NEW YORK STATE
MATERNAL AND CHILD HEALTH SERVICES
TITLE V BLOCK GRANT PROGRAM

2010 APPLICATION / 2008 ANNUAL REPORT

Submitted to:

U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
Office of State and Community Health

Submitted By:

New York State Department of Health
Center for Community Health
Division of Family Health
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Note to the Reader:

The primary purpose of this document is to make application to the Federal government for New York's appropriation under the Maternal and Child Health Services Block Grant (Title V). As such, each State is required to follow very specific instructions for formatting and content, as directed by the Federal Health Resources and Services Administration (HRSA). This document follows the guidance provided by HRSA and reflects grant requirements.

Readers who have questions about the document should contact the Office of the Director, Division of Family Health, New York State Department of Health, Corning Tower, Room 890, Albany, NY 12237-0657.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower, The Governor Nelson A. Rockefeller Empire State Plaza
Albany, New York 12237

Richard Daines, MD
Commissioner

Wendy E. Saunders
Executive Deputy Commissioner

I. A. LETTER OF TRANSMITTAL

July 3, 2009

Cassie Lauver, Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, 18-31
Rockville, Maryland 20857

Dear Ms. Lauver:

With this letter, I transmit New York's FFY 2010 Maternal and Child Health Services Block Grant Application, 2008 Needs Assessment Update and FFY 2008 Annual Report.

New York once more 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,

Barbara L. McTague
Director, NYS Title V Program and
Director, Division of Family Health

Maternal and Child Health Services
Title V Block Grant

State Narrative for
NEW YORK

Application for 2010
Annual Report for 2008

Application for Federal Assistance

OMB Approval No. 0348-0043

		2. DATE SUBMITTED	**Applicant Identifier**
1. TYPE OF SUBMISSION:		**3. DATE RECEIVED BY STATE**	**State Application Identifier**
Application ☙ Construction X Non-Construction	**Pre-application** ☙ Construction ☙ Non-Construction	**4. DATE RECEIVED BY FEDERAL AGENCY**	**FEDERAL IDENTIFIER**

5. APPLICANT INFORMATION

Legal Name: New York State Department of Health	**Organizational Unit:** Division of Family Health
Address ***(give city, county, state, and zip code)*** Division of Family Health 1312 Corning Tower Building Albany, NY 12237-0657	**Name and telephone number of the person to be contacted on matters involving this application** ***(give area code)*** Barbara L. McTague, Director, Division of Family Health, 518-473-7922
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 1 4 – **6013200**	**7. TYPE OF APPLICANT:** ***(Enter appropriate letter in box) A*** **A. State** B. County C. Municipal D. Township E. Interstate F. Intermunicipal G. Special District H. Independent School District I. State Controlled Institution of Higher Learning J. Private University K. Indian Tribe L. Individual M. Profit Organization N. Other (Specify)_____
8. TYPE OF APPLICATION: **X New ☐ Continuation ☐ Revision** **If Revision, enter appropriate letter(s) in box (es)** ☐ ☐ A. Increase Award B. Decrease Award C. Increase Duration Decrease Duration Other *(specify):* _____	**9. NAME OF FEDERAL AGENCY:** Health Resources and Services Administration
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: **93.994** **TITLE: Maternal and Child Health Services Block Grant to the state**	**11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:** Maternal and Child Health Services
12. **AREAS AFFECTED BY PROJECT** ***(cities, counties, states, etc.)*** State: New York State	

13. PROPOSED PROJECT:		**14. CONGRESSIONAL DISTRICTS OF:**	
Start Date **10/1/2009**	**Ending Date** **9/30/11**	**a. Applicant**	**b. Project** NY – All Districts

15. ESTIMATED FUNDING:		**16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?**
a. Federal	$ 41,043,769	**a. YES, THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12373 PROCESS FOR REVIEW ON**
b. Applicant	$ 0.00	**DATE** _____
c. State	$ 363,695,631	**b. NO X PROGRAM IS NOT COVERED BY E.O. 12372**
d. Local	$ 299,499,317	**☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW**
e. Other	$ 0.00	
f. Program Income	$ 176,715,455	**17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT** **☐ Yes If "Yes", attach an explanation X No**
g. TOTAL	$ 880,954,172	

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Typed Name of Authorized Representative **Edward Cahill**	**b. Title** **Director, Fiscal Management Group, Bureau of Budget Management**	**c. Telephone number** **518-473-4263**
d. Signature of Authorized Representative		**e. Date Signed**

Previous Editions Not Usable
Standard Form 424 (REV. 4-88)

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) was sent directly to the Maternal and Child Health Bureau.
/2010/ Per the revised Guidance, the face sheet should now be submitted electronically, and is therefore not being sent in hard copy to MCHB.//2010//

C. Assurances and Certifications

Assurances and Certifications will be kept on file in the office of the Title V Director, New York State Department of Health, Division of Family Health, Corning Tower Room 890, Empire State Plaza, Albany NY 12237-0567. In addition, assurances and certifications are reprinted in hardcopy and web-based versions of the block grant application. Hardcopies are available at the above address. The grant application appears on the New York State Department of Health Website at: www.health.state.ny.us.

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; expires May 31, 2009.
/2010/ In April, 2009, a new Guidance document was released, with the same name and number, but with an expiration date of March 31, 2012.//2010//

E. Public Input

The New York State Department of Health, as New York's Title V agency, has several methods for making this application public and for soliciting, accepting and incorporating public input during its development and after its transmittal. These include:
-using a variety of public interactions /2008/, including outreach to specific stakeholders and populations, to introduce the grant and make known the various ways in which the public can be involved;//2008//
-placing the document on our public website and making hardcopies available through the Division of Family Health;
-an active and involved Advisory Council, statutorily-established as a method of public input, /2010/ and all Advisory Council meetings are broadcast via webcast to ensure availability of information to the public at large, as well as the broad array of professional societies, contractors and other stakeholders//2010//;
-public hearings, rotating locations across the State /2008/ (in 2007, hearings were held in Syracuse and NYC.)//2008//
/2010/ - given the large and diverse nature of maternal and child health programs in New York State, most programs obtain input via the RFP process when the programs competitively solicit for contractors, and many require ongoing input from community advisory councils or residents obtaining services. The contractors awarded funds for programs are also brought together periodically to discuss issues of interest, including new and emerging problems with the populations being served, difficulties in social marketing of

services, more effective ways to outreach to minorities, underserved individuals and children, and ways to make programs more effective. These processes provide excellent opportunities for ensuring that DOH staff are kept abreast of the needs and priorities of our target populations;//2010//
-surveying parents of Children with Special Health Care needs for parent involvement and other relevant issues /2008/, including New York's Family Champions;
-working with a Youth Advisory Committee; //2008//
-conducting focus groups with Title V consumers and Title V-eligible groups across the State;
/2010/ - special meetings or conferences are often convened to engage consumers and advocates directly in the planning process. For example, the annual meeting sponsored by family planning advocates invites adolescents to obtain their input on services and policies, and the perinatal networks and other providers meet every six weeks to discuss issues, and frequently invite state representatives to negotiate concerns and problems, to name just two examples;//2010//
-soliciting advice from the Healthy Start-Title V Collaboration Consumer Group;
-meeting annually with LEND scholars and others providing services to Children with Special Health Care Needs; and
-accepting phone calls, letters, faxes and e-mails regarding the content of the document and the needs of the population. See Section II.
/2010/ -working with other HRSA/MCHB-funded programs, such as the Region 2 New York – Mid-Atlantic Collaborative for Genetics and Newborn Screening Services (NYMAC), to educate the public about Title V activities//2010//

The Needs Assessment document has been updated to include information on what public input was obtained. Results of all public input processes are shared with program staff and agency administration for incorporation into program planning, policies and procedures.

/2010/ The Commissioner's new Prevention Agenda, for example, provided an opportunity for reaction around the state, particularly by hospitals and local health units, which all received information via two webinars provided by the state. The Prevention Agenda includes several maternal and child health indicators, such as infant mortality, low birthweight and very low birthweight births, and trimester of entry to prenatal care. While not solely an MCH vehicle, this new initiative offers a means of engendering public health discussion on key MCH indicators, and on methods of addressing these indicators. //2010//

Each year, New York updates the Glossary in order to facilitate public understanding of the Block Grant process. State-specific abbreviations and information are added to the Federal boilerplate in order to make the block grant application more understandable and readable to its multiple audiences.

An attachment is included in this section.

Attachment:
/2009/ In 2007 in preparation for the FFY 2009 application, public hearings were held in New York City, Buffalo and Albany. Topics brought to the hearing included continued support for the NYS Center for Sudden Infant Death and their services; childhood nutrition; and oral health.

In addition, focus groups were held in the southwestern part of the state to study adolescents' behavior and their perceptions of various risk behavior and health care. The purpose of conducting the focus groups was to assist the Department to evaluate its progress on certain Maternal and Child Health Services Block Grant Performances Measures,

both Federal and State and to improve the services and policies for youth and their families in New York State. New York considers these focus groups to be a very useful addition to other forms of public input. Confidentiality is of the utmost importance. Participants received travel reimbursement, culturally-appropriate nutritious snacks and stipends for their participation.

The populations represented the following:
- Adolescents deemed to be "at risk" for difficulties;
- Adolescents who exhibit signs that they may threaten their successful completion of high school;
- Typical adolescent high school students;
- Young women who have one or more children and are in a GED program;
- Incarcerated males serving their sentence in a county jail.

The areas for discussion included:

- Use of alcohol and drugs related to motor vehicle injury;
- Unintended pregnancy/birth and risk for sexually transmitted diseases;
- Risk for obesity, heart disease and diabetes related to smoking, physical activity and nutrition;
- Access to health care, dental care and mental health care.

The groups were asked to provide recommendations for protective factors, identify risk factors and then ranked (through a scoring methodology), their perceived greatest risk factors as well as their ideas for preventive measures.

The results of the focus groups are being shared with various bureaus and units within the Department that administer and manage adolescent programs.//2009//

/2010/ An adolescent sexual health focus group study was conducted by the ACT for Youth Center of Excellence for the Department. The purpose of project was:
- To learn more about how young people across New York State get information about sexual health, and how they access sexual health care services
- To learn more about young people's experiences with sexual health care services, and to obtain their ideas on how to improve these services
- To help inform New York State Department of Health planning activities
- To provide additional youth voice/youth recommendations at the New York State Sexual Health Symposium

Focus group sites were chosen with particular attention paid to capturing the diversity of New York state youth. Sites were identified based on geographic characteristics including upstate/downstate and rural/urban/suburban as well as participant characteristics including gender/gender identity and race/ethnicity. The final pool of potential focus group sites was narrowed down with input from the NYS DOH. A total of 291 youth participated in 27 focus groups across the State, conducted between July and December 2008.

The recommendations from this project are being shared with various bureaus and units within the Department that administer and manage adolescent programs, and will assist the NYSDOH to plan initiatives to better meet the sexual health needs of New York State youth. The report will be posted on the ACT for Youth web site, www.actforyouth.net //2010//

/2008/Our Family Champions continue to be a vital source of information and support for CSHCN and their family, as well as for the Medical Home Unit /2010/, now known as the

Child Health Unit, //2010//and the Division of Family Health.//2008// The Family Champions group was asked to focus their discussions on the national performance measures related to children with special health care needs and their families and how New York could improve their performance on these measures. /2009/ Through conference calls with Family Champions, the family perspective is obtained about consumer information and tools being developed by the Department. //2009// Each year, New York asks parents to score their participation on the scale that accompanies these performance measures. New York was the first state to include only non-employee parent scores on this scale.

Of the 17 Family Champions, 15 chose to participate in the focus group. For each measure, the Family Champions were asked to identify factors that hindered New York's ability to improve ("Challenges") and factors that they believed would help New York improve its performance ("Potential Solutions") on each measure. The process involved group brainstorming, combining ideas in a common strategy or category, and then having individuals vote for the items they believed to be of greatest importance, thereby establishing priorities for the group. Each parent had five votes. The opinions of the Family Champions regarding the greatest challenges and potential solutions are summarized in the discussion of performance measures in Section IV.

/2008/Parents also have a major role in the policy and program development in the Early Intervention Program. Early Intervention conducts parent policy development training and the Early Intervention Parent Workgroup addresses a variety of service delivery issues. /2010/ There are six parents represented on the Governor-appointed Early Intervention Coordinating Council and its task forces that address a variety of service delivery issues. //2010//

In 2007, the Department added a **Youth Advisory Committee**. The Youth Advisory Committee (YAC) was formed to advise the NYSDOH Children with Special Health Care Needs (CSHCN) Program on what youth need to transition successfully to adulthood in terms of employment, medical care and independent living. YAC members also provided information regarding their experiences with having a medical home and suggested methods for distributing materials and information to assist with the transition process. The YAC will give the youth an opportunity to develop their leadership skills and to be heard on issues that affect them directly.

The Youth Advisory Committee consists of 19 diverse young adults between the ages of 14 /2009/15//2009//-24 from all four regions of the state; five members are from the Capital region, two from the Central region, five from the Western region, and seven from the Metropolitan region. Their race/ethnicity is as follows: three Hispanics, three African Americans, and 13 Caucasians.

These young adults were brought together in the Albany area on April 20-21, 2007 for the first YAC meeting. Reflections from this session indicated that the youth were inspired by the individuals who presented and learned the importance of self- advocacy, perseverance and networking. They were interested in knowing more about accessibility on college campuses, independent living centers, their rights as a person with a disability, and how to drive with a disability that causes limited movement of the hands. The second day of the session focused on specific transition issues. Youth stated that the following would be helpful:

- a list of services that are available to help them live independently;
- information about Medicaid and how it works;
- updates on new technology,

- opportunities for learning life skills and social skills;
- information about good adult physicians who accept their insurance plans;
- someone to take care of their medical and medication needs;
- getting a job;
- learning from the examples of people who have already transitioned;
- making a slow transition from pediatrician to adult provider;
- getting a better understanding what it means to transition;
- having wheelchair accessible housing; and
- lists of doctors that specialize in their particular illnesses.

As an outcome of the first YAC, the youth showed increased knowledge of the Children with Special Health Care Needs Program and their role as youth advisors from the pre- to post-survey. They identified their areas of greatest need in the area of transition as products and actions that can address these needs, and methods of distributing materials and information to improve transition, such as a portable health summary. The YAC members were very informative and enthusiastic. Their reflections indicated that participants enjoyed meeting and sharing with new people and found the meeting to be organized and easy to follow. They plan to share the information that they learned with other organizations with which they are involved. /2009/In 2007, the youth and young adults continued to provide feedback about resources and tools being developed in response to their input from the previous year, and provided examples of items that would be helpful to youth in transitioning from adolescence to adulthood and independence.//2009//

New York is a part of the **New York-Mid-Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC).** NYMAC is currently undertaking a series of focus group meetings for consumers of genetic and specialty health care services and for lay advocates for people with special health care needs. /2009/ In 2007, three of these focus groups were held.//2009// The goal of this effort is to talk directly to those most involved in the care of people with special needs in order to improve the system of care and, ultimately, the health and wellbeing of those with special health care needs. Each meeting asked consumers and advocates to address medical home, health promotion, health insurance, special resources (including educational resources, transportation, and parent and child support), and transition of adolescents and young adults into adult medical care. Staff from the Wadsworth Center reached out to the SSDI Coordinator for her expertise in the organization and conduct of focus groups.//2008// /2009/ The NYMAC Advisory Council and each of the six work groups include members of the lay community. They are actively encouraged, both during meetings and privately, to propose activities or voice concerns about proposed actions.//2009//

Because the ultimate goal of public input is to ensure that services are appropriate to the populations served, results of all public input processes are shared with program staff and agency administration for incorporation into program planning, policies and procedures.

II. Needs Assessment

The updated Needs Assessment is submitted as an attachment to this Narrative.

/2009/ Summary:

New York continues to submit annual updates to its needs assessment not only as a service to the many organizations and individuals who rely on these data for their own planning needs, but also to ensure that the data is collated at least annually to allow course corrections as needed to the many Divisions, Bureaus, Units and Programs within the Department of Health.

Changes to the Needs Assessment include incorporation of NYC PRAMS data, which is presented in contrast to the PRAMS data for the rest of the state, since a combined dataset is not yet available. CDC representatives are working on developing the first-ever statewide sample, which is expected to be ready for reporting in the next MCHSBG application. State Performance Measures are unchanged. All data were updated to reflect the most recent year of data available.

The Needs Assessment provides a description of the needs assessment process, how it relates to priority setting, and how these result in funding decisions. This is not to say, however, that the process is simple or easy to understand. New York State has such a wealth of federal, state, and local programs and resources available to our residents, and an equally if not greater abundance of pockets of need, populations at risk for various conditions, gaps in services, etc., that there is no simple way to describe the multifaceted approach that is taken to priority setting. Nevertheless, this rather lengthy needs assessment section attempts to describe this process, using the most recent data available for decision-making purposes. We have also attempted to make clear that our methods for monitoring ensure that programs are accountable for activities and outcomes, and that this is an iterative process that shapes programs on an ongoing basis to take new methods into account and modify activities that do not meet outcome expectations.

A further purpose served by this needs assessment is that it provides an opportunity for New York State to provide a narrative overview of programs and initiatives in this state that comprise our maternal and child health services. While the outcome and performance objectives in the narrative provide specifics regarding particular topic areas, this approach does not permit an overall picture of our services, as described in the needs assessment.//2009//

/2010/ The current update of the Needs Assessment represents the final year of the five year cycle. New guidance was recently issued which enhances the focus on the process and rationale behind the Needs Assessment and selection of priorities, but given the optional nature of the Needs Assessment in this cycle, and the date of issuance, it was too late to redesign the development process for this year's submission. Instead, an attempt was made to adhere to the new format, and include a description of how the new guidance is already being addressed, and/or will be better addressed for the next 5 year cycle. The changes that will come about as a result of the new guidance involve increased attention to describing the process for engaging stakeholders and formalizing the team which will develop the needs assessment. Particular attention will be given to developing a cohesive rationale and framework for the needs assessment with input from major stakeholders, particularly the MCH Block Grant Advisory Council. The MCH Block Grant Advisory Council has already been informed about the changes in the guidance and the increasing focus on

describing the process and logic behind the process of priority selection, and is anxious to begin discussions at their next meeting in order to provide input into design of these underpinnings of the process.

Additional changes to the Needs Assessment include not only annual updates of data, where available, but also some streamlining to eliminate information extraneous to the process, such as adult causes of death, cancer incidence data, etc. In addition, the order in which topics were presented was changed to improve the flow and promote readability. Information that will be important at the start of the next cycle, but was basically unchanged from previous versions (such as the detailed description of data sources), was placed in an attachment, again to promote readability of the Needs Assessment.

In addition, NYS had planned to include PRAMS data from a statewide file to be developed by CDC, since Upstate and NYC have separate PRAMS studies, and the data cannot be easily combined. However, that file was not received as yet, and will be included in the next Needs Assessment, if available.

Added to the Needs Assessment was further description of information made available on an ongoing basis to the public and our contractors and providers via the Department's website. This helps to underscore in a small way the central role data and outcome indicators play in everyday life in New York State. Particularly in the perinatal arena, where data sources are unusually good and contain a number of key indicators helpful for program planning and evaluation, a wealth of information is made available not only at the state and regional level, but at the county level, and even zip code level, and most often by key demographic variables such as mother's age, education, race/ethnicity, and insurance status.

While reduction/elimination of health disparities represents a central tenet of much of the MCH work that is done in the state, it is so pervasive throughout our programs and activities that the focus placed on eliminating disparities is somewhat vitiated. For this reason, an attempt has been made to underline that focus a bit more in the current Needs Assessment.

//2010//

II. NEEDS ASSESSMENT

A. Needs Assessment Process -- Background and Conceptual Framework

Needs assessment of the maternal and child health population is a continuous and ongoing process, and is one that is critical to program development, to accurate program planning and targeting of services, and to monitoring the effectiveness of interventions. Comprehensive needs assessment requires ongoing sources of information about:

- *Maternal and child risk factors* (age, socioeconomic status, race/ethnicity, education, previous pregnancy history, physical and emotional stressors, intendedness of pregnancy, and maternal knowledge and behaviors);
- *Access to appropriate health care and capacity of the health care system* (entry into prenatal care; adequacy of prenatal care; availability of financially accessible, culturally acceptable and linguistically appropriate services; access to specialty/tertiary level of care; availability of ancillary or enabling services); and
- *Pregnancy and health outcomes* (fetal deaths, infant morbidity and mortality, maternal morbidity and mortality, low birthweight, prematurity, causes of death);

New York's Title V program relies heavily on the Public Health Information Group (PHIG) in development of the annual needs assessment. Under the guidance of the Director, Michael Medvesky, Pamela Sheehan provides her considerable analytic skills to development of updates to data from a wide variety of data sets. Overall, the needs assessment employs a variety of methods to identify need for various levels and types of care for pregnant women, mothers, infants and children, including children with special health care needs, depending on types and level of data available specific to the population group and/or issue.. Data are available on statewide, countywide and local levels, with ability to do comparisons. In addition to being able to determine geographic differences, most datasets are able to differentiate racial and ethnic groups in order to determine disparities. When small numbers make such determinations impractical or misleading, years of data can be combined to bring more meaning to the data. Program managers are responsible for incorporating data on changing demographics, and on risk factors and health outcomes for the MCH population into their program plans and into targeting methodologies.

Step 1. Engaging Stakeholders

New York State has an active and highly effective means of engaging stakeholders in the process of assessing needs and priorities, and determining that these needs have been met. The Division of Family Health, in which the state's Title V program is located, has over 600 contractors who have successfully competed to provide services to maternal and child populations. Each is required to perform an assessment of needs in their target population, as well as assess current resources and strengths, in order not to duplicate existing services. The state, and each program allocating particular resources to particular populations and objectives, works with relevant stakeholders, including not only potential contractors but professional associations and societies where relevant, to determine effective and evidence-based interventions (wherever possible) to meet specific needs. Each program then independently (to ensure unbiased competition) develops an RFA or RFP every 3-5 years to explain the particular problem to be addressed, the target population, the approved methods or types of interventions to be funded, the types of providers who are eligible to compete, and the amount of funding available by region or target population. Applications and the application process are rigidly monitored by fiscal staff to ensure that no bias is introduced, and that awards are made to the most qualified contractors who applied for funding.

Further, once awarded funding, progress is monitored on a quarterly and annual basis, and funding for additional years of a multi-year cycle is only made available if satisfactory progress is being made towards meeting objectives.

In addition, each County health department completes a Community Health Assessment, using both data provided by the state on particular measures, and county-specific sources of information. These Community Health Assessments are completed every few years, and updated as needed on an ongoing basis. Likewise, each hospital is required to develop periodic assessments of needs in their particular catchment areas. In the next five year Needs Assessment cycle, the Department plans to utilize these county and hospital assessments as a means of garnering additional regional and local perspective on needs across the state for MCH populations.

Step 2. Assessing Needs and Identifying Desired Outcomes and Mandates

In this assessment cycle, the needs of the maternal and child health population have been ascertained through a variety of methods and data sets, including statewide, program-specific, registry-specific, hospital-based, survey-generated, and community-based data sets, and via public input. Many of the data sets are available on the Department's intra-net Health Information Network or HIN, on the HPN or Health Provider Network, and most are on our public website www.health.state.ny.us as a part of the Community Health Data Set. Most data are available on the county level, and many on the sub-county or zip code level. (See Attachment for details on data sets and other sources of input for needs assessment process.) Following is the list of data sources, which are described further in the Attachment:

- Vital Statistics Data
- Census Data
- DOH Registries: including the HIV/AIDS, Congenital Malformations, Newborn Screening, Communicable Disease, Tuberculosis, Sexually Transmitted Disease, Cancer, Heavy Metals (lead), Trauma and Immunization Registries.
- State Education Department registry of licensed professionals.
- Provider-Generated or Program-Generated Data: Including data sets maintained by programs such as WIC, Medicaid, the Immunization Program, the Family Planning Program, the Childhood Lead Poisoning Prevention Program, the Early Intervention Program, the Newborn Screening Program, the Preventive Dentistry Program, the Children with Special Health Care Needs Program, the Dental Rehabilitation Program, and the Community Health Worker Program.
- Medicaid Utilization Data
- Medicaid provider performance reports such as the Quality Assurance Reporting Requirements (QARR) system.
- Statewide Perinatal Data System (SPDS) which includes the core (birth certificate), quality improvement, and NICU modules.
- Integrated Child Health Information System (ICHIS)

- Hospital Discharge Data, including emergency room discharge data
- Special Studies: Including the Pregnancy Risk Assessment Monitoring System (PRAMS), Youth Risk Behavior Study (YRBS), and Behavioral Risk Factor Surveillance System (BRFSS)
- Census Bureau's Current Population Survey (CPS)
- National, State and Local Area Integrated Telephone Survey of Children with Special Health Care Needs (SLAITS CSHCN Survey)
- Local Community and County Health Assessment Data
- Public input from the Communities Working Together process to Evidence-Based Public Health
- Input of Families and Consumers: including Family Champions and Youth Advisory Committee
- New York-Mid-Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC).
- Input from focus groups
- Health Disparities Forum
- Testimony at Public Hearings
- Input from the Maternal and Child Health Services Block Grant Advisory Council

Step 3. <u>Examining Strengths and Capacity</u>

To assess system strengths and capacity, New York's Title V program, consistent with the Ten Essential Services of Public Health and the CAST-V framework, continually re-evaluates New York's ability to:

a. Assess and monitor maternal and child health status to identify and address problems;
b. Diagnose and investigate problems and hazards affecting women, children and youth;
c. Inform and educate the public and families about maternal and child health issues;
d. Mobilize statewide and community partnerships between policy makers, health care providers, families, the general public and others to identify and solve maternal and child health problems;
e. Provide leadership for priority-setting, planning and policy development to support community efforts to assure the health of women, children, youth and families;
f. Promote and enforce legal requirements that protect the health and safety of women, children and youth and ensure public accountability for their well-being;
g. Link women, children and youth to health and other community and family services, and assure access to comprehensive, quality systems of care;
h. Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs;

i. Evaluate the effectiveness, accessibility and quality of personal health and population-based maternal and child health services; and
j. Support research and demonstration to gain new insights and innovative solutions to maternal and child health-related problems.

Each bureau and program in the Division of Family Health has a Logic Model that illustrates target populations and areas with health disparities, and the resources and partners needed to ensure capacity to carry out vital program elements, key objectives of each program, program activities and evaluation measures.

Assessing Capacity with regard to Direct Medical Services:
Comprehensive assessment of the maternal and child health population's ability to access high quality health care and determination of gaps in the health care delivery system takes place at both the state and local level. DOH program staff monitor for access issues at the provider and insurance plan levels, also.

Statewide, assessment activities utilize vital records and the Statewide Perinatal Data System to assess access to prenatal care and births by level of facility. SPARCS data, which are data on hospital discharges, are used to assess hospitalizations for ambulatory care sensitive conditions and source of payment at time of service or delivery. Program data and registries are used to monitor immunization and lead screening rates statewide, access to WIC and family planning services, and linkages to Early Intervention, specialty care and care coordination. QARR outlines access and quality of health care from Medicaid Managed Care, Child Health Plus and commercial Health Maintenance Organization enrollees. The Behavioral Risk Factor Surveillance Survey questions respondents about whether they were unable to consult a physician because of cost. Enrollment in public or private insurance and insurance status can relate directly to access to care, but should be interpreted with caution; enrollment in insurance, including public insurance, does not guarantee access to care. Further, access to care, in and of itself, is insufficient to enable proper utilization of care, mitigated as it is by issues of acceptability of services for a number of reasons, including cultural compatibility, linguistic issues, etc.

Information about high-risk populations, health needs and service delivery is best obtained through local county health departments, community-based organizations, health care providers and the consumers themselves. These are rich sources of information on gaps in local service delivery and the treatment experience of people in need. Key information is also obtained from contractor work plans and consumer focus groups. The new Children with Special Health Care Needs data system and the national SLAITS survey fill a gap in our knowledge of this population, augmenting what was learned through the Family Voices/Brandeis study. Focus groups also provide additional insight into barriers to care and needed supports.

New York employs multiple strategies to ensure access and availability of high quality primary and preventive maternal and child health services to its population. Strategies include:

- Providing low income and disabled New Yorkers with a generous Medicaid, Child Health Plus, Family Health Plus and Family Planning Benefit Program insurance packages;
- Providing incentives for small businesses to purchase health insurance for employees;
- Ensuring availability of adequate numbers of health care professionals through participation in programs such as the National Health Services Corps, the State Health Services Corps, providing practitioner incentives to practice in underserved areas, and recruitment of under-represented minorities to health professions;

- Ensuring cultural competence training of staff through training and such venues as the New York- New Jersey Public Health Training Center (www.nynj-thtc.org)
- Providing "public goods" such as bad debt and charity allowances and provision for graduate medical education through pools established under the New York Health Care Reform Act;
- Providing sufficient regulatory authority to ensure necessary programs are of high quality;
- Ensuring adequate infrastructure at the level of the State Health Department;
- Ensuring, by law, linkages between levels of care, such as between Level One birthing hospitals and Level Two and Three hospitals and with Regional Perinatal Centers;
- Raising awareness of health services in vulnerable populations through extensive health outreach and health education campaigns;
- Providing the Growing Up Healthy Hotline and extensive web pages to direct consumers to services;
- Encouraging cross-system collaborations to better meet the human services needs of New Yorkers;
- Contracting for the provision of gap-filling direct health services when none are available otherwise;
- Providing state local assistance funds to ensure public health capacity at local county health departments; and
- Monitoring utilization of care through birth records, to determine areas where prenatal care is not accessed in a timely manner, or numbers of prenatal visits may be less than expected, and determining if provider capacity is an issue, and if so, attempting to improve capacity.
- Actively monitoring gaps in services and access issues at the community level through local community health assessment.
- Monitoring provision of care delivered by contractors and Medicaid providers to assure that current standards of practice are met.
- Working with Regional Perinatal centers and ACOG District II to identify opportunities for improvement of maternal and neonatal care and implement training/education to disseminate promising practices.
- Assessing needs for genetics and specialty services (NYMAC) and for the enabling services that support those services.

Even 100% enrollment in expanded Medicaid or insurance initiatives does not assure that all children and pregnant or parenting women will get access to the care they need. Other factors, such as the maldistribution of providers, shortages in providers that will accept Medicaid clients, large distances to specialty centers, and shortages of culturally-competent, bilingual staff may have a negative effect on access to appropriate direct medical services. When these trends and issues in utilization are noted, Title V programs are expected to then assess appropriate interventions, whether in the area of direct medical services, enabling services, population-based approaches or infrastructure-building activities.

Assessing Capacity with regard for Enabling Services:

All Title V programs are required to examine barriers to health care in the populations they serve, whether financial, cultural, geographic, institutional or personal, and to institute measures to minimize or eliminate those barriers in collaboration with other stakeholders. Program evaluation, when done objectively and thoroughly, sheds light on reasons for underutilization or for programs not meeting their objectives.

All Title V and Title V-related programs are also required to have extensive linkages and referral networks, thus assuring that care is delivered at the appropriate level of specialty and in the appropriate community or regional setting. Programs that provide services for

vulnerable populations, such as pregnant women, infants, young children, and youth, especially those serving racial or ethnic minorities, the poor, migrants, linguistic minorities, or children with special health care needs, are especially targeted for enabling services. Need for additional services and capacity to provide these services is assessed on an ongoing basis through contract monitoring and ongoing close contact with service providers. These enabling services include special programs such as the Community Health Worker Program, which targets pregnant and parenting low income women, often minorities or recent immigrants, and their families, and provides home visiting, health education, and support to overstressed pregnant women; the Migrant Health program, which provides special on-site, culturally and linguistically appropriate health care as well as transportation to off-site visits as needed; and special dental case management programs for rural areas that reduce no-show rates and encourage enrollment of additional dental providers in Medicaid.

Assessing Capacity with regard for Population-Based Services:
The need for population-based services may surface on a statewide or community level, based on a health need that can be prevented, controlled, or ameliorated, through a public health intervention that is safe, accepted, economical and effective. Examples of factors assessed to determine the need for population-based services are immunization levels, blood lead screening levels, incidence of anemia and overweight, rates of hearing loss, oral health status, injury rates, rates of neural tube defects, or the recognition of a widespread need for certain knowledge. These needs may become known through the analysis of vital statistics or hospital discharge data, use of registry data, analysis of queries for health information, the administration of population-based knowledge, attitude and behavior (KAB) studies, focus groups or other types of special studies.

A good example of the recognition of this type of need is in the area of disaster response planning. The need for additional public information on emergency planning for maternal and child health populations and for better staff planning for emergencies prompted the Division of Family Health to partner with the staff from our Disaster Preparedness unit to work together to improve planning for this group. Division MCH staff under the leadership of the Division's Office of the Medical Director are actively participating on several agency committees. The MCH Disaster Preparedness Plan has been completed and both obstetric and pediatric emergency tool kits have also been developed and distributed. Plans are underway to monitor the usage of these toolkits by hospitals.

Assessing Capacity with regard for Infrastructure-Building Services:
The protection and promotion of the public's health is not possible without adequate public health infrastructure. Public health agencies must have the ability to collect and maintain appropriate data, perform adequate needs assessment, appropriately evaluate public health issues and programs, develop meaningful policies and standards, effectively engage their communities, coordinate existing resources, ensure quality, and to adequately train the public health workforce.

In late 2001, the New York State Public Health Council appointed a public health infrastructure workgroup and charged it with the task of assessing the public health system infrastructure in New York State. Members of this workgroup included individuals in academics, medicine, public policy, government, private foundations, the business community, and the voluntary sector. In December 2003, the Public Health Council presented a report titled, ***Strengthening New York's Public Health System for the 21st Century.*** The report reviewed the strengths and needs, and made recommendations for improvement of the public health infrastructure around: the public health workforce, public health organizational systems and relationships, public health data and information

systems. The Department is currently working toward implementing their recommendations.

The Department is able to assess the adequacy of the infrastructure for maternal and child health services through:

- Establishing and maintaining regular multi-directional communication with local health departments, local contractors and communities, our regional offices, other units within the State Health Department and other State and Federal agencies;
- Regularly and frequently monitoring the quality and the content of local health assessments, public health service plans and contractor work plans;
- Monitoring the ability of our programs, contractors and county health departments to effectively achieve the desired results;
- Monitoring and auditing the use of available resources, including available technical assistance;
- Monitoring the mainstream health care systems for their ability to respond to cultural and language differences, changing trends and demographics and public health emergencies;
- Annually reassessing our internal controls system for areas of vulnerability; and
- Performing special assessments relative to the ability of local agencies to perform essential public health services.

Step 4. <u>Selecting Priorities</u>

Utilizing the annual Needs Assessment, priority setting is conducted as a melding process, combining:

1. The results of the open, public input processes;
2. The use of the many and various data sets available to the Department;
3. The use of program data and provider input to identify trends, issues and areas of disparity;
4. Infrastructure evaluation;
5. Investigation of evidence-based interventions, and prioritization of competing needs based on likelihood of effecting the required change;
6. The input of the public and the Maternal and Child Health Services Advisory Council and consumers to assist in interpreting these data and identifying important trends, gaps in services or barriers to care; and
7. The input of key staff within the Department and the Governor's office.

The Department is currently in the process of setting a "Prevention Agenda" with the aim of making NY the healthiest state, which builds on the foundation created by the Communities Working Together (CWT) process from a decade ago, and current health reform efforts in NYS, which are attempting to create incentives for prevention rather than treatment. The progress made on the various CWT objectives was assessed as of the target year (2006). These objectives included a number of MCH targets, such as reduction in adolescent pregnancy rates, increases in percentage of women with early prenatal care, decrease in the percentage of women drinking and smoking during pregnancy, and reduction in low birth weight and very low birth weight births. Progress on these various objectives was not uniformly good, and further effort, using evidence-based design of programs, is needed.

The goal of the Prevention Agenda is to create a high-performing public health and health care system for the 21st century, that emphasizes community-based public health and

health care programs that promote health, early detection, correction of hidden conditions and proactive management of chronic diseases.

The process of developing and targeting new programs, or re-tooling and re-tasking existing programs, is currently in process, and should contribute to the priority-setting efforts that will be reported in the 2009 MCHBG report.

Step 5. Seeking Resources

Seeking resources is an ongoing process in NYS, as new priorities are identified, new legislative mandates are set, existing resources are depleted, and/or as program expansion to meet additional needs or serve additional populations is desired to better meet NYS objectives and targets.

Step 6. Setting Performance Objectives

New York State initially developed its state performance measures and performance targets under the pilot of the new application process eight years ago. Measures were picked that best depicted our State's goals for maternal and child health, but were not already in the core set of Federal Performance Measures. In the 2001 application, new measures were drafted based on the inclusion of some of our measures as Health Status Indicators, based on the new needs assessment, and based on enhanced consumer and Advisory Council input.

Following the five-year assessment cycle required by Title V, and in consideration of past progress, several performance targets were re-adjusted in 2002. For the Fiscal Year 2003 application, performance targets were updated based on this improvement cycle, based on parent and consumer input, and based on the more detailed needs assessment process required for that application.

The table that follows summarizes the relationship between New York's priority needs and Federal and State Performance and Outcome Measures.

Priority Area	Applicable National Performance Measure	Applicable State Performance Measures	Applicable Outcome Measure
Access to Care	1 – 18	1, 2, 4, 10	1 – 6, NY
Oral Health	9,15,18	3,9	1
Disparities	8, 11, 15, 17, 18	1, 2, 4, 5, 6	1 – 6, NY
Asthma	---	2	6
Tobacco	---	3, 9	1, 2, 3, 5
Alcohol	---	8	6
Resp. Sexual Activity	8	1, 4	---
Lead Screening	13, 14	10	6
Self-Inflicted Injury	16	7	6
Parent Partnership	2, 3, 4, 5, 6	---	---

Please refer to Form 11 for New York's Performance Targets. Performance targets were set in consideration of present status on the measures, Healthy People 2010 goals and, to ensure that the target set was realistic, trends in achievement over the past few years. In places where New York State had a perfect score, the goal is to remain at that level. The method varied somewhat with the measure.

National Performance Measure (NPM) #1: New York has consistently achieved 100% on newborn metabolic screening, and aspires to continue our success in this area.
National Performance Measure 2 through 6 are new as of last year, taken directly from the SLAITS survey. The first year's data will be used as a baseline.

The goals for the following measures were initially set based in part on Healthy People 2010 Objectives for the Nation and updated thereafter based on performance:

- National Performance Measure #8, the rate of births to teens ages 15 - 17;
- National Performance Measure #16, the rate of suicide deaths among 15-19 year olds;
- National Performance Measure #18, relative to first trimester prenatal care;
- State Performance Measure #1, relative to unintended pregnancies;
- State Performance Measure #3, women who smoked while pregnant;
- State Performance Measure #6, infants placed on their backs to sleep;
- State Performance Measure #8, high school students who drank alcohol in the last 30 days;
- Outcome Measure #1, infant mortality;
- Outcome Measure #3, neonatal mortality;
- Outcome Measure #5, perinatal mortality; and
- State Outcome Measure, maternal mortality.

National Performance Measure #9, percent of third grade children who have received protective sealants, was previously NPM #7. Goals were initially set at a level below the Healthy People Objective, but at a level that is believed to be a realistic endpoint.

The following targets were set based on trends or linear projection of current progress and by what is believed to be a realistic endpoint:

- National Performance Measure #7, immunization levels;
- National Performance Measure #10, deaths due to motor vehicle crashes in children under age 14;
- National Performance Measure #11, percentage of mothers who breastfeed their infants at hospital discharge;
- National Performance Measure #12, percentage of children screened for hearing loss before hospital discharge;
- National Performance Measure #13, percent of children without health insurance;
- National Performance Measure #14, percent of potentially Medicaid-eligible children who receive a service paid by the Medicaid program;
- National Performance Measure #15, percent of very low birthweight infants;
- National Performance Measure #17, percent of very low birthweight infants who were delivered at a facility for high risk deliveries and neonates;
- State Performance Measure #2, hospitalization rates for asthma;
- State Performance Measure #4, teen pregnancy rate;
- State Performance Measure #5, ratio Child Obesity (ages 2-4) Low Income
- State Performance Measure #7, hospitalizations for self-inflicted injuries;
- State Performance Measure #9, high school students who smoked cigarettes in the last month;
- State Performance Measure#10, children screened for blood lead before their second birthday;
- Outcome Measure #2, ratio Black Infant Mortality to White Infant Mortality;
- Outcome Measure #4, postneonatal mortality rate; and
- Outcome Measure #6, child death rate.

Endpoints may be above or below the Healthy People 2010 Objectives. Program staff and Division of Family Health and Center for Community Health administration review Division of Family Health and Center for Community Health administration review accomplishments on Core and State Negotiated Performance Measures, along with other strategic measures, in each application cycle. This information is then used to inform program managers of areas where improvement is or is not occurring at the expected rate and identify strategies for improvement.

About Targeting Resources to Eliminate Health Disparities:

All programs developed by Bureaus and Divisions within the Center for Community Health are targeted to areas of high need, based on the best available data. As previously explained, programs make use of Vital Records, including core and NICU modules available through the Statewide Perinatal Data System; hospital discharge data (SPARCS), special studies such as PRAMS and the Behavioral Risk Factor Surveillance System, and utilization data. Data are analyzed for utilization of health services, like prenatal care, and for differences in health outcomes by age, sex, race, ethnicity, socio-economic status, geography and other variables. Data are also developed by zip code in order to determine highest risk areas of the state.

Some of the indicators used to target resources and assess program outcomes include: (*This list is not meant to be all inclusive, but only meant as an illustration*.)

- Teen pregnancy rates;
- Intendedness of pregnancy;
- Percent of low (less than 2500 grams) and very low (less than 1500 grams) birthweight births;
- Month and trimester of entry into prenatal care;
- Number of prenatal care visits;
- Preterm (less than 37 weeks), late preterm (34-36 weeks), and very preterm (less than 32 weeks) birthrate;
- Type of insurance coverage of mother at birth;
- Race and ethnicity of mother;
- Infant mortality rate and neonatal mortality rate;
- Whether the level of the hospital of delivery matched the level of risk;
- Type of contraception used;
- Engagement in a medical home or into prenatal care; and
- Whether the infant is immunized/lead screened appropriately.

The needs assessment process includes multiple indicators that help determine which populations are at higher risk. As previously explained, while data are presented in this document on a statewide level, these indicators are also available on county, minor civil division and zip code levels for planning and evaluating public health interventions.

In addition to use of available data, programs ensure that their services meet the needs of the target populations through ongoing communication with community stakeholders. In that way, planning includes information on the strengths and assets of the communities, ensures that services are not only available, but accessible in a way that is acceptable to the community, promotes common understanding, and meets actual needs. Periodic meetings are held to foster communication and to review the status of programs and progress toward program outcomes. This is also an opportunity to hear about new and emerging issues from the communities. Key stakeholders are also involved in the development and implementation of data systems.

In each Request for Applications released by the MCH programs, the applicant must fully and completely describe the target population and how the applicant will reach, engage and meet the needs of the population. Prior to the initiation of services, providers must analyze community needs and resources to ensure that services are designed to meet the unmet needs of the target population. Providers are required to seek input from community advisory groups that are reflective of the diversity of the population they apply to serve. Consumers are included in advisory councils and consortia and are included in the composition of outreach and educational materials.

Step 7. Developing an Action Plan

Activities planned for FFY 2010 are included in Section IV. New York's annual plan flows from the identification of priority strengths and needs, progress on the National and State 5-year performance and outcome measures, consumer and advisory council input and the capacity and resources of this agency and its partners. Anticipated program activities will be described by level of the pyramid and by segment of the Title V population -- meaning whether the service relates to services for pregnant women, for mothers and infants, for children or specifically for children with special health care needs.

Step 8. Allocating Resources

Resources are allocated and targeted based on need. In each of the last program years, the Maternal and Child Health Services Block Grant Advisory Council has re-affirmed its "Principles and Guidelines for the Use of Block Grant Funds." This document has continued relevance to allocation decisions to ensure maximum benefit from New York's allocation. These guidelines, coupled with the structure for the MCHSBG reflected by the MCH Pyramid, guide their recommendations for reductions/increases in program allocations, and/or redirection of program focus or elimination.

Principles of Allocation of the Maternal and Child Health Block Grant Funds

I. Programs must support functions and be consistent with the purposes of Title V, the Maternal and Child Health Services Block Grant.

II. In general, MCHSBG funds must support needed functions for which adequate funds are not available through other sources. However, availability of these funds should be determined on a case-by-case basis considering criteria established below.

III. MCHSBG funds should be targeted so as to render the greatest public health benefits while maximizing limited resources. Criteria for targeting include:

- identification of populations at greatest risk or need based on geographic, demographic, social, cultural and economic factors;
- mortality and morbidity;
- availability of effective and cost-effective interventions;
- ability to measure program outcomes; and
- inadequate funding from other sources to meet the need.

IV. These funds should be used to augment, not supplant, other funding sources, and when possible, should support demonstration projects and coordination activities that can later be maintained by other funding sources.

V. Block Grant funds should not be used to support basic research.

VI. Block grant funds should be directed toward preventive services as much as possible. When funds must be allocated for personal health care services because of demonstrated need and lack of any other funding sources, preventive services must be incorporated into these services.

VII. Block Grant funds should be allocated in a manner consistent with Federal and State requirements and be consistent with the Public Health Priorities of New York State.

VIII. Block Grant funds should not be used to support established public health services.

Step 9. <u>Monitoring Progress for Impact on Outcomes</u>

The Department and the MCHSBG Advisory Council have been monitoring and will continue to carefully monitor MCHSBG-funded programs to assure that block grant resources complement rather than duplicate the direct provision of personal health care services under Medicaid and expanded insurance or eligibility initiatives such as PCAP, Child Health Plus and Family Health Plus. Careful attention has been given to ongoing need, effectiveness and availability of alternative resources, enabling the redirection of resources to bolster core public health functions, improve systems development and support community-based prevention initiatives and safety net services.

Program managers and administrators are responsible for monitoring progress on health and process outcomes related to their programs. Each bureau and program has a Logic Model describing key objectives and evaluation measures used to ascertain progress toward those objectives. In particular, program managers are expected to set measureable goals

for contractors and monitor progress toward the elimination of health disparities as well as to ensure that current program activities are successful toward that end. An integral part of this process is using information on program practices and success towards achieving (or not achieving) goals to inform subsequent effort, and make adjustments in methods or activities needed to successfully achieve program goals. All programs within the organization are periodically reviewed by the Division of Family Health and the Center for Community Health to ensure that they are incorporating the best evidence-based practices currently available.

Progress continues to be measured toward two goals that the New York State Department of Health shares with the Health Resources and Services Administration:

1. Elimination of health disparities and achievement of health equity; and
2. 100% access to primary and preventive health care, which we believe will significantly reduce the need for more expensive, invasive care.

Step 10. <u>Reporting Back to Stakeholders</u>

There are currently a number of mechanisms for reporting back to stakeholders and partners who have worked with the MCH staff throughout the Needs Assessment process. These include sharing statewide, county-specific and zip-code specific data via our websites, sharing the MCHBG annual application and report with partners, sharing the application and report with the MCHBG Advisory Council, and sharing information with our partners on an ongoing basis as part of collaborative activities undertaken. However, this reporting back mechanism will be given significant attention prior to completion of the five year Needs Assessment next year, to formalize the reporting back process after consultation with our partners, contractors, professional organizations, and other stakeholders in the MCH community.

B. Five Year Needs Assessment

Process for Conducting the Needs Assessment

The needs assessment cycle was described in Section II A. Stated simply, New York's Title V program determines need through continuous assessment of delivery systems, agency capacity and the health care environment; health status and health outcome data, particularly noting areas of health disparity; and information supplied by key informants, namely parents, consumers, program staff, providers and other interested parties. Needs are ranked according to the severity of the problem, the number of people affected, the human and monetary cost to individuals and society, and the years of productive life lost. Our framework for examining need and for designing effective solutions to public health issues was provided in the participative, community-based ***Communities Working Together*** process. New York State Department of Health also incorporates Healthy People 2010 Objectives for the Nation into virtually all goal setting and programming.

<u>New York's Planning Framework—From *Communities Working Together* to Evidence-Based Public Health</u>: In the summer of 1996, a committee of the **New York State Public Health Council** undertook an inclusive priority-setting process. In doing so, the Council enabled input from multiple partners and citizens, and established a framework for focusing community action in those areas that lead to the most significant improvement in the functional lifespan of all New Yorkers, as well as for reducing health disparities among New York residents. The Committee was guided by five key principles:

1.) Local communities can have the greatest impact on health by intervening in the **causes of poor health,** rather than focusing on the health problems themselves.

2.) The greatest improvements in health can be achieved in areas where there are **effective interventions that involve the entire community and the individual.**
3.) The priority health areas must address those conditions that result in the **greatest morbidity, mortality, disability and years of productive life lost.**
4.) The priorities should reflect **problems of greatest concern to local communities.**
5.) Progress should be measurable through **specific, quantifiable, and practical objectives.**

The Committee, in their final report ***Communities Working Together for a Healthier New York,*** identified 12 priority areas, most of which had a maternal and child health component, and addressed these priorities as "opportunities for action":

(Readers will note the similarity of the Committee's choice of "opportunities" with the ***Healthy People 2010*** "Leading Health Indicators," which came out later.)

- Access to and Delivery of Health Care
- Education
- Healthy Births
- Mental Health
- Nutrition
- Physical Activity
- Safe and Healthy Work Environment
- Responsible Sexual Activity
- Substance Abuse: Alcohol and other Drugs
- Tobacco Use
- Unintentional Injuries
- Violent and Abusive Behavior

The report asked communities to collaborate in addressing the underlying causes of poor health, stressing the need for a commitment from all New Yorkers and from all sectors of our society. While the regulatory role of government, for instance, in ensuring safe water or surveillance and control of infectious diseases, was not listed as a priority area, the report cautioned that government must continue to meet its responsibilities for essential public health infrastructure. The report underscored the need for assessment, policy development and assurance functions to be maintained to meet the objectives of the report.

As a state health agency, we continue to use these principles and goals as a guiding framework to approach health issues.

More specifically, the charts that follow summarize important data used to establish the need for services by population group and level of the MCH Pyramid.

Data Indicating Need for Direct Medical Care – Preventive and Primary Care for Pregnant Women, Mothers and Infants	
Need Identified	**Supporting Data/Documentation**
Improved access to comprehensive, continuous, family-focused, community-based, age- and sex-appropriate primary and preventive care, including access to: • family planning information and services; • medical homes; • dental services; • prenatal care; • mental health services; • health insurance; • statewide availability of services; • referral to appropriate levels of care; and • prevention of secondary disability.	Unwanted, mistimed pregnancy (rates) Adolescent pregnancy rates/birth rates Low birth weight rates Perinatal and infant mortality rates Early and late/no entry into prenatal care rates Kotelchuk Index (adequacy of prenatal care) Disparities in birth outcomes between population groups Disparities in care utilization Maternal mortality rates/study Behavior Risk Factor Survey results on access to care Percentages of uninsured children and families Immunization data Rates of hospitalization for asthma and otitis media Rates of perinatal transmission: HIV and Hepatitis B Differential utilization rates/disparities in outcomes Family and consumer input MCHSBG Advisory Council input Local community health assessments Program data, including data from Medicaid, Child Health Plus, CSHCN, Community-Based Adolescent Pregnancy Prevention Program, Children with Special Health Care Needs, Family Planning, the Preventive Dentistry Program, the Dental Rehabilitation Program, the Migrant Health and American Indian Health Programs, and School-Based Health Centers
Healthy births Healthy Infants	Low birth weight rates/very low birth weight rates Adolescent pregnancy and birth rates Perinatal, neonatal, post-neonatal and infant mortality rates Rates for early entry into prenatal care Differentials in care utilization rates Maternal morbidity and mortality rates Disparities in birth outcomes between population groups PRAMS data Family and consumer input MCHSBG Advisory Council input Local community health assessments Early intervention program and CSHCN program data Use of appropriate level of birth facility Cost of hospitalization for NICU in human suffering and dollars Medicaid and Managed Care data Congenital anomaly registry data Genetics services utilization data

Data Indicating Need for Direct Medical Care –Preventive and Primary Care Services for Children, Ages 1 through 21	
Need Identified	**Supporting Data/Documentation**
Improved access to comprehensive, continuous, family-focused, community-based, age- and sex-appropriate primary and preventive care, including access to: • family planning information and services; • medical homes; • dental services; • mental health services; • health insurance; • counseling on risk-taking behaviors; • statewide availability of services; • referral to appropriate levels of care; and • prevention of secondary disability.	Immunization Rates – by age, location, payment source, insurance status, etc Rates of dental caries – by age and economic level Rates for placement of dental sealants Lead screening data/prevalence of lead poisoning Prevalence of older housing stock Adolescent pregnancy rates Differentials in care utilization/health outcomes High rates of use for tobacco, alcohol and other drugs Rates for suicide attempts and suicides Family/suicide survivors' input Family and consumer focus groups MCHSBG Advisory Council input Local community health assessments Rates of hospitalization for self-inflicted injuries Rates of unintentional injuries STD and HIV screening and incidence rates Health disparities information Rates of hospitalizations for ambulatory care sensitive conditions Rates of risk-taking behaviors MA data/EPSDT/Child Health Plus coverage rates Free and reduced price lunch participation rates

Data Indicating Need for Direct Medical Care – Children with Special Health Care Needs	
Need Identified	**Supporting Data/Documentation**
Improved access to comprehensive, continuous, age- and sex-appropriate primary and preventive care and specialty level care, including access to: • medical homes; • referrals to appropriate specialty services and higher levels of care; • needed durable medical equipment and supplies; • supportive services, like respite; and • family involvement.	Use all of data sources mentioned above under "Children," plus: Parent and consumer input Public hearings MCHSBG Advisory Council input Family Voices/Brandeis study Children with Special Health Care Needs Program data Disparities data Dental Rehabilitation Program data Early Intervention Program data Local community health assessments MA data/Child Health Plus data SLAITS

Data Indicating Need for Enabling Services – Preventive and Primary Services for Pregnant Women, Mothers and Infants	
Need Identified	**Supporting Data/Documentation**
Early and improved access to prenatal care and other primary and preventive care through: • enhanced and sustained outreach; • transportation; • translation services; • role modeling appropriate care seeking behaviors; • parenting support; • health guidance; • insurance programs; • assistance with locating and accessing services; and • referral and support services.	Medicaid utilization and QARR data Rates of early and late/no entry into prenatal care Kotelchuck Index (adequacy of prenatal care) PRAMS data Program reports (migrant health, adolescent programs, school health) Rates of uninsured Data on source of payment for prenatal care and deliveries Disparities in utilization/health outcomes Family and consumer input MCHSBG Advisory Council input "Growing Up Healthy" Hotline and other MCH-related hotline calls The number of hotline callers who inquire about eligibility based on immigration status Local community health assessments MA/PCAP data

Data Indicating Need for Enabling Services – Preventive and Primary Care Services for Children, Ages 1 through 21	
Need Identified	**Supporting Data/Documentation**
Same as above.	Same as above. Substitute Hospitalizations for Ambulatory Care Sensitive Conditions for prenatal care measures.

Data Indicating Need for Enabling Services – Children with Special Health Care Needs	
Need Identified	**Supporting Data/Documentation**
Same as above. Additional need identified: Assistance with care coordination and with vendors for home care/medical equipment.	Use all of data sources mentioned above under "Children," plus: SLAITS Family Voices/Brandeis study Parent and consumer input MCHSBG Advisory Council input Early Intervention Program data Children with Special Health Care Needs data

Data Indicating Need for Population-Based Services – Primary and Preventive Care for Pregnant Women, Mothers and Infants	
Need Identified	**Supporting Data/Documentation**
Healthy births Healthy Infants	Health disparities data Rates of early entry into prenatal care Rates of late and no prenatal care Kotelchuck Index Perinatal Hepatitis B and HIV transmission rates Rates of prenatal HIV counseling and testing Rates of low and very low birth weight Mortality rates: infants, perinatal, neonatal and postneonatal Breast feeding data Maternal mortality SIDS rates WIC utilization PRAMS data PCAP/MOMS data Advisory Council and Public Hearings/consumer input

Data Indicating Need for Population-Based Services – **Primary and Preventive Care for Children, Ages 1 - 21**	
Need Identified	**Supporting Data/Documentation**
Improved oral health and better access to preventive oral health services	NYS Oral Health Survey Decayed, missing, filled percentages Sealant rates Percentages of water supplies that are fluoridated Rates of dental caries Data on dental underserved areas/disparities Rate of Medicaid children who receive a dental preventive service (includes sealants and dental exams) Data on lack of dental insurance and high out-of-pocket expense Family and Consumer Input Public Hearings/consumer input Advisory Council input Free and reduced price lunch participation

Data Indicating Need for Population-Based Services – **Primary and Preventive Care for Children, Ages 1 – 21 (Continued)**	
Need Identified	**Supporting Data/Documentation**
Improved access, on a population-wide basis, to comprehensive, continuous, family-focused, community-based, age- and sex-appropriate primary and preventive care, including access to: • family planning information and services; • medical homes; • mental health services; • health insurance; • counseling on risk-taking behaviors; • statewide availability of services; • referral to appropriate levels of care; and • prevention of secondary disability.	Rates of uninsured Disparities data Youth Risk Behavior Survey data on use of alcohol, drugs and tobacco Rates of intentional injuries/suicides/suicide attempts Rates of teen pregnancies and births SPARCS data on hospitalizations for ambulatory sensitive conditions including data on asthma Immunization levels and occurrences of vaccine-preventable diseases STD and HIV morbidity data Local community health assessment data Program data (lead poisoning, family planning, school health, etc.) Family and consumer input Public Hearings/consumer input MCHSBG Advisory Council input Free and reduced price lunch program participation
Completion of high school and compulsory health education	Data on drop out rates and associated socio-economic consequences, Level of maternal education, Rates of high school non-completion among teen moms and others/Disparities
Mental health	Rates for teen suicides, attempted suicides, intentional injuries/Disparities Youth Behavioral Risk Survey data on use of substances, mental health Program data (School-Based Health Centers, ACT for Youth)
Responsible sexual behavior	Youth Behavioral Risk Survey data on use of contraception, students forced to have sex when it wasn't wanted, age at initiation – noting disparities Unplanned and adolescent pregnancies and births Rates of induced terminations of pregnancies Morbidity data: STD, HIV/Disparities Program data (Family Planning, Community-Based Adolescent Pregnancy, Abstinence Education, School Health)
Nutrition and physical activity	Nutrition surveillance studies, WIC program data YRBS – noting disparities
Reduced use of tobacco, alcohol and other drugs	Youth Behavioral Risk Survey, PRAMS Rates of injuries where drugs and alcohol are involved – noting disparities
Reduction of violence/intentional injuries	Youth Behavioral Risk Survey, Hotline Calls SPARCS data on hospitalizations, ER use for injuries

Data Indicating Need for Population-Based Services – Children with Special Health Care Needs	
Need Identified	**Supporting Data/Documentation**
Need for comprehensive, continuous, family-centered, community-based system of care for the full population of children with special health care needs, including: • readily accessible information about the location and availability of services; and • access to and insurance for accessing appropriate levels of care and appropriate specialty services.	Use all of data sources mentioned above under "Children," plus: SLAITS Disparities data Family Voices/Brandeis study Parent and Consumer input –including focus groups Public Hearings input MCHSBG Advisory Council input

Data Indicating Need for Infrastructure Services – All Populations	
Need Identified	**Supporting Data/Documentation**
Continued need for a strong and vibrant public health infrastructure that supports maternal and child health services in New York State	There is a continued need for the infrastructure to support: • Assessment of problems and conditions that affect the MCH population, including health disparities; • Ability to identify and bring resources to bear on priority health issues; • Coalition-building and collaboration skills; • Availability and access to necessary technical assistance; • Appropriate numbers, types and distribution of MCH/public health personnel; • Statewide accessibility, availability and acceptability of MCH services at all levels of care; • Form effective linkages between/across systems of care; and • Assurance of quality through assessment and monitoring of local health departments, providers and contractors, law and regulations.
The need for infrastructure that supports access an array of affordable, high-quality, comprehensive, continuous, culturally-competent, linguistically-appropriate services for all MCH populations	Uninsured data and program utilization data GIS locators for facilities and practitioners/underserved areas Health personnel data and registries Locations of providers, comprehensiveness of provider networks – noting disparities Linkages between primary, secondary and tertiary levels of care Appropriate monitoring and regulation Special populations data/Special studies

Data Indicating Need for Infrastructure Services – Primary and Preventive Services for Pregnant Women, Mothers and Infants	
Need Identified	**Supporting Data/Documentation**
An infrastructure that promotes healthier births: • affordability and access to insurance for prenatal intrapartal and infant care; • appropriate array of services/ locations; • regionalized system of perinatal care; • family planning education to promote appropriate spacing; • content of care that includes risk assessment and patient education; and • links to nutrition/other supports.	Data on uninsured Disparities data Vital Statistics and SPARCS data on payment source for deliveries Locations of providers and facilities Linkage agreements between levels of care Rates of unintended and teen pregnancies and births QARR and MA data Percentages of high-risk infants born at Level 3 Facilities Distribution of Levels of birth hospitals statewide PRAMS data Program data (Family Planning, Community Health Worker, PCAP and MOMS Programs) Rates of low and very low birth weight/Mortality rates Infant Mortality Community Review Panel recommendations Public Hearing, Consumer and MCHSBG Advisory Council input Monitoring and regulatory data

Infrastructure Services – Primary and Preventive Services for Children, Ages 1- 21	
Need Identified	**Supporting Data/Documentation**
Need for infrastructure to support comprehensive child health and school health and wellness in order to promote: • access to insurance; • access to a full array of screening and treatment services for medical, dental and mental health issues; • responsible sexual behavior; • reduced use of tobacco, alcohol and other drugs; • reduction in unintentional injuries; and • reduction of violent behaviors.	Appropriate assessment capacity Ability to design and implement effective strategies Ability to form statewide and community-level coalitions Insurance/uninsured data– noting disparities Free and reduced price lunch data Teen pregnancy and birth rates– noting disparities Morbidity and mortality data – noting disparities Utilization data– noting disparities Program data– noting disparities ATUPA enforcement activities Presence or absence of health education services SPARCS data on injuries– noting disparities Youth Behavioral Risk Survey data Distribution and availability of school-based health centers in high needs areas

Infrastructure Services – Children with Special Health Care Needs	
Need Identified	**Supporting Data/Documentation**
Need for infrastructure that supports: • better assessment of need; • family-centered care/enhanced family participation in care; • easy access to necessary services; • compassionate, coordinated care.	Use all of data sources mentioned above under "Children," plus: SLAITS and Family Voices/Brandeis survey data Family and consumer input Health or utilization disparities– noting disparities MCHSBG Advisory Council input Public hearing testimony Children with Special Health Care Needs and Early Intervention Program data Medicaid and managed care data– noting disparities Program monitoring data

The following topics are currently under discussion as we begin the process of designing the Needs Assessment for the first year of the 5 year cycle. These topics will be addressed in detail in the next application and report, due in 2010:

- **Goals and Vision –** The Department is scheduled to begin working with stakeholders, particularly the Maternal and Child Health Block Grant Advisory Council, on refining the goals and vision of the MCH Block Grant.
- **Leadership –** Revisions to the current Needs Assessment team, and the roles and responsibilities of the various members, are under consideration.
- **Methodology** – NYS has a highly complex and ongoing methodology to assess needs across the State, and that methodology is described in this document. However, in keeping with the revised Guidance document, the methodology will be examined with fresh eyes by the revised leadership team in the coming cycle.
- **Methods for Assessing Three MCH Populations** -- While NYS has a number of relevant data sources, additional sources of information on the strengths and needs of each of the MCH populations will be reviewed and incorporated as appropriate. Under consideration are county-specific and hospital region-specific analyses completed periodically, and additional consumer input via focus groups or electronic interactive methods.
- **Methods for Assessing State Capacity** – While NYS has a close and highly interactive relationship with the state's Medicaid office (Office of Health Insurance Programs, or OHIP), additional effort can be made to more directly engage OHIP staff in planning for the Needs Assessment process.
- **Data Sources** – NY will continue to describe all data sources used, and the limitations of these data sources.
- **Linkages between Assessment, Capacity and Priorities** – While this is not always readily apparent, or even easily described, the interrelationships between assessment of strengths and needs, capacity and selection of priorities will be clarified.
- **Dissemination** – Current methods used for dissemination of the Needs Assessment will be examined and expanded, as feasible, and described in the next application.
- **Strengths and Weaknesses of the Process** – Every process has strengths and weaknesses, and often it is more difficult to own the weaknesses than to objectively enumerate the strengths of your process. However, in the next application, at the start of the 5 year Needs Assessment cycle, NYS will examine its revised process,

per the new Guidance, and make an attempt to objectively catalog both the portions of the process that worked well as well as those that did not, and use the analysis as a learning opportunity for future modifications of the process.

2. Needs Assessment Partnership Building and Collaboration

There are multiple collaborations and partnerships formed around needs assessment, planning and policy development. Here are just a few examples of the collaborations with NYSDOH:

The **State Education Department (NYSED)** is a key partner in needs assessment and priority setting for services relating to the school-aged population. NYSED and DOH have formal planning structures related to youth risk behavior surveillance, comprehensive school health, school-based primary care and dental services, and workforce and scope of practice issues. NYSED also collaborates with NYSDOH on the Supplemental Fluoride Distribution Program. The Children with Special Health Care Needs Program regularly interacts with SED's Vocational and Educational Services for Individuals with Disabilities (VESID) Program.

Other regular state-level collaborators include the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Office of Temporary and Disability Assistance, the Office of Children and Family Services, the Office of Substance Abuse and Alcohol Services, Developmental Disabilities Planning Council, the Commission on Quality of Care and Advocacy for Persons with Disabilities. There are also numerous private and not-for-profit groups who are consulted and enlisted in planning for maternal and child health services. Some examples follow:

The Bureau of Dental Health held a series of **regional oral health stakeholder meetings** involving school dental health and Head Start/Early Head Start stakeholders for the purpose of needs assessment and discussing implementation of the statewide Oral Health Plan. Attendees received meeting summaries, membership in the Oral Health listserv, information about additional potential regional and statewide partnerships, and an invitation to participate in the newly formed statewide Oral Health Coalition. The Dental Bureau also engaged an expert panel to consider the scientific evidence related to oral care during pregnancy and in early childhood and this panel participated in formulating practice guidelines for New York State dentists and obstetrical care providers. The guidelines have been distributed, and are available on the NYSDOH website at http://www.health.state.ny.us/prevention/dental/

NYS Touchstones, with the NYS Council on Children and Families in the lead, began as a collaborative of 13 NYS agencies that fund programs and services for children and families. Touchstones is a set of measurable goals and objectives as well as health, education and well-being indicators that reflect the status of children and families in relation to those goals and objectives. The Council produces the Touchstones/KIDS COUNT Data Book annually. The KWIC, Kids Well-being Indicators Clearinghouse, makes vital youth statistical information more timely, accessible and usable to communities in a user-friendly format. The Clearinghouse is available on the website http://www.nyskwic.org/ .

The **New York State Youth Development Team** is a partnership established in 1998 by more than two dozen public and private organizations. The partnership has led efforts to develop and promote youth development strategies across health and human services systems in New York State. Agency team members include all major state agencies serving youth (health, mental health, education, public assistance, juvenile justice, substance abuse), as well as the New York State Nurses Association, Cornell University, the YMCA, the

NYS Association of Youth Bureaus, the Mount Sinai Adolescent Health Center the Association of Family Services Agencies, the NYS Center for School Safety, University of Buffalo, Families Together of NYS, University of Rochester, the Schuyler Center for Analysis and Advocacy, the Conference of Local Mental Hygiene Directors, and the NYS Counseling Association. The team developed a compendium of outcome indicators for state and local use in measuring youth development efforts.

The **Coordinated Children's Services Initiative (CCSI)** is a cross-systems process for serving children with special emotional and behavioral services needs that builds upon legislation enacted in 2002. The process utilizes strength-based approaches, consistent and meaningful family involvement, individualized planning, and encourages creative, flexible decision-making and funding strategies. CCSI Statewide Partners are: Family Representatives, Office of Mental Health, State Education Department, Office of Children and Family Services, Council on Children and Families, Division of Probation and Correctional Alternatives, Office of Mental Retardation and Development Disabilities, Department of Health, NYS the Commission on Quality of Care and Advocacy for Persons with Disabilities, and the Developmental Disabilities Planning Council. Priority areas for CCSI include the development and delivery of training and technical assistance related to building and sustaining local systems of care, including a family advocacy training curriculum. CCSI continues to work to implement the comprehensive set of recommendations for improving services for children who have cross-systems needs (developed in 2004).

In 2005, Chapter 392 of the Laws of 2005 established the Out-of-State Placement Committee within the Council on Children and Families. The Out-of-State Placement Committee, in which the NYSDOH participates, is responsible for improving the monitoring of out-of-state residential placements, promoting coordination across all levels of government, and establishing a process for identifying and considering in-state resources prior to making an out-of-state placement.

The **Family Champions Project** engages parents of children with special health care needs in training on planning, policy and advocacy. Family Champions assisted Title V by participating in consumer focus groups and testifying before the Maternal and Child Health Services Block Grant Advisory Council. Family Champions will continue to be engaged in program planning and policy development initiatives with the Children with Special Health Care Needs Program.

Please see the discussion of the new Youth Advisory Board in this Needs Assessment document. The Youth Advisory Board is another partnership in Needs Assessment.

During July 2008 the NYS Department of Health and the state Office of Children and Family Services (OCFS) entered into a partnership to expand and improve **child fatality review and prevention** in NYS. The partnership will improve the collection and examination of information generated by local fatality reviews. It will identify specific issues involved in the deaths, and recommend changes in legislation, policy, practices and expanded efforts in child health and safety to prevent child deaths.

The partnership will improve interagency communication and combine the strengths of both agencies in addressing child deaths. The department has expertise in the areas of injury prevention, sudden unexpected infant death and epidemiological investigation and OCFS has expertise in child abuse and neglect, foster care and the current child fatality review system. The partnership is examining if it can implement the National Center for Child

Death Review's data system, the creation of a state level multi-agency workgroup and how it can expand and improve child fatality review and prevention in NYS.

The SIDS program continues to conduct frequent risk reduction educational and public awareness programs statewide and distributed over 10,000 pieces of literature. They provide education for first responders to the scene of an infant death and.maintain membership in 25 coalitions/organizations addressing infant mortality risk reduction. Families experiencing an infant death are contacted and provided with referrals to appropriate services, literature and other materials and occasionally receive home visits. Professional education and numerous case consultations are also conducted. .

In 2007, NYSDOH began working with the **Division of Criminal Justice Services** (DCJS) on a "Disproportionate Minority Contact" project. A new mandate requires DCJS to "address juvenile delinquency prevention efforts and system improvement efforts designed to reduce, without establishing or requiring numerical standards or quotas, the disproportionate number of juvenile members of minority groups, who come into contact with the juvenile justice system." Based on their review of client data, DCJS quickly recognized that a number of key primary prevention strategies rely on the health and mental health systems, and that poor school achievement, a key risk factor for confinement, is related to sound health and mental health. As a result, Department of Health staff have been asked to both serve on and appear before the project committee. There is an interest in hearing more about lead poisoning prevention, efficacy of public health nurse home visiting and other health-related topics.

Overall, needs assessment and health planning are the shared responsibility of every program within DOH and their local counterparts, which is successful because:

- *As a State Health Department, we have entered into a partnership with consumers and families, with local health agencies and local communities, and with other State agencies.* These partnerships help Title V to identify the need for additional information and act on those needs.
- *We are united in a common vision for New York and the health of New Yorkers*. Thanks to an inclusive planning process, to multiple collaborations and partnerships and to the Department's administrative, legislative and educational initiatives, localities are playing a larger role in identifying local needs, designing programs to effectively address local need, and evaluating local results.
- *We understand needs assessment as a continuous process***.**
- *Title V and the New York State Department of Health are supporting this process through the dedication of needed resources*. Support, technology and training are made available to local agencies and partners in their needs/capacity assessment and planning efforts.

3. Assessment of Strengths and Needs of the Maternal and Child Health Population and Desired Outcomes

Geography: New York State has a total area of 54,471 miles. That includes a landmass of 47,832 square miles and inland water covering 7,247 miles. Bordered to the north and west by Canada and the Great Lakes of Ontario and Erie, to the south and west by Pennsylvania and New Jersey, to the east by Vermont, Massachusetts and Connecticut, and to the southwest by the Atlantic Ocean, the geography of New York is both vast and diverse. Our borders hold 8,000 lakes, nine major rivers, four mountain ranges (the Adirondacks, the Catskills, the Taconics and the Shawangunks), hundreds of small, rolling valleys, fertile glacial plains, awe-inspiring gorges and waterfalls, quaint rural villages, and one of the most vibrant metropolitan areas in the world. (See *Figure Below*.)

New York's diverse geography can also present interesting public health challenges. While the Finger Lakes and our mountain ranges are among our most beautiful natural resources, these attributes can also impede transportation and delay access to health care. Its location southeast of the Great Lakes ensures temperate upstate summers, but it can also, especially for the Tug Hill plateau region, mean sudden and heavy "lake effect" snowstorms in the winter. And because New York's natural resources attract tourists year-round with recreational activities like boating and skiing, some areas experience a striking seasonal demand on health services, especially in the areas of emergency medical services and public health. Ellis Island, our various ports of entry, and the Statue of Liberty have historically been beacons to newcomers and are well-known entry points for many new New Yorkers and new Americans from around the world.

Population: New York State is notable for the great diversity of both its geography and its people. According to the 2000 US Census, New York State is home to almost 19 million people (18,976,457). New York is now the third most populous state, behind California and

Texas. Seven percent of the US population lives in New York. New York City contains 42% of the State's population with over 8 million people (8,008,276).

New York's population is aging. The median age in the State has increased from 32.0 years in 1980, to 37.7 years in 2007. This represents an aging of the "Baby Boomers" born between 1946 and 1964, as well as a longer survival rate for the elderly. The expectations for length of life for New York State residents has increased, from 75.2 years for those born in 1991 to 80.1 years for those born in 2006.

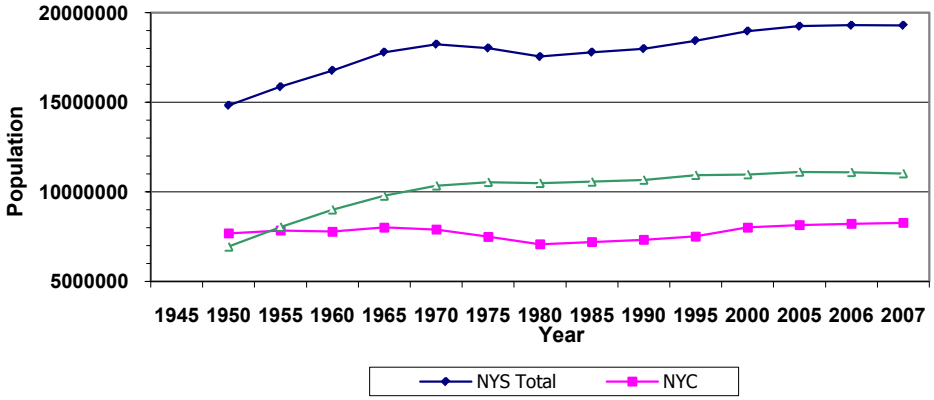
Population Growth: According to the 2007 Census estimates, 19,297,729 people live in New York State. While New York City's population experienced a modest gain between 2006 and 2007, the population residing in Rest of State actually declined slightly. Population trends indicate that, after a slight downward trend in the late 70's and early 80's, New York's population rose, and then leveled off. New York was the second most populous state until the late 1990's, when its population growth slowed to less than 1%.

Population of New York State, 1950-2007
Source: US Census Bureau

Year	New York State	New York City	Rest of State
1950	14,830,192	7,891,957	6,938,235
1960	16,782,304	7,781,984	9,000,320
1970	18,241,584	7,895,563	10,346,021
1980	17,558,165	7,071,639	10,486,526
1985	17,795,916	7,232,980	10,562,936
1990	17,990,455	7,322,564	10,667,891
1995	18,439,500	7,510,600	10,928,900
1996	18,506,400	7,542,500	10,963,900
1997	18,571,800	7,575,000	10,996,800
1998	18,637,800	7,609,200	11,028,600
1999	18,705,695	7,643,800	11,061,900
2000	18,976,457	8,008,278	10,968,179
2001	19,074,843	8,055,166	11,019,677
2002	19,157,532	8,084,316	11,073,216
2003	19,190,115	8,085,742	11,104,373
2004	19,227,088	8,104,079	11,123,009
2005	19,254,630	8,143,197	11,111,433
2006	19,306,183	8,214,424	11,091,757
2007	19,297,729	8,274,527	11,023,202

Population of New York State 1950-2007

Source: US Census Bureau



Population Density: Population density often determines the number and types of health services that an area can support. The US Census shows that in 2000 there were 401.9 persons per square mile in New York State, compared to 79.6 persons per square mile in the US, but population density within New York varies widely. New York City is 104 times more densely populated than the rest of the state, and New Yorkers are more likely to live in urban areas than residents of other states.

New York County (Manhattan) has the highest population density at 52,808 persons per square mile, while Hamilton County in the Adirondack Mountain Range has the lowest density, with only 3 people per square mile. New York City comprises over 40% of New York State's population, and the counties immediately north of New York City (Orange and Westchester Counties) and Long Island (Nassau and Suffolk Counties) comprise an additional 21% of the state's population. Other population centers are Buffalo (Erie County), Rochester (Monroe County), Syracuse (Onondaga County) and Albany (Albany County).

Many areas of New York are rural. Twenty-six percent of New Yorkers live in rural areas, compared to 36% nationwide. According to the New York State Senate Commission on Rural Resources, there are 44 rural counties out of the 62 in New York State that are home to approximately four million rural residents.

Households and Families: In 2000, there were 7,056,860 households in New York State. The average household size was 2.61 people. A family household, by Census definition, has at least two family members related by blood, marriage or adoption, one of which is the householder. The average family size in New York State was 3.22 in 2000. Families made up 65.7% of the households in New York in 2000. This figure includes married couple families (46.6%), female householders (14.7%), and male householders (4.4%). Non-family households made up 34.3% of all the households in New York State. The majority of the non-family households were people living alone. Households containing children under the age of 18 numbered 2,466,483 or 35.0%, and households with adults 65 and older numbered 1,767,452 or 25.0%.

Women of Childbearing Age: The population of women of childbearing age has been decreasing since 1990. In 2007, it is estimated there were 4,079,201 females between the ages of 15 and 44 in New York State. A total of 683,829 females were between the ages of 15 and 19. An additional 607,282 females were between the ages of 10 and 14.

Children: Of New York's 2007 population, 4.4 million (22.9%) were under age 18. The number of children under the age of 20 in 2007 was almost 5 million (4,994,163), broken down by age groups as shown in *Table 2.* Approximately 40% of these children (2,021,130) live in New York City.

Child Population in NYS 1990,2000,2004-2007

Source: US Census Bureau

Age in Years	Number in 1990	Number in 2000	Number in 2005*	Number in 2006*	Number in 2007*
<1	1,255,764	1,239,417	251,865	244,832	246,824
1-4			997,536	975,475	949,864
5-9	1,178,006	1,351,857	1,192,592	1,192,659	1,157,034
10-14	1,140,177	1,332,433	1,302,493	1,285,336	1,243,567
15-19	1,230,127	1,287,544	1,318,372	1,385,081	1,396,874
Total Birth-20	4,804,074	5,211,251	5,062,858	5,083,383	4,994,163
Total in NYC	1,888,075	2,153,450	2,130,541	2,160,085	2,021,130

*Bureau of Census estimates.

The U.S. Census Bureau estimates that the number of children ages 4 and under in New York City grew by an estimated 5% from 2000 to 2007. In the Rest of State, however, there was a 10% decline in population in this age group. Demographers attribute the growth in the youngest age groups to the influx of immigrant families in New York City, many of whom are of childbearing age. The Census Bureau estimated that Manhattan had a 20% gain in this age group, the Bronx had a 4.8% increase, Brooklyn a 2.3% increase, and Queens showed a 1.1% increase. Upstate rural counties lost the greatest number of infants and toddlers under age 5: Greene and Schoharie Counties lost 14% each, while Orleans County lost 13%.

Race and Ethnicity: New York's population reflects diverse race and ethnicity; we are more diverse than the nation as a whole. New York has higher percentages of non-Hispanic Black residents, Hispanic residents and non-citizen immigrant residents than the U.S. average. According to the American Community Survey conducted by the US Census Bureau, New York ranks second of all states in foreign born, with 21.6% of its total population or 4,178,962 people being foreign born in 2006. Almost 90% of New York's non-citizen immigrants live in New York City, with Queens County being the most diverse county in America. (As of the 2006 American Community Survey, immigrants comprise 48.5% of its residents.)

Between 1990 and 1998, there had been small shifts in the ethnic composition of New York's population, with the population of New York City being more racially and ethnically diverse than the rest of the State. The 1999 New York State population under age 24 was 72% white, 22% African American, and 18% Latino. Approximately 6% were identified as Asian/Pacific Islander.

In 2000, the Census, in an effort to reflect the growing diversity in the US, gave respondents the option of selecting one or more race categories to indicate their racial identities. Because of this change, data from the 2000 Census cannot be compared to earlier censuses. The six single race categories (White, Black or African American, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, and Some Other Race) and the two or More Races category are exclusive categories. The

majority of New Yorkers (96.9%) reported only one race; 3.1% identified themselves as being of more than one race.

According to the 2000 U.S. Census, the largest group (67.9%) reported White alone, while Black or African American alone represented 15.9 percent of New Yorkers. 7.1% reported being Some Other Race. 5.5% stated they were Asian alone, and 0.4% reported they were American Indian or Alaska Native. Native Hawaiian or Other Pacific Islander accounted for only 0.05% of those reporting.

Hispanics accounted for the majority of the Some Other Race category. Of New York State residents who selected Some Other Race, 94.4 percent identified themselves as Hispanic. Hispanics represent 15.1% of New York State's total population. In New York City, 27% indicated they were Hispanic. Four out of 10 Hispanics did not identify themselves with one of the five specific race alone categories or two or more races category. Of those New Yorkers identifying themselves as Hispanic, 44.2 said they were Some Other Race.

About 70% of African Americans and 75% of Hispanics/Latinos in the State reside in New York City. Among New York City residents, 44.7% reported their race as White alone, 26.6% reported Black or African American alone, 9.8 percent reported Asian alone, and 14.4 percent reported being Some Other Race. About 27% of New York City's population identifies themselves as Hispanic/Latino.

Several counties outside of New York City have significant Hispanic/Latino population, as well. In Rockland, Nassau, Orange, Suffolk, Sullivan and Westchester Counties, Hispanics/Latinos make up at least 9% of the population.

Population growth as a percentage of total population grew between 1990 and 2000 by 29.5% for Hispanics and 9.5% for non-Hispanic Blacks. The Asian population surged by 56.1% to over one million (1,035,926).

Census figures for Native Americans in New York may represent a serious undercount. New York is home to the *Haudenosaunee* or the "People of the Longhouse." These members of the Iroquois League, which was formed centuries ago, formed their confederacy to advance "peace, civil authority, righteousness, and the Great Law." Many traditional members of their nations (the Mohawks, Keepers of the Eastern Door; the Senecas, Keepers of the Western Door; the Onondagas, known as the Firekeepers; the Oneidas; the Cayugas; and the Tuscaroras) do not participate in the US Census. This produces an undercount in US Census data on New York for these important groups.

New York State Population Breakdowns by Race *Source:* 2000 US Census						
Race Categories	**New York Population**		**New York Hispanic Population**			
	Number	**% Total Pop.**	**Number**	**% of Total Population**	**% of Total Hispanics**	**% of Race Category**
One Race	18,386,275	96.9	2,643,517	13.9	92.2	14.4
▪ White	12,893,689	67.9	1,132,708	6.0	39.5	8.8
▪ Black or African American	3,014,385	15.9	201,762	1.1	7.0	6.7
▪ American Indian/ Alaska Native	82,461	0.4	29,962	0.2	1.0	36.3
▪ Asian	1,044,976	5.5	9,050	0.0	0.3	0.9
▪ Native Hawaiian/ Other Pacific Islander	8,818	0.0	3,588	0.0	0.1	40.7
▪ Some Other Race	1,341,946	7.1	1,266,447	6.7	44.2	94.4
Two or More Races	590,182	3.1	224,066	1.2	7.8	38.0
TOTAL	18,976,457	100.0	2,867,583	15.1	100.0	15.1

A great number of New Yorkers (over 4 million according to the 2006 American Community Survey) are foreign born. The largest group of the foreign born New Yorkers are from Latin America (2,067,155). Asians are the second largest group of immigrants (1,076,102), and Europeans the third (826,990). African immigrants, other North Americans, and Oceanians follow in descending order.

Languages: In addition to our great cultural diversity, there is also great diversity in languages spoken in New York. According to the 2007 American Community Survey, of the estimated 18,097,578 New Yorkers over age 5, an estimated 12,868,476 speak only English at home, while 5,229,102 speak a language other than English. Of those speaking a language other than English at home, 2,389,700 speak English less than "very well." About 2,556,829 New Yorkers speak Spanish at home. The New York State Education Department found that, of the 3.34 million students attending school in New York, 7.0% were identified as having limited proficiency in English.

Immigration: New York has always served as a major gateway for immigration, and as an entry point for many new New Yorkers and new Americans. The 2007 American Community Survey collected information on the characteristics of legal native and foreign-born populations living in New York State. The following estimates are based on the American Community Survey findings.

- New York had a foreign-born population of 4.2 million in 2007. This number represents 21.8% of the State's population, or about one in five people. Only California has a higher percentage (27.2%) of foreign-born residents. The national average for the foreign-born is approximately 12.5%.
- There were approximately two million legal resident aliens and over two million naturalized citizens in New York.
- New York had more naturalized citizens than the country as a whole, probably because more of New York's immigrants come from countries that tend to naturalize and more are long-term immigrants, who are also more likely to naturalize.
- New York's immigrant population was very diverse, with no particular region or country having clear dominance.
- Of the estimated 4.2 million immigrants in New York:
    - About 820,854 or ~20% came from Europe;

- About 1,092,921 or ~26% came from Asia;
- About 151,697 or ~3.6% were from Africa;
- About 11,298 or ~0.3% were from Oceania;
- About 1,021,273 or ~24% came from the Caribbean;
- About 468,273 or ~11% were from Central America;
- About 582,124 or ~14% were from South America; and
- About 56,749 or ~1.3% were from Canada.

- The largest single country of birth was the Dominican Republic, with about 405,720 or ~10%;

- About 235,668 or ~5.6% were from Mexico;
- About 150,866 or ~4% from India
- About 354,681 or ~8% were from China;
- About 40,460 or ~ 1% were from Israel
- About 212,910 or ~5% were from Jamaica; and
- About 87,960 or ~2% were from Russia.
-

- On average, 47% of the foreign born population speaks English less than "very well". Among foreign born New Yorkers who are not U.S. citizens, 57% speak English less than "very well."
- In New York State, the median household income for foreign-born individuals ($47,550) was lower than the median income for households headed by natives ($53,514).
- About 13% of natives and 15% of foreign born individuals live below poverty in New York State. Nineteen percent of non-citizen foreign born individuals in New York live below poverty.

Data on undocumented immigrants, is very scant, and does not break down immigrant populations by maternal and child health categories. The reliability of the data is uncertain, at best. One of the only sources of information on this group was a report published by the Urban Institute in April of 1998. According to that report:

- The majority of the foreign-born in New York were here legally (84%).
- About 16% of the State's immigrants were undocumented. Undocumented people represented a smaller percentage of the State's immigrant population than any other major immigrant state, except New Jersey. Nevertheless, New York was estimated to have the third highest number of illegal immigrants living in the state, behind California and Texas.
- Over a third (37.3%) of the households headed by undocumented immigrants contained one or more US natives. Babies born in this country are defined as natives and citizens.
- The average income for undocumented aliens was found to be substantially lower than for those foreign-born who were legally present, $12,100 vs. $18,000 (Based on 1995 data).

Education: According to the NYS Education Department, in the 2008-09 school year, 3.12 million students were enrolled in New York State's public schools. About 14 percent of the State's school children attend nonpublic schools. (Educational Statistics for New York State, Table 1, School Enrollment, NYS Department of Education)

In 2007-2008, funding for education in New York was from several sources. Specifically, 45.1 percent was from the State, 48.2 percent from local school districts and 6.7 percent from the federal government (Educational Statistics for New York State, Table 11 – Total

Expenditures and State Funds and Table 12 Federal Aid for Education, NYS Department of Education).

Data for fiscal year 2007 indicate the per-pupil expenditures in New York State were $15,536. The average for the U.S. as a whole was $9,603. With a rank of 1 being the best and 51 the worst, New York ranked 2nd in the US for per-pupil expenditure, reflecting the high priority of education in New York State (U.S. Department of Education, National Center for Education Statistics, Common Core of Data (CCD), "National Public Education Financial Survey (NPEFS)," fiscal year 2007).

The Distribution of NYS Enrollment by race and type of school are in the chart below.

Statistics for Public and Nonpublic Schools

Percent Distribution of Students by Race/ Ethnicity by Type of School, Fall 2006

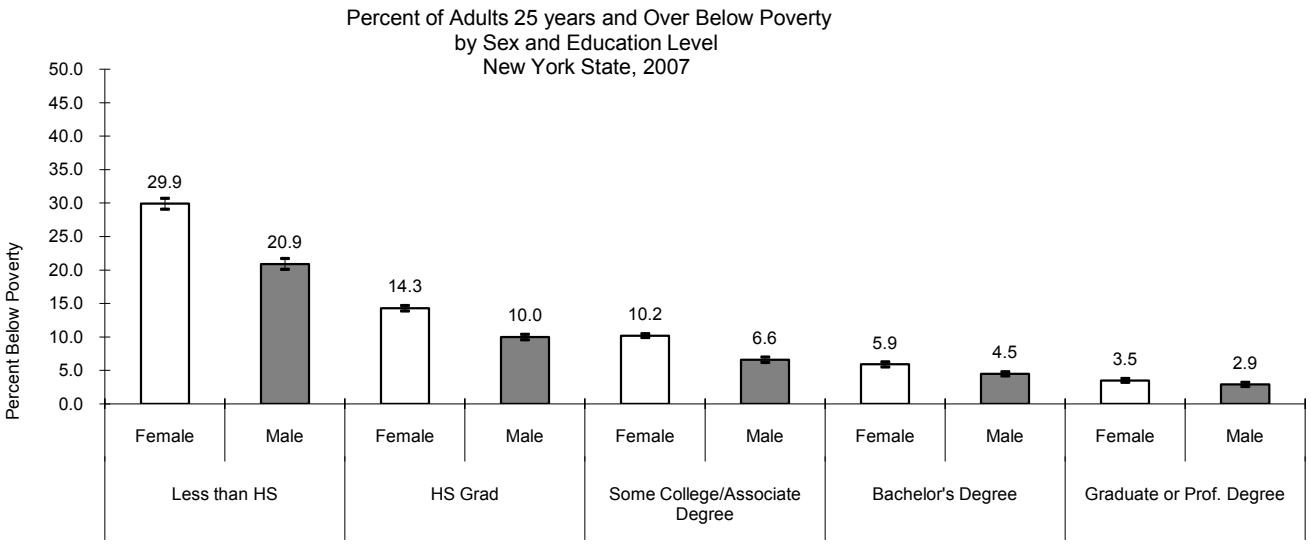
Source: NYS Education Department, Educational Statistics fro NYS – Tables 3 & 4

Enrollment				
	% White	% Black	% Hispanic	Other
New York City	14.1	32.3	39.4	14.2
Large City Districts (including NYC)	14.8	34.4	37.7	13.1
Districts Excluding the Big 5 (Rest of State)	78.0	8.7	8.8	4.5
Total Public	52.6	19.9	20.4	7.9
Total Nonpublic (Fall 2007)	67.8	13.3	11.6	8.4

According to the National Center for Educational Statistics, during the 2006-2007 school year, there were 12.8 pupils per teacher in New York State's public schools, compared to the US average of 15.5 pupils per teacher. Class sizes in New York State public schools ranged from an average of 22 students in elementary school classes to about 23 students in high school regents classes (NYS 2006-2007 School Report Card).

In New York State, 75 percent of the students in the 2002 graduation cohort (students expected to graduate by August 2006) actually graduated. Graduation rates varied among students. Fifty-five percent of black students, 53 percent of Hispanic students and 88 percent of white students graduated as expected. Of students considered economically disadvantaged, 60 percent graduated on time while among students with limited English proficiency the rate was 40 percent. These data are also reported in the NYS School Report Card of September 01, 2007.

Despite the heavy emphasis put on secondary and post-secondary education in our State, the percentage of students that do not complete high school is of significant concern. According to the 2007 American Community survey, in New York State, 26 percent of persons with less than a high school education live below poverty. Among females without a high school education the percent below poverty is 30 percent. The chart below presents education attainment by poverty level and sex for adults over the age of 25.



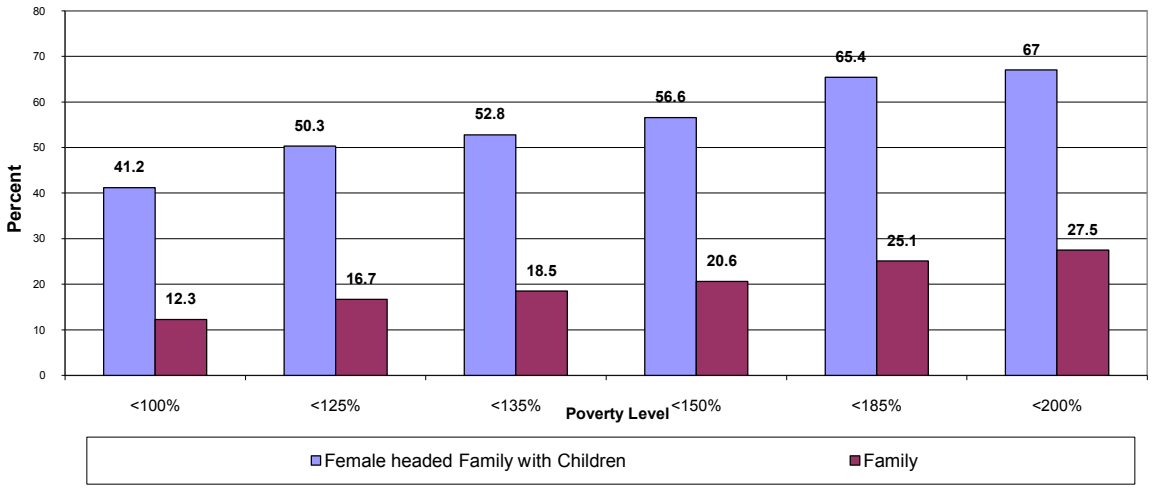
Source: US Census Bureau, American Community Survey 2008 - (S1501) Educational Attainment

Educational Attainment of Mothers: Lack of education is widely recognized as a factor in health, determining how and where people live and the quality of their lives. Low educational attainment influences occupational choices, income and quality of family life. Lack of maternal education is linked with higher utilization of health services, taking fewer precautions in safeguarding their child's health, and with higher infant mortality.

In New York State, 19.3% of women giving birth in 2007 had less than a high school education. Among African American and Hispanic women, the percentage is even higher (23.10% and 39.6%, respectively).

Mothers in New York City were significantly more likely than mothers in the rest of the state (22.0% vs. 16.8%) not to have completed high school. The number of mothers without a high school diploma in the Bronx and Brooklyn alone was nearly equal to the number of mothers in the rest of the state outside New York City. Women giving birth in the Bronx in New York City and in Yates County in Upstate New York were least likely to have graduated from high school, with graduation rates of 67% and 60%, respectively. On the other hand, mothers from Saratoga and Hamilton Counties had the highest high school completion rates, at 93% and 94% completion, respectively. Within New York City, Richmond (Staten Island) and New York (Manhattan) counties had the highest High School graduation rates (84% and 85%, respectively).

Poverty Status of Familes and
Persons Living in Female Headed Households with Children
New York State, 2007



Source: Current Population Survey, Annual Social and Economic Supplement 2008

Poverty is highly associated with poor health outcomes, especially for women and children. Poverty is most common in families headed by single females, and single-female headed households with children are more likely than other families to be living below poverty. This is true regardless of race or ethnicity. Given this, New York continues it's commitment to reduce rates of teen pregnancy and out-of-wedlock births and to provide poor heads of households with jobs. According to the 2008 Current Population Survey, during 2007, 41.2 percent of the people in female-headed households with children lived below poverty in New York State. For a female-headed household with two children, the Federal Poverty Level would be an income of $16,702 or less per year. Even at 200% of poverty, which includes 67 percent of female–headed families, the income level would be no more than $33,404.

Prior to the recent leveling off of poverty rates among children, New York State had made much progress in reducing child poverty. In 2000, New York's child poverty rate was at its lowest level in 21 years, largely because the State had increased employment among its most economically needy families. According to the US Bureau of the Census, employment for the State's most vulnerable families rose sharply after implementation of welfare reform in 1995. There was a concurrent 28% decline in the rate of child poverty, from 26.4% in 1994 to 20% in 2001. In 2007, 897,000 of New York's children (20.4 percent) were living below poverty. This is higher than the 10 percent in the nation as a whole. According to the NYS Office of Temporary and Disability Assistance, reductions in the number of families on Public Assistance were accompanied by a rise in employment among the disadvantaged and a reduction in both teen pregnancies and out-of-wedlock births. In addition, Census data indicates that the upward trend in single mother families and the downward trend in married couple families have abated.

New York is committed to employment for parents, and to supportive programs such as the Prenatal Care Assistance Program, Child Health Plus, Children's Medicaid, Family Health Plus, WIC and the Child and Adult Care Feeding Program. In 2007, 44.4 percent of all obstetrical deliveries were paid for by Medicaid or self-pay. In 2006 the percent was 42.7

percent and in 2005, 43.1% of all obstetrical deliveries were paid for by Medicaid or self-pay.

In comparing poverty levels among age groups, there is a general decrease in poverty, as individuals grow older. In 2000, the percent of those living in households earning less than 100% of the poverty level were: 19.2% for children birth to age 9, 18.2% for 10 to 19 year-olds, 14.1% for 20 to 29 year olds, 11.6% for 30-39 year olds, and 10.7% for those over 50.

Educational attainment also has a major impact on median income. As educational level increases, so does income. A female with a bachelor's degree earns 88 percent more than a female with just a high school education. Men earn more than their female counterparts with the same education. In fact, males with less than a high school education have a higher median income than females with a high school diploma.

Access to Primary Care: According to the latest available National Survey of Children's Health, 2005-2006, 54 percent of New York's children had a personal doctor or nurse and received care that was accessible, comprehensive, culturally sensitive, and coordinated. Eighty-eight percent had a preventive medical visit in the past year and about 69 percent had a preventive medical visit and a preventive dental visit in the past year. All of these percentages were higher than the national averages for these indicators.

More New Yorkers are establishing a medical home under a managed care plan. In 1998, 29.1% of New Yorkers enrolled in the Medicaid program received their care through enrollment in managed care. By March of 2007, about 69% or 1,999,688 of the 2,890471 Medicaid-eligible people in the State received their care through a managed care plan. Percentages are higher for New York City (75%) when compared to rates for the State outside New York City (56%).

Access to Dental Care:

New York State, with 83.6 dentists per 100,000 population, was well above the national rate of 63.6 and ranked 4th in the nation in dentists per capita. The per capita ratio of dental hygienists was slightly higher than the national rate. However, the distribution of dentists and dental hygienists is geographically uneven. There are many rural and inner city areas in the State where shortages of dentists and dental hygienists exist, where specialty services may not be available, and where the number of dental professionals treating underserved populations is inadequate.

The demand for dentists, based on current employment levels, is projected to increase by 3.1% from 10,220 jobs in 2002 to 10,530 in 2012. During the same time period, the demand for both dental hygienists and dental assistants are both projected to increase by nearly 30%. In 2004, of the 14,932 dentists licensed to practice in New York State, 46% were enrolled in Medicaid and 20% were enrolled in Child Health Plus. During the same time period, however, only 3,845 dentists statewide (26%) had at least one claim paid by Medicaid. Of the 3,845 dentists submitting at least one claim, 90% (3,454) had $1,000 or more in Medicaid claims during 2004.

Those who are most vulnerable to dental disease are those of low income, those with less education, those who do not have access to preventive dental care, and those with special health care needs or chronic conditions.

Even the comprehensive coverage New York offers under public and private dental insurance is not enough to guarantee access. Other factors, such as the geographic

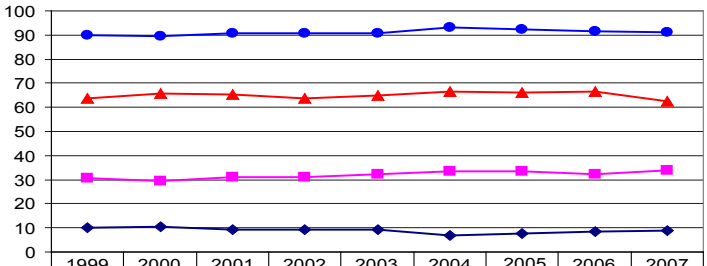
location, transportation, the availability and distribution of dentists and pediatric dental specialists, and parent and patient knowledge and attitudes play a significant role in access to dental care, especially for the poor. According to the Behavioral Risk Factor Surveillance System, in 2008, 72.5% of New York State respondents indicated that they had seen a dentist in the last year. Among Blacks and Hispanics, 66.2% and 68.7% had visited a dentist during 2008.

Health Insurance: According to the Current Population Survey, in recent years the number and percent of children under the age of 18 in New York State who are insured has increased incrementally. More children under the age of 18 were insured in 2007 than in 1999 (91.1% vs. 89.8), and there has been an increase of over 10 percent (10.1%) in the percentage of children under 18 with government insurance (increased from 30.6% in 1999 to 91.1% in 2007). This figure is expected to undergo even further improvement in the coming years, as coverage under Child Health Plus has been extended to children with incomes under 400 percent FPL.

Nationally, 11.0% of children under age 18 were uninsured in 2007, while in NYS only 8.9 percent of children were uninsured in 2007. According to a report by the American Academy of Pediatrics, 64% of U.S. uninsured children lived with one or both full-time working parents and 71% lived with at least one full-time or part-time working parent. The report estimated that 68% of uninsured children nationally, and 67% of uninsured children in New York State were eligible for public coverage but were not enrolled.

The 2007 rate of uninsured New York State residents under the age of 65 was 14.9%, which compares favorably with the national rate of 17.1% without health insurance in 2007.

Health Insurance Coverage Status
by Type of Insurance for Children less than 18 Years Old
New York State, 1999 - 2007

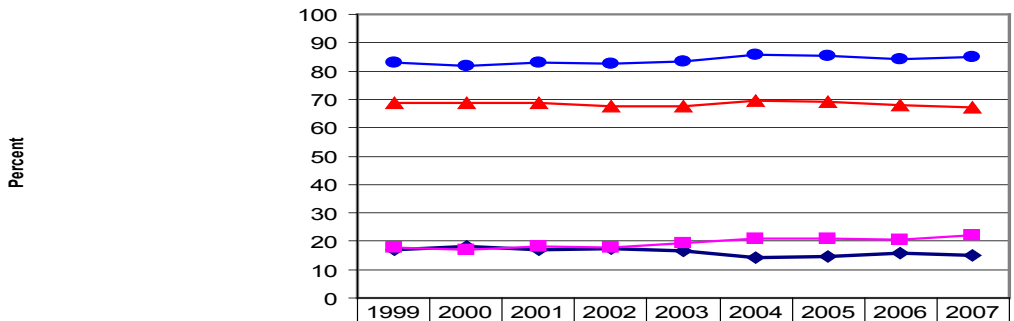


	1999	2000	2001	2002	2003	2004	2005	2006	2007
Uninsured	10.2	10.6	9.1	9.4	9.1	6.7	7.7	8.4	8.9
Government Insurance	30.6	29.3	31.2	31.1	32.1	33.5	33.3	32.4	33.7
Private Insurance	63.9	65.7	65.5	63.7	65.1	66.4	66.1	66.6	62.3
Insured	89.8	89.4	90.9	90.6	90.9	93.3	92.3	91.6	91.1

Year

Source: Current Population Survey (CPS) 2008 Annual Social and Economic Supplement-Health Insurance Table HI-5
Note: Government Insurance includes plans funded by governments on the federal, state, or local level.
Private Insurance includes plans provided through an employer, union or purchased by an individual from a private insurer. An individual can be covered by both private and government insurance.

Health Insurance Coverage Status
by Type of Insurance for Persons Under Age 65 Years of Age
New York State, 1999 - 2007



	1999	2000	2001	2002	2003	2004	2005	2006	2007
Uninsured	17.1	18.1	17.1	17.3	16.7	14.2	14.8	16.0	14.9
Government Insurance	17.9	17.1	18.1	17.9	19.3	21.1	21.0	20.7	22.1
Private Insurance	68.6	68.6	68.6	67.7	67.4	69.6	69.3	67.9	67.1
Insured	82.9	81.9	82.9	82.7	83.3	85.8	85.2	84.0	85.1

Year

Note: Government Insurance includes plans funded by governments on the federal, state, or local level. Private Insurance includes plans provided through an employer, union or purchased by an individual from a private insurer. Persons can be covered by both Private and Government Insurance.
Source: US Census Bureau, Health Insurance Table HI-6

Until recently, it has been difficult to estimate the number of uninsured within each county in the state. Recently, however, the US Census Bureau has developed a model-based methodology to estimate health insurance coverage for counties and states. Utilizing this methodology and data from the 2008 Annual Social and Economic Supplement to the Current Population Survey (CPS), NYSDOH staff have prepared county level uninsured estimates for NYS. According to these estimates 9.2% of New York State's children under the age of 19 were uninsured in 2007. The percent of children uninsured varied widely throughout New York State. The counties with the highest percentages of uninsured children were Hamilton (20.8%), Putnam (15.3%) and Otsego and Sullivan (12.7%). The lowest rates of uninsured children were in the counties of Monroe (5.5%), Chemung (5.7%), and Oswego (5.8%).

To address concerns for the 5.5–20.8% of New York's children who are uninsured, the Department and local partners are working diligently to find and enroll the children who are Medicaid- and Child Health Plus-eligible and their families who may be Family Health Plus-eligible. Office of Medicaid data showed 87.5% of Medicaid-eligible children were enrolled in 2001, up from 1999 & 2000, when 84.7% and 83.1%, respectively, of eligible children were enrolled. The birth to age four groups and the 15- to 19-year-olds were enrolled at the lowest rates, while the 5- to 9-year-olds and 10- to 14-year-olds were enrolled at higher rates. Facilitated enrollment projects are helping to reach un-enrolled children and enroll them in either Medicaid or Child Health Plus. In 2008, financial eligibility levels for S-CHIP were expanded to 400% of poverty, paid by state-only dollars, and ongoing efforts are being made to maintain enrolled children in care on a consistent basis.

The Urban Health Institute reported in June 2004 on the National Survey of America's Families. They reported, based on 2002 figures, that among the uninsured, 27.5% had incomes below the Federal Poverty Level (FPL), 21.2% had incomes between 100 and 200% of the FPL, 11.1% had incomes between 200 and 399% of the FPL, and 5.3% of the uninsured had incomes 300% or higher than the FPL. People living in metropolitan areas were slightly more likely to be uninsured than those in non-metropolitan areas (2.1% as opposed to 10.5%). Being uninsured was more common among foreign-born individuals (26.1%) as compared to U.S. born (8.4%). The uninsured were more likely to rate their current health status as fair or poor (23.6%) than excellent, very good, or good (10.3%). 12.8% of the uninsured reported having a limiting disability.

The State of New York has made a huge commitment to public support of health and social welfare services for state residents under Medicaid and other public insurance programs. Additionally, New York has had a Bad Debt and Charity Care Pool for a number of years to cross-subsidize hospitals that bear higher rates of uncompensated care from those with fewer non-paying users. People in need are not turned away from New York's hospitals for inability to pay for services.

Expanded Medicaid Eligibility for Immigrants: In New York, qualified immigrants formerly subject to the five year ban on Medicaid eligibility and immigrants who are Permanently Residing in the United States Under Color of Law (PRUCOL) may be eligible for state-only Medicaid and Family Health Plus, so long as they meet all financial eligibility and other rules to be eligible for benefits under these programs. Immigrants who are determined to be class members may also be eligible for reimbursement of payment of

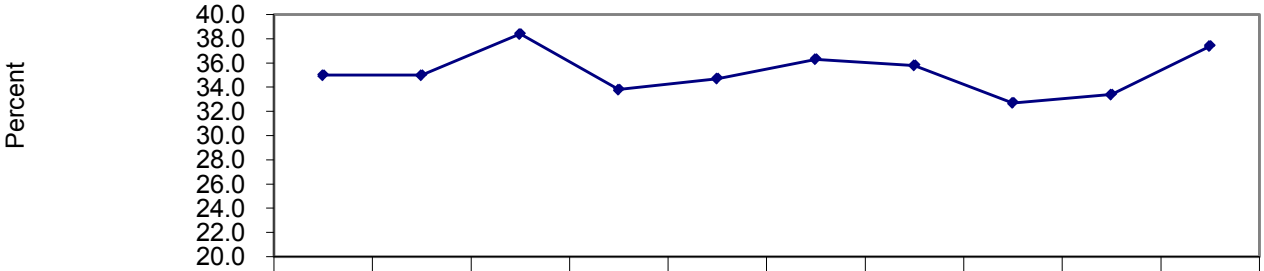
doctors' and other health care provider bills for care and services received on or after September 12, 1997 and August 5, 2004.

Overall Health: According to the United Health Foundation, the American Public Health Association and the Partnership for Prevention, which regularly assess the overall healthiness of the nation, New York ranked 25th in overall healthiness in 2008. In 2007, the ranking was 26th and in 2005, 29st. Reasons for the improved ranking include New York's ready access to primary care, high immunization coverage and low geographic disparity within the state as compared to other states.

A. Pregnant Women, Mothers and Infants

Unintended Pregnancy: In 2007, more than one third of new mothers responding to the PRAMS survey indicated that their pregnancy was unwanted or mistimed (37.4%). This rate was somewhat higher than the 2006 rate of 33.4%, but this number may not represent a true increase due to large variability over time in PRAMS numbers. About 63% of women reported that they wanted their pregnancy either when it occurred (46.6%), or earlier (16.0%).

Women Whose Pregnancy Was Unintended
New York State Excluding New York City 1996 - 2007
Source: PRAMS Survey



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
%Unintended	35.0	35.0	38.4	33.8	34.7	36.3	35.8	32.7	33.4	37.4

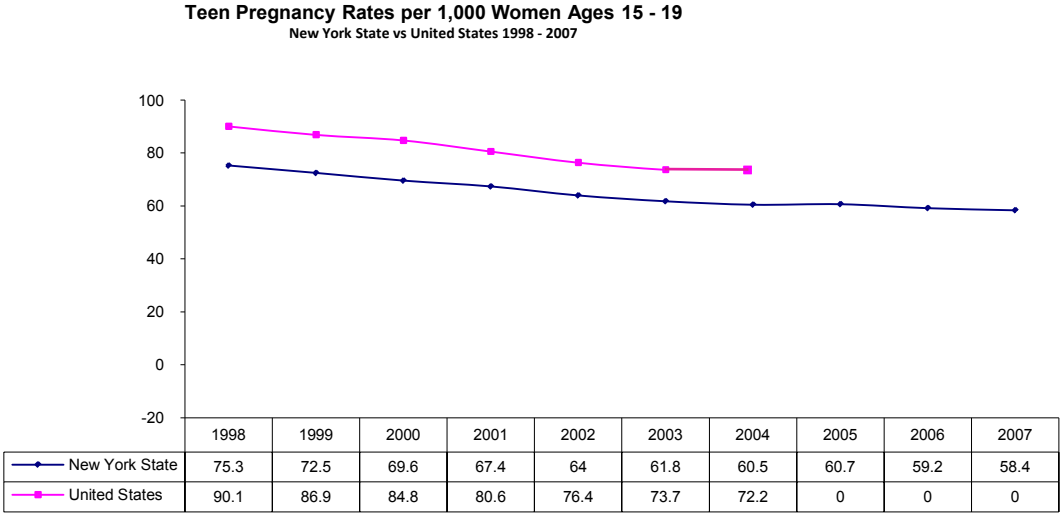
In New York City in 2006, 35.9% of moms responding to the PRAMS survey indicated that their pregnancy was not wanted or was wanted later. This was an incremental improvement over 2005, when 37.8% reported that their pregnancies were unintended at this time. NOTE: A statewide PRAMS file is expected from CDC, but has not yet been received. Until it is available, Upstate and NYC PRAMS data must be reported separately. Groups at highest risk for unintended pregnancy in 2007 were women under the age of 20 (62.7%); women who were not married (59.0%); African American women (60.1%); women on Medicaid (59.0%); and women with less than a high school education (46.0%). Changes in the percentages for these sub-groupings from year to year are generally not significant. The small number of respondents within these categories result in large confidence intervals and thus fluctuation in the rates from year to year.

Responses to Question on Intendedness of Pregnancy
PRAMS Survey 2000 to 2007 (NYS Excluding NYC)*

Response:	2000	2001	2002	2003	2004	2005	2006	2007
Total reporting pregnancy was unwanted or mistimed	38.4%	33.8%	34.7%	36.3%	35.8	32.7	33.4	37.4
Of those that were:								
Under age 20	76.4%	77.5%	81.7%	66.1%	77.9	63.4	75.6	62.7
Unmarried	67.9%	60.1%	63.2%	63.2%	59.5	54.5	56.3	59.0
African American	64.8%	56.6%	62.3%	71.1%	66.5	55.7	75.8	60.1
On Medicaid	57.9%	56.6%	57.2%	57.6%	56.1	48.1	48.1	59.0
Less than a high school education	51.2%	57.1%	51.9%	53.2%	54.3	48.9	40.3	46.0
Total reporting pregnancy was wanted when it occurred	44.5%	44.6%	44.1%	45.0%	42.4	46.4	47.9	46.6
Total reporting pregnancy was wanted earlier	17.2%	21.6%	21.2%	18.7%	21.8	20.8	18.7	16.0

<u>Adolescent Pregnancy Rates</u>: We know that adolescent pregnancy is highly correlated with lack of educational attainment and lasting disadvantage in earning power and economic potential. Teens are less likely to eat correctly, gain sufficient weight during pregnancy, or get early, continuous prenatal care. Teen moms are at greater risk than women over age 20 for pregnancy complications like premature labor, anemia and high blood pressure. The risks are even greater for teens under 15 years of age.

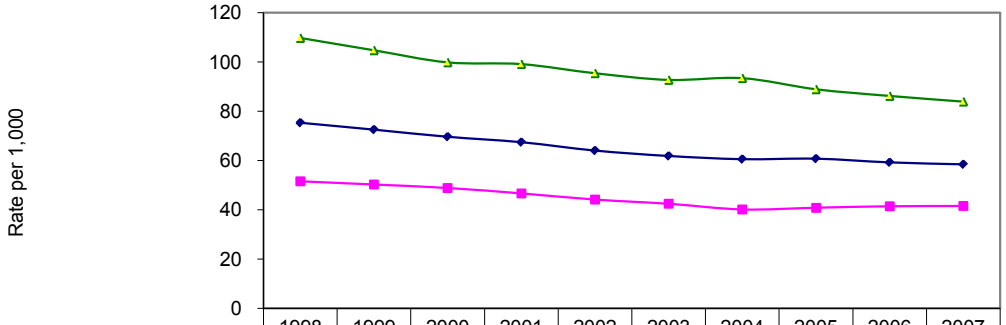
New York's adolescent pregnancy rate is lower than the national average. However, New York is continuing to address this issue in an effort to make even further gains in decreasing pregnancies in this age group.



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
New York State	75.3	72.5	69.6	67.4	64	61.8	60.5	60.7	59.2	58.4
United States	90.1	86.9	84.8	80.6	76.4	73.7	72.2	0	0	0

Since 1998, the pregnancy rate for girls aged 15-19 has been decreasing; the 2007 rate of 58.4 per 1,000 is 22% lower than the 1998 rate of 75.3 per 1,000.

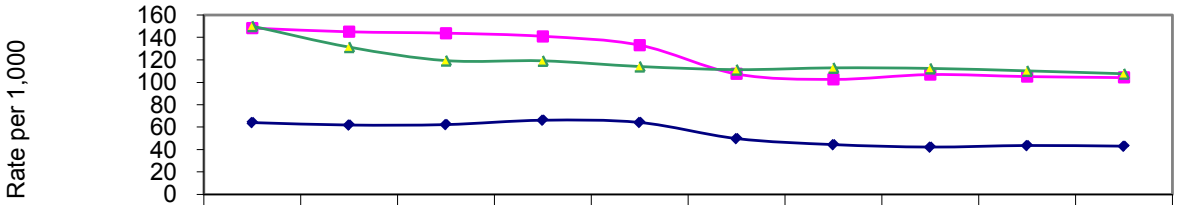
Teen Pregnancy Rates per 1,000 Women Ages 15 - 19
By Region



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
New York State	75.3	72.5	69.6	67.4	64.0	61.8	60.5	60.7	59.2	58.4
Upstate New York	51.6	50.3	48.9	46.7	44.2	42.5	40.2	40.9	41.5	41.6
New York City	109.7	104.7	99.8	99.1	95.4	92.7	93.4	88.9	86.2	83.9

Racial and ethnic disparities in teen pregnancy rates continue, although the actual magnitude of the disparity is decreasing. In 2007, the White teen pregnancy rate was 42.9 per 1,000 white teen girls, less than half the rate for Black (104.2) and Hispanic (107.6) teen girls. Rates for all race/ethnicity groups continue to decline. The black/white ratio of teen pregnancy rates was 3.6 to 1 in 1998, and had decreased to 2.4 to 1 in 2007, a significant decline.

Pregnancy Rate per 1,000 Women Ages 15 - 19
New York State Residents by Race 1998 - 2007

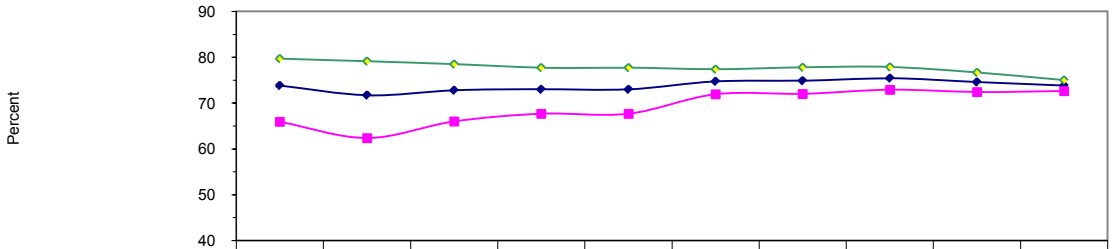


	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
White	64.0	61.8	62.2	66.1	64.1	49.7	44.3	42.1	43.5	42.9
Black	148.3	145.0	143.8	141.0	133.1	107.4	102.6	106.9	105.1	104.2
Hispanic	150.3	131.5	119.4	119.2	114.1	111.3	112.9	112.4	110.2	107.6

Prenatal Care: In 2007, the percent of women giving birth in New York State who received early prenatal care (first trimester) was 73.8%, a reduction from the 2006 percentage of 74.6%. However, rates of early entry to prenatal care, overall, have been basically stable over the past decade (73.8% in both 1998 and 2007), with some minor fluctuations. This does not mean, however, that the regional rates have been stable. The rate for women outside of NYC was initially significantly higher than the rate for NYC women, but NYC rates of early entry to prenatal care have improved more than 10 percent over the past decade (from 65.9% to 72.6%), while rates for upstate women have fallen off

slightly, resulting in far less regional disparity. These rates do not meet the Healthy People 2010 goal of 90 percent first trimester entry to prenatal care.

Early (First Trimester) Prenatal Care
New York State, New York City and Rest of State, 1998 - 2007

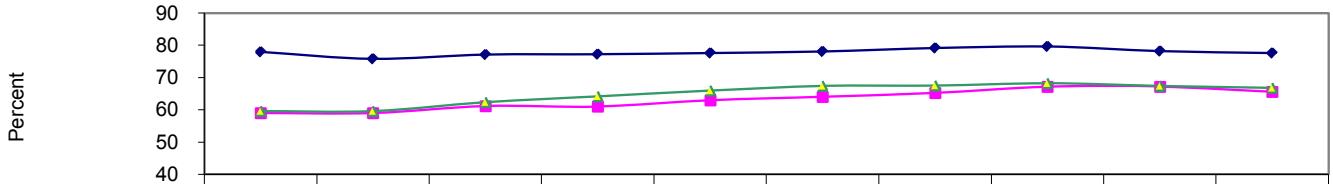


	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
New York State	73.8	71.7	72.8	73.0	73.0	74.7	74.9	75.4	74.6	73.8
New York City	65.9	62.4	66.0	67.7	67.7	71.9	72.0	72.9	72.4	72.6
Rest of State	79.7	79.1	78.5	77.7	77.7	77.4	77.8	77.9	76.7	75.0

Consistent with the slight decline in the statewide rate of early entry to prenatal care compared to 2006, early prenatal care rates in 2007 were somewhat lower among all race/ethnicity groups in NYS. A significant, though declining, race/ethnic disparity exists in the percentage of women receiving early care. Rates for white women (77.6%) were 18% higher than rates among black (65.8%) and Hispanic (66.8%) women, while a decade ago the rate for whites was 31-32 percent higher than the rate for black or Hispanic women.

<u>Prenatal Care Among Teens</u>: Women under the age of 18 are less likely than women in

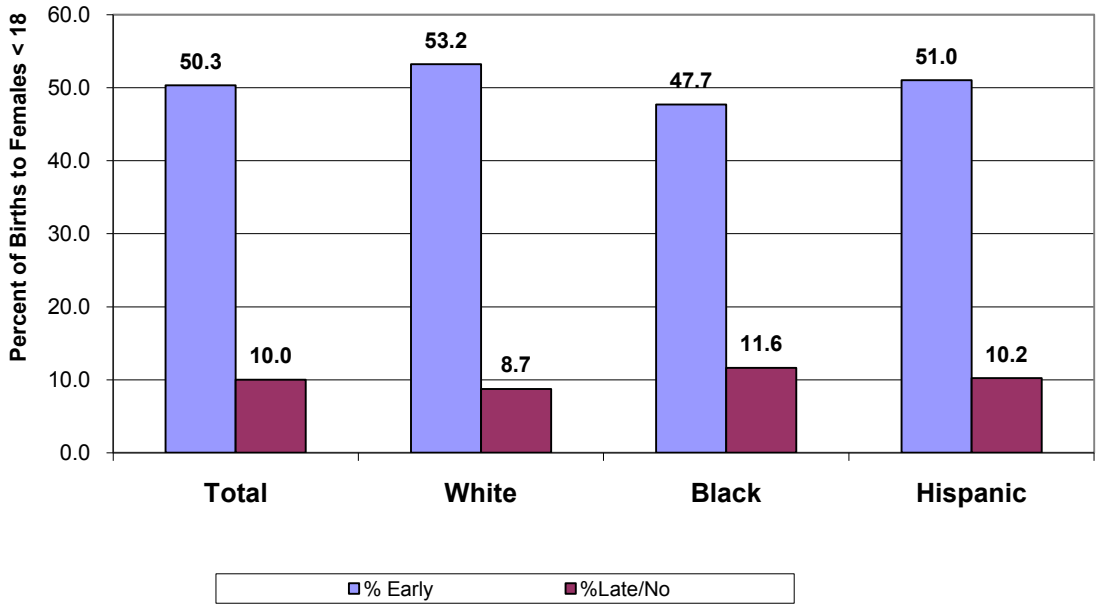
Early (First Trimester) Prenatal Care
By Race, NY State 1998 - 2007



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
White	77.9	75.8	77.1	77.2	77.6	78.1	79.1	79.6	78.2	77.6
Black	59.0	59.0	61.2	61.0	63.0	64.0	65.2	67.1	67.2	65.6
Hispanic	59.6	59.6	62.3	64.2	65.9	67.4	67.5	68.2	67.4	66.8

general to get prenatal care during the first three months of pregnancy. In 2007, just over 50 percent of women under the age of 18 received early prenatal care. The percent was lowest among black (48%) and Hispanic (51%) teens. White teen girls were the most likely to receive early care (53%). About 10% of teen girls gave birth after receiving only late (the seventh month of pregnancy or later) or no prenatal care. Twelve percent of black, 10% of Hispanic and 9 percent of white teen girls received late or no prenatal care before giving birth in 2007. Among women of all ages giving birth in New York State in 2007, 5% received late or no prenatal care.

Percent of Births to Females Aged less than 18 with Early and Late or No Prenatal Care by Race/Ethnicity, New York State, 2007



Adequacy of Prenatal Care: The Kotelchuck Index is a calculation based on the number of prenatal care visits received by pregnant women ages 15 to 44 who had a live birth during the reporting year, expressed as a percentage of observed-to-expected number of prenatal visits. Adequate prenatal care is defined as completion of greater than 80% of expected visits, based on their timing of entry to prenatal care.

The Kotelchuck index for New York State women aged 15-44 giving birth in 2007 was 63.5. This was slightly lower than what was reported in 2006 (65.9). Indices were higher among women residing in Rest of State (68.9) as compared to women residing in New York City (58.0) and higher for White women (67.4) as compared to Black (51.2) and Hispanic women (54.3). However, both geographic (NYC vs. ROS) and racial/ethnic disparities have been reduced over the past decade.

Adequacy of Prenatal Care as demonstrated by Kotelchuck Index
New York State Births
1998 through 2007

	Year →	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07
Region	New York City	56.1	57.6	57.6	56.6	56.5	57.8	59.9	59.5	59.8	58.0
Region	Rest of State	73.9	73.8	72.3	69.7	69.9	67.6	72.7	73.2	71.8	68.9
Region	Total NYS	66.4	66.9	65.6	63.5	63.6	63.1	66.4	66.5	65.9	63.5
Race	White	71.2	71.5	70.1	68.0	68.6	66.6	70.2	70.7	69.7	67.4
Race	Black	51.7	52.9	53.4	50.6	51.8	49.8	53.0	53.6	54.1	51.2
Race	Hispanic	55.5	56.2	56.1	55.0	57.1	55.8	57.8	57.9	57.0	54.3

Location of Prenatal Care: PRAMS responses indicate that 71.4% of women residing in NYS (excluding NYC) in 2007 received their prenatal care in physicians' offices (private MDs or health maintenance organizations). Other sources of care were hospital clinics (12.6%), and community health centers (8.3%). In the recent years, health department clinics provided less prenatal care: 4.6% in 2000, 3.8% in 2004, and 3.6% in 2006. In 2007, however, a higher percentage (5.3%) of women surveyed received care in health department clinics.

Women participating in the 2007 NYC PRAMS Survey were most likely to get their care from a hospital clinic (40.7%) or from an MD/HMO (49.5%).

Content of Care: PRAMS questions on prenatal care elicited responses to indicate that most women received educational information during their pregnancy on nutrition, drinking, smoking, and HIV testing. According to the 2007 survey, of the 88% of women who reported that their prenatal care provider talked to them about HIV testing, 95% went on to be tested during their pregnancy. Of the 12% who were not talked to about HIV testing, 52.5% report being tested.

The proportion of women who reported via PRAMS having read or heard about the importance of folic acid intake in prevention of birth defects increased from 67.9% in 1996 to 77.3% in 1998 to 85.1% in 1999. Between 2002 and 2007, women were asked if they could identify the reason folic acid is important in a multiple choice question. The percent of women answering this question correctly has ranged between 91 and 86 percent. In 2007, 86.8% answered correctly.

Use of Alcohol and Tobacco during Pregnancy: Smoking during pregnancy can cause stillbirth, low birthweight, SIDS and other serious pregnancy complications. About 23% of women who responded to the NYS (excluding NYC) PRAMS survey in 2007 reported they had smoked in the three months prior to pregnancy (up from 22% in 2006), and though most reported they stopped smoking while they were pregnant (13.7% in 2007 reported smoking in the last three months), many reported they returned to smoking (17.9%) after their pregnancy. The percentage of those that smoked after pregnancy, however, was consistently lower than the percentage that smoked before pregnancy. About 3% reported their infants were exposed to second-hand smoke.

According to the 2007 NYC PRAMS Survey, 4.7% of NYC moms answering smoked during their pregnancies and 11.3% were smokers before they became pregnant.

Drinking alcohol during pregnancy is associated with fetal alcohol syndrome, a birth defect that is 100 percent preventable by not drinking alcohol during pregnancy. Women sampled in the PRAMS survey reported that they reduced the use of alcohol during pregnancy. In 2007, 52% reported drinking alcohol in the three months prior to pregnancy, but only 7% drank alcohol during the last three months of pregnancy. This percentage has been relatively unchanged since 2005, but represents an improvement over the 8.2% reporting drinking while pregnant in 2002.

Oral Health and Pregnancy - Evidence is emerging to show that poor oral health may be associated with adverse pregnancy outcomes. Several studies have shown the associations between periodontal disease and increased risk for preterm labor and low birth weight babies. Visits to a dentist during pregnancy are recommended to avoid the consequences of poor oral health. In New York State (exclusive of NYC) in 2007, 45% percent of pregnant women, as estimated from PRAMS, used dental services during their pregnancies. White

women (48%) were more likely to have used dental services during their pregnancy than Black women (33%) and women of "other" races (33%).

Because of the concern about the potential effect of poor oral health prior to and during pregnancy, and because of potential effects of maternal oral health on early childhood caries, and because there are no national standards for the oral health care of women during pregnancy, New York convened an expert panel of obstetricians, dentists and pediatricians to formulate guidelines for the oral care of women during pregnancy and the prevention of early childhood caries. The guidelines were released in the Fall 2005 and were disseminated through professional meetings, patient and professional educational materials and teleconferencing. The Bureau of Dental Health was able to obtain a March of Dimes grant to complete the teleconferencing and web broadcasts.

Maternal Conditions in Pregnancy:

Please see the chart that follows for a summary of maternal behaviors and other findings from the PRAMS data.

Tracking of Selected PRAMS Responses, 1998 – 2007
New York State excluding New York City

Percent of mothers who reported that…	**'98**	**'99**	**'00**	**'01**	**'02**	**'03**	**'04**	**'05**	**'06**	**'07**
…they drank alcohol during pregnancy	7.4	7.2	6.5	6.7	8.2	6.2	6.2	7.0	7.6	7.2
…they smoked prior to pregnancy	28.0	28.0	27.1	24.8	23.3	25.6	28.4	23.0	22.3	23.4
…they smoked during pregnancy	13.8	15.7	17.0	14.4	14.6	14.6	15.6	12.9	12.2	13.7
…they smoked after pregnancy	21.7	22.8	22.4	20.6	19.3	19.2	21.6	17.5	16.9	17.9
…they experienced physical abuse during preg'cy	5.0	5.0	3.7	4.2	4.4	3.4	3.2	2.8	3.2	3.0
…their pregnancy was unwanted or wanted later	35.3	35.1	38.4	33.8	34.7	36.3	35.8	32.7	33.4	37.5
…they initiated breastfeeding	66.9	67.0	69.1	68.6	72.1	71.6	72.4	72.9	76.1	73.9
…they put their babies to sleep on their side.	29.5	25.1	20.2	15.3	15.0	14.3	16.3	17.9	13.6	15.1
…back	53.0	56.7	66.3	68.5	69.4	70.9	69.5	67.2	71.9	70.5
…stomach	17.4	18.2	13.3	15.9	15.1	14.4	14.1	14.3	14.2	14.3
…their babies were exposed to 2nd hand smoke	6.9	6.8	9.9	9.4	7.7	5.3	6.5	4.1	5.6	3.4
…knew that folic acid can prevent birth defects	77.3	81.3	92.0	90.5	90.7	90.7	86.4	87.7	88.1	86.8

Mental Health During Pregnancy:

In 2007, 33.4% of those responding to the PRAMS (Upstate only) survey reported that it was "one of the happiest times of [their] life." 2.6% reported that it was "one of the worst times of [their] life." Most reported that it was somewhere in between:

- 42.5% reported that it was "a happy time with a few problems;"
- 14.2% responded that it was a "moderately hard time;"
- 7.3% reported that it was a "very hard time."

In 2007, 3% of PRAMS respondents in NYS outside of NYC reported they experienced physical abuse during pregnancy while 4% reported abuse during the 12 months before they were pregnant. In 2006, 3% reported abuse prior to pregnancy and 5% reported

abuse during their pregnancy. Due to the small numbers in these categories the differences in these rates are not statistically significant.

Data from the 2007 the NYC PRAMS indicates that 3.6% of respondents reported they were abused before their pregnancy and 3.3% during their pregnancy.

PRAMS Indicators – Rest of State and New York City Comparison: PRAMS (the Pregnancy Risk Assessment Monitoring System) is a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. Initially, the New York State Department of Health collected pregnancy related information from women who resided in areas in Upstate New York (New York State excluding New York City). Then, in 2001, the New York City Health Department received a grant from the CDC to collect these data from women that resided in New York City.

Following is a comparison of data from the New York City and Upstate PRAMS surveys for 2005-2007 (earlier data was unavailable for NYC due to low response rates). The New York State PRAMS coordinators in both New York City and Upstate are working out a plan with CDC to develop statewide estimates for the PRAMS indicators in the near future, and expect to have a statewide sample compile in time for inclusion in next year's MCHBG application. Until that time, NYC and upstate PRAMS data must be reported separately.

In comparing New York City PRAMS responses to Upstate responses:

- The percent of unintended pregnancies in 2007 was lower in New York City (36.0%) as compared to Upstate NY (37.4%).
- Upstate residents were much more likely to receive their prenatal care from a private physician or health maintenance organization as compared to New York City residents (71.4% and 49.5% respectively) in 2007.
- Women giving birth in Upstate New York in 2007 were more likely to smoke during the last 3 months of pregnancy as compared to women residing in New York City (13.7% and 4.7% respectively).
- Women giving birth in New York City in 2007 were more likely to initiate and continue breastfeeding after one month as compared to women residing in Upstate New York.
- More than half of women giving birth in both New York City (57.6%) and Upstate New York (70.5%) put their babies to sleep on their back during 2007.

Comparison of Rest of State and New York City PRAMS Responses – Eligible Quarters in 2005 and 2007						
	2005		2006		2007	
Timing of Pregnancy	**Upstate**	**NYC**	**Upstate**	**NYC**	**Upstate**	**NYC**
Wanted Sooner	20.9%	18.0%	18.7%	19.4%	16.0%	20.3%
Wanted Later	26.6%	31.0%	26.5%	30.1%	29.7%	28.1%
Wanted Then	46.4%	44.2%	47.9%	44.7%	46.6%	43.7%
Did not want	6.2%	6.7%	6.9%	5.8%	7.8%	7.9%
Unintended Pregnancy (not wanted or wanted later)	32.7%	37.8%	33.4%	35.9%	37.5%	36.0
Source of Prenatal Care	**Upstate**	**NYC**	**Upstate**	**NYC**	**Upstate**	**NYC**
Hospital Clinic	15.7%	41.6%	13.0%	43.7%	12.6%	40.7%
MD/HMO	70.3%	48.0%	72.2%	47.2%	71.4%	49.5%
Other	3.7%	1.7%	5.4%	2.4%	2.4%	1.8%
Neighborhood Clinic	n.a	8.8%	n.a.	6.7%	n.a.	8.1%
Health Department Clinic	3.8%	n.a.	3.4%	n.a.	5.3%	n.a.
Community Health Center	6.3%	n.a.	6.1%	n.a.	8.3%	n.a.
HIV	**Upstate**	**NYC**	**Upstate**	**NYC**	**Upstate**	**NYC**
HIV Education Received	93.0%	85.3%	91.5%	87.6%	88.0%	88.6%
Smoking	**Upstate**	**NYC**	**Upstate**	**NYC**	**Upstate**	**NYC**
Smoked 3 Mo Before Pregnancy	23.0%	12.3%	22.3%	10.7%	23.4%	11.3%
Smoked Last 3 Mo of Pregnancy	12.9%	5.4%	12.2%	3.9%	13.7%	4.7%
Domestic Violence	**Upstate**	**NYC**	**Upstate**	**NYC**	**Upstate**	**NYC**
Abuse Before Pregnancy	3.3%	4.9%	3.2%	3.7%	4.0%	3.6%
Abuse During Pregnancy	2.8%	3.7%	5.1%	3.2%	3.0%	3.3%
Breastfeeding	**Upstate**	**NYC**	**Upstate**	**NYC**	**Upstate**	**NYC**
Initiated	72.9%	82.7%	76.1%	84.3%	73.9%	86.5%
At 1 month	56.4%	69.1%	62.3%	71.6%	61.5%	87.0%
Sleeping Position	**Upstate**	**NYC**	**Upstate**	**NYC**	**Upstate**	**NYC**
Side	17.9%	19.7%	13.6%	21.9%	15.1%	17.3%
Back sometimes or always	67.2%	62.5%	71.4%	62.6%	70.5%	57.6%

Prenatal HIV Counseling and Testing:

Since 1990, there has been a 70% decline in HIV infected women giving birth in New York State. Specifically, the number of HIV infected women giving birth in the state went from 1,898 in 1990 to 567 in 2007. As of December 2006 women represented 34.0% of persons living with HIV in the State.

The percent of all women presenting for delivery who were tested for HIV during pregnancy was 95% in 2007 up from 89% in 2000 and 46.7% in 1999.

Prenatal care enrollment among HIV-positive women is high. The percent of HIV-infected women who gave birth that were known to have received some prenatal care was 93% in 2006.

Currently in New York, perinatal HIV counseling and testing are a standard of prenatal care. In 1996, the Department promulgated regulations requiring HIV counseling with testing recommended for all women in prenatal care in regulated facilities (licensed clinics, hospitals, and managed care plans). The Department worked with the American College of Obstetricians and Gynecologists, the New York State Academy of Family Physicians and the American Academy of Pediatrics to establish HIV counseling and testing as the standard of care. Compliance is monitored through chart review by a professional review agent, through the Quality Assurance Reporting Requirements (QARR) submission to the Office of Managed Care, and by own public health program nurses who monitor PCAP compliance.

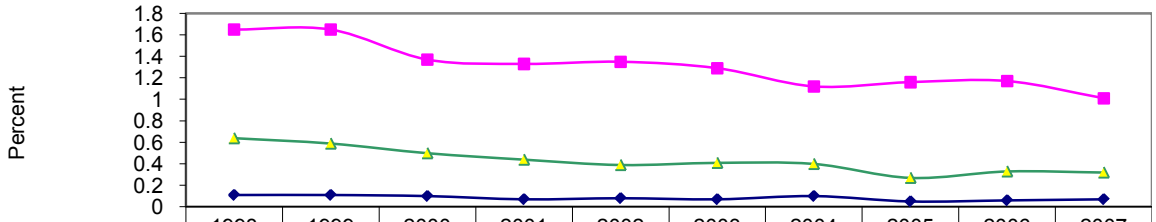
Perinatal HIV Transmission Rates: As a result of various State initiatives, perinatal HIV transmission rates declined dramatically from 1997 through 2007. In 1997, the perinatal HIV transmission rate was 10.9 percent with 97 HIV-infected infants born. In 2000, it was 3.7 percent (28 HIV-infected infants). In 2007, the rate was 1.4 percent, resulting in 8 HIV-infected newborns.

The percent of HIV-infected mothers and/or HIV-exposed infants who received prenatal, intrapartum or neonatal ARV to reduce HIV transmission increased from 64% in 1997 to 99% in 2006.

Perinatal HIV Seroprevalence Rates: Perinatal prevalence rates are significantly higher in African American and Hispanic/Latina women and significantly higher in New York City residents.

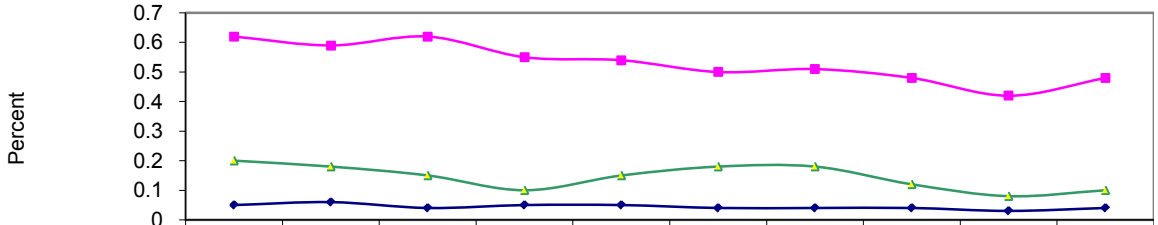
New York's partner/spousal notification law is in effect. The Department tracks the effects on HIV transmission rates. It is important to note that the law also contains a mandate that providers screen for the potential for domestic violence.

HIV Prevalence in Childbearing Women
New York City Residents by Race 1998 - 2007



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
White	0.11	0.11	0.1	0.07	0.08	0.07	0.1	0.05	0.06	0.07
Black	1.65	1.65	1.37	1.33	1.35	1.29	1.12	1.16	1.17	1.01
Hispanic	0.64	0.59	0.5	0.44	0.39	0.41	0.4	0.27	0.33	0.32

HIV Prevalence in Childbearing Women
New York State, Excluding NYC Residents, by Race 1998 - 2007



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
White	0.05	0.06	0.04	0.05	0.05	0.04	0.04	0.04	0.03	0.04
Black	0.62	0.59	0.62	0.55	0.54	0.5	0.51	0.48	0.42	0.48
Hispanic	0.2	0.18	0.15	0.1	0.15	0.18	0.18	0.12	0.08	0.1

Births: There were 252,662 births in New York State in 2007. Of these, 122,932 (48.7%) were to residents of NYC and the remaining 129,730 were to Upstate NY residents. This is 3,456 more births than occurred in 2006. The numbers of births increased among New York City residents and declined slightly among residents of Upstate New York.

In 2007, births to white mothers accounted for 65 percent of all births while births to Black mothers represented 21 percent of the total. Fourteen percent of births were in the "other" category. This includes births to persons of multiple races, as well as all other races.

The majority of births occurred to women between the ages of 20 and 39 (89%). Women aged 45 plus had 811 births and women under fifteen had 193.

Out-of-wedlock births accounted for 40.5 percent of total births. This is slightly more than in 2006 when 39.9 percent of births were out-of-wedlock. Mothers 17 years of age and younger were more likely (95%) to be unmarried compared to mothers aged 25 or older (29%). Out-of-wedlock births were also more common among Black (69.8%) and Hispanic (64.4%) mothers.

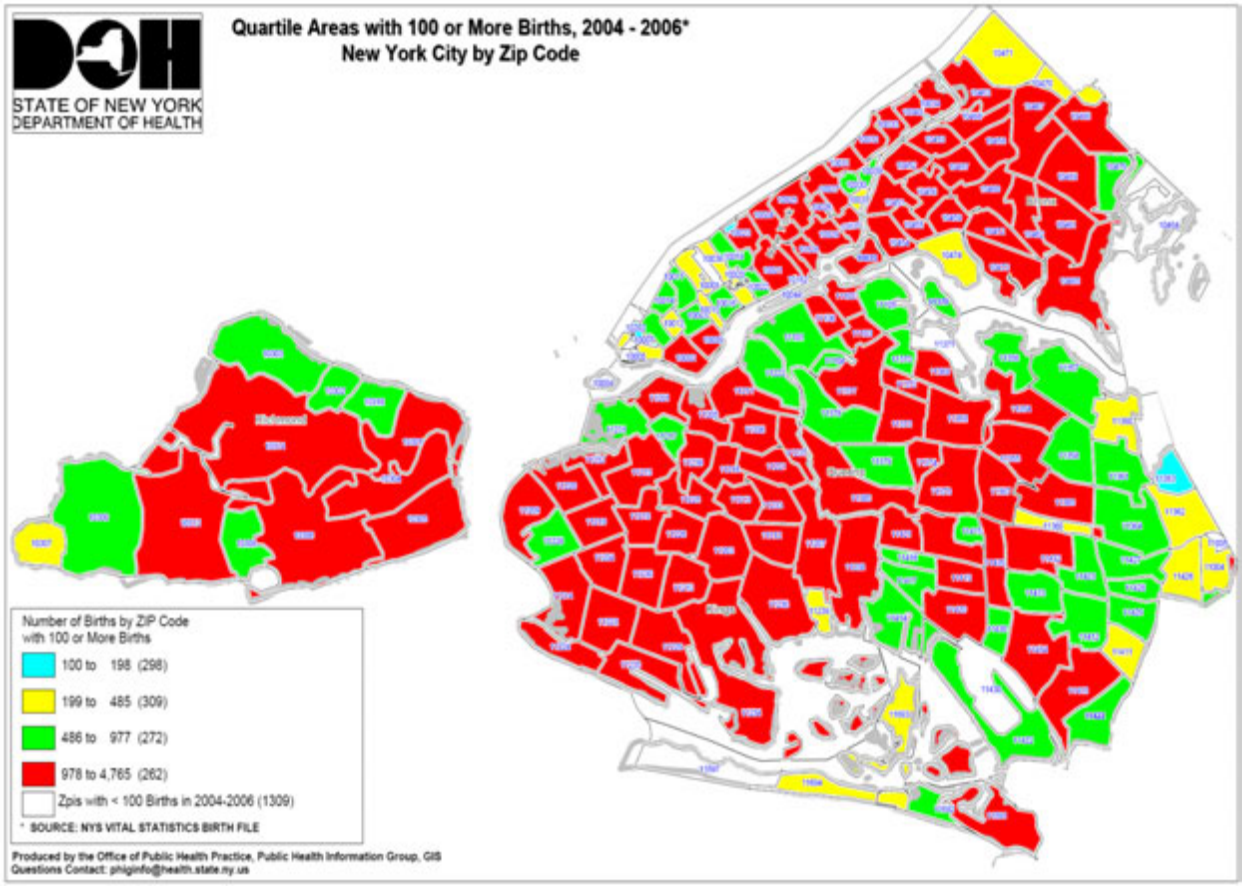
In 2007, 44.4 percent of all obstetrical deliveries were paid for by Medicaid or self-pay. In 2006 the percent was 42.7 percent and in 2005, 43.1 percent.

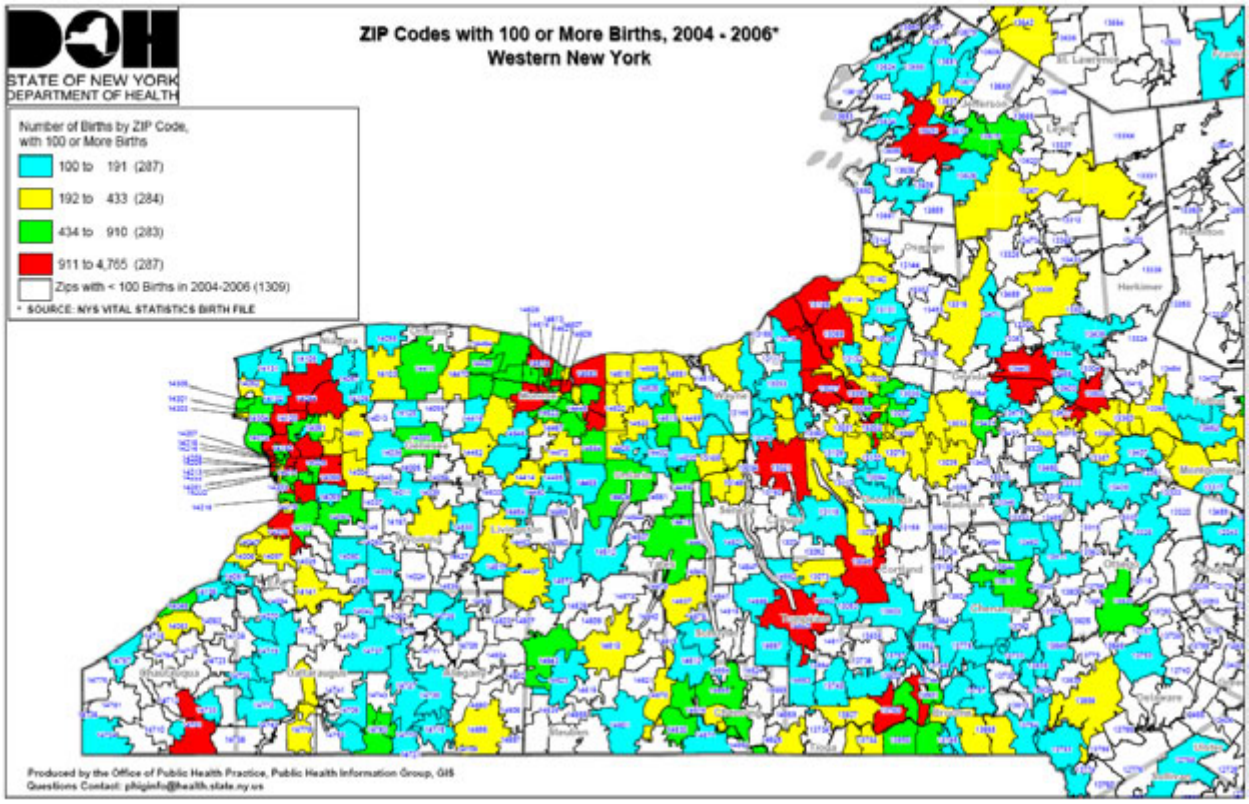
Category	2007 Births -- Mother's Age										
	Total	**<15**	**15-17**	**18-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45 +**	**N.S.**
All Births	252,662	193	5,277	12,322	51,543	67,290	66,128	39,457	9,613	811	28
Sex											
Male	129,027	98	2,687	6,319	26,369	34,178	33,829	20,160	4,955	418	14
Female	123,630	95	2,590	6,003	25,172	33,111	32,298	19,297	4,658	393	13
Not Stated	5	0	0	0	2	1	1	0	0	0	1
Race[1]											
White	164,555	86	2,892	7,166	31,731	42,798	45,151	27,614	6,549	557	11
Black	52,450	87	1,938	4,086	13,400	13,699	10,641	6,485	1,961	146	7
Other	35,324	20	443	1,057	6,346	10,699	10,253	5,314	1,084	104	4
Not Stated	333	0	4	13	66	94	83	44	19	4	6
Ethnicity [2]											
Hispanic	60,326	86	2,361	4,619	16,011	16,878	12,278	6,418	1,564	108	3
NonHispanic	192,336	107	2,916	7,703	35,532	50,412	53,850	33,039	8,049	703	25
Marital Status											
Out of Wedlock	102,394	190	4,997	10,666	33,594	26,498	15,520	8,288	2,467	174	0
Married	147,271	2	242	1,564	17,613	40,184	49,603	30,498	6,961	602	2
Not Stated	2,997	1	38	92	336	608	1,005	671	185	35	26

(1) Race coding based on 2000 census categories: White Alone, Black Alone, Other, Not Stated.
(2) Hispanic is a separate count equal to Hispanic White Alone + Hispanic Black Alone + Hispanic Other + Hispanic Race Not Stated.

For purposes of targeting perinatal programs to areas appropriate to the number of births (for example, a program targeted to all births in a region would not require a high density of births, but one targeted to a relatively rare event, such as postpartum home visiting to families with elective late preterm deliveries, would require a substantial density of births in a relatively small area to have sufficient numbers of the target population to justify staffing), zip code-specific maps are produced on birth density by state, region, and individual areas. As shown in the next figure, where zip codes are color-coded by birth density, in New York City boroughs almost any neighborhood would reach sufficient density for a program targeted to relatively rare events, while in the Western region, seen in the next figure, there are relatively few zip codes that had even 100 births in the three year period used for calculating birth density areas.

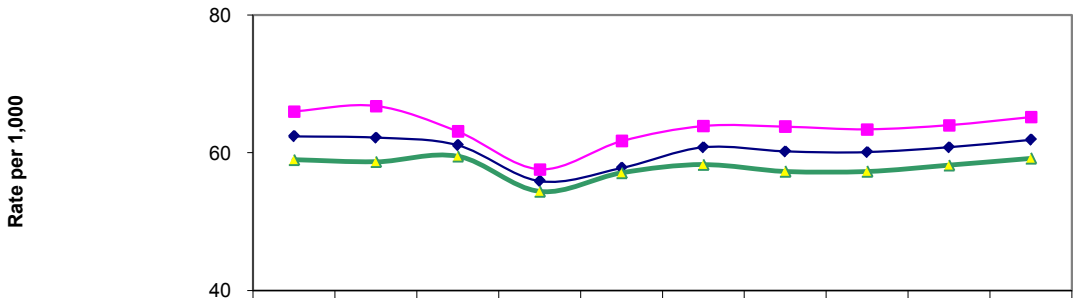
Note: Maps such as these are also produced for targeting of programs to areas of with specific issues, e.g., high rates of infant mortality, low birthweight, cesarean sections, late preterm deliveries, etc. The areas of need are reviewed in conjunction with the birth density areas to determine where programs can best be targeted, if limited funding is available for implementation of programs.


STATE OF NEW YORK
DEPARTMENT OF HEALTH
Quartile Areas with 100 or More Births, 2004 - 2006*
New York City by Zip Code
Number of Births by ZIP Code
with 100 or More Births
100 to 198 (298)
199 to 485 (309)
486 to 977 (272)
978 to 4,765 (262)
Zips with < 100 Births in 2004-2006 (1309)
* SOURCE: NYS VITAL STATISTICS BIRTH FILE
Produced by the Office of Public Health Practice, Public Health Information Group, GIS
Questions Contact: phiginfo@health.state.ny.us


STATE OF NEW YORK
DEPARTMENT OF HEALTH
ZIP Codes with 100 or More Births, 2004 - 2006*
Western New York
Number of Births by ZIP Code,
with 100 or More Births
100 to 191 (287)
192 to 433 (284)
434 to 910 (283)
911 to 4,765 (287)
Zips with < 100 Births in 2004-2006 (1309)
* SOURCE: NYS VITAL STATISTICS BIRTH FILE
Produced by the Office of Public Health Practice, Public Health Information Group, GIS
Questions Contact: phiginfo@health.state.ny.us

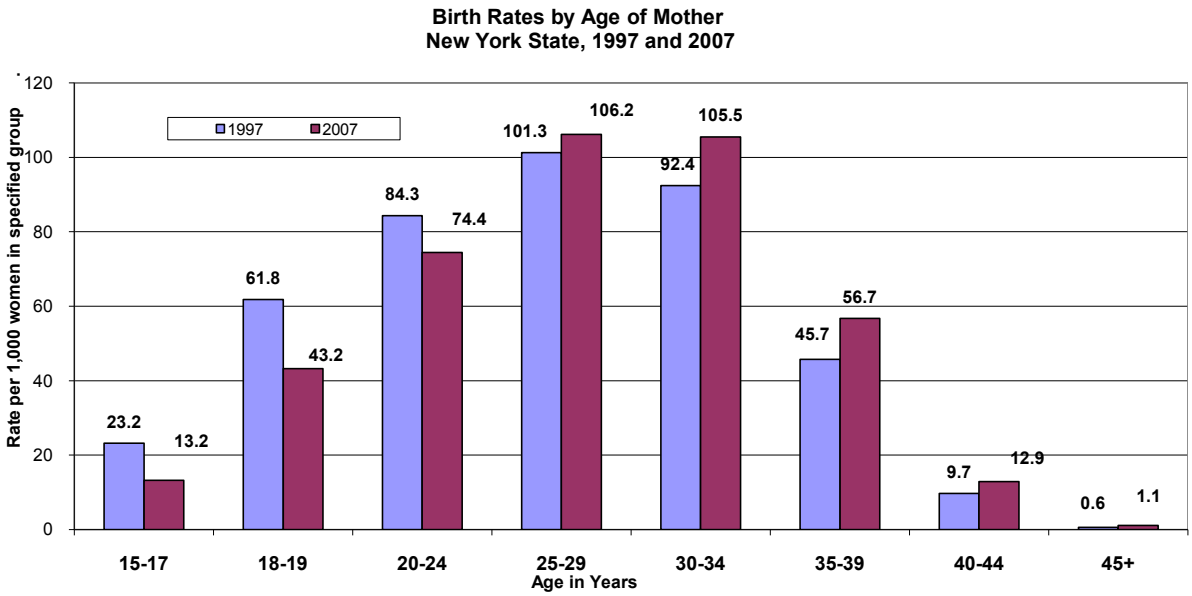
Fertility Rates: After declining from 2000-2001 to 55.9 per 1,000 females aged 15 to 44 years, the fertility rate in New York State has been increasing slowly in recent years. In 2007, the rate was 61.9/1,000. The rate in New York City, at 65.2 per 1,000, was higher than the rate for Rest of the State (59.2 per 1,000). Rates in both New York City and Rest of State were higher compared to the 2006 rates.

Births per 1,000 Females Ages 15 - 44
New York State by Region 1998 - 2007



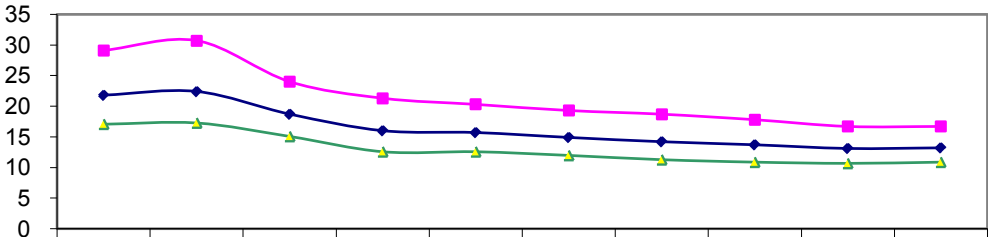
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
New York State	62.4	62.2	61.1	55.9	57.8	60.8	60.2	60.1	60.8	61.9
New York City	66	66.8	63.1	57.6	61.7	63.9	63.8	63.4	64	65.2
Rest of State	59	58.7	59.5	54.4	57.1	58.3	57.3	57.3	58.2	59.2

When comparing rates in New York State by age for the time periods 1997 and 2007, some interesting trends emerge. Between 1997 and 2007 birth rates among women aged 15-25 have all declined. Women aged 15-17 and 18-19 experienced the steepest reduction. Among women aged 25-45+, however, the birth rate has increased. In 2007, women aged 30-34 gave birth at a rate similar to women aged 25-29 (106.2 per 1,000 and 105.5 per 1,000 respectively). In 1997 the birth rate among women aged 25-29 was 101.3 per 1,000, 10 percent higher than the rate among women aged 30-44 (92.4 per 1,000).



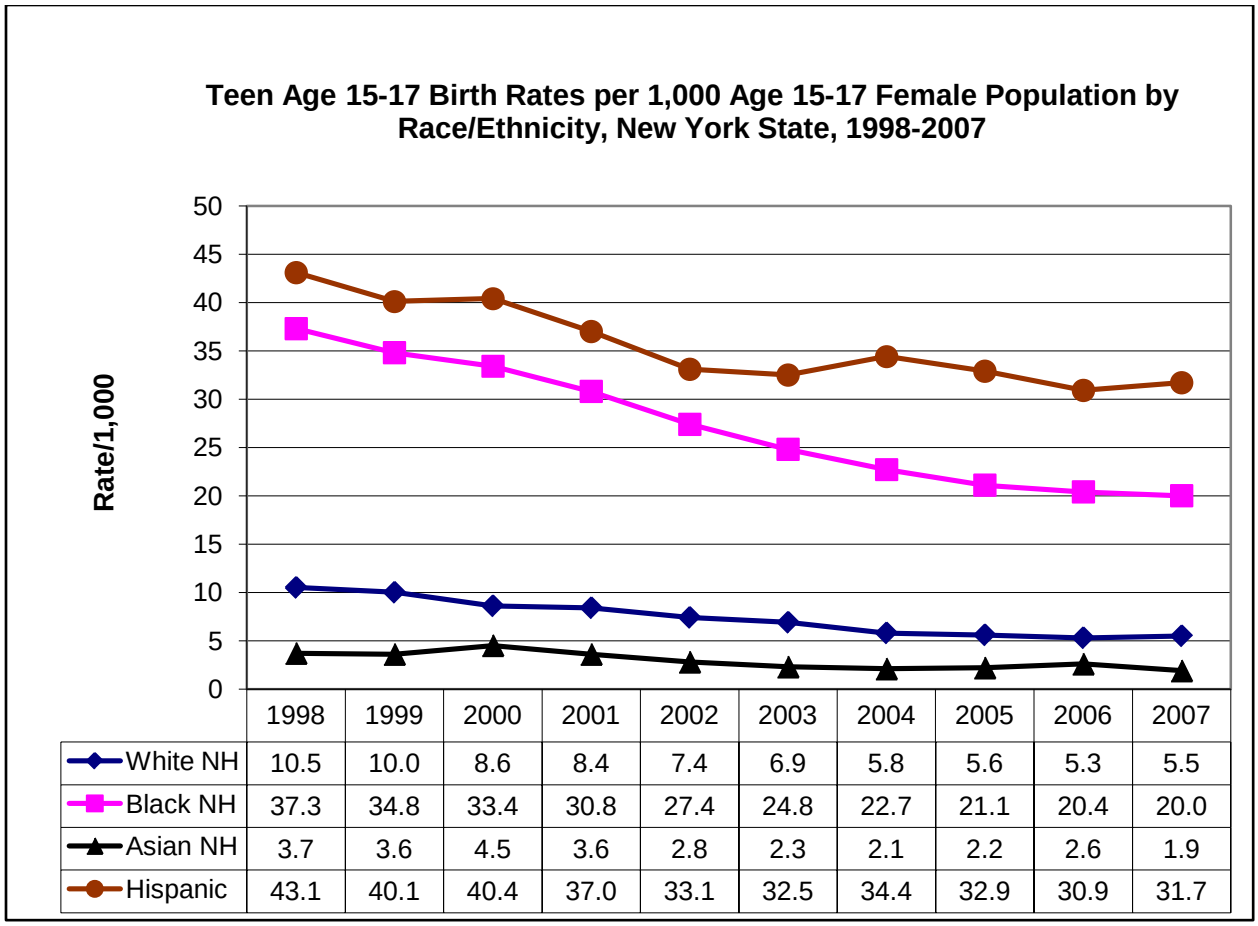
Adolescent Birth Rates: New York State has had excellent success in terms of keeping the birth rate for 15-17 year old girls low, and in 2005 was ranked 9th in the nation on this measure. The birth rate for teenagers aged 15 – 17 rose very slightly between 2006 and 2007 from 13.1 to 13.2 per 1,000 teen girls. Prior to 2007, the birth rate for this age group had been declining over the past 7 years. The 2007 rate of 13.2 was 41 percent lower than the 1999 decade high rate of 22.4 per 1,000 teen girls. The New York City rate, at 17.2 per 1,000, is higher than the Rest of State rate, which was 10.8 per 1,000 young women between the ages of 15 and 17.

Births per 1,000 Females Ages 15 - 17
New York State by Region 1998 - 2007



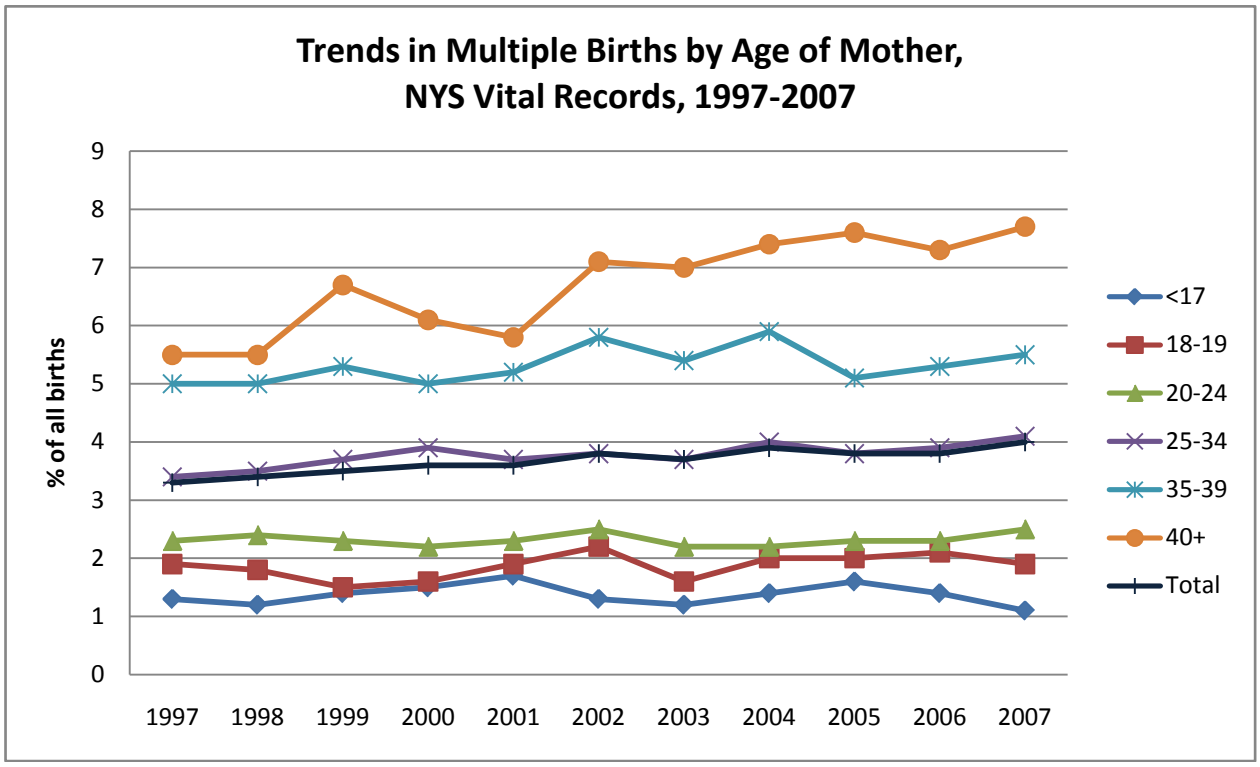
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
New York State	21.8	22.4	18.7	16	15.7	14.9	14.2	13.7	13.1	13.2
New York City	29.1	30.7	24	21.3	20.3	19.3	18.7	17.8	16.7	16.7
Rest of State	17.1	17.3	15.1	12.6	12.6	12	11.3	10.9	10.7	10.9

Birth rates among Black and Hispanic teens were significantly higher than among White teens. During 2007 there were 31.7 births for every 1,000 Hispanic teen girls aged 15-17 in New York State. This is more than 3 times the rate for White teens (10.3 per 1,000) in this age group. Among Black 15-17 year olds the birth rate, at 21.9 per 1,000, was more than double the rate for white teens.



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
White NH	10.5	10.0	8.6	8.4	7.4	6.9	5.8	5.6	5.3	5.5
Black NH	37.3	34.8	33.4	30.8	27.4	24.8	22.7	21.1	20.4	20.0
Asian NH	3.7	3.6	4.5	3.6	2.8	2.3	2.1	2.2	2.6	1.9
Hispanic	43.1	40.1	40.4	37.0	33.1	32.5	34.4	32.9	30.9	31.7

Multiple Births: From 1997 through 2007 there was a slow rise in the percentage of all babies born that were either twins or higher order multiples. In 1997 the rate of non-singleton babies born was 3.3%, and in 2007 the rate was 4.0%, a rise of 21.2%. This rise was not uniform across all age groups, with older women (40+) having the highest rate in each year, as well as the largest increase (from 5.5% to 7.7%, an increase of 40%), and teens <18 having both the lowest rate annually, and the lowest increase (2007 showed an actual decrease over 1997). White women had the highest rates of non-singleton babies, followed fairly closely by black women. Hispanic women and women of other races had rates that were close, and often tied, between 1997 and 2007, and were approximately one-third less than rates for whites.

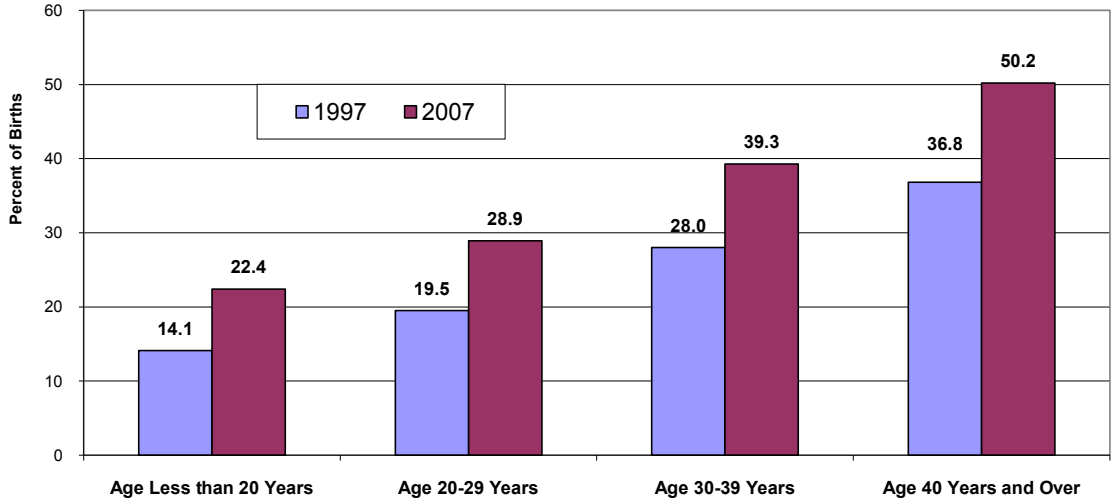


Cesarean Delivery Rates: As in the nation as a whole, the percent of births delivered by c-section in New York State has been steadily increasing over the past decade, from 23.2% of births in 1997 to the current rate of 33.6% of all births, an increase of 45% over this period. Nationally, the percent of all births delivered by c-section was 31.8 in 2007, a new record high, which represents a 50% increase over the past decade.

Deliveries by c-section have increased within all age groups. Women over the age of 40 experienced the highest cesarean delivery rate (50.2%) in 2007, a 36% increase over the 1997 rate. Women less than 20 years of age experienced the largest relative percentage increase (59%) between 1997 and 2007, although the lowest absolute increase. About 22% of women under the age of 20 giving birth in 2007 were delivered by cesarean, compared to over 50 percent of women age 40 and above.

Cesarean Delivery Rates by Age of Mother
New York State, 1997 and 2007

Source: NYS Bureau of Biometrics and Health Statistics



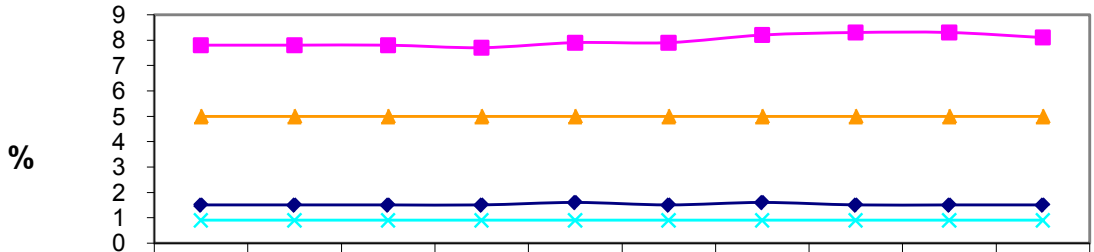
Babies delivered prior to 39 weeks, and in particular those delivered between 34 and (up to but not including) 37 weeks (34-36+) have emerged as an increasing concern, particularly when delivery prior to term is not medically indicated. The New York State Department of Health has begun investigating patterns of preterm delivery, particularly those involving C-section without medical risk factors, but not limited to this group. Failed medical induction has emerged as a significant risk factor for early delivery, but investigations are not yet complete. It is expected that action plans involving the state's perinatal system of regionalized care will be mobilized to address this issue.

Low and Very Low Birth Weight: New York State's low birthweight rate declined slightly in 2007, to 8.1% from 8.3% in 2006. Previously the rate had either increased or stayed the same since 2001. The percentage of low birthweight births in 2007 was still higher than the 1998 rate of 7.8% and 62% greater than the Healthy People 2010 goal of 5.0%. Nationally, 8.2% of births were low birthweight.

The percent of very low birthweight births (<1500 grams) in New York State and the nation as a whole was 1.5% in 2007. The very low birthweight rate is also higher (67%) than the Healthy People 2010 goal of 0.9%.

According to the National Center for Health Statistics, some reasons for the lack of improvement in the rate of low birthweight births are increases in multiple births, obstetric interventions such as induction of labor and cesarean delivery, older maternal age and increased use of infertility therapies (National Vital Statistics Reports, Vol.55, No.1, September 29, 2006).

Percent Low (<2.5 kg) and Very Low (<1.5 kg) Birth Weight
New York Total Births 1998 - 2007

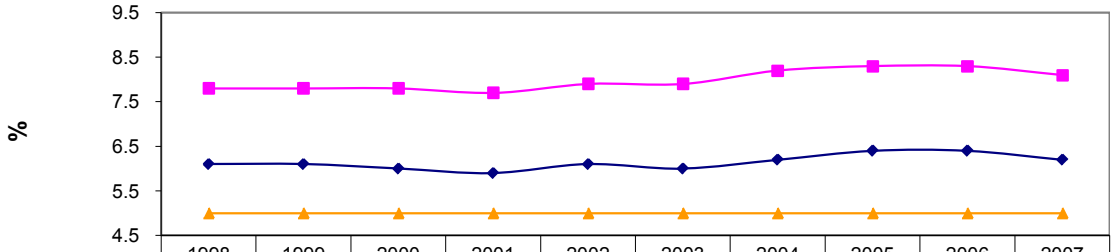


	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Very Low Birthweight	1.5	1.5	1.5	1.5	1.6	1.5	1.6	1.5	1.5	1.5
Low Birthweight	7.8	7.8	7.8	7.7	7.9	7.9	8.2	8.3	8.3	8.1
HP Goal/LBW	5	5	5	5	5	5	5	5	5	5
HP Goal/VLBW	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9

When low birthweight rates for total births are compared to those for singleton births, the rates among singletons are consistently better. Very low and low birthweight births occur more frequently during multiple births. There has been an increase in the past decade in multiple births, as previously discussed, due in part to advances in the technology of assisted reproduction, where multiple births are more common.

The ten-year trends of very low birthweight for both singleton and total births are similar. They were basically unchanged over the past 10 years.

Percent Low Birth Weight (<2500 gms)
New York Singleton and Total Birth 1998 - 2007



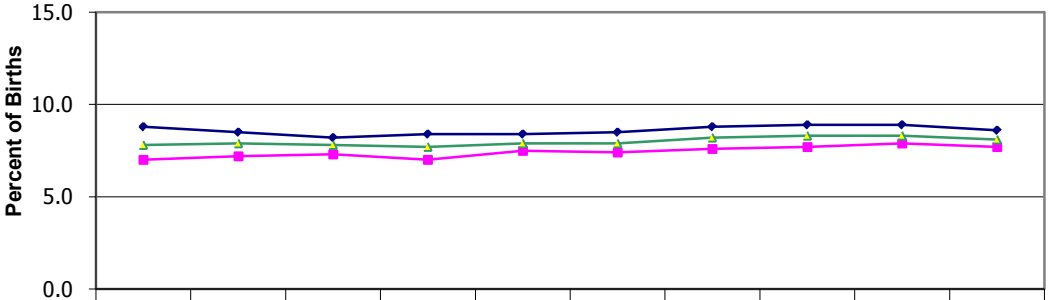
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Singletons	6.1	6.1	6	5.9	6.1	6	6.2	6.4	6.4	6.2
Total	7.8	7.8	7.8	7.7	7.9	7.9	8.2	8.3	8.3	8.1
HP Goal/LBW	5	5	5	5	5	5	5	5	5	5

WIC participants in New York State fare better than WIC participants nationwide in relation to low birth weight. In 2007, the percentage of low birth weight births was 8.7% among NYS WIC participants, compared to 9.2% (2006 data) of WIC participants nationwide.

<u>Low Birth Weight by Region</u>: Low birthweight rates have been consistently higher in New York City as compared to Rest of State. In New York City, the low birth weight rate in

2007 was 8.6%, compared to 7.7% in the rest of State. Both regions experienced a small decrease in their rate between 2006 and 2007.

Percent Low Birth Weight (<2.5 Kg.)
by NYS, NYC and Upstate, 1998- 2007



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
NY City	8.8	8.5	8.2	8.4	8.4	8.5	8.8	8.9	8.9	8.6
Upstate	7.0	7.2	7.3	7.0	7.5	7.4	7.6	7.7	7.9	7.7
NY State	7.8	7.9	7.8	7.7	7.9	7.9	8.2	8.3	8.3	8.1

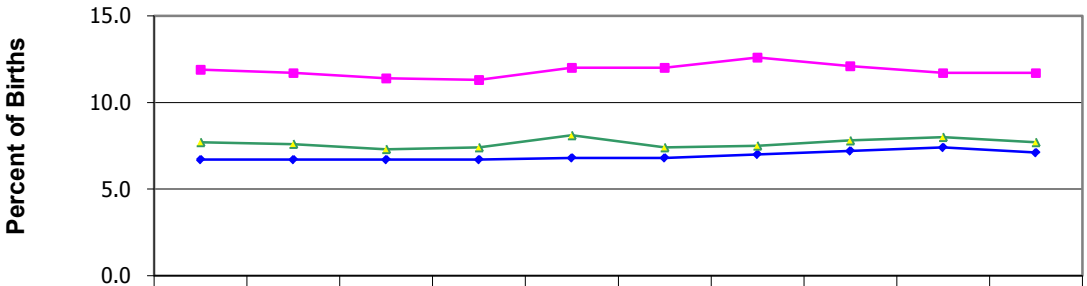
HP 2010 Goal = 5.0 percent

Low Birth Weight Trends by Race and Ethnicity: In 2007, 11.7% of Black infants were less than 2500 grams at birth (low birth weight). This rate is 65% higher than the percentage for White infants (7.1%) and 52% higher than the percentage for Hispanic infants (7.7%). The 2007 low birthweight rate for Black infants was unchanged from the rate in 2006 and is still higher than the 2001 low of 11.3%.

The low birthweight rate among Hispanic infants declined from 8.1% to 7.7% between 2006 and 2007. This rate is unchanged from what was reported 10 years ago and is higher than the 2000 low rate for Hispanic infants of 7.3%.

White infants were the least likely to be born with a low birthweight. In 2007, the percentage was 7.1%, down from 7.4% in 2006. Prior to 2007, the rate had been steadily increasing throughout the decade and in 2006 was at its highest level. Consistent with national trends, the 2007 rate is still higher than the rate reported 10 years ago in 1998 (6.7%).

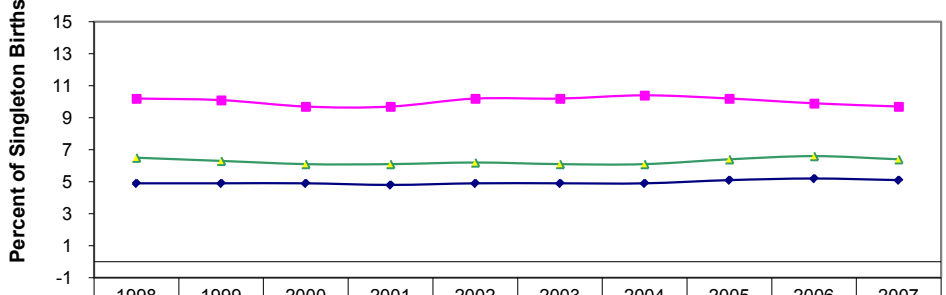
Percent Low Birth Weight (<2.5 Kg.)
NYS by Race 1998- 2007



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
White	6.7	6.7	6.7	6.7	6.8	6.8	7.0	7.2	7.4	7.1
Black	11.9	11.7	11.4	11.3	12.0	12.0	12.6	12.1	11.7	11.7
Hispanic	7.7	7.6	7.3	7.4	8.1	7.4	7.5	7.8	8.0	7.7

Trends in singleton low birthweight rates were basically flat for all race/ethnicity groups. Although there were small fluctuations in the rates over the ten-year period 1998-2007, the percentages of births that were low birthweight in 2007 were within a few tenths of a percentage point of what they were in 1998 among Whites and Hispanics, but represented an improvement of a half a percentage point (nearly 5%) for blacks.

Percent Low Birth Weight (<2.5 Kg.)
NYS Singleton Births by Race 1998-2007

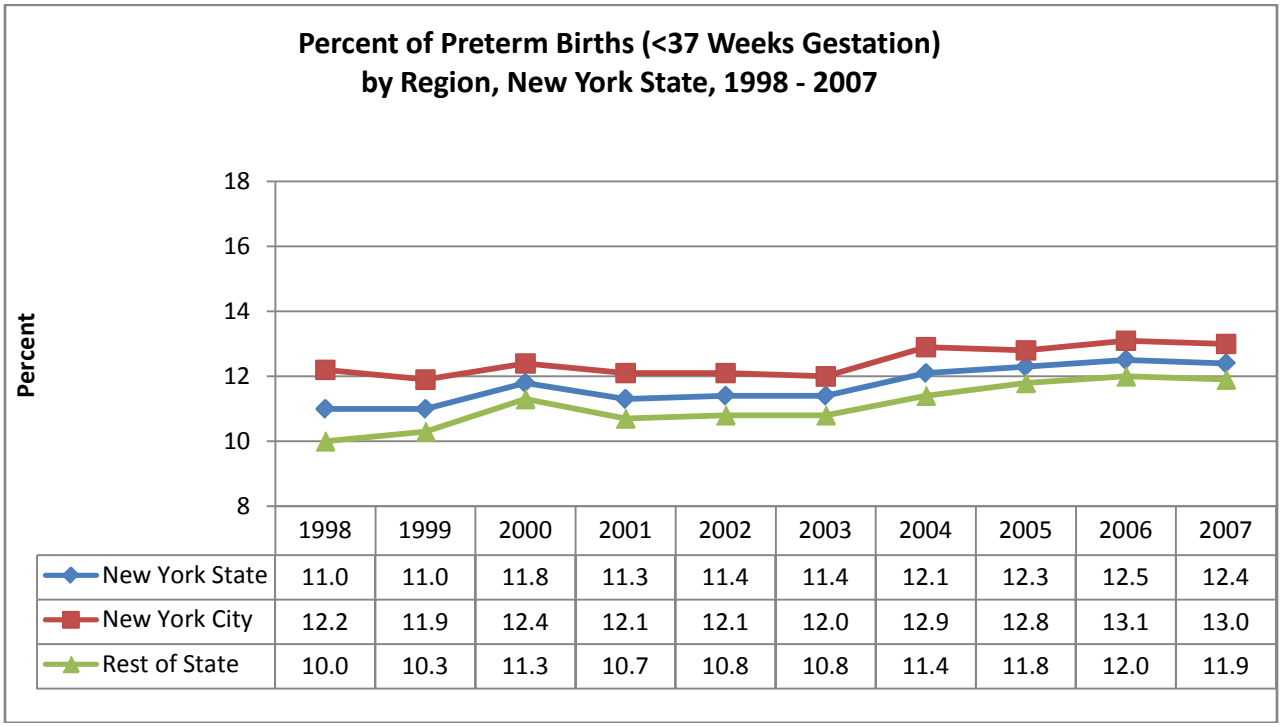


	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
White	4.9	4.9	4.9	4.8	4.9	4.9	4.9	5.1	5.2	5.1
Black	10.2	10.1	9.7	9.7	10.2	10.2	10.4	10.2	9.9	9.7
Hispanic	6.5	6.3	6.1	6.1	6.2	6.1	6.1	6.4	6.6	6.4

<u>Ratio of Black-to-White Low Birth Weight Rates</u>: Disparities in low birthweight rates have shown improvement since the early 1990s but have persisted at about the same rate in more recent years. These disparities may be measured in the ratio of the black low birthweight rate to the white low birth weight rate. The 2007 black/white ratio was 1.6 based on rates of 11.7% and 7.1% respectively. The ratio was unchanged from 2006. The same trend is also seen in the Black-to-White low birthweight rates for singleton births. There was a reduction from 2.5 in 1991 to 1.9 in 2007.

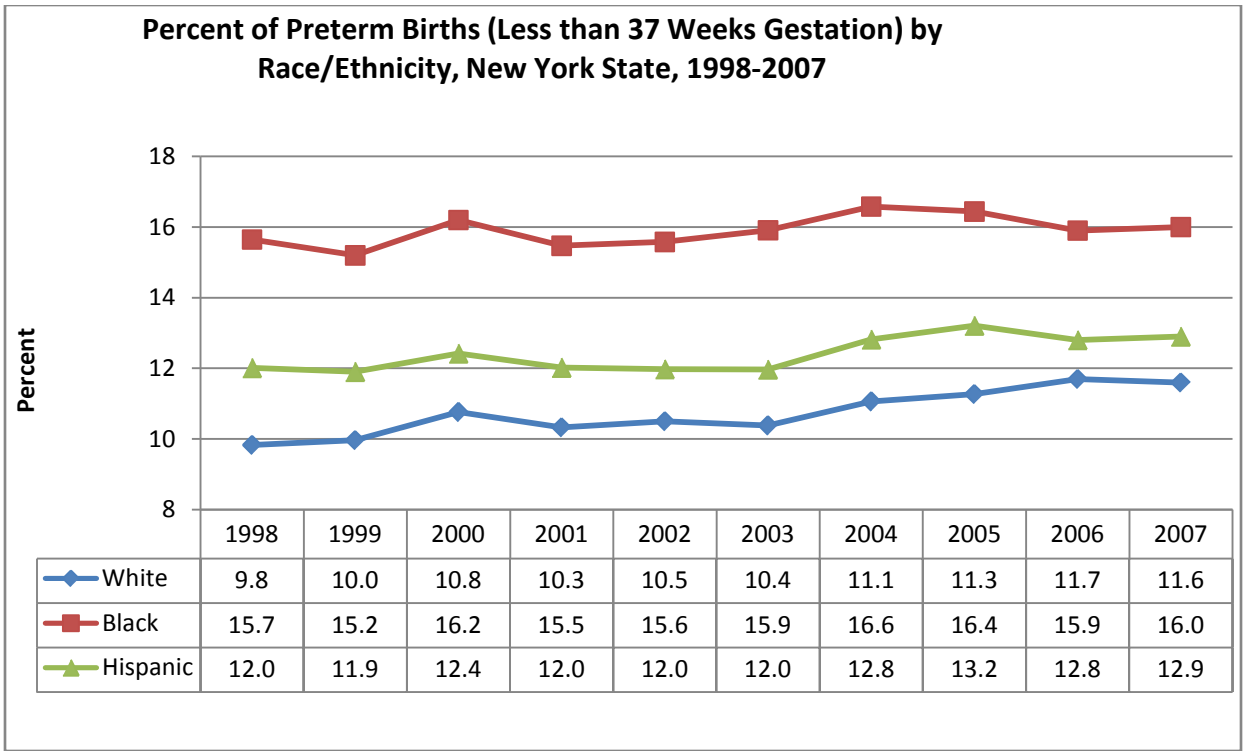
Ratio of Black Low Birth Weight Rate to White Low Birth Weight Rate –Total Births										
Year	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Ratio	1.8	1.7	1.7	1.7	1.8	1.8	1.8	1.7	1.6	1.6

Preterm Births: The preterm birth (less than 37 weeks gestation) rate in New York State decreased slightly between 2006 and 2007 from 12.5% to 12.4%. Small declines occurred in the rates in both New York City (13.1% to 13.0%) and the Rest of State (12.0% to 11.9%). The preterm birth rate in New York City has been consistently higher than rates in Rest of State during the past 10 years.



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
New York State	11.0	11.0	11.8	11.3	11.4	11.4	12.1	12.3	12.5	12.4
New York City	12.2	11.9	12.4	12.1	12.1	12.0	12.9	12.8	13.1	13.0
Rest of State	10.0	10.3	11.3	10.7	10.8	10.8	11.4	11.8	12.0	11.9

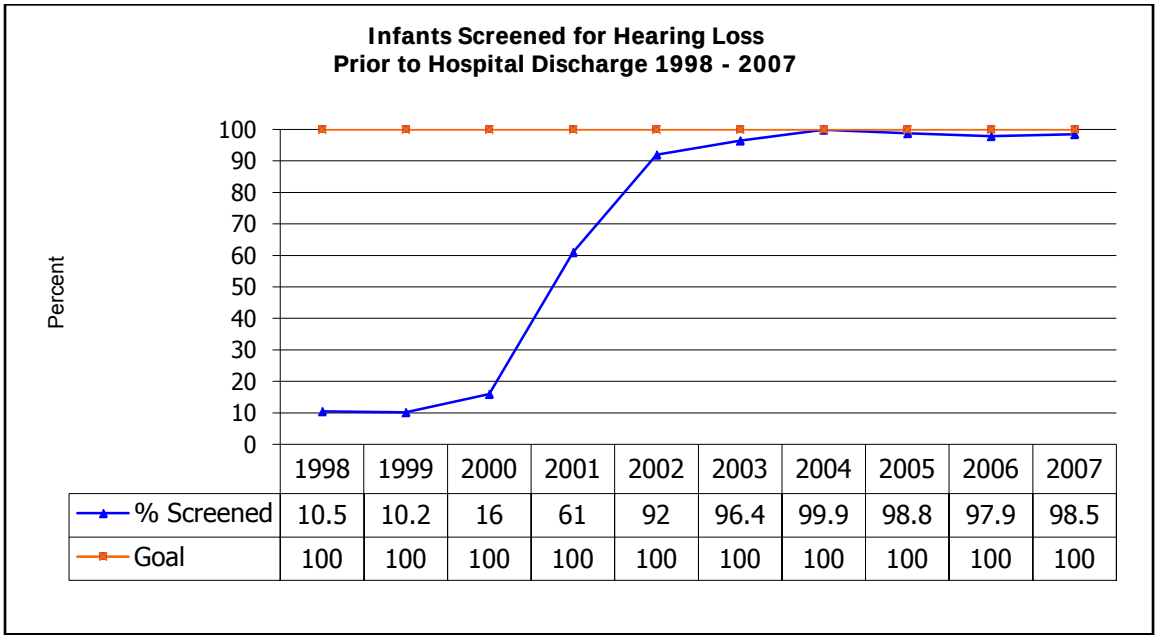
The percentage of black women delivering at less than 37 weeks gestation was 16.0% in 2007, 38% higher than the 11.6% rate among white women. Hispanic women giving birth had a premature rate of 12.9% in 2007. This was 11% higher than the rate among white women but 19% lower than the rate for black women. Disparities between black, white and Hispanic births have persisted over the past ten years, although the black/white ratio has declined from 1.6:1 to 1.4:1 over this period.



Universal Newborn Hearing Screening: Since the passage of legislation mandating the screening of all newborns for hearing deficits, the percentage of newborns screened before hospital discharge has steadily risen until leveling off at near 100%. New York conducted a pilot program from 1996 to 1999 that included all regional perinatal centers and high-risk nurseries in the State, which provided a strong foundation for launching universal screening.

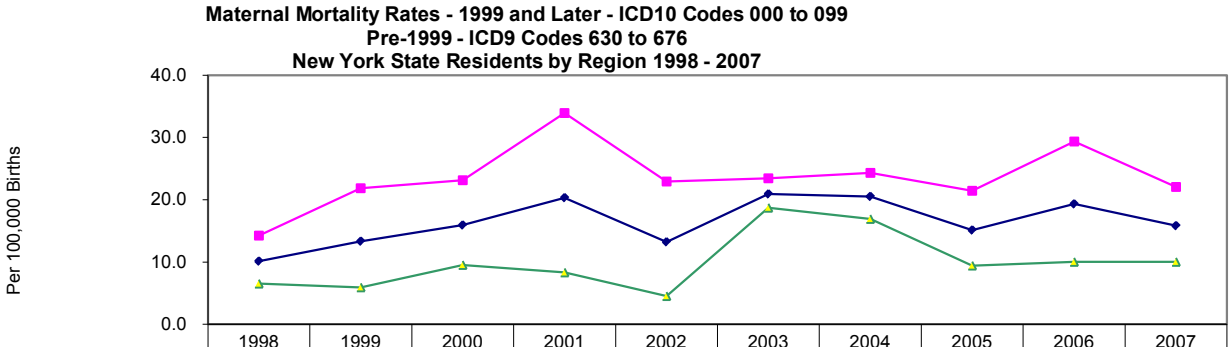
Infants Screened for Hearing Loss Prior to Hospital Discharge
As a Percentage of Total Births
Source: NYS Early Intervention Program

Year	Infants Screened	Total Births	Percent Screened
1998	27,063	257,748	10.5%
1999	26,578	260,571	10.2%
2000	41,355	258,449	16%
2001	156,000	255,529	61%
2002	231,123	250,434	92%
2003	227,848	236,259	96.4%
2004	240,921	240,577	99.9%
2005	245,675	242,628	98.8%
2006	242,212	242,352	97.9%
2007	247,960	251,760	98.5%



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
% Screened	10.5	10.2	16	61	92	96.4	99.9	98.8	97.9	98.5
Goal	100	100	100	100	100	100	100	100	100	100

Maternal Mortality: The maternal mortality rate declined between 2006 and 2007 from 19.3 to 15.8 per 100,000 live births. The lower rate was due to a reduction in the New York City rate from 29.3 in 2006 to 22.0 per 100,000 live births in 2007. The maternal mortality rate for residents of Rest of State was 10.0 per 100,000 live births in both 2006 and 2007.



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
NY State	10.1	13.3	15.9	20.3	13.2	20.9	20.5	15.1	19.3	15.8
NY City	14.2	21.8	23.1	33.9	22.9	23.4	24.3	21.4	29.3	22.0
Rest of State	6.5	5.9	9.5	8.3	4.5	18.7	16.9	9.4	10.0	10.0

Maternal mortality varied considerably during the past decade. The statewide rate has ranged from a high of 20.9 in 2003 to a low of 10.1 per 100,000 live births in 1998. Among New York City residents the rate was highest in 2001 when it reached 33.9 and lowest in 1998 at 14.2 per 100,000 live births. Residents living outside of New York City experienced the lowest rates of maternal mortality. Their rates ranged from a high of 18.7 in 2003 to a low of 4.5 per 100,000 live births in 2002.

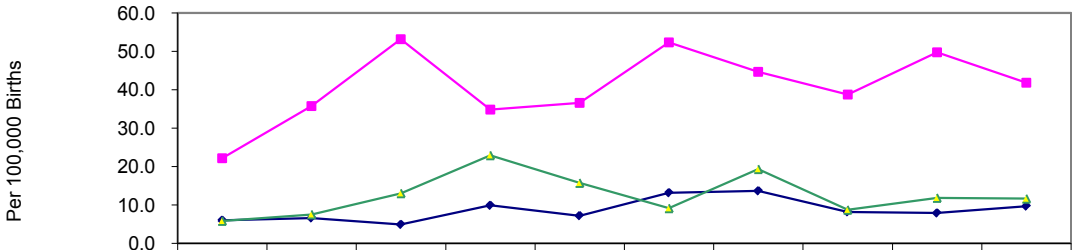
One reason for the wide fluctuation in the maternal mortality rate is the rarity of the occurrence. The small numbers of deaths that occur each year create great swings in

rates. In 2007, there were 40 maternal deaths in New York State; 27 in New York City and 13 in Rest of State. In 2006, there were 48 deaths; 35 in New York City and 13 in Rest of State.

The maternal mortality rate in 2007 of 15.8 per 100,000 births is more than 3 times the Healthy People 2010 goal of 4.3 per 100,000.

The racial disparity in maternal mortality in New York is dramatic and exceeds the differences seen in infant mortality and low birth weight. The 2007, the black maternal mortality rate of 41.9 per 100,000 births and the white rate of 9.7 per 100,000 births, result in a black-to-white ratio of 4.3 to 1. These rates are based on 22 deaths among African American women and 16 deaths among Caucasians. The rate for Hispanics in 2007 was 11.6 per 100,000 live births based on 7 deaths.

Maternal Mortality Rates - 1999 and Later - ICD10 Codes 000 to 099
Pre-1999 - ICD9 Codes 630 to 676
New York State Residents by Race 1998 - 2007



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
White	6.0	6.6	4.9	9.9	7.2	13.2	13.7	8.2	7.9	9.7
Black	22.2	35.8	53.2	34.9	36.6	52.4	44.7	38.8	49.8	41.9
Hispanic	5.8	7.5	13.0	22.9	15.7	9.1	19.3	8.7	11.8	11.6

There are also many reporting issues related to maternal mortality that contribute to inconsistent rates. For example, if investigators rely solely on the death certificates to identify maternal deaths, the relationship of certain conditions to a previous pregnancy may not be clear, and the death may never be classified as a maternal death. The greater the efforts made toward ascertainment of a previous pregnancy, the more likely investigators are to identify a true maternal death.

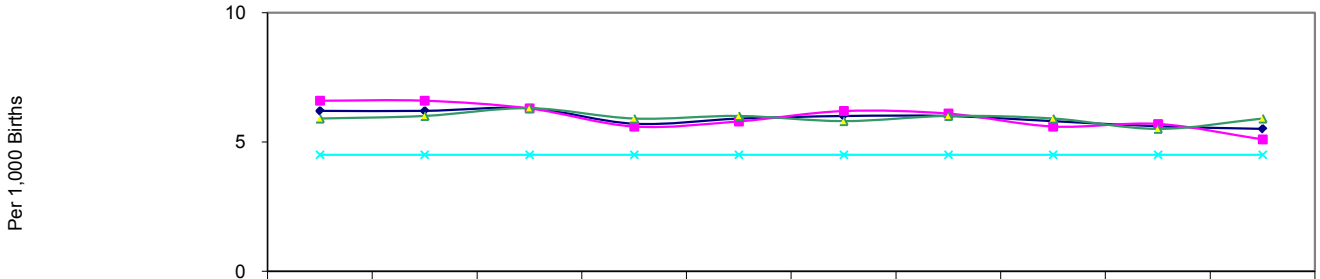
If the health care provider completing the death certificate does not connect the death to a recent pregnancy, the death is frequently reported under a non-maternal cause. Working with the NYS Chapter of ACOG through the Safe Motherhood Initiative, the NYSDOH has been working to increase awareness of maternal mortality, thereby increasing the rate. This initiative sought, in part, to improve the completeness of maternal death reporting through death certificates.

Infant Mortality: The 2007 infant mortality rate was 5.5 per 1,000 live births. The rate has declined the past three consecutive years to a record low for New York State. The New York State infant mortality rate declined most dramatically during the early 90's and at a slower pace in recent years.

In 2007, the New York City infant mortality rate was 5.1 per 1,000 live births, a reduction from the 2006 rate of 5.7 per 1,000 and a record low for New York City. Among residents of Rest of State the rate increased in 2007, to 5.9 from 5.5 per 1,000 live births in 2006.

The Healthy People 2010 goal for infant mortality, overall, is 4.5 per 1000 live births. Efforts to reduce infant mortality must continue and be reinforced in order to meet the Healthy People 2010 goal for the nation.

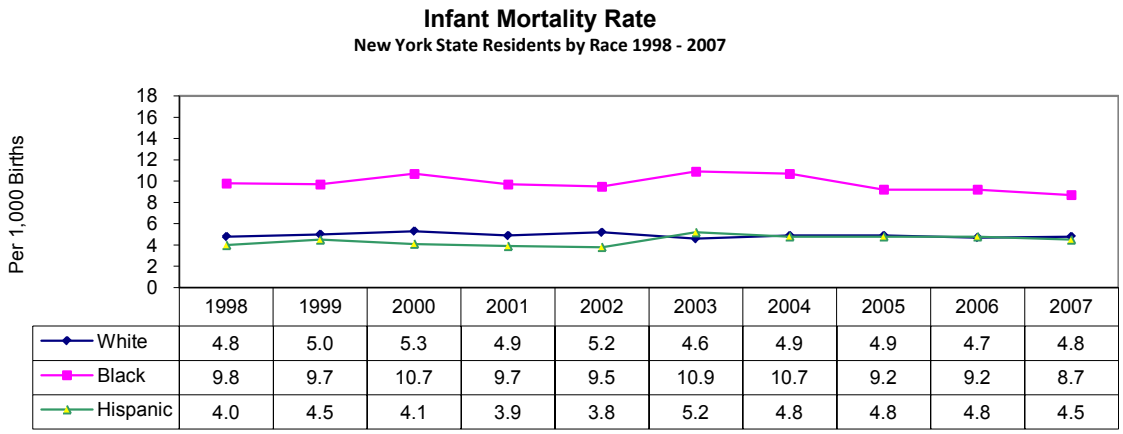
Infant Mortality Rate
New York State, New York City and Rest of State 1998 - 2007



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
New York State	6.2	6.2	6.3	5.7	5.9	6.0	6.0	5.8	5.6	5.5
New York City	6.6	6.6	6.3	5.6	5.8	6.2	6.1	5.6	5.7	5.1
Rest of State	5.9	6	6.3	5.9	6.0	5.8	6.0	5.9	5.5	5.9
HP 2010 Goal	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5

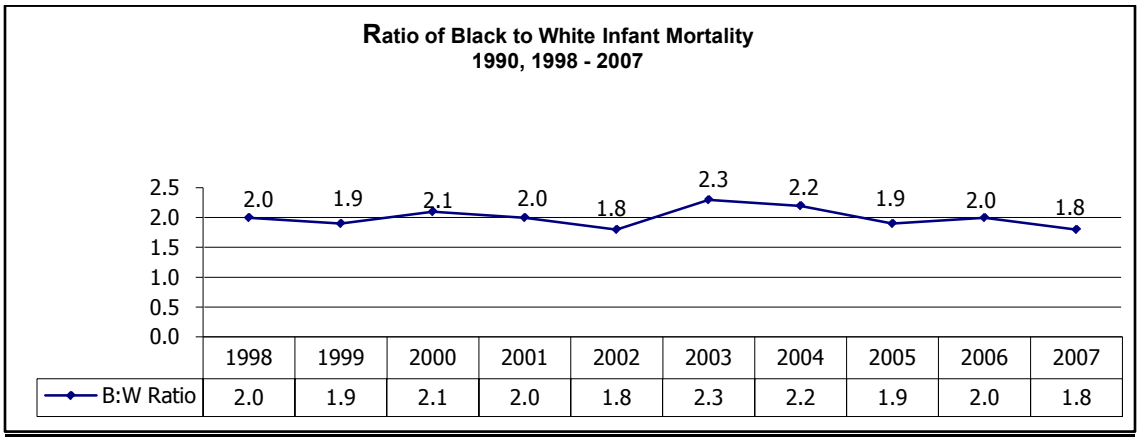
The infant mortality rate among black infants, which has declined by 11% since 1998, was down between 2006 and 2007, from 9.2 to 8.7 per 1,000 live births. The white infant mortality rate increased slightly between 2006 and 2007 (4.7 to 4.8 per 1,000 live births) and was at the same level it had been in 1998. Although infant mortality among Hispanic infants declined between 2006 and 2007 (4.8 to 4.5 per 1,000 live births, the mortality rate was still 12% higher in 2007 (4.5) than it was in 1998 (4.0).

Hispanic and white infant mortality rates have continued to be about half the rate for black infants. At 4.8 and 4.5 per 1,000, the rate for the white population is close to the Healthy People 2010 goal of 4.5 per 1,000 live births, while the rate for the Hispanic population actually meets the HP 2010 goal.



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
White	4.8	5.0	5.3	4.9	5.2	4.6	4.9	4.9	4.7	4.8
Black	9.8	9.7	10.7	9.7	9.5	10.9	10.7	9.2	9.2	8.7
Hispanic	4.0	4.5	4.1	3.9	3.8	5.2	4.8	4.8	4.8	4.5

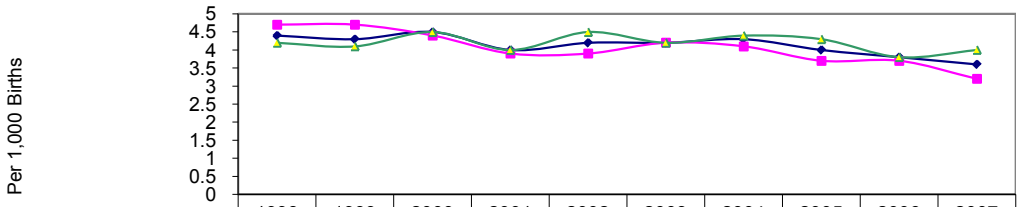
Disparities: Even though rates have been declining, black infant mortality rates are still significantly higher than rates for both whites and Hispanics. In 1990, the disparity between black and white rates peaked when the black/white ratio for infant mortality reached 2.7, meaning there were 2.7 black infant deaths for every one white infant death per 1000 births. The ratio was based on rates of 16.0 and 6.0, respectively. Between 1991 and 1997 the black/white ratio was reduced to 2.0. It has fluctuated slightly in both directions between 1998 and 2007. In 2007, the ratio was 1.8 to 1 based on rates of 8.7 and 4.8 for blacks and whites, respectively.



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
B:W Ratio	2.0	1.9	2.1	2.0	1.8	2.3	2.2	1.9	2.0	1.8

Neonatal Mortality: Trends in neonatal mortality mimic those of infant mortality. Between 1998 and 2007 neonatal mortality declined 18% to 3.6 per 1,000 live births. The 2007 neonatal mortality rate was lower than the 2006 rate of 3.8 per 1,000 live births and a record low for New York State. The New York City neonatal mortality rate, at 3.2 in 2007, has been reduced by 32 percent since 1998, when it was 4.7 per 1,000 live births. Rates have declined more modestly in the Rest of State. Since 1998, the rate has declined by 5 percent to 4.0 per 1,000 live births in 2007. In 2000, New York City's rate dropped below the rate for the Rest of State and has been either equal to or lower than the rate for the Rest of State since that time.

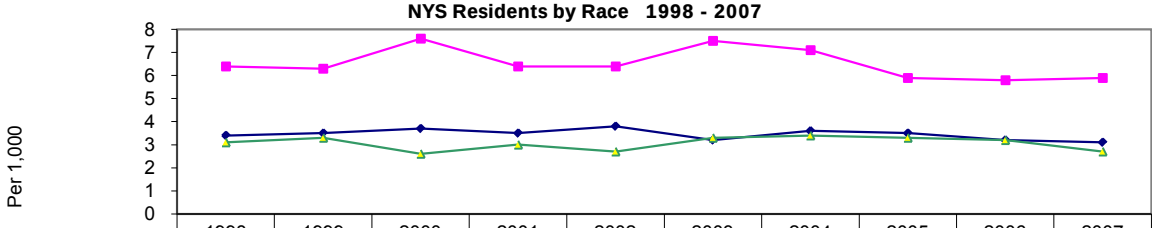
Neonatal Mortality Rate
New York State Residents by Region 1998 - 2007



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
New York State	4.4	4.3	4.5	4.0	4.2	4.2	4.3	4.0	3.8	3.6
New York City	4.7	4.7	4.4	3.9	3.9	4.2	4.1	3.7	3.7	3.2
Rest of State	4.2	4.1	4.5	4.0	4.5	4.2	4.4	4.3	3.8	4.0

In 2007, the black neonatal death rate was 5.9 per 1,000 births, 90 percent higher than the rate for whites of 3.1 per 1,000 live births, and more than double the rate for Hispanics (2.7 per 1,000 live births). The black/white neonatal mortality ratio was 1.9 in 2007.

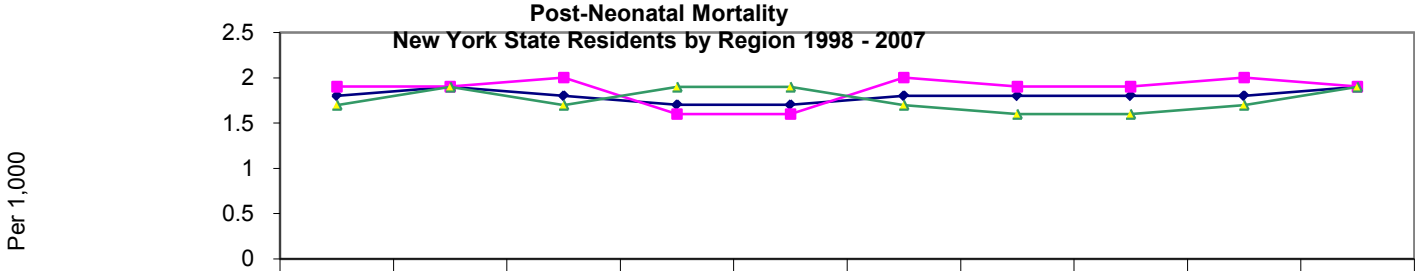
Neonatal Mortality Rate
NYS Residents by Race 1998 - 2007



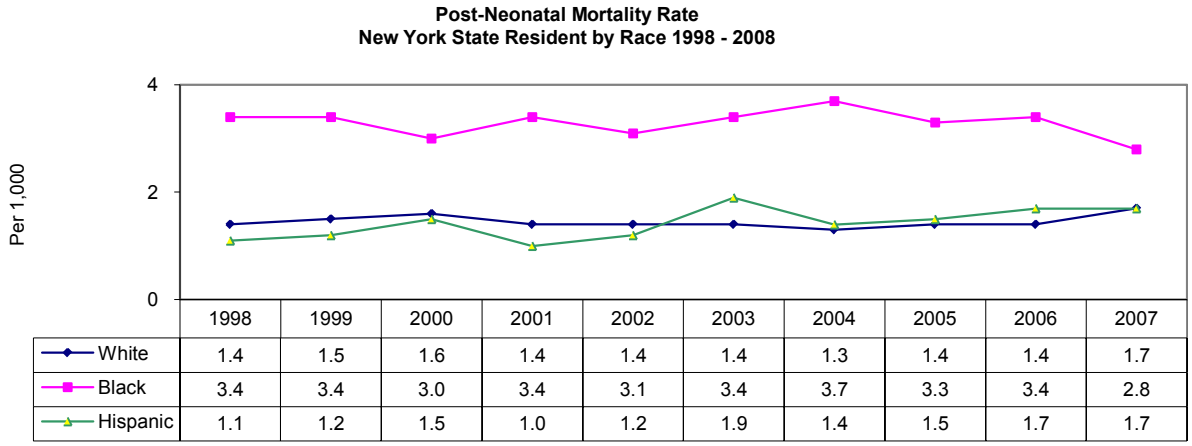
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
White	3.4	3.5	3.7	3.5	3.8	3.2	3.6	3.5	3.2	3.1
Black	6.4	6.3	7.6	6.4	6.4	7.5	7.1	5.9	5.8	5.9
Hispanic	3.1	3.3	2.6	3.0	2.7	3.3	3.4	3.3	3.2	2.7

<u>Postneonatal Mortality Rate</u>: The postneonatal mortality rate in New York State has changed very little over the past decade. Between 1998 and 2007, it has fluctuated between 1.7 and 1.9 per 1,000 live births. In 2007 the postneonatal mortality rate was 1.9 per 1,000 live births Statewide and in both New York City and Rest of State. The disparities in rates between Blacks and Whites and Hispanics that were seen in both infant and neonatal mortality rates are also seen in postneonatal mortality. Although black postneonatal mortality in 2007 represented a decline of 17.6 percent compared to the 1998 rate, from 3.4 to 2.8 per 1,000 live births, the rate was still 65% higher than the rates for White (1.7/1,000) and Hispanic (1.7/1,000) infants. The black/white postneonatal mortality ratio was 1.6 to 1 in 2007.

Post-Neonatal Mortality
New York State Residents by Region 1998 - 2007



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
New York State	1.8	1.9	1.8	1.7	1.7	1.8	1.8	1.8	1.8	1.9
New York City	1.9	1.9	2	1.6	1.6	2	1.9	1.9	2.0	1.9
Rest of State	1.7	1.9	1.7	1.9	1.9	1.7	1.6	1.6	1.7	1.9



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
White	1.4	1.5	1.6	1.4	1.4	1.4	1.3	1.4	1.4	1.7
Black	3.4	3.4	3.0	3.4	3.1	3.4	3.7	3.3	3.4	2.8
Hispanic	1.1	1.2	1.5	1.0	1.2	1.9	1.4	1.5	1.7	1.7

Sudden Infant Death Syndrome: The table below illustrates the relationship between occurrence of SIDS deaths as a subset of total infant and postneonatal deaths. The table also contains PRAMS Survey responses indicating mothers who reported putting their infants to sleep on their backs. It is widely believed that changing infant sleep position to backs exclusively has greatly reduced the SIDS rate from 0.6 per 100,000 population in 1998 to 0.3 per 100,000 in 2008. Total SIDS deaths in New York State declined from 100 in 1998 to a low of 23 in 2004. Between 2005 and 2007 the number of deaths attributed to SIDS were 49, 61 and 63, respectively. SIDS related deaths now account for about 13.3% percent of all postneonatal deaths. In 1998, SIDS was the cause for 21.4% of these deaths.

Proportion of Post-Neonatal Deaths that Are SIDS, % Moms Reporting Back-to-Sleep, 1997 - 2006

Year	All deaths < 1 Year	Post-neonatal deaths	SIDS deaths	% SIDS of Post-Neonatal Deaths	% PRAMS Moms responding that they put their infants on their back to sleep
1998	1607	467	100	21.4%	53.0%
1999	1571	478	74	15.5%	56.7%
2000	1436	443	74	16.7%	66.3%
2001	1450	447	74	16.6%	68.5%
2002	1489	436	57	13.1%	69.4%
2003	1450	458	51	11.1%	70.9%
2004	1503	445	23	5.2%	69.5%
2005	1414	431	49	11.4%	67.2%
2006	1391	454	61	13.4%	71.9%
2007	1382	473	63	13.3%	70.5%

B. Children

Breastfeeding: New York uses PRAMS data to track breastfeeding trends. PRAMS data show that since 1998, rates of breastfeeding initiation and breastfeeding at one month postpartum have improved.

Highlights from the PRAMS 2007 (New York State – excluding NYC) data are as follows:

- Breastfeeding rates have shown slight but steady improvement over the last few years.
- Breastfeeding rates drop by one month postpartum.

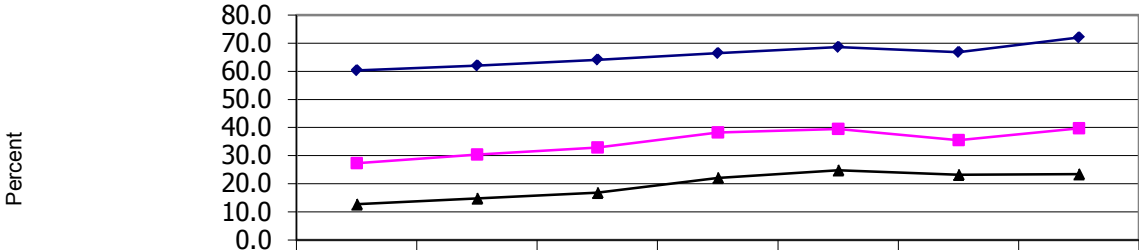
- Mothers with more than 12 years of education were more likely to breastfeed.
- Marriage increases the likelihood that mothers will initiate breastfeeding and continue to breastfeed past the immediate postpartum period.
- Of the 26.1% that chose not to breastfeed in 2007, 41.9% stated that they did not do so because they did not like breastfeeding, and 27.0% indicated that they didn't breastfeed because they had other children to care for. About 20.8% said they had to return to work or school, 13.8% said they had other household duties, and 10.3% did not want to be tied down.
- Among women who initiated breastfeeding and then stopped, 43% said they were not producing enough milk, 42.7% said breast milk alone did not satisfy their baby and 19.4% said their nipples were sore.

Breastfeeding Initiation and Duration for PRAMS Respondents
New York State Excluding New York City
1998 – 2007 *Source: PRAMS data*

Year>	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
PRAMS – Initiation	65.4 %	65.4%	69.1%	68.6%	72.1%	71.6%	72.4	72.9	76.1	73.9
PRAMS –1 m Postpartum	52%	50%	57.1%	55.3%	57.6%	57.4%	56.3	59.5	62.3	61.5

In 2007, the percent of WIC moms who reported they ever breastfed increased from 2006 to a record high rate of 72.0%. The percentage of WIC moms continuing to breastfeed for at least 6 months also increased to an all time high rate (39.7%) in 2007. About 23% of WIC Moms breastfed for at least 12 months.

Trends in Breastfeeding 2001-2007
Source: Pediatric Nutrition Surveillance - WIC



	2001	2002	2003	2004	2005	2006	2007
% ever	60.3	62.0	64.1	66.4	68.6	66.8	72.0
% at least 6 mo.	27.3	30.4	32.9	38.2	39.5	35.5	39.7
% at least 12 mo.	12.7	14.8	16.8	22.1	24.8	23.2	23.4

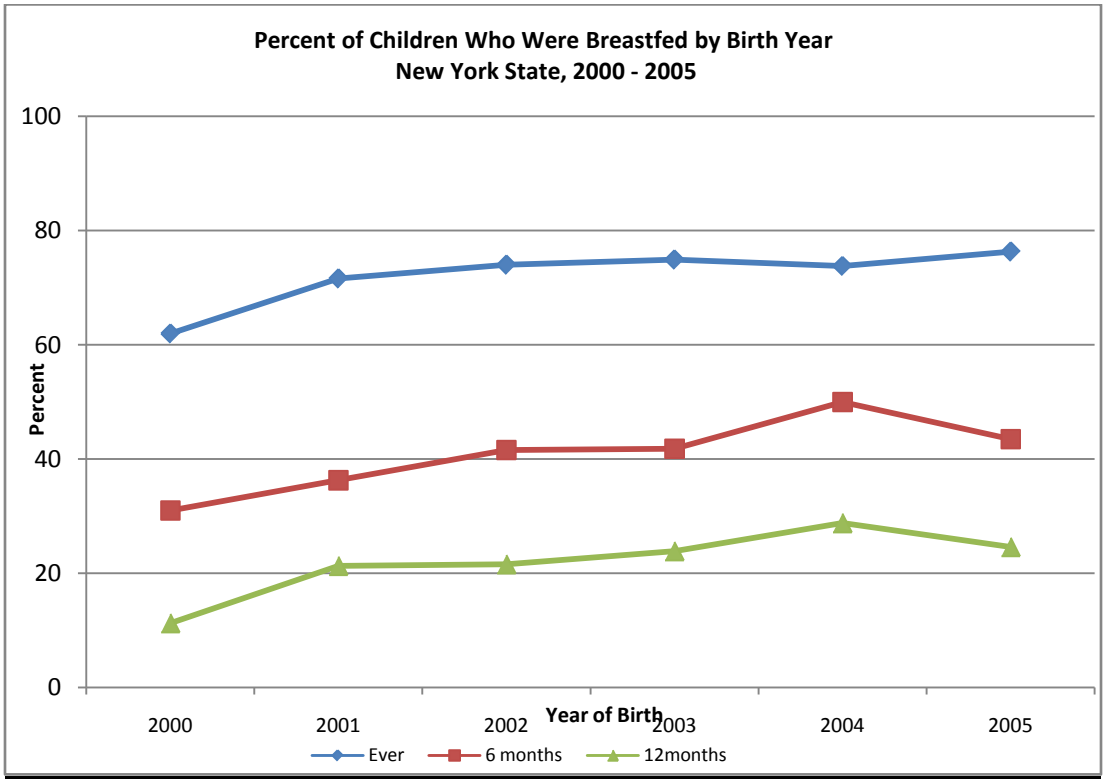
National Immunization Survey Data on Breastfeeding: Each year since 1994, the CDC National Immunization Program, in partnership with CDC's National Center for Health Statistics, has conducted the National Immunization Survey (NIS) within all 50 states, District of Columbia, and selected geographic areas within the states. Since January 2003, breastfeeding questions have been asked of all survey respondents selected to participate in the National Immunization Survey (NIS). All data collected on breastfeeding in this survey relates to the child about whom immunization data is being collected. Beginning with the

2006 survey, NIS breastfeeding data are being presented according to the year of the child's birth rather than the year the information was collected. As a result, information collected from the 2006 survey pertains to children born in 2004. In previous reports these data would have been reported as 2006 data. The change was made to make it easier to evaluate interventions and progress toward goals.

The following NIS results were collected as part of the NIS Breastfeeding Supplement and provide breastfeeding rates for children born in 2005 in New York State, New York City and nationwide:

- Of children born in 2005 in New York State, 76.3 percent were ever-breastfed. Children born to women in New York City were more likely to have been breastfed (84.0%) as compared to infants statewide. Nationally, 74.2% of infants born in 2005 were ever breastfed.
- About 43% of children born nationally and in New York State in 2005 were being breastfed when they were 6 months of age. Rates were higher among New York City children (51.7%). The American Academy (AAP) of Pediatrics recommends that infants be breast-fed exclusively for the first 6 months of life; 8.4 percent of children in New York State and 11.9% of children nationally met this recommendation. In New York City 10.3% of children were exclusively breast-fed at 6 months of age.

New York State's breastfeeding rate, at 76.3%, meets the national *Healthy People 2010* objective of 75% of mothers initiating breastfeeding.



Source: National Immunization Survey, Breastfeeding Supplement 2007

	2001	2002	2003	2004	2005
Ever Breastfed	70.3+/-4.8	74.0+-3.9	74.9+/-3.5	73.8+/-4.9	76.3+/-4.6
Breastfed at 6 months	36.3+/-5.3	41.6+-4.1	41.8+/-3.9	50.0+/-4.6	43.5+/-5.1
Breastfed at 12 months	21.3+/-4.2	21.6+/-3.3	23.9+/-3.2	28.8+/-5.8	24.6+/-4.3

Childhood Nutrition: Currently, the WIC program provides services to a monthly average of 482,686 participants through 101 local agency direct service providers. Due to funding limitations, the program currently serves approximately 51 percent of the WIC-eligible women, infants and children in New York State. Funds received totaled approximately $477 million.

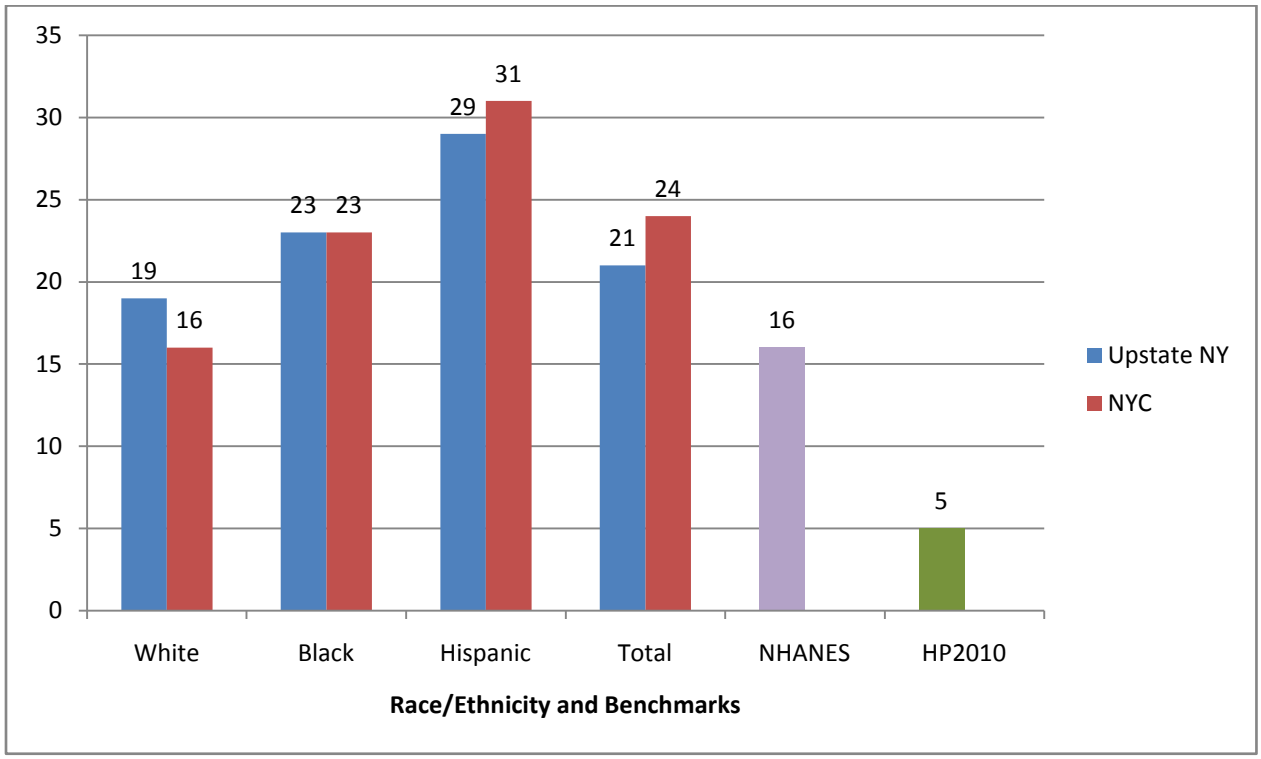
Approximately 1,800,000 children participate in the School Lunch Program, and an additional 250,000 children participate in the Child and Adult Care Food Program (CACFP). Food Stamps reach about 800,000 children.

Respondents to WIC participant surveys reported an increase in the number of children drinking low fat or skim milk from 5.4% in 1998 to 8.9% in 2000. Responses on numbers of fruits and vegetables consumed per day increased in the same time period from 2.8 to 3.0 servings of fruit and from 1.6 to 1.7 servings of vegetables a day. While improvement is encouraging, this is still below the recommended servings per day.

Childhood Overweight: There is growing concern about the national epidemic in childhood overweight and adult obesity. Research indicates that adult morbidity and mortality are increased by childhood obesity, even if the condition does not persist into adulthood. And a recent study by the University College of London found that children who are overweight at age 11 continue to be overweight at age 16.

The prevalence of obesity among elementary school children in New York State has increased dramatically between 1988 and 2003-2004. Based on measured height and weight in 2003, 24% of elementary school children (grades K-5) in New York City were obese. In 2004, 21% of third grade school children in Upstate New York were obese. These prevalence rates greatly exceed the prevalence reported for the U.S. (15.8%) in NHANES 1999-2002, and the Healthy People 2010 target of 5%. In both New York City and upstate NY, prevalence rates differed across racial/ethnic categories; Hispanics have the highest rates (29.3% and 31.1%), with rates for non-Hispanic Whites the lowest (18.7% and 15.9%), and rates for non-Hispanic Blacks in between (22.5% and 22.8%, respectively).

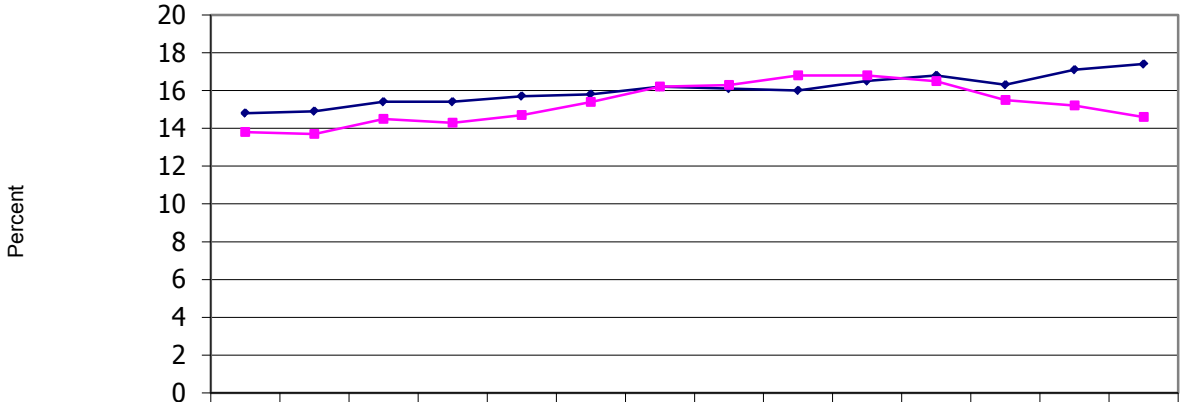
Proportion of elementary school children in upstate NY and New York City who are obese



Source: Upstate NY, Grade 3 Oral Health, Physical Activity, and Nutrition Survey, 2004. New York City; Am J Public Health, 2004; 94: 1498. U.S.: NHANES, 1999-2002, J Am Med Assn 2004;291:2847-2850.

For preschool-age children in New York State, data are only available for children from low-income families enrolled in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). In 2007, 14.6% of the two- to four-year-olds participating in New York's WIC Program were overweight. This is down 13% from the 2003 high of 16.8%, but still an 11% increase since 1990.

Trends in Overweight and At-Risk for Overweight
Among WIC Program Children Ages 2 to 4 Years
1990 - 2007
Source: WIC Program



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
At Risk	14.8	14.9	15.4	15.4	15.7	15.8	16.2	16.1	16	16.5	16.8	16.3	17.1	17.4
Overweight	13.8	13.7	14.5	14.3	14.7	15.4	16.2	16.3	16.8	16.8	16.5	15.5	15.2	14.6

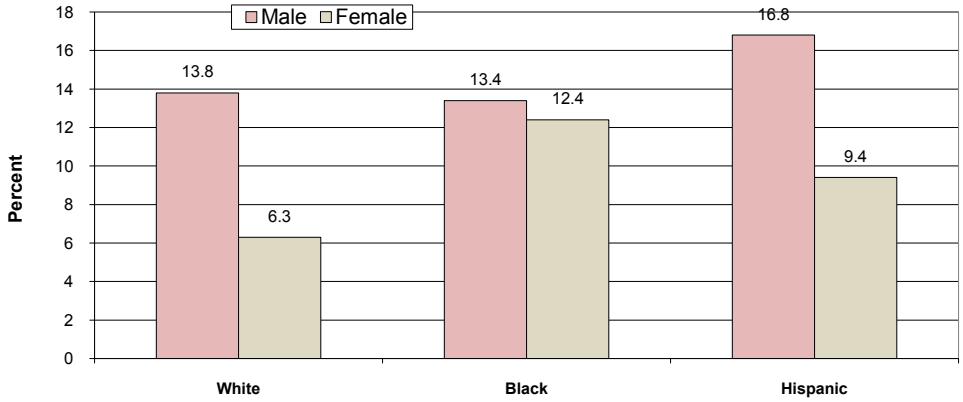
At risk of overweight= BMI greater than 85th percentile, less than the 95th percentile
Overweight= BMI greater than or equal to the 95th percentile
Both measured by age- and sex-specific 2000 CDC growth charts

While the percent of children who are overweight has been decreasing, in 2007, the percent of WIC children at risk for being overweight (between the 85th and 95th percentile) increased from 17.1% in 2006 to 17.4% in 2007. The percent of overweight children varies considerably by race and ethnicity. Hispanic children are almost twice as likely to be overweight as black or white children.

Current research suggests there is a relationship between TV watching and obesity. Specifically, one study found that, in 26-year-olds, 17 percent of overweight can be attributed to watching television for more than 2 hours per day during childhood and adolescence (Vol. 264 July 2004). Another study found that for each hour increase of television viewing, fruit and vegetable intake decreases 1.4 servings per day (Pediatrics, 2003 Dec: 112 (6 Pt 1):1321-6). The 2001 *Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* recommended that children watch no more than two hours of television per day. The American Academy of Pediatrics (AAP) recommends that children younger than two years of age be discouraged from viewing television, and that viewing for children two years and older be limited to no more than one to two hours per day of high quality educational shows (American Academy of Pediatrics, 2001).

Data from the 2007 YRBS found that 10.9% of adolescents are overweight (BMI ≥ 95%). This is up slightly from the 10.5% rate in 2005 but an improvement over 2003 when 12.9 percent of high school students were overweight. Adolescent males were more likely to be overweight than females and African American adolescents were more likely to be overweight than white adolescents. Hispanics males were the most likely of high school students to be overweight (16.8%).

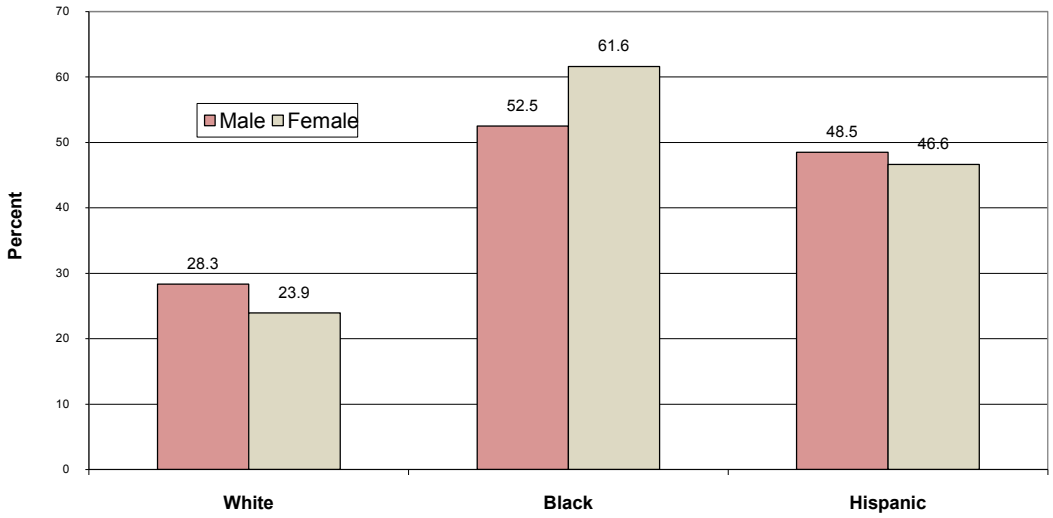
Percent of High School Students Who Were Overweight by Sex and Race
New York State, 2007



Source: YRBS

Excessive TV watching is thought to be a contributing factor to high rates of obesity among children and adolescents. Among high school students, more than 60% of Black females and 50% of Black males watched three hours or more of TV per weekday. Among Hispanic male and female high school students, close to 50% reported watching more than 3 hours of TV daily. White students were the least likely (less than 30%) to report watching more than 3 hours of TV on weekdays.

Percent of High School Students Who Watched Three of More Hours of TV on an Average School Day by Sex and Race, New York State, 2007



Source: YRBS

Adolescents also reported the amount of time they spent playing video and computer games on an average school day. Twenty-nine percent of high school students reported playing these games for 3 or more hours per day during and average school week. Males were more likely (31%) to report 3 hours or more of playing time as compared to females (28%).

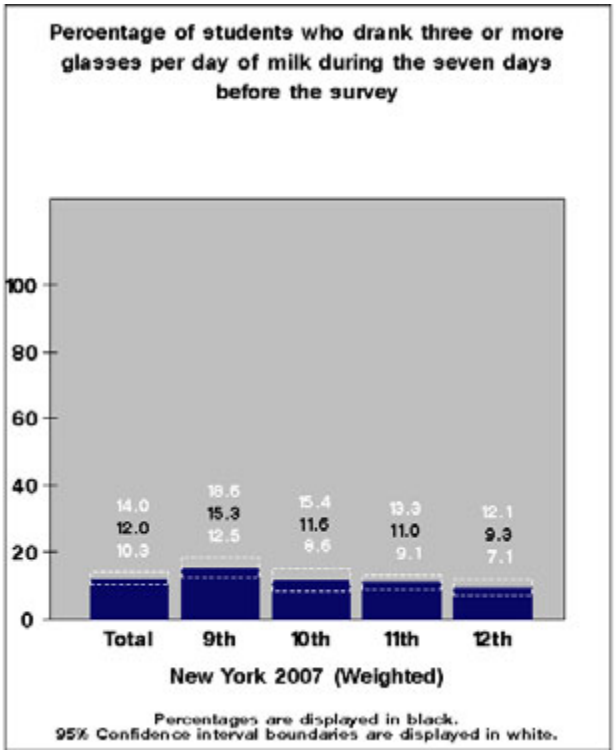
Younger children are also at risk for watching too much TV. A random sample of third grade children surveyed in upstate NYS in 2004 revealed that 18.4% watched more than 2 hours per day. Among WIC participants aged 2 up to 5 years, 21% watched more than 2 hours per day of TV in 2007. Twenty percent of children and 20% of adults usually or always snacked while watching TV and 38% had a TV in their bedroom (Dennison et al., 2002).

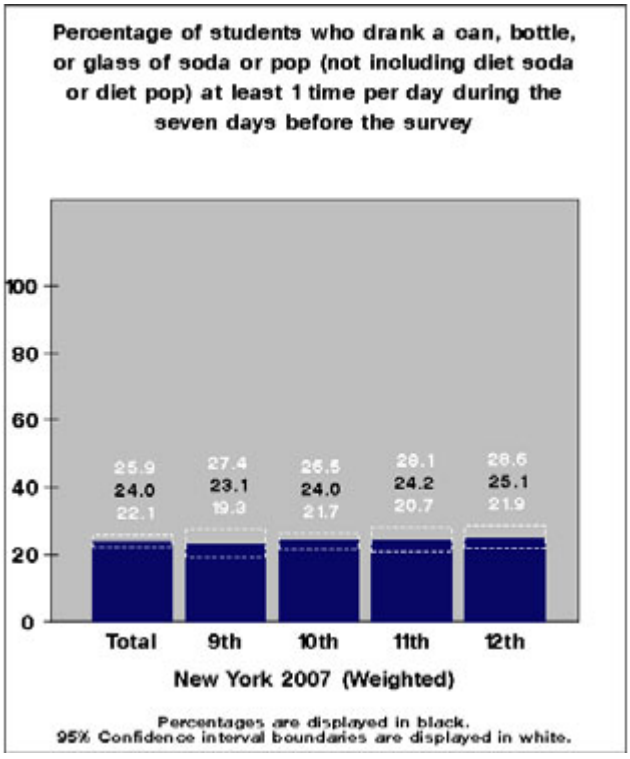
Obesity and Soft Drink Consumption Studies have linked soft drink consumption with obesity in children and adolescents. Each 12-ounce soft drink consumed per day by children increases their odds of becoming obese by 60% (Overweight School Children in NYC: Prevalence Estimates and Characteristics, Melnik TA, Rhoades SJ).

A study conducted by the National Heart, Lung, and Blood Institute (NHLBI), which followed over 2,000 girls from ages 9-10 years until 18-19 years of age, found their average soda consumption increased almost 300% over the 10 years of the study. Soda was the only beverage that was associated with increased obesity (BMI). Several studies have also found soft drink intake was associated with lower intakes of milk, calcium, and other nutrients.

According to the 2007 Youth Risk Behavior Survey, 24% of New York State high school students drank at least one can, bottle or glass of soda every day. Students in grade 9 were slightly less likely to drink soda every day as compared to students in grade 12. Since this question was recently added to the Youth Risk Behavior Survey, trend data are not available for soda consumption.

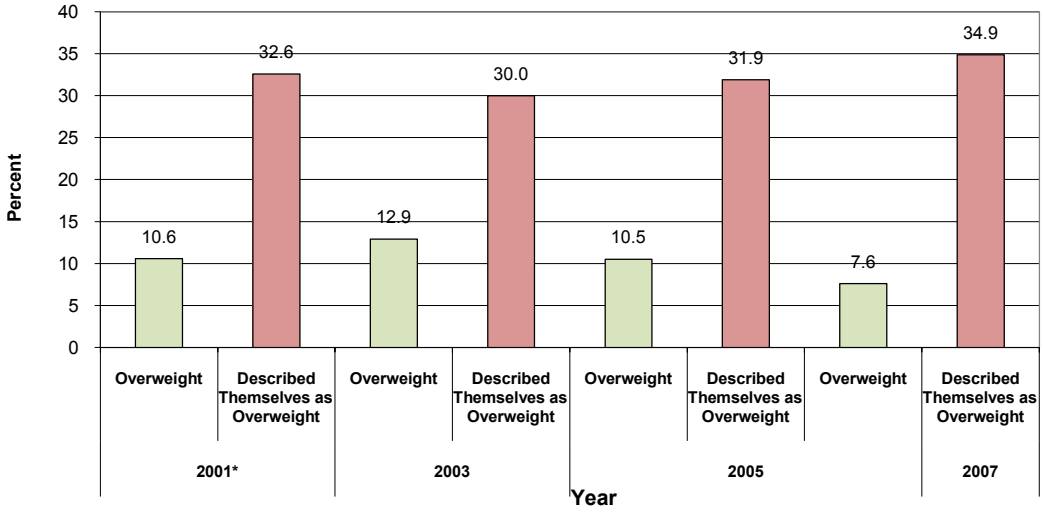
The Youth Risk Behavior Survey also collects information about milk consumption. In 2007, about 12% of New York State high school students reported drinking 3 or more glasses of milk per day. Milk consumption was less common among students at higher grade levels. About 15% of grade 9 students drank 3 or more glasses of milk per day compared to 9% of grade 12 students. These percentages are considerably less than what was reported in 1999. In 1999, an average of 21% of students drank 3 glass of milk per day. Among 9th graders, 24%, and among 12th graders, 18%, reported drinking 3 glasses of milk per day.





Eating Disorders: Other weight-related health issues that impact adolescents are eating disorders. The National Institute of Mental Health estimates there are 5-10 million people in the US with eating disorders, which include anorexia, bulimia, binge eating disorder and other conditions. Eating disorders cause more deaths than any other mental disorder. Females are much more likely to suffer from an eating disorder than males. Only 5- 15 percent of people with anorexia or bulimia are males. One characteristic of persons with an eating disorder is a perception that they are overweight when they are not.

Overweight and Overweight Perception Among Female High School Students, New York State, 2001-2007



According to the 2007 YRBS, 34.9 percent of female high school students described themselves as overweight when only 7.6 percent were actually overweight. This discrepancy between perception and actual weight has increased slightly between 2001 and 2007. Among males in 2007, 24 percent thought they were overweight while 14 percent actually were.

Among female New York State high school students in 2007, 58.4 percent reported they were trying to lose weight. While most used methods such as exercise (66.8%) or eating fewer calories (52.0%), 7 percent vomited or took laxatives.

Nutrition Assistance: According to the US Department of Agriculture in 2006, food insecurity in New York State is thought to be in the range of 10% ($\pm$0.74%) and food insecurity with hunger is thought to be in the range of 3.9% ($\pm$0.31%). Approximately 56% of all licensed childcare entities participate in the Child and Adult Care Feeding Program.

Physical Activity: According to the 2007 YRBS, 38% of adolescents were estimated to have participated in physical activity for at least 60 minutes on at least five or more of the past seven days. There were no substantial differences noted by race, grade or gender.

While 90 percent of students said they attended physical education class at least once per week, only 13 percent reported having a daily PE class. Half of both male and female students (55.3%) reported that they played on a sports team. Males were somewhat more likely (61%) to play on a sports team as compared to females (50%).

Oral Health Status of Children: In the United States and in New York, dental caries in children is the most common chronic disease. Nationally, a progress review toward Healthy People 2010 observed that the prevalence of dental caries in 2-4 year old children was approximately 23%, where the *Healthy People 2010* target is 11%. Of children aged 1-5 years enrolled in the Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT), only 16% received any preventive service. A survey of a disadvantaged group of children in northern Manhattan found a high level of unmet need. Because management of children of this age group in a dental office is difficult, many children require treatment in an operating room. In New York, approximately 2900 children younger than 6 years of age visit a hospital annually for dental caries.

According to a survey of 3rd grade children conducted during 2002-2004 by the New York State Health Department in collaboration with many partners, the prevalence of dental caries was 54.1%. The estimated percent of children with untreated caries was 33.1%. The *Healthy People 2010* target for caries experience and untreated caries for 6-8 year old is 42% and 20% respectively. Consistently, both caries experience and untreated caries were more prevalent in the low-income group.

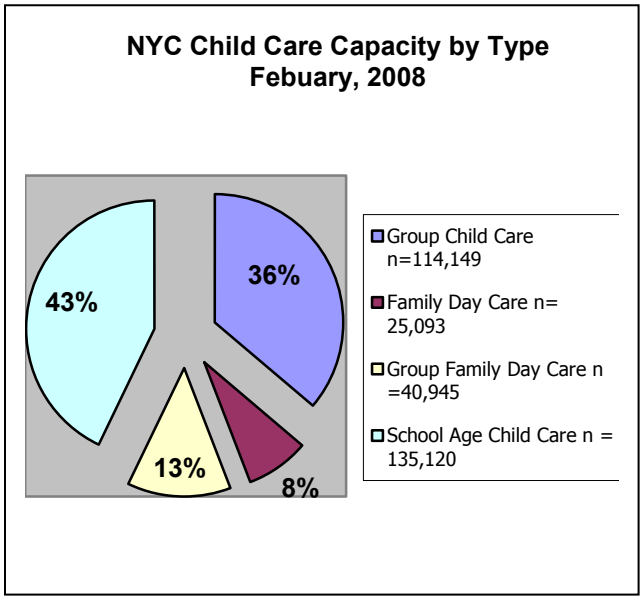
Childcare: According to the 2007 American Community Survey, in New York State, 52% of children under age 6 and 63% of children aged 6 through 17 live with two working parents. Childcare is a major issue for working families. Each family needs to decide who will care for their children while they work and, for their peace of mind, needs to feel comfortable that their child is safely cared for in a supportive, nurturing environment.

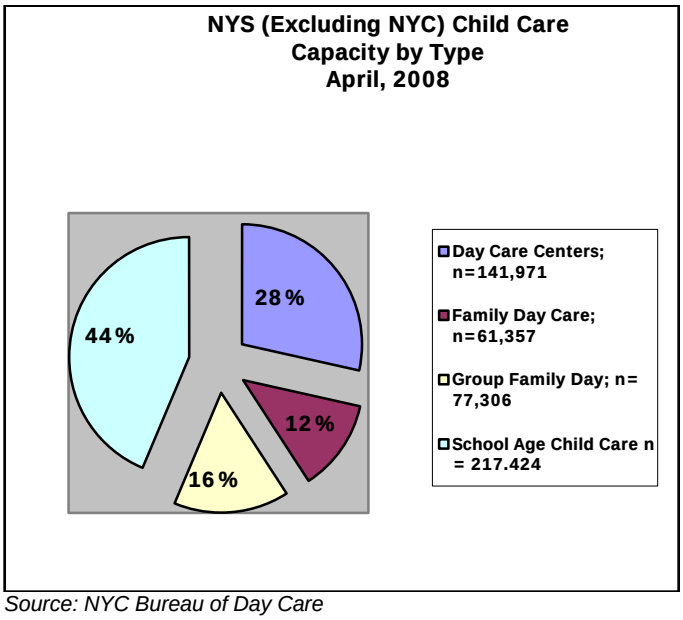
In June 2004, the Urban Institute released a report entitled, "State Profile of New York: Data from the 2002 National Survey of America's Families." According to the report, among NYS full-time employed mothers with children under 5, 35.8 percent of the children spend about 35 hours per week in non-parental care. Nationwide the figure is 38 percent. In NYS, center-based care accounts for 24.5 percent of the arrangements for kids under 5 years of age. Other arrangements are family childcare (12.6%), relative (24.7), babysitter/nanny (7.4%) and parent/other (31.0%). On the average, working families who pay for childcare spend one out of every ten dollars they earn on childcare.

Grandparents are also playing a major role in caring for their own grandchildren. According to the 2007 American Community Survey, in New York State an estimated 285,840 children under 18 are living with grandparents. Grandparents are considered the adult responsible for 129,805 of these children and 44,417 have no parent present. Forty-four percent of children with no parent present being cared for by grandparents are living below poverty. The median family income in these families is $29,023 per year.

The growing use of self-care for children is of great concern. Self-care means that an adult does not directly supervise children. The uses of self-case increases as children grow older. Almost 20% of 6- to 9-year olds whose moms are employed are in before- and/or after-school care, but less than 10% of 10- to 12-year olds are in such programs. Fewer than 10% of 6- to 9-year olds spend any time in self-care on a regular basis, compared to more than 25% of the 10- to 12-year olds.

The Office of Children and Family Services (OCFS), which licenses and regulates child care facilities in this State, reports that in 2008 there was a total of 25,240 licensed facilities in the State, with the capacity to provide day care to 813,367 children. Of these facilities, 9,696 (38.4% of the total facilities) are located in New York City, serving 315,307 children (38.7% of all children served). It is important to keep in mind that these data reflect only licensed facilities, and not more informal arrangements. (see chart below).





Source: Office of Children and Family Services

Source: NYC Bureau of Day Care

Types of Day Care Facilities:

Day Care Centers/Group Child Care - provide care for more than six children at a time, not in a personal residence. **Family Day Care Homes** - provide care for three to six children at a time in a residence; may add one or two school-age children. **Group Family Day Care Homes** - provide care for seven to twelve children at a time in a residence; may add one or two school-age children. A provider must use an assistant when more that six children are present. **School-Age Child Care Programs** - provide care for more than six children from kindergarten through age twelve. Care for children during non-school hours; also may provide care during school vacation periods and holidays.

The state's 58 local social services districts recently increased inspections of those family care settings that have been exempt from OCFS licensure requirements. This type of childcare is generally provided by relatives, friends and neighbors, and involves only one or two children at a time. Under this initiative, providers and household members will undergo checks for criminal history and history of abuse or neglect of children. The new rules also make it a crime for a provider to provide false information on child care subsidy enrollment forms. Annually, onsite inspections will be conducted for at least 20% of the active providers of this type not participating in the Child and Adult Care Food Program. The Child Care Resource and Referral Agencies will also be increasing their efforts to improve the safety and developmental appropriateness of this form of care.

There are currently over 100 trained Childcare Health Consultants across the State. These consultants are mostly public health nurses or public health educators who work for local health departments. Employment of a Child Health Consultant by a local health department is reimbursable through Article 6, New York's state aid for local public health services.

A total of 48,818 New York children participated in the Federal Head Start program in FFY 2006 and 2007, somewhat lower than the 49,127 in FFY 2005, 49,300 in FFY 2004 and 49,473 in FFY2003 (U.S. Department of Health and Human Services, Administration for Children and Families, Head Start Fact Sheet).

The Child Care and Development Fund (CCDF) is a program financed by both federal and state funds that assists low income families, families on public assistance and families that are transitioning from public assistance to work with obtaining and paying for childcare. In New York State, during FFY 2007, $467,646,279 were allocated to assist an average 69,400 families monthly with 115,500 children.

According to the NYS Department of Labor, salaries for child care workers in New York State in 2008 ranged from an average annual income of $17,040 for entry level workers to $26,890 per year for experienced workers. The average earnings were $23,610 annually. This is an improvement in wages from 1998, when the average annual income of a childcare worker in New York was $16,890.

Young Children of Migrant and Seasonal Farmworkers: The Agri-Business Child Development in 2004 released a Needs Assessment of the children and families enrolled in their migrant and seasonal Head Start Program. Family needs included:

- Child care for school-aged children who are over the age for services of Head Start;
- Assistance with transition to public school;
- English as a Second Language (ESL) and high school equivalency diploma (GED) classes;
- Help with overcoming barriers to enrolling and utilizing insurance;
- Help with successfully completing follow-up services for children referred to dental care and to specialists, given the short timeframe during which the family remains in any given area;
- Access to bi-lingual, bi-cultural mental health providers and removing the stigma of using mental health services; and
- Assistance with enabling services, such as transportation and translation.

Many parents felt it was critical that children speak English prior to entering kindergarten. Parents also link their success with English to greater economic success for themselves and their families. Less than 2% of the parents of the Head Start children have a high school diploma or its equivalent. They state that onsite childcare is a significant factor in whether they are able to take part in ESL or GED classes.

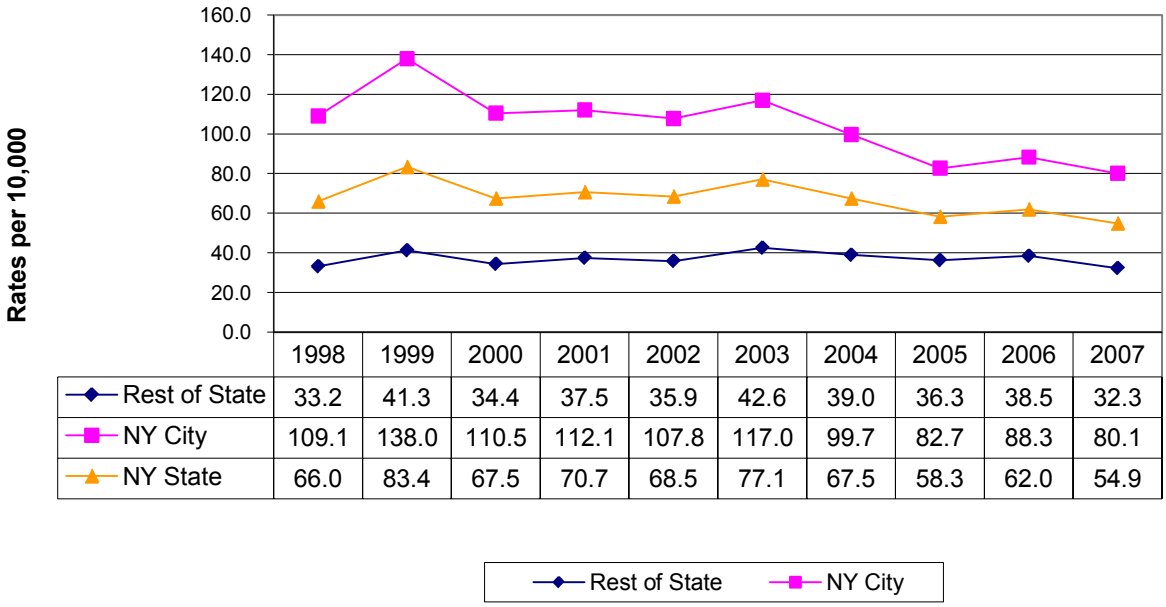
With regard to health and dental services, parents reported that sometimes their coverage lapses. They point out that sometimes, due to the nature of their employment and the time it takes to process applications, their applications or re-applications are pending in one area when they move on to other areas of the state. Families also reported being confused by HIPAA paperwork. The Head Start Program is working diligently with their community partners and state agencies (such as the Migrant Health Program) to overcome the lack of Spanish language materials and translators, and to improve access throughout the state for migrant children and their families. A representative of the Bureau of Dental Health serves on the migrant Head Start Health Services Advisory Committee.

Ambulatory Care Sensitive Conditions: Conditions are considered "ambulatory care sensitive" if early care and treatment make hospitalization avoidable. Two conditions often tracked as ambulatory care sensitive are asthma and otitis media (middle ear infection).

Asthma Hospitalizations: Since the 1999 ten year high rate of 83.4 per 10,000, asthma hospitalization rates for children aged birth to four-years-old have declined 34 percent to an all time low of 54.9 per 10,000 in 2007. Between 2001 and 2007 the rate fluctuated in both directions before reaching the 2007 record low rate.

The asthma hospitalization rate in New York City for children aged 0 to four continued to be more than double the rate among 0 to 4 year old children residing in Rest of State. Between 2006 and 2007, the rates for children residing in both New York City and Rest of State declined.

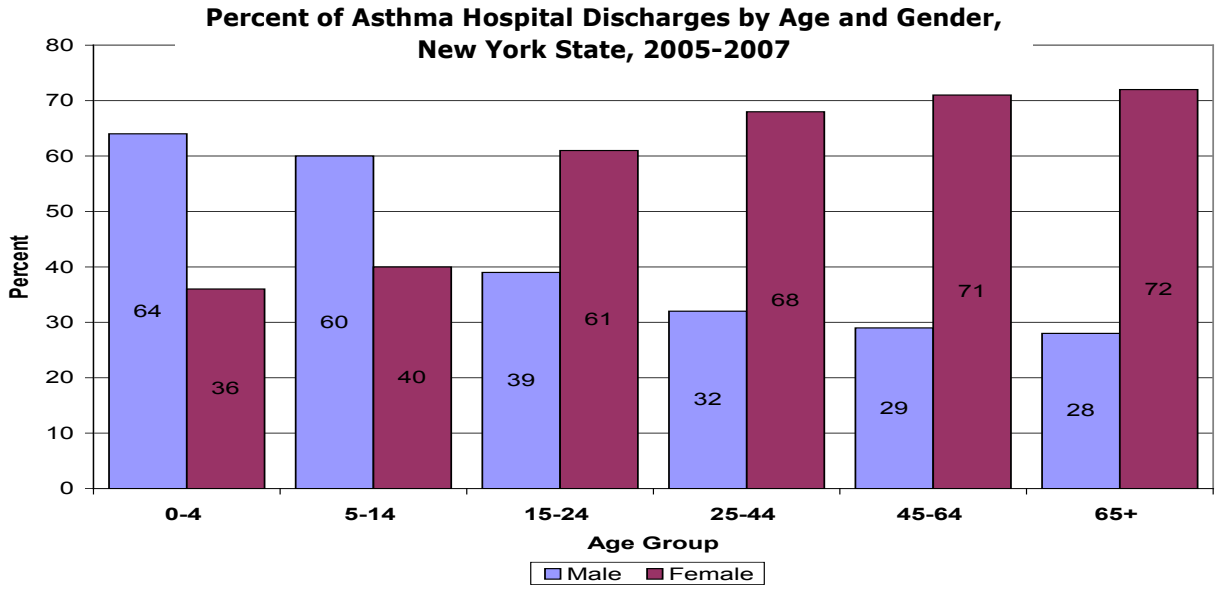
Asthma Hospital Discharge Rates (Ages 0-4) per 10,000
New York State, New York City and Rest of State
1998-2007



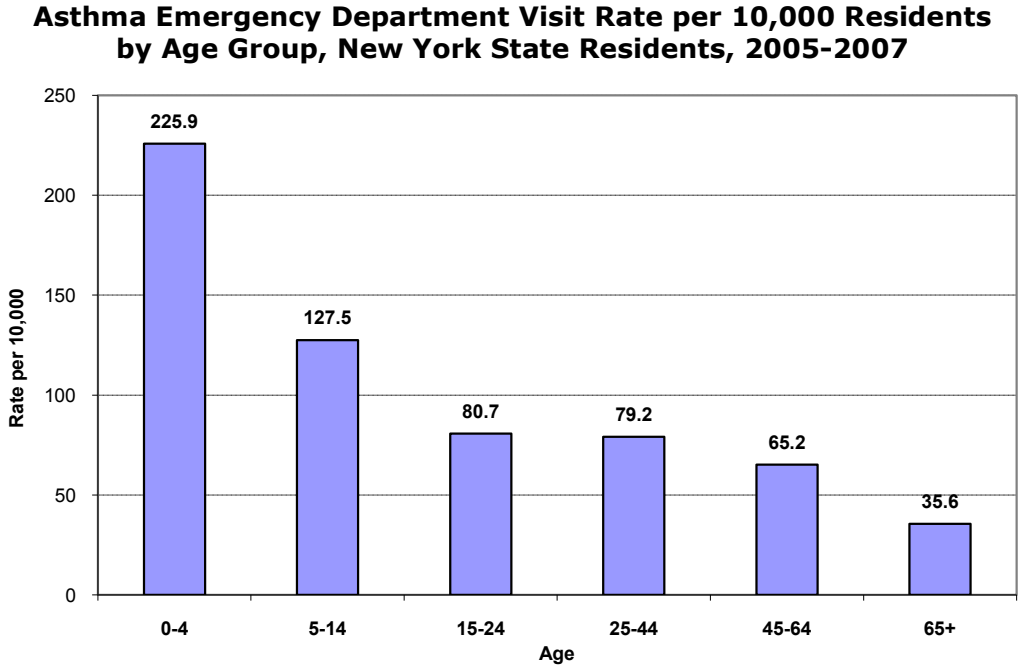
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Rest of State	33.2	41.3	34.4	37.5	35.9	42.6	39.0	36.3	38.5	32.3
NY City	109.1	138.0	110.5	112.1	107.8	117.0	99.7	82.7	88.3	80.1
NY State	66.0	83.4	67.5	70.7	68.5	77.1	67.5	58.3	62.0	54.9

There is an interesting age and gender-related pattern in asthma hospitalizations. At ages under 15, there is a higher proportion of males than females among all asthma hospital discharges (0-4 years: males-64%, females-36%; 5-14 years: males-60%, females-40%).

In contrast, for those aged 15 years and older, females had a higher proportion of asthma hospital discharges compared to males (15-24 years: males-39%, females-61%; 25-44 years: males-32%, females- 68%; 45-64 years: males-29%, females-71%; 65+ years: males-28%, females-72%). This is especially significant for women during child bearing years because asthma can cause complications during pregnancy and must be monitored closely. Use of inhaled corticosteroids (ICS) prior to pregnancy has been shown to decrease physician visits, whereas not using ICS prior to pregnancy was associated with an increase in physician and ER visits (Schatz M, Leibman C. Annuals Allergy Asthma Immunology. 2005 Sep;95(3):234-8.)



Asthma is a condition that results in a large number of emergency department (ED) visits During 2005- 2007, children aged 0-4 had the highest ED visit rate (225.9 per 10,000) compared to all other age groups and accounted for 17% of all asthma related ED visits. Children aged 5-14 had the second highest rate at 127.5 per 10,000 and accounted for 19% of all asthma related ED visits. Among New Yorkers, the asthma ED rate decreased in older age groups.



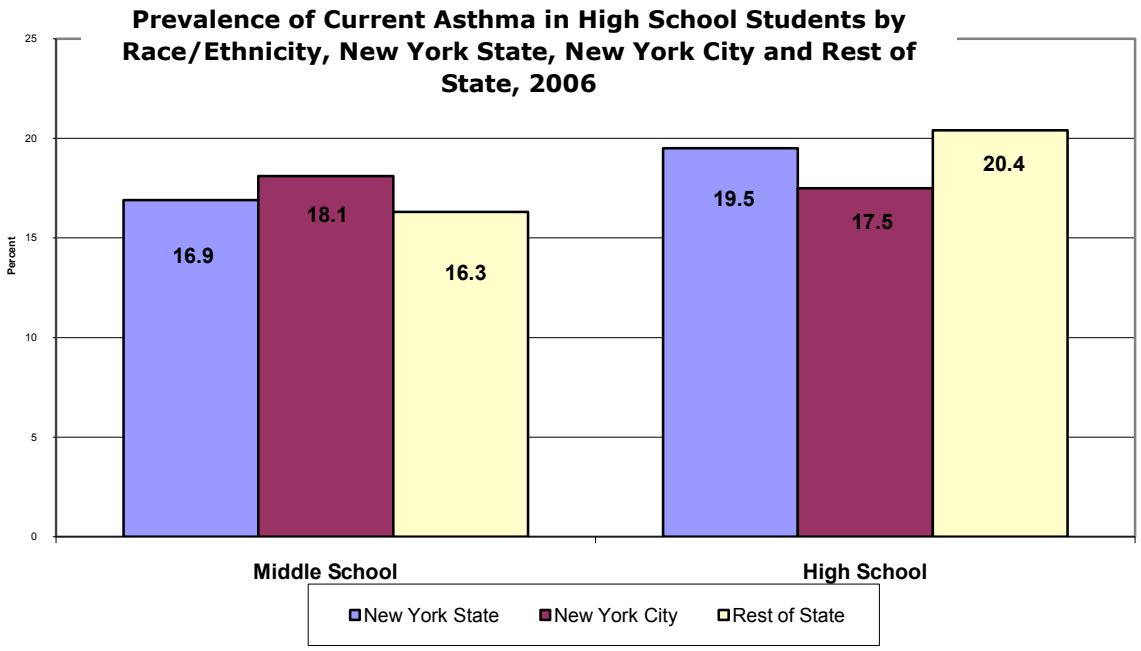
The National Asthma Survey for New York State was conducted in 2003. In findings that closely parallel hospital discharges for asthma by age and gender, this survey found that at ages birth to 4, 8.4 percent males and 4.9 percent of females reported they had been diagnosed with asthma. Among males ages 5-9, 11.9 percent reported being diagnosed with asthma compared to 6.8 percent of the females. Interestingly, at ages 15-17 the percent of males with asthma dropped to 8.6 percent while the females increased to 8.0 percent.

National Asthma Survey, Children ages Birth through 17 New York State - 2003	
Children <18 years	**Percent with Asthma**
% Total Pop with Asthma	8.4%
Gender	
Male	9.8%
Female	6.9%
Race/Ethnicity	
White	7.3%
Black	10.0%
Hispanic	10.9%
Household Income	
<$10,000	11.5%
$10,000-$14,999	12.2%
$15,000-$19,999	7.5%
$20,000-$29,999	8.7%
$30,000-$39,999	10.6%
$40,000-$49,999	9.2%
$50,000-$74,999	9.4%
$75,000-$99,999	8.1%
$100,000+	6.1%

In 2003, asthma in New York State among children less than 18 was more prevalent among blacks and Hispanics and children living in homes with incomes below $15,000 per year.

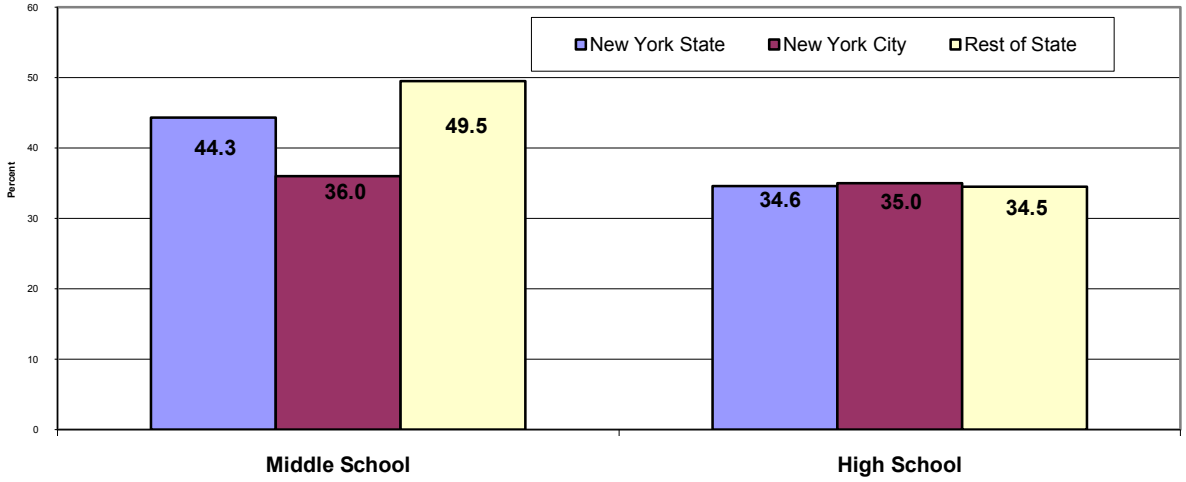
In 2004 and 2006, the Youth Tobacco Survey (YTS), a survey administered in New York State bi-annually to middle school and high school students in grades 6 through 12, added several questions related to current asthma and asthma attack/episode information. According to the 2006 YTS, 16.9% of middle school students and 19.5% of New York State high school students reported having current asthma. High school students residing in Rest of State were somewhat more likely to report current asthma compared to their New York City counterparts. In middle school, New York City students were the most likely to report current asthma.

Among students with current asthma, middle school students were more likely to suffer an attack or episode during the past year. Middle school students residing in Rest of State (49.5%) reported the highest percentage of attacks. High school students residing in New York City and Rest of state reported about the same percentage of attacks (35%).



Source: 2006 New York State Youth Tobacco Survey

Asthma Episodes/Attacks During the Past 12 Months in Middle and High School Students with Current Asthma by Region, NYS, 2006

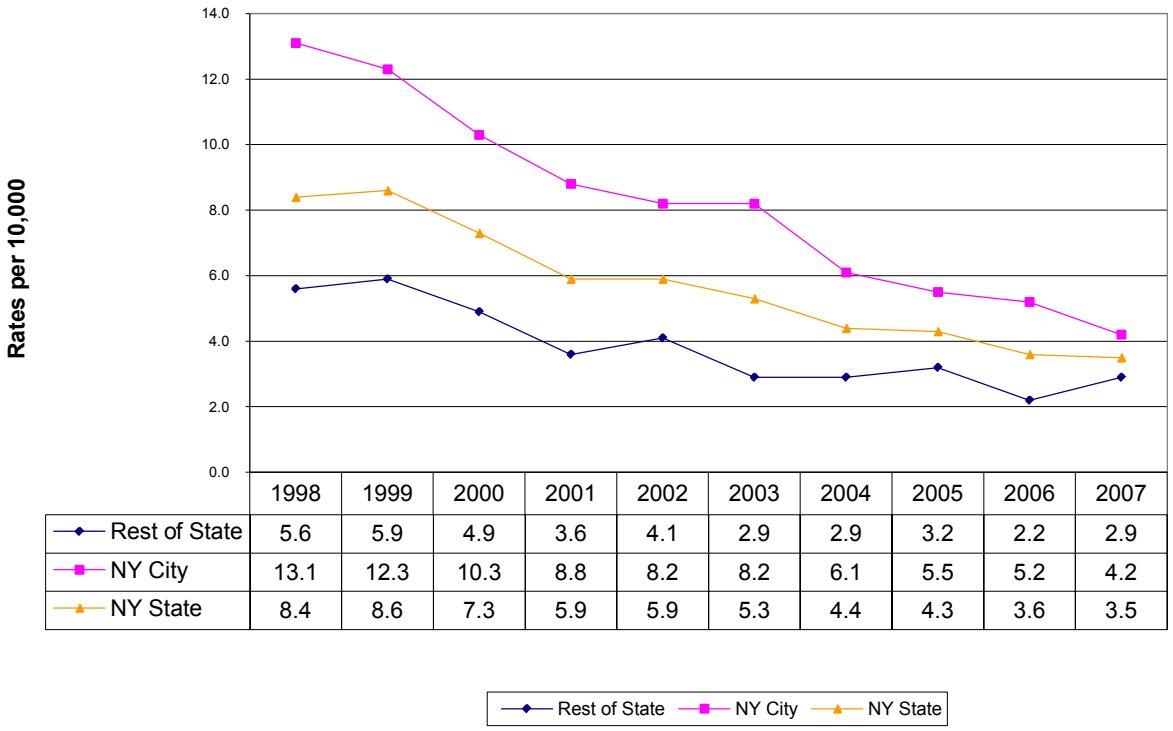


Source: 2006 New York State Youth Tobacco Survey

Otitis Media Hospitalizations: Otitis media hospitalizations have declined over the past ten years. In 2007, 3.5 per 10,000 children aged birth to four were hospitalized for otitis media. This is down 58% from 1998, when the rate was 8.4 per 10,000. New York City

has traditionally had higher otitis media hospitalization rates as compared to Rest of State. This was also true in 2007, but the gap between the New York City and Rest of State rates has been closing in recent years. In New York City, the rate was 4.2 per 10,000 children 0-4 compared to 2.9 per 10,000 in Rest of State. Over the past 10 years, the rate has declined 68% in New York City and 48% in Rest of State.

Otitis Media Hospital Discharge Rates (Ages 0-4) per 10,000
New York State, New York City and Rest of State
1998-2007



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Rest of State	5.6	5.9	4.9	3.6	4.1	2.9	2.9	3.2	2.2	2.9
NY City	13.1	12.3	10.3	8.8	8.2	8.2	6.1	5.5	5.2	4.2
NY State	8.4	8.6	7.3	5.9	5.9	5.3	4.4	4.3	3.6	3.5

<u>Childhood Lead Poisoning</u> : Progress continues to be made in protecting New York's children from lead poisoning. Childhood lead poisoning is a serious health problem that can have a devastating effect on the child, and that has serious repercussions for society as a whole. Human interaction with lead in the environment is most dangerous for children under the age of six. Exposure to even small amounts of lead can contribute to behavior problems, learning disabilities and lowered intelligence. Screening and prompt and effective intervention have been shown to prevent some of the more advanced effects of lead poisoning, such as seizures and severe kidney and nervous system damage.

Provisional data not yet released from the New York State Department of Health Childhood Lead Poisoning Prevention Program, exclusive of New York City for the years 2006-2007 showed that:

- The number of children newly identified with lead poisoning, defined as children with blood lead levels of 10 micrograms per deciliter or higher, declined.
- In 2006, the incidence rate declined to 10.3 from a 2005 incidence rate of 11.9 and in 2007 the incidence rate declined further to 9.2. In 2006, the prevalence rate declined to 15.9 from a 2005 prevalence rate of 18.6 and in 2007 the prevalence rate declined

further to 14.0. Incidence and prevalence rates are expressed per 1,000 children tested for blood lead.

- The number of children with higher blood lead levels requiring an environmental intervention, defined as 20 micrograms per deciliter or higher, declined an additional 10.2% over the two years studied from 324 in 2006 to 291 in 2007. Incidence rates declined, from 1.6 per 1,000 children in 2006 to 1.4 in 2007.
- Analysis of screening rates for the 2004 birth cohort of children showed that more children received at least one screening test by age 36 months compared to children born in 2003; 81% versus 82.8%.
- The screening rate for those children enrolled in Medicaid managed care was higher than for the rate for the state as a whole. Eighty-six percent of children enrolled in Medicaid managed care programs were screened for blood lead in New York State in 2005, compared to seventy-six percent in 2003.
- New York City reported a similar decline in new childhood lead poisoning cases. The recently released New York City Department of Health 2006 annual report showed a decline in incidence of childhood lead poisoning over the period from 2005 to 2006.

The number of new cases identified in 2006 – 2,310 among children ages 6 months to 6 years – marks a 13% decline from 2005. Incidence rate declined from 8.5 to 7.3 per 1,000 children

Rates are expressed per 1,000 children tested for blood lead. Due to differences in methodology, these data cannot be directly compared to those figures for the rest of the State.

Childhood Immunization Levels and Vaccine Preventable Diseases: Childhood immunization has had a major effect on reducing and eliminating some important causes of illness and death among children. Monitoring immunization levels is one of the key strategies that will increase immunization rates in under-immunized populations, and helps the Department to evaluate current public health strategies to increase immunization rates. The state passed legislation requiring reporting of all children's immunizations to a central registry, starting 1/1/08, which is expected to significantly improve monitoring efforts.

Between 2006 and 2007, the Hepatitis B case rate remained at 1.1 per 100,000. This rate is considerably lower than the 2002 high of 4.6 per 100,000. Since 2002, the case rate has declined steadily.

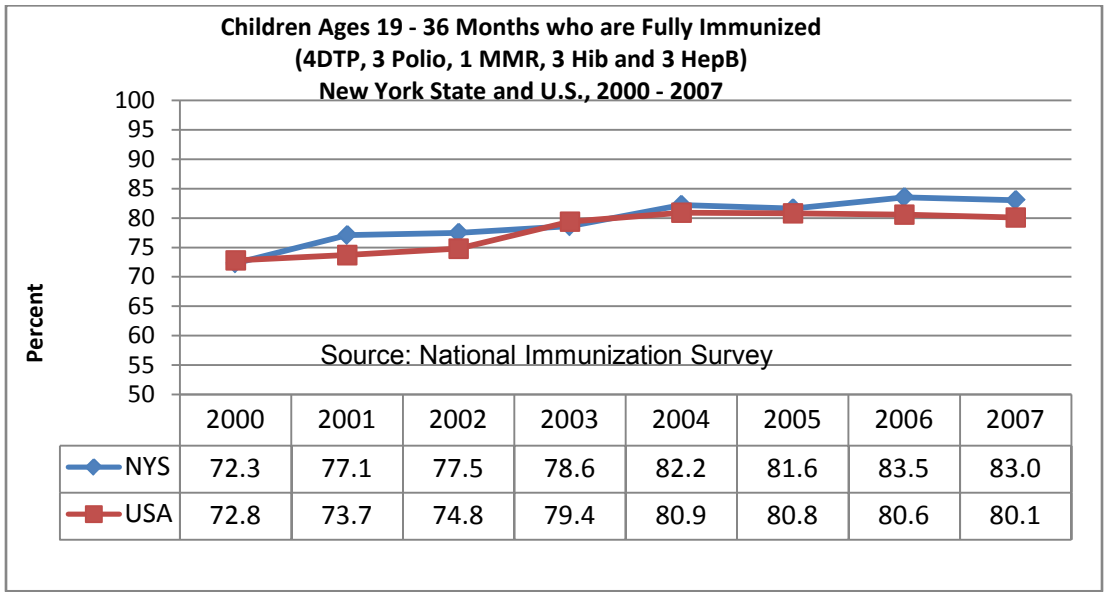
During 2003 and 2004 there was a significant increase in the number of pertussis cases reported nationwide and in New York State. The case rate in New York State went from 2.4/100,000 in 2002 to 11.3/100,000 in 2004. The number and rate of pertussis cases in New York State declined significantly in 2005, and fluctuated in both directions between 2005 and 2007, but remained lower than the rate in 2004. There were 699 pertussis cases reported in 2007, or 3.6 per 100,000 New York State residents.

The Advisory Committee on Immunization Practice (ACIP) has now recommended that adolescents aged 11-18 receive further immunization against pertussis. The US Food and Drug administration has approved two new vaccines for a booster immunization.

Cases of Vaccine-Preventable Diseases, New York State, 2002-2007												
Year>	2002		2003		2004		2005		2006		2007	
Disease	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Hepatitis B	867	4.6	314	1.6	255	1.3	233	1.2	204	1.1	211	1.1
HiB**	205	1.1	222	1.2	226	1.2	222	1.2	247	1.3	254	1.3
Measles	91	---	7	.04	5	0.0	7	0.0	10	-	8	-
Mumps	7	---	15	0.1	26	0.1	47	0.2	70	0.4	43	0.2
Pertussis	447	2.4	1217	6.4	2165	11.3	772	4.0	1195	6.2	699	3.6

*Rate is per 100,000 ****Hemophilus inflenza* B**

Childhood Immunization: New York has surpassed the Healthy People 2010 goal of 80% for childhood immunization. Since 2000, the percent of New York State children ages 19-36 months who were fully immunized has been increasing. The 2007 rate at 83.0%, was about the same as the 2006 rate of 83.5%. New York State's childhood immunization rate was higher than the 2007 nationwide rate of 80.1%.



	2000	2001	2002	2003	2004	2005	2006	2007
NYS	72.3	77.1	77.5	78.6	82.2	81.6	83.5	83.0
USA	72.8	73.7	74.8	79.4	80.9	80.8	80.6	80.1

Onset of Sexual Activity: There is a relationship between age of sexual initiation, number of partners, frequency of sexual activity, history of sexual abuse, and a myriad of other risk factors particular to adolescents.

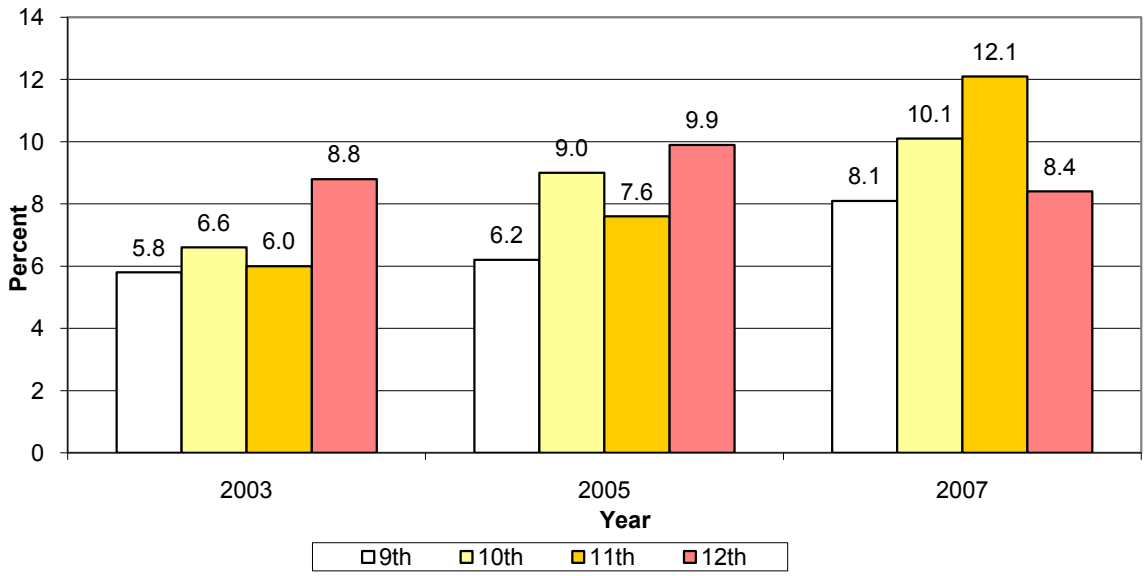
In New York State, the 2007 Youth Risk Behavior Survey (YRBS) found the percentage of teens that have experienced sexual intercourse increases with age, from 28.0% of ninth graders to 62.6% of 12th graders. Although these numbers are cause for great concern, they are comparable to the national average of 30.2% of ninth graders and 56.4% of 12th graders (2005 YRBS). Of New York students responding, 7.0% reported having had sexual intercourse for the first time before the age of 13, which was identical to the national rate; 31.1% of New York State high school students describe themselves as currently sexually active, compared to 33% nationally.

Sexual Assault: According to the U.S. Department of Justice, one of every six American women has been the victim of an attempted or completed rape in her lifetime. About 44

percent of rape victims are women under age 18. Girls 15-19 are four times more likely than the general population to be victims of rape, attempted rape or sexual assault. (Making the Grade on Women's Health: A National and State-by-State Report Card, 2004 – Fact Sheet: the Health of Teenagers, www.nwlc.org).

According to the 2007 New York State Youth Risk Behavior Survey, one out of every 10 female high school students reported that they have been forced to have sex when they did not want to in their lifetime.

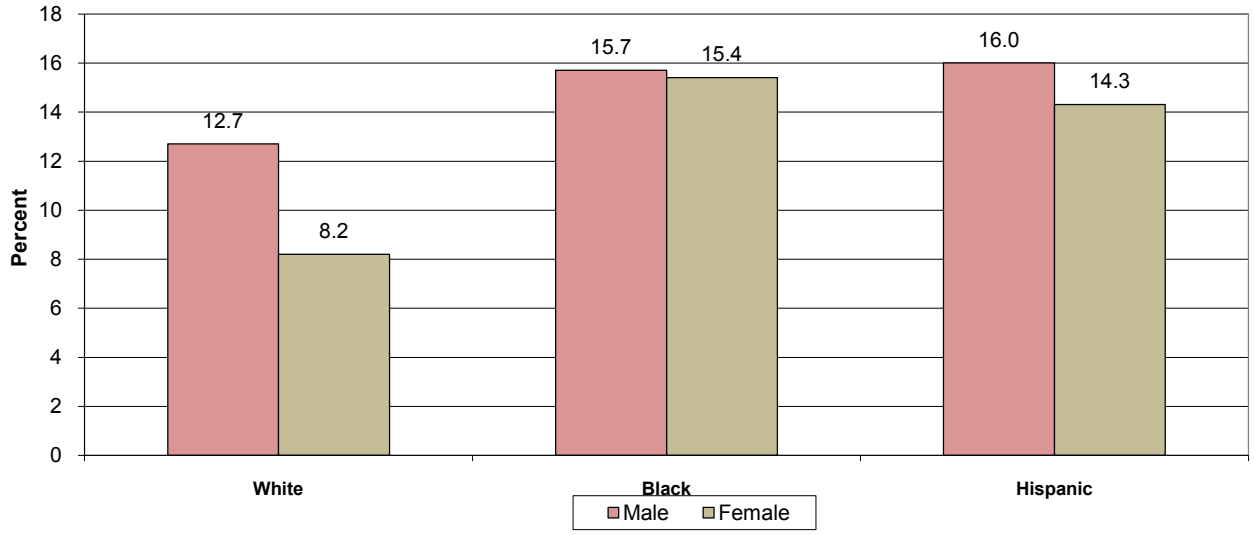
Percent of Female High School Students who were Physically Forced to Have Sexual Intercourse When They Did Not Want To. New York State, 2003, 2005 and 2007



Source: Youth Risk Behavior Survey – 2003, 2005 and 2007

The 2007 Youth Risk Behavior Survey also asked students about physical abuse. Twelve percent of New York high school students reported they were physically hurt (hit, slapped or physically hurt on purpose) by a girlfriend or boyfriend in the past 12 months. Rates were highest among Black and Hispanic males and females. Males were more likely (13.5%) to report physical abuse by a girlfriend or boyfriend as compared to their female (10.5%) counterparts.

Percent of High School Students Who, During the Past 12 Months, Were Physically Hurt by a Girlfriend or Boyfriend by Sex and Race New York State, 2007



Source: Youth Risk Behavior Survey – 2007

Contraceptive Use: There is often a significant period of time between initiation of sexual intercourse and the choice and utilization of an effective method of contraception. According to the 2007 YRBS:

- The percentage of sexually active New York teens reporting condom use during their last sexual intercourse was 66.7, up from 63.3% on the 1999 survey but below the 70.7% reported in the 2005 survey.
- New York State adolescent males reported higher use of condoms during their last sexual intercourse than did adolescent females – 72.5% of adolescent males (compared to 67.6% in 1999 and 75.9 in 2005) and 61.9% of adolescent females (compared to 58.9% in the 1999 survey and 66.3% in the 2005 survey) reported using condoms during their last intercourse.
- In New York State, 15.4% of high school students reported using birth control pills during their last sexual intercourse.
- 26.8% of the adolescent males responding to the survey and 19.3% of adolescent females who responded reported alcohol or drug use at last sexual intercourse. Use of alcohol is generally associated with reduced inhibitions and has a negative statistical correlation with effective use of contraceptives. These data for the 2005 survey were at levels of 23.4% for males and 14.6% for females.
- Although 56.4% of New York State high school students in 2007 reported they never had sex, 10.4% of male students and 3.6% of female students reported having their first sexual intercourse before the age of 13.
- Black high school students were the most likely to report ever having had sexual intercourse (59.8%), followed by Hispanic students (52.3%) and then White students (38.4%). These rates are similar to what was reported in 2005.

Sexually Transmitted Diseases and HIV: Unprotected, high-risk sexual behavior places individuals at risk for sexually transmitted diseases and HIV. If undiagnosed and untreated, there can be lifelong consequences, including infertility and death. Genital sores caused by syphilis make it easier to transmit and acquire HIV infection sexually. There is an estimated 2- to 5-fold increased risk of acquiring HIV infection when syphilis is present.

HIV/AIDS: As of December 2007, 795 children under 12 and 1,859 children ages 13-19 were living with HIV or AIDS in New York State. Approximately half of these children were males and half were female. About 90% of these cases are attributable to perinatal HIV transmission. Children between the ages of 0 and 19 represent about 2.2% of New Yorkers living with HIV and AIDS.

Chlamydia: In 2007, 80,733 cases of Chlamydia were reported in New York State, making it the most commonly reported communicable disease. Chlamydia morbidity has continued to increase since reporting began 2000. Women are disproportionately affected by Chlamydia. The case rate per 100,000 population for females in 2007 was more than twice the rate for males (569.6 vs. 256.9). Young women had the highest rates of infection. In both NYC (3692.3 per 100,000) and Upstate, NY (2080.8 per 100,000), females aged 15-19 had the highest infection rates in 2007.

Syphilis and Gonorrhea: In 2007, there were 2,222 cases of early stage syphilis in New York State. This was an increase over the 1,731 cases reported in 2006. The bulk of the cases were in New York City and among males. In 2007, 17 cases of congenital syphilis were reported statewide. Of the 17 cases, 7 were reported in New York City and 10 were reported in the rest of the state.

Gonorrhea is the second most commonly-reported STD in New York State. In 2007, 17,699 cases of gonorrhea were reported statewide. The case rate of 93.3 per 100,000 population was slightly higher than the 2006 rate of 92.0 per 100,000. Overall, rates of gonorrhea by sex were similar with 100.0 cases per 100,000 males and 83.8 cases per 100,000 females. Gonococcal infection rates were highest among adolescent and young adults. Statewide, age-specific rates by sex were highest among 20-24 year old males (359.3 per 100,000) and 15-19 year old females (423.5 per 100,000).

About 90% of High School students over the past decade reported they have ever been taught in school about AIDS or HIV infection. Overall, in 2007, 89% of students reported receiving AIDS/HIV related education, with rates highest among white students at 90%, and at about 85% among Black and Hispanic students.

Other Youth Risk Behavior: The 2007 Youth Risk Behavior Survey offers a great deal of information about high school students across the State. A summary of these data follows:

Risk for Unintentional Injuries- According to the survey, more than four out of five (83%) students who rode bicycles in the past 12 months reported they never or rarely wore a bike helmet. Students at highest risk were older (85.9% of seniors vs. 78.9% for ninth graders), and male students were less likely to wear helmets (85.9%) than female students (79.1%).

Only nine percent reported on the survey that they never or rarely wore seatbelts when in a car driven by someone else. Twenty-three percent reported this behavior in 1997.

Seven percent reported they had driven a car or other vehicle when drinking alcohol; males were more likely to report doing so than females (8.5% vs. 5.6%).

Risk for Intentional Injuries – The 2007 YRBS shows that males in New York were almost three times more likely to carry a weapon to school than females (6.7% vs. 2.5%).

6.5% of students responding to the 2007 YRBS reported that they had missed school because they felt unsafe at school or on the way to school, females at the rate of 6.2% and males at the rate of 6.7%.

7.3% of students reported being threatened or injured with a weapon while on school property. More males were threatened than females (8.9% vs.5.4%). Ninth graders were more likely to be threatened or injured than seniors (6.6% vs. 5.7%).

About a third of the students (31.7%) reported participating in a physical fight. Ninth graders were again more likely to report this behavior than seniors (35.5% vs. 23.8%). 12.1% of students reported being slapped or being physically hurt by a boyfriend or girlfriend. 10% of females and 7.1% of males reported being forced to have sexual intercourse when it was not wanted.

25.8% of students reported feeling sad or hopeless almost every day for 2 weeks or more. The rate for females (33.5%) was higher than for males (18.1%). 12.1% of students seriously considered attempting suicide. Females were more likely to have considered this than males (15.1% vs. 9.0%). 10.2% of students actually made a plan for how they would attempt suicide. 7.6% reported attempting suicide one or more times. Females attempted at a higher rate than males (8.0% vs. 6.9%). 2.7% needed medical care.

Youth Tobacco Use – Tobacco use is a major risk factor in adolescents. According to the 2006 New York State Youth Tobacco Survey, the current use of cigarettes among middle school and high school students is approximately 4.1% and 16.3% respectively. Among high school students, the current use of cigarettes for white, black and Hispanic students was 20.1%, 7.9% and 13.4%, respectively.

The Youth Risk Behavioral Risk Survey (YRBS) also queries students about smoking. During the past decade, there has been significant progress in reducing teen smoking.

- Of students participating in the Youth Risk Behavior Survey in New York in 2007, 45.4% reported they had tried smoking sometime in their life. This is down slightly from 47.3% in 2005 and 33% lower than the 68.1% reporting this in 1997.

- The percentage of high school students who reported smoking a whole cigarette before the age of 13 was about 11% in 2005 and 2007, half of the 22.7% reporting smoking by age 13 in 1997.
- The current smoking rate (smoking one or more cigarettes in the last 30 days) among NYS high school students in 2007 of 13.8% was 58% lower than the 1997 rate of 32.9%.
- In 2007, White students had the highest current smoking rate (16.1%), followed by Hispanic (15.7%) and Black students (5.8%). Both White and Black students have reduced their smoking rates by at least 50% since 1997. The rate among Hispanic students has been reduced by 37% since 1997.
- Female students had a higher current smoking rate (14.7%) than Male students (12.9%) in 2007. Both males and females have cut their smoking rates in half since 1997.
- Of current student smokers in 2007, 57.3 percent of students tried to quit during the past 12 months.

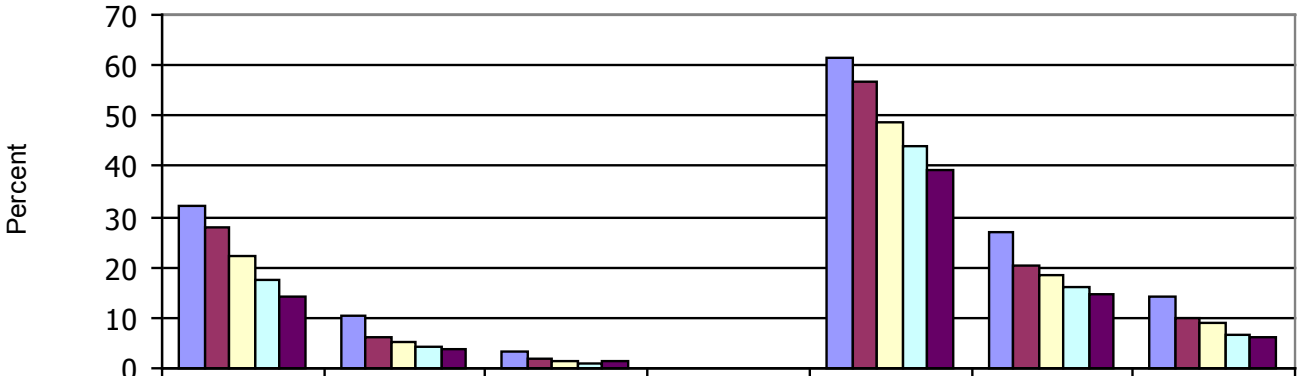
Among New York City high school students in 2005, 11.2 percent of students reported smoking on one or more of the past 30 days. White students were the most likely to report smoking (29.3%) followed by Hispanic (11.4%) and Black (7.3%) students. In addition to their current smoking habits, New York City high school students were asked if they think they will be smoking 5 years from now. About 13 percent answered yes. Among white

students the percent was even higher (18.6%). Of Black and Hispanic NYC high school students, 11.0 and 12.9% respectively, predicted they would be smoking 5 years from now.

The Youth Tobacco Survey (YTS) is also administered in New York State on a biannual basis to students in sixth through twelfth grades, and supplements information obtained through YRBS. The YTS estimates tobacco use, exposure to environmental tobacco smoke, knowledge and attitudes about tobacco, access to tobacco products by minors, counter-marketing and tobacco cessation in middle and high school students. The results of the 2000, 2002, 2004, 2006 and 2008 YTS show important declines in youth tobacco use. Among New York State middle school students, current use of tobacco declined from 10.5% in 2000 to 3.8% in 2008. High school students had a decline in current use (from 27.1% to 14.6%), frequent use (from 14.3% to 6.2%) and ever use (61.7% to 39.1%).

Middle & High School Ever, Current, & Frequent Use of Cigarettes

Source: NYS Youth Tobacco Survey, 2000, 2002, 2004, 2006 and 2008



	Middle School - Ever Use	Middle School - Current	Middle School - Frequent		High School - Ever Use	High School - Current	High School - Frequent
2000	32.3	10.5	3.1		61.7	27.1	14.3
2002	28.1	6.3	1.9		56.8	20.4	10.1
2004	22.0	5.4	1.4		48.5	18.5	9.1
2006	17.7	4.1	0.8		44.2	16.3	6.6
2008	14.1	3.8	1.4		39.1	14.6	6.2

Youth Alcohol and Substance Use - Of respondents to the 2007 YRBS, 75.9% of all students reported having had at least one drink of alcohol in their lifetime; 22.9% had their first drink before age 13. In 2003, these data were at 74.2% and 27.0%, respectively. In 2007, 43.7% of respondents reported having at least one drink of alcohol in the last 30 days, compared to 43.4% on the 2005 survey. Binge drinking (five or more drinks of alcohol in a row on one or more days in the last 30 days) in 2007 was reported by 25.7% of males and 23.8% of females. In 2005, 26.2% of males and 21.4% of females reported binge drinking.

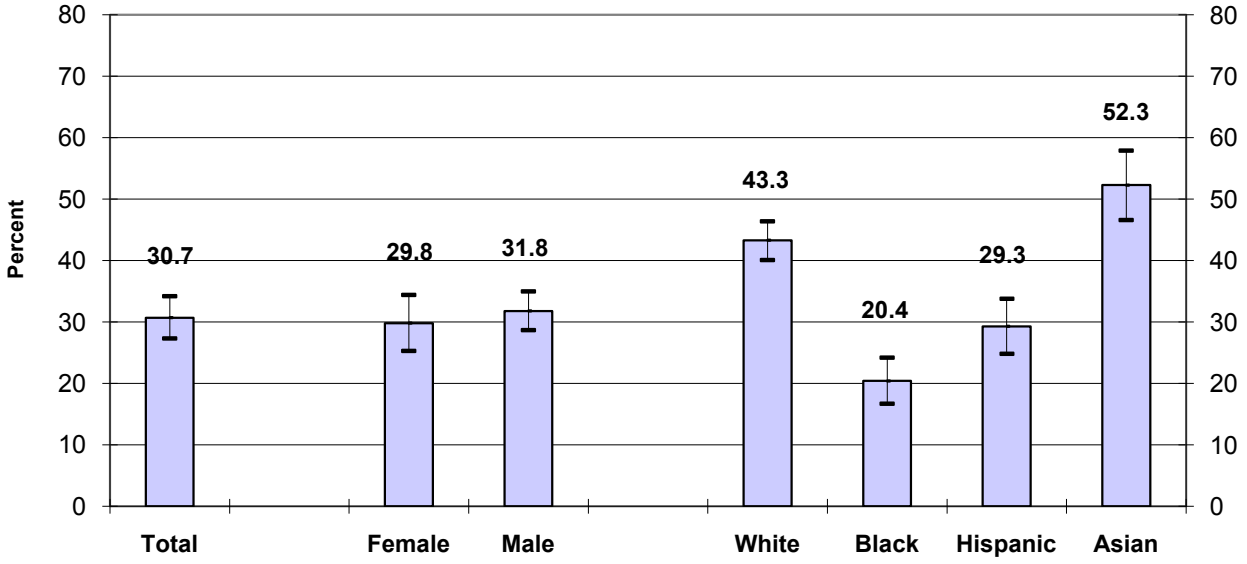
The use of drugs other than alcohol was consistently higher for males than for females. The 2007 survey also found increased reporting of substances used compared to 2005 rates for the following:

- 35.2% of students reported they had tried marijuana, compared to 34.7% in 2005;
- 18.6% used marijuana one or more times in the last 30 days, compared to 18.3% in 2005;
- 7.0% of students reported using cocaine, compared to 5.1% in 2005;

- 11.9% of students reported they had sniffed glue or breathed the contents of aerosol cans to get high, compared to 8.6% in 2005;
- 3.4% used heroin one or more times during their life, compared to 1.8% in 2005.
- 4.4% reported using methamphetamines, compared to 3.3% in 2005;

Family Meals: Research by The National Center on Addiction and Substance Abuse (CASA) at Columbia University consistently finds that the more often children eat dinner with their families, the less likely they are to smoke, drink or use drugs. As an extension of the New York City Youth Risk Behavior Survey, New York City high school students in 2005 were asked about how often they share meals as a family in their home. On average, 30.7% of New York City high school students ate meals with their families 5 or more times during the week. Asian (52.3%) and White (43.3%) New York City students were significantly more likely to eat 5 or more family meals in a week as compared to Black (20.4%) and Hispanic (29.3%) students.

High School Students who Ate Meals With Their Families 5 or More Times in the Past Week by Race/Ethnicity and Gender New York City, 2005



Source: New York City Youth Risk Behavior Survey - 2005

Leading Causes of Death for Children: The leading causes of death for children, birth to 19 years in 2007 for New York State, New York City, and the rest of the state are reflected on the table that follows.
The figures show:

- More than half of the infant deaths in the state are caused by conditions arising in the perinatal period.
- Among children aged 1-9, unintentional injury is the most likely cause of death in both New York City (23.3%) and New York State-excluding NYC (24.2%). Homicide and legal intervention remains in the top five causes of death for this age group.
- Unintentional injuries are the leading cause of death among children ages 10 to 19 years in New York State – excluding New York City (43.7%) followed by homicide and legal intervention (10.7%). In New York City, the category of homicide and legal intervention

is the leading cause of death (25.9%) for this age group while unintentional injuries (20.1%) were next most common cause of death.

- Suicide is the fourth leading cause of death among New York State 10- to 19-year-olds. Suicide accounts for 8.3% of deaths in this age group, and when New York City is excluded, it represents 9.3 of deaths in the rest of the state.

LEADING CAUSES OF DEATH, 2007

FOR CHILDREN BIRTH TO AGE 19 YEARS

New York State Children

All Ages

Cause	Number	Percent
All Causes	146,266	100.0
Diseases of the heart	49,313	33.7
Malignant Neoplasms	35,183	24.1
CLRD	6,465	4.4
Cerebrovascular disease	5,881	4.0
Unintentional Injuries	4,905	3.4

Under Age 1

Cause	Number	Percent
All Causes	1,382	100.0
Cond Orig in Perinatal Period	761	55.1
Congenital Anomalies	259	18.7
SIDS	63	4.6
Unintentional Injuries	44	3.2
Diseases of the Heart	25	1.8

Ages 1 – 9 Years

Cause	Number	Percent
All Causes	344	100.0
Unintentional Injuries	82	23.8
Malignant Neoplasms	50	14.5
Congenital Anomolies	38	11.0
Homicide and legal intervention	22	6.4
Diseases of the Heart	17	4.9

Ages 10 – 19 Years

Cause	Number	Percent
All Causes	700	100.0
Unintentional Injuries	239	34.1
Homicide & Legal Intervention	114	16.3
Malignant Neoplasms	82	11.7
Suicide	58	8.3
Diseases of the Heart	28	4.0

New York State – Exclusive of New York City

All Ages

Cause	Number	Percent
All Causes	93,395	100.0
Diseases of the Heart	28,140	30.1
Malignant Neoplasms	22,733	24.3
CLRD	5,062	5.4
Cerebrovascular disease	4,280	4.6
Unintentional Injuries	3,247	3.5

Under Age 1

Cause	Number	Percent
All Causes	760	100.0
Cond Orig in Perinatal Period	409	53.8
Congenital Anomalies	130	17.1
SIDS	59	7.8
Unintentional Injuries	27	3.6
Diseases of the Heart	12	1.6

Ages 1 – 9 Years

Cause	Number	Percent
All Causes	198	100.0
Unintentional Injuries	48	24.2
Malignant Neoplasms	26	13.1
Congenital Anomalies	21	10.6
Homicide & Legal Intervention	14	7.1
Diseases of the Heart	12	6.1

Ages 10 – 19 Years

Cause	Number	Percent
All Causes	441	100.0
Unintentional Injuries	187	42.4
Homicide & Legal Intervention	47	10.7
Suicide	41	9.3
Malignant Neoplasms	39	8.8
Diseases of the Heart	21	4.8

New York City

All Ages

Cause	Number	Percent
All Causes	52,871	100.0
Diseases of the Heart	21,173	40.0
Malignant Neoplasms	12,450	23.5
Pneumonia	2,346	4.4
Unintentional Injuries	1,658	3.1

Under Age 1

Cause	Number	Percent
All Causes	622	100.0
Cond Orig in Perinatal Period	352	56.6
Congenital Anomalies	129	20.7
Unintentional Injuries	17	2.7
Diseases of the Heart	13	2.1

Cerebrovascular disease	1,601	3.0	Homicide & Legal Intervention	13	2.1
Ages 1 – 9 Years			**Ages 10 – 19 Years**		
Cause	**Number**	**Percent**	**Cause**	**Number**	**Percent**
All Causes	146	100.0	All Causes	259	100.0
Unintentional Injuries	34	23.3	Homicide & Legal Intervention	67	25.9
Malignant Neoplasms	24	16.4	Unintentional Injuries	52	20.1
Congenital Anomalies	17	11.6	Malignant Neoplasms	43	16.6
Homicide & Legal Intervention	8	5.5	Suicide	17	6.6
Pneumonia	7	4.8	Congenital Anomalies	8	3.1

Children with Special Health Care Needs

New York applauds national efforts to establish data for numbers of children with special health care needs. As a State Health Department, we are working to improve what is known about special needs children in our State in order to better serve them and better serve their families.

Early identification of children with special health care needs is evident in reviewing NYSDOH program data, which shows a significant proportion of children referred between their birth and four years of age (26%). The largest group referred is children 10 to 14 years old (30%), representing the large number of families seeking assistance with medically necessary orthodontia. Children 5-9 years of age represent 19% of the referrals and 15-19 year-olds represents 22%. Three percent of the referrals are for children 20 to 21 years of age. The emphasis of the program at this age is on transitioning young adults from the pediatric setting to adult health care and social support systems.

Data from the local health units indicate that, of the children referred to the CSHCN Programs, 75.5% in 1999, 74.2% in 2000 and 61.0% in 2001 had primary health care providers. In 2006, 74% of the children referred to the program had primary care providers. Data are collected only on admission. These percentages were felt to be related to increasing success with enrollment of children with special health care needs in Medicaid and Child Health Plus. Once enrolled in CSHCN Program and insurance, families find it easier to enroll in primary care. The CSHCN Program is most likely to get referrals when families are uninsured or underinsured.

The major sources of referrals in 2005 for the Children with Special Health Care Needs Program are:

- Hospitals or specialty providers (42%);
- Parents/family (23%);
- The Physically Handicapped Children's Program (14%);
- The Early Intervention Program (5%); and
- Primary health care providers (4%).

The racial background of the children referred was reported as white (62%), African-American (5%), other (2%), Asian (1%) and no response (30%). For those for whom race was reported, the percentages of those served roughly reflect Upstate demographics.

Consistent with the large number of adolescents referred to the program, orthodontia represents the most common diagnosis, accounting for 32% of the children referred. Ear disorders are second at 16%; followed by nervous system disorders (6%), musculoskeletal disorders (5%), apnea/prematurity (4%), diabetes (4%), disorders of the respiratory

system (3%), congenital anomalies (3%), and heart disorders (3%). Other diagnoses representing less than 2% each include neoplasms; cleft lip/palate; late effects injury; and GU, blood, endocrine, circulatory, skin, thyroid metabolic, eye, digestive and mental disorders.

Insurance coverage is determined at the time of referral. Program data indicated insurance status of those served as follows: 88% have insurance, 8% are uninsured, and for 4% insurance status is unknown. Of those with insurance, 47% request assistance for services not covered by their benefit package, 37% need assistance with co-payments, 14% with paying premiums, 13% have exceeded their annual and/or lifetime benefits and 12% need assistance with deductibles.

SLAITS Study: The Maternal and Child Health Bureau at HRSA identified six core outcomes for measuring States' progress toward implementing family-centered, community-based, comprehensive, coordinated, easily accessible system for Children with Special Health Care Needs. MCHB also developed a monitoring strategy utilizing a national telephone survey conducted by the National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC) called SLAITS – State and Local Area Integrated Telephone Survey.

From the SLAITS collected in 2005-2006, New York learned that:

- The percentage of children and youth with special health care needs, ages birth through 17, is approximately 12.7%, lower than the national average of 13.9%.
- Prevalence by age group was as follows: 8.4% of children from birth through age 5; 14.1% of children ages six through eleven; and 15.3% of children 12 through 17 years of age.
- Prevalence of children with special health care needs in families with incomes under 100% of the Federal Poverty Level (FPL) was 12.6%, 12.8% in the families with incomes 100-199% of FPL, 13.7% in families with incomes 200-399% FPL, and 11.5% in families over 400% FPL.
- Prevalence by race/ethnicity was: 9.0% among Hispanics, 13.9% among non-Hispanic Whites, 15.3% among non-Hispanic Blacks, 18.9% among mixed-race non-Hispanics, and 2.7% among Asians.
- 23.7% of the children and youth with special health care needs reported that their conditions consistently and often greatly affect their daily activities.
- An estimated 59.0% of New York families of children with special health care needs were partners in decision-making and were satisfied with the services they are receiving.
- An estimated 45.2% of New York families of children with special health care needs were obtaining care within a medical home.
  - About 94% reported a usual source of care.
  - About 95% had a personal doctor or nurse.
  - About 77% said they had no problem receiving needed referrals.
  - About 67% said their care was usually family centered.
- An estimated 62.1% of New York families of children with special health care needs had adequate insurance coverage to pay for the services they need.
  - About 17% pay $1,000 or more out of pocket in medical expenses per year for the child.
  - About 18% had conditions that caused financial problems for the family.
- Approximately 90.6% of families said systems were organized in a way that families can use them easily.
- Relative to transition of children with special health care needs to adulthood, an estimated 38.4% said they received services necessary to make appropriate transitions to adult health care, work, and independence.

The results of the SLAITS study for New York are documented on **Form 11. National Performance Measures 2 through 6.**

Fetal Alcohol Syndrome Surveillance: Fetal Alcohol Syndrome or FAS is a preventable birth defect caused by maternal alcohol drinking during pregnancy. The syndrome is diagnosed by using a combination of findings, which may include poor growth, central nervous system disorders, certain FAS-related facial features, and a history of maternal alcohol use during pregnancy. The syndrome may be more difficult to recognize in newborns, but easier to diagnose in older children. New York has two systems to ascertain Fetal Alcohol Syndrome cases: the statewide birth defects registry and FASSNet, or the Fetal Alcohol Syndrome Surveillance Network. FASSNet is a population-based, multi-source system where records of children with FAS or known or suspected prenatal exposure to alcohol are actively enrolled and their records abstracted. In a recent study comparing the accuracy of FAS reports to the registry with the FASSNet system, FASSNet was shown to identify more children than the registry alone.

From 1996 through 2003, New York was a part of the National Birth Defects Prevention Study, a CDC-funded collaborative. For this study, a random sample of women who gave birth from 1997 to 2003, whose children did not have a major structural malformation were controls. The study area was an 8-county region in Western New York. Women were interviewed within two years of childbirth. The study questionnaire asked about alcohol intake before and during pregnancy. In the three months before conceiving, 50% of the women reported any drinking (95% CI 41-59%), and 15.2% reported at least one episode of binge drinking (95% CI 9.4 to 22.7%). In the first three months of pregnancy, 8% reported at least one episode of binge drinking (95% CI 4.0 to 14.1%). Past studies have shown that drinking during pregnancy tends to be under-reported. Also, while most women reduce or stop drinking once they know they are pregnant, pre-pregnant levels of alcohol consumption may continue in the earliest stages of pregnancy until the woman realizes or is told she is pregnant.

In the project area, the 1995-1999 birth cohort had an incidence of FAS of 0.72 per 1,000. Rates were higher in urban Buffalo, where there was an overall rate of 1.92 per 1,000. The non-Hispanic white rate was 0.83 /1,000; the rate for African Americans was 3.4/1,000.

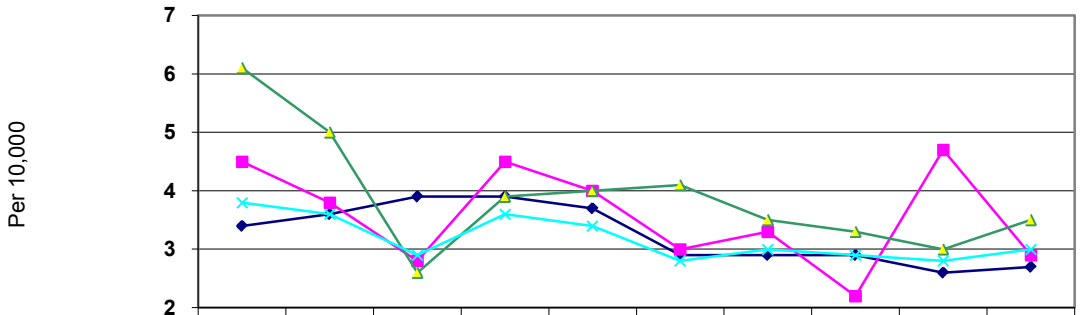
Sickle Cell Disease: The Newborn Screening Program screens for Sickle Cell Disease and Trait. The report of 2008 achievements is located on Form 11, National Performance Measure 01. Of over 252,793 infants screened in 2008, 144 screened positive for Sickle Cell Disease, and of these, 124 were confirmed positives.

Sickle Cell Disease affected at least 2,844 New York Medicaid patients in 2005. As a result of Medicaid Drug Utilization Review, it was noted that Hydroxyurea, a drug approved by the Food and Drug Administration for the prevention of sickle cell crises, has been underutilized. As a result, the Medicaid program, in order to draw attention to the underutilization of this drug, wrote to providers of patients with sickle cell disease who were not receiving the drug to inform providers of the availability and efficacy of this drug.

Neural Tube Defects: The table that follows shows that the trend in incidence of neural tube defects has declined since 1997 when the rate was 3.8 per 10,000 to 3.0 per 10,000 in 2006. In 2006, rates were highest among Hispanics, and rates for blacks were comparable to the rates for whites. The source of these data is the New York State Congenital Malformations Registry. Please note: The Black and White categories do not include Hispanics in the calculation. Information is reportable to this registry for up to two years

from the date of birth. Therefore, later figures are not available. This rate is affected by rates of pregnancy termination based on the information provided by prenatal testing.

Rate of Neural Tube Defects per 10,000 Live Births
New York State 1997 - 2006*



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
White	3.4	3.6	3.9	3.9	3.7	2.9	2.9	2.9	2.6	2.7
Black	4.5	3.8	2.8	4.5	4.0	3.0	3.3	2.2	4.7	2.9
Hispanic	6.1	5.0	2.6	3.9	4.0	4.1	3.5	3.3	3.0	3.5
Total*	3.8	3.6	2.9	3.6	3.4	2.8	3.0	2.9	2.8	3.0

*Including unknown race

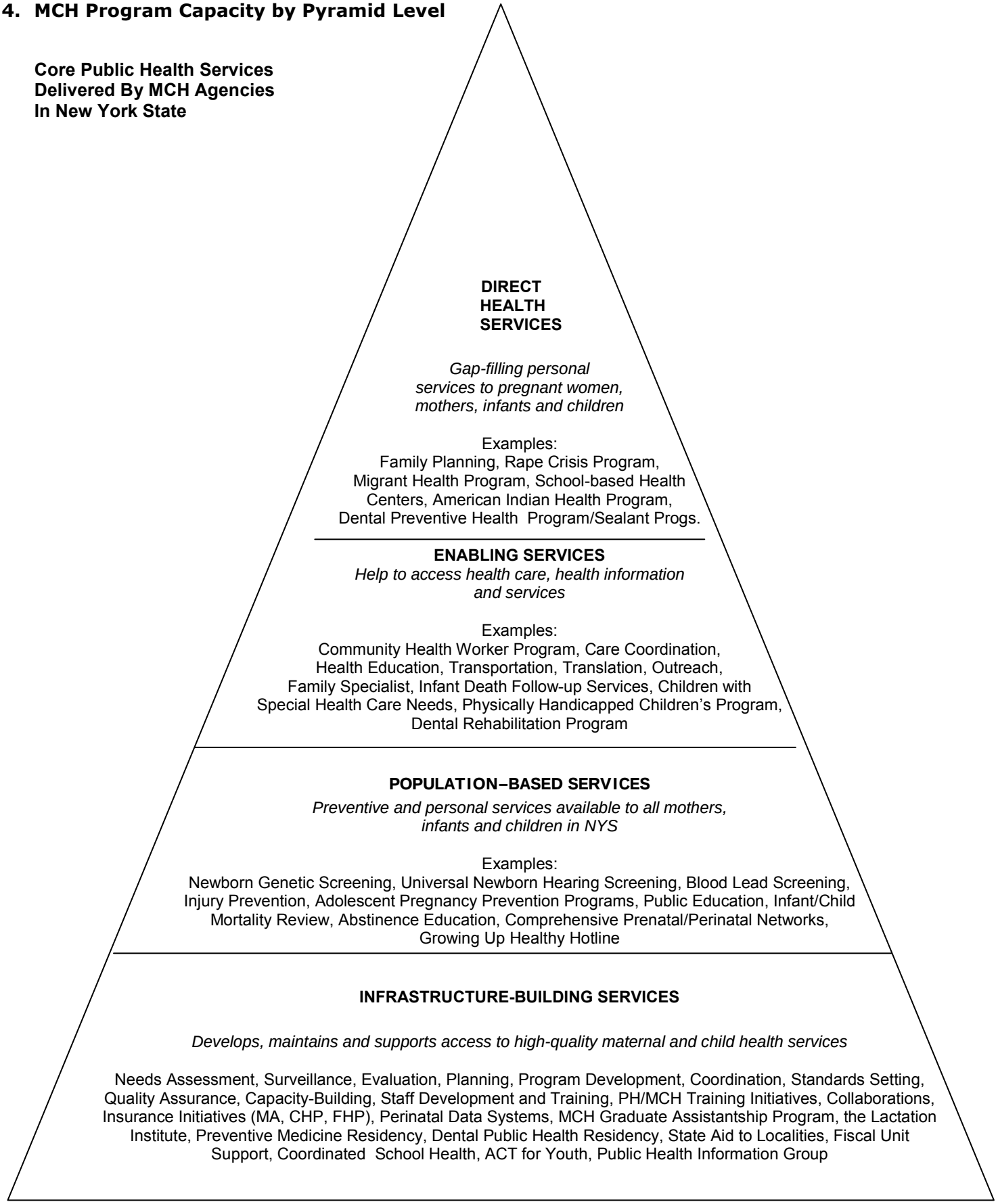
Cleft Lip and Palate: During 2002-2006, 1595 children (over 300 per year) in this state, at a rate of 12.9 per 10,000 live births, were born with cleft lip, palate or both.
The prevalence of Cleft lip and palate is somewhat higher among males as compared to females and among non-Hispanic Whites. New York has an effective mechanism for identifying, recording, and referring these infants for treatment. Cleft lip and palate are eligible conditions under the Physically Handicapped Children's Program (PHCP) and the Dental Rehabilitation component of PHCP.

Prevalences of Oral Clefts (BPA=749.x) per 10,000 live births by birth year, sex & race, New York State, 2002-2006

Birth year	Total children	Total Preva-lence	Male	Female	Preva-lence Ratio (M\F)	Non Hispanic White	Non Hispanic Black	His-panic	Other & Unknown Race	Mothers Age <35yrs	Mothers Age >=35yrs
2002	332	13.2	14.8	11.6	1.3	14.2	9.6	12.9	15.0	12.8	15.2
2003	317	12.5	13.6	11.4	1.2	12.9	9.5	12.6	14.8	12.4	13.2
2004	290	11.8	12.3	11.2	1.1	13.2	7.5	12.2	10.9	12.5	8.8
2005	314	12.9	12.8	13.1	1.0	13.4	8.9	12.9	17.7	13.5	10.9
2006	342	13.9	13.4	14.4	0.9	15.5	10.7	12.0	15.7	13.0	17.5
All	1595	12.9	13.4	12.3	1.1	13.8	9.2	12.5	14.8	12.8	13.1

4. MCH Program Capacity by Pyramid Level

Core Public Health Services Delivered By MCH Agencies In New York State



a. State Capacity to Provide Direct Health Services

Health Workforce: According to HRSA State Health Workforce Profiles for New York, in 2004, New York had over 48,000 active patient care physicians. At 264 physicians per 100,000 populations, New York is well above the national average of 214 per 100,000. New York ranked sixth among the 50 states for physicians per capita behind Massachusetts, Maryland, Vermont, Rhode Island and Connecticut. New York had 73 active primary care physicians per 100,000 population in 1998, compared to 59 per 100,000 in the US. By 2004, New York had 87.6 primary care physicians per 100,000 of population, compared to 76.6 for the US. Minorities are under-represented. Only five percent of active physicians in New York are African American and four percent are Hispanic/Latino, compared to a general population of about 15% of each.

New York is also fourth in the country for the number of dentists in the state, and fourth in the US for number of psychologists. New York ranks 3rd out of 50 for number of registered professional nurses, tenth for number of nurse practitioners, and first for number of home health aides. New York ranks 48th out of 50 states for number of emergency medical technicians.

These rates do not tell the full story, however. While New York has sufficient personnel in terms of numbers, the distribution of health professionals is uneven. The Federal government has helped support workforce development and ease maldistribution through several Health Resources and Services Administration (HRSA) programs. According to HRSA's State Profile for New York, in addition to the Block Grant and Ryan White Act funds, HRSA helps fund:

- 36 Community/Migrant Health Centers;
- 14 Health Care for the Homeless grantees;
- one Health Services in Public Housing grantee;
- 93 State loan re-payers;
- 30 National Health Service Corps (NHSC) scholars;
- 117 participants in the NHSC Loan Repayment Program;
- 240 NHSC providers, including 133 primary care physicians, 8 non-primary care physicians, 32 physician assistants, 27 nurse practitioners, 27 dentists, and 13 licensed midwives;
- the State Office of Rural Health, two rural health outreach grants, one state rural hospital flexibility grant and three rural health network development grants;
- nine training grants to improve workforce diversity;
- 56 scholarship and loan programs for disadvantaged and/or financially needy students in health professions;
- 101 training grants to improve access to health care for the underserved;
- 12 training grants to improve public health;
- five projects training maternal and child health professionals;
- a Workforce Information and Analysis State Center for Excellence;
- two emergency medical services for children grants;
- five Healthy Start communities;
- three Emergency Relief Assistance (Title 1) programs in the City of New York, Dutchess and Nassau Counties;
- a grant for HIV/AIDS care, including the AIDS Drug Assistance Program;
- nine HIV/AIDS programs for children, youth and families;
- one AIDS Educational Training Center
- seven new models of AIDS care;

- 31 organizations providing oral health services to people living with HIV/AIDS; and
- one traumatic brain injury grant.

All of these programs share these common goals: to increase access to comprehensive, high-quality, primary and preventive care, to improve access for vulnerable and underserved populations, and to strengthen the safety net within communities to address the needs of the vulnerable populations at risk for poor health outcomes. This assistance is helping New York and HRSA to meet mutual goals for "100% access, zero disparities."

Health Insurance Initiatives: Improving and sustaining access to high-quality, continuous primary health care and treatment services are critical to improving health outcomes for all New Yorkers and achieving our public health and maternal and child health priorities. The hallmarks of success will be prevention, early intervention, and continuity of care through establishing and maintaining a "medical home" for every New Yorker. Success will also depend on the actual delivery of appropriate, high-quality, comprehensive health services to people in need, and requires practitioners to be knowledgeable about and practice good preventive and therapeutic medicine.

New York is committed to removing the most significant barrier to health care: lack of health insurance. The Governor pledged a fundamental restructuring of New York's health care system. His plan is to provide access to health care coverage for currently uninsured children in New York and, through streamlining enrollment, to encourage 900,000 additional children and adults to obtain Medicaid coverage.

Approximately 400,000 children under the age of 19 are currently uninsured whose families have incomes under 400% of the Federal Poverty Level. It is these children that we will be trying to reach and enroll.

The Governor's plans have been endorsed by numerous advocacy groups, including the Children's Defense Fund, and by the Community Health Centers.

The 2007-2008 state budget brought several new changes to the Medicaid program.
1) Self-attestation of residency and income will be allowed at renewal;
2) There is guaranteed 12-months of coverage for adults to reduce gaps in coverage; and
3) Medicaid will now allow presumptive eligibility for children.

The reasons for being uninsured or underinsured were many. Urban Institute data show that a smaller percentage of New York's employers offer health insurance than in the US as a whole (64.0% in 1999 compared to 66.7% for the US). Many employers offer insurance for the employee only, and offer family coverage only at unaffordably high rates. Families have testified that the rates offered are too high for the families to "buy in" to family coverage. As a result, they told us, fathers are covered by their employers, young children were covered by Child Health Plus, but many mothers and older children were not covered at all. New York's insurance programs for the uninsured and underinsured are helping. In addition to offering these families Child Health Plus, families like these were targeted for Family Health Plus, a State insurance program. The Healthy New York Insurance Program is also helping, as is Medicaid coverage for pregnant women whose family income is less than 200% FPL, adjusted for family size. Methods to potentially improve health in the critical preconception/interconception period, which is increasingly becoming the focus of efforts designed to improve birth outcomes, are under discussion.

The high number of immigrants in New York State must certainly be another factor in the number of remaining uninsured. There has been misunderstanding among the documented immigrant communities regarding use of Medicaid and Child Health Plus being used to "count against" immigrants as having used public services (a "public charge"). The Immigration and Naturalization Service (INS) has issued statements to try to correct this misinformation about public charge, and the Medicaid Program has also provided guidance to local districts on this ruling.

There have been three situations in which undocumented immigrants in New York have been entitled to government coverage: 1.) uninsured children are eligible for Child Health Plus under the state-financed portion of the program; 2.) anyone accessing care at an emergency room has been eligible for emergency Medicaid; and 3.) poor, undocumented immigrant women were eligible for prenatal care using state-only funds.

In May 2000, the United States Court of Appeals for the Second Circuit, in Manhattan, ruled that undocumented immigrant women are not entitled to federally-financed prenatal care. This ruling overturned a 1991 Federal District Court (Lewis v. Grinker) ruling that ordered the federal government to provide prenatal care (care of the unborn) for undocumented immigrants. The children born of those pregnancies, who are US citizens, are still automatically eligible for one full year of Medicaid benefits after their birth. The Court of Appeals sent the ruling back to a lower court for a decision as to how to carry out this ruling, which would affect approximately 13,000 women. It was decided that undocumented immigrant women would continue to receive prenatal care until the lower court provided guidelines.

Then, Chapter 16 of the Laws of 2002 amended the Social Services Law to continue to provide Prenatal Care Assistance Program (PCAP) coverage to undocumented aliens as a State-only funded program. This became effective February 1, 2002. Now, no matter what the court ruling on Lewis v. Grinker, undocumented women in our State will be able to receive comprehensive services under PCAP.

Ensuring access to health care coverage for the uninsured and underinsured remains a very high priority in New York State. New York State's Title V Program will continue to work with the Office of Health Insurance Programs (OHIP), which oversees the State's Medicaid program, to address access to care through public insurance programs.

Medicaid and Child Health Plus: There have been major expansions in New York's Medicaid Program over the last few years relative to the maternal and child health population. Medicaid also administers or provides access to several special programs and federal waivers designed to improve the health of Medicaid-eligible women and children. County governments play a major role in administration of Medicaid and TANF in New York; counties contribute 25% of the costs for these programs.

Most children under age 19 who have been determined eligible for Medicaid receive **12 months of continuous coverage**, even if their family's income exceeds eligibility levels during that year. Infants up to one year of age may be eligible with incomes up to 200% FPL. Children ages one through five may be eligible with incomes up to 133% of the Federal Poverty Level, and children from age 6 through 18 years of age may be eligible with incomes up to 100% of the Federal Poverty Level. There is no resource test for Medicaid eligibility for children under age 19.

Pregnant women may be eligible with incomes up to 200% of the FPL and have no resource test. Coverage continues through 60-90 days postpartum. An infant born to a woman eligible for and receiving Medicaid is eligible for Medicaid until the end of the month in which the child turns age 1.

The **Family Planning Extension Program:** Women and adolescents residing in New York State and insured by Medicaid during their pregnancy who lose Medicaid eligibility for any reason are eligible for up to 26 months of family planning benefits immediately following their pregnancy. These women are eligible whether their pregnancy ended in miscarriage, live birth, stillbirth or induced termination. Approved under a Centers for Medicare and Medicaid Services (CMS) 1115 waiver, at present the program is only available from our contracted Family Planning Providers. The federal Medicaid Program supports 90% of the cost of family planning services for eligible women. The benefit package includes all services normally provided by family planning programs for their patients.

There is also a **Family Planning Benefit Program,** the waiver for which was also approved by CMS. Under the Family Planning Extension Program, a woman needs to first become pregnant to be eligible for its services. The Family Planning Benefit Program, addresses this issue by expanding family planning eligibility based solely on the countable income being below 200% of the Federal Poverty Level, regardless of previous Medicaid eligibility or pregnancy. Both men and women are eligible. New York is one of a limited number of states that have pursued this approach. Under the waiver, Federal Medicaid will support 90% of the cost of contraceptive services for eligible women and men and the State pays the other 10%. No local share is required of the counties.

Pregnant women and infants under age one who have countable income at or below 200% of the Federal Poverty Level (up from 185%), are eligible for Medicaid. With this Medicaid expansion, more pregnant women can now choose to enroll in the clinic-based **Prenatal Care Assistance Program (PCAP),** or the **Medicaid Obstetrical and Maternal Services Program (MOMS)**, the private physician model, for a special package of prenatal care services: nutrition screening and referral, psychosocial screening and referral for needed services, health education on a wide variety of topics, laboratory services, prescriptions, inpatient care, antepartum and postpartum services, and related services such as dental services and home visiting, as needed. PCAP and MOMS also offer presumptive Medicaid eligibility for women seeking coverage, a streamlined way to obtain care immediately where eligibility is verified after the fact. Effective in early 2009, PCAP will be superseded by the implementation of Ambulatory Patient Group (APG) methodology, which will take the place of special rate-based services for the most part. Instead of a clinic threshold visit triggering payment of the PCAP rate, each component of a prenatal visit will be reimbursed at its own rate, depending on whether the service is a major procedure, is bundled with other services, discounted, etc. Providers previously selected and approved to bill PCAP rates will all be eligible to bill the new rate codes, and with the exception of FQHCs, will be required to use this new methodology (FQHCs will be given the option of using their old payment methods or of using this new methodology). In addition, all additional Medicaid providers of prenatal care services will be able to provide services according to the comprehensive model of care, adhering to the prenatal care standards, and will be able to bill on a procedure-specific basis. This should expand the availability of this model of care to a larger number of Medicaid eligible women than were served by PCAP.

Updated standards of care, inclusive of the comprehensive approach designed for the high risk recipients of prenatal care under PCAP, are currently being finalized, and will be implemented when APGs are fully in place. The PCAP (as well as the standards to

supersede them) will require timely, risk-appropriate, coordinated, comprehensive prenatal care for all pregnant women.

The provision of high quality prenatal care and the appropriate level of care mandated by the standards was shown to reduce low birth weight rates among Medicaid women, particularly minority women, when compared to non-participants. In studies comparing Medicaid women receiving care under these programs with Medicaid women receiving other types of prenatal care, PCAP and MOMS clients had consistently better birth outcomes, and these outcomes were better even more pronounced at the lower birth weights. Presumptive eligibility helps ensure timely entry into care.

The **Newborn Project** has taken steps to enroll all newborns whose delivery was paid by Medicaid in Medicaid within fifteen business days of birth. In this way, Medicaid coverage is assured for babies during the first year of life, a critical time for many babies born to low-income families. Enrollment is now facilitated via the Statewide Perinatal Data System (SPDS), or, in New York City, the Electronic Birth Record System (EBRS), which was implemented in January 2008.

Medicaid provides comprehensive health care to both medically needy and categorically eligible children in the State under the aegis of **EPSDT**, known in New York as the **Child/Teen Health Program (C/THP)**. Using a broad definition of medical necessity, Medicaid covers medical, mental health and substance abuse in a rich service package. New York recently reviewed their EPSDT standards, and developed a new provider manual describing the EPSDT benefit, and adopting the American Academy of Pediatrics Guidelines as their standard of care, except in cases where State law contravenes. Title V staff was involved in the process. The manual is available on the NYSDOH website at http://www.health.state.ny.us/health_care/_managed_care/partner/operatio/prot6.htm

Medicaid has also undertaken many **special initiatives** to promote access to quality care for children:

- **Teenage Services Act (TASA) Case Management:** More than half of our county departments of social services choose to meet their state obligation to provide TASA case management to pregnant, parenting and at-risk teenagers through Medicaid targeted case management.

- **Early Intervention (EI):** Medicaid provides targeted case management and the full complement of EI services to developmentally delayed, Medicaid-eligible children ages birth to three participating in New York's Early Intervention Program.

- **Preschool and School Supportive Health Program:** For Medicaid-eligible children ages three through twenty, Medicaid also reimburses counties and school districts for the provision of a wide array of medically-related services in the students' individualized educational programs.

- Medicaid reimburses **school-based health centers** located in designated high-need areas of the State that meet children's health, mental health and dental needs in the school setting.

- Several federal **Home- and Community-Based Services Medicaid Waivers** allow the State to provide non-traditional services in the community to populations of special needs children who qualify for institutional placement. There are waivers specifically for physically disabled children and for developmentally disabled children who would

not otherwise qualify for Medicaid coverage. Developmentally disabled children may participate in a waiver program that includes the family home, as well as small-scale residential alternatives to Intermediate Care Facilities and a wide array of habilitative services to developmentally disabled adults and children. There is also a waiver operating in many counties in the State to cover children who have serious emotional disturbances. This waiver provides innovative treatment to children who would ordinarily be in in-patient psychiatric settings. Recently the age of eligibility for the Traumatic Brain Injury Waiver was lowered from age 22 to age 18 and the requirement that the age at which the injury occurred be after the individual turned 18 has been removed.

- Medicaid has also utilized fee enhancement as an approach to promoting access to quality care. The **Preferred Physicians and Children's Program (PPAC)** has been in operation for over ten years and has brought and retained thousands of highly qualified pediatricians, family practitioners and nurse practitioners into Medicaid.

- In marketing the Medicaid program for children statewide, the State formerly adopted the name "Child Health Plus A" for children's Medicaid. It was hoped that this might remove any perception parents might have of a stigma attached to Medicaid. The name change also underscored efforts to make the two programs as seamless as possible. However, in 2008, the program became simply Medicaid (for children), and the "Child Health Plus B" program became known simply as the Child Health Plus program.

- Medicaid has collaborated extensively for several years with the State Office of Children and Family Services to improve access to health care services for children in Foster Care by upgrading the eligibility process, revamping policies and procedures, sharing Foster Care Medicaid data with counties, and troubleshooting the child care agency rate-setting process. Title V staff have been involved, as well. Many major improvements to care have resulted for this special needs population.

Medicaid Managed Care: More New Yorkers than ever before are receiving care through managed care providers. Mandatory Medicaid managed care represents the single greatest effort the State has made to ensure that every New Yorker with Medicaid has access to high-quality primary care in a "medical home" model. This ensures that more care takes place within the context of the primary and preventive care setting, with less reliance on more expensive and less continuous forms of care, including the emergency rooms.

Health Plans participating in Child Health Plus A (Medicaid) and B are required to submit New York's **Quality Assurance Reporting Requirements (QARR)** reports annually. Among other measures, the QARR contains measures of preventive care and health outcomes related to maternal, infant, child and adolescent health.

According to the Quality Assurance Reporting Requirements (QARR) Report, there have been significant advances in the quality of care for individuals in Medicaid managed care. With ten years of QARR data, we have seen a trend in which the difference between the historically under-served Medicaid population and those individuals with private insurance has narrowed or disappeared with respect to primary care access and receipt of preventive services. There has been continuous improvement in usage of screening mammograms, cervical cancer testing, and immunizations. In addition, with respect to care of people with chronic diseases like asthma, heart disease and diabetes, there has been an improvement in the delivery of recommended interventions that will positively impact health outcomes. The

Department, providers and plans are engaged in prioritizing areas for further quality improvement, which is further advancing the health status of New Yorkers.

The Child Health Plus Program (Formerly called Child Health Plus B): Child Health Plus provides free or low-cost private health insurance to children from age one month to age 19 in low-income working families who are not eligible for Medicaid. The program is paid for through a combination of state funding and federal funding under Title XXI, the State Child Health Insurance Program (SCHIP). The program encourages parents to seek routine primary and preventative care, resulting in healthier children. Effective September 1, 2008, the household income eligibility level for subsidized Child Health Plus enrollment increased from 250 percent to 400 percent of the Federal Poverty Level (FPL). There is a six month waiting period for children in families whose household income is between 251 percent and 400 percent of the FPL that dropped employer-based insurance during the six month period prior to the date of application (exceptions to the waiting period do apply). Children in households with income above 400% FPL are still eligible for Child Health Plus and will pay the full premium. The full premium varies by plan.

Other recent changes to Child Health Plus include:

1) An intensive effort will be made to retain enrollees in care on a continuous basis, rather than having them enroll, disenroll and then re-enroll over time.
2) A new program to promote employer-sponsored health insurance programs will be established. The program will provide cost-effective premium subsidies for families with children eligible for the Child Health Plus Program and individuals eligible for Family Health Plus.
3) Child Health Plus insurers will begin reporting encounter data to the Department.

Medicaid for Children and Pregnant Women: Please note that as of 2008, Child Health Plus A is called simply "Medicaid" and Child Health Plus B is called simply "Child Health Plus."

The most current information may be found on the NYSDOH website at http://www.health.ny.gov/health_care/child_health_plus/who is eligible.htm

2008 Medicaid Income Eligibility Levels for Children and Pregnant Women are as follows:

- Infants to age one and pregnant women - 200% of the federal poverty level.
- Children age 1 through 5 years - 133% of the federal poverty level.
- Children age 6 through 18 years - 100% of the federal poverty level.

Income and Resources Levels* for Health Insurance Programs

Medicaid and PCAP Income Eligibility Levels								
Monthly Income by Family Size								
	FPL	1	2	3	4	5	6	Each Add'l Person
Children under 1 yr; Pregnant Women*	200%	$1,734	$2,334	$2,934	$3,534	$4,134	$4,734	$600
Children 1-5 yrs	133%	$1,153	$1,552	$1,951	$2,350	$2,749	$3,148	$399
Children 6-18 yrs	100%	$867	$1,167	$1,467	$1,767	$2,067	$2,367	$300
Children 19-20 yrs; Parents/Disabled Indiv		$725	$1,067	$1,234	$1,392	$1,550	$1,709	$159
Non-Disabled single adults and childless couples, 21-64 yrs		$673	$840					
*Pregnant Women count as 2 people								

If a child has too much family income and is not eligible for Medicaid, the child may be eligible for Child Health Plus.

Child Health Plus Initial 2008 Family Contributions by Income and Household Size

Premium Categories	FPL	1	2	3	4	5	6	Each Add'l Person
Free Insurance	<160%	$1,386	$1,866	$2,346	$2,826	$3,306	$3,786	$480
$9/Child/Month (Max. $27/Family)	222%	$1,924	$2,590	$3,256	$3,922	$4,588	$5,254	$666
$15/Child/Month (Max $45/Family)	250%	$2,167	$2,917	$3,667	$4,417	$5,167	$5,917	$750
$20/Child/Month (Max $60/Family)	300%	$2,600	$3,500	$4,400	$5,300	$6,200	$7,100	$900
$30/Child/Month (Max $90/Family)	350%	$3,034	$4,084	$5,134	$6,184	$7,234	$8,284	$1,050
$40/Child/Month (Max $120/Family)	400%	$3,467	$4,667	$5,867	$7,067	$8,267	$9,467	$1,200
Full Premium*/ Child/Month	>400%	Over $3,467	Over $4,667	Over $5,867	Over $7,067	Over $8,267	Over $9,467	
*The full premium varies, depending on the health plan chosen by the family.								

As of March, 2009, a total of 381,303 children were enrolled in Child Health Plus. See the table that follows for the number of children enrolled in each age group. Approximately 14.9% of the children ever enrolled in the national child health insurance program were New York State-enrolled Child Health Plus children in 2004.

Number of Child Health Plus Enrollees by Age, by Point in Time March 2000, April 2001 – March 2009					
Ages > Date V	**Birth - 1 Yr.**	**1 – 9 years**	**10 – 14 years**	**15- 19.1 years**	**Total**
March '00					
#	13,122	260,018	133,168	79,707	**486,015**
%	2.7	53.5	27.4	16.4	
April '01					
#	10,339	254,419	146,073	90,107	**500,993**
%	2	51	29	18	
April '02					
#	10,471	250,880	164,223	111,588	**537,162**
%	2	47	31	21	
April '03					
#	7,916	192,648	126,325	89,059	**486,015**
%	2	46	30	21	
April '04					
#	6,073	167,441	109,444	81,020	**359,910**
%	1.7	46	30.1	22.3	
April '05					
#	3,846	142,532	98,394	76,797	**321,569**
%	1.2	44.3	30.6	23.9	
April '06					
#	3804	156,933	120,788	94,506	**376,031**
%	1.0	41.7	32.1	25.1	
April '07					
#	3,865	160,450	126,259	100,467	**391,041**
%	1.0	41.0	32.3	25.7	
March '08					
#	1,829	142,036	120,453	96,118	360,436
%	0.5	39.4	33.4	26.7	
March '09					
#	2,095	147,681	127,432	104,095	381,303
%	0.5	38.7	33.4	27.3	

According to a report by the Urban Institute, the extent to which Medicaid and Child Health Plus reach uninsured children varies with the characteristics of the child. Younger children participate at higher rates than older children. Also, children with health issues were more likely to participate than other children. This is not surprising, given that younger, sicker children tend to have more contact with the health care system.

The Family Health Plus Program: In 2000, the federal Centers for Medicare and Medicaid Services approved an amendment to the Partnership 1115 Waiver, which enabled New York to establish the **Family Health Plus Program.** Like the **Child Health Plus Program**, this program offers comprehensive health insurance at no cost to low-income, uninsured individuals who are not income-eligible for Medicaid due to income or resources. However, unlike the Child Health Plus Program, Family Health Plus is a Medicaid funded program and it is for adults only. To qualify, the individuals must be between the ages of 19 and 65 and not meet the criteria for Medicaid but meet the following income criteria:

- In the case of an adult with children under the age of 21, gross family annual income is up to 150% of the Federal Poverty Level.
- In the case of a single adult, gross family income is up to 100% of the Federal Poverty Level.

The 2007-2008 state budget made changes to Family Health Plus, similar to the changes in Medicaid and Child Health Plus.

1) Self-attestation of residence and income will be allowed at renewal.
2) There will be 12-month guaranteed continuous coverage for adults to reduce gaps in service.

Income eligibility levels for 2008 for Family Health Plus were as follows:

Current eligibility is as follows: ***FHPlus Income Eligibility Levels***							
Parents with Children Under 21 in Their Household, and Children 19-20 yrs Residing with Their Parents							
Family Size (Income limit <150% FPL)	*1*	*2*	*3*	*4*	*5*	*6*	*Each Add'l Person*
FHPlus Income Limit	*$1,300*	*$1,750*	*$2,200*	*$2,650*	*$3,100*	*$3,550*	*$450*
Non-Disabled single adults and childless couples, 21-64, and Children 19-20 yrs ***NOT*** *Residing with Their Parents* -- Income Limit 100% FPL							
Family Size	*1*	*2*					
FHPlus Income Limit	*$867*	*$1,167*					

Note: Income levels change annually. For most recent information, please check the NYSDOH website.

Medicaid and FHPlus Resource Levels									
No. of persons in Household	1	2	3	4	5	6	7	8	Each Add'l Person
Resource Allowance	$13,050	$19,200	$22,200	$25,050	$27,900	$30,750	$33,600	$36,600	$2,850

The Family Health Plus managed care benefit package is similar to that of Child Health Plus, covering:

- physician services;
- inpatient and outpatient health care;
- prescription drugs and smoking cessation products;
- laboratory tests and x-rays;
- vision, speech and hearing services;
- rehabilitative services (some limits may apply);
- durable medical equipment;
- radiation, chemotherapy, and hemodialysis;
- emergency room visits and emergency ambulance services;
- behavioral health and chemical dependence treatment services (some limits may apply);
- hospice services;
- diabetic supplies and equipment; and
- dental services (if offered by the plan).

A toll-free help-line is currently available at 1-877-934-7587 or 1-877-9FHPLUS.

Coordination: Under these initiatives and expansions, the Department is striving to make the transitions between these systems seamless to the consumer in every way possible. Facilitated enrollers provide outreach and application assistance to Medicaid, Child Health Plus and Family Health Plus programs and a joint Medicaid-Child Health Plus-Family Health Plus-WIC application has been implemented. To facilitate children's retention of their primary care provider, most Child Health Plus providers are also Medicaid managed care providers. Many of the Family Health Plus providers participate in Medicaid managed care, as well. Quality is also being monitored in a coordinated fashion, with plans participating in New York's public insurance program required to submit reports annually. This year, the Department will be implementing more changes designed to make the system more user friendly, and therefore more likely to support eligible families in becoming and staying enrolled.

The Title V programs continue to have a role in outreach, enrollment, standards development, quality assurance and evaluation.

Dental Rehabilitative Services: Dental rehabilitative services are available both under the Medicaid Program and the Physically Handicapped Children's Program. Screening clinics are provided in Article 28 facilities in New York City. In other areas of the state, the Department has implemented a new process for the Dental Rehabilitation Program in Upstate counties that bypasses screening clinics and allows initial evaluations to be done by the child's orthodontist. In all participating counties outside of New York City, children who are financially eligible for services have direct access to orthodontists who perform screening exams and request authorization for the services through NYSDOH. Additional Diagnostic and Evaluation funds are used for non-Medicaid recipients who sought services under the Physically Handicapped Children's Program.

School-Based Health Centers: School-based health centers were established in New York under Chapter 198 of the Laws of 1978. Under this statute, school-based health centers are jointly established by the Commissioner of Education and the Health Commissioner. New York establishes these centers only in areas of high need for services and under the auspices of an Article 28 facility (hospital or diagnostic and treatment center). New York currently has over 190 of these centers, serving approximately 120,000 children. The Department also authorizes freestanding school-based dental services under this same provision of law.

Federally Qualified Health Centers/Community Health Centers: As the state primary care agency, the Department of Health is a partner to a three-way **Cooperative Agreement** with the US Public Health Service and the Community Health Care Association of New York State (CHCANYS), the organization representing the bulk of the Federal 330 contractors in New York. This cooperative agreement provides the basis for mutual support of primary care development. Community Health Centers are often contractors for DOH initiatives under MCH, Family Planning, School-based Health Center and the Primary Care Initiatives. CHCANYS and Department staff will assist localities with obtaining designation as a medically underserved are or a health professional shortage designation.

Other Primary Care and Insurance Initiatives: Under the Health Care Reform Act (HCRA), funding is designated to **encourage education of minorities in health professions**, and monies are available for **loan repayment**.

The **Healthy New York Insurance Program** is available to pay health insurance premiums for employers with 50 or fewer employees who have not offered health insurance to their employees for at least one year. In addition, individuals whose employers do not

offer health insurance coverage or who lost their coverage may purchase comprehensive health insurance directly through the Healthy New York Program. All of the State's Health Maintenance Organizations (HMOs) are required to offer the Healthy New York standardized, steam-lined, low-cost managed care benefits package. There are different eligibility requirements for individuals, small businesses and sole proprietors. Eligibility requirements may be viewed from this website:
http://www.ins.state.ny.us/website2/hny/english/hnyec.htm

Healthy New York Income Guidelines* 2007	
Family Size	**Monthly Household Income**
1	Up to $2,107
2	Up to $2,832
3	Up to $3,557
4	Up to $4,282
5	Up to $5,007
Each Additional Person	Add $725

*When calculating family size, include the number of family members in your household whether they will be included on the Healthy NY policy or not. Students aging off of a parent's insurance policy should not count their parents' income.

New York in 1992 passed a landmark **community ratings** law that established subsidies for insurance companies serving the individual and small groups market. This law allows insurers that serve these markets to draw down donations to a pool to cover costs of serving a disproportionate number of sick enrollees due to adverse selection.

The **Catastrophic Insurance Program** assists low-income, uninsured New Yorkers facing devastating medical bills. HCRA also created a new **Individual Health Insurance Program** to defray the cost of premiums for people with incomes below 200% FPL, and a **Cancer and Children Initiative** provided grant funds to health care providers to expand access and quality of cancer services and for specialty cancer and children's hospitals. The **AIDS Drug Assistance Program** helps employed persons with HIV or AIDS purchase expensive medications that they need to control their illness.

New York State has approximately102 **federally-designated primary care shortage areas and facilities** with more than 3.8 million people residing in them, mostly rural and inner-city areas. Access to care in rural areas is especially variable. Providers are usually clustered in small cities and towns, but are caring for residents whose homes are scattered over larger geographic areas. Access problems can be exacerbated by a shortage of health personnel and by fiscal constraints of rural health care facilities. HCRA 2000 continued numerous provisions designed to assist rural areas and rural hospitals. Local communities

are assisted in completing their applications for shortage designation by staff from the Department of Health.

The **New York State Council on Graduate Medical Education** has been involved in developing policies that support the education of primary care physicians, expanding opportunities for training of physicians who are under-represented minorities, and expanding use of community-based ambulatory care sites as training sites for physicians. In addition, New York's **Area Health Education Centers** are expanding opportunities for training students in primary care and for engaging students in health careers.

As the designated **Primary Care Organization**, the State Health Department sponsors or collaborates with several programs designed to increase the health workforce in underserved areas of New York State. These include the federally-funded **National Health Service Corps** loan repayment and scholarship programs and the a state-funded scholarship program, the **New York State Regents Scholarship Program in Medicine and Dentistry.**

The **National Health Service Corps,** with two program components, is highly competitive. The **National Health Services Corps Loan Repayment Program** pays for up to four years of education at varying amounts. There is one year of obligated service for each year of assistance. The **National Health Services Corps Scholarship Program** pays tuition, fees, books, supplies, equipment and a monthly stipend. The program will pay for up to four years of assistance, with one year of obligated service for every year of assistance. The **Regents Scholarships in Medicine and Dentistry Program** gives disadvantaged minority candidates priority in accessing up to $5,000 annually in tuition, fees, books, supplies and equipment for up to four years, with one year of obligated service for each year of assistance.

Private Sector Resources: New York remains a world center for commerce, learning, finance and the arts. In a time of increasing government fiscal restraint and increasingly complex social and health issues, private sector resources are increasingly called upon to help improve the health of communities. Businesses hold great purchasing power as suppliers of employee benefits and purchasers of health insurance coverage. Business and unions have helped to set the health care agenda and to assist New York in meeting goals for health insurance enrollment, as well. To enhance its competitiveness in national and international markets, and to retain its international stature in business, education, the arts, research and development, continued collaboration from all sectors, including business and private concerns, is expected, enlisted and enjoyed. The New York State Department of Health regularly partner with the private sector to address issues related to health, education and public health and safety. Business is a major force in ensuring access to health care and insurance coverage for all New Yorkers.

According to the National Survey of America's Families (NSAF), private employer-sponsored health insurance in 1999 covered about 70.8% overall of adult New Yorkers ages 19 to 64 and about 64% of those under age 19. Not surprisingly, the percentages are higher in those with incomes over 200% of the Federal Poverty Level, where employer-sponsored insurance covers 84.6% of adult New Yorkers ages 19 to 64, and 86.5% of those under age 19. (US averages are 83.7% and 85.3%, respectively.)

Overall, New York has done better than the US average for insuring the poor uninsured. NSAF data shows 16.1% of New Yorkers under age 19 and under 200% of the Federal Poverty Level to have been uninsured in 1999, compared to 22.4% as the US average. For adults ages 19-64 under 200% of poverty, 32.1% of New Yorkers are uninsured, compared to 34.9% as the US average.

b. Capacity to Deliver Enabling Services

Please see descriptions of Community Health Worker Program, Care Coordination Waivers, Health Education, Transportation, Translation, Outreach, Family Specialist, Sudden Infant Death Follow-up Services, the Dental Rehabilitation Program, Children with Special Health Care Needs, Physically Handicapped Children's Program elsewhere in this application.

Healthy Start: Many of the federal Healthy Start grantees are also grantees of New York State Department of Health under the **Comprehensive Prenatal/Perinatal Services Network** initiative. The Networks were initially funded under Title V, but have now moved onto a different source of funding. However, the need for close association with Title V programs continues in order to maximize our mutual effectiveness. For the past few years, Healthy Start grantees met with the Department at least twice annually to explore opportunities for collaboration, explore areas for potential collaboration and share late-breaking developments. Regional staff meet with the Networks on a routine basis.

Family Support New York: The goal of this collaborative is to advance an agenda that transforms public/private systems and services to support and foster empowerment of families in New York State. The Council on Children and Families is the lead agency. Other members include the Department of State, the Department of Health, the Office of Children and Family Services, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Family Development Association of New York State, Family Support NYS, and various community and parent representatives.

Adolescent Pregnancy Prevention and Services (APPS) Program: The **Office of Children and Family Services** also administers the **Adolescent Pregnancy Prevention and Services (APPS) Program**, providing prenatal support and parenting education to high-risk teens in high need communities.

Family Planning/TANF Outreach: In 2005, the State Legislature allocated $2.1 M in funding from the federal **Temporary Assistance to Needy Families (TANF) Block Grant** to the Department of Health for outreach and education activities to prevent unintended pregnancies. Family Planning Program providers provide outreach and education activities in community settings, including schools, to educate children and adults regarding reproductive health and to provide programs to prevent adolescent pregnancy. TANF funding expanded the program consistent with state and federal priorities, including:

- increased community education, public information and counseling to prevent adolescent pregnancy and increase access to clinic services for sexually active teens;
- increased outreach to women not likely to seek services, especially underserved minorities, homeless and substance-abusing women;
- improved access in underserved areas to women and adolescents at risk for unintended pregnancy.

$10 M in HCRA funds were added to provide expanded outreach to low-income adolescents and adults.

Coordinated Children's Services Initiative (CCSI): The goal of this collaborative is to improve local service coordination for children and adolescents with serious emotional disturbances and to reduce reliance on residential placements. The lead agencies are the State Education Department and the Office of Alcohol and Substance Abuse Services. Agency partners include the Department of Health, the Office of Children and Family Services, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, and the Office of Alcohol and Substance Abuse Services.

c. Capacity to Deliver Population-Based Services

The Bureau of Women's Health supervises the operation of the toll-free **Growing Up Healthy Hotline (1-800-522-5006 and TTY 800-655-1789).** The hotline provides information to pregnant women, mothers, children and adolescents on over thirty topics, and helps to ensure access to needed maternal and child health services. It operates 24 hours per day/seven days per week, with both English- and Spanish-speaking trained tele-counselors. Answering services are contracted to the Association for the Blind and Visually Impaired, Goodwill Inc., a not-for-profit telecommunications group that specializes in community information and referral services. A requirement of the contract is that callers will be immediately connected to an information specialist, with no busy signal or answering tape, at least 94% of the time. The contractor actually achieves 98%, which is one of the best performances in the nation. In order to maximize its usefulness, the Growing Up Healthy Hotline provides services for the hearing-impaired and to people who are not English- or Spanish-speaking through the AT&T Language Line, extending access to referral services to callers speaking over twenty additional languages.

In 2008 the Growing Up Healthy Hotline provided information to 69,506 callers on a variety of maternal and child health issues, including information on eligibility for programs and the location of the nearest services. Of these, 9,543 were for provision of pregnancy-related information and services. Under five percent (2,763) of calls required handling in languages other than English. Of these calls, 2,542 were from Spanish-speaking callers and 221 of the calls were in languages other than English or Spanish. Eighty-nine percent of callers were female, and 11% male. There was a 15% increase in the total number of calls to the hotline in 2008 compared to 2007 and a 19% increase compared to 2006.

Last year, callers requested assistance in the following areas: adult insurance 0.5%, Child Health Plus 2.8%, child/adult care food program 0.8%, dental/orthodontia 0.1%, early intervention 1.5%, educational materials 0.4%, Family Health Plus 1.1%, family planning 1.7%, farmer's market 6.6%, food and nutrition programs 1.1%, health department programs 0.8%, immunizations 0.2%, Medicaid for adults 2.9%, Medicaid for children 0.8%, newborn screening 0.3%, pregnancy testing 0.1%, pregnancy care 12.0%, rape crisis <0.1%, social services 0.8% 1.3%, summer food program 3.0%, WIC 57.0%, WIC complaints 1.1%, and other 3.4%. Sixteen callers asked about perinatal depression information and services.

The hotline number is published in local telephone directories and used in public information campaigns directed at the maternal and child health population throughout the state. The most frequent sources of reference to the hotline are community organizations, the internet, WIC, doctor's offices, friends or relatives, pamphlets, insurance company materials, hospitals, letters, telephone book, bus/train/subway placard, and farmer's markets.

When appropriate, callers are also given toll-free hotline numbers where they may have questions answered about AIDS, child abuse, domestic violence, substance abuse, and assistance for people with disabilities.

Title V staff test the availability and accuracy of the hotline at various times, with positive results.

The declining percentage of calls about prenatal care has been a concern, even knowing that New York City Department of Health and Mental Hygiene operates a **toll-free hotline for the five boroughs of New York** that handles a substantial number of calls. New York State Department of Health implemented a statewide, multimedia prenatal care promotion campaign in 2008 using television, radio, and print media, including posters; bus sides, shelters and interiors; and subway interiors. The materials advertised the toll-free and TTY hotline numbers. The benefits of prenatal care and access to services under the Prenatal Care Assistance Program (PCAP) are broadly promoted and women are given the toll-free Growing Up Healthy hotline number to call for a link to local services. Our experience has been that the more media coverage there is, the greater the use of the hotline. As a result of the media campaign there is typically a 60-75% increase in the number of calls requesting information on prenatal care was noted compared to similar periods without media campaigns.

New York also has a toll-free hotline for **Child Health Plus** calls, which is linked to take rollover calls from the National Governor's Association hotline. However, the volume of Child Health Plus-related calls remains very heavy on the Title V hotline. In 2003, the Growing Up Healthy Hotline received 11,267 calls for information about Child Health Plus. The Child Health Plus hotline offers certain advantages, in that they can provide the public with more in-depth information about eligibility for Medicaid and Child Health Plus. The number for the Child Health Plus hotline is 1-800-698-4KIDS or 1-800-698-4543.

The list below is a partial listing of statewide hotlines and info-lines serving mothers and children:

Toll-Free Hotlines Serving the Maternal and Child Health Population in New York State	
Title V Growing Up Healthy Hotline – covering: Immunization Child Health Plus Insurance Early Intervention Food and Nutrition, including WIC Infant Health Assessment Prenatal Care Sudden Infant Death Syndrome (SIDS) Teen Pregnancy Dental Health/Orthodontia	1-800-522-5006 TTY 1-800-655-1789
Child Health Plus Hotline	1-800-698-4KIDS
Family Health Plus Hotline	1-877-9FH-PLUS
Child Abuse and Maltreatment Hotline	1-800-342-3720 (TDD 1-800-638-5163)
Domestic Violence Hotline	1-800-942-6906 (English) -6908 (Spanish) 1-800-621-HOPE (NYC English and Spanish)
Missing Children Hotline	1-800-FINDKID -- or – 1-800-346-3543

Toll-Free Hotlines Serving the Maternal and Child Health Population in New York State (Continued)	
Child Care Complaint Hotline	1-800-732-5207
Child and Adult Care Food Program	1-800-942-3858
Disabilities Information Line	1-800-522-4369
HIV/AIDS Information Service	1-800-541-AIDS; Spanish: 1-800-233-7432
HIV/AIDS Drug Assistance Program	1-800-542-2437
HIV Counseling and Testing Hotline	
After hours	1-800-872-2777
Albany Area	1-800-962-5065
Buffalo Area	1-800-962-5064
Nassau County	1-800-462-6785
New Rochelle	1-800-828-0064
Rochester Area	1-800-962-5063
Syracuse Area	1-800-562-9423
Suffolk County	1-800-462-6786
Cancer Information Service	1-800-462-1884 or in Erie Co.: 716-845-3380
Cancer Maps	1-800-458-1158
Roswell Park Cancer Referral Services	1-800-767-9355
Ovarian Cancer Information	1-800-682-7426
Smokers Quit Line	1-866-697-8487
Medicaid Helpline	1-800-541-2831
Medicaid Managed Care	1-800-505-5678 – NYC only
Medicaid Billing Assistance for Instate Providers	1-800-522-5518 – Practitioner Assistance 1-800-522-1892 – Institutional Assistance 1-800-522-5535 – Professional Services
Medicaid Fraud Reporting Line	1-877-87FRAUD
Child Support Info Line	1-800-846-0773
New York State Parent Connection Hotline	1-800-345-5437
Environmental Health Info Line	1-800-458-1158
Drug Abuse Information Hotline	1-800-522-5353
Consumer Fraud Hotline	1-800-771-7755 (TTY 1-800-788-9898)
Crime Victims Board	1-800-247-8035
Mental Hygiene Complaint Line (MH facilities)	1-800-624-4143 (TTY 1-800-624-4143)
Mental Hygiene Customer Relations	1-800-597-8481 (TTY 1-800-597-9810)
Organ and Tissue Donation Hotline	1-877-752-3175
Managed Care Complaint Line	1-800-206-8125
Home Health Care	1-800-628-5972
Environmental Health	1-800-458-1158
Health Care Fraud Hotline	1-800-771-7755
Talking Book/Braille Library	1-800-342-3688
Office of Professional Discipline – for health care professions other than medicine	1-800-442-8106
Medical Conduct Complaint Line – physicians	1-800-663-6114

Local health departments and local departments of social services often get phone calls directly from the residents of their municipality. Local departments of health and social services are generally very active in providing information and referral services on a county level, as are the Comprehensive Prenatal/Perinatal Services Networks. Local agencies also have access to hotline numbers and directories in order to handle calls for residents outside of their districts.

Newborn Screening: Under mandate of **New York State Public Health Law §2500(a)**, all newborns must be screened for the following disorders:

Amino Acid Disorders	
	Homocystinuria/Hypermethioninemia
	Maple syrup urine disease
	Phenylketonuria
	Tyrosinemia
Endocrine Disorders	
	Congenital adrenal hyperplasia
	Congenital hypothyroidism
Fatty Acid Disorders	
	Carnitine uptake deficiency
	Carnitine palmitoyltransferase I deficiency
	Carnitine palmitoyltransferase II deficiency
	2,4-Dienoyl-CoA reductase deficiency
	Long chain 3-hydroxyacyl-CoA dehydrogenase deficiency/Mitochondrial trifunctional protein deficiency
	Medium chain acyl-CoA dehydrogenase deficiency/Multiple acyl-CoA dehydrogenase deficiency/Medium chain ketoacyl-CoA thiolase deficiency
	Short chain acyl-CoA mutase dehydrogenase deficiency
	Very long chain acyl-CoA mutase dehydrogenase deficiency
	Medium/short chain hydroxyacyl-CoA dehydrogenase deficiency
Hemoglobin Disorders	
	Sickle cell anemia
	Sickle C disease
	Hemoglobin C disease
	Other
Infectious Disease	
	HIV –1
Organic Acid Disorders	
	Mitochondrial acetoacetyl-CoA thiolase deficiency/ 2-Methyl 3-hydroxybutyryl-CoA dehydrogenase deficiency
	Glutaric academia type 1
	Isobutyryl-CoA dehydrogenase deficiency
	Isovaleric academia / 2-Methylbutyryl-CoA dehydrogenase deficiency
	3-Hydroxy-3-methylglutaryl-CoA lyase deficiency / 3-Methylcrotonyl-CoA carboxylase deficiency / 3-Methylglutaconic academia
	Malonic acidemia
	Propionic academia / Methylmalonic academia / Multiple carboxylase deficiency / Cobalamin A, B, C, D cofactor deficiencies
Other Genetic Disorders	
	Biotinidase deficiency
	Cystic Fibrosis
	Galactosemia
	Krabbe Disease
Urea cycle Disorders	
	Citrullinemia / Argininosuccinic academia
	Argininosuccinic academia
	Hyperammonemia/hyperornithinemia/homocitrullinemia

The **Newborn Screening Program** tests these samples, tracks findings, provides education and follows up on infants needing additional evaluation or treatment. Findings of

the tests conducted, number of presumptively positive screens, and number of confirmed cases and those needing treatment who received follow-up, are shown on Form 6.

The purpose of testing newborns is to permit early detection and treatment of these conditions that, if untreated, lead to mental retardation or other disability. In 2008, 252,793 infants were screened for genetic disorders by NYSDOH's Wadsworth Center Newborn Screening Program. All (100%) newborns in NYS are tested for over 40 congenital conditions. The Newborn Screening Program consistently achieves 100% follow-up on confirmed cases. In 2001, three new tests were added: congenital adrenal hyperplasia, medium chain Acyl-Co-A dehydrogenase (MCAD), and cystic fibrosis. Local health units can and do use Article 6 State Aid reimbursement to pay for follow-up visits by public health nurses or bill insurance companies for these services. Children identified through the metabolic screening process are referred to Children with Special Health Care Needs Specialty Centers. NYSDOH is in the process of certifying/re-certifying various specialty centers.

Of children screened in 2008 there were 14 confirmed amino acid disorders including PKU; 10 confirmed cases of congenital adrenal hyperplasia; 130 confirmed cases of congenital hypothyroidism; 31 confirmed fatty acid disorders including MCAD; 134 hemoglobinopathies; 39 confirmed organic acid disorders including 3-MCC; 6 cases of biotinidase deficiency; 53 cases of cystic fibrosis, 9 cases of galactosemia and 3 cases of Krabbe disease.

Clinical genetics services, including follow-up genetics counseling for families of children with inborn metabolic errors are available through the **Genetics Program**. The Wadsworth Center for Laboratories and Research administers programs that cover services to families statewide. Prenatal Genetics Services were provided to 26,929 pregnant women in 2008, and another 21,660 individuals received Clinical Genetics Services through genetics services grantees.

Universal Newborn Hearing Screening: In 1999, the New York State Legislature passed and Governor Pataki signed a **bill requiring Universal Newborn Hearing Screening** in birthing hospitals in New York State. In 2000, the Department convened an Ad Hoc Work Group on Newborn Hearing Screening. This group advised the Department on the development of policies and procedures for newborn hearing screening, tracking, and follow-up as necessary to ensure successful expansion of the program statewide. Final regulations were published for implementation in August 2001. New York had a four-year grant from the Health Resources and Services Administration to ensure that babies are appropriately screened, diagnosed and tracked for the timely receipt of needed services.

In the latter part of 2001, the program's focus shifted from development of regulations to provision of technical assistance and training to hospitals on the implementation of universal newborn hearing screening. In addition, public/parent education materials were developed and provided to facilities to coincide with the effective date of regulations. In 2001, the Department developed clinical practice guidelines and established quality assurance and review protocols with hospitals. State level review of protocols was initiated in 2001.

Health Information Materials: As in past years, the **Bureau of Health Media and Marketing** planned, developed, produced, distributed and/or evaluated MCHSBG-related materials and campaigns. The following is a partial listing of recent projects. For a complete list, please visit our website:
http://www.health.state.ny.us/nysdoh/publication_catalog/n_zpub.htm#oral_health

- After a Sexual Assault (brochure)
- Anabolic Steroids and Sports
- Antibiotic Resistance (professional brochure, viral prescription order forms and prescription pads)
- Are You and Your Baby in Danger? (brochure)
- As I Grow (new parent developmental guide and video)
- Asthma: Don't Let Asthma Knock the Wind Out of Your Child (statewide campaign, brochures in English, Spanish, French, Chinese, Russian and low-literacy versions; posters in English and Spanish; TV and radio spots; prescription form)
- Berenstain Bears Tobacco Use Prevention Initiative (booklets in English and Spanish for all second graders)
- Booster Seat Demonstration Project (activity book, jungle, CD-ROM, tambourine, sunglasses)
- Breast is Best (brochure)
- Breast is Best…Unless you have HIV (poster)
- Child and Adult Care Food Program (brochures and posters in English and Spanish)
- Condom Comebacks…Things to do instead of doin' it. (wheel)
- Dental Sealants Work Hard (stickers)
- Dental Sealants at Work (handout)
- Ear Infections in Children (brochure)
- Early Prenatal Care (poster)
- Eat Well, Play Hard (nutrition and activity campaign for children)
- Eat at Moms (for WIC on breastfeeding)
- Emergency Contraception (brochure)
- Fall Prevention for Children Birth to Three (brochure)
- Female Circumcision (brochure)
- Folic Acid Awareness Week (informational campaign)
- Get Mouthy! (Oral Health Issues for Teens)
- Guidelines for Oral Health Care during Pregnancy and Early Childhood (for providers)
- Having A Baby (booklet in English and Spanish)
- Help Your Baby To A Healthy Start (brochure)
- How to Have a Healthy Baby (brochure)
- If you do drugs, your baby's health can go up in smoke (poster)
- Important News for Pregnant Women (poster on HIV testing)
- Life! Pass it On! (brochure on organ donation)
- Maternity Information Law (brochure given to each mother upon registering for hospital maternity services)
- Molly and Michael Molar (about dental sealants)
- Moms Like You (for pregnant teens)
- Mr. Fluoride Beats the Sugar Bugs (about fluoride supplements)
- Newborn Hearing Screening Education (4 brochures and 7 posters in English, Spanish, Chinese, Creole, Russian, Urdu and Bengali)
- No One Deserves to Be Abused (poster)
- Oral Health is Important (for Kids with HIV/AIDS)
- Oral Health Plan for New York State
- Parents Resource Directory for Families of Children with Special Health Care Needs (English, Spanish, French, Russian, Mandarin Chinese and Urdu)
- Pedestrian Safety (formative research/focus groups)
- Physician and Parent Guidelines for the Treatment of Otitis Media (brochure)
- Pregnancy Care calendar – Updated to include Oral Health
- Pregnant? WIC can help you eat right from the start (poster)
- Protect Your Baby from Smoke (brochure)
- Sale of BIDIs (poster)

- Scooter Safety (brochure)
- Shaken Baby Syndrome (brochure, information kit, poster- see our website)
- Take Folic Acid Every Day (emery boards with countertop display holder)
- Welcome to Parenthood (packet given to every new mother after delivery, English and Spanish)
- WellNYS Weekend (health screening fact sheets)
- A Whale of a Smile (stickers)
- Your Baby is Special and So Is Your Breastmilk (brochure)
- Your Guide to a Healthy Birth (booklet, English and Spanish)

The Bureau of Dental Health is currently working with the Bureau of Health Media and Marketing on revamping Oral Health information, based on a recent needs assessment.

Immunization Services: The **Immunization Program** provided vaccines through the **NYS Vaccines for Children Program**, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted local health departments with disease surveillance and outbreak control activities, and continued to develop a statewide immunization registry. CDC categorical grants and State funds were used to provide staffing in both central and regional offices. Both CDC and State dollars were used to purchase vaccines and support local immunization activities at county health departments. Laboratory reports of Hepatitis B surface antigen-positive mothers are follow-up to ensure that their infants received appropriate vaccinations and treatment.

Over 90% of two year-old children in New York State (outside New York City) are vaccinated in private doctor's offices, not public clinics. Under the **Provider-Based Immunization Initiative**, county staff visit pediatricians and assess the medical records of their patients. The information is then keyed into a computer using CDC-developed software, the Clinical Assessment Software Application, (CASA). CASA calculates the providers' immunization rate and enables them to improve their vaccination protocols, when necessary.

Childhood Lead Poisoning Prevention: The **Childhood Lead Poisoning Prevention Program** coordinates efforts to prevent, detect and treat childhood lead poisoning; educates the public and health professionals about prevention, early detection and appropriate medical management of childhood lead poisoning; ensures that families of children with lead poisoning are given appropriate advice and assistance in locating and eliminating sources of lead within the child's environment; provides lead-safe interim housing while lead hazards are being removed; and collects and analyzes statewide data on the extent and severity of childhood lead poisoning.

In New York, blood lead testing is done primarily by the child's medical provider. The Childhood Lead Poisoning Prevention Program has contracts with 58 local health departments to provide prevention programs and provide care coordination. Seven teaching hospitals serve as Regional Lead Resource Centers. Seven local health departments and community-based organizations provide interim lead-safe housing. Local health departments and State Health Department District Offices provide environmental assessments and assure lead hazards are corrected.

The Program completed a comprehensive New York State Lead Elimination Plan in conjunction with the Center for Environmental Health.

Childhood Overweight Prevention: Eat Well, Play Hard was initiated in 1997 as a comprehensive response to the childhood overweight epidemic. The program's three-part strategy has been incorporated into all New York State Department of Health nutrition programs. To reduce the prevalence of overweight among New York State children, Eat Well, Play Hard promotes:

- Increasing developmentally-appropriate physical activity;
- Increasing the consumption of 1% or lower fat milk and low-fat dairy products; and
- Increasing the consumption of fruits and vegetables.

Eat Well, Play Hard later became a part of New York's obesity prevention program. This program also includes other strategies and programs such as Just Say "Yes" to Vegetables, Steps to a Healthier New York, the Hunger Prevention and Nutrition Program, Minority Health Mini-Grants, Healthy Heart, Team Nutrition Training Grants, Obesity Prevention through Physical Activity and Nutrition, and the Statewide Strategic Plan for Overweight and Obesity Prevention. Eat Well, Play Hard also sponsors physical activities such as bike trips. These initiatives are under the supervision of the Division of Chronic Disease Prevention and Adult Health and the Division of Nutrition.

The Bureau of Child and Adolescent Health, in collaboration with New York State chapters of the American Academy of Pediatrics and the American Academy of Family Physicians will be distributing BMI growth charts and BMI wheels (to determine BMI) along with resource information on childhood obesity and interventions.

New interventions focus on improving the health and fitness of young children and preventing the development of overweight among preschool children by targeting the environment where children spend an increasing amount of time: preschools, child care and Head Start centers. The Division of Chronic Disease Prevention and Adult Health will be testing community-wide interventions that will collaboratively develop food and physical activities guidelines and policies, increase physical activity, decrease television and video watching, and address behaviors that encourage overeating or discourage physical activity.

The Governor signed an executive order creating a Council on Food Policy. The Council will coordinate state agricultural policy and recommend policies that will ensure fresh, nutritious and affordable food for all New Yorkers, particularly low-income New Yorkers, senior citizens and children. The Council will recommend ways to increase sale of New York agricultural products to New Yorkers and expand the consumer market for organic foods.

The Department will also be implementing and expanded initiative in child care called NAPSACC, which stand for Nutrition and Physical Activity Self-Assessment in Child Care. This is adapted from the North Carolina model. The plan is to eventually implement the program statewide.

The Department of Health's **Maternal Mortality Program** was formerly funded by the CDC via cooperative agreement with the **Association of Schools of Public Health**. A new collaboration on maternal mortality review has developed with the **American College of Obstetricians and Gynecologists** with funding from the New York State Health Commissioner's Priority Pool and, starting in 2007, state funds as well. The goal of this initiative is to institutionalize maternal mortality review as one of the responsibilities of the Regional Perinatal Centers. A protocol and data collection tool are complete and in use, and reviews of maternal deaths initiated. Educational programs targeted towards obstetricians and gynecologists are being developed and implemented based on findings from these reviews. Examples of programs completed to date include a preconception flyer distributed

to all physicians in the state to encourage optimal health prior to pregnancy, Grand Rounds on maternal hemorrhage, as well as distribution of materials for posting in delivery rooms, encouraging ongoing drills, and work with Policies and Procedures of hospitals statewide.

Welcome to Parenthood, a packet given to the family of each newborn born in New York, contains information about normal growth and development, parenting, child safety, calming a crying baby, early intervention and childhood immunizations.

d. Capacity to Deliver Infrastructure-Building Services

The protection and promotion of the public's health is not possible without adequate public health infrastructure. Public health agencies must have the ability to perform adequate needs assessment, to appropriately evaluate public health issues and programs, to develop meaningful policies and standards, to engage their communities, to coordinate existing resources, to ensure quality, and to adequately recruit and train the public health workforce.

The Department is able to assess the adequacy of the infrastructure for maternal and child health services through:

- Establishing and maintaining regular multi-directional communication with local health departments, local contractors, our regional offices, other units within the State Health Department and other State and Federal agencies;

- Regularly and frequently monitoring the quality and the content of local health assessments, public health service plans and contractor workplans;

- Monitoring the ability of our programs, our contractors and county health departments to effectively achieve the desired results;

- Monitoring and auditing the use of available resources, including available technical assistance;

- Periodically reassessing our internal controls system for areas of vulnerability; and

- Performing special assessments relative to the ability of local agencies to perform essential public health services.

Health Insurance Infrastructure

New York has developed adequate infrastructure for health insurance (previously described under Overall Capacity and Capacity to Deliver Direct Medical Services), with linkages to essential public health services, health information, education and collaboration among agencies.

Health Services Infrastructure

Since most of the maternal and child health services delivered in this State are not delivered directly by the New York State Department of Health, not only is State infrastructure important, but the local infrastructure is also critical to the delivery of high-quality services. The Department employs various mechanisms to ensure that services are coordinated and resources are maximized. The Department's ability to keep apprised of local conditions and to ensure the stability of the MCH infrastructure is supported the Public Health Law, strong regulations, its regional offices of health, its data collection and data analysis capacity, technical assistance capacity, and through oversight of contracts and letters of agreements with local providers of service.

Local Health Departments: County health departments continue to play an essential role in the assurance of high-quality, accessible maternal and child health services. They assessed the needs of their local communities, worked with their communities to design and implement programs that meet those needs, and evaluated the effects on their communities.

Under New York State Public Health Law, the **58 local health departments** extend the powers of the state health commissioner. Each of the 57 non-New York City counties have a county health department, while all five counties in New York City are covered by the New York City Department of Health. The county health departments provide community health assessment, family health services, health education and disease control services. Most also provide environmental services. Counties that do not provide their own environmental services rely on the State Health Department's District Office in their area. Most counties in New York also operate certified home health agencies or licensed home health care agencies, through which they provide a variety of home-based services, including skilled nursing, home health aide, therapies, early intervention, maternal and child health and disease control visits. Most counties also operate diagnostic and treatment centers licensed under Article 28 of the New York State Public Health Law. The trend has been for counties to either divest personal care services or ensure that they are competitive in the market environment. There is also an emerging trend toward streamlining the administrative structures of local agencies. As a result, a handful of New York's local health agencies have combined with other county agencies, such as mental health or social services.

Under **Article 6 of the New York State Public Health Law**, local health departments perform comprehensive community health assessment and subsequently produce a county-wide (or in the case of New York City, a city-wide) Municipal Public Health Service Plan (MPHSP). These local plans explicitly address the needs of the maternal and child health population in sections on health education, infant mortality prevention, child health, family planning, chronic disease prevention, injury control, disease control and nutrition. The Title V program staff provide technical assistance to local health units in plan development and participate in the review and approval process, as well as in monitoring of the implementation of the plans. Because local health departments know their local systems and community needs, the Plans address coordination across public and private resources, and across the continuum of primary, secondary and tertiary care. Local health departments play a critical role in fostering local collaborations.

Relationships with local health departments are coordinated through the **Office of Public Health Practice** (formerly known as the Office of Local Health Services)**,** the unit that also administers the local assistance/state aid program. Collaboration between the counties and the State and between agencies on the local level is yielding better use of data, better local plans, and more attention to outcomes of public health activities.

Perinatal Regionalization/Tertiary Care Centers/Regional Perinatal Centers: New York State has a long-established system of regionalized perinatal care with highly specialized **Regional Perinatal Centers (RPCs)** in each region of the state. These Centers provide tertiary level clinical care to high-risk mothers and newborns, and also serve as important contact points for the Department of Health in our interactions with the health care community. They help ensure that high-risk mothers and newborns receive appropriate levels of care by working with their affiliate hospitals to provide quality improvement oversight, including monitoring of perinatal morbidity and mortality and providing education and technical assistance to physicians and others. The RPCs have helped the Department address important public health issues such as perinatal HIV,

breast-feeding promotion, cesarean prevention, and collection, improved reporting, and use of perinatal data.

The Department of Health worked collaboratively with hospitals of all levels and stakeholders statewide in perinatal care to re-examine the **perinatal designation levels** of all hospitals that provide obstetrical and newborn care. Factors like managed care, hospital downsizing and hospital mergers have altered the relationships between individual facilities and the Regional Perinatal Centers. New designations were prepared for all obstetrical hospitals based on the level of care available to both high-risk mothers and infants.

The Regional Perinatal Centers not only serve as the hub for consultation and transport within a network, but lead quality improvement activities within their network. The implementation of the Statewide Perinatal Data System (described under Information Infrastructure) has been closely tied to Perinatal Regionalization**.** The Regional Perinatal Centers are key to the development of a system for quality improvement within an affiliate network. SPDS is an important source for data for those activities. The Centers have responsibility for data quality within the network, including responsibility for training and technical assistance to affiliate hospitals. During 2002, Regional Perinatal Centers received their final designations as to level of perinatal care. Workplan guidance was developed and disseminated to all Regional Perinatal Centers in order that they gain a clearer understanding of their roles as leaders in regionalization. The Department worked with the Regional Perinatal Centers to enhance their understanding of the provision of quality improvement activities among their affiliate network and promoted their leadership in the Regional Perinatal Forums to work with community collaborators in promoting improved perinatal outcomes within their regions. In addition, the Department provided additional two-year funding on a competitive basis to RPCs and other hospitals to implement a number of quality improvement initiatives utilizing the specific expertise, interests and collaborative networks available to maximize the utility of products. The Department is in the process of evaluating the findings and products of these projects for possible dissemination statewide.

Public Health Workforce: The New York State Public Health Workforce Task Force, established by the Public Health Council in 2005, requested that the Center for Workforce Studies at the University at Albany School of Public Health work with the New York State Association of Counties to conduct a local workforce enumeration study. These are a few of their findings:

- Only 11% of local health department employees are under the age of 35, while 24% are between 35 and 44, 37% are between 45 and 54, and 25% are between the ages of 55 and 64. Three percent are over the age of 65.
- 20% of the younger workers are planning to leave the field of public health sometime in the next 5 years. 26% of older workers also plan to leave within the next 5 years.
- 64% of the employees reported receiving emergency preparedness training and about one in six would like more training in this area. A number of other training needs were also identified.

The Task Force will be using the results of the study to identify priority needs and enact strategies to address those needs. Recruitment and retention of workers has emerged as one need to address, but the Task Force will also be addressing workplace incentives, career ladders, training and education, and additional leadership development.

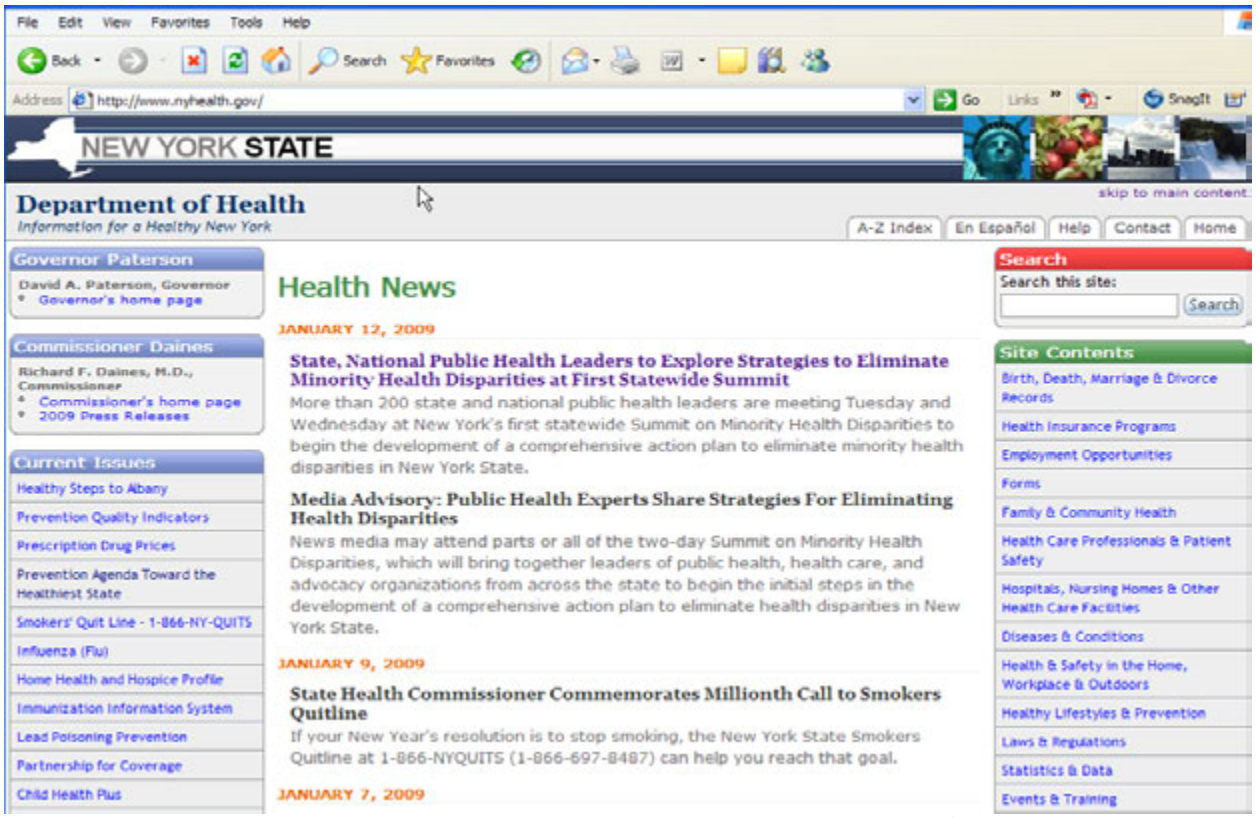
Assessment of Local Capacity for MCH Home Visiting: The Center for Community Health conducted a survey of local health departments to assess their capacity for prenatal and postpartum home visiting services. 56 of the 57 counties responded. It was

determined that prenatal services are less utilized than postpartum home visiting, although ten counties reached more than 20% of their pregnant population and one county reached 70% of its pregnant women. The average prenatal client received 2.6 home visits. Counties reported 39,506 home visits last year to pregnant and postpartum women.

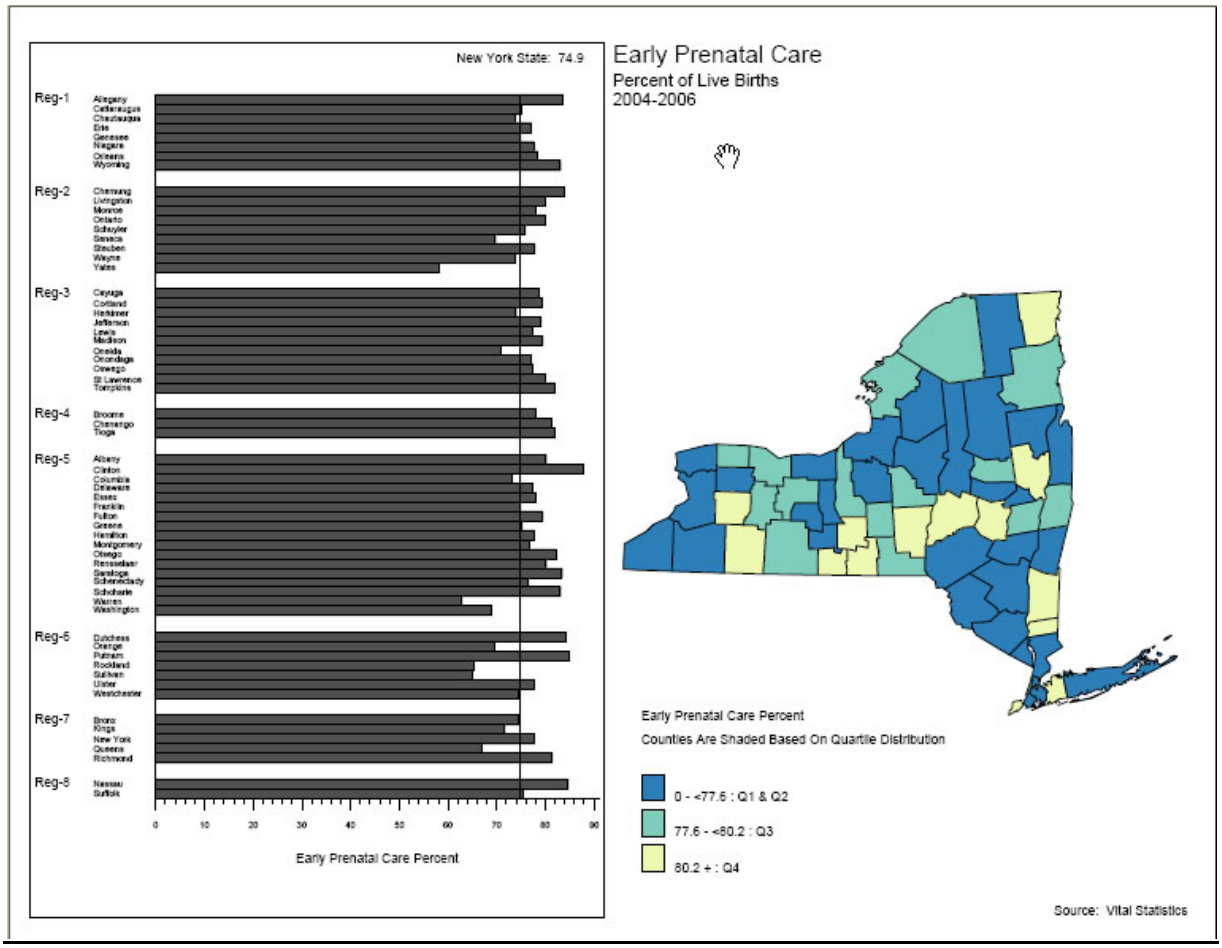
Information Infrastructure

The Department of Health continued to improve accessibility of local data, both on the internet-based public website and on our intra-net, the **Health Information Network (HIN).** More and better data are constantly becoming available via electronic means. This application has been posted on our public website since 1997.

The following is a screenshot from the Department's public website. Statistics and data, on the lower right side of the screen, result in an alphabetic listing of numerous data sources, including Community Health Assessments, Vital Statistics Data, hospital discharge data, etc.



Data can be obtained on a county-specific basis on a wide variety of indicators, and even zip code specific information is available on the state's Health Information Network/Health Provider Network, which is accessible by Department staff and most health care providers, as well as others. County-specific information can be easily compared to all other counties, to allow localities to judge their progress in relation to other comparable areas (see below). In addition, the MCHBG Application and Report is posted annually on the website for easy access by the public, and it contains a significant amount of perinatal data and information, including trends on a number of indicators.



<u>Statewide Perinatal Data System</u>: The **Statewide Perinatal Data System** collects all data required for completion of the birth certificate in all areas of the state outside of New York City (which is a separate Vital Records reporting area), and information on all Neonatal Intensive Care Unit admissions throughout the state, including New York City. New York City implemented its own internet-based system for collection of birth certificate information on 1/1/08, using the SPDS to inform their efforts. New York City is currently developing the reporting functionality of their system, in collaboration with staff from the Division of Family Health. It is anticipated that the NYC-based reports for the core module data will be comparable, and therefore combinable into a single statewide report.

The SPDS system involves the regional centers in coordinating data analysis for their regions and in helping their affiliated hospitals and others in the community (such as perinatal networks) use data for needs assessment, planning and quality improvement activities. All of standardized reports are available to each (Upstate only, currently) birthing hospital through the year and to RPCs for all of their of affiliates hospitals.

The Statewide Perinatal Data System (SPDS) provides a wealth of information useful for monitoring achievement of our goals. The system is an internet-based, secure network consisting of all data from the Electronic Birth Certificate and data collected from hospitals and free-standing birth centers within the State as well as additional data elements. The system is used to assess birth outcomes at three levels: within hospitals, in integrated health care systems and in the community (however defined). It enables the Department

to identify, in real-time, health care delivery and public health problems. It provides a powerful tool for quality assurance and quality improvement. At the same time that electronic birth certificate information is being collected, the system also collects the content of prenatal care, breastfeeding status on discharge from the hospital, maternal depression during pregnancy and periodontal disease during pregnancy. The development of the Statewide Perinatal Data System required regulatory amendments. New regulations were proposed and adopted, as well as new statutory language to allow inclusion of the zip code and medical record number in de-identified affiliate hospital datasets provided to the RPCs to enable follow-back on records and analysis of geographic trends and information within their networks.

Indicators of maternal and child health are built into the **Quality Assurance Reporting Requirement (QARR) System** for monitoring managed care and Child Health Plus providers. Title V works closely with the Office of Managed Care to make health plan performance data available to county health departments so that they may monitor the delivery of care to the population within their county.

The **SSDI Project** continued to support the **Children with Special Health Care Needs (CSHCN) Program** by assisting with the development of the data system. The CSHCN data will be linked with other child health data sets via the **Integrated Child Health Information System**. The Project also revised and reprinted the Resource Directory for CSHCN. Over 50,000 directories were distributed to local health departments, hospitals, community-based organizations, schools, libraries, families and other providers. The directory is available in English, Spanish, Russian, Chinese and French.

MCH and Public Health Education Infrastructure

The **New York State Preventive Medicine Residency Program** trains five physicians annually, preparing them for leadership careers in state and local health departments. The program seeks to reduce health disparities among New Yorkers by increasing the number of well-trained public health physicians to address the needs of high-risk populations. This two-year residency program for physicians consists of an academic year, leading to a Masters in Public Health degree, and a practicum year, during which public health residents complete projects throughout the New York State Department of Health and affiliated sites. Many of the residents go on to employment at the New York State Department of Health and other public health agencies in important maternal and child health positions. They include the former director of the Division of Family Health, the director of the Bureau of Child and Adolescent Health, and the medical directors of the Division of Family Health, the Immunization Program and the Hospital Epidemiology Program. The Program was recently awarded a three-year grant from the American Cancer Society, supplementing the support provided by the Maternal and Child Health Services Block Grant.

The **Dental Public Health Residency Program** graduated three residents from its statewide program. The Program continued its accreditation status and continued to collaborate with four dental residency sites in New York State. Dental residents are involved in numerous studies and projects. Current residents are working on a fluoride varnish project and conducting an oral health surveillance project involving Head Start children.

The Bureau of Women's Health worked with the **Research, Advocacy, Information Network for the Bodily Integrity of Women (RAINBOW)**, a non-profit organization, to develop and disseminate professional and community education materials dealing with medical, religious, cultural, and legal issues related to female circumcision. The project raised awareness of female circumcision among New York families and to provided

physicians, midwives, nurses, and other health care providers with information about caring for women experiencing short- and long-term consequences of the circumcision. By reducing the practice of female circumcision and ensuring the medical practitioners are aware, children may be spared this traumatic and life-threatening experience, and potentially fatal long-term complications may be averted.

Area Health Education Centers (AHECs): The **State University of New York at Buffalo**, Division of Family Medicine is developing **Area Health Education Centers (AHECs)**. The Centers work to recruit, retain, and support health professionals to practice in communities with health provider shortages. They do so by developing opportunities and arranging placements for future health professionals to receive their clinical training in underserved areas, by providing continuing education and professional support for professionals in these communities and by encouraging local youth to pursue careers in health care. Plans currently call for the establishment of 9 AHEC offices across the State by the year 2010. Sites are currently operational in: Buffalo, Batavia, Potsdam, Glens Falls, Cortland, the Bronx. Two additional sites will be located in the Erie-Niagara and Catskill area, with the exact sites to be determined.

Title V has established a relationship with the AHECs. Dr. Thomas Rosenthal, AHEC Project Director, met with the Maternal and Child Health Services Advisory Council to exchange information and investigate collaboration opportunities. The Advisory Council and the AHECs are mutually concerned about the aging of the health care workforce, the aging of nursing faculty, current shortages in certain key health professions, and in interesting young people in health careers early in their student careers. The Bureau of Dental Health is working with AHECs to improve access to primary dental care, especially in rural areas.

Universities and Schools of Public Health: The **University at Albany School of Public Health** is unique in that it is jointly sponsored by a university and a state health department. The New York State Department of Health serves as the laboratory for the University at Albany School of Public Health, with graduate students working shoulder-to-shoulder with practicing professionals in the state health department or in local departments. A number of DOH and Title V staff serve as faculty and advisors to the school. Title V staff also serve on the School's **Continuing Education Advisory Board**, providing approvals for continuing medical and nursing education. Title V has utilized the School of Public Health as the continuing medical education provider for its annual Breastfeeding Grand Rounds, and for forums on public health genetics, HIV/AIDS, the dental public health residency, home visiting, women's health and female circumcision. Among the other offerings through continuing education are: social marketing, environmental health, Hepatitis C, substance abuse, and occupational health and safety.

Title V staff in the Division of Family Health coordinate the **MCH Graduate Assistant Program**, under which 14-15 University at Albany School of Public Health graduate students per semester (fall, spring and summer) are supported by block grant funds to work on priority MCH research and planning projects. This arrangement supports the Department of Health's mission through attracting bright and motivated individuals who are interested in gaining both theoretical and practical knowledge of public health and maternal and child health. The use of students also enhances the Department's research capacity, and improves the availability of pertinent and timely educational offerings for practicing public health professionals in the region.

The University at Albany's School of Public Health sponsors the **Northeast Public Health Leadership Institute (NEPHLI)**, serving the northeast corner of the US. Several Title V staff have attended the Institute. Several graduates of the Institute also serve Title V in

other states and at the New York City Department of Health. Title V staff from New York and other states serve on the NEPHLI Advisory Council.

The Department also maintains a relationship with the **Columbia University School of Public Health** through a **Collaborative Studies Initiative**. Metropolitan Area Regional Office staff serve as advisors to the program. Columbia students and public health faculty identify current issues in maternal and child health, and apply public health theory and practice in designing and implementing solutions to those issues.

University Affiliated Programs: New York is fortunate to be home to three **University-Affiliated Programs** which offer **Leadership Education in Neurodevelopmental Disabilities (LEND)**. The three are located at the **University of Rochester**, the **Westchester Institute at Valhalla**, and **Jacobi/Albert Einstein Medical Center**. LEND Programs provide for leadership training in the provision of health and related care for children with developmental disabilities and other special health care needs and their families. The Department works with the LENDs on a variety of issues related to children with special health care needs and to meet training needs, and the University Affiliated Programs are a great source for physician consultants on a variety of issues. For example, the Bureau of Child and Adolescent Health worked with staff at Jacobi/Albert Einstein to improve identification of children with special health care needs. The Department has participated in joint planning with the Westchester Institute, and Title V staff have offered classes for LEND students.

Title V and the Adolescent Coordinator maintain linkages to the **Leadership Education in Adolescent Health (LEAH) Program** at the **University of Rochester.** The purpose of LEAH is to prepare trainees in a variety of professional disciplines for leadership roles in the public and academic sectors and to ensure high levels of clinical competence in the area of adolescent health. Training is given in the biological, developmental, emotional, social, economic and environmental sciences, within a population-based public health framework. Prevention, coordination and communication are stressed.

Pediatric Pulmonary Center: New York's **Pediatric Pulmonary Center** is located at **Mount Sinai Medical Center** in Manhattan. The Pediatric Pulmonary Center takes an interdisciplinary approach to developing health professionals for leadership roles in the development, enhancement or improvement of community-based care for children with chronic respiratory diseases and their families. In addition serving as a model of excellence in interdisciplinary training, Mount Sinai also engages in active partnership with state and local health agencies and provides model services and research related to chronic respiratory conditions in infants and children. The Department is working with a pediatric pulmonologist from Mount Sinai on a school-based asthma management initiative. Mount Sinai was a CDC National Cooperative Inner-City Asthma Study grantee, as were Albert Einstein College of Medicine and Bronx-Lebanon Hospital in the Bronx and University of Buffalo.

Statewide Satellite Broadcasts: The Department of Health, with the School of Public Health at the University at Albany, the New York State Community Health Partnership and the New York State Association of County Health Officials, sponsors monthly **Third Thursday Breakfast Broadcasts (T2B2).** T2B2 provides continuing education opportunities covering a variety of public health issues. Local site coordinators in each county health department coordinate local logistics. Out-of-state attendees can locate sites by visiting the University at Albany's website: www.albany.edu/sph/coned/t2b2site.html. Continuing medical and nursing education credits are available.

The Office of Children and Family Services also sponsors monthly satellite broadcasts on child health and safety topics such as SIDS and risk reduction in conjunction with partners such as DOH, the SUNY Distance Learning Project, and the New York State Child and Family Trust Fund,.

Web-Based Education and Materials: The Department's websites, both internal and public, are linked to a variety of health-related sites. In addition, our partnership with the University at Albany School of Public Health and the New York – New Jersey Public Health Training Center broaden the availability of high-quality web-based course and materials available to NYSDOH and Title V staff.

Infrastructure for Collaboration

The Department of Health continued to support a variety of **regional and local collaboratives** to improve needs assessment, identify and build local capacity, outreach to hard-to-reach segments of the population, and assure quality. The common thread among these efforts is community engagement and commitment to collaboration and coordination in the use of resources. Examples of such efforts include: Comprehensive Prenatal Perinatal Services Networks, Rural Health Networks, community assessment and joint planning initiatives, Comprehensive Planning for Youth Services, Partners for Children, Early Intervention Coordinating Councils, the affiliation networks of the regional perinatal centers, regional EMS councils, Infant Mortality Review Community Councils, HIV/AIDS Prevention Planning Groups, and many more. The RPCs and CPPNS jointly sponsor Regional Perinatal Forums, which bring together health, ancillary and non-health services providers in each region of the state to take a proactive appropriate to improving pregnancy outcomes.

Voluntary and Professional Organizations: DOH strives to maintain positive and collaborative relationships with several not-for-profit, voluntary groups who share concerns for the health and well-being of mothers, infants, children and women of childbearing age. The Department's Title V program has active relationships/collaborations with:

- American Academy of Family Practice, New York State Chapter;
- American Academy of Pediatrics –NY District II;
- American College of Nurse Midwives, New York State Chapter;
- American College of Obstetricians and Gynecologists, New York State Chapter;
- American Lung Association of NYS and NYC;
- Association of New York State Youth Bureaus;
- Association of Perinatal Networks;
- Boards of Cooperative Education Services (BOCES);
- Children for Children
- Columbia University School of Public Health;
- Community Health Centers Association of NY;
- Cornell University
- Cornell University Cooperative Extension, Human Development Center and 4-H;
- Families Together in NYS
- Family Support New York;
- Family Voices;
- Greater New York Hospital Association (representing hospitals in the Greater Metropolitan area);
- Healthcare Association of New York State (representing hospitals across the state);
- Healthy Start;
- Leadership Education in Adolescent Health at University of Rochester;
- March of Dimes;
- Medical Society of the State of New York;
- Mount Sinai Adolescent Center;

- New York Academy of Medicine;
- New York Chapter American College of Physicians;
- New York Counseling Association
- New York State Academy of Family Physicians;
- New York State Alliance for Family Literacy;
- New York State Association of Counties;
- New York State Association of County Health Officials;
- New York State Association of Perinatal Programs;
- New York State Association of School Nurses;
- New York State Child Care Coordinating Council;
- New York State Coalition of Prepaid Health Services Plan;
- New York State Community Health Partnership;
- New York State Health Plan Association;
- New York State Nurses Association;
- New York State Partners for Children;
- New York State Perinatal Association;
- New York State Public Health Association;
- New York State School Boards Association;
- New York State Thoracic Society;
- New York State United Teachers;
- NYS Conference of Local Mental Hygiene Directors
- Parent-to-Parent, New York State;
- Pharmacy Society of the State of New York;
- School Nurses statewide;
- Schuyler Center for Analysis and Advocacy;
- SIDS Alliance;
- The Association of Community Health Nursing Educators;
- The Association of State and Territorial Dental Directors;
- The Association of State and Territorial Directors of Nursing;
- The Community Health Center Association of New York State;
- The Head Start Association and the Head Start Collaboration Office;
- The New York – New Jersey Public Health Training Center;
- The New York State Council on Sexual Assault;
- The New York State Dental Hygiene Society;
- The New York State Dental Society;
- United Way of New York State;
- University Affiliated Programs at Westchester, Rochester and Jacobi/Albert Einstein;
- University at Albany School of Public Health;
- University at Buffalo School of Social Work;
- University of Rochester
- YMCA of New York State;

  and many others who enhance the capacity of Title V programs to operate effectively.

5. Selection of State Priority Needs

The overall goals for health care delivery in New York are:

- to improve insurance coverage and enrollment of the uninsured and underinsured;
- to assure that the health care delivered in New York State is of high quality;
- to emphasize prevention and education by involving communities in addressing and improving health;
- achieving health equity through the elimination of health disparities; and
- creating a seamless health care system whereby our residents may retain continuous health care delivery at a "medical home" irrespective of insurance status.

Improving and sustaining access to high-quality, continuous primary health care and treatment services are critical to improving health outcomes for all New Yorkers and achieving our public health and maternal and child health priorities, including the elimination of health disparities. The hallmarks of success will be prevention, early intervention, and continuity of care through establishing and maintaining a "medical home" for every New Yorker. Success will also depend on the actual delivery of appropriate, high-quality, comprehensive health services to people in need, and requires practitioners to be knowledgeable about and practice good preventive and therapeutic medicine.

As previously described, New York's public health programs have undergone extensive priority-setting processes. Throughout, participants decline to rank priorities, preferring that each of these "opportunities for improvement" be considered of equal importance. The ten priorities that follow, and the specific performance measures related to each, stem specifically from areas of unmet need in the State.

Most often, programs that address maternal and child health issues initiate services and interventions on a variety of levels. For example, in addressing access to care, we are improving the insurance and charity care infrastructure, targeting population-based messages, enabling clients to access and sustain their relationship to a medical home, and work to remove barriers to accessing high-quality direct medical services. Where high quality services are unavailable to vulnerable populations, we provide gap-filling direct health services. Thus, each of the four levels of the MCH pyramid may be relevant to a particular need.

Revision of the NYS priority-setting process is currently underway, to ensure compliance with the revised Guidance recently issued. For the start of the next five year cycle, NYS will provide:

- A **List of Potential Priorities**, and a short discussion of why they were not included.
- **Methodologies for Ranking/Selecting Priorities –** describing the methodology used and why the selected priorities were chosen.
- **Comparison with Prior Needs Assessment –** highlighting priorities continued from previous assessments, those replaced, those added, and an explanation for each.
- **Priority Needs and Capacity –** including a discussion of how the priority needs relate to the four levels of the MCH pyramid, and a description of MCH program capacity and how that will impact success.
- **MCH Population Groups --** provide assurances that priorities cover the 3 major MCH population groups (pregnant women, mother and infants; children; and CSHCN).
- **Priority Needs and State Performance Measures –** describing how the state will measure success in meeting each priority need, and how each is linked to performance measures.

The following are New York's current maternal and child health services priority needs:

- To improve access to high-quality health services for all New Yorkers, with a special emphasis on prenatal care and primary and preventative care which includes attention to mental health issues and which serves those with special health care needs;
- To improve oral health, particularly for pregnant women, mothers and children, and among those with low income;
- To prevent and reduce the incidence of overweight for infants, children and adolescents;

- To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality;
- To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;
- To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women;
- To reduce unintended and adolescent pregnancies;
- To ensure the availability of comprehensive genetics services statewide, including follow-up on positive newborn screening tests, specialty services and genetics counseling for affected families;
- To reduce the rate of violence across all age groups, including inflicted and self-inflicted injuries and suicides in 15- to 19-year-olds; and
- To improve parent and consumer participation in the Children with Special Health Care Needs Program, as evidenced by parent scores.

The Maternal and Child Health Services Block Grant Advisory Council elaborated on these needs:

- Relative to access to care, the Advisory Council reinforced that all children and adolescents need access to comprehensive primary and preventive services that is consistent with the Child-Teen Health Plan (EPSDT) and includes a specific source for ongoing primary care or a "medical home" and a specific source for ongoing dental care.
- Dental services for children should include fluoridation or fluoride treatment and dental sealants.
- Children with special health care needs should also have access to a source on care that prevents secondary disability and improves or maintains their quality of life. This includes access to evaluation and treatment sources for CSHCN, access to early developmental and hearing screening, access to early intervention services, early coordination of their care and family support services, and access to clinical and laboratory genetics services.
- Relative to pregnant women, the MCHSBG Advisory Council stressed the need for comprehensive and effective prenatal care. This should include health education on pregnancy and child care, outreach and home visitation, nutritional counseling, prevention of tobacco, drug, alcohol and substance abuse, HIV prevention services, prevention of congenital infection, and detection or prevention of genetic disorders.
- On the subject of education, the MCHSBG Advisory Council stressed the need for comprehensive health education, beginning at an early age, and including HIV prevention, substance abuse, family life, sexuality, conflict resolution skill building, and healthy lifestyles.
- Mental health issues and issues related to violence clearly have an impact on the health status of the maternal and child population. The Advisory Council sees the need for suicide prevention and postpartum depression services in each community.
- Further, violence related to homicide, child abuse and neglect, other domestic violence and assault are clearly issues. The Advisory Council stressed the need for families to provide nurturing care to their children.
- The Advisory Council continually re-affirms the value of parent and consumer input in their decision-making process.

Priority needs relate to all MCH population groups and all levels of the MCH Pyramid.

State Performance Measures and Priority Needs

Please see Form 20 and 21 for multi-year reports on required Health Status Indicators. Below, please see brief explanations of program efforts designed to address the indicators.

#01A Health Status Indicator
The percent of live births weighing less than 2,500 grams.

Please see graphs and discussion of low birthweight and very low birthweight data already presented in the Needs Assessment.

These data may be affected by multiple births, which are increasing, possibly as a result of the growth of assisted reproductive technology, which is associated with an increase in multiple and preterm births.

The availability of comprehensive prenatal care to all women through the PCAP and MOMS Programs contributes to healthier births. The Community Health Worker Program continues to work to link pregnant women to prenatal care early in pregnancy and to sustain their engagement in the health care system.

Through preconception and prenatal genetic counseling and screening, babies who may be at risk for genetic, infectious or other congenital conditions can be identified before birth. The mother is offered appropriate options, including close monitoring of fetal development throughout the pregnancy, fetal surgery or other medical interventions, deliver in tertiary medical facilities with neonatal intensive care units, early developmental assessments and interventions, and termination of pregnancy.

#01B Health Status Indicator
The percent of live singleton births weighing less than 2,500 grams.
#02A Health Status Indicator
The percent of live births weighing less than 1,500 grams.
#02B Health Status Indicator
The percent of live singleton births weighing less than 1,500 grams.

For discussion and trend information on these indicators, please refer to previous sections of this Needs Assessment and program efforts briefly described above.

#03A Health Status Indicator
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

- Bureau of Injury Control sponsors multiple programs in pedestrian and passenger safety, head injury prevention, burn prevention, and child safety.
- Bureau of Injury Control included a handout in the Medicaid Update on poisoning prevention.
- Bureau of Injury Control is represented at meetings of the Governor's Traffic Safety Committee.
- Data on camper and staff injuries were collected and entered into the injury surveillance database. Center for Environmental Health conducts safety inspections and investigate injuries and deaths at Children's Camps. Local health departments are audited for permit issuance, inspections, written safety plan, and injury reporting and investigation requirements. As a result of one such analysis, the State Sanitary Code was amended to require bunk bed guardrail installation.
- Statewide Children's Camp inspector training programs are conducted in the spring and fall, training inspectors in camp safety and regulations.

- Written information regarding injury prevention was sent to all local health departments.
- Safety information was presented to camp operators at the American Camping Association Upstate Camp Conference.
- Allegations of abuse are reported, investigated and entered into the incident surveillance system. Prevention strategies and findings from these incidents are shared in trainings and through mailings.
- Typical incidents reported include incidents of illness, bat exposures and epinephrine administrations and outbreaks.
- Data from analysis of illness due to potable water supplies was used to justify amendment of the State Sanitary Code to require additional disinfection, start-up procedures and sampling requirements.
- The Public Health Law and the State Sanitary Code now require additional immunizations be completed.
- Children's Camp regulations were amended relative to on-site, off-site and wilderness swimming and incidental water immersion to better protect against drowning. Drownings are now a rare occurrence, but when they do occur, they are immediately investigated.

#03B Health Status Indicator
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger due to motor vehicle crashes. – and –
#03C Health Status Indicator
The death rate per 100,000 due to unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.
#04B Health Status Indicator
The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.
#04C Health Status Indicator
The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

New York's rate of motor vehicle crashes are at an all-time low. This phenomenon was recently studied at the direction of HRSA by the University of North Carolina at Chapel Hill's School of Public Health.

The low rates are attributed to:
- a long history of stakeholder collaboration around traffic safety and the positioning of the Traffic Safety Commission, which reports directly to the Governor;
- highway engineering that provides wide shoulders on roads, good visibility, rumble strips, easily accessible and sensibly spaced rest areas, and clear, well-placed directional signs;
- STOP DWI efforts, and efforts of private groups such as Mothers Against Drunk Driving and RID, which advocates for removing intoxicated drivers from the roadways;
- excellent enforcement; and
- stringent driving regulations.

The lead within NYSDOH for traffic related public health issues is the director of the Injury Control Program. See information above on program efforts of the Bureau of Injury Control.

#04A Health Status Indicator
The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.

- Please see information above on the Bureau of Injury Control.

- 56 Bushwick families enrolled in the Healthy Families New York Program (Bushwick Bright Start) received home safety assessments, education and remediation plans and services. All families received fire extinguishers, carbon monoxide detectors, and first aid kits. All family services workers in the program were trained in home safety and scored 95% or higher on post-training assessment.
- Comprehensive Prenatal/Perinatal Service Networks sponsor educational offerings, some of which focus on domestic violence and child safety.
- Welcome to Parenthood provides every new parent in the state with infant safety information.

#05A Health Status Indicator
The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.
#05B Health Status Indicator
The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

Please see discussion and data display already presented in this Needs Assessment. Chlamydia rates are rising, but it is impossible to assess how much of the increase in cases is due to increased awareness, testing and case ascertainment.

#06A and B, 07 A and B, 08 A and B, 09 A and B, 10, 11 and 12 Health Status Indicators
Demographics - Please see Form 21.

6. Outcome Measures – Federal and State

Outcome measures denote the final desired result of Title V program activities and interventions. Progress on outcome measures can be attributed to any number of program activities and influences from the health care and social environments. Effectively reducing adverse events requires programmatic investment across the various levels of the MCH Pyramid and the various MCH populations.

Please refer to Form 12, which tracks New York's progress on the six required outcome measures. Outcome measures are indicative of the collective efforts of New York's public and private health care systems to obtain optimum health for all New Yorkers. Local health departments, who monitor health outcomes through statutorily required community health assessments, may use local funds and State Aid to Localities to pay for tracking of outcomes in their municipality. However, Title V funding supports training and technical assistance, data production and posting of information on Department of Health websites on the Internet and the intranets.

Relative to our State Outcome Measure, maternal mortality, all of the Department's maternal and child health programs, but especially the Prenatal Care Assistance Program (PCAP), MOMS, Medicaid and Managed Care, promoted early entry into prenatal care, provision of related services, coordination of care through the intrapartum and postpartum periods, risk assessment and provision of risk-appropriate care. PCAP Part 85.40 standards apply to all pregnancy-related care under Medicaid and Managed Care. See descriptions of the Safe Motherhood Initiative, sponsored jointly with ACOG.

The table below indicates how New York State MCH priorities relate to Federal and State Outcome Measures.

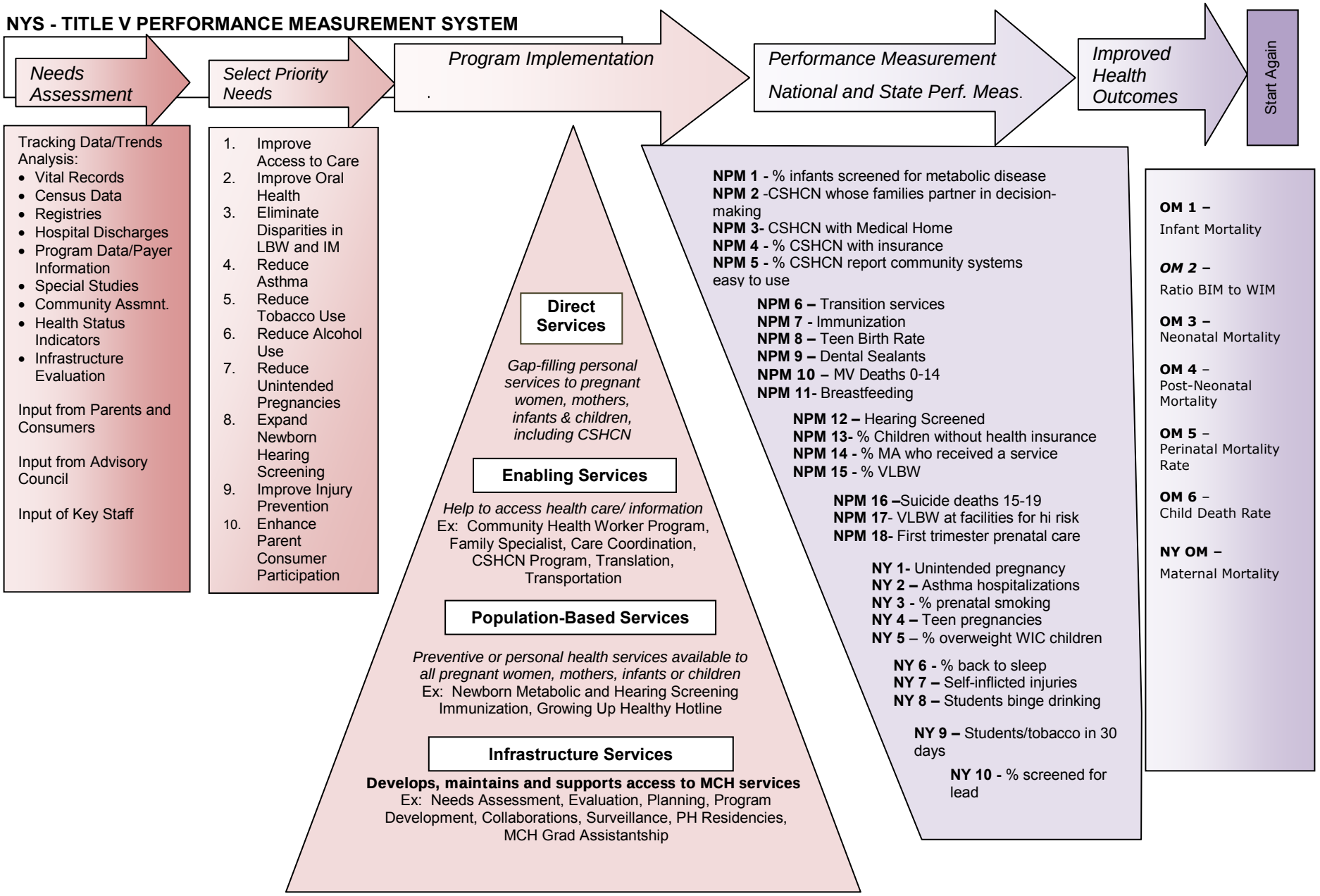
Priority Area	**Applicable Outcome Measure**
Access to Care	1 – 6, NY
Oral Health	1
Disparities, especially LBW and IM	1 – 6, NY
Asthma Hospitalizations	6
Reducing Use of Tobacco among Students	1, 2, 3, 5
Reducing Use of Alcohol among Students	6
Responsible Sexual Activity	---
Lead Screening	6
Self-Inflicted Injury	6
Parent Partnership	---

The matrix on the next page gives examples of how the various programs relate to the various Federal and State Performance and Outcome measures. On the page after that appears the model for NYS Title V performance evaluation.

Relationship of Measures to Program Activities: In New York State, multiple programs contribute to multiple outcomes. The following matrix cross-references programs with the National Performance Measures, National Outcome Measures and State-Selected Performance Outcome Measures. Each performance measure or outcome is only counted once below, though the measure or outcome may be related to more than one level of the pyramid.

NYS MCH Programs	National Performance Measures																		National Outcome Measures						State Selected Performance Measures									State Outcome Measure
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	1	2	3	4	5	6	1	2	3	4	5	6	7	8	9	10	
Abstinence Education						★		★							★				★	★	★	★	★	★	★			★							★
ACT for Youth/ Youth Development			★			★		★								★								★	★		★			★	★	★	★		
American Indian Health Program	★	★	★	★	★	★	★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Asthma/ Asthma Coalitions		★	★		★																					★									
Childhood Injury Prevention										★						★			★					★							★	★			
CSHCN Program		★	★	★		★						★	★	★					★					★		★								
Chlamydia/STD								★																											
Columbia Collaborative		★																								★									
Communities Working Together	★	★	★	★	★	★	★	★	★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Comm-based Adoles. Preg. Prev.						★		★							★				★	★	★	★	★	★	★			★							★
Community Health Worker		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Congenital Anomolies Registry																			★	★	★	★	★	★											
Dental Public Health Residency									★				★	★																					
Dental Preventive Programs		★		★	★				★				★	★																					
Early Intervention	★	★	★	★	★					★		★	★	★					★					★										★	
Eat Well, Play Hard																													★						
Family Planning				★	★	★		★					★	★	★	★		★	★	★	★	★	★	★	★		★	★	★		★	★	★		★
Genetics Services/ Newborn Screening	★	★	★	★	★	★						★	★	★				★	★	★	★	★	★	★											★
HIV-Related Services	★	★	★	★	★	★		★					★	★	★	★		★	★					★											
Hotlines and CPPSN	★		★	★	★	★	★	★			★		★	★	★	★		★	★	★	★	★	★	★	★	★	★	★	★		★			★	★
Immunization & Hep B Follow-up		★	★	★	★	★	★						★	★			★																		
Infant /Child Mortal Review/ SIDS															★	★	★	★	★	★	★	★	★	★	★	★	★	★		★	★	★			
Lactation Institute/ Breastfeeding Prom		★								★	★																		★						
Lead Poisoning Prevention & Fllwup		★	★	★	★								★	★										★										★	
Medicaid/Uninsured Projects/CHP	★	★	★	★	★	★	★	★				★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★		★	★	★	★	★
Migrant Health	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Pediatric Enhanced Services		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★			★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
Pren. Care Assist. Prog. (PCAP)		★	★	★	★	★	★	★		★		★	★	★	★	★	★	★	★	★	★	★	★		★		★	★	★	★		★	★		★
School Health		★	★	★	★	★	★	★	★	★			★	★	★	★		★						★	★	★	★	★	★	★	★	★	★	★	★
Tobacco Control Activities						★									★											★	★						★		

NYS - TITLE V PERFORMANCE MEASUREMENT SYSTEM



Sources of Data and Information for Needs Assessment: Additional Detail

Vital Statistics Data: Historically, birth, death and fetal death certificates have been the main source of information for maternal and child health surveillance. They offer information on birth outcomes, maternal socio-demographic characteristics, and prenatal and intrapartal care on an annual basis on the state, county and sub-county level. From these sources, information is generated on different mortality rates, the percentages at various birth weights, the percentages of prenatal care in each trimester, the adolescent pregnancy rates, fetal losses, live birth-to-pregnancy ratios and maternal mortality. Geographic information provided by birth and death certificates can also be used to target public health interventions, as can racial and ethnic information provided.

Census Data: The US Census is a classic and elegant source of demographic data down to the sub-county level. The Department is making full use of data from the 2000 Census and subsequent projections. These data are also helpful in targeting public health interventions. The Census is also a good source of information on other social and economic factors, such as income and age of the housing stock.

Registries: De-identified aggregated information is also available from the Department's various registries, including the HIV/AIDS, Congenital Malformations, Newborn Screening, Communicable Disease, Tuberculosis, Sexually Transmitted Disease, Cancer, Heavy Metals (lead), Trauma and Immunization Registries. Identified information is used for individualized interventions, for surveillance and for choosing participants for special studies.

The State Education Department maintains a registry for each of the licensed professions and this is a good source of data on age, specialty and practice location. This information is useful in assessing access to care in the various areas of the State and predicting or verifying health personnel shortages. This year, the Dental Bureau worked with the Center for Workforce Studies to conduct a survey of all dentists at the point of licensure/re-licensure.

Provider-Generated or Program-Generated Data: Programs such as WIC, Medicaid, the Immunization Program, the Family Planning Program, the Childhood Lead Poisoning Prevention Program, the Early Intervention Program, the Newborn Screening Program, the Preventive Dentistry Program, the Children with Special Health Care Needs Program, the Dental Rehabilitation Program, and the Community Health Worker Program generate considerable data. These data are often useful in profiling various segments of the community that are using services, but have the limitation that not all are population-based. Caution must be used in interpreting these data, since they reflect only the characteristics of those who are program-eligible and have actually sought and enrolled in services.

Medicaid Utilization Data has been very useful in the past. As less of Medicaid is fee-for-service and more Medicaid-financed care is delivered under a managed care model, newer systems have been developed and are being refined. These systems provide data to serve as a basis for inference regarding the adequacy and quality of care.

Provider performance reports have been released annually since 1994 for commercial, Medicaid and Child Health Plus providers through New York's **Quality Quality Assurance Reporting Requirements (QARR)** system. QARR measures many maternal and child health indicators, such as risk-adjusted low birth weight rates, initial access to prenatal care, vaginal birth after cesarean section (VBAC) rates, risk-adjusted primary cesarean section rates, rates for HIV testing of pregnant women, completion of postpartum check-

ups, access to facilities for high-risk deliveries, completion of health preventive screenings, childhood immunization rates, and well child visits both in the first 15 months of life and at ages 3, 4, 5, and 6. Adolescent well care visit rates are also calculated, as are screening rates for alcohol, tobacco and substance use. The system also monitors appropriate use of medications for people with asthma, ages 5 through 20. These data can also compare outcomes for Medicaid and commercial enrollees, as well as across racial/ethnic groups.

The **Statewide Perinatal Data System (SPDS)** is able to provide information on the course of prenatal, perinatal and newborn care. SPDS presently consists of 2 modules, the Neonatal Intensive Care Unit (NICU) module that collects data on all admissions to NICUs throughout the state, inclusive of New York City and the Core module, consisting of birth certificate data and additional quality of care indicators. All obstetrical hospitals outside of New York City have been using the Core module since January 1, 2004. The secure, internet-based system allows real-time access to important perinatal information on an individual, institutional, regional and statewide basis. New York City implemented their own version of the SPDS recently, and the Department will work on including any new data collected into a statewide data set as feasible.

The **Integrated Child Health Information System (ICHIS)** is a data warehouse of children's health-related information, linked anonymously and longitudinally across multiple data sources. The primary goal of ICHIS is to serve as a single, primary source of child health data and information that identifies and monitors different child populations, allows identification and follow-up of specific child health areas of need, and enables improved targeting and effective planning of children's health programs and services. Currently, ICHIS is populated with data from birth certificates, death certificates, SPARCS, congenital malformations registry and vaccine-preventable disease occurrences. ICHIS de-duplicated Immunization Registry information for potential addition. PRAMS, WIC Pediatric Nutrition Surveillance, MA managed care encounters, child blood lead screening tests, lead poisoning case management, newborn metabolic screening and dental surveillance data are under discussion for addition to ICHIS.

Hospital Discharge Data: Hospital discharge data offer detailed medical information and information about the socio-demographic characteristics of mothers, infants and children who enter and are discharged from New York's hospitals. The **SPARCS** data system, which collects information on every hospital discharge in the State, yields information on length of stay, level of care required (i.e. NICU vs. regular nursery), costs and rates of hospitalization for various morbidities (such as asthma, gastroenteritis, otitis media, head injuries and other conditions). Information is available on how many hospitalizations are drug-related or occur as the result of a motor vehicle crash. As more care is handled on an outpatient basis, information in this system becomes less reflective of the health of the community. Systems are now in place for collecting Emergency Room encounter data.

Special Studies: The **Pregnancy Risk Assessment Monitoring System** or **PRAMS** collects population-based information on maternal knowledge, attitudes and behaviors, on service access and utilization, and on possible physical and emotional stressors during pregnancy from a sample of women who have recently given birth. Examples of data that are available through PRAMS include: percentage of moms who drank alcohol or smoked during their pregnancies, who experienced physical violence in the year prior to delivery, who were satisfied with the number of prenatal visits, and who breastfed beyond their baby's first week of life. Data from PRAMS also includes the number of pregnancies that were unintended, that is, not wanted or wanted later.

New York initiated PRAMS in 1993 with assistance from the Centers for Disease Control and Prevention. The State's PRAMS grant covers those parts of the state outside New York City. New York City Department of Health initiated PRAMS in 2001 and began collecting data in August of that year. The first years of data collection, response rates from the City, were less than 70%, the optimal response rates required by CDC for data analysis.

In 2004, response rates of 70% where achieved for half of the New York City batches (two quarters). As a result, CDC has agreed to develop a statewide PRAMS dataset for those quarters. Unfortunately, this statewide sample was not developed in time for this report, so NYC and rest of state PRAMS results are reported separately again this year. As long as NYC continues to achieve 70% response rates with in at least six months of a calendar year for their PRAMS data, statewide datasets based on partial data years will be available. The State PRAMS staff continue to collaborate with New York City Department of Health a regular basis.

Each year, the Office of Medicaid Management creates a **prenatal study file**. This is an annual match of birth certificates with Medicaid prenatal care records that supports evaluation of prenatal care and birth outcomes for Medicaid-enrolled women.

The **Youth Risk Behavior Study (YRBS)** collects information on the knowledge, attitudes and behaviors of high school students in the State. This study excluded New York City until 1996, but New York City data are now available. YRBS is conducted and distributed every two years by the State Education Department. YRBS data are used extensively by a number of NYSDOH programs.

On a wider adult population, the **Behavioral Risk Factor Surveillance System (BRFSS)** collects valuable information on behaviors associated with the development of chronic diseases and the use of health resources. Information on these risks is collected nationally by telephone survey using a standardized questionnaire.

BRFSS information is made available at the county and regional level. Population-based telephone surveys are conducted in 38 localities comprising the entire state using methods comparable to the Centers for Disease Control and Prevention (CDC) methods. A number of the localities are single counties; other counties are grouped together. A total of 630 interviews with adults, aged 18 years and older, are conducted in each of the 38 localities. The questionnaire includes an 8-minute Core module that is the same in each locality. In addition, each locality is able to select modules they would like added to the basic survey. A standard 4-minute questionnaire is also available for counties who do not opt for selecting an individualized set of additional questions. The advantage to selecting the standard module is that those counties will be able to compare responses to other counties that selected the standard questionnaire.

The Census Bureau's **Current Population Survey (CPS)** reflects demographics such as age, sex, race and socioeconomic status. These data are available on the state level only. The last available year is 2006, the data for which was collected in 2005.

The Federal Maternal and Child Health Bureau has recently completed a second wave of the National State and Local Area Integrated Telephone Survey of Children with Special Health Care Needs (SLAITS CSHCN Survey). The Division of Family Health has incorporated these data into the New York State data as indicated in this application.

Local Community Health Assessment Data: Each of the State's 58 local health departments in New York are required to submit a Community Health Assessment to the State Health Department every six years, with updates required every two years. This assessment interprets vital statistics information, local trends, disease rates and special access issues, which the local health departments are then expected to address. Community health assessments are a particularly rich source of data describing unmet needs for direct medical services or for enabling services on a local level.

The Public Health Information Group and the Office of Local Health Services coordinate intensive review of each county's assessment and provided feedback to local departments. They have helped local health department staff to identify their training needs, further advance their local assessment skills, select priorities that provide the greatest opportunities to impact public health in their jurisdiction, and define their plans as a community. Many local departments are developing more comprehensive assessments and plans as a result. In order to assist counties and the general public in accessing health related data for assessing their communities' health status, the Public Health Information Group posts and maintains county level data on the NYS Department of Health website. See the sample data set in the appendix for examples.

The satellite version of the CDC training program, "Public Health Data: Our silent partner" has been televised as a collaboration with the Public Health Information Group, the Office of Local Health Services, the University at Albany School of Public Health, and the New York State Association of County Health Officials. Public Health Information Group staff also provide live training sessions to improve data analysis capacity at the local level. More recently, offerings have been added that address disparities in birth outcomes, cultural competency and cross-cultural communication. Courses were made available on the New York – New Jersey Public Health Training Center's website: www.nynj-phtc.org. The New York – New Jersey Public Health Training Center also has a web-based course available on Evidence-Based Public Health: Using a systemic approach to address disparities in health outcomes.

From the *Communities Working Together* Public Participation Process to Evidence-Based Public Health: *Communities Working Together* served as great model for including communities in the process of setting public health priorities. The Department continues to assist localities in identifying and addressing local priorities through a collaborative, open, community-based process via several training initiatives in **Assessment** and **Evidence-Based Public Health** that continue the themes of community-involvement and data use. Hospitals and local health departments continue to collaborate in formulating Community Services Plans required of all hospitals by the State Hospital Code.

Input of Families and Consumers: The Department continues to work to improve parent and consumer input into the design and implementation of maternal and child health and Children with Special Health Care Needs programs. New York has been conducting focus groups on maternal and child health issues since 1999. The purpose of conducting focus groups is to gather information directly from consumers about health issues and what most concerns them. New York considers these focus groups to be a very useful addition to other forms of public input. Confidentiality is of the utmost importance and is assured for all participants. Participants receive travel reimbursement, culturally-appropriate nutritious snacks and stipends for their participation. Child care is also provided.

Three years ago, family and consumer forums were conducted in twelve locations with the goal of having families and consumers identify, through their own experiences, parts of the

health care system that are not welcoming, supportive or working for them. Last year, that process was again repeated, and eleven additional focus groups were conducted. The idea is to improve maternal and child health programs through the expressed needs of consumers.

These focus groups came about because the Family Specialist, the SSDI Coordinator and the Title V Coordinator met with parents and graduates of the "Making the Pieces Fit" training to write a strategic plan for enhanced parent involvement. Parent planners then assisted in formulating the agenda for the groups. The plan was then implemented with assistance from parents, local agency partners and the NYSDOH regional staff. Parents of children with special health care needs are surveyed annually for their input on implementation of the parent involvement plan.

Through a contractual arrangement with the Association of Prenatal-Perinatal Networks, more focus groups were conducted. Downstate, the Northern Manhattan Perinatal Partnership conducted focus groups with Native Americans in Suffolk County, African-American women from Nassau County and Far Rockaway (Queens), Asian women from Lower Manhattan, Middle Eastern families from Brooklyn, Puerto Rican and Mexican women from Nassau County, homeless moms at an American Red Cross shelter, and Caribbean/Dominican women from Northern Manhattan. Upstate, the Mothers and Babies Perinatal Network conducted focus groups with refugees from Bosnia and other Eastern European countries settled in the Mohawk Valley, and with rural, low-income mothers and migrant and seasonal farmworker families from Western New York, as well as pregnant and parenting teens and a group of grandparents raising young children in the Southern Tier area.

Last year, groups were conducted at Akwasasne (Franklin County) with Native American women; Rochester (Monroe County) with Hispanic women; Syracuse (Onondaga County) with mothers of children with special health care needs; Westfield (Chautauqua County) with rural residents/parents; Schenectady (Schenectady County) with Guyanese women; and in the Capital District area with Family Champions who are all parents of children with special health care needs from around the state.

Most of the attendees received their care from Community Health Centers or private physicians and had incomes below the Medicaid level. The feedback from these consumers identified the following concerns as barriers to receiving care for themselves or their children:

- Lack of transportation/distance to reach care;
- Limited hours of operation of their providers;
- Lack of insurance coverage; and
- Long waits for appointments and services.

The changes consumers would most like to see included quicker service and more respect for the parents'/patients' time, effort and energy. Consumers complained that service providers often don't know/aren't sensitive to "what it takes" to get ready for, appear and wait for services. NYSDOH staff are to include these areas in quality reviews of contractor services.

The Family Champions group was asked to focus their discussions on the national performance measures related to children with special health care needs and their families and how New York could improve their performance on these measures. Each year, New York asks parents to score their participation on the scale that accompanies these performance measures. New York was the first state to include only non-employee parent scores on this scale.

Of the 17 Family Champions, 15 chose to participate in the focus group. For each measure, the Family Champions were asked to identify factors that hindered New York's ability to improve ("Challenges") and factors that they believed would help New York improve its performance ("Potential Solutions") on each measure. The process involved group brainstorming, combining ideas in a common strategy or category, and then having individuals vote for the items they believed to be of greatest importance, thereby establishing priorities for the group. Each parent had five votes. The opinions of the Family Champions regarding the greatest challenges and potential solutions are summarized in the discussion of performance measures in Section IV.

Later in the program year, five additional focus groups were added, with the purpose of getting adolescents' input on the national and state performance measures that most related to them and their age group. These groups, which included one group of institutionalized males and one group of institutionalized females, responded to questions about risk behavior associated with binge use of alcohol, motor vehicle crashes, depression and suicide, and smoking.

In 2007, the Department added a **Youth Advisory Committee**. The Youth Advisory Committee (YAC) was formed to advise the NYSDOH Children with Special Health Care Needs (CSHCN) Program on what youth need to transition successfully to adulthood in terms of employment, medical care and independent living. YAC members also provided information regarding their experiences with having a medical home and suggested methods for distributing materials and information to assist with the transition process. The YAC will give the youth an opportunity to develop their leadership skills and to be heard on issues that affect them directly.

The Youth Advisory Committee consists of 19 diverse young adults between the ages of 15-24 from all four regions of the state; five members are from the Capital region, two from the Central region, five from the Western region, and seven from the Metropolitan region. Their race/ethnicity is as follows: three Hispanics, three African Americans, and 13 Caucasians.

These young adults were brought together in the Albany area on April 20-21, 2007 for the first YAC meeting. Reflections from this session indicated that the youth were inspired by the individuals who presented and learned the importance of self- advocacy, perseverance and networking. They were interested in knowing more about accessibility on college campuses, independent living centers, their rights as a person with a disability, and how to drive with a disability that causes limited movement of the hands. The second day of the session focused on specific transition issues. Youth stated that the following would be helpful:

- a list of services that are available to help them live independently;
- information about Medicaid and how it works;
- updates on new technology,
- opportunities for learning life skills and social skills;
- information about good adult physicians who accept their insurance plans;
- someone to take care of their medical and medication needs;
- getting a job;
- learning from the examples of people who have already transitioned;
- making a slow transition from pediatrician to adult provider;
- getting a better understanding what it means to transition;
- having wheelchair accessible housing; and

- lists of doctors that specialize in their particular illnesses.

As an outcome of the first YAC, the youth showed increased knowledge of the Children with Special Health Care Needs Program and their role as youth advisors from the pre- to post-survey. They identified their areas of greatest need in the area of transition as products and actions that can address these needs, and methods of distributing materials and information to improve transition, such as a portable health summary. The YAC members were very informative and enthusiastic. Their reflections indicated that participants enjoyed meeting and sharing with new people and found the meeting to be organized and easy to follow. They plan to share the information that they learned with other organizations with which they are involved.

Our Family Champions continue to be a vital source of information and support for CSHCN and their families as well as for the Medical Home Unit and the Division of Family Health. Parents also have a major role in the policy and program development in the Early Intervention Program. Early Intervention conducts parent policy development training and the Early Intervention Parent Workgroup addresses a variety of service delivery issues.

New York is a part of the **New York-Mid-Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC).** NYMAC is currently undertaking a series of focus group meetings for consumers of genetic and specialty health care services and for lay advocates for people with special health care needs. The goal of this effort is to talk directly to those most involved in the care of people with special needs in order to improve the system of care and, ultimately, the health and wellbeing of those with special health care needs. Each meeting asked consumers and advocates to address medical home, health promotion, health insurance, special resources (including educational resources, transportation, and parent and child support), and transition of adolescents and young adults into adult medical care. Staff from the Wadsworth Center reached out to the SSDI Coordinator for her expertise in the organization and conduct of focus groups.

Each year, New York updates the Block Grant Application Glossary, which is included herein. State-specific abbreviations and information are added to the Federal boilerplate in order to make the block grant application more understandable and readable to its multiple audiences.

Because the ultimate goal of public input is to ensure that services are appropriate to the populations served, results of all public input processes are shared with program staff and agency administration for incorporation into program planning, policies and procedures.

Health Disparities Forum: In December 2006, 100 Department employees, representatives from the Center for Community Health; the AIDS Institute; the Offices of Managed Care, Medicaid Management and Health Systems Management; the Center for Environmental Health and the School of Public Health, came together in an interdepartmental forum on health disparities. The purposes of the forum were to raise awareness of health disparities related to race, ethnicity, income and primary language; to provide participants with the latest data on heath care access and utilization; to stimulate discussion on the collection, analysis and dissemination of data for departmental activities to eliminate health disparities; and to begin discussion on interpretation of data and implications for future departmental priorities and interventions.

Participants heard presentations on an overview of available NYS and NYC data, racial/ethnic disparities in Medicaid managed care data, public access to data on the world wide web, highlights of interventions/approaches, including the way data are used to target,

design and evaluate interventions. The director of the Office of Minority Health provided a reflection on common themes and the challenges/complexities inherent in designing interventions that work. Discussion focused on defining health disparities, sharing success stories, data shortfalls, data access/availability/quality issues, the need to shift to pragmatic approaches, use of a systems approach to look at all variables and interrelationships, the need to be flexible and to questions assumptions, and the use of available knowledge. There was also a great deal of discussion about community involvement in identifying problems and designing interventions.

Recommendations made as a result of the discussion included:

- Expand access to heath disparities data. It was suggested that a workgroup be convened to identify how to make high-quality health disparities data more widely available, both internally and externally.
- Improve the collection of race and ethnicity data in the Medicaid program. It was suggested that the Department enforce the need to adhere to the OMB mandate that race and ethnicity classification follow the Census classifications. It was also recommended that separate fields be created for ethnicity in two categories, so that race categories are not mutually exclusive.
- Improve NYSDOH capacity to identify and design evidence-based programs that eliminate health disparities. It was recommended that there be an expanded role for the Office of Minority Health that would provide resources and leadership to ensure a coordinated, department-wide focus on elimination of health disparities.
- Design more effective evidence-based interventions. It was recommended that pilots be based on solutions suggested by the communities that are most affected. It was also recommended that a Department-wide portfolio be established on disparities that are a priority to address and on evidence-based interventions.

Eighty-five percent of those attending requested additional forums on this topic. On the evaluation, many staff noted that these discussions were a good first step, but wanted additional forums that focus on sub-populations and evidence-based successful interventions.

Testimony at Public Hearings: In 2007 in preparation for the FFY 2009 application, public hearings were held in New York City, Buffalo and Albany. Topics brought to the hearing included continued support for the NYS Center for Sudden Infant Death and their services; childhood nutrition; and oral health.

Focus groups were held in the southwestern part of the state to study adolescents' behavior and their perceptions of various risk behavior and health care. The purpose of conducting the focus groups was to assist the Department to evaluate its progress on certain Maternal and Child Health Services Block Grant Performances Measures, both Federal and State and to improve the services and policies for youth and their families in New York State. New York considers these focus groups to be a very useful addition to other forms of public input. Confidentiality is of the utmost importance. Participants received travel reimbursement, culturally-appropriate nutritious snacks and stipends for their participation.

Input from the Maternal and Child Health Services Block Grant Advisory Council:
The New York State Department of Health established the Maternal and Child Health Services Block Grant Advisory Council in 1983, following the enactment of Chapter 884 of the New York State Laws of 1982. The Council serves in an advisory role to the Department regarding the administration of funds under Title V of the Social Security Act. The Council assists the department in determining the program priorities and in soliciting public input for the preparation of annual applications.

By mandate of statute, the Council is composed of twelve individuals, six of whom are appointed by the Governor, three of whom are appointed by the Temporary President of the Senate and three of whom are appointed by the Assembly Speaker. Also by law, members are to include representatives of local government, the not-for-profit sector, and the community. The Council was fully constituted at twelve active members until November 2005. At this time, there is a Senate-appointed seat and a Governor-appointed seat on the Council that are vacant. Title V staff are working with the Office of Governmental Affairs to secure replacements.

The Council members, in their advisory capacity, bring a wealth of experience, information and concern to the table. Advisory Council members carefully consider the testimony offered at public hearing, and often bring new information encountered in their daily professional lives, in formulating their recommendations to the Commissioner and the Governor.

Current members are:

- **Richard Aubry, M.D., M.P.H., Interim Chairperson**
  SUNY Health Science Center, Syracuse, New York
  (Senate appointment)
- **Thomas R. Curran, D.D.S.**
  Maxillofacial surgeon and member of Chemung County Board of Health
  (Governor's Appointment)
- **Joan Ellison, M.P.H., R.N.**
  Director of the Livingston County Department of Health, Mt. Morris, New York
  (Governor's appointment)
- **Shirley Gordon**
  Gordon & Gordon Associates, Inc., Albany, New York
  (Senate appointment)
- **Neil Heyman**
  Southern New York Health Association, New York, New York
  (Governor's appointment)
- **Sarah Liebschutz, Ph.D.**
  University of Rochester, Rochester, New York
  (Governor's appointment)
- **Donna O'Hare, M.D.**
  New York, New York
  (Assembly appointment)
- **Christine Saltzberg, Ph.D., R.N.**
  Pittsford, New York
  (Assembly appointment)
- **Joseph S. Sanfilippo**
  Binghamton, New York
  (Assembly appointment)
- **Terri Bailer**
  Melville, NY
  (Appointed by the Governor in early 2009)

III. State Overview

A. Overview

/2010/ Summary: The transition to new state leadership was completed in 2008, and the state began the process of adjusting activities and priorities as the state's budget crisis took center stage. While all programs received a cut in funding, many received no net reduction in the final analysis, due to a COLA still available through the 2008-09 fiscal year that offset the reductions. However, although the funding reductions that loomed created an unsettled atmosphere among providers of services, our partners in the MCH community demonstrated the commitment to service that has been their hallmark, and there were minimal disruptions in service, even with fiscal uncertainty. At the Department of Health level, despite tight budgets for personnel and supplies, progress was made in advancing the state's commitment to MCH populations, with rollout of the Commissioner of Health's Prevention Agenda. In addition, there was a major commitment made to shifting Medicaid funds from the inpatient to the outpatient/prevention side of the health care equation, and that shift was implemented for outpatient hospital-based clinics before the end of 2008, and was scheduled for non-hospital-based clinics in early 2009. While the State's Title V unit, the Division of Family Health, has had a long and close working relationship with the state's Medicaid program, that relationship became even closer in 2008, as plans were made to expand the model of services used in the state's premier prenatal care program for Medicaid women, the Prenatal Care Assistance Program, to all Medicaid providers.

This state overview, in conformance with the guidance document, includes information that will help to place the state's Title V program within the overall context of the state's government, and show some of the basic interrelationships with other units within the government and the Department of Health that contribute to its ability to make significant contributions on an ongoing basis to maternal and child health.//2010//

/2009/ Summary: In early 2008, as will be addressed more fully in the 2008 report, the Lieutenant Governor, David Paterson, assumed the role of Governor in New York State. The Governor has a strong commitment to improving public health. The Commissioner of Health in New York State, as his representative, has made significant inroads in implementing public health initiatives designed to further improve the health of New Yorkers. These initiatives include extending accessibility and streamlining processes for obtaining insurance benefits, further enhancing our focus on prevention efforts, increasing the effectiveness of surveillance efforts and emergency preparedness, and improving and sustaining access to high quality, continuous primary health care for all New Yorkers. These priorities will all be addressed in a manner cognizant of the diversity of our population, including differences in socioeconomic status, and the need to especially ensure that services for pregnant women, infants, and children are accessible and effective. A re-design of the state's Medicaid payment system to better reimburse provision of comprehensive services to vulnerable populations is anticipated in the coming year.//2009//

/2008/In 2007, New York has both a new Governor and a new Health Commissioner. As a result, New York is now placing a new emphasis on extending health insurance and putting patients first. Here are some of the Commissioner's overall goals for the Department:

- Working with the Governor, the Legislature and other constituencies, the Department of Health will help design a plan whereby every New Yorker has access to affordable health insurance. In /2009/ former //2009//Governor Spitzer's State of the State address

/2009/ in 2007 //2009//, he pledged to reform New York's health care system to make health care affordable for every person, family and business, as well as for government.

- To improve the health status of all New Yorkers, the Department will promote a "culture of wellness" in New York State where prevention and healthy lifestyles are taught, valued and exercised.
- To prevent serious health problems and improve outcomes, the Department will seek reforms in the health care system that result in greater use of prevention, health education and primary care.
- The Department will strengthen statewide and community-based efforts to reduce the most preventable causes of illness and disability, including tobacco use, obesity, asthma, diabetes, HIV/AIDS, heart disease, and certain preventable types of cancer.
- To protect New Yorkers from environmental health risks, the Department will strengthen efforts in environmental health education, prevention, surveillance and response.
- To improve the quality of life for New York's seniors and disabled, the Department will seek to expand options that allow these individuals to obtain needed medical care and assistance with daily living while remaining in their homes and other least-restrictive community settings.
- To improve quality and effectiveness in the health care system, the Department will expand the use of health information technology and evidence-based strategies that achieve the best outcomes while preventing medical errors.
- Recognizing that minorities and other low-income New Yorkers continue to experience lower health status than others, the Department will develop and implement more effective health care provider and community-based strategies to eliminate these health disparities.
- To provide the greatest protection possible to New Yorkers in the event of a public health emergency, the Department will improve disease surveillance and reporting, educate New Yorkers on prevention, and strengthen planning and preparedness with the Department's federal, state and local partners.
- To ensure a strong scientific foundation for the Department's public health efforts and to enhance efforts to detect, prevent and treat serious public health conditions, the Wadsworth Center will strengthen research, testing and quality assurance activities.
- To increase the effectiveness of local public health efforts across New York State, the Department will strengthen collaboration with, and support for, local public health departments.
- To ensure the availability of a strong public health workforce, the Department in conjunction with the School for Public Health will strengthen efforts to promote careers in public health and provide cutting-edge public health education and training.

Commissioner Daines is in the process of developing additional public health goals for the Department as he meets with employees and the public over the coming months. He is encouraging all staff to identify all barriers to achieving our goals and to break them down.//2008//

/2010/ The Commissioner's "Prevention Agenda Toward the Healthiest State" was promoted to County Health Departments and Hospitals around the state in 2008, building on the previous "Communities Working Together" effort of the past decade. This agenda emphasizes the potential cost savings in preventing rather than treating health problems, yet the paucity of funding directed at prevention. Healthy mothers, babies and children was one of the ten priority areas selected for inclusion in this prevention agenda.//2010//

/2008/On January 26th, 2007, /2009/ former //2009// Governor Spitzer outlined his agenda for fundamental reform and restructuring of the health care system, decreasing costs while increasing coverage. These reforms will save taxpayers billions of dollars while still improving patient outcomes. This agenda is called **Patients First.** This new agenda calls for greater scrutiny of where health care dollars are being expended and holding institutions

to greater accountability for health care dollars. Monies will be shifted away from institutions-centered health care system to an effective patient-centered system for the future.
/2010/ Implementation of this plan began in 2008, with the shift of hospital-based clinics to a new reimbursement methodology based on procedures performed rather than clinic threshold rates. The "Ambulatory Patient Groups" (APG) methodology is expected to provide significantly better reimbursement for hospital-based clinics than the previous reimbursement scheme. The APG methodology is expected to be expanded to community-based (non-hospital) clinics in 2009.//2010// Cornerstones of this plan include:

- Providing access to health insurance to all 400,000 uninsured children. To do this, New York will extend Child Health Plus to cover children in families up to 400% of the federal poverty level, so that every family in New York will be able to provide their children with the health insurance coverage that they need.
/2010/ In 2008, Governor Paterson announced expansion of income guidelines for enrollment of children in Child Health Plus, to $70,000 per year for a family of three, which provides an opportunity to significantly reduce the number of uninsured children in NYS.//2010//

- Removing bureaucratic barriers that prevent people from getting on and staying on Medicaid. While implementing safeguards against fraud, we will no longer require families to produce documents for continued eligibility. Our own data will be used to confirm continued eligibility.

The goal of these two measures is to cut the uninsured population in half over the next four years and to save the state millions of dollars by reducing charity care in emergency rooms.

The Patients First agenda also includes a plan to develop an affordable, universal health insurance system for all New Yorkers. This cannot be achieved unless our health care delivery system is restructured to lower health care costs to ensure that it is not an undue burden on families, businesses and government to cover the cost of universal coverage.

The plan is that as New York expands coverage, there will be reforms in the Medicaid delivery system. Medicaid rates paid to nursing homes and hospitals are to be frozen, with a partial freeze on Medicaid managed care. Reform efforts include:

- Ensuring that the Graduate Medical Education (GME) system provides the state with the value desired for the funds invested;

- No longer using Medicaid to cross-subsidize commercial insurers, nor supporting deep discounts for hospital services their members use.

- Paying fair reimbursements that reflect the true costs of providing high-quality care through a workforce whose needs are met fairly, redirecting Medicaid dollars to those facilities that serve the bulk of the Medicaid patients.

- Strengthening the state's Preferred Drug List, increasing the use of clinical equivalents and promoting best practices. New York is looking into bulk purchasing and the federal 340B drug discount program.

- Purchasing health care in the appropriate setting, using the highest standards at the best price, and starting with the patients that have multiple medical needs. With better coordination of care, patients with medically-complicated conditions will get better care, their conditions will be better managed, and the cost of their total care will be reduced.

- Expanding the managed long-term care programs which have been successful in coordinating and managing long-term care needs.

- Driving the implementation of health information technology, which is essential to improving health care quality, reducing bureaucratic barriers and saving health care dollars.

- Increasing efforts to root out Medicaid fraud, which wastes precious resources and reduces our ability to care for those in need. /2010/ Former //2010// Governor Spitzer is proposing to the New York State legislature a Martin Act of Medicaid and a State False Claims Act. This legislation saved the federal government billions since its implementation.

- Targeting primary and preventive public health strategies that will decrease obesity rates, increase healthy eating and physical exercise, prevent childhood lead poisoning, expand access to cervical cancer vaccines, prenatal and postpartum home visiting, high-quality mammograms and public health education.

The Governor has called for collaboration and partnership in making the Patients First agenda a reality. It is his intention that partners will include individuals, businesses, health care workers and the health care industry. He has called for all to come together as One New York. //2008//

/2008/In addition to these goals for health in New York, /2009/ former //2009// Governor Spitzer and /2009/ former //2009// Lieutenant Governor /2009/, and current Governor //2009// David Paterson have announced a comprehensive strategy to ensure that all of New York's children are given an equal opportunity to achieve success. The Children's Agenda is a plan for a series of actions that will provide the groundwork for healthy and successful lives. Governor Spitzer explains that the children's agenda will "focus our state's resources and energy on the particularly vulnerable period in a child's life when development is most important." /2009/ Former //2009// Lieutenant Governor /2009/, now Governor, //2009//Paterson, goes on to state, "All of our children deserve a level playing field. From the prevention and treatment of childhood obesity to protecting them from violent video games, this initiative ensures that we have the tools in place for them to succeed in New York."

The Children's Agenda will:

- Through Executive Order, establish a Children's Cabinet that will bring together the multiple state agencies to implement the reforms that will be required for the success of New York's children. The cabinet will consist of the diverse agency commissioners, chaired by the Director of State Operations Olivia Golden, and co-chaired by the Deputy Secretary for Health and Human Services Dennis Whalen and Deputy Secretary for Education Manny Rivera.
/2010/ Established through Executive Order in 2007, the Children's Cabinet is comprised of the commissioners and directors of 20 state health, education, and human services agencies along with several senior staff of the Governor's Office.//2010//

- Charge the Children's Cabinet with the implementation of budget priorities to support the positive development of children and universal pre-Kindergarten.
/2010/ Originally, the Children's Cabinet focused primarily on enrollment of all children in the state in health insurance and implementation of the Universal Prekindergarten program. After obtaining success in each of those areas, the Children's Cabinet's efforts have now extended to addressing the needs of disconnected youth. More recently, in response to the a requirement in the Head Start Reauthorization Act requirement for Governors to establish or designate Early Childhood Advisory Councils, the Children's Cabinet has decided to reorganize its Advisory Board and establish an Early Childhood Advisory Council. This new

group will include current members of the Advisory Board with early childhood expertise and representatives of early childhood, health care, child welfare, and mental health programs, advocacy organization, parents, higher education, unions, state agencies and others involved in the provision of comprehensive services to young children and their families.

From 2003 through May of 2009, the New York State Department of Health (NYSDOH) Title V Program was the recipient of a federal Early Childhood Comprehensive Systems (ECCS) grant. The first three years of the grant focused on cross-systems, strategic planning, resulting in a comprehensive early childhood plan for New York State. The last three years have focused on incremental implementation of the plan, with a strong emphasis on building state level cross-systems infrastructure for early childhood work.

From its inception, NYSDOH collaborated with the New York State Council on Children and Families (CCF) to lead and coordinate the ECCS initiative. CCF is uniquely positioned to coordinate this cross-agency effort as an independent state agency charged with coordinating the activities of its member health, human service and education state agencies. CCF co-chaired the planning phase of the initiative with NYSDOH, and this collaboration was subsequently formalized through a subcontract to CCF of a major portion of NY's ECCS grant. Through this subcontract, CCF, in ongoing partnership with NYSDOH and many other public and private partners, has coordinated the ongoing implementation and updating of New York's ECCS plan for the past three years. In the latest round of competitive funding for the grant cycle that began June 1, 2009, at the urging of New York and other states that had pursued these types of collaborative arrangements, HRSA expanded the eligibility criteria for this grant to allow organizations other than Title V programs to apply. As CCF is uniquely positioned to coordinate this cross-agency effort as an independent state agency charged with coordinating the activities of its member health, human service and education state agencies, it was determined that CCF would directly apply to administer this grant The NYSDOH will continue to collaborate on this initiative. Formal grant award announcements are currently pending.

The overarching goal of the NYS ECCS plan is to support families and communities in nurturing the healthy development of children ages 0-5. The plan outlines goals, objectives and strategies within four cross-sector focus areas: Healthy Children, Strong Families, Early Learning, and Supportive Communities/ Coordinated System. In developing and implementing the plan, emphasis has been on establishing systems-level cross-agency leadership, and on facilitating coordination and collaboration across state agencies and other external partners. A major emphasis and accomplishment over the past two years has been to align the ECCS initiative with the work of the New York's Children's Cabinet, and most recently the Cabinet's Early Childhood Advisory Council. The Cabinet is convened by the Governor's office and is comprised of the commissioners and directors of 20 state agencies. To assist the Cabinet in its efforts, the Governor also established a Children's Cabinet Advisory Board, comprised of non-governmental leaders with expertise in a range of children's issues. CCF provides staff support to the Children's Cabinet and its Advisory Board. This year, Governor Paterson formally designated the Children's Cabinet and its Advisory Board as his Early Childhood Advisory Council (ECAC), including responsibility for overseeing both the Head Start Collaboration Project and the ECCS Initiative. The ECCS plan was reviewed and updated to incorporate input from the Cabinet, and was formally printed and disseminated in spring 2009. The ECAC convened its first meeting in May 2009, with the NYSDOH staff member who had co-chaired the initial ECCS project (Dr. Rachel de Long, Director of Bureau and Child and Adolescent Health) serving as DOH's representative on the ECAC.

In addition to these major organizational accomplishments, significant progress has continued to be made by ECCS partners across a wide range of program areas, including enrollment of young children in health insurance programs, expanded mental health screening for children, parent education projects, funding for universal pre-kindergarten, significant work to coordinate and expand home visiting programs to serve at-risk families, quality improvement projects to improve developmental screening of young children with medical homes, completion and dissemination of a comprehensive data report on the health and development of children birth to five years of age and submission of a cross-agency Project LAUNCH grant application to SAMSHA.//2010//

- Introduce legislation including a Healthy Schools Act to strengthen school nutrition and junk-food standards, a Safe Games Act to create of mechanism whereby retailers cannot sell sexually-explicit and excessively-violent video content to children, and Anti-Tobacco legislation that will prohibit the sale of flavored cigarettes because of their dangerous ability to hook kids on smoking. //2008//

/2010/ In 2008, Governor Paterson and First Lady Michelle Paige Paterson announced release of a "Healthy Kids, Healthy New York After School Initiative" to help fight childhood obesity. The initiative offers guidelines and a toolkit to help fight childhood obesity in the schools by providing after school programs with model guidelines to help children acquire healthy habits such as making nutritional food choices and increasing physical activity while limiting TV watching. In September, reporting of student weight and BMI summary statistics to the state became mandatory, to allow for better public health planning and policy efforts relative to this issue.

Context of the State's Title V program within the State's health care delivery environment:

The State's Title V program is located within the State Health Department, as is the state's Medicaid program. The State's Title V program resides in the Division of Family Health (DFH), under the direction of the Division Director, Barbara L. McTague. Ms. McTague oversees programs that serve women, infants, children, and children with special health care needs, as well as their families. The Division has four Bureaus, Women's Health, Child and Adolescent Health, Dental Health, and Early Intervention, and is assisted by the Office of the Medical Director, and the newly formed Policy and Research Unit, which is responsible for coordination of the Block Grant Application. DFH is one of four Divisions reporting to the Center for Community Health (CCH), and through CCH, to the Office of Public Health, which was newly recreated in the past two years. CCH includes an Office of Minority Health, which assists all Center programs in better serving the needs of minority populations, an Internet Development and Communications unit, which facilitates development of web-based materials, an Office of Information Technology and Project Management, and a Resource Management Unit. This arrangement of services within the Center helps to ensure proper oversight and assistance of all program functions within the Center (see attached organizational chart).

DFH works very closely with the other Divisions within CCH, particularly the Division of Nutrition (DON) and the Division of Chronic Disease Prevention and Adult Health (DCDPAH), as well as with the major organizational segments of the Department whose work complements that of the Division, in particular the Office of Health Systems Management (OHSM) and the Office of Health Insurance Programs (OHIP). DON, which includes the WIC program and various other nutrition and fitness programs, works closely with the DFH in implementing both prenatal programs and children's programs to ensure that the nutritional needs of at risk pregnant and nursing women as well as infants and children are being met. DCDPAH works closely with the family planning program in DFH, which collects extensive annual data on Chlamydia testing for reproductive age women in NYS, and with the cancer

screening program in referral of women for screening and treatment for breast and cervical cancer.

OHSM oversees all hospitals and licensed clinics as well as related services in NYS. These facilities, licensed under Article 28 of the Public Health Law to provide health care services, are frequently targeted by the Division's programs in RFPs as eligible awardees for contracts. Since the licensing and monitoring process carried out on an ongoing basis ensures that facilities obtain approval for provision of specific services, these facilities have a demonstrable range of services and quality of care level appropriate for many of the services and programs provided by the Division of Family Health. Further, the Bureau of Women's Health (BWH), in particular, within DFH, collaborates closely with OHSM in designation of hospitals for level of perinatal care, and in fact drafted the revisions of hospital regulations on which these designations are based. BWH and DFH are consulted by OHSM whenever hospital or clinic closures are threatened, to ensure that sufficient service providers are available to meet the obstetric and perinatal needs within the region

While there has been a long and very close partnership between the state's Medicaid programs and the state's maternal and child health programs, in 2008 the relationship became even stronger. The Office of Medicaid Management and the state's Office of Managed Care were combined to form the Office of Health Insurance Programs (OHIP), consolidating and streamlining the administration of these two offices. This has further facilitated collaboration between DFH and Medicaid. While DFH has had responsibility for outreach, provider recruitment and enrollment, provider approval, and quality improvement efforts for some of the state's premier Medicaid programs, such as the Prenatal Care Assistance Program and the Family Planning Extension Program since their inception, there is now increased emphasis on coordination of available services and expanding availability of these programs to a wider audience of Medicaid providers. DFH is working closely with OHIP to ensure that guidelines for high quality care are in place, in addition to helping inform providers of changes, streamline application processes, and generally provide a systems level approach to implementation.

A further characteristic of the state's Title V program is maintenance of local level contacts through the network of regional offices around the state. These offices all have family health directors, who keep Ms. McTague informed on an ongoing basis, via monthly meetings or more frequent contact, as required, of local level issues that might potentially influence services or health care status of Title V populations in any area of NYS.//2010//

As previously described, New York has undergone extensive priority-setting processes /2010/ and reevaluates priorities on an ongoing basis, changing priorities as data indicates a shift in health status of the population or new risks//2010//. The ten priorities that follow, and the specific performance measures related to each, stem specifically from areas of unmet need in the State.

The following are New York's maternal and child health services priority needs:

- To improve access to high-quality health services for all New Yorkers, with a special emphasis on prenatal care and primary and which includes attention to mental health issues and which serves those with special health care needs;
- To improve oral health, particularly for pregnant women, mothers and children, and among those with low income;
- To prevent and reduce the incidence of overweight for infants, children and adolescents;
- To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality;
- To improve diagnosis and appropriate treatment of asthma in the maternal and child

health population;
- To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women;
- To reduce unintended and adolescent pregnancies;
- To ensure the availability of comprehensive genetics services statewide, including follow-up on positive newborn screening tests, specialty services and genetic counseling for affected families /2009/ and for individuals and families at risk for genetic disease//2009//;
- To reduce the rate of violence across all age groups, including inflicted and self-inflicted injuries and suicides in 15- to 19-year-olds; and
- To improve parent and consumer participation in the Children with Special Health Care Needs Program, as evidenced by parent scores.

Improving and sustaining access to high-quality, continuous primary health care and treatment services are critical to improving health outcomes for all New Yorkers and achieving our public health and maternal and child health priorities. The hallmarks of success will be prevention, early intervention, and continuity of care through establishing and maintaining a "medical home" and a "dental home" for every New Yorker. Success will also depend on the actual delivery of appropriate, high-quality, comprehensive health services to people in need, and requires practitioners to be knowledgeable about and practice good preventive and therapeutic medicine. Title V works closely with the /2008/new Office of Health Insurance Programs//2008// to ensure continuity and coordination with public insurance programs and to ensure that any gaps in care are recognized and acted upon.

Please see Section II. Needs Assessment for a more complete description of New York State's geography, population, resources /2010/, health care and health status indicators //2010//, and health care delivery environment.

Measuring success will rely on accurate assessment of progress. Factors that play a role are /2010/summarized in brief below//2010//:

Diversity: Recapping the Needs Assessment, New York's diverse geography can also present interesting public health challenges. The state has both urban centers and sparsely populated rural areas. New York's beautiful natural resources attract tourists year-round to our historic and recreational attractions, which can produce variable seasonal demand on health services, especially in the areas of emergency medical services and public health. Seasonal variations in weather also affect how and when New Yorkers seek services. Heavy "lake effect" snowstorms can delay access to care and make travel dangerous, especially in the northern and eastern areas of the State.

Our population is even more diverse than our geography, more diverse than the nation as a whole, with New York City being the most diverse area. On the 2000 Census, 67.9% of New York residents reported they were White alone, 15.9% reported they are Black or African American alone, 5.5% reported that they were Asian alone, 0.4% reported they were American Indian or Alaskan Native, and 7.1% reported being some other race. 15.1% of the State's total respondents reported that they were Hispanic. Over 3.1% of New Yorkers identified themselves as being of more than one race. Native Americans were severely undercounted.

New York is also home to many new New Yorkers and new Americans. New York ranks higher than the country as a whole for non-Hispanic Black residents, Hispanic residents, and non-citizen residents. We are second among states for non-citizen immigrants. /2008/According to the American Community Survey conducted by the US Census Bureau,

New York ranks second of all states in foreign born, with 21.4% (±0.2%) of its total population or ~4,120,500 people being foreign born in 2005.//2008// /2009/ In 2006, 21.6% of the state's total population, or 4,178,962, were estimated as being foreign born, as slight increase over 2005.//2009// Almost 90% of New York's non-citizen immigrants live in New York City. Of the estimated 17,144,924 New Yorkers over age 5, an estimated 12,440,299 speak only English at home, while 4,704,625 speak a language other than English. 2,092,875 speak English less than "very well." About 2,360,792 New Yorkers speak Spanish at home. /2009/ According to the 2006 American Community Survey, these numbers increased in 2006. With an estimated 18,085,173 New Yorkers over age 5, it was estimated that 12,875,365 speak only English at home, while 5,209,808 speak a language other than English. Of those speaking a language other than English at home, 2,372,334 speak English less than "very well." About 2,574,121 New Yorkers speak Spanish at home.//2009//

Poverty and Health Care: Poverty is major factor for affordability and access to health care services. /2008/In 2005, 14.5 percent of the population lived below the federal poverty level (FPL). This is higher than the national average of 12.6 percent. About 18.6 percent of New Yorkers had incomes below 125% of poverty. According to the 2005 American Community survey, in New York State, 26 percent of persons with less than a high school education live below poverty. Among females without a high school education the percent below poverty is 31 percent. In New York State, 19.1% of women giving birth in 2005 had less than a high school education. Among African American and Hispanic women, the percentage is even higher (24.0% and 40.2%, respectively). According to the 2006 Current Population Survey, during 2005, 43.6 percent of the people in female-headed households with children lived below poverty in New York State.//2008//

/2008/ Lack of Insurance: About 7.7 percent of children between birth and 17 years of age were uninsured in NYS in 2005. According to the New York State Behavioral Risk Surveillance Survey, 10.6% of those surveyed in 2006 did not see a doctor when they needed to because of cost.//2008// To address the health care needs of the uninsured, New York has a comprehensive Medicaid package, Child Health Plus, Family Health Plus and Healthy New York.

Pregnancy and Birth Rates: /2008/ In 2005, there were 3,474 fewer births than occurred in 2004. Adolescent birth and pregnancy rates continued declining and are below national averages. /2009/There were 249,206 births in New York State in 2006. Of these, 119,430 were to residents of NYC and the remaining 129,776 were to Upstate NY residents. This is 3,804 more births than occurred in 2005. The numbers of births increased in both New York City and Upstate New York.//2009// /2008/Birth rates among Black and Hispanic teens were significantly higher than among White teens. During 2005, there were 34.4 births for every 1,000 Hispanic teen girls aged 15-17 in New York State. This is more than 3 times the rate for White teens (11.1 per 1,000) in this age group. Among Black 15-17 year olds the birth rate, at 22.2 per 1,000, was exactly double the rate for white teens.//2008// /2009/ These rates were essentially unchanged in 2006.//2009// The rate of unintended pregnancy among PRAMS respondents /2008/ declined slightly to 32.7%//2008 during this same time period. Those most at risk for unintended pregnancy were /2008/ women under the age of 20 (63.4%); women who were not married (54.5%); African American women (55.7); women on Medicaid (48.1%); and women with less than a high school education (48.9%).//2008// /2009/ In 2006, about one third of new mothers responding to the PRAMS survey indicated that their pregnancy was unwanted or mistimed (33.4%), which was slightly higher than the 2005 rate.//2009//

Prenatal Care: The percentage of women entering prenatal care in the first trimester /2008/ continued to show//2008// improvement. /2008/ In 2005, the rate was

75.4%.//2008// /2009/ The rate fell slightly in 2006, to 74.6%.//2009// During that same time period, adequacy and content of prenatal care improved among all regions and among all racial and ethnic groups. /2009/ In 2006, however, there was a slight decrease in adequacy of prenatal care in NYS outside of NYC, from 73.2 to 71.8 percent.//2009//

Other positive trends in the PRAMS data were noted:
- Fewer mothers reported drinking alcohol while pregnant.
- Fewer mothers reported smoking prior to, during, and after pregnancy.
- Fewer mothers exposed their babies to second-hand smoke.
- Fewer mothers experienced physical abuse during pregnancy.
- More mothers initiated breastfeeding.
- /2008/ Fewer mothers reported that their pregnancy was unwanted or mistimed.//2008/
- More mothers had knowledge of the positive effects of folic acid on birth defects.

/2009/ The 2006 PRAMS data indicated a slight rise in the percentage of mothers reporting drinking during the last 3 months of pregnancy, 7.6% vs. 7.0% in 2005, but in general, positive trends in behaviors reported by pregnant women continued.//2009//

/2009/In 2006, 95.7% of women presenting for delivery in New York State had received counseling and testing during pregnancy.//2009// Prenatal care enrollment increased among HIV+ women and more women presenting for delivery had received counseling and testing during pregnancy. The percent of HIV-exposed infants who received prenatal, intrapartal or neonatal ARV to reduce transmission also increased /2010/ from 63.8% in 1997 to 99% by 2003, and has remained at 99.6% since then. //2010// /2008/ Despite these efforts the number of HIV infected infants rose slightly in 2005 to 13 (up from 8 in 2004.).//2008// /2009/ In 2006, this number decreased to 10 (1.7% of the exposed infants) infants infected by mother-to-child transmission.//2009// /2010/In 2007, there were 8 infants infected by maternal-to-child HIV transmission statewide for a rate of 1.4%.//2010//

/2009/ In 2007, the New York State Department of Health widely distributed a "Health Alert: Steps to Further Reduce Mother-to-Child HIV Transmission in New York State" to all NYS birth facilities as well as to over 13,000 NYS physicians including obstetricians/ gynecologists and family practitioners. The Health Alert was also distributed to midwives, HIV specialists and designated AIDS Centers. The "Health Alert" contained recommendations for repeat HIV testing in the third trimester, identifying acute HIV infection during pregnancy, a one-hour turnaround time for rapid HIV test results in delivery settings, and assuring access to care and supportive services for HIV-positive pregnant and postpartum women.//2009//

Low and Very Low Birth Weight: Overall rates of low birth weight and very low birth weight have been relatively unchanged over ten or more years. The rate for singleton births has declined, indicating that the increase in multiple births seems to be responsible for the unchanged overall rates. Though disparities in low birth weight rates have shown some improvement over time, they still persist.

/2008/Preterm Births: The preterm birth rate in New York State increased 8% over the two years from 2003 until 2005. Rates in both New York City and the Rest of State have increased since 2003. /2009/ These rates continued to rise in 2006, reaching 12.5% for the state as a whole, an increase of 9.6% since 2003.//2009// The preterm birth rate in New York City has been consistently higher than rates in Rest of State during the past 10 years. The percentage of Black women delivering at less than 37 weeks gestation was higher than among White women. Hispanic women giving birth had a premature rate 17% higher than

the rate among White women but 20% lower than the rate for Black women. These disparities between Black, White and Hispanic births have persisted over the past ten years. //2008// /2009/ Racial disparities decreased somewhat in 2006, with the rate among Hispanic women only 9.4% above the rate for whites, and 19.1% below the rate for black women.//2009//
/2010/ In addition, since 1997, NYS is the only state in the nation to screen all newborns for HIV-1 antibodies, which is both a measure of newborn exposure to HIV and indicative of infection in the mother.//2010//

Maternal Mortality: Wide fluctuations in rates appear to be a result of the rarity of the occurrence and the zealousness of ascertainment. Rates are highest in New York City and among African American women. /2008/The overall rate declined markedly from 2004 to 2005, from 20.5 per 100,000 in 2004 to 14.7 per 100,000, which is about 4.5 times the Healthy People 2010 goal of 3.3 per 100,000. Racial and ethnic disparities persist. The 2005 Black maternal mortality rate was 38.8 (20 deaths), the Hispanic rate was 8.7 (5 deaths) and the White rate was 8.2 (13 deaths). The Black-to-White ratio was 4.7. //2008// /2009/ The rate again increased in 2006, to 19.3 deaths per 100,000 births, but this may have resulted from Department of Health efforts to address the rate in conjunction with the American College of Obstetricians and Gynecologists, through our Safe Motherhood project. Correct ascertainment and reporting of maternal deaths is a key component of this initiative.//2009//

Children: There were some very encouraging and some not-so-encouraging trends. /2008/

- In 2005, the percent of two- to four-year-olds participating in New York's WIC Program that were overweight was down 5% from 2004, but still a 28% increase since 1989. The percent of overweight children varies considerably by race and ethnicity. Hispanic children are almost twice as likely to be obese than Black or White children. /2009/ In 2006, 15.2% of the two- to four-year-olds participating in New York's WIC Program were overweight. This is down 9% from the 2003 high of 16.8%, but still a 16% increase since 1990. //2009//
- Breastfeeding initiation rates and breastfeeding at one month of age among PRAMS respondents increased. Rates are also up among the WIC population and among respondents to the National Immunization Survey.
- Data from the 2005 YRBS found that 10.5% of adolescents are overweight (BMI ≥ 95%). Adolescent males were more likely to be overweight than females and African American adolescents were more likely to be overweight than white adolescents. Among Hispanic males almost 20% were overweight in 2005. /2009/ The 2007 YRBS found 10.9% of adolescents were overweight, a slight increase over 2005 levels.//2009//
- On a NYSDOH third grade survey 54.1% had experienced dental caries. 33.1% had untreated caries, well above the *Healthy People 2010* target of 42% and 20%, respectively. Consistently, both caries experience and untreated caries were more prevalent in the low-income group.
- From 1995 to 2005, childhood asthma hospitalization rates declined 36% to 58 per 10,000. /2009/ During 2006, there was a small increase in the rate to 60.1 per 10,000. //2009// Otitis media hospitalizations declined dramatically in the same time period.
- 98.8% of infants born in the state were tested for hearing before discharge from the hospital.
- New York has surpassed the HP 2010 goal for immunization levels in two-year-olds. Vaccine-preventable disease rates are down.
- Rates of gonorrhea have declined among teens, but rates for early syphilis increased slightly among NYC teen females. Chlamydia rates declined among males and females, but less dramatically among females. /2009/ Chlamydia rates for male teens increased

significantly in 2006, possibly because of increased emphasis on Chlamydia testing for sexually active teens.//2009//

- /2010/ Despite national increases, New York's teen pregnancy rate continues to decline. The rate of pregnancy for 15 to 19 year olds in 2007 has declined 39% since its peak in 1993. //2010//
- With regard to risk-taking behavior, the 2005 YRBS showed seat belt and bike helmet use increasing, fewer students using violence, and fewer students feeling sad or hopeless every day. New York has a lower percentage of sexually active teens than the country as a whole. More New York teens reported using condoms at last intercourse than teens in the rest of the country. However, more children reported being afraid for their safety at school.
- Infant mortality rates are declining. //2008//

Health Insurance: New York's public insurance programs include the Medicaid program, Child Health Plus and Family Health Plus. There are additional health insurance programs that assist small businesses and people who have lost health insurance with access to insurance products. Data from the National Survey of American Families shows New York to do better than the U.S. average for insuring the poor (13.5% uninsured vs. 15.9% in the U.S., according to adjusted Census figures).

Health Care Access: Health care access is most difficult for the uninsured, those with less education and those whose primary language is not English. Other barriers to access include high out-of pocket-expenses, lack of public transportation and a maldistribution of health care professionals, especially dentist and specialists that are willing to accept Medicaid as payment.

B. Agency Capacity

/2009/ Summary: //2009// The New York State Department of Health, as the Title V agency in New York State, plays a major role in assuring quality and access to essential maternal and child health services. Title V, the Maternal and Child Health Services Block Grant, provides the basic framework for provision of all maternal and child health services by the New York State Department of Health. /2009/ This section of the application describes the roles and responsibilities of the Department of Health, the types of monitoring methods utilized to ensure that problems are quickly identified and addressed, and the methods used to ensure that new health hazards are quickly identified and appropriate interventions deployed. This section also reflects our approach to ensuring health by describing how we work to educate the community, since an educated consumer is one who assumes a strong role in his/her own health, and how we mobilize community organizations and others to partner with us in implementing health initiatives. This section also describes the array of statutory and regulatory tools available to the state to inform providers and consumers of current standards of care, and compel compliance as needed to ensure the health of our citizens. Another role described in this section is how the state promotes linking of women, infants and children to high quality health and human services – a multifaceted effort to ensure not only access to services, especially for women and children who face special challenges, but to improve the quality of services on an ongoing basis. This effort presupposes that monitoring of the quality, availability, accessibility (financial, linguistic, and cultural), and quality of services is conducted on an ongoing basis. The full scope of this massive state effort is difficult to adequately convey, since the process for funding services, which are largely conducted by external contractors, involves an extensive system of checks and balances to ensure that appropriate services are delivered to the most needy segments of the population, that funds are used exclusively for specified purposes, that only contractors fully informed about the needs of their target population and capable of

providing high quality services receive funding, that monitoring and reporting on progress are an integral part of the process, and that an ongoing, iterative process of program re-design is undertaken to ensure that modifications of activities, target populations, types of services delivered, etc., occur as needed to best improve the health and well being of our citizens. Part of this process is implementation of research and demonstrations to gain insights and develop innovative solutions for maternal and child health populations, and ensuring that a properly trained public health work force is maintained. Recognizing the role of cultural competency in service delivery settings, a separate subsection has been added to provide a macro view of Department efforts to improve the cultural competency of our staff and our providers statewide.//2009//

Please see a full description of agency capacity as it appears in the Needs Assessment.

Title V Roles and Responsibilities: The Title V role of the New York State Department of Health includes:

- assessing and monitoring maternal and child health status to identify and address /2008/ problems and disparities in health outcomes;//2008
- diagnosing and investigating health problems and health hazards affecting women, infants, children and youth in New York State
- informing and educating the public and families in New York State about maternal and child health issues (and we encourage the public to educate and inform us, as well);
- mobilizing partnerships between policy makers, providers, families and the public to identify and solve maternal and child health issues in New York State, /2008/ especially to address disparities in health outcomes;//2008//
- providing leadership in priority-setting, planning and policy development to support county and community efforts to assure the health of women, infants, children, youth and their families;
- promoting and enforcing legal requirements that protect the health and safety of women, infants, children and youth in New York State and to ensure public accountability for their well being;
- linking women, their infants, children and youth to health and other human services and to assure access to comprehensive, high quality systems of care /2008/ and health equity//2008//;
- assuring the capacity and competency of the public health/maternal and child health workforce to effectively address maternal and child health needs within the State;
- evaluating the effectiveness, accessibility and quality of personal health and population-based maternal and child health services; and
- supporting research and demonstrations to gain insights and innovative solutions to maternal and child health-related problems.

  <u>Assessing and monitoring maternal and child health status to identify and address problems</u>: Please refer to the Needs Assessment portion of this document, which reflects our structures and capacity to gather, analyze and report data across a variety of areas, populations and providers.

NYSDOH is able to track problems and hazards specific to the maternal and child health population, including but not limited to:

- vital events (births, deaths, fetal losses, causes of death);
- vaccine-preventable and other diseases and conditions affecting the maternal and child health population (STDs, lead poisoning, dental caries, unintended pregnancies, injuries);
- perinatal conditions of the newborn and mother (low birth weight, very low birth weight)

- /2009/ care delivered to newborns in neonatal intensive care units statewide, via the NICU module of the Statewide Perinatal Data System; //2009//
- /2008/surveillance systems, like the Oral Health Surveillance System; //2008//
- sentinel events;
- service usage;
- knowledge, attitudes and behaviors of mothers and youth; and
- treatment experience of /2008/ pregnant women and //2008// at-risk infants and toddlers;
- /2010/ screening of all newborns for all DHHS/American College of Medical Genetics/March of Dimes-recommended conditions, HIV-1 and Krabbe disease//2010//.

  Likewise, NYSDOH and the Title V program are able to prepare, analyze and report information about the maternal and child health population to inform needs assessment, planning and policy development, including, but not limited to:

  - population demographics (age, race, ethnicity);
  - populations/areas at risk and health disparities;
  - socioeconomic conditions (poverty, employment, insurance coverage);
  - behavioral and other health risks (teen drinking, smoking, seat belt use, drug use /2009/ and similar data for pregnant women //2009//); and
  - health status (morbidity and mortality rates);
  - health services utilization (early trimester prenatal care, immunization coverage); and
  - public perception of health problems and needs (through interaction with the public that includes block grant public hearings and focus groups).

NYSDOH maintains an active public website at www.health.state.ny.us and has additional intranet sites for state and local health department use and for the use of health providers. Our public website gets well over 32,000,000 hits annually. The Community Health Data Set is more fully described in the Needs Assessment.

/2010/The Wadsworth Center, NYS's public health laboratory, also has an active public website at www.wadsworth.org which has links to all public health-related diagnostic and reference services such as newborn screening and response to disease threats; clinical and environmental laboratory quality assurance activities; and cutting-edge research in medical and environmental areas. //2010//

Diagnosing and investigating health problems and health hazards affecting women, infants, children and youth in New York State: In addition to its normal surveillance activities, Title V and the NYSDOH maintains the capacity for conducting and have a conducted a number of special studies involving such areas as communicable diseases, childhood lead poisoning, oral health, height/weight/BMI, maternal and infant mortality, substance abuse, and smoking.

Each municipal health department in New York is required to provide local community health assessments, which are available to Title V staff and which serve as a basis for the municipalities' public health service plans and can serve as a needs assessment for counties seeking additional funds to address MCH issues.

Informing and educating the public health and families in New York State about maternal and child health issues: Title V provides the Growing up Healthy Hotline and provides for development of printed and promotional materials, media campaigns and educational experiences. (A more thorough discussion of some of DOH's recent maternal and child

health related public education topics is included elsewhere in this application.) The NYSDOH website is a major source of information on health topics and provides numerous linkages to other, related sites.

Through public hearings, meetings, focus groups, libraries and web postings, we encourage the public to educate and inform the Department, as well. In this grant year, under the auspices of the Maternal and Child Health Services Block Grant Advisory Council, public hearings were again held in various locations across the State. /2008/ This year, Title V collaborated with NYMAC to complete focus groups on genetics issues.//2008// We strive to make all materials and events culturally-, linguistically-, and age- appropriate. Consumers are paid for their time, childcare and travel expenses to participate in the focus groups. We require our contractors to provide translation services, as appropriate, and to provide nutritious, culturally-appropriate snacks.

Mobilizing partnerships between policy makers, providers, families and the public to identify and solve maternal and child health issues in New York State: The Title V agency develops and provides materials and mechanisms for dissemination of information on maternal and child health status and services, needs, and gaps in addressing needs to policy makers, health delivery systems, consumer organizations and the general public. Collaborating agencies are listed in the Needs Assessment. Collaborative efforts /2009/, such as the work conducted with the state's Regional Perinatal Centers and Regional Perinatal Forums to improve the quality of prenatal and intrapartum care in New York State, //2009// lead to the betterment of the maternal and child health population and enables access to additional populations.

Providing leadership in priority-setting, planning and policy development to support county and community efforts to assure the health of women, infants, children, youth and their families: The Title V agency has developed and promoted an MCH agenda using Healthy People 2010 and /2008/our own collaboratively-developed state health plans as our framework.//2008// The NYSDOH also provides the infrastructure/communication structures for collaborative partnerships in the development of MCH needs assessments, policies, services and programs through:

- /2009/ targeting of resources to address identified problems, ensuring that requests for applications require providers to design programs that meet the specialized needs of the target population served by each provider, that providers prove the need for new services in the community prior to development of new services, that a monitoring component be designed and that regular reports justifying the appropriate use of funds be sent to the Department, and lastly, that the Department modify program requirements on an as-needed basis, depending on effectiveness of particular approaches and services and/or the changing needs of the population.//2009//
- providing routine communications (newsletters, website postings and links, technical assistance workshops, conferences, "Dear Administrator" letters, mass mailings, and, if the need arises, through a provision of in the Public Health Law called a "Commissioner's Call," which allows the State Commissioner of Health to summon the commissioner or public health director of each county to a meeting);
- convening advisory councils, task forces or workgroups composed of consumers, business, community organizations, elected officials and/or others to review health data and make recommendations;
- convening and staffing commissions and advisory councils for the oversight of maternal and child health services planning and recommending resource allocation; and
- providing funding and support for parent networks and coalitions.

It is the information gathered in performance of its essential roles and responsibilities that, taken together with knowledge of the existing trends and systems of care, form the strategic process that determines the priorities for Title V effort. /2008/ In 2007, the Title V and Preventive Health Services Advisory Councils held a joint meeting to discuss issues of mutual interest.//2008//

Promoting and enforcing legal requirements that protect the health and safety of women, infants, children and youth in New York State and to ensure public accountability for their well being: The Department works with our Office of Governmental Affairs and Division of Legal Affairs to help ensure consistency in legislative mandates, to resolve inconsistencies, to write regulations and ensure consistent policy across family and child-serving programs. Title V provides expertise in development of legislation and regulations. Title V requires contractors to adhere to all required regulations and contractual obligations and ensures compliance through program monitoring and audits. /2008/Internal Controls are tested on a routine basis.//2008// Contractors and health plans are required to regularly report on health services process and outcome measures.

To help protect the health and well being of our MCH population, New York State has a strong legislative base for:

- MCH-related governance and the organization and function of advisory bodies;
- MCH practice and facilities standards, including standards for all hospitals and freestanding diagnostic and treatment facilities, for levels of /2009/ not only routine but also //2009// high-risk perinatal care and for educational and practical preparation of health care providers;
- uniform data collection through vital records /2009/, the Statewide Perinatal Data System, //2009// and statewide registries;
- public health reporting of communicable diseases, births and deaths, child abuse and other adverse events;
- environmental protections, such as indoor smoking laws, firearms control, traffic safety, and regulations covering children's camps, temporary (farm worker) housing, use of pesticides and toxic chemicals in schools, swimming pools and bathing beaches; and
- access and quality assurance monitoring required by public insurance programs.

The Title V program in New York takes a role in development, promulgation, and regular review of statutes, regulations, standards and guidelines related to health services delivered and funded through the public and private sectors. For example, Title V worked with Medicaid to review and update a provider manual containing standards for health supervision under New York's EPSDT Program, the Child-Teen Health Program. Title V staff regularly interact in such matters with WIC, Title X, Title XIX, and Part C (IDEA). Title V staff have participated in certification, monitoring, onsite reviews and quality improvement activities of health plans and public health providers with respect to MCH services, standards and regulations. Title V staff have also been involved in review of care of children in foster care and detention services. /2008/ Title V staff are also involved with activities to improve Child Death Review.//2008// A listing of some of New York's statutes related to maternal and child health /2009/ formerly //2009// listed in Section D /2009/ are now shown below in accordance with Guidance instructions (previously in section IIID)://2009//

Statutory Authority: The New York State Public Health Law provides statutory authority for various maternal and child health programs, including establishment of health departments and health care facilities and agencies, qualifications of public health officials, newborn

screening, lead poisoning prevention, immunization, and health care financing.

Article 6 of the Public Health Law authorizes payment of State Aid to Localities for certain public health services, including maternal and child health services.

The New York Code, Rules and Regulations (NYCRR) interpret how Public Health Laws are to be implemented.

State Budget Bills delineate the use of State funds, including for public health and maternal and child health programs.

State Finance Law provides the requirements for management of State funds and federal funds coming through the state, and Article 7 of the Public Health Law relates to Grants In Aid.

State Education Law regulates the professions, including physicians, nurses, nurse practitioners, medical social workers, pharmacists, therapists and midwives.

Chapter 884 of the Laws of 1982 outlines the composition and responsibilities of the Maternal and Child Health Block Grant Advisory Council.

Statutory Authority for childhood lead poisoning prevention and intervention is found in Section 206 of the Public Health Law and Title X of Article 13, the Lead Poisoning Prevention Act. Regulations are contained in Sub-Part 67-1.

/2010/ Statutory Authority for the Adolescent Pregnancy Prevention and Services Act of 1984 was transferred from Social Service Law through an amendment of Article 25, Section 2515 of the Public Health Law.//2010//

Article 25 of the Public Health Law covers Maternal and Child Health, with Title I- General Provisions, Title II - Prenatal Care, Title III - Midwifery, Title IV - Institutions for Children, Title V - Children with Physical Disabilities, Title VI is expired, Title VII - Nutrition Outreach and Public Education.

The Healthy Heart Program is authorized by Article 27-B of the NYS Public Health Law. Article 27-C relates to the Birth Defects Institute, 27-D relates to Burn Care, and 27-E and F relate to HIV and AIDS.

Children's camps in New York are regulated under PHL Article 13-B.

/2009/ Emergency Medical Services for Children (EMSC) Program is authorized by Chapter 614 Article 30-C of NYS Public Health Law. EMSC Program works to expand and improve emergency medical services for children who need treatment for life threatening illnesses or injuries.//2009//

Section 2500(1) of the PHL authorizes the Commissioner to oversee care in hospitals, while section 2800 give these Department responsibility for development of state policy relative to hospitals. Both statutes authorize the Commissioner to establish standards and promote quality of maternal, child and infant health and for prevention of maternal, perinatal and infant mortality and low birth weight.

The Prenatal Care Assistance Program (PCAP) is authorized under PHL 2522. Section 85-40 in the NYCRR sets forth the regulatory parameters of the program. Comprehensive

Prenatal/ Perinatal Services Networks are authorized under the legislation authorizing the Prenatal Care Assistance Program, Public Health Law 2522, which includes a provision for outreach, public education and promotion of community awareness of the benefits of preconception health care and early and continued prenatal care.

The Children with Special Health Care Needs Program is authorized by Title V of the federal Social Security Act and New York State Public Health Law 2580.

Article 27-C relates to the Birth Defects Institute, 27-D relates to Burn Care, and 27-E and F relate to HIV and AIDS.

/2009/ Public Health Law 2500-a mandates newborn blood-spot screening. //2009//

/2009/Regulations for HIV screening of newborns through the Newborn Screening Program appear in 10, NYCRR, Subpart 69-1. These HIV-related regulations were last amended in 2003, requiring a 12-hour turnaround for test results when expedited testing is conducted per regulation in the delivery setting of a delivering mother or her newborn when the mother's HIV status is not documented on presentation for delivery.//2009//

Final regulations on universal newborn hearing screening appear in Subpart 69-8 of 10 NYCRR.

Abstinence Education is authorized by Public Health Law 104-193 and the federal Personal Responsibility and Work Opportunity Act (Welfare Reform). /2010/ New York's program was discontinued 9/30/07. //2010//

The American Indian Health Program is administered pursuant to Public Health Law SS 201(1)(s), under which the Department is required to "administer to the medical and health needs of the ambulant sick and needy Indians on reservations."

Comprehensive Prenatal/Perinatal Services Networks are authorized under the legislation authorizing the Prenatal Care Assistance Program, Public Health Law 2522, which includes a provision for outreach, public education and promotion of community awareness of the benefits of preconception health care and early and continued prenatal care.

The statewide Early Intervention Program was established in Public Health Law Title II-A, Article 25 in 1992.

Family Planning is authorized under federal Title X and 10 NYCRR 42CFR, 43CFR, 45CFR, BCHS Guidelines.

Chapter 198 /2009/ of the Laws of 1978 //2009//authorizes the Health and Education Departments to certify school-based health centers and school-based dental centers.

/2009/ Chapter 170 of the Laws of 1994 authorizes the Commissioner of Health to enter into contracts for, issue operating certificates and provide funds for school-based health services operated by clinics licensed under Public Health Law Article 28 and other providers.//2009//

PHL 2500-B directs the Commissioner to provide professional and public education on Sudden Infant Death Syndrome, as well as counseling to the families affected by SIDS.

/2009/ The Childhood Obesity Prevention Program is established under Section 2599 of Public Health Law, Title VIII, for the purpose of preventing and reducing the incidence and prevalence of obesity in children and adolescents, especially among populations with high rates of obesity and obesity-related health complications including, but not limited to, diabetes, heart disease, cancer, osteoarthritis, asthma and other conditions.

Sections 903 and 904 of state education law provide for a system to assess childhood obesity throughout New York State except in the five boroughs of New York City. It places the responsibility for screening children and adolescents for weight-related disorders with the students' healthcare providers using Body Mass Index (BMI)-for-age percentiles as the standard for screening, required as of the 2008-2009 academic year. //2009//

New York has laws requiring:

- /2010/ Provisions for physical activity, sugar-sweetened beverages, and TV viewing in child day care centers in New York City //2010//
- Helmets while riding bikes, scooters, /2009/ in-line skates,//2009// and motorcycles;
- Seatbelt use and passenger restraint /2009/ primary law //2009//;
- 3-tiered graduated drivers license;
- Child death review by a panel that includes citizen reviewers;
- Provision of safe havens for abandoned infants;
- School district nutrition advisory committees;
- Universal newborn genetic, /2009/ congenital,//2009//HIV and hearing screening and follow-up;
- Restriction of use of vaccines containing thimerosol;
- Insurance coverage of child immunizations and food for special dietary usage;
- Free or reduced price lunch programs to provide food for special diets;
- Mandated reporters to report suspected methamphetamine labs; and
- A ban on purchase or use of elemental mercury in primary and secondary schools. In addition, NYSDOH recommends school inventories include location of any mercury containing products and, if found, that they be given highest priority for removal.

  Pending legislation would give the Commissioner authority to train civilians in health care in the case of emergency. Also pending is a law to require all registered professional nurses practicing in New York who are educated at the diploma or associates degree level to obtain a baccalaureate in nursing within ten years of initial licensure.

  Laws relating to public health are described on the Department's public website, www.health.state.ny.us/nysdoh/phforum/phforum.htm and all New York State laws and regulations are available on the world wide web at this address: http://unix2.nysed.gov/ils/topics/laws.htm. /2008/Staff are able to link to the Office of Governmental Affairs internal website to track how health-related bills are progressing. //2008//

All necessary assurances and certifications are kept on file in the office of the Title V director and can also be found on the Department's website; www.health.state.ny.us/nysdoh/grants/main.htm

Linking women, their infants, children and youth to health and other human services and to assure access to comprehensive, quality systems of care: Title V and the NYSDOH provide a range of outreach interventions including street-level outreach and home visiting in targeted efforts to reach MCH populations that can be hard to find, hard to keep engaged and/or hard to keep in services because of their unique life circumstances (homeless women

who move frequently, geographically isolated women and families, drug abusing women, and those of different languages and cultures).

DOH provides culturally and linguistically appropriate staff, resources, materials and communications, either directly or through our contractors. The availability and use of toll-free telephone information and referral lines, resource directories, public advertising and enrollment assistance greatly assists in this effort. Please see the description of the Growing Up Healthy Hotline and other health hotlines and the use of the AT&T Language Line in the Needs Assessment. /2009/ The Bureaus of Injury Prevention, Chronic Disease Services and Health Risk Reduction provide statewide cultural competency training annually to assist local contractors and other professionals. //2009//

Title V monitors public response to health plans, facilities and public provider enrollment practices with respect to consumer understanding of required forms and procedures, orientation of new enrollees, and ease of access to care, and has provided assistance with identifying at-risk, or hard-to-reach individuals and in using effective methods to reach them.

Title V also provides, arranges or administers women's, children's and adolescent health services, and specialty services for children with special health care needs. We provide, generally through contractual services, those gap-filling services not generally available through health plans or mainstream benefits packages, such as school-based primary care and dental services, school-based mental health services, care coordination, public health nursing or social work, community health worker services and dental rehabilitation services. We have universal screening programs for genetic/metabolic disorders, hearing impairment, and perinatal HIV. Statute requires health care providers to screen children for childhood lead poisoning at ages one and two.

Assuring the capacity and competency of the public health/maternal and child health workforce to effectively address maternal and child health needs within the State: NYSDOH provides the infrastructure and technical capacity for efforts to ensure the competency of the public health/maternal and child health workforce training efforts.

- Title V staff serve as faculty and preceptors to the University at Albany's School of Public Health (SPH), in a unique arrangement where NYSDOH, an active State Health Department, provides the learning laboratory for SPH students.
- Title V provides paid internships and graduate assistantships to graduate students in public health to work on various research and planning projects related to Maternal and Child Health.
- Title V and other NYSDOH staff serve on the University at Albany School of Public Health's Continuing Education and Public Health Leadership Institute Advisory Councils.
- NYSDOH sponsors both a Preventive Medicine Residency Program for physicians and a Dental Public Health Residency Program for dentists, /2010/ training public health physicians and dentists for leadership roles in national, state, or local government.//2010//
- Title V sponsors regular satellite broadcasts on current issues in public health and maternal and child health.
- /2010/Title V staff serve on the NYSDOH's Institutional Review Board to assure that research conducted by the department protects the rights and benefits the interests of the maternal and child population.//2010/
- Title V sponsored Healthy Children New York, an effort that educated public health nurses and public health educators to provide consultation to child-serving agencies, such as child care providers. Staff also participate in efforts with the Office of Children

and Family Services to educate child care providers in health and safety issues through their satellite broadcast system.
- Title V and NYSDOH staff work with their community partners to educate the public and providers in their area on important issues, in areas such as asthma and women's health.
- Title V staff provide workshops on community health assessment, use of data, and best practices to improve services to the maternal and child health population.
- NYSDOH recently sponsored a one-day seminar for local public health directors and county attorneys on Public Health Emergency Law, utilizing a curriculum developed by the Centers for Disease Control and Prevention
- /2008/Title V staff participated on a national ASTHO taskforce on public health workforce enumeration.//2008//
- NYSDOH commissions studies of health workforce issues.
- /2008/ Cultural competency training and a number of other courses are available to all Title V staff linked from our intranet.//2008//
- /2009/ NYSDOH Division of Chronic Disease Prevention and Adult Health conducts Cultural Competency training for Health Care Professionals in NYS.
- NYSDOH Bureau of Emergency Medical Services sponsors a statewide EMS Conference. This annual Conference draws more than 2000 pre-hospital care providers (EMTs, Paramedics) and emergency department clinicians. Conference workshops include topics on pediatrics including caring for children with special health care needs.//2009//

Evaluating the effectiveness, accessibility and quality of personal health and population-based maternal and child health services: The Department regularly reviews program effectiveness and uses information to formulate responsive policies, standards and programs. DOH has the capacity to develop surveys and profiles of health status, health care access, and health care availability (types of service, provider distribution, hours of service, etc.), as well as profiles of consumer and provider knowledge, attitudes and behaviors. Programs regularly identify and report on barriers to care and collect and analyze information on community and constituent perceptions of needs within their communities. /2009/ Programs are routinely adjusted, sometimes on an annual basis via work plan requirements in contracts, to accommodate changes in populations, needs, or to reflect promising practices or eliminate activities with little demonstrated effectiveness. The contract mechanism, which is used to implement the majority of programs in New York State, provides a convenient mechanism to make timely adjustments on an as-needed basis. //2009//

Title V supports a number of gap-filling direct services programs, such as the School Health Program, Preventative Dental Programs, Family Planning and the Migrant and Seasonal Farmworker Health Program. All funded programs are regularly reviewed for quality by DOH staff.

Supporting research and demonstrations to gain insights and innovative solutions to maternal and child health-related problems: Current examples of the research to gain insights and innovative solutions are the /2009/ maternal mortality surveillance (Healthy Motherhood) initiative, which reviews maternal deaths throughout the state, and makes recommendations that are translated into recommendations for changes in practice, //2009// oral health surveillance initiatives (third grade surveys and Head Start surveys), the Dental Case Management pilots and SSDI consumer focus groups. Title V also funds 14 or more graduate assistantships per semester /2009/ through the MCH Graduate Assistant Program //2009//, allowing graduate students in public health to complete investigations into current research issues in maternal and child health.

NYSDOH also has an active Institutional Review Board that sponsors researcher training and reviews all requests for vital records data, health department-related research, and registry data. Title V staff serve on this important agency review board.

The Title V agency continues to play a major role in assuring the quality and access to essential maternal and child health services in New York State. The Title V programs have worked to support the expansion of health care programs that enable women, infants and children to receive high-quality, comprehensive, appropriate services, to assure that essential maternal and child health services are strengthened by this transition, and to ensure that the public health safety net effectively and appropriately protects vulnerable populations. We do so in the context of careful, coordinated department-wide and statewide strategic planning, collaboration with other State agencies and private organizations, and State support for local communities. Our goal is to eliminate all health disparities. A list of major program objectives appears in the appendix of the application.

/2009/ Providing culturally competent approaches to provision of service delivery: The Department uses a variety approaches to promote cultural competency. As indicated in the Health Disparities section, all programs developed by the Bureaus and Divisions within the Center for Community of Health work with the communities they serve to assure that their programs meet community needs. The following processes help to ensure ongoing improvements in cultural competency:

- The Request of Applications (RFAs) process used to select contractors requires applicants to demonstrate competence in serving the target populations including linguistic and cultural competency.
- The Department provides programs with health risk data, enabling programs to tailor their programs to the community. /2010/ Data are provided by major race/ethnicity categories, when available, and at the lowest feasible geographic unit, e.g., zip code.//2010//
- Programs use community-based organizations with diverse staff, representative of the racial and ethic backgrounds of the communities.
- Programs that serve non-English speaking populations must have staff to deliver services who are fluent in the predominant foreign languages spoken in the community and/or provide access to a telephone language line.
- Written and outreach materials are translated, adapted and/or provided in alternate formats based on the needs and preferences of the population served.
- Programs actively engage the community on an ongoing basis. The School-Based Health Center (SBHC) program, for example, has a community advisory council that assures that the views of the community members are reflected in the SBHC polices priorities and plans. The Act for Youth program partners with the communities and the youth they serve to develop programs.
- Program staff receive cross-cultural competency training. The Department encouraged or sponsored the following activities:
- Family Planning providers developed and implemented cultural competency training for all contractors around the state, utilizing a curriculum developed by Family Planning Advocates in conjunction with Cicatelli Associates.
- In the perinatal arena, the Department's the Office of Minority Health developed a training curriculum entitled "Cross Cultural Communication" for Bureau of Women's Health contractors including Family Planning, Rape Crisis, Community Health Worker and Comprehensive Prenatal-Perinatal Services Networks programs. The workshops were designed to strengthen participants' capacity to work across cultures and in diverse communities; consider the steps necessary to establish and foster positive relationships; make the connection between communication and culture; and apply cultural competency models.

/2010/ In 2008, four three-hour workshops were conducted in various regions of the state to ensure the ability of all contractors to participate. Workshops in Nassau County, the cities of Albany and Syracuse, and the borough of Manhattan were at capacity with over 100 maternal and child health professionals in attendance. In general, feedback on the workshops was positive. In response to participants' requests, full-day workshops are planned for 2009. //2010//

In June of 2008, Bureau of Women's Health Regional Perinatal Center contractor, Albany Medical Center hosted training entitled "Transcultural Education: A Journey to Cultural Proficiency," The training included didactic discussion and group activities and reviewed perinatal conditions in which disparities in heath outcomes are due to race, ethnicity or culture. The training was designed to help practitioners become more aware of their own cultural values, beliefs and practices and how this affects interaction with others. The training was open to nurses, physicians and others who interact with families during pregnancy and childbirth. The training is a program of the National Perinatal Association and was developed with the interest of reducing disparities in perinatal health outcomes. This training has also been used by the Bureau's Comprehensive Prenatal-Perinatal Services Networks contractors.

Recognizing that State and local Department of Health staff also need to improve their cultural competency, the Department's Office of Minority Health offers training and a cross-cultural communication toolkit that is available to the government staff responsible for RFP development, program design, monitoring of activities, and program evaluation. This training and toolkit enables participants to make connections between communication and culture; enhances awareness, knowledge and application of cultural competency models; addresses techniques and standards; and addresses cross-cultural communication strategies. This training also increases awareness about the impact of health disparities on racial and ethnic populations. As mentioned earlier in the document, staff have used other training venues such as the New York–New Jersey Public Health Training Centers. /2010/ In 2008, a statewide workshop was planned (held in early 2009) on eliminating health disparities. The workshop was targeted to senior public health program managers and administrators, and included a wide range of minority leaders from around the state. The goal of the workshop was to reenergize staff to take a fresh look at the existence of health disparities, and to rethink program design and allocation of resources to better address these disparities. The results of the conference will be more fully reported in the 2011 application.//2010//

It is important to note the role played by the Office of Minority Health (OMH) and the Minority Health Council (located within the Center for Community Health). OMH and the Council provide leadership, expertise and technical assistance for all New York State Department of Health programs. Created by an amendment to the public health law in 1992, the Office of Minority Health's mission is to promote, and serve as the department's focal point for, minority health matters. The Office accomplishes this mission by working with departmental programs, other federal, state and local government agencies, and community organizations. The Office's responsibilities include minority clinical training and curriculum improvement as well as other functions (community strategic planning, improved health care delivery systems/networks in minority areas; impact reviews of programs, regulations, and health care reimbursement policies on minority health services, delivery and access, etc).

- Further, the Department recognizes that healthy communities are communities that honor differences, consider all community members as assets and celebrate diversity. The Department is committed to addressing disparities in health care and promoting strategies to resolve them. The Health and Human Services for Lesbian, Gay, Bisexual and Transgender Individuals and their Support Systems Initiative focuses on addressing disparities through building a wider, more sensitive and appropriate system to promote health and wellness for lesbian, gay, bisexual and transgender (LGBT) individuals, their families and support systems. Activities center on development of community-based initiatives that present a variety of opportunities to enhance the health and human service system that LGBT individuals encounter in their communities.//2009//

C. Organizational Structure

/2009/ Summary: As previously stated, the organizational structure of the Department was modified in early 2008 to put even further emphasis on preventive and community health, and this will be discussed in greater detail in the 2008 report. The state continues to maintain a significant public health infrastructure, including both Bureaus and Programs devoted exclusively to maternal and child health, and a significant array of other programs that address these populations for specific health issues.

As previously stated in the Needs Assessment, the responsibility for New York's Title V Program is located within the New York State Department of Health, Center for Community Health, Division of Family Health, which is "responsible for the administration (or supervision of the administration) of programs carried out by Title V." [Section 509(b)]

/2008/The New York State Department of Health is an executive agency, with Commissioner Richard Daines, MD, reporting /2009/ previously //2009// to Governor Eliot Spitzer /2009/ and now to Governor David Paterson, //2009// through Secretary for Health Dennis Whalen, our former Executive Deputy Commissioner.//2008//

Maternal and child health programs are located throughout the Department, but are mostly located in the Center for Community Health and the Division of Family Health, where administrative oversight for the Block Grant is vested. /2009/ As will be described in more detail in the 2008 report, as appropriate, there was a significant change in organizational structure of the Department in early 2008, with re-creation of the Office of Public Health, which oversees the vast majority of programs and initiatives reported in this document. Dr. Guthrie Birkhead was appointed, at the Deputy Commissioner level, to head the Office of Public Health, and Ellen Anderson was appointed to fill his former role as Director of the Center for Community Health. //2009//

/2010/ The re-creation of the Office of Public Health expanded Dr. Birkhead’s area of responsibility to include not only the AIDS Institute and the Center for Community Health, as previously, but also the Wadsworth Center for Laboratories and Research, and the Center for Environmental Health. The Wadsworth Center is New York's public health laboratory, and also has responsibility for issuance of operating licenses to clinical laboratories, environmental testing laboratories and human tissue banks for transplantation and research in the state. Wadsworth Center scientists diagnose diseases of public health importance, develop rapid, molecular-based tests for detecting pathogens, including biothreat agents, and perform complex, reference-level tests not readily available elsewhere. They also determine the presence and concentration of environmental toxicants, and explore the relationship between exposure and disease. The Center's largest testing program screens all the state's newborns for 45 congenital disorders.

Within the Office of Public Health, the Public Health Information Group, under the direction of Michael Medvesky, is responsible for ongoing analysis of data for planning purposes, but also special projects. As part of his responsibilities, Mr. Medvesky undertakes an annual update of all data in the MCHBG application, and his staff, most notably Pamela Sheehan, assumes a major part of the responsibility for production of this document on an annual basis. While required only once every five years, the New York State Department of Health produces the Needs Assessment annually as a service to our many contractors and community based organizations, who rely on this document for timely access to maternal and child health data.

The Center for Environmental Health, another new area of responsibility under Dr. Birkhead, works to identify, understand, prevent and mitigate risks to human health from New York State's living and working environments. The various divisions within this Center include Environmental Health Assessment (occupational health, toxic substance assessment and environmental and occupational epidemiology), Environmental Health Protection (water supply, food protection and environmental health) and Environmental Health Investigations (such as radiation protection and other environmental exposures).

The AIDS Institute strives to: eliminate new HIV infections; ensure early diagnosis and ongoing access to quality care, support and treatment for all infected; provide support for those affected; and eradicate stigma, discrimination and disparities in health outcomes.

The Center for Community Health, which oversees the Division of Family Health, also has oversight of the Division of Chronic Disease Prevention and Adult Health (includes diabetes, cancer control, Alzheimer's disease, heart health and other chronic and disabling conditions), the Division of Epidemiology (maintains routine surveillance for approximately 50 communicable diseases, such as rabies and tuberculosis, as well as outbreaks such as the current H1N1 influenza), and the Division of Nutrition, which contains the WIC program as well as other supplemental food and nutrition education programs for women, infants, children and adults, particularly those with health issues. The Division of Nutrition, in particular, works closely with the Division of Family Health in implementation of programs that have a significant impact on the health of the MCH population.

Dr. Birkhead's position as Deputy Commissioner places him in an even better position to facilitate the ongoing collaborative relationships of the state's Title V program with the Office of Health Insurance Programs (OHIP), which is responsible for the state's Medicaid programs; and the Office of Health Systems Management (OHSM), which has oversight responsibility for all of the licensed health care facilities in the state, including hospitals and outpatient facilities. While cooperation with Medicaid and hospitals has always been close, there has been an even greater degree of mutual planning and collaboration since the re-creation of the Office of Public Health, including not only development of standards and regulations, but implementation of Medicaid programs using Title V program contacts to help promote changes and facilitate transition.//2010//

In addition to its responsibility for Title V, the Division of Family Health is responsible for family planning (Title X), early intervention (Part C/IDEA) services, the Prenatal Care Assistance Program, perinatal networks, designation of perinatal centers and CSHCN specialty centers, /2009/approval and oversight of school-based health centers, //2009// dental health, lead poisoning prevention, adolescent health, youth development, adolescent pregnancy prevention, universal newborn hearing screening and programs for children with special health care needs, /2009/ as well as the state's Growing Up Healthy Hotline, which provides referrals to these and other programs to all residents of New York State, 24/7, in English and Spanish, with other languages available, and with a TTY line for the hearing impaired. //2009//

The State Health Department's organizational chart is included with this submission in the Appendix. Organizational structure and staffing support our mission, vision and values.

Division of Family Health has four Bureaus:

- The Bureau of Child and Adolescent Health;

Title V and Title V-related programs within the Bureau of Child and Adolescent Health include: Childhood Lead Poisoning Prevention, Children with Special Health Care Needs (including the Family Specialist), the Physically Handicapped Children's Program, Youth Development, the School Health Program, the Coordinated School Health Initiative, ACT for Youth, Abstinence Education /2009/ (Abstinence Education was discontinued effective 9/30/07) //2009//, the Community-Based Adolescent Pregnancy Prevention Program, /2010/ the Adolescent Pregnancy Prevention and Services Program, //2010// Interim Housing for Lead Poisoned Children and their Families, the Regional Lead Poisoning Resource Centers, and the Gay, Lesbian, Bisexual and Transgendered Youth Initiative. /2010/ The Gay, Lesbian, Bisexual and Transgendered Youth Initiative was transferred to AIDS Institute 11/1/08. //2010// BCAH also has responsibility for the Early Childhood Comprehensive Services Initiative. /2010/Effective September 2009, the Council on Children and Family Services (CCF) will be the lead applicant for the Early Childhood Comprehensive Services (ECCS) grant. The Department will continue to be a collaborative partner with CCF in ECCS activities.//2010//

- The Bureau of Dental Health;

Title V and Title V-related programs within the Bureau of Dental Health include Dental Public Health Education, the Preventive Dentistry for High-Risk Underserved Children's Program/Dental Sealant Program, the Fluoride Supplementation Program, the Dental Public Health Residency Program, Oral Health Surveillance and Dental Research, the Dental Rehabilitation (Orthodontia) Program, the Statewide Oral Health Technical Assistance Center, and School-Based Dental Services.

- The Bureau of Early Intervention Services; and

The Bureau of Early Intervention Services administers the Part C/IDEA programs and the Universal Newborn Hearing Screening Program. /2010/ The Early Intervention Program is a statewide service delivery system for infants and toddlers (ages birth through age two years) with disabilities and their families. //2010// This Bureau is also responsible for publication of "Welcome to Parenthood," a publication received by all new mothers delivering in any of New York State's hospitals.

- The Bureau of Women's Health.

Title V and Title V-related programs within the Bureau of Women's Health include the Family Planning Program/Title X, /2009/ which includes the Infertility Prevention Program, as well as the Family Planning Benefit Program and the Family Planning Extension Program, //2009//the Growing Up Healthy Hotline, the Community Health Worker Program, /2009/ the Universal Prenatal and Postpartum Home Visiting Program, the //2009// Comprehensive Prenatal/Perinatal Services Networks, the Prenatal Care Assistance Program (PCAP) and the Medicaid Obstetrical and Maternal Services (MOMS) Program, the Lactation Institute, the Preventive Medicine Residency Program, the Coordinated Women's Health Program, the Osteoporosis Program and Advisory Committee, Maternal Mortality Review, /2009/ the Infertility Demonstration Program, //2009// and the Statewide Perinatal Data System, and responsibility for designation of all birthing hospitals for perinatal services level. BWH also works with the AIDS Institute on the Community Action for Prenatal Care (CAPC) Program. /2009/ The Preventive Medicine Residency Program now is co-managed by its longtime director, Dr. Mary Applegate, who is currently at the School of Public Health, with on-site management by Dr. Debra Blog, Medical Director of the Immunization Program.//2009// /2010/ Dr. Blog is now Director of the Bureau of Immunization.//2010//

The Division of Family Health directly administers the State Systems Development Initiative (SSDI), the American Indian Health Program, the Columbia Collaborative Public Health Education Project, the Asthma Collaborative, and Migrant and Seasonal Farmworker Health Services. Genetics Services and the Newborn Metabolic Screening /2009/ (blood spot) //2009// Program are administered by NYSDOH's Wadsworth Laboratories. The Congenital Malformations Registry is located within the Center for Environmental Health. A more complete description of the agency's capacity appears in the Needs Assessment.

/2010/ The Division of Family Health also has an Office of the Medical Director, which provides medical leadership for the Division of Family Health. Physicians in the office provide medical consultation and support to the various programs within the division. This support includes assistance in policy development and programmatic initiatives; participation in quality improvement initiatives and advice on emerging medical issues. The Office of the Medical Director directly administers the State Systems Development Initiative (SSDI), the American Indian Health Program, the Columbia Collaborative Public Health Education Project, the Asthma Collaborative, the Migrant and Seasonal Farmworker Health Services Program, and the Childhood Morbidity and Mortality Prevention Unit.//2010//

D. Other MCH Capacity

/2010/ Summary://2010//The Division of Family Health continues responsibility for coordinating MCH-related programs and directly managing many MCHSBG-funded initiatives. /2008/ Overall, there are currently 207 filled Title V-funded positions within the NYSDOH and an additional 613 non-Title V-funded positions performing Title V-related activities. Positions are located within the Department’s central, regional and district offices. Staff cover the full range of MCH activities, including child and adolescent health, women’s health, perinatal health, dental health, local health services, nutrition, child safety, injury control, laboratory operations, human genetics, congenital malformations, data and information systems infrastructure, health communications, managed care and facility surveillance. //2008//

/2009/ Barbara McTague is the Director of the Division of Family Health and Director of the New York State Title V Maternal and Child Health Services Program in the New York State Health Department. Ms. McTague provides policy and program direction and administrative oversight for the Division’s bureaus, including the Bureau of Women’s Health, the Bureau of Child and Adolescent Health, the Bureau of Dental Health, the Bureau of Early Intervention and the Migrant and Indian Health. Employed by the New York State Department of Health since 1987, she has managed several programs and Bureaus within the Department. While in the AIDS Institute, she developed, implemented and managed a number of innovative, new public health programs related to the prevention and treatment of HIV, including: the AIDS Drug Assistance Program, women’s HIV counseling, testing and supportive services, the Substance Abuse Initiative, which provides the full continuum of HIV services in substance abuse treatment settings, including the development of needle exchange programs. In 1996, Ms. McTague became the Director of the Department’s new Bureau of Women’s Health, where she managed the statewide family planning program, including development and implementation of Medicaid waiver programs to expand access to family planning services, as well as Department’s initiatives related to adolescent pregnancy prevention. In addition, she developed programs related to violence against women, including standards of hospital care for victims of sexual assault. Ms. McTague also spearheaded a perinatal regionalization initiative which resulted in significant changes in the perinatal health services arena, including the development of a statewide perinatal data system and significant improvement in the regionalized system of perinatal care. Ms.

McTague has also directed the Bureau of Early Intervention, the statewide service delivery system for toddlers with disabilities. During her tenure, Ms. McTague led a significant effort to clearly articulate program policies and goals and to standardize and improve the quality of program performance. Ms. McTague has made considerable contributions to improving the health of women, children and adolescents throughout New York State.

Wendy Shaw, R.N., was appointed as Associate Director of the Division of Family Health in August, 2007 following the retirement of Dennis Murphy. Wendy had been serving as the Director of the Bureau of Women's Health since the retirement of Barbara Brustman in January of 2007. She maintains her clinical skills as a labor and delivery nurse by actively practicing at a local area hospital. Wendy served as Director of the Perinatal Health Unit within the Bureau of Women's Health from 2000 through 2002, when she became Assistant Director of the Bureau of Women's Health. Her previous state experience in the Early Intervention program provides her with further valuable knowledge in her new role within the Division of Family Health.

Within the Director's office, Barbara A. Brustman, Ed.D., coordinates MCHSBG-grant application development and submission, grant management activities and special projects. Dr. Brustman received her doctorate from Columbia University and has worked for the Department of Health in various maternal and child health programs for over 27 years, all within the Division of Family Health. She served as Director of the Behavioral Science section of the Bureau of Dental Health, as Head of the Research and Development Section of the Planning, Development and Evaluation Unit, Director of Research and Evaluation of the Perinatal Health Unit, Director of Perinatal Health, and finally Director of the Bureau of Women's Health. She has served as Principal or Co-Principal Investigator on studies such as the PRAMS project, and recently the Perinatal Depression initiative. She was a longstanding member of the Center for Community Health's Survey Review Committee. Barbara has recently retired from full time service, and has undertaken MCHSBG application development on a part time basis.
/2010/ In mid-2008 Barbara resumed full time work as Director of the Bureau of Women's Health for a transition period of 6 months following Wendy Shaw's move to the Division of Family Health, and then assumed her new position as Director of the Division of Family Health's office of Research and Policy in January, 2009. She continues to coordinate submission of the MCHSBG application as part of her new duties.//2010//

In 2006, the Division of Family Health established an Office of the Medical Director to bring clinical expertise to the Division's broad array of programs. This office, under the direction of Marilyn Kacica, M.D., M.P.H., provides leadership and collaborates closely with the Bureaus in the Division. In April of 2006, Dr. Marilyn Kacica was appointed Medical Director of the Division of Family Health. Dr. Kacica is a graduate of St. Louis University and received her M. D. from the St. Louis University Medical School. She completed pediatric residency training at the Cardinal Glenon Children's Hospital, subspecialty training in pediatric infectious disease at the Children's Hospital of Cincinnati, and her preventive medicine residency at the New York State Department of Health. Her M.P.H. was awarded from the State University of New York at Albany, School of Public Health, where she is currently a Clinical Associate Professor of Epidemiology. She is board certified in Pediatrics. Prior to moving to the Division of Family Health, she served as the Director of the Healthcare Epidemiology Program in the Division of Epidemiology's Bureau of Communicable Disease Control. She is providing leadership on a myriad of clinical, epidemiological, data utilization and quality improvement issues within the Division. She is currently serving on the AMCHP Emergency Preparedness Committee as well as the Emerging Issues Committee and leads preparedness efforts being made on behalf of New York's maternal and child health population. Dr. Kacica serves as the Principal Investigator (PI) to the State Systems

Development Initiative. In addition Dr. Kacica is the Program Director for the New York State Department of Health's Child Health Integration Initiative /2010/ and is co-chair of the New York State eHealth Collaborative's Clinical Priorities Public Health Subcommittee. //2010//

Christopher Kus, M.D., M.P.H., serves as Associate Medical Director for the /2010/ Office of the Medical Director in the //2010// Division of Family Health, and is a pediatric consultant to the Division. He is a graduate of Michigan State University and the Wayne State University School of Medicine. He received an M.P.H. from University of North Carolina at Chapel Hill. He is a developmental pediatrician who has worked with the New Hampshire and Vermont Departments of Health prior to coming to New York. He has been with the New York State Department of Health for over ten years. Dr. Kus is Past President of the Association of Maternal Child Health Programs (AMCHP). He has chaired their committee on Service Delivery and Financing Systems and co-chaired the MCH-Medicaid Technical Advisory Group.

Patricia Waniewski, M.S., R.N. is the Asthma Coordinator for the New York State Department of Health (NYSDOH), providing leadership for coordinating, implementing and evaluating the New York State Asthma Plan. She received her Bachelor of Science degree in nursing from Villanova University and her Master of Science degree in Medical and Surgical Nursing and Health Systems Administration from Russell Sage College. She has been working in the health arena as a clinician, administrator and educator for the past 30 years, primarily in community and ambulatory health care services, and more recently in public health. She represents the NYSDOH Asthma Program on asthma related issues at the Centers for Disease Control and Prevention (CDC) and on other national and state workgroups**.** Prior to her public health role, she directed a regional Ambulatory Care Network where she designed, implemented and evaluated systems, programs and services in response to the diverse needs of urban, suburban and rural communities with a focus on quality improvement. From 1974 –1994, Pat served on active duty and in the Naval Reserve as a Nurse Corps Officer.

Marianne Heigel, R.N., is the Regional Asthma Coalition Coordinator within the Division of Family Health, New York State Department of Health. She provides contract management oversight and technical assistance to the eleven regional asthma coalitions. Her other public health experience with the Department includes monitoring public health outcomes in Child and Adolescent Health, Communicable Disease Control and a NIH Lead study with Environmental and Occupational Health. Prior to her career with the NYSDOH, she also worked in the hospital setting in upstate NY as an RN in the coronary care unit and operating room. She received her Associates Degree in nursing from Maria College. //2009//

Wendy Stoddart, R.N. serves as Program Director of the American Indian Health Program. Ms. Stoddart /2010/ has a BSN from the University of Vermont, and works with primary care contractors throughout the state and the Nations' clinic staff to ensure that the Native American nations across the state have access to primary health care services, preventive health education, pharmacy, eye care and home care services. Ms. Stoddart is a member of the workgroup charged with sheltering of special populations in an emergency event. Wendy Stoddart R.N. is a former Director of Patient Services for St. Lawrence County Public Health Department. She has over (almost) 30 years of experience planning and implementing preventive health programs. She is working with Dr. Marilyn Kacica on the NYS DOH preparedness document for pediatric and obstetrical populations. She also is a member of the NYS Sheltering task force working with special needs populations.

Thomas Carter, Ph.D., continues to coordinate the cross-systems, cross-agency partnerships for the Department, and serves as the coordinator of the NYS Youth Development Team, a state-level, public/private collaboration focused on improving health, education and other outcomes for youth. Dr. Carter also coordinates the MCH Graduate Assistant Program, which matches priority MCH projects with graduate students from the School of Public Health, University at Albany, and directs the Migrant and Seasonal Farmworker Health Program, which provides access to high quality, culturally and linguistically appropriate health and social support services to improve the health status of this important, vulnerable population.

The Child Morbidity and Mortality Prevention Program, formerly in the Bureau of Child and Adolescent Health, is now located within the Office of the Medical Director. James Raucci heads this project. Mr. Raucci also works with Ms. Stoddart on special needs sheltering issues and manages the Enhanced Services for Children and Youth program.

In 2007, New York's State Systems Development Initiative (SSDI) grant, coordinated by Ms. Cathy Tucci-Catalfamo was relocated to the Office of the Medical Director. The goal of the SSDI grant is to foster an infrastructure to improve data linkages among multiple data sources for child health information to assure program and policy development for maternal and child health.

Rachel de Long, M.D., M.P.H., has served as the Director of the Bureau of Child and Adolescent Health at the New York State Department of Health since 2005. Prior to this role she served as the Bureau's Medical Director from 2003 to 2004. Dr. de Long also serves on the faculty of the SUNY at Albany School of Public Health in the Department of Health Policy, Management, and Behavior. She earned a B.S. in Rural Sociology from Cornell University, M.D. from University of Wisconsin Medical School, and M.P.H. from SUNY Albany School of Public Health. She completed a medical internship in Family Practice at the Guthrie Clinic and residency training in Preventive Medicine at SUNY Albany/NYS Department of Health, and is Board Certified in Preventive Medicine and Public Health. As Bureau Director, she has overall responsibility for developing, implementing and evaluating policies and programs related to a range of child and adolescent health issues. She serves as Principal Investigator for several major child health related federal grants.

Elmer Green, DDS, MPH, has been the Director of the Bureau of Dental Health since 1985. Prior to that, he served as the Assistant Director of the Bureau of Dental Health from 1974-1984 and as a regional public health dentist in the Department of Health. Dr. Green earned his undergraduate and dental degrees from Howard University in Washington, D.C. and has a master's in public health from the University of Michigan. As the Bureau Director, Dr. Green oversees the Department's public health dental programs targeting high-risk underserved women and children, the supplemental fluoride program for preschool and school-aged children residing in non-fluoridated areas of the State, the Dental Rehabilitation Program for children with congenital or acquired physically-handicapping malocclusions, and the Preventive Dentistry Program for Deaf/Handicapped Children in conjunction with Bellevue Hospital in New York City. Other Bureau activities and programs include Dental Health Education, the Dental Public Health Residency Program, research and epidemiology, the oral health initiative, and targeted oral health service systems for women and children.

Brad Hutton received his Bachelor of Arts from Columbia University and his Master's of Public Health from the University at Albany School of Public Health, where he has also completed all requirements except the dissertation for a Ph.D. in epidemiology. He has been with the New York State Department of Health for fourteen years, serving as the Director of its Bureau of Early Intervention for the last one and a half years. As Director,

Brad oversees a team of 50 staff with responsibility for the administration of New York's Early Intervention Program which serves more than 70,000 infants and toddlers with disabilities or developmental delays each year. Previously, Brad directed the Department's Cancer Services Program for six years. He has served on several committees that advise the Centers for Disease Control and Prevention on cancer control and also served on the Institute of Medicine's Committee to Improve Mammography Quality due to his leadership role in identifying and improving the quality of mammography in New York. //2009//

/2010/ Projected changes to the state work force, including the state's Title V work force, may be occurring in the coming year. Ongoing budget shortfalls have led to reductions in contract amounts, and some layoffs of staff are projected. However, how this will affect the MCH work force, if at all, is not yet clear.//2010//

E. State Agency Coordination

/2010/ Summary://2010// The New York State Department of Health has formalized relationships with other state agencies, local public health agencies, federally-qualified health centers, tertiary care facilities, academic institutions and the non-profit voluntary sector, which all enhance the capacity of the Title V program to utilize state health status indicators to provide information on the State's residents, assist in directing and targeting public health measures, note trends and conditions of the population and function as evaluative measures.
/2010/ Since the Department contracts for almost all direct services with outside agencies, the many hundreds of contracts overseen result in not only relationships with providers under contract, but a host of other statewide and local community-based and other agencies, as well as professional organizations, who provide guidance, input, valuable critique, and invaluable support to the many projects undertaken in the MCH arena. The true value of the collaborative relationships and numerous partnerships the Department is privileged to have is immeasurable. We have attempted to briefly summarize some of these below, and mean no discredit to those not listed in this section, whose agencies may have already been addressed in one or more previous sections.//2010//

Agreements with Other State Agencies

State agencies are coordinated at the level of the Governor's cabinet. The Department of Health is a party to several written agreements or memoranda of understanding with other state agencies. These agreements serve to formalize collaborative activities between DOH and partner agencies.

- The State Education Department is not an executive agency in New York, but a constitutional body, not under the Governor nor the Legislature. The State Education Department (SED) is responsible for general supervision of all educational institutions in the State, for operating certain educational and cultural institutions, for certifying teachers, and for certifying or licensing practitioners of thirty-eight professions. The department's supervisory activities include chartering all schools, libraries and historical societies; developing and approving school curricula; accrediting colleges and university programs; allocating state and federal financial aid to schools; and providing coordinating vocational rehabilitation services.

- The State Education Department administers the Youth Risk Behavior Surveillance System with NYSDOH collaboration. NYSDOH also collaborates with the Education Department on issues such as placement of automated external defibrillators in schools,

administration of fluoride rinse programs, issues related to the healthcare/public health workforce, scope of practice issues, transition from early intervention to preschool programs, and approval of school-based primary care and dental care centers.

- The Department has a Memorandum of Understanding with the State Education Department regarding school health infrastructure and coordination. This memorandum supports the statewide implementation of comprehensive school health and wellness /2010/ through the Coordinated School Health Initiative. The Statewide Student Support Services Center provides professional development and technical assistance to school districts across the State to //2010//.

  Comprehensive School Health and Wellness Centers help school districts across the State create positive learning environments for their students. Schools that model and encourage students to engage in healthy behaviors create an atmosphere for academic success and individual growth.

- As the lead agency for the Early Intervention Program, the Department has letters of agreement with the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the State Education Department, and the Office of Alcohol and Substance Abuse Services related to the implementation of this program.

- The Office of Children and Family Services also administers the Adolescent Pregnancy Prevention and Services (APPS) Program, providing prenatal support and parenting education to high-risk teens in high need communities. /2009/ Effective in 2008, this program will be administered by the Department of Health in order to improve coordination of all adolescent pregnancy prevention efforts.//20009// /2010/ Effective 7/1/2008 the Adolescent Pregnancy Prevention and Services (APPS) Program transferred to the Department of Health from the Office of Children and Family Services. This program provides education, case management, prenatal support and parenting education to high-risk teens in high need communities. This change now allows for improved coordination of all adolescent pregnancy prevention efforts.//2010//

- DOH Title V staff work with the Office of Children and Family Services on health care of children in foster care and on issues related to the health and safety of infants and children in child care. The Early Intervention Program collaborated with OCFS in the development of a guidance document entitled, "Protocols for Children in Foster Care Who Participate in the Early Intervention Program." /2010/ OCFS staff participated in the development of "Health and Safety Standards for Early Intervention." //2010//

- /2008/Title V staff work with the Office of Children and Family Services on new parameters for child death review. (See page 33 of the Needs Assessment for a full explanation of recent changes.) //2008//

- The State Legislature allocated funding from the federal Temporary Assistance to Needy Families (TANF) Block Grant to the Department of Health for outreach and education activities to prevent unintended pregnancies and for School Health. /2010/ However, in 2006, the TANF funding allocated to the School-Based Health Centers Program was discontinued and replaced by state local assistance funds. //2010// The Department has entered into a Memorandum of Understanding with the Office of Temporary and Disability Assistance to provide for the transfer of these funds to the Department. This office is also the lead agency for the Teenage

Services Act (TASA) Program, providing services to pregnant and parenting teens on Public Assistance.

Other State Agency Collaborations

- The Touchstones Initiative, with the Council on Children and Families as the lead agency, began as a collaborative of 13 New York State agencies that fund programs for children and families. State agencies were challenged to agree on the benefits of funded services in clear, consistent, measurable terms. The Team established a Kids Wellbeing Indicator Clearinghouse (KWIC) on the Internet, the purpose of which is to make vital youth statistical information more timely, accessible and usable to communities.

- The New York State Youth Development Team is a partnership established in 1998 by more than two dozen public and private organizations. The partnership has lead efforts to develop and promote youth development strategies across health and human services systems in New York State. Agency team members include all major state agencies serving youth (health, mental health, education, public assistance, juvenile justice, substance abuse, /2009/ labor //2009//), as well as the New York State Nurses Association, Cornell University, the YMCA, the NYS Association of Youth Bureaus, the Mount Sinai Adolescent Health Center, the Association of Family Services Agencies, the NYS Center for School Safety, University of Buffalo, Families Together of NYS, University of Rochester, the Schuyler Center for Analysis and Advocacy, the Conference of Local Mental Hygiene Directors, and the NYS Counseling Association. The Team's vision is for families, schools and communities partnering to support the development of healthy, capable and caring youth. /2009/ Recent changes to the team's configuration include loss of Mount Sinai and University of Buffalo, and addition of the School of Public Health at the State University of New York at Albany, and Children for Children, NYS After School Network, and United Way of NYS. //2009//

  The Youth Development team, co-chaired by DOH and OCFS, has guided the creation of several cutting edge products, events and initiatives, including a resource notebook. /2008/ For more details, see the Partners for Children/Youth Development website at: http://www.nyspartnersforchildren.org/teen.htm//2008// /2009/ Additional products of the NYS Youth Development team include a Journal Supplement focused solely on youth development (i.e., Journal of Public Health Management and Practice, Nov. 2006). Web site access has been updated to the following sites: http://www.health.state.ny.us/community/youth/development/ and the Cornell University ACT for Youth website http://www.actforyouth.net/. //2009//

  /2010/ The NYS Youth Development team has positioned itself to be more aligned with the Governor's children/youth agenda (e.g., Governor's Children's Cabinet, Governor's Task Force on Juvenile Justice Reform, the Commissioners' Committee on Cross-System Services (e.g., the Children's Plan), the Governor's Summit on Student Engagement and Dropout Prevention and regional follow-up efforts). //2010//
- The Coordinated Children's Services Initiative (CCSI) is a cross-systems process for serving children with special emotional and behavioral services needs that builds upon legislation enacted in 2002. The process utilizes strength-based approaches, consistent and meaningful family involvement, individualizing planning, and encourages creative, flexible decision-making and funding strategies. CCSI Statewide Partners are: Family Representatives, Office of Mental Health, State Education Department, Office of Children and Family Services, Council on Children

and Families, Division of Probation and Correctional Alternatives, Office of Mental Retardation and Development Disabilities, Department of Health, NYS Commission on Quality of Care and Advocate for Persons with Disabilities, and the Developmental Disabilities Planning Council.

Priority areas for CCSI include the development and delivery of training and technical assistance related to building and sustaining local systems of care, including a family advocacy training curriculum. CCSI continues to work to implement the comprehensive set of recommendations for improving services for children who have cross-systems needs (developed in 2004).

- The goal of Family Support New York is to transform public/private systems and services to support and foster empowerment of families in New York State. The Council on Children and Families is the lead agency. Other members include the Department of State, the Department of Health, the Office of Children and Family Services, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Family Development Association of New York State, Family Support NYS, and various community and parent representatives.

- The NYS Developmental Disabilities Planning Council (DDPC) is seeking to develop more non-segregated socialization opportunities (beyond one-time events) for youth with and without disabilities, through a statewide technical assistance and capacity building model. DDPC will issue a competitive Request for Proposals targeting a statewide entity such as the YWCA, Boy Scouts, Girl Scouts, etc. to serve as an umbrella organization that will provide information, skill-building, and technical assistance to build capacity within schools and "chapter" organizations of the chosen statewide entity to facilitate the development of friendship and socialization between youth with and without disabilities.

- In effort to address the issue of successful health care transitioning, the NYS Developmental Disabilities Planning Council (DDPC) established an Institute for Training on Health Care Transitioning. The Institute is developing statewide expertise on youth with developmental disabilities, age 14-25, as they transition from pediatric to adult health care, caregivers who support the transition and primary care physicians who are integral to making a successful transition. The Institute will develop three interrelated curricula on health care transitioning including:

  a) Curricula for primary care medical providers, covering information such as: understanding and recognizing disabilities, understanding developmental aspects of disabilities, providing accommodations including physical, sensory and other disability related issues.

  b) Curricula for individuals with developmental disabilities covering information such as: developing a relationship with adult medical providers, asking questions and sharing relevant information with adult health care providers, keeping track of and sharing medical history.

  c) Curricula for caregivers covering information such as: planning for transition to adult health care providers, locating and interviewing adult health care providers, decision making issues after the child turns 18.

/2009/The Department of Health is collaborating with the Developmental Disabilities Planning Council (DDPC) to support the successful transition of youth with special needs to adult learning, earning and independence. //2009//

/2008/ The new Youth Advisory Council is making recommendations to DOH relative to transition issues. (See description on pages 7-8 of the Needs Assessment.) //2008//

/2010/ The Fetal Alcohol Spectrum Disorder (FASD) Interagency Workgroup was formed in February 2008 to discuss coordination among State agencies on FASD. //2010//

Other Collaborations

- /2010/ New York State participates in the March of Dimes' "Big 5" collaborative of large states. The intent is to develop the ability of these states to provide leadership in use of data to promote improved birth outcomes.

- The Division of Family Health is in the process of developing a collaborative relationship with the National Initiative for Children's Healthcare Quality (NICHQ) to implement standardized quality improvement processes in hospitals for newborns and infants. //2010//

- Healthy Start: Many of the federal Healthy Start grantees are also grantees of New York State Department of Health under the Comprehensive Prenatal/Perinatal Services Network initiative. The Networks were initially funded under Title V, but have now moved onto a different source of funding. However, the need for close association with Title V programs continues in order to maximize mutual effectiveness. The Department holds periodic meetings (at least two per year) with Healthy Start grantees in order to foster better communication, explore areas for potential collaboration and share late-breaking developments. The Healthy Start consumer group assisted Title V in evaluating focus group methods and provided feedback that will be incorporated in planning for the next wave of consumer focus groups. /2008/The April 2007 meeting focused on successful social marketing. //2008// Regional staff also meet with the Networks on a routine basis.

- /2009/ The Comprehensive Prenatal-Perinatal Services Networks collectively have formed the Association of Perinatal Networks (APN) that meets regularly with the Department of Health. //2009//

- Local Health Departments: County health departments continued to play an essential role in the assurance of high-quality, accessible maternal and child health services. They assessed the needs of their local communities, worked with their communities to design and implement programs that meet those needs, and evaluated the effects on their communities.

  Under Article 6 of the New York State Public Health Law, local health departments extend the powers of the state health commissioner. Under Article 6, local health departments perform comprehensive community health assessments, and subsequently produce a Municipal Public Health Service Plan. Plans address the needs of the maternal and child health population in health education, infant mortality prevention, child health, family planning, chronic disease prevention, injury control, disease control and nutrition. Title V provides technical assistance to local health units in plan development, participates in the review process and monitors

implementation. of the plans. Because local health departments know local systems and community needs, plans address coordination across public and private resources, and across the continuum of primary, secondary and tertiary care. Local health units play a critical role in fostering local collaborations and locally addressing disparities in health outcomes.

- /2009/ New York State also partners closely with the American College of Obstetricians and Gynecologists, District II, on a number of maternal initiatives, including the Maternal Mortality/Safe Motherhood initiative, which attempts to identify each maternal death in New York State and use reviews of these deaths to help inform policy decisions, in conjunction with the Department of Health. In addition, this collaboration leads to training initiatives that are implemented across the state to improve the hospital-based and prenatal care of pregnant women.//2009//

- New York State has a long-established system of highly specialized Regional Perinatal Centers (RPCs). These Centers provide tertiary level clinical care to high-risk mothers and newborns, and also serve as important contact points for the Department of Health in our interactions with the health care community. They help ensure that high-risk mothers and newborns receive appropriate levels of care by working with their affiliate hospitals to monitor perinatal morbidity and mortality and to provide education and technical assistance to physicians and others. The Regional Perinatal Centers not only serve as the hub for consultation and transport within a network, but lead quality improvement activities within their network. All birthing hospitals in the state, including Regional Perinatal Centers, were reassessed and re-designated in 2001. /2009/ The Regional Perinatal Centers (RPCs) are represented by the Association of Regional Perinatal Programs and Networks (ARPPN), which meets with the Department regularly for purposes of planning and quality improvement.

- The Prenatal Care Assistance Program (PCAP) provides comprehensive prenatal care services to women under 200 percent of the Federal Poverty Level, and these providers are reimbursed at a higher rate for these more comprehensive prenatal and related services. PCAP providers are comprised of more than 134 different agencies, providing care at more than 400 sites statewide. In addition to the improved access to comprehensive prenatal care for low income women, one of the most important features of PCAP is that women not enrolled in Medicaid prior to pregnancy can be screened for eligibility by these prenatal care providers, and if "presumptively eligible" can begin services immediately. Providers assist women to complete application forms for Medicaid, and are authorized to submit these forms to the local social services office, which in turn does not require these women to have a face-to-face encounter with social services staff.//2009//

- /2009/ Outreach to enroll pregnant women in prenatal care is conducted locally by the Comprehensive Prenatal-Perinatal Services Networks, the Community Health Worker Program, or, when implemented, the Universal Prenatal and Postpartum Home Visiting Program, where available, as well as through coordination conducted by the local PCAPs with other area service providers, locally-conducted outreach activities, and statewide outreach campaigns, which are conducted periodically.

- New York State provides the vast majority of services through contracts with community-based providers, including hospitals, diagnostic and treatment centers, community-based organizations, colleges and universities, etc. These contracts are

specific about the services to be provided and the outcomes expected. However, all of the nearly 750 contracts maintained by the Division of Family Health that perform Title V or related services represent a collaboration between the contractor and the State Department of Health to provide high quality services to the people of the state, and the commitment of our contractors to serving the public is extraordinary. The interactions of the Department with our service providers represents an ongoing collaborative relationship of the highest order on behalf of the state's medically needy.//2009//

- Area Health Education Centers (AHECs) work to recruit, retain, and support health professionals to practice in communities with health provider shortages, developing opportunities and arranging placements for future health professionals to receive their clinical training in underserved areas, and providing continuing education and professional support for professionals in these communities. They encourage local youth to pursue careers in health care. The MCH Advisory Council, the State Health Department and the AHECs are mutually concerned about the aging of the health care workforce; the aging of nursing and dental faculty; current and future shortages in certain key health professions; and in interesting young people in health careers early in their student careers. The Bureau of Dental Health is working with AHECs and local rural health networks to improve access to primary dental care in rural areas.

- The University at Albany School of Public Health is unique in that it is jointly sponsored by the university and our state health department. The New York State Department of Health serves as the laboratory for the University at Albany School of Public Health, with graduate students working shoulder-to-shoulder with practicing professionals in the state health department or in local departments. A number of DOH and Title V staff serve as faculty and advisors to the school. Title V staff also serve on the School's Continuing Education Advisory Board and on the advisory council for the North East Public Health Leadership Institute. /2009/ The Bureau of Women's Health maintains a health education contract with the SUNY School of Public Health that facilitates calling upon the resources of the school for training and education of professionals, such as family planning providers, prenatal care providers, etc. In the past several years, training of health care professionals, including front line workers, in recognizing signs of domestic abuse was held in all regions across the state by the school, and repeated in the following year. Four sessions on Cross Cultural Communication intended for family planning, rape crisis and community-based providers were held to aid participants in strengthening their capacity to work across cultures and in diverse communities. //2009//

- Title V staff coordinate the MCH Graduate Assistant Program, under which fourteen University at Albany /2010/ School of Public Health //2010// graduate students per semester (fall, spring and summer) are supported by block grant funds to work on priority MCH research and planning projects. This arrangement supports the Department of Health's mission through attracting bright, motivated individuals who are interested in gaining theoretical and practical knowledge of public health and maternal and child health. The relationship with the University enhances the Department's research capacity, and improve the availability of pertinent and timely educational offerings for practicing public health professionals in the region. The arrangement also enhances NYSDOH's ability to hire stellar students from diverse backgrounds whose performance on public health projects has already been evaluated during their internships /2009/ and field placements. //2009//

- The University at Albany's School of Public Health sponsors the Northeast Public Health Leadership Institute (NEPHLI), now serving the northeast corner of the US. Several Title V staff have attended the Institute. Several graduates of the Institute also serve Title V in other states and at the New York City Department of Health. Title V staff and Dr. Birkhead serve on their advisory council.

- The Department also maintains a relationship with the Columbia University School of Public Health through a Collaborative Studies Initiative. Metropolitan Area Regional Office staff serve as advisors and contract managers to the program. Columbia students and public health faculty identify current issues in maternal and child health, and apply public health theory and practice in designing and implementing solutions to those issues. As a result, several projects in very high needs areas of New York City have been planned, implemented and evaluated. Students are required to submit their projects to peer-reviewed journals and to present at national meetings.

- New York has three University-Affiliated Programs who offer Leadership Education in Neurodevelopmental Disabilities (LEND). They are the University of Rochester, the Westchester Institute at Valhalla, and Jacobi/Albert Einstein Medical Center. LEND Programs provide for leadership training in the provision of health and related care for children with developmental disabilities and other special health care needs and their families. The Department works with the LENDs on a variety of issues related to children with special health care needs and to meet training needs, and the University Affiliated Programs are a great source for physician consultants on a variety of issues. Several LEND fellows /2009/ and faculty //2009// recently traveled to Albany to meet with Title V staff in the Division of Family Health and to discuss their recent research /2009/ as well as to learn about the Department's MCH initiatives.//2009//. Several LEND fellows attended an orientation to Title V sponsored by the New York Medical College, School of Public Health.

- Title V and the Adolescent Coordinator maintain linkages to the Leadership Education in Adolescent Health (LEAH) Program at the University of Rochester. The purpose of LEAH is to prepare trainees in a variety of professional disciplines for leadership roles in the public and academic sectors and to ensure high levels of clinical competence in the area of adolescent health. Training is given in the biological, developmental, emotional, social, economic and environmental sciences, within a population-based public health framework. Prevention, coordination and communication are stressed.

- Healthy Tomorrows Partnership for Children is a collaboration between HRSA and the American Academy of Pediatrics (AAP) formed to stimulate innovative programs in areas of limited health care access and high need. In May 2006, Title V staff from the Bureau of Dental Health accompanied AAP on a Technical Assistance visit to the project at the University of Rochester Medical Center, the Dental Home for Children Project. This project targets children with significant dental needs to address barriers to service and other related issues. The project also seeks to improve communication between primary care providers and dentists.

- New York's Pediatric Pulmonary Center is located at Mount Sinai Medical Center in Manhattan. The Pediatric Pulmonary Center takes an interdisciplinary approach to developing health professionals for leadership roles in the development, enhancement or improvement of community-based care for children with chronic respiratory diseases and their families. In addition serving as a model of excellence in interdisciplinary training, Mount Sinai also engages in active partnership with state

and local health agencies and provides model services and research related to chronic respiratory conditions in infants and children.

- Montefiore Medical Center sponsors the Behavioral Pediatrics Training Program. Training grants from the Federal Maternal and Child Health Bureau support faculty who demonstrate leadership and expertise in the teaching of behavioral pediatrics, scholarship and community service. Fellows who have completed training are board-eligible in pediatrics. The three-year fellowship program includes course work and clinical practice in growth and development, adaptation, injury prevention, disease prevention and health promotion. The program is also available to provide continuing education and technical assistance.

- The Department of Health, with the School of Public Health at the University at Albany, the New York State Community Health Partnership and the New York State Association of County Health Officials, sponsors monthly Third Thursday Breakfast Broadcasts (T2B2). T2B2 provides statewide continuing education opportunities covering a variety of public health issues. Local site coordinators in each county health department coordinate local logistics. Out-of-state attendees can locate sites by visiting the University at Albany's website: www.albany.edu/sph/coned/t2b2site.html . Continuing medical and nursing education credits are available.

- 2009/The Department of Health, under a community grant from the March of Dimes, collaborated with staff at the School of Public Health at the University at Albany and other partners to provide web-based training for oral health professionals, prenatal care providers and child health professionals on practice guidelines on oral health during pregnancy and early childhood. The training was part of the Women's Health Grand Round Series. Over 320 health professional attended the live broadcast and close to 1,600 individuals have visited the site to review the training program.//2009//

- The Office of Children and Family Services also sponsors with partners such as DOH, the SUNY Distance Learning Project, and the New York State Child and Family Trust Fund, monthly satellite broadcasts on child health and safety topics such as SIDS and Risk Reduction.

- /2008/Title V staff worked with the Weatherization Program at the Division of Housing and Community Renewal to distribute information about local weatherization contacts to MCH programs and contractors. For many families in the northeast, fuel prices are such that families suffering from fuel insecurity may need to choose between "heat or eat." //2008//

- DOH strives to maintain positive and collaborative relationships with several not-for-profit, voluntary groups who share concerns for the health and well-being of mothers, infants, children and women of childbearing age. The Department's Title V program has many active relationships/collaborations.

  /2008/Please see pages 166-168 in the Needs Assessment section for a list of active collaborations.//2008//

F. Health Systems Capacity Indicators

/2009/ Summary: //2009// Health System Capacity Indicators (HSCIs) are helpful in tracking trends in the population and measuring progress toward our health system goals. The HSCIs are also helpful in benchmarking with other states.

New York goes well beyond the Health System Capacity Indicators in its published Needs Assessment document each year. /2008/NYSDOH also publishes many of these data in more detail, with New York City vs. Rest of State data and with breakdowns by race/ethnicity, sex, age and other variables. All data are analyzed from different perspectives to determine whether the benefits of public health interventions are being realized by all segments of New York's population.//2008// /2009/ These key Health Systems Capacity Indicators show some minor changes from the last year's reported figures, some positive, some negative. //2009//
/2010/ /What these indicators often fail to highlight is the ongoing problem of disparities in health, with minorities frequently showing higher rates of poor outcomes and service utilization, despite the fact that most, if not all, programs are designed to target segments of the population most in need of the particular services being delivered. Clearly, despite the Department's focus on reducing disparities, more evidence-based techniques and programs, better social marketing, more coordinated approaches with better attention to complementary messages across multiple media and points of contact, are needed. The Department is extremely aware of disparities in health, and is working to better address the issue in a more systematized, and hopefully more effective, manner. //2010//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	65.4	72.7	67.3	57.9	62	54.9	54.9
Numerator	8026	8833	8381	7236	7567	5,569	5,569
Denominator	1228144	1215052	1246045	1,249,101	1,220,468	1,196,688	1,196,688
Is the Data Provisional or Final?				Final	Final	Final	Provisional

/2010/ **Notes – 2010**
2007 data are being used as a proxy for 2008, and 2007 data have been updated and finalized.//2010//

Narrative:
Rates went from 65.8 in 1998, to 81.5 in 1999, to 62.9 in 2000, to 66.6 in 2001, 65.4 in 2002, 72.7 in 2003 and 67.3 in 2004. /2008/Rates declined in 2005.//2008// /2009/ Although there was an increase in 2006, the increase was small, and the rate is still significantly below the rate in 2004. //2009// Rates continued to be higher in New York City, compared to the rest of the State. We are continuing to monitor these rates as we continue implementing the Statewide Asthma Plan.

/2010/ The updated 2006 rate was somewhat higher than the uncorrected rate reported last year (62 vs. 59.9 per 10,000 children less than 5 years of age.) The decreases shown in 2007, and in 20080 using 2007 as a proxy, represent a decline of over 7 points in the rate, or over 11 percent.

/2008/ In 2006, New York State Department of Health published a Summary Report of New York data from the National Asthma Survey, which was widely distributed. The National Asthma Survey is a random digit dialing telephone survey that screened for presence of asthma in each household called. A maximum of one adult and one child who ever had asthma were randomly selected for a more detailed interview. Overall 31,090 individuals from 11,713 household were screened, with 1,970 detailed interviews completed (1,323 adults and 647 children).
/2010/ In 2008, New York State Department of Health published a New York State Asthma Surveillance Summary Report, which was widely distributed and posted on the NYSDOH Website. This report presents New York State asthma data compared to the United States in 2003 2004 and to the Healthy People 2010 objectives. In addition, this report provides information regarding asthma prevalence in children and Healthy People.//2010//

About 467,000 children, birth to age 17 or 10.6% of the NYS child population have been told by a health professional that they ever had asthma and about 368,000 or 8.4% had current diagnosed asthma.

Current asthma prevalence varied by age groups. For children birth to age 4, the rate was 6.7%, for five- to nine-year-olds, the rate was 9.4%, for 10- to 14-year-olds, the rate was 8.8%, and for 15- to 17-year-olds, the rate was 8.3%. For adults, the 18- to 24-year-old age group had the highest current asthma prevalence at 9.8%. The 65+ age group had the lowest rate at 6.0%.

Current asthma prevalence is significantly higher in male children (9.8%) compared to female children (6.8%), but prevalence in adult females (9.0%) is higher than in adult males (6.0%).

Current asthma prevalence also varied by race. Black children had the highest prevalence at 10.0%, compared to White (7.2%) and Asian children (4.3%). Black adults also had higher rates (8.3%) than White (6/6%) and Asian (1.8%) adults.

Ethnicity is also a factor. Hispanics had higher current asthma prevalence than non-Hispanic children (10.9% vs. 7.4%) and adults (9.0% vs. 6.3%).
There were also regional variations, with New York City children having higher prevalence than children in the rest of the State (9.7% vs 7.4%), and New York City adults having lower rates than adults in the rest of the state (7.1% vs. 8.0%).

Children and adults living below the Federal Poverty Level (FPL) had higher current asthma prevalence than those above the FPL. For children the prevalence rates were 10.1% for those below FPL vs. 8.7% for those above; for adults rates were 9.2% for those below FPL vs. 7.2% for those above.

Current asthma prevalence increased as body mass index (BMI) increased. Underweight children had prevalence lowest rates at 7.4% vs. overweight children who had the highest prevalence rates at 10.1%. Among adult, the obese group also had the highest prevalence rates at 12.3%.

/2010/ Children aged 0-4 years had the highest emergency department visit rate (181.4/10,000) compared to all other ages. The asthma emergency department visit rate decreased in older age groups.

During 1996-2005, the 0-4 year age group had the highest hospital discharge rate compared to all other age groups.//2010//

Asthma coalitions are using regional approaches to track these and other data, and to ensure that New Yorkers with asthma have asthma management plans and receive high-quality care. Please see additional details under Priorities, Performance and Program Activities.

Columbia University, in collaboration with the Harlem Family Asthma Center at Harlem Hospital, is providing a comprehensive, multi-disciplinary family program to children with severe asthma. The program will improve asthma management practices for primary care practitioners who care for children with mild to moderate asthma. Among 140 children, hospital admissions decreased 22% to 14% of clients. The number of clients with two or more emergency department visits decreased from 36% to 10%. The percentage of children with ten or more days of school missed went from 24% to 0%. Use of preventive asthma medications increased from 76% to 95%. Each client having an asthma action plan increased from 38% to 90%.

"Use of Appropriate Asthma Medications" is a performance measure in QARR and is reported annually in the Managed Care Plan Performance document. Statewide we are at 94% for commercial and Child Health Plus plan performance and 90% for Medicaid plan performance. //2008// /2009/ For the most recent data year available, QARR data shows that 95% of commercial, 94% of Child Health Plus and 92% of Medicaid plans achieved this goal.//2009//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	74.9	74.7	76.5	76.9	72.7	77.6	77.6
Numerator	81213	103303	110535	111,874	108,995	117,580	117,580
Denominator	108485	138216	144460	145,432	149,958	151,439	151,439
Is the Data Provisional or Final?				Final	Final	Provisional	

/2010/ Notes – 2010
2007 data are being used as a proxy for 2008, and 2007 data have been updated and finalized. 2008 data are not expected to be finalized until 2010, due to reporting delays.//2010//

/2009/ Notes – 2009
2006 data are being used as a proxy for 2007, and 2006 data have been updated and finalized.//2009//

Notes - 2008
/2008/2005 data are being used as a proxy for 2006. //2008//

Notes - 2003
Comparable Data not available for 1999 - 2001

Narrative:
Idiosyncrasies in data sources and analysis make these data hard to interpret. It appears we are on an upward trend, but have just /2008/four//2008// /2009/ five //2009// years of data consistency. /2009/ The 2006 numbers, however, represent a slight decrease. //2009//

Title V staff continue to monitor access to programs and services on a local level and work with the Office of Medicaid Management to identify and solve access issues. /2008/ The related QARR measure is "Five or More Well Child and Preventive Care Visits in the First 15 Months of Life." While rates are 90% for the commercial managed care population, they are 65% for Medicaid plans and 85% for Child Health Plus plans. //2008// /2009/ In the most recent data year available (2006), new data was reported only for the Medicaid managed care plans, whose rate increased to 70%.//2009//

Health Systems Capacity Indicator 03: *The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	67	79	79	84	84	88	88
Numerator							
Denominator							
Is the Data Provisional or Final?				Final	Final	Final	Provisional

/2010/ **Notes – 2010**
2007 data are being used as a proxy for 2008, and 2007 data have been updated and finalized. See note below about unavailability of numerator and denominator data due to use of weighted rate.//2010//

/2009/ **Notes – 2009**
2006 data are being used as a proxy for 2007, and 2006 data have been updated and finalized.//2009//
Notes - 2008
/2008/2005 data are being used as a proxy for 2006. //2008//

Notes - 2003
We do not have reliable data for Child Health Plus enrollees under age one. As a proxy, the percentage of children under age 15 months who have received a well child or preventive health visit is used.

Starting in 1999 a new data source became available. Using this source the percentage is weighted by plan enrollment. Since the rate is a weighted rate the numerator and denominator are not available or relevant.

Narrative:

New York uses QARR data from the Office of Managed Care to generate these data, and as a result, have slightly different categories of data. What is available is "Five or More Well Child and Preventive Care Visits in the First Fifteen Months of Life." These data remain about stable or increasing: 62.0% in 2001, 67.0% in 2002, 79% in 2003 and 2004, /2008/ and 84% in 2005//2008//. /2009/ The increase to 84% has been stable for 2006, and if maintained, represents an overall increase of more than 35 percent since 2001.//2009// /2010/ The increase to 88 percent in 2007/2008 represents a further increase, with an overall increase since 2001 of 26 percentage points, an increase of nearly 42 percent.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	63.6	63.1	66.4	66.5	65.9	63.5	63.5
Numerator	147385	137129	132863	130854	131,416	126,795	126,795
Denominator	231785	217201	200115	196825	199,342	199,659	199,659
Is the Data Provisional or Final?				Final	Final	Final	Provisional

/2010/ **Notes – 2010**
2007 data are being used as a proxy for 2008, and 2007 data have been updated and finalized. //2010//

/2009/ **Notes – 2009**
2006 data are being used as a proxy for 2007, and 2006 data have been updated and finalized.//2009//

Notes - 2008
/2008/2005 data are being used as a proxy for 2006. //2008//

Narrative:
These data have been trending toward improvement. There was a one-year of decrease from 2000 to 2001, then rates were relatively unchanged from 2001 to 2002, at 63.5% and 63.6%, respectively. The rates showed improvement from 63.1% in 2003 to 66.4 % in 2004. /2008/ At 66.5%, the rate is level with 2004 rates.//2008// /2009/ A slight decrease, to 65.9% in 2006, was observed.//2009//
/2010/ Current figures indicate a reversion to 2002 levels, and a loss of the modest gains that were observed in the interim. This may be due, in part, to the implementation of new internet-based data collection upstate in recent years, and the preparations for a changeover to a similar format in NYC in 2007 for implementation in early 2008.//2010//

There are racial and geographic disparities in these rates. In New York City in 2004, the Kotelchuk Index was 59.9, while the rest of the state achieved 72.2 on the index. For White

New Yorkers, the index was 70.2, for African Americans it was 53.0, and for Hispanic women it was 57.8. /2008/ The 2005 Kotelchuk indices for New York women ages 15 to 44 were higher among women residing in Rest of State (73.2) as compared to women residing in New York City (59.5) and higher for White women (70.7) as compared to Black (53.6) and Hispanic women (57.9). The 2005 rates were similar to rates in 2004, but much improved over rates reported in 1996. These data are also tracked in QARR.//2008

The Prenatal Care Assistance Program sets clinical standards for content of prenatal care, which are codified in Part 85.40 of New York State Public Health Law. Programs are reviewed for their compliance with these standards. /2008/ These same standards are applied to the MOMS (Medicaid Obstetrical Maternity Services) Program, as well. These regulations serve as the standard of care. //2008//
/2010/ The Department partnered with the Island Peer Review Organization (IPRO) to review the existing PCAP standards and compare them to current American College of Obstetrics and Gynecology (ACOG) and American Association of Pediatrics (AAP) guidelines. In addition, IPRO reviewed recommendations for prenatal care, as well as other national standards of obstetric practice and standards used in other states. Experts in the field of prenatal care, prenatal care practitioners and representatives of community organizations were invited to take part in a statewide advisory workgroup charged with the responsibility for developing a revised set of Medicaid Prenatal Care Standards for New York State. The group recommended that the new Medicaid prenatal care standards should be the ACOG/AAP Guidelines for Perinatal Care, 6th edition and all future updates and editions.

In December 2008, the Department began a new payment methodology for Medicaid services called Ambulatory Patient Groups (APG). The APG method of payment is being phased in throughout 2009. APGs are being used to make payments for outpatient clinic, ambulatory surgery and emergency department services. Implementation of APGs is one component of the Department's larger, multi-year agenda to transition funds from inpatient to outpatient services to support quality outpatient care and to address the problem of avoidable hospitalizations. //2010//

/2009/ The prenatal media campaign encourages women to access services through the Prenatal Care Assistance Program, and outreach efforts conducted through the Community Health Worker program, and the soon-to-be-implemented Universal Prenatal and Postpartum Home Visiting Program, represent key efforts to encourage women to seek early and continuous prenatal care. In addition, the 2008-09 Executive Budget includes initiatives to improve birth outcomes for the close to 50 percent of births in the state that are paid for by Medicaid, because women insured by Medicaid have higher rates of infants with complicated and costly neonatal intensive care. Over a period of 4 years, reimbursement methodology will be reallocated primarily for investments in ambulatory care and preventive care for Medicaid patients. It is anticipated that this process will be fully implemented in 2011-2012. As a first step the Budget proposes to invest in a new standardized system of early identification of clinical and psychosocial risks for poor birth outcomes. Additionally, nurse practitioners who previously could only bill Medicaid for primary care services will now be able to bill in all specialties, including mental health; and, licensed clinical social workers will be reimbursed for services for children, adolescents and pregnant women.

The transfer of the Adolescent Pregnancy and Parenting Services (APPS) program from the Office of Children and Family Services has allowed for greater coordination of services for pregnant adolescents through 21 years of age. Twenty-six programs are funded through community based organizations across the state providing the following services: counseling; basic needs; academic education; health services; employment services;

recreational services; parent education; housing services; child care; and, services for infants and children.//2009//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	87.5	91.0	93.4	94.6	94.4	90.0	90.0
Numerator	1550279	1834078	1974655	1966625	1.909,170	1805488	1805488
Denominator	1770911	2015608	2113319	2079460	2,021,928	2006098	2006098
Is the Data Provisional or Final?				Final	Final	Final	Provi-sional

/2010/ **Notes – 2010**
2007 data are being used as a proxy for 2008, and 2007 data have been updated and finalized. Due to reporting delays, 2008 data will not be finalized until late 2009. //2010//

/2009/ **Notes – 2009**
2006 data are being used as a proxy for 2007, and 2006 data have been updated and finalized.//2009//

Notes - 2008
/2008/2005 data are being used as a proxy for 2006.//2008//

Narrative:
/2008/These data are difficult to interpret because it is unclear what the purpose of the visit was.//2008// /2009/ However, this indicator demonstrated an increasing trend until 2005, and relative stability in 2006.//2009//

/2008/In 2005, 43.1% of all obstetrical deliveries were either paid by Medicaid or self-pay. QARR tracks plan performance on a variety of primary and preventive health care measures, including immunization status, lead testing, use of appropriate asthma medications, annual dental visits, and appropriate treatment for Upper Respiratory Infection. /2010/ A Bureau of Child and Adolescent Health staff person provided an overview of Title V and New York State's Maternal and Child Health Programs and services to LEND fellows of the Westchester Institute for Human Development.//2010//
Also tracked are: appropriate testing for pharyngitis, number of well child visits, follow-up on medications for ADHD, and adolescent preventive measures, including BMI screening, nutrition and exercise assessment, sexual activity counseling and education, depression screening, and tobacco and substance use screening and counseling. //2008//

All Title V programs have a component that assures that potentially-eligible families are referred to public insurance programs. /2008/Title V programs have linkages to facilitated enrollment programs and the local departments of social services, where eligibility determinations are often performed.//2008//

Local CSHCN Program staff inquire as to the insurance status of each child who is referred to the CSHCN Program. Staff link families to public insurance programs such as Medicaid, Child Health Plus and Family Health Plus and gap-filling programs such as the Physically Handicapped Children's Program. In 2005, 6% of CSHCN were reported as without health insurance. There were 82 CSHCN referred and enrolled in Medicaid, 33 CSHCN referred and enrolled in CHP-B, and 13 CSHCN referred and enrolled in SSI. There are 145 referrals to insurance pending results at this point of data collection. /2010/ In 2008, 6 percent of CSHCN were reported to have no health insurance. Local CSHCN Program staff referred 338 CSHCN to Medicaid, 292 CSHCN to Child Health Plus, and 397 CSHCN to SSI. //2010//

/2009/Obtaining information about health insurance status, including Medicaid coverage, is a required part of the initial enrollment process for students who enroll in school-based health centers (SBHC). SBHC staff request parents/guardians to include this information on the background and consent forms required for students to obtain services through the SBHC. If the parent/guardian reports no coverage, staff of the SBHC and/or the sponsoring health care provider, works with them through a facilitated enrollment process, to identify any health care coverage for which they are eligible for such as Medicaid, Child Health Plus or Family Health Plus.

The Department of Health, under a community grant from the March of Dimes, collaborated with staff at the School of Public Health at the University at Albany and other partners to provide web-based training for oral health professionals, prenatal care providers and child health professionals on practice guidelines on oral health during pregnancy and early childhood in an effort to encourage provision of services to these populations. The training was part of the Women's Grand Round Series. Over 320 health professional attended the live broadcast and close to 1,600 individuals have visited the site to review the training program.//2009//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	35.8	35.2	36.3	38.9	44.3	46.4	46.4
Numerator	124393	134265	140454	144365	159,486	166217	166217
Denominator	347546	381935	386892	370657	360,268	358116	358116
Is the Data Provisional or Final?				Final	Final	Final	Prov-isional

/2010/ **Notes – 2010**
2007 data are being used as a proxy for 2008, and 2007 data have been updated and finalized. Due to reporting delays, 2008 data will not be finalized until late 2009. //2010//

/2009/ **Notes – 2009**
2006 data are being used as a proxy for 2007, and 2006 data have been updated and finalized.//2009//

Notes - 2008
/2008/2005 data are being used as a proxy for 2006.//2008//

Narrative:
In 2002, the percentage was 35.8%; in 2003 the percentage was 35.2%: in 2004 the percentage was 36.3%/2008/ and in 2005, 38.9%//2008//. It appears that percentages are stable /2008/ with a slight increase in 2005.//2008//. /2009/ Adjustments to preliminary data show that this indicator has been relatively stable in increasing over the past 5 years, with a significant jump in 2006.//2009// We believe this/2009/ (the generally low overall number) //2009// is due to the limited number of dentists willing to take Medicaid. (The number of clients across all age groups who receive MA-financed dental services is low, despite fees having been raised.) /2009/ Statewide, approximately 50% of all licensed dentists are enrolled as approved Medicaid providers, but only half of these actually provide services to Medicaid beneficiaries. //2009// These issues are addressed in our statewide Oral Health Plan. /2008/The New York State Oral Health Coalition has a special Access to Care Sub-Committee that meets regularly to implement those sections of the plan that relate to access to oral health care.//2008// /2009/Data on Medicaid claims for dental services during 2006 were available for 6-7 year olds and 8-11 year olds. Based on an analysis of unduplicated beneficiaries, 42.0% of 6-7 year olds and 42.5% of 8-11 year olds had at least one dental visit during 2006. //2009//

/2008/ The Bureau of Dental Health recently published information on a successful strategy that was tested in New York called Dental Case Management. This is a promising strategy for improving access to dental care statewide. The Bureau is currently seeking resources to expand the use of this model in more communities. In addition, 32 community-based sites were recently awarded Preventive Oral Health Services Grants. These sites will undertake a variety of activities that will contribute to more children having a dental home, from case management, to sealant programs, to coalition building, to comprehensive dental treatment programs.//2008// /2009/ There are currently 31 contracts for Preventive Oral Health Services in place, as one awardee declined a contract.//2009//

/2008/ In addition, the Bureau of Dental Health recently funded an additional 32 Preventive Dentistry applicants across the state. These projects are entirely focused on the maternal and child health populations. /2010/ There are currently 31 projects for preventive oral health services in place, as one awardee declined a contract.//2010// The majority of the projects are to provide either dental sealants or fluoride varnish. Several of the projects focus on pregnant women, with the goal of positively impacting knowledge, attitudes and behaviors of pregnant women, who will become better advocates for and consumers of oral health care, not only for themselves, but also for their young children.//2008// /2009/ In addition, these projects undertake a variety of activities that will contribute to more children having a dental home, from case management, to sealant /2010/ or varnish //2010// programs, to coalition building, to comprehensive dental treatment programs.

The Bureau of Dental Health is in year one of a four year HRSA grant targeting oral health services to the maternal child health population. Grant activities focus on increasing access to and utilization of dental services by children covered under EPSDT and in increasing the provision of treatment services to 6-9 year old children identified through the school-based dental program with active decay.//2009//

/2008/The Bureau of Dental Health is working with other CDC chronic disease grant programs within the department on issues where there is a similar target audience or message. One area that is promising for joint intervention is in the area of tobacco use prevention. /2010/ Dental hygienists are screening all patients for tobacco dependence

treatment and offering brief tobacco dependence treatment interventions consistent with the U.S. Department of Health and Human Services Clinical Practice Guideline for Treating Tobacco Use and Dependence. They also provide referrals to the NYS smokers' Quitline and patients' primary care physicians for assistance with quitting smoking. The tobacco control program cessation centers work with dental offices to help them implement the tobacco dependence treatment guideline concordant care in health systems. This year, the Bureau has initiated discussions to collaborate with the Diabetes program.//2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2002	2003	2004	2005	2006	2007	2008
Annual Indicator	NaN	100.0	100.0	100.0	100	100	100
Numerator	0	1	1	1	1	1	1
Denominator	0	1	1	1	1	1	1
Is the Data Provisional or Final?					Final	Final	Final

Notes - 2008
All SSI beneficiaries receive Medicaid, which is a more generous package than that available under the Physically Handicapped Children's program/Children with Special Health Care Needs Program. /2009/ In 2007, 1.24% of children enrolled in the CSHCN Program had SSI. //2009//
/2010/ In 2008, 2 percent of children enrolled in the CSHCN Program had SSI.//2010//

Narrative:
This indicator is not particularly applicable to New York, since all SSI recipients automatically have Medicaid, which is more generous than our Physically Handicapped Children's Program/Children with Special Health Care Needs Program.

The local Children with Special Health Care Needs Program provides information and referral to families in need of services, including referrals and assistance with enrollment in Medicaid, Child Health Plus, and /2009/ Supplemental Security Income and enabling services.//2009//

In 2007, an additional care coordination model became available to Medicaid children who receive skilled nursing in their homes. Title V staff worked with staff from the Office of Health Insurance Programs/Medicaid to write the program standards for the new model.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (<2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2007	payment source from birth certificate	8.4	7.9	8.1

/2010/ **NOTES**: 2008 data were not yet available at the time of submission, and it is not known when 2008 data will be finalized, as NYC implemented a new electronic birth certificate data collection system in 2008, and programming for integration of the new system with the Upstate birth certificate files has not yet been completed. However, it is expected that final data should be available by mid-2010.//2010//

Narrative:
In general, health outcomes are less favorable for those of lower socioeconomic status than those that enjoy higher standards of living. Medicaid populations generally fair less favorably than privately insured populations with regard to low birth weight rates, infant mortality, rates of early prenatal care and adequacy of prenatal care. This is not totally related to the source of payment for their care, but more likely attributable to a confluence of life factors.

/2008/ The presence of PCAP and MOMS Programs across the state increases access to high-quality prenatal care for high-risk, hard-to-reach women. PCAP/MOMS engages strategies to enroll and sustain enrollment of women in prenatal care. Standardized risk assessment helps to identify women at risk for poor pregnancy outcome and provides additional services to address those needs. Women at highest risk are referred to regional perinatal centers and supportive health and social services.//2008// /2009/ In addition, a prenatal outreach media campaign was conducted to encourage pregnant women to seek prenatal care early, by calling the Growing Up Healthy Hotline, while the Community Health Worker Program provided individual outreach to high risk pregnant women. The Universal Prenatal and Postpartum Home Visiting Program was also designed in 2007, to be implemented in 2008, to provide universal screening to pregnant and postpartum women to connect them with needed services. A re-design of the Medicaid payment system, inclusive of prenatal care, is also being undertaken to ensure that the current high standard of care for Medicaid-enrolled women is both universal and of meets the current standard of practice.

/2010/ The Fetal Alcohol Spectrum Disorder (FASD) Interagency Workgroup was formed in February 2008 to promote coordination among State agencies on FASD. The workgroup consists of representatives of the Council on Children and Families, the Office of Children and Family Services, Office of Mental Retardation and Developmental Disabilities, the Office of Alcoholism and Substance Abuse Services (OASAS), and the Department of Health. Four subcommittees have been formed to work on coordination of state agency activities, including Education and Awareness, Prevention and Prenatal Screening, Diagnosis and Screening of Children, and Interventions and Treatment Services. Staff of the Bureau of Women's Health co-chair the Prevention and Prenatal Screening sub-committee and participate on other subcommittees. The workgroup will assess existing resources and gaps of services, and identify opportunities for collaboration. The goal is to design and support a comprehensive system of care with the aim of eliminating alcohol use during pregnancy and improving the lives of New Yorkers affected by prenatal alcohol exposure.//2010//

The transfer of the Adolescent Pregnancy Prevention and Services program to the Department of Health has allowed the Department to better track the pregnancy outcomes of high risk pregnant adolescents. One of the five statewide performance targets for the projects is the expectation that at least 90% of those babies born by teen parents in their program will have a birth weight above 88 ounces.//2009//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	payment source from birth certificate	6.6*	5.1*	5.5

/2010/ It is not known when 2008 data will be finalized, as NYC implemented a new electronic birth certificate data collection system in 2008, and programming for integration of the new system with the Upstate birth certificate files has not yet been completed. However, it is expected that final data should be available by mid-2010. *The Medicaid and Non-Medicaid infant death rates are based on deaths of infants residing in NYS excluding NYC. The 2007 birth-death match file from NYC has not yet been provided by NYC. //2010//

/2009/*The Medicaid and Non-Medicaid infant death rates are based on deaths of infants residing in NYS excluding NYC. The 2006 birth-death match file from NYC has not yet been provided by NYC.//2009//

Narrative:

Infant mortality for all births to NYS residents living outside of NYC was 6.0 per 1,000 births in 2004/2008/, while the rate was 5.8 per 1,000 births in 2005. //2008// /2009/ In 2006, the infant mortality rate for NYS babies, exclusive of NYC, was 6.2 percent for Medicaid clients, and 29% lower for non-Medicaid babies, at 4.4%. //2009//

In general, health outcomes are less favorable for those of lower socioeconomic status than those that enjoy higher standards of living. Medicaid populations generally fair less favorably than privately insured populations with regard to low birth weight rates, infant mortality, rates of early prenatal care and adequacy of prenatal care. This is not totally related to the source of payment for their care, but more likely attributable to a confluence of life factors.

/2008/ The presence of PCAP and MOMS Programs across the state increases access to high-quality prenatal care for high-risk, hard-to-reach women. PCAP/MOMS engages strategies to enroll and sustain enrollment of women in prenatal care. Standardized risk assessment helps to identify women at risk for poor pregnancy outcome and provides additional services to address those needs. Women at highest risk are referred to regional perinatal centers and supportive health and social services.//2008// /2009/ As previously stated, the Growing Up Healthy Hotline, the Community Health Worker Program and the Universal Prenatal and Postpartum Home Visiting Programs were designed to address the issue of ensuring that all pregnant and postpartum women are provided with access to needed services. Though the latter program is in the earliest stages of implementation, it is expected to add an additional element to the state's armamentarium with respect to improving birth outcomes. A further element, previously described, is the Medicaid payment reform effort, which will use the payment structure to encourage delivery of prenatal care according to the highest professional standards. //2009//

/2010/ After a review of the PCAP standards, evidence-based literature, ACOG/AAP Guidelines for Perinatal Care, programs/standards in other states and valued input from the Advisory

Workgroup, it was recommended that the basis for the new Medicaid prenatal care standards should be the ACOG/AAP Guidelines for Perinatal Care, 6th edition and all future updates and editions. In December 2008, the Department began a new payment methodology for Medicaid services called Ambulatory Patient Groups (APG). The APG method of payment is being phased in throughout 2009. APGs are being used to make payments for outpatient clinic, ambulatory surgery and emergency department services. Implementation of APGs is one component of the Department's larger, multi-year agenda to transition funds from inpatient to outpatient services to support quality outpatient care and to address the problem of avoidable hospitalizations. Under APGs, all clinic-based Medicaid providers of prenatal care will be able to access the APG rates, and all will be required, as well, to adhere to the more stringent prenatal care standards developed originally for PCAP. This should enhance the availability of high quality prenatal care to women statewide, and potentially reduce infant mortality thereby.//2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	61.9	83.1	73.8

/2010/ It is not known when 2008 data will be finalized, as NYC implemented a new electronic birth certificate data collection system in 2008, and programming for integration of the new system with the Upstate birth certificate files has not yet been completed. However, it is expected that final data should be available by mid-2010.//2010//

Narrative:

In general, health outcomes are less favorable for those of lower socioeconomic status than those that enjoy higher standards of living. Medicaid populations generally fair less favorably than privately insured populations with regard to low birth weight rates, infant mortality, rates of early prenatal care and adequacy of prenatal care. This is not totally related to the source of payment for their care, but more likely attributable to a confluence of life factors.

The presence of PCAP and MOMS Programs across the state increases access to high-quality prenatal care for high-risk, hard-to-reach women. PCAP/MOMS engages strategies to enroll and sustain enrollment of women in prenatal care. Standardized risk assessment helps to identify women at risk for poor pregnancy outcome and provides additional services to address those needs. Women at highest risk are referred to regional perinatal centers and supportive health and social services. Outreach and case finding components of the state's prenatal care strategy also include the Community Health Worker Program, which is targeted to very high risk pregnant women, the Growing Up Healthy Hotline, which links women to a comprehensive array of needed services, and the Universal Prenatal and Postpartum Home Visiting Program, which is still in the earliest implementation stages, but is designed to fill a gap in the state's current array of programs. /2010/ In addition, as previously described, a re-design of the state's Medicaid reimbursement system was undertaken in 2008 to ensure that Medicaid will promote only the highest standards of

evidence-based care, targeted to the risk-based needs of each woman. After a review of the PCAP standards, evidence-based literature, ACOG/AAP Guidelines for Perinatal Care, programs/standards in other states and valued input from the Advisory Workgroup, it was recommended that the basis for the new Medicaid prenatal care standards should be the ACOG/AAP Guidelines for Perinatal Care, 6 edition and all future updates and editions.

In December 2008, the Department began a new payment methodology for Medicaid services called Ambulatory Patient Groups (APG). The APG method of payment is being phased in throughout 2009. APGs are being used to make payments for outpatient clinic, ambulatory surgery and emergency department services. Implementation of APGs is one component of the Department's larger, multi-year agenda to transition funds from inpatient to outpatient services to support quality outpatient care and to address the problem of avoidable hospitalizations. Under APGs, all clinic-based Medicaid providers of prenatal care will be able to access the APG rates, and all will be required, as well, to adhere to the more stringent prenatal care standards developed originally for PCAP. This should enhance the availability of high quality prenatal care to women statewide.//2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	payment source from birth certificate	51.3	71.6	63.5

/2010/ NOTE: It is not known when 2008 data will be finalized, as NYC implemented a new electronic birth certificate data collection system in 2008, and programming for integration of the new system with the Upstate birth certificate files has not yet been completed. However, it is expected that final data should be available by mid-2010.//2010//

Narrative:

In general, health outcomes are less favorable for those of lower socioeconomic status than those that enjoy higher standards of living. Medicaid populations generally fair less favorably than privately insured populations with regard to low birth weight rates, infant mortality, rates of early prenatal care and adequacy of prenatal care. This is not totally related to the source of payment for their care, but more likely attributable to a confluence of life factors.

/2008/ The presence of PCAP and MOMS Programs across the state increases access to high-quality prenatal care for high-risk, hard-to-reach women. PCAP/MOMS engages strategies to enroll and sustain enrollment of women in prenatal care. Standardized risk assessment helps to identify women at risk for poor pregnancy outcome and provides additional services to address those needs. Women at highest risk are referred to regional perinatal centers and supportive health and social services.//2008// /2009/ Integral to the state's outreach and referral efforts are the Community Health Worker Program, targeted to very high risk women, the Growing Up Healthy Hotline, which provides referrals on a whole

range of services to all women statewide, and the Universal Prenatal and Postpartum Home Visiting Program, currently in the planning stages. In addition, reform of the state's Medicaid reimbursement system to an APG-based structure is currently being developed, and is being designed in a manner that should aide in improvements in the delivery of prenatal care in New York State.

/2010/ After a review of the PCAP standards, evidence-based literature, ACOG/AAP Guidelines for Perinatal Care, programs/standards in other states and valued input from the Advisory Workgroup, it was recommended that the basis for the new Medicaid prenatal care standards should be the ACOG/AAP Guidelines for Perinatal Care, 6th edition and all future updates and editions. In December 2008, the Department began a new payment methodology for Medicaid services called Ambulatory Patient Groups (APG). The APG method of payment is being phased in throughout 2009. APGs are being used to make payments for outpatient clinic, ambulatory surgery and emergency department services. Implementation of APGs is one component of the Department's larger, multi-year agenda to transition funds from inpatient to outpatient services to support quality outpatient care and to address the problem of avoidable hospitalizations. Under APGs, the PCAPs will no longer bill special rate codes of prenatal care services. Instead, all Medicaid prenatal care providers will be required to adhere to the standards of care developed for PCAP and recently reaffirmed by the committee of experts, and all will be reimbursed for the provision of comprehensive prenatal care to pregnant women through the APG payment methodology.//2010//

Pregnant school-based health center enrollees are entered into prenatal care immediately. School-based health center staff may provide services directly, coordinate services with another provider or refer pregnant students for appropriate prenatal care. School-based health center staff follow-up to ensure that there is continuity of care. Where indicated, referrals are made for additional supportive health and social services.//2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL** **Medicaid**
Infants (0 to 1)	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL** **SCHIP**
Infants (0 to 1)	2008	See above – all infants 0-1 who are <200% FPL are eligible for Medicaid

Narrative:
Medicaid: Pregnant women and infants under one year of age, at or below 200% of the Federal Poverty Level, are eligible for Medicaid. Women are eligible for family planning based solely on the woman's income being below 200% of the Federal Poverty Level, planning based solely on the woman's income being below 200% of the Federal Poverty Level, regardless of previous Medicaid eligibility or pregnancy. If women are on New York State Medicaid at the time of pregnancy, then lose their eligibility, they are eligible for 24 months of continuous family planning coverage following their pregnancy. /2010/ Both women and men are eligible for the Family Planning Benefit Program, if their incomes are

below 200% FPL.//2010//

Children one through five are eligible for Medicaid at 133% of FPL. Children ages six to nineteen are eligible at 100% of the FPL.

Child Health Plus (New York's SCHIP): Children, ages one month to age 19 years, with family incomes at or below 250% of the FPL are eligible for subsidized health insurance coverage under Child Health Plus. Coverage for those under 160% FPL is free. Premium contribution for families between 160 and 222% is $9 per child per month, with a maximum of $27 per family per month. For families with incomes between 222 and 250% FPL, the contribution is $15 per child per month, with a maximum of $45 per family. For families with incomes over 250% of the FPL, Child Health Plus is available at full premium. There are no co-payments for services. /2010/Eligibility levels were increased in 2008. Premium contribution for families between 160 and 400% gradually increases in increments from $9 per child per month, with a maximum of $27 per family per month to $40 per child per month, with a maximum contribution per family of $120 per month. For families with incomes over 400% of the FPL, Child Health Plus is available at full premium. There are no co-payments for services. //2010//

Family Health Plus is available at two levels. Adults with children under the age of 21, whose gross family annual income is up to 150% of the Federal Poverty Level, or $30,000 per month for a family of four, are eligible. Single adults, whose gross family income is up to 100% of the Federal Poverty level or $9,800 per individual, are also eligible. /2010/ In 2008, these levels were, respectively, $31,800 for incomes <150% FPL for adults with children age 19 and 20 living with their parents, and $10,404 for single adults with incomes below 100% FPL.//2010//

/2008/ *These eligibility levels are scheduled to change very soon. New York is working toward making Child Health Plus available up to 400% of the Federal Poverty Level. The New York State Department of Health website is the best source of current eligibility information. Use www.health.state.ny.us or www.nyhealth.gov //2008// /2010/ As noted above, eligibility levels of up to 400% FPL have been implemented for Child Health Plus. //2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18)	2008	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19)	2008	400% (No monthly premiums if <160% FPL)

Notes - 2007

This section of the form is labeled wrong. It should read "Children under SCHIP" and not "Medicaid Children."
/2010/ As noted previously, this labeling would now correctly reflect NYS terminology. //2010//

Narrative:
Medicaid: Pregnant women and infants under one year of age, at or below 200% of the Federal Poverty Level, are eligible for Medicaid. Women are eligible for family planning based solely on the woman's income being below 200% of the Federal Poverty Level, planning based solely on the woman's income being below 200% of the Federal Poverty Level, regardless of previous Medicaid eligibility or pregnancy. If women are on New York State Medicaid at the time of pregnancy, then lose their eligibility, they are eligible for 24 months of continuous family planning coverage following their pregnancy. /2010/ Both women and men are eligible for the Family Planning Benefit Program, if their incomes are below 200% FPL.//2010//

Children one through five are eligible for Medicaid at 133% of FPL. Children ages six to nineteen are eligible at 100% of the FPL.

Child Health Plus (New York's SCHIP): Children, ages one month to age 19 years, with family incomes at or below 250% of the FPL are eligible for subsidized health insurance coverage under Child Health Plus. Coverage for those under 160% FPL is free. Premium contribution for families between 160 and 222% is $9 per child per month, with a maximum of $27 per family per month. For families with incomes between 222 and 250% FPL, the contribution is $15 per child per month, with a maximum of $45 per family. For families with incomes over 250% of the FPL, Child Health Plus is available at full premium. There are no co-payments for services. /2010/Eligibility levels were increased in 2008. Premium contribution for families between 160 and 400% gradually increases in increments from $9 per child per month, with a maximum of $27 per family per month to $40 per child per month, with a maximum contribution per family of $120 per month. For families with incomes over 400% of the FPL, Child Health Plus is available at full premium. There are no co-payments for services. //2010//

Family Health Plus is available at two levels. Adults with children under the age of 21, whose gross family annual income is up to 150% of the Federal Poverty Level, or $30,000 per month for a family of four, are eligible. Single adults, whose gross family income is up to 100% of the Federal Poverty level or $9,800 per individual, are also eligible. /2010/ In 2008, these levels were, respectively, $31,800 for incomes <150% FPL for adults with children age 19 and 20 living with their parents, and $10,404 for single adults with incomes below 100% FPL.//2010//

/2008/ *These eligibility levels are scheduled to change very soon. New York is working toward making Child Health Plus available up to 400% of the Federal Poverty Level. The New York State Department of Health website is the best source of current eligibility information. Use www.health.state.ny.us or www.nyhealth.gov //2008// /2010/ As noted above, eligibility levels of up to 400% FPL have been implemented for Child Health Plus. //2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	200

Notes - 2007
Pregnant women are eligible for Medicaid and Child Health Plus up to 200% of poverty.

Narrative:
Medicaid: Pregnant women and infants under one year of age, at or below 200% of the Federal Poverty Level (up from 185%), are eligible for Medicaid. Women are eligible for family planning based solely on the woman's income being below 200% of the Federal Poverty Level, regardless of previous Medicaid eligibility or pregnancy. If women are on New York State Medicaid at the time of pregnancy, then lose their eligibility, they are eligible for 24 months of continuous family planning coverage following their pregnancy. /2010/ Both women and men are eligible for the Family Planning Benefit Program if their incomes are below 200% FPL.//2010//

Children one through five are eligible for Medicaid at 133% of FPL. Children ages six to nineteen are eligible at 100% of the FPL.

Children, ages one month to age 19 years, with family incomes at or below 250% of the FPL. are eligible for subsidized health insurance coverage under Child Health Plus. Coverage for those under 160% FPL is free. Premium contribution for families between 160 and 222% is $9 per child per month, with a maximum of $27 per family per month. For families with incomes between 222 and 250% FPL, the contribution is $15 per child per month, with a maximum of $45 per family. For families with incomes over 250% of the FPL, Child Health Plus is available at full premium. There are no co-payments for services. /2010/Eligibility levels were increased in 2008. Premium contribution for families with incomes between 160 and 400% FPL gradually increases in increments from $9 per child per month, with a maximum of $27 per family per month to $40 per child per month, with a maximum contribution per family of $120 per month. For families with incomes over 400% of the FPL, Child Health Plus is available at full premium. There are no co-payments for services. //2010//

Family Health Plus is available at two levels. Adults with children under the age of 21, whose gross family annual income is up to 150% of the Federal Poverty Level, or $30,000 for a family of four, are eligible. Single adults, with gross family income is up to 100% of the Federal Poverty level or $9,800 per individual, are also eligible. /2010/ In 2008, these levels were, respectively, $31,800 for incomes <150% FPL for a family of four, including adults with children age 19 and 20 living with their parents, and $10,404 for single adults with incomes below 100% FPL.//2010//
/2008/These eligibility levels are scheduled to change very soon. New York is working toward making Child Health Plus available up to 400% of the Federal Poverty Level. //2008// /2010/ As noted above, eligibility levels of up to 400% FPL have been implemented for Child Health Plus. //2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	No
Annual linkage of birth certificates and newborn screening files	3	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes – 2008 –
/2008/WIC matches are on a study basis only. //2008//

Narrative:
MCH data is placed on the NYSDOH's public website, HIN and on the HPN (NYSDOH's provider health networks). Regional Perinatal Centers and Local Health Departments also have access. The Title V application is available on the public website, as well.

/2008/ In addition to data matching and survey activities, several NYSDOH initiatives currently have data capacity expansion projects either planned or in process.

- The Early Childhood Comprehensive Systems initiative is working on ways to share information between state agencies working on early childhood issues.
- The Dental Public Health Residency Program has contributed to the development of reports on the impact of oral diseases that is widely shared, both within the department and outside through the New York State Oral Health Coalition.

- The Bureau of Dental Health partners with PRAMS and produced reports that were the basis of oral health guidelines for the care of pregnant women and young children. The Bureau is also working on a report on the current status of fluoride varnish application in the state.
- The Bureau of Dental Health and the Dental Public Health Residents are currently conducting a surveillance study of Early Head Start/Head Start children for oral disease. /2009/ This study has recently been completed.
- The Bureau of Dental Health works closely with Medicaid on producing county and age-specific data on the use of dental services by the maternal child health population and the actual types of services received. The data are being used to identify areas in the state with the greatest need for services as well as to formulate policy recommendations for changes in Medicaid procedures in order to increase access and utilization of dental services to best address unmet needs. //2009//
- The Bureau is working with the Integrated Child Health Information System (ICHIS) to investigate the addition of oral health and BMI data to the existing ICHIS records.
- The Children with Special Health Care Needs Program data upgrade is in cue for data cleansing and pilot testing. The upgraded application will improve the quality of the data reported to the NYSDOH and provide local program with the capability to run reports on their own data. The generation of these reports is a new feature that will allow use of the data to make local service systems improvements.
- The Comprehensive School Health Initiative works with the State Education Department and facilitates the widespread dissemination of Youth Risk Behavior Survey (YRBS) data. //2008// /2010/ The Comprehensive School Health Initiative is now known as the Coordinated School Health Initiative.
- An additional data source collected by the Division of Family Health, Bureau of Women's Health, is the Neonatal Intensive Care Unit data set, which collects information on each baby admitted to a NICU in New York State. Plans are underway to link this data set to birth certificates, hospital discharge data, and death certificates in 2009.//2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Youth Tobacco Survey	3	No

Notes - 2008

Narrative:
New York participates /2008/ in the Youth Risk Behavior Survey (YRBS) through the State Education Department (NYSED). Adolescent smoking rates are available //2008// to the New York State Department of Heath through both the YRBS and through the Youth Tobacco Survey. The Division of Chronic Disease Prevention and Adult Health employs an epidemiologist for the tobacco program who works with both adult and child smoking data. /2008/ These data analyses are readily accessible to the Title V programs and the Public Health Information Group. NYSED publishes the survey data on their website. //2008//

IV. Priorities, Performance and Program Activities

A. Background and Overview

This section profiles New York's maternal and child health priorities, selected performance measures, and program activities and discusses the extent to which National and State objectives were met in this program year. /2010/ Summaries have been included at the beginning of each section, to provide an overview of general state progress on measures.//2010//

As previously described, New York has undergone extensive priority-setting processes. Throughout, participants decline to rank priorities, preferring that each of these "opportunities for improvement" be considered of equal importance. Following the last five-year assessment cycle required by Title V, and in consideration of past progress, several performance targets were re-adjusted. The ten priorities that follow, and the specific performance measures related to each, stem specifically from areas of unmet need in the State.

New York Title V is using an Oracle-based system for gathering and managing program information that delineates goals, objectives, sources of funds, staffing and performance measures for the maternal and child health-related programs. These data are gathered from program managers in all of the MCH-related programs, whether or not the programs are block grant funded. /2009/ Due to staffing and other changes, the Oracle-based system was supplanted by a more streamlined information gathering approach, requesting programs to review the narrative for the application and update their programmatic information more directly. This provision of a context for their updates resulted in closer contact of program managers with the content of the application, and allowed them a better overview of how their program contributed to the overall MCH picture in NYS. Fiscal information requested was pared down to essentials in order to improve the quality of the information collected. Since the methodology for collection of fiscal information was completely changed, continuity of data from the 2008 to the 2009 application may be impacted, although any changes should result in improvements in the quality of the fiscal information.//2009//

Most often, programs that address maternal and child health issues initiate services and interventions on a variety of levels. For example, in addressing access to care, we are improving the insurance and charity care infrastructure, targeting population-based messages, enabling clients to access and sustain their relationship to a medical home, and work to remove barriers to accessing high-quality direct medical services. Thus, each of the four levels of the MCH pyramid may be relevant to a particular need.

A brief summary of New York's accomplishments through use of Title V and other funds appears in Section B. New York's progress on Federal and State Performance and Outcome Measures are tracked on Forms 11 and 12.

/2009/ National Performance Measures overview: The number of births are up after several years of decline, and again are near the 2001 level. Our newborn screening percentages, including genetic (blood spot) and newborn hearing, are perfect or nearly perfect, representing a significant commitment to ensuring that all newborns receive appropriate services to ensure their health and development. New York involves families in decision making for children with special health care needs, and this has remained very steady for a number of years. In 2007, data from the SLAITS study indicated a slight dip reported in

percent of CSHCN receiving comprehensive, coordinated services within a medical home, and programs. However, conversely, the percentage of these children with adequate insurance increased at the same time, and there was a dramatic increase in the number of these families reporting that services were easy to access (from 75.3 to 90.6), and the percentage of youth transitioning to adult health care, work and independence (from 5.8 to 38.4). Percent of 19-35 month old children fully immunized rose to 85.8 percent from 83.5 percent, and is expected to increase further with the implementation of the statewide immunization registry, which will prompt physicians to enter data on their patients. The teen birth rate dropped yet again, for the 6th year in a row, and is now 13.1/1000 live births. The rate of deaths to children age 14 and younger caused by motor vehicle crashes remained stable at 1.3 per 100,000 children. In terms of breast-feeding, there has been another reported increase in the percent of mothers breast-feeding their children at 6 months of age, from 43.3 percent in 2005 to 50 percent in 2006/7. Obesity prevention initiatives, such as children receiving WIC who are at or above the 85th percentile for BMI remains stable at 32 percent, while the percentage of women smoking in the last 3 months of pregnancy decline yet again to 12.2 percent over the 12.9 percent reported in 2005. Similar good news was observed on rates of delivery of very low birth weight infants at appropriate facilities, where the figure is over 88%, although there is still room for further improvements, in this as well as in the percent of pregnant women receiving care in the first trimester.//2009//

B. State Priorities

After the last full Needs Assessment (which is done annually in New York), priority setting was conducted as a melding process, combining:

- The use of the many and various data sets available to the Department;
- The use of program data and provider input to identify trends and issues;
- Infrastructure evaluation;
- The results of multiple cross-departmental and public participative processes;
- The input of the public and the Maternal and Child Health Services Advisory Council to assist in interpreting these data and identifying important trends, gaps in services or barriers to care; and
- The input of key staff within the Department.

The process remains unchanged since the last application. Collaborations and partnerships that contribute to the needs assessment process /2008/ continue to expand and grow.//2008//

- As a result of the needs assessment process and subsequent discussion, the following priorities were identified:
- To improve access to high-quality health services for all New Yorkers, with a special emphasis on prenatal care and primary and preventative care, which includes attention to mental health issues and which serves those with special health care needs;
- To improve oral health, particularly for pregnant women, mothers and children, and among those with low income;
- To prevent and reduce the incidence of overweight for infants, children and adolescents;
- To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality;
- To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;

- To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women;
- To reduce unintended and adolescent pregnancies;
- To ensure the availability of comprehensive genetics services statewide, including follow-up on positive newborn screening tests, specialty services and genetic counseling for affected families;
- To reduce the rate of violence across all age groups, including inflicted and self-inflicted injuries and suicides in 15- to 19-year-olds; and
- To improve parent and consumer participation in the Children with Special Health Care Needs Program, as evidenced by parent scores.

The justification for their selection as priorities may be found in Section II. B. 1. and a description of our planning/targeting framework may be found in Section II. A. of the Needs Assessment. This same section also contains a table that summarizes the relationship between New York's priority needs and the measurement of their progress through Federal and State Performance and Outcome Measures.

C. National Performance Measures

/2010/ New York State continues to show overall progress on National Performance Measures, including exemplary performance in newborn bloodspot and hearing screening, with perfect or near perfect rates of screening and follow-up. New York also has a very generous Medicaid package and fairly liberal coverage of families in need. New York covers medically needy CSHCN through Medicaid, as well as offering special services to ensure that the system is meeting the needs of these special children and their families. Our pregnancy and birth rates for teens 15-17 are fairly low, and yet, after many years of decline, the rate of teen births has shown its first, albeit minor, increase. While only a tenth of a point, it is still concerning after the steady progress previously made. This increase coincides with a decline in the numbers of teens receiving family planning services through our contracted providers. Resources are being tasked to identify factors contributing to this troubling decline. On the more negative side, we continue to have low rates of early (first trimester) entry to prenatal care, despite a rather concerted effort on the part of multiple programs to promote early entry to prenatal care. Breastfeeding rates at six months postpartum continue to be less than ideal, and though rising, this is another topic to which considerable Department resources are being devoted in a multipronged effort to increase both initiation and duration of breastfeeding. While most women are breastfeeding at hospital discharge (between two-thirds to three-quarters, depending on which of the various data sources you look at), new evidence indicates that total length of time a woman spends breastfeeding over her lifetime can contribute to decreased cardiovascular disease, diabetes, hypertension and other conditions. This is definitely an opportunity to leverage greater commitment to initiation and maintenance of breastfeeding from pregnant women.

Percentage of young children in WIC, ages 2-5, who have BMIs above the 85th percentile, is high, and has remained flat for a few years, despite the multiple efforts to address diet quality and activity levels via new programs. This is definitely an issue to be closely watched as more evidence-based initiatives become available.

Immunization levels of 19-35 month olds are high, but have shown a decrease in 2008, perhaps, as suggested, due to the number of households that have given up landlines, which negatively impacts telephone survey findings. There may also be a component related to the recession that contributed to this decrease. Whatever the reason, NYS will continue its efforts to ensure that all children are properly immunized for their age.

Though the percentage of women who smoke in the last three months of pregnancy is less than 14 percent, this is an extremely important and potent indicator of poor outcomes of pregnancy and continued risk for the newborn. While NYS has several programs that address smoking cessation, including those targeted to pregnant women, and a new Medicaid initiative to pay physicians for smoking cessation counseling, it is always possible to do more, and additional initiatives will be discussed.//2010//

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective		100	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100	100	100	100
Numerator	253545	254018	250209	246243	252014	4,459*	4,427*
Denominator	253545	254018	250259	246243	252014	4,459*	4,427*
Is the Data Provisional or Final?				Final	Final	Final	Final
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	100	100	100	100	100		

2010 Notes – 2007 and 2008 numerator and denominator data represent only screen positives, unlike previous years, where these numbers represent all newborns screened.

a. Last Year's Accomplishments

- 252,793 infants were screened for all the 29 core conditions and most of the secondary conditions plus HIV and Krabbe disease, both of which are unique to NYS, in 2008 by NYSDOH's Wadsworth Center Newborn Screening Bloodspot Program.
- 100% of newborns in NYS are tested for at least 43 congenital conditions on bloodspots, including:
  - Congenital adrenal hyperplasia (CAH)
  - Congenital hypothyroidism (CH)
  - Sickle cell disease
  - Exposure to HIV-1
  - Homocystinuria
  - Hypermethioninemia
  - Maple syrup urine disease
  - Phenylketonuria
  - Tyrosinemia
  - Carnitine-acylcarnitine translocase deficiency (
  - Carnitine palmitoyltransferase deficiency
  - Carnitine uptake defect
  - 2,4-Dienoyl-CoA reductase deficiency
  - Long-chain 3-hydroxyacyl-CoA dehydrogenase deficiency
  - Medium-chain acyl-CoA dehydrogenase deficiency
  - Medium-chain ketoacyl-CoA thiolase deficiency (
  - Medium/short-chain hydroxyacyl-CoA dehydrogenase deficiency
  - Mitochondrial trifunctional protein deficiency
  - Multiple acyl-CoA dehydrogenase deficiency

    - Short-chain acyl-CoA dehydrogenase deficiency
    - Very long-chain acyl-CoA dehydrogenase deficiency
    - Glutaric acidemia
    - 3-Hydroxy-3-methylglutaryl-CoA lyase deficiency
    - Isobutyryl-CoA dehydrogenase deficiency
    - Isovaleric acidemia
    - Malonic acidemia
    - 2-Methylbutyryl-CoA dehydrogenase deficiency
    - 3-Methylcrotonyl-CoA carboxylase deficiency
    - 3-Methylglutaconic acidemia
    - 2-Methyl 3-hydroxybutyryl-CoA dehydrogenase deficiency
    - Methylmalonic acidemia
    - Mitochondrial acetoacetyl-CoA thiolase deficiency
    - Multiple carboxylase deficiency
    - Propionic acidemia
    - Argininemia
    - Argininosuccinic acidemia
    - Citrullinemia
    - Hyperammonemia/hyperornithinemia/homocitrullinemia
    - Biotinidase deficiency
    - Cystic Fibrosis
    - Galactosemia
    - Krabbe Disease
- Of children screened in 2008 there were 14 confirmed amino acid disorders including PKU; 10 confirmed cases of congenital adrenal hyperplasia; 130 confirmed cases of congenital hypothyroidism; 31 confirmed fatty acid oxidation disorders including MCAD; 234 hemoglobinopathies; 39 confirmed organic acid disorders including 3-MCC; 6 cases of biotinidase deficiency; 53 cases of cystic fibrosis, 6 cases of galactosemia and 3 cases of Krabbe disease.
- (See Form 6.) Expanded testing began in November 2004.
- The Newborn Screening Program and the Children with Special Health Care Needs Program implemented standards for new types of Specialty Centers.
- Prenatal Genetics Services were provided to 26,994 pregnant women in 2008.
- Another 22,047 individuals received Clinical Genetics Services through genetics services grantees.
- Wadsworth Laboratories continued to provide certification of clinical and environmental laboratories serving NYS residents.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 252,793 infants were screened for genetic disorders in 2008 by NYSDOH's Wadsworth Laboratories Newborn Screening Bloodspot Program. 100% of newborns in NYS are tested for over 40 congenital conditions.			X	X
2. Of children screened in 2008 there were 14 confirmed amino acid disorders including PKU; 10 confirmed cases of congenital adrenal hyperplasia; 130 confirmed cases of congenital hypothyroidism; 39 confirmed fatty acid disorders including MCAD; 234 hemoglobinopathies; 39 confirmed organic acid disorders including 3-MCC; 6 cases of biotinidase deficiency; 53 cases of cystic fibrosis, 6 cases of galactosemia and 3 cases of Krabbe disease.		X	X	X
3. The Newborn Screening Program and the Children with Special Health Care Needs Program implemented and continues to monitor standards for Endocrine, Cystic Fibrosis and Inherited Metabolic Diseases Specialty Centers.				X
4. Prenatal Genetics Services were provided to 26,994 pregnant women in 2008.	X	X	X	X
5. Another 22,047 individuals received Clinical Genetics Services through genetics services grantees.	X	X	X	X
6. Comprehensive Prenatal/Perinatal Services Networks promote newborn screening and appropriate follow-up through newsletters and provider meetings.				X
7. NYMAC has formed two workgroups specifically charged to educate the professional and lay public about genetics and newborn screening. They are developing the means to distribute new and existing materials.			X	X
8. NY began screening for Krabbe Disease in August 06.	X	X	X	X
9. Through the NYS Newborn Screening website and the NYMAC website, http://www.wadsworth.org/newborn/nymac/index.html, individuals concerned with genetics services or specialty care are able to access educational resources or identify clinical services providers, support groups and other needed services.		X	X	X

b. Current Activities

- Wadsworth Center continues to conduct bloodspot screening on 100% of the state's newborns for the conditions listed. 98% of presumptive positive screens are followed to confirmation.
- Title V continues to monitor follow-up on active cases to ensure that infants with positive results receive appropriate follow-up.
- Local health units continue to use Article 6 State Aid reimbursement to pay for follow-up visits by public health nurses or bill insurance companies for these services.

- Clinical genetic services, including follow-up genetic counseling for families of children with inborn metabolic errors, are available through the 24 funded Genetics Program contracts.
- Comprehensive Prenatal/Perinatal Service Networks promote newborn screening and appropriate follow-up through newsletters and provider meetings.
- NYMAC has formed two work groups specifically charged to educate the professional and lay public about genetics and newborn screening, and maintains an extensive mailing list of all persons involved in or interested in genetics, newborn screening and specialty care.
- About 105,006 children were tested for Krabbe disease from August to December 2006; all newborns were screened for Krabbe in 2007 and 2008.
- Hemoglobinopathy criteria for specialty centers were jointly reviewed by the CSHCN and Newborn Screening staff and the Office of the Medical Director. The Hemoglobinopathy standards were finalized and have received approval by the Department.

c. Plan for the Coming Year

- The Newborn Screening Program will continue to screen all newborn blood spots. Courier pick-up will continue with delivery at the Laboratory expanding to include Saturday.
- The CSHCN and the Genetic Screening Programs will continue to monitor implementation and ensure appropriate follow-up services.
- NYSDOH Title V staff will remain involved in NYMAC activities.
- NYMAC and the Genetic Service Program will investigate ways to maximize resources/reimbursement for genetic services providers.
- Wadsworth Center will continue to assure that clinical public health laboratories are available to the residents of New York State, including but not limited to: an anatomic pathology laboratory; a cytogenetic laboratory for diagnosis of prenatal and clinical abnormalities; and a laboratory for identification of reproductive and metabolic disorders.
- Wadsworth Center will continue to operate a state-of-the-art clinical and environmental laboratory evaluation program to ensure that laboratories offering tests to NYS residents meet appropriate quality requirements and can pass proficiency tests.
- There are no plans for further changes at this time. NYS will continue to implement the expanded test panel and follow-up on all positive findings.
- Article 28 hospitals will be invited to apply for designation as a Hemoglobinopathy Specialty Center.
- Both through the NYS Newborn Screening website and the NYMAC website, individuals concerned with genetics or specialty care will be able to access educational resources or identify clinical services providers, support groups and other public health resources: www.wadsworth.com/newborn; www.wadsworth.org/newborn/nymac.

Performance Measure 02: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006	2007	2008
Annual Performance Objective		65	70	62	64	66	66
Annual Indicator	60.3	60.3	60.3	60.3	60.3	59.0	59.0
Numerator							
Denominator							
Is the Data Provisional or Final?					Final	Final	Final
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	67	67	68	68	68		

2010 -- NOTES: 2008 indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey

a. Last Year's Accomplishments

- The CSHCN Program continued to employ a Family Specialist, the parent of a child with special health care needs.
- The CSHCN Program continued to engage our cadre of Family Champions by seeking their perspectives on the development, implementation and evaluation of resources and tools for use by CSHCN families and the MCH programs that serve these families. The cadre of family representatives was expanded to include the four family representatives to the Child Development Learning Collaborative.
- The CSHCN Program continues to broaden parent input in policy development, improving access to health and related services for CSHCN, identifying and referring CSHCN to appropriate services, and collecting information to identify gaps and barriers in order to improve the system of care for CSHCN. One example is our Family Specialist holds a voting seat on the Emergency Medical Services for Children Advisory Committee. This Committee provides the NYSDOH Commissioner with policy guidance on the pre-hospital health care needs of children, including CSHCN.
- Parents of CSHCN spoke at public hearings sponsored by the MCHSBG Advisory Council.
- Healthy Start consumers met with Title V staff to discuss consumer involvement and focus groups.
- In April 2007, a Youth Advisory Committee was formed. Nineteen culturally diverse youth and young adults with special health care needs met with CSHCN Program staff. These representatives are providing NYSDOH with their perspectives on transition to adult care services and other issues. They have provided consumer input for the development of a statewide plan for transition resources. Youth Advisory Committee (YAC) have provided input on the development of a Health Insurance Fact Sheet.
- A Family Champion received a scholarship to attend the AMCHP annual meeting.
- The Department has invited its Title V staff and outside agency staff in planning
- community engagement meeting to discuss pandemic flu planning for special needs populations, including families of children with special health care needs and young adults with special health care needs. Title V staff have been involved with recruiting families of CSHCN and young adults with special needs.
- The Genetic Service Project at Dor Yeshorim provides genetic testing for eight genetic diseases in adolescents in the ultra-Orthodox and Chasidic Jewish community. The information is used when the young adults are considering marriage to inform them if both members of the couple have disease-causing mutations for the same condition(s). Funds are also targeted for upgrading the computer system which stores the supporting databases, for validation of clinical validity and utility of new tests and for expanding the

program into the modern Orthodox community.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHCN Program continued to employ a Family Specialist, the parent of a child with special health care needs, and several other employees		X		X
2. The Bureau of Child and Adolescent Health has expanded the diverse group of family representatives advising the Program on the development, implementation and evaluation of resources and tools.				X
3. The CSHCN Program continues to broaden parent input in policy development, improving access to health and related services for CSHCN, identifying and referring CSHCN to appropriate services, and collecting information to identify services gaps.				X
4. Conference calls are held with parent representatives.				X
5. A Youth Advisory Committee, consisting of culturally diverse youth representatives, has provided input on transitions tools, such as the portable health summary and transition software. The youth perspective drove the format of the portable health summary. Youth advisors' suggestions to enhance transition software that will be utilized by youth with special needs have been considered as part of the software development.				X
6. Parents of CSHCN spoke at public hearings sponsored by the MCHSBG Advisory Council.				X
7. The NYS Child Development Learning Collaborative was completed in October 2007. Parent representatives were included and integral to the project.				X
8. The CSHCN Program collects information about the needs expressed by the family to assist with program evaluation and design.				X

b. Current Activities

- CSHCN Program staff continues to work with the parent involvement strategic plan to improve consumer input into MCH programs and policy development. The CSHCN Program continues to seek input from Family Champions on the development, implementation and evaluation of resources and tools for use by families and programs that serve these families.
- The Early Intervention Program offers leadership training programs, informational bulletins, a parent corner of the EI web page and parent web page.
- The Early Intervention Program employs a Family Initiatives Coordinator, who is the parent of a child with a disability, to coordinate a range of parent initiatives.
- The CSHCN Program designed a "Special Health Care Needs" web page which included a portable health summary that can be downloaded by families for their use was added to this web page.

- The CSHCN Program hosted a second meeting of the Youth Advisory Committee (YAC) to share resources and tools developed with consumer input. The Youth Advisory Committee is providing consumer perspective on the development of a statewide plan for transition resources.
- The CSHCN Program collects information about the needs expressed by the family: 44% needed assistance as their insurance was not adequate and 15% needed financial assistance with reimbursement for a diagnostic evaluation.

c. Plan for the Coming Year

The Child Health Unit will:
- Continue to enhance the function of our cadre of Family Champions by seeking their perspectives on the development, implementation and evaluation of resources and tools for use by families and MCH Programs that serve families.
- The Family Champions will be engaged to provide perspectives on transition resources needed by their youth/young adults with special health care needs and themselves.
- Conference calls will be maintained to keep family representatives abreast of program initiatives.
- Continue funding local health departments to assist CSHCN and their families.
- Continue to engage a diverse stakeholder group to advise the Department on the identification, recruitment, and training of family advisors (a.k.a. Family Champions) to the Title V Program. The stakeholders group includes representatives from the Department of Health and other state agencies (Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, Developmental Disabilities Planning Council), family organizations (Parent to Parent, Family Voices, Families Together, and Parent Training and Information Centers). Family Champions will be provided with additional training, and engaged in CSHCN Program activities.
- The Youth Advisory Committee will continue to convene to assist the CSHCN Program with the statewide plan for transition resources.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective		55	60	52	55	58	58
Annual Indicator	51.7	51.7	51.7	51.7	51.7	45.2	45.2
Numerator							
Denominator							
Is the Data Provisional or Final?			Final			Final	Final
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	58	59	59	60	60		

NOTES 2010: 2008 indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM03 indicator for both the 2001 and the 2005-2006 CSHCN survey

a. Last Year's Accomplishments

- CSHCN Program funds local county health departments to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service needs.
- Montefiore Hospital established the Bronx Alliance for Special Children, a comprehensive program for children with special health care needs and their families in the Bronx and upper Manhattan. The program screens its large pediatric outpatient department to identify children with special health care needs; 140 were identified as such. The program develops individual care plans provides care coordination, home visits and supports to the families with the greatest needs. Some parents and families are integrated into the clinical teaching of the pediatric attendings. Clients' individual care plans averaged 2.5 goals per plan. Over the last two years, 76% of client goals have been achieved.
- In FFY 2008, 70% or 3,958 children with special health care needs served by the program reported having a primary care provider.
- Local health departments actively link lead poisoned children with special health care needs to appropriate services, if available in communities. In most cases, lead poisoned children are automatically given developmental tests and/or referred to the Early Intervention Program Child Find component to ensure care coordination. Local Lead Poisoning Prevention Program staff follow-up with primary care providers to assure that appropriate surveillance, diagnostic and treatment services are provided to lead poisoned children.
- The Early Intervention Program assists children referred to the Early Intervention Program to obtain a medical home, if not already connected to one.
- The Youth Advisory Council assisted the Program with identifying issues and concerns with transitioning to adult medical services and will continue to provide perspective to contribute to a statewide plan for transition resources and services.
- The American Indian Health Program and the Migrant and Seasonal Farm Worker Health Program both work to improve access to comprehensive care and to establish a medical home for children. Because of the unique circumstances of migrant children, providers concentrate on connectivity and continuity of care along the migrant stream.
- The School Based Health Center Program provides onsite primary care in schools in high need areas. If the enrolled student has another community provider, school-based health center services are coordinated with that provider to help ensure continuity of care and to reduce unnecessary duplication of effort.
- Seven community-based cancer support contractors support children with cancer, or children whose parents or siblings have cancer. Contracts for these programs ended 12/31/08 and new contractors have not yet been established.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The CSHCN Program funds local county health departments to provide health information and referral, assistance with obtaining health insurance coverage, finding a medical home, and linking with specialty care and other supportive services.		X	X	X
2. The Children with Special Health Care Needs (CSHCN) Program completed the Child Development Learning Collaborative, in partnership with families of CSHCN, District II of the American Academy of Pediatrics, the American Academy of Family Physicians.	X	X		X

Activities (cont)	Pyramid Level of Service			
3. Montefiore Hospital established the Bronx Alliance for Special Children, a comprehensive program for children with special health care needs and their families in the Bronx and upper Manhattan.	X	X		X
4. The CSHCN Program continued to collect information about the needs expressed by the family for evaluation and program design purposes.				X
5. The Early Intervention Program assists children in their program in accessing a medical home.	X	X	X	X
6. The Youth Advisory Council provided input on transition issues.		X		X
7. The American Indian Health Program and the Migrant and Seasonal Farm Worker Health Program continue to work to improve access to comprehensive care and to establish a medical home for children.		X		X
8. Local health departments continued to link lead poisoned children to medical homes and the Early Intervention Program, and the Growing Up Healthy Hotline continued to make referrals to medical and health insurance programs for residents statewide.		X	X	X
9. The School–Based Health Center Program provides onsite primary care in schools in high need areas and coordinates care with other community providers to ensure continuity of care and to reduce duplication of effort.	X	X		X

b. Current Activities

- The Growing Up Healthy Hotline continues to provide information to callers about access to medical homes for children.
- School-based health centers in New York coordinate care with other community providers to ensure continuity of care. They are required to provide access to care 24 hours per day, seven days per week.
- All NYSDOH programs dealing with prenatal care (PCAP, MOMS, Community Health Worker) work with expectant parents to help find a provider for their baby.
- Title V staff completed the 19-month Child Development Learning Collaborative to improve developmental screening of children birth to five years of age. Early results suggest that this will facilitate development of practice-based change strategies and identify systems issues.
- The Office of the Medical Director and CSHCN Program staff have been collaboratively planning with the American Academy of Pediatrics, District II, New York State, to host sessions that will encourage and support pediatricians to conduct developmental screening within a medical home setting.
- NYS Title V staff have examined SLAITS data from NYS and include these data in all presentations for the CSHCN Program. Staff query the Data Resource Center for Child and Adolescent Health/Child and Adolescent Health Measurement Initiative data base.
- CSHCN Program staff continue to assist families without medical homes to find medical homes for their children.

c. Plan for the Coming Year

- Local CSHCN Programs will continue to increase the percentage of CYSHCN through increasing the number of children who have a primary care provider and medical home. Upon a child's intake into the local CSHCN Program, program staff inquire whether a

child has a primary care provider. If a child does not, local CSHCN Program staff will assist families in locating a primary care provider who participates in their insurance plan.

- Continue funding local health departments to provide CSHCN Program information and referral services and consumer involvement activities. Funds were added to local contracts to provide consumer stipends, child care, travel reimbursement and other costs associated with consumer meetings/trainings.
- Continue Medical Home/Child Development outreach and implementation by integrating the concepts into other Department initiatives, the school-based health center Asthma Learning Collaborative and regional asthma coalitions.
- Implement three information sessions with pediatricians that support and encourage developmental screening within a medical home.
- The Physically Handicapped Children's Program (PHCP) will continue to provide reimbursement for diagnostic and treatment services for eligible children who are underinsured. Participation by localities in the treatment program is voluntary in the form of state aid reimbursement for 50% of the county's expenditures. The state's capacity to assist families is limited by the degree that localities participate in the program.
- Local health department programs will continue to actively link lead poisoned children with special health care needs to the appropriate services, if available in the communities. In most cases, a lead poisoned case is automatically given a developmental screening and/or referred to the local Early Intervention (EI) program Child Find component to ensure developmental surveillance is conducted. Local Lead Poisoning Prevention Program staff will continue to follow up with primary care providers to assure that appropriate diagnostic and treatment services are provided to lead poisoned children.
- The Early Intervention Program has an active Medical Home Workgroup to assist children in their program in accessing medical homes.
- Continue the Youth Advisory Committee. Formulate a plan for transition resources and services.
- Continue to produce and disseminate the transition resources that were developed as part of the transition plan, i.e. the Health Insurance Fact Sheet and the transition software.
- Continue to analyze the 2005/2006 SLAITS data. Use as 2005/2006 data as benchmarking for 2009.
- The American Indian Health Program and the Migrant and Seasonal Farmworker Health Program both work to improve access to comprehensive care and to establish a medical home for children. Because of the unique circumstances of migrant children, providers concentrate on connectivity with upstream and downstream providers.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective		60	65	70	68	70	72
Annual Indicator	59.1	59.1	59.1	59.1	59.1	62.1	62.1
Numerator							
Denominator							

Is the Data Provisional or Final?			Final	Final	Final	Final	Final
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	74	74	74	75	75		

NOTES 2010: 2008 indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey

a. Last Year's Accomplishments

- The Physically Handicapped Children's Program under the NYS Children with Special Health Care Needs Program continued to provide gap-filling coverage for children with special health care needs birth to age 21 for services that insurances will not cover or for children in special financial circumstances who are ineligible for Medicaid or Child Health Plus.
- This program assists families who are underinsured to obtain a diagnostic evaluation for their child by reimbursing specialty providers for their services. In 2008, over 400 children received diagnostic evaluations under the Physically Handicapped Children's Program. Additionally, over 2,000 children were served through the PHCP Treatment Program.
- The CSHCN Program continued to collect information about the needs expressed by the family. A significant portion (~59%) of the CYSHCN who presented to the CSHCN Program needed gap filling assistance as their insurance was not adequate for diagnostic and treatment services. This need is reflected in national survey data as well. The 2005-2006 State and Local Integrated Telephone Survey shows that 34.7% of NYS families of CSHCN report their insurance is inadequate. Most commonly, families needed assistance with paying for deductibles, co-payments, and items not covered by or exceeding their benefit package.
- The CSHCN Program continued to fund local county health departments to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service needs.
- Each county within NYS has enrollment sites where families can be assisted to gain access to public insurance and fill out enrollment forms. Each local health department CSHCN Program is required to have a referral linkage to the facilitated enrollment agency in their area. In some cases, the facilitated enrollment program is within the same agency.
- NY uses a combined Medicaid, Food Stamps, Child Health Plus, Family Health Plus and WIC enrollment application.
- All children identified as uninsured and underinsured by the Lead Poisoning Prevention Program are referred to appropriate local public insurance enrollment source. Lead poisoned children and their families, without health insurance are directed to and assisted with enrollment in MA and/or Child Health Plus to expedite access to care. Systems are in place to help uninsured needing immediate medical attention.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Physically Handicapped Children's Program under the NYS CSHCN Program continued to provide gap-filling coverage for over 2,000 CSHCN age birth to 21 for services/treatments their insurances will not cover. NOTE: 2008 data are incomplete at this time.	X	X	X	X
2. Over 400 children were authorized to receive a diagnostic evaluation under the Physically Handicapped Children's Program (PHCP).	X	X		
3. The CSHCN Program continues to collect information insurance coverage and make referrals where needed.	X	X	X	X
4. The CSHCN Program continued to fund local county-level CSHCN programs.	X	X	X	X
5. Each county within NYS has enrollment sites where families can be assisted to gain access to public insurance and fill out enrollment forms. Each CSHCN Program is required to have a referral linkage to facilitated enrollers.		X		X
6. NY uses a combined Medicaid, Food Stamps, Child Health Plus, Family Health Plus and WIC enrollment application.		X	X	X
7. All children identified as uninsured and underinsured by the Lead Poisoning Prevention Program were referred to appropriate local public insurance enrollment source.		X		
8. DOH continued to revise and make available the Resource Directory for CSHCN.		X	X	X
9. The Family Champions and other family participants continued to advise the Program on coverage issues.				X
10. CSHCN parents participated in consumer focus groups.				X

b. Current Activities

Same as above. There were no major changes of programming.

There is discussion about changing the performance goals for this measure, but it is difficult to determine based on a single data point. There are no new SLAITS data this year. Program data differs significantly from SLAITS results. Performance targets will be modified when there is a second data point that indicates in what direction trends are moving.

The CSCHN Program formed a Youth Advisory Committee that is advising the program on transition issues. The result will be a statewide plan for transition resources and services. The Family Champions and Learning Collaborative parents are also working with the program and sharing their perspectives on coverage issues.

A new Medicaid waiver program has been developed for children in foster care under the age of 21 who have significant mental health, developmental disabilities or health needs. This waiver will allow payment for some services not normally provided through Medicaid, including family care giver supports and services, crisis respite, adaptive and assistive

equipment and accessibility modifications that will enable the children to live in a home or community-based setting. The CSHCN Resource Directory has been updated to include information about this waiver.

c. Plan for the Coming Year

- Major changes are planned with regard to Medicaid or Child Health Plus coverage. The Governor planned to extend coverage to an additional 400,000 individuals. It is anticipated that changes will be made to how systems are accessed and what is required for certifications/re-certifications in order to make getting and staying insured easier for the consumer.
- The Physically Handicapped Children's Program will continue to provide reimbursement for diagnostic and treatment services for those eligible children who are underinsured. Participation by localities in the Treatment Program is voluntary in the form of state aid reimbursement for 50% of expenditures. The state's capacity to assist families is limited by the degree that localities participate in the program.
- The CSHCN Program will continue to fund local CSHCN Programs to work with CSHCN and their families to ensure access to health insurance and medical homes.
- Local programs will continue to link with facilitated enrollers.
- The CSCHN Program will continue to work with the Family Champions, the Learning Collaborative families and the Youth Advisory Council in FFY 2010.
- When the new SLAITS data are available, program and Department staff will analyze areas of progress and lack of progress and alter program plans accordingly.
- The Resource Directory, which includes information about public insurance programs and services, will be reprinted and distributed to health care providers, child serving organizations and agencies, and consumers.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective		80	85	78	80	82	1
Annual Indicator	75.3	75.3	75.3	75.3	75.3	90.6	90.6
Numerator							
Denominator							
Is the Data Provisional or Final?			Final			Final	Final
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	92	92	92	93	93		

a. Last Year's Accomplishments

- The CSHCN Program continued to fund local county health departments to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service needs.
- The CSHCN Program, under authority of the Physically Handicapped Children's Program legislation, is authorized to approve Specialty Centers. Specialty Centers are expected

to provide family-centered, comprehensive, culturally- and language-appropriate care. They are also expected to work in a coordinated fashion with the child's community-based medical home.

- The Early Intervention Program is funded by a Federal appropriation. EIP services are funded by state, county and insurance reimbursement. The EIP has strong ties to the MCHSBG programs and services, providing direct services to infants and young children who are identified as having a diagnosed condition or disability. The child find component under EI locates and tracks developmental surveillance of at-risk infants and their families and links families with appropriate community resources and services. EIP is a major source of MCH referrals. The Early Intervention Program continues to work with the Children with Special Health Care Needs Program on cross-program issues, such as parent involvement and sharing of data.
- The Early Intervention Program has two types of service coordination. The first type assists families through the initial phase of entry into the Early Intervention Program, helping families deal with the multidisciplinary evaluation and development of the first Individualized Family Services Plan. The second type of service coordination is ongoing, designed to ensure that families are supported through all aspects of the Early Intervention Program and that EI services are coordinated with other services and supports offered to families including sources outside of the EI program.
- The Community Health Worker Program assists families to connect to health care services and sustain that connection.
- Consumer focus groups were asked about their experiences with accessing services. This information was shared with program managers and policy makers to ensure incorporation into program planning.
- The Congenital Malformations Registry staff sent informational mailings to notify families of children born with malformations of the Early Intervention Program and support groups available statewide.
- Local health department programs actively link lead poisoned children with special health care needs to the appropriate services, if available in the communities. In most cases, a lead poisoned child is automatically given a developmental screening and/or referred to EIP.
- Regional Perinatal Programs are required to establish and implement referral networks to ensure that families have access to the appropriate services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The CSHCN Program continued to fund local CSCHN programs to provide assistance to CSCHN and their families.		X	X	X
2. The CSHCN Program, under authority of the Physically Handicapped Children's Program, continued to approve Specialty Centers as needed.	X		X	X
3. EI provides services to infants and young children who are identified as having a diagnosed condition or a developmental disability.		X	X	X
4. The Early Intervention Program provided service coordination to some CSHCN who qualify.		X		X
5. The Community Health Worker Program assisted families to connect to health care services and sustain that connection.		X		

6. Consumer focus groups were asked about their experiences with accessing services. This information was shared with program managers and policy makers to ensure incorporation into program planning.				X
7. The Resource Directory for Children with Special Health Care Needs continues to be distributed.		X	X	X
8. The Congenital Malformations Registry staff sent informational mailings to notify families of children born with malformations of the Early Intervention Program and support groups available statewide.		X	X	X
9. Local health department programs actively link lead poisoned children with special health care needs to the appropriate services.		X	X	X
10. Regional Perinatal Centers utilize their established referral networks to ensure families receive needed follow-up services.		X	X	X

b. Current Activities

- The Medical Home Unit activities, including the Child Development Learning Collaborative, are organized to have an impact on the "family friendliness" of local systems of care.
- Local health department CSHCN Coordinators work with families and providers to enable needed referrals to specialty providers and other needed services.
- The Early Intervention Program continues to provide initial and ongoing service coordination.
- The CSHCN Program continues to seek input in conference calls with the Family Champions on how systems of care can be more responsive to family and consumer needs.
- The CSCHN Program will continue to work with the Youth Advisory Committee to get their input.
- The CSHCN Program updated the Resource Directory for Children with Special Health Care Needs. This comprehensive directory provides information to families of CSHCN about health insurance programs, Medicaid Waiver Programs, family support, and special education services.

c. Plan for the Coming Year

There was a major expansion in health insurance coverage last year. Changes will be made to how systems are accessed and what is required for certifications/re-certifications in order to make getting and staying insured easier for the consumer. The Resource Directory will be translated into Spanish, Russian, French, and Chinese. The Directory will be placed on the Department's public website and be distributed to public health programs, health care providers and consumers.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006	2007	2008
Annual Performance Objective		10	20	7	7	9	40
Annual Indicator	5.8	5.8	5.8	5.8	5.8	38.4	38.4

Numerator							
Denominator							
Is the Data Provisional or Final?			Final	Final		Final	Final
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	40	40	43	43	43		

a. Last Year's Accomplishments

- The Youth Advisory Committee (YAC) was formed in order to get input of consumers on issues related to the transition to adult health care and independence. The YAC's goal is for the youth to assist the CSHCN Program with formulating a statewide plan for transition resources and services.
- Transition activities were included in the local CSHCN workplans.
- Family Champions were queried about transition issues during needs assessment focus groups.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The CSHCN Program sends out materials to children enrolled in the program who have reached transitional ages. Materials explain the need for transition planning and give key points to consider.		X		
2. Transition activities were included in the local CSHCN work plans.			X	X
3. Family Champions were queried about transition issues during needs assessment focus groups.				X
4. The Youth Advisory Council provided input on transition issues.				X
5. CSHCN Program staff monitor and provide technical assistance to local programs around transition issues.			X	X
6. Staff provide sessions for parents regarding transition of youth and importance to families.		X		X
7. A hand-held record/health diary has been created that can ease in the transition. The document will be carried with the youth and will be a tool to comprehensive and coordinated services.			X	X

b. Current Activities

- CSHCN Program staff continues to work with the State Education Department on transition issues.
- CSHCN Program staff monitor and provide technical assistance to local programs around transition issues.
- Title V staff continue to utilize SLAITS data in understanding the status of this issue for NYS.
- Staff provide sessions for parents regarding transition of youth and importance to families.
- The Youth Advisory Committee has helped to identify what transition resources are needed for youth and helped the state CSHCN Program to formulate a plan to address transition issues. The youth representatives have engaged in usability testing of

transition software and provided their comments regarding enhancements to make the software more consumer friendly. The transition software was piloted with students in one high school.
- The CSHCN Program is working with other Youth Development groups for help and advice with inclusion of youth in policy development.
- A hand-held health summary developed to be carried by youth will be a tool to promote comprehensive and coordinated services. The Portable Health Summary, named "H.I. Doc," has been placed on the Department's website, and is quite popular with consumers.
- The state CSHCN Program addressed a statewide meeting of Regional Transition Coordinators about the transition resources and tools available through the Health Department.

c. Plan for the Coming Year
- DOH will continue to work with the State Education Department and the State on transition issues. Youth advisors have participated in testing the usability of transition software that is part of the Healthy Transitions Network. This network was developed with support from a Developmental Disabilities Planning Council grant and the Department has been collaborating in the user testing phase. The secure network consists of individual websites that link youth with one another and members of their transition team. Each website offers tools for transition planning and care coordination. The youth advisors reacted favorably to the software during the usability testing phase. Testing of the transition software with students in three additional regions of the state is planned.
- CSHCN staff will continue to monitor the performance of local programs on issues related to transition.
- CSHCN staff will continue to work on information systems development that will assist the program to track these activities.
- Continue working with the Youth Advisory Committee to evaluate resources and tools that have been developed and assess ongoing needs regarding successful transition from parental responsibility to self-responsibility, from pediatric to adult medical care and from school to work.
- Continue working with the Family Champions and other parent representatives on transition issues.
- Reprint and distribute the Portable Health Summary to health care providers, School Based Health Centers, schools and Transition Coordinators, and consumers.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	77	79	81	85	86	87	88
Annual Indicator	75.3	78.8	82.2	81.6	83.5	83	78.9
Numerator							
Denominator							
Is the Data Provisional or Final?					Final	Final	Final
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	89	90	90	90	90		

a. Last Year's Accomplishments

- The National Immunization Survey (NIS) rates have decreased, in part, due to changes in the survey methodology. Decreasing prevalence of families with land lines (the NIS is a telephone survey) and a small sample size contribute to the variability of the results (confidence intervals are in the 4–6% range).
- The Immunization Program provided vaccines through the NYS Vaccines for Children (VFC) Program, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted local health departments with disease surveillance and outbreak control activities, and continued to develop a statewide immunization registry. CDC categorical grants and State and Local Assistance dollars were used to provide staffing in both central and regional offices and to purchase vaccines. County health departments assist in recruiting VFC providers.
- Over 90% of two year-old children in New York State (outside New York City) are vaccinated in private doctor's offices, instead of public clinics. Under the Assessment, Feedback, Incentives and eXchange (AFIX) initiative, local health department staff visits health care providers to assess the medical records of their patients for compliance with immunization schedules. The information is entered in CDC-developed software called, the Comprehensive Clinic Assessment Software Application (CoCASA). CoCASA calculates the providers' immunization rates and identifies opportunities for improvement in immunization practices.
- Comprehensive Prenatal/Perinatal Services Networks provide education and outreach to engage children into the health care system. Some networks conducted outreach for Child Health Plus and to ensure that parents are aware of the need for comprehensive immunization.
- Article 6 State Aid to Localities reimbursed local health departments for the infrastructure that supports immunization surveillance, tracking, parent and provider education and special studies.
- Up-to-date immunizations were provided to over 600 children in migrant day care settings in NYS.
- The Community Health Worker Program educated parents about immunization, assessed the immunization status of all children in the program, referred and assisted families to obtain immunization, and followed-up with families to assure they actually received the service. Assistance is given with insurance enrollment. In 2008, 76% of the children entering the program had up-to-date immunizations. Of the children who did not have complete immunizations, 91% received immunizations while in the program. A total of 80.3% had complete immunizations.
- PCAP and MOMS educated parents in the need for preventive services, including immunization. Assistance is given with health insurance enrollment.
- WIC reviews immunization records. In WIC, all infants and children are screened until all marker immunizations are received. Infants and children not adequately immunized must be referred to a health care provider or immunization clinic.
- Child care providers are required to check immunizations and refer.
- Age-appropriate immunizations are part of the comprehensive primary care services provided by school-based health centers (SBHC) for enrolled students. SBHCs, as extension clinics of Article 28 facilities, obtain vaccines through the Vaccine for Children's Program (VFC) and administer them to students who are eligible to receive vaccines through this mechanism. Students' immunization records are reviewed on a periodic basis to determine which students require a vaccine.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Immunization Program provided vaccines through the NYS Vaccines for Children Program, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted providers.			X	X
2. Under the Assessment, Feedback Incentives and eXchange (AFIX) Initiative, county staff visit pediatricians and assess immunization records.			X	X
3. Comprehensive Prenatal/Perinatal Services Networks provided education and outreach to engage children into the health care system.		X	X	X
4. Article 6 State Aid to Localities reimbursed local health departments for the infrastructure that supports immunization surveillance, tracking, parent and provider education and special studies.			X	X
5. Up-to-date immunizations were provided to over 600 children in migrant day care settings in NYS.	X	X		X
6. The Community Health Worker Program educated parents about immunization, assessed the immunization status of children, referred and assisted families to obtain immunization, and followed-up with families to assure receipt of vaccines.		X		X
7. PCAP and MOMS also educated parents in the need for preventive services, including immunization. Assistance is given with health insurance enrollment.		X	X	X
8. In WIC, immunization records are reviewed and children who are not up-to-date are referred to health-care providers or immunization clinics.		X	X	X
9. School-based health centers administer age-appropriate vaccines, as part of comprehensive primary care. Enrolled students immunization records are reviewed on a periodic basis to determine if their immunizations are current. If necessary SBHC staff administers the vaccines. Eligible students receive vaccines through the VFC Program.	X	X		X

Note: Data on immunizations in Migrant and Seasonal Farm Worker Health Programs are from 2007, as 2008 data are not yet complete.

b. Current Activities

The new statewide, computerized immunization registry system (begun in January 2008) enables physicians to identify and track under-immunized children and raise immunization rates.

c. Plan for the Coming Year

Further development and enhancement of the statewide electronic immunization registry, with increased reporting capability, is planned for the coming year.

The APG method of payment is being phased in throughout 2009. APGs are being used to make payments for outpatient clinic, ambulatory surgery and emergency department services. Implementation of APGs is one component of the Department's larger, multi-year agenda to transition funds from inpatient to outpatient services to support quality outpatient care and to address the problem of avoidable hospitalizations. Under APGs, the PCAPs will be joined by all Medicaid prenatal care providers in terms of requirements to adhere to the comprehensive model of care developed under PCAP, and all will be reimbursed for the provision of comprehensive prenatal care to pregnant women through the APG payment methodology.

Performance Measure 08: *The rate of births (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	16	15	14	13	12	11	11
Annual Indicator	15.7	14.9	14.2	13.7	13.1	13.2	13.2
Numerator	5867	5566	5415	5332	5,214	5,277	5,277
Denominator	374080	373439	381221	390618	398,091	398,693	398,693
Is the Data Provisional or Final?				Final	Final	Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	11	11	10	10	10		

2010 Notes: 2006 data are being used as a proxy for 2007 data. 2007 data have been updated and finalized.

a. Last Year's Accomplishments

- The rate of births to teens 15-17 steadily declined from 2001-2006 and rose slightly to its current level of 13.2 per 1,000 live births in 2007 (and in 2008 this number is used as a proxy until 2008 data is available).
- The Family Planning Programs provide community education, comprehensive reproductive health care, a full range of contraceptive methods, counseling and testing for HIV, and screening and treatment for sexually transmitted diseases. Fifty-three family planning programs provided services to 335,306 individuals in 2007, and 25% were under the age of 20.
- The Bureau received funds for a series of initiatives and services related to emergency contraception (EC), including collaboration with ACOG for educational efforts and media campaigns to reach OB/Gyns, supplemental funding to family planning providers to provide distribution of EC, support to School-Based Health Centers for EC initiatives and development of public awareness materials. A brochure for pharmacists was developed and is being distributed.

- Additional funding has been received to support the provision of cervical cancer vaccine to uninsured young women not eligible through the Vaccines for Children program.
- In 2005, the Office of Population Affairs (OPA) competitively awarded funds to provide onsite HIV counseling and testing to the highest risk target populations. It is estimated that the HIV Integration Projects provided nearly 30,000 individual prevention counseling sessions and over 20,000 Rapid HIV tests in 2008.
- Through OPA, the Bureau of Women's Health receives funding for the expansion of family planning services to bring in additional clients and to serve the hard-to-reach populations that could benefit from these services.
- Since 1995, the Bureau of Women's Health has participated in the CDC Infertility Prevention Project, which supports funding for Chlamydia testing in family planning clinics. Approximately 100,000 Chlamydia tests are reported via this project annually to CDC.
- The Community-Based Adolescent Pregnancy Prevention Program's goal is to reduce teen pregnancies in the highest risk zip codes (now 194 statewide) across New York State. C-BAPPP promoted abstinence and the delay of sexual activity among teens; encouraged educational, recreational and vocational opportunities as alternatives to sexual activity; taught assertiveness skills; and promoted access to family planning and comprehensive reproductive health services.
- The Comprehensive Prenatal/Perinatal Services Networks promoted reduction of adolescent pregnancy rates through provider and community conferences, outreach and education efforts. The Networks conduct education and outreach activities to improve the reproductive health of all women, including teens.
- The Rape Crisis Program developed and implemented a Sexual Violence Primary Prevention Committee (SVPPC) whose 30 member agencies meet quarterly to identify and address issues related to sexual violence.
- Risk assessment and anticipatory guidance and health education pertaining to sexual activity is a part of the initial assessment and annual comprehensive physical exam for adolescents enrolled in a school-based health center. When indicated, students have access to either onsite or referral for family planning services and pregnancy testing is done.
- ACT for Youth Centers for Excellence provided information statewide to youth serving providers regarding Positive Youth Development approaches towards adolescent pregnancy prevention and training on evidence-based approaches to adolescent pregnancy prevention.
- An adolescent sexual health focus group study was conducted by the ACT for Youth Center of Excellence for the Department to learn more about how NYS youth get information about sexual health, how they access sexual health care services, and what can be done to improve these services. Focus group sites were chosen with particular attention paid to diversity. A total of 291 youth participated in 27 focus groups across the State between July and December 2008.
- Effective 7/1/2008 the Adolescent Pregnancy Prevention and Services (APPS) Program transferred to DOH from the Office of Children and Family Services. This program provides education, case management, prenatal support and parenting education to high-risk teens in high need communities. This change now allows for improved coordination of all adolescent pregnancy prevention efforts.
- Healthy Start collaborations continued.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Family Planning Programs provide community education, comprehensive reproductive health care, a full range of contraceptive methods, counseling and testing for HIV, and screening and treatment for sexually transmitted diseases.	X	X	X	X
2.Community Based Adolescent Pregnancy Prevention Program provided comprehensive sexuality education and assured access to reproductive health services in high need target zip codes and case management, prenatal support and parenting education to teens in high-risk areas.		X	X	X
3. The Comprehensive Prenatal/Perinatal Services Networks promoted reduction of adolescent pregnancy rates through provider and community conferences, outreach and education efforts. The Networks conduct education and outreach activities.			X	X
4. Article 6 reimbursed local health departments for health education and other population-based efforts, and support infrastructure needed to provide data collection, data evaluation, community-based planning and implementing collaboratives.			X	X
5. The Adolescent Pregnancy Prevention and Services (APPS) program, newly transferred to DOH, provides education, case management, prenatal support and parenting education to high risk teens.		X	X	X
6. Risk assessment and anticipatory guidance and health education pertaining to sexual activity are part of the initial assessment and annual comprehensive physical exam offered in School-Based Health Centers. Pregnancy testing is done when indicated. Students have access to either onsite or referral for family planning services.	X	X		X
7. ACT for Youth continued its youth development focus, building assets for resiliency and resourcefulness among youth.			X	X
8. ACT for Youth Centers for Excellence provided information statewide and in various conferences on Youth Development concepts and best practices.				X
9. The Department meets with Healthy Start grantees in order to enhance communication and coordination among grantees and Title V.				X
10. SSDI conducted teen focus groups. Results are disseminated to DOH programs.				X

b. Current Activities

See above. There were no major changes in activities in this program year.

c. Plan for the Coming Year
With the redirection of state funds formerly used for Abstinence-only education programs, a new initiative will be implemented to expand comprehensive sexuality education in schools and other community settings to provide teens with medically accurate information and life skills to equip them with the necessary tools that they need to make the crucial healthy life choices needed for a healthy adulthood. This was accomplished through the enhancement of the Community Based Adolescent Pregnancy Prevention contracts.
The transfer of the Adolescent Pregnancy and Parenting Services (APPS) program from the Office of Children and Family Services will allow for greater coordination of services for pregnant adolescents through 21 years of age. Twenty-six programs are funded through community based organizations across the state providing the following services: counseling; basic needs; academic education; health services; employment services; recreational services; parent education; housing services; child care; and, services for infants and children.

In 2009, $554,000 in State funding is included in the family planning contracts to support HIV Rapid Testing in all family planning contractors not funded for an HIV Integration Project.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	40	50	60	30	35	35	40
Annual Indicator	57.5	38.2	27.0	27.0	27.0	27.0	27.0
Numerator	1791	3961	10534	10534	10534	10534	10534
Denominator	3115	10369	39014	39014	39014	39014	39014
Is the Data Provisional or Final?			Final			Provi-sional	Provi-sional
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	40	45	45	45	45		

Notes - 2010
2004 data is being used as a proxy for 2008. Data are from the 2002-2004 New York State Oral Health Surveillance System which surveyed 10,534 students from 272 schools.

a. Last Year's Accomplishments
- The Bureau of Dental Health completed dissemination of dental surveillance data for each county. The surveillance grant was active across the State, enrolling children for oral health screening and referring children to dental care. In 2006, the Bureau gained approval to conduct Head Start/Early Head Start surveillance. Dental Public Health residents conducted open mouth examinations at 13 Head Start/Early Head Start Centers on 232 children. Surveillance data are currently being analyzed and will be made available to our community partners.
- Ongoing oral health services were available to all school-based dental health center enrollees. The School-Based Health Center Dental Program operates in 38 sites serving

over 50,000 students. A full range of services are provided, including, but not limited to, education and outreach, screening, sealants, referral and follow-up. Some also provided onsite treatment services. Sites are staffed with a combination of dentists, dental hygienists and dental assistants. Dental students and residents also participated in these programs and were provided with professional development opportunities.

- Thirty-six School-Based Preventive Dentistry Programs continued to place sealants in 2007, serving over 50,000 children. This program targeted school children in low socioeconomic areas and provided children with a point of entry into the dental care system. Students were screened for adverse dental conditions and for the need for application of sealants. Sealant sites increased participation in their program each year. Children who need restorative oral health services are referred. All families in targeted school districts receive promotional and educational information, which appears to contribute to the program's success.
- Other dental programs also promote the use of sealants, including the Preventive Dentistry Fluoride Supplement Program, which provided 300 schools, day care and Head Start programs in non-fluoridated areas with fluoride supplementation. Over 100,000 children are reached through this initiative.
- Program entered into community partnerships involving parents, consumers, providers and public agencies for identifying and addressing community problems related to oral health. This community-based problem solving approach has help to identify effective interventions to suit community needs.
- The Bureau of Dental Health continues to fund a Technical Assistance Center at the Rochester Primary Care Network. The Center assists in building community-based organizations responsive to children's dental needs and provided consultation to developing projects.
- The New York State Oral Health Coalition's four working committees (Access to Care, Communications and Social Marketing, Workforce Development and Public Policy) continued their activities on implementing the Statewide Oral Health Plan. Dr. Thomas Curran, an oral-maxillary surgeon who is also a member of the Maternal and Child Health Services Block Grant Advisory Council, was active in the formulation of the Oral Health Plan and remains active in the committee structure.
- Article 6 State Aid provided funding for dental health education to each county in New York.
- The Bureau of Dental Health revamped, updated and supplemented public education materials (including sealant brochures) based on a needs assessment of oral health stakeholders. Staff also continued to update the NYSDOH web pages on a regular basis to expand the oral health materials available to the public through the website.
- The American Indian Health Program offered dental services to approximately 2000 children under age 20 either onsite or via off-reservation referrals. The children's fluoride program is on-going for Pre-K through Grade 6.
- Dental services were offered to approximately 2300 children through our Migrant and Seasonal Farm Worker Health Program. Sealants are also promoted in this setting.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Bureau of Dental Health completed dissemination of dental surveillance data for each county and initiated surveillance activities at 13 Head Start/Early Head Start sites.				X
2. 36 School-Based Preventive Dentistry Programs continued to provide ongoing oral health screening and	X	X	X	X

assessment to all dental health center enrollees, and placed sealants on over 50,000 children in low socioeconomic areas.				
3. Other dental programs also promote the use of sealants, including the Supplemental Fluoride Program, which provided over 100,000 children with fluoride supplementation in non-fluoridated areas through schools, day care and Head Starts.	X	X		X
4. The Bureau of Dental Health continued to fund a Technical Assistance Center at the Rochester Primary Care Network.		X		X
5. The NYS Oral Health Coalition's working committees (Access to Care, Communications and Social Marketing, Workforce Development and Public Policy) continued implementation of the Statewide Oral Health Plan.	X	X	X	X
6. The Bureau of Dental Health continued to implement an oral health listserv.			X	X
7. Article 6 State Aid provided funding for dental health education to each county in New York.				X
8. The Bureau of Dental Health revamped, updated and supplemented public education materials (including sealant brochures) based on a needs assessment of oral health stakeholders. The Webpage was updated, too.			X	X
9. The American Indian Health Program offered dental services to approximately 2000 children under age 20 either onsite or via off-reservation referrals. Fluoride is offered to children Pre-K through Grade 6.	X	X	X	X
10. Dental services were offered to approximately 2300 children through our Migrant and Seasonal Farm Worker Health Program. Sealants are also promoted in this setting.	X	X	x	X

b. Current Activities

- Thirty-one Preventive Dentistry Program contracts continued providing services in 2008.
- The Bureau of Dental Health continues to work with stakeholders on implementation of the statewide Oral Health Plan.
- The Statewide Oral Health Technical Assistance Center contract was awarded in 2008.
- Ongoing oral health screenings and referrals were provided for all school-based health center – Dental (SBHC-D) enrollees.
- The Department, in collaboration with the State Education Department, established over 200 new School-Based Dental Center sites.
- The Bureau and its contractors continue to implement the CDC SEALS software in order to evaluate our school-based sealant programs.
- The Bureau of Dental Health, in collaboration with the State Education Department, worked on implementing legislation passed in 2007 which requires New York State public schools to request, or ask, for a dental health certificate of students, at the time of school entry and in grades K, 2, 4, 7, and 10, declaring their dental health condition. A webinar was held for the school-based dental health center programs, with over 30 participating, to provide locally-based strategies for meeting the legislative requirements.

c. Plan for the Coming Year

- Continue to promote the use of effective preventive services such as community-based supplemental fluoride, dental sealants, education and other innovative programs.
- Ongoing oral health screening and referral will be available to all School-Based Dental Health Center enrollees.
- Complete analysis of Head Start/Early Head Start surveillance data and disseminate results.
- Promote use of Dental Surveillance data.
- Continue implementation of the Statewide Oral Health Plan.
- Continue sealant program evaluation, using CDC SEALS software and contextual information provided by quarterly and annual report.
- Continue work with State Education to implement legislation requiring children entering school to provide a dental health certificate.
- Continue collaborative efforts with coalitions, Medicaid, Child Health Plus, and professional associations to improve access to care and further the concept of a dental home for children.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	0.6	0.6	0.5	1.3	1.1	1.0	0.9
Annual Indicator	1.0	0.7	2.2	1.3	1.3	1.3	1.3
Numerator	38	27	85	49	50	48	48
Denominator	3846325	3766916	3790880	3744186	3,916,635	3,597,289	3,597,289
Is the Data Provisional or Final?			Final	Final		Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	0.9	0.8	0.8	0.8	0.8		

Notes - 2010
2007 data are being used as a proxy for 2008. The number of motor vehicle deaths is based on the definition used by the NYSDOH Bureau of Biometrics and Health Statistics and includes pedestrians and cyclists. The definition changed in 2004.

a. Last Year's Accomplishments

- Childhood Injury Prevention Projects have built successful coalitions for injury prevention at the local level, reaching out to diverse segments of the community to ensure that the populace is well informed on issues related to childhood injury prevention.

- The Bureau of Injury Prevention performs traffic related research and conducts surveillance of passenger, bicycle and pedestrian safety in NYS. The Bureau of Injury Prevention also represents the Department on the Governor's Traffic Safety Committee.
- The Emergency Medical Services for Children Project continued to compile data to assist providers in prevention activities and in further enhancing the pediatric trauma care system. 2005 NYS data show that motor vehicle crashes accounted for 19.8% of all pediatric trauma cases and are responsible for the largest percentage of all pediatric dead-on-arrival cases (about 35%).
- The Community Health Worker, PCAP and MOMS Programs all have extensive child safety components, which stress car seat use and other infant safety measures.
- Parents who are enrolled with Community Health Workers are given extensive information about childhood safety. Homes are assessed for hazards and workers role model positive parenting skills.
- American Indian Nations with Community Health Worker Programs all have formalized car seat education components. Other reservation clinics promote vehicle safety during individual health education/risk reduction encounters. Last year, a vehicular accident helped rally the tribal members to address alcohol/substance abuse, vehicle safety and risk reduction.
- PCAP and MOMS have an extensive health education agenda, including infant and child safety, use of safety seats, and burn prevention and other causes of infant injuries.
- All school-based health centers provide screening for psychosocial and health risk assessment beginning with the initial visit. Additionally, age appropriate anticipatory guidance is provided in a typical encounter which includes student and family education about safety issues and injury prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Childhood Injury Prevention Projects have built successful coalitions for injury control at the local level, reaching out to diverse segments of the community to ensure that the populace is well informed on issues.			X	X
2. The Bureau of Injury Prevention performs traffic related research and conducts surveillance of passenger, bicycle and pedestrian safety in NYS. The Bureau of Injury Prevention also represents the Department on the Governor's Traffic Safety Committee.			X	X
3. The Emergency Medical Services for Children Project continued to compile data to assist providers in prevention activities and in further enhancing the pediatric trauma care system. Motor vehicle crashes account for 19.8% of all pediatric trauma cases.			X	X
4. The Community Health Worker, PCAP and MOMS Programs all have extensive child safety components, which stress car seat use and other infant safety measures. Parents who are enrolled with Community Health Workers are given extensive safety information.		X	X	X
5. American Indian Nations with Community Health Worker Programs all have formalized car seat education components. Other reservation clinics promote vehicle safety during individual health education/risk reduction		X	X	X

encounters.				
6. All school-based health centers provide screening for psychosocial issues and complete health risk assessment beginning with the initial visit. Additionally, age appropriate anticipatory guidance is provided to students and families which includes education about safety issues and injury prevention.	X	X		

b. Current Activities
The Bureau of Injury Prevention is developing tool kits and fact sheets to provide up to date data, best practices and evidence-informed programs to reduce unintentional injuries, particularly traffic related, for medical providers, researchers, educators and consumers.

c. Plan for the Coming Year
The Bureau of Injury Prevention will conduct a Childhood Unintentional Injury Prevention Campaign. Tool kits will be distributed for local health departments to tailor for their community's needs. Training for Local Health Department staff will be available at a one-day symposium.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*
Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					40	43	51
Annual Indicator			37.2	42.3	50.0	50.0	43.5
Numerator							
Denominator							
Is the Data Provisional or Final?				Final	Final	Final	Final
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	52	53	54	55	55		

Notes - 2010
In 2006, data from the Pediatric Nutrition Surveillance System (PedNSS) indicated that 35.5 % of WIC children aged < 5 years were breastfed at least 6 months. No annual 2007 PedNSS data is available until summer 2009. The 2008 data above is from the National Immunization Survey.

a. Last Year's Accomplishments
- The Governor declared the first week of August as state breastfeeding week to call attention to the numerous benefits of breastfeeding, including the lifelong health of the baby and prevention of obesity. Mothers were encouraged to continue breastfeeding even if they were returning to work, and reminded of the responsibility of employers to support breastfeeding women.
- State regulation requires each hospital to have a lactation coordinator. Regulations specifically forbid the administration of anti-lactation drugs by standing order and the issuance of sample packs of formula without prescription.
- The Department of Health continued to support the New York State Institute for Human Lactation with the School of Public Health to provide continuing education on breastfeeding to physicians, midwives, nurses and other health care providers, helping them to promote and manage breastfeeding effectively. The Institute produces an

annual videoconference called Breastfeeding Grand Rounds that addresses both clinical and public health issues related to breastfeeding, e.g. breastfeeding and maternal depression, use of social marketing to promote breastfeeding. The national broadcast, with an audience of over 1000 professionals annually, includes a clinical lecture, a public health lecture, discussion of case studies, and extensive opportunity for audience questions. Past broadcasts are available via web streaming on the School of Public Health's website.

- For over 30 years, the WIC Program has been effective in reducing the incidence and prevalence of nutrition-related disorders of pregnancy, infancy and early childhood, specifically low birth weight, infant mortality and iron deficiency anemia. New York's WIC Program supports a service delivery system of 100 local agencies, 570 delivery sites, 4,500 retail food vendors and 515,000 participants. Breastfeeding promotion and support activities were expanded into all local WIC agencies. WIC provides extensive support for lactation and breastfeeding.
- Breastfeeding initiation among PRAMS respondents was 73.9% in 2007, the latest year for which data are available. At one month postpartum, 62.3% of PRAMS respondents reported they were still breastfeeding.
- In 2006, 66.8% of WIC moms reported ever breastfeeding. At 12 months, 23.2% of WIC participants reported in 2006 that they were still breastfeeding. In 2001, the ever breastfed rate for WIC moms was 60.1%; the rate has increased 6.7% since 2001.
- The WIC Program continues to support a culturally-diverse peer counselor program. As of October 2008, all WIC local agencies were funded to establish a paid peer counselor program through a USDA grant and state funds. Agencies who have had paid peer counselors during the past several years have higher breastfeeding rates.
- National Immunization Survey data indicate that in 2005 76.3% of New York women initiated breastfeeding. New York City women were more likely to breastfeed (84.0%). This is the second year that New York has exceeded the Healthy People 2010 goal for breastfeeding initiation.
- It is important to initiate discussion early. PCAP and MOMS encourage breastfeeding through education during prenatal care and at the postpartum visit.
- The Community Health Worker Program (CHWP) promotes breastfeeding and provides support and referrals for services. Home visits are conducted shortly after birth with ongoing visits. In 2008, 72% of the women were breastfeeding at hospital discharge; 30% continued at least 6 months.
- The Networks developed and implemented several workshops and conferences on the importance of breastfeeding. Part of this strategy is to work with obstetrical nurses and hospital staff to encourage breastfeeding. Based on the work of the Networks, some hospitals developed breastfeeding support groups as a mechanism to provide ongoing support of breastfeeding women. In addition, the Maternal Infant Services Network is training health professionals to present the business case for breastfeeding in order to increase workplace support for breastfeeding women.
- A Center for Best Practices to Prevent Childhood Obesity was established to address the issues of overweight and obesity in pregnancy and infancy, including breastfeeding.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. State regulation requires each hospital to have a lactation coordinator. Regulations specifically forbid the administration of anti-lactation drugs by standing order and the issuance of sample packs of formula without			X	X

prescription.				
2. The Department of Health continued to support the New York State Institute for Human Lactation to increase the breastfeeding initiation and continuation rate. A satellite broadcast reached over 1,000 health professionals.			X	X
3. The WIC Program continued to support breastfeeding. WIC data system (PedNSS) data indicate that 66.8% of WIC children aged < 5 years were ever breastfed and 23.2% were breastfed at least 12 months. 8.9% were exclusively breastfed at least 3 months and 2.9% at least 6 months. Hispanic children have the highest rates of infants who were breastfed for at least some time.			X	X
4. Breastfeeding initiation among PRAMS respondents was 76.1% in 2006 and 62.3% at one month postpartum. National Immunization Survey data indicate NY has reached the HP 2010 goal.			X	X
5. PCAP and MOMS Programs encourage breastfeeding through education during prenatal care and at the postpartum visit.	X	X	X	X
6. The Community Health Worker Program (CHWP) continued to promote breastfeeding. CHWs provided support and referrals for services at early postpartum home visits.		X	X	X
7. The Comprehensive Prenatal/Perinatal Services Networks developed and implemented workshops on the importance of breastfeeding.			X	X
8. Several networks linked with obstetrical nurses. Breastfeeding support groups were developed.	X	X	X	X
9. The Bureau conducts periodic hospital surveys to monitor breastfeeding rates, and is currently implementing a Statewide Perinatal Data System that will allow, among other things, more detailed assessments of breastfeeding rates and trends.				X
10. The Bureau of Women's Health responds to inquiries about the Department's K through 12 breastfeeding education materials. Materials are posted on the DOH website http://www.health.state.ny.us/nysdoh/b_feed/index.htm				X

b. Current Activities

The WIC Program continues to work with established and new paid peer counselor programs to continue to promote breastfeeding.

To support implementation of New York's 2007 *Nursing Mothers in the Workplace Act,* the Bureau of Community Chronic Disease Prevention and the NY Statewide Breastfeeding Coalition are co-sponsoring nine Business Case for Breastfeeding trainings for up to 50 participants each. Participants are expected to work with at least one worksite to implement or improve worksite breastfeeding support measures.

The Department of Health has convened an agency-wide breastfeeding workgroup. The workgroup will develop a comprehensive plan to promote and support breastfeeding in the

prenatal, intrapartum and postpartum periods. Initial activities will focus on assessing and improving hospital breastfeeding support practices.

c. Plan for the Coming Year

In addition to the above, the Department began a new Obesity Prevention initiative which includes promoting exclusive breastfeeding at hospital discharge. As part of this effort, Regional Perinatal Centers (RPC) were surveyed regarding breastfeeding rates within their perinatal networks; best practices used by RPCs to promote breastfeeding; perceived obstacles to successful and/or exclusive breastfeeding; training provided and/or needed at RPCs and affiliates; and RPCs' policies or standards regarding formula gift packs was distributed to all RPCs. Common themes in the responses include: the availability of qualified staffing, especially for late and weekend shifts; the promotion of best practices such as hospital-grade electric breast pumps provided to mothers in the labor and delivery, mother-baby units, and NICUs to encourage extraction of breast milk for nutrition when breastfeeding is not possible and active midwifery programs that encourage breastfeeding; and obstacles to promoting breastfeeding, including cultural beliefs and community attitudes about breastfeeding benefits, lack of breastfeeding education during the prenatal period, and flexibility for mothers, especially those who need to return to work quickly. Efforts to promote breastfeeding will include, in the short term, a call to action, providing opportunities for hospital staff to attend certified lactation consultant training, sharing data on breastfeeding rates with hospitals, including adding information to the Maternity Information Leaflet, and reviewing hospitals' policies and procedures, and newborn admit orders.

The Bureau of Community Chronic Disease Prevention working with the Bureau of Women' Health and Regional Perinatal Centers will sponsor the 5-day Certified Lactation Counselor (CLC) Course for up to 2 staff from each of 104 maternity hospitals.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	95	100	100	100	100	100	100
Annual Indicator	92.3	96.4	99.9	98.8	97.9	98.5	98.5
Numerator	231123	227848	240577	242628	242,212	247,960	247,960
Denominator	250343	236259	240921	245675	247,352	251,760	251,760
Is the Data Provisional or Final?				Final	Final	Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	100	100	100	100	100		

Notes - 2010
2007 data are being used as a proxy for 2008.

a. Last Year's Accomplishments

- New York continued to monitor newborn hearing screening rates through the Universal Newborn Hearing Screening Program.
- In 2008, New York screened 98.5% of infants discharged from hospitals for hearing loss. Total number of births was 251,760. Total number of infants screened was 247,960.
- The Department continued to support hospital-based newborn hearing screening programs through technical assistance and data maintenance. Program and Data Unit staff maintain data reporting requirements and continue to refine data collection and management protocols.
- Early Intervention Guidance Memorandum 2003-03 on Newborn Hearing Screening is disseminated on an ongoing basis. The document contains guidance on newborn hearing screening, the program requirements for maternity hospitals and birthing centers, and the role of the Early Intervention Program in facilitating follow-up for infants referred.
- Program staff provided ongoing training and technical assistance to local Newborn Hearing Screening Program managers and to local Early Intervention Programs. Quality Improvement efforts targeted data collection from the state's 144 maternity hospitals/birthing centers.
- Although the Community Health Worker Program does not screen for hearing loss, the program uses the Ages and States Questionnaire (ASQ), a parent-completed developmental screening tool. Through this process, the Community Health Worker program can potentially identify issues related to the child's development that could include hearing loss. The program refers to the Early Intervention Program, as appropriate. In 2006, there were 170 referrals made to the Early Intervention Program as a result of ASQ screening. Of these referrals, 84% were completed. In 2007, there were 225 referrals made to the Early Intervention Program as a result of ASQ screenings. Of these referrals, 92.4% were completed.
- The program continued to make award-winning educational materials available to the public.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. In the first 3 quarters of 2008, 98.5% of infants discharged from New York hospitals were screened for hearing loss.	X	X	X	X
2. The Department continued to support hospital-based newborn hearing screening programs through technical assistance and data maintenance.				X
3. Early Intervention Guidance Memorandum 2003-03 on Newborn Hearing Screening is disseminated on an ongoing basis.				X
4. Program staff provided ongoing training and technical assistance to local Newborn Hearing Screening Program managers and to local Early Intervention Programs. Quality Improvement efforts targeted data collection methods.				X
5. Although the Community Health Worker Program does not screen for hearing loss, the program uses the		X		X

Ages and States Questionnaire (ASQ), which resulted in 2007 in 225 referrals to the Early Intervention Program.				
6. DOH continues to reinforce links between newborn hearing screening and the Early Intervention Program and continues to target data improvement.			X	X
7. Award winning public education/parent education materials on newborn hearing screening are available in six languages.			X	X

b. Current Activities

- Currently, all hospitals have systems for testing, tracking and reporting newborn hearing screening. DOH continues to provide technical assistance to hospitals and other constituents on newborn hearing screening program implementation.
- DOH continues to reinforce links between newborn hearing screening and the Early Intervention Program and continues to target data improvement.
- Award winning public education/parent education materials on newborn hearing screening are available in six languages.

c. Plan for the Coming Year

- Continue efforts to establish data-driven quality assurance and review protocols, and to continue provision of technical assistance on newborn hearing screening for hospitals and other constituents, with an emphasis on follow-up for infants who do not pass their initial hearing screening and/or who are suspected of having a hearing loss.
- Continue training efforts on the Hearing Disorder Clinical Practice guidelines on assessment and intervention. The training will focus on issues related to hearing loss in young infants to other groups, such as early intervention service providers, physicians and primary health care providers.
- Enhance Universal Newborn Hearing Screening (UNHS) program tracking and surveillance system to accurately identify, match, and collect unduplicated, individual identifiable data at the state level. Plans are being made to investigate inclusion of newborn hearing screening data elements on the Statewide Perinatal Data System, so demographic information could be pre-populated from the birth certificate and an automatic link would exist.
- Enhance the capacity of the UNHS Program to accurately report the status of every birth as part of NYS's progress in meeting the Healthy People 2010 goals

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	9	9	9	9	8.5	8.0	8
Annual Indicator	9.9	9.4	7.1	7.7	8.4	8.9	8.9
Numerator	461000	432000	396000	347000	380,000	395,000	395,000
Denominator	4663000	4572000	4604000	4534000	4,547,000	4437000	4437000
Is the Data Provisional or Final?				Final	Final	Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	7.5	7	6.5	6.5	6.5		

Notes - 2010
2007 data are being used as a proxy for 2008.

a. Last Year's Accomplishments
- Children ages one through five years were eligible for Medicaid at 133% of the Federal Poverty Level (FPL) for twelve months of continuous coverage, even if their family's income exceeded eligibility levels during that year. Children ages six through 18 years of age were eligible for Medicaid at 100% of the FPL.
- Since November 2000, pregnant women and infants were eligible at or below 200% of poverty. All infants born to mothers enrolled in Medicaid were automatically MA-eligible for at least the first year of life.
- PCAPs also refer to programs such as Child Health Plus and/or Family Health Plus as appropriate. The Department has developed an application for all programs to help simplify the application process.
- Eligibility for Family Planning coverage was available up to 200% of poverty, regardless of previous pregnancy or eligibility. Under this waiver, the Federal government pays 90%, the State 10%, and there is no local share. The Family Planning Benefit Program (FPBP) screens every enrolled family for eligibility for public insurance.
- Facilitated enrollers are available statewide to assist families with public insurance enrollment processes.
- Families at or below 400% of the Federal Poverty Level are eligible for Child Health Plus (New York's State Child Health Insurance Program). Families over 400% of FPL are eligible for participation at full premium.
- Comprehensive Prenatal-Perinatal Services Networks facilitate the implementation of Medicaid Managed Care within their catchment areas. Many Networks are facilitated enrollers for health insurance programs. Networks provide outreach, information and education regarding Managed Care and have the ability to identify new and emerging issues related to managed care.
- All MCHSBG funded programs are required to facilitate enrollment in insurance.
- Children with Traumatic Brain Injury injured before the age of 18 are eligible for Medicaid under a special waiver.
- CSHCN who did not have a source of insurance were assisted by the CSHCN Program to enroll in an insurance program, if eligible.
- The Community Health Worker Program (CHWP) assists any child or member of an enrolled family to access health insurance. Success rates are tracked. In 2008, 9% of children entering the CHWP did not have any health insurance. Of these children, 89% were subsequently enrolled in Medicaid and 3.7% were pending at the time of data collection. Of those ineligible for Medicaid, 100% were successfully enrolled in Child Health Plus. These percentages of children assisted with enrollment all represent improvements compared to the 2007 percentages.
- The insurance status for all students enrolled in school-based health centers is determined as part of the initial enrollment process. A facilitated enroller works with students/parents/guardians with no insurance to connect them to Child Health Plus and Medicaid.
- All children identified as uninsured and underinsured by the Lead Poisoning Prevention Program continue to be referred to appropriate local public insurance enrollment source. Lead poisoned children and their families, without health insurance are directed to and assisted with enrollment in MA and/or Child Health Plus to expedite access to care.
- Systems are in place to help uninsured needing immediate medical attention.
- Healthy Children New York increased the number of child health consultants who assist children in child care to obtain insurance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Children ages 1-5 years of age were eligible for Medicaid at 133% of the Federal Poverty Level (FPL) for twelve months of continuous coverage, even if their family's income exceeded eligibility levels during that year. Children ages 6-19 at 100%			X	X
2. Since November 2000, pregnant women and infants were eligible at or below 200% of poverty. All infants born to mothers enrolled in PCAP were MA-eligible for at least the first year of life. PCAPs also refer to programs such as Child Health Plus.			X	X
3. Eligibility for Family Planning coverage is available up to 200% of poverty, regardless of previous pregnancy or eligibility. Under this waiver, the Federal government pays 90%, the State 10%, and there is no local share.			X	X
4. Facilitated enrollers are available statewide to assist families with public insurance enrollment processes. All MCHSBG funded programs are required to facilitate enrollment in insurance.		X	X	X
5. Families at or below 400% of the Federal Poverty Level are eligible for Child Health Plus (New York's State Child Health Insurance Program). Families over 400% of FPL are eligible for participation at full premium.			X	X
6. Comprehensive Prenatal/Perinatal Services Networks facilitate the implementation of Medicaid Managed Care within their catchments area. Many Networks are facilitated enrollers for health insurance programs.			X	X
7. Children with Traumatic Brain Injury injured before the age of 18 are eligible for Medicaid under a special waiver.			X	X
8. CSHCN who did not have a source of insurance were assisted by the CSHCN Program to enroll in an insurance program, if eligible.		X	X	X
9. The Community Health Worker Program (CHWP) assists any child or member of an enrolled family to access health insurance. Success rates are tracked.		X		
10. The insurance status for all students enrolled in school-based health centers is determined as part of the initial enrollment process and a facilitated enroller works with students/parents/guardians with no insurance to connect them to Child Health Plus and Medicaid.		X		X

b. Current Activities

NYSDOH has implemented a major expansion in coverage for the uninsured. The Governor extended public insurance to all eligible uninsured families under 400% of the Federal Poverty Level. Current eligibility levels are always available on the NYSDOH public website: www.health.state.ny.us or www.nyhealth.gov. All public health programs will be involved in finding and enrolling unenrolled, eligible families.

CSHCN staff are monitoring the quarterly reports of local contactors to ensure that insurance status is recorded and analyzed. The goal is to ensure that insurance status is recorded 100% of the time.

c. Plan for the Coming Year
See above. Ensuring that all programs responsible for families are aware of the change in eligibility levels to 400% FPL will be a major task in the coming year. All programs and contractors play a role in ensuring that families obtain insurance coverage.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006	2007	2008
Annual Performance Objective			34	33	32	31	30
Annual Indicator			33.4	31.8	32.0	32.0	32
Numerator			64151	62903	63874	63373	63373
Denominator			192060	197807	199608	198041	198041
Is the Data Provisional or Final?				Final	Final	Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	29	29	28	28	28		

Notes - 2010
In 2006, 15.2% of the two- to four-year-old children participating in New York's WIC Program were overweight. This is down 9% from the 2003 high of 16.8%, but still a 16% increase since 1990. 2007 data are being used as a proxy for 2008. The WIC data are collected and analyzed as part of the Pediatric Nutrition Surveillance System, and 2008 data will not be available until summer 2009.

a. Last Year's Accomplishments
- The Division of Chronic Disease Prevention and Adult Health and the Bureau of Dental Health in the Division of Family Health collaborated to complete surveillance of third-graders across the state. Height, weight and BMI measurements were added to an existing dental surveillance project. Dental hygienists were trained to accurately gather and record anthropometric data while completing oral screening. The Nutrition, Physical Activity, TV Viewing and Obesity Status of Third Grade Students in New York State (excluding New York City) report was prepared by the Bureau of Health Risk Reduction.
- Obesity data are available both from the WIC program and from the Youth Risk Behavior Survey. There are also data collection efforts associated with individual community-level interventions.
- The Department continued to support the Eat Well, Play Hard (EWPH) program, designed to prevent childhood overweight and long-term risks for chronic disease by promoting healthy eating habits and increased physical activity. The EWPH strategies targeted to children ages 2 and older are: increase developmentally-appropriate physical activity; increase consumption of fruits and vegetables; and increase consumption of 1% or less milk and low fat dairy products. Two key EWPH initiatives include the EWPH Community Projects and the EWPH in Child Care Settings initiatives. EWPH was implemented in 187 child care centers in FFY 2008, with another 251 centers to be

reached during the current FFY. Since October 2008, another 126 centers have received the intervention, bringing the total number of centers who have received the intervention to 382 in 33 counties plus 4 NYC boroughs.

- Just Say Yes to Fruits and Vegetables (JSY) is a Food Stamp Nutrition Education program designed to increase consumption of fruits and vegetables by individuals and families receiving food stamps and WIC benefits. JSY nutritionists conducted nutrition interventions, including over 900 nutrition education sessions and 95 community marketing events with over 19,559 individuals.
- The Bureau of Health Risk Reduction (BHRR) continued to implement a program for the prevention of childhood overweight and obesity, formerly known as Activ8Kids! The components of the program include: centers for best practices, school and community partnerships, and initiatives in the child care setting.
- BHRR also provided the Fit 5 Kids Reduction of TV Viewing Preschool Curriculum to three child care centers in the state. The curriculum provides lessons in language arts, math, music and movement, and arts and crafts with take home activities children can do with their parents in place of watching TV.
- A project to encourage physicians to track BMI was completed under the Preventive Medicine Residency and the Bureau of Child and Adolescent Health. The study provided a baseline for physician practice related to BMI-for-age, an educational intervention, and follow-up evaluation. Subsequently, Pediatric BMI Screening Toolkits were developed and distributed to 21,000 pediatric health care providers statewide by the Bureau of Health Risk Reduction.
- The WIC Program provides nutrition information to all participants. EWPH focuses on obesity prevention by promoting healthy lifestyles, including nutritious food and nutrition counseling/education, while Fit WIC, a physical activity initiative, teaches simple age-appropriate movements, games and activities that support a life-long habit of staying active. As of October 2008, all WIC local agencies were funded to promote healthy lifestyles including Fit WIC. The WIC Program also has a Special Projects Grant funded by USDA to support Fit WIC research.
- As of January 2009, New York was the first state WIC program in the nation to implement the new lower fat, higher fiber food packages.
- Health educational materials were constructed and made available through the NYSDOH publications catalog and on the public website.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Division of Chronic Disease Prevention and Adult Health and the Bureau of Dental Health in the Division of Family Health collaborated to complete surveillance of third-graders across the state. Height, weight and BMI measurements. A draft report has been prepared.			X	X
2. Obesity data are available both from the WIC program and from the Youth Risk Behavior Survey. There are also data collection efforts associated with individual community-level interventions.			X	X
3. The Department continued to support the Eat Well, Play Hard program. The program is an intervention to prevent childhood overweight and long-term risks for chronic disease by promoting healthy eating habits and increased physical activity.			X	X
4. The Eat Well, Play Hard Community Projects program			X	X

funded 15 new sites covering 22 counties.				
5. Eat Well, Play Hard in Child Care Settings was implemented in 179 low-income child care centers during FFY 2008.			X	X
6. The Bureau of Health Risk Reduction continued to implement a program for the prevention of childhood overweight and obesity, formerly known as Activ8Kids! A curriculum to decrease TV viewing among preschool children was provided to child care centers.			X	X
7. BMI wheels were distributed to physicians. Follow-up questionnaires determined change in practice.			X	X
8. FitWIC, a physical activity initiative, was implemented in 2005. The WIC Program offers/provides participant-centered nutrition counseling/education promoting physical activity.			X	X
9. Health education materials were improved.			X	X

b. Current Activities

- Local data from the oral health/BMI surveillance project are now being analyzed and there is a plan to disseminate these data. The draft report is under review.
- North Bronx Health Network, with Jacobi Hospital, provides a Pediatric Obesity Clinic providing comprehensive multi-disciplinary programs to overweight and obese children 3-18 years of age and their families. The program has medical, nutritional, educational, psycho-social and physical activity components and focuses on improving prevention, detection and management of childhood obesity. The project has demonstrated a significant decrease in BMI z scores across each client age group.
- Brookdale Hospital is working with obese and overweight children and adolescents who have one or more associated metabolic disorders of obesity. Treatment, nutrition, education, supervised physical activity and behavior modification are given to obese and overweight children, and their families; primary care providers are assisted in identifying, assessing and providing follow-up to obese children. 61% of patients decreased their BMI z score; 53% reduced their cholesterol and 43% reduced blood pressure.
- BHRR has 3 Centers for Best Practices, which will continue to conduct CME trainings to increase use of recommended obesity screening methods and obesity prevention counseling.
- EWPH's will now work to limit TV viewing time and increase breastfeeding
- 129 more centers are scheduled to implement the EWPH this year.

c. Plan for the Coming Year

Continue with current activities, including:

The Bureau of Community Chronic Disease Prevention, formerly Health Risk Reduction, will continue to work with the National Institute for Children's Healthcare Quality (NICHQ) to develop a statewide implementation plan of the *Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity***.** As part of this implementation plan, the OPP will release a Request for Applications to establish five Regional Pediatric Obesity Prevention Centers. Regional Pediatric Obesity Prevention Centers will develop education and skill training opportunities and tools to support health care systems changes concordant with the *Expert Committee Recommendations*.

The three Centers for Best Practices for the Prevention of Overweight and Obesity will continue to conduct continuing medical education (CME) and other training to increase use of recommended obesity screening methods and obesity prevention counseling.

The Bureau will continue its collaboration with the NYSDOH OHIP on the Pediatric Obesity Performance Improvement Projects required by Medicaid Managed Care Plans to improve their performance on the mandated obesity screening and provision of nutrition and physical activity counseling Quality Assurance Reporting and HEDIS Requirements. The Bureau will convene at least three conference calls to connect interested Medicaid Managed Care plans with the three Centers for Best Practices for the Prevention of Overweight and Obesity.

Through a joint initiative between the Bureau and the New York City Department of Health and Mental Hygiene (NYCDOHMH) practice-based toolkits for health care providers and innovative, web-based podcasts and music CDs for youth and parents based on evidence-based strategies and/or evidence informed recommendations to improve the assessment, prevention and management of pediatric overweight and obesity will be developed. Materials will be disseminated in New York City by the NYCDOHMH, provided to Medicaid Managed Care providers via the NYSDOH OHIP and made available to all other health care providers through the NYSDOH website.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					15	14	14
Annual Indicator		14.6	15.6	12.9	12.2	13.7	13.7
Numerator							
Denominator							
Is the Data Provisional or Final?				Final	Final	Final	Provi-sional
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	13	12	11	11	11		

Notes
Data are from the NYS Prams Survey and are for New York State excluding New York City. 2007 data are being used as a proxy for 2008.

a. Last Year's Accomplishments
This measure is similar to a previously-selected NYS Performance Measure.

- These data are tracked and reported via PRAMS.
- Efforts to reduce smoking in pregnant women are a part of the multi-pronged efforts to reduce smoking in the general public. These efforts include: a coordinated set of evidence-based activities implemented by the tobacco control program: Community Partnerships work to change the community environment to support the tobacco free norm; Youth Action partners work with youth activists to change community norms and de-glamorize and de-normalize tobacco use; Cessation Centers work with health care organizations and providers to implement systems to screen patients for tobacco use

and provide help; statewide media and counter marketing including TV, radio, outdoor, print and internet advertising with the goals of educating New Yorkers about the health risks of tobacco use and the dangers of second hand smoke, motivating tobacco users to stop, and promoting use of the NYS Smokers' Quitline and Quitsite (1-866-NY-QUITS, www.nysmokefree.com). Counter-marketing efforts seek to expose the manipulative and deceptive marketing practices of the tobacco industry, de-glamorize tobacco use, and build and sustain a tobacco-free norm.

- PCAP promotes healthy behaviors during pregnancy. PCAPs provide information regarding the impact of smoking on the woman and the fetus and have developed various programs to deal with smoking, including individual counseling and referrals to group or other programs that support smoking cessation.
- The School Health Program continued to screen for tobacco use and make appropriate referrals, including to obstetrical services and smoking cessation programs, and to counsel students accordingly.
- The Comprehensive Prenatal-Perinatal Services Networks' priorities included developing and implementing programs to reduce the number of women who smoke or use other substances during pregnancy. Networks provide education and training to health and human services providers on ways to assist women to enhance healthy behaviors, including smoking cessation.
- Although the Community Health Worker Program does not keep specific data on smoking, an important role of the Community Health Worker is to provide education for women to increase their understanding of behaviors that pose a risk to health. This includes the use of tobacco. The Community Health Worker will not only provide this information, but will provide appropriate referrals for those women seeking assistance in this area, including accompanying them to care, if necessary.
- Family Planning Programs refer for smoking cessation.
- All Migrant and Seasonal Farm Worker Health and American Indian Health Program providers screen for tobacco use and make appropriate referrals.
- School-based dental health center staff continue to screen all enrollees, including pregnant adolescents, for tobacco-use, provide counseling and make appropriate referrals.
- New York State continued to enforce the Clean Indoor Air Act.
- NYS Medicaid covers smoking cessation products and programs.
- All WIC local agencies are required by policy to screen all prenatal, postpartum and breastfeeding participants regarding their use of tobacco.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. New York continued to invest in anti-smoking messages. Efforts to reduce smoking in pregnant women are a part of the multi-pronged efforts to reduce smoking in the general public.			X	X
2. PCAP and WIC promote healthy behaviors during pregnancy. PCAPs and WICS provide information regarding the impact of smoking on the woman and the fetus and have developed various programs to deal with smoking, including individual counseling and referrals.			X	X
3. The School Health Program continued to screen for tobacco use and make appropriate referrals, including to	X	X	X	X

obstetrical services and smoking cessation programs, and to counsel students accordingly.				
4. The Comprehensive Prenatal/Perinatal Services Networks' priorities included developing and implementing programs to reduce the number of women who smoke or use other substances during pregnancy.			X	X
5. Although the Community Health Worker Program keeps no specific data on smoking, an important role of the Community Health Worker is to provide education for women to increase their understanding of behaviors that pose a risk to health and refer accordingly.		X	X	X
6. Family Planning Programs refer for smoking cessation.	X	X	X	X
7. All Migrant and Seasonal Farmworker Health and American Indian Health Program providers screen for tobacco use and make appropriate referrals.	X	X	X	X
8. School-based dental health center staff continue to screen all enrollees, including pregnant adolescents, for tobacco-use, provide counseling and make appropriate referrals.	X	X	X	X
9. New York State continued to enforce a tough Clean Indoor Air Act.			X	X
10. NYS Medicaid covers smoking cessation products and programs.	X	X	X	X

b. Current Activities

- New York continued to invest heavily in anti-smoking efforts.
- The Center for Environmental Health monitors implementation of the Clean Indoor Air Act. The Tobacco Control Program contracts with an independent evaluator to evaluate programmatic efforts.
- All WIC local agencies are required by policy to screen all prenatal, postpartum and breastfeeding participants and regarding their use of tobacco.
- Pregnancy Nutrition Surveillance System data reflects cigarettes/day -3 months prior to pregnancy collected on prenatal and postpartum participants.
- All PCAPs will continue to screen pregnant women for tobacco use, counsel them about the need to quit or reduce smoking while pregnant, and refer women to services, as needed, to assist them with quitting.
- Prenatal care providers will need to be informed about the newly available reimbursement for smoking counseling for pregnant women, as well as the changeover to APG-based reimbursement. This will represent a significant education and outreach effort.

c. Plan for the Coming Year

- In December 2008, the Department began a new payment methodology for Medicaid services called Ambulatory Patient Groups (APG). The APG method of payment is being phased in throughout 2009. APGs are being used to make payments for outpatient clinic, ambulatory surgery and emergency department services. Implementation of APGs is one component of the Department's larger, multi-year agenda to transition funds from inpatient to outpatient services to support quality outpatient care and to address the problem of avoidable hospitalizations. Under APGs, all NY Medicaid clinic-based providers of prenatal care will be reimbursed for the provision of comprehensive

prenatal care to pregnant women through the APG payment methodology, thus making these comprehensive services more widely available.
- One of the components of prenatal care that will be reimbursed separately for all pregnant women will be smoking cessation efforts by physicians. In January 2009 the NYS Medicaid Program began reimbursing providers for tobacco dependence counseling for pregnant women, and covers six counseling sessions per year for women who are pregnant. NYSDOH will continue promoting the availability of this reimbursement to ensure that as many pregnant women as possible who use tobacco receive such counseling.

Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	4.8	4.6	4.4	4.2	4.1	4.1	4
Annual Indicator	5.3	4.5	5.2	3.9	3.7	3.9	3.9
Numerator	68	57	68	52	51	54	54
Denominator	1279332	1279454	1297818	1318372	1,385,051	1,396,874	1,396,874
Is the Data Provisional or Final?				Final	Final	Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	4	3.9	3.7	3.7	3.7		

Notes
2007 data are being used as a proxy for 2008.

a. Last Year's Accomplishments
- Bureau of Injury Prevention and the Public Health Information Group make suicide data available and are able to perform additional analyses for use in planning.
- The Office of Mental Health (OMH) was given the lead in all suicide prevention activities in the state. OMH continued to make available their prevention campaign. Title V programs have access to the campaign and associated materials.
- OMH funds community mental health services that include suicide prevention and crisis hotlines.
- Teen alcohol use is correlated with suicide attempts. The New York State Office of Alcohol and Substance Abuse Services (OASAS) continued to make available their campaign entitled, "Underage drinking: Not a minor problem." The package includes fact sheets and resource directories. MCHSBG Advisory Council members were also presented with this package. Title V programs have access to the campaign and associated materials.
- The School-Based Health Center (SBHC) Program includes an evaluation for suicide risk as a part of the initial health assessment and whenever indicated, crisis intervention

visits. Mental health services, including crisis intervention, were available through the school-based health center or by referral. Referrals are also made for more intensive consultation or treatment. School staff, family members and other students are also offered consultation and education. Approximately 25% of SBHC visits indicated emotional problems as a primary reason for the visit.

- An Office of Mental Health initiative continued to operate expanded school-based mental health services in five schools. This initiative provides a range of psychological support, education, consultation and treatment for students and families, co-located with a comprehensive school-based health center. School staff education and support were also an integral component of the model.
- Assets Coming Together (ACT) for Youth focuses community attention on asset-building activities for youth as a way of reducing risk-taking behaviors. Through these community collaborations, ACT for Youth has developed youth forums on violence abuse and risky sexual behaviors, as well as peer education materials, conflict resolution training to train peer mediators, and mentoring programs.

- NYS continued implementation of the Lesbian, Gay, Bisexual and Transgendered Health Initiative. Over half of the grantees under this initiative are focused on issues related to gay and lesbian youth and issues with alcohol, substance abuse and self-inflicted injuries. Data from other states indicate that gay, lesbian and bisexual youth are approximately 4 times more likely to attempt suicide than their heterosexual counterparts.
- The Sexual Violence Primary Prevention Committee (SVPPC), as part of the needs assessment being conducted, is looking at data associated with other forms of violence as risk factors for victimization or perpetration of sexual violence. Studies also show that over one half of rapes and sexual assaults occur to women between the ages of 12 and 24. Although it is difficult to document the true prevalence of sexual violence, studies indicate that 1 in 6 of adult females and 1 in 33 of adult males have been victims of rape or attempted rape. More than half of all rapes of females occurred to women younger than 18; 22 percent occurred to females younger than 12. In approximately 8 out of 10 cases (83 percent) the victim knew the perpetrator. Victims of sexual violence are left with emotional scars such as fear, anger and anxiety which can lead to depression or suicide attempts.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Bureau of Injury Prevention and the Public Health Information Group make suicide data available and are able to perform additional analyses for use in planning.			X	X
2. The Office of Mental Health (OMH) was given the lead in all suicide prevention activities in the state. OMH continued to make available their prevention campaign. Title V programs have access to the campaign and associated materials.			X	X
3. Teen alcohol use is correlated with suicide attempts. The New York State Office of Alcohol and Substance Abuse Services (OASAS) continued to make available their campaign entitled, "Underage drinking: Not a minor problem."			X	X
4. OMH continued to operate an expanded school-based mental health initiative in 5 schools. This initiative co-	X	X	X	X

located a comprehensive mental health services clinic with school-based health centers.				
5. Assets Coming Together (ACT) for Youth focuses community attention on asset-building activities as a way of reducing risk-taking behaviors. Through these community collaborations, ACT for Youth has developed youth forums on violence/abuse.			X	X
6. NYS continued implementation of the Lesbian, Gay, Bisexual and Transgendered Health Initiative.			X	X
7. There is continued collaboration with the Bureau of Chronic Disease Prevention and Adult Health, Bureau of Injury Prevention, Office of Mental Health and Office of Children and Family Services.			X	X
8. The SVPPC will continue to work towards the ultimate goal of stopping sexual violence before it occurs. Some of the potential activities to accomplish this include developing or partnering with existing mentoring programs or other skill-based activities that address healthy sexuality and dating relationships, addressing social and cultural influences, creating policies that address sexual harassment, and looking at existing social norms and developing messages that promote healthy attitudes toward women, masculinity, relationships, and sexuality.		X	X	X

b. Current Activities
There have been no major changes in programming. Title V will continue to collaborate with partners in suicide prevention.

c. Plan for the Coming Year
We plan continued collaboration with the Bureau of Chronic Disease Prevention and Adult Health, Bureau of Injury Prevention, Office of Mental Health and Office of Children and Family Services.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	83	85	87	88	89	92	92
Annual Indicator	84.6	86.2	87.2	87.1	88.6	89.7	89.7
Numerator	3401	3436	3453	3281	3345	3252	3252
Denominator	4018	3986	3962	3765	3774	3627	3627
Is the Data Provisional or Final?				Final	Final	Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	94	94	95	95	95		

Notes
2007 data are being used as a proxy for 2008.

a. Last Year's Accomplishments

- In 2008, as a result of mergers and closures, there are currently 144 birthing hospitals, including: 65 Level 1 hospitals, 25 Level 2 hospitals, 36 Level 3 hospitals, and 18 hospitals constituting 16 Regional Perinatal Centers. Bureau of Women's Health continued to work with designated hospitals over the past year to ensure that hospital levels are appropriately assigned, and to review requests for changes in level.
- All hospitals with Level I, II or III designations are required to by State Hospital Code to have perinatal affiliation/patient transfer agreements with a Regional Perinatal Center that is accessible within 2 hours.
- The Bureau of Women's Health has continued to support the 11 Regional Perinatal Forums that combine the expertise of the hospital provider community with the expertise of the non-hospital community to bring a public health perspective to the regionalization process.
- Regional Perinatal Centers and Comprehensive Prenatal-Perinatal Services Networks collaborate in the development and the governance of regional Perinatal Forums, designed to improve perinatal outcomes across the RPC's network region. Forum membership includes a range of community-based agencies that provide prenatal care and related services, as well as local March of Dimes, Community Health Worker Programs and others. There is one Forum in each borough of New York City, one on Long Island, and five in Upstate, providing full statewide representation. Perinatal Forums identified a number of public health concerns that on which they plan to work, including: smoking cessation, improving prenatal care and using vital statistics data to identify areas where services are needed.
- In 2008, findings from the quality improvement funding distributed through a Request for Proposals (RFP) to improve the quality of perinatal services in NYS were received. The Bureau of Women's Health and the Association of Regional Perinatal Programs and Networks (ARPPN) collaborated on the initiative, with ARPPN administering the RFP. The grants provided funding for the development of six perinatal quality improvement programs on topics defined by DOH. Proposals funded through the QI RFP should provide guidance and assistance in areas such as assessing the quality of care delivered by hospitals and developing quality improvement programs that can be tailored to individual hospitals.

Utilizing Statewide Perinatal Data System (SPDS) and other datasets, awardees developed quality improvement projects designed to improve perinatal outcomes in obstetric hospitals across the State. These projects included Reduction of Elective Deliveries Prior to 39 Weeks, Regional Reporting and Benchmarking Using the SPDS Core and NICU Modules, Neonatal Intensive Care Unit Benchmarking to Reduce Nosocomial and Percutaneously Inserted Central Catheters, Perinatal Performance Improvement Program, An Assessment of the Quality of Care Delivered at and by RPCs, and Healthy Students, Healthy Communities: A Toolkit to Improve Community Adolescent Health. The projects have prompted dialogue and cooperation among RPCs, and provide an opportunity to share quality improvement initiatives with hospitals across the State. The final reports of each of these projects are currently being evaluated by Bureau of Women's Health staff to determine its suitability for replication across the state.

- Bureau of Women's Health staff worked with the New York City Department of Health and Mental Hygiene to implement a City-wide Forum that brought together hospitals, community providers of ancillary services, and advocates to discuss issues across New York City.
- All Prenatal Care Assistance Programs (PCAPs) conduct risk assessment on all patients to identify any high risk factors that warrant appropriate follow-up. They have

agreements with tertiary care centers for referral of high risk women for appropriate level of care. In that way, women can receive an appropriate level of service prior to admission to the hospital (perinatologist, maternal-fetal medicine specialist, etc.) and also receive inpatient services at a hospital that is capable of providing the level of care required for the pregnant woman and/or her infant.
- The cytogenetic laboratory provides prenatal and postnatal cytogenetic analysis, identifying congenital abnormalities and enabling treatment.
- Title V staff continue to collaborate with Healthy Start projects within our state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. NYSDOH continued to work with all 144 designated obstetrical hospitals in the State to ensure that all pregnant women and newborns have timely access to the appropriate level of perinatal care.				X
2. All hospitals with Level I, II or III designations are required to by State Hospital Code to have perinatal affiliation/patient transfer agreements with a Regional Perinatal Center that is accessible within 2 hours.			X	X
3. NYSDOH has 11 Regional Perinatal Forums that join the expertise of the hospital provider community with the expertise of the non-hospital community to bring a public health perspective to the regionalization process.			X	X
4. Bureau of Women's Health continued to work with New York City Department of Health and Mental Hygiene to implement a City-wide Forum to bring together perinatal issues across New York City.			X	X
5. All Prenatal Care Assistance Programs (PCAPs) conduct risk assessment on all patients to identify any high risk factors that warrant appropriate follow-up. They have agreements with tertiary care centers for referral of high risk women.			X	X
6. The cytogenetic laboratory provides prenatal and postnatal cytogenetic analysis, identifying congenital abnormalities and enabling treatment.			X	X
7. Perinatal Forums identified a number of public health concerns that on which they plan to work, including: smoking cessation, improving prenatal care and using vital statistics data to identify areas where services are needed.			X	X
8. NYSDOH Title V staff meet with New York's Healthy Start projects at least twice per year.				X

b. Current Activities
- DOH is continuing to implement Regionalization and Perinatal Regional Forums.
- In early 2007, funding was distributed through a Request for Proposals (RFP) to improve the quality of perinatal services in New York State (NYS). The Bureau of Women's Health and the Association of Regional Perinatal Programs and Networks (ARPPN), the organization representing the Regional Perinatal Centers (RPCs) in NYS, collaborated on this initiative, with the ARPPN responsible for distributing the funds to hospitals on a

competitive basis. The funded projects are designed to improve perinatal outcomes in obstetric hospitals across the state, such as reduction of elective deliveries prior to 39 weeks gestation, regional reporting and benchmarking using the SPDS core and NICU modules, NICU benchmarking to reduce nosocomial infections and those from percutaneously inserted central catheters, a perinatal performance improvement program, an assessment of quality of care delivered at and by the RPCs, and a Healthy Students, Healthy Communities toolkit to improve community adolescent health. Manuals, toolkits and other materials developed as a result of these projects were provided to the Department over the course of 2008, and are in the process of being analyzed for dissemination potential to other RPCs in the state.

- Perinatal Forums identified a number of public health concerns, including: smoking cessation, improving prenatal care and using data to identify areas where services are needed.

c. Plan for the Coming Year

To ensure and promote the high quality of care that is expected of obstetric hospitals and to improve maternal and newborn outcomes, organizations with noted expertise in areas of implementation of quality improvement initiatives, such as the National Initiative for Children's Healthcare Quality (NICHQ), the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, will be consulted regarding design and implementation of high level quality improvement initiatives, as well as design of the evaluation process. It is expected that quality improvement initiatives based on sound evidence of success may be initiated as early as the end of 2009, or perhaps the beginning of 2010.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2001**
Annual Performance Objective	77.5	80	82.5	85	77	78	78
Annual Indicator	73.0	74.7	74.9	75.4	74.6	73.8	73.8
Numerator	172109	180870	175151	174737	174078	174979	174979
Denominator	235766	242030	233802	231661	233441	236903	236903
Is the Data Provisional or Final?				Final	Final	Final	Provi-sional
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	80	81	82	82	82		

Notes

2007 data are being used as a proxy for 2008 data. The denominator is the total number of births for which prenatal care initiation is known. Total births calculation excludes births to moms with unknown prenatal care.

a. Last Year's Accomplishments

- The Growing Up Healthy Hotline handled 8,315 phone calls in 2008 requesting referral and other information related to prenatal care providers and 10 relating to pregnancy testing.
- One of the primary objectives of the Comprehensive Prenatal/Perinatal Services Networks (CPPSNs) is to increase the percentage of women entering prenatal care in

their first trimester. In addition to the statewide Growing Up Healthy Hotline, Networks have local toll-free numbers, web sites, resource directories or other mechanisms to provide pregnant women with information and referral to prenatal care. Networks also identify gaps and barriers to the service system, and in collaboration with the Consortium, work to increase accessibility and the quality of the local perinatal service system.

- PCAP and MOMS encouraged early enrollment in prenatal care, and provided presumptive eligibility to ensure that women who appeared, based on a financial screen, to be eligible for Medicaid were able to begin prenatal care immediately, thus helping to ensure prompt initiation of services.
- A media campaign promoting the Prenatal Care Assistance Program ran from March 31, 2008 to June 30, 2008. The campaign was intended to increase use of prenatal care among low-income women by raising awareness of the availability of comprehensive care at no cost to eligible women. The campaign consisted of television, radio and transit advertising spots in Albany, Binghamton, Buffalo, Plattsburgh, Elmira, Rochester, Utica, Watertown and New York City. Eligible women were directed to contact the Growing Up Health Hotline for information on where to receive services, and resulted in a significant increase in calls during the period of the campaign.
- An important collaboration between Title V and the AIDS Institute is the Community Action for Prenatal Care (CAPC) Program. This initiative seeks to decrease negative birth outcomes, including mother-to-child HIV transmission, by engaging high risk pregnant women in early prenatal care. CAPC is closely coordinated with the Community Health Worker Programs in overlapping regions of New York City and Buffalo.
- The Community Health Worker Program is a premier enabling service. Specially trained individuals from the target communities educate pregnant women and parents about health needs and instruct as well as serve as role models for the appropriate use of the health care system. They provide enhanced outreach services to engage families and individuals into the system and assist them to sustain relationships with appropriate providers. Of those women who were not already in prenatal care, 96% were assisted to receive prenatal care within 1 month of entry to the program. Of the total number of pregnant women in CHWP, 79.2% entered prenatal care in the first trimester, 17.2% in second, 3% in third; 0.8% did not receive prenatal care and there are no data for 0.7% of the pregnant women in CHWP.
- School–based health centers provided pregnancy testing and reinforced the need for early prenatal care. Access is provided either on-site or through referral to the back-up facility. Nearly 2% of visits indicated pregnancy or contraception as a primary diagnosis.
- The Family Planning Programs made early referrals for women testing positive for pregnancy, thereby improving rates for early access to prenatal care in the populations served. Early entry into prenatal care continues to be a high priority.
- The Bureau of Women's Health periodically conducts a statewide media campaign to increase awareness of the importance of early prenatal care. Whenever such a campaign was conducted, calls to the Hotline increased.
- Preconception care materials were developed by the Department and the American College of Obstetricians and Gynecologists, District II, as a result of the findings of the Safe Motherhood Initiative. These materials included a booklet on preconception care and an accompanying laminated card, a tri-fold pamphlet on managing obesity, encouraging physicians to consider reproductive consequences of obesity and providing advice on mitigating preconception risks for women of childbearing age. The materials were mailed to over 16,000 physicians throughout New York State.
- A web-based module on Preconception Health was developed by SUNY Albany and was tested by CHW and CPPSN programs before going live in 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Growing Up Healthy Hotline handled 8,315 phone calls in 2008 relating to prenatal care and 10 relating to pregnancy testing.		X	X	X
2. The Comprehensive Prenatal/Perinatal Services Networks (CPPSNs) have as one of their objectives to increase the percentage of women entering prenatal care in their first trimester. Community campaigns were conducted.			X	X
3. PCAPs and MOMS programs encouraged early enrollment in prenatal care, and provided presumptive eligibility to ensure prompt initiation of services.	X	X	X	X
4. Public awareness campaigns and the Growing Up Healthy Hotline helped raise awareness of the need for early prenatal care.		X	X	X
5. The Community Action for Prenatal Care (CAPC) Program engages pregnant, HIV positive women in early prenatal care.		X	X	X
6. The Community Health Worker Program is a premier enabling service. Specially trained individuals from the target communities and populations educate pregnant women and parents about the need for early prenatal care.		X	X	X
7. Of the pregnant women entering CHWP, 53% were already engaged in prenatal care. Of those women who were not, 96% were assisted to receive prenatal care within 1 month of entry to the program.		X		X
8. The School Health Program provided pregnancy testing and reinforced the need for early prenatal care. Access is either on-site or through referral to back-up facilities. Nearly 2% of visits indicated pregnancy or contraception as the reason for the visit.	X	X		X
9. The Family Planning Programs make early referrals for women testing positive for pregnancy, thereby improving rates for early access to prenatal care in the populations served. Early entry into prenatal care continues to be a high priority.	X	X	X	X
10. The Safe Motherhood Initiative collaboration between the American College of Obstetricians and Gynecologists (ACOG) and NYSDOH resulted in development of preconception care materials that were distributed to 16,000 physicians statewide.			X	X

b. Current Activities

- The Safe Motherhood Initiative, collaboration between the American College of Obstetricians and Gynecologists (ACOG) and NYSDOH, reinforced that early entry into high-quality care to deter maternal mortality. The Bureau of Women's Health is

currently working on implementing as number of recommendations coming out of this initiative.

- In the State Fiscal Year 2007-2008 budget, funds were appropriated for perinatal home visiting. Title V staff were involved in the planning and design of the new Healthy Mom – Healthy Baby Universal Perinatal Home Visiting Program, which is designed to ensure all pregnant women enter prenatal care in the first trimester, remain in prenatal care and receive the support they need to have healthy babies, including home visits to assess family needs and provide anticipatory guidance and referral services. The Department is currently reviewing options for award of these funds.
- The 2008-09 Executive Budget included legislation requiring early identification of clinical and psychosocial risks for poor birth outcomes. This is under development. Additionally, nurse practitioners will now be able to bill in all specialties, including mental health; and, licensed clinical social workers will be reimbursed for services for children, adolescents and pregnant women.

c. Plan for the Coming Year

See above.

- NYSDOH will be implementing a new home visiting initiative. The Department is currently reviewing options to award funding under the Healthy Mom – Healthy Baby Universal Perinatal Home Visiting Program. It is anticipated that contracts will be funded in 5 counties with high population densities and high rates of births to adolescents, teenage pregnancy, low birth weight, infant mortality, and NICU admissions for Medicaid births, and will support county-based initiatives to improve and integrate services for all pregnant women, with special emphasis on provision of services to high risk women.
- The Healthy Mom – Healthy Baby Universal Perinatal Home Visiting Program will outreach to organizations serving women of childbearing age to identify pregnant women, particularly those not engaged in prenatal care. Home visits will be provided to screen women for eligibility for comprehensive home visiting programs, provide basic health education, and to make referrals to needed services. Families in need will have access to more intensive sustained home visiting services, where available.
- In December 2008, the Department began a new payment methodology for Medicaid services called Ambulatory Patient Groups (APG) payment. The APG method of payment is being phased in throughout 2009. APGs are being used to make payments for outpatient clinic, ambulatory surgery and emergency department services. Implementation of APGs is just one component of the Department's larger, multi-year agenda to transition funds from inpatient to outpatient services to support quality outpatient care and to address the problem of avoidable hospitalizations.
- DOH and an expert panel of advisers reviewed prenatal care standards under the medical assistance program, and affirmed the ACOG/AAP standards as the base for all Medicaid clients.
- The transfer of the Adolescent Pregnancy Prevention and Services program to the Department of Health has allowed for closer coordination of services for pregnant adolescents in communities. Due to the role of the community council within each of the 26 funded projects, an extensive network is available in each community to identify pregnant adolescents and assure that they are connected with prenatal care in the first trimester.
- An additional web-based training module for CHW workers is being developed. This module will provide community health workers with access to information on maternal and child health topics such as the importance of prenatal care visits, the stages of pregnancy, staying healthy during pregnancy, preparing for birth and homecoming, and the role of the father in pregnancy and birth. The module will allow new community health workers to gain knowledge critical to their roles, and it will provide a resource to those in need of a refresher course.

D. State Performance Measures

/2009/ Summary: There is significant good news reported in the State Performance Measures, including continuing reductions in asthma hospitalization rates for children, a continuing, though slight, increase in the percentage of babies put down on their backs to sleep, reduction in teen pregnancies, a decline in the percent of High School Students who watched 3 or more hours of TV on an average school day or smoked cigarettes in the last month, and a decrease in the percent of women who felt down or depressed after their baby was born. Measures that showed either no change or a negative trend included a slight increase in the percent of live births reported from unintended pregnancies, and a slight increase in hospitalizations of teens for self-inflicted injuries and High School Students who report binge drinking in the past month. Measures with stable or negative changes in indicators will be particularly targeted for increased scrutiny and activity. An example of this is the lead program, where the most recent data reflect a stable rate of screening, but increased attention to this activity has already resulted in an increase in screening that will be reflected in subsequent years.//2009//

State Performance Measure 1: *Percent of Live Births Resulting from Unintended Pregnancies*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006	2007	2008
Annual Performance Objective		35	34	33	32.8	32.7	31
Annual Indicator		36.3	36.3	35.8	33.4	37.5	37.5
Numerator							
Denominator							
Is the Data Provisional or Final?				Final	Final	Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**		
Annual Performance Objective	31	30.5	30.0	29.5	29.0		

Notes
2007 data are being used as a proxy for 2008. Numerator and denominator data are not available. Data are from the NYS PRAMS Survey for areas in New York State outside of NYC.

a. Last Year's Accomplishments

- The New York State Family Planning program, overall, provides comprehensive family planning and reproductive health services to nearly 340,000 reproductive age individuals every year, the vast majority of whom are women. Clients average nearly 2 visits each per year, bringing the total number of service visits to close to 700,000 annually. Special effort is made to target minorities and low income women and men for outreach.
- As part of its ongoing commitment to ensuring that every birth is a planned birth, NYS obtained a Medicaid waiver to offer coverage for family planning only services for women and men with incomes less than 200% FPL. This program, the Family Planning Benefit Program, can be billed by all Medicaid providers of family planning services in NYS.
- The Family Planning Program continued to increase access to services through the Family Planning Benefit Program. Four Regional coordinators continue to provide

training and outreach. Eligibility does not depend on previous pregnancy or previous Medicaid status, and provides a full range of contraceptive services and reproductive health care. As a result of extensive collaboration, the terms of the 1115 Medicaid Waiver were renewed. All services under the FPBP now require appropriate ICD-9 coding, and some enhanced services were approved as follow up to a family planning visit.

- In addition, as an added incentive to access these services and to ensure the health and safety of the public, NYS authorized funding to cover follow-up visits for the treatment of certain sexually transmitted infections that were diagnosed during a family planning visit. In 2008, 25,648 clients received services through the Family Planning Benefit Program.
- The Family Planning program continued to provide access to reproductive health care through the Family Planning Extension Program. This program provides family planning benefits to eligible women for 24 months after a pregnancy ends. In 2008, 13,914 women received family planning services through the Family Planning Extension program.
- Family Planning Programs provided over 8,649 community education sessions, reaching approximately 100,996 individuals. In addition to education, the program provided comprehensive reproductive health care, including screening for breast and cervical cancer, STD screening and treatment, and HIV counseling and testing.
- The Community Health Worker Program provided family planning information to all women of childbearing age and referred clients to family planning services. They then follow-up to see that services were received.
- The Adolescent Pregnancy Prevention and Services Program worked to reduce teen pregnancies in high risk zip codes and provided services to high risk youth in the areas of pregnancy prevention, self-sufficiency, and child development while also promoting coordination of services and community awareness.
- The Community-Based Adolescent Pregnancy Prevention Program's worked to reduce teen pregnancies in the highest risk zip codes across New York State. C-BAPPP promoted abstinence and the delay of sexual activity among teens; encouraged educational, recreational and vocational opportunities as alternatives to sexual activity; taught assertiveness skills; and promoted access to family planning and comprehensive reproductive health services.
- School–based health centers provided risk assessment, anticipatory guidance and health education for sexual activity as part of the initial assessment and annual comprehensive physical examination. Pregnancy testing is done, where indicated. Students have access to family planning services, either onsite or by referral. Students are also provided access to prenatal services either on site or through referral. Students are referred early for prenatal services; practitioners co-manage the student's prenatal care. School-based health centers provide services to approximately 34,000 female students ages 15-19, annually.
- The Comprehensive Prenatal-Perinatal Services Networks implemented activities to decrease pregnancies by providing family planning information and education on the importance of interconceptional care. Some Networks provide in-school educational programs re reproductive health and pregnancy care. One Network developed a peer-mentoring program to encourage healthy behaviors in adolescents. Others developed teen pregnancy coalitions to address local issues related to adolescent pregnancies.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Family Planning Benefit Program, a Medicaid waiver program, provided 25,648 men and women with family planning services in 2008.	X	X	X	X
2. The Family Planning Extension Program provides benefits to eligible women for 24 months after a pregnancy ends. In 2008, 13,914 women received family planning services through the Program.	X	X	X	X
3. Family Planning Programs provided over 8,659 community education sessions, reaching approximately 100,996 individuals.		X	X	X
4. Family Planning Programs provided comprehensive reproductive health care, including screening for breast and cervical cancer, STD screening and treatment, and HIV counseling and testing to 340,000 people in 2008.			X	X
5. The Community Health Worker Program provided family planning information to all women of childbearing age and referred clients to family planning services.		X		X
6. The Community-Based Adolescent Pregnancy Prevention and the Adolescent Pregnancy Prevention and Services Programs worked to reduce teen pregnancies in the highest risk zip codes across New York State.		X	X	X
7. SBHCs provided risk assessment, anticipatory guidance and health education for sexual activity as part of the initial assessment and annual physical examination. Pregnancy testing and referrals for prenatal services are made, where indicated.	X	X		X
8. The Comprehensive Prenatal/Perinatal Services Networks implemented several activities related to decreasing pregnancies through provision of family planning information and education on the importance of inter-conceptional care.			X	X
9. A law requiring all hospitals to promptly provide information on emergency contraception (EC) to survivors of sexual assault, and provide EC if necessary, has been implemented.			X	X

b. Current Activities

- All activities listed above continue. In addition:
- New York State held an Adolescent Sexual Health symposium in February 2009 through their contract with the Assets Coming Together (ACT) for Youth Center of Excellence (COE) at Cornell University (and their partners). The purpose was to obtain input from experts on adolescent sexual health, teen pregnancy prevention and key stakeholders, review data, research and best practices, and make recommendations for future programming. A summary of the symposium is being prepared and will be distributed to interested stakeholders to ensure as wide a dissemination of ideas as possible.

- PCAP provides family planning education and services to women, generally before delivery, including education on pregnancy spacing, and this is especially important for teens.
- A law requiring all hospitals to promptly provide information on emergency contraception (EC) to survivors of sexual assault, and provide EC if necessary, was implemented. An EC brochure was drafted and made available in seven languages. It is also available on the NYSDOH website. Hospitals and other sites are directly compensated for forensic exams.
- School-based health centers provide risk assessment, anticipatory guidance and education as part of the initial assessment and annual comprehensive physical examinations. Pregnancy testing is done and students are referred to prenatal services, when indicated.

c. Plan for the Coming Year

- New York is redirecting state funds from the discontinued Abstinence Education and Promotion Initiative to the Community-Based Adolescent Pregnancy Prevention Program in order to expand comprehensive sexuality education in schools and other community settings. This will enhance the state's ability to provide teens with medically accurate information and life skills to equip them with the necessary tools that they need to make the crucial healthy life choices needed for a healthy adulthood.
- The transfer of the Adolescent Pregnancy and Parenting Services (APPS) program from the Office of Children and Family Services has allowed for greater coordination with CBAPP providing a full continuum of programming including services for pregnant and parenting adolescents through 21 years of age. Twenty-six programs are funded through community based organizations across the state providing the following services: case management; basic needs; academic education; health services; employment services; recreational services; parent education; housing services; child care; and, services for infants and children.
- The findings and discussion from the Adolescent Sexual Health symposium in February 2009 will be used as a yardstick by which we will evaluate existing adolescent programming to determine ways in which existing programs can be modified to improve targeting and/or effectiveness, and what new programs should be considered in order to more fully address adolescent health issues.

State Performance Measure 2: *Hospitalization Rate for Asthma in Children 1 to Age 14*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Perfor-mance Data	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	400	350	300	245	235	235
Annual Indicator	401.5	384.0	335.9	346.5	320.5	320.5
Numerator	14119	13588	11729	11968	10738	10738
Denominator	3516854	3538603	3492321	3453631	3350465	3350465
Is the Data Provisional or Final?			Final	Final	Final	Provisional

	2009	2010	2011	2012	2013	
Annual Performance Objective	235	230	230	230	220	

Notes - 2010
2007 data are being used as a proxy for 2008.

a. Last Year's Accomplishments

- Asthma Partnership of New York (APNY): The State Asthma Control Program has developed a formal statewide infrastructure involving over a thousand public-private organizations such as state agencies (DOH, DEC, SED), the New York City Department of Health and Mental Hygiene, the New York City Asthma Partnership, etc., who have embraced the New York State Asthma Plan as the blueprint for action.
- The NYS Asthma Guideline Toolkit was developed to promote and translate the recommendations of the National Asthma Expert Panel report into practice in New York State. The toolkit has two components, (a) a decision support tool in the form of a booklet that describes the national asthma recommendations and (b) a case based DVD that guides the translation of the recommendations into practice.
- New York State Consensus Clinical Guideline for the Diagnosis, Evaluation and Management of Adults and Children with Asthma- 2008 (Booklet) was developed by the NYS Consensus Asthma Guideline Expert Panel for primary care providers, and has been endorsed by the State and NYC health departments, as well as numerous professional societies and groups.
- The NYS Consensus Asthma Guideline Expert Panel recommended the case-based presentation developed by Mamta Reddy be produced as a CME DVD as a companion to the NYS Consensus Clinical Asthma Guideline for statewide distribution. This DVD will be posted on the IPRO website for provider distance learning opportunities.
- New York State Asthma Outcomes Learning Network is a quality improvement initiative led by the New York State Asthma Program with assistance from NICHQ. This initiative aims to strengthen the capacity of the asthma coalitions and their partners to improve asthma care processes and outcomes for children in a variety of settings.
- An Asthma Learning Collaborative focused on improving the system of care for children with asthma and improving outcomes among children with poorly controlled asthma in the areas with the highest asthma hospitalization rates among children 0-14 years in New York City. Five SBHCs in elementary schools in East and Central Harlem participated, and teams averaged 21-26 system changes during the project. Lessons learned from this demonstration project have been integrated into the larger NYS SBHC QI that reaches 225 SBHCs in New York. A manuscript, highlighting key findings, is being prepared for publication.
- A subcommittee of the NYS Consensus Asthma Guideline Expert Panel and APNY was created to review the assessment and assist the Asthma Program in conducting an analysis of existing gaps in asthma care health insurance coverage.
- Emergency Department data is now available in New York State, and was assessed for its utility in asthma surveillance. 2,334 ED records analyzed for this study. Findings indicated that the data quality for asthma and respiratory diagnoses, patient’s age, gender, and zip code information are sufficient for utilization in surveillance and for targeting interventions.
- Asthma hospital discharge data from SPARCS were used to create zip code level data for all 62 NYS counties. During 2008, the NYS Asthma Control Program produced over 700 asthma zip code level maps and tables for the 2004-2006 time period for different age groups and are available on the Department's public website for use by regional asthma coalitions, local health departments, health plans, etc. Feedback from users indicates that this data was particularly useful in assessing, planning, targeting, monitoring and

evaluating asthma interventions. (For more information: http://www.nyhealth.gov/statistics/ny_asthma/index.htm) .

- The NYS School AIR Collaborative: The *Asthma and the School Environment in NYS report* was disseminated to school districts and stakeholders across NYS to share findings and statewide information that may help schools to create asthma-friendly learning environments.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Asthma Coordinator continued to play a pivotal role in coordinating asthma prevention and control efforts across the agency.				X
2. DOH continues to make asthma information available on the Department's intranet, the public website, and also by hardcopy. The public website includes information on asthma interventions, asthma care and asthma-related patient materials.			X	X
3. The Occupational Lung Disease Registry collects information about work-related asthma.			X	X
4. Medicaid fee-for-service and managed care data have been used to generate age- and county-specific rates. These data were also used to generate asthma-related costs.			X	X
5. User-friendly asthma treatment guidelines are available through the Asthma Program. The finalized Clinical Guidelines build on the NAEPP/NIH guidelines.			X	X
6. An assessment of public (Medicaid, Family Health Plus and Child Health Plus) health insurance benefit coverage for asthma care was conducted, gaps identified and recommendations were made to close those gaps.			X	X
7. The NYSDOH continued to award funds to 9 regional asthma coalitions across the State in an effort to reduce asthma-related morbidity and mortality.		X	X	X
8. The School Nurse Asthma Management Program is a school-based program to improve asthma care and management in the school setting.	X	X	X	X
9. Over 900 school nurses participated in a project to improve the health and learning potential of students with asthma.	X	X	X	X
10. School-based health centers develop Asthma Action Plans for students diagnosed with asthma and when indicated, work with other community providers to coordinate care.	X	X		X

b. Current Activities

- The results of the SBHC Asthma Learning Collaborative are being translated to all 225 SBHCs in New York State.
- A new statewide virtual network was created for those interested in defining the business case for the integration of in-home environmental asthma management with usual primary care.

- 44 community health centers, primary care providers, SBHCs, day care centers and school health services are participating in an ongoing Quality Improvement Project based on the principles of the Chronic Care Model.
- A survey of influenza rates among children who receive care in NY's SBHCs was completed. An Asthma and Influenza campaign was conducted during the 2008-2009 influenza season.
- Distribution of the guideline will begin in the Spring of 2009 to approximately 20,000 primary care providers in New York. In addition, an electronic version of the NYS guideline is available on the Department of Health Website: http://www.health.state.ny.us/diseases/asthma/pdf/2009_asthma_guidelines.pdf
- NYSDOH is partnering with four managed care plans to identify and refer high-risk asthma patients for free in-home environmental assessments. To date, over 100 patients have been referred to the program.
- NYS Asthma Program is currently working with 10 schools in the Capital District region to explore barriers to implementation of indoor air quality (IAQ) programs and identify strategies to overcoming those barriers.

c. Plan for the Coming Year

In addition to the activities listed above, a post asthma and influenza campaign survey will be conducted among SBHCs and a coordinated statewide initiative will be conducted through the Asthma Partnership of New York, implementation activities associated with the new asthma self management legislation will be completed, a medical home initiative will be launched among Medicaid managed care plans to reduce asthma health care disparities and a new active emergency department surveillance system will be developed to support an enhanced community response to the high emergency room visit rates, especially among young children.

State Performance Measure 4: *Teenage Pregnancy Rate for Girls Ages 15-17*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007	2008
Annual Performance Objective	38	37	36	35	34	34
Annual Indicator	38.2	37.5	36.4	36.3	35.1	35.1
Numerator	14276	14283	14,256	14444	14011	14011
Denominator	373439	381221	390,618	398,091	398,693	398,693
Is the Data Provisional or Final?			Final	Final	Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**	
Annual Performance Objective	33	33	32	32	31	

Notes - 2010

2007 data are being used as a proxy for 2008.

a. Last Year's Accomplishments

- MCHSBG funds support 53 local Family Planning Programs. These programs serve low-income, uninsured women, or approximately one third of those estimated in need, more than one quarter of whom are under the age of 20. The program strives to ensure that each pregnancy is intended. Family Planning Programs provided community education and public information services, comprehensive medical exams, a full range of contraceptive services, and special counseling to teens.

- Community-Based Adolescent Pregnancy Prevention Programs (CBAPP) employed numerous strategies including school-based comprehensive reproductive health education, peer counseling, parental education, and facilitating access to reproductive health services in 194 high risk zip codes to effectively educate youth, dispel common myths about sexuality, encourage discussions about abstinence and responsible sexual behavior, and provide accurate information about how and where to obtain primary and preventive health services. CBAPP worked with schools and parents to increase communication skills and sexual literacy.
- The Adolescent Pregnancy Prevention and Services (APPS) program was transferred, along with responsibility for the 26 current contracts, from the Office of Children and Family Services. This allowed for greater coordination of this program with the Department of Health's pregnancy prevention programming. This program provided comprehensive services to at risk adolescents up to the age of 21, including services to pregnant and parenting teens and their children. Services included pregnancy prevention services, case management, parenting education, GED education and vocational training, pre-employment and life skills training, child care, nutrition education, and recreation, among others.
- The Networks implemented several activities related to decreasing adolescent pregnancies through provision of family planning information and education on the importance of preconceptional and interconceptional care. Some Networks have accessed schools to provide structured educational programs addressing reproductive health and pregnancy care. One Network has a peer mentoring program to encourage and model healthy behaviors in adolescents. Others have developed groups such as teen pregnancy coalitions to address local issues related to adolescent pregnancies. Some are lead agencies for the Adolescent Pregnancy Prevention Program.
- The Comprehensive Prenatal-Perinatal Services Networks provided conferences on adolescent pregnancy prevention for their communities. Each Network takes a localized approach to the issue.
- School-based health centers provided risk assessment as part of the initial assessment and as part of an annual comprehensive physical examination, provided consultation and health education, anticipatory guidance, family planning services (either directly or by referral), pregnancy testing, prenatal care (either directly, by co-managing care, or by referral), and follow-up consultation and patient education.
- The Community Health Worker Program educated women of childbearing age regarding family planning, referred teens and others to family planning services and followed up to determine whether appointments were kept and services were received.
- All NYS hospitals are required to offer emergency contraception to reproductive age women who have experienced a rape. The 76 rape crisis programs in NYS ensure that this standard is met, along with DOH standards for compassionate care and structured collection of physical evidence.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCHSBG funds support 53 local Family Planning Programs. These programs serve low-income, uninsured women, or approximately one third of those estimated in need, and more than one-quarter of whom were under the age of 20.	X	X	X	X
2. Community-Based Adolescent Pregnancy Prevention Program provided services in 194 high risk zip codes.		X	X	X

3.The Adolescent Pregnancy Prevention and Services Programs worked to reduce teen pregnancy in high risk zip codes and provide services, referrals and supports for pregnant and parenting teens.		X	X	X
4. The Networks implement several activities related to decreasing adolescent pregnancies through provision of family planning information and education on the importance of preconceptional and interconceptional care.		X	X	X
5. The Comprehensive Prenatal/Perinatal Services Networks provided conferences on adolescent pregnancy prevention for their communities.			X	X
6. SBHCs provided risk assessment as part of the initial assessment and annual physicals, provided consultation and health education, f/u consultation, pregnancy testing, and, either directly or by referral, family planning services and prenatal care.	X	X		X
7. The Community Health Worker Program educated women of childbearing age regarding family planning, referred to family planning services and followed up to determine whether appointments were kept and services were received.		X		
8. The "Growing Up Healthy" Hotline links women (including adolescents) with prenatal, nutrition, family planning, psychosocial and supportive services, which contributed to healthy pregnancies and improved birth weights.		X	X	X
9. ACT for Youth utilizes an assets-based approach to reduce risk-taking behavior among youth.		X	X	X
10. The 76 Rape Crisis Centers work to reduce the incidence of rape and sexual assault, as well as to ensure emergency contraception is available to victims.	X	X	X	X

b. Current Activities

- The Growing Up Healthy Hotline links women (including adolescents) with prenatal, nutrition, family planning, psychosocial and supportive services, which continues to contribute to healthy pregnancies and improved birth weights.
- Teens may be eligible for PCAP/MOMS and WIC.
- ACT for Youth utilizes an assets-based approach to reduce risk-taking behavior among youth.
- The Department continues to work with other agencies, including the Office of Children and Family Services and the State Education Department.
- The 76 Rape Crisis Centers work to reduce the incidence of rape and sexual assault, as well as to ensure effective, compassionate treatment of victims to reduce debilitating consequences once an assault has occurred, including ensuring that reproductive age women are offered emergency contraception following a rape. In addition, the rape crisis centers also provide comprehensive primary prevention education programs to the community they serve.
- Please refer to State Performance Measure 01 on unintended pregnancy.

c. Plan for the Coming Year

Previous activities will continue. In addition:

- New York State will hold an Adolescent Sexual Health symposium in February 2009 through their contract with the Assets Coming Together (ACT) for Youth Center of Excellence (COE) at Cornell University (and their partners at University of Rochester School of Medicine, New York State Center for School Safety and New York City Cornell Cooperative Extension). This symposium will be convened with experts on adolescent sexual health, teen pregnancy prevention and key stakeholders to review data, research and best practices, and make recommendations for future programming. Dr. Jonathan Klein, Professor of Adolescent Medicine at University of Rochester, current president of New York State Chapter 1 of the American Academy of Pediatrics and past chairman of the Adolescent Health Committee of the American Academy of Pediatrics, will provide the professional leadership for this event through his role with the ACT for Youth Center of Excellence.
- New York will continue to direct state funds to the Community Based Adolescent Pregnancy Prevention Program in order to expand comprehensive sexuality education in schools and other community settings to provide teens with medically accurate information and life skills to equip them with the necessary tools that they need to make the crucial healthy life choices needed for a healthy adulthood.

State Performance Measure 6: *Percent of infants who are put down on their backs to sleep.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	76	78	80	82	84	84
Annual Indicator	70.9	69.5	67.2	71.9	70.5	70.5
Numerator						
Denominator						
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**	
Annual Performance Objective	85	85	85	86	86	

Notes – 2010

2007 data are being used as a proxy for 2008 data. Numerator and denominator data are not available (because this is survey/weighted data). Data are from the PRAMS Survey which includes women from areas in NYS outside of NYC.

a. Last Year's Accomplishments

- Again, there was a decline in the number of SIDS deaths, however, the number of mothers reporting putting their babies to sleep on their backs to sleep on the PRAMS survey declined slightly compared to 2006, which may indicate a need to renew the "Back to Sleep" Campaigns. In 1999-2001, the Department produced T-shirts imprinted on the front and back with, "Put me on my back to sleep." These T-shirts and a flyer on SIDS prevention were distributed through all hospitals in the State.
- SIDS Prevention Information Cards (the same cards that were made available with the T-shirt) are still available through our health publications catalog and on the public website.
- SIDS Prevention Posters were developed after staff learned of the lack of awareness of the "Back to Sleep" message in the child care community. We continue to distribute posters to childcare providers in the state as a reminder to place babies on their backs to sleep. Other SIDS prevention messages were included, too.

- Statewide training efforts continue. Police, firefighters, emergency medical personnel and public health nurses are educated on appropriate responses to SIDS. The Department oversees notification of infant deaths by funeral directors, coroners and medical examiners. The Center for Sudden Infant Death at SUNY Stony Brook and its satellites provide training and family support services. For families that have experienced any infant death in the last year, they provide a 1-800 "warm line" for support, information and referral to self-help groups and other mental health services. The Center also arranges a home visit by a public health nurse. Newsletters are sent on a regular basis, and are a very popular item. The Center also released health education materials about the dangers of placing infants to sleep in adult beds.
- A special SIDS prevention project initiated among the St. Regis Mohawks in 2005 continued.
- In May 2002, a State law was passed amending the autopsy provisions of the Public Health Law and requiring standardized protocols for the performance of autopsies in cases of sudden, unanticipated death in infants under the age of one year. Protocols were developed. This law is now fully implemented.
- "Welcome to Parenthood" contains messages concerning back-to-sleep and overlaying dangers.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Again, there was a decline in the number of SIDS deaths.			X	X
2. SIDS Prevention Posters were developed after staff learned of the lack of awareness of the "Back to Sleep" message in the child care community.			X	X
3. Statewide training efforts continue. Police, fire fighters, emergency medical personnel and public health nurses are educated on appropriate responses to SIDS.			X	X
4. The Department oversees notification of infant deaths by funeral directors, coroners and medical examiners.			X	X
5. The Center for Sudden Infant Death at SUNY Stony Brook and its satellites provide training and family support services.		X	X	X
6. For families that have experienced any infant death in the last year, they provide a 1-800 "warm line" for support, information and referral to self-help groups and other mental health services. The Center also arranges a home visit by a PHN.		X	X	X
7. Newsletters are sent on a regular basis, and are a very popular item. The Center also released health education materials about the dangers of placing infants to sleep in adult beds.			X	X
8. A special SIDS prevention project was implemented among the St. Regis Mohawks.			X	X
9. "Welcome to Parenthood" contains information concerning back-to-sleep and overlaying dangers.			X	X

b. Current Activities

See above. No major changes were implemented.

c. Plan for the Coming Year
See above. NYSDOH will revisit current activities in light of the downward trend in PRAMS data that seems to indicate that fewer new moms are placing their babies on their backs to sleep.

State Performance Measure 7: *Hospitalizations for Self-Inflicted Injuries for 15-19 Year Olds per 100 teens aged 15-19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	0.1	0.1	0.1	0.1	0.1	0.1
Annual Indicator	0.1	0.1	0.1	0.1	0.1	0.1
Numerator	1257	1421	1291	1320	1280	1280
Denominator	1279454	1297818	1318372	1385081	1396874	1396874
Is the Data Provisional or Final?			Final	Final	Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**	
Annual Performance Objective	0.1	0.1	0.1	0.1	0.1	

Notes - 2010
2007 data are being used as a proxy for 2008.

a. Last Year's Accomplishments
- See National Performance Measure 16. This measure was selected because rates of suicide attempts are higher than rates of completion would indicate.
- All school-based health centers provided psychosocial assessment as part of the initial assessment and visit, the annual comprehensive physical examination and at follow up visits, when indicated. Students and families were offered individualized education regarding safety issues and abuse, and when indicated, mental health services were made available. Potential abuse and neglect cases were reported. Staff followed-up on all referrals for mental health services and behavioral issues.
- Over 180,000 students have access to mental health services through school-based health centers. 59% of school-based health center sites in New York State provided onsite mental health services, and 41% provided mental health services through referral.
- Through community collaborations, the ACT for Youth Initiative has developed: youth forums on violence, abuse and risky sexual behaviors; peer education for violence prevention; conflict resolution training to train peer mediators; and mentoring programs. Janis Whitlock, PhD, MPH, of the ACT for Youth Center of Excellence provided training statewide to adolescent health providers on self-injurious behavior in adolescents.

- Through community collaborations, the ACT for Youth Initiative has developed: youth forums on violence, abuse and risky sexual behaviors; peer education for violence prevention; conflict resolution training to train peer mediators; and mentoring programs.
- The Community-Based Adolescent Pregnancy Prevention Program employs a youth development/youth empowerment approach to build resiliency and developmental assets.
- The Emergency Medical Services for Children Advisory Committee developed a White Paper with recommendations for NYSDOH Commissioner for the standardization and regionalization of pediatric hospital care. This White Paper provided evidence that the standardization and regionalization of pediatric care in NYS will improve health outcomes for children. EMSC continues moving forward garnering support and stakeholder input to the regionalized system to be developed.
- NYSDOH continues to collaborate with the Office of Mental Health and the Office of Alcohol and Substance Abuse Services.
- The Early Childhood Comprehensive Systems seeks to bolster early relationships and positive development, with the end result of higher functioning youth, adults and families. Parental support is a key issue. The Early Childhood Comprehensive Systems initiative recently released its plan for developing a comprehensive system of supports and services for young children and their families. The plan will serve as the framework for the initial work of the Early Childhood Advisory Council.
- The Advisory Council hosted speakers from Mary Imogene Bassett Hospital and Johns Hopkins University who presented their project on improving communication skills for primary care providers. This model appears to improve patient outcomes while making effective use of limited practitioner time. Final data from the project are pending.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. See National Performance Measure 16. This measure was selected because rates of suicide attempts are higher than rates of completion would indicate.			X	X
2. SBHCs provided psychosocial assessment as part of the initial assessment, annual physicals and at follow up visits, when indicated. Individualized education re safety issues and abuse, and mental health services were made available as indicated.	X	X		X
3. Over 180,000 students have access to mental health services through school-based health centers.	X	X		X
4. Through community collaborations, the ACT for Youth Initiative has developed: youth forums on violence, abuse and risky sexual behaviors; peer education for violence prevention; conflict resolution training to train peer mediators.		X	X	X
5. The Community-Based Adolescent Pregnancy Prevention Program employs a youth development/youth empowerment approach.			X	X
6. Emergency Medical Services for Children Advisory Committee developed a White Paper with recommendations for NYSDOH Commissioner for the standardization and regionalization of pediatric hospital care.			X	X

7. The NYS ECCS Plan provides strategies for improved parental support in early childhood, which should result in more intact, adaptable families and youth.			X	X
8. NYSDOH continues to collaborate with the Office of Mental Health and the Office of Alcohol and Substance Abuse Services.			X	X
9. The Advisory Council examined models for incorporation of mental health interventions into primary care.	X			X

b. Current Activities

- Bureau of Child and Adolescent Health continued working with the Office of Mental Health and other partners to identify key elements of a statewide suicide prevention plan.
- School-Based Health Centers continue to assess students for suicide risk, and provide enhanced mental health services, either directly or by referral.
- Youth development continues to be a focus of all youth-related activities.
- The Council is discussing various models for better incorporating mental health interventions into primary care.

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c. Plan for the Coming Year

See above. No major changes are planned.

State Performance Measure 8: *Percent of High School Students who had five or more drinks of alcohol in a row at least once in the Last Month*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007	2008
Annual Performance Objective	20	20	19	19	18	18
Annual Indicator	25.3	25.3	23.9	23.9	24.9	24.9
Numerator						
Denominator						
Is the Data Provisional or Final?					Final	Final
	2009	**2010**	**2011**	**2012**	**2013**	
Annual Performance Objective	18	18	18	18	18	

Notes – 2010

2007 data are being used as a proxy for 2008. Data are from the YRBS, which takes place only every two years.

a. Last Year's Accomplishments

Please Note: In previous years, the indicator tracked those that reported drinking alcohol at least once in the last month.

- DOH/Title V staff continued to collaborate with our state Office of Alcoholism and Substance Abuse Services (OASAS) on substance abuse and alcohol-related prevention policy. Beginning in 1999, OASAS involved multiple human service agencies at the county level in identifying alcohol and substance abuse risk and protective factors, and in strengthening and expanding local partnerships for alcohol and substance abuse prevention. Fifteen (15) counties were funded for three years to develop and implement countywide, prevention- and results-focused work plans. These work plans identified,

re-directed, and leveraged state and local resources for a comprehensive, multi-system approach to alcohol and substance abuse prevention at the local level.

- OASAS implemented a new statewide prevention campaign entitled, "Underage Drinking: Not a Minor Problem." Title V programs promoted the campaign to health care providers.
- The focus of ACT for Youth, (Assets Coming Together for Youth) is to empower youth and engage them in community strategies to prevent abuse, violence and risky sexual activities, all of which are associated with low self-esteem; poor decision making related to sexual behavior, alcohol and substance use and abuse; poor nutrition and eating disorders. Collaborations for Community Change seek to engage all youth in their communities in order to reach the most vulnerable populations (substance abusing/using, those in foster care and group homes, homeless and runaway, orphaned, out-of-school, incarcerated, HIV affected/ infected, migrant, parenting, with disabilities, with different sexual preferences, in special education programs, and Black/African American, Hispanic/Latino, Asian/Pacific Islander and Native American). A fact sheet was written by staff and the ACT for Youth Center of Excellence on youth substance abuse in New York State and the impact of youth development programming on risk-taking behaviors.
- Over half of the Lesbian, Gay, Bi-Sexual, Trans-gendered Health Initiative contractors targeted issues related to alcohol, substance abuse and self-inflicted injury.
- PCAP/MOMS clients are assessed for alcohol and substance abuse issues; referrals are made accordingly.
- The initial school-based health center assessment, and subsequent annual comprehensive physical examination, include questions about tobacco and alcohol use. Students are counseled and educated accordingly. Referral is available for consultation/intervention where onsite services are not provided.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DOH/Title V staff continued to collaborate with our state Office of Alcoholism and Substance Abuse Services (OASAS) on substance abuse and alcohol-related prevention policy.			X	X
2. OASAS implemented a statewide prevention campaign entitled, "Underage Drinking: Not a Minor Problem." Title V programs promoted the campaign to health care providers.			X	X
3. The focus of ACT for Youth, (Assets Coming Together for Youth) is to empower youth and to prevent abuse, violence and risky sexual activities, all of which are associated with low self-esteem; poor decisions; alcohol and substance use.			X	X
4. Community Development Partnerships target the most vulnerable youth populations.			X	X
5. Over half of the Lesbian, Gay, Bi-Sexual, Trans-gendered Health Initiative contractors targeted issues related to alcohol, substance abuse and self-inflicted injury.	X	X	X	X
6. PCAP/MOMS clients are assessed for alcohol and substance abuse issues; referrals are made accordingly.	X	X	X	X

7. The initial SBHC assessment and annual physicals include questions about tobacco and alcohol use. Students are counseled and educated accordingly. Referral for consultation/intervention is available when onsite services are not provided.	X	X	X	X

b. Current Activities

- No major changes.
- All Title V related programs continue focus on youth empowerment/ youth development.

c. Plan for the Coming Year

All Title V related programs will continue to employ a youth empowerment/youth development focus.

The Bureau of Women's Health, through interagency collaboration and coordination with the Fetal Alcohol Spectrum Disorders (FASD) Interagency Work Group, is working to advance the effective prevention and treatment of FASD in New York State. The member agencies include: Council on Children and Families (CCF), Developmental Disabilities Planning Council (DDPC), Department of Health (DOH), Department of Probation and Correctional Alternatives (DPCA), Office of Alcoholism and Substance Abuse Services (OASAS), Office of Court Administration (OCA), Office of Children and Family Services (OCFS), Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), and State Education Department (SED).

- From the multi agency Workgroup four Sub-Committees were established. The sub-committees are made up of members from a variety of state agencies. The four sub-committees are: Education and Awareness; Prevention and Prenatal Screening; Diagnosis and Screening of Children; and Interventions and Treatment Services.
- The Education/Awareness and the Prevention/Prenatal Screening Subcommittees have worked on proposals for 'Many Doors, Same Message: Mid-level Clinician Education in New York State' and a Poster Contest/Educational Campaign to be held in schools to raise FASD awareness.
- FASD Workgroup initiative with New York Association of School Psychologists, with input from several workgroup members and the Office of Children and Families Services (OCFS) has authored 'Take Another Look: A Guide on Fetal Alcohol Spectrum Disorders for School Psychologists and Counselors'. With the assistance of the New York Association of School Psychologists, the guide will be distributed to school psychologists across the State.
- The NYS Office of Alcohol and Substance Abuse Services (OASAS) Training Initiative: 'Paradigm Shift: How We Treat Individuals with FASD and Mental Health Issues". This initiative seeks to convene a series of regional trainings for mental health professionals across the State, conducted by national FASD expert Dan Dubovsky.
- A logo for the NYS FASD Interagency Workgroup has been developed in an effort to brand and identify the materials that are produced by the Workgroup.
- A Website for the NYS FASD Interagency Workgroup has been developed. http://www.ccf.state.ny.us/Initiatives/FASDHome.htm

State Performance Measure 9: *Percent of High School Students Who Smoked Cigarettes in the Last Month*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	20	20	15	5	5	5
Annual Indicator	20.2	20.2	16.2	16.2	13.8	13.8
Numerator						
Denominator						
Is the Data Provisional or Final?			Final		Final	Final
	2009	**2010**	**2011**	**2012**	**2013**	
Annual Performance Objective	5	5	5	4	4	

a. Last Year's Accomplishments

- These data are tracked via the Youth Risk Behavior Survey (YRBS).
- Beginning June 3, 2008 New York State has the highest State cigarette excise taxes in the nation. Raising the price of cigarettes discourages youth smoking.
- Enforcement of a tough indoor air law continued, banning smoking in public places, including restaurants and bars.
- The Tobacco Control Program continues to fund Youth Action Partners to work with youth to become activists in the movement to change community norms related to tobacco use. These 46 programs engage middle and high school youth in activities aimed at de-glamorizing and de-normalizing tobacco use in their communities.
- The State also funds local Tobacco Control Community Partnerships in every county of the state. These partnerships work to change the community environment to support the tobacco-free norm. Partnerships engage local stakeholders, educate community leaders and the public, and mobilize the community to strengthen tobacco-related policies to restrict the use and availability of tobacco products and tobacco product promotion and limit opportunities for exposure to second hand smoke.
- The Tobacco Control Program funded contractors' work with local leaders to educate them on the public health benefits of passing local ordinances on smoking in public places, removing tobacco products from the reach of youth, and reducing tobacco advertising in areas frequented by youth.
- PCAP, MOMS, WIC and the Community Health Worker Program assess prenatal clients for tobacco use and refer to or provide smoking cessation and other counseling/health teaching.
- Comprehensive Prenatal/Perinatal Services Networks create awareness of the dangers of smoking, particularly in pregnancy.
- New York makes smoking cessation assistance available through a toll-free hotline which provides free coaching and nicotine replacement therapy to eligible callers and purchase of smoking cessation products is available through Medicaid.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. These data are tracked via the Youth Risk Behavior Survey (YRBS). NYSODH collaborates with NYS Education Department on YRBS.			X	X
2. As of June 3, 2008 New York State has the highest state cigarette excise taxes in the nation. Raising the price of cigarettes discourages smoking.			X	X
3. Enforcement of a tough indoor air law continued,			X	X

banning smoking in public places, including restaurants and bars.				
4. The Tobacco Control Program continued to engage youth in unannounced compliance checks on retail sales of tobacco to minors.			X	X
5. New York state law requires that all tobacco products be kept behind the counter.			X	X
6. The Tobacco Control Program continued to fund Youth Partnerships for Health (YPH) to help change community norms regarding tobacco use.			X	X
7. NYS funds local Tobacco Control Coalitions in every county of the state to mobilize communities in counter-advertising activities such as banning billboards that promote tobacco near schools and playgrounds.			X	X
8. NY makes smoking cessation assistance available through a toll-free hotline and web site, which both offer free nicotine replacement therapy to eligible NYS smokers (most are eligible), and smoking cessation products are available through Medicaid.		X	X	X
9. PCAP, MOMS, WIC and the Community Health Worker Program assess prenatal clients for tobacco use and refer to or provide smoking cessation and other counseling/health teaching.	X	X	X	X
10. Comprehensive Prenatal-Perinatal Services Networks create awareness of the dangers of smoking, particularly in pregnancy.			X	X

b. Current Activities
NYSDOH continued to implement successful programs as outlined above.

c. Plan for the Coming Year
Title V will continue to collaborate with Division of Chronic Disease Prevention and Adult Health, who is the DOH lead for smoking related public health programming.

State Performance Measure 10: *Percent of children in the birth year cohort who were screened for high blood lead before the age of two.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective		87	87	87	87	80
Annual Indicator	64	63	63	69.5	69.5	69.5
Numerator						
Denominator						
Is the Data Provisional or Final?				Final	Provi-sional	Provi-sional
	2009	**2010**	**2011**	**2012**	**2012**	
Annual Performance Objective	81	82	83	83	83	

a. Last Year's Accomplishments

- 2006 and 2007 screening rates of children born in 2004 in NYS, showed that 69.5% received at least one blood lead screening test by age 24 months, and 82.8% by age 36 months. Approximately 86% of low income children in Medicaid Managed Care plans in 2007 were screened at least once for lead by age 2.
- NYS has implemented a plan to eliminate childhood lead poisoning by 2010, consistent with Federal guidance, with improving blood lead screening as one of the primary goals. Trend data show improvements in the proportion of children receiving blood lead screening tests by age 24 months and by age 36 months over the last few years. The incidence of elevated blood lead levels (BLLs) among children under age six is steadily declining. Trend data show the dramatic improvement in both the number and percent of children identified with confirmed BLLs $\geq$ 10 mcg/dL, the current definition of lead poisoning established by the Centers for Disease Control and Prevention. In 1998, 5,198 children less than six years of age were newly identified with BLLs $\geq$ 10 mcg/dL, compared to 1,901 children in 2007. This represents a striking 63.4% decline in the number of children with elevated BLLs since 1998.
- The Department of Health secured funding totaling $3 million to support a new primary prevention program to identify and reduce lead hazards in children's environments before they become lead-poisoned. Seven target counties and NYC, which account for 80% of cases of childhood lead poisoning, have been identified as high incidence areas.
- The Lead Poisoning Prevention Program coordinates a comprehensive public health approach to prevent and eliminate the problem of childhood lead poisoning in NYS.
- Because NYS has more pre-1950's housing than any other state, New York has a universal screening policy. Health care providers are required to screen children for high blood lead at ages 1 and 2, and up to age 6 if a risk is identified.
- The Lead Poisoning Prevention Program has contracts with 57 local health departments and New York City to provide prevention programs and provide care coordination.
- In 2007, a competitive application and awards process was completed to fund three Regional Lead Resource Centers. The three funded centers, Kaleida Health/Women and Children's Hospital of Buffalo, SUNY Upstate Medical Center, and Montefiore Medical Center and two subcontractors, University of Rochester and Albany Medical Center, are located strategically throughout the state to provide statewide coverage. The Centers will provide outreach, education, consultation and technical assistance to health care providers and local health departments on lead screening and management for children and pregnant women. In this new funding cycle, increased emphasis was placed on effective outreach and education to improve lead screening practices.
- In collaboration with the NYS Office of Children and Family Services, the Department distributed a letter to all licensed NYS child care providers reinforcing the importance of lead screening and NYS lead screening requirements; requirements specific to child care health records; and resources available, to assist child care providers. The letter was distributed to 20,000 child care providers located in upstate NY, including: child care centers, group family day care and family providers.
- Local health departments and State Health Department District Offices provide environmental assessments and lead hazard control services.
- Wadsworth Center operates a public health lead screening laboratory where blood from children throughout the state is tested for lead levels.
- Promoting an understanding of the need for lead screening and the importance of primary health care is a priority of the Community Health Worker Program. The CHWP will continue to strive to improve percent of children screened.
- In June, 2008, a two-day meeting was held for local health department nursing and environmental health staff. The meeting provided updates on current research and emerging trends related to lead poisoning prevention in children and pregnant women and primary prevention.

- In November 2008, formally proposed changes to state regulations to authorize lead testing in private physician office laboratories and clinics, and require reporting of results to the Department.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A plan to eliminate childhood lead poisoning by 2010 has been formulated and is being implemented.	X	X	X	X
2. NY is a universal screening state. The overall screening rate for by age 2 is approximately 69.5%.			X	X
3. Local health department staff conduct outreach efforts to health care providers in their county to provide education and information on lead screening.			X	X
4. The Childhood Lead Poisoning Prevention Program has contracts with 57 local health departments and New York City to provide prevention programs and provide care coordination.	X	X	X	X
5. Additional funding to the Lead Poisoning Prevention Program was used to assist local health departments with targeting high incidence areas.			X	X
6. Wadsworth Center operates a public health lead screening laboratory where blood from children throughout the state is tested for lead levels.			X	X
7. The Center for Environmental Health will take the lead on primary prevention efforts related to environmental lead in housing.			X	X
8. Local health departments nursing and environmental staff met to discuss current research and emerging trends related to lead poisoning prevention in children and pregnant women and primary prevention.			X	X
9. Environmental assessment and assistance on abatement are available from local health departments and NYSDOH district offices.			X	X

b. Current Activities

- The state's Primary Prevention Pilot Program continues to expand since it began in October 2007, from 8 Local Health Departments (LHDs) to 12 LHDs. This program was increased by $1.9 million to support the expansion of the project.
- WIC and PCAP continue to stress the need for preventive services for infants, including lead screening, and assess all pregnant women for possible exposure to lead.
- Local health department programs actively link lead poisoned children with special health care needs to the appropriate services, if available in the communities. In most cases, a lead poisoned case is automatically given a developmental screening and/or referred to local Early Intervention (EI) program to ensure care coordination.
- The Lead Poisoning Prevention Program was re-funded by the CDC.
- The Department is collaborating with the Office of Children and Family Services to provide child care providers in NYS with education and materials to promote providers' role in lead screening and parent education.
- Provide local Lead Poisoning Prevention Programs with current local data to support program planning and monitoring.

- Updates and enhancements continue to be made to the electronic, relational lead registry, LeadWeb.
- The Department is working to develop Medicaid reimbursement for office-based lead testing to lower the level to 15 mcg/dL for comprehensive intervention, including an environmental investigation.

c. Plan for the Coming Year

- Continued development and deployment of additional reporting functions of LeadWeb and release of expanded data.
- Continue with implementation of statewide Lead Elimination Plan.
- Strengthen and expand partnerships with key state agencies, programs, and organizations that will advance lead poisoning elimination.
- Development and dissemination of additional educational materials and clinical tools for health care providers, including the guidelines for the identification, prevention and management of lead poisoning in pregnant women.
- Pending adoption of state regulations, implement regulations that authorize lead testing by private physician office laboratories and monitor required reporting of lead test results to the Department.
- Work with the Office of Health Insurance Programs to complete an analysis of the Medicaid and Lead Registry datasets to assess and improve lead testing rates among children on Medicaid.
- Legislation has been proposed with the Governor's Executive budget that would authorize linkage between the statewide childhood lead registry (LeadWeb) and the New York State Immunization Information System (NYSIIS). Pending enactment of this proposed legislation, populate NYSIIS with lead test results for children under six years and accept lead test reports from physician office laboratories in NYSIIS.

State Performance Measure 11: *Percent of High School Students who watched 3 or more hours of TV on an average school day.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	46	44	42	40	38	34
Annual Indicator	43.6	43.6	41.9	41.9	35.3	35.3
Numerator						
Denominator						
Is the Data Provisional or Final?			Final	Final	Final	Final
	2009	**2010**	**2011**	**2012**	**2013**	
Annual Performance Objective	33	32	31	30	30	

a. Last Year's Accomplishments

- This is a fairly new measure which replaces a State Performance Measure on overweight WIC children which became a National Performance Measure. This measure was selected due to the relationship between television watching and overweight in teens.
- The goals of the obesity prevention program formerly known as Activ8Kids! are to get kids to consume 5 fruits and vegetables each day, to participate in at least one hour of physical activity each day and to limit screen time to 2 or less hours daily. This is done by incorporating these messages into a variety of activities and programs.
- "Steps to a Healthier New York" is in four counties in NYS (Broome, Chautauqua, Jefferson and Rockland). This is an approach to working with entire communities. Each site must have a school coordinator to pull the community activities into the school.

- Eight regional Type 2 Diabetes Prevention in Children projects successfully implemented interventions to increase opportunities for physical activity and healthier food choices for children in home, school and community environments.
- The School Nutrition and Physical Activity Best Practices Tool kit is available in an electronic version on the DOH public website.
- Twenty-four (24) school districts are participating in the Healthy Schools Leadership Institute, which promotes and supports good nutrition and physical activity in schools.
- The WIC Program assesses screen time and provides participant-centered nutrition counseling and education on healthy lifestyles. Training on FitWIC, a physical activity initiative, was completed with WIC local agency staff at all 100 agencies from January 2005 to June 2007 on how to interact with WIC families to focus on good health and physical activity rather than weight. FitWIC teaches simple age-appropriate movements, and incorporates cultural games and activities that support a life-long habit of staying active. The WIC Program also has a Special Projects Grant funded by USDA to support FitWIC research.
- Pre- and post-surveys were completed for the BMI-for-age project.
- New York has laws mandating physical education in schools and that all student complete a mandated, semester-long course in health.
- Since 2005, the Healthy Heart Program has funded local organizations that have worked with 1,232 schools (reaching 734,346 students) statewide to improve policy and environmental supports for nutrition and physical activity. Physical activity improvements include: increasing active time during physical education, increasing the number of children walking or bicycling to school, increasing opportunities for physical activity (e.g., installing climbing walls, providing snow shoes, etc.), improving or maintaining recess times, and prohibiting the use of physical activity as a punishment. Nutrition policies adopted include: increasing the availability of low-fat milk, increasing the number of healthful options sold in school stores and vending machines, prohibiting the use of food for reward or punishment, and prohibiting the sale of unhealthy foods as fund raising activities. MCH Block Grant funds support approximately 50% of this activity.
- The Bureau of Health Risk Reduction conducts the statewide Turnoff Week in April. Training and materials to school representatives are provided to help decrease TV viewing and increase physical activity.
- The Bureau also funded contractors to provide the "Do More, Watch Less" TV viewing reduction curriculum in afterschool programs.
- The Healthy Kids, Healthy New York After-School Toolkit, which contains model TV/screen-time viewing reduction guidelines, was released to after school programs.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Statewide Turnoff week was conducted, and the Healthy Kids/ Healthy New York Toolkit was released.			X	X
2. Obesity Prevention Program encourages children to eat their 5-a-day, do at least one hour of exercise a day and limit their screen time to less than 2 hours/day.			X	X
3. "Steps to a Healthier New York" is in four counties in NYS. This is an approach to working with entire communities. Each site must have a school coordinator to pull the community activities into the school.			X	X
4. The School Nutrition and Physical Activity Tool kit is on the public website.			X	X

5. Twenty-four school districts participated in the Healthy Schools Leadership Institute, which promotes and supports good nutrition and physical activity in schools.			X	X
6. The WIC Program continues to promote FitWIC through 1:1 counseling sessions and facilitated group sessions with exercise/activities.			X	X
7. BMI data collected during the oral health surveillance are analyzed and being disseminated.			X	X
8. New York has laws mandating physical education in schools and that all student complete a mandated, semester-long course in health.			X	X
9. 250 schools made healthy changes affecting over 75,000 students.			X	X
10. The "Do More, Watch Less" curriculum was implemented.			X	X

b. Current Activities

- This measure will be tracked through the Youth Risk Behavior Survey.
- See National Performance Measure 16.
- Currently, the Department has a number of initiatives that address improving physical activity, including the Coordinated School Health Team; "Steps to a Healthier New York" in four counties; Eight Type 2 Diabetes Prevention in Children projects; the School Nutrition and Physical Activity Toolkit; the Healthy Schools Leadership Institute, which promotes and supports good nutrition and physical activity in schools; the Healthy Heart Program school-based contractors; and FitWIC, a physical activity initiative in WIC.
- The WIC Program also has a Special Projects Grant funded by USDA to support Fit WIC research and continue activities/exercises at WIC local agencies.
- New York continues to mandate physical education in schools and that all student complete a mandated, semester-long course in health.
- This year, approximately 1,900 schools and school districts were required to report BMI and Weight Status Category to the DOH.
- Statewide Turnoff Week will be conducted in April and September.
- Obesity Prevention Program contractors will expand implementation of "Do More, Watch Less" curriculum
- Healthy Kids, Healthy New York After-School Toolkit statewide dissemination to continue.

c. Plan for the Coming Year

Legislation is pending to improve school nutritional programs. The Diabetes Prevention and Control Program in collaboration with the Obesity Prevention Program will implement a new procurement entitled Creating Healthy Places to Live, Play, Work and Learn. Funded contractors will implement strategies to create policy, systems and environmental changes that will lead to the following outcomes:

- Increase physical activity and reduce sedentary behavior among children.
- Increase access to and consumption of healthy foods and reduce access to and consumption of foods with minimal nutritional value among children.

The Bureau of Community Chronic Disease Prevention will support Statewide Turnoff Week in April and September. Obesity Prevention Program contractors will expand implementation of "Do More, Watch Less" curriculum. Contractor work will continue to expand the adoption, implementation and evaluation of the *Healthy Kids, Healthy New York After-School Initiative,* to include a baseline survey of nutrition, physical activity and screen time

practices in after-school care settings and a mini-grant program to promote implementation of the model guidelines by after-school care provider organizations and networks.

State Performance Measure 12: *Percent of Women that felt down, depressed or hopeless always or often after their baby was born.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective		12.0	11.7	11.5	11.4	8
Annual Indicator		10.4	9.9	8.3	7	7
Numerator						
Denominator						
Is the Data Provisional or Final?			Final	Final	Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**	
Annual Performance Objective	8	7.5	7.5	7	7	

Notes - 2010
2007data are being used as a proxy for 2008. The PRAMS survey collects information from women residing in areas in New York State outside of New York City.

a. Last Year's Accomplishments
This was a new performance measure as of the FFY 2007 application. This measure replaces a State Performance Measure on smoking during pregnancy, which became a National Performance Measure. This measure has been tracked using PRAMS and was selected based on the implications of maternal depression on health of the mother, parenting styles, family functioning and child outcome.

- The Department's 24 Community Health Worker Programs have policies and procedures for conducting perinatal depression screening and making referrals for further evaluation if needed. Community Health Workers educate pregnant and postpartum clients about perinatal depression including signs and symptoms and the availability of help and local resources. All pregnant and postpartum clients are screened for depression using a standardized screening tool such as the Edinburgh Postnatal Depression Scale. CHWP coordinators closely supervise all cases where there is a positive screen. In 2008 the CHWP served 3,522 women, of whom 123 pregnant and 87 postpartum women were referred for further evaluation and treatment of depression.
- Comprehensive Prenatal-Perinatal Services Networks implement a variety of strategies designed to improve pregnancy outcomes including improving access to health care services and promoting positive behaviors. CPPSN activities in 2008 around prenatal/postpartum depression included:
  - The Bronx Health Link trained 44 providers on perinatal mood disorder screening and treatment, including identifying risk factors and making referrals.
  - The Maternal-Infant Services Network trained 94 health and human services providers on identifying risks factors for perinatal mood disorders and created a resource of providers offering perinatal mood disorders services.
  - Mothers and Babies of Central New York conducted consumer education on postpartum depression including signs and symptoms and available resources.
  - Nassau County Perinatal Network educated 50 women on perinatal mood disorders.
  - Suffolk County Perinatal Coalition screened 25 women for postpartum depression. Of these, 7 demonstrated signs of depression and were referred for appropriate services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This measure is tracked using PRAMS data.			X	X
2. Comprehensive Prenatal-Perinatal Networks conducted professional education sessions, including co-hosting conferences, grand rounds and in-services.		X	X	X
3. Networks conducted consumer education, developed support groups for women with perinatal depression, and developed materials that promote awareness and services for perinatal depression.		X	X	X
4. The CHW program screened 3,522 pregnant and postpartum women for depression, and referred 123 pregnant and 87 postpartum women for further evaluation and treatment.		X		X

b. Current Activities

- Materials are available on the NYSDOH public website.
- The Growing Up Healthy Hotline continues to take calls on perinatal depression and refer callers to appropriate services.
- Community Health Workers continue to screen clients for signs and symptoms of depression, both prenatally and in the postpartum period.
- Comprehensive Prenatal/Perinatal Networks continue to promote awareness of and provide information on dealing with perinatal depression.
- NYSDOH staff continue to work with the Office of Mental Health and various stakeholders to plan future activities.

c. Plan for the Coming Year

Continue to implement current recommendations.

E. Health Status Indicators

New York updates its full needs assessment, including Health Status Indicators, annually. Annual updates are needed to track trends in resident health status and to assist in program planning, monitoring and evaluation. Please see Section II Needs Assessment for trend graphs and health status indicators for various Maternal and Child Health Population Groups. Please refer to forms 20 and 21 for annual reporting of Health Status Indicators.

/2008/ A major focus for NYSDOH is on health disparities and the achievement of health equity. Numerous indicators are broken down by race and ethnicity in an effort to determine if certain groups are not benefiting equally from current interventions. //2008//

/2010/ In an effort to improve both maternal and newborn health status indicators, funding was distributed through a Request for Proposals to improve the quality of perinatal services in NYS. The Bureau of Women's Health and the Association of Regional Perinatal Programs and Networks (ARPPN) collaborated on the initiative, with ARPPN delegated responsibility for administering the RFP. Proposals funded through the QI RFP are providing valuable input and guidance and assistance in areas such as assessing the quality of care delivered by hospitals and developing quality improvement programs that can be tailored to individual hospitals. Once the results have been analyzed, initiatives will be selected for replication throughout the state. //2010//

F. Other Program Activities

- /2008/Vital Records processed over 125,000 birth records; 95,000 death records; 80,000 marriage records; 65,000 divorces; 15,000 research records; and 22,000 genealogy-related requests.//2008//
- Wadsworth Center provided public health laboratory facilities to the residents of New York State including, but not limited to, laboratories for testing water purity, for identifying lead levels and strains of microorganism (anthrax, botulism, rabies, E. coli, and other bacterial and viral organisms), for diagnosis of sexually transmitted diseases, for review of cytologic specimens, including pap smear review, for an anatomic pathology analysis, for cytogenetic identification of prenatal and clinical abnormalities, and for identification of reproductive and metabolic disorders. Wadsworth Center operates state-of-the-art clinical laboratory and environmental laboratory evaluation programs to ensure that laboratories offering tests to NYS residents meet appropriate quality requirements and can pass proficiency tests. Wadsworth Center performs basic scientific research to ensure that technologic advances and scientific knowledge have application in public health. Wadsworth Center maintains appropriate laboratory capacity in the event of an epidemic or terrorist attack.
- The Genetic Centers provided educational opportunities to medical students (approximately 200 programs), practicing health professionals (about 300 programs), people with a diagnosed genetic condition (about 80) and the general public (about 175). The Genetic Program works closely with March of Dimes to produce educational materials for populations with an interest in genetics or with a genetic condition.
- /2008/The Division of Family Health initiated discussion with the Office of Emergency Preparedness to ensure that the needs of the maternal and child health population would be adequately addressed in times of emergency. As a result, a Maternal and Child Health Preparedness Workgroup was formed, for which there are several subcommittees. Title V staff have been involved in the formulation of Continuity of Operations Plans, pediatric and obstetrical formulary discussions, and emergency planning for pandemic influenza. Presently, staff are working on guidelines for non-pediatric and non-obstetrical hospitals that may be asked to care for pediatric or obstetric patients in an emergency.//2008//
- /2010/ A Pediatric and Obstetrical Toolkit was completed and published in August 2008 to assist hospitals with children and pregnant women during an emergency.//2010//
- /2009/ Title V staff have been involved in community engagement meetings for pandemic flu planning. Four regional meetings will be held throughout the state, and families of CSHCN have been invited to attend these regional meetings. Title V staff will facilitate at one regional meeting. //2009//
- The New York State Preventive Medicine Residency Program provided academic and/or practicum training to seven physicians, including three with strong interests in MCH. Residents contributed to a wide variety of initiatives in maternal and child projects, /2010/ for example development of materials to educate providers and parents about the new HPV vaccine//2010//.
- The Fluoride Supplementation Program provided educational training on early childhood oral health issues to day care centers, Head Start centers and professional educators. Supplemental fluoride is distributed across the state to school and Head Start centers in non-fluoridated areas. Children participate with the consent of their parents.
- The Dental Public Health Residency Program graduated three residents from its statewide program. The Program continued its accreditation status and proceeds to collaborate with the other four dental residency programs in New York State.
- The Rape Crisis Program continued to implement the DOH Hospital-Based Sexual Assault Forensic Examiner Program. /2009/ NYSDOH developed standards for approving Sexual Assault Forensic Examiner (SAFE) hospital programs, approving programs that train individual SAFE examiners, and certifying individual SAFE examiners. //2009//

- In 2006, 15 Migrant and Seasonal Farmworker Health Program contractors provided primary healthcare to more than 8,000 adults and 5,000 children, ages 18 and under. About 2,500 children and adults received dental care. The program completed over 13,800 screenings for blood pressure, vision, hearing, blood lead, HIV/AIDS, STDs and tuberculosis. They provided more than 9,900 educational encounters, over 16,400 translation encounters, 6,000 transportation encounters and 19,000 home visits.
- Regional Perinatal Forums (RPFs) are operational in all regions of the state. The Perinatal Networks have become co-leaders with Regional Perinatal Centers in the development and implementation of the Forums in their regional areas. The purpose of the Forums is to engage medical providers, community-based organizations and other key stakeholders in identifying perinatal health problems and developing solutions, from a public health perspective, in a regional action plan. This process and these activities impact many of the measures identified above.
- The provision of early intervention services to eligible infants and toddlers took into account the specific needs of the family and the types of services required that would enhance the child's development. Services are based on the results of multidisciplinary evaluation.
- /2008/The Department convened a Child Health Improvement Partnership focused on standardizing tools for increased identification of children with developmental problems. //2008
- /2008/The basic functionality of recording and registering births was completed and the Statewide Perinatal Data System (SPDS) Core module was implemented. During 2006, programming was complete to generate statewide reporting and to provide data access to individual hospitals and de-identified reports to regional perinatal centers. //2008// /2010/ In 2008, analyses were begun to assess the quality of the data submitted by hospitals through the SPDS. //2010//
- /2008/NYSDOH continues to work with NYCDOHMH Vital Records to adapt the Statewide Perinatal Data System (SPDS) for New York City births. New York City is recognized by the Federal government as a separate vital records registration district and therefore maintains its own birth certificate system. It is anticipated that New York City will begin implementing a new vital records system in January 2008 that will collect data in a manner that is compatible with the requirements of the SPDS. /2010/In 2008, New York City implemented a new vital records birth certificate system compatible with the SPDS. //2010//
- /2008/The NYS Osteoporosis Prevention Program Regional Center at the Hospital for Special Surgery is conducting a multi-year "SNEAKER" project. The SNEAKER curriculum incorporates the food pyramid guidelines. Workshops were conducted for 16- to 21-year-old girls. The Long Island regional resource center has continued to build on TWEEDS, an interactive website for osteoporosis education (www.tweedsnet.com/bone). Professional education on osteoporosis was provided throughout NYS to communicate current, evidence-based information about prevention, diagnosis and treatment. Universal recommendations for bone healthy behaviors are a cornerstone of this educational effort. //2008//
- /2008/In 2006, a total of 21,102 referrals were made by the Community Health Worker Program for health care services, transportation, education and support services. 89% of referrals were completed.//2008// /2009/ In 2007, a total of 18,942 referrals were made by the CHWP for health care services, transportation, education and support services. 87% of referrals were completed.//2009//
- /2008/All municipalities conducted Early Intervention outreach activities to ensure that eligible infants and toddlers in whom a developmental delay was suspected received timely evaluation. Approximately 4.29% of the State's birth through age two population and 1.11% of the State's population under age one received Early Intervention Services during the program year.//2008//

- /2008/The Bureau of Occupational Health staff have developed a Heavy Metals Registry Annual Report 2000-2005, which has been posted on the NYSDOH website.//2008//
- /2010/ In 2008 a media campaign informed adolescents about STDs.
- An adolescent sexual health focus group study was conducted by the ACT for Youth Center of Excellence for the Department. //2010//

G. Technical Assistance

Title V staff /2008/ continue to //2008//recommend a second "large states" technical assistance meeting to discuss issues of mutual concern.

/2008/Last //2008//year, New York /2008/requested//2008// TA in the areas of genetics services and adolescent health. /2008/ This year, we are asking for Technical Assistance to implement our plans for fluoride varnish. We are requesting TA from a large state that has implemented early childhood programs in pediatricians offices and public health settings where very young children are served.//2008//

/2010/ Programs have not indicated any technical assistance needs in the current year. //2010//

V. Budget Narrative

A. Expenditures

Completion of Budget Forms: Please refer to budget columns on Forms 2, 3, 4, and 5 for a summary of state, local, federal and program income as it contributes to the MCH Partnership.

Principles for Allocation: Also, please refer to the Principles for Allocation of Maternal and Child Health Services Block Grant Funds in the Needs Assessment.

Historical Note: Due to ongoing allocation reviews and expenditure disbursement analyses, reallocations have resulted with efforts made to reduce the unobligated balance. Until the FFY 2005 application, carryover was noted in the "Unobligated Balance" column. In reality, all funds were obligated, though not all spent at the time of submission. NYSDOH was given guidance from HRSA that these funded should not be shown as unobligated. Therefore, starting with the FFY 2006 application, budgeted and expended amounts are shown on Form 3 within Line 1 only and are not displayed as unobligated balance. The total Federal allocation is committed to program services and will no longer be viewed as unobligated.

Concerted efforts are made to reduce the carryover balance by addressing areas of need as indicated in emerging public health issues for mothers and children. Program areas receiving increased fund allocations include: nutrition and physical activities in schools, oral health and pediatric overweight initiatives. /2009/ As of 2007, there is no carryover balance on the MCH block grant funds. All funds were expended.//2009//

/2008/Each year, program managers are required to fill out a survey on an internal web portal, from which service information is pulled for calculation of final expenditures by MCH population group and by level of the MCH pyramid.//2008// /2009/ Effective for this application, the data set previously used to collect both programmatic and fiscal data from program and administrative staff was no longer available. A new method of collecting these data was developed, which differed substantially from the previous data system. The information collected, though, remained remarkably stable despite the significant difference in collection methods.//2009//

B. Budget

Maintenance of Effort: New York meets and exceeds the maintenance of effort requirements of Section 505 (a) (4). The New York State Department of Health plans continued Title V funding for the following efforts in FFY 2009:

- The Adolescent Health Initiative, including ACT for Youth and Youth Risk Behavior Surveillance;
- An Adolescent Health Coordinator;
- American Indian Health Program Community Health Workers;
- Asthma Coalitions;
- Children with Special Health Care Needs Program, including the Physically Handicapped Children's Program Diagnostic and Evaluation Program;
- Columbia Collaborative Projects;
- Community-Based Adolescent Pregnancy Prevention;
- Congenital Malformations Registry;
- Family Planning;
- The Genetics Program and Newborn Metabolic Screening;
- SUNY School of Public Health MCH Graduate Assistantship Program;
- Health Communications;
- /2009/ NYS Youth Development Team Coordinator; //2009//
- Immunization activities;
- Infant and Child Mortality Review;
- Infertility Demonstration Project;
- Injury Prevention;
- The Lactation Institute;
- Lead Poisoning Prevention;
- Migrant and Seasonal Farmworker Health;
- Newborn Hearing and Metabolic Screening /2010/, now known as Newborn Hearing and Bloodspot Screening//2010//;
- Innovative Oral Health Initiatives;
- Osteoporosis Prevention;
- Parent and Consumer Focus Groups;
- Public Health Information/Community Assessment infrastructure;
- The Statewide Perinatal Data System;
- Preventive Dentistry Initiatives and the Dental Residency Program, including an expanded dental sealant program and a task force on oral health in pregnancy;
- School-Based Health Centers and School Health Infrastructure;
- STD Screening and Education;
- Universal Newborn Hearing Screening;
- Vital Records; and
- Women and Disabilities.

- The Monroe Consolidated Child and Family Health Grant will continue in FFY 2009. Under this initiative, seven grants are given to the county with an integrated work plan.

  Methodology: Effort is made to match funding to the level of unmet need, and to address the four layers of the MCH pyramid and the three target populations. Because funded programs often take more than one structural approach to targeted needs and populations, program appropriations are proportioned out to reflect percentage of effort in infrastructure-building, population-based services, enabling services and direct health care services. Program appropriations also take into account the "30-30-10" requirements of Title V.

New York State uses a fair method to allocate Title V funds among individuals and areas identified as having unmet needs for maternal and child health services. The State uses its MCH funds for the purposes outlined in Title V, Section 505 of the Social Security Act. The MCHSBG Advisory Council assists the Department in determining program priorities and has been instrumental in seeking public input into the application process. The Council developed in 1984 a document entitled "Principles and Guidelines for the Use of Block Grant Funds," which was updated and affirmed each year. New York is using an Oracle-based system of gathering program information which more finely delineates sources of funds for the programs for only the second year. /2009/ As previously stated, the Oracle-based system has been replaced in the current year with a more streamlined fiscal information gathering system.// 2009//

The methodology used to identify State expenditures for MCH-related programs has not changed:

- Appropriate cost centers, representing specific areas of activity related to MCH, are identified.
- Data for the appropriate fiscal periods are obtained from the Office of the State Comptroller (OSC).
- Data for selected cost centers are extracted on a quarterly basis.
- Quarterly data is compiled from relevant cost centers to reflect expenditures made during the federal fiscal year.
- All expenditure data represent payments made on a cash (vs. accrual) basis.
- Transactions associated with specific grants are identified and tracked through appropriation, segregation, encumbrance and reporting processes to permit proper and complete recording of the utilization of available funds.
- Identifying codes are assigned to record these transactions by object of expense within each cost center.

Any amount payable to the State under this title from allotments for this fiscal year which remain unobligated at the end of that year are carried forward and obligated in the following fiscal year. The Department and the Office of the State Comptroller (OSC) maintain budget documentation for Block Grant funding and expenditures consistent with Section 505(a) and Section 506(a)(1) for the purpose of maintaining an audit trail. The grant expenditures are recorded through standard OSC documents.

Reporting requirements and procedures for each particular grant are instituted to comply with conditions specified within each notice of grant award.

The state share in MCH services is considerable, more than meeting the requirements for state match. State appropriations dedicated to MCH include:

- /2009/HIV-related appropriations: Children, Adolescents and Families Affected by AIDS/HIV, High Risk women and children, HIV prevention and health care services to high risk adolescents and young people, Comprehensive Health and Supportive Services for Women and Children, Maternal and Child HIV Services, HIV Prevention Programs for Adolescents, Permanency Planning and Supportive Services for Families Affected by HIV, Grants to CBOs for Provision of HIV Education and Prevention Services for Youth at Risk in a School Setting, HIV Counseling and Testing Services in Family Planning Program Projects, and ACT for Youth – Assets Coming Together for Youth.//2009//
- Child Care;
- Early Intervention;
- Family Planning;

- Genetic Screening and Human Genetics;
- Health Care Reform Act Allocations;
- Immunization, Vaccine Distribution and State Aid for Immunization;
- Lead Control and Prevention, Lead Poisoning Prevention Local Assistance and Lead Interim Housing;
- Physically Handicapped Children's Treatment Program/Children with Special Health Care Needs Program;
- /2009/ Migrant and Seasonal Farmworker Health Program;
- Community Health Worker
- Comprehensive Prenatal-Perinatal Services Networks
- Perinatal Regionalization
- Maternal mortality initiative (Safe Motherhood)
- Support for higher level infertility services //2009//
- School-Based Health Centers;
- State Aid to Local Health Departments;
- SIDS and Infant Death; and
- Tobacco Settlement Dollars.

Federal sources of MCHSBG dollars other than the block grant included:

- Abstinence Education /2009/ (through 9/30/07 only) //2009//;
- Centers for Disease Control and Prevention (Lead, Immunization, Public Health Information Infrastructure; Oral Health Surveillance, Oral Health Systems /2009/ , HIV/CAPC;//2009//);
- CISS grants;
- Early Intervention, Part C;
- Family Planning;
- /2009/ Preventive Health and Health Services Block Grant; //2009//
- Rape Crisis;
- STD/fertility;
- SPRANS Grants;
- /2009/ HRSA – Ryan White HIV/AIDS Treatment Modernization Act of 2006;//2009//
- SSDI Funds;
- TANF Funds;
- Early Childhood Comprehensive Systems planning grant.

A regional analysis of Title V external contracts shows that about 65% of funds are contracted for the metropolitan New York City area, where most of the State's population is located; about 16% goes to the Western New York area, our second most populous region; about 11 % goes to Central New York; and about 8% goes to the Northeastern and Capital District areas of the state. These breakdowns are fairly consistent with the proportion of New York's population residing in each of these areas.

/2008/The State more than meets "30-30-10 Requirements" for 30% allocation to primary and preventive care to children ($13,846,454 or 33.26%), for 30% for children with special health care needs ($13,905,147 or 33.40%) and under 10% for administration ($2,585,600 or 6.211%). //2008//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

Attachment:

VIII. GLOSSARY

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

/2010/ AFIX - an abbreviation for **Assessment, Feedback, Incentives eXchange Initiative** - a program under which county health department staff visit private pediatricians to assess the immunization records of their patients.

Ambulatory Patient Groups (APGs) – APGs represent the new payment methodology for most Medicaid outpatient services. APG methodology will be used to reimburse for outpatient clinic, ambulatory surgery and emergency department services. //2010//

Article 6 – Refers to Article 6 of the New York State Public Health Law, which sets for the conditions under which local health departments are reimbursed for general public health work.

Assessment - (see Needs Assessment)

ATUPA - an abbreviation for **The Adolescent Tobacco Use Prevention Act.**

BCAH – an abbreviation for the **Bureau of Child and Adolescent Health**.

BDH – an abbreviation for the **Bureau of Dental Health**.

BEIS – an abbreviation for the **Bureau of Early Intervention /2010/~~Services~~//2010//.**

BRFSS – an abbreviation for the **Behavioral Risk Factor Surveillance System.**

BWH – an abbreviation for the **Bureau of Women's Health.**

CACFP - An abbreviation for the **Child and Adult Care Feeding Program,** a program providing reimbursement for nutritional meals and snacks in regulated and approved day care facilities.

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities,

program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, what does the State need to achieve the results we want?

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year's MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *[Title V Sec. 501(b)(4)]*

C-BAPP - an abbreviation for **Community-Based Adolescent Pregnancy Prevention Program** - a program that targets New York State adolescent in the zip codes at highest risk for adolescent pregnancy with public health interventions.

Child Health Plus - New York's subsidized insurance program for the uninsured and underinsured as established by the Health Care Reform Act of 1996 and later supplemented by Federal Child Health Insurance Program funds.

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - ***(For budgetary purposes)*** Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. ***(For planning and systems development)*** Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

/2009/**CHW** – an abbreviation for the **Community Health Worker Program**. //2009//

CISS - an abbreviation for **Comprehensive Integrated Services Systems**. This is a grant program administered by the Federal Maternal and Child Health Bureau.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under Pregnant Women, Infants, Children with Special Health Care Needs, Children, and Anthers.

CMR – An abbreviation for the New York State **Congenital Malformations Registry.**

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

CPPSN - an abbreviation for **Comprehensive Prenatal/Prenatal Services Network**.

CSHCN - See **Children with Special Health Care Needs**

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

DFH – an abbreviation for the **Division of Family Health -** The division within the New York State Department of Health and Center for Community Health that is responsible for the administration of Title V and Title V-related activities.

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

DOH – an abbreviation for **Department of Health.**

DRM – an abbreviation for **Disaster Relief Medicaid**.

EIP – an abbreviation for the New York State **Early Intervention Program**.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

FPL – an abbreviation for the **Federal Poverty Level.**

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

/2009/ GUHH – an abbreviation for the **Growing Up Healthy Hotline**.

HCRA – an abbreviation for the Health Care Reform Act. See below for definition.

Health Care Reform Act (or HCRA) - A New York State law passed in 1996 and renewed in 2000 that authorizes, among other things, the financing of health services, graduate medical education, insurance coverage for the uninsured and rural health networks.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

HIN - an abbreviation for the **Health Information Network,** a Department of Health intranet accessible to local county health departments and state staff, containing community health data.

/2009/ **HIPAA** – Health Insurance Portability and Accountability Act, a measure to safeguard confidentiality of electronic health information.//2009//

HPN - an abbreviation for the **Health Provider Network,** a Department of Health intranet accessible to local county health departments, state staff, and health care providers, containing health-related data and notifications.

HPSA - Abbreviation for a **Health Professional Shortage Area**. This designation by the Federal Government means that there are less than the number needed of certain health care professionals, like doctors or dentists.

IMR – an abbreviation for **Infant Mortality Rate**, the rate per 1,000 at which infants under the age of one year die.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in

accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. *[Title V, Sec. 501 (b)(2)]*

MA - an abbreviation for **Medicaid,** also known as **Title XIX**.

MCH – an abbreviation for **maternal and child health.**

MCHSBG – An abbreviation for the Maternal and Child Health Services Block Grant, or Title V.

MCH Pyramid of Health Services - (see Types of Services)

MCO - an abbreviation for **Managed Care Organization**, a provider of managed health care.

Measures - (see Performance Measures)

Medical/Health Home - The Maternal and Child Health Bureau and the New York State Department of Health use the American Academy of Pediatrics (AAP) definition of medical/health home. The medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family-centered, coordinated and compassionate. It should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them. These characteristics define the medical/health home and describe the care that has traditionally been provided by pediatricians in the office setting. In contrast, care provided by emergency departments, walk-in clinics, and other urgent-care facilities is often less effective and more costly. (American Academy of Pediatrics, Volume 90, Number 5, November 1992.)

MUA – an abbreviation for **Medically Underserved Area.**

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:
1) What is essential in terms of the provision of health services;
2) What is available, and
3) What is missing.

NTD – an abbreviation for **neural tube defect**, a congenital condition involving the brain and the spinal cord.

NYCRR- abbreviation for **New York Code, Rules and Regulations.** These are the regulations that further clarify how New York State Public Health Law will be carried out.

NYSDOH – an abbreviation for the **New York State Department of Health**.

OASAS - an abbreviation for the **New York State Office of Alcoholism and Substance Abuse Services.**

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also Performance Objectives)

OCFS – An abbreviation for the New York State **Office of Children and Family Services.** This is a "sister" agency to the New York State Department of Health.

/2009/ OHIP – an abbreviation for the **Office of Health Insurance Programs**, which has replace the Office of Managed Care and the Office of Medicaid Management in an effort to make transitions among health insurance programs more seamless.//2009//

OHSM – an abbreviation for the **Office of Health Systems Management,** the division of the New York State Department of Health that is responsible for facilities licensing and monitoring.

OMC – an abbreviation for the **Office of Managed Care**. This is an office within the New York State Department of Health.

OMH - an abbreviation for the **New York State Office of Mental Health.** This is a "sister" state agency to the New York State Department of Health.

OMM – an abbreviation for the **Office of Medicaid Management**. This is an office within the New York State Department of Health.

OSC - an abbreviation for the **New York State Office of the State Comptroller.**

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, why does the State do our program?

PBII - an abbreviation for **Provider Based Immunization Initiative** - a program under which county health department staff visit private pediatricians to assess the immunization records of their patients.

PCAP - an abbreviation for the **Prenatal Care Assistance Program** - a New York State program covering prenatal, postpartum and perinatal care for uninsured, underinsured and Medicaid women and newborns who are financially eligible for the program.

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: The rate of women in [State] who receive early prenatal care in 20__. This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

PHCP - an abbreviation for **New York's Physically Handicapped Children's Program** - an insurance type program for children with special heath care needs to assure access to specialty care for medically and financially eligible children. PHCP now operates within the context of a broader Children With Special Health Care Needs Program.

PHL – an abbreviation for (New York State) **Public Health Law.**

PHN – an abbreviation for **Public Health Nurse**, nurses with bachelor's degrees and special training in public health who work for local health departments.

PMRP - an abbreviation for **New York's Preventive Medicine Residency Program.**

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - An abbreviation for the **Pregnancy Risk Assessment Monitoring System** - collects population-based information on maternal knowledge, attitudes and behavior, on service access and utilization, and on possible physical and emotional stressors during pregnancy from a sample of women who have recently given birth.

PRC – ***The definition depends on context*****. PRC** is an abbreviation for **Pediatric Resource Centers -** a program under the New York City Medical and Health Research Administration, targeting infants at high risk who are program eligible. **PRC** may also be an abbreviation for **Perinatal Regional Centers.**

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State=s MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

QARR or Quality Assurance Reporting Requirements - The QARR is an annual analysis of quality performance of managed care plans in New York State. The annual report includes measures such as childhood immunization, blood lead testing, HIV testing of pregnant women, well child care, cancer screening and the treatment of chronic diseases such as asthma and diabetes, and (since the 1997 report) results of standardized consumer satisfaction surveys for the commercial population.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, why should the State address this risk factor (i.e., what health outcome will this result support)?

RPC – an abbreviation for **Regional Perinatal Center.**

SBHC- an abbreviation for **School Based Heath Center** - a source for primary and supportive health services located within a school setting.

SIDS - an abbreviation for **Sudden Infant Death Syndrome**.

SPARCS - a data system that collects information on every hospital discharge in the state.

SPDS – an abbreviation for New York's **Statewide Perinatal Data System.**

SPRANS - an abbreviation for **Special Project of Regional and National Significance** - a grant program administered by the Federal Government.

SSDI - an abbreviation for **State Systems Development Initiative** - a grant program administered by the Federal MCH Bureau.

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Pelau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

STD - an abbreviation for **Sexually Transmitted Disease.**

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include: systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (Medicaid) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (Medicaid) program.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block Grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the State), *Other* Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by State MCH agencies from insurance payments, Medicaid, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," Population Based Services, Enabling Services, and Direct Medical Services.

Universal Coverage - A situation under which the whole population is covered by public or private health insurance coverage.

VFC – an abbreviation for the **Vaccines for Children Program** - an initiative that provides vaccines to health care providers for administration to eligible children without cost.

WIC - an abbreviation for **Women, Infants, and Children** - a nutrition education and supplement program sponsored by the Federal Department of Agriculture for financially and medically eligible prenatal and breast feeding women, infants and at-risk children.

YRBS (Youth Risk Behavior Survey) – A biennial survey conducted in New York State secondary schools by the State Education Department.

YTS (Youth Tobacco Survey) – A survey administered every two years to students in sixth through twelfth grade.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

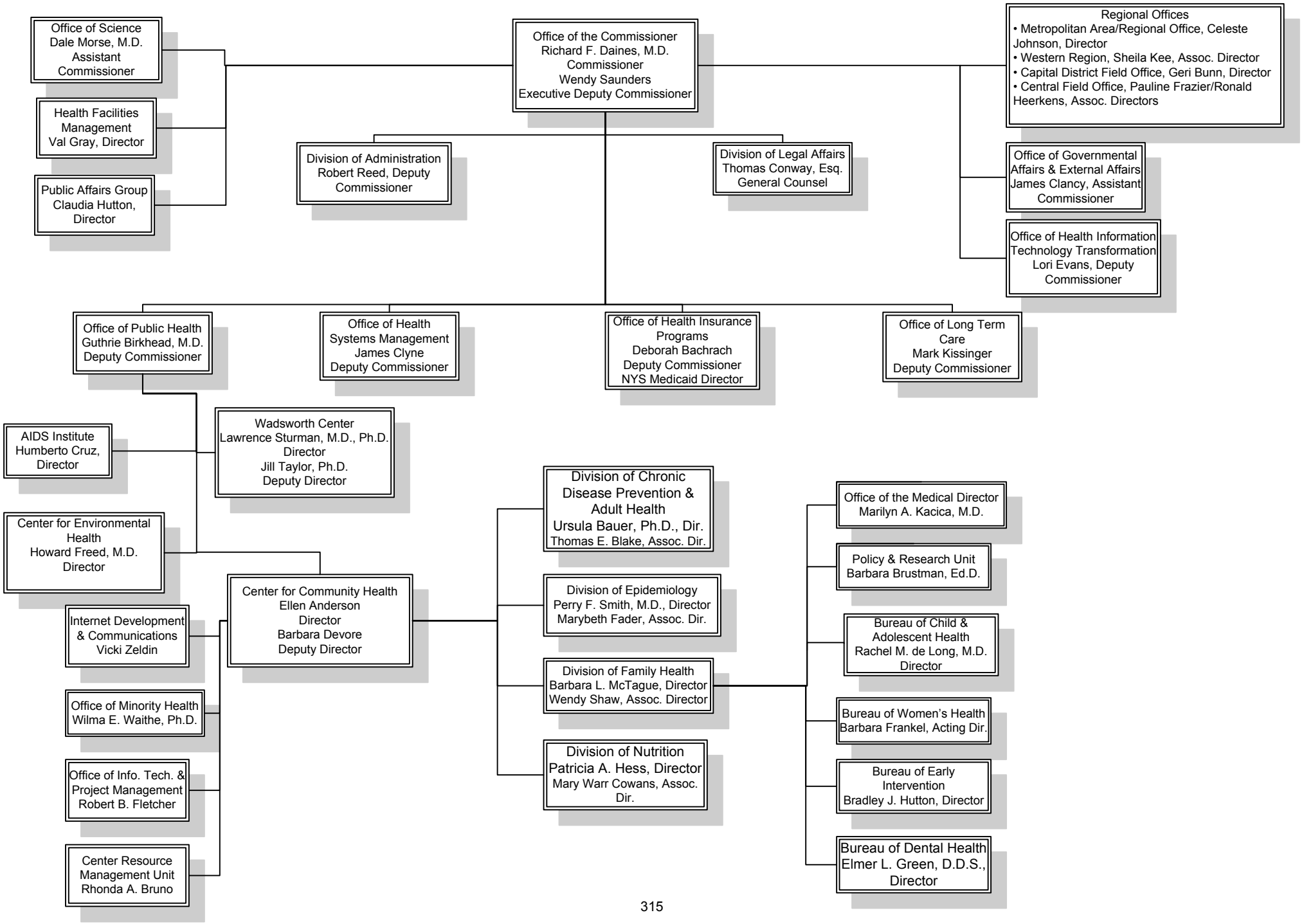
C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.

New York State Department of Health



Title V Block Grant Application
Forms (2-21)
State: NY
Application Year: 2010

FORM 2

MCH BUDGET DETAILS FOR FY 2010

[Secs. 504 (d) and 505(a)(3)(4)]

STATE: NY

1. FEDERAL ALLOCATION $ 41,043,769

(Item 15a of the Application Face Sheet [SF 424])
Of the Federal Allocation (1 above), the amount earmarked for:

A.Preventive and primary care for children:

$ 13,967,896 (34.03 %)

B.Children with special health care needs:

$ 12,479,126 (30.4 %)

(If either A or B is less than 30%, a waiver request must accompany the application)[Sec. 505(a)(3)]

C.Title V admininstrative costs:

$ 2,432,003 (5.93 %)

(The above figure cannot be more than 10%)[Sec. 504(d)]

2. UNOBLIGATED BALANCE (Item 15b of SF 424) $ 0

3. STATE MCH FUNDS (Item 15c of the SF 424) $ 363,695,631

4. LOCAL MCH FUNDS (Item 15d of SF 424) $ 299,499,317

5. OTHER FUNDS (Item 15e of SF 424) $ 0

6. PROGRAM INCOME (Item 15f of SF 424) $ 176,715,455

7. TOTAL STATE MATCH (Lines 3 through 6) $ 839,910,403

(Below is your State's FY 1989 Maintainence of Effort Amount)
$ 58,268,752

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL) $ 880,954,172

(Total lines 1 through 6. Same as line 15g of SF 424)

9. OTHER FEDERAL FUNDS

(Funds under the control of the person responsible for the administration of the Title V program)

a. SPRANS:	$ 150,000
b. SSDI:	$ 568,638
c. CISS:	$ 0
d. Abstinence Education:	$ 0
e. Healthy Start:	$ 0
f. EMSC:	$ 0
g. WIC:	$ 0
h. AIDS:	$ 0
i. CDC:	$ 1,334,619
j. Education:	$ 23,831,850
k. Other:	
Medicaid Match	$ 9,503,861
Title X-Fam Planning	$ 10,512,876

10. OTHER FEDERAL FUNDS (SUBTOTAL of all Funds under item 9) $ 45,901,844

11. STATE MCH BUDGET TOTAL $ 926,856,016

(Partnership subtotal + Other Federal MCH Funds subtotal)

FORM NOTES FOR FORM 2

None

FIELD LEVEL NOTES

None

FORM 3

STATE MCH FUNDING PROFILE

[Secs. 505(a) and 506((a)(I-3)]

STATE: NY

	FY 2005		FY 2006		FY 2007	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
1. Federal Allocation *(Line1, Form 2)*	$ 44,048,128	$ 40,665,186	$ 43,450,702	$ 43,450,702	$ 41,621,706	$ 41,629,217
2. Unobligated Balance *(Line2, Form 2)*	$ 7,500,000	$ 3,043,124	$ 0	$ 0	$ 0	$ 0
3. State Funds *(Line3, Form 2)*	$ 378,564,700	$ 365,856,081	$ 388,295,930	$ 387,035,471	$ 351,809,825	$ 347,801,378
4. Local MCH Funds *(Line4, Form 2)*	$ 242,527,827	$ 261,412,884	$ 266,309,718	$ 283,491,639	$ 242,471,037	$ 245,642,140
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
6. Program Income *(Line6, Form 2)*	$ 274,010,452	$ 299,360,489	$ 299,431,541	$ 286,125,086	$ 268,918,266	$ 182,431,876
7. Subtotal *(Line8, Form 2)*	$ 946,651,107	$ 970,337,764	$ 997,487,891	$ 1,000,102,898	$ 904,820,834	$ 817,504,611
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 50,506,443	$ 41,885,193	$ 44,307,745	$ 40,019,155	$ 42,076,539	$ 39,471,805
9. Total *(Line11, Form 2)*	$ 997,157,550	$ 1,012,222,957	$ 1,041,795,636	$ 1,040,122,053	$ 946,897,373	$ 856,976,416
	(STATE MCH BUDGET TOTAL)					

FORM 3

STATE MCH FUNDING PROFILE

[Secs. 505(a) and 506((a)(I-3)]

STATE: NY

	FY 2008		FY 2009		FY 2010	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
1. Federal Allocation *(Line1, Form 2)*	$ 41,629,217	$ 40,842,301	$ 41,629,217	$	$ 41,043,769	$
2. Unobligated Balance *(Line2, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
3. State Funds *(Line3, Form 2)*	$ 351,565,000	$ 337,067,557	$ 390,311,698	$	$ 363,695,631	$
4. Local MCH Funds *(Line4, Form 2)*	$ 361,355,556	$ 357,876,779	$ 309,987,228	$	$ 299,499,317	$
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
6. Program Income *(Line6, Form 2)*	$ 189,548,660	$ 179,051,322	$ 174,723,376	$	$ 176,715,455	$
7. Subtotal *(Line8, Form 2)*	$ 944,098,433	$ 914,837,959	$ 916,651,519	$ 0	$ 880,954,172	$ 0
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 40,337,744	$ 40,337,744	$ 46,143,937	$	$ 45,901,844	$
9. Total *(Line11, Form 2)*	$ 984,436,177	$ 955,175,703	$ 962,795,456	$ 0	$ 926,856,016	$ 0
	(STATE MCH BUDGET TOTAL)					

FORM NOTES FOR FORM 3

None

FIELD LEVEL NOTES

1. **Section Number:** Form3_Main
   Field Name: FedAllocExpended
   Row Name: Federal Allocation
   Column Name: Expended
   Year: 2008
   Field Note:
   level of funding provided for FFY08

2. **Section Number:** Form3_Main
   Field Name: ProgramIncomeExpended
   Row Name: Program Income
   Column Name: Expended
   Year: 2007
   Field Note:
   Methodology used to determine program income applied percentages based on analysis done years ago. It had not been updated in a number of years and none of the staff that developed the methodolgy is available to revise it. Current calculations are based on local government and sub-recipient reported income and therefore is readily retrievable by multiple staff and/or changing staff.

3. **Section Number:** Form3_Main
   Field Name: OtherFedFundsExpended
   Row Name: Other Federal Funds
   Column Name: Expended
   Year: 2007
   Field Note:
   $2.6M of Federal Abstinence funding not expended as the State declined subsequent awards.

FORM 4

BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: NY

	FY 2005		FY 2006		FY 2007	
I. Federal-State MCH Block Grant Partnership	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
a. Pregnant Women	$ 51,497,820	$ 52,883,408	$ 53,904,738	$ 47,044,245	$ 48,860,325	$ 45,117,681
b. Infants < 1 year old	$ 198,607,402	$ 208,622,619	$ 173,879,542	$ 158,679,430	$ 185,488,271	$ 104,879,584
c. Children 1 to 22 years old	$ 52,633,802	$ 49,002,057	$ 139,787,098	$ 154,144,896	$ 54,289,250	$ 97,346,038
d. Children with Special Healthcare Needs	$ 556,441,521	$ 572,014,112	$ 547,371,892	$ 525,266,481	$ 531,129,829	$ 498,360,642
e. Others	$ 40,138,007	$ 39,298,680	$ 30,594,283	$ 67,047,059	$ 39,812,117	$ 43,678,763
f. Administration	$ 47,332,555	$ 48,516,888	$ 51,950,338	$ 47,920,787	$ 45,241,042	$ 28,121,903
g. SUBTOTAL	$ 946,651,107	$ 970,337,764	$ 997,487,891	$ 1,000,102,898	$ 904,820,834	$ 817,504,611
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 0		$ 0		$ 0	
b. SSDI	$ 100,000		$ 100,000		$ 100,000	
c. CISS	$ 0		$ 0		$ 0	
d. Abstinence Education	$ 3,755,454		$ 3,614,500		$ 3,675,827	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 0		$ 0		$ 0	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 1,150,161		$ 3,854,137		$ 2,380,573	
j. Education	$ 26,175,777		$ 26,210,607		$ 25,623,183	
k.Other						
Title X (Family Plan	$ 0		$ 0		$ 10,296,956	
Family Planning	$ 19,325,051		$ 10,528,501		$ 0	
III. SUBTOTAL	$ 50,506,443		$ 44,307,745		$ 42,076,539	

FORM 4

BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: NY

	FY 2008		FY 2009		FY 2010	
I. Federal-State MCH Block Grant Partnership	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
a. Pregnant Women	$ 64,999,538	$ 61,029,725	$ 76,287,545	$	$ 77,507,975	$
b. Infants < 1 year old	$ 129,744,213	$ 128,292,591	$ 46,193,308	$	$ 67,645,380	$
c. Children 1 to 22 years old	$ 116,647,102	$ 107,617,387	$ 125,026,052	$	$ 121,371,304	$
d. Children with Special Healthcare Needs	$ 496,870,196	$ 486,426,590	$ 540,975,612	$	$ 506,821,678	$
e. Others	$ 97,300,581	$ 93,049,666	$ 112,109,458	$	$ 94,488,959	$
f. Administration	$ 38,536,803	$ 38,422,000	$ 16,059,544	$	$ 13,118,876	$
g. SUBTOTAL	$ 944,098,433	$ 914,837,959	$ 916,651,519	$ 0	$ 880,954,172	$ 0
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 150,000		$ 150,000		$ 150,000	
b. SSDI	$ 100,000		$ 100,000		$ 568,638	
c. CISS	$ 0		$ 140,000		$ 0	
d. Abstinence Education	$ 3,614,500		$ 0		$ 0	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 0		$ 0		$ 0	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 1,837,125		$ 1,939,252		$ 1,334,619	
j. Education	$ 25,550,992		$ 23,636,568		$ 23,831,850	
k.Other						
Medicaid Match	$ 0		$ 9,758,117		$ 9,503,861	
Title X-Fam Planning	$ 0		$ 10,420,000		$ 10,512,876	
Title X (Family Plan	$ 9,085,127		$ 0		$ 0	
III. SUBTOTAL	$ 40,337,744		$ 46,143,937		$ 45,901,844	

FORM NOTES FOR FORM 4

None

FIELD LEVEL NOTES

1. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenBudgeted
   Row Name: Pregnant Women
   Column Name: Budgeted
   Year: 2009
   Field Note:
   adjust $1 for rounding

2. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Expended
   Row Name: Infants <1 year old
   Column Name: Expended
   Year: 2007
   Field Note:
   We are unable to identify the FFY07 initiatives and/or percentages that equal to the budget allocations indicated in the grant application and surmise that dollars were incorrectly categorized therefore resulting in the large differences in expenditures for "infants under one year only" and "children 1 to 22 years old".

3. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_1_22Expended
   Row Name: Children 1 to 22 years old
   Column Name: Expended
   Year: 2007
   Field Note:
   We are unable to identify the FFY07 initiatives and/or percentages that equal to the budget allocations indicated in the grant application and surmise that dollars were incorrectly categorized therefore resulting in the large differences in expenditures for "infants under one year only" and "children 1 to 22 years old".

4. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: AdminExpended
   Row Name: Administration
   Column Name: Expended
   Year: 2007
   Field Note:
   The budget for Administrative costs was constructed using using some methodology that derived percentages that we are not able to duplicate. The expenditure amount uses percentage or amounts reported by program.

FORM 5

STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: NY

TYPE OF SERVICE	FY 2005		FY 2006		FY 2007	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 628,765,665	$ 655,463,160	$ 635,696,049	$ 617,901,245	$ 587,681,132	$ 545,637,112
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 174,562,464	$ 176,116,304	$ 187,621,486	$ 179,091,959	$ 171,011,137	$ 124,847,808
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 67,590,889	$ 64,527,461	$ 102,671,574	$ 105,710,343	$ 70,123,615	$ 68,531,654
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 75,732,089	$ 74,230,839	$ 71,498,782	$ 97,399,351	$ 76,004,950	$ 78,488,037
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 946,651,107	$ 970,337,764	$ 997,487,891	$ 1,000,102,898	$ 904,820,834	$ 817,504,611

FORM 5

STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: NY

TYPE OF SERVICE	FY 2008		FY 2009		FY 2010	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 479,686,457	$ 468,968,888	$ 542,289,899	$	$ 549,101,044	$
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 111,547,731	$ 103,589,315	$ 72,957,273	$	$ 73,676,681	$
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 118,240,385	$ 113,204,948	$ 110,605,239	$	$ 114,544,747	$
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 234,623,860	$ 229,074,808	$ 190,799,108	$	$ 143,631,700	$
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 944,098,433	$ 914,837,959	$ 916,651,519	$ 0	$ 880,954,172	$ 0

FORM NOTES FOR FORM 5

None

FIELD LEVEL NOTES

1. **Section Number:** Form5_Main
   Field Name: EnablingExpended
   Row Name: Enabling Services
   Column Name: Expended
   Year: 2007
   Field Note:
   Under expenditures in the Enabling Services Category are most likely due the inclusion of a number of initiatives that should not have been included coupled with program income and some local calculation methodologies that could not be duplicated.

FORM 6

NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED, AND TREATED

Sect. 506(a)(2)(B)(iii)

STATE: NY

Total Births by Occurrence: 252,793 | **Reporting Year: 2008**

Type of Screening Tests	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	%
Phenylketonuria	252,793	100	34	13	13	100
Congenital Hypothyroidism	252,793	100	993	130	130	100
Galactosemia	252,793	100	18	9	9	100
Sickle Cell Disease	252,793	100	72	61	61	100
Other Screening (Specify)						
Congenital Adrenal Hyperplasia	252,793	100	331	10	10	100
Homocystinuria	252,793	100	22	0	0	
Maple Syrup Urine Disease	252,793	100	17	0	0	
Tyrosinemia Type I	252,793	100	10	1	1	100
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	252,793	100	10	1	1	100
Argininosuccinic Acidemia	252,793	100	6	1	1	100
Citrullinemia	252,793	100	6	1	1	100
Carnitine Uptake Defect	252,793	100	9	6	6	100
Methylmalonic acidemia (Cbl A,B)	252,793	100	31	10	10	100
Multiple Carboxylase Deficiency	252,793	100	31	9	9	100
Trifunctional Protein Deficiency	252,793	100	2	1	1	100
Sickle Cell Anemia (SS-Disease)	252,793	100	144	124	124	100
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	252,793	100	9	0	0	
Other Hemoglobin Disorders	252,793	100	40	35	35	100
3-Hydroxy-3-methylglutaryl-CoA lyase deficiency	252,793	100	94	24	24	100

Screening Programs for Older Children & Women (Specify Tests by name)

(1) Use occurrent births as denominator.
(2) Report only those from resident births.
(3) Use number of confirmed cases as denominator.

FORM NOTES FOR FORM 6

None

FIELD LEVEL NOTES

1. **Section Number:** Form6_Other Screening Types
   Field Name: Other
   Row Name: All Rows
   Column Name: All Columns
   Year: 2010
   Field Note:
   247,960 newborns received hearing screening. Follow-up results for 2008 were not available as yet. In addition, 252,793 newborns received screening for HIV-1, and 528 were presumptively positive.

FORM 7

NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V (BY CLASS OF INDIVIDUALS AND PERCENT OF HEALTH COVERAGE)

[Sec. 506(a)(2)(A)(i-ii)]

STATE: NY

Reporting Year: 2008

	TITLE V	PRIMARY SOURCES OF COVERAGE				
Types of Individuals Served	**(A) Total Served**	**(B) Title XIX %**	**(C) Title XXI %**	**(D) Private/Other %**	**(E) None %**	**(F) Unknown %**
Pregnant Women	391,034	42.2				57.8
Infants < 1 year old	246,824	32.7	1.0	57.4	8.9	
Children 1 to 22 years old	5,583,705	26.9	6.8	57.4	8.9	
Children with Special Healthcare Needs	542,758				2.0	98.0
Others	511,395	22.1		63.0	14.9	
TOTAL	7,275,716					

FORM NOTES FOR FORM 7

None

FIELD LEVEL NOTES

1. **Section Number:** Form7_Main
   Field Name: CSHCN_TS
   Row Name: Children with Special Health Care Needs
   Column Name: Title V Total Served
   Year: 2010
   Field Note:
   Includes children served by: School-Based Health Centers (151,694), CSHCN program (5,703), Early Intervention Program (71,035), Newborn Screening program (almost all screened for both inborn metabolic disorders and hearing -- 252,793), the Lead Poisoning program (3048), and 12.7% (estimated percentage of all children in NYS with SHCN, from SLAITS) of children served by Community-based Adolescent Pregnancy Prevention Program (50,645 out of 405,160), and the Adolescent Pregnancy Prevention Program (7,840 out of 62,720). The number does not include 12.7% of adolescents served by the family planning program, since there may be some overlap with the CBAPP program.

2. **Section Number:** Form7_Main
   Field Name: AllOthers_TS
   Row Name: Others
   Column Name: Title V Total Served
   Year: 2010
   Field Note:
   This estimate includes the 87.8% of CBAPP and APPS clients not covered under CSHCN (409,395), plus the 102,000 adolescents served by the Family Planning Program.

FORM 8
DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE XIX
(BY RACE AND ETHNICITY)
[SEC. 506(A)(2)(C-D)]
STATE: NY

Reporting Year: 2007

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 and Unknown
DELIVERIES								
Total Deliveries in State	240,624	156,167	50,325	391	22,987	0	0	10,754
Title V Served	240,624	156,167	50,325	391	22,987	0	0	10,754
Eligible for Title XIX	105,462	54,905	32,466	216	11,242	0	0	6,633
INFANTS								
Total Infants in State	245,586	159,642	51,339	396	23,322	0	0	10,887
Title V Served	245,586	159,642	51,339	396	23,322	0	0	10,887
Eligible for Title XIX	106,896	55,568	33,058	217	11,355	0	0	6,698

II. UNDUPLICATED COUNT BY ETHNICITY

				HISPANIC OR LATINO (Sub-categories by country or area of origin)				
	(A) Total NOT Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(B.1) Mexican	(B.2) Cuban	(B.3) Puerto Rican	(B.4) Central and South American	(B.5) Other and Unknown
DELIVERIES								
Total Deliveries in State	181,321	58,535	768	0	0	0	0	58,535
Title V Served	181,321	58,535	768	0	0	0	0	58,535
Eligible for Title XIX	65,538	39,779	145	0	0	0	0	39,779
INFANTS								
Total Infants in State	185,489	59,316	781	0	0	0	0	59,316
Title V Served	185,489	59,316	781	0	0	0	0	59,316
Eligible for Title XIX	66,519	40,229	148	0	0	0	0	40,229

FORM NOTES FOR FORM 8

None

FIELD LEVEL NOTES

None

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: NY

	FY 2010	FY 2009	FY 2008	FY 2007	FY 2006
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 522-5006	(800) 522-5006	(800)522-5006	(800) 522-5006	(800) 522-5006
2. State MCH Toll-Free "Hotline" Name	The Growing Up Healthy Hotline	The Growing Up Healthy Hotline	The Growing Up Healthy Hotline	The Growing Up Healthy Hotlilne	The Growing Up Healthy Hotline
3. Name of Contact Person for State MCH "Hotline"	Michael Acosta	Michael Acosta	Michael Acosta	Rudy Lewis	Rudy Lewis
4. Contact Person's Telephone Number	(518) 474-1911	(518) 474-1911	(518)474-1911	(518) 474-1911	(518) 474-1911
5. Contact Person's Email	maa04@health.state.ny.u				
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	69,506	60,471	55,380

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM (OPTIONAL)
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: NY

	FY 2010	FY 2009	FY 2008	FY 2007	FY 2006
1. State MCH Toll-Free "Hotline" Telephone Number					
2. State MCH Toll-Free "Hotline" Name					
3. Name of Contact Person for State MCH "Hotline"					
4. Contact Person's Telephone Number					
5. Contact Person's Email					
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	0	0	0

FORM NOTES FOR FORM 9

None

FIELD LEVEL NOTES

None

FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE FOR FY 2010
[SEC. 506(A)(1)]
STATE: NY

1. State MCH Administration:
(max 2500 characters)

The New York State Department of Health's Division of Family Health administers the Title V program in New York State. The Title V program supports activities designed to improve the health status of women, particularly those of reproductive age, infants, children and adolescents, including those with special health care needs. Funds support public health/infrastructure, population-based, enabling and gap-filling personal health care services for those with limited access to high quality, continuous health care. The Division of Family Health encompasses four Bureaus (Women's Health, Dental Health, Early Intervention, and Child and Adolescent Health), and is supported by the Office of the Medical Director and the Research and Policy office. The Division also provides leadership for the State Systems Development Initiative (SSDI), the American Indian Health Program, the Asthma Coordinators, MCH Graduate Student Assistantship Program, and the Migrant and Seasonal Farmworker Health Program. All programs work closely with the Department's Office of Health Insurance Programs (OHIP), which oversees the state's Medicaid program, and the Office of Health Systems Management, which licenses and monitors hospitals and clinics throughout the state.

Block Grant Funds	
2. Federal Allocation (Line 1, Form 2)	$ 41,043,769
3. Unobligated balance (Line 2, Form 2)	$ 0
4. State Funds (Line 3, Form 2)	$ 363,695,631
5. Local MCH Funds (Line 4, Form 2)	$ 299,499,317
6. Other Funds (Line 5, Form 2)	$ 0
7. Program Income (Line 6, Form 2)	$ 176,715,455
8. Total Federal-State Partnership (Line 8, Form 2)	$ 880,954,172

9. Most significant providers receiving MCH funds:

School-based health centers

Family planning programs

Newborn screening and genetics services

Lead poisoning prevention and education services

10. Individuals served by the Title V Program (Col. A, Form 7)

a. Pregnant Women	391,034
b. Infants < 1 year old	246,824
c. Children 1 to 22 years old	5,583,705
d. CSHCN	542,758
e. Others	511,395

11. Statewide Initiatives and Partnerships:

a. Direct Medical Care and Enabling Services:
(max 2500 characters)

Genetics services, School-based Health Centers, family planning, tracking and follow-up of lead poisoned children, primary care and dental services for migrant and seasonal farmworkers and their families, public health nurse home visiting. The Prenatal Care Assistance Program (PCAP/MOMS), the Community Health Worker Program, Children with Special Health Care Needs program, services to Native American women and children, care coordination, patient education, translation, transportation, and Physically Handicapped Children diagnosis and evaluation.

b. Population-Based Services:
(max 2500 characters)

Newborn genetics and hearing screening, population-based health education campaigns, including prenatal outreach and educaton, child find, the Growing Up Healthy Hotline, injury prevention, immunization, Welcome to Parenthood, fluoridation services, health information and referral, nutrition and physical activities programs for children, adolescent pregnacy prevention, Youth Development, migrant health outreach and education.

c. Infrastructure Building Services:
(max 2500 characters)

Maternal m ortalitly program, surveillance and public health information, community health assessments, vital records, Statewide Perinatal Data System, hospital discharge data system (SPARCS), immunization registries, including NYSIIS, workforce development, staff development, evaluation and monitoring, contract management, perinatal regionalization, emergency preparedness, standards and guidelines development, contractor training, policy development. Education-related activities include the Preventive Medicine and Dental Public Health residency program,s the MCH Graduate Assistantship program, Public Health Grand Rounds, monthly T2B2 Satellite broadcasts, Centers for Excellence, the Statewide Oral Health Technical Assistance Center, participation in the NY/NJ Public Health Training Center, and participation in national meetings and organizations.

	Barbara L. McTague	Name	Susan Slade, MS, RN
Title	Director, Division of Family Health	Title	Co-Director, Medical Home Unit
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Fax	(518) 473-2015	Fax	(518) 473-8673
Email	blm01@health.state.ny.us	Email	sjs11@health.state.ny.us
Web	www.health.state.ny.us	Web	www.health.state.us

FORM NOTES FOR FORM 10

None

FIELD LEVEL NOTES

None

FORM 11
TRACKING PERFORMANCE MEASURES
[SECS 485 (2)(2)(B)(III) AND 486 (A)(2)(A)(III)]
STATE: NY

Form Level Notes for Form 11

None

PERFORMANCE MEASURE # 01

The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	250,209	246,243	252,014	255,275	252,793
Denominator	250,259	246,243	252,014	255,275	252,793
Data Source					Newborn Screening Program data set
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	100	100	100	100	100
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

None

FORM 11
TRACKING PERFORMANCE MEASURES
[SECS 485 (2)(2)(B)(III) AND 486 (A)(2)(A)(III)]
STATE: NY

Form Level Notes for Form 11

None

PERFORMANCE MEASURE # 01

The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	250,209	246,243	252,014	255,275	252,793
Denominator	250,259	246,243	252,014	255,275	252,793
Data Source					Newborn Screening Program data set
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	100	100	100	100	100
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

None

PERFORMANCE MEASURE # 02

The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	70	62	64	66	66
Annual Indicator	60.3	60.3	60.3	59	59
Numerator					
Denominator					
Data Source					CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	60	62	63	64	65
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey

2. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

3. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

PERFORMANCE MEASURE # 03

The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	60	52	55	58	58
Annual Indicator	51.7	51.7	51.7	45.2	45.2
Numerator					
Denominator					
Data Source					CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	46	48	49	50	50
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

2. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

3. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

PERFORMANCE MEASURE # 04

The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	65	70	68	70	72
Annual Indicator	59.1	59.1	59.1	62.1	62.1
Numerator					
Denominator					
Data Source					CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	64	64	66	66	68
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

2. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

3. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

PERFORMANCE MEASURE # 05

Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	85	78	80	82	91
Annual Indicator	75.3	75.3	75.3	90.6	90.6
Numerator					
Denominator					
Data Source					CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	92	92	92	93	93
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

2. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

3. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

PERFORMANCE MEASURE # 06

The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	20	7	7	9	40
Annual Indicator	5.8	5.8	5.8	38.4	38.4
Numerator					
Denominator					
Data Source					CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	40	40	43	43	43
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

2. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

3. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

PERFORMANCE MEASURE # 07

Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	81	85	86	87	88
Annual Indicator	83.3	81.6	83.5	83	78.9
Numerator					
Denominator					
Data Source					National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	80	80	82	82	84
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data from the National Immunization Survey. Numerator and Denominator data are not available. Data are for the time period 7/07-6/08

2. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data from the National Immunization Survey. Numerator and Denominator data are not available. Data are for the time period 1/07-12/07.

PERFORMANCE MEASURE # 08

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	14	13	12	11	11
Annual Indicator	14.2	13.7	13.1	13.2	13.2
Numerator	5,415	5,332	5,214	5,277	5,277
Denominator	381,221	390,618	398,091	398,693	398,693
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	12.5	12.3	12.1	11.9	11.9
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

PERFORMANCE MEASURE # 09

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	60	40	30	35	40
Annual Indicator	27.0	27.0	27.0	27.0	27.0
Numerator	10,534	10,534	10,534	10,534	10,534
Denominator	39,014	39,014	39,014	39,014	39,014
Data Source					NYS 3rd Grade Dental Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	28	39	39	30	31
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2002-2004 data are being used as a proxy for 2007.

2. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   2002-2004 data are being used as a proxy for 2007.

3. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   2002-2004 data are being used as a proxy for 2006.

PERFORMANCE MEASURE # 10

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	0.5	0.5	1.1	1	0.9
Annual Indicator	2.2	1.3	1.3	1.3	1.3
Numerator	85	49	50	48	48
Denominator	3,790,880	3,790,880	3,916,635	3,597,289	3,597,289
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	1.3	1.2	1.2	1.2	1.2
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.
   The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

2. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

3. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

PERFORMANCE MEASURE # 11

The percent of mothers who breastfeed their infants at 6 months of age.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective			40	43	51
Annual Indicator		37.2	50	50	43.5
Numerator					
Denominator					
Data Source					National Immunization Survey - breastfeeding suppl
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	44.5	45.5	47	48	49
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2008 data are based on the 2005 birth cohort.
   Data Source: National Immunization Survey - breastfeeding supplement

2. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   2007 data are based on the 2004 birth cohort.
   Data Source: National Immunization Survey - breastfeeding supplement

3. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   2006 data are based on the 2004 birth cohort.
   Data source: National Immunization Survey - breastfeeding supplement.

PERFORMANCE MEASURE # 12

Percentage of newborns who have been screened for hearing before hospital discharge.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	100	100	100	100	100
Annual Indicator	99.9	98.8	97.9	98.5	98.5
Numerator	240,577	242,628	242,212	247,960	247,960
Denominator	240,921	245,675	247,352	251,760	251,760
Data Source					Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	100	100	100	100	100
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

PERFORMANCE MEASURE # 13

Percent of children without health insurance.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	5	9	8.5	8	8
Annual Indicator	8.6	7.7	8.4	8.9	8.9
Numerator	396,000	347,000	380,000	395,000	395,000
Denominator	4,604,000	4,534,000	4,547,000	4,437,000	4,437,000
Data Source					Current Population Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	8.5	8.4	8.2	8	8
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

2. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   .

PERFORMANCE MEASURE # 14

Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective			32	31	30
Annual Indicator		32.1	32.0	32.0	32.0
Numerator		24,562	63,874	63,373	63,373
Denominator		76,566	199,608	198,041	198,041
Data Source					PedNSS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	29	29	28	28	28
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

2. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   2006 data are being used as a proxy for 2007.

PERFORMANCE MEASURE # 15

Percentage of women who smoke in the last three months of pregnancy.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective			15	14	14
Annual Indicator		15	12.2	13.7	13.7
Numerator					
Denominator					
Data Source					PRAMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	13	12	11	11	11
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 NYS PRAMS data, exclusive of NYC, are being used as a proxy for 2008. Numerator and denominator data are not available (survey data).

2. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   2006 NYS PRAMS data, exclusive of NYC, are being used as a proxy for 2007.

PERFORMANCE MEASURE # 16

The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	4.4	4.2	4.1	4.1	4
Annual Indicator	5.2	3.9	3.7	3.9	3.9
Numerator	68	52	51	54	54
Denominator	1,297,818	1,318,372	1,385,081	1,396,874	1,396,874
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	3.8	3.8	3.7	3.7	3.6
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

2. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   .

3. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   revised 4/2009

PERFORMANCE MEASURE # 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	87	90	91	92	92
Annual Indicator	87.2	87.1	88.6	89.7	89.7
Numerator	3,453	3,281	3,345	3,252	3,252
Denominator	3,962	3,765	3,774	3,627	3,627
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	94	94	95	95	95
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

2. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   2006 data are being used as a proxy for 2007.

3. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   2006 data have been updated and finalized.

PERFORMANCE MEASURE # 18

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	82.5	85	77	78	79
Annual Indicator	74.9	75.4	74.6	73.8	73.8
Numerator	175,151	174,737	174,078	174,949	174,949
Denominator	233,802	231,661	233,441	236,903	236,903
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	80	81	82	82	82
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

STATE PERFORMANCE MEASURE # 1

Percent of Live Births Resulting from Unintended Pregnancies

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective			32.8	32.7	31
Annual Indicator	36.3	35.8	33.4	37.5	37.5
Numerator					
Denominator					
Data Source					PRAMS
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	31	30.5	30	29.5	29
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008. Numerator and denominator data are not available. Data are from the NYS PRAMS survey for areas in NYS outside of NYC.

2. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Numerator and denominator data are not available. Data are from the NYS PRAMS survey for areas in NYS outside of NYC.

STATE PERFORMANCE MEASURE # 2

Hospitalization Rate for Asthma in Children 1 to Age 14

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective			245	235	235
Annual Indicator	384.0	335.9	346.5	320.5	320.5
Numerator	13,588	11,729	11,968	10,738	10,738
Denominator	3,538,603	3,492,321	3,453,631	3,350,465	3,350,465
Data Source					SPARCS
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	235	230	230	230	220
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

2. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   revised 4/2009

STATE PERFORMANCE MEASURE # 4

Teenage Pregnancy Rate for Girls Ages 15-17

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective			35	34	34
Annual Indicator	37.5	36.5	36.3	35.1	35.1
Numerator	14,283	14,256	14,444	14,011	14,011
Denominator	381,221	390,618	398,091	398,693	398,693
Data Source					Vital Records
Is the Data Provisional or Final?				Provisional	Final

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	33	33	32	32	31
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

2. **Section Number:** Form11_State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   .

STATE PERFORMANCE MEASURE # 6

Percent of infants who are put down on their backs to sleep.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective			82	84	84
Annual Indicator	69.5	67.2	71.9	70.5	70.5
Numerator					
Denominator					
Data Source					PRAMS
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	85	85	85	86	86
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008. Data are from the NYS PRAMS Survey which includes women residing in NYS outside of NYC

2. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data are from the NYS PRAMS Survey which includes women residing in NYS outside of NYC.

3. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data are from NYS PRAMS Survey which includes women residing in NYS outside of NYC.

STATE PERFORMANCE MEASURE # 7

Hospitalizations for Self-Inflicted Injuries for 15-19 Year Olds

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective			0.1	0.1	0.1
Annual Indicator	0.1	0.1	0.1	0.1	0.1
Numerator	1,421	1,291	1,324	1,280	1,280
Denominator	1,297,818	1,318,372	1,385,081	1,396,874	1,396,874
Data Source					SPARCS
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	0.1	0.1	0.1	0.1	0.1
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

2. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   .

3. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   revised 4/2009

STATE PERFORMANCE MEASURE # 8

Percent of High School Students who had five or more drinks of alcohol in a row at least once in the Last Month

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective			19	18	18
Annual Indicator	25.3	23.9	23.9	24.9	24.9
Numerator					
Denominator					
Data Source					YRBS
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	18	18	18	18	18
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #8
   Field Name: SM8
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2008 data are from the 2007 YRBS (biannual) survey. There are no numerator or denominator data available from this survey

2. **Section Number:** Form11_State Performance Measure #8
   Field Name: SM8
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Numerator and Denominator data are not available (2007 YRBS survey data)

3. **Section Number:** Form11_State Performance Measure #8
   Field Name: SM8
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   2006 data are from the 2005 YRBS (biannual) survey. There are no numerator or denominator data available from this survey.

STATE PERFORMANCE MEASURE # 9

Percent of High School Students Who Smoked Cigarettes in the Last Month

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective			5	5	5
Annual Indicator	20.2	16.2	16.2	13.8	13.8
Numerator					
Denominator					
Data Source					YRBS
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	5	5	5	4	4
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2008 data are from the 2007 (biannual)Youth Risk Behavior Survey. Numerator and denominator data are not available (survey data).

2. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Numerator and Denominator data not available (2007 YRBS survey data).

3. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data are from the Youth Risk Behavior Survey. Numerator and denominator data are not available (survey data). 2005 data are being used as a proxy for 2006.

STATE PERFORMANCE MEASURE # 10

Percent of children in the birth year cohort who were screened for high blood lead before the age of two.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective			87	87	80
Annual Indicator	63	63	69.5	69.5	69.5
Numerator					
Denominator					
Data Source					NYS Lead Tracking System
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	81	82	83	83	83
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #10
   Field Name: SM10
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data are from the NYS Lead Tracking System, based on the 2004 birth cohort ,with testing through 2007.

2. **Section Number:** Form11_State Performance Measure #10
   Field Name: SM10
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data are from the NYS Lead Tracking System, based on the 2004 birth cohort ,with testing through 2007.

3. **Section Number:** Form11_State Performance Measure #10
   Field Name: SM10
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data are based on the 2004 birth cohort with testing through 2007.

STATE PERFORMANCE MEASURE # 11

Percent of High School Students who watched 3 or more hours of TV on an average school day.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective			40	38	34
Annual Indicator	43.6	41.9	41.9	35.3	35.3
Numerator					
Denominator					
Data Source					YRBS
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	33	32	31	30	30
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #11
   Field Name: SM11
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2008 data are from the 2007 biannual YRBS survey. Numerator and Denominator data are not available .

2. **Section Number:** Form11_State Performance Measure #11
   Field Name: SM11
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Numerator and Denominator data are not available (2007 YRBS survey data)

3. **Section Number:** Form11_State Performance Measure #11
   Field Name: SM11
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   2005 data are being used as a proxy for 2006. Numerator and denominator data are not available (survey data).

STATE PERFORMANCE MEASURE # 12

Percent of Women that felt down, depressed or hopeless always or often after their baby was born.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective			11.5	11.4	8
Annual Indicator	10.4	9.9	8.3	7	7
Numerator					
Denominator					
Data Source					PRAMS
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	8	7.5	7.5	7	7
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #12
   Field Name: SM12
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008. Data are from the NYS PRAMS survey which includes women residing in NYS outside of NYC

2. **Section Number:** Form11_State Performance Measure #12
   Field Name: SM12
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data are from the NYS PRAMS survey which includes women residing in NYS outside of NYC.

3. **Section Number:** Form11_State Performance Measure #12
   Field Name: SM12
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data are from the NYS PRAMS survey which includes women residing in NYS outside of NYC.

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[SECS 505 (A)(2)(B)(III) AND 506 (A)(2)(A)(III)]
STATE: NY

Form Level Notes for Form 12

None

OUTCOME MEASURE # 01

The infant mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	5.8	5.7	5.6	5.5	5.5
Annual Indicator	6.0	5.8	5.6	5.5	5.5
Numerator	1,503	1,414	1,391	1,382	1,382
Denominator	248,876	245,378	249,207	252,662	252,662
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	5.5	5.4	5.3	5.2	5.2
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 vital records data are being used as a proxy for 2008 statewide data. Infant deaths for a given year are used as numerator data, and the births in that year are used as the denominator number. The resulting rate may be slightly different that a rate derived from matched birth-death files.

2. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Infant deaths for a given year are used as numerator data, and the births in that year are used as the denominator number. The resulting rate may be slightly different that a rate derived from matched birth-death files.

OUTCOME MEASURE # 02

The ratio of the black infant mortality rate to the white infant mortality rate.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	1.5	1.4	1.4	1.3	1.3
Annual Indicator	2.2	1.9	1.9	1.8	1.8
Numerator	10.7	9.2	9	8.7	8.7
Denominator	4.9	4.9	4.7	4.8	4.8
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	1.3	1.3	1.2	1.2	
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 vital records data are being used as a proxy for 2008 statewide data. Infant deaths for a given year are used as numerator data, and births for the same year as denominator data. The resulting rate may differ somewhat from a rate based on matched birth-death files

2. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Infant deaths for a given year are used as numerator data, and births for the same year as denominator data. The resulting rate may differ somewhat from a rate based on matched birth-death files.

OUTCOME MEASURE # 03

The neonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	4	3.9	3.9	3.8	3.8
Annual Indicator	4.3	4.0	3.8	3.6	3.6
Numerator	1,058	983	936	909	909
Denominator	248,876	245,378	249,207	252,662	252,662
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	3.7	3.7	3.6	3.6	3.6
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008. Vital statistics data are used to determine the rate: infant s who died within 28 days of birth in the target year constitute the numerator, and births for that same year are used as the denominator. The rate may vary somewhat from a rate derived from matched birth-death files.

2. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Vital statistics data are used to determine the rate: infant s who died within 28 days of birth in the target year constitute the numerator, and births for that same year are used as the denominator. The rate may vary somewhat from a rate derived from matched birth-death files.

OUTCOME MEASURE # 04

The postneonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	1.3	1.1	1.1	1	1
Annual Indicator	1.8	1.8	1.8	1.9	1.9
Numerator	445	431	456	473	473
Denominator	248,876	245,378	249,207	252,662	252,662
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	1	1	1	1	1
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 statewide vital records data are being used as a proxy for 2008. Postneonatal mortality rates are determined using infant deaths from 28d-1y in a given year, divided by infant births from the same year. This rate may vary marginally from a rate calculated using matched birth-death certificates.

2. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Postneonatal mortality rates are determined using infant deaths from 28d-1y in a given year, divided by infant births from the same year. This rate may vary marginally from a rate calculated using matched birth-death certificates.

OUTCOME MEASURE # 05

The perinatal mortality rate per 1,000 live births plus fetal deaths.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	11.6	11.5	5.9	5.7	5.5
Annual Indicator	7.2	7.3	5.6	5.3	5.3
Numerator	1,793	1,798	1,411	1,343	1,343
Denominator	250,019	246,397	249,862	253,297	253,297
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	5.3	5.2	5.2	5.2	
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 statewide vital statistics data are being used as a proxy for 2008 data, not yet available. The numerator is derived from the number of infant deaths in the perinatal period plus fetal deaths, as reported on death and fetal death certificates for the year. The denominator is all births for the same year. This gives a rate that may vary somewhat from a rate calculated using matched birth-death files plus fetal deaths.

2. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   The numerator is derived from the number of infant deaths in the perinatal period plus fetal deaths, as reported on death and fetal death certificates for the year. The denominator is all births for the same year. This gives a rate that may vary somewhat from a rate calculated using matched birth-death files plus fetal deaths.

OUTCOME MEASURE # 06

The child death rate per 100,000 children aged 1 through 14.

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective	11.5	10	10	9.5	9.5
Annual Indicator	15.7	15.6	13.9	15.1	15.1
Numerator	557	545	480	506	506
Denominator	3,536,587	3,502,575	3,453,631	3,350,465	3,350,465
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	9.5	9.4	9.4	9.3	9.3
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

2. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   revised 4/2009

STATE OUTCOME MEASURE # 1

Maternal Mortality Rate per 100,000 Live Births

Annual Objective and Performance Data

	2004	2005	2006	2007	2008
Annual Performance Objective			20	19.5	19
Annual Indicator	20.5	14.7	19.3	15.8	15.8
Numerator	51	36	48	40	40
Denominator	248,876	245,378	249,207	252,662	252,662
Data Source					Vital Records
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	18.5	18	17.5	17	16
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form12_State Outcome Measure 1
   Field Name: SO1
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 statewide vital records data are being used as a proxy for 2008. The variability of this rate can be substantial on an annual basis, and depends on a number of factors, primary among which is the intensity with which case ascertainment is pursued. The Safe Motherhood/ Maternal Mortality initiative being implemented in NYS by the American College of Obstetricians and Gynecologists, in collaboration with DOH, has improvement in case ascertainment as one of its major foci. We should therefore expect the rate to increase somewhat in response to this effort, while the impact of educational initiatives designed to reduce maternal mortality is expected to lag behind ascertainment in terms of impact on the rate

2. **Section Number:** Form12_State Outcome Measure 1
   Field Name: SO1
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   The variability of this rate can be substantial on an annual basis, and depends on a number of factors, primary among which is the intensity with which case ascertainment is pursued. The Safe Motherhood/ Maternal Mortality initiative being implemented in NYS by the American College of Obstetricians and Gynecologists, in collaboration with DOH, has improvement in case ascertainment as one of its major foci. We should therefore expect the rate to increase somewhat in response to this effort, while the impact of educational initiatives designed to reduce maternal mortality is expected to lag behind ascertainment in terms of impact on the rate.

FORM 13
CHARACTERISTICS DOCUMENTING FAMILY PARTICIPATION IN CSHCN PROGRAMS
STATE: NY

1. Family members participate on advisory committee or task forces and are offering training, mentoring, and reimbursement, when appropriate.

3

2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

3

3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.

3

4. Family members are involved in service training of CSHCN staff and providers.

3

5. Family members hired as paid staff or consultants to the State CSHCN program (a family member is hired for his or her expertise as a family member).

3

6. Family members of diverse cultures are involved in all of the above activities.

3

Total Score: 18

Rating Key
0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

FORM NOTES FOR FORM 13

No comments were received on any of the survey items.

A similar study was sent to young people, with similar findings. All item responses except for the last one (cultural diversity) had scores that averaged to 3, while item 6 had a score that rounded down to 2. Reasons for this lower score are unclear, but will be investigated by program staff in an effort to improve this score in subsequent years.

FIELD LEVEL NOTES

None

FORM 14
LIST OF MCH PRIORITY NEEDS

[Sec. 505(a)(5)]

STATE: NY FY: 2010

Your State's 5-year Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children and services for Children with Special Health Care Needs. With each year's Block Grant application, provide a list (whether or not the priority needs change) of the top maternal and child health needs in your state. Using simple sentence or phrase ,list below your State's needs. Examples of such statements are: "To reduce the barriers to the delivery of care for pregnant women, " and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top 7 to 10 priority needs in an information system for comparison, tracking, and reporting purposes; you must list at least 7 and no more than 10. Note that the numbers listed below are for computer tracking only and are not meant to indicate priority order. If your State wishes to report more than 10 priority needs, list additional priority needs in a note at the form level.

1. To improve access to high-quality health services for all New Yorkers, with a special emphasis on prenatal care and primary and preventative care which includes attention to mental health issues and which serves those with special health care needs;
2. To improve oral health, particularly for pregnant women, mothers and children, and among those with low income;
3. To prevent and reduce the incidence of overweight for infants, children and adolescents;
4. To eliminate racial, ethnic and geographic disparities in health outcomes, especially with regard to low birth weight and infant mortality;
5. To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;
6. To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women;
7. To reduce unintended and adolescent pregnancies;
8. To ensure the availablity of comprehensive genetics services statewide, including follow-up on positive newborn screening tests, specialty services, and genetics counseling for affected families;
9. To reduce the rate of violence across all age groups, including inflicted and self-inflicted injuries and suicides in 15- to 19-year-olds;
10. To improve parent and consumer participation in the Children with Special Health Care Needs Program, as evidenced by parent scores.

FORM NOTES FOR FORM 14

None

FIELD LEVEL NOTES

None

FORM 15
TECHNICAL ASSISTANCE(TA) REQUEST

STATE: NY **APPLICATION YEAR: 2010**

No.	Category of Technical Assistance Requested	Description of Technical Assistance Requested *(max 250 characters)*	Reason(s) Why Assistance Is Needed *(max 250 characters)*	What State, Organization or Individual Would You suggest Provide the TA (if known) *(max 250 characters)*
1.	**Other** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: N/A	None at present -- we reserve the option to request assistance at a later time	N/A	N/A
2.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
3.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
4.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
5.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
6.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
7.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
8.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			

9.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			
10.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			
11.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			
12.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			

FORM NOTES FOR FORM 15

None

FIELD LEVEL NOTES

None

FORM 16
STATE PERFORMANCE AND OUTCOME MEASURE DETAIL SHEET
STATE: NY

SP # 1

PERFORMANCE MEASURE:	Percent of Live Births Resulting from Unintended Pregnancies
STATUS:	Active
GOAL	To decrease the number of unintended pregnancies
DEFINITION	Births to women that were unintended. **Numerator:** Number of women surveyed that reported they wanted to be pregnant later or not at all. **Denominator:** Number of women responding to the survey times 100 **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	The NYS PRAMS Survey is the source for these data. One limitation is that the survey is only available for NYS excluding NYC.
SIGNIFICANCE	Unintended pregnancy is a problem among women in all age groups. in 1994 48% of American females aged 15-44 years had at least one unintended pregnancy in their lifetime and nearly 1/3 had one or more abortions.

SP # 2

PERFORMANCE MEASURE:	Hospitalization Rate for Asthma in Children 1 to Age 14
STATUS:	Active
GOAL	To reduce asthma morbidity among children.
DEFINITION	Rate of asthma hospitalizations per 100,000 children ages 1 to 14. **Numerator:** Number of hospitalizations for asthma among children age 1 to 14. **Denominator:** Number of children ages 1 to 14 times 100,000. **Units:** 100000 **Text:** Rate
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	The NYS SPARCS Data System is the source for the hospitalization data. The NYSDOH Bureau of Biometrics provides population estimates. .
SIGNIFICANCE	Increased asthma prevalence among children and the associated morbidity due to exacerbations and persistent symptoms present a huge burden to affected individuals and their families. In the US, over 10 million school days are lost anually by children with asthma. Consequently lost productivity of their parents was almost $1M. Patients with inadequately controlled severe asthma have high expenditures in health care costs, especially in terms of hospitalizations. The social and economic burdens of asthma can be alleviated through appropriate asthma preventin and management strategies.

SP # 4

PERFORMANCE MEASURE:	Teenage Pregnancy Rate for Girls Ages 15-17
STATUS:	Active
GOAL	To lower the pregnancy rate among teenagers.
DEFINITION	**Numerator:** Number of pregnancies (including abortions, spontaneous fetal deaths, and births) to females aged 15-17 years old. **Denominator:** Number of females aged 15-17 years of age times 1000. **Units:** 1000 **Text:** Rate
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Vital Records are the source for data on mothers' age and pregnancies. Population numbers are estimated by the Bureau of Biometrics, NYS Health Department.
SIGNIFICANCE	Adolescent sexual activity can have life-changing or life-threatening consequences; unintended pregnancy and infection with sexually transmitted diseases or HIV. Teen parenting is associated with non-completion of high school and the initiation of a cycle of poverty. Adolescent pregnancy reduces employment opportunities leading to increased poverty, and is associated with poorer health coutcomes, less likeliness to marry, and increased dependence on public assistance.

SP # 6

PERFORMANCE MEASURE:	Percent of infants who are put down on their backs to sleep.
STATUS:	Active
GOAL	To increase the number of infants that are placed on their backs to sleep.
DEFINITION	To increase the number of infants that are placed on their backs to sleep. **Numerator:** Number of mothers that reported they placed their babies on there back to sleep. **Denominator:** Number of moms responding to the survey times 100. **Units:** 100 **Text:** 1
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	The PRAMS survey is the source for these data. One limitation is that the survey is only available for NYS excluding NYC.
SIGNIFICANCE	Much research has shown that infants who are placed on their backs for sleeping are at reduced risk for Sudden Infant Death Syndrome (SIDS).

SP # 7

PERFORMANCE MEASURE: Hospitalizations for Self-Inflicted Injuries for 15-19 Year Olds

STATUS: Active

GOAL To reduce self-inflicted, preventable morbidity and mortality.

DEFINITION hospitalizations

Numerator:
Number of hospitalizations attributed to self-inflicted injures among youth 15-19 years of age.

Denominator:
Number of youth 15-19 years of age times 100,000.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES The New York State SPARCS Data System is the source for the hospitalization data. The Bureau of Biometrics, NYSDOH, provides population estimates.

SIGNIFICANCE Enhancing the mental health status of communities is, by itself, an important goal. Its significance is magnified by the fact that mental and physical health are often inexorably entwined. Personal characteristics or experiences such as low self-esteem, concerns about social acceptance, the agsence of strong family structure and support, early exposure to violence and abuse, compulsive behavior, and fatalism are often associated with a wide range of risk behaviors and adverse health outcomes. Self-inflicted injury is one of the extreme manifestations of poor emotional health. Among adolescents and young adults, self-inflicted injuries are five times more likely to occur as compared to their older counterparts. A 1993 study of high school students in the state outside of NYC revealed that approximately 10% of those surveyed actually attempted to kill themselves. 25% of them needed medical attention as a result of their attempt.

SP # 8

PERFORMANCE MEASURE: Percent of High School Students who had five or more drinks of alcohol in a row at least once in the Last Month

STATUS: Active

GOAL To reduce alcohol use among adolescents.

DEFINITION Students who had five or more drinks of alcohol in a row, that is, within a couple of hours, on one or more of the past 30 days.

Numerator:
The number of high school students that reported they drank five or more drinks of alcohol in a row at least once in the last month.

Denominator:
The number of high school students in the survey times 100.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES The YRBS is the source for these data.

SIGNIFICANCE Alcohol is the most commonly used drug in NYS with approximately one million adult and 100,000 youth drinkers in the state. Alcohol use is also associated with high rates of injuy and contributes to lack of inhibition and irresponsible sexual activity, which in turn may contribute to higher rates of unintended pregnancy, sexually transmitted diseases and HIV transmission.

SP # 9

PERFORMANCE MEASURE: Percent of High School Students Who Smoked Cigarettes in the Last Month

STATUS: Active

GOAL To reduce smoking among adolescents.

DEFINITION The rate of current smoking among high school students.

Numerator:
The number of high school students that reported smoking at least one cigarette during the last month.

Denominator:
The number of students in the survey times 100.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES The New York State Youth Tobacco Survey is the source for these data.

SIGNIFICANCE Tobacco is an addictive substance. Tobacco causes more disease and death in NYS than any other pathogen. In 1993, 31,600 New Yorkers died of tobacco-associated conditions, accounting for 19% of all deaths. The direct medical costs related to smoking in NYS is believed to be over $3 billion annually. Tobacco causes 30% of all cancer deaths, 82% of all deahts due to pulmonary disease, and 21% of deaths due to chronic cardiac disease. More than 1,500 fire deaths and 4,600 injuries in the US are attributable to cigarettes. In NYS in 1992 alone, cigarettes caused 33% of fatal fires, taking 733 lives. NYS surveys indicate teen smoking, afterfalling steadily for a number of years, is on the rise in NYS. Most (89%) adult smokers initiated their habit while young, under the ate of 18. 71% of adult smokers reported thay they began smoking daily before age 18.

SP # 10

PERFORMANCE MEASURE:	Percent of children in the birth year cohort who were screened for high blood lead before the age of two.
STATUS:	Active
GOAL	To identify all children that have been exposed to high levels of lead.
DEFINITION	**Numerator:** Number of children in the birth year cohort who have been screened at least once for high blood lead levels before the age of two. **Denominator:** Number of children times 100. **Units:** 100 **Text:** Per 100 children in th birth cohort.
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	NYS Heavymetals and Childhood Lead Registry, the data base for the NYS Childhood Lead Poisoning Prevention Program, is the source for these data. The NYSDOH Bureau of Biometrics provides population estimates.
SIGNIFICANCE	NYS is committed to screening for lead in children one and two years of age in order to identify all children with high lead levels. High lead levels are associated with learning disabilities and severe physical consequences, including death.

SP # 11

PERFORMANCE MEASURE:	Percent of High School Students who watched 3 or more hours of TV on an average school day.
STATUS:	Active
GOAL	To decrease the amount of time high school students watch TV.
DEFINITION	Number of high school students who indicate they watch 3 or more hours of TV. **Numerator:** Number of high school students who indicate they watch 3 or more hours of TV. **Denominator:** Number of high school students **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	22-11 Increase the proportion of children and adolescents who view television 2 or fewer hours per d
DATA SOURCES AND DATA ISSUES	Youth Risk Behavior Survey.
SIGNIFICANCE	Children who watch more than 2 hours per day of television are at an increase risk for obesity in both childhood and into adulthood.

SP # 12

PERFORMANCE MEASURE:	Percent of Women that felt down, depressed or hopeless always or often after their baby was born.
STATUS:	Active
GOAL	To reduce symptoms of depression in postpartum women.
DEFINITION	x **Numerator:** Number of women participating in the PRAMS survey that always or often felt down, depressed or hopeless after their baby was born. **Denominator:** Women responding to the PRAMs survey. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Pregnancy Risk Assessment Monitoring System
SIGNIFICANCE	Postpartum women are at an increased risk for depression but their symptoms can be controlled through treatment.

SO # 1

OUTCOME MEASURE:	Maternal Mortality Rate per 100,000 Live Births
STATUS:	Active
GOAL	To reduce the number of maternal deaths
DEFINITION	Deaths from causes related to pregnancy **Numerator:** Number of deaths occurring to women from causes related to pregnancy (ICD 9: 630 through 676) **Denominator:** Number of Live Births **Units:** 100000 **Text:** Rate
HEALTHY PEOPLE 2010 OBJECTIVE	Reduce the maternal mortality rate to no more than 3.3 per 100,000 live births
DATA SOURCES AND DATA ISSUES	Source: Vital Records Issues: Maternal deatsh as cause of death are under reported. More aggressive case ascertainment results in what appear to be higher rates.
SIGNIFICANCE	Due to general improvement in social and economic conditions and medical practices, maternal deaths have become more rare and are thought to be mostly preventable.

FORM NOTES FOR FORM 16

None

FIELD LEVEL NOTES

None

FORM 17
HEALTH SYSTEMS CAPACITY INDICATORS
FORMS FOR HSCI 01 THROUGH 04, 07 & 08 - MULTI-YEAR DATA
STATE: NY

Form Level Notes for Form 17

None

HEALTH SYSTEMS CAPACITY MEASURE # 01

The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	67.3	57.9	62.0	54.9	54.9
Numerator	8,381	7,236	7,567	6,569	6,569
Denominator	1,246,045	1,249,101	1,220,468	1,196,688	1,196,688
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

2. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   revised 4/2009

HEALTH SYSTEMS CAPACITY MEASURE # 02

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

	Annual Indicator Data				
	2004	2005	2006	2007	2008
Annual Indicator	76.5	76.9	72.7	72.7	77.6
Numerator	110,535	111,874	108,995	108,995	117,580
Denominator	144,460	145,432	149,958	149,958	151,439
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

2. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   .

HEALTH SYSTEMS CAPACITY MEASURE # 03

The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

	Annual Indicator Data				
	2004	2005	2006	2007	2008
Annual Indicator	79	84	84	88	88
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.
   Data are for the percent of children aged 15 months who recieved 5+ well child visits

2. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data are for the percent of children aged 15 months who recieved 5+ well child visits

HEALTH SYSTEMS CAPACITY MEASURE # 04

The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	66.4	66.5	65.9	63.5	63.5
Numerator	132,863	130,854	131,416	126,795	126,795
Denominator	200,115	196,825	199,342	199,659	199,659
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

HEALTH SYSTEMS CAPACITY MEASURE # 07A

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	93.4	94.6	94.4	90.0	90.0
Numerator	1,974,655	1,966,625	1,909,170	1,805,488	1,805,488
Denominator	2,113,319	2,079,460	2,021,928	2,006,098	2,006,098
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008. The denominator represents all children currently enrolled in Medicaid

2. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   .

HEALTH SYSTEMS CAPACITY MEASURE # 07B

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

	Annual Indicator Data				
	2004	2005	2006	2007	2008
Annual Indicator	36.3	38.9	44.3	44.3	46.4
Numerator	140,454	144,365	159,486	159,486	166,217
Denominator	386,892	370,657	360,268	360,268	358,116
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008. The denominator represents all children age 6-9 enrolled in Medicaid in 2008.

2. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   .

HEALTH SYSTEMS CAPACITY MEASURE # 08

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

	Annual Indicator Data				
	2004	2005	2006	2007	2008
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	1	1	1	1	1
Denominator	1	1	1	1	1
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   All SSI beneficiaries receive Medicaid which is a more generous package than that available under the Physically Handicapped Children's Program

2. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   All SSI beneficiaries receive Medicaid which is a more generous package than that available under the Physically Handicapped Children's Program.

3. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   All SSI beneficiaries receive Medicaid which is a more generous package than that available under the Physically Handicapped Children's Program.

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #05
(MEDICAID AND NON-MEDICAID COMPARISON)
STATE: NY

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
a) *Percent of low birth weight (< 2,500 grams)*	2007	Payment source from birth certificate	8.4	7.9	8.1
b) *Infant deaths per 1,000 live births*	2007	Payment source from birth certificate	6.6	5.1	5.5
c) *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*	2007	Payment source from birth certificate	61.9	83.1	73.8
d) *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*	2007	Payment source from birth certificate	51.3	71.6	63.5

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(MEDICAID ELIGIBILITY LEVEL)
STATE: NY

INDICATOR #06 ***The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.***	**YEAR**	**PERCENT OF POVERTY LEVEL MEDICAID (Valid range: 100-300 percent)**
a) *Infants (0 to 1)*	2008	200
b) *Medicaid Children* (Age range 1 to 5) (Age range 6 to 18) (Age range _____ to _____)	2008	133 100
c) *Pregnant Women*	2008	200

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(SCHIP ELIGIBILITY LEVEL)
STATE: NY

INDICATOR #06 ***The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women.***	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
a) *Infants (0 to 1)*	2008	200
b) *Medicaid Children* (Age range 1 to 18) (Age range _____ to _____) (Age range _____ to _____)	2008	400
c) *Pregnant Women*	2008	200

FORM NOTES FOR FORM 18

SCHIP eligibility for children up to 19 includes a variety of levels of co-pays based on the family income as a percentage FPL. These levels range from <160% FPL, for which there is no monthly premium, to 160-222% FPL, at $9/child/month or a maximum of $45/family/month up to 350-400% FPL with a premium of $40/child/month with a family maximum of $120/month. Any family with >400% FPL must pay the full premium per child per month.

FIELD LEVEL NOTES

1. **Section Number:** Form18_Indicator 05
   Field Name: InfantDeath
   Row Name: Infant deaths per 1,000 live births
   Column Name:
   Year: 2010
   Field Note:
   Medicaid and non-Medicaid infant death rates are based on infant deaths among residents of NYS excluding NYC.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: NY

HEALTH SYSTEMS CAPACITY INDICATOR #09A (General MCH Data Capacity)
(The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Informatioin)

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) *	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES **Annual linkage of infant birth and infant death certificates**	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	No
Annual linkage of birth certificates and newborn screening files	3	No
REGISTRIES AND SURVEYS **Hospital discharge survey for at least 90% of in-State discharges**	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

*Where:
1 = No, the MCH agency does not have this ability.
2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis.
3 = Yes, the MCH agency always has this ability.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: NY

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)*	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Other: **NYS Youth Tobacco Survey**	3	No

*Where:
1 = No
2 = Yes, the State participates but the sample size is not large enough for valid statewide estimates for this age group.
3 = Yes, the State participates and the sample size is large enough for valid statewide estimates for this age group.

Notes:

1. HEALTH SYSTEMS CAPACITY INDICATOR #09B was formerly reported as Developmental Health Status Indicator #05.

FORM NOTES FOR FORM 19

None

FIELD LEVEL NOTES

None

FORM 20
HEALTH STATUS INDICATORS #01-#05
MULTI-YEAR DATA
STATE: NY

Form Level Notes for Form 11

None

HEALTH STATUS INDICATOR MEASURE # 01A

The percent of live births weighing less than 2,500 grams.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.2	8.3	8.3	8.1	8.1
Numerator	20,356	20,367	20,760	20,560	20,560
Denominator	248,876	245,378	249,207	252,662	252,662
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008

HEALTH STATUS INDICATOR MEASURE # 01B

The percent of live singleton births weighing less than 2,500 grams.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.2	6.4	6.4	6.2	6.2
Numerator	14,754	15,020	15,253	14,994	14,994
Denominator	239,013	236,138	239,709	242,655	242,655
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

HEALTH STATUS INDICATOR MEASURE # 02A

The percent of live births weighing less than 1,500 grams.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.6	1.5	1.5	1.5	1.5
Numerator	3,962	3,765	3,849	3,716	3,716
Denominator	248,876	245,378	249,207	252,662	252,662
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

HEALTH STATUS INDICATOR MEASURE # 02B

The percent of live singleton births weighing less than 1,500 grams.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.2	1.2	1.2	1.1	1.1
Numerator	2,804	2,751	2,767	2,720	2,720
Denominator	239,013	236,138	239,709	242,655	242,655
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

HEALTH STATUS INDICATOR MEASURE # 03A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.6	3.7	4.0	4.7	4.7
Numerator	174	138	148	168	168
Denominator	3,790,880	3,744,186	3,698,463	3,597,289	3,597,289
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

2. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   .

3. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   revised 4/2009

HEALTH STATUS INDICATOR MEASURE # 03B

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	2.2	1.3	1.4	1.3	1.3
Numerator	85	49	50	48	48
Denominator	3,790,880	3,744,186	3,698,463	3,597,289	3,597,289
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.
   The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics

2. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics

3. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   revised 4/2009
   The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

HEALTH STATUS INDICATOR MEASURE # 03C

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	13.0	14.0	9.6	11.2	11.2
Numerator	338	366	360	313	313
Denominator	2,606,675	2,620,399	3,754,978	2,790,818	2,790,818
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2007.

2. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

3. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   revised 4/2009
   The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

HEALTH STATUS INDICATOR MEASURE # 04A

The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	284.1	268.9	260.4	270.3	270.3
Numerator	10,771	10,069	9,632	9,722	9,722
Denominator	3,790,880	3,744,186	3,698,463	3,597,289	3,597,289
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

2. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   revised 4/2009

HEALTH STATUS INDICATOR MEASURE # 04B

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	32.5	26.9	30.1	29.0	29.0
Numerator	1,231	1,020	1,114	1,044	1,044
Denominator	3,790,880	3,790,880	3,698,463	3,597,289	3,597,289
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.
   Non-fatal MV related injuries include pedestrians and cyclists

2. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Non-fatal MV related injuries include pedestrians and cyclists.

3. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   revised 4/2009
   Non-fatal MV related injuries include pedestrians and cyclists.

HEALTH STATUS INDICATOR MEASURE # 04C

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	120.3	118.2	121.8	122.1	122.1
Numerator	3,135	3,097	3,355	3,407	3,407
Denominator	2,606,675	2,620,399	2,754,978	2,790,818	2,790,818
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.
   Non-fatal MV related injuries include pedestrians and cyclists

2. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Non-fatal MV related injuries include pedestrians and cyclists

3. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   revised 4/2009
   Non-fatal MV related injuries include pedestrians and cyclists.

HEALTH STATUS INDICATOR MEASURE # 05A

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	25.7	25.6	25.6	29.8	29.8
Numerator	16,279	16,449	17,351	20,378	20,378
Denominator	633,458	643,315	677,708	683,829	683,829
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 data are being used as a proxy for 2008.

HEALTH STATUS INDICATOR MEASURE # 05B

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

	Annual Indicator Data				
	2004	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.7	8.0	11.4	10.0	10.0
Numerator	26,824	27,515	38,939	34,020	34,020
Denominator	3,485,833	3,441,631	3,418,040	3,395,372	3,395,372
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

None

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #06A - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

For both parts A and B: Reporting Year: 2007 Is this data from a State Projection? No Is this data final or provisional? Final

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	246,824	167,554	59,084	1,282	18,904	0	0	0
Children 1 through 4	949,864	662,295	210,192	3,673	73,704	0	0	0
Children 5 through 9	1,157,034	825,892	242,918	7,248	80,976	0	0	0
Children 10 through 14	1,243,567	883,184	266,651	10,470	83,262	0	0	0
Children 15 through 19	1,396,874	1,000,658	297,558	11,605	87,053	0	0	0
Children 20 through 24	1,393,944	1,002,961	281,638	11,714	97,631	0	0	0
Children 0 through 24	6,388,107	4,542,544	1,358,041	45,992	441,530	0	0	0

HSI #06B - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity. (Demographics)*

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	188,255	58,569	0
Children 1 through 4	734,361	215,503	0
Children 5 through 9	921,450	235,584	0
Children 10 through 14	1,001,470	242,097	0
Children 15 through 19	1,141,587	255,287	0
Children 20 through 24	1,131,538	262,406	0
Children 0 through 24	5,118,661	1,269,446	0

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #07A - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

For both parts A and B: Reporting Year: 2008 Is this data from a State Projection? Yes Is this data final or provisional? Final

CATEGORY TOTAL LIVE BIRTHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	193	86	87	1	2	0	0	17
Women 15 through 17	5,277	2,892	1,938	25	48	0	0	374
Women 18 through 19	12,322	7,166	4,086	50	203	0	0	817
Women 20 through 34	184,961	119,680	37,740	349	18,487	0	0	8,705
Women 35 or older	49,881	34,720	8,592	66	4,892	0	0	1,611
Women of all ages	252,634	164,544	52,443	491	23,632	0	0	11,524

HSI #07B - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)*

CATEGORY TOTAL LIVE BIRTHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	107	86	0
Women 15 through 17	2,908	2,361	8
Women 18 through 19	7,677	4,619	26
Women 20 through 34	139,217	45,167	577
Women 35 or older	41,620	8,090	171
Women of all ages	191,529	60,323	782

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #08A - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

For both parts A and B: Reporting Year: 2008 Is this data from a State Projection? No Is this data final or provisional? Final

CATEGORY TOTAL DEATHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	1,382	786	457	5	51	7	0	76
Children 1 through 4	207	130	56	0	11	1	0	9
Children 5 through 9	137	87	40	0	6	0	0	4
Children 10 through 14	162	111	41	0	4	2	0	4
Children 15 through 19	538	335	162	1	15	2	0	23
Children 20 through 24	853	558	224	4	34	2	0	31
Children 0 through 24	3,279	2,007	980	10	121	14	0	147

HSI #08B - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)*

CATEGORY TOTAL DEATHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	1,108	270	4
Children 1 through 4	167	40	0
Children 5 through 9	109	28	0
Children 10 through 14	133	29	0
Children 15 through 19	447	89	2
Children 20 through 24	706	147	0
Children 0 through 24	2,670	603	6

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #09A - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

Is this data final or provisional? Provisional

CATEGORY Miscellaneous Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	4,994,163	3,539,583	1,076,403	34,278	343,899	0	0	0	2007
Percent in household headed by single parent	33.9	22.1	63.5	54.3	13.9	0.0	41.6	55.9	2007
Percent in TANF (Grant) families	3.1	0.0	0.0	0.0	0.0	0.0	0.0	3.1	2008
Number enrolled in Medicaid	2,006,098	0	0	0	0	0	0	2,006,098	2007
Number enrolled in SCHIP	381,303	0	0	0	0	0	0	381,303	2008
Number living in foster home care	28,574	0	0	0	0	0	0	28,574	2007
Number enrolled in food stamp program	754,462	0	0	0	0	0	0	754,462	2007
Number enrolled in WIC	292,187	131,983	112,813	3,656	36,186	0	7,549	0	2007
Rate (per 100,000) of juvenile crime arrests	2,469.2	0.0	0.0	0.0	0.0	0.0	0.0	2,469.2	2007
Percentage of high school drop-outs (grade 9 through 12)	3.1	0.0	0.0	0.0	0.0	0.0	0.0	3.1	2007

HSI #09B - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity.(Demographics)*

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
All children 0 through 19	3,987,123	1,007,040	0	2007
Percent in household headed by single parent	0.0	51.5	0.0	2007
Percent in TANF (Grant) families	0.0	0.0	3.1	2008
Number enrolled in Medicaid	0	0	2,021,928	2006
Number enrolled in SCHIP	0	0	381,303	2008
Number living in foster home care	0	0	28,574	2007
Number enrolled in food stamp program	0	0	754,462	2007
Number enrolled in WIC	292,187	177,164	0	2007
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	2,469.2	2007
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	3.1	2007

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #10 - Demographics (Geographic Living Area) *Geographic living area for all resident children aged 0 through 19 years old. (Demographics)*

Reporting Year: 2004 Is this data from a State Projection? Yes Is this data final or provisional? Final

GEOGRAPHIC LIVING AREAS	TOTAL
Living in metropolitan areas	4,794,878
Living in urban areas	479,878
Living in rural areas	416,373
Living in frontier areas	0
Total - all children 0 through 19	896,251

Note:
The Total will be determined by adding reported numbers for urban, rural and frontier areas.

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #11 - Demographics (Poverty Levels) *Percent of the State population at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2007 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Total Population	19,021,000.0
Percent Below: 50% of poverty	6.3
100% of poverty	14.5
200% of poverty	31.9

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #12 - Demographics (Poverty Levels) *Percent of the State population aged 0 through 19 at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2007 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	4,929,000.0
Percent Below: 50% of poverty	9.6
100% of poverty	20.2
200% of poverty	40.9

FORM NOTES FOR FORM 21

None

FIELD LEVEL NOTES

1. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_Children
   Row Name: All children 0 through 19
   Column Name:
   Year: 2010
   Field Note:
   Source: NCHS population estimates - "Bridged Race Vintage 2007"

2. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_SingleParentPercent
   Row Name: Percent in household headed by single parent
   Column Name:
   Year: 2010
   Field Note:
   Source: US Census Bureau, 2007 American Community Survey

3. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_TANFPercent
   Row Name: Percent in TANF (Grant) families
   Column Name:
   Year: 2010
   Field Note:
   This rate is based on children through age 18 since TANF includes children up to age 18.
   Source: US HHS, Office of Family Assistance, 2008 TANF Case Load Report. (145,467 children in TANF Family)

4. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_MedicaidNo
   Row Name: Number enrolled in Medicaid
   Column Name:
   Year: 2010
   Field Note:
   Source: NYS Department of Health, Office of Medicaid Management, FFY 2007-2008 Report.

5. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_SCHIPNo
   Row Name: Number enrolled in SCHIP
   Column Name:
   Year: 2010
   Field Note:
   Data represents SCHIP enrollment for March 2009.

6. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_FoodStampNo
   Row Name: Number enrolled in food stamp program
   Column Name:
   Year: 2010
   Field Note:
   Source: NYS Office of Temporary and Disability Assistance, Welfare Management System

7. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_WICNo
   Row Name: Number enrolled in WIC
   Column Name:
   Year: 2010
   Field Note:
   NYS Pediatric Nutrition Surveillance System, 2007

8. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_JuvenileCrimeRate
   Row Name: Rate (per 100,000) of juvenile crime arrests
   Column Name:
   Year: 2010
   Field Note:
   Data includes 39,924 arrests in 2007 for violent and property index crimes in NYS among youth ages 16-21. The rate is based on a population figure of 1,616,862 youth ages 16-21.
   Source: NYS Division of Criminal Justice Services, Computerized Criminal History System

9. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_DropOutPercent
   Row Name: Percentage of high school drop-outs (grade 9 through 12)
   Column Name:
   Year: 2010
   Field Note:
   Dropout rates are for Public School students for the 2006/2007 school year.

10. **Section Number:** Form21_Indicator 09A
    Field Name: HSIRace_FosterCare
    Row Name: Number living in foster home care
    Column Name:
    Year: 2010
    Field Note:
    Source: NYS Office of Children and Family Services, Child Care Review Service