New York State Prevention Agenda
Promote Healthy Women, Infants, and Children Action Plan

Updated: June 30, 2023

Introduction

"Improving the well-being of mothers, infants, and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system." - Healthy People 2020

The health of women, infants, children, and their families is fundamental to population health. This Prevention Agenda priority aligns directly with the Maternal and Child Health Services Block Grant (Title V) Program, the core federal and state public health program for promoting the health and well-being of the nation's mothers, infants, and children, including children and youth with special health care needs, and their families.[7] As part of Title V, states are required to develop a Maternal and Child Health (MCH) State Action Plan that includes state priorities, objectives, and strategies, which are established based on data and stakeholder input obtained through a comprehensive and ongoing needs assessment process.[8]

Addressing these priorities requires strong partnerships and collaboration at all levels. Such partnership and collaboration are at the heart of the Prevention Agenda, providing a natural opportunity to align the Prevention Agenda 2019-2024 with NY's Title V State Action Plan. The Prevention Agenda goals, objectives, and interventions for Healthy Women, Infants, and Children were drawn from the state's Title V plan, with special consideration for those areas that would benefit from enhanced local action and cross-sector collaboration, and for which local data are available to track progress across the state.

Mirroring NY's Title V action plan, the Prevention Agenda Healthy Women, Infants, and Children (HWIC) priority focuses on health outcomes in three focus areas:

1. Maternal and Women's Health,
2. Perinatal and Infant Health, and
3. Child and Adolescent Health, including children with special health care needs (CSHCN).

New York State Title V
State Action Plan priorities (2016-2020)

- Reduce maternal mortality and morbidity.
- Reduce infant mortality and morbidity.
- Support and enhance children's and adolescents' social-emotional development and relationships.
- Increase supports to address the special needs of children and youth.
- Increase use of primary and preventive health care services across the life course.
- Promote oral health and reduce tooth decay across the life course.
- Promote supports and opportunities that foster healthy home and community environments.
- Reduce racial, ethnic, economic and geographic disparities and promote health equity.

In addition, the HWIC plan includes a fourth cross-cutting focus area on social determinants of health and health equity, intended to address the entire MCH life course.

It is important to view these focus areas in the context of a life course perspective. Promoting healthy development, behaviors, and relationships early in life and during critical periods lays the groundwork for health promotion and disease prevention throughout the lifespan. Supporting the health and wellness of all women is essential to their current and lifelong well-being, regardless of their age, sexual or gender identity, pregnancy history, or future reproductive plans. Moreover, it requires a deep commitment to promoting health equity and eliminating racial, ethnic, economic, and other disparities, as reflected in the fourth cross-cutting focus area.

Guided by a life course framework, interventions must focus on mitigating risk factors, strengthening support for individuals and families, building resiliency, and addressing the broad social, economic, and environmental determinants of health. Interventions need to focus on critical periods of development (such as fetal development and early childhood), as well as the cumulative impact of exposures and adverse experiences over the life course and across generations. Public health efforts must include strategies that engage and support individuals, families, and providers across different settings and sectors and over time.[9]

The health of women, infants, and children is integral to other priorities addressed by the Prevention Agenda. Thus, information presented for this priority should be viewed in conjunction with, not separately from, other sections of the Prevention Agenda.

For additional information about the importance of promoting healthy women, infants and children and the life course perspective/framework, see the: *NYS Health Assessment Contributing Causes of Health Challenges:* https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/sha/contributing_causes_of_health_challenges.pdf

Focus Area 1: Maternal and Women's Health

Goal 1.1: Increase use of primary and preventive health care services among women of all ages, with a focus on women of reproductive age.

Objective 1.1.1: By December 31, 2024, increase the percentage of women ages 18-44 years with a past year preventive medical visit by 10% to 80.6%. (*Baseline:73.3%, Year: 2016; Source: Behavioral Risk Factor Surveillance System; Data availability: State (by race/ethnicity, income), County (selected years).*

Objective 1.1.2: By December 31, 2024, increase the percentage of women ages 45 years and older with a past year preventive medical visit by 2% to 85.0%. (*Baseline: 18-44 years: 83.3%, Year 2016; Source: Behavioral Risk Factor Surveillance System; Data availability: State (by race/ethnicity, income), County (selected years).*

Objective 1.1.3: By December 31, 2024, increase the percentage of women ages 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy by 10% to 38.1%. (*Baseline: 34.6%; Year 2014; Source: Behavioral Risk Factor Surveillance System; Data availability: State (by race/ethnicity, income, and region), County (selected years).*

Intervention 1.1.1: **Incorporate strategies to promote health insurance enrollment, well-woman visits, and age-appropriate preventive health care across public health programs serving women**

Description: A well-woman visit provides a critical opportunity to receive recommended clinical preventive services, including age-appropriate screenings, counseling, and immunizations, to support women's health across the life span.[10] The annual well-woman visit is endorsed by the American College of Obstetrics and Gynecologists (ACOG),[11] and is one of the preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost sharing.[12] NYS survey data show that women without health insurance are significantly less likely to report having a preventive visit in the past year, highlighting the importance of continuing to promote enrollment in affordable health insurance for all women.[13]

For women of reproductive age (defined as ages 15-44 or 18-44 years, depending on the data source), well-women visits provide a key opportunity for provision of reproductive health care (see Intervention 1.1.2 below). New York State survey data demonstrate that women ages 18-44 years are significantly less likely to receive annual preventive medical visits than older women.

A recent review by the Women's and Children's Health Policy Center at Johns Hopkins University found strong evidence that patient reminders/invitations are effective in increasing use of preventive health care visits by women. Other interventions - including community-based group education, patient navigation supports, provider reminder/recall systems, provider education, designated clinics/extended hours, community-level media, and expansion of insurance coverage - also appear to be effective.[14]

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 1: Well-Woman Visit:

- Evidence Analysis Report. NPM 1: Well-Woman Visit, Johns Hopkins University
- Evidence Brief. Well Woman Visits. National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University
- Title V Transformation Tools. Recommendations to support NPM1 – Well Woman Visit. MCH Navigator
- Title V National Performance Measure Resource Sheet. NPM 1: Well-Women Visit. Association of Maternal and Child Health Programs (AMCHP)

ACOG Committee Opinion on Well-Woman Visit. American College of Obstetricians and Gynecologists, Committee on Gynecologic Practice.

Maternal and Infant Community Health Collaboratives (MICHC) Initiative. New York State Department of Health.

New York State of Health: The Official Health Plan Marketplace. New York State Department of Health.

Technical Assistance Document: Implementing USPSTF Recommendations into Professional Education Programs. Agency for Healthcare Research and Quality (AHRQ).

Think Cultural Health. U.S. Department of Health &Human Services, Office of Minority Health.

Women's Preventive Service Guidelines. U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA).

Age groups impacted by this intervention: adolescents age 13-21 years; adults age 21-60 years; older adults age 60+ years

Social determinants of health addressed by this intervention: health care, *other:* social support, discrimination, health literacy

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Employers, businesses, and unions; Insurers; Community-based organizations and human service agencies; Policymakers & elected officials;
- **Supporting:** Media; Colleges & universities; Community or neighborhood residents; Transportation agencies; Economic development agencies; Urban planning agencies.

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies implemented by your organization to increase 1) women's enrollment in health insurance 2) women's use of preventive health care/ well woman visits.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Preventing Chronic Diseases – Preventive Care and Management

Intervention 1.1.2: Integrate discussion of reproductive goals, pregnancy planning, and pregnancy prevention in routine health care for all women of reproductive age.

Description: Both the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Family Physicians (AAFP) recommend that every health care visit should include a discussion of women's reproductive life plan and pregnancy intentions. For women who desire pregnancy, discussion should address pregnancy risk factors including chronic disease management, how to prepare for a healthy pregnancy, and optimal birth spacing. For women, who wish to delay or prevent pregnancy, discussion should address contraceptive options, and effective contraception should be provided.[15] [16] Reproductive life planning discussions and care should include adolescents.

Nearly half of all pregnancies in the United States are unplanned (either mistimed or not wanted), which underscores the importance of raising discussions about pregnancy planning and promoting women's health across the lifespan, regardless of pregnancy intentions.[17] While over 70% of women ages 18-44 years report having a preventive medical visit in the past year, only 35% report that a health care provider had ever talked with them about ways to prepare for a healthy pregnancy.[18]

The NYS Partnership for Maternal Health (PMH), established in 2015, brings together key organizational partners committed to decreasing maternal mortality and morbidity (see Goal 1.2). The PMH has focused on preconception health as an initial priority, with several provider education projects, including a 2016 Commissioner's letter, completed to date.[19]

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 1: Well-Woman Visit:

- Evidence Analysis Report. NPM 1: Well-Woman Visit, Johns Hopkins University.
- Evidence Brief. Well Woman Visits. National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University.
- Title V Transformation Tools. Recommendations to support NPM1 – Well Woman Visit.
- Title V National Performance Measure Resource Sheet. NPM 1: Well-Women Visit. Association of Maternal and Child Health Programs (AMCHP).

ACT for Youth. Act for Youth Center for Community Action (2018).

Action Plan for the National Initiative on Preconception health and Health Care (2012-2014). Centers for Disease Control and Prevention.

Bedsider and Bedsider Provider

Before, Between & Beyond pregnancy: Resource Guide for Clinicians (2018). Clinical Work Group of the National Preconception Health and Health Care Initiative.

IMPLICIT Interconception Toolkit. March of Dimes Foundation.
Know Your Options, Get the Facts. New York State.
Preconception Care webinars for Health Home Providers. New York State Department of Health

- Well Woman Care and Preconception Care: Webinar for Health Home Providers.
- Preconception, Contraception and Conception for Women Living with HIV (WLWH): How Health Home Care Managers Can Provide Support to Facilitate Improved Health Outcomes. (July 2018).
- Postpartum Care for Women Living with HIV (WLWH) and their Newborns: How Health Home Care Managers Can Provide Support to Facilitate Improved Health Outcomes. (August 2018)

Preconception Health and Health Care: The Clinical Content of Preconception Care. American Journal of Obstetrics and Gynecology.

Preconception Health is Essential Well Woman Care – Webinar. New York State Partnership for Maternal Health. (August 2018).

Show Your Love Campaign. Centers for Disease Control and Prevention National Preconception Health Consumer Workgroup (2013).

Age groups impacted by this intervention: adolescents, adults age 21-60 years
Social determinants of health addressed by this intervention: health care, *other:* social support, health literacy, discrimination, reproductive rights and justice.
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers.
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Transportation agencies.

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies developed to integrate discussion of reproductive goals, pregnancy planning, and pregnancy prevention in primary health care visits for women of reproductive age.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Preventing Chronic Diseases – Preventive Care and Management

Goal 1.2: Reduce Maternal Mortality and Morbidity

- **Objective 1.2.1:** By December 31, 2024, decrease the maternal mortality rate by 22% to 16.0 maternal deaths per 100,000 live births. (*Baseline: 20.4; Year 2014-2016; Source: NYS Vital Statistics; Data availability: State (by race/ethnicity and region), County.*
- **Objective 1.2.2:** By December 31, 2024, decrease the racial disparity in maternal mortality rates (ratio of black maternal mortality rate to white maternal mortality rate) by 34% to 3.1. (*Baseline: 4.68; Year 2014-2016; Source: NYS Vital Statistics; Data availability: State.*

- **Objective 1.2.3:** By December 31, 2024, decrease the rate of severe maternal morbidity to 79.3 per 10,000 delivery hospitalizations. (*Baseline: 80.0; Year 2016; Source: Healthcare Cost and Utilization Project – State Inpatient Database (HCUP-SID); Data availability: State.*
- **Objective 1.2.4:** By December 31, 2024, increase the percentage of women who report that a health care provider asked them about depression symptoms at a postpartum visit by 5% to 80.0%. (*Baseline: 76.1%; Year 2016; Source: PRAMS; Data availability: State (by race/ethnicity, income, and region)*

Intervention 1.2.1: Systematically review maternal deaths and several maternal morbidities and use results to inform maternal mortality and morbidity prevention efforts.

Description: Maternal mortality – the death of a woman while pregnant or within six weeks of a pregnancy from causes related to her pregnancy – is a devastating outcome. While New York's maternal mortality rate has been declining, it remains higher than many other states, with dramatic racial disparities. The most recent complete review of maternal deaths for New York State identified embolism, hemorrhage, infection, cardiomyopathy, and hypertensive disorders as the leading causes of maternal deaths. Severe Maternal Morbidity (SMM), also referred to as "near misses", encompasses life threatening medical complications or the need for life-saving interventions during delivery-related hospitalizations. SMM is 50-100 times more common than maternal mortality, with similar racial and ethnic disparities. A study identifying and analyzing SMM cases in New York State was published in 2017 to expand knowledge of these events.[20]

The New York State Department of Health (NYSDOH) conducts comprehensive maternal mortality surveillance activities. Linked birth and death records, hospital in-patient and emergency department data, and a hospital-based adverse event reporting system are used to identify maternal deaths. All identified deaths are reviewed using a standardized tool. Data are analyzed and aggregated for review, discussion, and action. A multidisciplinary committee reviews the findings and provides recommendations for prevention, improvements in medical care and management, and education. The NYS Partnership for Maternal Health, established in 2015, brings together key organizational partners committed to decreasing maternal mortality and morbidity through collaboration.

In 2018, as part of the state's comprehensive maternal mortality initiative (see Intervention 1.2.2), NYSDOH is implementing an enhanced process for maternal death reviews, developed in collaboration with the state's chapter of the American College of Obstetricians and Gynecologists (ACOG). A formal multidisciplinary Maternal Mortality Review Board will have an active role in reviewing maternal death cases to assess causes of death, factors leading to death, preventability, and opportunities for intervention. Findings will be translated into issue briefs, Grand Rounds, quality improvement projects, and reports.

Resources

New York State Maternal Mortality Review Report, 2012-13. New York State Department of Health.

New York City, 2008-2012 Severe Maternal Morbidity. (2016) New York City Department of Health and Mental Hygiene, Bureau of Maternal, Infant and Reproductive Health.

Pregnancy-Associated Mortality: New York City, 2006-2010 New York City Department of Health and Mental Hygiene, Bureau of Maternal, Infant and Reproductive Health.

Proceedings of the 2018 New York Maternal Mortality Summit.

Severe Maternal Morbidity in the United States. Centers for Disease Control and Prevention

Severe maternal morbidity: A population-based study of an expanded measure and associated factors.

Severe Maternal Morbidity: Screening and Review. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine.

Age groups impacted by this intervention: adolescents, adults age 21-60 and their families
Social determinants of health addressed by this intervention: health care, community cohesion, *other:* social support, family support, discrimination, reproductive rights and justice.
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system
- **Supporting:** Insurers; Media; Colleges & universities; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of prevention strategies implemented by your organization based on state and local data about maternal morbidity and mortality.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Preventing Chronic Diseases – Preventive Care and Management

Intervention 1.2.2: Collaborate with partners to advance a comprehensive maternal health agenda that includes policy, community prevention, and clinical quality improvement strategies, with a focus on reducing disparities in maternal mortality and morbidity.

Description: In April 2018, New York State launched a comprehensive initiative to target maternal mortality and reduce racial disparities in maternal health outcomes. Building on the state's established maternal mortality review process, this initiative encompasses a range of approaches to reducing maternal deaths and racial disparities, including:

- Creating a state Task Force on Maternal Mortality and Disparate Racial Outcomes
- Establishing a Maternal Mortality Review Board, building on the Department of Health's current maternal mortality review committee;
- Launching a Best Practice Summit with hospitals and obstetric providers;
- Piloting expansion of Medicaid coverage for doulas;
- Supporting *Centering Pregnancy* demonstration projects;
- Requiring Continuing Medical Education (CME) and curriculum development for health care practitioners and trainees;
- Expanding the New York State Perinatal Quality Collaborative (NYSPQC) clinical quality improvement activities; and,
- Convening a series of Commissioner listening sessions with women across the state.

These strategic activities should build on the rich array of existing clinical, community, and policy initiatives in the state. It is essential that a wide range of partners – including clinical providers and institutions, community-based organizations and leaders, and community members – be engaged in these efforts.

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 2 (Low-Risk Cesarean Delivery)

- Evidence Analysis Report NPM 2: Low-Risk Cesarean Deliveries. Johns Hopkins University
- Evidence Briefs. Cesarean Births among Low Risk First Births. National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University.
- Title V Transformation Tools. Recommendations to support NPM 2 – Low-risk Cesarean Delivery

Alliance for Innovation on Maternal Health (AIM). Council on Patient Safety in Women's Health Care

Centering Pregnancy. Centering Healthcare Institute (2018).

Cochrane Systematic Review: Continuous Support for Women During Childbirth.

Home Visiting Evidence of Effectiveness (HomVee). U.S. Department of Health and Human Services and Administration for Children and Families.

Levels of Maternal Care. Obstetric Care Consensus. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine (2016).

Maternal and Infant Community Health Collaboratives (MICHC) Initiative. New York State Department of Health.

New York State's Home Visiting Programs: Support for Pregnant and Parenting Families. New York State Department of Health

New York State Perinatal Quality Collaborative (NYSPQC). New York State Department of Health.

New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes.

Safe Motherhood Initiative (SMI). American College of Obstetricians and Gynecologists (ACOG) District II, New York State.

Training Modules for Community Health Workers.

Age groups impacted by this intervention*:* adolescents, adults age 21-60 years and their families
Social determinants of health addressed by this intervention: community cohesion, economic stability, education, food security, health care, housing, transportation, *other:* family support, social support, health literacy, home environment, discrimination, reproductive rights and justice,
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Media; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials;
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Schools (K-12); Transportation agencies; Housing agencies; Economic development agencies; Urban planning agencies; *other:* Criminal justice system

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies implemented in collaboration with partners to reduce disparities in maternal mortality and morbidity.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Preventing Chronic Diseases – Preventive Care and Management

Intervention 1.2.3: Increase use of effective contraceptives to prevent unintended pregnancy and support optimal birth spacing.

Description: Approximately 55% of pregnancies in New York State are unintended (not wanted or mistimed). Reducing unintended pregnancies is a fundamental public health approach to reducing maternal mortality and morbidity. Use of effective contraceptives is key to reducing unintended pregnancy. Long acting reversible contraceptives (LARC), which include Intrauterine Devices (IUDs) and subdermal hormonal implants, are the most effective reversible methods available. Patient and provider knowledge, contraceptive coverage, and acquisition costs and logistics are all important factors to address use of effective contraception.

Over the past several years, several national and New York State initiatives have focused on: provider reimbursement for postpartum LARC insertion and LARC acquisition costs; provider education and

training; integration of reproductive life planning in well-woman care; and, enhanced consumer outreach and pregnancy prevention education by Community Health Workers through the state's Maternal Infant Community Health Collaboratives (MICHC) program.

Resources

6 | 18 Initiative: Prevent Unintended Pregnancy. Centers for Disease Control and Prevention (CDC).

Bedsider and Bedsider Provider

Increasing Access to Contraception. Association of State and Territorial Health Officials (ASTHO).

Know Your Options, Get the Facts. New York State

Long-Acting Reversible Contraception (LARC) Program. American College of Obstetricians and Gynecologists (ACOG).

- National ACOG LARC Program
- New York State (ACOG District II) LARC Program
- ACOG District II LARC Resource Summary

Medicaid Coverage of Long-Acting Reversible Contraception (New York State)

- Medicaid Update (September 2016)
- eMedNY reimbursement guidance for physicians (May 2014)

New York State Family Planning Training Center.

Age groups impacted by this intervention: adolescents, adults age 21-60 years and their families
Social determinants of health addressed by this intervention: education, health care, other: family support, social support, health literacy, discrimination, reproductive rights and justice.
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Media; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials;
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Schools (K-12); Transportation agencies; Economic development agencies; Urban planning agencies; other: Criminal justice system

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies implemented to discuss the use of effective contraception to prevent unwanted pregnancy and support optimal birth spacing as part of well care visits for women of reproductive age.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Preventing Chronic Diseases – Preventive Care and Management

Intervention 1.2.4: **Screen all pregnant and postpartum women for depression, with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.**

Description: Depression is the most common morbidity among postpartum women, affecting 10-20% of women during or within 12 months of pregnancy. Depression has implications for the well-being of the entire family and the development of infants and children. Legislation enacted for NYS in 2014 requires hospitals to educate patients about maternal depression and requires insurers to cover postpartum depression screening regardless of which health care provider performs the screening, when depression screening is a covered benefit.

The United States Preventive Services Task Force recommends screening for depression in pregnant and postpartum women. For screening to be effective, systems must be in place to ensure accurate diagnosis and effective treatment and follow-up for women with positive screening results. The USPSTF review identified a range of systems to support screening follow-up, from having designated nurses to implement protocols for facilitated referrals to more intensive systems that include: staff and clinician training (1- or 2-day workshops); clinician manuals; monthly training lectures; academic detailing; materials for clinicians, staff, and patients; an initial visit with a nurse specialist for assessment, education, and discussion of patient preferences and goals; a visit with a trained nurse specialist for follow-up assessment and ongoing support for medication adherence; a visit with a trained therapist for cognitive behavioral therapy (CBT); and a reduced copayment for patients referred for psychotherapy. Multidisciplinary team–based primary care that includes self-management support and care coordination has been shown to be effective in management of depression, as detailed in recommendations from the Community Preventive Services Task Force (CPSTF).

In a multi-year prenatal care quality improvement project conducted by the NYSDOH with Medicaid prenatal care providers, documentation of depression screening increased from 63% to 85% at initial prenatal visit and from 51% to 84% at postpartum visits (2009 to 2014 data) - although use of standardized screening tools was much lower. PRAMS data, which are based on an annual survey of a representative sample of women giving birth in New York State, show that approximately 76% of women report being asked about depression symptoms at their postpartum visit (2016 survey). While these data are encouraging, more efforts are needed to increase screening and strengthen supports and services for women with postpartum depression. A variety of collaborative initiatives have been implemented and are in progress to address this key issue, including updates to Medicaid coverage and reimbursement, the First 1000 Days on Medicaid initiative, the Healthy Steps program led by NYS Office of Mental Health, and the Early Childhood Comprehensive Systems (ECCS) Impact initiative led by NYS Council on Children and Families.

Resources

A Comprehensive Approach for Community-Based Programs to address Intimate Partner Violence and Perinatal Depression. Social Solutions International, Inc.

Depression in Adults: Screening. United States Preventive Services Task Force (USPSTF)

Early Childhood Comprehensive Systems Collaborative Improvement and Innovation Network (ECCS CoIIN).

- National ECCS CoIIN Coordinating Center
- New York State ECCS Impact Initiative

First 1000 Days on Medicaid Initiative.

Healthy Steps.

- National Healthy Steps
- New York Office of Mental Health Implementation of Healthy Steps

Maternal Depression: Information for Health Care Providers. New York State Department of Health.

Medicaid Update: NYS Medicaid Coverage of Postpartum Maternal Depression Screening. New York State Department of Health.

Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders. The Guide to Community Preventive Services. Community Preventive Services Task Force (CPSTF). June 2010.

Postpartum Depression Toolkit. American Academy of Family Physicians National Research Network.

Postpartum Resource Center of New York.

Age groups impacted by this intervention: adolescents, adults age 21-60 and their families
Social determinants of health addressed by this intervention: community cohesion, health care, other: family support, social support, health literacy, home environment.
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Employers, businesses, and unions; Media; Community or neighborhood residents; Community-based organizations and human service agencies;
- **Supporting:** Insurers; Media; Colleges & universities; Schools (K-12); Policymakers & elected officials; Transportation agencies; Economic development agencies; Urban planning agencies; other: Child care, Criminal justice system

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies implemented to effectively screen pregnant and postpartum women for depression and provide appropriate follow up.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Prevent Mental and SU Disorders

Focus Area 2: Perinatal & Infant Health

Goal 2.1: Reduce infant mortality and morbidity

- **Objective 2.1.1:** By December 31, 2024, decrease the infant mortality rate by 13% to 4.0 infant deaths per 1,000 live births.
  (*Baseline: 4.6; Year 2015; Source: National Vital Statistics System; Data availability: State (by race/ethnicity and region), County.)*
- **Objective 2.1.2**: By December 31, 2024, decrease the percentage of births that are preterm by 5% to 8.3 percent of live births.
  (*Baseline: 8.7; Year 2015; Source: National Vital Statistics System; Data availability: State (by race/ethnicity and region), County.)*
- **Objective 2.1.3**: By December 31, 2024, increase the percent of very low birthweight (VLBW) infants born in a Level III or higher hospital by 3% to 95.1%
  (*Baseline: 92.3; Year 2014; Source: National Vital Statistics System; Data availability: State (by race/ethnicity and region), County.)*
- **Objective 2.1.4**: By December 31, 2024, decrease the rate of infants born with neonatal abstinence syndrome and/or affected by maternal use of drugs of addiction by 10% to 9.1 per 1,000 newborn discharges.
  (*Baseline: 10.1; Year 2016; Source: SPARCS; Data availability: State, Region, County.)*
- **Objective 2.1.5:** By December 31, 2024, decrease the Sudden Unexpected Infant Death (SUID) mortality rate by 17% to 0.5 per 1,000 live births.
  (*Baseline: 0.6; Year 2015; Source: Vital Statistics; Data availability: State (by race/ethnicity and region), County.)*

Intervention 2.1.1: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals and centers

Description: There is strong evidence that very high risk infants – such as those with very low birth weight (VLBW) or extreme prematurity – are significantly more likely to survive and thrive when born in facilities with Level III Neonatal Intensive Care Units equipped to handle high-risk newborns.[21] For decades the American Academy of Pediatrics and others have recommended that VLBW and very preterm infants be delivered at hospitals with Level III/IV NICU facilities, designated based on uniform standards and organized within a statewide regionalized system of perinatal care.[22] More recently, there has been renewed attention on the importance of standards and systems for regionalized maternal care to ensure that high risk women receive care in facilities prepared to provide the required level of care to reduce maternal morbidity and mortality.[23]

The New York State Department of Health oversees a regionalized perinatal system in which every birthing hospital and birthing center in the state is designated at one of four levels based on the level of perinatal care it provides to women and newborns. Regional systems of Level I-III hospitals are led by Regional Perinatal Centers that provide or coordinate maternal-fetal and newborn transfers of high

risk patients from affiliate hospitals and birthing centers, and are responsible for support, education, consultation, and improvement in quality of care in their regional affiliates. A comprehensive process to update standards of care and designations, including incorporating midwife-led birthing centers in the system, is in progress. The New York State Perinatal Quality Collaborative (NYSPQC) initiative engages birthing hospitals and centers and other partners to translate evidence-based guidelines to clinical practice to improve outcomes for both mothers and infants.

A recent review by the Women's and Children's Health Policy Center at Johns Hopkins University found that population-based systems level approaches– such as statewide policies and guidelines – are an important component of interventions to increase risk-appropriate perinatal care. Adding a hospital component – such as ongoing education of hospital staff and clinical providers - to these systems interventions appears to increase their effectiveness.[24] New York's systems-building and quality improvement approaches are consistent with this evidence base and serve as a strong foundation for continued work in this area.

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) NPM 3: Perinatal Regionalization:

- Evidence Analysis Report. NPM 3: Risk-Appropriate Perinatal Care, Johns Hopkins University.
- Evidence Brief. Perinatal Regionalization. National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University.
- Title V Transformation Tools. Recommendations to support NPM3 – Perinatal Regionalization.

Levels of Neonatal Care Policy Statement. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine.

New York State Perinatal Quality Collaborative (NYSPQC).

Perinatal Regionalization. New York State Department of Health.

Toward Improving the Outcome of Pregnancy III: Enhancing Perinatal Health Through Quality, Safety and Performance Initiatives. March of Dimes Foundation.

Age groups impacted by this intervention: adolescents, adults age 21-60 years, infants and their families
Social determinants of health addressed by this intervention: health care, family support
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Transportation agencies;

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of local birthing hospitals that have been updated in accordance with perinatal designations.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote a Healthy and Safe Environment – Built and Indoor Environments

Intervention 2.1.2: **Increase capacity and competencies of local maternal and infant home visiting programs**

Description: Home visiting programs are a cornerstone of public health efforts to support pregnant and parenting families. An extensive body of research demonstrates that evidence-based home visiting programs improve numerous short- and long-term outcomes for mothers, infants, and families. As part of the national Maternal and Infant Early Childhood Home Visiting (MIECHV) program, the Home Visiting Evidence of Effectiveness (HomVee) project conducts ongoing in-depth analysis of research findings to identify evidence-based home visiting program models. In New York, MIECHV grant funds have supported the expansion of two specific evidence-based home visiting models: Nurse Family Partnership (NFP) and Healthy Families New York (HFNY). These complement other evidence-based programs operating in New York communities, including Early Head Start, Parents as Teachers, and Home Instruction for Parents of Preschool Youngers (HIPPY), as well as other traditional and emerging service models that include community outreach, home visit, and family support elements such as public health nursing, community health workers, and doulas.

Under New York State's MIECHV initiative, local home visiting programs have been engaged in a variety of efforts to build capacity and improve effectiveness in key areas, including: increasing referrals, client enrollment, and retention; extending the duration of breastfeeding; and increasing home visitors' knowledge and skills related to key topics such as intimate partner violence, substance use, mental health, smoking cessation, self-care, and post-partum/interconception care. Additionally, several local programs are working with the state to pilot the development of local coordinated intake and referral systems in communities with multiple home visiting programs.

Resources

Community Health Workers Toolkit. NORC Walsh Center for Rural Health Analysis, University of Minnesota rural Health Resource Center, and Rural Health Information Hub.

First 1000 Days on Medicaid Initiative.

Home Visiting Evidence of Effectiveness (HomVee). U.S. Department of Health and Human Services and Administration for Children and Families.

Home Visiting Collaborative Improvement and Innovation Network (CoIIN).

Home Visiting – Your Partner in Helping Families. New York State Department of Health and University at Albany School of Public Health Center for Public Health Continuing Education. (April 2018).

Home is where the Start Is: Expanding Home Visiting to Strengthen All of New York's Families. Schuyler Center for Analysis and Advocacy (SCAA).

New York State Home Visiting County Data Snapshots. Schuyler Center for Analysis and Advocacy (SCAA).

New York State's Home Visiting Programs: Support for Pregnant and Parenting Families. New York State Department of Health. State

Training Modules for Community Health Workers.

Age groups impacted by this intervention: adolescents, adults age 21-60, infants, children, and their families.
Social determinants of health addressed by this intervention: community cohesion, economic stability, education, food security, health care, housing, transportation, other: family support, social support, health literacy, learning environment, home environment, discrimination, reproductive rights and justice, incarceration, crime & violence
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials.
- **Supporting:** Health care delivery system; Employers, businesses, and unions; Insurers; Media; Colleges & universities; Transportation agencies; Housing agencies; Economic development agencies; Urban planning agencies; other: Child care, Criminal justice system

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies implemented to increase capacity and competencies of maternal and infant home visiting programs.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

Intervention 2.1.3: Engage in collaborative clinical and community-based strategies to reduce sleep-related infant deaths.

Description: Sudden Unexpected Infant Deaths (SUID) - a classification that includes Sudden Infant Death Syndrome (SIDS), accidental suffocation and strangulation in bed, and sleep-related deaths of unknown cause - are the leading cause of infant death after the first month of life and one of the leading causes of infant death overall. Because infants placed to sleep on their sides or stomachs (prone) are at increased risk of SIDS, the American Academy of Pediatrics and other public health organizations have long recommended that infants be placed to sleep on their backs. In 2011, these

recommendations were expanded to address other risk factors for sleep-related deaths by promoting safe sleep environments, breastfeeding, and avoiding smoke exposure.

A recent review by the Women's and Children's Health Policy Center at Johns Hopkins University found that national campaigns and interventions targeting caregivers, health care providers, and hospital levels appear to be effective at increasing exclusive back sleeping position in infants. There is less evidence to support interventions targeting only caregivers, health care providers, or child care providers alone. Researchers also noted substantial variation in following safe sleep recommendations by race and ethnicity, highlighting the need for interventions to consider these differences.[25] A variety of efforts to promote safe sleep and reduce sleep-related mortality have been completed or are underway in New York State, including community awareness campaigns and materials and several hospitals- and community-based quality improvement projects.

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 4: Safe Sleep:

- Evidence Analysis Report. NPM 4: Safe Sleep, Johns Hopkins University.
- Evidence Brief. Safe sleep. National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University.
- Title V Transformation Tools – Safe Sleep

Building Integrated Systems for Address Sudden Unexpected Infant Death. National Center for Cultural Competence, Georgetown University

Caring for our Children – Safe Sleep Standards in Child Care Settings.

Collaborative Improvement and Innovation Network to Reduce Infant Mortality (CoIIN).

National Action Partnership to Promote Safe Sleep Improvement and Innovation Network (NAPPSS-IIN) - Maternal and Child Health Bureau/ National Institute for Children's Health Quality (NICHQ).

New York State Perinatal Quality Collaborative (NYSPQC). New York State Department of Health.

Safe to Sleep Campaign®. Directed and managed by the National Institute of Child Health and Human Development.

SIDS and other sleep-related infant deaths: Expansion of recommendations for a safe infant sleeping environment. American Academy of Pediatrics

Sudden Unexpected Infant Death (SUID) and Sudden Infant Death Syndrome (SIDS) Gateway. National Center for Education in Maternal and Child Health, Georgetown University.

Toolkit for community health providers: Engaging ethnic media to inform communities about safe infant sleep. National Center for Cultural Competence, Georgetown University.

Age groups impacted by this intervention: infants and their families.
Social determinants of health addressed by this intervention: community cohesion, health care, other: family support, social support, health literacy, home environment.
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Media; Community or neighborhood residents; Community-based organizations and human service agencies; other: Child care.
- **Supporting:** Employers, businesses, and unions; Insurers; Colleges & universities; Schools (K-12); Policymakers & elected officials.

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of clinical or community-based strategies developed to reduce sleep related infant deaths.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

Intervention 2.1.4: Engage in collaborative strategies to respond to increasing use of opioids among women, including pregnant women, and impact on infants.

Description: Use of opioids among reproductive age women, including during pregnancy, has increased dramatically in recent years, paralleling the national and state opioid crisis. The rate of infants born with neonatal abstinence syndrome (withdrawal from opioids) increased by over 100% from 2008 to 2014, to nearly 6 infants per 1,000 delivery hospitalizations. Addressing the opioid epidemic is a public health priority in NYS. In 2014, the state established the Heroin and Opioid Task Force and enacted Combat Heroin legislation, establishing a multi-faceted response with a focus on prevention, harm reduction, treatment, recovery, and law enforcement. A collaborative approach is essential to addressing this complex issue. Several initiatives are in place and in process at the state level, including efforts focused specifically on pregnant women and families.

Resources

A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. Substance Abuse and Mental Health Service Administration (SAMHSA).

Combating the Heroin and Opioid Crisis: Heroin and Opioid Task Force Report (June 2016). Report of NYS Task Force

Institute for Research, Education and Training in Addictions (IRETA).

National Collaborative for Maternal Opioid Use Disorders. Alliance for Innovation on Maternal Health.

National Registry of Evidence-Based Programs and Practices (NREPP). Substance Abuse and Mental Health Services Administration (SAMHSA).

New York State Opioid Overdose Prevention Program. New York State Department of Health Opioid Addiction Prevention & Management Collaborative. Health Care Association of New York State (HANYS).

Opioid-related Data in New York State. New York State Department of Health (2018).

During Pregnancy. National Institutes of Health (NIH) National Institute on Drug Abuse (NIDA).

Preventing Opioid Misuse in Pregnant Women and New Moms Challenge. Maternal and Child Health Bureau.

Age groups impacted by this intervention: infants, adolescents, adults age 21-60 and their families.
Social determinants of health addressed by this intervention: community cohesion, economic stability, education, health care, other: family support, social support, health literacy, discrimination, incarceration, crime & violence
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Economic development agencies; Criminal justice system
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Schools (K-12); Transportation agencies; Housing agencies; Urban planning agencies;

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies implemented by local health organizations to address the increase in opioid use among women as well as its effect on infants.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Prevent Mental and SU Disorders

Goal 2.2: Increase breastfeeding

- **Objective 2.2.1:** By December 31, 2024, increase the percentage of infants who are exclusively breastfed in the hospital by 10%:
- from 47.0% (2016) to 51.7% among all infants
- from 34.0% (2016) to 37.4% among Hispanic infants
- from 34.9% (2016) to 38.4% among Black, non-Hispanic infants
- from 34.7% (2016) to 38.2% among infants insured by Medicaid
  (Data Source: Vital Statistics)

- **Objective 2.2.2:** By December 31, 2024, decrease the percentage of breastfed infants supplemented with formula in the hospital by 10%:
  - from 46.6% (2016) to 41.9% among all infants
  - from 62.6% (2016) to 56.3% among Hispanic infants
  - from 59.4% (2016) to 53.5% among Black, non-Hispanic infants

  (Data Source: Vital Statistics)
- **Objective 2.2.3:** By December 31, 2024, increase the percentage of infants enrolled in WIC who are breastfed at 6 months by 10%:
  - from 41.4% (2016) to 45.5% among all WIC infants
  - from 37.7% (2016) to 41.5% among Black, non-Hispanic WIC infants
  - from 41.8% (2016) to 46.0% among Hispanic, WIC infants

  (Data Source: Pediatric Nutrition Surveillance System)

Intervention 2.2.1: Increase access to professional support, peer support, and formal education to change behavior and outcomes.

Description: Local health departments, hospitals, health centers, insurers (including Medicaid Managed Care), businesses, CBOs and other stakeholders should collaboratively work to ensure increased awareness, availability and accessibility of culturally competent lactation consultants, and breastfeeding support prenatally and postpartum. This includes ensuring that culturally competent, professional lactation consultants (e.g., IBCLCs); peer support (e.g., WIC); and formal breastfeeding education is available in the local area, and that information and resources on accessing support and contacts is up-to-date and accessible.

Resources

Cochrane Systematic Review (2016). Interventions for Promoting the Initiation of Breastfeeding

U.S. Preventive Services Task Force (2016). Primary Care interventions to Support Breastfeeding Recommendation Statement and Breastfeeding: Primary Care interventions

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). Full Report and Evidence Summary

U.S. Department of Agriculture (2018). Partnering with WIC to Support Breastfeeding

United States Breastfeeding Committee (2010). Core Competencies in Breastfeeding Care and Services for All Health Professionals

Centers for Disease Control and Prevention (2013). Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies Atlanta: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services (2011). The Surgeon General's Call to Action to Support Breastfeeding Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Actions 1, 2,3, 8 and 9: pgs. 38-40, 45-47).

Evans A, Marinelli KA, Taylor JS and The Academy of Breastfeeding Medicine (2014). ABM Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: "The Going Home Protocol," Revised 2014 doi: 10.1089/bfm.2014.9996.

New York State Department of Health. Women, Infants, and Children (WIC) Program Site Information Dataset

New York State Department of Health. Breastfeeding Friendly Practices by County

Age range(s): Pregnant and Postpartum Women
Social Determinant of Health addressed: Health Care, Education, Community Cohesion
Sector(s) playing lead role: Healthcare Delivery System
Sector(s) playing contributing role: Insurers, Media, CBOs and Human Service Agencies
Intermediate-level measure: 1) Number of Supplemental Nutrition Program for Women, Infants and Children (WIC) local agencies or sites, hospitals, hospital-affiliated clinics, primary care practices) that provide professional support, peer support and formal education to change behavior and outcomes.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

Intervention 2.2.2: Promote and implement maternity care practices consistent with the Baby Friendly Hospital Initiative - Ten Steps to Successful Breastfeeding.

Description: Local health departments, health centers, insurers, businesses, CBOs and other stakeholders should work with hospitals to implement recommended maternity care practices and policies, and support hospitals in becoming certified as Baby Friendly. The goal is to increase the percent of mothers and newborns who are exposed to recommended maternity care practices, and the percent of infants born in Baby Friendly Hospitals.

Resources

World Health Organization (1998). Evidence for the Ten Steps to Successful Breastfeeding

World Health Organization (2018). Revised Baby-Friendly Hospital Initiative Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services

Baby-Friendly USA, Inc. (2016). The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation

United States Lactation Consultant Association (2010). International Board Certified Lactation Consultant Staffing Recommendations for the Inpatient Setting

Nickel NC, Labbok MH, Hudgens MG, Daniels JL. The Extent that Noncompliance with the Ten Steps to Successful Breastfeeding Influences Breastfeeding Duration

J Hum Lact 2013;29(1): 59-70.

Baby-Friendly USA, Inc. (2016).

- The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation
- Baby-Friendly Hospital Initiative: Facility Self-Appraisal Tool
- Designated Facilities by State

Centers for Disease Control and Prevention (2015). Maternity Practices in Infant Nutrition and Care (mPINC) Survey

Age range(s): Pregnant and Postpartum Women
Social Determinant of Health addressed: Health Care, Education
Sector(s) playing lead role: Healthcare Delivery System
Sector(s) playing contributing role: Insurers, Media, CBOs and Human Service Agencies
Intermediate-level measure: 1) Number of hospitals that improve their maternity care practices towards consistency with the Ten Steps to Successful Breastfeeding.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

Intervention 2.2.3: Promote and implement early skin-to-skin contact in hospitals

Description: Local health departments, hospitals, health centers, insurers (including Medicaid Managed Care), businesses, CBOs and other stakeholders should work to promote early skin-to-skin contact by educating women and their families of the benefits of skin-to-skin contact. Hospitals and health centers can ensure that providers and staff are knowledgeable and informed, and their policies, practices, and staff support skin-to-skin contact between mother and newborn immediately following birth (until the first breastfeeding is completed), and the first six hours.

Resources:

Cochrane Systematic Review (2016). Early Skin-to-Skin Contact for Mothers and Their Health Newborn Infants

Hung KJ & Berg O. Early Skin-To-Skin after Cesarean to Improve Breastfeeding MCN 2011;36(5):318-324.

Feldman-Winter L, Goldsmith JP, Committee on Fetus and Newborn, Task Force on Sudden Infant Death Syndrome. American Academy of Pediatrics (AAP). Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns Pediatrics 2016;138(3):e1-e10.

Association of Women's Health, Obstetric and Neonatal Nurses. Immediate and Sustained Skin-to-Skin Contact for the Healthy Term Newborn After Birth

AWHONN Practice Brief Number 5. JOGNN 2016;45:842-844.

United States Institute for Kangaroo Care. Kangaroo Care Resources
Rosen-Carole C, Hartman S and The Academy of Breastfeeding Medicine. ABM Clinical Protocol #19: Breastfeeding Promotion in the Prenatal Setting, Revision 2015

Baby-Friendly USA, Inc. (2016).

- The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation
- Baby-Friendly Hospital Initiative: Facility Self-Appraisal Tool
- Designated Facilities by State

Centers for Disease Control and Prevention (2015). Maternity Practices in Infant Nutrition and Care (mPINC) Survey; questions A4, A5, A10, A11

Age range(s): Newborn infants up to 1 month; Pregnant and Postpartum Women
Social Determinant of Health addressed: Health Care, Education
Sector(s) playing lead role: Healthcare Delivery System, Governmental Public Health Agencies
Sector(s) playing contributing role: Healthcare Delivery System, Insurers, CBOs and Human Service Agencies
Intermediate-level measure: 1) Number of hospitals that improve their maternity care practices to promote and ensure early skin to skin contact 2) Number of staff (nurses, lactation consultant or other professionals, doulas, and/or WIC nutrition educators) trained in Kangaroo Care, who provide prenatal education and/or maternal support on early skin-to-skin contact after delivery.
Related interventions, focus areas and goals from other priorities: Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

Intervention 2.2.4: Increase access to primary care practices that are supportive of breastfeeding.

Description: Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders should work with primary care practices to support staff education and training, provide guidance in developing policies and procedures that are consistent with recommended guidelines, and that practices meet the criteria to become designated as a NYS Breastfeeding Friendly Practice. The goal is to increase the number of designated practices, and the number of patients who are supported and receive primary care in a Breastfeeding Friendly Practice.

Resources

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). Full Report and Evidence Summary

The Academy of Breastfeeding Medicine Protocol Committee. ABM Clinical Protocol #14: Breastfeeding Friendly Physician's Office, Part 1: Optimizing care for infants and children, Revised 2013. Breastfeeding Med 2006;1(2):115-119.

Shariff F, Levitt C, Kaczorowski J, et al. Workshop to implement the Baby Friendly Office initiative. Effect on community physicians' offices. Can Fam Physician 2000;46:1090-1097.

The American Academy of Pediatrics, Breastfeeding Initiatives. How to Have a Breastfeeding Friendly Practice

American College of Obstetricians and Gynecologists (ACOG). Optimizing Support for Breastfeeding as Part of Obstetric Practice. Committee Opinion. No. 756. Obstet Gynecol 2018;132:e187-196.

New York State Department of Health.

- Breastfeeding Friendly Practice Designation
- NYS Breastfeeding Friendly Practice Designation Assessment Survey
- Breastfeeding Friendly Practices by County

Age range(s): Infants and Young Children (0 - 3 years), Prenatal and Postpartum Women
Social Determinant of Health addressed: Health Care, Community Cohesion, Education
Sector(s) playing lead role: Healthcare Delivery System
Sector(s) playing contributing role: Insurers, Community or Neighborhood Residents, Governmental Public Health Agencies
Intermediate-level measure: 1) Number of health care practices that improve their policies and practices to support breastfeeding mothers and families. 2) Number of practices (pediatric, obstetric or family medicine) with breastfeeding office policies. 3) Number of practices that become designated as a NYS Breastfeeding Friendly Practice.

Related interventions, focus areas and goals from other priorities: Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

Intervention 2.2.5: Increase access to community-based interventions that provide mothers with peer support via home visits in the prenatal and early postpartum period.

Description: Local health departments, hospitals, health centers, insurers (including Medicaid Managed Care), businesses, and other stakeholders should establish partnerships with community-based organizations (i.e., trained community health workers, doulas and other peer support) to provide prenatal breastfeeding education, assistance, support, and facilitate coordination to community resources, and continuity of care post-discharge.

Resources

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). Full Report and Evidence Summary

Cochrane Systematic Review (2017). Schedules for Home Visits in the Early Postpartum Period

U.S. Department of Health and Human Services. Home Visiting Evidence of Effectiveness

Centers for Disease Control and Prevention (2005). Shealy KR, Li R, Benton-Davis S, Grummer-Strawn LM. The CDC Guide to Breastfeeding interventions Atlanta: U.S. Department of Health and Human Services.

Centers for Disease Control and Prevention (2013). Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies Atlanta: U.S. Department of Health and Human Services.

New York State Department of Health. Find a Home Visiting Program and List of Home Visiting Programs in NYS

Age range(s): Infants, Prenatal and Postpartum Women
Social Determinant of Health addressed: Health Care, Community Cohesion, Education
Sector(s) playing lead role: Governmental Public Health Agencies, Healthcare Delivery System
Sector(s) playing contributing role: Insurers, Community or neighborhood residents, CBOs and Human service agencies, Policy makers and other elected officials
Intermediate-level measure: 1) Number of community-based organizations that provide information, support and referrals to promote and support breastfeeding via home visits 2) Number of mothers that receive information, support and referrals to promote support breastfeeding via home visits.

Related interventions, focus areas and goals from other priorities: Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

Intervention 2.2.6: Increase support for breastfeeding in the workplace.

Description: Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders should ensure their worksite has fully implemented the NY Nursing Mothers in the Workplace Act (NY Labor Law 206-c) and can work to assist other worksites to implement this Labor Law and adopt and implement policies and recommended multi-component worksite breastfeeding support programs. At the county or regional level, several health departments are working together to develop interventions to support local worksites, including educational materials, assessment tools, and guidelines to designate worksites as Breastfeeding Friendly.

Resources

Dinour L, Szaro J. Employer-Based Programs to Support Breastfeeding Among Working Mothers: A Systematic Review. Breastfeeding Medicine 2017:12(3).

New York State Department of Labor. NYS Nursing Mothers in the Workplace Act

Centers for Disease Control and Prevention (2013). Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies Atlanta: U.S. Department of Health and Human Services (Strategy 5: Support for Breastfeeding in the Workplace pg. 23 - 28)

U.S. Department of Health and Human Services (2011). The Surgeon General's Call to Action to Support Breastfeeding Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Action 13: pg. 50).
Making It Work Toolkit

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (2008). Business Case for Breastfeeding

New York City Department of Health, Center for Health Equity (2018). Breastfeeding Toolkit for Business Owners

Niagara County Breastfeeding Friendly Employer Initiative
http://www.niagaracounty.com/health/Services/Lactation-and-Breastfeeding

Centers for Disease Control and Prevention (2014). The CDC Worksite Health Score Card: An Assessment Tool for Employers to Prevent Heart Disease, Stroke, & Related Health Conditions Lactation Support Module (6 questions); page 21

Niagara County Department of Health. Breastfeeding Friendly Workplace Assessment

Age range(s): All Infants (0-3yrs), Women of Child-Bearing Age, Prenatal and Postpartum Women
Social Determinant of Health addressed: Economic Stability
Sector(s) playing lead role: Governmental Public Health Agencies; Policy Makers and Elected Officials
Sector(s) playing contributing role: Media; Insurers; Healthcare Delivery Systems
Intermediate-level measure: 1) Number of worksites that improve their policies and practices to support breastfeeding mothers and families.
Related interventions, focus areas and goals from other priorities: Healthy Eating and Food Security

Intervention 2.2.7: Increase access to Early Care and Education programs that support breastfeeding families.

Description: Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders should work to assist child care providers support breastfeeding families. This includes encouraging and supporting child care providers to receive training and education to support breastfeeding families, helping facilities develop breastfeeding friendly policies and working with day care centers and homes to meet the criteria to become designated as breastfeeding friendly.

Resources

Batan M, Li R, Scanlon K. Association of child care providers breastfeeding support with breastfeeding duration at 6 months. Matern Child Health J. 2012 doi: 10.1007/s10995-012-1050-7.
Centers for Disease Control and Prevention (2013). Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies Atlanta: U.S. Department of Health and Human Services. (Strategy 6: Support for Breastfeeding in the Early Care and Education pg. 29 – 32)

American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. 2011. *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs*. 3rd Edition. Also available at http://nrckids.org

Chapter 4: Nutrition and Food Service, 4.3 Requirements for Specials Groups or Ages of Children, 4.3.1 Nutrition for Infant

Breastfeeding and Early Care and Education – Centers for Disease Control and Prevention

New York State Department of Health - CACFP Breastfeeding Friendly Child Care Designation Program

- Child Care Center Breastfeeding Friendly Self-Assessment

- Day Care Home Breastfeeding Friendly Self-Assessment
- Day Care Home Breastfeeding Friendly Self-Assessment Spanish
- Breastfeeding Friendly Child Care Centers by County
- Breastfeeding Friendly Child Care Homes by County

Age range(s): Infants and young children (6 weeks – 3 years), Women of Child-Bearing Age, Prenatal and Postpartum Women
Social Determinant of Health addressed: Economic Stability, Food Security, Community Cohesion
Sector(s) playing lead role: Governmental Public Health Agencies; Employers, Businesses and Unions; Policy Makers and Elected Officials
Sector(s) playing contributing role: Media; Insurers; Healthcare Delivery Systems
Intermediate-level measure: 1) Number of child care programs that improve their practices to support breastfeeding mothers and families.
Related interventions, focus areas and goals from other priorities: Healthy Eating and Food Security

Intervention 2.2.8: Increase access to peer and professional breastfeeding support by creating drop-in centers (e.g., Baby Cafés®) in faith-based, community-based or health care organizations in communities.

Description: Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders should work together to support and establish breastfeeding support groups in faith-based, community-based or health care organizations in communities. Support groups should provide access to lactation consultants (IBCLCs), other lactation professionals and peer support (pregnant and/or breastfeeding), their families, and other support persons).

Resources

Fox, Rebekah & McMullen, Sarah & Newburn, Mary. (2015). UK women's experiences of breastfeeding and additional breastfeeding support: a qualitative study of Baby Café services. BMC Pregnancy and Childbirth. 15:147. DOI 10.1186/s12884-015-0581-5.

Evans, Marinelli, Taylor, Academy of Breastfeeding Medicine (2014). ABM Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: "The Going Home Protocol," Revised 2014 Breastfeeding Med 2014; 9(1). DOI: 10.1089/bfm.2014.9996

U.S. Department of Health and Human Services (2011). The Surgeon General's Call to Action to Support Breastfeeding. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Actions 3 and 11: pgs. 40 and 48).

Centers for Disease Control and Prevention (2013). Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies Atlanta: U.S. Department of Health and Human Services.

Baby Café USA: http://www.babycafeusa.org/ and List of Baby Cafés in your state

Age range(s): Infants and Young Children (0-3 years), Women of Child-Bearing Age, Prenatal and Postpartum Women
Social Determinant of Health addressed: Economic Stability, Food Security, Community Cohesion, Health Care
Sector(s) playing lead role: CBOs and Human Service Agencies, Community or Neighborhood Residents
Sector(s) playing contributing role: Media; Insurers; Healthcare Delivery Systems; Policy Makers and Elected Officials; Governmental Public Health Agencies
Intermediate-level measure: 1) Number of faith-based, community-based or health care organizations that provide peer and professional breastfeeding support by creating drop-in centers/Baby Cafés® 2) Number of mothers who received peer- and professional support at drop-in centers/Baby Cafés®.
Related interventions, focus areas and goals from other priorities: Healthy Eating and Food Security

Focus Area 3: Child and Adolescent Health

Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships

- **Objective 3.1.1:** By December 31, 2024, increase the percentage of children ages 9-35 months who received a developmental screening using a parent-completed screening tool in the past year by 20% to 21.0%. (*Baseline: 17.5%; Year: 2016; Source: National Survey of Children's Health; Data availability: State).*
- **Objective 3.1.2:** By December 31, 2024, increase the percentage of children and adolescents, age 3-17 years, with a mental/behavioral health condition who received treatment or counseling by 10% to 49.8%. (*Baseline: 45.3%; Year: 2016; Source: National Survey of Children's Health; Data availability: State*).
- **Objective 3.1.3:** By December 31, 2024, decrease the percentage of adolescents in grades 9-12 who felt sad or hopeless for two or more weeks in a row in the past year by 25% to 21.5% (*Baseline: 28.6%; Year: 2015; Source: Youth Risk Behavior Survey; Data availability: State (by race, grade, sex, sexual identity).*
- **Objective 3.1.4:** By December 31, 2024, decrease the suicide mortality rate for youth ages 15-19 years by 6% to 4.7 per 100,000. (*Baseline: 5.0 deaths per 100,000 population ages 15-19 years; Year: 2014-16; Source: Vital Statistics; Data availability: State (by race), County).*

Intervention 3.1.1: Increase awareness, knowledge, and skills of providers serving children, youth, and families related to social-emotional development, adverse childhood experiences (ACEs), and trauma-informed care.

Description: Supporting the healthy social-emotional development of children has emerged as a public health priority. Social-emotional development is foundational to children's development in other domains, school readiness and success, and lifelong health and well-being.[26] Adverse childhood experiences (ACEs) including abuse and neglect, parental mental illness and addiction, family separation, and other traumatic experiences can have profound impact on children's development. ACEs are associated with significantly increased risk for a wide range of chronic health conditions and risk factors later in life – as well as adverse pregnancy outcomes such as preterm birth.[27] [28] [29]

Strategies to increase individual foundational knowledge and skills for those working with children and families are a key element of building an effective capacity and response. A variety of state projects and national resources are available for individual practitioners and organizations to support this aspect of workforce development. Additional resources will be added as this emerging area of practice continues to grow.

Resources

Docs for Tots.

National Center of Trauma Informed Care (NCTIC). Supported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)

The Pyramid Model.

Trauma Informed Care: Perspectives and Resources. Developed by the National Technical Assistance Center for Children's Mental Health at Georgetown University Center for Child and Human Development.

The Trauma Informed Care Project (TCIP).

Age groups impacted by this intervention: infants, children, adolescents and their families
Social determinants of health addressed by this intervention: education, community cohesion, health care, family support, social support, incarceration, discrimination.
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Colleges & universities; Schools (K-12); Community-based organizations and human service agencies; Media; Other: Child care, Criminal justice
- **Supporting:** Insurers; Policymakers & elected officials; Economic development agencies; Housing agencies

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of providers who have received training/professional development to improve knowledge and skills related to social emotional development, adverse childhood experiences, or trauma informed care.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

Intervention 3.1.2: Identify and integrate evidence-based and evidence-informed strategies to promote social-emotional wellness through public health programs serving children, youth, and families.

Description: As noted for Intervention 3.1.2, social-emotional development is foundational to children's development in other domains, school readiness and success, and lifelong health and well-being.[30] Adverse childhood experiences (ACEs) including abuse and neglect, parental mental illness and addiction, family separation, and other traumatic experiences can have profound impact on children's development and are associated with significantly increased risk for a wide range of chronic health conditions and risk factors later in life – as well as adverse pregnancy outcomes such as preterm birth.[31] [32] [33]

Collaborative strategies to promote positive development, build resiliency, and support safe, stable, and nurturing relationships and environments throughout childhood and adolescence have the potential to improve health outcomes across the life course.[34] Integrating basic trauma-informed approaches and practices can help recognize and respond to the impact of trauma on individuals and communities. While intensive behavioral health and trauma-informed care interventions are beyond the scope of some service settings and programs, strategies to promote positive social-emotional development and fundamental trauma-informed approaches should be integrated across all programs serving children, youth, and families. (See also Intervention 3.1.1)

Resources

Essentials for Childhood Framework: Creating Safe, Stable, Nurturing Relationships and Environments for All Children. Centers for Disease Control and Prevention (CDC).
First 1000 Days on Medicaid Initiative.

Healthy Steps.

- National Healthy Steps
- New York Office of Mental Health Implementation of Healthy Steps

Help Me Grow.

- Help Me Grow National Center
- Help Me Grow New York

Meeting the Social-Emotional Development Needs of Infants and Toddlers: Guidance for Early Intervention and Other Early Childhood Professionals (2017). Joint Task Force on Social-Emotional Development: New York State Department of Health Early Intervention Coordinating Council and New York State Early Childhood Advisory Council.

The National Center for Pyramid Model Interventions (NCPMI).

The Resilience Project. American Academy of Pediatrics.

The Search Institute.

Supporting Social-Emotional Learning with Evidence-Based Programs. Annie E. Casey Foundation.

Teaching Students to Prevent Bullying: Curriculum and Resources. National Education Association.

Age groups impacted by this intervention: infants, children, adolescents and their families
Social determinants of health addressed by this intervention: education, community cohesion, health care, family support, social support, incarceration, discrimination.
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Schools (K-12); Community-based organizations and human service agencies; Other: Child care, Criminal justice system
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Community residents; Policymakers & elected officials; Housing agencies; Economic development agencies; Natural environment agencies; Urban planning agencies

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies implemented that promote social-emotional wellness among children, youth, and families through public health programs.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

Intervention 3.1.3: Engage in collaborative strategies to increase developmental screening of young children in accordance with professional medical guidelines.

Description: Early identification of developmental delays and disabilities is critical to the well-being of children and their families. Routine developmental screening at specified intervals, combined with ongoing developmental surveillance, is an integral component of children's health care. The American Academy of Pediatrics recommends that developmental screening using standardized tools be completed at the 9, 18, and 30 (or 24) month well-child visits, but screening rates have remained low. Based on the 2016 National Survey of Children's Health (NSCH), only 30.4% of children ages 9 to 35 months nationally, and 17.5% in New York State, received a parent-completed standardized developmental screening in the previous year. National data also reveal disparities in screening rates, with lower rates among black and Asian children, children living in poverty, and children whose parents have lower education.[35] A study published in *Pediatrics* found that disparities in age at diagnosis for autism spectrum disorders (ASD) between white and Latino children may be due in part to lack of language-appropriate screenings, culturally appropriate materials for families, and access to developmental specialists.[36]

A recent review by the Women's and Children's Health Policy Center at Johns Hopkins University found evidence that structured quality improvement activities (e.g., Plan-Do-Study-Act cycles) in health care settings appear to be effective. Quality improvement initiatives that include additional systems-level approaches - such as collaboration with health departments, insurance coding or payment changes, or involvement in larger systems-change initiatives or improvement partnerships - also appear to be effective. Other interventions, including health care provider training and home visiting programs may be effective, but because the number of published studies is limited, further evidence is needed to fully assess these.[37]

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 6: Developmental Screening:

- Evidence Analysis Report. NPM 6: Developmental Screening, Johns Hopkins University.
- Evidence Brief. Developmental Screening. National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University.
- Title V Transformation Tools.

American Academy of Pediatrics - clinical guidelines:

- Recommendations for preventive pediatric health care (periodicity schedule)
- Policy statement: Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening.
- Bright Futures Tool and Resource Kit.

Birth to Five: Watch me Thrive.

Early Childhood Comprehensive Systems Collaborative Improvement and Innovation Network (ECCS CoIIN).

- National ECCS CoIIN Coordinating Center
- New York State ECCS Impact Initiative

First 1000 Days on Medicaid Initiative.

Healthy Steps.

- National Healthy Steps
- New York Office of Mental Health Implementation of Healthy Steps

Help Me Grow.

- Help Me Grow National Center
- Help Me Grow New York

Learn the Signs, Act Early. Centers for Disease Control and Prevention

Age groups impacted by this intervention: infants, children
Social determinants of health addressed by this intervention: economic stability, education, health care
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Other: Child care
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Schools (K-12); Policymakers & elected officials; Economic development agencies; Urban planning agencies.

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: Number of strategies implemented to increase developmental screening in young children.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Chronic Disease - Preventive Care & Management

Goal 3.2: Increase supports for children and youth with special health care needs

- **Objective 3.2.1:** By December 31, 2024, increase the percentage of infants who fail their initial hearing screening who have a documented follow-up by 60% to 50.0% (*Baseline: 31.0%; Year 2015; Source: Early Hearing Detection and Intervention Program; Data availability: State, County).*
- **Objective 3.2.2:** By December 31, 2024, increase the percentage of children ages 9-35 months who received a developmental screening using a parent-completed screening tool in the past year by 20% to 21.0%. (*Baseline: 17.5%; Year: 2016; Source: National Survey of Children's Health; Data availability: State (by race, income, insurance, other child & family factors).* [same as Objective 3.1.1]
- **Objective 3.2.3:** By December 31, 2024, increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale by 20% to 73.9% (*Baseline: 61.6; Year 2015-16; Source: Early Intervention Program Data; Data availability: State, County).*
- **Objective 3.2.4:** By December 31, 2024, increase the percentage of children with special health care needs (CSHCN) ages 0-17 years whose families report that they receive care in a well-functioning system by 20% to 13.2%. (*Baseline: 11.0; Year 2016; Source: National Survey of Children's Health; Data availability: State).*
- **Objective 3.2.5:** By December 31, 2024, increase the percentage of adolescents with special health care needs (CSHCN) ages 12-17 years whose families report that they received services necessary to make transitions to adult health care by 20% to 18.4%. (*Baseline: 15.3; Year 2016; Source: National Survey of Children's Health; Data availability: State).*

Intervention 3.2.1: Engage families in planning and systems work to improve family centered services and effective practices for supporting CSHCN and their families.

Description: Children with special health care needs (CSHCN) are those who have chronic physical, developmental, behavioral, or emotional conditions and require health and related services beyond that which generally is required by most children – nearly one in five children ages birth to 17 years in New York State. Families of children with special health care needs (CSHCN) face unique challenges and bring tremendous knowledge, experience, and strengths to the care of their children that is an asset to both individual and population-based public health efforts. Systems must be designed and implemented to meet the needs of families, and to engage them in meaningful roles as their children's most important caregivers.

The New York State Department of Health Children with Special Health Care Needs (CSHCN) Program recently completed a Systems Mapping project to engage families from across the state in identifying successes, gaps, and barriers to services for CSHCN, using tools and technical support from the Maternal Child Health Workforce Development Center at the University of North Carolina (UNC). Through this process, over 130 family members of CSHCN from all regions of the state and diverse demographics participated in facilitated discussions. The resulting qualitative data (system maps) will inform the future practices of the CSHCN Program.

Throughout this systems mapping process and other ongoing needs assessments, parents and providers of CSHCN in New York State have emphasized the fragmentation of services for CSHCN, the complexity of finding providers and accessing the myriad of services needed, and disparities in care – with some families getting what they need for their children and others "going without".[38] Parents are seeking better information about their child's diagnosis and service systems, and they want more connections to other families who have had similar experiences. Partnering with and supporting families who reflect the diversity of our communities is essential to improving these service systems and experiences.

Family engagement may help to improve the quality and efficiency of the health care and public health systems at all levels, from direct care to organizational design to policy.[39] There are opportunities for parents to receive leadership training and participate in state and local advisory and workgroups through several core programs.

Resources

Children and Youth with Special Health Care Needs (CYSCHN) Program
Early Intervention Program.

Early Intervention Family Outcomes Project.

- Child and Family Outcomes Survey
- Early Intervention Family Outcomes & the State Systemic Improvement Plan
- Improving Family Centeredness Together
- Early Intervention Partners Training Project.

Families Together in New York State.

Hands and Voices.

- National organization: http://www.handsandvoices.org
- New York State chapter: http://www.handsandvoicesny.org/

Parent to Parent of New York State.

National Center for Family/ Professional Partnerships (NCFPP).

Age groups impacted by this intervention: infants, children, adolescents and their families
Social determinants of health addressed by this intervention: community cohesion, economic stability, education, health care, family support, social support
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Schools (K-12); Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Child care; Criminal justice
- **Supporting:** Employers, businesses, and unions; Insurers; Media; Colleges & universities; Transportation agencies; Housing agencies; Economic development agencies; Urban planning agencies.

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: Number of families of CSHCN participating in the development or improvement of family centered services for CSHCN.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

Intervention 3.2.2.: Engage health care providers and other partners in efforts to improve newborn hearing screening and follow up, including reporting of results into the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS).

Description: NYS Public Health Law requires all maternity hospitals and birthing centers to administer newborn hearing screening programs, which is consistent with national public health goals and guidelines for early detection of hearing loss. Infants are screened shortly after birth in the hospital or birthing facility. Infants that do not pass their initial screenings are referred for follow up, which may include a second screening and, when needed, a full diagnostic hearing assessment. Infants with hearing loss are referred to the NYS Early Intervention Program for appropriate intervention services. Providers at each step in this process are required to report screening and follow-up test results in the state's Early Hearing Detection and Intervention Information System (NYEHDI-IS). Timely follow up of infants with hearing loss is critical to optimizing their development. Documentation of follow up in NYEHDI-IS is essential to tracking progress and informing public health improvement efforts.

Over 97% of infants born in New York State in 2016, had a documented initial hearing screening after birth. Of those infants who failed this initial screening, only 37.5% had follow-up test results documented in the NYEHDI-IS system. Although this percentage has improved significantly from the baseline of 9% in 2014, there is still substantial need for improvement. For the past several years, the New York State Department of Health has been engaged in a variety of efforts to improve newborn hearing screening and follow up, including enhancements to the data system to make it more useful for providers, dissemination of data to hospitals and other partners to reinforce the need for reporting, and convening structured quality improvement collaboratives with health care providers and families to improve follow up services, including linkage to the Early Intervention Program. There is a need to build on these efforts and engage more partners to ensure that all babies who fail their initial hearing screening receive timely and appropriate follow up.

Resources

Early Hearing Detection and Intervention Program (EHDI). New York State Department of Health.

Hands and Voices.

- National organization: http://www.handsandvoices.org
- New York State chapter: http://www.handsandvoicesny.org/

Joint Committee on Infant Hearing.

National Center on Birth Defects and Developmental Disabilities (NCBDD). (2018). Centers for Disease Control and Prevention.

National Center for Hearing Assessment and Management (NCHAM).

Program to Enhance the Health & Development of Infants and Children (PEHDIC): Early Hearing Detection & Intervention (2018). American Academy of Pediatrics (AAP).

Age groups impacted by this intervention: Infants, children and their families
Social determinants of health addressed by this intervention: education, health care, family support, social support
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Policymakers & elected officials;
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Community or neighborhood residents; Community-based organizations and human service agencies;

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: Number of health care providers that are consistently reporting results of newborn hearing screening and follow up.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Chronic Disease - Preventive Care & Management

Intervention 3.2.3: Enhance care coordination and transition support services for eligible children and youth with special health care needs.

Description: Care coordination is the purposeful organization of care activities and information sharing among patients and those involved in their care to improve efficiency, quality of care, health outcomes, and patient satisfaction. The Institute of Medicine has identified care coordination as a key strategy with the potential to improve the effectiveness, safety, and efficiency of the U.S. health care system, improving outcomes for patients, providers, and payers.[40]
Children with special health care needs (CSHCN) may require specialty medical services across multiple providers and service settings. They may experience multiple transitions as they develop and "age out" of specific programs or services (e.g., from Early Intervention to Special Education, elementary to

secondary school, pediatric to adult health care) and move across service and community settings (e.g., hospital to community, home to school).

Both formal care coordination/ care management services and more informal transition supports can be critical for CSHCN and their families to manage their health and family needs during key periods of change and over time. The 2016 National Survey of Children's Health found that about 73% of children age birth to 17 years in New York State who needed care coordination services received effective services, while about 15% of youth with special health care needs received services necessary to transition to adult health care.[41]

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 12: Transition to Adulthood:

- Evidence Analysis Report. NPM 12: Transition, Johns Hopkins University.
- Evidence Brief. Transition to Adulthood. National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University.
- Title V Transformation Tools - Transition.

Care Coordination for CSHCN Challenge. Maternal and Child Health Bureau

Coordinating Care and Supporting Transition for Children, Adolescents and Young Adults with Sickle Cell Disease. New York State Department of Health

Got Transition. Maternal and Child Health Bureau/ National Alliance to Advance Adolescent Health

Medicaid Health Homes Serving Children. New York State Department of Health.

- New York State Health Homes Serving Children Website
- Find a Health Home

National Technical Assistance Center on Transition (NTACT). U.S. Department of Education's Office of Special Education Programs (OSEP)/ Rehabilitation Services Administration (RSA).

State Department of Health Early Intervention Program to the State Education Department Preschool Special Education Program or Other Early Childhood Services.

Age groups impacted by this intervention: infants, children, adolescents and their families
Social determinants of health addressed by this intervention: community cohesion, economic stability, education, food security, health care, housing, transportation, family support, social support
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Schools (K-12); Community or neighborhood residents; Community-based organizations and human service agencies; Economic development agencies; Policymakers & elected officials; other: child care

- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Transportation agencies; Housing agencies; Urban planning agencies; other: Criminal justice system

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies implemented to enhance care coordination or transition services.

***Related interventions, focus areas, or goals from other Prevention Agenda priorities*:** Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

Goal 3.3: Reduce dental caries among children

- **Objective 3.3.1:** By December 31, 2024, increase the percentage of New York State residents served by community water systems that have optimally fluoridated water by 9% to 77.5% (*Baseline: 71.1; Year 2016; Source: Safe Drinking Water Information System (SDWIS); Data availability: State, County).*

- **Objective 3.3.2:** By December 31, 2024, decrease the percentage of children ages 1-17 years who had decayed teeth or cavities in the past year by 20% to 6.7%. (*Baseline: 8.4; Year 2016; Source: National Survey of Children's Health; Data availability: State).*

- **Objective 3.3.3:** By December 31, 2024, increase the percentage of children ages 1-17 years who had one or more preventive dental visits in the past year by 10% to 85.4%. (*Baseline: 77.6; Year 2016; Source: National Survey of Children's Health; Data availability: State).*

Intervention 3.3.1: Maintain and expand community water fluoridation.

Description: The US Surgeon General's Reports have emphasized oral health as a critical aspect of overall individual and population health. Research demonstrates the large number of lost school and work hours attributed to oral health problems. Dental cavities (also called dental caries or tooth decay) are one of the most common chronic diseases of childhood.

Drinking fluoridated water keeps teeth strong and reduces cavities by about 25% in children and adults. By preventing cavities, community water fluoridation has been shown to save money for families and for the US health care system. Community water fluoridation is the most cost-effective way to deliver fluoride to people of all ages, education levels, and income levels who live in a community. Most water has some natural levels of fluoride, but usually not enough to prevent cavities. Community water systems can add the right amount of fluoride to the local drinking water to prevent cavities. Community water fluoridation is recommended by nearly all public health, medical, and dental organizations. It is recommended by the American Dental Association, American Academy of Pediatrics, US Public Health Service, World Health Organization, and the Community Preventive Services Task Force. Grant funds are available from the New York State Department of Health to support implementation and maintenance of fluoridation systems in communities.

Resources

Best Practice Approach Reports - Use of Fluoride: Community Water Fluoridation. Association for State and Territorial Dental Directors.
Community Water Fluoridation. Centers for Disease Control and Prevention.

Community Water Fluoridation. National Association of County and City Health Officials.
Dental Caries (Cavities): Community Water Fluoridation. Community Preventive Services Task Force.

Drinking Water Fluoridation Grant Program. New York State Department of Health.

Patient Engagement About Fluoride and Fluoridation. New York State Department of Health, University at Albany School of Public Health, and New York State Dental Foundation.

Age groups impacted by this intervention: infants, children, adolescents, adults age 21-60 years, older adults
Social determinants of health addressed by this intervention: economic stability, education, food security, health care, built environment
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Media; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Urban planning agencies; other: Community water systems
- **Supporting:** Health care delivery system; Employers, businesses, and unions; Insurers; Colleges & universities; Schools (K-12); Economic development agencies.

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: Number of strategies implemented to expand or maintain community water fluoridation.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote a Healthy and Safe Environment - Water Quality

Intervention 3.3.2: Increase delivery of evidence-based preventive dental services across key settings, including school-based and community-based primary care clinics.

Description: Access to oral (dental) health care is critical to maintain oral health throughout the life course. Early dental visits teach children that oral health is important and improve children's positive attitudes about oral health professionals and dental visits. Pregnant women who receive dental care are more likely to take their children to get oral health care, and untreated maternal dental caries may increase the odds of her children developing cavities. [42] [43] Children should be taught proper oral hygiene, including daily teeth brushing, at an early age.

Preventive dentistry encompasses several practices to keep teeth healthy and prevent cavities, gum disease, enamel wear, and tooth loss. It includes personal oral hygiene practices (including daily tooth brushing), dental cleanings, the application of sealants, and fluoride supplementation. To maintain optimal oral health, the American Dental Association (ADA) recommends visits to the dentist at regular intervals determined by a dentist. The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride, and that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. The Community Preventive Services Task Force (CPSTF) recommends school-based programs to deliver dental sealants and prevent tooth decay among children (see also Intervention 3.3.1).

A recent review by the Women's and Children's Health Policy Center at Johns Hopkins University found evidence that school-based oral health services, preschool interventions (participation in Head Start), enrollment in public health insurance programs (Medicaid or CHIP/Child Health Plus), and Medicaid reforms (e.g., increased provider reimbursements, enhanced benefits, administrative changes, and health plan incentives) appear to be effective. Caregiver education/counseling, home visits, and outreach to recruit dental practices to provide care may be effective but there is currently insufficient evidence to assess their effectiveness.[44] There is also insufficient evidence currently to assess the effectiveness of interventions to increase dental visits of women during pregnancy.[45] Of note, this particular review did not look at other promising strategies to increase use of preventive oral health services such as integration of oral health in primary medical care settings, co-location of dental and medical services, enhanced patient outreach and reminder systems (which have been found effective in increasing use of other preventive health services), or delivery of oral health services through other community-based programs.

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 13: Oral Health:

- Evidence Analysis Reports (2017) Johns Hopkins University. Reports include detailed tables of interventions reviewed with citations for individual studies.
    - NPM 13A – Oral Health in Pregnancy
    - NPM 13B – Oral Health in Childhood.
- Evidence Brief. Oral Health. National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University.
- Title V Transformation Tools – Oral Health.

Best Practice Approach Reports. Association for State and Territorial Dental Directors.

- School-Based Dental Sealant Programs (2017)
- Use of Fluorides in Schools. (2018)
- Prevention and Control of Early Childhood Tooth Decay (2011).

Dental Sealants. Centers for Disease Control and Prevention.

Dental Caries (Cavities): School-Based Dental Sealant Delivery Programs. Community Preventive Services Task Force.

Medical-Dental Integration New York State Department of Health and University at Albany School of Public Health.

Patient Engagement About Fluoride and Fluoridation. New York State Department of Health, University at Albany School of Public Health, and New York State Dental Foundation.

Smiles for Life: A National Oral Health Curriculum, Third Edition.

Age groups impacted by this intervention: all ages (focus on infants, children, adolescents)
Social determinants of health addressed by this intervention: community cohesion, economic stability, education, food security, health care, housing, transportation, natural environment, build environment, family support, social support
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Employers, businesses, and unions; Health care delivery system; Insurers; Schools (K-12); Community-based organizations and human service agencies; other: Child care
- **Supporting:** Media; Colleges & universities; Community or neighborhood residents; Policymakers & elected officials; Transportation agencies; Economic development agencies; Urban planning agencies

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of schools or community centers providing preventive dental care in the community.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Chronic Disease - Preventive Care & Management

Intervention 3.3.3: Integrate oral health messages and evidence-based prevention strategies within community-based programs serving women, infants, and children.

Description: Integrating oral health messages and prevention strategies in other public health programs has the potential to increase awareness, knowledge, and preventive oral hygiene practices among children and their families. Home visiting programs, nutrition programs, child care, and other early care and education programs are examples of community-based programs that may have opportunities to reinforce oral health promotion.

Resources

Best Practice Approach Reports. Association for State and Territorial Dental Directors.

- Improving Children's Oral Health through the Whole School, Whole Community, Whole Child (WSCC) Model. (March 2017)
- Oral Health of Children, Adolescents and Adults with Special Health Care Needs. (August 2007)

- Perinatal Oral Health. (October 2012).

Caring for Our Children: National Health and Safety Performance Standards for Early Care and Education Programs – Oral Health

- Routine Oral Hygiene Activities
- Toothbrushes and toothpaste
- Oral Health Education
- Oral Health Policy

Cavity Free Kids.

Oral Health Educational Resources for Home Visitors and Families: Environmental Scan. (2018 update). Association of State and Territorial Dental Directors, Early Childhood Committee.

Age groups impacted by this intervention: infants, children age 2-12, adolescents age 13-21 years; pregnant women.
Social determinants of health addressed by this intervention: community cohesion, economic stability, education, health care, other: family support, social support, health literacy, learning environment.
Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; employers, businesses, and unions; Schools (K-12); Community or neighborhood residents; Community-based organizations and human service agencies; other: Child care.
- **Supporting:** Health care delivery system; Insurers; Media; Colleges & universities; Policymakers & elected officials; Economic development agencies.

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of community-based programs serving women, infants, and children, that incorporate oral health promotion messages.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

Focus Area 4: Cross Cutting Healthy Women, Infants, & Children (applicable to all HWIC focus areas and goals)

Goal: *Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations.*

Intervention 4.1: **Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course.**

Description: The focus within public health increasingly is on addressing social determinants of health: the conditions in which people are born, grow, live, work, and age. Social factors such as food insecurity, homelessness, employment conditions, poverty, adverse neighborhood environments, inadequate health care, lack of educational opportunities, social exclusion, racism and discrimination, lack of social support, and gender-based inequities are important forces that influence MCH outcomes, both directly and through their impact on other individual risk factors. These social determinants help explain why rates of key indicators – such as infant mortality and maternal mortality – are worse in the United States compared to other countries. They also help to explain the persistent racial, economic, and other disparities we see across virtually all key indicators of maternal and child health.

A dedicated focus on social determinants of health across the life course is consistent with input received from youth, families, and service providers as part of New York's needs assessment activities over the past three years. Stakeholders repeatedly identified factors that influence their use of health care services: health insurance coverage, accessibility of health care, provider diversity and cultural competence, transportation, stigma and confidentiality concerns, language barriers, cost, inability to take time off from work, and competing life responsibilities (cite: Title V applications for 2017 and 2019). Additionally, stakeholders noted lack of social support, unsafe neighborhoods, lack of affordable housing, limited access to affordable, healthy food, and lack of opportunities for physical activity as key barriers to good health.

While these factors may be addressed in the context of other topic-specific interventions described throughout this plan, it is essential that public health organizations and practitioners partner with other sectors to address them directly as foundational influences on all aspects of health and well-being. For this reason, the stakeholder group contributing to this action plan endorsed the inclusion of this cross-cutting goal and intervention to underpin other sections of the plan.
Healthy People 2020 has emphasized the need to address social determinants of health by including a new goal to "create social and physical environments that promote good health for all" as one of the four overarching goals for the decade.[46] Achieving this goal in New York State will require new approaches, partnerships, and collaborations across a wide range of sectors, at both the community and state level.

Resources:

Essentials for Childhood Framework: Creating Safe, Stable, Nurturing Relationships and Environments for All Children. Centers for Disease Control and Prevention (CDC).

The EveryONE Project™. American Academy of Family Physicians.

The Guide to Community Preventive Services: Health Equity Reviews. Community Preventive Services Task Force.

Health Impact in 5 Years (HI-5). Centers for Disease Control and Prevention.

Healthy People 2020: Social Determinants of Health Interventions & Resources. Office of Disease Prevention and Health Promotion

National Center for Cultural Competence (NCCC). Georgetown University Center for Child and Human Development.

Paid Family Leave – New York State.

Policy Resources to Support Social Determinants of Health. Centers for Disease Control and Prevention

Sources for Data on Social Determinants of Health. Centers for Disease Control and Prevention

Technical Packages for Violence Prevention. Centers for Disease Control and Prevention.

Think Cultural Health. U.S. Department of Health &Human Services, Office of Minority Health.

Tools for Putting Social Determinants of Health into Action. Centers for Disease Control and Prevention:

- At-a-Glance: 10 Essential Public Health Services and How They Can Include Addressing Social Determinants of Health Inequities.
- Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health.

Age groups impacted by this intervention: All
Social determinants of health addressed by this intervention: All
Sectors that can play lead and contributing roles in implementing this intervention: All
Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of collaborations with partners that address social determinants of health impacting women, infants, children, and families.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: All