Maternal and Child Health Services Title V Block Grant

New York

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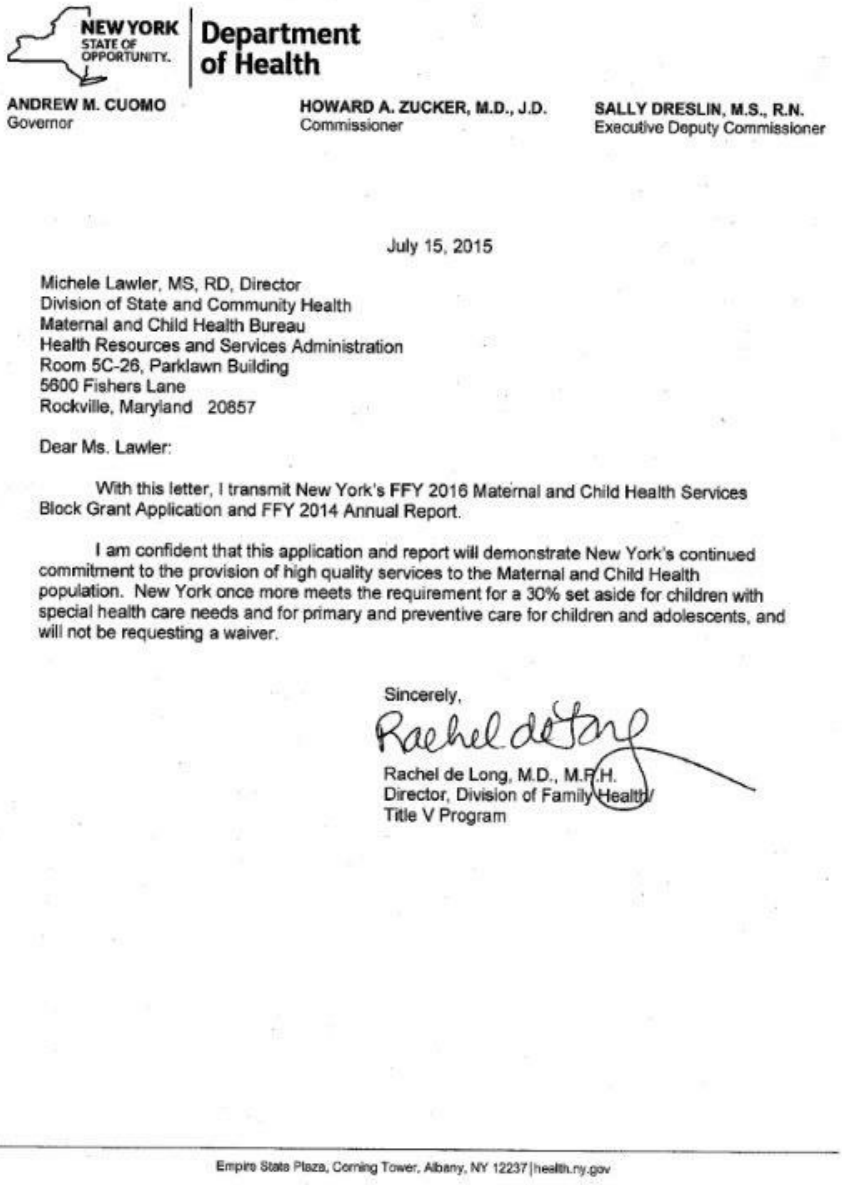
Table of Contents

I. General Requirements

I.A. Letter of Transmittal



NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

July 15, 2015

Michele Lawler, MS, RD, Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
Room 5C-26, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Lawler:

With this letter, I transmit New York's FFY 2016 Maternal and Child Health Services Block Grant Application and FFY 2014 Annual Report.

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

Sincerely,

Rachel de Long

Rachel de Long, M.D., M.P.H.
Director, Division of Family Health/
Title V Program

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

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

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

Each year, states submit an application & annual report in accordance with MCHB guidance. This year's application from NYS reflects our continued leadership & commitment to protect & promote the health of women, infants, children & families, within the context of a changing health care landscape, the continued adoption of a life course perspective & a focus on data-driven, evidence-based public health interventions. As the beginning of a new five-year cycle, this application incorporates a statewide MCH needs assessment & the selection of eight core MCH priorities for NYS. The Action Plan for 2016-20 summarizes objectives, strategies & performance measures to address these priorities across six defined MCH population health domains: maternal & women's health, perinatal & infant health, child health, adolescent health, CYSHCN & cross-cutting life course. NY's application reflects significant input from families, providers & other key stakeholders across NYS.

Within the New York State Department of Health (DOH), Title V activities are led by the Division of Family Health (DFH). Under Title V leadership, a comprehensive process was convened to complete NY's MCH needs assessment & action plan:

Step 1 – Engaging Stakeholders: An internal leadership team of DOH staff from DFH & other MCH-serving programs was convened to guide the process, & to identify & engage external partners. Over 400 stakeholders including health & human service providers, policymakers, parents & youth provided input through listening forums, interviews & surveys conducted by Title V staff & partners across NYS. NY's MCHSBG Advisory Council provided feedback & guidance at key steps throughout the process. Additionally, other recent assessments including local community health assessments & the 2013-2017 NYS Prevention Agenda, were reviewed.

Step 2 – Assess Needs & Identify Desired Outcomes: NY's Needs Assessment is informed by public health data, published literature & qualitative input from stakeholders (Step 1). Quantitative data analysis focused on national priority areas & outcome measures defined by MCHB & other state priorities. A rich array of data sources were used including vital statistics, hospital & health plan data, population health surveys & program-specific data. Health status, trends & disparities were examined. Literature was reviewed to identify key contributing factors, & extensive input from stakeholders regarding unmet needs, barriers, & priorities was gathered & reviewed.

Step 3 – Examine Strengths & Capacity: Coupled with assessment of needs & gaps is an examination of

strengths, assets & capacity. Data analysis & literature reviews served to assess protective factors & the evidence base for action. Stakeholders provided input on effective services & factors that support healthy behaviors. Current MCH programs, services & workforce were assessed to identify capacity, areas of success & opportunities to leverage other key initiatives to advance MCH goals.

Step 4 – Select Priorities: The selection of state priorities builds directly on the Needs Assessment. Profiles were developed for each MCH domain using information collected in Steps 2 & 3. Findings were presented to the DOH Leadership Team & the MCHSBG Advisory Council, & criteria for selecting priorities were considered. Through this process, a total of eight priorities were selected (see below).

Step 5 – Select Performance Objectives: In accordance with MCHB guidelines, NY adopted a total of eight National Performance Measures (NPMs) that align with our selected priorities & encompass all six MCH domains. Baseline data, historic & projected trends were analyzed & considered in the context of planned strategies to establish preliminary targets for each NPM for the next five years. In Year 2, State Performance Measures will be established.

Step 6 – Develop Action Plan: With input from the MCHSBG Advisory Council & DOH Leadership Team, a *preliminary* MCH State Action Plan for 2016-20 was developed. This plan aligns NY's eight MCH priorities & corresponding NPMs with the six MCH domains, & describes objectives & strategies planned to address each priority. Strategies that represent continuation of longstanding MCH activities are more specific, while those to address emerging priorities requiring further development are less specific & will be refined over time.

Title V State MCH Priorities and Performance Measures, 2016-2020

Domains	State Priority Needs	National Performance Measures
Maternal and Women's Health	Reduce maternal mortality and morbidity Increase use of preconception and interconception (well woman) health care services* Increase use of prenatal postpartum health care services*	NPM1 Percent of women with a past year preventive medical visit
Perinatal and Infant Health	Reduce infant mortality and morbidity Increase use of primary and preventive("well-baby") care among infants*	NPM3 Percent of Very Low Birthweight (VLBW) infants born in a hospital with a Level III-IV NICU NPM5 Percent of infants placed to sleep on their backs
Child Health	Support and enhance children's social-emotional development and relationships Increase use of primary and preventive ("well child") health care services by children*	NPM6 – Percent of children age 10-71 months receiving a developmental screening using a parent-completed screening tool
CSHCN	Increase supports to address the special health care needs of children and youth	NPM12 – Percent of adolescents with special health care needs who receive services necessary to make transitions to adult health care

Adolescent Health	Support and enhance adolescents' social-emotional development and relationships Increase use of primary and preventive ("well teen") health care services by adolescents*	NPM10 – Percent of adolescents age 12-17 with a preventive medical visit in the past year
Cross Cutting or Life Course	Increase use of primary and preventive health care across the life course* Promote oral health and reduce tooth decay across the life course Promote home and community environments that support health, safety, physical activity and health food choices Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population	NPM13 Percent of: a) women who had a dental visit during pregnancy; b) children age 1-17 who had a preventive dental visit in the past year NPM8 – Percent of children age 6-17 who are physically active at least 60 minutes per day
** - as part of cross-cutting priority to increase use of preventive health care services across the life course*		

Domain 1 – Maternal/Women's Health "It takes me too long to see my doctor – I have to work"

NY has made important strides in improving birth outcomes, but striking disparities remain. Key outcomes of concern are high rates of unintended pregnancy & short birth intervals, stagnant rates of early prenatal care, & high rates of maternal mortality & morbidity. Improving preconception & interconception health, including pregnancy planning & prevention, are key to achieve further improvements. Successes include robust surveillance systems, generous Medicaid (MA) coverage including comprehensive prenatal care standards, a statewide maternal mortality review system, highly effective clinical quality improvement (qi) models, evidence-based community health initiatives & strong partnerships with health reform initiatives. NY's State Action Plan addresses priority areas to improve the health & well-being of women including engaging women into health insurance, integrating preconception & interconception health in routine women's health care, strengthening & expanding maternal mortality & morbidity reviews & applying findings to address key factors identified, increasing enrollment in evidence-based/-informed home visiting services & developing collaborative strategies to address maternal depression. Strong partnerships will be enhanced or developed to improve the reach & effectiveness of the strategies to improve these outcomes.

Domain 2 – Perinatal/Infant's Health "Mothers need support to be healthy and to keep their babies healthy; services like home visiting help families."

Infant mortality has been steadily declining in NYS, but striking racial, economic & geographic disparities persist in this indicator. An emerging concern for infant health is increasing rates of opiate withdrawal, particularly in upstate NY. Key accomplishments include a mature statewide system of regionalized perinatal care, strong community-based perinatal services including evidence-based home visiting & breastfeeding supports, clinical qi initiatives with

birthing hospitals & involvement in the national COIIN initiative to decrease infant mortality. NY's Action Plan includes Title V leadership to update perinatal regionalization standards & develop performance measures to promote qi, benchmarking & ongoing assessment of levels of perinatal care. NY's infant mortality COIIN team will lead efforts to promote Safe Sleep to decrease sleep-related infant mortality rates. Collaborative efforts will be enhanced or developed to improve perinatal practices such as breastfeeding, & to assess new & emerging public health & health issues such as maternal opioid use to determine strategies to improve perinatal outcomes.

Domain 3 – Child Health "It's not that families don't want to be healthy – they have more important things to deal with"

The majority of NY's children are in good health, with declining mortality & hospitalization rates & high rates of health insurance coverage. Key concerns for child health include overweight & obesity & social-emotional & behavioral health needs. While most children receive annual well child visits, specific elements of care including immunizations & developmental screening need improvement. Key accomplishments include generous public health insurance options, rich networks of health care providers including the largest School Based Health Center (SBHC) program in the nation, & strong public health programs to promote physical activity & provide access to nutritious meals. A key challenge to achieve further improvements in child health is to strengthen collaboration across child-serving programs, as supports & services for children are spread throughout DOH & other State agencies. In addition to continuing strong support for core programs including home visiting & SBHCs, NY's Action Plan addresses the need to develop new collaborative strategies to support children's social-emotional health as well as to improve engagement of vulnerable families in high quality primary & preventive care.

Domain 4 – Children with Special Health Care Needs "I am told I am an important member of my child's health care team, but I don't feel like I really am"

Although the majority of NY's children are insured, families of CYSHCN continue to report lack of consistent or inadequate health care coverage, & lack of care coordination to meet special needs. Adolescents with special needs also remain challenged with navigating health care coverage & services as they transition to the adult care system. Key accomplishments include extensive health insurance options for children, the availability of comprehensive early intervention (EI) services for infants & toddlers with developmental delays & disabilities, extensive engagement of Title V staff in developing & implementing new Health Home (HH) care coordination system for children, family representation on key advisory groups, & funding for local health department-based information & support services for families of CYSHCN. NY's Action Plan highlights continued strong engagement with MA to support successful implementation of HH for children, enhancing policy & practice supports for children with Autism Spectrum Disorders, improvement projects to enhance family support practices within EI & disseminate best practices to other Title V programs, & leading a critical assessment of current Title V programming to identify opportunities to strengthen local & regional supports for CYSHCN.

Domain 5 – Adolescent Health "Get us involved. The minute I feel like my word matters, I will stay involved…I will think and I will make better choices"

NY's Title V program has been a national leader in building comprehensive service systems for adolescents including access to confidential reproductive health services & delivery of evidence-based programming to improve adolescent health & well-being including a strong focus on positive youth development. NY's teen pregnancy rate has reached an all-time low, though significant disparities remain. Health care providers with expertise in adolescent health are limited & rates for preventive health care visits decline in adolescence during a period of critical developmental transition. Overweight & obesity, mental health issues, suicide, sexual violence & bullying are significant persistent & emerging issues for adolescents. Key successes in NYS include strong networks of youth-serving providers including SBHCs & community-based programs, policies that support access to health insurance & confidential health care services, & strong technical support for evidence-based programming through state-academic partnerships/Centers of Excellence. NY's Action plan includes strengthening partnerships to address

adolescent mental health issues & suicide, & integrating additional evidence-based strategies to support social-emotional development, healthy relationships, wellness, health literacy & transition to adult roles in adolescent health initiatives.

Domain 6 – Cross-Cutting/Life Course "My kids would be healthier if they could go out to play instead of watching TV"

Throughout NY's needs assessment, several cross-cutting themes emerged, including oral health, health insurance coverage & use of preventive health care services, neighborhood & community environments that support health (in particular, access to healthy food & opportunities for physical activity) & striking disparities in most health outcomes. Key successes include new investments to maintain & expand community water fluoridation, continued funding for school-based preventive dental services, growing capacity & commitment to investing in "place-based" health promotion initiatives that span MCH, chronic disease & environmental health interests, including efforts to address social determinants of health. NY's Action Plan emphasizes enhanced collaborations with other public health programs, schools, & child care & other community partners to develop & implement new strategies in this area.

II. Components of the Application/Annual Report

II.A. Overview of the State

As of 2014, New York State (NYS) has the fourth largest population after California, Texas and Florida with a population of 19.7 million. The State very diverse, with over 44% of residents being members of racial and ethnic minorities. Compared to the national population, a larger percentage of NYS' population is Black (17.5% NYS; 13.2% US); Asian (8.2% NYS; 5.3% US); and Hispanic (18.4% NYS: 17.1% US). The State also has a significantly higher foreign-born population (22.1% NYS: 12.9% US), and larger population speaking a language other than English at home (29.9% State: 20.7% US). NYS's cultural diversity is both a strength and challenge. Racial and ethnic minorities often have poorer quality health care than white Americans, even when they are able to access insurance. A strategic priority for NYS is to ensure that health care systems meet the needs of diverse populations at all levels to promote equity in health care and eliminate disparities in health access and outcomes.

In 2009-13, the percent of New Yorkers who graduated from high school is slightly below the national level (85.2% versus 86% US), while the percentage with a bachelor's degree or higher is higher (33.2% versus 28.8%). NY's per capita income in the past 12 months (2013 dollars – 2009-13) is higher than the national average ($32,382 versus $28,155 US), and NY's median household income for 2009-13 is also higher ($58,003 versus $53,046). However, the State's percentage of persons below the poverty level percent during that same period is only slightly less than the national percentage (15.3% versus 15.4%). Educational attainment has a major impact on income and is a significant factor in access and quality of health care. Poverty is also associated with poor health outcomes, especially for women and children. Racial and ethnic minorities are significantly impacted by lower educational attainment and poverty in NYS.

NYS' population is dense; in 2010 there were 411 persons per square mile in NYS, compared to 88 in the US. New Yorkers are more likely to live in urban areas than residents of other states. Sixty-four % of NYS's population live in the NY Metropolitan area; 43% in New York City (NYC) alone. NYS is also geographically diverse; population density varies widely, from 69,467 persons per square mile in Manhattan to only 3 persons per square mile in Hamilton County in the Adirondack Mountain Range; NYC is 104 times more densely populated than the rest of the state. Population density often determines the number and types of health services in an area.

NYS has a rich system of health care. The State has the fourth-highest ratio of physicians to residents in the nation, with approximately 360 physicians per 100,000 residents, compared to a national average of 271 per 100,000. NYS also has 40% more specialists per capita than other states and 22% more primary care physicians per capita than average. NYS is home to more than 2,500 outpatient hospital and free standing health clinics, including over 60 Federally Qualified Health Centers (FQHCs) with approximately 600 sites throughout the state; 226 school-based health center clinics; and 178 family planning clinic sites. In addition, NY has over 220 hospitals. Despite the substantial health care resources, many areas of the state lack access to needed services due to a maldistribution of resources. As of September 2014, there were 181 Health Professional Shortage Areas (HPSAs) in NYS, of which 93 are primary care; 35 are dental; and 53 are mental health. Of the 181 total HPSAs, about 38% of HPSAs are located in metropolitan areas; 62% are in rural or mostly rural (non-metropolitan) areas.

NY's per capita health care costs are among the highest in the nation and have been increasing. Total health care costs are the second highest in the nation ($163 billion) with spending forecast to rise by more than 50% by 2020. Health care premiums have eroded wages and harmed businesses, individuals and families. NYS's large employers contribute a higher share of premium costs than employers in any other state. NYS's Medicaid (MA) Program, the nation's largest, was spending nearly $53 billion to serve 5 million people, which is twice the national average when

compared on a per recipient basis.

While NYS performs well related to some public health measures such as obesity and smoking, the high cost of health care in NYS does not show a consistent relationship to health care quality based upon national rankings. In addition, quality problems exist, for example related to unavoidable hospital use. Significant disparities exist in health status among racial, ethnic and socioeconomic groups. To address these concerns, NYS has become a national leader in initiating health reform, including redesigning MA, implementing a successful exchange marketplace, and initiating creative models of health care.

Working with the legislature through the budget process, NY's Governor Andrew Cuomo continues to reshape the health environment through significant reforms. Upon taking office, the Governor brought together health care providers, labor, government and other stakeholders to form the MA Redesign Team (MRT). In reforming the MA Program, NYS embraces the Center for Medicare and Medicaid (CMS) services triple aim for delivery reform, including improving the quality of care; improving health by addressing root causes of poor health; and reducing per capita costs. The MRT recommended a series of 78 proposals to restructure NY's extensive MA program which were a mix of traditional cost containment, systemic reforms, and traditional public health interventions. State budgets since 2011 include many of the MRT recommendations which have been implemented under the State's Office of Health Insurance Programs (OHIP) in the DOH.

MA reform efforts focused on achieving greater efficiency without creating barriers to enrollment or reducing benefits for those eligible for MA services. There was increasing recognition that payment reform was necessary to shift the payment incentives from expensive facility-based care to keeping people healthy, including management of chronic diseases in outpatient clinic and physician primary care settings. To better serve patients in the right setting at the right price, NYS has invested more than $600 million in outpatient care in the last three years. The investments include investments in hospital programs, including outpatient clinics, ambulatory surgery, and emergency room; physicians' fees; primary care; freestanding programs; and mental hygiene enhancements.

In addition, NY is moving away from a fee-for-service payment structure that is volume driven to more value driven payment and promotes coordination of care. As a result, the MRT has set NY on a multiyear path to "care management for all." The state has expanded enrollment in the MA Managed Care Program (MMCP) by requiring many of the high need populations which were previously exempted or excluded to enroll in managed care plans. The MMCP provides an organized system of care, an accountable entity and the ability to coordinate and manage care. The Title V Program has worked extensively with OHIP to plan for the transition of other MCH services into managed care such as prenatal care services, MA waiver programs for children, including medically fragile children, children in foster care and school-based health services.

NYS has been promoting advance Patent-Centered Medical Homes (PCMHs). Currently, 1.4 million MA recipients utilize primary care from a National Committee for Quality Assurance (NCQA) recognized medical home, most of them at Level 2 or 3, which will expand to Level 3 PMCHs for all MA recipients in the next several years. This achievement was made possible since the State invested in care management payments to help primary care practices meet the standard. In addition, grants have been provided to establish health homes to improve the quality of care for NY's highest need/cost patients. A key element of NYS's approach will be to integrate patient-centered medical homes, health plans, health homes and Medicare accountable care organizations into a single system of effective case management. The DFH has worked with OHIP on several additional MRT initiatives relevant to the MCH population, including developing a children's health home initiative to provide enhanced care coordination for children with chronic physical and behavioral health needs, denying MA payment for elective C-sections prior to 39 weeks gestation without medical indication, moving the Family Planning Benefit Program, an income expansion of MA eligibility approved through a MA waiver, to NYS's MA State Plan with inclusion of a presumptive eligibility

process; among others.
In April 2014, the Governor announced that NY reached an agreement with CMS on a federal waiver that allows the state to reinvest $8 billion in federal savings generated by the MRT to further transform the state's health care system and preserve vital health services in NYS. The Delivery System Reform Incentive Payment (DSRIP) program is one component of NY's proposed MA Waiver Amendment submitted to CMS, and is designed to stabilize the state's health care safety-net system, including hospitals with severe financial difficulties and to re-align the state's delivery system to reduce avoidable hospitalizations and emergency department use by 25% over the next 5 years.
The projects funded through DSRIP will assist safety-net institutions in their effort to both right-size inpatient capacities as well as transform their care delivery models to provide a more precise mix of services necessary in the communities in which they serve. Additionally, the DSRIP program will incentivize collaboration across previously siloed providers to reduce system fragmentation. Increased support for community health navigators, clinical perinatal improvement projects, establishment or expansion of the evidence-based maternal-infant home visiting programs and Community Health Worker programs and population health projects to reduce preterm births, are part of the DSRIP initiative.

NYS has also aggressively responded to implementation of the Affordable Care Act. The NYS of Health (NYSOH), the state's official health plan marketplace, was created to assist New Yorkers to gain access to quality affordable health care coverage. In its first open enrollment period, nearly 1 million New Yorkers enrolled in coverage. More than 80% of those who have enrolled were uninsured at the time of application. To date, nearly two million New Yorkers have enrolled in NY's health plan marketplace, and 89% of enrollees have reported that they had no coverage at the time they joined the Marketplace. New Yorkers who have enrolled through the Marketplace have overwhelmingly reported that they are satisfied with their health insurance (92%) and are using their coverage to access care (84%). The approved rates for 2014 and 2015 are more than 50% lower than what individuals would have paid before creation of the marketplace in October 2013. Nearly three-quarters of those who enrolled in private coverage in 2014 were eligible for tax credits to lower the cost of their coverage.

Individuals, families and small businesses can use the Marketplace to help them compare insurance options, calculate costs and select coverage online, in-person, over the phone or by mail. In addition, New Yorkers may obtain MA and Child Health Plus (CHP) coverage through the Marketplace. The Marketplace helps people to check their eligibility for health care programs like MA and sign up for these programs, if they are eligible, and provides information regarding what type of financial assistance is available to applicants. NYSOH has trained and certified almost 9,000 navigators, brokers and Certified Application Counselors to provide free, in-person enrollment assistance to New Yorkers applying for coverage and are available to provide in-person assistance in the community at convenient times and locations across the State

NYSOH features a state-of-the-art website where New Yorkers can shop and enroll in coverage and a customer service center to answer questions and enroll people into coverage. The NYSOH's website plan preview that allows individuals to shop for a health plan before starting an application, was used more than 2.6 million times during this period. The NYSOH Customer Service Center has answered more than 945,134 calls since the start of open enrollment. Customer Service Representatives (CSRs) at the Customer Service Center are ready to directly assist consumers in 170 languages and assist consumers in other languages through the Language Line translation service. In addition, navigators provide assistance in 48 languages, and brokers and Certified Application Counselors also provide assistance in languages other than English. NYSOH has also continued to expand its outreach efforts to ensure that every New Yorker knows that affordable health care options are available.

Title V staff have actively supported implementation of ACA in the state and continue to assess its impact on MCH populations. From 2011-14 there was a slight decrease in the percentage of uninsured individuals, and small increases in the percentage insured through public or private insurance. Further analysis is needed due to the

recency of ACA implementation.

NYS has benefitted from the receipt of ACA funding. Over $18 million in Personal Responsibility Education Program (PREP) funding supports pregnancy prevention programs designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections. Over $16 million in Abstinence Education Grant Program (AEGP) funding supports an initiative to implement mentoring, counseling and adult-supervised activities designed to delay the initiation of sexual activity in young people ages 9-12 residing in high-need communities. Over $42 million in Maternal, Infant and Early Childhood (MIECHV) funding is being used to implement evidence-based home visiting programs. DOH works closely with the NYS Office of Children and Family Services (OCFS) and other state agency partners to implement this initiative. DOH administers MIECHV funded Nurse-Family Partnership (NFP) projects while OCFS oversees the Health Families America/New York (HFNY) program and oversees MIECHV-funded HFNY projects. Over $4 million in ACA funds have been used to improve immunization rates, practices and the NYS Immunization Information System (NYSIIS). Over $17 million in ACA funds have been used to support chronic disease prevention programs, including smoking cessation; evidence-based cancer screening and detection programs; implementation of comprehensive population-based strategies in community and health systems setting to prevent obesity, diabetes, heart disease and stroke, and to reduce health disparities among adults. Overall, ACA funding has provided NYS with tremendous opportunities to improve and enhance NY's MCH services and eliminate disparities.

Changes in MA have proven they can drive the broader health care system-wide innovations. Building on previous successes, the Governor wants to align the entire health care system, including private insurance, to further improve quality, keep costs low, and improve the health of all New Yorkers. NY was recently awarded a four-year, nearly $100 million State Innovations Model Testing (SIM) grant by the federal Center for Medicare and MA Innovation, which will support the Governor's State Health Innovation Plan (SHP), a five-year strategic blueprint that works to give New Yorkers access to high quality, coordinated care. NY developed the Plan and the SIM grant application with the support of numerous stakeholders. The state's official project period of the grant began on February 1, 2015 and will continue for four years. NY was one of eleven states to receive a Round Two Model Test Award.
The SHIP works toward the development and implementation of innovative health service delivery and payment models premised on a strong foundation of advanced primary care that is supported by both public and private payers in all regions of the state. Updated health information technology, quality measurement, integration with population health, and enhanced transparency will reduce costs and better enable consumers to make wiser healthcare choices. The SHIP will improve coordination and integration of care from primary care to long-term care, specialists and community supports, creating a continuum of care that links physicians and community-based resources to help promote the state's Prevention Agenda which is described below and MA reform efforts.
Maternal and child health programs continue to be relatively successful in maintaining State funding levels. In addition, the Governor continues to support important health proposals related to the MCH population, including:

- a plan to decrease new HIV infections to end the AIDS epidemic in NY. Since the mid-1990's, NY has already eliminated HIV transmission via blood products; virtually ended mother to child HIV transmission; and decreased new HIV diagnoses due to injection drug use by 96%;
- a proposal to pass a state law requiring that all colleges in NYS adopt a uniform set of sexual assault prevention and response practices that has already been implemented on State university campuses;
- a $10 million drinking water partnership fund to provide assistance to community water systems incurring costs for the installation, repair and upgrade of drinking water fluoridation facilities;
- proposals related to the use, sale and marketing of e-cigarettes; and
- a stronger consumer protection law to reduce exposure of children to harmful products and chemicals.

In addition, the Governor has reintroduced ambitious legislation to address gender inequality. The Governor's 10-

point women's equality agenda proposed amending state law to: prohibit employers from denying work or promotions to workers simply because they have children; protect workers from sexual harassment regardless of the size of the workplace; create a specific protection in the Human Rights Law requiring employers to provide reasonable accommodations for pregnancy-related conditions; provide further protections of victims of domestic violence; strengthen human trafficking laws; and, protect Freedom of Choice by amending NYS law to codify the *Roe v. Wade* decision.
The Prevention Agenda (PA) 2013-17 was developed by the Public Health Committee of the NYS Public Health and Health Planning Council (PHHPC) in collaboration with DOH and in partnership with more than 140 organizations across the state. This plan serves as a blueprint for local communities and agencies including local health departments, hospitals and other organizations that are conducting community health assessments, identifying local priorities and developing, implementing and evaluating plans for improvement. Across all the priority areas, the PA focuses on eliminating the profound health disparities that impact racial and ethnic minorities.

The Prevention Agenda has five overarching goals: improving health status and reducing disparities; addressing broad social determinants of health; creating and strengthening public -private and multi-stakeholder partnerships to achieve public health improvement at state and local levels; increasing investment in public health to improve health, control health care costs and increase economic productivity, and strengthening governmental and nongovernmental public health agencies and resources at state and local levels. It encompasses five specific priority areas: Healthy and Safe Environment; Prevention of Chronic Disease; STIs, HIV and Vaccine-Preventable Diseases; Mental Health and Substance Abuse; and Healthy Women, Infants and Children (co-chaired by NYS Title V Director).

DOH provides information and technical assistance to health care providers, counties and communities including county-specific performance data, evidence-based strategies, and monitoring performance through a Prevention Agenda dashboard. Building on the success of the prevention agenda, DOH submitted an application for accreditation to the Public Health Accreditation Board, the national accrediting organization for state, local, tribal and territorial health departments. The Prevention Agenda has been incorporated within other major systems reform efforts including DSRIP and SHIP.

Health care reform at both the State and national level, as well as the changing landscape of NY's population, services and resources, has been the impetus for strategic planning processes for the NYSDOH. In 2011, DOH leadership redefined the mission and vision of the DOH to protect, improve and promote the health and well-being of all NYS residents through outcome-based, cost-effective strategies. Many of the specific objectives under these DOH goals are also very consistent with the MCH agenda, including: reducing tobacco usage and substance abuse, especially among youth; improving diet and physical activity; promoting safer sexual behaviors; increasing health insurance coverage and the scope of health insurance benefits; eliminating disparities in health access and outcomes; increasing the availability of primary health care services for underserved populations; and increasing the availability and effectiveness of preventive health services, services for treatment and management of chronic diseases and services for children with special health care needs. DOH has also established the Office of Minority Health and Health Disparities Prevention (OMH-HDP) that works to ensure high quality, affordable and accessible health care for all New Yorkers.

Analysis of data from a wide variety of sources, including MCH Program data, provides a substantial window on the needs of the MCH population. DFH works very closely with the other Divisions within CCH, as well as with the major organizational segments of DOH whose work complements that of DFH, to identify and address MCH priorities especially related to elimination of health disparities. A priority of the DFH is to promote performance-based, evidence-based practice with a clear understanding of DFH priorities and outcomes. The DFH has also eliminated or substantially revised MCH programs that were not effectively addressing MCH priorities and focuses more on burden to make a larger impact on MCH priorities.

In a state as large and complex as NY, it is imperative to foster collaborative relationships to address the needs of the MCH population and address disparities. The DFH communicates regularly with DOH regional staff, the MCHBG Advisory Council, the MCH committee of the New York State Association of County Health Officials, the NYC Department of Health and Mental Health, Bureau of Maternal, Infant and Reproductive Health (BMIRH), with various MCH contractor workgroups, and through consumer surveys and forums. This communication has helped to identify global MCH priorities, as well as specific priorities at a regional level, for example, a lack of prenatal or obstetric services. These regular communication mechanisms have also been useful vehicles to convey important information to the MCH community, for example, information regarding addressing health outbreaks affecting the MCH population.

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

The functions, powers and duties of DOH and the Commissioner of Health and other DOH officers and employees are detailed in PHL Article 2. Some important powers granted by the legislature to DOH and the Commissioner include: supervision and funding of local health activities; the ability to receive and expend funds for public health purposes; reporting and control of disease; control and supervision of abatement of nuisances affecting public health; and to serve as the single state agency for the federal Title XIX (MA) program. Article 2 also provides that DOH shall also exercise all functions that, "…hereafter may be conferred and imposed on it by law."

Law governing the organization and operation of NY's local public health infrastructure, which includes the health departments of 57 counties and the City of NY, is contained in PHL Article 3, Local Health Organization. A major component of the Title V program capacity, these local health departments are supported by millions of state local assistance dollars, which the DOH administers under the provisions of PHL Article VI, State Aid to Cities and Counties.

A key determinant of DOH's capacity to serve mothers, infants and children is PHL Article 7, Federal Grants-in-Aid, which specifically authorizes DOH to "…administer the provisions of the federal social security act or any other act of congress which relate to maternal and child health services, the care of children with physical disabilities and other public health work and to co-operate with the duly constituted federal authorities charged with the administration thereof." This provision not only empowers DOH to obtain and distribute Title V funds, but also those from Title X of the PHS Act, WIC nutrition, and other federal resources essential to the health of the MCH population.

The comprehensive tobacco control capacities of DOH are specified in PHL Article 13-E, regulation of smoking in certain public areas, which enables DOH to reduce environmental exposure to tobacco smoke by prohibiting smoking in most indoor public places; PHL Article 13-F, regulation of tobacco products and herbal cigarettes; distribution to minors, which defines the State tobacco use prevention and control program, prohibits free distribution of promotional tobacco and herbal cigarette products, and which prohibits sale of such items to minors.

PHL Article 21, Control of Acute Communicable Diseases, details the role of local health officials in control efforts, and specifies reporting requirements and patient commitment procedures. This Article also provides control requirements for specific diseases, including HIV, rabies, typhoid fever, poliomyelitis and Hepatitis C. PHL Article 23, Control of Sexually Transmissible Diseases, outlines the roles of state and local health officials in the identification, care and treatment of persons with a sexually transmissible disease specified by the Commissioner, and provides for the injunction and abatement of houses of prostitution.
Direct reference to the duties of the Commissioner regarding the health needs for mothers, infants and children is made in PHL Article 25, Maternal and Child Health.

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

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

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

The ability of NYS to regulate hospitals, including ambulatory health facilities, is conferred by PHL Article 28, Hospitals, and is a prime determinant of DOH's capacity to promote and protect the health of mothers and children. Among the specific provisions relating to hospitals is the NYS Health Care Reform Act (HCRA), which is codified as PHL §2807-j – 2807-t. A major component of NYS Health Care financing laws, HCRA governs hospital reimbursement methodologies and targets funding for a multitude of health care initiatives. The law also requires that certain third-party payers and providers of health care services participate in the funding of these initiatives through the submission of authorized surcharges and assessments.

Similarly, DOH has been given broad powers to regulate home health care agencies and health maintenance organizations through PHL Article 36 and PHL Article 44, respectively. With increased interest in, and funding allocated to, maternal home visiting programs, the importance of DOH's home health agency regulation has grown considerably. Now that the majority of MA-eligible mothers and children are enrolled in MA managed care plans, DOH relies on its delegated powers to ensure the quality of care rendered to them.

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

II.B. Five Year Needs Assessment Summary

II.B.1. Process

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

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

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

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

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

II.B.2. Findings

II.B.2.a. MCH Population Needs

Domain 1: Maternal & Women's Health

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

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

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

Maternal Mortality is a devastating outcome with dramatic impact on families and communities. NYS maternal mortality peaked at 29.2 deaths/100,000 live births in 2008 and declined to 18.8 in 2012, with rates four times higher among Black women and 1.5 times higher among NYC women 4. Both mortality rates and racial disparities for NYS are notably higher than national rates. Leading causes include cardiac disorders, hemorrhage, hypertension and

embolism. Severe or “near miss” maternal morbidity increased in NYS from 2008-10 then declined, with significant racial, ethnic and economic disparities 7. Risk factors identified in NYS analyses include: greater maternal age; obesity and chronic medical conditions; multiple pregnancies; delayed or inadequate prenatal care; depression; and, Cesarean delivery. Maternal depression is the most common morbidity among postpartum women, affecting 10-20% of women during or within 12 months of pregnancy. Risk increases with low social support, personal or family mental illness, substance abuse and pregnancy or birth complications.

Key successes to build on in NYS include:
• Robust surveillance and data systems including SPDS, PRAMS, Family Planning and Home Visiting data systems and Maternal Mortality Review systems. A new partnership with BRFSS provides data on women’s preconception health and family planning practices.
• Promising public awareness and education work including Text4Baby, media campaign on tobacco use among women of reproductive age and emerging resources on maternal depression for consumers and providers.
• Highly effective clinical quality improvement strategies to increase use of contraception among family planning clients, reduce non-indicated elective deliveries and improve management of maternal hemorrhage and hypertension.
• Integration and expansion of evidence-based/-informed strategies within community health initiatives including maternal and infant home visiting, community health workers and supports for pregnant and parenting teens.
• Strong and emerging partnerships with health reform initiatives including ACA health insurance expansion, Medicaid Redesign, Medicaid Health Home and State Health Innovation Plan/Advanced Primary Care model.

“The family planning learning collaborative provided a platform to engage in an educated discussion about how to improve performance regarding contraceptives and LARC”

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

Domain 2: Perinatal and Infant Health

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

Rates of drug-related discharges for newborns increased by 60% since 2008, with increases both upstate and in NYC and across all racial and ethnic groups, and higher rates outside NYC and among black infants 7. The rate of Neonatal Abstinence Syndrome has doubled outside of NYC since 2008 to 4.5 per 1000 delivery hospitalizations,

primarily among white infants 7. Fetal alcohol exposure among newborns has been steady, with ~8% of women reporting alcohol use in the last three months of pregnancy, and higher rates in NYC 2. Tobacco use during pregnancy has declined steadily since 2000, with higher rates outside of NYC and among younger, lower income and unmarried women 2.

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

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

"Mothers need support to be healthy and to keep their babies healthy; services like home visiting help families"

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

"We need to employ more people in front line positions to reflect the communities we serve"

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

Domain 3: Child Health

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

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

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

"It's not that families don't want to be healthy – They have more important things to deal with"

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

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

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

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

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

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

Support for families is a key cross-cutting need identified by stakeholders 3. In 2009-10, 17.6% of CYSHCN families indicated their child's health needs created financial problems for the family, 14.4% spent 11+ hours/week providing or coordinating their child's health care and 26.7% cut back or stopped working due to their child's health condition, while 43.1% reported their child does not receive family-centered health care 18. Increasing support for families is a central priority for the state's Early Intervention (IDEA Part C) program, for which the proportion of families reporting positive family outcomes decreased from 2008 to 2012.

"I am told I am an important member of my child's health care team, but I don't feel like I really am"

In addition to those noted for Domain 3, key NYS strengths and successes to build on include:
• Generous public health insurance for children including several expanded Medicaid options for CYSHCN;
• Comprehensive statewide Early Intervention Program serving over 65,000 infants and toddlers with developmental delays, with a focus on both child and family outcomes and strong commitments to better addressing children's social-emotional developmental needs as well as family-centered practices and outcomes;
• Highly effective partnership with Medicaid to develop a new Health Home benefit to provide enhanced care coordination for CYSHCN pursuant to ACA – Title V has played a central role in all steps of this initiative, with continued collaboration for implementation;
• Family representation on state advisory groups for MCHSBG, Early Intervention and Hands & Voices and strong partnerships with statewide family support organizations and other child-serving agencies.
• A high level of family satisfaction with information and referral services provided to families of CYSHCN by LHD programs, with gap-filling financial supports available for families in some counties.

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

Domain 5: Adolescent Health

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

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

About 97% of NYS teens age 12-17 had health insurance in 2012, though 6% had inconsistent insurance coverage over the year and only 71% had coverage adequate for all the services they need 11. NYS parents report that 50% of teens receive care meeting all medical home criteria, and 90.7% had a preventive medical visit in the past year, with lower utilization among older, Hispanic, publicly-insured and English language learners 11. However, state quality reporting data from Medicaid and commercial managed care plans indicate that 61-64% of teens had a preventive visit in the past year, and among these ~60-75% received preventive counseling on weight status, sexual activity,

depression, tobacco use and substance use (data vary by visit component) 10. Among teens age 13-17 in 2013, 61.7% of girls and 38.6% of boys had at least one dose of HPV vaccine, 89.5% had at least one dose of Tdap and 83.3% at least one dose of meningococcal vaccine all of these are increasing 12. About 66% of teens with mental health problems receive treatment, higher than for younger children 11.

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

"Get us involved. The minute I feel like my word matters, I will stay involved…I will think and I will make better choices"

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

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

Domain 6: Cross-Cutting & Life Course

Throughout NY's needs assessment process, several recurring themes emerged that cut across all MCH populations and life course stages: oral health; mental health; enrollment in affordable and adequate health insurance; access to

and use of preventive health care services; social support and healthy relationships; neighborhood and community environments that protect health and support healthy behaviors; and the need to reduce health disparities and promote health equity. See Domains 1-5 above for additional domain-specific references to these cross-cutting factors and II.A for additional information on NYS health insurance capacity and reforms.

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

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

Across all MCH stakeholder groups, home, neighborhood and community environments were noted as key factors influencing cross-cutting health risks and issues including nutrition, physical activity, social supports and relationships, violence, injury prevention, asthma and lead poisoning 3. Parents report that 79% of children and youth age 0-17 live in supportive/cohesive neighborhoods and 80% feel that their child is usually or always safe in their community or neighborhood, with disparities for non-white and lower income young people 11. About 58% of young people live in a neighborhood that has a park, recreation center, sidewalks and library; 85% live in neighborhoods with at least three of these resources 11. In contrast, about 17% of young people live in neighborhoods with two or more detracting elements (vandalism, rundown housing, litter), with notable racial and ethnic disparities 11. In 2011, USDA identified food deserts in more than half of NYS counties, with about 2.5% of low-income NYS residents living > 1 mile (urban) or > 10 miles (rural) from a supermarket or grocery store that provides affordable fruits and vegetables 22. About 19% of young people age 0-17 live in a household in which someone smokes, which is declining 11. Common home environmental hazards identified by the DOH Healthy Neighborhoods Program include: second-hand smoke, lack of carbon monoxide and smoke detectors, lead paint hazards, rodent and insect pests, mold and structural disrepairs 23.

"My kids would be healthier if they could go out to play instead of watching TV"

Throughout NYS' needs assessment, racial, ethnic, economic and geographic disparities are highlighted for virtually all MCH outcomes and factors assessed. While we have made great progress in some areas, profound disparities persist that must be addressed, hand-in-hand with attention to addressing social determinants of health and

promoting health equity.

In addition to those noted for Domains 1-5 above, key strengths to build on in NYS include:
• Strong evidence base for action to improve oral health through community water fluoridation, school-based programs and other prevention practices, combined with diverse partnerships and new funding support;
• Infrastructure to conduct in-home assessments and interventions for environmental health hazards in targeted neighborhoods through the state's Healthy Neighborhoods Program, with significant improvements in tobacco control, fire safety, lead poisoning risks, indoor air quality and asthma triggers on follow-up visits.
• A strong cross-sector commitment to investing in proven community-based programs to improve physical activity and nutrition and reduce tobacco use, with particular focus on policy and environmental change strategies.
• Statewide nutrition programs that provide resources for healthy food as well as family and community nutrition education in a number of settings.
• An array of strategies to reduce disparities and promote health equity across MCH programs and initiatives, with a shared commitment to advancing further evidence-based approaches.

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

II.B.2.b Title V Program Capacity

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

NY's state government is comprised of executive, legislative and judicial branches. The bicameral Legislature includes a 62 member Senate and 150 member Assembly. The judicial branch, comprised of courts with jurisdictions from village/town to the State Court of Appeals, functions under a Unified Court System to resolve civil, family, and criminal matters and provide legal protection for children, mentally ill persons and others entitled to special protections. The Governor heads the executive branch, including 20 departments; department and agency heads are appointed by the Governor, with the exception of the Commissioner of the State Education Department who is appointed by the State Board of Regents.

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

The OPH encompasses all DOH public health programs, including: biomedical research, public health science and quality assurance of clinical and environmental laboratories (Wadsworth Center); disease surveillance and the provision of quality prevention, health care and support services for those impacted by HIV, AIDS, sexually transmitted diseases and related health concerns (AIDS Institute); protection of human health from environmental contaminants through regulation, research and education (Center for Environmental Health); nutrition, chronic disease prevention and management, tobacco control, promotion of maternal and child health and public health

surveillance and disease prevention and control activities (Center for Community Health, CCH); support and oversight of local health departments and public health workforce development (Office of Public Health Practice); and, comprehensive emergency preparedness and response activities (Office of Public Health Preparedness). Public health programs serving MCH populations span DOH, but are mainly focused in the four Divisions of CCH: Chronic Disease Prevention; Nutrition; Epidemiology; and, Family Health (DFH).

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

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

NY's commitment to ensuring the health and well-being of the MCH population is manifest in an extraordinary array of resources. Supports and services span organizational units within DOH and other state and local agencies and organizations. As a large and diverse state most "front line" services are carried out by local partners, with funding, policy, planning, training, technical assistance, quality improvement and other supports from DOH/NYS Title V program. DFH manages in excess of $800 million annually in state and federal funds to support a comprehensive portfolio of MCH services, and collaborates with many other DOH programs and state agencies to advance additional MCH activities. A full description of MCH programs and resources is beyond the scope and limits of this NA summary; key resources are highlighted below. Note that resources are organized by primary population health domain, but many are relevant to multiple domains. (See also II.A. for health insurance and health care systems capacity).

Domain 1: Women's & Maternal Health

Family Planning Program – community-based outreach and clinical services with 49 agencies in 177 sites serving 340,000 clients annually in accordance with Title X standards; expanded Medicaid (MA) coverage for family planning (FP) services through Family Planning Extension Program (FP benefits up to 26 months postpartum for women MA eligible during pregnancy) and Family Planning Benefit Program (FP benefits for individuals <223% FPL, with presumptive eligibility period). Training, TA and QI support through FP Center of Excellence.

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

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

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

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

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

Domain 2: Perinatal & Infant Health

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

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

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

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

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

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

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

Domain 3: Child Health

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

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

Immunization Program – multi-pronged program to educate families and providers, ensure access to vaccines

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

Domain 4: Children with Special Health Care Needs

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

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

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

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

Domain 5: Adolescent Health

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

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

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

Domain 6: Cross-cutting & Life Course

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

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

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

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

Tobacco Prevention – comprehensive initiatives to prevent initiation, reduce current use, eliminate exposure to

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

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

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

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

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

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

• Rachel de Long, M.D., M.P.H., Director, DFH and NYS Title V Director
• Wendy Shaw, M.S., B.S.N., Associate Director, DFH
• Marilyn Kacica, M.D., M.P.H., Medical Director, DFH
• Christopher Kus, M.D., M.P.H., Associate Medical Director, DFH
• Kristine Mesler, M.P.A., B.S.N., Director, Bureau of Women, Infant and Adolescent Health and NYS Title V Adolescent Health Coordinator
• Susan Slade, RN, MS, CHES, Director, Bureau of Child Health and NYS Title V CSHCN Director
• Brenda Knudson Chouffi, MS.Ed, Co-Director, Bureau of Early Intervention
• Donna Noyes, PhD, Co-Director, Bureau of Early Intervention
• Rachel Gaul, MBA, Director, Bureau of Administration

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

May 2015.

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

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

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

II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	Reduce maternal mortality and morbidity	New	
2	Reduce infant mortality & morbidity	New	
3	Support and enhance social-emotional development and relationships for children and adolescents	New	
4	Increase supports to address the special health care needs of children and youth	New	
5	Increase the use of preventive health care services across the life course.	New	
6	Promote oral health and reduce tooth decay across the life course	New	
7	Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course.	New	
8	Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).	New	

As a result of the Needs Assessment summarized in II.B, New York selected eight MCH priorities for 2016-20:

1. Reduce maternal mortality & morbidity
2. Reduce infant mortality & morbidity
3. Support and enhance social-emotional development and relationships for children and adolescents
4. Increase supports to address the special health care needs of children and youth
5. Increase the use of preventive health care services across the life course:
   Preconception/ Interconception (“well woman”, including pregnancy planning and prevention)
   Prenatal & Postpartum
   Infants (“well baby”)
   Children (“well child”)
   Adolescents (“well teen”, including family planning)

6. Promote oral health and reduce tooth decay across the life course
7. Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course
8. Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population (cross-cutting)

The process to select priorities had several key steps. As summarized in II.B, a profile was constructed for each MCH domain that included: population health status; strengths and needs; state successes, challenges, gaps and disparities; and Title V capacity. A webinar was held with the state's MCHSBG Advisory Council to present highlights of findings from each profile and facilitate discussion of potential priorities within the respective domains. Council members were asked to consider several factors in identifying potential priorities, including: impact on MCH health and well-being; status and trends in key measures; gaps and disparities; evidence base for action; capacity (including financial resources, infrastructure and workforce) for action and implementation; momentum and buy-in to build on existing work and success; and the unique need for Title V leadership and attention. Profiles and presentations were refined to incorporate Council member input and feedback, and then used as the basis for a meeting with the internal DOH Leadership group (see II.B.1), at which in-depth discussion was facilitated to generate a list of potential priorities for each MCH domain. Group members then had the opportunity to vote for up to 10 priorities, with at least one vote in each Domain; voters were asked to consider the same criteria as listed above for the Advisory Council. Finally, the core MCH management team (Title V Director, Associate Director and Medical Director) reviewed the voting results along all information gathered throughout the process to select the final 7-10 priorities. The list of potential priorities from the leadership group was refined to consolidate similar ideas. Along with the voting results, consideration was given to all the criteria referenced above as well as overall feasibility and importance and alignment with the NYS Prevention Agenda, other major MCH initiatives and health systems reform efforts. In particular, the need for strong leadership from Title V to advance work in an area was considered in choosing the final priorities. Finally, the eight selected priorities were presented to leadership staff and Advisory Council members at the Council's all-day in-person meeting in April 2015; participants expressed endorsement for the priorities selected and enthusiasm for working together to develop and advance an action plan to achieve them.

The Priority Results Table (Attachment 3) compares the eight priorities selected for 2016-20 to the current/previous 2011-2015 priorities. Note that several priorities appear more than once within the table as they apply to more than one population domain. As illustrated, nearly all current priorities will continue to be addressed in the new cycle, either directly as continued priorities and/or as objectives or strategies encompassed within priorities set for 2016-20 in the context of the new life course framework. The only current priority that is not specifically reflected in the eight priorities for 2016-20– diagnosis and treatment of asthma in women and children - will continue to be addressed through other Department of Health programs. In many cases, priorities have been expanded or refined from the current cycle to reflect the key needs and opportunities identified in the Needs Assessment findings. Further detail about each selected priority is included in the table in Attachment 3
Overall, there was good consensus among the leadership group and Council members about the priority areas selected, and because the framework adopted provides for more specific issues or strategies to be addressed within a broader priority, no major priorities that rose to the level of strong consideration in our process needed to be deferred.

Domain 1: Maternal/Women Health

NY will continue its focus on maternal mortality as the rate of mortality in NYS is higher than the national rate and has great racial disparity. We will expand this focus to include maternal morbidity, including severe ("near miss") morbidity and the more common specific issue of maternal depression. By examining severe maternal morbidity, we can highlight aspects which need immediate focus, such as hemorrhage and hypertension, to focus interventions for improvement. Maternal depression and increasing use of opioids were identified as key emerging issues with

significant implications for both maternal health outcomes and infant's and children's health and social-emotional development (Domains 2&3). Addressing disparities will also continue specific to maternal mortality and through cross-cutting focus (Domain 6).

NY will continue and expand work associated with the use of preventive services by women of reproductive age and the use of early and comprehensive prenatal care, as elements of the cross cutting life course priority on use of preventive health care services (Domain 6) relevant to maternal and women's health. Previous work has focused primarily on prenatal care along with reducing and eliminating disparities in birth outcomes and unintended pregnancies. There is increasing recognition that further improvements in birth outcomes for both women and infants require focus on women's health before (preconception) and between (interconception) pregnancies, reinforced by NA findings demonstrating high rates of unintended pregnancy and the disproportionate burden of maternal mortality on women with chronic health conditions. While we continue efforts to increase early enrollment in prenatal care and improve the quality and effectiveness of that care, we will expand our focus on the use and quality of "well woman" preventive services and specifically the integration of pregnancy planning and prevention in primary care for all women, with enhanced attention to women with known risk factors. This priority aligns with our NYS IM CoIIN as well as major healthcare reform efforts in NYS, thus providing opportunities to leverage and strengthen collaborations with the NY State of Health, MA DSRIP and Health Home and the SHIP/Advanced Primary Care initiative.

Domain 2: Perinatal/Infant Health

NY will continue a priority focus on reducing infant mortality and expand the focus to include morbidity. Within this priority, key focus areas include preterm birth, perinatal regionalization, safe sleep, breastfeeding and reducing disparities, which align with the Department's Prevention Agenda and national IM CoIIN Initiative. NY's CoIIN projects include a focus on safe sleep to reduce infant mortality that will align with NY's systems approach that incorporates clinical quality improvement, family education and support, through work with hospitals, health care providers and maternal and infant community collaboratives and home visiting programs. NY also will continue to focus on use of comprehensive high quality "well baby" preventive services as an element of the cross cutting life course priority on use of preventive health care services (Domain 6).

Domain 3 & 5: Child & Adolescent Health

NY's priorities for child and adolescent health reflect consistent stakeholder input concerning the impact of poverty, toxic stress, early development and social-emotional relationships on lifelong health and well-being including issues such as obesity, behavioral health and school success. While there has been significant attention to social-emotional development for very young children, our NA highlighted the importance of continuing to support and nurture healthy relationships throughout development. This is closely related to the Domain 6 priority to support healthy and safe environments, and aligns with partnerships with the state Office of Mental Health and Early Childhood and Early Intervention Advisory Councils. This priority will enable the Title V program to collaborate with other Department programs as well as other state agencies to make a collective impact. Additionally, NY will continue to focus on use of comprehensive high quality "well child" and "well teen" preventive services as an element of the cross cutting life course priority (Domain 6), with particular focus on developmental screening, behavioral screening and counseling for adolescents and other areas of care that need improvement.

Domain 4: Children and Adolescents with Special Health Care Needs

NYS continues its work to identify and support the growing population of children and youth with special health needs. This priority closely aligns with NY's current work to implement a tailored Medicaid Health Home benefit for CSHCN pursuant to ACA, in which the Title V program has been extensively engaged; Health Home is a key strategy to improve care coordination and transition supports for CSHCN, which will help meet medical and behavioral needs of

CSHCN, improve health and school attendance and lessen the stress on families, which were priorities of our stakeholders. This priority also aligns with a major systems improvement initiative to strengthen family support and family outcomes within the Early Intervention Program.

Domain 6: Cross-cutting Life Course

The introduction of the life course framework prompted stakeholders to re-frame many of NY's previous specific MCH priorities within this Domain, as themes that cut across all MCH populations and life course stages. Previous priorities related to specific health care services (such as prenatal care) were revised to emphasize age-appropriate preventive health care services across the life course; priorities for oral health at specific stages were similarly expanded to embrace a life course focus. Previous issue-specific priorities related to obesity, tobacco, alcohol and substance use and lead poisoning were integrated within the new priority to support home and community environments, which will strengthen partnerships with other Department programs and other stakeholders. Given NY's diversity and striking disparities across virtually all MCH outcomes, it was determined that a specific priority to focus on reducing racial, ethnic, economic and geographic disparities and promoting health equity was needed, with measures and strategies to be incorporated across all of NY's MCH work.

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

NPM 1-Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	73.4	73.8	74.2	74.7	75.1

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	91.0	91.0	92.0	93.0	94.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	77.0	77.0	77.8	78.9	80.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	33.2	35.6	38.0	40.4	42.8

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

Annual Objectives					

	2016	2017	2018	2019	2020
Annual Objective	27.1	27.5	27.8	28.1	28.5

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	94.9	95.6	96.2	96.9	97.6

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	41.9	42.4	42.6	42.9	43.3

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	57.2	59.0	61.1	63.0	65.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	77.8	78.5	79.3	80.0	80.7

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

National Performance Measures (NPMs) for NY's MCH Action Plan were determined through the needs assessment conducted by NYS that consisted of extensive data analysis and evaluation, stakeholder input and discussion as well as the discussions related to selection of state priorities. The eight NPMs selected for focus are listed in the following table. Additional State Performance Measures (SPMs), as well as Evidence-Based Strategy Measures (ESMs) will be developed in Year 2. Alignment of selected NPMs with NY's priorities and federally-defined MCH population domains is demonstrated below. Note that while eight NPMs have been selected for routine reporting in accordance with grant guidelines, NY anticipates following additional performance and outcome measures as well as part of our ongoing MCH needs assessment.

MCH Priorities, National Performance Measures and Federal Population Domains

2016-2020 MCH Priority	
Reduce maternal mortality and morbidity	(1) P
Reduce infant mortality and morbidity	(3) P (5) P
Support and enhance children's social-emotional development and relationships for children	(6) P
Increase supports to address the special health care needs of children and youth	(6) P (12)
Increase use of preventive health care services across the life course: • Preconception/ Interconception ("well woman", including pregnancy planning and prevention) • Prenatal and Postpartum • Infants ("well baby") • Children ("well child") • Adolescents ("well teen", including family planning)	(1) P (6) P (10)
Promote oral health and reduce tooth decay across the life course	(13A (13B
Promote home and community environments support health, safety, physical activity and healthy food choices	(8) P
Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population	Use

Maternal mortality and morbidity will be followed by **NPM1 percent of women with a past year preventive visit** for all women. The **NYS Expanded BRFSS Report 2008-2009 shows the NYS** performance on NPM1 is 78.5% which is better than the national average of 73.4% (**as reported by the CDC BRFSS 2007-2009**). More recent information from the NYS BRFSS Report (2013) has a percentage of 69.4% for women ages 18 – 44 years compared to a US average of **66.7% (the US rate is from the CDC BRFSS 2007-2009**). This visit is the basis to beginning preventive healthcare as well as initiating pregnancy planning and prevention of unintended pregnancies.

Infant mortality and morbidity will be followed by multiple National Performance Measures.

NPM3 percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) will impact both mortality and morbidity. We have seen from NYS data that since 2009, 90% of VLBW infants have been delivered in hospitals with Level III-IV NICUs, with a corresponding decline in mortality rates. If an infant is delivered in a hospital with the correct clinical expertise and equipment, risk should be decreased for poor outcomes. NYS will continue to focus on its system of regionalized perinatal care to evaluate mortality and morbidity to identify areas for intervention and improvement. **NPM5 percent of infants placed to sleep on their backs** has improved slowly over time with a 2011 NYS rate of 70% while the NYC rate is 64.3% and rest of state rate of 75.6% (PRAMS). NYS will be focusing on this measure specifically as part of the NYS IM CoIIN initiative to effect improvement.

Social-emotional development and relationships for children and adolescents will be followed by NPM6. **NMP6 Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool** is a measure of child development. Although parent reporting of screening based on this measure has increased over time to 21.3% in 2012, we lag behind the national average of 30.8%. We anticipate selecting or developing additional state performance measures for this domain given the limits of this particular NPM.

Supports for children and youth with special health care needs will be followed by a series of measures. **NPM6 Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool** reflects the importance of routine developmental screening to identify CSHCN, and as noted above current NYS performance is relatively low on this measure. **NPM12 percent of children with special health care needs who received services necessary to make transitions** to adult health care was reported in 2010 to be 39.7% with a HP2020 target of 45.3%. This measure needs improvement in NYS.

Oral health and tooth decay will be followed with **NPM13 A and B. NPM13A percent of women who had a dental visit during pregnancy** has been a focus in NYS for many years and is a focus of the NYS Prevention Agenda. However, with this focus, rates have hovered between 40 – 50% without improvement (PRAMS**). NPM13B percent of infants and children, ages 1 to 17 years, who had a preventive dental visit in the last year** through parent report was 77% in 2012. This measure also needs improvement.

Use of preventive and primary health care services across the life course addresses all of the population Domains. **NPM1 percent of women with a past year preventive visit** for all women is 78.5% for NYS which is better than the national average of 73.4%. More recent information from the NYS Expanded BRFSS Report 2013 has a percentage of 69.4% for women ages 18 – 44 years compared to a US average of 69.4%. This visit is the basis to beginning preventive healthcare as well as initiating pregnancy planning and prevention of unintended pregnancies. **NPM6 percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool** measures a key recommended component of comprehensive well child care. Although parent reporting of developmental screening based on this measure has increased over time to 21.3% in 2012, we lag behind the national average of 30.8%. **NPM10 percent of adolescents with a preventive services visit in the last year** has seen a slight increase from 85.3% in 2003 to 91.7% in 2012. When ages are viewed separately, the percentage of adolescents receiving a preventive visit decreases with age; for adolescents age 12 years, the frequency was 97.7% in 2012 while age 17 years was 89.1%. Since older adolescents are transitioning to adult care and health care consumer roles, and have changing developmental needs related to sexual health and other health behaviors, this is a crucial visit.

Home and community environments that support health, safety, physical activity and healthy food choices will be followed by NPM8. **NPM8 percent of children ages 6 through 11 and adolescents ages 12**

through 17 who are physically active at least 60 minutes per day has remained relatively stable and was 24.6% in 2012. In 2012, children age 12 – 17 (19.6%) and females (19.4%) were less likely to exercise at least 20 minutes daily.

Racial, ethnic and economic disparities across in all core MCH outcomes. Since NYS has diverse populations and noted disparities, we will monitor all measures stratified by racial, ethnic, economic and geographic stratifiers.

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

States are not required to provide a narrative discussion on the State Performance Measures (SPMs) until the FY2017 application

II.F. Five Year State Action Plan

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

As stated previously, NY's process to develop the State Action Plan has been comprehensive, built on years of experience in the MCH arena, data driven and shaped by input from families and professionals across NYS. NY's approach emphasizes the incorporation of a performance-based approach in all domains to ensure that evidence-based, measurable strategies are incorporated into all MCH initiatives. In order to fully understand the factors influencing the priority needs in NYS, the Title V program will perform a complete analysis of available data and the evidence-based (EB) or evidence-informed (EI) strategies in order to develop State Performance Measures and EBs and EI strategies for the FY 2017 application. Therefore targets for most action plan objectives in this application are to be determined (TBD) through a deliberate process with staff that takes into account baseline data, trends and planned startegies. NY's state action plan will form the basis for all MCH initiatives with a strong evidence-based approach.

The plan supports Title V's vision of "a nation where all mothers, children and youth, including CSHCN, and their families are healthy and thriving." The strategies operationalize MCH's Essential Services to ensure that the unique needs of families are adequately addressed to forward the mission of Title V.

State Action Plan Table

New York State Department of Health

Title V Maternal and Child Health Services Block Grant Five-Year State Action Plan

2016-2020

Domains	State Priority Needs	Objective	Strategies
Maternal and Women's Health	**Reduce maternal mortality and morbidity**	*By September 30, 2020:* • Reduce the maternal mortality rate in NYS to [TBD] • Increase the percentage of women screened for depression during and after pregnancy to [TBD]	• Finalize and institutionalize maternal death ca ascertainment and review process, issue regu reports of maternal death review findings and trends and expand surveillance and reporting activities to include severe maternal morbidity • Apply information learned from maternal deat morbidity reviews to policy, community prever and clinical quality improvement strategies to address key contributing factors. • Collaborate with Medicaid and OQPS to integ pregnancy planning and contraception in routi primary care and care management for all wo of reproductive age, including linkage to *NYS Health Innovation Plan/ Advanced Primary* (

Domains	State Priority Needs	Objective	Strategies
			Medicaid *Health Home* and other state healt systems reform initiatives. • Provide enhanced support to assist women ir getting health insurance, engaging in health c services and practicing healthy behaviors thro evidence-based home visiting and community health worker program models, and expand availability of evidence-based home visiting a community health worker services through *Medicaid/ DSRIP*, *Pay for Success*, federal *MIECHV* and state budget funding. • Collaborate with OMH to develop and implem strategies to increase screening and follow-u maternal depression.
	Increase use of preconception and interconception ("well woman") health care services among women of reproductive age *(as part of priority on use of preventive health care services across the life course)*	*By September 30, 2020:* • Increase the percentage of women with a past year preventive medical visit to [TBD] • Reduce the rate of unintended pregnancy to [TBD] • Reduce the percentage of pregnancies that are conceived less than 18 months from a previous birth to [TBD] • Increase the percentage of women who report that a health care provider has talked with them about ways to	• Integrate performance standards, measures a improvement strategies related to health insu and health care service utilization across all T programs serving women of reproductive age • Collaborate with Medicaid and OQPS to inte pregnancy planning and contraception in routi primary care and care management for all wo of reproductive age, including linkage to NYS *Health Innovation Plan/ Advanced Primary* Medicaid *Health Home* and other state healt systems reform initiatives. • Develop and implement a public awareness campaign related to preconception & interconception health. • Convene and lead structured quality improver collaborative to improve outreach and engage of underserved populations in family planning services. • Provide funding, training and technical assista to community-based partnerships to improve and interconception health in low income

Domains	State Priority Needs	Objective	Strategies
		prepare for a healthy pregnancy and baby to [TBD]	populations and communities. • Promote policies and practices to increase th of Long Acting Reversible Contraceptives (LA • Strengthen linkages with public health chronic disease prevention programs to enhance dat capacity and target health promotion strategie women at risk for adverse pregnancy outcom
	Increase use of prenatal and postpartum health care services *(as part of priority on use of preventive health care services across the life course)*	*By September 30, 2020:* • Increase percentage of live births with prenatal care starting in the first trimester to [TBD]	• Integrate performance standards, measures a improvement strategies related to health insu and health care service utilization across all T programs serving pregnant and postpartum w • Provide subject matter and technical support Medicaid and OQPS to improve prenatal and postpartum care in accordance with Medicaic standards through the Perinatal Quality Improvement Project • Continue and expand state pilot project in sel communities to leverage health information technology to improve risk assessment, refer follow up care for pregnant women, and expar effective strategies to additional communities • Provide enhanced support to assist pregnant women in getting health insurance, engaging prenatal and postpartum health care services practicing healthy behaviors through evidence based home visiting and community health wo program models, and expand availability of services through Medicaid/ DSRIP, Pay for Success, federal MIECHV and state budget funding. • Develop and evaluate models for mobilizing l resources to support pregnant and parenting • Develop and implement a public awareness

Domains	State Priority Needs	Objective	Strategies
			campaign, including promotion of NYS' Text4B resource, related to prenatal and postpartum • Convene and coordinate workgroup with OQP OHIP and external MCH partners on policy an practice issues related to securing and using OHP to prevent preterm labor. • Collaborate with NYSDOH Bureau of Immuniz to implement multi-pronged strategies to incre vaccination rates for pregnant women.
Perinatal and Infant Health	**Reduce infant mortality and morbidity**	*By September 30, 2020:* • Decrease the infant mortality rate to [TBD] • Decrease the preterm birth rate to [TBD] • Increase the percent of very low birthweight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) to [TBD]	• Update NYS perinatal regionalization standar and designations and implement new perform measures. • Build on completed NYSPQC projects to incorporate performance standards and meas for early elective inductions and C-sections a relevant projects including Medicaid/DSRIP a perinatal regionalization. • Continue to lead and convene structured state quality improvement initiatives in birthing hosp through the NYS Perinatal Quality Collaborati (NYSPQC), including implementation of new improvement projects on safe sleep and ante corticosteroid use. • Continue to convene and lead state workgrou interagency and external partners to reduce in mortality through participation in national and Infant Mortality CoIIN initiative. • In collaboration with NYS CoIIN partnership, develop and implement a multi-pronged strate promote safe sleep policies and practices. • Provide enhanced support to assist families i getting health insurance, engaging in materna

Domains	State Priority Needs	Objective	Strategies
			infant health care services and practicing heal behaviors and parenting skills through eviden based home visiting and community health wo program models, and expand availability of services. • Collaborate with NYSDOH Division of Chroni Disease Prevention to develop, implement ar evaluate a multi-pronged strategy to decrease smoking among pregnant women. • Collaborate with NYSDOH Divisions of Nutriti and Chronic Disease Prevention to implemer multi-pronged strategy to promote breastfeed both hospital and community settings • Collaborate with the NYS OASAS and other partners to assess and develop strategies to address substance use, in particular opioid us among pregnant and parenting women.
	Increase use of primary and preventive ("well-baby") care among infants (*as part of priority on use of preventive health care services across the life course)*	*By September 30 2020*: • Increase the percentage of infants who receive recommended number of well-baby visits to [TBD]	• Integrate performance standards, measures a improvement strategies related to health insu and health care service utilization across all T programs serving infants and their families. • Provide enhanced support to assist families i getting health insurance and engaging in well health care services through evidence-based visiting and community health worker program models, and expand availability of services. • Promote the use of NYS Text4Baby resource reinforce importance and schedule of well-bal visits. • Develop and evaluate models for mobilizing l resources to support pregnant and parenting • Collaborate with NYS AAP, WIC, Medicaid, L Health Departments and other partners to dev

Domains	State Priority Needs	Objective	Strategies
			and implement strategies to increase use of v baby care and improve preventive care practi accordance with *Bright Futures* standards.
Child Health	**Support and enhance children's social-emotional development and relationships** (*as part of shared priority for children and adolescents*)	*By September 30, 2020:* • Increase the percentage of children meeting criteria for social-emotional healthy development to [TBD] *(developmental – pending new NSCH to be defined)* • Increase the percentage of children receiving developmental screening in accordance with *Bright Futures* standards to [TBD]	• Assess available child health data sources, including forthcoming revisions to National Su of Children's Health, and develop relevant performance measures and data analysis pla support public health activities. • Provide enhanced support to assist families i practicing healthy behaviors and parenting sk and nurture children's development through evidence-based home visiting and community health worker program models, and expand availability of services. • Support adult mentoring and supervision acti for youth in underserved communities • Issue recommendations of joint EICC-ECAC Force to address social-emotional developme needs of children enrolled in NYS Early Interve Program, and identify action steps for implementation. • Explore collaborative opportunities with the na Center on Social and Emotional Foundations Early Learning (CSEFEL) to promote social emotional development in children. • Collaborate with NYS Early Childhood Adviso Council, State Education Department/Commu Schools and other partners to develop and implement additional strategies to support an enhance children's social- emotional develop and positive relationships across child-servin settings. • Collaborate with the Office of Mental Health to

Domains	State Priority Needs	Objective	Strategies
			develop and implement strategies to improve screening and follow-up of maternal depressi • Explore the feasibility of developing a public awareness campaign related to supporting children's social-emotional development.
	Increase use of primary and preventive ("well child") health care services by children. (*as part of priority on use of preventive health care services across the life course)*	*By September 30, 2020*: • Increase the percentage of children who receive the recommended schedule of well-child visits to [TBD] • Increase the percentage of children who receive preventive health care services including immunizations, developmental screening and age-appropriate anticipatory guidance in accordance with *Bright Futures* standards to [TBD]	• Integrate performance standards, measures a improvement strategies related to health insu and health care utilization across all Title V programs serving children. • Collaborate with Medicaid, OQPS, other NYS public health programs, health plans and professional medical organizations to identify advance strategies to increase use of well-ch care and promote preventive care practices i accordance with *Bright Futures* standards, including linkage to relevant state health syste reform and quality improvement initiatives. • Collaborate with WIC, Child Care, Community Schools, home visiting and other child-servinç programs to develop and advance strategies children to health insurance and primary healt services. • Provide subject matter and technical support OCFS to develop and implement health-relate quality indicators for child care programs • Maintain support for statewide network of SB support SBHCs' transition to Medicaid mana care and update and implement performance standards and measures for SBHCs • Provide subject matter and technical support SED to ensure that Community Schools have information and linkages needed to promote h of children and families

Domains	State Priority Needs	Objective	Strategies
CSHCN (CSHCN)	**Increase supports to address the special health care needs of children and youth**	*By September 30, 2020:* • Increase the percentage of CSHCN with a medical home to [TBD] • Increase the percentage of CSHCN who need and receive care coordination services that meet their needs to [TBD] • Increase the percentage of adolescents with special health care needs who receive services necessary to make transitions to adult services to [TBD] • Increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale to [TBD]	• Assess available data sources, including forthcoming revisions to National Survey of Children's Health/CSHCN, and develop upda performance measures and data analysis pla support public health activities. • Convene and lead a structured learning collaborative with birthing hospitals to improv screening, reporting and follow-up for early he loss among newborns • Provide subject matter and technical support Medicaid to implement enhanced care coordi and transition support services for CSHCN th *Health Home*, including integration of eligible children also receiving services through the E Intervention Program. • Build on findings from recently completed res study to enhance policy and practice supports children with Autism Spectrum Disorders and families within and beyond the Early Interventi Program • Identify and seek policy solutions to address in insurance coverage for CSHCN. • Complete critical assessment/ evaluation of c CSHCN and PHCP public health programs a develop proposal(s) for strengthening local ar regional program models for CSHCN. • Update and enhance previous strategies and materials to support transition to adult roles a services for CSHCN. • Collaborate with OCFS to develop and imple quality indicators related to child health, includ CSHCN, for child care programs

Domains	State Priority Needs	Objective	Strategies
			• Identify effective practices for delivering family centered services and improving family outco within the Early Intervention Program, and disseminate findings to other relevant Title V a partner programs. • Integrate performance standards and measur related to family engagement and support acr Title V programs serving children. • Ensure that relevant workgroups, committees advisory councils led by NYS Title V program meaningful family representation.
Adolescent Health (AH)	**Support and enhance adolescents' social-emotional development and relationships** (*as part of shared priority for children and adolescents)*	*By September 30, 2020:* • Increase the percentage of adolescents meeting criteria for social-emotional healthy development by [TBD]*(developmental – pending new NSCH to be defined)* • Reduce the percentage of adolescents who feel sad or hopeless for two weeks or longer in the past year by [TBD] • Reduce the rate of suicide among adolescents by [TBD] • Decrease the percentage of	• Conduct further assessment of available data sources, including YRBS and forthcoming rev to National Survey of Children's Health, and develop updated annual data analysis plan to inform public health activities • Incorporate evidence-based/ -informed strate to address adolescent social-emotional development, wellness and healthy relationsh within Title V adolescent grant programs • Continue to support the delivery of evidence-b sexual health education and confidential reproductive health care services for teens in community and school-based clinical settings • Collaborate with the Office of Mental Health a other partners to develop and implement add strategies for prevention of suicide among adolescents • Support the delivery of evidence-based and promising sexual violence prevention strategi create community change

Domains	State Priority Needs	Objective	Strategies
		adolescents who experience physical or sexual dating violence by [TBD]	• Develop and evaluate models for coordinatin resources to support pregnant and parenting (through *Pathways to Success* initiative)
	Increase use of primary and preventive ("well teen") health care services by adolescents (*as part of priority on use of preventive health care services across the life course)*	*By September 30, 2020:* • Increase the percentage of adolescents who received a preventive health care visit in the last year to [TBD] • Increase the percentage of adolescents who receive preventive health care services including immunization and age-appropriate screening and anticipatory guidance in accordance with *Bright Futures* standards to [TBD] • Reduce the adolescent pregnancy rate by [TBD]	• Integrate performance standards and measur related to health insurance and health care utilization across all Title V programs serving adolescents. • Continue to support the delivery of evidence-l sexual health education and confidential reproductive health care services for teens in community and school-based clinical settings • Incorporate evidence-based/ -informed strate to address adolescent health literacy and use health care services, including transition to ad health care services, within Title V adolescent programs • Collaborate with Medicaid, OQPS, other NYS public health programs, health plans and professional medical organizations to identify advance strategies to increase use of well-ch care and promote preventive care practices i accordance with *Bright Futures* standards, including linkage to relevant state health syste reform and quality improvement initiatives. • Maintain support for statewide network of SB support SBHCs' transition to Medicaid mana care and update and implement performance standards and measures for SBHCs

Domains	State Priority Needs	Objective	Strategies
Cross Cutting or Life Course (LC)	**Increase use of primary and preventive health care across the life course**	*See domain-specific objectives above*	• Integrate performance standards, measures a improvement strategies related to health insu and health care utilization across all Title V programs • Collaborate with NY State of Health to ensure V programs have current and accurate inform regarding health insurance resources in the s and that issues identified by local partners are shared with policymakers • Collaborate with Medicaid and OQPS to link health care service priorities to key state heal systems reform and quality improvement initia including *NYS Health Innovation Plan/ Adva Primary Care*, *Medicaid Health Home* and *P Centered Medical Home*
	Promote oral health and reduce tooth decay across the life course	*By September 30,2020*: • Increase the percentage of NYS residents served by community water systems with optimally fluoridated water by [TBD]	• In collaboration with the NYSDOH Center for Environmental Health, administer funding and provide technical support to public water supp support maintenance and expansion of comm water fluoridation • Support the delivery of oral health screening a preventive dental services through school-bas clinics and programs, with a focus on evidenc

Domains	State Priority Needs	Objective	Strategies
		• Reduce the prevalence of dental caries among NYS children by [TBD] • Increase the percentage of children and adolescents who had a preventive dental visit in the past year by [TBD] • Increase the percentage of pregnant women who had a dental visit during pregnancy by [TBD]	based practices • Collaborate with NYSDOH Division of Nutritio explore the integration of oral health preventic strategies within public health nutrition progra serving MCH populations • Complete pilot project on integration of oral h messages and strategies in community-base maternal and infant health programs. and sha lessons learned with other MCH programs • Collaborate with NYS AAP, DA dental hygiene association and other partners to develop and implement strategies to integrate oral health practices within primary care services for chil and to increase the supply of dental providers serve MCH population • Support dental public health residency *(see workforce below)*
	Promote home and community environments that support health, safety, physical activity and healthy food choices	*By September 30, 2020*: • Increase the percentage of children and adolescents who are physically active at least 60 minutes daily by [TBD] • Reduce the percentage of children and adolescents who are obese by [TBD] • Reduce the percentage of women age 18-44 who are obese by [TBD]	• Collaborate with the NYSDOH chronic diseas nutrition, injury prevention and environmental h programs to incorporate relevant standards, measures and evidence-based/ -informed practices and policies across Title V program to ensure that Title V grantees are linked with community development initiatives • Provide subject matter and technical support OCFS to develop and implement health-relate quality indicators for child care programs • Provide subject matter and technical support SED to ensure that Community Schools have information and linkages needed to promote h of children and families • Collaborate with the NYSDOH Center for Environmental Health to support neighborhoo

Domains	State Priority Needs	Objective	Strategies
		• Reduce the injury-related hospitalization rate for children and teens by [TBD] • Increase the percentage of children and adolescents who live in supportive/ cohesive neighborhoods by [TBD] • Increase the percentage of children and adolescents who are usually or always safe in their community or neighborhood by [TBD]	based, door-to-door assessments and educa through Healthy Neighborhoods Program • Support the delivery of evidence-based and promising sexual violence prevention strategi create community change
	Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population	*By September 30, 2020:* • Reduce disparities for key MCH measures by [TBD]	• Conduct additional analyses of available data fully assess disparities in MCH outcomes and information to development of public health strategies • Identify and support use of evidence-based/ – informed strategies with evidence of effective for disparately impacted populations • Assess equity in distribution of MCH services resources and prioritize available funding/ resources for underserved communities • Prioritize funding for organizations with exper serving, and staffing reflective of, underserved communities, including support for community

Domains	State Priority Needs	Objective	Strategies
			health workers • Integrate performance standards, measures a improvement strategies related to engageme community members in planning, selecting ar implementing local MCH programming acros V programs

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

The needs assessment summary emphasized the importance of ensuring women's health prior to pregnancy in order to improve birth outcomes. After years of focusing on engaging women into prenatal care earlier in their pregnancy, NY will place a stronger emphasis on the development of strategies to promote preconception and interconception care. Although progress has been made in improving birth outcomes in NYS, these birth outcomes including maternal mortality, entry into prenatal care, birth spacing and preterm births, among others, have not met HP 2020 goals and disparities in these outcomes continue to exist. Although some poor birth outcomes are unavoidable, optimizing a woman's health and knowledge before planning and conceiving a pregnancy is paramount to addressing the complex health and social factors that impact birth outcomes. This involves strategic, multi-layer approaches to impact public policy as well as regional, local and clinical practices, thereby institutionalizing these approaches for positive health outcomes.

Maternal mortality (MM) is a tragic birth outcome. MM in NYS is unacceptably high with significant disparities, mirroring that of the nation as a whole. NY's data related to maternal morbidity also reflects significant racial, ethnic and economic disparities. Data on maternal morbidity mirrors that of MM. As stated in the annual report section of this application, NYS has more than a decade of history of assessing factors leading to maternal deaths and developing strategies to reduce the risk of maternal mortalities. NY's Title V program led the effort to establish the Maternal Mortality Review (MMR) process in 2010 which is a comprehensive review of all maternal deaths. In the MMR initiative, the DOH conducts comprehensive surveillance activities based on linked birth and death record data, hospital in-patient and emergency department data (inpatient and outpatient records from the Statewide Planning and Research Cooperative System records (SPARCS)) and a hospital-based adverse event reporting system, the New York Patient Occurrence Reporting and Tracking System (NYPORTS). NYPORTS is a statewide, mandatory reporting system that collects information from hospitals and diagnostic treatment centers concerning adverse events defined as unintended, adverse and undesirable developments in a patient's condition. Maternal deaths are one of the 31 occurrences reportable to NYPORTS.

The data used to determine cases for surveillance consists of death records of women ages 10 to 55 years that died within one year (365 days) of a live birth or fetal death. The cases include: maternal death certificates that match to a live birth certificate or a fetal death; maternal death certificates that do not match to a live birth certificate but have an ICD-10 code indicating a pregnancy-related cause of death and/or pregnancy is checked on death certificate; and, maternal death certificates that match to a SPARCS record in which there is an indication of pregnancy (established using the diagnoses and procedure codes listed in the record). The cases are organized for surveillance based on

the case ascertainment data sources. Standard surveillance cases consist of female deaths linked to a live birth with a year or less between the two events. To expand the identification of maternal deaths, NYS added an enhanced surveillance component that focuses on the examination of female death records not linked to a live birth certificate that occurred within a year after a hospitalization, but indicates a pregnancy in SPARCS, or the death certificate included an obstetric cause of death, or the woman was pregnant at the time of death. NYPORTS cases not captured under standard surveillance are also included in the enhanced surveillance. The hospital records with an indication of pregnancy from SPARCS are identified using a broad list of ICD-9 codes for pregnancy-related diagnosis and procedure codes.

The current MM review abstraction tool was developed based on previous MMR experience from multiple review tools with the goal to ensure a comprehensive review of medical records. In addition to demographic, medical, psychosocial and intimate partner violence information, the form has sections dedicated to addressing the cause of death gleaned from multiple sources, autopsy reports and potential preventability based on clinical review. The tool collects health information potentially impacting MM: information about past pregnancies, prenatal and intra-partum medical history, prenatal hospitalizations, and postpartum information.

Information is also periodically provided to the MM Expert Workgroup comprised of a collaboration of multidisciplinary clinicians and other key stakeholders from professional organizations and hospitals. This committee considers the analysis trends present in maternal mortality and provides recommendations for prevention and improvements in medical care and management as well as identifying focus areas for education.

This comprehensive review of maternal deaths has resulted in the identification of the leading causes of death for the cohort reviewed, namely hemorrhage, hypertension, embolism, and cardiovascular problems that enabled the DOH to focus on areas for improvement. For example, in collaboration with the Expert Workgroup, the DOH developed guidelines for the identification and management of hypertension during pregnancy that were widely disseminated to clinicians and hospitals across NYS.

This process is not without challenges. The identification of maternal deaths as well as a review of the medical information associated with that death is labor and time intensive. The current maternal death review process is extremely relevant for public health surveillance and to identify improvement opportunities, however Title V staff will lead efforts to identify areas for improvement in this review process. Title V staff recently completed an analysis of the maternal death cohort from 2006 – 2008 and developed an accompanying report currently under review through the DOH. Over the next year, Title V staff will assess the current maternal death process, and focus on more timely reviews in order to produce more current results and reports to inform policy and practice. This will include discussion with the Expert Workgroup to obtain multidisciplinary input and support.

In addition, the Title V program will lead efforts to carefully assess the information gleaned from the first cohort reviews and develop strategies to influence policy, program and clinical care to prevent maternal deaths. The Expert Workgroup is comprised of multidisciplinary membership including New York Academy of Medicine, ACOG, NYS Society of Pathologists, NYS Nurses Association, NYS Association of County Health Officials, NYS Association of Licensed Midwives, NYS Academy of Family Physicians, National Association of Social Workers, New York City Department of Health and Mental Hygiene, NYS Association of County Coroners and Medical Examiners, New York City Office of the Chief Medical Examiner, Association of Regional and Perinatal Networks, NYS Office of Alcoholism and Substance Abuse, New York American College of Emergency Physicians, Medical Society of the State of New York, NYS Society of Anesthesiologists, NYS Dietetic Association, Greater New York Hospital Association, Healthcare Association of NYS, and Regional Perinatal Centers. The Title V program will release the 2006-2008 Maternal Mortality Review report and, in collaboration with this workgroup, assess opportunities for improvement on the State, regional, local and provider level.

NYS has a long history of developing and supporting a regionalized perinatal system of services, led by Regional Perinatal Centers (RPCs), the highest level of perinatal hospital in NYS with groups of affiliative perinatal hospitals (Level, 1, 2 and 3) to which they provide training, technical assistance, consultation and quality improvement activities. The NYS Perinatal Quality Collaborative (NYSPQC) works with the perinatal hospitals to improve quality of care and outcomes for the MCH population. NYSPQ will serve as an important vehicle to improve clinical care to improve birth outcomes.

Recognizing the value of this process, NY's State Action Plan includes strategies to strengthen and expand this process through identifying factors impacting maternal morbidity. Through birth and SPARCs data, the Title V program will enhance surveillance activities to identify significant maternal morbidity or "near misses" such as Intensive Care Unit admissions, cases where transfusions were required, increased lengths of hospital stay, unanticipated operating room procedures, among others to start to identify opportunities for improvement beyond those factors resulting in maternal deaths. The analysis of "near miss' situations may result in further highlight the factors that impact birth outcomes and identify opportunities for improvement that are not necessarily identified through the maternal death reviews.

An important component of NY's State Action Plan is to ensure the incorporation of preconception and interconception policies and practices into NY's health care system. In 2014, NYS was awarded a four year, $100 million State Innovations Model Testing grant from the Centers for Medicare and Medicaid Innovation, to support the Governor's State Health Innovation Plan (SHIP), an ambitious blueprint to give all New Yorkers access to high quality, coordinated care throughout NYS. The SHIP serves as NY's roadmap to achieve the "Triple Aim" for all New Yorkers: improved health, better health care quality and consumer experience, and lower costs. The SHIP, recognizing that lasting health delivery system reform requires a high-performing primary care system, facilitates statewide implementation of an enhanced medical home model, "Advanced Primary Care" (APC). NY's APC model is consistent with principles of NCQA Patient Centered Medical Home (PCMH) criteria, seeking to move beyond structural criteria to achieve lasting, meaningful changes in processes and outcomes. APC seeks to provide patients with access to high quality, integrated care, delivered by teams of providers with the capacity to manage the care of patients with chronic illnesses. These efforts are led by NYSDOH's Office of Health Insurance Programs (OHIP) and Office of Quality and Patient Safety (OQPS).

This funding also extends the reach of NY's population health initiative, the Prevention Agenda 2013-2017 (PA) by integrating PA activities with clinical care delivered under the APC Care model to better achieve strategic outcomes. NY's PA, created by a diverse set of stakeholders including local health departments, health care providers, health plans, community based organizations, academia, employers, state agencies, schools and businesses, has five priority areas: Prevent Chronic Disease; Promote Healthy and Safe Environments; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; and Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare Associated Infections. Each priority area identifies goals and indicators to measure progress and recommended policies and evidence based interventions using the National Prevention Strategy and other sources. PA goals were not only integrated into the SHIP, but also the State's Medicaid waiver Delivery System Reform Incentive Program (DSRIP), and progress on achieving goals is measured using a dashboard. Oversight of the PA and the SIM Population Health initiative is under the jurisdiction of NY's Public Health and Health Planning Council (PHHPC). This Council is part of the overarching SHIP governance structure, serves as the Population Health workgroup convened to oversee relevant SIM funded initiatives and ensures integration and alignment of the PA, DSRIP and the SHIP.

Title V staff has been, and will continue to be involved in work of the PHHPC, as well as OHIP and OQPS, in forwarding the goals of the SHIP. An ongoing priority is identifying opportunities to decrease maternal deaths including incorporating preconception and interconception health into primary and preventive care including APC.

This also includes identifying those women with chronic disease eligible for Health Home and ensuring all Health Homes understand the importance of ensuring women of reproductive age, and those women who have a history of a poor birth outcome, are counseled regarding those health and other factors that may impact pregnancy and birth. Over the next year, Title V staff will continue to work collaboratively within DOH and with the PHHPC to incorporate pregnancy planning and contraception counseling into all models of primary and preventive care for all women of reproductive age.

DOH's Division of Chronic Disease Prevention (DCDP) supports several major initiatives to ameliorate chronic disease such as smoking, obesity, and diseases such as diabetes and hypertension. Their initiatives touch a significant number of women of reproductive age. Ensuring messages regarding preconception and interconception health are incorporated into chronic disease providers and contractors is vitally important to improving maternal health. An important aspect of NY's State Action Plan will be forging a stronger working relationship with DCDP in order to ensure that chronic disease providers are ensuring women of reproductive age, and those women who have had a poor birth outcome, are counseled regarding those health and other factors that may impact pregnancy and birth.

In order for women to remain healthy, it is imperative that they have access to health insurance and quality health care. All MCH programs and initiatives are expected to facilitate enrollment into health insurance for all women they encounter including Family Planning Programs, School Based Health Centers, Comprehensive Adolescent Pregnancy Prevention Programs, among others. NY's maternal and infant health programs integrate broad-based systems approaches involving regional and local planning; one-on-one outreach and support; population-based education; public health insurance and clinical practice standards; and extensive surveillance to support public health planning and clinical quality improvement efforts. These efforts include the Maternal and Infant Community Health Collaboratives Initiative (MICHC) that work to implement evidence-based/best practice strategies across the reproductive life course, including enrollment in health insurance and engagement in preventive health services. Each MICHC also employ community health workers, individuals indigenous to the communities served, to conduct outreach to engage women into prenatal care and ongoing primary and preventive health care. The Maternal, Infant and Early Childhood Home Visiting (MIECHV) initiative provides evidence-based home visiting services to pregnant and parenting families in several high-risk counties in NYS. All of these efforts focus on engaging women into ongoing health care, including prenatal care where appropriate and supporting healthy behaviors. Over the next year, Title V will expand efforts to ensure all Title V MCH providers will prioritize engaging women into health care to NY's Exchange and continue to focus on ensuring women understand the importance of healthy behaviors and planning for pregnancy to improve birth outcomes. This will include closer collaboration across the NYSDOH to develop stronger working relationships with programs and services such as WIC to ensure all women are insured.

Title V staff has a close working relationship with OHIP focusing on Medicaid Prenatal Care. Through the MA Prenatal Care Program, quality prenatal care is provided to women up to 200% of the FPL based on current clinical standards of care. These standards include, but are not limited to, risk assessment for the identification and treatment of social, emotional, behavioral and chronic conditions to prevent poor outcomes. This includes chronic medical conditions such as hypertension or diabetes, oral health issues, psychological disorders such as maternal depression, substance use issues, among others. Title V staff meet regularly with OHIP staff to discuss strategies to improve prenatal outcomes through the provision of comprehensive prenatal care. A continued focus of this relationship will be to incorporate preconception and interconception health practices into the prenatal care clinics. In addition, the use of 17 alpha-hydroxyprogesterone caproate (17P) to prevent preterm births in high risk women has not been strong. NY's State Action Plan also includes a strategy to work with OHIP, OPQS and other key stakeholders to promote appropriate and consistent use of 17P to improve birth outcomes. Finally, ensuring pregnant women receive recommended vaccinations (e.g. TDAP, influenza, etc.) will also be an important initiative to better ensure the health and wellness of NY"s pregnant women.

In order to best promote preconception and interconception health, it is imperative that NY's men and women understand its importance. Over the next year, Title V staff will develop a public awareness campaign that will promote preconception health across the life span and encourage the development of a reproductive health plan. This approach will also incorporate the promotion of effective methods of contraception, namely Long Acting Reversible Contraception (LARC) through Title V's network of family planning providers as well as obstetric hospitals in the postpartum period. Medicaid recently approved reimbursement for LARC in the hospital postpartum period (reimbursement previously presented a barrier to this practice) so Title V staff will lead efforts to increase awareness of this practice through communication, education and potentially quality improvement efforts.

Ensuring communication of health information is also an important component of improving birth outcomes. As part of the its MRT efforts, the Title V program is piloting a Maternal and Infant Health – Health Information Technology (MIH-HIT) project which aims to develop, test and implement a technology infrastructure that supports perinatal risk identification, assessment and referral, and facilitates information sharing across a network of health and social service providers for coordination and delivery of care for pregnant women. Poor perinatal outcomes are major cost drivers for health care institutions and the Medicaid program. When high risk pregnant and postpartum women receive early and comprehensive screening to identify special needs and risk factors, along with timely social and medical interventions to address those risks identified, birth outcomes for women and babies are greatly improved.

As part of MRT, four MIH-HIT pilot projects are supported to demonstrate the effective use of HIT to coordinate perinatal services across a network of providers. These 4 pilot projects have developed web-based systems to identify medical and psychosocial needs and risk factors, and facilitate timely referrals to social and medical interventions to address those needs; and recruited partner agencies to participate in the HIT system. The DFH will continue to assess the impact of this project and potentially expand this system to improve birth outcomes.
Finally, addressing maternal depression is also a priority of the Title V in NYS. Maternal depression is a serious and common problem that impacts the mother's and child's well-being. Title V has built a solid working relationship with NY's Office of Mental Health and will collaborate with OMH as well as MCH providers and stakeholders to promote awareness, screening and treatment for women suffering from maternal depression.

Women/Maternal Health - Annual Report

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	73.4	73.8	74.2	74.7	75.1

A priority of FY2014 was to design and implement the NY State of Health (NYSOH), NY's exchange developed pursuant to the ACA. In October 2013, the NYSOH, the state's official health plan marketplace, was created to assist all New Yorkers to gain access to quality affordable health care coverage. From October 1, 2013 and through April 15, 2014, 960,762 New Yorkers enrolled into a health plan through NY State of Health. Thirty-four percent of New Yorkers that enrolled in a Qualified Health Plan are under the age of 35, 18% are between ages 35 and 44, 23% between ages 45-54, and 25% are over the age of 55. Females comprised a slightly larger percentage of total

enrollees. An additional 2.1 million individuals enrolled through the second enrollment period ending February 2015. Recognizing that health insurance coverage is essential in order for women to access primary and preventive health care services, an emphasis of Title V in NYS over the past year was to ensure women were enrolled into health care coverage. Staff from NYSOH provided several educational opportunities for DFH staff and contractors to increase an understanding regarding NY's Health Exchange. This included major providers of women's health services including family planning and maternal and child health providers and others providing health and supportive services to women and their families. All family planning providers also participated in ACA-related webinars sponsored by the Family Planning National Training Center. These included "Enrollment and Your Family Planning Agency" and "Inreach/Outreach and Enrollment for Title X Family Planning Agencies" as well as additional webinars related to the Title X required Outreach and Enrollment Data Survey. In 2011 57.3% of family planning clients had health insurance. Preliminary data shows an increase to 71.1% in 2014. Many Title V contractors, including family planning providers and school based health center sponsors and community-based maternal and infant health collaboratives, among others, are also approved Navigators to assist individuals to enroll in health insurance. All contractors are required to identify uninsured women and assist them to enroll in health insurance or refer them to a Navigator for enrollment.

Supporting and promoting access to early prenatal care has been a cornerstone of NY's perinatal services for all women, but especially low income women disengaged from the health care system. The percent of infants born to women receiving prenatal care in the first trimester has seen a slight increase from 73.8% in 2012 to 74.7% in 2013. The percentage of infants born to Black and Hispanic women receiving prenatal care in the first trimester remained relatively stable at 66.9% both in 2012 and 2013. NY's Medicaid Prenatal Care Program provides comprehensive prenatal care to women up to 223% of FPL including undocumented women (using state only funding.) Presumptive eligibility ensures women can receive care immediately when accessing services, while awaiting full eligibility determination. NY's maternal and infant health programs integrate broad-based systems approaches involving regional and local planning; one-on-one outreach and support; population-based education; public health insurance and clinical practice standards; and extensive surveillance to support public health planning and clinical quality improvement efforts. These efforts include the Maternal and Infant Community Health Collaboratives Initiative (MICHC) comprised of 24 projects in 31 high-risk counties that work to implement evidence-based/best practice strategies across the reproductive life course, including enrollment in health insurance and engagement in preventive health services. Each MICHC also employ community health workers, individuals indigenous to the communities served, to conduct outreach to engage women and families into prenatal care and ongoing primary and preventive health care. The Maternal, Infant and Early Childhood Home Visiting (MIECHV) initiative provided home visiting services to 2,293 pregnant and parenting families through 5 Nurse Family Partnership and 5 Healthy Families New York programs in 6 high-risk counties. DOH supports a total of 17 evidence-based home visiting programs, including 7 Nurse Family Partnership and 10 Healthy Families New York programs in 7 high-risk counties. All of these efforts focus on engaging women into ongoing health care, including prenatal care where appropriate and supporting healthy behaviors.

Promoting healthy behaviors is also paramount to improving the health and wellness of women in NYS, including pregnant women. Although the percentage of women who smoke in the last three months of pregnancy has decreased over time, NYS is still below the HP 2020 target of 98.6% of women delivering a live birth abstaining from smoking. In 2013, 6.2% pregnant women smoked in the last 3 months of pregnancy, with NYC (2.3%) being much lower than the rest of NYS (11.4%). NY has been a leader in addressing smoking cessation for all New Yorkers, including pregnant women. Effective January 1, 2014, Medicaid expanded the frequency of smoking cessation counseling (SCC) coverage for all Medicaid eligible recipients, including pregnant women. In accordance with the ACA, current coverage of smoking cessation counseling services was modified to include a maximum of two quit attempts per 12 months, including up to four face-to-face counseling sessions per quit attempt, thus increasing the limits on SCC from 6 to 8 per 12 months. Any cost sharing when SCC is provided to pregnant women, including both counseling and pharmacotherapy, was abolished.

There were also other initiatives that specifically targeted pregnant women. The DFH promoted a NYS customized version of Text4baby, a free text messages service with messages delivered each week, timed to the woman's due date or baby's date of birth to provide new and expecting mothers with important health information to promote good health for their babies. Women sign up for the service by texting BABY to 511411(BEBE for Spanish) or online at http://text4baby.org. Messages focus on maternal and child health topics, including the prevention of birth defects, immunization, nutrition, seasonal flu, mental health, oral health, healthy behaviors, with a specific message addressing smoking cessation, and safe sleep. Text4baby also connects women to prenatal and infant care, and other health services and resources. NY participated in a friendly competition between states to increase Text4baby membership that was sponsored by the American Public Health Association (APHA). NY boosted enrollment in the free prenatal Text4baby messaging service by 16 percent since May 2014, outpacing every other large state, and was honored at APHA's annual meeting for this accomplishment. DOH also promotes the national text4baby program through a statewide marketing campaign and targeted outreach through community-based partners, including NYC and local health departments, health insurers and advocacy groups. Text4baby is available through a broad public-private partnership that includes the U.S. Department of Health and Human Services; the National Healthy Mothers, Healthy Babies Coalition; state and local governments; corporations; professional organizations; and community -based organizations. 17,000 NYS women are now enrolled in Text4baby.

The DFH also initiated the development of a media campaign in collaboration with the DOH Bureau of Tobacco Control to develop and implement a smoking cessation media campaign targeted to preconception and pregnant women in 24 rural counties with high rates of babies born to women who smoked. The media messaging will be designed to motivate women of reproductive age to quit smoking by providing information on the effects of smoking, available resources and supports available to attempt quitting. The campaign will include television, YouTube and Facebook messages modeled after CDC's Amanda Campaign, and is expected to launch in June 2015. Amanda smoked during pregnancy, and in the campaign materials she talks about the weeks her baby spent in the NICU after she was born 2 months early.

DOH also promoted anti-smoking messages to target all New Yorkers, including pregnant women. Over the past year, DOH supported media campaigns, using television, radio, digital and out of home channels. Campaigns included tobacco-free pharmacies, encouraging tobacco users to talk with their doctor about quitting and Medicaid cessation benefits. The DOH-funded campaign generated 27,980 calls to the Smokers Quitline over 3-1/2 months.

In line with federal guidelines and recommendations, DOH also supported two new programs including the Advancing Tobacco-Free Communities (ATFC) and Health Systems for a Tobacco-Free NY (HS) programs. Regional contractors use evidence-based and high-level systems interventions to promote policy changes that reduce the uptake of tobacco use, increase cessation and eliminate secondhand smoke exposure. The primary focus is on tobacco-disparate populations, i.e., persons with low income, low educational attainment, poor mental health or substance use disorders. Over the past year, thirteen public housing authorities with over 8,000 rental units adopted smokefree policies. Forty municipalities or counties and 13 major employers adopted and implemented smoke- or tobacco-free outdoor policies. NY has some of the strictest laws regarding smoking in the nation including PHL that prohibit smoking on hospital and residential health care facility grounds.

The DFH recognizes the importance of oral health services as a vital component of primary and preventive health care. Access to oral health care for pregnant women at times presents challenges due to a lack of understanding by dentists and a lack of availability of dentist that accept Medicaid. NY was a leader in the development of the Oral Health Care During Pregnancy and Early Childhood Guidelines and has widely disseminated information regarding these guidelines. The Medicaid prenatal care standards requires all prenatal care provider to conduct an

assessment of the woman's oral health care needs at the first prenatal care visit including but not be limited to interviewing the patient regarding current oral health problems, previous dental problems, and the availability of a dental provider. The guidelines recommend that pregnant women identified as having a current oral health problem or not having a dental visit in the past six months be referred to a dentist as soon as possible, preferably before 20 weeks gestation.

NY's dental workforce faces challenges, namely, an uneven distribution of dentists, an aging workforce and low participation of dentists in the Medicaid program. Approximately 1.6 million residents live in designated Dental Health Professional Shortage Areas (D-HPSA). The BDH in partnership with the OPCHSM oversees HRSA Dental Workforce Grant that focuses on increasing opportunities for new graduates and dentists to establish linkages with underserved communities and obtain community support for establishing practices; reducing the need for dental services and thereby the number of dentists by focusing on prevention and early intervention. The grant also focuses on the training of dentists to become champions of fluoridation. The DFH is also home for the Dental Public Health Residency program designed to provide dentists with field experience in administration, management and evaluation of community-based programs. In the past year, a total of four dental public health residents were involved in planning and implementing prevention and treatment services for high risk and underserved population groups.

Over the past year, the DFH was awarded the NYS Perinatal and Infant Oral Health Collaborative Initiative grant through CDC. The overall goal of this grant is to improve the oral health of pregnant women and infants in NYS through organizational and system level changes. This initiative builds on the work of the DOH funded MICHC in a high need area of the state with the objectives to: increase the percent of women who visit a dentist during pregnancy; increase the percent of women who receive an assessment for oral health problems and appropriate referral by a prenatal care provider; and, increase the percent of women engaged in healthy behavior (appropriate feeding habits and infant oral hygiene practices). The community agencies are working with the NYS Oral Health Center of Excellence (OHCE) to implement their proposed strategies and activities. (OHCE was established by DOH to provide statewide assistance to communities, local health departments, and health care institutions to improve population oral health as well as to enhance access to evidence-based oral health services.) Over the past year, the contractor initiated the development of training materials that will be used to train prenatal care and dental providers, as well as community health workers and case managers. They are also modifying a pregnancy and oral health toolkit that can be used to educate providers, women and families in the community. The toolkit will be introduced during the first webinar training, which is scheduled for July-August 2015. All lessons learned from this initiative, as well as tools and resources developed by the contractor, will be shared with the remaining MICHC projects throughout NYS to increase the reach and impact of this most important initiative.

Maternal mortality is a tragic event and determining causes for poor birth outcomes and developing strategies to address these issues is of significant importance. Although NYS's maternal mortality rate has dropped over the past few years (23.1 per 100,000 live births in 2010 vs. 17.9 in 2013), it remains above the HP 2020 goal of 11.4 per 100,000 live births that includes maternal deaths occurring within 42 days from termination of pregnancy. Racial disparities in maternal deaths are significant and exceed any disparity noted in infant mortality and low birth weight births. The ratio of Black non-Hispanic to White non-Hispanic maternal deaths in NYS is 4.0 (2012) versus a national ratio of 3.2 (2007).

The DFH in conjunction with OPCHSM developed a comprehensive maternal mortality review process. The process takes a public health approach to ascertain and review all maternal death cases and analyze data to identify populations at risk and factors contributing to maternal mortality, including the development of recommendations and interventions to reduce maternal risk. DOH has convened an expert review committee to review the results of maternal death reviews and provide recommendations related to improvement opportunities. The processes identifies pregnancy-related death defined as the death of a woman while pregnant or within a year from termination

of pregnancy, occurring as result of a pregnancy-related illness (i.e. preeclampsia) or as a result of an underlying illness exacerbated by the physiology of pregnancy (i.e. mitral stenosis.) A pregnancy-related death that occurred within 42 day of the termination of the pregnancy is considered a maternal death. Pregnancy-associated, not related death is defined as the death of a woman while pregnant or within one year of termination of pregnancy from any cause, not as a cause of pregnancy or illness exacerbated by pregnancy (i.e. motor vehicle accident.)
Over the past year, the DFH completed surveillance activities of pregnancy associated deaths that occurred between 2006 and 2008 that showed the leading causes of death to be: hypertension, hemorrhage and embolism. Chronic illness, obesity and prenatal risk factors were also identified as common factors in many of the cases reviewed. This resulted in identification of several priorities including management of hypertension, obesity and embolism/deep vein thrombosis (DVT) for development of clinical guidelines. In conjunction with DOH's Expert Review Committee guidelines on the diagnosis, evaluation and management of the hypertensive disorders of pregnancy were developed and widely disseminated, including accompanying materials such as posters regarding correct assessment of blood pressure in pregnancy. This information was distributed to hospitals across the state as well as clinicians. An on-line self-directed Power Point presentation of the guidance was created and continuing education credits are offered to providers that successfully complete this presentation. The DFH continues to lead work on this important issue and address improvement activities through the NYPQC.
The DFH is also working with the Public Health Committee of the NYS Public Health and Health Planning Council (PHHPC) to address this significant public health issue. The focus of this work is on the "pre-hospital" antecedents of maternal mortality, including: promotion of women's health and wellness across the reproductive life course; early identification and coordinated management of high-risk pregnancies; and, prevention of unintended pregnancies among women with known serious risk factors.
Maternal depression has a significant impact on mothers as well as the social-emotional stability of their children and is the most common maternal morbidity. In 2014 NYS passed a law requiring hospitals to educate patients about maternal depression, and maternal depression screening and referral. Over the past year the DFH in collaboration with the OPCHSM notified all obstetrical hospitals of this requirement. In addition, the DFH initiated discussions with the Office of Mental Health and other key stakeholders to discuss strategies to improve maternal depression screening and enhance resources for those women experiencing depression.

Finally, DOH's Growing Up Healthy Hotline (GUHH) is available 24/7, provides information and referral in English and Spanish and in other languages via the AT&T language line. In 2013 GUHH responded to 34,500 calls including 2,418 calls requesting referral and information related to pregnancy testing and/or prenatal care, and 3,494 calls related to health insurance.

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

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

The last comprehensive review of NY's regionalized system was in the early 2000s. Although NY continues to exceed the HP 2020 goals for delivery of very low birthweight infants being born at Level 3 or higher perinatal hospitals, standards of perinatal care have evolved and the landscape of the perinatal hospital system, as well as health care coverage and systems, has changed as well. It is therefore imperative for NY to ensure all perinatal hospitals are functioning in accordance with current standards of care. To that end, the Title V program will lead efforts to redefine standards for perinatal regionalization in NYS. Over the next year, Title V staff will initiate efforts to

update standards of perinatal care and develop a process to redesignate all obstetrical hospitals in NYS. Due to the complexity of this undertaking, this will be a multiyear effort, culminating with the development of performance standards and measures that all perinatal hospitals, as well as the Title V program can use to monitor and improve performance.

Title V staff will continue to improve maternal and newborn birth outcomes and increase patient safety through NYSPQ, an initiative of NY's RPCs, DOH and NICHQ. This process applies evidence-based system change interventions to establish capacity within RPCs for ongoing QI activities. As stated in the annual report section of this application, through NYSPQ, the DFH has made much progress in decreasing elective inductions and C-sections prior to 39 weeks gestation without medical indication.

Building on the success of this initiative, the Title V program will be partnering with the RPCs and MOD Big 5 Prematurity Collaborative to educate health care professionals and increase awareness of antenatal corticosteroid therapy (ACT) and appropriate use of ACT to promote fetal lung maturity. The Big 5 states include California, Florida, Illinois, New York and Texas and account for nearly 40 percent of all births and 36.8 percent of preterm births in the US. Participating perinatal hospitals will have an increased understanding of the importance of and correct timing for administration of ACT and standardize practices to decrease variability in the provision of ACT. Similar efforts will also be undertaken as other priorities are identified (e.g., factors leading to maternal mortality and morbidity) through NYSPQC, and Title V's work with Medicaid Prenatal Care and other partners.

Title V program is leading NY's efforts in the national Infant Mortality Collaborative Improvement and Innovation Network (IM-CoIIN). The IM-CoIIN is a platform designed to accelerate improvement in priority strategy areas through collaborative learning, quality improvement and innovation. NYS-IM CoIIN project was launched in two areas of focus including: Safe Sleep: Reduce infant safe sleep related deaths and improve safe sleep practices, and pre/interconception care through the promotion of healthy birth spacing and reducing unintended pregnancy. Teams were established to focus on these topic areas including: DOH; staff from state agencies such as the Office of Children and Family Services (OCFS); NICHQ; birthing facility staff; doctors; nurses; social workers; community organizations; MOD; and hospital associations such as the Healthcare Association of New York State (HANYS) and the Greater New York Hospital Association (GNYHA). The team has been working to strategize, and develop goals and potential interventions to improve outcomes related to each focus area.

Over the next year the NYS Safe Sleep CoIIN will focus on creating a unified safe sleep message throughout the state based on currently available scientific evidence and national recommendations. The project will also work across agencies to promote safe sleep among infants during the first year of life, and center on modeling safe sleep practices from the very start by encouraging birthing hospitals to not only teach safe sleep but model safe sleep practices before babies go home. Participating birthing hospitals and the DOH will work together to implement and evaluate evidence-based education and safe sleep modeling to reduce infant mortality due to unsafe sleep by increasing the proportion of healthy infants sleeping safely in hospitals and the proportion of primary caregivers who intend to practice safe sleep at home. Participating hospitals will also participate in learning sessions aimed at improving the operationalization of hospital safe sleep procedures and effectiveness of educational messaging to caregivers

The Safe Sleep project will also recruit community-based pilot sites, such as MICHC and MIECHV sites to assess effectiveness of safe sleep education. Participating community-based organizations will work together to implement and evaluate evidence-based education to increase the proportion of infants sleeping in safe sleep environments as defined by the AAP and CDC. Participating organizations will learn and apply key principles to improve education and associated measures as the primary focus of work. Organizations will participate in learning sessions aimed at improving the operationalization and effectiveness of educational messaging to caregivers.

The preconception/interconception aspect of COIIN will focus on the prevention of unintended pregnancies and

improve birth spacing by increasing access to contraceptive services including long acting reversible contraceptives (e.g. inter-uterine devices and implants). The goals are to: improve birth intention, including use of most and moderately effective contraception among women seeking reproductive health services; improve the percentage of postpartum women in the state who are using LARC relative to state baseline; and improve the integration of evidence-based preconception messages into routine preventive care services

Over the next year, the project will develop pilot projects in agencies that serve women of reproductive age to assess the impact of asking women age 15-44 their intention of becoming pregnant within the next year ("One Key Question") on the increased use of effective contraception, particularly LARC. The project will also attempt to increase the number of women who have postpartum visits and reduce the number of women having another child within 24 months of a previous birth.

The Title V staff will work with three FQHCs involved in the NYS family planning program to build on their capacity to provide contraceptive services by implementing use of the "One Key Question" in non-family planning clinic settings including pediatrics, for both adolescents and mothers during well baby checkups, family health, and obstetrics. These groups will not only measure the use of "The One Key Question" but also referral to family planning services and same day access to of prescriptions for contraceptives for women who do not intend to be pregnant within the next year. The goal is to reduce the number of unintended pregnancies by increasing knowledge and access to effective methods of contraception.

The Title V staff will also work with several home visiting programs in NYS, including the NFP, HFNY and CHWs to address postpartum education of women by tracking education regarding postpartum visits and family planning (including birth spacing and contraceptive use) as well as adherence to the postpartum visit and uptake of contraceptives. The projects with use the *Preconception Care Clinical Toolkit* developed through the national Preconception Health and Health Care project to guide their work. Experience gleaned through the COIIN over the next year will form the basis for expansion of this work in other agencies and health care providers serving women of reproductive age to expand and integrate this work into primary and preventive health care practices.

The changing landscape of Medicaid in NYS has presented challenges but also significant opportunities. As previously stated, in April 2014, Governor Cuomo announced that NY had finalized terms and conditions with the federal government for a groundbreaking waiver that allows the state to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms. $6.42 billion of this was allocated to the Delivery System Reform Incentive Payment (DSRIP) program. Year one began April 1, 2015, and it will extend through to March 31, 2020. Over these five years, the program will promote community-level collaborations and focus on healthcare system reform. DSRIP is the foundation for "Better care, less cost," and has the major goal to achieve a 25 percent reduction in avoidable hospital use over five years. Title V staff have been key players in this process to ensure the needs of the MCH population are included and addressed.

All DSRIP plans must include at least one project from Domain 4 that focuses on increasing the use of evidence-informed policies and evidence-based programs pertaining to the healthy development of children, youth, and adults. The project must be based on the Community Needs Assessment and consistent with their project plan. These Domain 4 projects are based on the New York State Prevention Agenda, and, as such, the DSRIP providers are encouraged to work in collaboration with the community and other providers to address these statewide public health priorities including: Prevention of Chronic Diseases; Promoting a Healthy and Safe Environment; Promoting Healthy Women, Infants and Children; Promoting Mental Health and Prevent Substance Abuse; Prevention of HIV/STDs; and, Vaccine-Preventable Disease and Healthcare-Associated Infections. The focus of Healthy Women, Infants and Children is the prevention of prematurity. Several projects are focused on increasing support for maternal and child health through expansion of home visiting (Nurse Family Partnership) or the use of Community Health Workers to conduct community outreach and engage women into

prenatal care. Others are focusing on evidence-based models of care such as Centering Pregnancy, enhanced services and the use of Health Information Technology (HIT) for communication to improve prenatal care. Title V staff have been, and will continue to be, directly involved in the development of these initiatives and over the next year will continue to identify opportunities through DSRIP and other models of care to improve practice and system to improve birth outcomes.

Ensuring supports are available in the community to improve maternal and infant health outcomes and to reduce racial, ethnic and economic disparities in those outcomes is a priority of NY's Title V program. The Title V program will continue to oversee the implementation of the MICHCs, community-based organizations that strive to improve maternal and infant health outcomes for Medicaid-eligible high-need low-income women and their families while reducing persistent racial, ethnic and economic disparities in those outcomes. MICH strategies will continue to focus on improving: outreach to find and engage high-need women and their families in health insurance, health care and other needed community services; timely identification of needs and risk factors and coordinated follow-up to address risks identified; the integration and coordination of services within larger community systems; and, the development of supports, opportunities and social norms that promote and facilitate healthy behaviors across the lifespan. MICHC grantees work collaboratively with other community partners including health and human service providers, faith based organizations, community leaders among others to assess and prioritize specific community needs and strengths, and to select and implement specific improvement strategies to address those needs.

As stated previously, an important component of all MICHCs are CHWs, trained paraprofessionals working under the direction and supervision of a licensed professional. CHWs will continue to perform a combination of community outreach, home visits, group activities /workshops, and community-based supportive services to provide a source of enhanced social support and create a bridge between under-served and hard-to-reach populations and formal providers of health, social and other community services. CHWs provide ongoing support during preconception and interconception periods to promote healthy behaviors, including initial and continuous engagement with health and community services, for high-need women of reproductive age within target communities. (Refer to Annual Report section for further information regarding NY's MICHC project.)

Four performance standards define the goals of the MICHCs including: high-need women and infants are enrolled in health insurance; high-need women and infants are engaged in health care and other supportive services appropriate to their needs; the medical, behavioral, and psychological risk factors of high-need women and infants are identified and addressed through timely and coordinated counseling, management, referral, and follow-up; and, within the community there are supports and opportunities in place that help high-need women engage in and maintain healthy behaviors and reduce or eliminate risky behaviors

Recognizing the enormity of these performance standards and the need to provide these organizations with supports to achieve these standards, the Title V program established a Maternal and Infant Health Center of Excellence (MIH-COE) to provide additional guidance and technical support to grantees on performance measure development, data collection and reporting systems, and quality improvement methodology. A significant focus of the MIH-COE over the next year will also be to strengthen the collaboration of the MICHCs and home visiting programs and provide ongoing assistance to help these providers improve their engagement with community providers and key organizations and stakeholders to reach the hardest-to-engage women and families.

Work will continue to build collaborative efforts between MICHC grantees and HS grantees. Title V staff will continue to work with the HRSA Regional HS Project Officer to coordinate communication, collaboration and coordination between the HS and MICHC programs. Webinar trainings and educational materials developed by our MIH-COE will be shared with the HS grantees, including trainings and materials on implementation of evidence-based/promising strategies, and outreach and engagement of high-risk populations. HS grantees will also be

invited to the annual meeting of MICHC and MIECHV grantees.

As stated previously, the Title V program also oversees evidence-based home visiting, including the MIECHV Program that promotes and improves the health, development and well-being of at-risk children and families through evidence-based home visiting programs. Title V staff, in close partnership with OCFS, oversee two specific established evidence-based program models that have demonstrated positive outcomes in maternal health, child health and child maltreatment: NFP and HFNY. The goals of these initiatives are to: improve pregnancy outcomes for high-need women and babies; improve children's health and development; and, strengthen family functioning and life course. Additional state funding has been appropriated and the Title V program will be establishing new evidence-based home visiting programs in high needs areas in the coming year, and continue to see opportunities to expand the reach of these programs to impact perinatal and infant outcomes.

NY's Title V program has a close working relationship with OHIP that oversees NY's Medicaid Prenatal Care program. Based on a review of medical records to assess key aspects of prenatal care delivery, numerous areas were identified for improvement activities, including risk screening and referral and follow-up for identified risks. DOH recently began collecting data from providers on prenatal care provided to a random sample of Medicaid patients in NYS. The data collection tool includes standardized measures of prenatal care, which will allow providers to benchmark performance to statewide averages and performance goals. These data, that include information related to key areas such as tobacco cessation counseling, depression screening, care coordination, chronic disease management, recommended immunizations, assessment and treatment for preterm birth, will serve to inform internal quality improvement initiatives and provide a valuable component of quality oversight in addition to other approaches currently used by the DOH, including MMC plan measurement through the Quality Assurance Reporting Requirements (QARR) and requirements in the MMC model contract. Title V will continue to collaborate with OHIP on this initiative to promote improve perinatal and infant outcomes.

An emerging public health problem nationally, as well as in NYS is Neonatal abstinence syndrome (NAS) that impacts newborns of mothers who used addictive illegal or prescription drugs during their pregnancy. The infant becomes addicted to the drug as it passes through the placenta and will be born dependent on the substance or substances. As a result of the infant not receiving the drug following birth, the child enters into withdrawal. Through a close working relationship with RPCs, and assessment of preliminary data, the Title V program has noted a dramatic increase in the number of infants born suffering from NAS. In order to address this issue, Title V staff will conduct further data analysis to gain a better understanding of the scope and impact of this significant public health problem. Working in partnership with the Office of Alcoholism and Substance Abuse services, RPCs and other key partners and stakeholders, Title V staff will assess this issue and develop strategies to start to address this issue with serious impacts on the health of newborns.

Over the next year, the Title V program will expand efforts to collaborate with internal partners to maximize resources and increase "reach" to individuals of reproductive age. Title V staff continue to assess factors impacting birth outcomes that can be addressed in the preconception/interconception period. Smoking among pregnant women, especially outside of NYC, continues to be a significant health issue. The Division of Chronic Disease Prevention has had much success in the development and implementation of evidence-based practice to decrease smoking. In addition, DOH's Division of Nutrition provides significant statewide services to the MCH population such as WIC, Child and Adult Food Program, regional food banks, among others. Title V staff will meet with both Divisions to develop strategies to promote preconception/interconception messages and strategies to improve birth outcomes. Title V program will develop collaborative efforts with key stakeholders such as the AAP, WIC, OHIP and local health departments to increase the use of well-baby care and to improve preventive care practice. The Title V program also oversees Text4Baby that reaches over 17,000 women annually and will continue to develop messages for pregnant and parenting women to encourage primary and preventive health care as well as healthy behaviors and the development of a reproductive life plan to decrease unintended and mistimed pregnancies and improve birth

outcomes.

Perinatal/Infant Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	91	91	92	93	94

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	77	77	77.8	78.9	80

Improving the health of NY's mothers and infants is paramount. Overall, infant and neonatal mortality rates are declining in NYS. State rates for infant mortality and morbidity outcome measures are better than the HP 2020 targets. NYS's infant mortality rate was 4.97 per 1,000 live births in 2012; this represents a 16.6% decline from a rate of 5.96 per 1,000 live births in 2002. The number of infant deaths was 1,188 in 2012: 308 fewer than in 2002. From 2002 to 2012, the infant mortality rate declined 20.1% for non-Hispanic whites to 3.70 per 1,000 live births; 17.6% for non-Hispanic blacks to 8.96 per 1,000 live births; and 0.8% for Hispanics to 5.27 per 1,000 live births. Asian and Pacific Islanders had the lowest rate in 2012 at 3.54 per 1,000 live births; however, this represented a 6.9% increase since 2002 for this group. From 2002 to 2012, the neonatal mortality rate declined by 20.7% to 3.37 per 1,000 live births, while the post-neonatal mortality rate declined 7.0% to 1.59 per 1,000 live births.

Despite improvements, disparities still exist. The ratio of Black infant low birth weight rate to White infant low birth weight rate in 2013 was 1.6, though a slight improvement from 1.8 in 2012 and 1.9 in 2010. In 2012, the mortality rate for early term infants (37-38 weeks gestation) was more than twice the rate of full term infants (39-40 weeks gestation): 2.61 and 1.21 per 1,000 live births, respectively. The three leading causes of infant death in 2012 were prematurity, congenital malformation and cardiovascular disorders originating in the perinatal period.

Ensuring access to comprehensive prenatal care is imperative to improve birth outcomes. As stated previously, the DFH collaborates with OHIP to ensure quality prenatal care services are available to NY's MA population. Services are available to women up to 223% of the FPL and to undocumented women using State only funding. Supports are also provided to women on an ongoing basis to promote ongoing healthy behaviors and foster infant development. The DFH is home to the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP) NY's MIECHV initiative that works to improve the health and well-being of at-risk families through implementation of evidence-based home visiting programs proven to positively impact maternal and child health including Nurse Family Partnership (NFP) and Healthy Families New York (HFNY). In 2014, the MIECHV initiative provided home visiting services to 2,293 pregnant and parenting families through 5 Nurse Family Partnership and 5 Healthy Families New York programs in 6 high-risk counties. In addition, OHIP has also obtained state plan approval to provide MA funding support to three NFPs in Onondaga and Monroe Counties and in NYC as targeted case management programs.

Additional expansion of NFP and Community Health Worker Programs (CHWP) is anticipated as part of the Medicaid DSRIP waiver process.

DOH recognizes the need to promote systems change on the local level to improve MCH outcomes for the long term. Maternal and Infant Community Health Collaboratives (MICHC) are working to improve maternal and infant health outcomes for high-need MA-eligible women and their families. MICHC projects work with other community partners to assess community needs and strengths and to foster the development and coordination of services within larger community systems. Projects develop systems that: find and engage high-need women and their families in health insurance and needed services; promote timely identification of their risks and ensure coordinated follow-up to address them; and, facilitate healthy behaviors across the lifespan.
NYS currently has Healthy Start (HS) grantees in Queens, Brooklyn, Staten Island, Harlem, Bronx, Syracuse and Rochester. All 7 of these communities are served by the MICHC programs, and 5 of the 7 HS grantees are also MICHC grantees. Staff are working with the HRSA Regional HS Project Officer to coordinate communication, collaboration and coordination between the HS and MICHC programs. MICHC projects are required to coordinate outreach, intake and referral processes with other community maternal and infant health programs including HS.

NY has also been a long-standing leader in the field of perinatal regionalization. In 2013, 89.5% of VLBW infants were delivered at facilities for high risk deliveries and neonates, well above the HP 2020 target of 82.5%. NYS's system of regionalized perinatal services includes a hierarchy of four levels of perinatal care provided by the hospitals within a region and led by a Regional Perinatal Centers (RPCs). The regional systems are led by RPCs capable of providing all the services and expertise required by the most acutely sick or at-risk pregnant women and newborns. RPCs provide or coordinate maternal-fetal and newborn transfers of high-risk patients from their affiliate hospitals, and are responsible for support, education, consultation, and improvements in the quality of care in the affiliate hospitals within their regions.

The NYS State Perinatal Quality Collaborative, an initiative of NY's RPCs, DOH and National Initiative for Children's Healthcare Quality (NICHQ), builds on the comprehensive system of regionalization in NYS. Through NYSPQC, DOH is working to improve maternal and newborn birth outcomes and increase patient safety by applying evidence-based system change interventions, and to establish capacity within RPCs for ongoing QI activities. A priority of NYSPQC is to reduce the number of scheduled deliveries performed without a medical indication between 36 0/7 and 38 6/7 weeks gestation. Of the 126 total NYS birthing facilities, 97 (77%) have participated in the NYSPQC Obstetrical Improvement Project since its expansion in 2012 to its completion in December of 2014. As a result, there were significant decreases in the percentage of scheduled deliveries occurring without a medical indication among the participating hospitals. From June 2012 through 2014, participants reported a 94% reduction in scheduled deliveries without a medical indication, including an 89% decrease in scheduled inductions without a medical indication, and a 96% decrease in scheduled C-sections without a medical indication, including a 93% reduction in primary C-sections without a medical indication. Participants also reported a 67% increase in the percent of women informed about the maternal and fetal risks and benefits of scheduled delivery between 36 0/7 and 38 6/7 weeks documented in the medical record. Overall, NYS's primary cesarean delivery rate has been declining since 2010. Declines in the primary cesarean rates in recent years may be due in part to multipronged efforts such as NYSPQC, and other perinatal initiatives.

Early identification of medical issues in newborns is critical to ameliorating long-term health impact. NY's Newborn Metabolic Screening Program (NBSP), performs blood testing and processes the data from over 275,000 specimens annually for 49 diseases and conditions, including all core conditions recommended by the American College of Medical Genetics and the March of Dimes. In 2014, 240,671 newborns were screened for all 49 diseases and conditions The NBSP follows all screen positive newborns and measures are taken to better ensure appropriate follow-up is received at a specialty center. In 2014, 2,894 newborns were referred for follow-up specialty evaluation

and 2,791 received follow-up services.
All birthing facilities are also required to have in place a newborn hearing screening program to conduct hearing screenings on all babies born in NYS and for critical congenital heart defects of the newborn. If the result of a screening test is abnormal, a referral is made to an appropriate specialized care center. The NY Early Hearing Detection Initiative-Information System (NYEHDI-IS), an online information system, was successfully launched statewide last year. The information system integrates information from the NY's two vital records systems, which were modified in 2011 to capture inpatient hearing screening, and allows for the manual entry of additional hearing screening and follow-up that occurs after the birth certificate is registered. The system is integrated with the state's immunization information system.
In 2014, DOH was awarded a three-year quality improvement (QI) grant from HRSA to reduce loss to follow-up for newborn hearing screening and follow-up. The grant continues through March 31, 2017. NYSPQC has had great success working with hospitals to improve outcomes for mothers and newborns. The collaborative will be expanded to collaborate with hospitals to improve reporting of hearing screening into the statewide information system, and to identify root causes for loss to follow-up and solutions to reduce it by 5% each year over the three-year grant. The individual level data collected by NYEHDI-IS is critical to the QI initiative and will be used to monitor the birthing facilities' performance during the QI initiative. A statewide QI team of stakeholders, including parents and a young adult who is deaf, was identified to provide guidance and expertise to the initiative. The statewide QI meeting was held in December 2014, with the start of the QI initiative in spring 2015.
In 2010, the Breastfeeding Mothers' Bill of Rights law was enacted to inform new mothers about the benefits of breastfeeding and to require that health care providers and maternal health care facilities encourage and support breastfeeding. DOH has been actively engaged in implementation of this law, including: developing media and education campaigns: assessing facility compliance and partnering with NICHQ to improving the quality of facility services through learning collaboratives; certifying facilities as "breastfeeding friendly"; and, addressing workplace issues. NY's Women's Infant and Children (WIC) program promotes and supports breastfeeding among its clients, through the work of lactation consultants and peer counselors, and WIC offers a food package especially for breastfeeding mothers. These concerted efforts have had a positive impact on breastfeeding rates in NYS, namely the percent of mothers who breastfeed their infants at six months of age. In 2013 the rate of mothers breastfeeding their infants at 6 months of age was 52.6 percent, an increase from 47.7 percent in 2011. Efforts continue as NYS remains below the HP 2020 rate of 60.5 percent.

Finally, DOH is participating in the national Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN), with quality improvement strategies to promote safe sleep practices, promote healthy birth spacing and reduce unintended pregnancy. Although sleep-related infant death rates in Black, non-Hispanics and Hispanics have been decreasing, rates are 2.5 times higher in Black, non-Hispanics than White, non-Hispanics. Efforts will also be made to promote immediate postpartum long acting reversible contraception (LARC), and integration of preconception and interconception messages into the delivery of primary care services.

Child Health

Child Health - Plan for the Application Year

As stated in the needs assessment summary, public health and health services for children are decentralized across the DOH as well as other agencies more than those for other MCH population domains. Therefore, this section of our State Action plan contains a significant focus on building and leveraging collaborative relationships to improve child health outcomes.

Because New York's selected priority to support children's social emotional development and relationships reflects an emerging area of MCH practice, many of the strategies to address this priority are developmental. Population and program data are needed to help drive and evaluate work in this arena, and as an initial strategy Title V staff will

work with partners to assess all available data sources to identify or develop and monitor relevant measures, including potential additional state performance or outcome measures. This will include a careful analysis of the revised National Survey of Children's Health when available.

Several current Title V programs include a strong focus on social-emotional and behavioral health that will be built upon to address this new priority. Evidence-based home visiting programs including NFP and HFNY, as well as the DOH-developed Community Health Worker component of the MICHC collaborative, include dedicated strategies to support and assist families in developing and practicing positive parenting skills that enhance early bonding and nurture children's development, as well as developmental screening of infants and young children with referral to local EI programs, pediatric providers and other local resources as needed. As noted in other sections of the plan, we will continue to implement expansion of these programs supported through federal MIECHV and various state funding sources. School-Based Health Centers (SBHC) are required to provide behavioral health screening for all patients (elementary, middle and high school age) as part of ongoing primary care, and most provide additional mental health services on-site within SBHC clinics; mental health services are provided by referral in sites that do not have in-clinic resources.

Through New York's innovative Successfully Transitioning Youth to Adolescence (STYA) program, funded through the federal Abstinence Education Grant Program, 17 community based organizations across NYS focus on implementation strategies to build protective factors for young people ages 9-12 living in high risk communities, including youth in foster care, youth with physical disabilities, and homeless and disconnected youth to promote a transition to a healthy, productive, connected adolescence. Mentors provides youth with support and information on a wide range of topics framed in a youth development philosophy, focusing on the needs of youth and building on and nurturing the youth's individuals strengths and needs. They provide adult-supervised activities to stimulate cognitive, social, physical and emotional growth. Group discussions occur to share information regarding topics of interest to pre-teen youth. Caring adults are available for more in-depth support and discussions. These programs also provide parent education to parent, guardians and adult caregivers to create a more nurturing environment for these youth. Title V staff will continue to work with these providers to promote social emotional development of NY's pre-teen population.

New York's Early Childhood Advisory Council (ECAC) will be a key partner to develop and implement strategies related to supporting children's social-emotional development. Formed in 2009, the ECAC is comprised of experts in education, health care, child welfare and mental health. Members represent state agencies, advocacy groups, foundations, higher education, unions and other key organizations concerned with the wellbeing of young children and their families. The Title V director serves on the Council and its Steering Committee, and several other key Title V staff members (from the Bureaus of Child Health, Early Intervention and Women, Infant and Adolescent Health) serve on the Council and/or its workgroups. Through the ECAC, significant work has been done to build a common understanding of the importance of social-emotional development among early childhood practitioners across many sectors, create educational messages and materials for parents and professionals on practices to nurture development and developmental screening and develop and integrate quality standards and measures related to social-emotional development for child care programs. Over the next five years, Title V staff will continue to be engaged in and help lead this work, with additional attention to how Title V can help advance relevant strategies. In addition, we will build on the expertise and products of this work to expand our focus to older children and youth, including continued collaboration with the state's Community Schools initiative (see below) and exploration of a potential public awareness campaign focused on social-emotional development and parenting practices.

A specific project currently underway is the convening by the ECAC and Early Intervention Coordinating Council (EICC) of a Joint Task Force on Social-Emotional Development. This Task Force has been charged with developing

guidance for the systems that provide care for infants and toddlers and their families - including early childhood education programs, Early Intervention and health and mental health care services - to assist them in partnering with families to support healthy social-emotional development of infants and toddlers. It is anticipated that this work will help articulate the unique roles as well as interrelationships between these sectors, including recommendations for identification, screening and treatment supports for children experiencing social-emotional developmental delays through the Early Intervention Program, in the coming year, as members and co-conveners of this Task Force, NY's Title V program will help inform the completion and implementation of these guidance documents.
New York's plan also recognizes that in order to improve the health and development of children it is imperative to support the health and well-being of parents, including those experiencing depression. Maternal depression is a serious and common problem that can impact both the mother's and child's well-being. Pregnant women and new mothers have frequent contact with the health care system – including both maternal and pediatric health care providers however providers may not know how to identify or address depression within their practices. In addition, women may be reluctant to raise questions with their providers because of stigma or lack of knowledge about depression. Over the next year, the Title V program, in partnership with the state Office of Mental Health, will lead efforts to increase awareness of this issue and the importance of screening and to strengthen capacity of relevant service providers and programs to provide supports and link families to services.

Additionally, our action plan continues a strong focus on promoting comprehensive preventive health care services for children, which includes attention to both access/utilization as well as quality of care. As stated previously, the Title V program oversees the largest School Based Health Center (SBHC) program in the country, providing preventive, acute, chronic disease management, reproductive health and mental health services to approximately 160,000 students annually; SBHC-dental (SBHC-D) programs provide preventive dental services to approximately 63,000 students annually. Effective July 2016, the provision of SBHC and SBHC-D services will be incorporated into the Medicaid Managed Care (MMC) benefit package, and Medicaid Managed Care Plans (MMCPs) will be responsible for reimbursing SBHC sponsor agencies for services provided by SBHCs to MMC enrollees. The goal of this transition is to maintain access to these critical SBHC services while integrating the services into the larger health care delivery system and strengthening the coordination of services to improve quality and effectiveness. Over the next year, Title V staff will continue to work closely with OHIP, including co-chairing a large workgroup of SBHCs, MMC plans and other stakeholders, to complete a policy paper and implement the transition to managed care. In parallel, and building on previous program work, Title V staff will work with SBHCs to develop and implement updated performance standards, measures and improvement strategies to improve the quality and sustainability of care for children and adolescents served through SBHCs.

Title V will also continue and enhance its role in leading the integration of health promotion and linkages to health care across other child-serving programs. The NYS Community Schools initiative, launched in 2014, was developed to transform schools in distressed communities into hubs for a wide range of support services for children and their families including health care, counseling, nutrition, job preparation and employment services. Community Schools emphasize family engagement and include strong partnerships with non-profit community-based organizations, local and state government agencies, higher education institutions, and the philanthropic and business communities. Title V staff were engaged in the initial design of Community Schools and have supported implementation by providing information and technical support to SED (as the lead implementing agency) and local grantees. Most recently, Title V staff coordinated a structured interactive workshop and open TA session for the first and second cohorts of Community Schools grantees, with participation from multiple public health and health insurance programs across NYSDOH. The Title V program will continue to connect with Community Schools to promote linkages to primary and preventive care, after school nutrition programs and other community health promotion resources.

Title V staff have also been involved in the development and implementation of health-related standards for child care

programs, including health and safety regulations as well as additional quality standards for QUALITYstarsNY, New York's tiered quality rating and improvement system for early learning programs. Building on this work, over the next year, Title V staff will coordinate a team of DOH staff to work with OCFS on the development of a quality indicators for regulated child care programs including those not reached to date by QUALITYstarsNY, which currently operates in a limited number of target communities.

Within DOH are numerous supports and services for young children, presenting continued opportunities for collaborations to link children to health care. Additionally, the multiple health systems reform efforts described in earlier sections create new opportunities for improving health care services for children through a combination of professional education, training and policy levers. Over the next year, the Title V program will further explore and pursue strategies to leverage these partnerships to improve preventive health care for children.

Child Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	33.2	35.6	38	40.4	42.8

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	27.1	27.5	27.8	28.1	28.5

The majority of NYS children are insured which increases their likelihood of accessing primary and preventive health care. NY provides insurance to nearly 2.2 million children. MA covers over 1.9 million children and nearly 300,000 children are covered by Child Health Plus (CHPlus). The NYSOH, a web-based eligibility and health insurance enrollment Marketplace opened 10/1/13 for enrollments effective 1/1/2014. The ACA made several changes to waiting periods in place under the Children's Health Insurance Program. Waiting periods can be no longer than 90 days in duration. In addition, NY added three new exceptions to its waiting period including children with special health care needs (CSHCN), children who lost coverage as a result of a divorce; and when the cost of family coverage is more than 9.5% of the household income. Exceptions are determined based on the applicant's responses to questions on the on-line application. In 2012 only 5.6 per cent of NY's children were uninsured as compared to 7.9 percent in 2010. As stated in Section IIA State Overview, NYS has devoted significant efforts to increasing awareness of, and enrolling individuals into health insurance.

Recognizing that health care coverage doesn't always equate with receipt of quality health care services, NY is committed to ensuring all children have access to health care coverage and health care services. In 2013, 82 percent of Medicaid enrolled children ages three to six years had a well- child and preventive health visit as compared to 83 percent in 2012 and 79 percent in 2010. A priority of DOH is improve children's access to primary and preventive health care. The DFH oversees the largest School-Based Health Center Program (SBHC) in the country that

improves access to comprehensive health care for children and adolescents in high-need areas. SBHCs provide preventive, acute, chronic disease management and mental health services through more than 680,000 health care visits to approximately 160,000 students annually. Effective July 1, 2016, the provision of SBHC and SBHC-Dental (SBHC-D) Services will be incorporated into the Medicaid Managed Care (MMC) benefit package, and reimbursement for SBHC services to Medicaid enrollees will be transitioned from current fee for service “carve out” to Medicaid Managed Care Plans (MMCPs). Starting in 2013-2014, DOH initiated ongoing meetings with SBHC and MMCP representatives to discuss the transition to MMC. The goal of this transition is to maintain access to these critical SBHC and SBHC-D services while integrating the services into the larger health care delivery system. It is anticipated that the integration of SBHC and SBHC-D services within the existing managed care framework and coordination of services with the child’s primary care provider will improve quality and promote an efficient, effective delivery system. Maintaining the continuity of care and the wellness of the child to facilitate learning and improved school attendance is of utmost importance in this transition.

DOH also oversees a strong childhood immunization program that works to prevent the occurrence and transmission of vaccine-preventable diseases by ensuring the delivery of vaccines to children and adults. The program assures that: all children have access to vaccines irrespective of financial status; adequate vaccine supplies are available for all primary health care providers; and that health care providers are aware of immunization standards of practice. During the past year, under the Assessment, Feedback, Incentives and eXchange (AFIX) quality improvement strategy used by DOH to raise immunization coverage levels and improve standards of practice, local health department (LHD) staff visited health care providers to assess immunization rates for compliance with the Advisory Committee on Immunization Practices (ACIP) vaccine recommendations. Provider immunization rates are assessed for the 4:3:1:3:3:1:4 series for all patients 19-35 months of age and for ACIP-recommended adolescent vaccines at 13 years of age. DOH Bureau of Immunization (BI) staff worked with LHD staff to assess and improve pediatric immunization rates by providing technical assistance and subject-matter experts via materials available on the NYSDOH public website and at statewide webinars. In 2013, 76.2 percent of 19 to 36 month old children had received the full schedule of age-appropriate immunizations against mumps, measles, rubella, polio, diphtheria, tetanus, pertussis, haemophillis influenza and hepatitis B as compared to 71.3 percent in 2010.

In 2014, NYS updated school immunization requirements to better reflect ACIP recommendations. DOH worked with the State Education Department and other partners to provide technical assistance to public and private schools, day care programs and pre-kindergarten programs to implement the new requirements.

Oral health is an integral aspect of primary and preventive health care (See Life Course Domain for further information regarding oral health). The SBHC- Dental Program (SBHC-D) ensures those students with limited or no access to care have access to preventive dental care through SBHC dental sites. Through fifty-six Article 28 facilities, the program provides dental services with mobile vans, portable equipment or in a fixed facility within the school in more than 1,200 schools that provide services to over 60,000 students. The primary objective the SBHC-D program is to increase the prevalence of dental sealants in second and third grade children. NY’s Oral Health Collaborative Systems grant through HRSA supports school-based primary and preventive care services. In NYS, third grade children received protective sealants on at least 1 permanent molar tooth in 2013 as compared to 41.9% in 2010-2011. Access to oral health services has also improved the past few years. In 2011 41.8 percent of Medicaid children and adolescents ages two to twenty-one years had at least one dental visit within the past year while 43.6 percent had a visit in 2013.

Fluoridation is recognized as a significant public health success in preventing dental caries. Legislation was recently passed in NY that established a $5 million grant program to support community water systems to receive funding for costs related to the construction, installation, repair, rehabilitation, replacement, or upgrade of drinking water fluoridation facilities. It also required notice of DOH as well as public notice for communities considering

discontinuation of community water fluoridation. DOH also promotes Fluoride Mouth Rinse (Supplemental Fluoride) Programs in schools that serve children without public water systems that provide a safe and effective method of reducing dental decay through the provision of fluoride to children living in non-fluoridated communities.

Childhood obesity has both immediate and long-term impacts. Children who are obese are more likely to experience obesity as adults. Obesity prevention is a priority of NYS to better ensure health across the lifespan. The Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the third largest WIC program in the country, offers nutrition education, breastfeeding support, referrals and a variety of nutritious foods to approximately 500,000 participants per month, through 93 WIC local agencies via a network of 500 service sites and approximately 1,500 local agency staff influence lifetime nutrition and health behaviors. The Child and Adult Care Food Program (CACFP) ensures that nutritious and safely prepared meals and snacks are available to children age 18 and under and to functionally impaired adults and senior citizens participating in eligible day care programs. More than 1,400 sponsoring organizations representing 14,000 licensed or registered center-based or family day care sites are participating statewide serving approximately 340,000 meals to children and adults each day. Statewide, the percent of WIC children consuming vegetables, fruits and whole grains was 83%, 93% and 65% respectively in 2014. Overall, children consume an average of 8% more vegetables, fruits and whole grains than adult participants.

In 2014, CACFP also partnered with the Office of Children and Family Services (OCFS) to develop training materials for over 4,000 non-participating DCH providers to comply with new child care regulations. The regulations require healthy beverages in child care and obesity prevention/wellness information for parents of 150,000 children enrolled in home-based care. CACFP provided nutritious meals to more than 340,000 children and disabled adults daily, an increase of 7.74%.
The Hunger Prevention and Nutrition Assistance Program (HPNAP) provides funding to 47 contractors and their 2,400 emergency food programs to provide nutritious food to supplement meals to those in need throughout NYS. These efforts appear to be making a significant impact on childhood obesity in NYS. In 2010, 31.4 percent of children ages 2 to 5 years receiving WIC services had a Body Mass Index (BMI) at or above the 85th percentile and 14.5 percent were obese (above the 95th percentile) as compared to 29.6 percent (85th percentile) and 13.9 percent (95th percentile) in 2013.
In addition to efforts to decrease obesity through breastfeeding and nutrition programs, DOH established programs to increase physical activity and improve nutrition among residents of NYS, with a focus on the prevention of childhood obesity. Program goals are achieved through policy, systems and environmental interventions in early child care, school, health care and community settings. Eat Well Play Hard in Child Care Settings (EWPHCCS) is a nutrition education and obesity prevention intervention in selected child care centers serving low-income children and their families. The EWPHCCS obesity prevention intervention reached over 16,000 children, their families and child care staff; 219 child care centers and 125 family DCH participated. A Farm to Preschool project was implemented in 25 child care centers where 2,500 parents purchased locally grown produce totaling $66,925. An evaluation of EWPH in Day Care Homes (DCH) showed providers purchased/served healthier foods, improved mealtime environments, and increased adult led indoor active play.

Healthy Schools New York (HSNY) provides technical assistance and resources to 180 school districts to establish healthful eating environments and daily physical activity opportunities, including physical education. The Healthy Eating and Active Living by Design (HEALD) Program implement community policy, systems and environmental changes in schools and communities to reduce risks for heart disease and obesity by increasing access to healthful foods and opportunities for physical activity. The Just Say Yes to Fruits and Vegetables Project (JSY) uses nutrition education workshops, food demonstrations and environmental strategies to improve access to healthier foods and physical activity.

NY has long-standing established efforts to address childhood asthma as evidenced by the slight decrease in the rate of hospitalization for asthma per 100,000 children and adolescents ages 0-17 years. In 2013 25.9 per 100,000 were hospitalized for asthma as compared to 27.1 per 100,000 in 2010. Asthma coalitions, serving geographic regions with a high burden of asthma, are funded to bring healthcare and community systems together to develop, implement, spread and sustain policy and system level changes aimed at improving asthma care and health outcomes. In 2014, the coalitions implemented 26 new projects in collaboration with their partners and through support from the Asthma Outcomes Learning Network. Performance across a core set of required process measures was monitored to assess improvement in care processes and health outcomes. In partnership with the regional asthma coalitions, the DOH Asthma Program implements the NYS Asthma Outcomes Learning Network designed to build quality improvement capacity and spread best practices.

DOH also updated the NYS Asthma Surveillance Summary Report and current NY regional, county and zip code level asthma surveillance data was made available to the Regional Advisory Councils (RACs) and other partners via this report, the DOH public website, and other reports and data summary documents. Focused technical assistance was provided to the RACs to assist in their utilization of this data. In addition, more than 5,700 hard copies of the "Clinical Guideline for the Diagnosis, Evaluation and Management of Adults and Children with Asthma", a NYS consensus asthma guideline decision support tool for health care providers, were distributed at no cost to health care providers, educators, health plans and community-based partners in NY.

NY's Childhood Lead Poisoning Prevention Program (LPPP) supports lead poisoning prevention surveillance, case coordination, and primary prevention. LHDs receive grant funds to target neighborhoods and housing most at risk for containing lead hazards. Three Regional Lead Resource Centers (RLRCs) in five teaching hospitals throughout NYS to provide expert clinical support, education and outreach to LHDs and health care providers to improve lead testing and other preventive practices.

Revisions to state regulations, effective 2009, authorized private physician office laboratories (POLs) and limited services registrant laboratories to conduct blood lead testing using point-of-care (POC) testing devices. More than 500 devices had been purchased in NYS as of the end of 2014, and over 40 new laboratories were contacted and trained on how to report the results. Over the past year, LPPP program staff continued to work with both physician office laboratories (POLs) and limited service laboratories (LSLs) that conduct blood lead testing using point-of-care blood lead testing devices. The LPPP program staff trained POLs and LSLs on how to accurately report the blood lead test results to DOH. The use of point-of-care testing has decreased one of the barriers in performing the required lead testing at ages 1- and 2-years-old by physicians. In 2012, 57.6 percent of NY's children were tested for lead two or more times by age three years. This is up from 53% in 2010.

DOH's Healthy Neighborhood Program (HNP) is designed to develop a comprehensive and holistic approach to addressing a broad range of housing hazards associated with lead poisoning, asthma, and injury prevention within their targeted communities. Residents of the dwellings are interviewed to determine their individual needs and a room-by-room visual inspection was conducted to identify peeling paint, carbon monoxide hazards, asthma triggers and fire hazards. Over the past year a total of 11,421 dwelling units were approached by HNPs statewide and 5,216 (45%) households had a home assessment initiated; 3,138 (60%) of the dwellings visited had a minority respondent; 2,208 (42%) dwellings visited did not have a functional smoke alarm on floors with living space; 1,639 (31%) households had children younger than six years old.

State and LHD staff conducted direct outreach to health care providers with low lead screening rates. Over the past year staff visited and inspected the interior of 31,615 housing units, inspected 10,678 units with confirmed or potential interior lead-based paint hazards, and made at least 7,759 units lead-safe through remediation of interior lead-based paint and lead-based paint dust hazards. (Potential interior lead hazards are those identified through

visual assessment alone. Confirmed interior lead hazards are hazards identified through sampling or testing, such as XRF measurement, paint chip sampling, among others).
The rate of deaths of children aged 14 years and younger in NYS caused by motor vehicle crashes has had a slight downward trend over the past few years. In 2010, there were 1.3 deaths per 100,000 children as compared to 1.1 per 100,000 in 2013. In 2014, the DOH-led Injury Community Planning Group (ICPG) focused on enhancing injury infrastructure in NY, including childhood and motor vehicle safety and the continued development of the NY Injury Action Plan. The Child Injury Prevention Policy Subgroup of the ICPG focused specifically on startegies to decrease childhood injuries. A major goal of this policy subgroup is to educate decision makers and public health professionals about safety benefits for children ages 12 and under to ride properly restrained in the back seat of a motor vehicle. NY law requires children to be properly restrained but does not require children to be in the back seat. In 2014, the DOH Bureau of Occupational Health and Injury Prevention (BOHIP) provided the Governors Traffic Safety Committee (GTSC) with fact sheets for all NY counties that demonstrated the injury burden for unrestrained passengers. The fact sheets were also distributed to all law enforcement agencies and posted on the NY State Police Intranet. The BOHIP in collaboration with the GTSC, the NYS Association of Chiefs of Police and the Federal Highway Administration conducted Pedestrian and Bicycle Law Enforcement Training to improve pedestrian and bicycle safety throughout Nassau County. The provision of this training resulted from the efforts of the Hempstead Turnpike Pedestrian Safety Team that was formed by the NYS Department of Transportation to address the high incidence of pedestrian injuries and fatalities over the past several years. DOH also collaborates with the NY Child Passenger Safety Advising Board to continue to develop outreach messages increase the number of children riding properly restrained in a motor vehicle and the NY Safe Routes to School Network, the NYS Association of Traffic Safety Boards, SAFE KIDS Worldwide and the NY Bicycle Coalition to promote helmet use at a variety of traffic safety and bicycling promotion events. The BOHIP works with these agencies to incorporate helmet distribution, helmet fitting and bicycle safety education at a variety of annual events. Event opportunities to incorporate bicycle helmet safety include, but are not limited to Safe Kids Week, child passenger safety check up events, or “Bike to School Day” events. Community-based home visiting and other maternal and infant health initiatives will continue to emphasize injury prevention and motor vehicle safety.

Finally, DOH spearheaded the Keeping Kids Alive Initiative. In collaboration with other state agencies, the program is working to develop a more comprehensive statewide child death review and prevention initiative. By partnering with these agencies the program helps coordinate child safety initiatives aimed at reducing the risk for future deaths. The program also provides public outreach and education about risk factors associated with sudden unexplained infant deaths (SUID). Although sleep-related SUID rates in Black, non-Hispanics and Hispanics have been decreasing, rates are 2.5 times higher in Black, non-Hispanics than White, non-Hispanics.
The SAFE Sleep Work Group of the Infant Mortality CoIIN is aimed at reducing infant deaths and relative racial disparities by 10% through a learning network of public and private partners.

Adolescent Health

Adolescent Health - Plan for the Application Year

Because New York’s selected priority to support adolescent’s social emotional development and relationships reflects an emerging area of MCH practice, many of the strategies to address this priority are developmental. Population and program data are needed to help drive and evaluate work in this arena, and as an initial strategy Title V staff will work with partners to assess all available data sources to identify or develop and monitor relevant measures, including potential additional state performance or outcome measures. This will include a careful analysis of the revised National Survey of Children’s Health when available.

A cornerstone of NY’s Title V adolescent health services is the Comprehensive Adolescent Pregnancy Prevention Program (CAPP), a statewide primary pregnancy prevention initiative which utilizes a youth development framework,

including comprehensive sexual health evidence-based programs and access to reproductive health care services, to promote health, reduce the risk of initial and repeat pregnancies, STDs and HIV among NYS adolescents, and reduce racial, ethnic, and geographic disparities that are related to adolescent sexual health outcomes. This also incorporates NY's Personal Responsibility Education Program (PREP) that work with youth in foster care and youth with emotional and behavioral problems. The Successfully Transitioning Youth to Adolescence (STYA) program provides mentoring, counseling and adult supervision programs designed to delay the initiation of sexual behavior among youth, ages 9-12, residing in high-risk communities. All these initiatives are based on evidence-based programming to achieve measurable outcomes. Title V will continue to support and promote CAPP initiatives. Experience has shown that all evidence-based programming may not meet the needs of the population receiving these supports and services or the model may require modification to achieve successful outcomes. In the coming year, Title V staff will work with the ACT for Youth Center of Excellence (ACT COE) through Cornell University to evaluate program outcomes and assess modifications to evidence-based programming in collaboration with program developers. The ACT COE evaluation will be used to inform new (CAPP) adolescent pregnancy prevention procurement for 2016 as Title V staff will be developing a new procurement based on a performance management structure supportive of evidence-based and best practice strategies. In addition, Title V staff will be assessing the impact of these services for adolescents with disabilities to ensure programming is meeting the needs of a diverse population and identifying steps to incorporate additional evidence-based startegies to address adolescent social emotional development, healthy relationships, wellness and health literacy through our adolescent programming.

An important aspect of NY's adolescent health services are comprehensive reproductive health services. NY's comprehensive family planning and reproductive health program consists of a state-wide network of 49 agencies in 168 sites, that provide women, men, and adolescents, especially low income individuals and those without health insurance, confidential contraceptive services, preconception planning and counseling, pregnancy testing and counseling, HIV testing and counseling, STD testing and treatment, screening for breast and cervical cancer, health education, and referral to primary and prenatal care and other preventative services. Over the past year, Title V staff led a performance improvement initiative with the family planning providers to increase the use of Long Acting Reversible Contraception (LARC). As stated in the annual report, this resulted in an increase in teens ages 15-17 and 18-19 who left a family planning visit with an effective contraceptive or a highly effective method of contraception. These efforts will continue in the coming year as well as a new performance management initiative to provide training and technical assistance to all family planning providers to conduct more effective and efficient outreach to engage individuals, including teens into family planning services.

NY is also home to the largest system of School Based Health Centers (SBHCs) in the nation providing preventive, acute, chronic disease management and mental health services through more than 680,000 health care visits to approximately 160,000 students annually. Both family planning agencies and SBHCs provide a significant opportunity to engage adolescents into reproductive health care. A continuing priority of Title V in NYS is to expand the reach of reproductive health services through the Family Planning Benefit Program (FPBP) that provides Medicaid coverage for confidential family planning services to individuals with incomes at or below 223 percent of the federal poverty level. FPBP provides an opportunity for adolescent to access confidential family planning services on an ongoing basis. In order for health care clinics and providers to participate in the FPBP, they must have a Memorandum of Understanding with the DOH. Title V staff have worked with these providers to increase their understanding of FPBP and increase the number of providers having a MOU. The SBHC program has implemented a performance improvement project specifically to increase the numbers of SBHCs that have a MOU and therefore have the ability to enroll more adolescents into the FPBP and obtain reproductive health care services.

Effective July 2016, the provision of SBHC and SBHC-D services will be incorporated into the Medicaid Managed Care (MMC) benefit package, and Medicaid Managed Care Plans (MMCPs) will be responsible for reimbursing SBHC sponsor agencies for services provided by SBHCs to MMC enrollees. The goal of this transition is to

maintain access to these critical SBHC services while integrating the services into the larger health care delivery system and strengthening the coordination of services to improve quality and effectiveness. Over the next year, Title V staff will continue to work closely with OHIP, including co-chairing a large workgroup of SBHCs, MMC plans and other stakeholders, to complete a policy paper and implement the transition to managed care. In parallel, and building on previous program work, Title V staff will work with SBHCs to develop and implement updated performance standards, measures and improvement strategies to improve the quality and sustainability of care for children and adolescents served through SBHCs.

NY's Pathways to Success program Title V's Pathways to Success initiative, supported with federal Pregnancy Assistance Funds through the Office of Adolescent Health, aims to create and sustain supportive communities that assist expectant and parenting adolescents and young adults travel pathways to success through health, education, self-sufficiency and strong families. Community partnerships are essential to the success of this program to ensure pregnant and parenting adolescents have the supports and services needed to become successful parents and individuals. Over the past year, Title V staff will be working with Pathway contractors to utilize the Partner tool to assess collaboration. Partner is a social network analysis tool designed to measure and monitor collaboration among people and organizations. The tool is sponsored by the Robert Wood Johnson Foundation and designed for use by collaboratives to demonstrate how members are connected, how resources are leveraged and exchanged, the levels of trust, and to link outcomes to the process of collaboration. Through this process, Title V and the contractors will have the capacity to understand how collaborative activity has evolved over time and assess progress made in regard to how community members and organizations participate in the effort to enhance services to this population. Lessons learned through Pathways will help to inform and expand other efforts to provide support for pregnant and parenting adolescents.

Addressing the complex issues and needs of NY's adolescents experiencing mental health issues is paramount to ensuring their health and well-being. Title V staff will continue to play a key role in defining the system of services related to behavioral health in the SBHC carve-in process as well as Health Home for Children. In the coming year, Title V staff will also further develop collaborative relationships with internal and external partners to strengthen NY's efforts to promote mental health services for adolescents. Title V staff will work with the Office of Mental Health, DOH Bureau of Occupational Health and Injury Prevention and other internal and external stakeholders to identify issues and strategies to improve and enhance mental health services for adolescents.

Adolescents are also particularly vulnerable to sexual violence and bullying. Through the Title V Sexual Violence Prevention Program, regional centers will continue to conduct sexual violence primary prevention community-level and individual-level change strategies to youth and young adults aged 10-24 years old and influential adults in the community who work closely with them. An emphasis is on evidence-based or promising practices to promote healthy relationships and/or decreasing bullying in adolescents and young adults, help parents, teachers and influential adults gain a greater understanding of the importance of building and modeling healthy, respectful relationships and challenging rigid gender roles, develop community-wide effort to prevent interpersonal violence and empower girls to seek healthy, supportive relationships, among others. Title V staff will also focus on the development of sexual violence prevention programs on selected college campuses to prevent rape and sexual assault that impacts students health and mental health and overall well-being.

Adolescents tend to seek health care as needed for specific health issues rather than engaging in primary and preventive health care practices. DOH has a rich system of health services that may not be consistently sensitive to the unique needs of adolescents or accessed by adolescents for a variety of reasons. In order to ensure all health care providers and addressing the needs of NY's adolescents based on quality standards of care, Title V will lead efforts to collaborate with the Office of Health Insurance Programs, Office of Quality and Patient Safety, other DOH partners that provide services to adolescents such as the Divisions of Chronic Disease Prevention and Nutrition, SBHCs, family planning providers, external partners and others to identify and advance strategies to increase

adolescents' access to primary and preventive care and ensure that the care provided is in accordance with standards of care to best meet the needs of this unique population.

Adolescent Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	27.1	27.5	27.8	28.1	28.5

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	94.9	95.6	96.2	96.9	97.6

Adolescent pregnancy rates in NYS are at an all-time low. For adolescents 15 through 17 years of age, the rate has dropped from 11.2 per 1,000 in 2010 to at 8.2 per 1,000 in 2013. DOH's Comprehensive Adolescent Pregnancy Prevention Program (CAPP) is a statewide primary pregnancy prevention initiative which utilizes a youth development framework, including comprehensive sexual health evidence-based programs and access to reproductive health care services, to promote health, reduce the risk of initial and repeat pregnancies, STDs and HIV among NYS adolescents, and reduce racial, ethnic, and geographic disparities that are related to adolescent sexual health outcomes. Funding supports 50 community-based organizations throughout NYS in high-need communities. Through federal funding from HHS Administration on Children and Families HHS Administration on Children and Families, the Personal Responsibility Education Program (PREP) supports programs that are part of the statewide adolescent primary prevention initiatives as well as a program working with youth in foster care and youth with emotional and behavioral problems. In 2014, CAPP and PREP provided evidence-based program (EBPs) to over 25,000 adolescents.

The Successfully Transitioning Youth to Adolescence (STYA) is supported through the federal Abstinence Education Grant Program and supports community-based organizations that provide mentoring, counseling and adult supervision programs designed to delay the initiation of sexual behavior among youth, ages 9-12, residing in high-risk communities. The ACT for Youth Center of Excellence ACT COE) through Cornell University provides essential support to the adolescent health initiatives, specifically related to promoting optimal sexual health for all young people in the state. In 2014, DFH implemented a performance management approach to many initiatives, including CAPP, to monitor participant dosage at Evidence-Based Programs (EBP) (100% of youth participants in EBPs complete 75% or more of the EBP sessions). The ACT COE monitored performance and reported to DOH quarterly. Tools were developed by ACT COE to assist programs to improve attendance and meet performance measure, including on-line implementation course for new educators and an attendance toolkit. There has been a 4% increase in participant dosage since the implementation of this process. One additional organization funded through PREP was chosen to participate in the Federal Impact Evaluation Study to evaluate their adolescent pregnancy prevention program as an EBP.

Title V's Pathways to Success initiative, supported with federal Pregnancy Assistance Funds through the Office of Adolescent Health, aims to create and sustain supportive communities that assist expectant and parenting adolescents and young adults travel pathways to success through health, education, self-sufficiency and strong families. Over the past year, Title V staff have worked collaboratively in three target communities in the Bronx, Erie and Monroe Counties through public school districts, community colleges and one academic research institution, namely Hostos Community College, Monroe Community College, Erie Community College, Fund for Public Health NY, Buffalo Public Schools, Rochester City School District, and Cornell University (ACT for Youth Center of Excellence). Emphasis has been on the development of strong collaborative relationships among various organizations in the community to promote a systems based approach to support and services for these adolescents. Served 291 high school and 356 community college students, 766 total. 60 were expectant and 455 were parenting students (remainder had unknown status). 647 Female, 119 Male, and 32 children of students were served by our programming.

As stated previously, the DFH oversees the largest School-Based Health Center Program (SBHC) in the country that improves access to comprehensive health care for children and adolescents in high-need areas. SBHCs provide preventive, acute, chronic disease management and mental health services through more than 680,000 health care visits to approximately 160,000 students annually. Effective July 1, 2016, the provision of SBHC and SBHC-Dental (SBHC-D) Services will be incorporated into the Medicaid Managed Care (MMC) benefit package, and reimbursement for SBHC services to Medicaid enrollees will be transitioned from current fee for service "carve out" to Medicaid Managed Care Plans (MMCPs). Starting in 2013-2014, DOH initiated ongoing meetings with SBHC and MMCP representatives to discuss the transition to MMC. The goal of this transition is to maintain access to these critical SBHC and SBHC-D services while integrating the services into the larger health care delivery system. It is anticipated that the integration of SBHC and SBHC-D services within the existing managed care framework and coordination of services with the child's primary care provider will improve quality and promote an efficient, effective delivery system. Maintaining the continuity of care and the wellness of the child to facilitate learning and improved school attendance is of utmost importance in this transition.

NY's comprehensive family planning and reproductive health program consists of a state-wide network of 49 agencies in 168 sites, that provide women, men, and adolescents, especially low income individuals and those without health insurance, confidential contraceptive services, preconception planning and counseling, pregnancy testing and counseling, HIV testing and counseling, STD testing and treatment, screening for breast and cervical cancer, health education, and referral to primary and prenatal care and other preventative services. Over the past year, family planning programs served 53,057 clients between the ages of 13-19 in 2014, which represents 17.2% of all clients served. In addition, DFH led a performance improvement initiative with the family planning providers to increase the use of Long Acting Reversible Contraception (LARC). As a result, the percent of teens ages 15-17 and 18-19 who left a family planning visit with an effective contraceptive method increased 6 % and 5.2% respectively from 2013 to June 2014; and increased 2.1% and 1.7% respectively for a highly effective method.

Obesity is a cross-cutting health issue that impacts all populations across the lifespan, including adolescents. There has been a slight improvement in this issues in NYS related to adolescents the past few years. In 2010, 25.7 percent of high school students were overweight or obese as compared to 24.4 in 2013 which remains above the HP 2020 target of 16.1 percent. The Healthy Schools New York (HSNY) initiative (discussed previously in the Child Health domain) also targets adolescents and provides technical assistance and resources to 180 school districts to establish healthful eating environments and daily physical activity opportunities, including physical education. The Healthy Eating and Active Living by Design (HEALD) Program implement community policy, systems and environmental changes in schools and communities to reduce risks for heart disease and obesity by increasing access to healthful foods and opportunities for physical activity. The Just Say Yes to Fruits and Vegetables Project

(JSY) uses nutrition education workshops, food demonstrations and environmental strategies to improve access to healthier foods and physical activity.

DOH has and continues to lead very successful youth smoking cessation initiatives. The rate of high school students smoking declined from 11.9% in 2012 to 7.3% in 2014, a 39% decrease.
The percentage of high school students who smoked cigarettes in the last month has been declining as well from 12.6 percent in 2010 to 11.9 percent in 2012. DOH- funded community-based contracts, that cover every county in NYS, included a youth action component, Reality Check (RC), to engage youth in civic action to denormalize and deglamorize smoking in their communities and drive down youth smoking rates, with a focus on point of sale (POS) and tobacco-free media. Over the past year, RC contractors and youth held local events on “Kick Butts Day” that garnered earned media. RC contractors and youth also held a Twitter chat with U.S. and Canadian youth to discuss the desired Motion Picture Association of America R-rating for smoking imagery in movies. Tweets had a reach of nearly 6,000 with 13,771 timeline deliveries through retweeting and other social media uses. RC contractors and youth also attended Philip Morris International Inc.’s annual shareholder meeting. Some youth spoke on behalf of the problem of POS and youth smoking, while the rest participated in street advocacy activities. The DOH Bureau of Tobacco Control director testified before the NY Senate health committee on adding electronic cigarettes in NY’s Clean Indoor Air Act, the need to regulate liquid nicotine, which often contain youth-attracting flavors and scents, and the questionable and unproven use of Electronic Nicotene Delivery Systems (ENDs) as a harm reduction method in light of existing and proven cessation therapies.

The NY Education Department (NYSED) conducted the Youth Risk Behavior Surveillance System (YRBS) in 2013 and CDC published in 2014. There were no statistical differences in questions about youth use between 2011 and 2013; however, more youth in 2009 were likely to try cigarette smoking and identified as current smokers and tobacco users than in 2013.
DOH published a summary on data analyzed from the 2000 through 2012 NYS Youth Tobacco Survey (ATS) to look at trends in any current tobacco use (cigarettes, smokeless tobacco, cigars or hookah) over time, including the use of on at least one day in the past 30 days. Cigarette use declined significantly to 11.9% in 2012, but other tobacco product use rose to 16.7% in 2012. Any tobacco use has declined since 2000, but is beginning to plateau (21.8% in 2012). DOH also revised and submitted a draft Youth Tobacco Survey to its contacted independent evaluator to use to recruit of schools for the 2014 survey. The 2014 survey was expanded to capture the use, interest in and attitudes toward electronic cigarettes. The survey was completed with 8,262 students participating from 73 schools in 34 school districts completed surveys. Information gleaned with inform future anti-smoking cessation efforts.
Many mental health problems emerge in late childhood and early adolescence. Recent studies have identified mental health problems, in particular depression, as the largest cause of the burden of disease among young people. Poor mental health can impact health and development of adolescents and is association with several health and social outcomes such as higher alcohol, tobacco and illicit substances use, adolescent pregnancy, school drop-out rates and delinquent behaviors.
OMH’s Suicide Prevention Office (SPO) was established in May 2014 to oversee all aspects of a comprehensive and coordinated approach to suicide prevention in NYS. SPO is aligned with the guidelines offered by the National Action Alliance for Suicide Prevention, and committed to advancing the Zero Suicide approach in health and behavioral care. SPO works in concert with key stakeholders, including the Center for Practice Innovation (CPI). Under the direction of Dr. Barbara Stanley, CPI adds its core competency in implementation of evidence based practices to the statewide efforts, particularly in the area of clinical training. In addition, SPO relies on the operational support of the Suicide Prevention Center of New York (SPCNY) which has been instrumental in coordinating and providing gatekeeper training throughout NYS.

The NYSDOH Bureau of Occupational Health and Injury Prevention (BOHIP) and the NYS Office of Mental Health

(OMH) worked collaboratively to develop research opportunities to enhance efforts to address suicide in the population. Under the leadership of OMH, NY continued a major Suicide Prevention (SP) Initiative. OMH provided Prevention, Intervention and Postvention Curriculum to schools throughout NYS. OMH added Nassau and Suffolk Counties to its Garret Lee Smith "Caring and Competent Suicide Prevention Counties." OMH added a major behavioral health provider, Federation Education Guidance Services, to its Zero Suicide Collaborative; this agency serves over 40,000 children and families in NYC and Long Island. OMH worked with the NY Army National Guard (NYANG) family readiness groups to improve family awareness of suicide prevention, intervention and postvention supports. OMH provided Creating Suicide Safety in Schools workshops and its Lifelines program. All SBHCs continue to address the mental health needs of enrolled students, either directly or by referral.

Adolescents are also particularly vulnerable to sexual violence and bullying. DOH is currently funding six Regional Centers for Sexual Violence Prevention (Regional Centers) who are conducting sexual violence primary prevention community-level and individual-level change strategies to youth and young adults aged 10-24 years old and influential adults in the community who work closely with them. Three out of the six Regional Centers are conducting activities with adolescents and young adults on healthy relationships and/or decreasing bullying. One Regional Center is providing educational programs for parents, teachers and influential adults on building and modeling healthy, respectful relationships and challenging rigid gender roles. Another Regional Center has initiated "Working Group on Girls'" which is a community-wide effort to prevent interpersonal violence and empower girls to seek healthy, supportive relationships. This center is also working with LGBTQ youth providing a Healthy Relationship Skills curriculum. Another is developing a healthy relationship, social norms project to be implemented with middle and high school youth using PhotoVoice Participatory Photography for Social Change as a tool for communication, self-expression, advocacy, and social change. The RCSVPP developed and distributed a toolkit which provides an overview of existing programs and resources designed for youth that utilize the bystander intervention approach. Reducing teen suicide and promoting mental health were selected as priority areas of focus in the 2013-17 NYS DOH Prevention Agenda.

Children with Special Health Care Needs

Children with Special Health Care Needs - Plan for the Application Year

Similar to the child health domain, to build NY's Title V efforts in improving health outcomes for CSHCN, Title V staff will continue to assess all available data sources to inform public health improvement strategies. This will include a careful analysis of the revised National Survey of Children's Health/CSHCN when available. In addition, performance measures may be developed, based on available data to ensure strategies developed to address identified issues are improving CSHCN health outcomes.

Developing a comprehensive, coordinated, seamless system of supports and services for CSHCN and their families is imperative to promote health, wellness and self-sufficiency. NY is fortunate to have extensive supports and services for CSHCN in NYS. This includes NY's Newborn Screening Program (NBSP) that performs blood testing and processes the data from over 275,000 specimens annually for 49 diseases and conditions, including all core conditions recommended by the American College of Medical Genetics and the March of Dimes. Follow-up is provided through specialty centers located throughout NYS.

All birthing facilities conduct hearing screening on all babies born in NYS. Improving loss to follow-up is important to ensuring these children receive the assessment and services in a timely manner to promote their growth and development. Through a three-year quality improvement (QI) grant from HRSA, the Title V program will coordinate a quality collaborative with birthing hospitals to improve reporting of hearing screening into the statewide information system, and to identify root causes for loss to follow-up and solutions to reduce it by 5% each year over the three-year grant. A statewide QI team of stakeholders, including parents and a young adult who is deaf, will provide

guidance and expertise to the initiative.

NY is home to the largest Early Intervention Program in the country, providing services to more than 65,000 infants and toddlers and their families statewide. Ensuring quality supports and services to CSHCN and their families is extremely important to promoting positive health and development. Over the past year, the EIP pursuant to a requirement of the U.S. Department of Education, Office of Special Education Programs (OSEP) developed a State Systemic Improvement Plan (SSIP). OSEP required that the SSIP be focused on a child outcome, family outcome, or on a constellation of outcomes related to the child and family outcome indicators currently reported to OSEP. Extensive data analyses and synthesis were required to prepare the SSIP including more than a decade of child and family outcomes data collected on families of children in the EIP. Based on this work, and with support of NY stakeholders including the NY's Early Intervention Coordinating Council (EICC), a decision was made to focus on positive family outcomes for NY's State Identified Measurable Results. The goal will be to increase the percentage of families exiting the EIP who report that the EIP helped them achieve the level of positive family outcomes defined in conjunction with stakeholders as representing the State standard. A state-level advisory council, including state agency, provider and family membership, will guide the project. Over the next year, the DFH will use the Institute for Healthcare Improvement (IHI) Breakthrough Series Model to work with local counties, responsible for local implementation of early intervention services, as well with providers and families to improve family-centered practices. The goals of this initiative will be to ensure providers use family-centered practices in delivering early intervention services, and that families are engaged as partners and meaningfully involved in promoting their children's development. Lessons learned from this initiative will inform other programs and initiatives to better meet the needs of families of CSHCN.

NY has been a leader in the development of effective services for children with autism spectrum disorders (ASD) as far back as 1996 with the development of clinical practice guidelines for children with autism/pervasive developmental disorders. As stated previously, starting in 2014 NYS law required insurers to cover services for individuals with autism spectrum disorders (ASD), including Applied Behavior Analysis (ABA). Regulations were then adopted that established standards for EIP providers of ABA services. NY's Title V program will continue to spearhead efforts to screen and identify children birth through age three with ASD to provide an opportunity for early intervention and supports for the family. Findings from the HRSA-funded autism research grant will inform this work.

NY's CSHCN Program assists CSHCN birth to 21 and their families in accessing necessary health care and related services; promote "medical homes" for the provision of high-quality health care services that meet the needs of children and families; and, develop partnerships with families of children with special health care needs that involve them in program planning and policy development. Local CSHCN programs obtain family input to inform plans to improve services. To supplement these services, the Physically Handicapped Children's Program (PHCP), operating in 31 counties in NYS, provides reimbursement for specialty health care for severe chronic illness or physically handicapping conditions in children. Medical equipment, office visits, hospitalizations, pharmaceuticals, and other health-related services can be reimbursed for children meeting county financial and medical eligibility criteria. An important aspect of this program, the Dental Rehabilitation Program (DRP) provides children with physically-handicapping malocclusions access to appropriate orthodontic services. The DRP provides both diagnostic/evaluative and treatment services and is open to children under the age of 21 in counties participating in PHCP. In 2013, 157 children received an evaluation and 657 received treatment services. Through the CSHCN program, 1,171 CSHCN and their families received support and services. This is undoubtedly a small fraction of the CSHCN in NYS.

Another "piece" to the CSHCN puzzle in NYS is Health Homes for Children. An extremely important role that NY's Title V program has, and will continue to play in the future is ensuring the needs of CSHCN are addressed in Health Home for Children. As stated previously, to enhance services for CSHCN and their families, DOH (including the Office of Health Insurance Programs, the Center for Community Health, Division of Family Health and the AIDS Institute) and State Agency partners (the Office of Mental Health, the Office of Alcoholism and Substance Abuse

Services, and the Office of Children and Family Services) have been working collaboratively to develop Health Home (HH) for Children. The HH will provide care management to children with Medicaid who have complex physical and/or behavioral health conditions under the NYS HH model as tailored to serve the unique needs of children.

NY's Title V program has been intimately involved with the development of eligibility criteria and determination, care management model and service delivery system to ensure NY's HH best meets the needs of CSHCN. To achieve the goal of ensuring eligibility condition-based criteria captures high need children's populations, including Medically Fragile Children with complex health issues, children in foster care, children with Serious Emotional Disturbance, children enrolled in "Waiver" programs and other case management programs, NYS is proposing to Centers for Medicare and Medicaid Services (CMS) to modify HH eligibility criteria to include trauma as defined as "exposure to a single severely distressing event, or multiple or chronic or prolonged traumatic events as a child or adolescent, which is often invasive and interpersonal in nature.

Health Homes will expand the availability of care management from the limited population of children served by "waivers" (e.g., Bridges to Health) and targeted case management programs (approximately 12,000 children) to potentially 150,000-200,000 children across the Medicaid population that have unique needs and may qualify and be appropriate for HH. HH provide an opportunity to establish critical linkages and help break down silos of care of by linking systems and programs (education, child welfare, Early Intervention) to comprehensive care planning.

In the coming year, Title V staff will continue to work with OHIP and key stakeholders to ensure children ages birth to 3 with developmental delay or disability in the EIP who are eligible for Health Home have a smooth transition in that system. Much work is to be done to ensure Health Home care managers can provide the supports and services required by the federal Individuals with Disabilities Education Act Part C and state law and regulations. Similarly, systems must be designed to ensure that those children in Health Home are referred to the EIP when potentially eligible for those services. The Title V program will work with OHIP and others to guide the development of policies and procedures as well as training that will be necessary to ensure that all CSHCN and their families receive the highest quality supports and services from agencies approved to serve a Health Homes.

As with any child, ensuring quality, supportive child care is important to supporting a child's growth and development. As stated in the Child domain section (above), over the next year, the Title V program will be working with OCFS on the development of a set of quality indicators for regulated child care programs. These standards will reflect best practice approaches in health and education, will be developmentally and culturally relevant to ensure children, including CSHCN, in these settings receive high quality care.

The Title V program also oversees the Genetic Services Program that provides genetic counseling services ensure that individuals affected with, at-risk for transmitting, or concerned about a genetic disorder are able to make informed health decisions, and that all such individuals are provided access to comprehensive genetics services including screening, diagnosis, counseling and preventive services.

Transition of CSHCN to adult services continues to be a challenge in NYS. Local CSHCN programs will continue to provide adolescents with information about transitions to adult services. The Title V program also oversees a sickle cell transition programs to provide supports and services for young adults with sickle cell disease and other hemoglobinopathies to adult medical care. These providers serve as "transition navigators," to assist the adolescent make a successful transition to an adult hematologist or other adult medical care provider. They also focus on providing these adolescents with the skills they need to successfully transition to adult care as evidenced by evaluation of readiness and follow-up post transition for satisfaction with care. Experience gleaned through this initiative will help inform future planning regarding CSHCN as discussed below.

Involving families and individuals served by Title V programs and initiatives is important to ensure services are meeting their needs. All funded programs are required to obtain input in a variety of ways including on local groups

and advisory boards, through interviews, surveys, among others. Key state advisory committees under the purview of Title V have family representation including the EICC. The DFH is seeking to replace the parent representative on the MCHSBG Advisory Council as the previous parent representative has resigned.

Providing the skills and supports families need to navigate the service system, become advocates for their family and future MCH leaders is an important role of Title V. As stated in the annual report section, the Family Initiatives Coordination Services Project in the BEI coordinates the development and implementation of a variety of family initiatives which train parents involved in the EIP to become advocates for special needs children at local, state and national levels. This initiative will continue to build tomorrow's family leaders. The CSHCN program will continue to work with Parent to Parent of NYS to obtain input regarding the needs of CSHCN and input into how to improve the system. Family involvement will be an important aspect of building a more coordinated system for CSHCN and their families as discussed below.

Creating a more seamless, comprehensive system of care and support for CSHCN and their families is one of NY's challenges for the coming year and the future. CSHCN and their families require access to health services and supports that take into account their overall growth and development as well as specialized needs. These services may include pediatric specialty
and subspecialty care, family support services, including respite care, early intervention, special education and related habilitative and rehabilitative services. In addition, while receiving these specialized services, it important to keep in mind that CSHCN will need the same life course information, supports and services as other children need to grow into healthy, well-adjusted adults, including but not limited to, life skills and reproductive health.

A major challenge for families of CSHCN in NY is accessing an often-fragmented system of care. The needs assessment reflected some of these challenges. Specialty services may not be coordinated with primary care or other community-based services, and coverage for services is not comprehensive. The size and diversity of NY presents additional challenge to designing an effective system that works for all families. Even with health reform, NY's CSHCN and their families may still face challenges of underinsurance, coordination of care, access to a medical home, and transition to adult services. In order to effectively improve the health and well-being of NY's CSHCN and their families, it is imperative to work with professionals, families and other stakeholders to take stock of the services that currently exist and identify areas for improvement. Over the next year, Title V staff will carefully assess the initiatives in NYS that provide support to CSHCN and their families for the purpose of developing a comprehensive strategy to coordinate across services systems to better ensure CSHCN and their families have care that is comprehensive, coordinated, family-centered, and culturally sensitive that best meets their needs.

Impacting policy is a major role that is played by the Title V program in NYS. For example, effective April 2014, NYS public health law was amended to add coverage for outpatient blood clotting factor concentrates and other necessary treatments/services for persons with hemophilia under the CHPlus program. Title V staff will continue to seek opportunities to ensure CSHCN and their families receive the needed supports and services and gaps in coverage for needed services are addressed.

Children with Special Health Care Needs - Annual Report

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	41.9	42.4	42.6	42.9	43.3

The proportion of children reported by their parents to have a special health care needs has been slowly increasing in NYS from 17% in 2003 to 20.8% in 2011/2012. It is unclear if this is a valid increase or improved reporting. The proportion of children with a medical home has remained stable since 2003 and was 53.3% in 2011/2012 approximately 8.9 percentage points lower than the HP 2020 target of 63.3%. However, children with special health care needs (CSHCN) are less likely than well children to have a medical home. Approximately 38.4% of NYS CSHCN have a medical home in 2009-2010 compared to the 43% of CSHCN in the US. NYS has a long-standing history of striving to improve health and supportive services for CSHCN and their families. Since 2010, NYS has made incentivized payments to MA medical providers who offer a higher level of coordinated primary care as recognized by the National Committee for Quality Assurance's Patient Centered Medical Home (PCMH). Payments are made either through increased capitation of MA Managed Care (MMC) plans or fee-for-service PCMH "add-ons" for qualifying visits. Nearly 4,500 NYS providers are recognized by NCQA as PCMH, the largest number in any state.

To enhance services for CSHCN and their families, DOH (including the Office of Health Insurance Programs, the Center for Community Health, Division of Family Health and the AIDS Institute) and State Agency partners (the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office of Children and Family Services) have been working collaboratively to develop Health Home (HH) for Children. The HH will provide care management to children with Medicaid who have complex physical and/or behavioral health conditions under the NYS HH model as tailored to serve the unique needs of children.
The HH model was implemented in NYS in 2012 with 33 HH serving every county in NYS. NYS initially implemented the HH program by prioritizing the enrollment of adults. This approached allowed NYS to establish the HH infrastructure and subsequently tailor that infrastructure to recognize the differences between children and adults by: tailoring the eligibility criteria for HH; and, expanding the networks of existing HH and potentially new HH serving children to ensure HH and their provider networks accommodate the special needs of children. These needs include care managers with expertise in serving children, networks of providers that meet special needs of children with chronic and complex conditions (pediatricians, children's specialty providers), linkages to systems and programs that care for an interface with children (education, child welfare, juvenile justice); and, tailoring the delivery of the six core HH services to the needs of children and their families
The DFH has been intimately involved with the development of eligibility criteria and determination, care management model and service delivery system to ensure NY's HH best meets the needs of CSHCN. To achieve the goal of ensuring eligibility condition-based criteria captures high needs children's populations, including Medically Fragile Children with complex health issues, children in foster care, children with Serious Emotional Disturbance, children enrolled in "Waiver" programs and other case management programs, NYS is proposing to Centers for Medicare and Medicaid Services (CMS) to modify HH eligibility criteria to include trauma as defined as "exposure to a single severely distressing event, or multiple or chronic or prolonged traumatic events as a child or adolescent, which is often invasive and interpersonal in nature. Trauma includes complex trauma exposure which involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse." A child or adolescent who has experienced trauma would be defined to be at risk for another chronic condition if they have one or more functional limitations that interferes with their ability to function in family, school, or community activities, or they have been placed outside the home. Functional limitations are defined as "difficulties that substantially interfere with or limit the child in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills, or for a child who experienced trauma due to child maltreatment, a functional limitation is defined as a serious disruption in

family relationships necessary for normal childhood growth and development."

Health Homes will expand the availability of care management from the limited population of children served by "waivers" (e.g., Bridges to Health) and targeted case management programs (approximately 12,000 children) to potentially 150,000-200,000 children across the Medicaid population that have unique needs and may qualify and be appropriate for HH. HH provide an opportunity to establish critical linkages and help break down silos of care of by linking systems and programs (education, child welfare, Early Intervention) to comprehensive care planning.
Current eligibility criteria is condition-based in accordance with ACA requirements and includes: at least 2 chronic conditions (e.g., substance abuse disorder, diabetes, asthma, heart disease, over weight (BMI> 25), hypertension); or serious mental illness; or, HIV/AIDS; and must be "appropriate" for Health Homes (i.e., need intensive care management and coordination). Over the past year, in addition to the design of HH, DFH staff have been involved in discussions regarding the transition of infants and toddlers birth through age 3 into HH and ensuring care management/service coordination is provided to best meet the needs of infants those children and their families and also in accordance with Part C of IDEA. DOH released a Request for Applications for entities to serve as HH for children. Applications were submitted and DFH staff participated in the review of these applications. The enrollment of children in HH will begin October 2015. DFH will continue to be involved in the implementation of HH for Children and ongoing training and education of care management staff.
The first few years of a child's life are a particularly sensitive period in the process of development, laying a foundation in childhood and beyond for cognitive functioning; behavioral, social, and self-regulatory capacities; and physical health. However, many children face stressors in their early years that can impact their healthy growth and development. Early childhood intervention programs are designed to mitigate the factors that place children at risk of poor outcomes. Such programs provide supports for the parents, the children, or the family as a whole.
NY's Title V director and Co-director of the BEI actively participate in NY's Early Childhood Advisory Council (ECAC). The ECAC was formed in 2009 to provide counsel to the Governor on issues related to young children and their families. The mission of the ECAC is to provide strategic direction and advice to NYS on early childhood issues. By monitoring and guiding the implementation of a range of strategies, the ECAC supports NY in building a comprehensive and sustainable early childhood system that will ensure success for all young children. Members represent state agencies, advocacy groups, foundations, higher education, unions and other key organizations concerned with the wellbeing of young children and their families, as appointed by the Governor. Over the past year, a major focus of this group has been on developing supportive systems to foster children's social-emotional development, including the establishment of a joint task force with the EICC.
The DFH is home to the largest Early Intervention Program (EIP) in the nation. EIP is a statewide service delivery system for infants and toddlers (birth to three years) with disabilities and their families. Its mission is to identify and evaluate those children whose healthy development is compromised and provide appropriate interventions to improve child and family development. The EIP currently provides services to more than 65,000 infants and toddlers and their families statewide. Through grant funding, the DFH has undertaken efforts to improve awareness and identification of autism to ensure children are identified and receive services as early as possible. Starting in 2014, NYS law required insurers to cover services for individuals with autism spectrum disorders (ASD), including Applied Behavior Analysis (ABA). Regulations were then adopted that established standards for EIP providers of ABA services.
NY's ¬CSHCN Program provides funding to Local Health Departments (LHDs) to provide services to CSHCN birth to 21 and their families. The local CSHCN Programs assist families in accessing necessary health care and related services; promote "medical homes" for the provision of high-quality health care services that meet the needs of children and families; and, develop partnerships with families of children with special health care needs that involve them in program planning and policy development. Local CSHCN programs obtain family input to inform plans to improve services. Families of CSHCN were asked "How easy is it to get information & help from staff?" 81% stated "always easy"; 16% stated "sometimes easy" & almost 2% stated "never easy". DFH staff have regular contact with

CSHCN programs to share information and promote improvement activities. During the past year, CSHCN programs also provided adolescents with information about Healthy Transitions and a health summary document. Information regarding transition resources were made available on DOH's website.

Ensuring access to needed health and supportive services is important in the health and development of CSHCN. In NYS, all SSI beneficiaries are categorically eligible for Medicaid. For CSHCN in the EIP with SSI, the local EIP reimburses for those services not covered by MA.
To supplement these services, the Physically Handicapped Children's Program (PHCP), operating in 31 counties in NYS, provides reimbursement for specialty health care for severe chronic illness or physically handicapping conditions in children. Medical equipment, office visits, hospitalizations, pharmaceuticals, and other health-related services can be reimbursed for children meeting county financial and medical eligibility criteria. In 2013, 157 children received an evaluation and 657 received treatment services. Service categories were orthodontia; medications; durable medical equipment/ supplies and hearing aids. An important aspect of this program, the Dental Rehabilitation Program (DRP) provides children with physically-handicapping malocclusions access to appropriate orthodontic services. The DRP provides both diagnostic/evaluative and treatment services and is open to children under the age of 21 in counties participating in PHCP. The DFH is also a strong partner with OHIP in the development of Health Home for children. (Refer to the State Overview for further information.)

DOH is a strong advocate to ensure all children and their families receive the supports and services necessary to live healthy, productive lives. For example, promoting changes in law and policy is paramount. Effective April 2014, NYS public health law was amended to add coverage for outpatient blood clotting factor concentrates and other necessary treatments/services for persons with hemophilia under the CHPlus program.

The Family Initiatives Coordination Services Project in the BEI coordinates the development and implementation of a variety of family initiatives which train parents involved in the EIP to become advocates for special needs children at local, state and national levels. Activities that are carried out through this program which provides leadership training to parents who have children eligible for the EIP, include the following:
• Assisting in orienting and preparing family members of the Early Intervention Coordinating Council (EICC)
• Participate in ad hoc early intervention activities in support of families
• Sponsor the attendance of family leaders at relevant national conferences
• Develop family-friendly materials that complement Department issued EIP policy guidance
• Plan and deliver the Early Intervention Partners training for parents.
• This nationally renowned leadership training project helps parents of various diverse backgrounds to learn more about opportunities for parent involvement with the EIP. The training sessions provide information, resources and skill-building activities designed to increase advocacy and leadership skills.
• Training consists of three consecutive weekend sessions for parents that are offered twice per year in different locations throughout New York State. It is expected that parents will attend all three sessions. The first session is provided as an interactive webinar where information is provided to parents and they are given opportunities to participate in "chat" activities to develop work products. The second and third session is in person training which consists of training provided by parents who are members of the EICC, and include group activities, some informal lecture, small groups working with parent's Early Intervention officials, interaction with a Department policy maker and other speakers who provide leadership and advocacy training.
• Eighty-four parents in the Partners Training sessions over the past year.

Parents are also members of the EI Coordinating Council as well as the MCHSBG Advisory Council.

Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application Year

The landscape of health insurance has changed dramatically over the last couple years and continues to evolve. Title V staff play a significant role in advocating to ensure the needs of the MCH population are well addressed. Changes are communicated across NYS in a variety of ways, individuals are engaged into health care coverage and policies and practices do not impede access to need health care services. Title V staff will continue to serve as that important connection between the MCH population and the providers who serve them and OHIP staff establishing policy and overseeing the implementation of the NY State of Health to ensure comprehensive, quality health care services is available and accessible to NY's MCH population.

While linking individuals served to health insurance is a long-standing expectation of NY's Title V program, as MCH programs are updated over the next several years, the DFH will integrate more formal performance standards and measures related to health insurance assessment and enrollment across all Title V programs. Title V staff also will continue to engage in major state health systems reform initiatives, including the Delivery System Reform Incentive Payment Program (DSRIP), Patient Centered Medical Home and the emerging State Health Improvement Plan (SHIP)/Advance Primary Care (APC) to identify and pursue options to leverage those key policy initiatives to reinforce and improve health care service access and quality for the MCH population.

A major cross cutting priority of Title V is the promotion or oral health across the life span. Oral health issues such as tooth decay, infections and orthodontic problems continue to impact NY's MCH population. Among children, tooth decay is the most common chronic disease and it is five times more common than asthma, and 20 times more common than diabetes. Disparities in oral health in NYS mirror national data. Although most oral diseases are preventable, not all individuals in NYS benefit fully from preventive measures. While community water fluoridation has been found to be highly effective in controlling tooth decay, only about 72 percent of the population on public water supplies receives fluoridated water in NYS. Dental sealants, a protective coating applied on the chewing surfaces of teeth to prevent tooth decay, are present in approximately 40 percent of third-grade children in NYS. Poor oral health is strongly linked to adverse general health outcomes.

Title V staff are leading NY's newly funded Community Water Fluoridation Program. Legislation was recently passed in NY that established a $5 million grant program to support community water systems to receive funding for costs related to the construction, installation, repair, rehabilitation, replacement, or upgrade of drinking water fluoridation facilities. It also required notice of DOH as well as public notice for communities considering discontinuation of community water fluoridation. In partnership with the DOH Center for Environmental Health, Title V staff will be releasing a procurement to award these funds to communities seeking to fluoridate their water system as well as communities that currently have fluoridated water but require funding to maintain their system. Title V staff will also be working with fluoridation advocates and key stakeholder to promote an understanding of the health benefits and costs savings that result from community water fluoridation. The Fluoride Mouth Rinse (Supplemental Fluoride) Program that provides children in schools without public water systems a safe and effective method of reducing dental decay through the provision of fluoride to children living in non-fluoridated communities also will be implemented.

Title V staff will lead a major effort to integrate oral health education and practice into all MCH programs and services. Work will continue on the integration of oral health information, education and practices in all MCH programs. For example, the Prenatal Infant Oral Health Quality Initiative (PIOHQI) will continue to address and improve perinatal and infant oral health services and outcomes in a Maternal, Infant and Child Health Collaborative (MICHC) to promote systems changes with respect to improving perinatal and infant oral health at the community level. Successful startegies gleaned from this initiative will be expanded to other MICHCs. Home visiting programs will provide essential information to pregnant and parenting women regarding the importance of oral health for themselves and their infants and children. The Title V staff will develop a comprehensive approach to incorporate

oral health information and messages in all program and initiatives.

Over the next year, the Title V program will expand efforts to collaborate with internal partners to maximize resources to promote oral health throughout the life span. The Division of Chronic Disease Prevention as well as the Division of Nutrition provide a significant number of services to NY's MCH population. The DFH will meet with both Divisions to develop strategies to promote oral health for the MCH population. The DFH will also develop collaborative efforts with key stakeholders such as the Dental Association, AAP, Dental Hygienists' Association of the State of NY, among others to identify barriers and issues related to oral health and develop strategies to improve access to oral health services.

A strong message heard throughout NY's comprehensive needs assessment process from professionals and families alike was the need to address home and community factors to improve health outcomes. These factors are complex and challenging to impact. A priority of Title V will be to strengthen collaborative efforts within DOH to promote health environments. Stronger linkages will be established with those Divisions, Bureaus and programs addresses issues related to chronic disease, nutrition, injury prevention, health services, environmental health among others to begin to develop evidence-based or promising practices that can be incorporated across all programs and services targeted to the MCH population. Other efforts previously addressed include working with OCFS to develop quality indicators for child care programs that reflect the health and well-being of children in that setting, establishing stronger linkages with Community Schools, working closely with DOH's Center for Environmental Health to determine opportunities to impact environmental issues across NYS, and supporting sexual violence efforts to create community change.

An overarching priority of Title V is also to address racial, ethnic, economic and geographic disparities to promote health equity for the entire MCH population. Title V staff will lead an analysis of available data to gain a more comprehensive understanding of disparities that exist in NY's MCH population. The analysis will them inform the development of strategies to address gaps, barriers and issues that impact disparate populations. This will include identifying evidence-based and promising practices that have demonstrated to improve health outcomes, identifying existing resources, services and supports that could influenced to improve outcomes, and working with internal and external partners to promote culturally sensitive practices. Information obtained through this process will also inform future planning and procurement in order to target resources to initiatives and organizations that can improve these outcomes.

Addressing the needs of ethnically and racially disparate populations is not NY's only challenge. With limited resources, services and other activities are often targeted to metropolitan or urban areas where there are larger concentration of population and burden is higher. In addition, evidence-based practices may not be relevant or realistic in rural areas. A focus in the coming year will be to seek opportunities and strategies to address the needs of the MCH population in rural areas to better meet the needs of all New Yorkers.

Cross-Cutting/Life Course - Annual Report

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	57.2	59.0	61.1	63.0	65.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	77.8	78.5	79.3	80.0	80.7

As discussed in Section IIA. State Overview section of this application, NYS has aggressively pursued implementation of the ACA through NY State of Health. Promoting access to quality health care throughout the life span is imperative to promote the health and well-being of a population. Other areas of focus for this domain including oral health, obesity, mental health and disparities are included in the prior domains.

Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

II.F.2 MCH Workforce Development and Capacity

A strong and diverse MCH workforce is needed to meet the needs of NY's MCH population. As stated previously, at the community level, most services and programs are implemented by local partners including LHDs, universities and academic medical centers, hospitals and clinics, and community based organizations.

To best meet the training and technical assistance needs of these providers, Centers of Excellence (COEs) have been established that provide information and education to major Title V provider groups including COEs for adolescent health, family planning and reproductive health and oral health. This allows the Title V program to provide maximum support to this MCH workforce including facilitating access to experts in the field, research, updates on new and emerging evidence to guide practice, and technical assistance to improve practice. The family planning and reproductive health COE is also facilitating performance improvement efforts within the network of family planning providers. This not only provides opportunities for current practice improvement efforts, but serves to provide MCH program staff with expertise in the science of improvement to lead quality efforts in the future.

MCH providers also use funds provided by the Title V program to access qualified and competent staff, participate in training and conferences and other activities to improve the quality of the workforce providing services.

As previously discussed, NY's Title V program also leads various efforts with hospitals throughout NYS and professional organizations to enhance practice. These include, but are not limited to, the improvement initiatives through NYSPQC, training and information provided to and through professional organizations such as the identification of children with ASD, developmental screening, the identification and treatment of hypertension during pregnancy, and a range of other topics.

Title V staff within DOH are the heart of the Title V program and responsible to ensure the scope and mission of Title V is carried out in NYS. To ensure of strong focus on the needs of the Title V program staff, over the past year the DFH formed a Personnel and Workforce Support within the Bureau of Administration to focus specifically on the training and development of Title V staff as well as ongoing recruitment efforts. Over the past year, this unit conducted assessments in collaboration with all staff and supervisors to obtain information regarding the training, education and support needs of staff at the present time as well as to support future growth and development. With NY's aging workforce, a major priority is to build MCH leaders for the future. Based on that assessment, plans are underway to provide support for the identified needs. Arrangements are underway for training programs in software such as Excel for support staff. Staff are being cross-trained to ensure continuous workflow as well as enable staff to learn new skills. Efforts are underway to strengthen the Title V program's "mid-level" management. All applicable staff have been encouraged to access the Association of Maternal and Child Health Programs' (AMCHP) Next Generation MCH Calls to begin to network and grow in the field of MCH. Title V staff are exploring a collaboration

with the National MCH Development Center to enhance the leadership skills of NY's future MCH leaders. The Title V program also continues to pursue approvals to recruit and hire new staff to continue to support the work of the Title V program.

Promoting MCH providers outside of DOH is also essential to ensure the needs of the MCH population are met. Through a Memorandum of Understanding with the State University of New York at Albany School of Public Health (SPH), Title V supports graduate-level students working towards their Masters in Public Health to work within the Title V program for a semester to gain real-life, practical experience in the field of MCH. The Preventive Medicine Residency and Dental Public Health Residency Program through the SPH are also well integrated into the Title V program. These residents work with Title V staff for approximately a year to gain experience in the MCH field. As an outgrowth of this partnership, SPH and DOH recently were awarded a new HRSA MCH Catalyst Program grant to develop an increased focus on MCH and introduce students to MCH careers.

Title V will continue to make workforce development a priority and promote internal and external efforts to address these needs.

II.F.3. Family Consumer Partnership

As stated previously, at the community level, most services and programs are implemented by local partners including LHDs, universities and academic medical centers, hospitals and clinics, and community based organizations. When procuring services, efforts are made to locate services within communities served provided by individuals from the community or reflect the diversity of the community. Contractors are required to obtain consumer input from the MCH population served whether it is membership on a board to guide services, workgroups to provide input regarding education materials or outreach strategies, or direct input from families served. In a state the size of NY, obtaining input through provider organizations or other organizations representative of the population is the most practical, meaningful way to obtain input from the broad population that is MCH in NY. As stated in the state plan narrative, a focus in the Early Intervention Program this coming year will be on assessment of family outcomes that will assist NY's Title V program to enhance the understanding of family input and disseminate this learning to other programs and services.

The Family Initiatives Coordination Services Project that coordinates the development and implementation of a variety of family initiatives including training and support for parents involved in the EIP to become advocates for special needs children at local, state and national levels will continue. Parents are also members of the EI Coordinating Council as well as the MCHSBG Advisory Council and provide valuable input to guide policy and practice. The parent representative on the MCHSBG Advisory Council recently resigned. Plans are underway for the addition of a new parent representative.

The Title V program will seek to develop standardized processes and measures to ensure all MCH providers obtain and use meaningful consumer input to improve the MCH system of services in NYS.

II.F.4. Health Reform

As stated throughout this report, Title V staff have been directly involved in NY's implementation of the Affordable Care Act. This includes input into the basic health plan, outreach and awareness and in keeping abreast of developments and the impact on the MCH population. Title V staff have facilitated information sharing with providers and consumers throughout NYS and requires all MCH programs to assess individuals for insurance status and facilitate enrollment into the Exchange. Work on this, Health Homes, DSRIP including SHIP/APC and others will remain a key part of the work of NY's Title V program to ensure the MCH population has ongoing access to

comprehensive health care coverage.

II.F.5. Emerging Issues

All issues have been succinctly addressed in previous sections of this application, including the State Plan section. Title V staff in NY will continue to monitor the status of health insurance coverage for the MCH population, access to Health Home for Children, implementation of DSRIP, SHIP, including APC and other health care reform initiatives to advocate for supports and services for the MCH population. Throughout the next year, Title V staff will also continue the development of the State plan to identify evidence- based or evidence-informed practice to potentially update policy, program and other supports as new evidence emerges.

II.F.6. Public Input

As stated in the Needs Assessment Summary section of this application, extensive internal and external input was obtained during the development of this application. Several discussions were held with the MCHSBG Advisory Council to guide the development of the state action plan as well as provide input into the final State Action Plan. The State Plan will also be posted on the DOH public web site and information regarding the plan widely disseminated to provide an opportunity for further input into the Title V State Plan.

II.F.7. Technical Assistance

NY's Title V program would welcome the opportunity to have periodic teleconferences with HRSA and other large states that may be experiencing similar challenges, discussing similar policy issues and developing and evaluating programs and initiatives to support Title V outcomes. Issues such as establishing policy to promote systems change, identifying evidence-based or evidence-informed practices on an ongoing basis, modifying evidence-based programs to better fit the needs of certain populations, and addressing public health issues in more rural areas where the burden is not as great and resources are limited are just a few examples of areas that may be of benefit to discuss in a forum with large states. As the landscape of health insurance continues to evolve, NY would benefit from dialogue with HRSA, other states and experts in the field regarding enhancing and developing policy and practice to improve outcomes of the MCH population, including evidence-based or evidence-informed practice on integrating preconception and interconception health across the lifespan and addressing social determinants of health that impact the health and safety of the MCH population.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 41,036,806	$ 40,036,911	$ 40,033,023	$ 36,320,452
Unobligated Balance	$ 0	$ 0	$ 0	$ 0
State Funds	$ 144,502,296	$ 153,566,602	$ 62,208,171	$ 62,208,171
Local Funds	$ 301,048,616	$ 272,432,651	$ 271,491,225	$ 322,617,868
Other Funds	$ 0	$ 0	$ 0	$ 0
Program Funds	$ 404,365,207	$ 305,333,730	$ 314,762,086	$ 234,990,131
SubTotal	$ 890,952,925	$ 771,369,894	$ 688,494,505	$ 656,136,622
Other Federal Funds	$ 63,259,202	$ 55,450,663	$ 57,643,011	$ 49,857,001
Total	$ 954,212,127	$ 826,820,557	$ 746,137,516	$ 705,993,623

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 37,919,712	$ 37,919,712	$ 38,909,810	$
Unobligated Balance	$ 0	$ 0	$ 0	$
State Funds	$ 62,208,171	$ 78,841,785	$ 29,200,000	$
Local Funds	$ 271,646,100	$ 224,894,104	$ 22,198,393	$
Other Funds	$ 0	$ 0	$ 0	$
Program Funds	$ 236,737,888	$ 292,856,562	$ 12,794,604	$
SubTotal	$ 608,511,871	$ 634,512,163	$ 103,102,807	$
Other Federal Funds	$ 62,905,602		$ 54,870,832	$
Total	$ 671,417,473	$ 634,512,163	$ 157,973,639	$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	$ 38,909,810	$
Unobligated Balance	$ 0	$
State Funds	$ 29,226,355	$
Local Funds	$ 25,254,603	$
Other Funds	$ 0	$
Program Funds	$ 34,368,556	$
SubTotal	$ 127,759,324	$
Other Federal Funds	$ 72,809,819	$
Total	$ 200,569,143	$

III.A. Expenditures

Completion of Budget Forms: Please refer to budget columns on Forms 2, 3a and 3b for a summary of state, local, federal and program income as it contributes to the MCH
Partnership.

Principles for Allocation: Please refer to Section 504, Use of Allotment of Funds and Section 505, Application for Block Grant Funds. The total Federal allocation is committed to program services, support and administration. The State estimates it will expend thirty four percent (34%) of federal Title V funds for preventive and primary care services for children and thirty two percent (31.8%) for services for CSHCN. Roughly 5.6% will be used for administrative costs. The state maintained more than the level of funds from fiscal year 1989, $596.6M vs. $58.3M. The FFY14 original budget and resulting expenditures utilize a greater state match than the FFY16 budget due to the department's efforts to maximize funding by identifying initiatives eligible for match funding resulting in a decrease in the overmatch demonstrated in the grant. Although certain match dollars are no longer included, the maternal and child health related services continue to be provided by the state at the same level.

Program managers prepared the population served by pyramid level. Significant changes related to the new definition of Direct Services are evident; $12k was spent in FFY14 vs the budgeted amount of $8.5M. The Division directly pays for a very small amount of services and in accordance with the rule that MCH funds must be used as a payer of last resort. All allowable expenditures for eligible applicants are supported at 50% by MCH and 50% by Local Health Departments. Rates do not exceed the Medicaid fee schedule.

Expenditure reports are generated for the appropriate period and distributions by population and pyramid level are then calculated.

For FFY14, total partnership expenditures are estimated to equal the total budgeted allocation of $37,919,712.

III.B. Budget

The FFY 16 partnership budget is $38,909,810. NYS's allocation of $88.8 M demonstrates a continued obligation of funds above our statutory maintenance of effort level from FY1989 of $58,268,752. This level of state funding budgeted includes a State Match ($2.30 state for every $1.00 federal) of $88,849,514 for the $38,909,810 of Federal MCH Block Grant funds. As previously stated, the match has been reduced from FFY 14 expenditures of $596.6 M to the FFY 16 budgeted amount of $88.8 M. Obvious variances in the match amount budgeted from FFY 14 and FFY 16 amount can be attributed to the Department's efforts to identify and match state dollars for appropriate, unmatched initiatives; a result of this has been a decrease or elimination of those dollars in the MCHSBG application. Although these dollars are no longer included, the maternal and child health related services continue to be provided by the state at the same level.

This budget reflects New York State's commitment to Title V programs and services. New York more than meets the maintenance of effort requirements of Section 505 (a) (4) and match requirements for FFY 16 which assures continuation of essential maternal and child health services.

The MCHSBG Advisory Council assists the Department in determining program priorities and is instrumental in seeking public input into the application process. Effort is made to match funding to the level of unmet need, and to address the three layers of the MCH pyramid by domain. Because funded programs often take more than one structural approach to targeted needs and populations, program appropriations are proportioned out to reflect percentage of effort in public health services and systems, enabling services and direct health care services. Program appropriations also take into account the "30-30-10" requirements of Title V. The State more than meets "30-30-10 Requirements" for 30% allocation to primary and preventive care to children ($12.6M, 33%), for 30% for children with special health care needs ($12.3M, 32%) and under 10% for administration ($1.8M or 5%) for block grant distribution.

New York State plans to use its Federal MCH funds for the following programs:
The Adolescent Health Initiative, including Centers for Excellence and Youth Risk Behavior Surveillance; American Indian Health Program Community Health Workers; Asthma Coalitions; Children with Special Health Care Needs Program, including the Physically Handicapped Children's Program Diagnostic and Evaluation Program; Community-Based Adolescent Pregnancy Prevention; Family Planning; The Genetics Program and Newborn Metabolic Screening; SUNY School of Public Health MCH Graduate Assistantship Program; Health Communications; Lead Poisoning Prevention; Migrant and Seasonal Farmworker Health; Statewide Dental Technical Assistance Center; Public Health Information/Community Assessment infrastructure; Preventive Dentistry Initiatives; the Dental Residency Program; Dental Supplemental Fluoride Program, School-Based Health Centers; and STD Screening and Education.

The state share for MCH services is considerable, more than meeting the requirements for state match. New York State-funded programs dedicated to MCH include:
Genetic Screening and Human Genetics; Physically Handicapped Children's Treatment Program; Migrant and Seasonal Farmworker Health Program; School-Based Health Centers; SIDS and Infant Death, Child's Asthma Program, Appropriations included in previous applications as match are no longer being included as those dollars are used as match for other federal grants. However, services continue to be a component of the NYS MCH related programming.

The methodology used to identify State expenditures for MCH-related programs has also not changed from prior years:
• Appropriate cost centers, representing specific areas of activity related to MCH, are identified.
• Data for the appropriate fiscal periods are obtained from the Office of the State Comptroller
• Data for selected cost centers are extracted on a quarterly basis.

• Data is compiled from relevant cost centers to reflect expenditures made during the federal grant award period.
• All expenditure data represent payments made on a cash (vs. accrual) basis.
• Transactions associated with specific grants are identified and tracked through appropriation, segregation, encumbrance & reporting processes to permit proper and complete recording of the utilization of available funds.
• Identifying codes are assigned to record these transactions by object of expense within each cost center.

The Department and the Office of the State Comptroller maintain budget documentation for Block Grant funding and expenditures consistent with Section 505(a) and Section 506(a) (1) for the purpose of maintaining an audit trail. Reporting requirements and procedures for each particular grant are instituted to comply with conditions specified within each notice of grant award.

Federal sources of MCH targeted dollars other than the block grant included: Centers for Disease Control and Prevention (Lead, Immunization, Public Health Information Infrastructure; Oral Health), Department of Education, IDEA Part C; Family Planning Title X; STD/fertility; Oral Health; SSDI Funds; TANF Funds; Early Childhood Comprehensive Systems planning grant; SAMHSA Project LAUNCH, MIECHV Home Visiting, STYA and PREP.

The overmatch reflected in this application is considerably less than previous years; however, the state's funding for the MCHS initiatives remains fairly consistent. The decreased match of roughly $500 M in the FFY 14 and FFY 16 budgets is attributable to the department's efforts to maximize funding by identifying initiatives eligible for match funding resulting in a decrease in the overmatch demonstrated in the grant. The increase of $8.0 M (10%) in matching funds between the FFY 15 budget and the FFY 16 budget of is due to additional FPAR and Article VI revenues.

As in prior years, additional state funded initiatives have been identified as potential sources to leverage increased funding for dwindling resources and increasing needs. For FFY 16, the following initiatives are not included in the MCHSBG application budget but continue to be NYS funded and remain a component of the state's maternal and child health services: HIV related counseling and testing, Early Intervention, Maternal and Infant Community Health Collaboratives, "Growing Up Healthy" Hotline, Perinatal Regionalization, Statewide Perinatal Data Systems, Nurse Family Partnerships, Immunization, Infertility and General Public Health Work support to counties. Collectively, the state appropriations for these initiatives total approximately $243 million.

IV. Title V-Medicaid IAA/MOU

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

V. Supporting Documents

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

Supporting Document #01 - Attachment 1Partnerships Workforce and References.pdf

Supporting Document #02 - Attachment 2 DOH Org Chart 6-24-15.pdf

Supporting Document #03 - Attachment 3 Proposed or Current Priority.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: New York

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION	$ 38,909,810	$ 37,919,712
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		
A. Preventive and Primary Care for Children	$ 12,598,789	$ 12,987,407
B. Children with Special Health Care Needs	$ 12,257,757	$ 12,073,260
C. Title V Administrative Costs	$ 1,815,301	$ 2,107,586
2. UNOBLIGATED BALANCE	$ 0	$ 0
(Item 18b of SF-424)		
3. STATE MCH FUNDS	$ 29,226,355	$ 78,841,785
(Item 18c of SF-424)		
4. LOCAL MCH FUNDS	$ 25,254,603	$ 224,894,104
(Item 18d of SF-424)		
5. OTHER FUNDS	$ 0	$ 0
(Item 18e of SF-424)		
6. PROGRAM INCOME	$ 34,368,556	$ 292,856,562
(Item 18f of SF-424)		
7. TOTAL STATE MATCH	$ 88,849,514	$ 596,592,451
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	$ 58,268,752	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL	$ 127,759,324	$ 634,512,163
(Same as item 18g of SF-424)		
9. OTHER FEDERAL FUNDS		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS	$ 72,809,819	
(Subtotal of all funds under item 9)		
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL	$ 200,569,143	$ 634,512,163
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 37,919,712
A. Preventive and Primary Care for Children	$ 14,453,978
B. Children with Special Health Care Needs	$ 11,800,923
C. Title V Administrative Costs	$ 1,943,395
2. UNOBLIGATED BALANCE	$ 0
3. STATE MCH FUNDS	$ 62,208,171
4. LOCAL MCH FUNDS	$ 271,646,100
5. OTHER FUNDS	$ 0
6. PROGRAM INCOME	$ 236,737,888
7. TOTAL STATE MATCH	$ 570,592,159

	FY16 Application Budgeted
9. OTHER FEDERAL FUNDS	
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prevent Block Grant;	$ 2,120,737
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Part C - Early Inter;	$ 24,971,913
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Abstinence Education;	$ 2,856,276
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > MIECHV;	$ 15,696,241
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > PREP;	$ 3,022,144
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > SSDI;	$ 77,054
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Title X;	$ 9,571,200
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match;	$ 13,461,825
Department of Health and Human Services (DHHS) > Health Resources and Services	$ 1,032,429

Administration (HRSA) > Other HRSA;

Form Notes For Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: This amount is the same as the FFY 15 Application.	
2.	**Field Name:**	**7. TOTAL STATE MATCH**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The State Match has increased by roughly $8M, primarily due to additional program income from Family Planning (FPAR) and Article VI Family Health Revenues.	
3.	**Field Name:**	**8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The Total Partnership Budget has increased by roughly $8M, primarily due to additional program income from Family Planning (FPAR) and Article VI Family Health Revenues.	
4.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: More funds were spent on Children with Special Health Care Needs than originally budgeted.	
5.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: FFY 14 administrative spending is in line with historical administrative spending on the MCH block grant for New York State. Next year's budgeted amount is $1.8M.	

6.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Increased spending is the result of higher than expected spending for American Indian Health Programs and Lead Poisoning Prevention Programs.	
7.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: A decrease is local program income is attributed to a decrease in early intervention program revenue.	
8.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Increased program income due to higher than expected Family Planning (FPAR) and Article VI Family Health revenues.	
9.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prevent Block Grant**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: CDC Prevent Components = State Based Perinatal Quality Collaborative ($165,538), NYS Oral Disease Prevention Components 1 & 2 ($254,127), New York Rape Prevention and Education Program ($1,572,456) and EHDI Tracking and Surveillance ($128,616)	
10.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Abstinence Education**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: HRSA - Supporting Healthy Transitions to Adolescence	
11.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > MIECHV**
	Fiscal Year:	**2016**

	Column Name:	**Application Budgeted**
	Field Note: Maternal, Infant, and Early Childhood Home Visiting - Competitive and Formula Based Grants	
12.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > PREP**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Personal Responsibility Education Program	
13.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > SSDI**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: HRSA - State Systems Development Initiative	
14.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Title X**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Title X Family Planning Grant	
15.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Includes matching funds for Comprehensive Adolescent Pregnancy Prevention, Regional Perinatal Centers and Maternal and Infant Community Health Collaborative.	
16.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Other HRSA**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Oral Health Workforce ($408,572), Children's Oral Health Access ($194,379), Children's Oral Healthcare Access	

($220,693), Universal Newborn Hearing Screening ($208,785)

Data Alerts:

None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: New York

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 6,102,472	$ 5,998,827
2. Infants < 1 year	$ 691,297	$ 2,261,134
3. Children 1-22 years	$ 11,907,492	$ 10,726,273
4. CSHCN	$ 12,257,757	$ 12,073,260
5. All Others	$ 6,135,491	$ 4,752,633
Federal Total of Individuals Served	$ 37,094,509	$ 35,812,127
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 19,136,954	$ 26,433,459
2. Infants < 1 year	$ 6,534,603	$ 37,361,483
3. Children 1-22 years	$ 27,529,327	$ 80,209,173
4. CSHCN	$ 17,377,493	$ 410,652,771
5. All Others	$ 18,271,137	$ 41,935,565
Federal Total of Individuals Served	$ 88,849,514	$ 596,592,451
Federal State MCH Block Grant Partnership Total	$ 125,944,023	$ 632,404,578

Form Notes For Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Form 2, line 1 includes Infants Under 1, whereas, this number does not. If you add Infants Under 1 and Children 1-22 Years, you will get the same value as Form 2, line 1	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Form 2, line 1 includes Infants Under 1, whereas, this number does not. If you add Infants Under 1 and Children 1-22 Years, you will get the same value as Form 2, line 1.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Form 2, line 1 includes Infants Under 1, whereas, this number does not. If you add Infants Under 1 and Children 1-22 Years, you will get the same value as Form 2, line 1	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Form 2, line 1 includes Infants Under 1, whereas, this number does not. If you add Infants Under 1 and Children 1-22 Years, you will get the same value as Form 2, line 1.	

Data Alerts:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: New York

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$ 75,000	$ 12,016
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 75,000	$ 12,016
2. Enabling Services	$ 26,800,826	$ 19,921,217
3. Public Health Services and Systems	$ 12,033,984	$ 17,986,479
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 12,016
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Total		$ 12,016
Federal Total	$ 38,909,810	$ 37,919,712

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 1,200,000	$ 409,284,740
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 44,202,752
B. Preventive and Primary Care Services for Children	$ 0	$ 92,963,514
C. Services for CSHCN	$ 1,200,000	$ 272,118,474
2. Enabling Services	$ 51,418,768	$ 103,368,227
3. Public Health Services and Systems	$ 36,230,746	$ 83,939,484
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 65,485,558
Physician/Office Services		$ 4,092,847
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 24,557,084
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		$ 4,092,847
Laboratory Services		
Other		
Other		$ 311,056,404
Direct Services Total		$ 409,284,740
Non-Federal Total	$ 88,849,514	$ 596,592,451

Form Notes For Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIB. - Other - Other**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**

Field Note:
Other includes program income for early intervention, American Indian Health Program expenses and CSHCN expenses

Form 4

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

State: New York

Total Births by Occurrence 240,671

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Propionic acidemia	240,193 (99.8%)	58	8	8 (100.0%)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	240,193 (99.8%)	58	8	8 (100.0%)
Methylmalonic acidemia (cobalamin disorders)	240,193 (99.8%)	8	8	8 (100.0%)
Isovaleric acidemia	240,193 (99.8%)	6	3	3 (100.0%)
3-Methylcrotonyl-CoA carboxylase deficiency	240,193 (99.8%)	58	8	8 (100.0%)
3-Hydroxy-3-methyglutaric aciduria	240,193 (99.8%)	22	11	11 (100.0%)
Glutaric acidemia type I	240 (0.1%)	1	1	1 (100.0%)
Medium-chain acyl-CoA dehydrogenase deficiency	240,193 (99.8%)	20	9	9 (100.0%)
Very long-chain acyl-CoA dehydrogenase deficiency	240,193 (99.8%)	6	2	2 (100.0%)
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	240,193 (99.8%)	5	0	0 (0%)
Maple syrup urine disease	240,193 (99.8%)	5	0	0 (0%)
Homocystinuria	240,193 (99.8%)	5	0	0 (0%)
Classic phenylketonuria	240,193 (99.8%)	21	11	11 (100.0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Tyrosinemia, type I	240,193 (99.8%)	5	0	0 (0%)
Primary congenital hypothyroidism	240,191 (99.8%)	624	87	87 (100.0%)
Congenital adrenal hyperplasia	240,174 (99.8%)	290	15	15 (100.0%)
S,S disease (Sickle cell anemia)	240,184 (99.8%)	145	132	132 (100.0%)
S,C disease	240,184 (99.8%)	65	65	65 (100.0%)
Biotinidase deficiency	240,168 (99.8%)	2	1	1 (100.0%)
Cystic fibrosis	240,170 (99.8%)	866	30	30 (100.0%)
Severe combined immunodeficiences	240,173 (99.8%)	109	3	3 (100.0%)
Classic galactosemia	240,168 (99.8%)	3	2	2 (100.0%)

1b. Secondary RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Carnitine acylcarnitine translocase deficiency	240,193 (99.8%)	20	2	2 (100.0%)
Carnitine palmitoyltransferase type I deficiency	240,193 (99.8%)	2	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency	240,193 (99.8%)	20	2	2 (100.0%)
2,4 Dienoyl-CoA reductase deficiency	240,193 (99.8%)	0	0	0 (0%)
Hypermethioninemia	240,193 (99.8%)	5	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Medium/short-chain L-3-hydroxyacl-CoA dehydrogenase deficiency	240,193 (99.8%)	1	0	0 (0%)
3-Methylglutaconic aciduria	240,193 (99.8%)	22	11	11 (100.0%)
2-Methyl-3-hydroxybutyric aciduria	240,193 (99.8%)	0	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	240,193 (99.8%)	21	11	11 (100.0%)

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	210,851 (87.6%)	0	0	0 (0%)

3. Screening Programs for Older Children & Women

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
None	0	0	0	0

4. Long-Term Follow-Up

No information is available on long-term follow-up

Form Notes For Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Newborn Hearing - Receiving At Lease One Screen**
	Fiscal Year:	**2014**
	Column Name:	**Other Newborn**
	Field Note: Data not collected for 2014 but will be available in 2015	
2.	**Field Name:**	**Newborn Hearing - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Other Newborn**
	Field Note: Data not collected for 2014 but will be available in 2015	
3.	**Field Name:**	**Newborn Hearing - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Other Newborn**
	Field Note: Data not collected for 2014 but will be available in 2015	
4.	**Field Name:**	**Newborn Hearing - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Other Newborn**
	Field Note: Data not collected for 2014 but will be available in 2015	
5.	**Field Name:**	**None - Receiving At Lease One Screen**
	Fiscal Year:	**2014**
	Column Name:	**Older Children & Women**
	Field Note: no data collected	
6.	**Field Name:**	**None - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Older Children & Women**

	Field Note: no data collected	
7.	**Field Name:**	**None - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Older Children & Women**
	Field Note: no data collected	
8.	**Field Name:**	**None - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Older Children & Women**
	Field Note: no data collected	

Form 5a
Unduplicated Count of Individuals Served under Title V

State: New York

Reporting Year 2014

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	0	45.8	0.0	51.4	1.7	1.1
2. Infants < 1 Year of Age	0	44.8	1.0	51.4	1.7	1.1
3. Children 1 to 22 Years of Age	0	30.8	6.9	54.4	7.9	0.0
4. Children with Special Health Care Needs	593	37.2	6.9	52.8	3.1	0.0
5. Others	0	21.4	0.0	61.9	16.7	0.0
Total	593					

Form Notes For Form 5a:

This figure is reflective of the only Title V direct services provided in NYS. It includes the Physically Handicapped Children's Program (PHCP) Diagnosis and Evaluation and Treatment services. The decrease from last year's data is a result of the change of HRSA's definition of direct services.

Field Level Notes for Form 5a:

None

Form 5b
Total Recipient Count of Individuals Served by Title V

State: New York

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	18,712
2. Infants < 1 Year of Age	25,727
3. Children 1 to 22 Years of Age	255,593
4. Children with Special Health Care Needs	336,335
5. Others	209,228
Total	845,595

Form Notes For Form 5b:

The decrease in individuals served is due to the change in definition of "direct health care services" and "enabling services". Therefore, the figure is not within 10% of the total birth by occurrence in Form 4 either.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2014**
	Field Note: The change in definition of direct health care services and enabling services results in a figure below 10% of births by occurrence (form 4.)	

Form 6

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

State: New York

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	234,788	141,521	38,783	478	25,353	1,705	5,012	21,936
Title V Served	0	0	0	0	0	0	0	0
Eligible for Title XIX	0	0	0	0	0	0	0	0
2. Total Infants in State	239,442	144,508	39,579	486	25,778	1,734	5,102	22,255
Title V Served	0	0	0	0	0	0	0	0
Eligible for Title XIX	0	0	0	0	0	0	0	0

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	181,251	53,537	0	234,788
Title V Served	0	0	0	0
Eligible for Title XIX	0	0	0	0
2. Total Infants in State	185,160	54,282	0	239,442
Title V Served	0	0	0	0
Eligible for Title XIX	0	0	0	0

Form Notes For Form 6:

None

Field Level Notes for Form 6:

None

Form 7

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

State: New York

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 522-5006	(800) 522-5006
2. State MCH Toll-Free "Hotline" Name	The Growing Up Healthy Hotline	The Growing Up Healthy Hotline
3. Name of Contact Person for State MCH "Hotline"	Cindi Dubner	Michael Acosta
4. Contact Person's Telephone Number	(518) 474-0535	(518) 474-0535
5. Number of Calls Received on the State MCH "Hotline"		35,065
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes For Form 7:

None

Form 8

State MCH and CSHCN Directors Contact Information

State: New York

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Rachel de Long
Title	Bureau Director, Division of Family Health
Address 1	Corning Tower room 890
Address 2	Empire State Plaza
City / State / Zip Code	Albany / NY / 12237
Telephone	(518) 474-6968
Email	rachel.delong@health.ny.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Susan Slade
Title	Children with Special Healthcare Needs Director
Address 1	Corning Tower room 821
Address 2	Empire State Plaza
City / State / Zip Code	Albany / NY / 12237
Telephone	(518) 474-1388
Email	susan.slade@health.ny.gov

3. State Family or Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City / State / Zip Code	
Telephone	
Email	

Form Notes For Form 8:

None

Form 9

List of MCH Priority Needs

State: New York

Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Reduce maternal mortality and morbidity	New	
2.	Reduce infant mortality & morbidity	New	
3.	Support and enhance social-emotional development and relationships for children and adolescents	New	
4.	Increase supports to address the special health care needs of children and youth	New	
5.	Increase the use of preventive health care services across the life course.	New	
6.	Promote oral health and reduce tooth decay across the life course	New	
7.	Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course.	New	
8.	Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).	New	

Form Notes For Form 9:

None

Field Level Notes for Form 9:

Field Name: Priority Need 1
Field Note:
Field Name: Priority Need 2
Field Note:
Field Name: Priority Need 3
Field Note:
Field Name: Priority Need 4
Field Note:
Field Name: Priority Need 5
Field Note: Including: Preconception/ Interconception (“well woman”, including family planning) Prenatal & Postpartum Infants (“well baby”) Children (“well child”) Adolescents (“well teen”, including family planning)
Field Name: Priority Need 6
Field Note:
Field Name: Priority Need 7
Field Note:
Field Name: Priority Need 8
Field Note:
Field Name: Priority Need 9

Field Note:

Field Name:

Priority Need 10

Field Note:

Form 10a
National Outcome Measures (NOMs)

State: New York

Form Notes for Form 10a NPMs and NOMs:

None

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	75.4 %	0.1 %	173,442	230,047
2012	74.5 %	0.1 %	173,825	233,372
2011	73.7 %	0.1 %	172,588	234,324
2010	73.9 %	0.1 %	174,690	236,300
2009	74.1 %	0.1 %	174,327	235,200

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-1 Notes:

None

Data Alerts:

None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	235.4	3.2 %	5,441	231,131
2011	214.1	3.1 %	4,831	225,668
2010	217.8	3.1 %	4,935	226,617
2009	196.2	2.9 %	4,510	229,831
2008	173.9	2.7 %	4,047	232,716

Legends:
Indicator has a numerator ≤10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2013	20.6	1.3 %	250	1,211,693
2008_2012	22.2	1.4 %	272	1,225,096
2007_2011	21.2	1.3 %	262	1,237,631
2006_2010	20.5	1.3 %	256	1,246,423
2005_2009	19.9	1.3 %	248	1,248,399

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

State Provided Data	
	2014
Annual Indicator	17.9
Numerator	42
Denominator	235,274
Data Source	Vital Records
Data Source Year	2013

NOM-3 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	8.0 %	0.1 %	18,847	236,671
2012	7.9 %	0.1 %	19,074	240,654
2011	8.1 %	0.1 %	19,557	241,031
2010	8.2 %	0.1 %	20,049	244,116
2009	8.2 %	0.1 %	20,341	247,850

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	2014

State Provided Data	
Annual Indicator	7.9
Numerator	
Denominator	
Data Source	Vital Records
Data Source Year	2013

NOM-4.1 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.4 %	0.0 %	3,210	236,671
2012	1.5 %	0.0 %	3,494	240,654
2011	1.5 %	0.0 %	3,533	241,031
2010	1.5 %	0.0 %	3,682	244,116
2009	1.5 %	0.0 %	3,767	247,850

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.6 %	0.1 %	15,637	236,671
2012	6.5 %	0.1 %	15,580	240,654
2011	6.7 %	0.1 %	16,024	241,031
2010	6.7 %	0.1 %	16,367	244,116
2009	6.7 %	0.1 %	16,574	247,850

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.3 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	8.9 %	0.1 %	21,052	236,558
2012	9.1 %	0.1 %	21,884	240,504

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	9.2 %	0.1 %	22,117	240,932
2010	9.4 %	0.1 %	22,904	244,016
2009	9.5 %	0.1 %	23,527	247,770

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.1 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.6 %	0.0 %	6,213	236,558
2012	2.7 %	0.0 %	6,589	240,504
2011	2.7 %	0.0 %	6,601	240,932
2010	2.9 %	0.0 %	7,036	244,016
2009	2.9 %	0.0 %	7,052	247,770

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.3 %	0.1 %	14,839	236,558
2012	6.4 %	0.1 %	15,295	240,504
2011	6.4 %	0.1 %	15,516	240,932
2010	6.5 %	0.1 %	15,868	244,016
2009	6.7 %	0.1 %	16,475	247,770

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.3 Notes:

None

Data Alerts:

None

NOM-6 Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	22.9 %	0.1 %	54,190	236,558
2012	23.4 %	0.1 %	56,356	240,504

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	23.5 %	0.1 %	56,643	240,932
2010	24.2 %	0.1 %	59,001	244,016
2009	24.9 %	0.1 %	61,620	247,770

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-6 Notes:

None

Data Alerts:

None

NOM-7 Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013/Q2-2014/Q1	5.0 %			

Legends:
Indicator results were based on a shorter time period than required for reporting

NOM-7 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.8	0.2 %	1,386	237,712
2012	5.8	0.2 %	1,398	241,663
2011	6.1	0.2 %	1,483	242,097
2010	6.2	0.2 %	1,521	245,195
2009	6.3	0.2 %	1,561	248,922

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-8 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.9	0.1 %	1,169	236,980
2012	5.0	0.1 %	1,207	240,916
2011	5.1	0.2 %	1,236	241,312
2010	5.1	0.1 %	1,242	244,375
2009	5.4	0.2 %	1,331	248,110

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	4.8
Numerator	
Denominator	
Data Source	Vital Records
Data Source Year	2012

NOM-9.1 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.5	0.1 %	829	236,980
2012	3.4	0.1 %	808	240,916
2011	3.5	0.1 %	855	241,312
2010	3.5	0.1 %	863	244,375
2009	3.7	0.1 %	918	248,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-9.2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.4	0.1 %	340	236,980
2012	1.7	0.1 %	399	240,916
2011	1.6	0.1 %	381	241,312
2010	1.6	0.1 %	379	244,375
2009	1.7	0.1 %	413	248,110

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.3 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	184.0	8.8 %	436	236,980
2012	188.5	8.9 %	454	240,916

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	182.3	8.7 %	440	241,312
2010	191.9	8.9 %	469	244,375
2009	197.9	8.9 %	491	248,110

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.4 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	55.7	4.9 %	132	236,980
2012	54.8	4.8 %	132	240,916
2011	51.4	4.6 %	124	241,312
2010	50.3	4.5 %	123	244,375
2009	60.9	5.0 %	151	248,110

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.5 Notes:

None

Data Alerts:

None

NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	8.4 %	0.7 %	18,417	218,407
2010	8.1 %	0.7 %	18,042	222,166
2008	7.3 %	1.0 %	8,464	115,245
2007	8.4 %	0.7 %	19,845	235,020

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

NOM-10 Notes:

None

Data Alerts:

None

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	4.2	0.1 %	974	231,133
2011	4.3	0.1 %	975	225,668
2010	3.3	0.1 %	751	226,617
2009	3.1	0.1 %	705	229,831

Year	Annual Indicator	Standard Error	Numerator	Denominator
2008	2.6	0.1 %	611	232,716

Legends:
Indicator has a numerator ≤10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-11 Notes:

None

Data Alerts:

None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts:

None

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

FAD Not Available for this measure.

NOM-13 Notes:

None

Data Alerts:

None

NOM-14 Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.4 %	1.3 %	773,251	3,983,245

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-14 Notes:

None

Data Alerts:

None

NOM-15 Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	15.1	0.9 %	314	2,083,766
2012	14.5	0.8 %	303	2,084,583
2011	15.0	0.9 %	311	2,076,119
2010	13.9	0.8 %	291	2,087,905
2009	15.9	0.9 %	330	2,082,079

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-15 Notes:

None

Data Alerts:

None

NOM-16.1 Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	22.7	1.0 %	557	2,458,767
2012	23.2	1.0 %	578	2,494,939
2011	25.8	1.0 %	651	2,520,885
2010	25.9	1.0 %	668	2,577,734
2009	27.0	1.0 %	702	2,603,195

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.1 Notes:

None

Data Alerts:

None

NOM-16.2 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	6.6	0.4 %	257	3,911,971
2010_2012	6.7	5.9 %	269	3,998,477
2009_2011	7.5	6.7 %	305	4,071,307
2008_2010	7.2	6.3 %	296	4,137,652
2007_2009	8.2	7.3 %	339	4,159,162

Legends:

Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.2 Notes:

None

Data Alerts:

None

NOM-16.3 Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	5.6	4.8 %	218	3,911,971
2010_2012	5.7	4.9 %	227	3,998,477
2009_2011	5.2	4.5 %	212	4,071,307
2008_2010	4.2	3.6 %	175	4,137,652
2007_2009	3.9	3.3 %	163	4,159,162

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.3 Notes:

None

Data Alerts:

None

NOM-17.1 Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	20.8 %	1.3 %	886,553	4,266,861
2007	18.5 %	1.3 %	817,664	4,420,982
2003	17.0 %	1.0 %	765,132	4,503,196

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.1 Notes:

None

Data Alerts:

None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	16.8 %	1.6 %	100,137	597,820

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.2 Notes:

None

Data Alerts:

None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2011_2012	1.9 %	0.4 %	67,419	3,574,950
2007	0.7 %	0.2 %	27,641	3,741,722

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	64.4
Numerator	
Denominator	
Data Source	National Survey of CSHCN
Data Source Year	209-2010

NOM-17.3 Notes:

NS-CSHCN is under revision data will be available in 2017

Data Alerts:

None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2011_2012	7.2 %	0.9 %	255,081	3,552,777

Year	Annual Indicator	Standard Error	Numerator	Denominator
2007	7.0 %	1.0 %	261,777	3,737,898

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.4 Notes:

None

Data Alerts:

None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	65.2 %	5.1 %	263,625	404,570
2007	61.4 %	6.6 %	144,514	235,493
2003	57.7 %	5.6 %	178,600	309,782

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-18 Notes:

None

Data Alerts:

None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	83.2 %	1.3 %	3,547,871	4,266,077
2007	83.4 %	1.3 %	3,684,697	4,420,982
2003	83.2 %	1.1 %	3,742,722	4,498,836

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-19 Notes:

None

Data Alerts:

None

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	32.4 %	2.2 %	595,108	1,835,215
2007	32.9 %	2.2 %	629,579	1,914,847
2003	30.9 %	1.9 %	611,888	1,978,692

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	31.3 %	0.1 %	59,424	190,138

Legends:
Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	24.4 %	0.9 %	173,389	711,539
2011	25.8 %	1.0 %	200,200	777,042
2009	26.1 %	1.2 %	166,963	639,137
2007	26.9 %	0.9 %	200,383	745,792
2005	27.1 %	1.1 %	207,294	765,158

Legends:
Indicator has an unweighted denominator <100 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-20 Notes:

None

Data Alerts:

None

NOM-21 Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.1 %	0.2 %	172,518	4,229,729

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	4.0 %	0.2 %	170,847	4,255,688
2011	4.4 %	0.2 %	188,067	4,276,363
2010	4.8 %	0.2 %	205,478	4,310,594
2009	4.8 %	0.2 %	211,576	4,422,300

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	4.0
Numerator	171,000
Denominator	4,231,000
Data Source	US Census Bureau
Data Source Year	2013

NOM-21 Notes:

None

Data Alerts:

None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	72.2 %	2.6 %	246,514	341,428
2012	63.7 %	2.3 %	218,450	343,098

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	61.3 %	2.7 %	213,239	347,888
2010	49.0 %	2.8 %	172,031	351,332
2009	47.8 %	2.7 %	175,404	367,087

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

State Provided Data	
	2014
Annual Indicator	76.2
Numerator	
Denominator	
Data Source	National Immunization Survey
Data Source Year	2013

NOM-22.1 Notes:

None

Data Alerts:

None

NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2014	64.5 %	1.3 %	2,569,841	3,983,768
2012_2013	60.9 %	1.4 %	2,443,270	4,014,396

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	54.8 %	1.8 %	2,235,474	4,081,388
2010_2011	54.3 %	1.8 %	271,893	475,337
2009_2010	47.8 %	2.4 %	254,462	491,239

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.2 Notes:

None

Data Alerts:

None

NOM-22.3 Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	61.7 %	3.2 %	364,115	589,991
2012	56.0 %	3.6 %	333,275	595,307
2011	46.6 %	3.0 %	282,584	605,855
2010	56.2 %	3.4 %	345,502	614,347
2009	48.8 %	3.8 %	310,829	636,755

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	38.6 %	3.1 %	238,089	616,868
2012	17.9 %	2.6 %	111,455	621,393
2011	6.4 %	1.4 %	40,463	632,743

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.3 Notes:

None

Data Alerts:

None

NOM-22.4 Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	89.5 %	1.5 %	1,079,545	1,206,859
2012	90.3 %	1.5 %	1,098,346	1,216,701
2011	88.5 %	1.3 %	1,096,560	1,238,598
2010	82.9 %	1.8 %	1,041,143	1,255,446
2009	69.2 %	2.4 %	901,124	1,302,154

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.4 Notes:

None

Data Alerts:

None

NOM-22.5 Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	83.4 %	1.7 %	1,005,909	1,206,859
2012	78.5 %	2.1 %	954,645	1,216,701
2011	74.9 %	1.9 %	927,636	1,238,598
2010	71.2 %	2.3 %	893,640	1,255,446
2009	62.9 %	2.6 %	818,840	1,302,154

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.5 Notes:

None

Data Alerts:

None

Form 10a
National Performance Measures (NPMs)

State: New York

NPM-1 Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	73.4	73.8	74.2	74.7	75.1

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	91.0	91.0	92.0	93.0	94.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	77.0	77.0	77.8	78.9	80.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	33.2	35.6	38.0	40.4	42.8

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

Annual Objectives					

	2016	2017	2018	2019	2020
Annual Objective	27.1	27.5	27.8	28.1	28.5

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	94.9	95.6	96.2	96.9	97.6

NPM-12 Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	41.9	42.4	42.6	42.9	43.3

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	57.2	59.0	61.1	63.0	65.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	77.8	78.5	79.3	80.0	80.7

Form 10b

State Performance/Outcome Measure Detail Sheet

State: New York

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet

State: New York

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: New York

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	100.0	88.5	89.4	99.0	99.0
Annual Indicator	86.8	98.8	97.9	96.4	
Numerator	3,300	2,988	2,906	2,791	
Denominator	3,800	3,024	2,967	2,894	
Data Source	Newborn Screening	Newborn Screening	Newborn Screening	Newborn Screening	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**

Field Note:
As shown in the table, the numerator is the number of closed cases with documentation of an evaluation, diagnostic testing and a diagnosis as appropriate. The denominator is the number of screen positive newborns for the year. The program follows all screen positive newborns to ensure they receive appropriate follow-up.

2.	**Field Name:**	**2012**

Field Note:
As shown in the above table, the numerator is the number of closed cases of screen positive newborns with documentation of an evaluation, diagnostic testing and a diagnosis as appropriate. The denominator is the number of screen positive newborns for the year. The program follows all screen positive newborns to ensure they receive appropriate follow-up.

The remaining open 2011 cases represent complicated patients with ongoing diagnostic evaluations. The Newborn Screening (NBS) Program has obtained confirmation that the patients are in care, but a definitive diagnosis is not available. The annual indicator improved significantly from 2010 to 2011 because routine meetings to review open cases were initiated. The number of lost-to-follow-up cases, where documentation of an ongoing evaluation, diagnostic testing and a diagnosis could not be obtained, remained consistent between 2010 (365 cases) and 2011 (381 cases).

2012 data is pending because the standard diagnostic evaluation for some of the disorders takes up to 6 months; therefore, the annual indicator would not be reliable if reported at this time. 2011 data are used as a proxy for 2012. 2012 data will be available in late 2013.

3.	**Field Name:**	**2011**

Field Note:
As shown in the above table, the numerator is the number of closed cases with documentation of an evaluation, diagnostic testing and a diagnosis as appropriate. The denominator is the number of screen positive newborns for the year. The program follows all screen positive newborns to ensure they receive appropriate follow-up.

The annual indicator is lower for 2010 than 2009 because in some cases, a definitive diagnosis is pending, but confirmation of an ongoing evaluation has been obtained by the Program. Lost-to-follow-up cases, where documentation of an evaluation, diagnostic testing and a diagnosis could not be obtained, remained consistent between 2009 (317 cases) and 2010 (365 cases). Therefore, it is anticipated that the annual indicator for 2010 will increase once the pending cases are resolved.

2011 data is pending because the standard diagnostic evaluation for some of the disorders takes up to 6 months; therefore, the annual indicator would not be a reliable if reported at this time. 2010 data are used as a proxy for 2011. 2011 data will be available in late 2012.

Data Alerts:

None

NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

	2011	2012	2013	2014	2015
Annual Objective	59.6	65.7	66.3	67.0	64.4
Annual Indicator	64.4	64.4	64.4	64.4	
Numerator					
Denominator					
Data Source	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease

Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	45.7	39.2	39.6	39.9	40.3
Annual Indicator	38.4	38.4	38.4	38.4	

	2011	2012	2013	2014	2015
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN Survey	CSHCN Survey	CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: CSHCH-NS-CCHCN under revision, plan is to field in 2016 and data release planned in 2017	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
4.	**Field Name:**	**2012**
	Field Note: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.	

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	62.7	57.9	58.5	59.1	59.6
Annual Indicator	56.8	56.8	56.8	56.8	
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN Survey	CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**

Field Note:
CSHCH - NS-CSHCN under revision, plan is to field in 2016 and data release planned in 2017

2.	**Field Name:**	**2014**

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. Due to the data generated by the new survey, previously established performance objectives prior to 2011 are not realistic and targets for upcoming years were decreased. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	91.5	66.9	67.6	68.2	68.9

	2011	2012	2013	2014	2015
Annual Indicator	65.6	65.6	65.6	65.6	
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN Survey	CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: CSHCH - NS-CSHCN under revision, plan is to test in 2016 and then data release is planned in 2017	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
4.	**Field Name:**	**2012**
	Field Note: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. Due to the data generated by the new survey, previously established performance objectives prior to 2011 are not realistic and targets for upcoming years were decreased. All estimates from the National Survey of CSHCN are	

subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	38.8	40.5	40.9	41.3	41.7
Annual Indicator	39.7	39.7	39.7	39.7	
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN Survey	CSHCN Survey	CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**

Field Note:
CSHCH - NS-CSHCN under revision, plan is to field in 2016 and data release planned in 2017

2.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease

Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

CDC current schedule for the next data collection of these data are in 2014.

3.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

CDC current schedule for the next data collection of these data are in 2014.

4.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator the 2009-10 survey. Therefore, the 2005-06 and 2009-10 surveys can be compared. Due to NY's success in achieving this performance measure, the annual performance objective has been increased over previously established targets. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. 2011 data is being used as a proxy for 2012.

5.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

	2011	2012	2013	2014	2015
Annual Objective	72.9	73.6	74.4	75.1	76.2
Annual Indicator	74.2	72.9	72.9	72.9	
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2013 data are being used as a proxy for 2014 data	
2.	**Field Name:**	**2013**
	Field Note: 2012 data are being used as a proxy for 2013 data.	
3.	**Field Name:**	**2012**
	Field Note: Data is from the National Immunization Survey, 2001, conducted by the CDC. Although NYS as a whole has improved statewide, NYC is 75.9 and Rest of State at 72.6, and is below the national average of 78.7. However, these results may be impacted, in part, due to changes in the survey methodology. Decreasing prevalence of families with land lines (the NIS is a telephone survey) and a small sample size contribute to the variability of the results. 2011 data are used as a proxy for 2012 data.	
4.	**Field Name:**	**2011**

Field Note:
The National Immunization Survey rates have decreased, in part, due to changes in the survey methodology. Decreasing prevalence of families with land lines (the National Immunization Survey is a telephone survey) and a small sample size contribute to the variability of the results. 2010 data are used as a proxy for 2011 data. It is estimated that final 2011 immunization data will be available from CDC in late 2012 or early 2013. NYS exceeds the HP 2020 baseline of 68% for the proportion of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and PCV vaccines but is below the target of 80%.

Data Alerts:

None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	12.0	11.0	10.0	9.4	9.3
Annual Indicator	10.1	9.5	9.5	9.5	
Numerator	3,811	3,500	3,500	3,500	
Denominator	376,774	369,426	369,426	369,426	
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2013 data are being used as a proxy for 2014 data	
2.	**Field Name:**	**2013**
	Field Note: 2012 data are being used as a proxy for 2013 data.	
3.	**Field Name:**	**2012**
	Field Note: 2011 Data are being used as a proxy for 2012.	
4.	**Field Name:**	**2011**
	Field Note: 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.	

Data Alerts:

None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	40.9	42.7	43.5	44.4	45.3
Annual Indicator	41.9	42.6	42.6	40.1	
Numerator		2,881	2,881		
Denominator		6,758	6,758		
Data Source	NYS 3rd Grade Dental Survey	NYS 3rd Grade Surviellance Survey	NYS 3rd Grade Or Health Surveillance Project	NYS 3rd Grade Or Health Surveillance Project	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2013 data are being used as a proxy for 2014 data	
2.	**Field Name:**	**2013**
	Field Note: The NY 3rd Grade Oral Health Surveillance Project (OHSP) is ongoing in both Upstate and NYC schools. Analysis of the data on 6,750 open mouth examinations as part of the second cycle has been completed. A report for the 2009-2012 cycle is being compiled. 2012 data is being used as a proxy for 2013 data.	
3.	**Field Name:**	**2012**
	Field Note: The NY 3rd Grade oral health surveillance project is currently underway in NYC schools. The Upstate NY component of the surveillance project, which had originally been completed in early 2011, is continuing, with additional schools being surveyed. Data for 2011 and 2012 are provisional as a result of continuation of the 3rd Grade Oral Health Surveillance Project. Data for 2010 are used as a proxy for 2011 since an updated analysis of the data is not available. Data show that the prevalence of sealants in Upstate school children has increased. However, it falls short of the national performance measure. Due to NY's success in achieving this performance measure in ROS, annual performance objectives were increased over previously established targets by approximately 2% per year. These increases are consistent with the NYS Prevention Agenda, which sets as a	

target a 10% increase in sealant utilization over a five-year period.

4.	**Field Name:**	**2011**

Field Note:
The NY 3rd Grade oral health surveillance project is currently underway in New York City (NYC) schools. The upstate NY component of the surveillance project was completed in 2011.
*Weighted to reflect the population distribution

Data show that the prevalence of sealants in Upstate school children has increased. However, it falls short of the national performance measure.

Data Alerts:

None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	1.0	1.3	0.8	1.0	0.9
Annual Indicator	0.8	1.2	1.2	1.2	
Numerator	29	43	43	43	
Denominator	3,515,032	3,508,643	3,508,643	3,508,643	
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
2013 data are being used as a proxy for 2014 data

2.	**Field Name:**	**2013**

Field Note:
2012 data are being used as a proxy for 2013 data.

3.	**Field Name:**	**2012**

Field Note:
The number of motor vehicle deaths is based on the definition used by the DOH Bureau of Biometrics and Health

Statistics and includes pedestrians and cyclists. The definition changed in 2004; prior to that time, pedestrians and cyclists were not included. 2011 data are being used for a proxy for 2012 data; 2012 data will be available in May 2014.

4.	**Field Name:**	**2011**

Field Note:
The number of motor vehicle deaths is based on the definition used by the DOH Bureau of Biometrics and Health Statistics and includes pedestrians and cyclists. The definition changed in 2004; prior to that time, pedestrians and cyclists were not included.

2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Data Alerts:

None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	47.9	48.3	53.9	54.0	54.2
Annual Indicator	47.7	53.7	52.6	52.6	
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**

Field Note:
Data Source: National Immunization Survey

2.	**Field Name:**	**2012**

Field Note:
2010 data represents the 2008 birth cohort. 2011 data represents the 2009 birth cohort. 2012 data represents the 2010 birth cohort.

3.	**Field Name:**	**2011**

Field Note:
2010 data are being used as a proxy for 2011 data. 2010 data represents the 2008 birth cohort. 2011 data will be available by May 2013.

Data Alerts:

None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	99.5	84.1	84.1	88.7	
Numerator	229,377	201,126	201,126	210,851	
Denominator	230,608	239,224	239,224	237,775	
Data Source	Newborn Screening	Newborn Hearing Screening	Newborn Hearing Screening Program	Newborn Hearing Screening Program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**
	Field Note: 2012 data are being used as a proxy for 2013 data.	
2.	**Field Name:**	**2012**
	Field Note: Due to the lag in data collection and reporting, 2011 data are used as a proxy for 2012 data. These data are incomplete. Ten hospitals have not submitted their quarterly aggregate data. Therefore, approximately 8,000 to 10,000 births are missing hearing screening data and therefore, 2010 data cannot be compared with 2011 data. Hospitals are no longer required under NY public health law to submit aggregate reports. New York Early Hearing Detection and Intervention (NYEHDI) is transitioning to the collection of individual level hearing screening data.	
3.	**Field Name:**	**2011**
	Field Note: 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.	

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	7.4	7.4	6.5	6.4	6.3
Annual Indicator	6.6	5.6	5.6	5.6	
Numerator	284,000	240,000	240,000	240,000	
Denominator	4,291,000	4,267,000	4,267,000	4,267,000	
Data Source	Current Population Survey	Current Population Survey	US Census Current Population Survey	US Census Current Population Survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2013 data are being used as a proxy for 2014 data	
2.	**Field Name:**	**2013**
	Field Note: 2012 data are being used as a proxy for 2013 data.	
3.	**Field Name:**	**2012**
	Field Note: 2011 Data is being used as a proxy for 2012.	
4.	**Field Name:**	**2011**
	Field Note: 2010 data are being used as a proxy for 2011 data. 2011 data will be available in early 2013.	

Data Alerts:

None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	31.5	31.2	30.3	29.4	29.2
Annual Indicator	31.2	30.4	29.6	13.9	
Numerator	72,042	58,819	61,456	28,795	
Denominator	230,903	193,464	207,856	207,855	
Data Source	PedNSS	PedNSS	PedNSS	NYS WIC	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2011**

Field Note:
2010 data are being used as a proxy for 2011 data. 2011 data will be available in early 2013.

Data Alerts:

None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	8.1	7.1	6.9	6.0	5.8
Annual Indicator	6.2	6.2	6.2	6.2	
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
2011 data are being used as a proxy for 2014 data.

2.	**Field Name:**	**2013**

Field Note:
2011 data are being used as a proxy for 2012 and 2013 data. 2012 data are delayed until December 2014.

3.	**Field Name:**	**2012**

Field Note:
2010 data is being used as a proxy for 2011 & 2012. 2012 data will be available the end of May 2013.

4.	**Field Name:**	**2011**

Field Note:
Numerator and denominator data are not available (survey data). Previous data reported for 2006-2007 were for NYS (Excluding NYC). CDC has recently provided statewide statistics for this indicator. The comparble NYS percentages for 2006 and 2007 are 8.5% and 9.1%, respectively. 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Data Alerts:

None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	4.2	4.5	5.9	5.8	5.7
Annual Indicator	6.1	6.0	6.0	6.0	
Numerator	81	78	78	78	
Denominator	1,324,252	1,307,947	1,307,947	1,307,947	
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
2013 data are being used as a proxy for 2014 data

2.	**Field Name:**	**2013**

	Field Note: 2012 data are being used as a proxy for 2013 data.	
3.	**Field Name:**	**2012**
	Field Note: 2011 data are being used as a proxy for 2012.	
4.	**Field Name:**	**2011**
	Field Note: 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.	

Data Alerts:

None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	91.0	91.3	91.7	92.0	92.4
Annual Indicator	90.7	88.6	88.6	88.6	
Numerator	3,131	3,104	3,104	3,104	
Denominator	3,453	3,505	3,505	3,505	
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2013 data are being used as a proxy for 2014 data	
2.	**Field Name:**	**2013**
	Field Note: 2012 data are being used as a proxy for 2013 data.	
3.	**Field Name:**	**2012**
	Field Note: 2011 data are being used as a proxy for 2012.	

4.	**Field Name:**	**2011**

Field Note:
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Data Alerts:

None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	74.0	74.8	75.5	76.2	77.0
Annual Indicator	72.9	73.8	73.8	73.8	
Numerator	167,091	171,806	171,806	171,806	
Denominator	229,052	232,710	232,710	232,710	
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
VS PNC Methodology Change: calculation of trimester has been revised to incorporate the clinical gestation date for records with unknown PNC start date. As the result – 2,000 records were added to the calculation of the indicators.

2.	**Field Name:**	**2013**

Field Note:
2012 data are being used as a proxy for 2013 data. Methodology Change: calculation of trimester has been revised to incorporate the clinical gestation date for records with unknown PNC start date. As the result – 2,000 records were added to the calculation of the indicators.

3.	**Field Name:**	**2012**

Field Note:
2012 data are being used as a proxy for 2012

4.	**Field Name:**	**2011**

Field Note:

The denominator is the total number of births for which prenatal care initiation is known and excludes births where trimester of entry into prenatal care is unknown. 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Data Alerts:

None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: New York

SPM 1 - The percentage of infants born to Black and Hispanic women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	64.9	65.6	66.2	66.9	66.9
Annual Indicator	65.2	66.7	66.7	66.9	
Numerator	58,996	60,402	60,402	60,402	
Denominator	90,516	90,533	90,533	90,353	
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: 2012 data are being used as a proxy for 2013 data.	
2.	**Field Name:**	**2012**
	Field Note: 2011 data are being used as a proxy for 2012 data. 2012 data will be available in May 2014.	
3.	**Field Name:**	**2011**
	Field Note: 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.	

Data Alerts:

None

SPM 2 - The percentage of Medicaid enrolled children between the ages of 3 and 6 years who had a well-child and preventive health visit in the past year

	2011	2012	2013	2014	2015
Annual Objective	79.5	79.9	80.4	80.9	81.4

	2011	2012	2013	2014	2015
Annual Indicator	80.0	83.0	82.0	82.0	
Numerator					
Denominator					
Data Source	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: These data represent children in this age group who are enrolled in the Medicaid Managed Care (MMC) which includes 88% of all children enrolled in Medicaid. Information on children enrolled in Medicaid fee-for-service is not included. Numerator and denominator data are not available (survey data).	
2.	**Field Name:**	**2012**
	Field Note: These data represent children in this age group who are enrolled in the Medicaid Managed Care (MMC) which includes 88% of all children enrolled in Medicaid. Information on children enrolled in Medicaid fee-for-service is not included. Numerator and denominator data are not available (survey data).	
3.	**Field Name:**	**2011**
	Field Note: These data represent children in this age group who are enrolled in the Managed Care type of Medicaid coverage which includes 87% of all children. Information on children enrolled in Medicaid fee-for-service is not included. Numerator and denominator data are not available (survey data).	

Data Alerts:

None

SPM 3 - The ratio of the Black infant low birth weight rate to the White infant low birth weight rate

	2011	2012	2013	2014	2015
Annual Objective	1.9	1.9	1.8	1.8	1.6

	2011	2012	2013	2014	2015
Annual Indicator	1.8	1.8	1.8	1.8	
Numerator	13	12	12	12	
Denominator	7	7	7	7	
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2012**
	Field Note: 2011 data are being used as a proxy for 2012 data. 2012 data will be available by May 2014. Data are based on rates of low birth weight for White non-Hispanic and Black non-Hispanic births.	
2.	**Field Name:**	**2011**
	Field Note: 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013. Data are based on rates of low birthweight for White non-Hispanic and Black non-Hispanic births.	

Data Alerts:

None

SPM 4 - The percentage of high school students who were overweight or obese

	2011	2012	2013	2014	2015
Annual Objective	26.3	26.1	25.8	25.5	25.3
Annual Indicator	25.7	25.7	25.7	24.4	
Numerator					
Denominator					
Data Source	YRBS	YRBS	YRBS	YRBSS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: 2013 data are being used as a proxy for 2014 data.	
2.	**Field Name:**	**2013**
	Field Note: Data not updated yet. 2012/2013 data will be available in June 2014	
3.	**Field Name:**	**2012**
	Field Note: The YRBS is conducted biannually. Numerator and denominator data from this survey are not available. 2011 data are being used as a proxy for 2012 data.	
4.	**Field Name:**	**2011**
	Field Note: Data are from the 2011 Youth Risk Behavior Suvey. Numerator and denominator data are not available (survey data).	

Data Alerts:

None

SPM 5 - The ratio of the Hispanic teen (ages 15-17) pregnancy rate to the non-Hispanic White teen (ages 15-17) pregnancy rate

	2011	2012	2013	2014	2015
Annual Objective	5.2	4.5	4.5	4.4	4.4
Annual Indicator	4.5	4.4	4.4	4.4	
Numerator	42			37	
Denominator	9			9	
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: 2012 data is being used as a proxy for 2013 data.	

2.	**Field Name:**	**2012**
	Field Note: 2011 data is being used as a proxy for 2012 data. 2012 data will be available in May 2014.	
3.	**Field Name:**	**2011**
	Field Note: 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.	

Data Alerts:

None

SPM 6 - Percent of High School Students Who Smoked Cigarettes in the Last Month

	2011	2012	2013	2014	2015
Annual Objective	12.5	12.3	12.2	12.1	12.0
Annual Indicator	12.5	11.9	11.9	7.3	
Numerator					
Denominator					
Data Source	YRBS	NYS Youth Tobacco Survey	NYS Youth Tobacco Survey	NYS Youth Tobacco Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: 2012 data are being used as a proxy for 2013.	
2.	**Field Name:**	**2012**
	Field Note: The YRBS and YTS are conducted biannually in alternating years. The numerator for each year and both surveys is the number of high school students who reportedly smoked on one or more days in the past 30 days. The denominator for each year and both surveys is the total number of students in grades 9 through 12.	
3.	**Field Name:**	**2011**
	Field Note:	

Data are from the 2011 Youth Risk Behavior Survey. Numerator and denominator data are not available (survey data).

Data Alerts:

None

SPM 7 - The percentage of Medicaid enrolled children and adolescents between the ages of 2-21 years who had at least one dental visit within the last year

	2011	2012	2013	2014	2015
Annual Objective	41.4	41.8	42.2	42.6	43.1
Annual Indicator	41.8	44.2	45.4	43.6	
Numerator	835,106	814,503	873,813	956,873	
Denominator	1,996,387	1,841,199	1,924,213	2,197,024	
Data Source	Bur of MA Statistics	Bureau of MA Statistics	Bureau of Mediciad Statistics & Program Analysis	Bureau of Mediciad Statistics & Program Analysis	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2012**
	Field Note: This indicator is based on data for all Medicaid recipients, including managed care and family health plus paid claims as of June 2012	
2.	**Field Name:**	**2011**
	Field Note: This indicator is based on information from both Managed Care and Fee-for- Sevice Medicaid Programs.	

Data Alerts:

None

SPM 8 - Percentage of children who were tested for lead two or more times before the age of three.

	2011	2012	2013	2014	2015
Annual Objective	51.0	51.5	52.0	52.5	53.0
Annual Indicator	55.0	57.6	57.6	57.6	
Numerator	137,431	142,143	142,143	142,143	
Denominator	249,655	246,592	246,592	246,592	
Data Source	NYS Lead Program	NYS Lead Program	NYS Lead Program	NYS Lead Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2012**
	Field Note: Data are reported for children turning three years of age in the year reported – i.e., data reported for 2011 are for children born in 2008. Data are statewide, including NYC. 2011 data are used as a proxy for 2012. 2012 data will be available in May 2014.	
2.	**Field Name:**	**2011**
	Field Note: Data are reported for children turning three years of age in the year reported – i.e., data reported for 2010 are for children born in 2007. Data is statewide, including NYC. 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.	

Data Alerts:

None

SPM 9 - Hospitalization Rate for Asthma in Children Ages 0 to 17 years.

	2011	2012	2013	2014	2015
Annual Objective	31.0	26.5	26.4	26.3	26.2
Annual Indicator	26.5	26.8	26.8	25.9	
Numerator	11,341	11,406	11,406	10,986	
Denominator	4,286,008	4,263,154	4,263,154	4,239,976	
Data Source	SPARCS	SPARCS	SPARCS	SPARCS	
Provisional Or				Provisional	

	2011	2012	2013	2014	2015
Final ?					

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: 2013 data are being used as a proxy for 2014 data.	
2.	**Field Name:**	**2013**
	Field Note: 2012 data are being used as a proxy for 2013 data.	
3.	**Field Name:**	**2012**
	Field Note: 2011 data are being used as a proxy for 2012 data. 2012 data will be available by May 2014	
4.	**Field Name:**	**2011**
	Field Note: 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.	

Data Alerts:

None

SPM 10 - The percentage of infants who were exclusively fed breast milk between birth and hospital discharge

	2011	2012	2013	2014	2015
Annual Objective	43.1	43.6	44.0	44.4	44.8
Annual Indicator	39.8	40.6	40.6	40.6	
Numerator	86,126	87,554	87,554	87,554	
Denominator	216,625	215,852	215,852	215,853	
Data Source	Statewide Perinatal Data System	Statewide Perinatal Data System	Statewide Perinatal Data System	Vital Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**

Field Note:
2012 data are being used as a proxy for 2013 data.

2.	**Field Name:**	**2012**

Field Note:
2011 data is being used as a proxy for 2012 data. 2012 data will be available in May 2014. The denominator includes all live born infants, excluding infants who were admitted to the NICU or transferred in or out of the hospital. The method the infant is fed is recorded on the Certificate of Live Birth and is defined as the period between birth and discharge from the hospital, up until 5 days of age (when NYS law requires report of live births). Infants are classified as being fed exclusively breast milk if they were fed only breast milk, and no other liquids or solids except for drops or syrups consisting of vitamins, minerals or medications.

It should be noted that the percentage of infants exclusively fed breast milk in the delivery hospital appears to have decreased from 43.5% in 2010 to 39.8% in 2011. Efforts were made to improve and standardize the reporting for the infant feeding variables, including exclusively fed breast milk. Guidance from the National Center for Health Statistics, that newborn infant feeding data should be reported for the entire period spent in the delivery hospital (i.e., between birth and discharge), was shared with hospitals. Some hospitals had been reporting infant feeding based only on the last 24 hours or the last day of hospitalization. This change in reporting resulted in a reduction in the percentage of infants reported as being exclusively fed breast milk.

3.	**Field Name:**	**2011**

Field Note:
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Data Alerts:

None

Form 11
Other State Data

State: New York

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: New York

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table

MCH Partnerships, Collaboration, and Coordination

As highlighted throughout its Needs Assessment (NA) and noted specifically in NA Summary *Section II.B.2.c*, NY's Title V Program has extensive partnerships to meet the needs of NY's MCH population, including coordination and collaboration with other public health programs, state and local agencies, private sector partners, families and consumers. Key partnerships, collaboration and coordination are summarized below. Note that due to the extensive nature of NYS Title V partnerships, this summary highlights selected partners and collaborations most relevant to MCH needs, priorities and strategies outlined in this application.

Partner	Selected Partnership Highlights
State Advisory Councils	
Maternal and Child Health Services Block Grant (MCHSBG) Advisory Council	• Title V staff convene and provide staff support to Council • Through regular virtual and in-person meetings, Council members provide input and feedback on full range of Title V priorities and activities. • Special series of meetings 2014-15 to provide input on Title V Needs Assessment and Action Plan development for 2016 application.
Early Intervention Coordinating Council (EICC)	• Title V/Early Intervention staff convene and provide staff support to Council • Extensive input on EI policy and program activities including State Systemic Improvement Plan to improve family outcomes • Co-convened, with ECAC, Joint Task Force on Social Emotional Development of Young Children
Early Childhood Advisory Council (ECAC)	• Title V staff represented on Council, Steering Committee and work groups • Development and implementation of health-related quality standards for QualityStarsNY (NY's tiered quality rating and improvement system for early learning programs) • Co-convening, with EICC, of Joint Task Force on Social Emotional Development of Young Children
NYS Office of Victims Services Advisory Council	• Title V staff represented on Council; provides expertise regarding prevention of sexual violence. •
Office for the Prevention of Domestic Violence	• Title V staff represented on Council; provides expertise regarding prevention of sexual violence and intimate partner violence.
Other HRSA MCHB Investments	
State Systems Development Initiative (SSDI)	• Directly managed by Title V program within DFH • SSDI staff support development of measures, review and analysis of data to support MCH planning and projects
Maternal, Infant and Early Childhood Home Visiting (MIECHV)	• Directly managed by Title V program within DFH, Bureau of Women, Infant & Adolescent Health

	• Strong focus on systems-building integrates MIECHV with other Title V and MCH resources
Early Childhood Comprehensive Systems (ECCS)	• Original NYS ECCS grant co-led by Title V and Council on Children and Families (CCF); subsequently transferred to CCF, with continued Title V engagement to support current grant focus on implementing child care quality standards and supporting child care health consultants
MCH Training Grants	• Successful joint application to establish new MCH Catalyst Program at SUNY Albany School of Public Health; Title V Director will co-direct Catalyst Program.
Autism Research Grant	• Completed a multi-year research project funded by the federal MCHB R-40 research program to evaluate the impact of participation in the State's EIP on toddlers with ASD and their families. • Identified ASD-specific outcomes expected to be achieved through EIP services. Results were used to modify a family survey, including an Impact on Child scale and Impact on Family scale, to include outcomes expected for ASD toddlers and their families.
Abstinence Education Grant Program - HRSA	• Directly managed by Title V program within DFH. Coordinates with pregnancy prevention efforts by targeting pre-adolescents in NYS' highest need communities by providing mentoring and adult supervised opportunities.
Other Federal Investments	
Family Planning (Title X) – Office of Population Affairs	• Directly managed by Title V program within DFH. Conducted a structured performance management project that has resulted in increased access to and use of effective contraceptive methods, including LARC, by women served in Title X family planning clinics.
Individuals with Disabilities Education Act (IDEA) Part C - OSEP	• Part C grant and EI is directly managed by Title V program within DFH. • DOH is the NYS designated lead agency to administer the EIP, a statewide service delivery system for infants and toddlers (ages birth to three) with disabilities and their families
Personal Responsibility Education Program (PREP) – HHS	• Directly managed by Title V program within DFH. Supports programming for priority populations served in the child welfare and juvenile justice systems. • Collaborates with CAPP programs to enhance pregnancy prevention efforts in the highest need communities.
Rape Prevention Education - CDC	• Directly managed by Title V program within DFH. Development of a multi-faceted plan to evaluate regional and statewide activities to reduce sexual violence
Special Supplemental Program for Women, Infants & Children (WIC) - USDA	• Managed by DOH Division of Nutrition. • Title V programs (e.g., home visiting) link eligible MCH populations to WIC resources • Exploring collaborations to promote oral health through WIC Program

Child Care Development Block Grant - ACF	• Managed by NYS Office of Children and Family Services. • Development of child care health and safety standards, including medication administration, as well as quality indicators for QualityStars NY • Plan to collaborate on development of subset of quality indicators for regulated child care settings in upcoming year
Support for Pregnant and Parenting Teens- OAH	• Directly managed by Title V program within DFH. Enhances services of Title V programming by engaging pregnant and parenting teens and young adults in educational and vocational opportunities.
Other HRSA Programs	
Federally Qualified Health Centers (FQHC)	• In collaboration with OPCHSM, the Title V Program facilitates approval of site establishment/ expansion applications to build or renovate school-based health and dental clinics funded by HRSA grants • Title X engaged FQHC representatives in workgroup to support transition of SBHCs from Medicaid fee-for-service to managed care • Title X engaged FQHC representatives in a national program improvement project focused on pre/interconception health; FQHCs will pilot documenting women's pregnancy intentions and receipt of contraceptive services in several non-reproductive health care settings within their health systems.
Healthy Start	• In collaboration with the HRSA Regional Healthy Start Project Officer, Title V program coordinates communication and collaboration between the Healthy Start and Title V Maternal, Infant & Child Health Collaboratives (MICHC) programs. • Ensure MICHC projects engage the 7 Healthy Start grantees serving common communities in outreach, intake and referral processes. • Share webinar trainings and educational materials developed by the Maternal and Infant Health Center of Excellence with Healthy Start grantees.
Association of University Partners on Disabilities (Yeshiva University/ Albert Einstein College of Medicine, Westchester Institute for Human Development and Strong Center for Developmental Disabilities)	• Title V participates in ongoing meetings with the Leadership Education in Neurodevelopment and Related Disabilities (LEND) fellows to share information regarding their post-graduate maternal and child health work performed as part of their fellowship training. Meetings also include representatives from the Developmental Disabilities Planning Council (DDPC), Disability Rights New York, Division of Family Children's Services, and CSHCN and other key stakeholders**.**
State, Tribal and Local MCH Programs	

Local Health Departments/ New York State Association of County Health Officials	• Title V developed Family Health components of updated statute, regulations and implementing guidance documents for State Aid to localities for core public health (Article VI) • Regular meetings with NYSACHO Steering and MCH committees and ad hoc work groups for input on CSHCN program planning, Health Home, Early Intervention and Title V needs and priorities • Collaborating to develop training and technical assistance for all LHDs to improve MCH outcomes on the local level.
Tribes, Tribal Organizations and Urban Indian Organizations	• Title V program administers a state program that provides access to primary medical care, dental care, eye care, pharmacy needs and preventive health services for approximately 25,000 Native Americans living within reservation communities. This includes nine recognized American Indian nations in NYS: Tonawanda, Tuscarora, Onondaga, Shinnecock, Unkechaug, Cayuga, St Regis Mohawk, Seneca and Oneida. • Title V staff serve as liaison with the Nations to ensure the interests of the nations are represented in decisions and information, such as ACA- related information, is conveyed to Nation leadership. • Title V staff participated in quarterly Tribal Consultation meetings with Office of Children and Family Services to share resources on child wellness, behavioral health, victim assistance programs, and educational resources for families. • Title V staff collaborated with CDC immunization liaison to encourage tribal participation in Vaccine for Children program and adult vaccine program.
Other NYS Department of Health Programs	
Chronic Disease Prevention	• Title V staff in collaboration with the Division of Chronic Disease Prevention jointly developed media campaign on tobacco use among women of reproductive age and during pregnancy • Title V staff in collaboration with the Division of Chronic Disease Prevention integrated new family planning/ preconception health module within state's BRFSS, including expanded BRFSS for county-level data • Support hospital- and community-based strategies to promote breastfeeding in alignment with evidence-based obesity prevention programming • Promoted evidenced-based models and methods to implement and sustain a population-based, system change response to reduce asthma-related hospitalizations. • Will explore options to promote preconception and interconception health for the MCH population.
Nutrition	• Title V staff facilitated collaboration between nutrition programs and state's ECAC to expand enrollment in

	CACFP and incorporate nutrition standards and implementation supports within child care quality standards • Promoted participation in CACFP with Title V afterschool programs serving high-need youth and helped link to new Community Schools initiative • Title V staff are exploring collaborations to promote oral health through statewide nutrition programs including WIC and HPNAP • Title V staff are working with WIC to promote reciprocal referrals with home visiting programs.
Injury Prevention	• Title V staff are collaborating with the Bureau of Occupational Health and Injury Prevention on evaluating the impact of DOH sexual violence prevention interventions • Title V staff are working with Injury Prevention to promote Safe Sleep through Infant Mortality COIIN.
Immunization	• Title V staff are working with Immunization program on providing training and educational tools for home visitors to support education to clients on importance and scheduling of required immunizations, and training of home visitors on the importance they themselves be up to date on immunizations. • Title V staff incorporated technical guidance on current immunization recommendations in clinical quality measures for SBHC program. • Title V staff are working with Immunization program to promote recommended immunizations (e.g. influenza and TDAP) for pregnant women.
HIV/AIDS	• Title V staff are collaborating with the DOH AIDS Institute and the State Education Department to promote the delivery of evidence-based HIV/STI prevention education.
Environmental Health	• Title V staff are collaborating with DOH Center for Environmental Health to support maintenance and expansion of community water fluoridation, including joint development of new initiative. • Ongoing collaboration to promote healthy living environments.

Medicaid	• Title V staff are working with DOH Office of Health Insurance Programs (OHIP) to integrate perinatal health strategies and measures within DSRIP. • Title V staff are implementing Medicaid-funded demonstration project to use health information technology to improve screening and coordinated follow-up for high risk pregnant women • Title V staff worked with DOH OHIP to convert Family Planning Benefit Program from 1115 waiver to state plan service pursuant to ACA, and expanded to include presumptive eligibility • Title V staff are extensively engaged in development and implementation of new Health Home benefit for CSHCN, including services for children enrolled in EI services • Title V staff and OHIP are jointly leading stakeholder workgroup to facilitate transition of MA coverage for SBHC services from fee-for-service to managed care. • Title V staff provide expertise in the development of Medicaid payment policies such as deliveries prior to 39 weeks without medical indication including C-sections, oral health and other areas impacting the MCH population.
NY State of Health (Health Insurance Exchange)	• Title V staff assisted with outreach to MCH programs to solicit patient navigators • Title V staff in collaboration with OHIP, facilitated training and the provision of information on NY's health benefit package and coverage to MCH programs and initiatives. Continue to monitor questions and issues that arise.
Quality & Patient Safety	• Title V staff provided input into the development of standards for Medicaid Prenatal Care clinics. • Title V staff provide input to, and serve on workgroups for the development and implementation of the SHIP and the development of models of Advanced Primary Care (APC). • Title V staff are collaborating on a CMS project with OHIP through NYSPQC as collaboration of regional perinatal centers to improve perinatal outcomes. • Title V staff have a strong partnership with the Office of Quality and Patient Safety to obtain vital statistics data for identification of priorities, program planning and evaluation as well as quality improvement initiatives.
Primary Care and Health Systems Management	• In collaboration with Title V staff, provides certificate of need (CON) approval to SBHC and SBHC-Dental clinics. Also provides CON approval to family planning clinics and consults with Title V staff for programmatic input. • In collaboration with Title V staff, developed standards and criteria for oversees the system of perinatal regionalization • Title V staff in conjunction with the Office of Victim Services developed communication disseminated to all

	NYS hospitals reminding them of the requirements concerning the reimbursement of forensic rape exams.
Minority Health & Health Disparities	• Title V staff are collaborating with DOH Office of Minority Health to develop plan to work with Tribal Nations to develop protocol to ensure that diagnostic services related to cancer screening that take place off reservation with a medical partner of the Cancer Services program, are charged to NYS CSP, to maximize utilization of AIHP funds for outpatient and pharmacy needs.
Public Health Practice	• Title V staff collaborate with the Office of Public Health Practice to provide guidance and training for LHDs to strengthen their efforts with the MCH population. • Title V staff are engaging with PHHPC public health committee on systems strategies to reduce maternal mortality
Office of Health Insurance Programs	• Title V staff are involved in ongoing collaboration to promote access to the Medicaid Family Planning Benefit Program • Title V staff work with OHIP to access vital statistics for evidence-based, data driven evaluation of activities.
Other State Agencies	
Office of Mental Health (OMH)	• Title V staff are collaborating with OMH to increase awareness of maternal depression, including providing information to providers and pregnant and postpartum women. • Title V staff are developing collaborative strategies with OMH to support young children's social and emotional development and provide supports for parents.
Office of Alcoholism and Substance Abuse Services (OASAS)	• Title V staff are collaborating with OASAS to increase awareness of FASD amongst providers and preconception and prenatal women. • Title V staff are collaborating with OASAS to develop strategies to identify pregnant women with opioid use and ensure they are engaged in prenatal care, substance use treatment and other needed services. • Title V staff serve on the Fetal Alcohol Spectrum Disorder (FASD) workgroup that includes state agencies as well as providers and other stakeholders to develop strategies to address FASD. Developed public awareness messages on the importance of abstaining from alcohol while pregnant. Provided information to the American Indian Health Nations on FASD.
Office of Children and Family Services (OCFS)	• Title V staff are collaborating with OCFS to provide training and technical assistance to home visiting programs including improving outreach and retention strategies and delivery of information and supports impacting maternal and infant health and early childhood development.

	• Title V staff provided input on the Navigating Multiple Systems site to ensure the issues and interests of the MCH population, including CSHCN are represented.
Office of Temporary and Disability Assistance (OTDA)	• Title V staff collaborate with OTDA to provide funding and support to Nurse Family Partnership programs including promoting shared goals of family self-sufficiency.
Office of Prevention of Domestic Violence (OPDV)	• Title V staff are involved in ongoing collaboration to address the domestic violence-related training needs of staff working in community maternal & child health, home visiting and family planning programs • Title V staff are collaborating with OPDV on development of training for home visitors on engagement and retention on high-risk clients including those who experience domestic violence. • Title V staff collaborate with OPDV to develop and distribute materials to providers, to increase awareness of domestic violence, supports, resources and tools.
Office of People with Developmental Disabilities (OPWDD)	• Title V staff partner with OPWDD on various issues related to individuals with disabilities.
Office of Victim Services (OVS)	• Title V staff are involved in ongoing collaboration to address needs of programs funded to serve victims of sexual violence and respond to issues that impact victims of sexual violence
State Education Department (SED)	• Title V staff provide technical assistance to Community schools to promote collaboration to maximize resources available to children and adolescents in those schools.
Council on Children and Families (CCF)	• Title V staff work with CCF on the ECAC, ECCS grant and other early childhood initiatives.
Academic Partners and Professional Membership Organizations	
SUNY Albany School of Public Health (SPH)	• Title V supports MCH student internships focusing on providing these students with public health experience at DOH on MCH initiatives. • Title V staff collaborated with the SPH on a series of webinars to improve knowledge and practices including topics such as breastfeeding and screening for Critical Congenital Heart Defects (CCHD. • Title V staff collaborated with the SPH on the development of a successful MCH catalyst grant.
Professional Medical Organizations	• Title V staff collaborate with ACOG to develop and promote best practices to improve perinatal outcomes. • Title V staff coordinate NY's Maternal Mortality Review Committee that includes representatives from NY Academy of Medicine, ACOG, NYS Society of Pathologists, NYS Nurses Association, NYS Association

	of County Health Officials, NYS Association of Licensed Midwives, NYS Academy of Family Physicians, National Association of Social Workers, NYC Department of Health and Mental Hygiene, NYS Association of County Coroners and Medical Examiners, NYC Office of the Chief Medical Examiner, Association of Regional and Perinatal Networks, NYS Office of Alcoholism and Substance Abuse, NY American College of Emergency Physicians, Medical Society of the State of New York, NYS Society of Anesthesiologists, NYS Dietetic Association, Greater New York Hospital Association, Healthcare Association of NYS, and Regional Perinatal Centers.
Cornell University	• Title V staff collaborate with Cornell through the Center of Excellence to support implementation of evidence based programming and evaluation of adolescent pregnancy prevention/pregnant and parenting teen activities.
University of Rochester	• Title V staff collaborate with the University of Rochester through the Center of Excellence on training, technical assistance and evaluation of community maternal and infant health initiatives.
Columbia University	• Title V staff collaborate with Columbia University to develop training for health care providers on adolescent health topics to improve general and sexual health outcomes.
University of Albany Center for Human Services Research	• Title V staff collaborate with the University at Albany on data management for community maternal and infant health initiatives.
New York State Perinatal Quality Collaborative (NYSPQC)	• Title V staff lead NYSPQC, a collaboration of NYS birthing facilities to improve perinatal outcomes through the translation of evidence-based findings to clinical practice • Successful collaborations with ~100 NYS birthing hospitals, HANYS, GNYHA, March of Dimes, ACOG and more
Family and Consumer Partners	
Parent to Parent of NYS	• Provided input, guidance and outreach for input on NY's Title V comprehensive needs assessment. • Title V staff collaborate with PTP to ensure the "parent voice" and point of view is reflected. For example, provided input into the parent materials on CCHD screening.
Hands and Voices	• Organization comprised of parents and providers dedicated to supporting families with children who are deaf or hard of hearing, regardless of communication modes or methodologies. Provides input into NY's Early Hearing Detection Initiative.
Other NYS organizations	
Schuyler Center for Analysis and Advocacy (SCAA)	• Title V staff participate on the SCAA State Home Visiting Workgroup which facilitates discussions on

	the critical elements of a statewide home visiting system including outreach and engagement of high-risk families, promotion of a continuum of services, and quantifying need for services. • Title V staff collaborate with SCAA to promote community water fluoridation.
New York-Mid-Atlantic Consortium for Genetics and Newborn Screening Services (NYMAC)	• Title V staff facilitated webinars on adolescent transition to adult services for genetic services providers, health care providers and CSHCN program.
Maternal Mortality Review Committee	• Convened by the Title V program with representation from over 20 professional organizations and associations. • Reviews aggregate data, discusses trends and emerging issues and provides recommendations regarding opportunities for improvement including preventive measures, strategies to improve care and medical management, and educational need to be addressed.
NYS CoIIN to Reduce Infant Mortality	• Statewide collaboration initiated by the Title V program targeting Safe Sleep and Pre/Interconception Care to reduce infant mortality. Includes staff from various state agencies such as the Office of Children and Family Services (OCFS); the National Institute for Children's Health Quality (NICHQ); birthing facility staff; doctors; nurses; social workers; community organizations; the March of Dimes; and hospital associations such as the Healthcare Association of New York State (HANYS) and the Greater New York Hospital Association (GNYHA).

MCH Workforce Development and Capacity

The DFH leads NY's Title V efforts. Rachel de Long, M.D., M.P.H. serves as the Director of the DFH and the NYS Title V program in the DOH. Dr. de Long is on the faculty of the SUNY at Albany School of Public Health in the Department of Health Policy, Management, and Behavior. She earned a B.S. in Rural Sociology from Cornell University, M.D. from University of Wisconsin Medical School, and M.P.H. from SUNY Albany School of Public Health. She completed a medical internship in Family Practice at the Guthrie Clinic and residency in Preventive Medicine at SUNY Albany/NYSDOH, and is Board-Certified in Preventive Medicine and Public Health. Dr. de Long provides policy and program direction and administrative oversight for all the Division's bureaus in addition to several quality initiatives.

Wendy Shaw, M.S., B.S.N. serves as Associate Director of the DFH. Ms. Shaw has a Bachelor's degree in nursing from the State University of New York at Albany, and a Master of Science degree from Russell Sage College. She is also a graduate of the Leadership Program in Public Health from Harvard University. Ms. Shaw started her career as a public

health nurse working with high-risk maternal and child health families and later moved to obstetric nursing before moving to state service. Ms. Shaw has 35 years of labor and delivery experience and continues to work in that field outside of state service. Ms. Shaw's education and experience provides an excellent foundation for her role in support of NY's Title V program.

Marilyn Kacica, M.D., M.P.H., the medical director of the DFH, is a graduate of St. Louis University and received her M.D. from the St. Louis University Medical School. She completed pediatric residency training at the Cardinal Glenon Children's Hospital, subspecialty training in pediatric infectious disease at the Children's Hospital of Cincinnati, and her preventive medicine residency at DOH. Her M.P.H. was awarded from the State University of New York at Albany, School of Public Health, where she is currently a Clinical Associate Professor of Epidemiology. She is board-certified in Pediatrics and is a fellow of the AAP. She is providing leadership on a myriad of clinical, epidemiological, data utilization and quality improvement issues within the DFH including the NYSPQC. In addition, she is the program director for DOH's Child Health Integration Initiative which is focusing on the integration of child health information for both public health and provider benefit.

Christopher Kus, M.D., M.P.H., the Associate Medical Director for the DFH, is a graduate of Michigan State University and the Wayne State University School of Medicine. He received his M.P.H. from University of North Carolina at Chapel Hill. A board-certified pediatrician and a fellow of the AAP, Dr. Kus is a Past President of the AMCHP and serves as co-chair of the AMCHP Legislative and Finance Committee.

Kristine Mesler, M.P.A., B.S.N., serves as the director of BWIAH. Ms. Mesler brings a wealth of experience in the field of maternal and child health to this position. Ms. Mesler graduated from the State University of New York at Albany with a Bachelor's degree in nursing, and a Master of Public Administration from Rockefeller College of Public Affairs and Policy. Ms. Mesler's education and her experience as both a public health nurse and in obstetric nursing provides a solid background for her leadership role in the Bureau's efforts related to the MCH population.

Susan Slade, RN, MS, serves as the director of the BCH as well as NYS's CSHCN director, and is an experienced clinical and public health nurse and public health administrator. Ms. Slade received her Bachelor's degree in nursing, and a Master of Science degree from Russell Sage College. Ms. Slade has extensive public health experience in addition to over 24 years in emergency medicine and she continues to work as an emergency department nurse outside of state service. She has led NY's efforts to improve the health and wellness of NY's CSHCN. In addition to being a licensed Registered Nurse, Ms. Slade is also a Masters Certified Health Education Specialist.

Jayanth Kumar, DDS, MPH, the former Director of the BDH retired in May 2015. Kara Connelly is serving as Assistant Director of the Bureau of Dental Health. Prior to that, Ms. Connelly served as the school-based dental program manager. Before joining the

Bureau of Dental Health in 2006, Kara worked in the DOH's Office of Science and Public Health as a training specialist and health educator. Ms Connelly holds a bachelor's degree in Broadcasting and Communications from SUNY Oswego and a Master of Science degree in Health Administration from Sage Graduate School. Prior to joining the department in 2002, Kara served as an intern in Washington, DC for U.S. Health and Human Services Secretary Tommy Thompson.

Brenda Knudson Chouffi, MS. Ed. and Donna Noyes, PhD are Co-directors of the Bureau of Early Intervention. Ms. Knudson Chouffi received a Master's of Education/Educational Psychology from the State University of New York at Albany and holds permanent teacher certification in Special Education. Ms. Knudson Chouffi has worked in the BEl for the past 16 years. Prior to her work with the DOH, she provided special education services under the EIP, Committee of Preschool Special Education and Committee of Special Education.

Dr. Noyes has an MS and doctorate in developmental psychology from Stony Brook University. She joined the Department's Early Intervention Program in 1989 and prior to that time, worked as a research associate in the NYS Council on Children and Families. Dr. Noyes is the PI on three grants related to improving early identification and evaluating the impact of intervention services for young children with autism spectrum disorders and their families.· She is Past President and Board Member of the national Infant Toddler Coordinators Association.

Needs Assessment Summary Attachment
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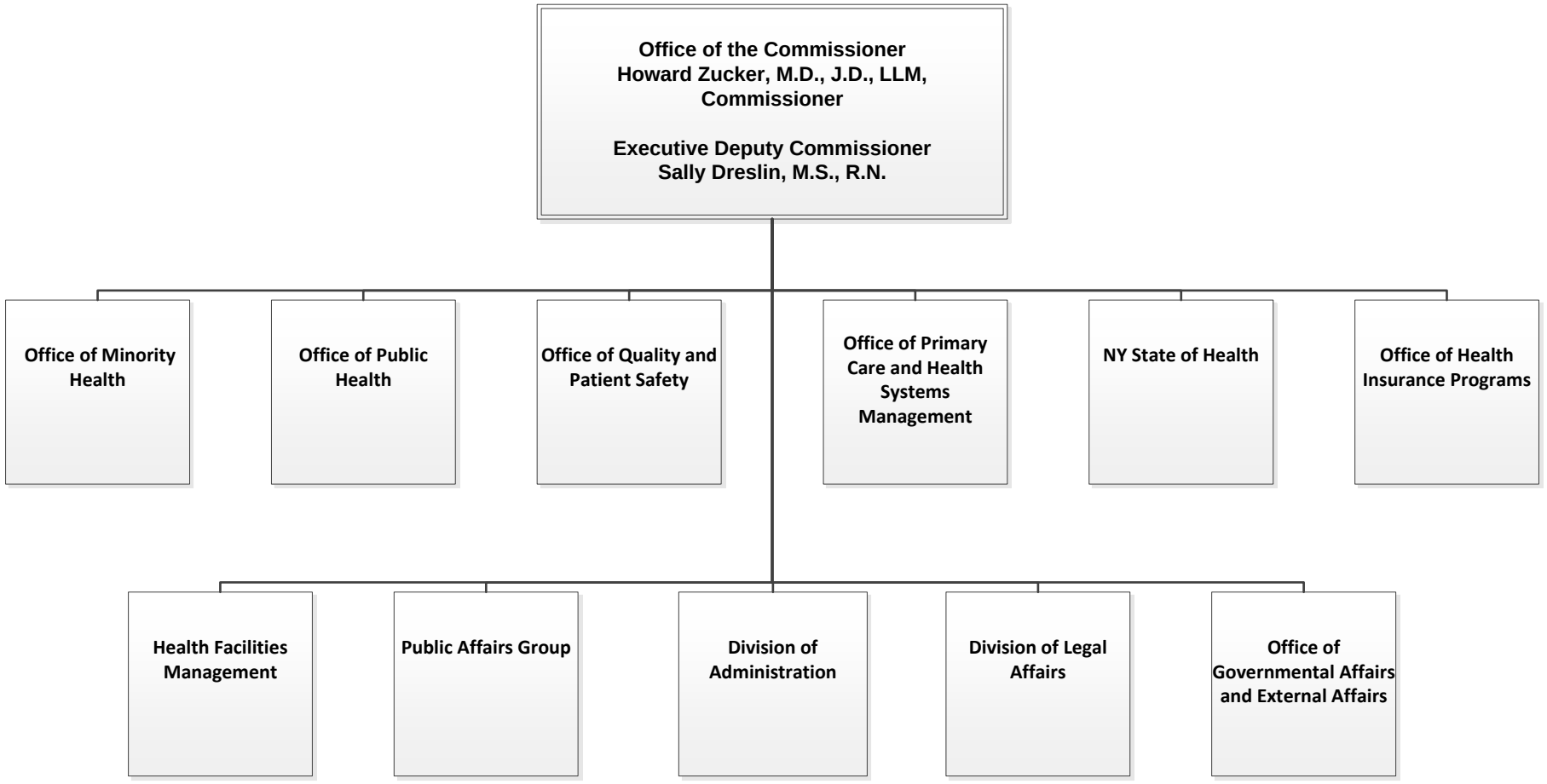

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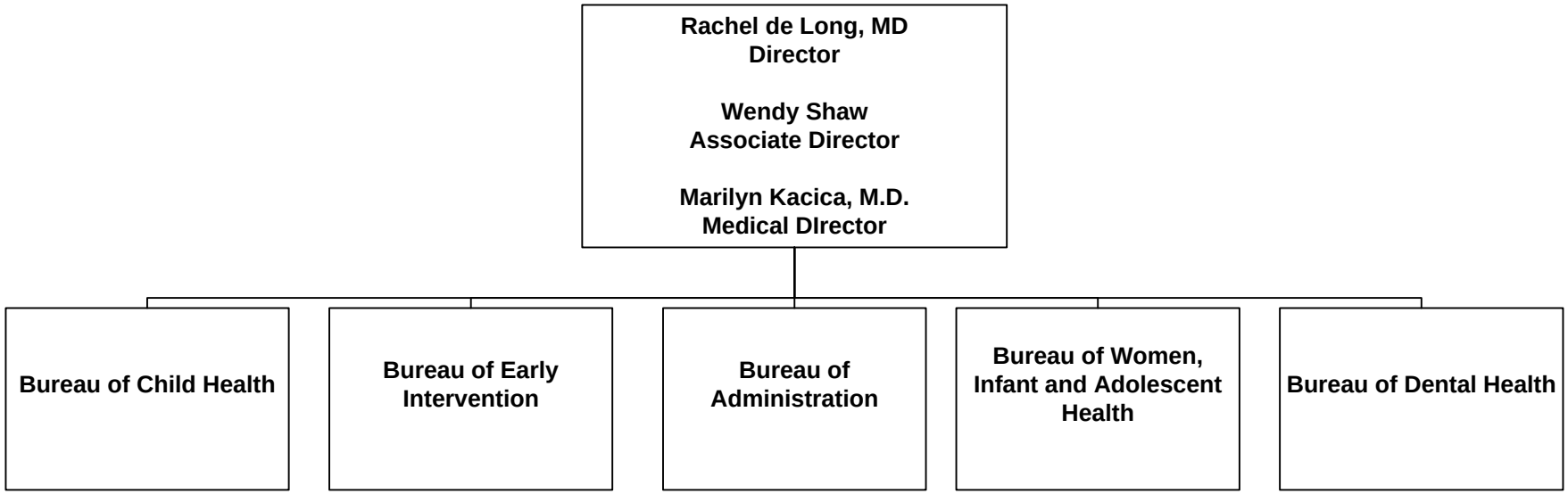

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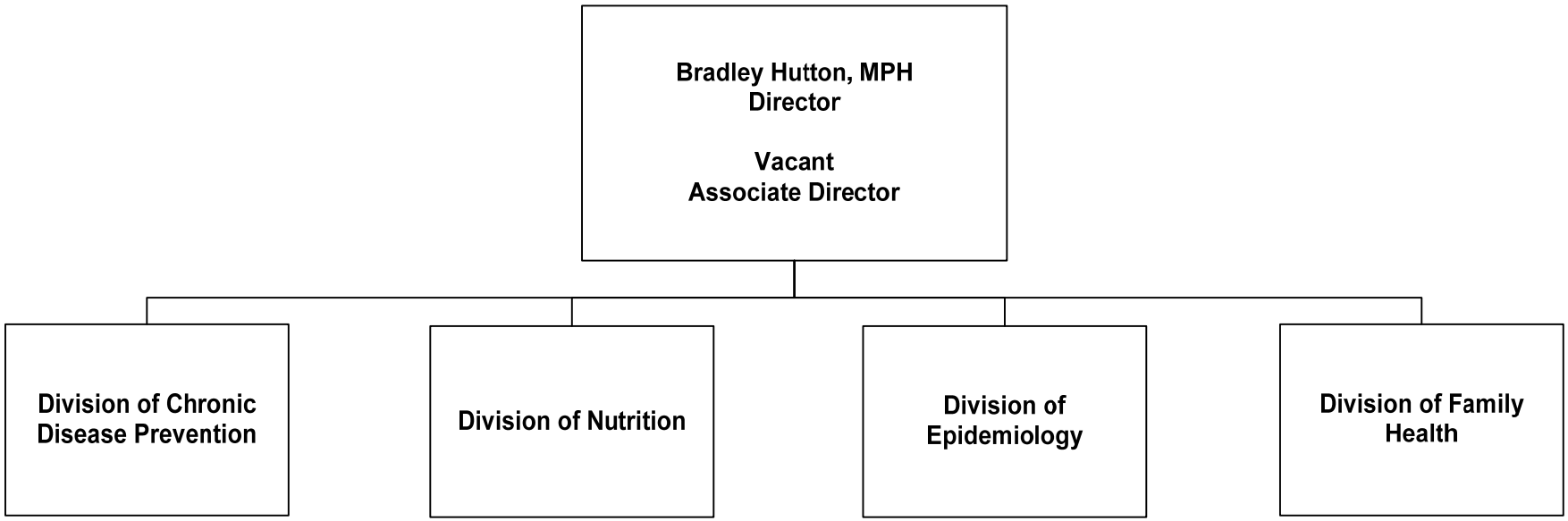
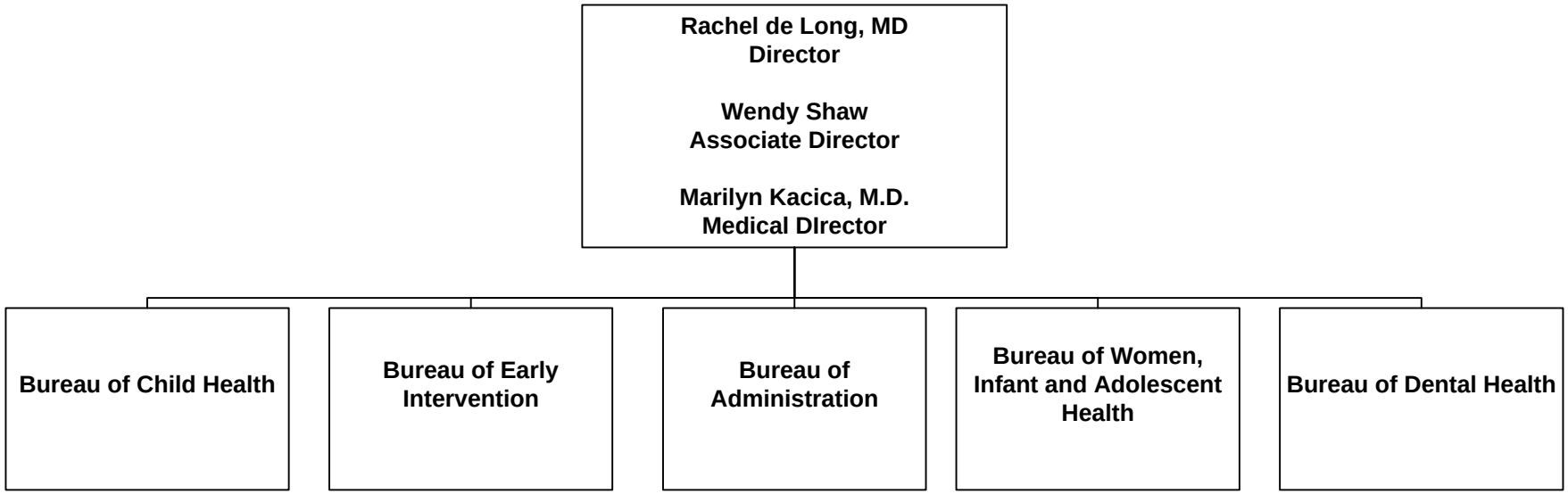
CENTER FOR COMMUNITY HEALTH



NYS DEPARTMENT OF HEALTH

DIVISION OF FAMILY HEALTH



Proposed or Current Priority	2011-2015 MCH Priorities	2016-2020 MCH Selected Priority
Domain 1: Maternal and Women's Health		
Reduce maternal mortality and morbidity	X *Specifically:* Eliminate disparities in birth outcomes; also a specific state outcome measure for maternal mortality rates	X
Increase use of preconception and interconception ("well-woman") services among women of reproductive age *(as part of priority on use of preventive health care services across the life course)*	X *Specifically:* Eliminate disparities in birth outcomes; Reduce unintended pregnancies in adults and adolescents	X
Increase use of prenatal and postpartum health care services *(as part of priority on use of preventive health care services across the life course)*	X *Specifically:* Improve access to early, adequate and high quality prenatal health with focus on health disparities	X
Improve diagnosis and treatment of asthma in MCH population	X	
Domain 2: Perinatal and Infant Health		
Reduce infant mortality and morbidity	X *Specifically:* Eliminate disparities in birth outcomes especially with regard to low birth weight and infant mortality	X
Increase use of preventive ("well baby") health care services for infants *(as part of priority on use of preventive health care services across the life course)*	X *Specifically:* Improve access to comprehensive, high quality primary and preventive health care for children	X
Domain 3: Child Health		
Support and enhance children's social-emotional development and relationships for children *(as part of shared priority for children and adolescents)*		X
Increase use of preventive ("well child") health care services by children	X *Specifically:* Improve access to comprehensive, high quality primary and preventive health care for children	X

Improve diagnosis and treatment of asthma in MCH population	X	
Domain 4: Children with Special Health Care Needs		
Increase supports to address the special health care needs of children and youth	X *Specifically*: Improve access to comprehensive, high quality primary and preventive health care consistent with medical home model for children including CSHCN	X
Domain 5: Adolescent Health		
Support and enhance adolescents' social-emotional development and relationships for children *(as part of shared priority for children and adolescents)*	X *Specifically:* Improve adolescent sexual health and development; Reduce tobacco, alcohol and substance use among youth	X
Increase use of preventive ("well teen") health care services by adolescents	X *Specifically:* Improve access to comprehensive, high quality primary and preventive health care for children; reduce unintended pregnancies among adolescents	X
Domain 6: Cross-Cutting Life Course		
Increase use of preventive health care services across the life course: • Preconception/ Interconception ("well woman", including pregnancy planning and prevention) • Prenatal and Postpartum • Infants ("well baby") • Children ("well child") • Adolescents ("well teen", including family planning)	X *see domain-specific language above for women, children and teens*	X
Promote oral health and reduce tooth decay across the life course	X *Specifically*: Improve oral health, particularly for pregnant women, mothers and children and those with low income	X

Promote home and community environments support health, safety, physical activity and healthy food choices	X *Specifically:* Reduce overweight and obesity; Eliminate tobacco, alcohol and substance use among children and pregnant women; Eliminate childhood lead poisoning.	X
Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population	X *Specifically*: elimination of health disparities was emphasized explicitly across priorities for prenatal care, birth outcomes, overweight and obesity and unintended pregnancy.	X

New York State Department of Health
Title V Maternal and Child Health Services Block Grant Five-Year State Action Plan
2016-2020

Domains	State Priority Needs	Objective	Strategies	National Performance Measures	National Outcome Measures
Maternal and Women's Health	**Reduce maternal mortality and morbidity**	*By September 30, 2020:* • Reduce the maternal mortality rate in NYS to [TBD] • Increase the percentage of women screened for depression during and after pregnancy to [TBD]	• Finalize and institutionalize maternal death case ascertainment and review process, issue regular reports of maternal death review findings and trends and expand surveillance and reporting activities to include severe maternal morbidity • Apply information learned from maternal death and morbidity reviews to policy, community prevention and clinical quality improvement strategies to address key contributing factors. • Collaborate with Medicaid and OQPS to integrate pregnancy planning and contraception in routine primary care and care management for all women of reproductive age, including linkage to *NYS Health Innovation Plan/ Advanced Primary Care*, Medicaid *Health Home* and other state health systems reform initiatives. • Provide enhanced support to assist women in getting health insurance, engaging in health care services and practicing healthy behaviors through evidence-based home visiting and community health worker program models, and expand availability of evidence-based home visiting and community health worker services through *Medicaid/ DSRIP, Pay for Success*, federal *MIECHV* and state budget funding. • Collaborate with OMH to develop and implement strategies to increase screening and follow-up for maternal depression.	NPM 1-Percent of women with a past year preventive medical visit	NOM #2 Percent of delivery or postpartum hospitalizations with an indication of severe maternal morbidity. NOM #3 Maternal mortality rate per 100,000 live births. NOM #7 Percent of non-medically indicated deliveries at 37, 38 weeks gestation among singleton deliveries without pre-existing conditions.
	Increase use of preconception and interconception ("well woman") health care services among	*By September 30, 2020:* • Increase the percentage of women with a past year preventive medical visit to [TBD] • Reduce the rate of unintended pregnancy to [TBD]	• Integrate performance standards, measures and improvement strategies related to health insurance and health care service utilization across all Title V programs serving women of reproductive age. • Collaborate with Medicaid and OQPS to integrate pregnancy planning and contraception in routine primary care and care management for all women of reproductive age, including linkage to	NPM 1-Percent of women with a past year preventive medical visit	NOM #2 Percent of delivery or postpartum hospitalizations with an indication of severe maternal morbidity. NOM #3 Maternal mortality rate per 100,000 live births.

Domains	State Priority Needs	Objective	Strategies	National Performance Measures	National Outcome Measures
	women of reproductive age *(as part of priority on use of preventive health care services across the life course)*	• Reduce the percentage of pregnancies that are conceived less than 18 months from a previous birth to [TBD] • Increase the percentage of women who report that a health care provider has talked with them about ways to prepare for a healthy pregnancy and baby to [TBD]	NY*S Health Innovation Plan/ Advanced Primary Care*, Medicaid *Health Home* and other state health systems reform initiatives. • Develop and implement a public awareness campaign related to preconception & interconception health. • Convene and lead structured quality improvement collaborative to improve outreach and engagement of underserved populations in family planning services. • Provide funding, training and technical assistance to community-based partnerships to improve pre- and interconception health in low income populations and communities. • Promote policies and practices to increase the use of Long Acting Reversible Contraceptives (LARC) • Strengthen linkages with public health chronic disease prevention programs to enhance data capacity and target health promotion strategies to women at risk for adverse pregnancy outcomes		NOM #4.1 – 4.3 Percent of low birthweight deliveries NOM #5.1 – 5.3 Percent of preterm births NOM #8 Perinatal mortality rate per 1,000 live births plus fetal deaths. NOM #9.1- 9.5 Infant mortality rates per 1,000 live births.
	Increase use of prenatal and postpartum health care services *(as part of priority on use of preventive health care services across the life course)*	*By September 30, 2020:* • Increase percentage of live births with prenatal care starting in the first trimester to [TBD]	• Integrate performance standards, measures and improvement strategies related to health insurance and health care service utilization across all Title V programs serving pregnant and postpartum women. • Provide subject matter and technical support to Medicaid and OQPS to improve prenatal and postpartum care in accordance with Medicaid standards through the Perinatal Quality Improvement Project • Continue and expand state pilot project in selected communities to leverage health information technology to improve risk assessment, referral and follow up care for pregnant women, and expand effective strategies to additional communities. • Provide enhanced support to assist pregnant women in getting health insurance, engaging in prenatal and postpartum health care services and practicing healthy behaviors through evidence-based home visiting and community health worker program models, and expand availability of services through Medicaid/ DSRIP, Pay for Success, federal MIECHV and state budget funding.		NOM#1 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Domains	State Priority Needs	Objective	Strategies	National Performance Measures	National Outcome Measures
			• Develop and evaluate models for mobilizing local resources to support pregnant and parenting teens • Develop and implement a public awareness campaign, including promotion of NYS' Text4Baby resource, related to prenatal and postpartum care • Convene and coordinate workgroup with OQPS, OHIP and external MCH partners on policy and practice issues related to securing and using 17-OHP to prevent preterm labor. • Collaborate with NYSDOH Bureau of Immunizations to implement multi-pronged strategies to increase vaccination rates for pregnant women.		
Perinatal and Infant Health	**Reduce infant mortality and morbidity**	*By September 30, 2020:* • Decrease the infant mortality rate to [TBD] • Decrease the preterm birth rate to [TBD] • Increase the percent of very low birthweight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) to [TBD]	• Update NYS perinatal regionalization standards and designations and implement new performance measures. • Build on completed NYSPQC projects to incorporate performance standards and measures for early elective inductions and C-sections across relevant projects including Medicaid/DSRIP and perinatal regionalization. • Continue to lead and convene structured statewide quality improvement initiatives in birthing hospitals through the NYS Perinatal Quality Collaborative (NYSPQC), including implementation of new improvement projects on safe sleep and antenatal corticosteroid use. • Continue to convene and lead state workgroup of interagency and external partners to reduce infant mortality through participation in national and state Infant Mortality CoIIN initiative. • In collaboration with NYS CoIIN partnership, develop and implement a multi-pronged strategy to promote safe sleep policies and practices. • Provide enhanced support to assist families in getting health insurance, engaging in maternal and infant health care services and practicing healthy behaviors and parenting skills through evidence-	NPM3-Percent of VLBW infants born in a hospital with a Level III + NICU NPM5-Percent of infants placed to sleep on their backs.	NOM #8 Perinatal mortality rate per 1,000 live births plus fetal deaths. NOM #9.1 Infant mortality rate per 1,000 live births. NOM #9.2 Neonatal mortality rate per 1,000 live births. NOM #9.3 Postneonatal mortality rate per 1,000 live births. NOM #9.4 Preterm-related mortality rate per 1,000 live births. NOM#9.5 Sudden Unexpected Infant Deaths (SUID) mortality rate per 1,000 live births. NOM #11 The rate of infants born with neonatal abstinence syndrome per 10,000 delivery hospitalizations.

Domains	State Priority Needs	Objective	Strategies	National Performance Measures	National Outcome Measures
			based home visiting and community health worker program models, and expand availability of services. • Collaborate with NYSDOH Division of Chronic Disease Prevention to develop, implement and evaluate a multi-pronged strategy to decrease smoking among pregnant women. • Collaborate with NYSDOH Divisions of Nutrition and Chronic Disease Prevention to implement a multi-pronged strategy to promote breastfeeding in both hospital and community settings • Collaborate with the NYS OASAS and other partners to assess and develop strategies to address substance use, in particular opioid use among pregnant and parenting women.		
	Increase use of primary and preventive ("well-baby") care among infants (*as part of priority on use of preventive health care services across the life course)*	*By September 30 2020*: • Increase the percentage of infants who receive recommended number of well-baby visits to [TBD]	• Integrate performance standards, measures and improvement strategies related to health insurance and health care service utilization across all Title V programs serving infants and their families. • Provide enhanced support to assist families in getting health insurance and engaging in well child health care services through evidence-based home visiting and community health worker program models, and expand availability of services. • Promote the use of NYS Text4Baby resource to reinforce importance and schedule of well-baby visits. • Develop and evaluate models for mobilizing local resources to support pregnant and parenting teens • Collaborate with NYS AAP, WIC, Medicaid, Local Health Departments and other partners to develop and implement strategies to increase use of well-baby care and improve preventive care practice in accordance with *Bright Futures* standards.		NOM#22.1 Percent of children ages 19-35 months with the 4:3:1:3(4):3:1:4 combined series of vaccines. NOM #22.2 Percent of children 6 months to 17 years who are vaccinated annually against seasonal influenza.
Child Health	**Support and enhance children's social-emotional development and**	*By September 30, 2020:* • Increase the percentage of children meeting criteria for social-emotional healthy	• Assess available child health data sources, including forthcoming revisions to National Survey of Children's Health, and develop relevant performance measures and data analysis plans to support public health activities.	NPM 6- Percent of children 10-71 months receiving developmental screening using a	NOM #13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Domains	State Priority Needs	Objective	Strategies	National Performance Measures	National Outcome Measures
	relationships (*as part of shared priority for children and adolescents)*	development to [TBD] *(developmental – pending new NSCH to be defined)* • Increase the percentage of children receiving developmental screening in accordance with *Bright Futures* standards to [TBD]	• Provide enhanced support to assist families in practicing healthy behaviors and parenting skills and nurture children's development through evidence-based home visiting and community health worker program models, and expand availability of services. • Support adult mentoring and supervision activities for youth in underserved communities • Issue recommendations of joint EICC-ECAC Task Force to address social-emotional developmental needs of children enrolled in NYS Early Intervention Program, and identify action steps for implementation. • Explore collaborative opportunities with the national Center on Social and Emotional Foundations for Early Learning (CSEFEL) to promote social emotional development in children. • Collaborate with NYS Early Childhood Advisory Council, State Education Department/Community Schools and other partners to develop and implement additional strategies to support and enhance children's social- emotional development and positive relationships across child-serving settings. • Collaborate with the Office of Mental Health to develop and implement strategies to improve screening and follow-up of maternal depression. • Explore the feasibility of developing a public awareness campaign related to supporting children's social-emotional development.	parent-completed screening tool.	NOM #17.3 Percent of children diagnosed with autism spectrum disorder. NOM #18 Percent of children with a mental/behavioral condition who received treatment. NOM #19 Percent of children in excellent or very good health.
	Increase use of primary and preventive ("well child") health care services by children. (*as part of priority on use of preventive health care services*	*By September 30, 2020*: • Increase the percentage of children who receive the recommended schedule of well-child visits to [TBD] • Increase the percentage of children who receive preventive health care services including	• Integrate performance standards, measures and improvement strategies related to health insurance and health care utilization across all Title V programs serving children. • Collaborate with Medicaid, OQPS, other NYSDOH public health programs, health plans and professional medical organizations to identify and advance strategies to increase use of well-child care and promote preventive care practices in accordance with *Bright Futures* standards, including linkage to relevant state health systems reform and quality improvement initiatives.	NPM 6- Percent of children 10-71 months receiving developmental screening using a parent-completed screening tool.	NOM #13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM #17.3 Percent of children diagnosed with autism spectrum disorder.

Domains	State Priority Needs	Objective	Strategies	National Performance Measures	National Outcome Measures
	across the life course)	immunizations, developmental screening and age-appropriate anticipatory guidance in accordance with *Bright Futures* standards to [TBD]	• Collaborate with WIC, Child Care, Community Schools, home visiting and other child-serving programs to develop and advance strategies to link children to health insurance and primary health care services. • Provide subject matter and technical support to OCFS to develop and implement health-related quality indicators for child care programs • Maintain support for statewide network of SBHCs, support SBHCs' transition to Medicaid managed care and update and implement performance standards and measures for SBHCs • Provide subject matter and technical support to SED to ensure that Community Schools have information and linkages needed to promote health of children and families		NOM #19 Percent of children in excellent or very good health. NOM #21 Percent of children without health insurance. NOM #22.1 Percent of children ages 19-35 months with the 4:3:1:3(4):3:1:4 combined series of vaccines. NOM #22.2 Percent of children 6 months to 17 years who are vaccinated annually against seasonal influenza.
CSHCN (CSHCN)	**Increase supports to address the special health care needs of children and youth**	*By September 30, 2020:* • Increase the percentage of CSHCN with a medical home to [TBD] • Increase the percentage of CSHCN who need and receive care coordination services that meet their needs to [TBD] • Increase the percentage of adolescents with special health care needs who receive services necessary to	• Assess available data sources, including forthcoming revisions to National Survey of Children's Health/CSHCN, and develop updated performance measures and data analysis plans to support public health activities. • Convene and lead a structured learning collaborative with birthing hospitals to improve screening, reporting and follow-up for early hearing loss among newborns • Provide subject matter and technical support to Medicaid to implement enhanced care coordination and transition support services for CSHCN through *Health Home*, including integration of eligible children also receiving services through the Early Intervention Program. • Build on findings from recently completed research study to enhance policy and practice supports for children with Autism Spectrum Disorders and their families within and beyond the Early Intervention Program	NPM 12 – Percent of adolescents with special health care needs who receive services necessary to make transitions to adult health care	NOM#17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system. NOM #18 Percent of children with a mental/behavioral condition who receive treatment. NOM #19 Percent of children in excellent or very good health.

Domains	State Priority Needs	Objective	Strategies	National Performance Measures	National Outcome Measures
		make transitions to adult services to [TBD] • Increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale to [TBD]	• Identify and seek policy solutions to address gaps in insurance coverage for CSHCN. • Complete critical assessment/ evaluation of current CSHCN and PHCP public health programs and develop proposal(s) for strengthening local and regional program models for CSHCN. • Update and enhance previous strategies and materials to support transition to adult roles and services for CSHCN. • Collaborate with OCFS to develop and implement quality indicators related to child health, including CSHCN, for child care programs • Identify effective practices for delivering family-centered services and improving family outcomes within the Early Intervention Program, and disseminate findings to other relevant Title V and partner programs. • Integrate performance standards and measures related to family engagement and support across all Title V programs serving children. • Ensure that relevant workgroups, committees and advisory councils led by NYS Title V program have meaningful family representation.		
Adolescent Health (AH)	**Support and enhance adolescents' social-emotional development and relationships** (*as part of shared priority for children and adolescents)*	*By September 30, 2020:* • Increase the percentage of adolescents meeting criteria for social-emotional healthy development by [TBD] *(developmental – pending new NSCH to be defined)* • Reduce the percentage of adolescents who feel sad or hopeless for two weeks or longer in the past year by [TBD]	• Conduct further assessment of available data sources, including YRBS and forthcoming revisions to National Survey of Children's Health, and develop updated annual data analysis plan to inform public health activities • Incorporate evidence-based/ -informed strategies to address adolescent social-emotional development, wellness and healthy relationships within Title V adolescent grant programs • Continue to support the delivery of evidence-based sexual health education and confidential reproductive health care services for teens in both community and school-based clinical settings • Collaborate with the Office of Mental Health and other partners to develop and implement additional strategies for prevention of suicide among adolescents • Support the delivery of evidence-based and promising sexual violence prevention strategies to create community change		NOM #16.3 Rate of suicide deaths among youths aged 15 through 19 per 100,000. NOM #18 Percent of children with a mental/behavioral condition who receive treatment.

Domains	State Priority Needs	Objective	Strategies	National Performance Measures	National Outcome Measures
		• Reduce the rate of suicide among adolescents by [TBD] • Decrease the percentage of adolescents who experience physical or sexual dating violence by [TBD]	• Develop and evaluate models for coordinating resources to support pregnant and parenting teens (through *Pathways to Success* initiative)		
	Increase use of primary and preventive ("well teen") health care services by adolescents (*as part of priority on use of preventive health care services across the life course)*	*By September 30, 2020:* • Increase the percentage of adolescents who received a preventive health care visit in the last year to [TBD] • Increase the percentage of adolescents who receive preventive health care services including immunization and age-appropriate screening and anticipatory guidance in accordance with *Bright Futures* standards to [TBD] • Reduce the adolescent pregnancy rate by [TBD]	• Integrate performance standards and measures related to health insurance and health care utilization across all Title V programs serving adolescents. • Continue to support the delivery of evidence-based sexual health education and confidential reproductive health care services for teens in both community and school-based clinical settings • Incorporate evidence-based/ -informed strategies to address adolescent health literacy and use of health care services, including transition to adult health care services, within Title V adolescent grant programs • Collaborate with Medicaid, OQPS, other NYSDOH public health programs, health plans and professional medical organizations to identify and advance strategies to increase use of well-child care and promote preventive care practices in accordance with *Bright Futures* standards, including linkage to relevant state health systems reform and quality improvement initiatives. • Maintain support for statewide network of SBHCs, support SBHCs' transition to Medicaid managed care and update and implement performance standards and measures for SBHCs	NPM 10 – Percent of adolescents age 12-17 with a preventive medical visit in the past year	NOM #16.1 Rate of deaths in adolescents age 10-19 per 100,000. NOM #16.3 Rate of suicide deaths among youths 15 through 19 per 100,000. NOM #18 Percent of children with a mental health/behavioral condition who receive treatment. NOM #19 Percent of children in excellent or very good health. NOM #20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile) NOM #22.2 Percent of children 6 months to 17 years who are vaccinated annually against seasonal influenza.

Domains	State Priority Needs	Objective	Strategies	National Performance Measures	National Outcome Measures
					NOM #22.3 Percent of adolescents, ages 13-17, who have received at least one dose of the HPV vaccine. NOM #22.4 Percent of adolescents, ages 13-17, who have received at least one dose of the Tdap vaccine. NOM #22.5 Percent of adolescents, ages 13-17, who have received at least one dose of the meningococcal vaccine.
Cross Cutting or Life Course (LC)	**Increase use of primary and preventive health care across the life course**	*See domain-specific objectives above*	• Integrate performance standards, measures and improvement strategies related to health insurance and health care utilization across all Title V programs • Collaborate with NY State of Health to ensure Title V programs have current and accurate information regarding health insurance resources in the state and that issues identified by local partners are shared with policymakers • Collaborate with Medicaid and OQPS to link MCH health care service priorities to key state health systems reform and quality improvement initiatives, including *NYS Health Innovation Plan/ Advanced Primary Care*, *Medicaid Health Home* and *Patient Centered Medical Home*	NPM 1-Percent of women with a past year preventive medical visit NPM 10 – Percent of adolescents age 12-17 with a preventive medical visit in the past year	*See domain-specific measures above*
	Promote oral health and reduce tooth decay across the life course	*By September 30,2020*: • Increase the percentage of NYS residents served by community water systems with optimally fluoridated water by [TBD]	• In collaboration with the NYSDOH Center for Environmental Health, administer funding and provide technical support to public water supplies to support maintenance and expansion of community water fluoridation • Support the delivery of oral health screening and preventive dental services through school-based clinics and programs, with a focus on evidence-based practices	NPM 13 Percent of a) women who had a dental visit during pregnancy and b) children age 1-17 who had a preventive	NOM #14 Percent of children ages 1-6 who have decayed teeth or cavities in the past 12 months. NOM #19 Percent of children in excellent or very good health.

Domains	State Priority Needs	Objective	Strategies	National Performance Measures	National Outcome Measures
		• Reduce the prevalence of dental caries among NYS children by [TBD] • Increase the percentage of children and adolescents who had a preventive dental visit in the past year by [TBD] • Increase the percentage of pregnant women who had a dental visit during pregnancy by [TBD]	• Collaborate with NYSDOH Division of Nutrition to explore the integration of oral health prevention strategies within public health nutrition programs serving MCH populations • Complete pilot project on integration of oral health messages and strategies in community-based maternal and infant health programs. and share lessons learned with other MCH programs • Collaborate with NYS AAP, DA dental hygiene association and other partners to develop and implement strategies to integrate oral health practices within primary care services for children, and to increase the supply of dental providers to serve MCH population • Support dental public health residency *(see workforce below)*	dental visit in the past year	
	Promote home and community environments that support health, safety, physical activity and healthy food choices	*By September 30, 2020*: • Increase the percentage of children and adolescents who are physically active at least 60 minutes daily by [TBD] • Reduce the percentage of children and adolescents who are obese by [TBD] • Reduce the percentage of women age 18-44 who are obese by [TBD] • Reduce the injury-related hospitalization	• Collaborate with the NYSDOH chronic disease, nutrition, injury prevention and environmental health programs to incorporate relevant standards, measures and evidence-based/ -informed practices and policies across Title V programs, and to ensure that Title V grantees are linked with other community development initiatives • Provide subject matter and technical support to OCFS to develop and implement health-related quality indicators for child care programs • Provide subject matter and technical support to SED to ensure that Community Schools have information and linkages needed to promote health of children and families • Collaborate with the NYSDOH Center for Environmental Health to support neighborhood-based, door-to-door assessments and education through Healthy Neighborhoods Program • Support the delivery of evidence-based and promising sexual violence prevention strategies to create community change	NPM 8- Percent of children age 6-11 and adolescents age 12-17 who are physically active at least 60 minutes per day	NOM #15 Rate of death in children aged 1 through 9 per 100,000. NOM #16.1 Rate of deaths in adolescents age 10-19 per 100,000. NOM #16.3 Rate of suicide deaths among youths aged 15 through 19 per 100,000. NOM #19 Percent of children in excellent or very good health. NOM#20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile.)

Domains	State Priority Needs	Objective	Strategies	National Performance Measures	National Outcome Measures
		rate for children and teens by [TBD] • Increase the percentage of children and adolescents who live in supportive/ cohesive neighborhoods by [TBD] • Increase the percentage of children and adolescents who are usually or always safe in their community or neighborhood by [TBD]			
	Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population	*By September 30, 2020:* • Reduce disparities for key MCH measures by [TBD]	• Conduct additional analyses of available data to fully assess disparities in MCH outcomes and apply information to development of public health strategies • Identify and support use of evidence-based/ –informed strategies with evidence of effectiveness for disparately impacted populations • Assess equity in distribution of MCH services and resources and prioritize available funding/ resources for underserved communities • Prioritize funding for organizations with experience serving, and staffing reflective of, underserved communities, including support for community health workers • Integrate performance standards, measures and improvement strategies related to engagement of community members in planning, selecting and implementing local MCH programming across Title V programs	Disparity ratios for all NYS-selected performance measures above	