs that are more process oriented will be retired, however the information will be rep
Goal:	Participate in intra- and interagency groups developing response to increased opioid use to ensure maternal and child health perspectives and populations are addressed.
Definition:	**Numerator:** Number of Title V staff that participate in intra-and inter-agency groups developing response to opioid use **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	NYS Title V Program records (inter- and intra-agency workgroup minutes and reports)
Significance:	Title V staff need to participate in opioid workgroups to ensure pregnant and parenting women's needs are addressed in responses developed.

ESM 1.14 - Percentage of women enrolled in Medicaid Managed Care who are screened for maternal depression during postpartum care.
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	Collaborate with partners to increase screening and follow-up support for maternal depression.
Definition:	**Numerator:** Number of postpartum women enrolled in Medicaid Managed Care who are screened for depression during postpartum care. **Denominator:** The number of postpartum women enrolled in Medicaid who are receiving postpartum care. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Medicaid Managed Care
Significance:	Increases in screening for postpartum depression will result in increased referral and treatment rates for depression. Nearly 50% of pregnant women are enrolled in Medicaid in NYS.

ESM 3.1 - Percentage of birthing hospitals re-designated with updated standards.
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Update NYS perinatal regionalization standards and designations and implement updated performance measures for Regional Perinatal Centers and affiliate birthing hospitals.
Definition:	**Numerator:** Number Birthing Facilities Re-designated **Denominator:** Total Number Birthing Facilities in the state **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NYS Title V Program records - current list of birthing facilities and updated list as birthing hospitals are re-designated.
Significance:	It is imperative for NYS to ensure all perinatal hospitals are functioning in accordance with current standards of care for both maternal and infant outcomes. The last comprehensive review of NY's regionalized system was in the early 2000s.

ESM 3.2 - Number of home visiting and community health worker staff trained in the identified competencies.
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:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Provide training & technical assistance to MIECHV & MICHC grantees to enhance competencies of home visitors & community health workers related to pre & interconception health smoking cessation substance abuse safe sleep & breastfeeding promotion.
Definition:	**Numerator:** Number of MIECHV-funded home visiting and MICHC community health worker staff trained in the identified competencies **Denominator:** Number of MIECHV home visitors and MICHC CHWs **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	MICHC and MIECHV program data
Significance:	Both MICHC and MIECHV are part of NY's core Title V infrastructure for reaching, engaging and supporting MCH populations, in particular high-need women, infants and families. These topics will be incorporated within training and other QI strategies for local MIECHV home visitors and MICHC community health workers to strengthen their competency and skill to work directly with families in these areas.

ESM 5.1 - Initial infant mortality and morbidity data report published.
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Inactive - Completed
Goal:	Develop and implement an expanded plan for analysis and reporting of infant mortality and selected morbidity data, and issue initial data report.
Definition:	**Numerator:** Initial infant mortality report issued. **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Public health surveillance and data analysis in each population health domain are an essential public health function to inform ongoing program and policy development, implementation and evaluation. As part of our action plan, Title V staff will review available sources of data and relevant methods to develop an updated plan for analysis and reporting of infant health data.

ESM 5.2 - Percentage of eligible birthing hospitals participating in a current QI activity.
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Inactive - Replaced
Goal:	Continue to convene and lead structured statewide clinical quality improvement initiatives in birthing hospitals through the NYS Perinatal Quality Collaborative (NYSPQC).
Definition:	**Numerator:** Number of Birthing Facilities Participating in a Specific QI Project **Denominator:** Number of Birthing Facilities Eligible to Participate **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NYS Title V Program records - list of birthing facilities participating in relevant projects
Significance:	The more facilities that are actively engaged in QI activities, the more rapidly improvements can be disseminated resulting in improvement of maternal and child health outcomes.

ESM 5.3 - Capacity rates of local home visiting grantee projects (to be aligned with new MIEHCV performance measure, currently pending from HRSA MCHB).
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Work with local home visiting grantees to increase capacity of established programs through improvements in outreach, enrollment and retention of eligible families.
Definition:	**Numerator:** Number of clients enrolled in MIECHV-funded home visiting programs **Denominator:** Total number of clients that can be enrolled in MIECHV-funded home visiting programs based on funding **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Nurse-Family Partnership Efforts to Outcomes database and Healthy Families New York database Note: data definition will be adjusted as needed to be aligned with new national MIEHCV performance measure, currently pending from HRSA MCHB
Significance:	When percent capacity is increased, more families are served and therefore benefit from enrollment in MIECHV-funded evidence-based home visiting programs.

ESM 5.4 - Number of collaborative strategies implemented to reduce sleep-related infant death.
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Lead collaborative strategies to reduce sleep-related infant death
Definition:	**Numerator:** Number of strategies implemented **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Title V Program data
Significance:	Strengthening collaborations with internal and external partners ensures that safe sleep messages are as widely spread as possible.

ESM 5.5 - Percent of infants, sleeping or awake-and-unattended in crib, in a safe sleep environment
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Active
Goal:	To reduce infant sleep-related deaths in NYS by improving safe sleep practices for infants in the hospital.
Definition:	**Numerator:** Number of infants, sleeping or awake and unattended in crib, positioned supine, in safe clothing, with head of crib flat and crib free of objects **Denominator:** Number of cribs audited **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NYSQPC NYS birthing hospitals submit data through the NYSDOH Health Commerce System. This data is currently submitted by 72/124 (58%) hospitals and can be a sample of 20 per month, so it is not necessarily representative of all birthing hospitals throughout the state.
Significance:	A higher percentage of infants in a safe sleep environment in the hospital will lead to better understanding of safe sleep practices by the parents/caregivers.

ESM 6.1 - Initial data report is issued.
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Inactive - Completed
Goal:	Develop and implement a plan for analysis and reporting of available data on children's social-emotional well-being and adverse childhood experiences (ACES).
Definition:	**Numerator:** A data plan is developed and implemented **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records
Significance:	As a fundamental starting point for public health work, population and program data are needed to help drive and evaluate work in this emerging area, both within Title V programs and with external partners.

ESM 6.2 - Number of child-serving MCH programs implementing the asset profile tool.
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Identify, pilot test and implement validated tool for measuring positive developmental social-emotional assets among children and adolescents that can be used across MCH child-serving programs.
Definition:	**Numerator:** Number of child-serving programs implementing an asset profile tool **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Research has demonstrated that children with more developmental assets are more likely to engage in positive behaviors and less likely to engage in negative behaviors; the NYS MCH programs will implement a validated tool to assess the children being served to identify and prioritize efforts to improve children's social emotional development.

ESM 6.3 - Number of DOH MCH staff and external partners trained on: a) social-emotional wellness and b) trauma-informed care practices.
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	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.
Definition:	**Numerator:** Number of DOH MCH staff and external partners trained on social-emotional wellness; and, Number of DOH MCH staff and external partners trained on trauma-informed care **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Providing DOH MCH staff and external partners training on social-emotional wellness and trauma-informed practices will increase capacity for supporting social-emotional development and wellbeing of children.

ESM 6.4 - Number of child-serving MCH programs identified with an evidence-based social-emotional component.
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Identify, support and integrate evidence-based/-informed strategies to promote children's social-emotional wellness and positive developmental assets through established Title V programs.
Definition:	**Numerator:** Number of child-serving programs with evidence-based SE component **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Programs implementing evidence-based social-emotional components help strengthen developmental assets, self-awareness, relationship skills, decision-making skills, as well as attitudes about self, others, and education, which has been demonstrated to be positively associated with positive health outcomes.

ESM 6.5 - Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Active
Goal:	Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for eligible children and adolescents with serious emotional disturbance and complex trauma.
Definition:	**Numerator:** Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10,000
Data Sources and Data Issues:	NYS Medicaid Health Home Data
Significance:	Children enrolled in a Medicaid Health Home are more likely to access key health care services and receive coordinated care across multiple systems, which may lead to better health outcomes and reduction of unnecessary emergency room visits and hospital stays.

ESM 6.6 - Number of strategies implemented to improve developmental screening.
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.
Goal:	Collaborate with partners to improve developmental screening in NYS.
Definition:	**Numerator:** Number of strategies implemented to improve developmental screening **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Title V Program Records
Significance:	The significant interest in developmental screening across many stakeholders and organizations in NYS creates both opportunity for collective impact as well as the challenge of coordinating and leveraging multiple partners and interests. The Title V Program is positioned to provide leadership in facilitating connections between partners and advancing collaborative strategies that span health insurance, health care and community-based settings and partners across the state.

ESM 8.1 - a) Number PBI workgroup meetings held and attended by Title V staff; b) Number of resources are developed and disseminated based on PBI workgroup.
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.
Goal:	Continue and increase Title V staff leadership and participation in the DOH Place-Based Initiative (PBI) work group.
Definition:	**Numerator:** A) Number of PBI workgroup meetings and B) Number of resources developed **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Title V Program data
Significance:	Public health approaches aimed at supporting healthy communities are the focus of a new place based initiatives (PBI) multidisciplinary team within NYSDOH. Title V staff can play a significant role in this process

ESM 8.2 - Number of community environmental changes demonstrated as a result of enhanced collaborations.
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Enhance collaboration with key partners to advance changes in community environments that promote maternal and child health
Definition:	**Numerator:** Number of community changes demonstrated as a result of Title V collaborations **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	Title V Program data
Significance:	Enhanced collaboration with key partners will promote maternal and child health as part of larger community environmental change initiatives.

ESM 8.3 - a) Evidence-informed framework to structure and measure collaborative efforts is established or identified; b) Number of internal partners trained; c)Number of external partners trained.
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.
Goal:	Establish or adopt an evidence-informed framework for structuring, measuring and improving collaboration at state and community levels, and provide support to strengthen both internal and external partner capacity to implement the framework across MC
Definition:	**Numerator:** Evidence-informed framework to structure and measure collaborative efforts is established/ identified; Internal and external partners trained in evidence-informed framework to structure & measure collaborative efforts. **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Title V Program data
Significance:	Measurement of collaborative effort will inform ongoing strategies

ESM 10.2 - Initial data report is issued.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Inactive - Completed
Goal:	Develop and implement a plan for analysis and reporting of available data on adolescent's social-emotional well-being and adverse childhood experiences (ACES), including Youth Risk Behavior Survey (YRBS) and forthcoming revised National Survey of Chi
Definition:	**Numerator:** A data plan is developed and implemented **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records
Significance:	As a fundamental starting point for public health work, population and program data are needed to help drive and evaluate work in this emerging area, both within Title V programs and with external partners.

ESM 10.1 - The number of focus groups conducted.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	With ACT For Youth Center of Excellence, convene focus groups & review literature to identify contributing factors & effective strategies for improving preventive health care service delivery to adolescents, with a focus on reducing disparities.
Definition:	**Numerator:** The number of focus groups conducted **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Title V Program records
Significance:	These focus groups can identify contributing factors and effective strategies for improving preventive health care service delivery to adolescents.

ESM 10.3 - Number of adolescents with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for young adults with serious emotional disturbance and complex trauma.
Definition:	**Numerator:** Number with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20,000
Data Sources and Data Issues:	NYS Medicaid Health Home Data
Significance:	Adolescents enrolled in a Medicaid Health Home are more likely to access key health care services and receive coordinated care across multiple systems, which may lead to better health outcomes and reduction of unnecessary emergency room visits and hospital stays.

ESM 10.4 - Number of strategies implemented to improve adolescent use of preventive health care services.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Improve adolescent access to/utilization of preventive health care by implementing strategies to support adolescent access to preventive care through BWIAH programs serving adolescents.
Definition:	**Numerator:** Number of actions taken to develop strategies (i.e. literature review, surveys, focus groups) **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	NYS Title V staff reporting activities completed. (Eventually, number of BWIAH programs serving adolescents which have implemented strategies)
Significance:	Adolescents having access to preventive care services will aid in healthy lifestyle and healthy behavior choices, knowledge for those with existing chronic conditions, and encourages the adolescent to manage care for themselves.

ESM 12.1 - Initial data report published.
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Develop and implement a plan for analysis and reporting of CSCHN data for NYS, including forthcoming data from revised National Survey of Children's Health, and issue initial data report
Definition:	**Numerator:** A data plan is developed and implemented **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Title V Record of report issued
Significance:	Understanding of CSHCN health status, issues and service needs in NYS is essential for program planning

ESM 12.2 - Number of partners engaged in system mapping.
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Engage parents, families and providers in a system mapping exercise to identify the gaps and barriers in the system of public health programs and services for CSHCN and their families
Definition:	**Numerator:** Number of partners engaged in the systems mapping process **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Title V Program records
Significance:	A comprehensive, family center integrated system of care is necessary to support CSHCN and their families. Creation of the systems map will inform Title V Programs of the access to availability of services for CSHCN and their families and will facilitate planning to improve supports and services. The number of partners participating in systems mapping will be recorded in units.

ESM 12.3 - Number of CSHCN enrolled in Health Homes designated to serve children.
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Provide subject matter and technical support to NYS Medicaid Program to implement enhanced care coordination and transition support services for CSHCN through Children's Health Homes.
Definition:	**Numerator:** Actual number of Medicaid children 0-18 enrolled in Health Homes **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10,000
Data Sources and Data Issues:	NYS Office of Health Insurance Programs Health Home data.
Significance:	Enhanced care coordination provided within Health Homes aims to improve quality outcomes and the experience of care for CSHCN and their families by connecting and partnering with multiple systems involved in the child's care (Early Intervention, foster care, juvenile justice and the educational system).

ESM 12.4 - Percent of Adolescents/ Young Adults with SCD age 12-21 years in the funded projects who have a transition readiness assessment completed and documented.
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

<table>
<tr><td>Measure Status:</td><td>Inactive - Pursuant to discussion at NY’s HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative</td></tr>
<tr><td>Goal:</td><td>Provide grant funding and technical assistance to support successful transition to adult services for young adults with Sickle Cell Disease (SCD), and evaluate projects to identify best practices for enhancing transition support to other key CSHCN po</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of AYA/SCD ages 12-21 that have an annual readiness assessment documented in their medical records.</td></tr>
<tr><td>Denominator:</td><td>Number of AYA/SCD registered in the practice</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>Data Source: Sickle Cell Clinic patient registry of AYA/SCD ages 12-21
Data Issues:
AYA/SCD may be sporadic attendees at a specific clinic.
The database will need to be continually updated to track those 12 year-olds entering transition and those 18 – 21 year-olds transitioning out.</td></tr>
<tr><td>Significance:</td><td>Assessment of readiness of AYA/SCD can identify gaps in knowledge about their disease, daily care, response to crises and ability to communicate with hospital and emergency personnel who may be unfamiliar with the presentation of SCD.</td></tr>
</table>

ESM 12.5 - Number of best practice strategies for improving family outcomes that are documented through review and learning collaboratives.
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

<table>
<tr><td>Measure Status:</td><td>Inactive - Pursuant to discussion at NY’s HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative</td></tr>
<tr><td>Goal:</td><td>Collaborate with University Centers for Excellence in Developmental Disabilities Education, Research, & Service (UCEDD) and other stakeholders implement NY’s IDEA Part C State Systemic Improvement Plan (SSIP).</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of best practice strategies for improving family outcomes documented through evidence-based review and learning collaboratives.</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>1</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data sources will for this measure will be a catalogue of evidence-based family-centered services prepared by Department contractors; and, process measures to be collected by learning collaboratives convened to improve family-centered service delivery.</td></tr>
<tr><td>Significance:</td><td>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. 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.</td></tr>
</table>

ESM 12.6 - Percent of children transitioning from EIP to Special Education services who have a documented referral to LHD-based CSHCN Program.
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Use EI family survey data to inform CSHCN Program, of the needs of families transitioning from EI to CSHCN Program in order to better coordinate services.
Definition:	**Numerator:** Number of children in the Part C EIP transitioning to Preschool Special Education with a referral to local CSHCN Program. **Denominator:** Number of children in the EIP transitioned to Preschool Special Education **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NYS DOH Children with Special Health Care Needs Program data, and NYS DOH Early Intervention Program data.
Significance:	A warm handoff between programs within a local Health Department will assist families as they transition from Part C EIP to Preschool Special Education.

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 who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Provide technical assistance and facilitate a structured quality improvement project to engage health care providers, parent representatives, & audiologists to improve reporting of initial hearing screening and follow up results into the NYEHDI-IS.
Definition:	**Numerator:** Number of infants who receive a follow-up hearing screening, diagnostic evaluation or referral to Early Intervention that is documented in NYEHDI-IS **Denominator:** Number of infants who receive an abnormal newborn hearing screening. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NYEHDI System Data
Significance:	Infants with abnormal hearing screening will have follow-up.

ESM 12.9 - Number of adolescent-serving MCH programs implementing the asset profile tool.
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Identify, pilot test and implement a framework and validated tool for measuring developmental social-emotional assets among children and adolescents that can be used across MCH programs.
Definition:	**Numerator:** Number of adolescent-serving programs implementing an asset profile tool **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Research has demonstrated that adolescents with more developmental assets are more likely to engage in positive behaviors and less likely to engage in negative behaviors; the NYS MCH programs will implement a validated tool to assess the adolescents being served to identify and prioritize efforts to improve adolescent's social emotional development.

ESM 12.8 - Number of DOH MCH staff and external partners trained on: a)social-emotional wellness b)trauma-informed care practices.
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Provide training for Title V staff and external partners, including local adolescent-serving grantees, to increase awareness, knowledge, and skills to support: 1) adolescents' social emotional development and 2) trauma-informed care practices.
Definition:	**Numerator:** A) Number of DOH MCH staff and external partners trained on social-emotional wellness; B) Number of DOH MCH staff and external partners trained on trauma-informed care **Denominator:** N/A **Unit Type:** Count **Unit Number:** 600
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Providing DOH MCH staff and external partners training on social-emotional wellness and trauma-informed practices will increase capacity for supporting social-emotional development and wellbeing of adolescents.

ESM 12.10 - Number of adolescent-serving MCH programs identified with an evidence-based social-emotional component.
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Identify, support and integrate evidence-based/-informed strategies to promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs
Definition:	**Numerator:** Number of child-serving programs with evidence-based SE component **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Programs implementing evidence-based social-emotional components help strengthen developmental assets, self-awareness, relationship skills, decision-making skills, as well as attitudes about self, others, and education, which has been demonstrated to be positively associated with positive health outcomes.

ESM 12.11 - Number of adolescents with documented serious emotional disturbance and/or complex trauma who are: a) enrolled in Medicaid Health Home; b)transitioned to adult-serving Health Homes.
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Inactive - Replaced
Goal:	Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination and transition supports for eligible youth and young adults with serious emotional disturbance and complex trauma.
Definition:	**Numerator:** Number with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home; Number with documented serious emotional disturbance and/or complex trauma who are transitioned to adult-serving Health Homes. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	NYS Medicaid Health Home Data
Significance:	Adolescents enrolled in a Medicaid Health Home and successfully transitioned to adult-serving Health Homes are more likely to access key health care services and receive coordinated care across multiple systems, which may lead to better health outcomes and reduction of unnecessary emergency room visits and hospital stays.

ESM 13.1 - Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Provide financial and technical support for maintenance and expansion of community water fluoridation.
Definition:	**Numerator:** Number of public water systems that receive financial and/or technical support from NYSDOH **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	NYS Title V Program records
Significance:	CWF improves oral health by reducing the prevalence and severity of tooth decay. DOH provides financial and other technical assistance directly and via contractor to support local water systems.

ESM 13.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants. NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the delivery of evidence-based preventive dental services across key settings: • school-based clinics • primary care practices • public health nutrition programs.
Definition:	**Numerator:** Number of 2nd and 3rd grade children who received sealants in School-Based Health Center – Dental (SBHC-D) **Denominator:** Number of children in 2nd and 3rd grade who are enrolled in SBHC-D programs **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	SEALS/ CDC Data
Significance:	Evidence based programs such as school-based or linked dental sealant programs have the potential to reduce the burden of oral diseases.

ESM 13.3 - Number Medicaid claims submitted by primary care providers for application of fluoride varnish for children aged 0-5.
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Measure Status:	Inactive - Challenge accessing all necessary data elements for this measure
Goal:	Increase the delivery of evidence-based preventive dental services across key settings: • school-based clinics • primary care practices • public health nutrition programs
Definition:	**Numerator:** Number of Medicaid claims for fluoride varnish for children ages 0-5 **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20,000
Data Sources and Data Issues:	CMS Medicaid Claims Data
Significance:	Dental caries, or tooth decay, is the most common chronic disease among children, dental care being the greatest unmet service need. If untreated, dental caries is often painful and can disrupt learning, school performance and daily activities. In extreme cases, dental caries is fatal. Dental care accounts for almost 15 percent of all health care expenditures among school-aged children. Insurance coverage is uneven and out-of-pocket expense is significant.

ESM 13.4 - Plan adopted in collaboration with NYSDOH Division of Nutrition to promote integration of oral health strategies in at least one public health nutrition program.
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative
Goal:	Increase the delivery of evidence-based preventive dental services across key settings: • school-based clinics • primary care practices • public health nutrition programs
Definition:	**Numerator:** Collaborative plan is adopted **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Partnering with providers across a variety of settings can enhance the delivery of evidence-based services to underserved children, including those who may not access dental care in traditional settings. Public health nutrition programs are a promising setting for promotion/ reinforcement of tooth brushing and other family oral hygiene practices.

ESM 13.5 - Percentage of pregnant women served by Title V community health workers that have a documented screening or referral for dental services.
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Integrate oral health messages and strategies within existing community-based maternal and infant health programs.
Definition:	<table><tr><td>**Numerator:**</td><td>Number of pregnant women served by the Title V community health workers that have a documented screening or referral for dental services</td></tr><tr><td>**Denominator:**</td><td>Number of pregnant women served by Title V community health workers</td></tr><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr></table>
Data Sources and Data Issues:	Reports from MICHC grant (Bureau of Women, Infant and Adolescent Health)
Significance:	Our current pilot project promotes community-level systems changes to integrate oral hygiene practices and information about services within MICHC and link families with dental services. Successful strategies gleaned from this initiative will be disseminated to other MICHC, and potentially other home visiting projects.

ESM 13.6 - Number of dental public health residents with completed residency projects utilizing data systems in the past year.
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Measure Status:	Inactive - Pursuant to discussion at NY's HRSA review, ESMs that are more process oriented will be retired but the information will be reported in the narrative.
Goal:	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.
Definition:	**Numerator:** Number of dental public health residents w/ completed dental residency projects utilizing data systems in past year **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	NYS Title V Program and Preventive Dental Residents Program Records
Significance:	Enhancement and expansion of the current system will provide an increase in the number of public health dentists with the capacity to perform data analysis and oral health surveillance. Residents build public health competencies to help them address data needed to identify problems, set priorities, establish quality improvement measures and assess progress toward goals and objectives.

Form 11
Other State Data

State: New York

The Form 11 data are available for review via the link below.

Form 11 Data

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

Abbreviated State Action Plan Table

State: New York

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce maternal mortality and morbidity	NPM 1 - Well-Woman Visit	ESM 1.1 *Inactive* ESM 1.2 *Inactive* ESM 1.3 ESM 1.4 *Inactive* ESM 1.5 *Inactive* ESM 1.6 *Inactive* ESM 1.7 ESM 1.8 *Inactive* ESM 1.9 *Inactive* ESM 1.10 *Inactive* ESM 1.11 *Inactive* ESM 1.12 *Inactive* ESM 1.13 *Inactive* ESM 1.14	
Reduce maternal mortality and morbidity			SPM 1
Reduce maternal mortality and morbidity			SPM 2

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce infant mortality & morbidity	NPM 3 - Risk-Appropriate Perinatal Care	ESM 3.1 ESM 3.2 *Inactive*	
Reduce infant mortality & morbidity	NPM 5 - Safe Sleep	ESM 5.1 *Inactive* ESM 5.2 *Inactive* ESM 5.3 *Inactive* ESM 5.4 *Inactive* ESM 5.5	

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Support and enhance social-emotional development and relationships for children and adolescents	NPM 6 - Developmental Screening	ESM 6.1 *Inactive* ESM 6.2 *Inactive* ESM 6.3 *Inactive* ESM 6.4 *Inactive* ESM 6.5 ESM 6.6 *Inactive*	
Support and enhance social-emotional development and relationships for children and adolescents			SPM 3
Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course.	NPM 8 - Physical Activity	ESM 8.1 *Inactive* ESM 8.2 ESM 8.3 *Inactive*	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Support and enhance social-emotional development and relationships for children and adolescents	NPM 10 - Adolescent Well-Visit	ESM 10.1 *Inactive* ESM 10.2 *Inactive* ESM 10.3 ESM 10.4	
			SPM 3
Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course.	NPM 8 - Physical Activity	ESM 8.1 *Inactive* ESM 8.2 ESM 8.3 *Inactive*	

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Increase supports to address the special health care needs of children and youth	NPM 12 - Transition	ESM 12.1 *Inactive* ESM 12.2 *Inactive* ESM 12.3 *Inactive* ESM 12.4 *Inactive* ESM 12.5 *Inactive* ESM 12.6 *Inactive* ESM 12.7 ESM 12.8 *Inactive* ESM 12.9 *Inactive* ESM 12.10 *Inactive* ESM 12.11 *Inactive*	
Increase supports to address the special health care needs of children and youth			SPM 4

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Promote oral health and reduce tooth decay across the life course	NPM 13 - Preventive Dental Visit	ESM 13.1 ESM 13.2 ESM 13.3 *Inactive* ESM 13.4 *Inactive* ESM 13.5 ESM 13.6 *Inactive*	
Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).	NPM 13 - Preventive Dental Visit	ESM 13.1 ESM 13.2 ESM 13.3 *Inactive* ESM 13.4 *Inactive* ESM 13.5 ESM 13.6 *Inactive*	
Increase the use of preventive health care services across the life course.			SPM 1
Increase the use of preventive health care services across the life course.			SPM 2
Promote oral health and reduce tooth decay across the life course			SPM 5
Promote oral health and reduce tooth decay across the life course			SPM 5