

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

2012 APPLICATION / 2010 ANNUAL REPORT

Submitted to:



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

Submitted By:



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

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

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

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

July 13, 2011

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

Dear Ms. Lauver:

With this letter, I transmit New York's FFY 2012 Maternal and Child Health Services Block Grant Application, 2010 Needs Assessment Update and FFY 2010 Annual Report.

New York once more meets the requirement for a 30% set aside for children with special health care needs and for primary and preventive care for children and adolescents, and will not be requesting a waiver.

Sincerely,



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

The Application was successfully submitted to HRSA.

| APPLICATION FOR FEDERAL ASSISTANCE | | |
|---|---|---|
| | | Version 7/03 |
| APPLICATION FOR FEDERAL ASSISTANCE | | 2. Date Submitted 7/13/2011 2:40:30 PM |
| 1. Type of Submission | | Applicant Identifier |
| Application | | 3. Date Received By State |
| Preapplication | | State Application Identifier |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Construction | 4. Date Received By Federal Agency |
| <input checked="" type="checkbox"/> Non-Construction | <input type="checkbox"/> Non-Construction | Federal Identifier |
| | | Application # 00090841 |
| 5. Applicant Information | | |
| Legal Name: | Organizational Unit | |
| NEW YORK STATE DEPT OF HEALTH | Department | New York State Dept of Health |
| Organizational DUNS: 806781340 | Division | Division of Family Health |
| Address: (give city, county, state and zip code) | Name and telephone number of the person to be contacted on matters of involving this application (give area code) | |
| Empire State Plaza, Tower Building FL 1312 Albany NY 12237-0657 | Name | Elizabeth Berberian |
| County | Tel Number (give area code): | (518)474-1911 |
| | Fax Number (give area code): | (518)474-7054 |
| 6. Employer Identification Number(EIN) | | 7. Type of Applicant |
| 14-6013200 | | A: State Government |
| | | Other (Specify): |
| 8. Type of Application | | 9. Name of Federal Agency |
| <input checked="" type="checkbox"/> New | <input type="checkbox"/> Continuation | <input type="checkbox"/> Revision |
| If Revision: | | Health Resources and Service Administration |
| <input type="checkbox"/> A. Increase Award | <input type="checkbox"/> C. Increase Duration | 11. Descriptive Title of Applicant's Project: |
| <input type="checkbox"/> B. Decrease Award | <input type="checkbox"/> D. Decrease Duration | Maternal and Child Health Services |
| Other (Specify): | | |
| 10. Catalog of Federal Domestic Assistance | | 12. Areas Affected by Project (Cities, Counties, States, etc.): |
| Number | 93.994 | |
| Title (Name of Program) | Maternal and Child Health Services Block Grant to the States | |
| 13. Proposed Project | | 14. Congressional Districts of |
| Start Date: | 10/1/2011 | a. Applicant |
| Ending Date: | 9/30/2013 | b. Project |
| 15. Estimated Funding | | 16. Is Applicant Subject To Review by State Executive Order 12372 Process? |
| a. Federal | \$41,036,806.00 | <input type="checkbox"/> YES This preapplication /application was made available to the state executive order 12372 process for review on: Date : |
| b. Applicant | \$0.00 | |
| c. State | \$144,502,296.00 | <input checked="" type="checkbox"/> NO <input type="checkbox"/> Program is not covered by e.o. 12372 |
| d. Local | \$301,048,616.00 | <input checked="" type="checkbox"/> Program has not been selected state for review |
| e. Other | \$0.00 | |
| f. Program Income | \$404,365,207.00 | 17. Is Application Delinquent on Any Federal Debt? |
| g. Total | \$890,952,925.00 | If "Yes," attach an explanation. |
| 18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED. | | |
| a. Name of Authorized Representative | b. Title | c. Telephone number (give area code) |
| Edward M Cahill | | (518)473-4263 |
| d. Signature of Authorized Representative | | e. Date Signed |
| | | 07/13/2011 |
| Previous Editions Not Usable Authorized for Local Reproduction | | Standard Form 424 (Rev. 9-2003) Prescribed by OMB Circular A-102 |

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I. General Requirements

A. Letter of Transmittal

An electronic letter of transmittal from the responsible New York State Department of Health official is included as the first page of the Application/Annual Report. The letter of transmittal is attached in the Title V Application to Section 1A.

B. Face Sheet

Each section of the Application Face Sheet (Standard Form 424) has been completed and submitted electronically along with the rest of the application and annual report.

C. Assurances and Certifications

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

D. Table of Contents

The 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, expiring March 31, 2012.

E. Public Input

New York State is substantially invested in obtaining public input into the state's MCH Program. Because of the diverse methods that contribute to the assessment of needs and capacity, DOH can be confident that the needs assessment and resulting program development reflect the needs of communities in our state. Major avenues for stakeholder input related specifically to the five year needs assessment process for the 2011 Title V Block Grant Application include the following:

- **The Department's Prevention Agenda development process**
In April, 2008, former Commissioner Daines launched the Prevention Agenda for the Healthiest State, establishing 10 statewide public health priorities with an emphasis on prevention strategies. The Prevention agenda was a call to action, asking hospitals, local health departments, and other health care and community partners to collaborate in planning to bring about measurable progress toward mutually-established goals related to two to three of the priorities. Across all the priority areas, the Prevention Agenda focuses on eliminating the profound health disparities that impact racial and ethnic minorities.
- **A survey of stakeholders related to MCH needs and priorities**
The Department's Needs Assessment leadership team developed a survey for key stakeholders to obtain their input related to the needs and priorities for the MCH populations in New York State. The survey included background information related to the MCH Block Grant, as well as specific information regarding current national outcome measures, performance measures and current state priorities. The survey was sent to over 183 MCH stakeholders, stakeholders in the

Department and other state agencies, as well as a substantial number of external partners, including perinatal consortia and regional perinatal centers, advocacy organizations, community based agencies servicing the MCH population, professional organizations and consumers.

- **Regional forums for youth/young adults with special health care needs and families of children with special health care needs** were conducted in February and March 2010 by the CSHCN Program to gather consumer input about the system of care for children and youth/young adults. The forums were facilitated to elicit information about the core Maternal and Child Health Bureau performance measures
- **A survey of families of children with special health care needs and youth representatives** was developed to elicit feedback for the Maternal Child Health Block Grant application item 13, “Characteristics Documenting Family Participation in the CSHCN Program”.
- **Focus groups with adolescents and their families** were conducted to inform the DOH about how young people get information about sexual health, where they go for sexual health care services, their experiences in accessing services, and their unmet needs. The Adolescent Sexual Health Focus Group study was conducted by the DOH-funded adolescence Center of Excellence (COE) at Cornell University (and their partners at University of Rochester School of Medicine, NYS Center for School Safety and New York City Cornell Cooperative Extension).
- **MCHBG Advisory Council** discussions related to MCH needs and priorities, development of the Maternal and Child Health Block Grant needs assessment and application was an agenda item for several Council meetings. In addition, a special session of the Council was convened with an agenda exclusively focused upon a review of needs assessment activities and results and development of state priorities.
- **Incorporation of local level stakeholder** input to inform the state level assessment, including structured listening sessions with:
 - the MCH committee of the New York State County Health Association which includes seventeen county members
 - local perinatal networks which represent consortia of health and human service providers who address MCH issues at the local level. These networks also co-chair regional perinatal forums which are also co-chaired by regional perinatal centers. These forums provide a comprehensive picture of MCH needs, incorporating both the community and hospital perspectives; and,
 - the New York City Department of Health and Mental Health MCH Bureau.
- In addition to these efforts to obtain input during the development of the application, a summary of the needs assessment and new state priorities were made available to key stakeholders, including the perinatal networks, the MCHBG Advisory Council, the MCH Committee of NYSACHO to provide any additional input for consideration prior to submission.
- The application was also posted on the Department’s website to obtain further information regarding development and implementation of the needs assessment.
- A summary of the needs assessment process was presented on June 17th at the New York Perinatal Association Conference with an opportunity to comment.

Each of these activities to obtain public input into the block grant is described in more detail in the Needs Assessment Section.

In addition, to the specific efforts described above to obtain public input related to assessment of need and development of state priorities, the Department has a significant number of regular mechanisms to obtain public input related to needs assessment, priority identification and resource allocation and program planning, development, implementation and evaluation. This includes obtaining ongoing input from families of CSHCN. These mechanisms are also described in more detail in the Needs Assessment Section.

A major effort to obtain public input regarding MCH services this year related to the development of the state needs assessment and plan related to creation of the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) authorized under the Patient Protection and Affordable Care Act (ACA) of 2010. This historic legislation marks a significant commitment to promote and improve the health, development and well-being of at-risk children and families through evidence-based home visiting programs. New York State's MIECHV State Plan reflects over a year of intensive assessment and planning work, led by the DOH MCH Program and conducted in collaboration with a core group of state agency partners and many other stakeholders.

Fourteen counties were identified through the Needs Assessment as “at-risk” communities for NYS’ MIECHV initiative. As part of the plan development process, a structured on-line survey was distributed to stakeholders in those 14 counties to further identify: community risk factors, strengths and resources; characteristics of target populations; mechanisms for screening identifying and referring families to home visiting programs; and referral resources currently available and needed. Additionally, in-person and conference call discussions were held with several stakeholder groups during the plan development process. Respondents include local home visiting programs as well as other stakeholder organizations. Through these processes, input was received from more than 100 community-based organizations, local government agencies and home visiting programs.

The Schuyler Center for Analysis and Advocacy (SCAA), a statewide, not-for-profit, policy analysis and advocacy organization that works to shape policies related to health and human services in New York State, assisted DOH in soliciting input from a broad range of stakeholders on the home visiting needs of families around the State. A list of stakeholders was compiled to be invited to participate in conference calls to provide input regarding the need for services and to offer their wealth of experience and knowledge about home visiting in New York State. The list of stakeholders included representatives from relevant programs funded by the State agencies (e.g. home visiting programs such as Community Health Worker Programs, Healthy Families NY, Healthy Start and Nurse Family Partnerships, child abuse prevention programs, substance abuse prevention and treatment programs, early childhood development programs, etc.), HRSA-funded Healthy Start grantees, inter-agency coordinating groups (e.g. Early Childhood Advisory Council), county health departments and departments of social services, advocacy groups, and other interested parties.

A state agency work group, initially established to support completion of the state's MIECHV needs assessment, continued to meet regularly to support development of the state plan. Core participating agencies include:

- NYS Office of Children and Family Services (OCFS)
- NYS Council on Children and Families (CCF)
- NYS Office of Mental Health (OMH)
- NYS Office for the Prevention of Domestic Violence (OPDV)
- NYS Education Department (SED)
- NYS Office for Alcoholism and Substance Abuse Services (OASAS)

Parent representatives have meaningful roles on councils and task forces that provide input to DOH policy and programs, including the MCHBG Advisory Council, the Early Intervention Advisory Council, and the Lead Poisoning Prevention Advisory Council. In addition, DOH has ongoing communication and engagement with parent organizations. DOH staff met with parent support staff of Parent to Parent of NYS, the Family-to-Family Health Care Information and Education Center grantee, to affirm collaboration on family support activities and to obtain input on DOH programming related to CSHCN. During the past year, the CSHCN Program has been contacted by Parent to Parent of NYS to assist in situations where additional assistance is necessary to supplement that offered by the family support organization.

In addition to these efforts to obtain public input, the Department continued a number of regular mechanisms to obtain public input related to MCH programs, including advisory council meetings, providers meetings, meetings with advocates and other activities. The application will be made available to key stakeholders, including the perinatal networks, the MCHBG Advisory Council and the MCH Committee of New York State Association of County Health Organizations (NYSACHO), to provide any additional input for consideration prior to submission. The application will be posted on the Department's website to obtain further public input.

II. Needs Assessment

In application year 2012, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

Section II C. Needs Assessment Summary

The Department's goal in the need assessment process is to comprehensively review the needs of the MCH populations; to examine existing program priorities and realign those priorities to address new identified needs to the extent that resources permit; and, to clearly assess performance related to program priorities to ensure MCH programming results in real improvement in the health and well being of the MCH populations in New York State. The needs assessment process was developed based upon three main components: stakeholder input from a variety of sources; analysis of extensive MCH data; and, information obtained from needs assessment cycles for specific MCH programs. This information was synthesized in making decisions regarding state priorities.

Major avenues for stakeholder input included the following: the Department's Prevention Agenda development process; a survey of stakeholders related to MCH needs and priorities; regional forums for youth/young adults with special health care needs and families of children with special health care needs; a survey of families of children with special health care needs and youth representatives; focus groups with adolescents and their families; MCHBG Advisory Council discussions related to MCH needs and priorities; and, local level stakeholder input, including the MCH committee of NYSACHO, local perinatal networks and the NYCDOHMH.

Determining what should be identified as a state priority and how those priorities should be ranked was based upon a number of factors including degree of stakeholder input identifying an issue as a priority; current capacity to meet identified needs, whether the need related to a health disparity / disparities, as well as other factors. The following are revised State Priorities for the 2011 through 2016 MCHBG grant cycle:

1. State Priority (revised): To improve access to early, adequate and high quality prenatal care, with a specific focus on eliminating health disparities
2. State Priority (revised): To improve access to comprehensive, high quality primary and preventive health care for children and adolescents, consistent with the medical home model, including children with special health care needs
3. State priority (current): To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality
4. State Priority (revised): To prevent and reduce the incidence of overweight and obesity for infants, children and adolescents, with a focus upon reducing health disparities
5. State Priority (revised): To reduce unintended pregnancies in adults and adolescents and improve adolescent sexual health and development, with a focus upon reducing health disparities
6. State Priority (current): To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women
7. State Priority (current): To improve oral health, particularly for pregnant women, mothers and children, and among those with low income
8. State Priority (new): To eliminate childhood lead poisoning

9. State Priority (current): To improve diagnosis and appropriate treatment of asthma in the maternal and child health population.
10. State Priority (new): To increase the percentage of infants who are breastfed for at least six months.

Section II D. Outcome Measures – Federal and State

In addition to the ten State priority measures, two outcome measures have been selected for this period:

1. **State Outcome Measure:** Maternal mortality rate per 100,000 births
2. **State Outcome Measure:** The percentage of elective deliveries, both cesarean sections and inductions, performed without appropriate indication between 36 and 38 6/7 weeks gestation.

New York State has made progress in reducing unintended and adolescent pregnancy, smoking in pregnancy, perinatal HIV transmission, delivery of very low birth weight babies in higher level hospitals, infant and neonatal mortality and breastfeeding rates over the past ten years. The statewide rates of early prenatal care and adequacy of prenatal care and alcohol use in pregnancy and post neonatal death have been stagnant. Rates of c-section delivery, preterm birth, low birth weight and maternal mortality have increased. In addition, children's health measures related to lead, immunization, oral health, asthma and obesity and tobacco use have generally improved. Chlamydia morbidity has continued to increase since reporting began in 2000. High rates of newborn screening and follow up continue, including significant increases in newborn hearing screening and children identified with autism. Despite the significant positive changes in outcomes, New York State is below Healthy People 2020 objectives for several measures, and, health disparities continue to be significant. The percent of children, including CSHCN, who have insurance coverage and who have a medical home have improved, though some other access and quality measures for primary and specialty care for CSHCN have been relatively stagnant.

Since the last MCHBG grant cycle, there have been significant changes in State capacity related to priorities. Reform in the State's public health insurance programs has been extensive with positive impacts upon MCH populations. In addition, new state funding became available to support a variety of initiatives, including support for: family planning and school based health clinics; home visiting; adolescent pregnancy prevention; perinatal regionalization; and, obesity, as well as others. The Department has also received federal grants and ARRA funding that has supported a variety of critical MCH initiatives, including newborn hearing screening and autism, breast feeding, immunization and obesity. Significant investments in MCH infrastructure have been made in improving quality analysis, integration and access to MCH data, as well developing initiatives to improve quality of MCH programs and services.

As was indicated in the 2011 application, priorities for the MCHB five year needs assessment were very closely aligned with priorities identified by the Department. The Department had already begun significant efforts to address these priorities as identified in the previous needs assessment and has continued those activities in the current year.

In July 2010, the New York State Department of Health (NYSDOH) was designated as the lead

entity for the State to accept and administer funds allocated to New York State for the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program (MIECHV). The Department completed a comprehensive statewide needs assessment which was completed and approved by HRSA/ACF. In preparation for the development of the needs assessment, New York State engaged in a thorough and multi-faceted process to gather and analyze the data and information required by HRSA, as well as collecting and reviewing additional data indicators and supporting information from a wide variety of sources.

To coordinate New York State's activities related to the MIECHV, the State established a work group of representatives from State agencies that have responsibility for managing programs for women, children and families. The Needs Assessment process entailed working closely with representatives from the State agency partners to gather data on the indicators of risk required by HRSA and additional indicators of risk recommended by the State agencies. A total of 23 indicators of risk were used and analyzed to determine which communities in the State have concentrations of premature birth, low birth weight infants, infant mortality, and other indicators of prenatal, maternal, and child health; poverty; crime; domestic violence; high rates of high school drop-outs; substance abuse; unemployment; and child maltreatment. Because of its breadth, the needs assessment will have wide applicability for use in other MCH Programs beyond home visiting.

Another facet of the process included a close review of the results of other statewide needs assessments to document home visiting-related needs identified by several service systems (e.g. maternal and child health, prevention and treatment of child abuse, Head Start). The information gathered through this review confirmed the important role that home visiting services play in promoting the health and stability of families in New York State.

A series of conference calls was convened to elicit feedback from the stakeholders. The conference calls were structured around questions, developed by the State agency home visiting work group, designed to elicit qualitative information about the needs of at-risk populations, strengths of current home visiting programs in the State, hard-to-reach populations, gaps and barriers to services, and suggestions about the use of the federal home visiting funding. A corresponding online survey was also widely disseminated to interested parties throughout the State. More than 75 individuals participated on the conference calls. Participants represented county health departments, county departments of social services, home visiting programs, and health and human service agencies located in urban, suburban and rural communities throughout the State, and a total of 176 surveys were completed and submitted from a diverse group of stakeholders.

This input process also complements ongoing work over the last year to engage stakeholders in providing input on the development of NYS' MIECHV plan. The NYSDOH Healthy Mom-Healthy Baby initiative has provided a specific forum for engaging local health departments from at-risk communities, including the three initial MIECHV target communities, in discussion of local home visiting services in the context of broader perinatal health systems-building efforts.

All of these venues have provided critical insight and input regarding needs, strengths, gaps and challenges in target communities that have informed the development of NYS' MIECHV plan.

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

**DIRECT
HEALTH
SERVICES**

*Gap-filling
personal
services to
pregnant women,
mothers, infants and
children*

Examples:

Early Intervention, Family Planning, Rape Crisis, Migrant Health Program, School-based Health Centers, Regional Perinatal Centers, American Indian Health Program, Medicaid Prenatal Care, Physically Handicapped Children's Program, Home Visiting Programs such as Community Health Worker Program, MIECHVP, Healthy Mom-Healthy Baby and NFP

ENABLING SERVICES

*Help to access health care, health information
and services*

Examples:

Case Management and Service/Care Coordination through Early Intervention, CSHCN, Medicaid Waiver Programs, Family Training, Family Specialist, Respite Care, Outreach and Education through DOH and contracted providers, Transportation, Translation, Infant Death Follow-up Services, Dental Rehabilitation Program

POPULATION-BASED SERVICES

*Preventive and personal services available to all mothers,
infants and children in NYS*

Examples:

Newborn Genetic and Universal Newborn Hearing Screening, Lead Poisoning Prevention Program, Immunization Services, Breastfeeding Promotion, Injury Prevention, Comprehensive Adolescent Pregnancy Prevention Program, PREP, Abstinence, Public Education, Infant/Child Mortality Review, SIDS and Child Death Prevention, Obesity Prevention, Maternal Mortality Reviews, NYS Obstetrical and Neonatal Quality Collaborative, Reproductive Health Education, Growing Up Healthy and Child Health Plus Hotlines

INFRASTRUCTURE-BUILDING SERVICES

Develops, maintains and supports access to high-quality maternal and child health services
Needs Assessment, Transformation of New York's Public Health Insurance Programs, Surveillance, Program Planning, Development, and Evaluation, Standards Setting, Capacity-Building, Staff Development and Training, Intra and Interagency Collaborations such as Early Childhood Council and FAS Workgroup, Quality Initiatives and Research, State Aid to Localities for Local Health Department capacity building, Information Infrastructure and Systems such as the Statewide Perinatal Data System, SPARCS, Medicaid Data System and CH12 Development, Public Health Workforce Development such as the PH/MCH Training Initiatives, MCH Graduate Assistantship Program Preventive Medicine Residency, and Dental Public Health Residency Programs.

III. State Overview

A. Overview of the State

The mission of the NYSDOH is to ensure that high quality appropriate health services are available to all NYS residents. Department functions and responsibilities include:

- Promoting and supervising public health activities throughout the State;
- Ensuring high quality medical care in a sound and cost effective manner for all residents;
- Reducing infectious diseases such as food and waterborne illnesses, hepatitis, HIV, meningitis, sexually transmitted infections, tuberculosis, vaccine preventable diseases and chronic disabling illnesses such as heart disease, cancer, stroke and respiratory diseases; and,
- Directing a variety of emergency preparedness initiatives in response to statewide and local epidemic outbreaks.

In a state as large and diverse as New York, achieving the mission is a daunting task. This task has now been complicated by the fact that New York is faced with the great economic and fiscal challenges. Wall Street, a pillar of New York's economy, has suffered a series of unprecedented shocks. The financial services sector, which accounts for twenty percent of state tax revenues, has been negatively impacted. Moreover, New York's broader economy is grappling with a deep recession that promises to be one of the worst in decades, and is expected to cost tens of thousands of New Yorkers their livelihoods. Both financial and human resources are limited to accomplish the Department's core mission. Yet, despite these obstacles, the Department is committed to ensuring New York meets the needs of its most vulnerable maternal and child health population.

Maximizing resources and cultivating collaborative relationships is essential to moving beyond this crisis. The Department works with the State's health care community to ensure appropriate readiness and response to potential public health threats. The Department is also the principal State agency that interacts with the Federal and local governments, health care providers and program participants for the State's Medicaid program.

Andrew M. Cuomo was elected the 56th Governor of New York State on November 2, 2010. One of the Governor's first significant acts was to obtain passage of a transformational 2011-12 New York State budget. The budget included historic reforms that redesign state government; create efficiencies through consolidation, cap spending increases for education and Medicaid and transform the future budgeting process.

The Governor's proposed Budget for 2011 continues to reshape the health environment in New York through significant reforms of the Medicaid Program. The budget process brought together health care providers, labor, government and other Medicaid stakeholders to form the Governor's Medicaid Redesign Team (MRT). Tasked with identifying ways to provide critical health care services at lower costs and control unsustainable growth, the MRT recommended a series of proposals to fundamentally restructure New York's extensive Medicaid program. The budget implemented a majority of the MRT recommendations resulting in a \$2.3 billion reduction. The budget implements significant reforms including major expansion of patient-centered medical

homes, better control of home health care services, and care management for individuals with complex and continuing health needs.

The Medicaid reform efforts focused on achieving greater efficiency without creating barriers to enrollment or reducing benefits for those eligible for Medicaid services. These reforms fully support the mission of New York's Title V program in ensuring comprehensive primary and preventive health and support services to the maternal and child health population, including children with special health care needs.

The state's overall goal is to expand enrollment in the Medicaid managed care program by requiring many of the high need populations which were previously exempted or excluded to enroll in a managed care plan. The Medicaid Managed Care Program provides an organized system of care, an accountable entity and the ability to coordinate and manage care. As part of this effort, the expedited enrollment of pregnant women into managed care will promote better management of health and psychosocial risks leading to improved birth outcomes.

Several additional proposals of the MRT pertain to the MCH population, including expanding current statewide patient-centered medical homes; Medicaid changes related to family planning, including the proposal to move the Family Planning Benefit Program, an income expansion of Medicaid eligibility approved through a Medicaid waiver, to a state Medicaid plan service; reducing inappropriate use of services such as C-section delivery and reforming malpractice and patient safety, including development of a NYS obstetrical patient safety workgroup. Staff from the Division of Family Health, as well staff from other public health offices, are participating in the implementation committees of relevant MRT proposals. Additionally, public health staff have had an opportunity to submit additional Medicaid reform proposal for consideration.

Despite the need for the budget to reduce a significant deficit, with some exceptions, maternal and child health programs were relatively successful in maintaining funding levels. Funding was restored to the state's Healthy Families program to ensure that the State would meet the state MOE requirements related to federal Maternal, Infant, and Early Childhood Home Visiting Initiative (MIECHV). The Governor has also supported specific health related efforts such as expanding fresh food access into urban areas. The Governor has indicated that he fully supports passage of reproductive rights legislation in the State to protect the fundamental right of reproductive freedom and a woman's right to make private health care decisions.

Under the direction of the Commissioner, Dr. Nirav Shah, who is appointed by the Governor, the Department meets its responsibilities through the Office of Health Insurance Programs (OHIP), the Office of Long Term Care, the centers located in the Office of Public Health, and the Office of Health Systems Management. In 2007, the Department established OHIP which consolidated operations of the State's public health insurance programs under the direction of the State Medicaid Director. OHIP is responsible for developing and implementing strategies to improve access to health insurance coverage for the uninsured and providing for an integrated approach to oversight and administration of the Medicaid program to strengthen coordination within the Department and among State agencies. The establishment of OHIP marked the adoption of a new mission for Medicaid, namely to expand coverage and access; to buy value with New York's health care dollars; and, to advance system wide reform. The Office of Health Insurance

Programs is responsible for Medicaid, Family Health Plus, Child Health Plus, Elderly Pharmaceutical Insurance Coverage, and the AIDS Drug Assistance Program. The Office of Long Term Care oversees the integration of planning and program development for services related to long term care. The Office of Public Health and the Office of Health Systems Management are responsible for providing policy and management direction to the Department's system of regional offices. Department staff located in regional offices conduct health facility surveillance, monitor public health, provide direct services and oversee county health department activities. In addition, the Department also contracts with organizations, such as the Island Peer Review Organization (IPRO), to conduct monitoring and surveillance activities for programs such as the Early Intervention Program. The Department is also responsible for five health care facilities that are engaged in patient care: the Helen Hayes Hospital in West Haverstraw, which offers specialty rehabilitation services, and four nursing homes for the care of veterans and their dependents in Oxford, New York City, Batavia and Montrose.

The Office of Public Health (OPH) was established in 2007 to strengthen coordination among the Department's public health programs and to ensure public health input into all the Department's programs. OPH is made up of the Department's four principal public health centers:

- AIDS Institute;
- Center for Community Health;
- Center for Environmental Health; and,
- Wadsworth Center.

In addition, the Office of Public Health Practice (formerly the Office of Local Health Services in the Center for Community Health), the Health Emergency Preparedness Program, the Office of Public Health Informatics and Project Management and the CDC Senior Management Official in New York report to OPH. The purposes of the OPH are to:

- continue and increase coordination and integration across the department's public health centers and programs;
- assure that public health is fully represented at the departmental level including full incorporation of public health principles into the redesign of the health care system and health insurance programs;
- keep New York active as an innovator in the emerging areas on the cutting edge of public health practice such as maternal and child health; chronic disease prevention; nutrition; environmental health; laboratory science; prevention and control of infectious diseases such as HIV, hepatitis C and others; genomics and informatics;
- coordinate public health activities with the Centers for Disease Control and Prevention, other federal agencies, other state health departments, and local health departments in New York;
- convene partners in the community, academia and the health care system to further public health goals; and,
- rebuild and strengthen the state and local public health infrastructure.

The Center for Community Health (CCH) works with communities to promote good public health for all New Yorkers. Whether it's developing programs to improve perinatal health, encourage people to exercise and eat healthier, or helping communities reduce the incidence of

disease, or helping young people build their self-esteem so they can become tomorrow's leaders, the focus is always on community action to help make the difference.

A priority of the CCH is to address the root causes of diseases, not just the diseases themselves, in order to make a longer term impact. Aiming programs at the problems of obesity, lack of exercise, poor diet and smoking, helps reduce illness and death from a variety of diseases including heart disease, cancer, diabetes mellitus and stroke--the nation's leading killers. Making sure children's homes are free of lead and that children are screened early in life for lead poisoning helps prevent a lifetime of underachievement and behavioral problems.

The majority of deaths in New York State are not caused by inadequate access to health care (10%) but by behavioral (50%), environmental (20%), and genetic (20%) factors that can be addressed by public health actions. According to a report on Public Health in America produced by the U.S. Department of Health and Human Services in 1994, public health provides ten essential services:

- Monitor health status to identify community health problems;
- Diagnose and investigate health problems and health hazards in the community;
- Inform, educate, and empower people about health issues;
- Mobilize community partnerships to identify and solve health problems;
- Develop policies and plans that support individual and community health efforts;
- Enforce laws and regulations that protect health and ensure safety;
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable;
- Assure a competent public health and personal health care workforce;
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services; and,
- Research for new insights and innovative solutions to health problems.

The CCH's responsibilities are broad and far-reaching, touching every aspect of public health in NYS. CCH identifies and assists local agencies with disease outbreaks, makes nutritious foods available to pregnant women, infants and children and tracks cancer incidence across the state. The center conducts public health surveillance to help identify and respond to emerging health threats; to plan, implement and monitor public health programs that respond to these threats; and to show New Yorkers how to minimize health risks. CCH staff helps local health agencies and community organizations fight the root causes of poor birth outcomes, killer diseases such cancer, heart disease and diabetes, help protect children from lead poisoning, and work to prevent people from starting to use tobacco and they help those already hooked to quit. Through surveillance, education, prevention and treatment they fight tuberculosis, adolescent pregnancy, sexually transmitted diseases, injuries, abuse, hunger, diseases carried by animals and insects, osteoporosis, dementias and the other public health threats known and still to be discovered. CCH staff work closely with the staff of other centers - Center for Environmental Health, Wadsworth Center, AIDS Institute - that make up the New York State Health Department's Office of Public Health (OPH). The OPH umbrella helps strengthen coordination among public health programs and ensures public health input into all the department's programs. CCH consists of four Divisions, including:

- The Division of Family Health that promotes the health of families by assessing needs, promoting healthy behaviors and providing services to support families.
- The Division of Chronic Disease and Injury Prevention that addresses specific risk factors associated with the leading causes of death, disability and chronic disease among New Yorkers.
- The Division of Nutrition that manages programs designed to improve the nutritional status of the residents of New York State. Improving the diet of the public is a key factor in improving public health among those most at risk for serious illness.
- The Division of Epidemiology whose mission is to use sound scientific practices and principles to protect the health of all New Yorkers through disease surveillance, expert technical assistance, collaborations with local health departments and health care professionals, and by sharing expertise, epidemiologic information, and knowledge the division confronts a variety of new and emerging communicable diseases found in the state.

CCH also includes an Office of Minority Health, which assists all Center programs in better serving the needs of minority populations, an Internet Development and Communications unit, which facilitates development of web-based materials, an Office of Information Technology and Project Management, and a Resource Management Unit. This arrangement of services within the Center helps to ensure proper oversight and assistance of all program functions within the Center.

New York's Title V program is located in the Division of Family Health in the Center for Community Health. The Division's primary focus is to improve the health of women, children and adolescents. Its programs touch new mothers, adolescents considering sexual activity, children with disabilities, rape victims and children with asthma, lead poisoning or lack of access to dental services. Programs promote healthy behaviors while also assuring access to quality health care. The division provides access to primary medical and dental care and preventive health services for migrant farmworkers and Native Americans living in reservation communities. The Division consists of the:

- Bureau of Maternal and Child Health;
- Bureau of Early Intervention;
- Bureau of Dental Health;
- Office of the Medical Director.

The DFH works very closely with the other Divisions within CCH, particularly the Division of Nutrition (DON) and the Division of Chronic Disease and Injury Prevention (DCDIP), as well as with the major organizational segments of the Department whose work complements that of the Division, in particular the Office of Health Systems Management (OHSM) and the Office of Health Insurance Programs (OHIP). DON, which includes the WIC program and various other nutrition and fitness programs, works closely with the DFH and OHIP in implementing both prenatal programs and children's programs to ensure that the nutritional needs of at risk pregnant and nursing women as well as infants and children are being met. DCDIP works closely with the DFH on programs such as the family planning program, which collects extensive annual data on Chlamydia testing for reproductive age women in NYS, with the cancer screening program in referral of women for screening and treatment for breast and cervical cancer. The DFH, DON and DCDIP are also collaborating on a major effort to promote exclusive breastfeeding in New

York State. Ongoing communication and collaboration are essential to ensure messaging is consistent in areas such as preconception and interconceptional health, screening for intimate partner violence and substance use and abuse, among other topics of importance to Title V.

OHSM oversees all hospitals and licensed clinics as well as related services in NYS. These facilities, licensed under Article 28 of the Public Health Law to provide health care services, are frequently targeted by the Division's programs in RFPs as eligible awardees for contracts. Since the licensing and monitoring process carried out on an ongoing basis ensures that facilities obtain approval for provision of specific services, these facilities have a demonstrable range of services and quality of care level appropriate for many of the services and programs provided by the DFH. Further, the BMCH, in particular, within DFH, collaborates closely with OHSM in designation of hospitals for level of perinatal care, and in fact drafted the revisions of hospital regulations on which these designations are based, as well as certifying hospitals as Sexual Assault Centers of Excellence (SAFE Centers). BMCH and DFH are consulted by OHSM whenever hospital or clinic closures are threatened, to ensure that sufficient service providers are available to meet the obstetric and perinatal needs within the region.

There has been a long and very close partnership between the state's Medicaid programs and the state's maternal and child health programs in New York State. The DFH worked closely with OHIP over the past couple years on major initiatives of significance to the MCH population including the transition of the Prenatal Care Assistance Program to the Medicaid Prenatal Care Program, revising prenatal care program policies and standards to conform with current standards of professional practice, streamlining enrollment of pregnant women from Fee for Service Medicaid into Managed Care, improving the coordination of home visiting services, including the development of a Risk Summary form to better ensure providers are working with Managed Care Plans to address identification and referral of pregnant women at risk for poor birth outcomes, development and implementation of the new Ambulatory Patient Group reimbursement to ensure providers were adequately reimbursed for comprehensive services, and efforts such as submission of the 1115 Medicaid Waiver to ensure New York can continue to provide comprehensive reproductive health services to eligible populations of the state. DFH is working closely with OHIP on an ongoing basis to ensure that guidelines for high quality care are in place, in addition to helping inform providers of changes, streamline application processes, and generally provide a systems level approach to implementation.

A further characteristic of the state's Title V program is maintenance of local level contacts through the network of regional offices around the state. These offices all have family health directors, who regularly communicate with the Title V Director via meetings or telephone contacts, as required, of local level issues that might potentially influence services or health care status of Title V populations in any area of NYS.

Title V's position within the OPH promotes collaborative efforts with programs and services aimed at the maternal and child health population and promotes maximizing resources to improve health outcomes.

Title V priorities align with the Department's overall priorities. At a hearing held by New York's Division of Budget in March, 2011, Dr. Nirav Shah, the Department's Health

Commissioner stressed the importance of restoring New York to national prominence in health care delivery and the need to reshape New York's health care system to serve New Yorkers more efficiently and cost effectively. Dr. Shah emphasized the need to maintain core public health programs in critical areas such as tobacco control, obesity prevention, and HIV/AIDS prevention and services. As with the previous budget, there are several themes that run through all of the Department's budget proposals for the new fiscal year including:

- preserving services that support the Department's core mission of protecting and improving the public's health;
- achieving reforms that increase efficiency while maintaining quality;
- accountability and transparency;
- elimination of duplication of services;
- consolidation, streamlining and simplification;
- flexibility to target resources where they are needed most; and,
- use of innovation to reduce the State's greatest public health threats while at the same time helping to reduce the deficit.

Major priority areas of the Department closely align with the priorities of New York's Title V program including:

- **Obesity Prevention -** Overweight and obesity are now challenging smoking for the top public health threat in New York State. Currently, about 60 percent of adults and 35 percent of children and adolescents in New York State are obese or overweight. The increase in overweight and obesity is dramatically increasing New Yorkers' risk for many chronic and debilitating conditions -- including heart disease, diabetes, hypertension, and some cancers. New York's approach to obesity as well as other chronic diseases uses the social-ecological model focusing on activities at all levels of influence (society, community, organizational, interpersonal and individual) in order to facilitate healthy choices and limit promoters of poor health. The obesity prevention agenda includes the promotion of exclusive breastfeeding, initiatives to increase exercise among children, decrease television viewing, and improve nutrition, including a calorie posting requirement, a ban on the use of trans fats in certain restaurants and food service establishments, and a ban on the sale of high-fat, high-sugar junk foods in schools.
- **Tobacco prevention and control -** Tobacco use continues to be New York's number one cause of preventable disease and death. Health care costs related to treating smoking-caused diseases total approximately \$8 billion annually for New York alone, including \$3 billion annually in Medicaid costs. Between 2000 and 2009, the adult smoking rate in New York State declined from 21.6 percent to 17.9 percent, resulting in 500,000 fewer smokers in only one year. Between 2000 and 2010, the high school smoking rate in New York State dropped from 27.1 percent to only 12.6 percent.
- **Lead poisoning -** New York has made a commitment to end childhood lead poisoning in New York State. Childhood lead poisoning has decreased by 17 percent in upstate New York since 2005. The Childhood Lead Poisoning Primary Prevention Program is a priority of the Department to keep New York's children safe from this public health threat.
- **HIV/AIDS and Sexually Transmitted Diseases -** The Department remains committed to addressing the AIDS/HIV epidemic and addressing sexually transmitted diseases.
- **Targeting primary and preventive public health strategies that will decrease obesity rates, increase healthy eating and physical exercise, prevent childhood lead poisoning, expand**

access to cervical cancer vaccines, prenatal and postpartum home visiting, high-quality mammograms and public health education.

- Early Intervention Program – The Department continues to work on reforms to the program including a variety of administrative actions that would require preferred assessment tools, modify speech eligibility standards, and revise reimbursement rates. In addition, the budget proposes legislative actions that require providers to bill Medicaid, and maximize commercial insurance reimbursement.
- Ensuring there are health care professionals available to meet the primary and preventive health care needs in New York's underserved areas of the state;
- Ensuring that the Graduate Medical Education (GME) system provides the state with the value desired for the funds invested;
- No longer using Medicaid to cross-subsidize commercial insurers, nor supporting deep discounts for hospital services their members use.
- Paying fair reimbursements that reflect the true costs of providing high-quality care through a workforce whose needs are met fairly, redirecting Medicaid dollars to those facilities that serve the bulk of the Medicaid patients.
- Purchasing health care in the appropriate setting, using the highest standards at the best price, and starting with the patients that have multiple medical needs. With better coordination of care, patients with medically-complicated conditions will get better care, their conditions will be better managed, and the cost of their total care will be reduced.
- Expanding the managed long-term care programs which have been successful in coordinating and managing long-term care needs.
- Driving the implementation of health information technology, which is essential to improving health care quality, reducing bureaucratic barriers and saving health care dollars.
- Increasing efforts to root out Medicaid fraud, which wastes precious resources and reduces our ability to care for those in need.

The Governor's proposed Budget for 2011 continues the historic health care reforms achieved over the last three years. The Department's efforts focus on achieving greater efficiency without creating barriers to enrollment for those eligible for Medicaid services. New York continues to rank first in the nation in Medicaid spending per capita – twice the national average. In New York, Medicaid is the largest single payer of health care, so through Medicaid reform, the Department will have an opportunity to leverage changes in the health care system. These reforms fully support the mission of New York's Title V program in ensuring comprehensive primary and preventive health and support services to the maternal and child health population, including children with special health care needs.

New York also leads the nation in Medicaid inpatient hospital spending. The State ranks 4th on per enrollee inpatient hospital spending and spends almost twice the national average. To better serve patients in the right setting at the right price, New York has invested more than \$600 million in outpatient care in the last two 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.

Another critical component of New York's historic health care reform of the last three years has been the updating of the decade-old hospital reimbursement system and addressing the issue of

potentially preventable hospital readmissions. Potentially preventable readmissions occur because the patient is discharged too soon or too sick or because of a lack of follow-up care in the community following the discharge. The 2010-11 Executive Budget proposed to begin reducing funding for preventable admissions and in 2012 begins to reinvest a portion of the savings in rewarding hospitals that reduce readmissions and in post discharge linkages. The budget also funded an additional 100 slots for Doctors Across New York – 50 for physician loan repayment and 50 for physician practice support – to improve access in medically underserved areas of the state.

The Department continues its efforts to make it easier for eligible individuals to access public health insurance programs. Since 2008, the Department has permitted self-attestation of income and residency at renewal for non-SSI related Medicaid beneficiaries and Family Health Plus members. The 2010-11 proposed budget permitted Medicaid enrollees receiving community-based long-term care to attest to their income and residency at renewal. The budget also proposed to allow the Department to pursue a federal option called Express Lane eligibility for children in Medicaid and Child Health Plus, that will allow children to transfer between Medicaid and Child Health Plus more easily, and it will allow for easier enrollment of children already in receipt of food stamps.

Plans are also underway for the implementation of the Statewide Enrollment Center that will consolidate the Medicaid, Family Health Plus, and Child Health Plus toll-free numbers to provide one-stop shopping for persons already enrolled in public health insurance and for those seeking information about applying, and it will augment the local social services districts by processing telephone and mail-in renewals.

The Health Care Reform Act (HCRA) at the federal level may significantly impact New York's public health programs and maternal and child health services, and support New York's efforts in this arena. Although the Department awaits specific guidance around some of these areas, the federal Patient Protection and Affordable Care Act will assist the Department to achieve improved maternal and child health outcomes if the Department has the ability to obtain funding and support. The Department has already been awarded a small Community Transformation Grant from the Centers for Disease Control and Prevention (CDC) through the Communities Putting Prevention to Work (CPPW) initiative. The Title V staff is collaborating with the Division of Chronic Disease to implement this grant that will help support the Department's initiative to increase exclusive breastfeeding rates in New York State. The Department is also awaiting guidance on the Oral Healthcare Prevention and Education component that will establish a 5-year national public health education campaign focused on oral healthcare prevention and education. The Department submitted a plan for the use of Personal Responsibility Education Program funding that will support additional programs in the Comprehensive Adolescent Pregnancy Prevention program to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS; and adult preparation subjects (financial literacy, parent child communication, career planning, etc). This funding will augment adolescent health services in the state. The OHIP has also obtained state plan approval to provide Medicaid funding support to two Nurse Family Partnership programs in Monroe County and New York City as targeted case management programs. The Department was awarded Abstinence Education funds

to support comprehensive sex education and evidence-based practices, mainly focusing on adult mentorship and supervision of children 9 through age 12 years. The Support, Education, and Research for Postpartum Depression component will amend Title V to provide new grants to states to provide services to individuals with, or at risk, of postpartum depression and their families. The Department is well positioned to use this funding to continue work on promoting identification, referrals and services for perinatal depression.

The Department also received funding through the Maternal, Infant, and Early Childhood Home Visiting Programs, a new section in Title V that provides funding to States to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s) that will support New York's evolving work on home visiting. Title V staff developed and submitted a comprehensive needs assessment on home visiting in New York in collaboration with the several State agencies and are currently working on a state plan for use of the funds.

The new federal law also contains measures that will enhance New York's already rich public health insurance system. The following are major highlights of those provisions impacting New York State.

- **Medicaid Expansion.** Creates a new mandatory Medicaid eligibility category for most adults and children with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. States are required to adopt a "modified adjusted gross income" (MAGI) test to further streamline eligibility determinations. The OHIP will be working with CMS to define the MAGI to ensure greater access for New York's uninsured or underinsured population. Eligibility for most non-disabled adults under age 65 will be based on this MAGI.
- **New York State is already in compliance with the requirement that there be no resource test for most populations, including pregnant women, most families, children and single adults.** That provision is required by the HCRA starting in 2014.
- **State Health Insurance Exchange.** The bill sets up a state health insurance exchange to offer basic health programs. States would have option to offer a community health insurance plan, similar to state plan and be able to offer a waiver to plans showing innovation around care management, care coordination and incentives for using preventive services. HCRA requires improved coordination of seamless enrollment for all programs, requires a single form, with on-line, in person, mail and telephone application options for the programs.
- **Upon enactment, States would be required to maintain income eligibility levels for CHIP through September 30, 2019.** Low income children will continue to be covered in New York up to 400% of the FPL either through Child Health Plus, Medicaid or the Exchange.

There are also provisions that will bolster New York's health care system, especially for underserved areas of the state, including:

- **Community Health Centers.** Creates a Community Health Center (CHC) Fund that provides mandatory funding for the Community Health Center program, the National Health Service Corps, and construction and renovation of community health centers. The Department is ensuring that CHCs are positioned to apply for grant funding to serve New York's populations whenever feasible.
- **Increasing Primary Care and Public Health Workforce.** Includes numerous provisions intended to increase the primary care and public health workforce by including amended and

expanded health workforce programs authorized under Title VII (health professions) and Title VIII (nursing) of the Public Health Service Act. A variety of incentives are included to support education and training of pediatric specialists, oral health providers, and nurses. Title V staff are working with the Office of Health Systems Management staff to identify workforce shortages and support community partners to address these shortages where possible.

Recognizing the complexity of Health Care Reform, the Governor created the Governor's Health Care Reform Cabinet to manage the implementation of federal health care reform in New York State. The Cabinet will advise and make recommendations to the Governor on all aspects of federal health care reform and strategic planning to guide the implementation of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. State agencies serving in the Cabinet include: the Department of Health, the Department of Insurance, the Division of the Budget, the Department of Civil Service, the Department of Taxation and Finance, the Department of Labor, the Office for Technology, the Office of Temporary and Disability Assistance, the Office of Mental Health, the Office for People with Developmental Disabilities, the Office of Alcoholism and Substance Abuse Services, the Office for the Aging, the Office of the Medicaid Inspector General, and the Office of Children and Family Services. The Deputy Secretary for Human Services, Technology and Operations, Deputy Secretary for Intergovernmental Affairs and Counsel to the Governor will also serve in the Cabinet. In addition, the Governor has named an external advisory group to assist and advise the Cabinet on reform provisions and ensure stakeholder and public engagement. The advisory group includes organizations representing health care providers, consumers, businesses, organized labor, local governments, and health plans and health insurers, as well as health policy experts. In this way, New York can be better assured that changes and improvements will be made to improve the health outcomes of all New Yorkers.

New York has proceeded to implement the health reform law provision related to the establishment of a temporary statewide insurance pool for high risk individuals. Coverage through this program is available until January 2014 when more health insurance coverage options become available through a Health Insurance Exchange. In New York State, the preexisting condition pool is called the NY Bridge Plan which covers a broad range of services, including primary and specialty care, inpatient and outpatient hospital care and prescription drugs, as well as assistance from professional nurses and caseworkers to help members manage chronic conditions and maintain health. Eligibility is not based on income. Coverage for preexisting conditions begins right away, with no waiting period.

A series of public forums are being held on the establishment of health insurance exchanges in New York State. A wide array of stakeholders are being invited to the meetings including health care consumers, administrators, doctors, hospitals and other health care providers, insurers, producers, businesses, unions, academics and the general public. Stakeholders are asked to provide input related to key design options related to exchanges.

New York is also committed to ensuring all New Yorker's are insured and do not lose their insurance due to unnecessarily high premiums. To that end the former Governor signed legislation requiring health insurers and HMOs to make an application to the State Insurance

Department to implement premium increases. The Department would have the opportunity to review the rate applications, as well as the underlying calculations, to ensure that the rates are justified and not excessive, and may approve, modify or disapprove the rate application. The law applies to all rate increases taking effect on or after October 1, 2010.

Through health care reform and investing in primary and preventive care, and strengthening New York's public insurance programs, as previously discussed, New York is striving to increase availability and accessibility of health care for historically underserved populations. In April, 2008, former Commissioner Daines launched the Prevention Agenda for the Healthiest State, establishing 10 statewide public health priorities with an emphasis on prevention strategies. The Prevention agenda was a call to action, asking hospitals, local health departments, and other health care and community partners to collaborate in planning to bring about measurable progress toward mutually-established goals related to two to three of the priorities. Across all the priority areas, the Prevention Agenda focuses on eliminating the profound health disparities that impact racial and ethnic minorities. The public health priorities include:

- Access to Quality Health Care
- Tobacco Use
- Healthy Mothers, Healthy Babies, Healthy Children
- Healthy Environment
- Physical Activity & Nutrition
- Community Preparedness
- Unintentional Injury
- Mental Health & Substance Abuse
- Chronic Disease
- Infectious Disease

Local Health Departments (LHDs) recorded their efforts in Community Health Assessments (CHA) and Municipal Public Health Service Plans (MHSP), which were submitted to the Department in July of 2009 as part of requirements for receipt of state funding through Article 6 of the NY Public Health Law. Hospitals submitted their Community Service Plans (CSP) in mid-September, 2009. With input from community members and stakeholders, two or three Prevention Agenda priorities were selected for community action and a plan was developed. By coordinating their needs assessment and program planning activities, all participants will be better able to meet the needs of their communities while avoiding duplicative efforts and achieving economies of scale. The goal is for local health departments and hospitals to develop shared visions of what must be addressed. The Department is providing technical assistance on accessing county-specific data, using evidence-based prevention approaches, and monitoring their impacts. Community-based efforts will be complemented by local and statewide policy initiatives to help achieve the prevention goals. Although Title V's major focus is Healthy Mothers, Healthy Babies, Healthy Children, all of the areas of focus impact health outcomes of the maternal and child health population.

As demonstrated in the Needs Assessment portion of New York's 2010-2011 application, health disparities continue to exist in New York State, and addressing those factors leading to ethnic and racial disparities in health outcomes remains a Department priority. Health disparities in New York often occur along the lines of race, ethnicity, nativity, language ability,

socioeconomic status, and geography, among other factors. The geographic distribution of New York State also complicates issues related to disparities as there is a great variation between rural and urban areas, providing a sharp contrast among residents and their access to health care services. Small community-based providers in underserved areas of the state often do not have the level of expertise and infrastructure to support comprehensible public health programs.

All efforts discussed previously are devoted to improving health outcomes for all New Yorkers, including ethnically and culturally diverse individuals. The major focus of the Department's efforts include partnerships at the state, local and community level. A 2009 report developed for the Department's Minority Health Council contained several strategies regarding eliminating disparities. The Title V program in New York State is working to operationalize these concepts to decrease the divide that exists among diverse groups in New York State. The report contained recommendations and promising strategies that New York could implement to potentially reduce disparities including:

- Leverage and expand core system and mission functions to assure an integrative approach for addressing health disparities
- Improve data collection, data systems, and mechanisms for monitoring and reporting disparities.
- Develop, implement and evaluate disparities interventions.
- Ensure leadership and stakeholder support for coordination of effort and institutionalize disparities-reduction work.

The report recognized New York's commitment to addressing disparities, but went on to state that stronger partnerships with local health departments to develop strategies to address disparities may impact the health disparity issue. To that end, the former and current Commissioner made the Prevention Agenda (discussed previously) a priority of state and local leaders. In April, 2010, local health departments and Department experts in specific topic areas (teen pregnancy prevention, prenatal care, obesity prevention) met to discuss local strategies to improve health outcomes and address disparities in selected health outcomes. These discussions focused on local public and private agencies that could partner to address specific issues, and evidence-based interventions and promising practices to address health issues, including health disparities. Title V staff will continue to promote partnerships to improve the health outcomes of New York's diverse community.

The Department has access to a wealth of data and information to identify issues related to maternal and child health outcomes and disparities. Although resources have always been targeted at high risk populations of the state, a more concerted effort is being made to ensure resources are going to the *highest* need areas. For example, although New York's outcomes in many areas are improving, in areas such as adolescent pregnancy, disparities continue to exist due to increasing numbers of immigrant and hard to reach adolescents. Extensive data analyses have been completed to target the highest need areas and provide better utilization of resources. The Department also provided statewide training to current and potential providers on evidence based programming and community coordination of resources, and outreached to providers in the hardest to reach areas to ensure there will be a pool of agencies positioned to apply for funds to address the need in the highest need areas of the state. In addition, all requests for applications

now specifically identify high risk groups as a priority including specific minority populations, youth in foster care or those otherwise not engaged in the service system.

The Title V program also continues to prioritize resources and activities to address disparities in population-based screening programs such as lead poisoning prevention in close collaboration with the Department's Center for Environmental Health. The Department is taking a multi-pronged, comprehensive public health approach to prevent and eliminate childhood lead poisoning. This approach encompasses:

- Surveillance, data analysis and laboratory reporting;
- Education to families, health care providers, professionals and the public;
- Policy and program activities to advance primary prevention of lead poisoning to reduce lead hazards before children become poisoned;
- Policy and program activities to promote secondary prevention of lead poisoning, including blood lead testing of children and pregnant women;
- Assurance of timely, comprehensive medical and environmental management for children with lead poisoning; and,
- Response to emerging lead-related public health issues, such as lead poisoning among immigrant and refugee children and recalls of lead-contaminated consumer products.

Targeted efforts at disparate populations include collaborative efforts with the NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigration Affairs and the Department's Refugee Health Program to address emerging state and national concerns about lead poisoning among refugee populations. The Department and OTDA jointly conducted an assessment of educational needs for LHDs and refugee resettlement agencies, resulting in a collaboration to translate basic low literacy lead educational materials for refugees and to develop a new video for local agencies. The Department worked with the Office of Children and Family Services to develop and disseminate materials on lead poisoning prevention for all child care providers throughout New York State.

All providers funded by the Department are required to assess community need and develop outreach strategies to engage hard to reach populations into their services. Providers submit quarterly reports and, if data are available, Title V staff review to determine if high risk populations are being reached, and work with providers to address issues when necessary. Through programs such as the Immigrant Women's Health Program, the Department funds Family Planning Advocates of New York State to work with family planning agencies, to enable them to develop strategies for providing more culturally and linguistically competent, reproductive health services, thereby increasing their reach into the targeted population. Included in the updated standards for Medicaid Prenatal Care Prenatal care providers is the provision that they shall provide, or arrange for, the provision of health and childbirth education based on an assessment of the pregnant woman's individual needs. Prenatal care providers are required to focus on the pregnant woman's ability to comprehend the information and use materials appropriate to the educational, cultural and language needs of the patient as well as her gestational history.

The Department is also requiring funded providers to use, whenever possible, evidence-based or promising practices that have been tested or evaluated to produce desired outcomes on the target

population. For example, in the comprehensive adolescent health request for applications released in 2010, only evidence-based practices were entertained for funding. New York also has a comprehensive system of perinatal regionalization, led by Regional Perinatal Centers (RPCs). This better ensures women at high risk for poor birth outcomes are referred to a hospital that has the capability to care for the women and her infant. The Department also supports Regional Perinatal Forums, that bring hospital and community organizations together to identify gaps and barrier sin the service systems that may lead to poor birth outcomes.

Title V staff communicate regularly with Department regional staff as well as community providers. This allows issues such a lack of obstetrical coverage in certain areas of the state or issues with health outbreaks or medical coverage to come to the forefront. For example, Title V staff became aware of inadequate obstetrical coverage in a rural area of the state. Title V staff facilitated discussions among local partners, the Department’s regional office and the state to address the issue.

The report also stressed the need for the Department to better coordinate the state’s data system and information technology to streamline and coordinate the flow of information. Through New York’s Office of Health Technology Transformation, New York’s health IT plan is being advanced in the public’s interest and with clinical priorities and quality and population health improvement goals leading the way. The plan includes key organizational, clinical and technical infrastructure as well as cross cutting consumer, financial and regulatory strategies to better coordinate data flow and information sharing. Within the DFH, staff are working on the development of the Child Health Information Integration Project (CHIP²) that aims to develop an integrated data system that will improve quality of care (via timely accurate data), reduce medical errors, collect individual data for activities such as Newborn Hearing Screening, provide seamless flow of information between jurisdictions, link events of public health significance in a child’s life (e.g. immunizations) and enable bi-directional data sharing.

The Title V Director is also taking a lead role for the Department in the New York State Strategic Partnership facilitated by HRSA. The initial meeting was convened in May 12, 2009. Ten individuals representing divisions within the Department and the Community Health Care Association of New York State participated in this meeting. Health indicators for the two priority areas were identified as:

- The percentage of New York State residents with access to primary health care (coverage, workforce, medical home)
- The number and percentage of New York State residents with access to oral health care.

A follow-up meeting took place in November, 2009 to discuss the two priority health indicators, identified areas of concern, collaborative strategies, action steps and identified champions to ensure the work on the priority health indicators continued. The Bureau of Dental Health, in the DFH, continues to work with the New York State Oral Health Coalition, and others to address access issues. In March 2010, the Department submitted a report to the legislature titled “Increasing the Supply of Dentists, Midwives, Physician Assistants, and Nurse Practitioners in Underserved Areas Through Doctors Across New York Physician Loan Repayment Program Incentives”. As part of the HRSA Grants to States to Support Oral Health Workforce Activities initiative, the Department is working with Area Health Education Centers, New York State

Dental Association and the Rochester Primary Care Network to improve recruitment efforts, promote school dental certificate program and address concerns about fluoridation.

Although there is much left to be done, the Department is committed to continue its work to ensure all New York's citizens receive high quality, comprehensive primary and preventive care to improve health outcomes.

Section III B. Agency Capacity

The NYSDOH, as the Title V agency, plays a major role in assuring access to quality, comprehensive, community-based, family centered care for all NY's women, children and families. Title V provides the foundation for NY's commitment to develop and support core public health functions such as resource development, capacity and systems building, population-based functions such as public information and education, knowledge development, outreach and referral to services, technical assistance to local health departments and communities to address core public health needs, and training and resources to support a cadre of professionals necessary to meet the needs of New York's maternal and child health population. New York's strong commitment to ensuring the health and well-being of the MCH population is manifest in an extraordinary array of resources made available to meet their needs. This section provides an overview of these resources, which extend from the legal framework that authorizes the Department's work, to the extensive programming conducted on behalf of New York's most vulnerable populations.

1) NYS Statutes Relevant to Title V Program Authority and Impact Upon the Title V

NY's Public Health Law (PHL) provides a strong legal foundation for the Department'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 the Department and the powers and duties of the Commissioner of Health and other Department officers and employees are detailed in PHL Article 2, the Department of Health. The same article also details the mission of the Office of Minority Health, which is discussed below in the section devoted to cultural competency. Some important powers granted by the legislature to the Department 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 (Medicaid) program. Article 2 also provides that the Department 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 Department administers under the provisions of PHL Article VI, State Aid to Cities and Counties.

A key determinant of the Department'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 the Department 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 our efforts to improve the health of the MCH population.

The Department's ability to control lead poisoning is conferred by PHL §1370-1376-a, which defines the State lead poisoning program, specifies lead screening and reporting requirements, and prohibits the manufacture, sale and use of specific products containing lead. The law also details abatement requirements where lead hazards exist, identifies enforcement agencies, and provides remedies for failure to act to abate lead hazards.

The comprehensive tobacco control capacities of the Department are specified in PHL Article 13-E, regulation of smoking in certain public areas, which enables the Dept. to reduce environmental exposure to tobacco smoke by prohibiting smoking in most 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 of Health regarding the health needs for mothers, infant 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 (§2500-a), HIV (§2500-f) and hearing problems (§2500-g). NY's Child Health Insurance Plan is detailed in PHL §2510-2511, and the statewide Adolescent Pregnancy Prevention and Services (APPS) Program is authorized by PHL §2515-2515-d. The Commissioner's extensive powers to affect prenatal care are enumerated in PHL §2520-2529. An important asset to Departmental 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.

The Department's Early Intervention (EI) Program, for children who may experience a disability because of medical, biological or environmental factors which may produce developmental delay, 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 public education program to promote utilization of nutrition 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 the Department's capacity to promote and protect the health of mothers and children. Among the specific provisions of 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, the Department 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/newborn home visiting programs, the importance of the Department's home health agency regulation has grown considerably. Now that the majority of Medicaid-eligible mothers and children are enrolled in Medicaid managed care plans, NYSDOH 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 Department to plan, implement and oversee a variety of programs focused on improving the health and wellness of the MCH population.

2) Capacity to Provide Preventive and Primary Care Services for Pregnant Women, Mothers, Infants and CSHCNs

NYSDOH oversees a broad array of programs designed to address the needs of pregnant women, mothers, infants and CSHCNs. Descriptions of the major Title V-related efforts are provided below.

Family Planning Program provides accessible reproductive health services in 51 agencies in 201 sites. Programs provide low-income, uninsured women with contraceptive education, counseling and methods to reduce unintended pregnancies and to improve birth spacing and outcomes. The program serves over 340,000 women and men per year. The Family Planning Extension Program, added in 1998, provides up to 26 months of additional access to family planning services for women who were pregnant while on Medicaid, and subsequently lost Medicaid coverage. The Family Planning Benefit Program began in October 2002 and provides Medicaid coverage for family planning services to individuals with incomes at or below 200 percent of the federal poverty level. Plans are underway to expand and streamline access to family planning services through Medicaid redesign. The MA Redesign proposal includes moving the FPBP into a State Plan service and auto-enrolling women into the program who would have previously entered the FPEP, including undocumented immigrants, and includes a presumptive eligibility period that would ensure immediate access to services while awaiting eligibility determination.

Comprehensive Adolescent Pregnancy Prevention (CAPP) Initiative is a new initiative launched in January 2011 that integrates and replaces NY's previous adolescent health programs, and includes a significant focus on reducing racial and ethnic disparities. Through the CAPP initiative, DOH awarded more than \$17.5 million in state grants to 50 community-based organizations that focus on the prevention of pregnancies, STDs and HIV among male and female adolescents age 10 to 21 years. Projects implement evidence-based sexuality education; ensure access to reproductive healthcare services; expand educational, social, vocational and economic opportunities; and engage adults to advance sustainable local community efforts to improve environments for young people

Personal Responsibility Education Program (PREP) initiative, supported through new federal funding (\$3.4 million), focuses on implementation of evidence-based sexual health education and preparation of youth for successful transition to adulthood to reduce adolescent pregnancy, making it closely aligned with the DOH CAPP initiative described above. A state plan describing NYS's plans for use of this funding was approved in April by the federal Administration on Children and Families. The majority of NYS' PREP funds will be used to make additional CAPP awards to organizations that were "approved but not funded" through the recent RFA, and will also be used to support an enhancement project targeting youth in foster care to be developed in consultation with OCFS.

Abstinence Education Grant Program (AEGP) is a new initiative supported by \$2.99 million in federal funding through the federal Abstinence Education Grant Program. NYS previously declined this federal funding due to significant restrictions on use of the funding. Under revised guidance, states have considerable flexibility to target younger youth and to focus on elements of programming determined to meet the needs of the selected populations. NYS will utilize grant funds to support a new initiative that will fund community-based mentoring, counseling and adult supervision programs designed to delay the initiation of sexual behavior among young people, ages 9-12, residing in high-risk communities.

Comprehensive Prenatal-Perinatal Services Networks are community-based organizations that mobilize the service system at the local level to improve perinatal health. The scope of service provided by these networks includes coalition building, conducting outreach and education to high-risk populations, and provider education on special topics, such as screening for substance abuse among pregnant women, or cultural sensitivity. Each of the 16 perinatal networks targets a region, ranging in size from several health districts in NYC to large multi-county regions in rural upstate.

Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP) is a new initiative supported by a grant from HRSA designed to improve health and developmental outcomes for at-risk children through implementation of evidence-based home visiting programs. To receive funding, states were required to complete a number of steps including an initial funding application and a statewide needs assessment.

The MIECHVP targets high risk communities with gaps in home visiting services as defined by the state home visiting needs assessment, and in accordance with the requirements of a home visiting state plan recently issued by HRSA. To date NYS has been awarded \$4,111,834 for FY

2010. HRSA required NY to provide \$673,000 annually of NYS' \$4.1 million award to a Rochester project previously directly funded by the Administration for Children and Families.

The purpose of the statewide needs assessment was to identify communities with high rates of maternal, infant and child health risk indicators and the existing home visiting programs and supportive resources in those communities. With input and assistance from a group of state agency partners, the NYSDOH collected and analyzed a set of 23 indicators based on HRSA criteria and additional state-defined criteria. For the initial needs assessment, county was used as the geographic unit of analysis.

Following the submission of the initial needs assessment to HRSA, additional analysis of ZIP code level data was completed. The results of this analysis are currently under review, which will inform further targeting of services. The needs assessment also included an inventory of existing home visiting programs, including county-specific inventories for each of the high risk counties. NY's state plan is due to HRSA in early June. MIECHVP will provide NY with an opportunity to maximize and coordinate the various models of home visiting services in NYS (listed below) to better serve the MCH population.

Community Health Worker Program (CHWP) - In 23 programs statewide, one-on-one outreach, education and home visiting services are provided to pregnant women who are at highest risk for poor birth outcomes, such as low birth weight infants or infant mortality. The CHWP is targeted towards specific communities with high rates of infant mortality, out-of-wedlock births, late or no prenatal care, teen pregnancies and births, and births to low-income women.

Healthy Mom/Healthy Baby is designed to improve the health of mothers and infants through the development and implementation of organized county systems of perinatal health and home visiting services. Six Local Health Departments (LHDs) in the highest need areas of the state receive funding to plan and develop a system of perinatal health and home visiting services, outreach and identification, home visiting for high-risk pregnant/postpartum women, and improved access to related health and human services. The program seeks to improve pregnancy outcomes and infant health and development by identifying high-risk pregnant women and postpartum women and their newborns, assessing their need for services, and assisting them in obtaining appropriate services, including home visiting.

Nurse Family Partnerships (NFP) is an evidence-based home visiting program that improves the health and self-sufficiency of low-income, first time parents and their children. NFP is a nurse-led model in which nurses promote the personal health of mothers, parental care of the child, environmental health, support systems for mother and infant, and parent's life course development. The Office of Temporary and Disability Assistance provided NYSDOH with up to \$5,000,000 in federal TANF funding via a Memorandum of Understanding to expand NFP programs. The three approved programs funded to provide services are: the NYC Department of Health and Mental Hygiene, Onondaga DOH and Monroe County DOH Nurse Family Partnership Programs. The OHIP has also obtained state plan approval to provide Medicaid funding support to two of these programs in Monroe County and New York City as targeted case management programs.

Regional Perinatal Centers (RPC) - 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 RPC. 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. RPC quality assurance activities are supported by the Statewide Perinatal Data System that provides affiliate hospital data to them. There are currently 136 birthing hospitals, including: 58 Level 1 hospitals; 25 Level 2 hospitals; 35 Level 3 hospitals; and, 18 hospitals constituting 15RPCs

Regional Perinatal Forums, involving hospital and community stakeholders, were established in each region to identify and address perinatal health issues on the local level. Forums are configured to bring a regional perspective to perinatal care statewide, and encompass all regions of the state.

Newborn Hearing Screening Program (NBHS) - Since October 2001, all facilities caring for newborn infants are required to have in place a newborn hearing screening program to conduct hearing screenings all babies born in NYS, and to refer for further evaluation and follow-up services when necessary. Effective January, 2011 NYS PHL was amended to require the submission of individual level hearing screening and follow up data on all infants up to the age of six months. The Department is engaged in the development and implementation of an information system to collect hearing data statewide.

Medicaid Prenatal Care provides comprehensive prenatal care for women up to 200% of the fpl based on in accordance with current standard of obstetrical care. The **Medicaid Obstetrical and Maternal Services (MOMS) Program** was developed to provide comprehensive prenatal care services to low-income women in rural settings. Prenatal care is provided in doctors' offices, while ancillary services such as health education, psychosocial and nutritional screening are provided by qualified Health Supportive Services Providers. Over 3,000 physicians are enrolled in the MOMS program. The Title V programs works closely with the OHIP to ensure women across NYS have access to prenatal care services.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides supplemental food, participant-centered nutrition education/counseling, breastfeeding support, and linkages with health and social services for low-income eligible women and children at no cost. WIC's purpose is to improve pregnancy outcomes, promote optimal growth and development for infants and children and influence lifetime nutrition and health behaviors. The NYS WIC program provides services via 94 local agency direct service providers at over 450 WIC clinic sites.

Tobacco Control Program is a comprehensive, coordinated program that seeks to prevent initiation of tobacco use, reduce current use of tobacco products, eliminate exposure to secondhand smoke and reduce the social acceptability of tobacco use. The program consists of community and statewide activities supported by surveillance and evaluation. NYSDOH issues grants for programs such as local tobacco control, youth action, tobacco enforcement and

prevention, and cessation. The NYS Smoker's Quitline (1-866-NY QUIT (1-866-697-8487)) continues to be a key evidence-based component of the program's cessation efforts.

School-Based Health Center Program (SBHC) – Through 230 SBHCs sponsored by 54 community health and mental health services providers, the SBHCs provide primary and preventive medical and mental health care services to more than 158,000 students living in high-need areas. SBHCs are extension clinics of Article 28 hospitals and/or diagnostic and treatment centers that provide services in school settings.

School-Based Health Center Dental Program ensures those students with limited or no access to care may have access to preventive dental care through SBHC dental sites. The program provides dental services with mobile vans, portable equipment or in a fixed facility within the school. Students are enrolled with parental consent. Where applicable, the SBHC Dental Program works with the students' primary dental providers to coordinate services and referrals.

Preventive Dentistry for High-Risk Underserved Populations Program addresses the problems of excessive occurrence of dental disease among children who reside in communities with a high proportion of persons living below 185 percent of the federal poverty level. The application of dental sealants, an extremely effective caries-prevention agent, in combination with a program of dental screening, referral and other preventive services significantly improves the dental health of children in underserved communities. Thirty-one projects provide preventive dental services to an estimated 260,000 children and 12,000 pregnant women in underserved areas across the state. Organizations providing preventive dental services under this program include LHDs, dental schools, hospitals and diagnostic and treatment centers, rural health networks and SBHCs. Contracts for this program end 6/30/11. A RFA was recently released to fund the Preventive Dental Services Program to increase the prevalence of dental sealants in second and third grade children. Contracts will be awarded for the period July 1, 2011- June 31, 2016.

Supplemental Fluoride Program is a school-based fluoride mouth rinse program, which serves elementary school children and includes a preschool preventive tablet program that serves three- and four-year-olds in Head Start centers in fluoride-deficient areas. More than 120,000 children are participating in these programs.

Child and Adult Care Food Program (CACFP) improves the nutritional quality of meals and snacks served in participating day care programs by establishing minimum standards for items served, providing reimbursement for qualifying meals and snacks, and mandating ongoing monitoring of food service programs and training of program staff. The goal of CACFP is to ensure 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.

Eat Well Play Hard in Child Care Settings (EWPHCCS) is an obesity prevention program that targets low income child care centers. EWPHCCS improves the nutritional and physical activity environments in child care, and educates pre-school children, their families, and child care center staff on how to adopt healthy lifestyle behaviors.

Creating Healthy Places to Live, Work and Play – Eat Well Play Hard Community Projects ended in September 2010. The DON and BCCDP collaborated on the development of a new community-based initiative. Twenty-two contractors maximize the impact on the prevention of obesity and type 2 diabetes by promoting the implementation of policies, systems and environmental change that will create healthy places for people to live, work, and play. Targeted strategies include: increasing availability of places to be physically active; creating community landscapes conducive to physical activity; increasing the availability of fresh fruits and vegetables; and increasing the healthful quality of foods offered for sale.

Overweight and Obesity Prevention Program was established to increase physical activity and improve nutrition among residents of NYS. The program's current primary focus is the prevention of childhood obesity. The program distributes funding for three Centers for Best Practices to address age-specific overweight and obesity prevention issues; School and Community Partnerships; and, a statewide organization to provide training, consultation, support and guidance to child care center staff to improve nutrition, increase physical activity and decrease television/media use.

Diabetes Prevention and Control - To address the obesity and type 2 diabetes epidemic, the Diabetes Prevention and Control Program (DPCP), in collaboration with the Obesity Prevention Program and Division of Nutrition's Eat Well Play Hard Program, has developed the Creating Healthy Places to Live Work and Play procurement, supporting 22 innovative projects implementing evidenced based and sustainable policy, systems and environmental change strategies in communities and worksites for individuals to be more physically active and eat more healthy foods.

Childhood Asthma Coalitions - 11 Regional Childhood Asthma Coalitions, reaching almost all counties and high risk neighborhoods, are organized groups of leaders in community organizations and volunteers within a specific region who work together to improve the quality of care and the quality of life for children and families with asthma.

Immunization Program 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.

Child Mortality Review/SIDS Prevention Program - In collaboration with other state agencies, the program is working to develop a more comprehensive statewide child death review initiative that will further expand the understanding of why children die, and will apply those findings to improve prevention activities. The program also provides public outreach and education about risk factors associated with SIDS.

Lead Poisoning Prevention Program (LPPP) - The goal of the LPPP is to reduce the occurrence and consequences of childhood lead poisoning throughout the state. The department, in collaboration with a wide range of partners, has developed a strategic plan for the elimination of childhood lead poisoning in NYS by 2010. Due to a significant decrease in funding from

CDC, as well as CDC's refocusing of the program into a new Healthy Home and Community Environments model, major responsibility for the LPPP will be transitioned to the Center for Environmental Health, with close collaboration by Title V staff.

Children with Special Health Care Needs (CSHCN) Program works closely with internal partners and LHDs, community-based and professional organizations to develop and implement systems initiatives to improve quality of services for children with special health care needs. The CSHCN Program has 55 contracts with LHDs to provide services to children with special health care needs birth to 21 and their families. With funding and technical assistance from the department, the local CSHCN Programs develop community-based resources to: 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.

The CSHCN Program, in conjunction with the department's Wadsworth Laboratories' Newborn Screening Program, oversees a statewide network of specialty centers that accept referrals of infants with positive newborn screens for endocrine, metabolic, cystic fibrosis or hemoglobinopathy disorders.

Physically Handicapped Children's Program (PHCP) operates in most counties in NYS. The program 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.

Early Intervention Program (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. To be eligible for services, infants and toddlers must have a delay in one or more areas of development (physical growth or development, learning skills, speech and language development) or a physical or mental diagnosis that impacts on development (such as cerebral palsy or Down syndrome). The EIP, created in 1993, currently provides services to more than 70,000 infants and toddlers and their families statewide.

Dental Rehabilitation Program (DRP) provides children with physically-handicapping malocclusions access to appropriate orthodontic services. Operated in most LHDs under the auspices of the PHCP, the DRP provides both diagnostic/evaluative and treatment services. The program is open to children under the age of 21 who have congenital or acquired severe malocclusions. Over 10,000 children receive services annually.

3) Capacity to Provide Culturally Competent Care

The NYS Office of Minority Health (OMH) was established by an amendment to the NYS PHL in 1992 and became operational in 1994. PHL § 240-243 outlines the duties and responsibilities

of the office, responsibilities and membership appointments of the NYS Minority Health Council, and specifies the contents of a minority health report which NYSDOH is required to prepare and distribute biennially.

Unequal access to high quality health care is a problem that has been documented for many racial and ethnic minorities. It has also been shown that when access is available, many populations face barriers which prevent them from utilizing health care. Programs funded under the NYS OMH help to reduce health care system access barriers for racial and ethnic minorities. In 1999, OMH created the State-Community Partnerships Program for minority health improvement in high need areas. Through this coalition-focused, asset-based, neighborhood-specific program, twenty-three community coalitions have been funded to address community-specific health disparities. Using the Spectrum of Prevention framework (this framework is made up of six complementary levels to effect community level change: strengthening individual knowledge and skills; promoting community education; educating providers; fostering coalitions and networks; changing organizational practices; and influencing policy legislation), these coalitions work to impact minority health on all six levels. The current cohort consists of three community coalitions providing services in Westchester, Manhattan and Onondaga counties. The Latino Health Outreach Program began in 2007. It provides outreach opportunities to engage more Latinos in the health care system. Populations being served by the four projects across NYS include Latinos across the life cycle (children, adolescents, adults and seniors) who are not engaged at all, or engaged sporadically, with the health care system, and immigrants from countries where Spanish is the primary language.

As a follow-up to the Minority Health Disparities Conference in 2009, OMH initiated a webinar series to spotlight minority populations in NYS. The webinars, which featured presenters with practical experience designing and implementing programs with the minority group highlighted, were scheduled as follows: April 15 (Asian Americans); May 12 (American Indians); May 20 (African Americans); May 26 (Hispanics/Latinos). A major focus of the Prevention Agenda is to ensure all New Yorkers have access to quality health care and ethnic and racial disparities can be addressed. In April, 2010, local health departments and Department experts in specific topic areas (teen pregnancy prevention, prenatal care, obesity prevention) met to discuss local strategies to improve health outcomes and address disparities in selected health outcomes. These discussions focused on local public and private agencies that could partner to address specific issues, and evidence-based interventions and promising practices to address health issues, including health disparities. DOH recently released the *NYS Minority Health Surveillance Report: County Edition* that assesses socio-demographic and health indicators for each county by race/ethnicity. LHDs can use these data to identify issues and plan effective public health interventions. Title V staff will continue to promote partnerships to improve the health outcomes of New York's diverse community.

The Department is also making a concerted effort to provide services and resources to the highest need areas of the state. For example, although New York's outcomes in many areas are improving, in areas such as adolescent pregnancy, disparities continue to exist due to increasing numbers of immigrant and hard to reach adolescents. Extensive data analyses have been completed to target the highest need areas and provide better utilization of resources. The Department also provided statewide training to current and potential providers on evidence based

programming and community coordination of resources, and outreached to providers in the hardest to reach areas to ensure there will be a pool of agencies positioned to apply for funds to address the need in the highest need areas of the state. In addition, all requests for applications now specifically identify high risk groups as a priority including specific minority populations, youth in foster care or those otherwise not engaged in the service system. All programs developed by the Bureaus and Divisions within the Center for Community of Health work with the communities they serve to assure that their programs meet community needs. In addition, the following processes help to ensure ongoing improvements in cultural competency:

- The Request of Applications process used to select contractors requires applicants to demonstrate competence in serving the target populations including linguistic and cultural competency.
- The Department provides programs with health risk data, enabling programs to tailor their programs to the community. Data are provided by major race/ethnicity categories, when available, and at the lowest feasible geographic unit, e.g., zip code.
- All programs are required to include outreach plans and activities to ensure the services are reaching the high risk, diverse populations in their catchment areas. This includes the LHD CSHCNs programs as well.
- The Child Health Information Integration Project (CHI²) that aims to develop an integrated data system that will improve quality of care, reduce medical errors, collect individual data for activities such as Newborn Hearing Screening, provide seamless flow of information between jurisdictions, link events of public health significance in a child's life (e.g. immunizations) and enable bi-directional data sharing. Ultimately health care providers will have access to child health information to ensure they have a complete picture of the child's health history and needs, which will benefit those high risk children who may access health care through a variety of settings and clinics.
- Programs use community-based organizations with diverse staff, representative of the racial and ethnic backgrounds of the communities.
- Programs that serve non-English speaking populations must have staff to deliver services who are fluent in the predominant foreign languages spoken in the community and/or provide access to a telephone language line.
- Programs are encouraged to hire staff that is from communities and populations served. For example, the CHWP uses paraprofessional home visitors indigenous to the communities and populations served.
- The Department funds Family Planning Advocates of New York State to work with family planning agencies, to enable them to develop strategies for providing more culturally and linguistically competent, reproductive health services, thereby increasing their reach into the targeted population.
- Written and outreach materials are translated, adapted and/or provided in alternate formats based on the needs and preferences of the population served.
- Programs actively engage the community on an ongoing basis. The SBHC program, for example, has a community advisory council that assures that the views of the community members are reflected in the policies priorities and plans. The Perinatal Networks have community coalitions that include community organizations, including individuals from the community served to guide program outreach and development.

Section III. C. Organizational Structure

This section reviews the general format of New York State government and provides further details regarding the placement of the Title V program within the NYSDOH and its constituent components as they relate to the administration of New York's Title V Program. Significant detail regarding the placement of the Title V program within the NYSDOH is contained in Section III.A.

The structure of the government of NYS mirrors that of the federal government, with three independent branches. The legislative branch consists of a bicameral Legislature, including a 62 member Senate and 150 member Assembly representing the nearly 20 million citizens of the State. All members are elected for two-year terms. The judicial branch comprises a range of courts (from trial to appellate) with various jurisdictions (from village and town courts to the State's highest court - the Court of Appeals). The Judiciary functions under a Unified Court System, which has responsibility for resolving civil claims, family disputes, and criminal accusations, as well as providing legal protection for children, mentally-ill persons and others entitled to special protections. The executive branch consists of 20 departments that is the maximum number allowed by the State Constitution. The New York State Department of Health is one of those 20 departments.

Only four statewide government officers are directly elected including:

- The Governor, who heads the Executive Department, and Lieutenant Governor (who are elected on a joint ballot).
- The State Comptroller, who heads the Department of Audit and Control.
- The Attorney General, who heads the Department of Law.

With a few exceptions, the Governor appoints the heads of all State departments and agencies of the executive branch. One important exception is the Commissioner of the State Education Department, who is appointed by and serves at the pleasure of the State Board of Regents.

Geographically, New York State is divided into 62 counties (five of which are boroughs of New York City). Within these counties are 62 cities (including New York City), 932 towns, 556 villages and 697 school districts. In addition to counties, cities, towns and villages, more than a thousand "special districts" meet local needs for fire and police protection, sewer and water systems or other services. Local governments are granted the power to adopt local laws that are not inconsistent with the provisions of the State Constitution or other general law.

Under the direction of the Commissioner, Nirav Shah, MD, MPH, who is appointed by the Governor, the Department meets its responsibilities through the Office of Health Insurance Programs, the Office of Long Term Care, the centers located in the Office of Public Health, and the Office of Health Systems Management. The Office of Health Insurance Programs is responsible for Medicaid, Family Health Plus, Child Health Plus, Elderly Pharmaceutical Insurance Coverage, and the AIDS Drug Assistance Program. The Office of Long Term Care oversees the integration of planning and program development for services related to long term care. The Office of Public Health and the Office of Health Systems Management provide policy and management direction to a system of regional offices, whose staff conduct health facility

surveillance, monitor public health, provide direct services and oversee county health department activities. Additionally, the Department is responsible for five health care facilities. The Department has a workforce of 4,992 filled positions, with 29 percent of those positions employed in the Department's health care facilities.

The **Office of Public Health** (OPH), led by Guthrie Birkhead, MD, MPH, brings together all Department public health programs under one organizational mantle. The Office's programs include: the biomedical research, public health science, and quality assurance of clinical and environmental laboratories of the Wadsworth Center; the counseling, education, prevention, health care and supportive services of the AIDS Institute; the protection of human health from environmental contaminants in air, water and food through regulation, research and/or education by staff of the Center for Environmental Health; the nutrition, health screening, immunization, tobacco control, maternal and child health programs and the public health surveillance and disease control activities of the Center for Community Health.; the support and oversight of local health departments and the efforts to help build public health workforce capacity of the Office of Public Health Practice; and, the comprehensive all-hazards preparedness and response activities of the Office of Public Health Preparedness.

The programs providing services to the maternal and child health population are spread throughout the Department, but are mainly focused in the **Center for Community Health** (CCH). CCH responsibilities touch practically every aspect of public health in NYS. Under the direction of Ellen Anderson, MS, the Center conducts programming through four Divisions: the Division of Chronic Disease and Injury Prevention; the Division of Nutrition; the Division of Epidemiology; and, the Division of Family Health. Each addresses a major component of the Department's public health mission, and all are involved in carrying out MCHSBG-related activities. The Office of Minority Health also resides within the Center, and plays a key role ensuring that Department programs address population health disparity issues.

The **Division of Family Health**, directed by Barbara L. McTague (who also serves as the Director of the NYS Title V Program), promotes the health of families by assessing needs, promoting healthy behaviors and providing services to support families. The division's primary focus is to improve the health of women, children and adolescents. Its programs touch new mothers, adolescents, children with disabilities, rape victims and children with lead poisoning or lack of access to dental services. Programs promote healthy behaviors while also assuring access to quality health care. The division provides access to primary medical and dental care and preventive health services for migrant farmworkers and Native Americans living in reservation communities. The Division provides the central focus for New York State's Title V MCH programming, and consists of three program bureaus and the Office of the Medical Director:

The **Bureau of Maternal and Child Health**, directed by Rachel M. de Long, MD, MPH, administers a variety of programs that focus on the prevention of adverse health conditions and promotion of health and wellness in women, children and youth. Over the past year, the newly formed BMCH was reorganized as follows to increase efficiencies and enhance program outcomes:

- **Perinatal Health Unit** is comprised of Article 28-based programs and community-based initiatives that support the direct delivery of clinical health care and supportive services to

achieve outcomes related to the accessibility, quality, and sustainability of perinatal services for NY's women and babies. These programs have substantial commonalities in terms of their focus on improving birth outcomes. Consolidating these programs within a common unit facilitates the establishment and implementation of more consistent and effective systems and standards to address these common issues. Programs included in the Perinatal Health Unit are:

- Perinatal Regionalization, including Regional Perinatal Centers and affiliate hospitals, Regional Perinatal forums, and the National Initiative for Children's Healthcare Quality (NICHQ) project.
 - Maternal, Infant and Early Childhood Home Visiting Program
 - Community Health Worker Program
 - Healthy Mom, Healthy Baby home visiting
 - Nurse Family Partnership
 - Comprehensive Prenatal Perinatal Services Networks
 - Growing Up Healthy Hotline
 - Infertility Demonstration Program
 - Osteoporosis Prevention and Education.
- The **Adolescent Health Unit** is comprised of community-based programs that focus on prevention and health promotion strategies to achieve outcomes related to healthy behaviors and health outcomes at the personal, family and community levels. These programs have substantial commonalities in terms of primary and secondary prevention strategies, emerging federal priorities and funding opportunities, and local partnerships to promote and improve health. Consolidating these programs supports use of evidence-based prevention strategies across programs, allows for alignment and ongoing meaningful collaboration between programs with similar target groups and outcomes, and facilitates the establishment and implementation of more consistent systems for program management and improvement. The Adolescent Health Unit includes:
 - Comprehensive Adolescent Pregnancy Prevention (CAPP) Program
 - Personal Responsibility and Education Program
 - Abstinence Education Program
 - Teenage Services Act (TASA), in conjunction with Office of Health Insurance Programs
 - ACT-for Youth Center of Excellence
 - Adolescent HIV Prevention
 - Act for Youth Healthy Transitions
 - Sexual Violence Prevention and Rape Crisis Services.
 - Hospital Sexual Assault Forensic Examiner (SAFE) program
- The **Community-Based Health Care Unit** is comprised of programs that provide comprehensive family planning and reproductive health care services to underserved populations, and the largest School Based Health Center program in the country that provides primary and preventive health care services to many of NY's most vulnerable children and adolescents.
 - Family Planning and Reproductive Health
 - School Based Health Center program.

- **Child Health Unit** that is comprised of programs and activities related to child health programs and outcomes. It also includes several cross-cutting child health-related activities and initiatives that support delivery of information to families and consumers and/or the integration of child health promotion practices across a range of other local child-serving settings (e.g. early care and education). Specific programs and initiatives within the unit include:
 - Lead Poisoning Prevention Program;
 - Children with Special Health Care Needs;
 - Physically Handicapped Children’s Programs; and,
 - Other cross-systems early childhood initiatives, including parenting education projects and the current federal Project LAUNCH grant. Consistent with the framework for public health MCH services, these programs and activities are characterized by a blend of public health approaches including population-based public and professional outreach and education, targeted care coordination and other enabling services, and gap-filling direct health care services.

- **Data Analysis, Research and Surveillance Unit** that consolidates the data systems, research and data analysis activities and staff currently housed within individual programs, including the Statewide Perinatal Data System, Rape Crisis program data system, and LeadWeb childhood lead registry. Consolidating these functions within a single unit facilitates important peer support between research staff and promotes consistent approaches to use of data to support ongoing program development, implementation and evaluation.

The **Bureau of Early Intervention**, directed by Bradley Hutton, MPH, is responsible for two major programs for young children with, or who may be at risk for, physical and cognitive disabilities. The 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 Bureau also administers DOH’s Newborn Hearing Screening Program, as well as the MCH Autism Intervention Research Grant and the State Implementation Grant for Improving Services for Children with Autism Spectrum Disorders.

The **Bureau of Dental Health**, under the leadership of Jay Kumar, DDS, MPH, implements and monitors a broad range of statewide dental health programs that prevent, control and reduce dental diseases and other oral health conditions, and promote healthy behaviors. In addition to maintaining the focus on children, programs promote dental health among adult populations. The Bureau’s dental health programs include:

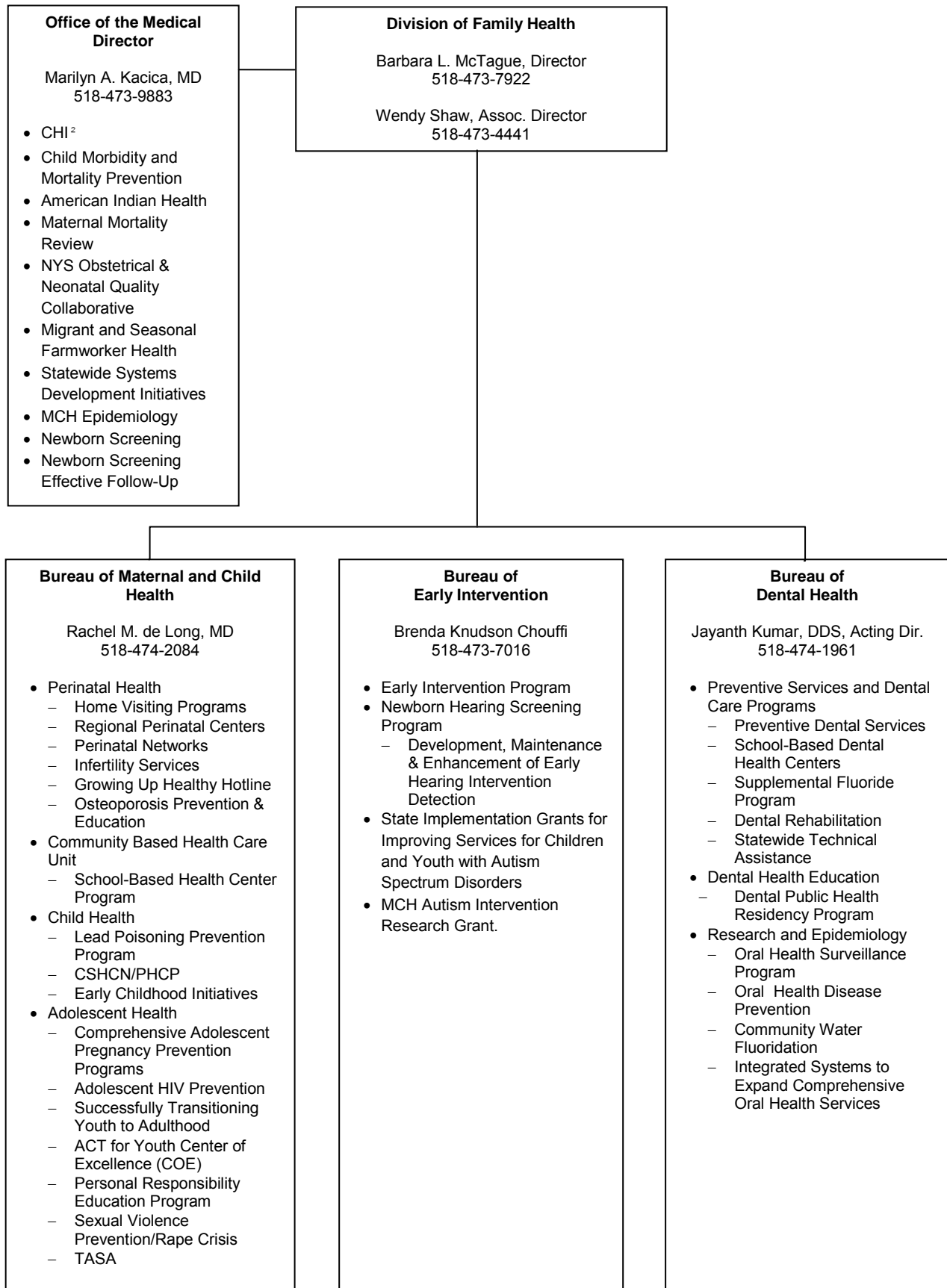
- Preventive Dentistry for High-Risk Underserved Populations Program
- Supplemental Fluoride Program
- Dental Rehabilitation Program
- Preventive Dentistry Program for Deaf/Adolescent Children
- Dental Health Education
- Dental Public Health Residency Program
- Research and Epidemiology
- State Oral Disease Prevention Program
- School-Based Health Center Dental Program

The **Office of the Medical Director** provides medical leadership for the DFH. Under the direction of Marilyn Kacica, MD, MPH, physicians in the office provide medical consultation and support to all division programs; support policy development and programmatic initiatives; participate in quality improvement initiatives and provide advice on emerging medical issues.

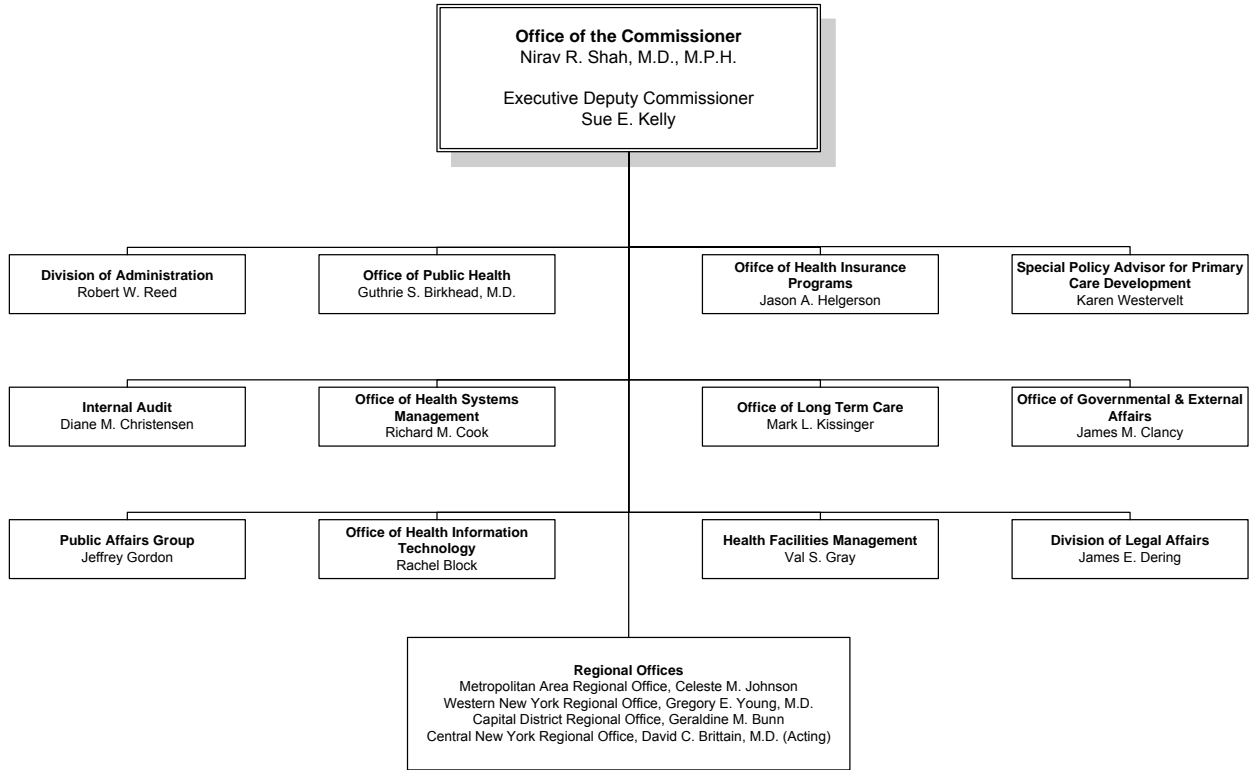
OMD programs include:

- CHI²
- Child Mortality Review/SIDS Prevention Program
- Maternal Mortality Review Program
- NYS Obstetrical and Neonatal Quality Collaborative
- American Indian Health Program
- Migrant and Seasonal Farmworker Health Program
- MCH Epidemiology Program
- Statewide Systems Development Initiatives.

Section III C. Organizational Structure – Organizational Charts



NEW YORK STATE DEPARTMENT OF HEALTH



Section III D. Other MCH Capacity

As stated previously, the DFH has responsibility for coordinating MCH-related programs and directly managing many MCHSBG-funded initiatives. There are currently 163 filled Title V-funded positions within NYSDOH, with an additional 613 non-Title V-funded positions performing Title V-related activities. Positions are located within NYSDOH's central, regional and district offices. Staff cover the full range of MCH activities, including child and adolescent health, women's health, sexual violence prevention, perinatal health, oral health, local health services, nutrition, child safety, injury control, laboratory operations, human genetics, congenital malformations, data and information systems infrastructure, health communications, managed care and facility surveillance.

Barbara McTague is the Director of the DFH and Director of the NYS Title V Maternal and Child Health Services Program in the NYSDOH. Ms. McTague provides policy and program direction and administrative oversight for the Division's bureaus, including the newly formed Bureau of Maternal and Child Health, incorporating the Bureau of Women's Health and the Bureau of Child and Adolescent Health, the Bureau of Dental Health, the Bureau of Early Intervention and the Office of the Division's Medical Director which includes the Migrant Health and Indian Health Programs. Employed by NYSDOH since 1987, she has managed several programs and Bureaus. While in the AIDS Institute, she developed, implemented and managed a number of innovative, new public health programs related to the prevention and treatment of HIV, including: the AIDS Drug Assistance Program, women's HIV counseling, testing and supportive services, the Substance Abuse Initiative, which provides the full continuum of HIV services in substance abuse treatment settings, including the development of needle exchange programs. In 1996, Ms. McTague became the Director of the Bureau of Women's Health, where she managed the statewide family planning program, including development and implementation of Medicaid waiver programs to expand access to family planning services, as well as Department's initiatives related to adolescent pregnancy prevention. In addition, she developed programs related to violence against women, including standards of hospital care for victims of sexual assault. Ms. McTague also spearheaded a perinatal regionalization initiative which resulted in significant changes in the perinatal health services arena, including the development of a statewide perinatal data system and significant improvement in the regionalized system of perinatal care. She has also directed the Bureau of Early Intervention, the statewide service delivery system for toddlers with disabilities. During her tenure, she led a significant effort to clearly articulate program policies and goals and to standardize and improve the quality of program performance. Ms. McTague has made considerable contributions to improving the health of women, children and adolescents throughout NYS.

Wendy Shaw, M.S., B.S.N., has served as Associate Director of the DFH since August, 2007. She previously served as the Director of the Bureau of Women's Health (BWH). Ms. Shaw served as Director of the Perinatal Health Unit within the BWH from 2000 through 2002, when she became Assistant Director. Her previous experience in the Early Intervention program provides her with further valuable knowledge in her role within the DFH.

With 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, Ms. Shaw started her career as a public health nurse working with high-risk maternal and child health families and later moved to Labor and Delivery nursing before moving to state service. She is also a graduate of the Leadership Program in Public Health from Harvard University School of Public Health in Boston. As a registered nurse with extensive clinical and administrative experience, she has her feet both in the world of administration and hands-on health care--remaining as a Labor and Delivery nurse at an area hospital.

Elizabeth Berberian, MPH, coordinates Title V Maternal and Child Health Services Block Grant application development, submission, and grant management activities. After receiving her MPH from the University of Michigan, Ms. Berberian began a 30 year career with NYS government, administering programs providing for the health and well-being of NY's children and families. She joined DOH in 1985 as the Director of the Adolescent Pregnancy Program. In 1994, she became the Director of the Upstate NY HIV Anonymous Counseling and Testing Program and served on a number of workgroups related to adolescents and HIV/AIDS. She later served as the Assistant Director of the Bureau of Chronic Disease Services where she contributed to the development of primary and secondary prevention initiatives for children, adolescents, families and adults. She has worked in injury prevention, where she acquired FEMA funding to develop a fire prevention and safety program targeted to families in high risk communities. She recently joined the Bureau of Maternal and Child Health where she will be contributing to initiatives in adolescent and perinatal health in addition to her responsibilities for Title V.

Under the direction of Marilyn Kacica, M.D., M.P.H., the Office of the Medical Director provides leadership and collaborates closely with the Bureaus in the Division. Dr. Kacica is a graduate of St. Louis University and received her M. D. from the St. Louis University Medical School. She completed pediatric residency training at the Cardinal Glennon Children's Hospital, subspecialty training in pediatric infectious disease at the Children's Hospital of Cincinnati, and her preventive medicine residency at NYSDOH. 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 American Academy of Pediatrics. Prior to moving to the DFH, she served as the Director of the Healthcare Epidemiology Program in the Division of Epidemiology's Bureau of Communicable Disease Control. She is providing leadership on a myriad of clinical, epidemiological, data utilization and quality improvement issues within the Division, was the co-chair of the AMCHP Emergency Preparedness Committee as well as the Adolescent Health Committee of the Emerging Issues Committee. This past year, she was appointed to be the Vice Chair of the Emerging Issues Committee. She leads preparedness efforts being made on behalf of NY's maternal and child health population. Dr. Kacica serves as the Principal Investigator (PI) to the State Systems Development Initiative and the NBS Effective Follow-up grants. In addition, she is the Program Director for the NYSDOH's Child Health Integration Initiative which is focusing on the integration of child health information for both public health and provider benefit. She is also leading quality improvement initiatives focusing on School-based health centers and perinatal health.

Christopher Kus, M.D., M.P.H., serves as Associate Medical Director for the DFH, and provides medical consultation to the Division. He 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. He is a developmental pediatrician who worked with the New Hampshire and Vermont Departments of Health prior to coming to NY. He has been with the NYSDOH for over ten years. A board-certified pediatrician and a fellow of the American Academy of Pediatrics, Dr. Kus is a Past President of the Association of Maternal Child Health Programs (AMCHP). He serves as co-chair of the AMCHP Legislative and Finance Committee. He was a member of the Early Childhood Expert Panel involved in developing the Third Edition of *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents* (2008). Dr. Kus serves as the Association of State and Territorial Health Officials (ASTHO) liaison to the HRSA Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC). He is a member of the National Academy for State Health Policy

New York's State Systems Development Initiative (SSDI) grant is coordinated by Ms. Cathy Tucci-Catalfamo in the Office of the Medical Director. The goal of the SSDI grant is to foster an infrastructure to improve data linkages among multiple data sources for child health information to assure program and policy development for maternal and child health. Ms. Tucci-Catalfamo has worked for the NYSDOH for over 30 years and has many years of experience in public health. She has worked for various bureaus and units within the DOH including the Cancer Control Bureau, Division of Occupational Health, Bureau of Injury Prevention, Bureau of AIDS Epidemiology, Bureau of Child and Adolescent Health, Division of Family Health and Bureau of Dental Health. Ms. Tucci-Catalfamo has assisted the NYSDOH Children with Special Health Care Needs Program to develop a data system and in gathering parent and consumer input for the MCHSBG needs assessment. SSDI staff will continue to play a key role in the CHI2 Project as well as other programs to assist Title V with building data linkages and infrastructure.

Rachel de Long, M.D., M.P.H., has served as the Director of the Bureau of Maternal and Child Health (formerly the Bureau of Child and Adolescent Health) at the NYSDOH since 2005. Prior to this role she served as the Bureau's Medical Director from 2003 to 2004. Dr. de Long also serves on the faculty of the SUNY at Albany School of Public Health in the Department of Health Policy, Management, and Behavior. She earned a B.S. in Rural Sociology from Cornell University, M.D. from University of Wisconsin Medical School, and M.P.H. from SUNY Albany School of Public Health. She completed a medical internship in Family Practice at the Guthrie Clinic and residency training in Preventive Medicine at SUNY Albany/NYSDOH, and is Board-Certified in Preventive Medicine and Public Health. As Bureau Director, she has overall responsibility for developing, implementing and evaluating policies and programs related to a range of child and adolescent health issues. She serves as PI for several major child health related federal grants.

Susan Slade, RN, MS, is a very experienced clinical and public health nurse and public health administrator. She has worked in the NYSDOH since 1987, with over ten years of that time in the Bureau of Maternal and Child Health (formerly the Bureau of Child and Adolescent Health). As the manager of the Bureau's Child Health Unit, Ms. Slade oversees several public health programs, including the Children with Special Health Care Needs Program and the Lead Poisoning Prevention Program, as well as non categorical activities related to health care

provider and parenting education. She's been involved with pediatric quality improvement initiatives related to developmental screening, standards development for pediatric specialty centers, and transition activities related to adolescents with special health care needs. In addition to being a licensed Registered Nurse, Ms. Slade is also a Certified Health Education Specialist.

Jayanth Kumar, DDS, MPH, is the Acting Director of the Bureau of Dental Health. He has served the Department since 1980 and most recently as Director of the Research and Epidemiology unit of the Bureau of Dental Health. He is also Associate Professor, School of Public Health, University at Albany. Dr. Kumar is a board-certified specialist in dental public health and a former director and president of The American Board of Dental Public Health. He has served as a consultant to many national and international organizations including the Centers for Disease Control & Prevention (CDC), National Institute of Dental & Craniofacial Research, NIH, Health Resources Services Administration (HRSA), the American Dental Association (ADA) and the National Research Council (NRC). He is project director for the Centers for Disease Control & Prevention's co-operative agreement to strengthen state's infrastructure. Dr. Kumar oversees the Department's fluoridation and other public health dental programs targeting high-risk underserved women and children, the supplemental fluoride program for preschool and school-aged children residing in non-fluoridated areas of the State, the Dental Rehabilitation Program for children with physically-handicapping malocclusions. Other Bureau activities and programs include Dental Health Education, the Dental Public Health Residency Program, research and epidemiology, the oral health initiative, and targeted oral health service systems for women and children.

Bradley Hutton, M.P.H. has been with the Department for seventeen years, serving as the Director of the Bureau of Early Intervention for the last five years. As Director, Mr. Hutton oversees a team of 50 staff with responsibility for the administration of New York's Early Intervention Program which serves more than 70,000 infants and toddlers with disabilities or developmental delays each year. Mr. Hutton received his Bachelor of Arts from Columbia University and his Master's of Public Health from the University at Albany School of Public Health, where he has also completed all requirements except the dissertation for a Ph.D. in epidemiology. Previously, Brad directed the Department's Cancer Services Program for six years. He has served on the Interagency Task Force on Autism and the Temporary Task Force on Preschool Special Education, as well as several committees that advise the Centers for Disease Control and Prevention on cancer control and also served on the Institute of Medicine's Committee to Improve Mammography Quality due to his leadership role in identifying and improving the quality of mammography in New York. Mr. Hutton served as the President of the National Infant and Toddler Coordinator's Association in 2010, a group representing state early intervention directors, and continues as a member of the Board.

Section III E. State Agency Coordination

As mentioned earlier, PHL §2500 specifies that the Commissioner shall, “cooperate with other state departments having jurisdiction over matters affecting the health of mothers and children, to the end that existing activities may be coordinated and duplication of effort avoided. He shall cooperate with and stimulate local agencies, public and private, in promoting such measures and undertakings as may be designed to accomplish the purposes of this section.” The Department has developed strong formal and informal relationships with other state agencies, local public health agencies, federally-qualified health centers, tertiary care facilities, academic institutions and the non-profit voluntary sector, all of which enhance the capacity of the Title V program to carry out its mission.

1) State Agencies – Bilateral Agreements

State agencies are coordinated at the level of the Governor's cabinet. The Department of Health is a party to several written agreements or memoranda of understanding with other state agencies. These agreements serve to formalize collaborative activities between DOH and partner agencies.

The **State Education Department (NYSED)** is a key partner in needs assessment and priority setting for services relating to the school-aged population. NYSED and DOH have formal planning structures related to youth risk behavior surveillance, comprehensive school health, school-based primary care and dental services, and workforce and scope of practice issues. NYSED also collaborates with NYSDOH on the Supplemental Fluoride Distribution Program. The Early Intervention Program and the Children with Special Health Care Needs Program regularly interact with SED's Vocational and Educational Services for Individuals with Disabilities (VESID) Program. NYSED is responsible for general supervision of all educational institutions in the State, for operating certain educational and cultural institutions, for certifying teachers, and for certifying or licensing practitioners of thirty-eight professions, including physicians and nurses. NYSED's supervisory activities include chartering all schools, libraries and historical societies; developing and approving school curricula; accrediting colleges and university programs; allocating state and federal financial aid to schools; and providing coordinating vocational rehabilitation services. The Youth Risk Behavior Surveillance System is administered by NYSED in collaboration with NYSDOH. We also work with the Education Department on issues such as placement of automated external defibrillators in schools, administration of fluoride rinse programs, healthcare/public health workforce matters, scope of practice issues, transition from early intervention to preschool programs, and approval of school-based primary care and dental care centers. The Department has a Memorandum of Understanding with NYSED regarding school health infrastructure and coordination. This memorandum supports the statewide implementation of comprehensive school health and wellness program. Comprehensive School Health and Wellness Centers help school districts across the State create positive learning environments for their students. Schools that model and encourage students to engage in healthy behaviors create an atmosphere for academic success and individual growth.

The **University at Albany School of Public Health** is jointly sponsored by the University and our Department, which serves as the laboratory for graduate students working shoulder-to-

shoulder with practicing professionals in the state health department and in local health departments. DOH and Title V staff serve as faculty and advisors to the school, and serve on the School's Continuing Education Advisory Board and on the advisory council for the North East Public Health Leadership Institute. The Bureau of Maternal and Child Health maintains a health education contract with the SUNY School of Public Health that facilitates calling upon the resources of the school for training and education of professionals, such as family planning providers, prenatal care providers, etc. Title V staff coordinate the MCH Graduate Assistant Program, under which twelve - fourteen graduate students per semester (fall, spring and summer) are supported by block grant funds to work on priority MCH research and planning projects. This arrangement attracts bright, motivated individuals who are interested in gaining theoretical and practical knowledge of public health and maternal and child health, enhances the Department's research capacity, and improves the availability of pertinent and timely educational offerings for practicing public health professionals in the region. The School of Public Health sponsors the Northeast Public Health Leadership Institute (NEPHLI). Several Title V staff have attended the Institute, and several graduates serve Title V in other states and at the New York City Department of Health. Title V staff and Dr. Birkhead serve on their advisory council.

As the lead agency for the Early Intervention Program, the Department has letters of agreement with the **Office of Mental Health**, the **Office of People with Developmental Disabilities**, the **State Education Department**, and the **Office of Alcohol and Substance Abuse Services** to coordinate the implementation and operation of this program.

Department Title V staff work with the **Office of Children and Family Services (OCFS)** on health care of children in foster care and on issues related to the health and safety of infants and children in child care. The Early Intervention Program collaborated with OCFS in the development of a guidance document entitled, "Protocols for Children in Foster Care Who Participate in the Early Intervention Program." In 2008 the Department and OCFS entered into a partnership to expand and improve child fatality review and prevention in NYS. The partnership works to improve the collection and examination of information generated by local fatality reviews. OCFS also sponsors, with partners such as DOH, the SUNY Distance Learning Project and the New York State Child and Family Trust Fund, monthly satellite broadcasts on child health and safety topics such as SIDS and Risk Reduction.

The State Legislature allocated funding from the federal Temporary Assistance to Needy Families (TANF) Block Grant to the Department of Health for Nurse Family Partnership (NFP), an evidence-based home visiting program that improves the health and self-sufficiency of low-income, first time parents and their children. The three approved programs funded to provide services are: the NYCDMMH, Onondaga DOH and Monroe County DOH Nurse Family Partnership Programs. The Department has entered into a Memorandum of Understanding with the **Office of Temporary and Disability Assistance (OTDA)** to provide for the transfer of these funds to the Department.

2) State Agencies – Multi-Agency Activities

The commissioners and directors of New York State's health, education and human services agencies recognized that to improve outcomes in each of the areas for which they had responsibility, it was necessary to shift to a new paradigm characterized by prevention, early

intervention and family/youth involvement. Further, to increase the effectiveness of the various systems, the agencies embarked on an effort to develop a common set of measurable goals and objectives that lead to improved outcomes for children and families. From these actions, the **Council on Children and Families (CCF)** and its [12 member agencies](#) developed New York State **Touchstones**. Soon after, the Council became part of the national KIDS COUNT network, funded by the Annie E. Casey Foundation. Recognizing the important link between Touchstones and KIDS COUNT, the Council saw the [NYS Touchstones/KIDS COUNT data books](#) as the vehicle for highlighting the status of New York's children and families. The first data dissemination effort was the NYS Touchstones/KIDS COUNT 1998 Data Book. CCF staff soon recognized the limitations of printed documents and began developing a website to make the data directly available to stakeholders in a format that could be used for further analysis. With a grant from the State's Office for Technology, the CCF was able to contract with a vendor to do the technical development of an interactive, web-based tool that would allow data users to gather, plot and monitor New York State Touchstones/Kids Count data. The NYS Touchstones vision is that all children, youth and families will be healthy and have the knowledge, skills and resources to succeed in a dynamic society. The Touchstones framework is organized by six major life areas: economic security; physical and emotional health; education; citizenship; family; and community. Each life area has a set of goals and objectives, and a set of indicators reflecting the status of children and families.

The **New York State Youth Development Team** is a partnership established in 1998 by more than two dozen public and private organizations. The partnership has lead efforts to develop and promote youth development strategies across health and human services systems in New York State. Agency team members include all major state agencies serving youth (health, mental health, education, public assistance, juvenile justice, substance abuse, labor), as well as a wide variety of professional and public advocacy organizations. The Team's vision is for families, schools and communities partnering to promote the development of healthy, capable and caring youth. The Youth Development team, co-chaired by DOH and OCFS, has guided the creation of several cutting edge products, events and initiatives, including a resource notebook. For more details, see: <http://www.health.state.ny.us/community/youth/development/>.

The comprehensive strategy of the **Children's Agenda** aims to provide the groundwork for healthy and successful lives for all New York's children. To respond to the federal requirement to establish or designate State Advisory Councils on Early Childhood Education and Care, New York established a new body— the Early Childhood Advisory Council (ECAC). The ECAC includes individuals with early childhood expertise who represent early care and education, health care, child welfare, and mental health programs, as well as state agencies, advocacy organizations, foundations, higher education, unions, and others involved in the provision of services to young children and their families. The ECAC focuses on addressing the structural issues that have impeded the development of a comprehensive system of early childhood supports and services. The Director of the Bureau of Maternal and Child Health, Dr. Rachel de Long, is an ECAC member, and several Title V staff participate on ECAC workgroups.

From 2003 through May of 2009, the Department's Title V Program was the recipient of a federal **Early Childhood Comprehensive Systems (ECCS)** grant. The early years of the grant focused on cross-systems strategic planning, and resulted in a comprehensive early childhood

plan. Recent years have focused on incremental implementation of the plan, with a strong emphasis on building state level cross-systems infrastructure for early childhood work. The overarching goal of the NYS ECCS plan is to support families and communities in nurturing the healthy development of children ages 0-5. The plan outlines goals, objectives and strategies within four cross-sector focus areas: Healthy Children, Strong Families, Early Learning, and Supportive Communities/ Coordinated System. A major emphasis and accomplishment in recent years has been to align the ECCS initiative with the work of the Early Childhood Advisory Council, accomplished in part by transferring administration of the State's ECCS grant to the NYS Council on Children and Families in 2010. In addition, significant progress has been made by ECCS partners across a wide range of program areas, including enrollment of young children in health insurance programs, expanded mental health screening for children, parent education projects, funding for universal pre-kindergarten, significant work to coordinate and expand home visiting programs to serve at-risk families, quality improvement projects to improve developmental screening of young children with medical homes, completion and dissemination of a comprehensive data report on the health and development of children birth to five years of age, and submission of a cross-agency Project LAUNCH grant application to SAMSHA.

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

The goal of **Family Support New York** is to transform public/private systems and services to support and foster empowerment of families in New York State. The Council on Children and Families is the lead agency. Other members include the Department of State, the Department of Health, the Office of Children and Family Services, the Office of Mental Health, the Office of People with Developmental Disabilities, the Family Development Association of New York State, Family Support NYS, and various community and parent representatives.

The Department of Health, with the Center for Public Health Continuing Education at the School of Public Health at the University at Albany, the **New York State Community Health Partnership** and the **New York State Association of County Health Officials**, sponsors monthly Public Health Live Webcast Services (PHLive; formerly the Third Thursday Breakfast Broadcasts (T2B2)). PHLive provides statewide continuing education opportunities covering a variety of emerging public health issues. This credit-bearing program is now hosted as a monthly Live Webcast, and subsequently archived. Interested parties can access the live

programs by visiting the UA-SPH-CPHCE website: <http://www.albany.edu/sph/cphce/phl.shtml>. Continuing medical and nursing education credits are available.

3) Local Health Departments

County and city (NYCDOH&MH) health departments play an essential role in the assurance of high-quality, accessible maternal and child health services. They assess the needs of their local communities, work with their communities to design and implement programs that meet those needs, and evaluate the effects of those programs on their communities. Under Article 6 of the New York State Public Health Law, local health departments extend the powers of the state health commissioner. Under Article 6, local health departments perform comprehensive community health assessments, and subsequently produce Community Health Assessments and Municipal Public Health Service Plans. The CHAs describe the needs and resources to meet those needs in the community, while the MHS Plans address the needs of the maternal and child health population in health education, infant mortality prevention, child health, family planning, chronic disease prevention, injury control, disease control and nutrition, and environmental health programs such as public water supply protection and community sanitation and food protection. Title V staff provides technical assistance to local health departments ~~units~~ in plan development, participate in the review process and monitor implementation of the plans. Because local health departments know local systems and community needs, plans address coordination across public and private resources, and across the continuum of primary, secondary and tertiary care. Local health departments play a critical role in fostering local collaborations and locally addressing disparities in health outcomes.

4) Provider and Academic Communities

Numerous private not-for-profit groups and educational institutions are consulted and enlisted in planning, developing, providing and evaluating maternal and child health services in New York State.

First, the Department provides the bulk of its services through contracts with **community-based providers, including hospitals, diagnostic and treatment centers, community-based organizations, colleges and universities**. These contracts are specific about the services to be provided and the outcomes expected. All of the nearly 650 contracts maintained by the Division of Family Health to perform Title V and related services represent collaborations to provide high quality services to the people of the state, and the commitment of those contractors is extraordinary. The interactions of the Department with our service providers represent collaborative relationships of the highest order on behalf of health of our maternal and child population.

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

New York State also partners closely with the **American College of Obstetricians and Gynecologists**, District II, on a number of maternal initiatives, including the Maternal Mortality/Safe Motherhood initiative, which attempts to identify each maternal death in New York State and use reviews of these deaths to help inform policy decisions, in conjunction with the Department of Health. Due to the voluntary nature of Safe Motherhood, hospitals were hesitant to report deaths and many deaths were not reviewed.

The Department recognized that it was imperative to redesign the process for maternal death reviews to ensure a comprehensive review of the factors leading to maternal deaths in NYS, and to have sufficient information to develop strategies to decrease the risk of these deaths. To that end, the DFH, in collaboration with the Office of Health Systems Management (OHSM) developed a process for the statewide Maternal Mortality Review Process. Through the New York Patient Occurrence Reporting and Tracking Systems (NYPORTS), as well as birth, death and SPARCS file matching, all pregnancy associated deaths will be identified for review. Using the DOH's Maternal Mortality case abstraction tool, all cases will be reviewed to identify the pregnancy related deaths. A multidisciplinary Expert will review de-identified data and develop strategies to improve patient safety and prevent future deaths. DOH will be working with a subgroup of the Expert Workgroup to develop clinical guidelines for the management of hypertension in pregnancy.

In addition, this collaboration with ACOG as well as other professional organizations on the Expert Workgroup leads to training initiatives that are implemented across the state to improve the hospital-based and prenatal care of pregnant women.

New York State has a long-established system of highly specialized **Regional Perinatal Centers (RPCs)**, described in Section III B. Starting in 2009, RPCs began a collaborative initiative with the DOH and the National Initiative for Children's Healthcare Quality (NICHQ) to implement several learning collaborative projects to improve newborn and maternal outcomes, reduce health care costs and establishes the state's capability for ongoing quality improvement/transformation in health care.

Three federal **Healthy Start** grantees are also grantees of New York State Department of Health under the Comprehensive Prenatal/Perinatal Services Network initiative. While the Networks, initially funded under Title V, have moved onto a different source of funding, the need for coordination with Title V programs continues. The **Comprehensive Prenatal/Perinatal Services Networks** collectively have formed the Association of Perinatal Networks (APN) that meets regularly with the Department of Health.

Area Health Education Centers (AHECs) work to recruit, retain, and support health professionals to practice in communities with health provider shortages, developing opportunities and arranging placements for future health professionals to receive their clinical training in underserved areas, and providing continuing education and professional support for professionals in these communities. They encourage local youth to pursue careers in health care. The MCH Advisory Council, the State Health Department and the AHECs are mutually concerned about the aging of the health care workforce; the aging of nursing and dental faculty; current and future shortages in certain key health professions; and in interesting young people in

health careers early in their student careers. The Bureau of Dental Health is working with AHECs and local rural health networks to improve access to primary dental care in rural areas.

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

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

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

Section III F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 62 | 46.5 | 58.1 | 61.3 | 61.3 |
| Numerator | 7,567 | 5,569 | 7,022 | 7,502 | 7,502 |
| Denominator | 1,220,468 | 1,196,688 | 1,208,495 | 1,223,080 | 1,223,080 |
| Data Source | SPARCS | SPARCS | SPARCS | SPARCS | SPARCS |
| Is the Data Provisional or Final? | Final | Final | Final | Final | Provisional |

Notes 2010

Data Source: Statewide Planning and Research Cooperative System (SPARCS). 2009 data have been revised with 2009 final data. 2009 data are used as a proxy for 2010. 2010 data will be available by May 2012.

Narrative

Over the past 10 years, the rate of children hospitalized for asthma fluctuated, but represents an overall decline from the 2000 rate of 62.9 per 10,000 children to the 2009 rate of 61.3. Rates continued to be higher in NYC as compared to the rest of NYS. NYS is far above the HP 2020 target of 18.1 hospitalizations for asthma per 10,000 children less than five years of age.

According to the BRFSS Asthma Call-Back Survey, for 2009, about 16.5% of the NYS child population aged 0 to 17 had been told by a health professional that they ever had asthma and about 10.1% had current diagnosed asthma. For 2006-2009, the asthma prevalence rate was 7.3% for children aged 0 to 4, 14.2% for 5- to 9-year-olds, 11.8% for 10- to 14-year-olds, and 9.6% for 15- to 17-year-olds. Current asthma prevalence is slightly higher in male children (11.4%) compared to female children (10.2%). The 2006-2009 prevalence of current asthma was higher in non-Hispanic Black children (15.4%) compared to non-Hispanic White (8.8%) and Hispanic children (11.5%). NYC children had a higher prevalence than in the rest of NYS (11.3% vs. 10.6%) and NYC adults had lower rates than in the rest of NYS (8.4% vs. 9.7%).

For 2006-2009, children from households with an annual income \$15,000-\$24,999 had the highest current asthma prevalence (15.9%), while children from households with annual household incomes of \$75,000 or more had the lowest current asthma prevalence (8.4%). For 2007-2009, children aged 0 to 4 had the highest asthma-related emergency department (ED) visit rate (221.0/10,000). During 2000-2009, the 0 to 4 year age group had the highest asthma-related hospital discharge rate.

The Regional Asthma Coalitions are working with local partners to develop and implement population-based system level changes within their communities. The initiative aims to: decrease the number of hospitalizations due to asthma; decrease the number of ED visits, school/work days lost and clinic/provider office urgent care visits due to asthma; and increase the quality of

life among people living with asthma. DOH is committed to maintaining coalition efforts in areas of NYS with high rates of asthma-related hospitalizations.

To increase access to quality asthma self-management support services and improve outcomes for individuals with asthma, the NYS Medicaid program, since 1/1/09, has provided coverage for asthma self-management services when provided by a NYS licensed, registered or certified health care professional, who is also certified as an educator by the National Asthma Educator Certification Board. DOH is leading an initiative to further develop the Certified Asthma Educator workforce and its integration into clinical practice.

To increase access to culturally and linguistically appropriate self management tools, the Asthma Program has partnered with an external organization to assist in the development of web-based and mobile phone-based information systems. These systems will deliver messages to individuals with asthma about asthma triggers and appropriate follow-up to an asthma ED visit. “Use of Appropriate Medications for People with Asthma” is a performance measure reported annually in eQARR. In 2010, for children aged 5 to11, NYS was at 97% for Commercial HMO plan performance, 96% for Commercial PPO plan performance, 94% for Child Health Plus plan performance and 92% for MA plan performance.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|--|-------------|-------------|-------------|-------------|
| Annual Indicator | 72.7 | 72.7 | 77.6 | 76.3 | 77.3 |
| Numerator | 108,995 | 108,995 | 117,580 | 116,490 | 113,092 |
| Denominator | 149958 | 149,958 | 151,439 | 152,710 | 146,242 |
| Data Source | Centers for Medicare/Medicaid Services (CMS) | CMS | CMS | CMS | CMS |
| Is the Data Provisional or Final? | Final | Final | Final | Final | Final |

Notes 2010

Data are for children enrolled in both Medicaid Fee-For-Service and Medicaid Managed Care.

Narrative

Medicaid (MA) rates for children's health measures generally have steadily increased over time and often surpass national average rates. Data above are for children enrolled in MA Fee-For-Service and MA Managed Care (MMC), and reflect steady capacity in this area over the last several years, with some year-to-year variation.

A related measure is collected for MMC Plans through the state’s Quality Assurance Reporting Requirements (QARR). For calendar year 2009, 97% of the children continuously enrolled in

MMC had at least one well child visit between birth and 15 months and 72% had 5 or more visits by age 15 months. These rates were similar to the 2007 calendar year of 98% and 79% respectively; however, data collection methodology differences between these two years make the results not comparable. The NCQA’s national average for MA plans for the 5 or more well care visit measure for 2007 was 70%. The majority of infants enrolled in MA in NYS are served through managed care rather than fee-for-service.

Improving the quality and frequency of preventive care for children is a priority of the MA and Title V programs and for MMC plans in NYS. MMC plans’ quality improvement efforts address barriers including: delays in processing newborn MA identification numbers; lack of provider reminder systems; non-standardized medical record documentation; and, lack of member/parent understanding of the importance of well child visits. Health plans educate members and providers through newsletters and reminder mailings, annual “birthday cards” as reminders to members and physician profiling to identify members who are due for a preventive visit. Health plans have encouraged their providers to use standardized forms to document well child visits, conduct on-site visits to review records for compliance, and some plans have offered providers financial incentives to improve their well child visit rates. Plans offer case management for high risk newborns is offered to assist in the assessment of newborn needs, develop care plans and assist members in obtaining care, including well child visits, in the first 15 months.

Title V staff monitor access to services on a local level and work with the DOH Office of Health Insurance Programs to identify and solve access issues. The DOH’s public health home visiting services provide community outreach and direct services to high-risk women and families. These programs promote well baby care visits, assisting women with keeping these visits after the baby is born. The Community Health Worker and the Nurse Family Partnership programs ensure that new mothers have a well baby visit within 4 weeks of delivery. The Healthy Mom Healthy Baby Prenatal and Postpartum Home Visiting program conducts activities to identify and engage high-risk women in home visiting services and keep their well baby appointments. These efforts will be further developed through NYS’s federal Maternal, Infant, and Early Childhood Home Visiting initiative. (Refer to HSCI 04 for further details.)

Title V staff will also continue to participate in the state’s ongoing MA Redesign initiative to support development and implementation of potential recommendations related to improving access to care and improved quality of care for infants and children.

Health Systems Capacity Indicator 03: *The percent of State Children’s Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 84 | 99 | 99 | 99.3 | 99.3 |
| Numerator | | 1,136 | 1,136 | 1,580 | 1,580 |
| Denominator | | 1,145 | 1,145 | 1,591 | 1,591 |
| Source | QARR | QARR | QARR | QARR | QARR |
| Is the Data Provisional or Final? | Final | Final | Final | Final | Provisional |

Notes 2010

Results are for children continuously enrolled in managed care plans who are 15 months of age in the calendar year. 2007 data excluded invalid data from one plan, resulting in a smaller denominator. Reliable data for Child Health Plus enrollees specifically under age one is not available. As a proxy, the percentage of children under age 15 months who received at least one well child or preventive health visit is used. Data reported for 2006 was the percentage of children who received five or more well child visits by age 15 months. This measure is collected on a rotating basis, so new data is not available for all years. 2009 data are used as a proxy for 2010. 2010 data will be reported in late 2011. Data Source is the Quality Assurance Reporting Requirements (QARR).

Narrative

Child Health Plus (CHPlus), NYS’s CHIP, is exclusively a managed care product. Data on provision of well child visits for children aged 15 months is reported by plans through NYS’s Quality Assurance Reporting Requirements (QARR). For children continuously enrolled in CHPlus, the percent of children with at least one well child visit by age 15 months rose from 98% in 2003 to 99% in 2007 and remained at 99% in 2009. A more meaningful measure of capacity and performance used for QARR is a subset of this group, the percent of children with five or more well child visits in the first 15 months. This figure was 82% for calendar year 2009. (This data is not shown.)

Improving the quality and frequency of preventive care for children is a priority of NYS’s CHPlus and Title V programs and for CHPlus managed care plans in NYS. As noted in Health Systems Capacity Indicator (HSCI) 02, plans’ quality improvement efforts have addressed numerous barriers to timely provision of well child care. Community-based public health programs that target high-need communities and families, which are described in HSCI 02 and HSCI 04, promote and facilitate utilization of primary and preventive health care for babies in families receiving services.

Health System Capacity Indicator 04: *The % of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 % on the Kotelchuk Index.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|---------------|---------------|--------------|---------------|---------------|
| Annual Indicator | 65.9 | 63.5 | 65.5 | 66.0 | 66.0 |
| Numerator | 131,416 | 126,795 | 124,528 | 148,291 | 148,291 |
| Denominator | 199,342 | 199,659 | 190,222 | 224,556 | 224,556 |
| Data Source | Vital Records | Vital Records | Vital Record | Vital Records | Vital Records |
| Is the Data Provisional or Final? | Final | Final | Final | Final | Provisional |

Notes 2010

2009 data have been revised with 2009 final data. 2009 data are used as a proxy for 2010. 2010 data will be available in May 2012.

Narrative

This data has remained relatively consistent over time. The most recent data show that 66% of pregnant women achieved the Kotelchuk Index objective, and the indicator held steady when compared with the rate from the previous year. Racial, ethnic and regional disparities continue to be reflected. The index was 73.2% for White non-Hispanic compared with 53.4% and 60% for Black non-Hispanic and Hispanics, respectively. Regionally, 64.4% of pregnant women in NYC and 67.6% in the rest of NYS achieved the target.

NYS has undertaken major efforts to improve access to prenatal care. The Office of Health Insurance Programs (OHIP) assumed responsibility for NYS's former Prenatal Care Assistance Program (PCAP). OHIP, in collaboration with the Division of Family Health, revamped PCAP, which provided prenatal care to women up to 200% FPL. Chapter 53-Laws of 2008 established MA payment methodology based on APGs, for MA services in outpatient clinics, ambulatory surgery, and emergency departments. The legislation also required DOH to update standards for prenatal care and eliminated the PCAP program, requiring all providers to comply with standards that incorporate evidence-based procedures and integrate standards from ACOG and AAP, and reflect expert consensus regarding care. Chapter 484 of the Laws of 2009 requires all MA enrolled Article 28 prenatal care providers to perform presumptive eligibility determinations and assist with completion of the full MA application and managed care plan selection; this allows women to immediately receive care while awaiting full MA determination.

DOH also oversees programs to improve early and continuous prenatal care including the Comprehensive Prenatal Perinatal Services Networks, community-based organizations whose mission is to organize the service system at the local level. The Community Health Worker Program provides outreach and home visiting services to pregnant women who are at highest risk for poor birth outcomes. The Healthy Mom-Healthy Baby Prenatal and Postpartum Home Visiting program is implemented in local health departments serving six highest need counties of NYS. The goal is to develop a systems approach to perinatal health, including early identification of women not engaged in prenatal care, identification of risk factors, coordination of home visiting services and referrals. One-time funding of \$7 million under TANF supports the Nurse Family Partnership (NFP) program to improve outcomes for first time mothers. The three certified NFPs in NYS have been funded for a two year period from 1/11/10-12/31/11 based on the number of TANF eligible women to be served. These efforts will be further developed and coordinated through NYS's federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative. DOH is currently developing a state plan for MIECHV federal home visiting funds.

Public awareness materials are available to promote early entry into prenatal care. A media campaign encouraging women to access prenatal services is being planned in areas with the highest rates of adverse perinatal outcomes. The campaign, which instructs women to call the 24/7 Growing Up Healthy Hotline for information, is expected to run from the fall of 2011 through the winter of 2012.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (<2,500 grams)*

| INDICATOR 05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|--|------|--|------------|--------------|-----|
| | | | MEDICAID | NON-MEDICAID | ALL |
| a. Percent of low birth weight (<2,500 grams) | 2009 | Vital Records: Payment source from birth certificate | 8.4 | 8.1 | 8.2 |

Notes 2010

2010 data will be finalized in May 2012.

Narrative

The percent of low birth weight has decreased slightly from 2006 for the entire NYS population (8.2%) and also in the Medicaid (MA) population (8.4%) but has remained consistent at approximately 8% for the Non-MA population. NYS is at the HP 2020 baseline of 8.2% of live births being low birth weight, but exceeds the HP 2020 target of 7.8%. A focus of DOH's efforts to reduce low birth weight is a systems-wide effort to improve early entry into prenatal care and supports and services offered through DOH's perinatal and home visiting programs as discussed in HSCI 04.

NYS has a well-organized system of regionalized perinatal care which ensures appropriate hospital care is provided to women and their newborns. A system of regionalized perinatal services includes a hierarchy of three levels of perinatal care provided by hospitals within a region and led by a Regional Perinatal Center (RPC). Women at highest risk for poor birth outcomes are referred to RPCs and supportive health and social services. Research strongly supports regionalization as a means of improving birth outcomes.

The MA requirement that all Article 28 facilities which offer prenatal care provide Presumptive Eligibility to pregnant women has expanded access to prenatal care and MA coverage. MA Redesign recommendations were adopted in 2011 to expedite enrollment of MA-eligible women into managed care plans; this is expected to promote earlier entry into prenatal care and increase utilization of care management for high risk women. Title V staff will continue to participate in the state's ongoing MA Redesign initiative to support development and implementation of potential recommendations related to improving access to care and improved quality of care for infants and children.

The health of women prior to pregnancy significantly impacts birth outcomes. A preconception care packet, including a Preconception Care checklist and Preconception Care Guide for

Optimizing Pregnancy Outcomes, was developed in collaboration with ACOG-NY and distributed to over 16,000 obstetricians, nurse practitioners, and pediatricians. The materials are designed to encourage medical professionals to ask women about reproductive intentions at every visit, assess risk of an unplanned pregnancy, and counsel women on appropriate health behaviors to optimize pregnancy outcomes. DOH also funded development of the Preconception Health Café, a web-based course about the importance of preconception health.

In 9/10, HRSA awarded DOH a *First Time Motherhood – New Parents Initiative* grant to increase awareness of preconception/interconceptional health to improve perinatal outcomes, with a focus on the promotion of positive health behaviors among high-risk Black adolescents. To date, adolescent focus groups were conducted to determine attitudes toward health and inform DOH’s future plans. Preconception health messages have been posted to DOH’s Facebook page, and DOH’s “Welcome to Parenthood” guide has been updated to include interconception, family planning and postpartum health messages.

Title V staff participate in interagency projects to address perinatal issues. A Fetal Alcohol Spectrum Disorder Interagency Workgroup promotes coordination among NYS agencies to support a comprehensive system of care to eliminate alcohol use during pregnancy and improve the lives of New Yorkers affected by prenatal alcohol exposure.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

| INDICATOR 05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|--|-------------|---|-------------------|---------------------|------------|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Infant deaths per 1,000 live births | 2008 | Vital Records 2008 matched birth/death file | 5.4 | 4.6 | 5.0 |

Notes 2010

Nineteen (19) deaths had unknown payer. Data on NYC deaths is incomplete. Medicaid data includes the Family Health Plus program. Infant death rates by payer are extracted from the matched birth/death file which becomes available about one year after the birth file. 2009 data will be available in May 2012. 2010 data will be available in May 2013.

Narrative

NYS’s capacity to reduce infant mortality includes a number of surveillance, community-based and clinical activities, services and supports.

Early access to quality comprehensive prenatal care remains a cornerstone of promoting infant well being. Analysis of Vital Statistics data indicates that conditions originating in the prenatal period and congenital malformations account for 72% of all infant deaths. Major elements of

NYS's system include: Medicaid (MA) standards for prenatal care; a requirement that all enrolled Article 28 prenatal care providers perform presumptive eligibility determinations, assist with the full MA application and managed care plan selection; home visiting programs including Community Health Worker, Nurse Family Partnership, Healthy Mom-Healthy Baby and the new Maternal, Infant and Early Childhood Home Visiting initiative; consumer outreach and education through media campaigns; and the Growing Up Healthy Hotline. In addition, preconception health is increasingly emphasized across all public health programs as a critical time period for impacting birth outcomes.

MA Redesign recommendations adopted in 2011 to expedite enrollment of MA-eligible women into managed care plans are expected to promote earlier entry into prenatal care, increase utilization of care management for high risk women, and improve birth outcomes. Title V staff will continue to participate in the state's ongoing MA Redesign initiative to support development and implementation of potential recommendations related to improving access to care.

Within the Title V Program, there are specific projects to monitor infant mortality data to guide the development of priorities. Based on 2009 data, the top five causes of infant death accounted for 80% of all infant deaths. Of the conditions originating in the prenatal period and congenital malformations, SIDS and accidents account for 6% of infant deaths, and diseases of the heart account for another 1.5%. Communicable and chronic disease and unknown causes account for many of the remaining 17% of deaths. Driven by these data, efforts have focused on promotion of safe sleep and reduction of SIDS, including risk reduction education. Over the past year, DOH launched the Keeping NY Kids Alive program which focuses on increasing the number of county based child death review teams; expanding the number and scope of cases reviewed; standardizing data collection and submissions; and enhancing local prevention measures and system improvements.

The Title V program also collaborates with other partner programs, including WIC, Injury Prevention, and Healthy Families New York (a home visiting program administered by the NYS OCFS for the prevention of child abuse), to address factors that contribute to infant mortality.

"Perinatal Periods of Risk" is in progress to assess factors that may contribute to infant deaths. Data analysis is underway for the entire State and counties with at least 60 infant deaths from 2003-2007. Consistent risk factors include young maternal age, Black race and lower educational attainment. Analysis with more current vital records is underway, along with secondary data sources to identify possible sources of discrepancies. These findings will further inform ongoing program development in this area.

Healthy Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

| INDICATOR 05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|--|-------------|---|-------------------|---------------------|------------|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester | 2009 | Vital Records Payment source from birth certificate | 62 | 82 | 73.3 |

Notes 2010

The denominator used excludes births with unknown prenatal care start dates. NYS’s overall rate of 73.3% exceeds the Healthy People 2020 baseline measure of 70.8%.

Narrative

Capacity in this area is closely related to that described for HSCI 04. Medicaid (MA) populations generally fare less favorably than privately insured populations for this and other perinatal health measures, although there has been a slight improvement for each category. MA prenatal care increases access for high risk women to high-quality prenatal care that includes standardized risk assessment, medical and supportive services. Establishing consistent standards in the MA prenatal care program and requiring all prenatal care providers that provide prenatal care to the MA population to provide care in conformance to these standards will increase access to high quality, comprehensive prenatal care.

A redesign of the state’s MA reimbursement system in 2008 ensures that MA reimbursement will promote the highest standards of evidence-based care. This should enhance the availability of high quality prenatal care to women statewide. (See HSCI 04 and 5B for details.) MA Redesign recommendations were adopted in 2011 to expedite enrollment of MA-eligible women into managed care plans, which is expected to promote earlier entry into prenatal care and increase utilization of care management for high risk women. Title V staff will continue to participate in the state’s ongoing MA Redesign initiative to support development and implementation of potential recommendations related to improving access to care and improved quality of care for women, infants and children.

A variety of public health strategies engage high risk pregnant women in early prenatal care. These include: Community Health Worker Program, Nurse Family Partnership for high risk first-time mothers early in pregnancy, and Healthy Mom-Healthy Baby Prenatal and Postpartum Home Visiting Program, designed to establish a county system of perinatal health services. The Title V program collaborates with state Office of Children and Family Services for its Healthy Families New York home visiting program. DOH is developing a state plan for new federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) funds, based on an extensive

needs assessment process to identify communities with high rates of maternal, infant and child health risk indicators and the existing home visiting programs and supportive resources in those communities. NYS's work in the MIECHV will support further coordination of services, and maximization of resources to improve birth outcomes. All of these programs are targeted to communities with highest needs. The statewide Growing Up Healthy Hotline links women to needed services, with periodic public awareness media campaigns conducted to direct women to the hotline.

DOH will continue to promote early entry to prenatal care through outreach and case finding strategies to identify high risk women early and ensure engagement in comprehensive, quality prenatal care.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal care visits in greater than or equal to 80% Kotelchuck index)*

| INDICATOR 05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|---|------|---|------------|--------------|------|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% (Kotelchuck Index)) | 2009 | Vital Records Payment Source From Birth Certificate | 57.4 | 73.3 | 66.0 |

Notes 2010

Capacity in this area is closely related to Health Systems Capacity Indicators 04 and 05C. Medicaid populations generally fare less favorably than privately insured populations in this and other perinatal health measures; however there was an improvement in the adequacy of prenatal care in the Medicaid population from 2008 (54.7%) to 2009 (57.4%). NYS is below the HP 2020 target of 77.6% of pregnant women receiving early and adequate prenatal care, as well as below the baseline of 70.5% for the Medicaid population. 2010 data will be available in May 2012.

Narrative

NY's commitment to ensuring the availability of comprehensive prenatal care through the Medicaid (MA) prenatal care program increases access to high-quality prenatal care for high-risk women. Providers enroll women and sustain utilization of care. Standardized risk assessment helps identify women at risk for poor pregnancy outcome and provides additional services to address those needs. Women at highest risk are referred to Regional Perinatal Centers and supportive health and social services. Parallel reforms of NYS's MA reimbursement system to

an APG-based payment structure are designed to aid improvements in the delivery of prenatal care. MA Redesign recommendations were adopted in 2011 to expedite enrollment of MA-eligible women into managed care plans, which is expected to promote earlier entry into prenatal care and increase utilization of care management for high risk women.

A variety of strategies are used to enhance outreach to engage high risk pregnant women in early prenatal care and support ongoing utilization of services throughout pregnancy. These include home visiting programs such as the Community Health Worker Program, Nurse Family Partnership, which engages high risk first-time mothers early in pregnancy, and the Healthy Mom–Healthy Baby Prenatal and Postpartum Home Visiting Program, designed to establish a county system of perinatal health services, with a strong focus on outreach to engage pregnant women in early prenatal care. All programs are targeted to communities with highest needs. NYS was awarded funds through the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program to support the development of evidence-based home visiting programs in high-risk communities. NYS is currently completing a state plan for home visiting services. NYS’s work in the MIECHV will support further coordination of services, and maximization of resources to improve birth outcomes. The statewide Growing Up Healthy Hotline links women to needed services, with periodic outreach media campaigns.

Public health programs that serve at-risk adolescents - including School-Based Health Center (SBHC), Family Planning, and Community-Based Adolescent Pregnancy Prevention programs - include provisions for preventive health services, pregnancy prevention, and, when needed, prompt referral of pregnant teens to prenatal care. Within the SBHC program, staff may provide prenatal care services directly, coordinate services with another provider or refer pregnant students for appropriate prenatal care, with follow-up to ensure that there is continuity of care. Where indicated, referrals are made for additional services.

NYS will continue to promote access to early, continuous and comprehensive quality prenatal care services through outreach to identify and engage high-risk women, implementation of comprehensive standards and reimbursement for promotion of MA prenatal care services, and steps to enroll MA-eligible pregnant women in managed care plans as early as possible to assure optimal management of prenatal care. Title V staff will continue to participate in NYS’s ongoing MA Redesign initiative to support development and implementation of potential recommendations related to improving access to care for all high risk populations.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and CHIP programs - Infants (0 to 1).*

| Indicator 06A | Year | Percent of Poverty Level Medicaid |
|---|-------------|--|
| The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women | | |
| a) Infants (0 to 1) | 2011 | At or below 200% |
| The percent of poverty level for eligibility in the State's CHIP programs for infants (0 to 1), children, SCHIP and pregnant women | | |
| a) Infants (0 to 1) | 2011 | Up to 400% |

Notes 2010

Data Source: DOH Office of Health Insurance Programs. Pregnant women are not eligible for NYS's CHIP program (Child Health Plus) but may be eligible to receive comprehensive prenatal care through Medicaid for pregnant women. See Health Systems Capacity Indicator 06C for details.

Narrative

Access to insurance, which is imperative for improved health outcomes and to mitigate racial and ethnic disparities, is a priority of NYS. The Office of Health Insurance Programs (OHIP) administers the Medicaid (MA) and Child Health Plus (CHPlus) programs. CHPlus is NYS's CHIP program. Infants up to age one whose household incomes are at or below 200% of the Federal Poverty Level (FPL) and who meet other eligibility criteria are eligible for MA. Those infants born to women covered by MA are eligible for coverage until the end of the month of their first birthday.

Infants whose household incomes are up to 400% of the FPL and meet other eligibility criteria are eligible for health insurance coverage under CHPlus. CHPlus insures children who are ineligible for MA due to household income or immigration status provided that they meet all other program eligibility requirements. Families with household income over 400% of the FPL may purchase CHPlus for their children at the full premium level which varies by participating health plan.

Eighty-seven percent (87%) of all NYS children who are enrolled in MA receive their services through a managed care plan while all children enrolled in CHPlus must be enrolled in a managed care plan. Coverage for children aged 0 to 1 enrolled in MA is free; families with children enrolled in CHPlus may be required to pay a monthly premium contribution based on their household income and family size. Coverage for those children with household incomes is under 160% FPL is free. The premium for families with household incomes between 160% and 222% FPL is \$9 per child per month, with a maximum of \$27 per family per month. Families with household incomes between 222% and 250% FPL contribute \$15 per child per month, with a maximum of \$45 per family. Families with household incomes between 251% and 300% FPL contribute \$30 per child per month, with a maximum of \$90 per family. Families with household

incomes between 301% and 350% FPL contribute \$45 per child per month, with a maximum of \$135 per family. Families with household incomes between 351% and 400% FPL contribute \$60 per child per month, with a maximum of \$180 per family. For those with household incomes above 400% of the FPL, CHPlus is available at full premium. There are no co-payments for CHPlus services.

NYS has partnered with community-based organizations, faith groups and health and human service providers for a “Connections to Coverage” outreach campaign which promotes the availability of public health insurance coverage for all uninsured children and eligible adults and to link uninsured children to facilitated enrollment in their communities.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State’s Medicaid and CHIP programs – Children*

| Indicator 06B The percent of poverty level for eligibility in the State's Medicaid and programs for infants (0 to 1), children, Medicaid and pregnant women | Year | PERCENT OF POVERTY LEVEL Medicaid |
|---|-------------|--|
| b) Medicaid Children (Age range 1 to through 5) (Age range 6 to through 18) | 2011 | At or below 133% At or below 100% |
| The percent of poverty level for eligibility in the State’s SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women. | | |
| b) CHIP Children (Age range 1 to through 5) (Age range 6 to through 18) | 2011 | Up to 400% |

Notes 2010

Data Source: DOH Office of Health Insurance Programs. In NYS, pregnant women are not eligible for Child Health Plus but can potentially receive comprehensive prenatal care through Medicaid. See Health Systems Capacity Indicator 06C for details.

Narrative

The Office of Health Insurance Programs (OHIP) administers the Medicaid (MA) and Child Health Plus (CHPlus) programs within DOH. Access to insurance coverage for all NYS residents is a priority of NYS. Children aged 1 through 5 years of age are eligible for MA if their household incomes are at or below 133% of the Federal Poverty Level (FPL) for 12 months of continuous coverage, even if the household income exceeded eligibility levels during that year. Children aged 6 through 18 whose household income is up to 100% of the FPL are eligible for MA.

Children in families ineligible for MA due to household income or immigration status are eligible for subsidized health insurance coverage under CHPlus, NYS’ CHIP program, if their household income is up to 400% of the FPL. CHPlus is available at the full premium cost for children in families whose household incomes are above 400% of the FPL. There are no

co-payments for CHPlus. National Performance Measure 13 includes strategies being employed to increase enrollment and retention in these programs.

Health System Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs – Pregnant Women*

| INDICATOR 06 The percent of poverty level for eligibility in the State's Medicaid and CHIP programs for pregnant women. | YEAR | PERCENT OF POVERTY LEVEL | |
|--|------|--------------------------|--------------|
| | | MEDICAID | CHIP |
| Pregnant Women | 2011 | At or below 200% | Not Eligible |

Notes 2011

Data Source: DOH Office of Health Insurance Programs

Narrative

Pregnant women with household incomes at or below 200% of the Federal Poverty Level (FPL) who can demonstrate NYS residency and proof of income, identity and pregnancy (including estimated date of confinement) are potentially eligible for MA. Pregnant women who meet these criteria and have household incomes up to and including 100% of the FPL are eligible for the full array of comprehensive Medicaid (MA) services. Eligible pregnant women with household incomes above 100% and less than or equal to 200% of the FPL receive a limited benefit MA package that covers prenatal care only.

Presumptive eligibility processes are in place to expedite initiation of MA coverage for pregnant women. New recommendations, adopted by the state's MA Redesign Team in 2011, will further expedite enrollment of MA-eligible women into managed care plans. Additional changes may be considered as part of the continued MA Redesign process.

In 1996, MA managed care legislation expanded MA benefits for 26 months after the end of a pregnancy to women who had previously been on MA while pregnant. This program is known as the Family Planning Extension Program (FPEP). The federal government also approved NYS's MA 1115 waiver to expand family planning services for more New Yorkers; this resulted in the implementation of the Family Planning Benefit Program (FPBP) on October 1, 2002. The FPBP provides MA coverage for family planning services for individuals with household incomes up to 200% of the FPL who are U.S. citizens or have satisfactory immigration status, regardless of previous MA eligibility or pregnancy.

Additional recommendations adopted through the state's MA Redesign process in 2011 will convert NYS's 1115 waiver into a State Plan service, and streamline FPEP and FPBP into a single program that includes auto-enrollment of women following pregnancy and the addition of presumptive eligibility for family planning services coverage. Additional changes may be considered as part of the continued MA Redesign process.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 94.4 | 90.0 | 90.0 | 90.7 | 87.0 |
| Numerator | 1,909,170 | 1,805,488 | 1,805,488 | 1,876,851 | 1,878,851 |
| Denominator | 202,1928 | 2,006,098 | 2,006,098 | 2,068,245 | 2,150,748 |
| Data Source | CMS | CMS | CMS | CMS | CMS |
| Are the Data Provisional or Final? | Final | Final | Final | Final | Final |

Narrative

This indicator offers a crude approximation of the extent of health care utilization by the population of children enrolled in MA in NYS. It tells us that a large proportion of Medicaid-enrolled children access at least one Medicaid-paid service of any kind each year, and that the proportion has decreased over the past three years. What it does not tell us are the reasons why children obtained services, nor whether there are major disparities in utilization of MA services. The indicator is also silent on the breadth, quantity, and quality of services rendered to those children. Of limited utility within NYS, this indicator is not useful for interstate comparison purposes, given the wide differences in Medicaid eligibility requirements and service environments that exist across the country, and might well be dropped in favor of more valid indicators of Medicaid service utilization

That said, NYS makes a considerable effort to help ensure that eligible children are enrolled in MA, and once enrolled, that they access health services -- especially preventive and primary care services -- in a manner that contributes to their health and well-being. To help gauge the extent of health insurance coverage and related utilization of health care, DOH relies on two major information resources. The first is the DOH report entitled *Profile of the Uninsured in New York State in 2008*. This profile is based on data from the US Census Bureau's 2008 Annual Social and Economic Supplement to the Current Population Survey and provides estimates for all NYS counties. Some highlights of the report include:

- In 2008, 7.4% of the state's population under 19 (about 343,000 children) was uninsured, a sharp decline from 2007 estimates of 9.2% and 434,481, respectively. In 2009, 7.8% of NYS's population under 19 (about 366,853 children) was uninsured.
- The 2009 rate is below the comparable value for the nation-at-large, which was 10% for children under 19.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

| Annual Indicator Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|-----------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 39.9 | 44.3 | 46.4 | 50.1 | 51.1 |
| Numerator | 144,365 | 159,486 | 166,217 | 186,258 | 200,375 |
| Denominator | 370,657 | 360,268 | 358,116 | 371,495 | 391,812 |
| Data Source | CMS | CMS | CMS | CMS | CMS |
| Is the Data Provisional or Final? | Final | Final | Final | Final | Provisional |

Notes 2010

Data source is Center for Medicare and Medicaid Services (CMS). 2009 data has been finalized since the previous submission. 2010 preliminary data are stated as provisional as the data will not be finalized until the fall of 2011.

Narrative

The percentage of EPSDT-eligible children aged 6 to 9 who receive dental services has increased each year since 2003. Obtaining services remains an ongoing problem with only a third of dentists accepting MA, leaving many vulnerable children without access to services. School-based dental health clinics have been shown to be effective in providing oral health services to low income children. The data show a 6.8 percentage point increase in the proportion of low income children aged 6 to 9 years receiving dental services over the past five years, although many children remain unserved.

Strategies for improving access to dental care are addressed in the NYS Oral Health Plan and by the NYS Oral Health Coalition (NYSOHC) Access to Care Sub-Committee. NYSOHC is comprised of individuals representing themselves and institutions, agencies, or organizations which share a common interest in oral health and access to care.

To assess the availability of dentists, BDH, in collaboration with the Primary Care Office and the ADA, developed a Children's Oral Health Atlas to facilitate the identification of Dental Health Professional Shortage areas. DOH funds 31 projects in high need underserved areas for preventive oral health services focused on the MCH population. The majority of projects provide preventive dental services to children through school-based and school-linked dental programs. A HRSA supported grant focuses on increasing access to, and utilization of, dental services by children. Currently 35 school-based programs provide oral health services to children at 629 schools across NYS. During the prior school year, 59,000 children received services.

Several statewide initiatives have been implemented to ensure that children have resources needed to achieve and maintain optimal oral health. Open mouth exams on a representative sample of third grade students were initiated in 2010. Based on preliminary data on a weighted

sample of 2,575 children, 50.1% had caries experience, compared to 54.1% with caries experience found by the 2002-2004 survey. Current findings are closer to the Healthy People 2020 target of no more than 49% of children aged 6- to 9-years old having caries experience.

To increase access to oral health care for children and identify at risk children in need of treatment services, a dental health certificate is requested for school children entering Kindergarten and grades 2, 4, 7, and 10. A pilot project is underway to evaluate the effectiveness of the dental health certificate in increasing access to dental services. Plans for next year are to expand the pilot project into a statewide evaluation study.

An RFA for school-based dental sealant programs was issued in early 2011 and is anticipated to fund up to 30 programs. The MA Program approved quarterly applications of fluoride varnish by dental and child health care professionals for children under age 7; this should result in more low-income infants and children receiving oral health services and timely identification and treatment of early signs of dental caries disease. A detailed analysis of fluoride varnish applications for 6-year-olds will be undertaken with 2010 MA claims data.

Health Systems Capacity Indicator 08: *Percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the state CSHCN Program*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 100 | 0 | 0 | 0 | 0 |
| Numerator | 1 | 0 | 0 | 0 | 0 |
| Denominator | 1 | | | 0 | 0 |
| Is the Data Provisional or Final? | Final | | | Final | Final |

Notes 2010

NYS has two Title V public health programs that assist families of children with special health care needs (CSHCN) access services and supports. The state CSHCN Program, through its local contractors, provides families of CSHCN with linkages and referrals to services and assistance programs, including SSI. The state Physically Handicapped Children’s Program (PHCP), administered by Local Health Departments, provides reimbursement of medical services for children who are uninsured or underinsured. In NYS, all SSI beneficiaries are categorically eligible for Medicaid. As Medicaid is a more comprehensive benefit package than PHCP and provides rehabilitative services, this measure is not applicable to NYS.

Narrative

In NYS, all SSI beneficiaries are categorically eligible for Medicaid (MA), which is a more generous health care insurance package than the Physically Handicapped Children’s Program (PHCP), a gap-filling program for children with special health care needs (CSHCN). In 2008, 2% of the children receiving care coordination and referral services through the CSHCN Program had SSI. In 2010, 1.6% of the children whose families received referral services through the CSHCN Program had SSI.

Children with special health care needs who have severe, handicapping conditions and who contact the CSHCN Program are referred to SSI. The assessment and referral activity of the CSHCN Program is significant as it demonstrates that staff recognizes the benefit SSI can provide families and accurately refers those children most likely to be determined eligible for SSI. SSI provides income to help families obtain needed services to care for their disabled child.

In 2009, 267 children were referred to SSI and 211 of those children successfully obtained SSI (79%). In 2010, 98 children were referred to SSI and 65 of those children successfully obtained SSI (66%). CSHCN referrals are closely tied to PHCP gap-filling services; therefore this decline is not unexpected. There has been a steady increase in orthodontia services provided in PCHP from 2008 to 2010 (from 68% of expenditures in 2008 to 74% in 2010). As orthodontia services (rather than medical) account for more of PHCP's service provision, it is expected that fewer children will be SSI recipients, as the need for orthodontia would not qualify a child as being disabled under SSI.

In the coming year, MCH staff will explore whether those children eligible for and who require Medicaid covered rehabilitative services, are actually receiving them. As an initial step, Title V staff will work with Office of Health Insurance Programs and Early Intervention Program staff to determine the percent of children with SSI who access rehabilitative services.

The CSHCN Program will continue to fund and provide technical support to local CSHCN Program contracts that support staff to perform information and referral activities.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

| DATABASES OR SURVEYS | Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) | Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N) |
|---|---|---|
| <u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates | 3 | Yes |
| Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files | 3 | Yes |
| Periodic linkage of birth certificates and WIC eligibility files | 3 | No |

| DATABASES OR SURVEYS | Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) | Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N) |
|--|---|---|
| Annual linkage of birth certificates and newborn screening (NBS) files | 3 | No |
| <u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges | 3 | Yes |
| Annual birth defects surveillance system | 3 | Yes |
| Survey of recent mothers at least every two years (like PRAMS) | 3 | Yes |

Notes 2010

Staff from the WIC and Newborn Screening programs provide data to the MCH program as needed. WIC matches are on a study basis only.

Narrative

The SSDI continues to support the development and implementation of CHI², a long-term DOH initiative to provide a standards-based architecture to integrate MCH-related data systems. An integrated system will bring together Newborn Screening (NBS), Newborn Hearing Screening (Immunization, Lead, Early Intervention, WIC, Medicaid (MA), Vital Statistics and other data sources in one interface. This system has the potential to dramatically increase the public health benefit and efficiency of many DOH programs. DOH will gain the ability for bi-directional sharing of its MCH data with external partners leading to improved patient care. The CHI² will continue to coordinate with other Health Information Exchange planning initiatives within DOH such as the exchange of data elements using service-oriented architecture and web services using an enterprise service bus.

Under the NBS Effective Follow-up Grant and CHI² Initiative, data transfer agreements and linkages are being developed between NBS and MCH Programs. NBS will share data with MCH for the CHI². The vendor hired for the initiative has successfully compiled a materialized view of NBS demographics and will test it for sharing. MCH and NBS staff are working together to provide data mapping between Vital Records, Immunization, and other program areas.

The linkage of NYSIIS and the lead registry has been activated to allow sharing of immunization and lead test history to authorized users (including health care providers, WIC Programs, health plans, DOH and local health departments). With future enhancements, the system will allow DOH to access relevant data to identify children by practice level who have not been tested for lead as per NYS requirements.

The Bureau of Dental Health (BDH) uses PRAMS data to generate a variety of reports on use of dental services by pregnant women. BDH and PRAMS staffs are collaborating on the inclusion of additional survey questions designed to better assess the oral health status of pregnant women.

BDH works closely with MA and CHPlus to produce county and age specific reports on dental claims and expenditures for specific preventive and treatment procedures. The data are used to determine oral health status, level of utilization of dental services by the MCH population and areas of unmet need and assess the impact of fluoridation on dental caries in children; improvements in age one dental visits; use of fluoride varnish for children under age 7; and disparities in oral health status and use of services within different NYS regions. These data provide the basis for determining where services, TA, outreach and education are most needed.

The CSHCN Program will improve quality of data reported to DOH by revising the local quarterly report form. When revisions are complete, local CSHCN programs will be required to use the new form, leading to the ability to generate annual statewide surveillance data for statewide and possibly local reports.

BMCH collects information on babies admitted to a NYS NICU. The NICU data base is being updated to include a link to the upstate birth certificate system; this will enable direct incorporation of identifying and medical information common to systems, diminishing the need for redundant data entry and enhancing data quality.

Health Systems Capacity Indicator 09B: *The ability of states to determine the % of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

| DATA SOURCES | Does your state participate in the YRBS survey? (Select 1 - 3) | Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N) |
|-----------------------------------|---|---|
| Youth Risk Behavior Survey (YRBS) | 3 | No |
| NYS Youth Tobacco Survey | 3 | Yes |

Notes 2010

NYS participates in these surveys and the sample size is large enough for valid statewide estimates for this age group.

Narrative

NYS participates in the YRBS through the NYS Education Department (NYSED). NYSED publishes the survey data on its website. In addition to YRBS, data are available from other sources. NYSED also participates in and conducts the School Health Profiles which are conducted with middle and high school principals and lead health education teachers to assess school health policies and practices in states, large urban school districts, territories, and tribal governments. Tobacco use prevention education and policies pertaining to tobacco and other health related topics are included. The profile information is available to DOH upon request.

Adolescent smoking rates are available to DOH through both the YRBS and Youth Tobacco Survey (YTS). The Division of Chronic Disease and Injury Prevention employs an epidemiologist for the tobacco program to work with both adult and child smoking data. These data analyses are readily accessible to Title V programs and the Public Health Information Group.

The NY Tobacco Control Program (NYTCP) has made significant progress in reducing youth smoking. In 2010, 12.6% of high school students smoked cigarettes on one or more days during the past month (2010 YTS). Compared to 2000, when 27.1% of high school students were smokers, NY has cut its youth smoking rate by more than half. The rate of established smoking among high school students in NY is also down significantly, from a high of 13% in 2000 to 4.3% in 2010, a 68% reduction.

Youth smoking in NYS is well below the national average. According to the YRBSS, 19.5% of high school students nationally reported smoking in the past month. NYS also exceeds the Healthy People 2020 baseline and target goals of 26% and 21% respectively for this indicator. Independent studies by RTI International, the NYTCP evaluator, indicate that rates of youth and adult smoking have declined at a faster pace in NYS as compared to national rates of decline.

NY TCP's approach to tobacco control is built on the social norm change model, in which reductions in tobacco use are achieved by creating a social environment and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible. The success in reducing youth smoking is attributable to high tobacco product taxes, a statewide clean indoor air law, and DOH's comprehensive tobacco control effort. NYTCP uses a policy-driven approach designed to prevent youth from smoking and motivate adult smokers to quit. The program increases access to effective cessation services, including support for the NYS Smokers' Quitline and supports media campaigns designed to increase public awareness of the dangers of tobacco use and motivate smokers to quit for good. NYTCP also supports a range of local programs designed to build and support tobacco-free communities including Reality Check, a youth engagement program which works to counter the tobacco industry influence in communities.

Over the past year, NYTCP has focused on action to reduce the impact of tobacco industry marketing on youth. Exposure to tobacco marketing in stores is a primary cause of youth smoking. NYTCP primary policy objective for the coming year is to advance statewide policy to address the impact of tobacco marketing on youth in the retail setting.

Section IV. Priorities, Performance & Program Activities

A. Overview

This section profiles New York's maternal and child health priorities, selected performance measures and program activities and discusses the extent to which National and State objectives were met in the program year. Summaries have been included at the beginning of each section to provide an overview of general state progress on measures.

As previously described in the Needs Assessment section, New York's priority setting process included a review of the needs of the MCH populations, an examination of existing program priorities and realignment of the priorities to address new identified needs to the extent that resource permit. Performance related to program priorities was assessed to ensure MCH programming results in real improvement in the health and well being of the MCH populations in New York State.

A brief summary of New York's accomplishments through the use of Title V and other funds appears in Section B. New York's progress on Federal and State Performance Measures and Outcome Measures are tracked on Forms 11 and 12.

A summary of the state's progress related to implementation of state priorities is included in Section IV B. A summary of the state's progress related to addressing the State's outcome measures is as follows:

1. **State Outcome Measure: The maternal mortality rate per 100,000 births** - In 2010, the Department implemented a new Maternal Mortality Review Initiative, which builds on the previous DOH-funded Safe Motherhood Initiative. The Department redesigned the previous process, in which ACOG was funded to conduct reviews of a selected sub-set of maternal deaths on a voluntary basis, to a DOH-led comprehensive process to systematically review all maternal deaths, in conjunction with IPRO and an expert committee that includes representation from ACOG and other professional groups/experts. The updated initiative is intended to ensure a comprehensive review of factors leading to maternal deaths in New York State, and to have sufficient information to develop strategies and measures to decrease the risk of these deaths. The first meeting of the expert committee included a review of preliminary 2006-2008 data on maternal deaths, resulting in identification of several priorities including management of hypertension, obesity and embolism/DVT for development of clinical guidelines. Management of hypertension during pregnancy has been selected as the first topic for development. A multidisciplinary subcommittee, and the Department will be working with the OHIP, IPRO and the subcommittee to develop guidelines over the next few months. The full Expert Review Committee will have the opportunity to review and comment on the guidelines before they are issued by the Department to health care providers who care for pregnant women in a variety of clinical settings.
2. **State Outcome Measure: The percentage of elective deliveries both cesarean sections and inductions performed without appropriate indication between 36 and 38 6/7 weeks** -To address concerns regarding elective preterm deliveries, the NYS Department of Health has implemented the New York State Obstetrical and Neonatal Quality Collaborative (NYSONQC) - a joint

initiative of the Department, New York's Regional Perinatal Centers (RPCs) and the National Initiative for Children's Healthcare Quality (NICHQ). The collaborative strives to improve maternal and newborn outcomes through the use of evidence-based healthcare improvement interventions to reduce the number of scheduled, elective deliveries performed without appropriate indication in women of 36 0/7 to 38 6/7 weeks gestation. Initial RPC Obstetrical Intervention teams activities include: collecting and submitting data on scheduled inductions and Caesarian deliveries without medical indication; revising admitting practices; employing "hard stop" processes to ensure that only elective deliveries with acceptable medical indicators are scheduled; and educating providers and patients. The Neonatal learning collaborative focuses on optimizing early enteral nutrition in preterm babies in the NICU. Ultimately, the goals of the Learning Collaborative are to improve care in the participating RPCs, as well as care in their affiliate hospitals. Both arms of the collaborative utilize data collected by the Department to analyze success in achieving collaborative objectives. RPC teams will learn and apply formal strategies to expand their findings from these QI projects to perinatal hospitals in their regions through the RPC QI role with their affiliate.

B. State Priorities

The relationship between the priority needs, the National and/or State Performance measures was extensively discussed in Section 5 of the needs assessment of New York's 2011 application. The State Performance measures, as well as the relevant national health system capacity indicators, Performance Measures, Outcome Measures and Health Status Indicators were also related to State priorities in Section V. The state capacity and resource capability to address these priorities was also extensively discussed in Section 3 of the needs assessment of New York's 2011 application. As discussed previously, stakeholder perceptions of state priorities for the MCHBG five year needs were very aligned with priorities identified by the Department. The Department has already begun significant efforts to address these priorities as described in the Needs Assessment.

The Department is very committed to reducing health disparities. This commitment is reflected in the priorities for the new MCHBG grant cycle. Although health disparities have narrowed in several MCH performance areas, health disparities at unacceptable levels continue to persist. These disparities may be caused by a number of factors, including socioeconomic and environmental factors, barriers related to access and quality of care, differences in health literacy, immigration status, linguistic and cultural differences which create barriers to access to health care, health literacy, as well as a variety of other factors. Addressing these disparities must begin with data analysis at finer level of stratification, a process which is currently underway in the Department. Program services are increasingly targeted to communities with health disparities and poor outcomes. Programs must be representative of the communities they serve, both in terms of board members and staff that provide services. Existing programs are evaluated and modified if they are ineffective in addressing issues of health disparities. The following is a brief implementation status related to state priorities identified in the 2011 needs assessment.

1. State Priority (revised) To improve access to early, adequate and high quality prenatal care, with a specific focus on eliminating health disparities - A major focus this year has been the expansion and enhancement of home visiting activities for high-risk pregnant women to

improve birth outcomes, which includes a focus on identifying and engaging women early in pregnancy. This effort has included a number of initiatives, including the DOH-developed Healthy Mom-Healthy Baby initiative supporting local health departments serving six highest need counties; the Community Health Worker (CHW) program that provides outreach and paraprofessional home visiting services to pregnant women at high risk for poor birth outcomes; and, the Nurse Family Partnership (NFP) programs in three high-need communities. BMCH was designated as the State lead and has developed a comprehensive, statewide needs assessment and state plan related to the provision of evidenced-based home visiting services in response to the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visitation (MIECHV) implemented by HRSA. MCH staff programs have worked closely with the Department's Office of Health Insurance Programs (OHIP) related to a Medicaid Redesign Team (MRT) proposal to expedite enrollment of MA-eligible women into managed care plans to promote earlier entry into prenatal care and increase utilization of care management for high risk women.

2. State Priority (revised) To improve access to comprehensive, high quality primary and preventive health care for children and adolescents, consistent with the medical home model, including children with special health care needs – There has been a significant expansion in health insurance eligibility for children in NYS, including expansion of Child Health Plus (NYS S-CHIP program) to 400% FPL in 2009 and expansion of Medicaid (MA) coverage for children aged 6 to 18 to 133% FPL in late 2011. All MCHSBG-funded programs are expected to facilitate public insurance enrollment for eligible children. In particular, the Title V CSHCN program provides grant funds to local health departments that include assistance in helping families of CSHCN who are uninsured or underinsured access health insurance, including Medicaid waiver programs. Title V staff have worked with OHIP to advance policies to improve access to health care for children and CSHCN, including participation in MRT efforts related to expansion of Medicaid Managed Care to additional MA-eligible populations (including children and youth in foster care); expanding the state's Patient-Centered Medical Home Program; and, implementing Health Home (enhanced care coordination services) for high-need MA enrollees. The Title V program continues to operate the largest School-Based Health Center Program in the nation, with over 50 hospitals and community health centers sponsoring 230 clinics within schools across the state. Title V staff have implemented quality improvement initiatives related to improving pediatric care, including developmental screening, autism screening and follow-up, and blood lead screening.

3. State Priority (current) To eliminate disparities in birth outcomes especially with regard to low birth weight and infant mortality – In the past decade, the NYSDOH MCH Program has worked to develop a highly structured, statewide system of regionalized perinatal care organized around regional perinatal centers (RPCs). RPCs provide care to the highest risk mothers and babies and provide quality improvement services to a network of affiliated hospitals offering varying levels of perinatal care. This year, the impact of perinatal regionalization on neonatal mortality among very low birth weight (VLBW) infants has been assessed. Regionalization has had a positive impact in NYS with VLBW babies more likely to be born at RPC and Level III hospitals and more likely to survive post-regionalization (2004-2006) than pre-regionalization (1996-2001). NYS's risk-adjusted VLBW neonatal mortality rate declined from 13.03 per 100 during 1996-2001 to 10.46 per 100 during 2004-2006. Improvements were noted by region, NYC (13.45/100 to 10.45/100) and Rest of State (12.49/100 to 10.47/100), and hospital level, RPCs (12.52/100 to 9.78/100) and Level IIIs (13.41/100 to 10.71/100). NYS is

first among 10 states that met the 2010 goal of 90% of VLBW infants delivered at a Level III or higher hospital.

4. State Priority (revised) To prevent and reduce the incidence of overweight and obesity for infants, children and adolescents with a focus upon reducing health disparities - DOH also continued work on the Overweight and Obesity Prevention Program focused on increasing physical activity and improving healthy eating, including breastfeeding, among residents of NYS, with a primary focus on the prevention of childhood obesity. The program supports a variety of initiatives including, funding for three Centers for Best Practices to address age-specific overweight and obesity prevention issues and a statewide center and coalition for obesity prevention, healthy eating and active living (Designing a Strong and Healthy New York). In addition, a new initiative was developed, Creating Healthy Places, that was designed to promote the implementation of policies, systems and environmental change that will create healthy places for people to live, work, and play. Nine new contracts are expected later this year for obesity prevention systems change in pediatric primary care settings. Contractors will contribute to state and regional capacity building, collaboration and planning by networking with local health departments and groups implementing nutrition, physical activity and obesity prevention programs / interventions to facilitate patient / family referrals to existing community resources and improve self-management of obesity and/or obesity-related health conditions.

5. State Priority (revised) To reduce unintended pregnancies in adults and adolescents and improve adolescent sexual health and development, with a focus upon reducing health disparities - In January 2011, BMCH launched a new \$17.5 million 5-year Comprehensive Adolescent Pregnancy Prevention CAPP initiative that includes a significant focus on implementation of evidence-based sexual health education and reducing racial and ethnic disparities. Grants were awarded to 50 community-based organizations that focus on the prevention of pregnancies, STDs and HIV among male and female adolescents ages 10 to 21 years. BMCH applied for and received federal funding for the Personal Responsibility Education Program (PREP) initiative which is closely aligned with CAPP and will support additional awards to organizations that were approved but not funded under CAPP, as well as to support an enhancement project targeting youth in foster care. BMCH also applied for and received \$2.99 million in federal funding for the Abstinence Education Grant Program (AEGP) which will support a new initiative that will fund community-based mentoring, counseling and adult supervision programs designed to delay the initiation of sexual behavior among young people, ages 9-12, residing in high-risk communities. Funding was awarded in a competitive application to 49 agencies operating more than 200 clinic sites to provide comprehensive family planning and reproductive health care services targeted to the highest need communities and populations to address health disparities. Services were expanded to several locations in the state. In addition to the clinical programs, the State is also supporting a new Statewide Center of Excellence (COE) for Family Planning and Reproductive Health Services that will partner with the Department of Health to develop and promote a comprehensive system of high quality family planning services. MCH Staff partnered with OHIP related to an MRT proposal to convert the state's programs that provide expanded access for family planning services from waiver programs to a State Medicaid plan service.

6. State Priority (current) To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women - NYS exceeds the Healthy People 2020 baseline and

target goals of 26% and 21% respectively for this indicator. In 2010, 12.6% of high school students smoked cigarettes on one or more days during the past month (2010 YTS), compared to 2000, when 27.1% of high school students were smokers. The New York Tobacco Control Program (NYTCP) approach to tobacco control is built on the social norm change model, in which reductions in tobacco use are achieved by creating a social environment and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible. The success in reducing youth smoking is attributable to high tobacco product taxes, a statewide clean indoor air law, and DOH's comprehensive tobacco control effort. The program increases access to effective cessation services, including support for the NYS Smokers' Quitline, and supports media campaigns designed to increase public awareness of the dangers of tobacco use. NYTCP supports a range of local programs designed to build and support tobacco-free communities, including Reality Check, a youth engagement program which works to counter the tobacco industry influence in communities. Exposure to tobacco marketing in stores is a primary cause of youth smoking. Over the past year, NYTCP has focused on action to reduce the impact of tobacco industry marketing on youth.

7. State Priority (current): To improve oral health, particularly for pregnant women, mothers and children, and among those with low income - According to a Pew report titled *The State of Children's Dental Health: Making Coverage Matter*, New York State met five of eight policy benchmarks aimed at addressing children's dental health needs. The overall performance improved from a C grade in 2010 to a B grade in 2011. The Bureau of Dental Health (BDH) continues to grow its School-Based Health Center-Dental program, with programs in a quarter of high-risk schools offering preventive services. The Bureau awarded \$1.5 million for 30 applications for preventive dental services in school-based/school-linked programs, with a primary objective to increase the prevalence of dental sealants in second and third grade children. BDH has completed the second year of the Oral Health, Physical Activity and Nutrition (OPAN) survey of 3rd grade children in upstate New York; over 5,000 3rd grade children have been screened for this project to date. BDH collaborated with OHIP related to developing Medicaid reimbursement for physicians, dentists, and nurse practitioners for the application of fluoride varnish to teeth in children younger than 7 years of age. BDH is educating and encouraging medical providers to incorporate oral health screening, anticipatory guidance, caries risk assessment, and where indicated, the application of fluoride varnish into well child visits as a routine standard of care for children, including development of a partnerships between WIC and local pediatricians to explore a WIC Fluoride Varnish Pilot Project Proposal. The BDH assisted the New York State Oral Health Coalition in re-establishing its Prenatal/Perinatal Committee to improve oral health education for pregnant women.

8. State Priority (new): To eliminate childhood lead poisoning - The Department continues to aggressively address the problem of childhood lead poisoning through multiple primary and secondary prevention strategies. A major initiative has been underway in BMCH to promote lead testing through linkage of lead registry with the NYS Immunization Information System (NYIIS). This linkage will reinforce and promote timely lead testing by practitioners, and improve the Department's ability to survey screening rates. The first two phases of implementation are in place, and physician office laboratories are now using NYIIS to review lead test histories for their patients and to submit reports of lead tests. Prompts to remind providers related to the need for testing or follow-up will be implemented shortly, followed by reports that will enable providers, plans and state and local health departments to assess lead

testing practices and target quality improvement activities. BMCH issued new guidelines for the blood lead testing of refugee children and pregnant women. Within DOH, BMCH continues to collaborate with Center for Environmental Health staff to support the Childhood Lead Poisoning Primary Prevention Program in 15 LHDs in the highest incidence counties. An application was submitted for a new CDC cooperative agreement for Healthy Homes and Lead Poisoning Prevention initiative that replaces the longstanding CDC Childhood Lead Poisoning Prevention Cooperative Agreement. We are very concerned that the expanded scope of this application to address a variety of environmental health and safety concerns beyond lead, coupled with a 50% reduction in the State's funding level, will greatly impact upon our ability to address this priority.

9. State Priority (current): To improve diagnosis and treatment of asthma in the maternal and child health population - DOH continued to fund 11 regional asthma coalitions across NYS with the goal of reducing asthma related morbidity and mortality. The coalitions, representing organizations that serve a pediatric population disproportionately affected by asthma, continue to implement and spread education and systems changes intervention through participation in the NYS Asthma Outcomes Learning Network, a quality improvement initiative led by the NYS Asthma program, with assistance from the National Initiative for Children's Health Care Quality (NICHQ). Managed care plans and health practices which provide benefits and services to African Americans with asthma are implementing interventions to improve asthma outcomes in the Eliminating Disparities in Asthma Care (EDAC) initiative. A partnership has been established to work on the development of culturally/linguistically appropriate mobile phone information systems to provide asthma self management support to consumers. To increase access to quality asthma self-management support services, Medicaid has provided coverage for asthma self-management services when provided by a Certified Asthma Educator. DOH is leading an initiative to further develop the Certified Asthma Educator workforce and their integration into clinical practice, including an analysis to understand Certified Asthma Educator workforce supply.

10. State Priority (new): To increase the percentage of infants who are breastfed for at least six months - Significant cross organizational efforts to improve breastfeeding rates continue, including promoting the development of Baby Friendly Hospitals and breastfeeding quality improvement in hospitals through a structured, data-driven, breastfeeding quality improvement learning collaborative, a joint initiative with the NICHQ. DOH and Regional Perinatal Centers (RPCs) are offering the 18 hour Ten Steps to Successful Breastfeeding Online course to staff in 125 obstetrical hospitals in NYS. The NYSDOH WIC Program received a performance award of \$1.6 million from the USDA to recognize its high rate of breastfeeding initiation. A statewide media campaign was funded, targeted to low income communities to increase awareness and support of breastfeeding, "Breastfeeding -For My Baby, For Me", which featured advertising via television, internet, bus shelters and bus interiors. Medicaid Prenatal Care Standards, revised in 2010, required providers to counsel and educate women during prenatal visits and immediately postpartum regarding infant feeding choices. The Maternity Information leaflet, required by state law, provides patients information on maternity-related procedures performed at each hospital. The law has now been expanded to also require that information on infant feeding practices at each hospital be included in this publication.

C. National Performance Measures

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

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|---------------------------|---------------------------|---------------------------|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 100 | 77.2 | 76.0 | 88.1 | 88.1 |
| Numerator | 252,014 | 3,542 | 3,238 | 15,853 | 15,853 |
| Denominator | 252,014 | 4,586 | 4,263 | 17,985 | 17,985 |
| Data Source | | | Newborn Screening Program | Newborn Screening Program | Newborn Screening Program |
| Is the Data Provisional or Final? | Final | Final | Final | Provisional | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

Notes 2010

Data in the cells for 2007 and 2008 numerators and denominators represent only screen positives or referrals. In previous years, these numbers represented all newborns screened. For 2007-2008, as shown in the above table, the numerator is the number of cases closed and the denominator is the number of screen positive newborns for the year. The annual indicator is the number of closed cases divided by number of screen positive cases reported as a percent. A case is considered closed when all predetermined closure criteria are met, including the newborn having an evaluation, any diagnostic testing, and a diagnosis has been made regarding the condition for which the newborn was referred. The program follows all screen positive newborns to ensure they receive appropriate follow-up, including an evaluation, diagnostic testing and a diagnosis as appropriate.

For 2009, the numerator is the number of referrals (previously called screen positives) plus the number of babies with a presumptive positive screen. Presumptive positive screens are those infants with slightly out of range results; a repeat specimen is required, and follow-up staff ensures a repeat sample is received, tested, and reported appropriately. Data for 2009 are cases opened and closed that calendar year. There are still instances where the annual indicator will increase as some infants have cases remaining open until a firm diagnosis is made by the clinician. NYS is below the HP 2020 target of 100% for the percent of screen positive newborns who received timely follow-up to definitive diagnosis and clinical management for conditions mandated by the State-sponsored newborn screening program. However, although the annual indicator is below 100%, almost all newborns will receive appropriate follow-up and testing, although all newborns will not receive that follow-up within a particular calendar year, resulting in an annual indicator that appears to be far below the performance objective. The diagnosis

may not be made by the clinician until the following year; therefore the 2009 data is provisional. 2009 data are used as a proxy for 2010. 2010 data will be available in late 2011.

a. Last Year's Accomplishments

- In 2009, 249,271 infants were screened for all 45 conditions, which include the 29 core conditions, most of the secondary conditions, and HIV and Krabbe disease, both of which are unique to NYS. Screening is performed by Wadsworth Center's Newborn Screening Program at the DOH.
- All newborns with a specimen submitted are tested for all 45 congenital conditions on bloodspots, including:
 - Congenital adrenal hyperplasia (CAH)
 - Congenital hypothyroidism (CH)
 - Sickle cell disease and other hemoglobinopathies
 - HIV-1 exposure
 - Homocystinuria
 - Hypermethioninemia
 - Maple syrup urine disease
 - Phenylketonuria
 - Tyrosinemia, types 1, 2, and 3
 - Carnitine-acylcarnitine translocase deficiency
 - Carnitine palmitoyltransferase deficiency, types 1 and 2
 - Carnitine uptake defect
 - 2,4-Dienoyl-CoA reductase deficiency
 - Long-chain 3-hydroxyacyl-CoA dehydrogenase deficiency
 - Medium-chain acyl-CoA dehydrogenase deficiency
 - Medium-chain ketoacyl-CoA thiolase deficiency
 - Medium/short-chain hydroxyacyl-CoA dehydrogenase deficiency
 - Mitochondrial trifunctional protein deficiency
 - Multiple acyl-CoA dehydrogenase deficiency
 - Short-chain acyl-CoA dehydrogenase deficiency
 - Very long-chain acyl-CoA dehydrogenase deficiency
 - Glutaric acidemia, type 1
 - 3-Hydroxy-3-methylglutaryl-CoA lyase deficiency
 - Isobutyryl-CoA dehydrogenase deficiency
 - Isovaleric acidemia
 - Malonic acidemia
 - 2-Methylbutyryl-CoA dehydrogenase deficiency
 - 3-Methylcrotonyl-CoA carboxylase deficiency
 - 3-Methylglutaconic acidemia
 - 2-Methyl 3-hydroxybutyryl-CoA dehydrogenase deficiency
 - Methylmalonic acidemia
 - Mitochondrial acetoacetyl-CoA thiolase deficiency
 - Multiple carboxylase deficiency
 - Propionic acidemia

- Argininemia
 - Argininosuccinic acidemia
 - Citrullinemia
 - Hyperammonemia/hyperornithinemia/homocitrullinemia
 - Biotinidase deficiency
 - Cystic Fibrosis (CF)
 - Galactosemia
 - Krabbe Disease
- Among children screened in 2009, there were 20 cases of amino acid disorders including PKU; 11 cases of congenital adrenal hyperplasia; 141 cases of primary congenital hypothyroidism; 20 cases of fatty acid oxidation disorders including MCAD; 271 cases of hemoglobinopathies; 42 cases of organic acid disorders including 3-MCC; 13 cases of biotinidase deficiency; 71 cases of cystic fibrosis, and 6 cases of galactosemia. Two infants were found to be at high risk for Krabbe disease.
 - The Newborn Screening Program (NBS) and the Children with Special Health Care Needs (CSHCN) Program implemented standards for new types of Specialty Centers in 2009.
 - Prenatal Genetics Services were provided to 23,417 pregnant women in 2009.
 - Another 23,609 individuals received Clinical Genetics Services through genetic services grantees.
 - Wadsworth Center continued to provide certification of clinical and environmental laboratories serving NYS residents.

Table 4a - National Performance Measure 1 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. All newborns with a specimen submitted in NYS were tested for over 40 congenital conditions. | | | X | X |
| 2. The Newborn Screening (NBS) Program and the Children with Special Health Care Needs Program implemented and continue to monitor standards for Endocrine, Cystic Fibrosis and Inherited Metabolic Diseases Specialty Centers. | | | | X |
| 3. Prenatal Genetics Services were provided to 23,417 pregnant women in 2009. | X | X | X | X |
| 4. Another 23,609 individuals received Clinical Genetics Services through genetics services grantees. | X | X | X | X |
| 5. Comprehensive Prenatal/Perinatal Services Networks promoted newborn screening and appropriate follow-up through newsletters and provider meetings. | | | | X |
| 6. NY Mid-Atlantic Consortium for Genetic & Newborn Services (NYMAC) workgroups, charged with educating the professional and lay public about genetics and newborn screening, are developing the means to distribute new and existing materials. | | | X | X |

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 7. Through the NYS NBS website and the NYMAC website, individuals concerned with genetics services or specialty care were able to access educational resources or identify clinical services providers, support groups and other needed services. | | X | X | X |

b. Current Activities

- Wadsworth Center conducts bloodspot screening on 100% of specimens received from NYS’s newborns for 46 conditions, 44 of which are rare genetic diseases. More than 98% of referred infants are followed to confirmation.
- NYS provides grant awards to 24 genetic centers across NYS to provide diagnostic services, laboratory testing, genetic counseling, and referral to treatment centers.
- NYS is a member of NYMid-Atlantic Consortium for Genetic & Newborn Services (NYMAC). NYMAC has formed 2 workgroups with a focus on educating about genetics and Newborn Screening (NBS).
- Wadsworth Center’s NBS Program initiated screening for severe combined immunodeficiency syndrome and, in collaboration with Title V, recruited Centers to provide follow-up of screen positive infants.
- Hemoglobinopathy criteria for specialty centers were reviewed. Resulting standards are being implemented.
- DOH was awarded the Effective Follow-up in NBS grant for enabling health information exchange (HIE) and improving communications regarding child health information. Goals are to:
 - Improve NBS short-term follow-up via enhanced HIE among NBS, hospitals, medical home/community practices, and subspecialists
 - Develop long-term follow-up for cystic fibrosis and inherited metabolic diseases
 - Integrate NBS data within an interoperable model for meaningful HIE
 - Develop a child health profile

c. Plans for the Coming Year

- The NBS Program will continue to screen all newborn blood spots. UPS pick-up will continue with 5 days a week delivery to Wadsworth Center.
- The NBS Program will continue to ensure appropriate follow-up.
- DOH Title V staff will remain involved in NYMAC activities.
- NYMAC and the Genetic Services Program will investigate ways to maximize resources/reimbursement for genetic services providers.
- Wadsworth Center will continue to assure that clinical public health laboratory services are available to NYS residents, including but not limited to: an anatomic pathology laboratory and a laboratory for identification of reproductive and metabolic disorders.
- Wadsworth Center will continue to operate a state-of-the-art clinical and environmental laboratory evaluation program to ensure that laboratories offering tests to NYS residents meet appropriate quality requirements and can pass proficiency tests.
- The NBS Program will investigate expansion of the program to include additional lysosomal storage diseases and others.

- Article 28 hospitals will continue to be invited to apply for designation as Specialty Care Centers for hemoglobinopathy services.
- Individuals concerned with genetics or specialty care can access educational resources or identify clinical services providers, support groups and other public health resources through both the NYS NBS and NYMAC websites: www.wadsworth.com/newborn; www.wadsworth.org/newborn/nymac
- NBS Effective Follow-up (EFU) will roll out the Remote Demographic Entry module to hospitals across NYS with a target of capturing at least 50% of all bloodspot screen data via electronic submission by the end of 2011.
- NBS EFU will implement use of the Remote Diagnostic Form with Cystic Fibrosis (CF) Specialty Centers, and based on lessons learned from the CF form, will develop and implement a Remote Diagnostic Form for use by Inherited Metabolic Disease (IMD) Specialty Treatment Centers.
- NBS EFU will continue to work with CF and IMD Specialty Centers to define criteria and goals for long-term follow-up, and implement a long-term follow-up tracking module in 2011.
- Pilot hospitals were engaged via email and conference calls to document current processes, define reporting requirements and determine the best approach for implementation of HL7 messaging. A technical specification document was developed for the pilot hospitals to use as a guide in implementing the Remote Demographic Entry HL7 module. The NBS EFU will continue to engage hospitals for HL7 messaging in the coming year.
- NBS EFU will continue to work across DOH units to enable the design and development of a HIE infrastructure. This infrastructure will also be used to support and populate a virtual child health profile, accessible by authorized users in both the private and public sector.
- NBS EFU will continue to work with Child Health Information Integration staff to coordinate activities for design, development and implementation of a virtual child health profile.

National Performance Measure 02: *The percent of children with special health care needs age 0 to 18 whose families' partner in decision making at all levels and are satisfied with the services they receive.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Annual Performance Objective | 64 | 66 | 66 | 60 | 60 |
| Annual Indicator | 60.3 | 59.0 | 59.0 | 59.0 | 59.0 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN |
| Is the Data Provisional or Final? | Final | Final | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 59.6 | 60.2 | 60.8 | 61.4 | 62 |

Notes 2010

Data reported for 2007, 2008 and 2009 are from the National Survey of Children with Special Health Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010 data. 2010 data will be available in the fall of 2011. Nationally, 57.4% of families with CSHCN report satisfaction with the services they need.

a. Last Year’s Accomplishments

- Extensive input from families was obtained as part of the state’s five-year needs assessment which identified the following concerns: difficulty in obtaining Medicaid-funded transportation to medical appointments; access to Medicaid-enrolled providers and specialists; service coordinators’ lack of knowledge about community resources related to special health care needs; and the need for additional training for coordinators and providers about the needs of children and families.
- Approximately 75,000 Early Intervention Program (EIP) families were engaged in decision making via the Individualized Family Services Plan (IFSP). The IFSP identifies the families’ concerns, priorities and objectives for their child’s development and the services needed to reach those objectives in the coming six months.
- EIP Partners Training Projects were conducted in two different locations. 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 provided information, resources, and skill-building activities designed to increase advocacy and leadership skills.
- Various activities associated with the State Implementation Grants for Improving Services for Children and Youth with Autism Spectrum Disorders (ASD) were conducted, including dissemination of materials about child developmental milestones, signs of autism, and resources for parents concerned about their child's development.
- A series of community forums were held in the spring 2010 to obtain input from families of children with special health care needs (CSHCN) and youth with special health care needs on their needs, and access to available services to meet these needs.
- Families were invited to participate in the Child Development Learning Collaborative (CDLC) with community practice teams. The purpose of the CDLC was to plan and implement strategies within pediatric practices to improve developmental and autism screening during well child visits. The CDLC was completed in October 2010.
- Funds were offered as part of local CSHCN Program contracts to enhance consumer involvement in local programs. These funds can be utilized to provide consumer stipends, child care, travel reimbursement and other costs associated with consumer meetings and trainings.

Table 4a - National Performance Measure 2 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The local Children with Special Health Care Needs (CSHCN) Programs continued to support consumer involvement in local program activities and work with families to identify and refer them to appropriate services for their CSHCN. | | | | X |

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 2. Parents of CSHCN are represented on the MCHSBG Advisory Council (MCHSBGAC), the Early Intervention Coordinating Council (EICC), the Lead Poisoning Prevention Advisory Council (LPPAC), and serve as representatives on several other state-level advisory groups. | | | | X |
| 3. The CSHCN Program collected information about the needs expressed by families to assist with identifying services gaps and provide responsive program planning. | | | | X |
| 4. Resources for families (i.e., a Health Insurance Fact Sheet and Resource Directory for CSHCN) are posted on the DOH website. | | | X | |
| 5. Conference calls are held with family/youth representatives and local health departments on topics concerning improving the ease by which families and youth can utilize the system of care for CSHCN. | | | X | |

b. Current Activities

- MCH programs promote family partnership in decision making at the individual, community and state levels.
- Family representatives support state planning as participants on the LPPAC, MCHBGAC and the EICC, a required EIP advisory committee; five of the 27 EICC members are family representatives. Providers, families, state agency and municipal representatives are equally represented on EICC committees.
- Engaging families in decision making is a key element of EIP as families are required to agree to services authorized on the IFSP. Families’ satisfaction is inherently linked with services received and their engagement level.
- EIP delivers the Partners Training Project for parents twice a year.
- Eighteen local CSHCN programs used consumer involvement funds to help families attend a special needs conference.
- Since the retirement of the Family Specialist, DOH met with the parent support staff of Parent to Parent of NYS, the Family-to-Family Health Care Information and Education Center grantee, to affirm collaboration on family support activities.
- DOH activities associated with HRSA’s State Implementation Grants for Improving Services for Children/Youth with ASD include regional focus groups with families to identify strategies to improve satisfaction with EIP services for children with an ASD.
- Title V staff participate in NYS’s MA Redesign process, including discussion of potential recommendations related to CSHC and assignment to relevant MRT implementation work groups.

c. Plans for the Coming Year

- During the next FFY, family representation at the state level will continue on the EICC, the MCHBG Advisory Council and the Lead Poisoning Prevention Advisory Council. Family

input and representation will be sought when planning major program initiatives that involve families and children.

- Title V staff will continue to participate in discussions related to Medicaid (MA) Redesign including proposals that relate to CSHCN. DOH will seek to involve family organizations in the Medicaid Redesign process.
- Conference calls will be held with family/youth representatives and local health departments on topics concerning improving the system of care for CSHCN.
- The local CSHCN program workplan is being revised to include a goal related to strengthening family and youth input in local programming, and will become a required element of the workplan.
- Continuing to engaging families in decision making is a key element of the NYS Early Intervention Program (EIP) as families are required to agree to the services authorized on the child's IFSP. Each IFSP identifies the families' concerns, priorities and objectives for their child's development and then identifies the services needed to reach those objectives in the coming six months. Families' satisfaction with the program is inherently linked with the services received and their level of engagement in the program.
- The EIP Partners Training Project will train parents several times annually. 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. The training is currently conducted twice a year, in different parts of NYS. One session is conducted via live webinar and the other in a two day face to face training.
- The EIP has allocated \$800,000 of its ARRA-Early Intervention funding to expand family initiatives over the two year period ending in 2011. This funding will continue to be used to develop the web site (www.eifamilies.com) to include information and communication with all of the 75,000 families in the EIP. The web site will provide links to existing programs sponsored by other state agencies; a blog which will allow readers to post commentary, news, or questions in an interactive format; learning opportunities through links to existing Web-based learning modules; and support opportunities through links to state and national Parent Centers. In addition, funding will be used to expand the EIP's Partners Training Project by adding a third training session (one live webinar session and two face-to-face sessions) for each of the next two years. The session will focus on learning of successful leadership accomplishments and/or current status of former Partners graduates and translation of identified early intervention materials into Spanish.

National Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Annual Performance Objective | 55 | 58 | 58 | 46 | 48 |
| Annual Indicator | 51.7 | 45.2 | 45.2 | 45.2 | 45.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 45.7 | 46.1 | 46.6 | 47 | 47.5 |

Notes 2010

Data reported for 2007, 2008 and 2009 are from the National Survey of Children with Special Health Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010 data. 2010 data will be available in the fall of 2011. NYS is below the national average of 47.1%, as well as the target for the HP 2020 goal of 54.8% of CSHCN (under age 18) who have access to a medical home. However, NYS exceeds the HP 2020 target for CSHCN who receive their care in family-centered, comprehensive, coordinated systems. For children 0 – 11years, the HP 2020 target is 22.4%, and for children 12-17 years of age the target is 15.2%

a. Last Year’s Accomplishments

- Chapter 58 of the Laws of 2009 authorized DOH to implement an initiative to incentivize the development of patient-centered medical homes to improve health outcomes through better coordination and integration of patient care for persons enrolled in NYS’s Medicaid (MA) and Family Health Plus programs. NYS chose to adopt the medical home standards consistent with those of the National Committee for Quality Assurance’s (NCQA) Physician Practice Connections-Patient Centered Medical Home Program. Hospitals, clinics and practitioners that coordinate and integrate patient care in accordance with these medical home standards receive additional fee-for-service and managed care payments. To receive reimbursement, providers must be designated as the enrollee’s primary care provider and achieve NCQA certification. The NCQA Program features three tiers of medical home recognition. Incentive payment from NYS to fee-for-service providers is made on a claims submitted basis depending upon the provider’s NCQA recognition level. State payment to Managed Care Plans are passed through to providers based on a per member per month basis depending upon the provider’s NCQA recognition level. Reimbursement commenced for visits performed on or after July 1, 2010.
- The School-Based Health Center (SBHC) Quality Improvement Learning Collaborative was launched in September 2009 with 25 participating teams. This learning collaborative was a joint initiative of DOH and the National Initiative for Children’s Healthcare Quality

(NICHQ). A kickoff webinar was held in September 2009, followed by two full-day regional learning sessions. Two additional webinars were held in 2009 and 2010. The project focused on improving primary care within SBHCs through the use of evidenced-based practices in the priority areas of comprehensive physical exams, overweight and obesity care, and asthma care. Each participating team focused on a comprehensive physical exam (CPE) indicator and chose either asthma or obesity as a second indicator. The CPE indicator was a required indicator as the SBHC annual workplan goal is that 95% of students enrolled in the SBHC will have a documented CPE. Monthly data reports were used to track individual team's progress for the indicators. The SBHC and Children with Special Health Care Needs (CSHCN) Program staff held regular monthly coaching sessions with the project teams as the initiative progressed through the end of the 2009-2010 school year.

- The CSHCN Program funds local health departments to provide health information and referral to CSHCN and their families and to assist them in obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service needs. Almost 76% of children with special health care needs served by the CSHCN Program reported having a primary care provider. Approximately 4.2% of contacts to the CSHCN Program resulted in referrals to obtain SSI or health insurance (CHPlus or Medicaid) which is consistent with the proportion of families (4.8%) whose CSHCN presented to the CSHCN Program without insurance.

Table 4a - National Performance Measure 3 Summary

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Children with Special Health Care Needs (CSHCN) Program funds local health departments to provide information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other services needs. | | X | | X |
| 2. Funding to enhance and strengthen local CSHCN program contracts was provided to improve consumer involvement in local programs. | | X | | X |
| 3. The CSHCN Program funds local CSHCN programs which integrate the medical home concepts into quality improvement initiatives. Local CSHCN programs assist families to access insurance and a primary care provider. | | X | | X |
| 4. State law and funding support implementation of an initiative to incentivize patient-centered medical homes for persons enrolled in NYS Medicaid. | | | | X |
| 5. The School-based Health Center (SBHC) Quality Improvement Learning Collaborative was launched in 9/2009 to improve primary care through use of evidenced-based practices in the priority areas of comprehensive physical exams, overweight and obesity care, and asthma care. The SBHC Learning Collaborative ended in 2010. | | | | X |

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 6. SBHCs that participated in the Learning Collaborative were encouraged to sustain improvements, share results and use a registry in the 2010-11 school years. | | | | X |

b. Current Activities

- **Funding support continues to incentivize patient-centered medical homes for persons enrolled in the NYS Medicaid Program.** Hospitals, clinics and practitioners that coordinate and integrate patient care in accordance with medical home standards receive additional fee-for-service and managed care payments.
- The School-Based Health Center (SBHC) project demonstrated significant improvements in the number of comprehensive physical exams completed and documented Body Mass Indices on enrolled children, with slower gains in the area of documented asthma actions plans. The early results of the use of a registry and learning collaborative were shared with all the SBHCs via three webinars held in February 2011. The purpose of sharing this information about the SBHC improvement project was to encourage the use of a SBHC registry as a tool to support planned care and promote best practices for all SBHC providers across NYS.
- Fifty-five local health departments receive funding to provide health information and referral to CSHCN and their families. Assistance includes helping families obtain health insurance, finding a medical home, linking with specialty care and assisting with other service needs.

c. Plans for the Coming Year

- The Office of Health Insurance Programs is considering development of a Centers for Medicare and Medicaid Services Medicaid waiver application for Health Homes for Individuals with Chronic Disease as part of the Affordable Care Act. The Division of Family Health has had discussions with the Office of Health Insurance Programs regarding inclusion of individuals with autism among those eligible for this waiver.
- NYS will continue to fund contracts for local Children with Special Health Care Needs (CSHCN) Programs that provide information and referral to health insurance and medical homes. The medical home concepts are continuously interwoven into local program activities and state quality improvement initiatives. Upon a child's intake into the CSHCN Program, program staff will inquire whether a child has insurance and a primary care provider and will assist families in applying for public insurance and obtaining a primary care provider.
- Funds will continue to be offered as part of local CSHCN program contracts for FFY 2011 to enhance consumer involvement in local CSHCN Programs. These funds can be utilized to provide consumer stipends, child care, travel reimbursement and other costs associated with consumer meetings and trainings. The CSHCN Program workplan for 2011-2012 is being revised to include a goal related to strengthening family and youth input in local programming. This goal will become a required element of the workplan and replaces an optional element that local programs could choose to complete.
- School-Based Health Centers (SBHCs) that have participated in the Learning Collaborative will be encouraged to sustain the improvements gained in 2009-2010, and continue to use a registry for the enrolled students who receive care from the health center. SBHCs are

required to report on the comprehensive physical exam indicator and are encouraged to continue to report on the asthma and body mass index indicators.

- Title V staff will continue to participate in the Medicaid Redesign process regarding any potential recommendations related to care for CSHCN.

National Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|--------------------------|-------------|-------------|-------------|
| Annual Performance Objective | 68 | 70 | 72 | 64 | 64 |
| Annual Indicator | 59.1 | 62.1 | 62.1 | 62.1 | 62.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | National Survey of CSHCN | NS of CSHCN | NS of CSHCN | NS of CSHCN |
| Is the Data Provisional or Final? | Final | Final | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 62.7 | 63.3 | 64 | 64.6 | 65.2 |

Notes 2010

Data reported for 2007, 2008 and 2009 are from the National Survey of Children with Special Health Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010 data. 2010 data will be available in the fall of 2011. Nationally, 62% of families have adequate insurance to pay for services they need.

a. Last Year's Accomplishments

- NYS' Early Intervention Program (EIP) provided comprehensive services, including service coordination, to infants and toddlers with developmental delay or disabilities. Approximately 75,000 children and families received services.
- DOH provided grant funding to support local Children with Special Health Care Needs (CSHCN) programs and annual state aid reimbursement to localities for gap-filling expenditures to assist families of children with special health care needs from birth to 21 years of age. DOH made available \$3,685,000 in state aid through the Physically Handicapped Children's Program (PHCP) for medical services to children aged birth to 21 years with severe, chronic illnesses or physically handicapping conditions. The gap-filling reimbursement is for services that health insurance will not cover or only partially covers. The children may be uninsured or underinsured and must meet local program financial and medical eligibility requirements. In 2010, 295 children received diagnostic evaluation and 1,550 children received treatment services through the PHCP. In descending order, the major categories of services and percent of funds expended in 2010 are as follows: orthodontia (74%), medication (10%), medical-surgical services (3%) and, hearing aids (3%). The CSHCN Program monitors the reasons why gap filling services are needed. In 2010, the most common reasons why families requested PHCP assistance were: service is not covered (46%); need help with insurance premium (11%); need help with copayment (3%) and need help with deductible (8%).

- In 2009 and continuing into 2010, the Resource Directory for CSHCN was updated to include information about the Home and Community-Based Medicaid Waiver Program (Bridges to Health) for children in foster care who have significant mental health, developmental disabilities or health needs. The Resource Directory for CSHCN is available on the DOH web site and print copies are available via the on-line order form. The Resource Directory is available in five languages including English, French, Spanish, Chinese, and Russian.

Table 4a - National Performance Measure 4 Summary

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Children with Special Health Care Needs (CSHCN) Program funded local departments of health to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and other service needs. | | X | | X |
| 2. DOH provides state aid through the Physically Handicapped Children's Program (PCHP) for medical services to children from birth to 21 years of age with severe, chronic illnesses or physically handicapping conditions. | X | | | |
| 3. In 2010, 295 children received diagnostic evaluation and 1,550 children received treatment services through the PHCP. | X | | | |
| 4. The CSHCN Program monitored the reasons why gap filling services were needed. | | X | | |
| 5. The Early Intervention Program (EIP) provided services to approximately 75,000 infants and toddlers with disabilities or developmental delays and their families. Service coordination is provided to assist parents in accessing such services as Medicaid, WIC, primary care and specialty services. | X | X | | |
| 6. The CSHCN Resource Directory continues to be a comprehensive online and print source of information for families and providers. | | | X | |

b. Current Activities

- DOH provides grant funding to support local CSHCN programs to assist families of CSHCN from birth to 21 years of age.
- DOH continues to make available state aid reimbursement for medical services to children under age 21 with severe, chronic illnesses or physically handicapping conditions. PHCP is a gap-filling reimbursement program that covers services that health insurance will not cover or only partially covers. The children may be uninsured or underinsured and must meet local program financial and medical eligibility requirements. Local programs monitor why gap filling services are needed and provide this information to DOH.
- Title V staff contributed information to OHIP to support a comprehensive benefit package that addresses the needs of children including CSHCN. OHIP was alerted that Child Health Plus does not cover in-office point of care lead testing while MA does and was asked to consider benefit package adjustments to include the portable lead testing strategy to

overcome access barriers for families. The in-office lead testing avoids travelling to an outside laboratory, thereby increasing rates of testing.

- More than 25,000 print copies of the Resource Directory for CSHCN were distributed in 2010.
- Title V staff are participating in NYS’s MA Redesign process, including discussion of potential recommendations related to CSHCN. Staff has been assigned to relevant implementation work groups and is contributing to the development of additional proposals.

c. Plans for the Coming Year

- NYS’s Early Intervention Program will continue to provide comprehensive services including service coordination, to infants and toddlers with developmental delays or disabilities and their families.
- The proposed state aid appropriations for state aid reimbursement for medical services to children under 21 years of age with severe, chronic illnesses or physically handicapping conditions for the state fiscal year 2011 remains level at \$3,685,000. The Physically Handicapped Children’s Program (PHCP) will continue to monitor the number of children served and the type of services being funded through the gap-filling program. The local Children with Special Health Care Needs (CSHCN) programs will monitor the reasons why gap filling services are needed and provide information on gaps and barriers to DOH.
- The CSHCN Program will continue to disseminate information about the gap-filling program to families, providers and community-based organizations that serve families through its local CSHCN Program and on-line through the DOH web site.
- The CSHCN Program will continue communication with the Office of Health Insurance Programs (OHIP) to identify common gaps in health insurance coverage and explore options for coverage through public health insurance programs.
- The CSHCN Program staff will continue to participate with OHIP in the Medicaid Redesign process, including discussions related to enhancing access to and coordination of services to CSHCN.

National Performance Measure 05: *The 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.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Annual Performance Objective | 80 | 82 | 91 | 92 | 92 |
| Annual Indicator | 75.3 | 90.6 | 90.6 | 90.6 | 90.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN |
| Is the Data Provisional or Final? | | Final | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 91.5 | 92.4 | 93.3 | 94.2 | 95.1 |

Notes 2010

Data reported for 2007, 2008 and 2009 comes from the National Survey of Children with Special Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010. 2010 data will be available in the fall of 2011. Nationally, 89.1% of families report that community-based service systems are organized so they can easily use them.

a. Last Year’s Accomplishments

- The Early Intervention Program (EIP) provided service coordination to approximately 75,000 infants and toddlers and their families. The service coordination assisted families through entry into the EIP to work through the multidisciplinary evaluation and development of the Individualized Family Services Plan. Ongoing service coordination ensured that families are supported through all aspects of the EIP and that early intervention services are coordinated with other family services and supports.
- DOH completed a non-competitive procurement for another five-year funding cycle with local health departments to provide information and referral services for families of Children with Special Health Care Needs (CSHCN) from birth to 21 years of age.
- DOH provided grants to 56 contractors for the CSHCN Program to link families to appropriate state and community health-related programs and services and to help identify and resolve gaps and barriers to care for children from birth to 21 years of age. Local health departments performed referral services in three counties which declined to accept grant funds.
- DOH completed a non-competitive procurement for another five-year funding cycle with local health departments to provide follow-up services for children with lead poisoning.

Table 4a - National Performance Measure 5 Summary

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. DOH provided grants to 56 contractors for the Children with Special Health Care Needs (CSHCN) Program to link families to state and community health-related programs and services, and helps to identify and resolve gaps and barriers to care for children ages birth to twenty-one years. | | X | | X |
| 2. The Early Intervention Program (EIP) provided service coordination to approximately 75,000 infants and toddlers and their families. | | X | | |
| 3. DOH convened six meetings of the Reimbursement Advisory Panel for the EIP to assess the current service delivery model in the program and the reimbursement methodology used | | | | X |
| 4. DOH completed a non-competitive procurement for another five-year funding cycle with local health departments which coordinate follow-up medical, educational and environmental services for children with lead poisoning | X | X | X | X |
| 5. The Title V Program is a key member of the Interagency Task Force on Autism Spectrum Disorders which issued a report detailing recommendations for improved collaboration among state agencies in delivering services. | | | | X |

b. Current Activities

- DOH provides grants to 55 contractors for the Children with Special Health Care Needs (CSHCN) Program to continue services.
- Staff updated local CSHCN contacts and the DOH’s CSHCN Web page. This page describes the state and local CSHCN programs and links families with phone numbers for local contacts.
- DOH awarded grants to 57 local health departments to provide preventive outreach and education, and coordinate follow up services for children with lead poisoning.
- The Early Intervention Program (EIP) continued to provide service coordination for infants and toddlers and their families.
- DOH staff participates in an Early Childhood Advisory Council that is assessing cross-systems priorities and strategies for streamlining services for families with young children, including health, mental health, early care and education, parenting education, support and other systems.
- Title V staff are participating in the state’s Medicaid Redesign process, including discussion of potential recommendations related to CSHCN. Staff has been assigned to relevant implementation work groups and is contributing to the development of additional proposals.

c. Plans for the Coming Year

- DOH will continue to provide grants to localities for the Children with Special Health Care Needs (CSHCN) Program to offer information and referral services for families. Approval to redistribute unused allocations across the remaining 55 counties for information and referral services is pending.
- Early intervention service coordination will continue to be offered to those children found eligible for the Early Intervention Program (EIP).
- The CSHCN Program staff will continue to participate with the Office of Health Insurance Programs in the Medicaid Redesign process, including discussions related to CSHCN.

National Performance Measure 06: *The percentage of youth with special health care needs who receive the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Annual Performance Objective | 7 | 9 | 40 | 40 | 40 |
| Annual Indicator | 5.8 | 38.4 | 38.4 | 38.4 | 38.4 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN |
| Is the Data Provisional or Final? | Final | Final | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 38.8 | 39.2 | 39.6 | 39.9 | 40.3 |

Notes 2010

Data for 2007, 2008 and 2009 comes from the National Survey of Children with Special Health Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010 data. 2010 data will be available in the fall of 2011. Nationally, 41.2% of youth indicated they received this service.

a. Last Year’s Accomplishments

- Improving transition services was a priority for the CSHCN program. The CSHCN program previously discussed with youth advisors which transition topics should be covered and which methods were most helpful to them. Youth advisors indicated they wanted to learn how to talk to doctors and health care providers about health needs, and how to find people and services in their community that could help them. They expressed a preference for a web-based interactive format for most effective learning.
- DOH collaborated with the Research Foundation of New York, State University of New York Upstate, to develop a youth-oriented, interactive website to help youth develop transition skills necessary to move from pediatric to adult health care. This website, <http://www.healthytransitionsny.org>, offers youth the opportunity to learn many new skills through viewing brief videos on topics including making a doctor’s appointment, managing medications, speaking up at a doctor’s visit, setting health goals and finding community resources.
- In 2008, the Children with Special Health Care Needs (CSHCN) program and the Research Foundation held an initial meeting with the NYS Education Department Transition Site Coordinators to discuss potential use of the transition website and curriculum in schools throughout NYS. In 2010, as an outcome of this and other contacts, the transition website and curriculum were presented to approximately 40 NYC Department of Education personnel and Office of Mental Retardation and Developmental Disabilities (now called the Office for People with Developmental Disabilities) providers. This resulted in an invitation to demonstrate the Healthy Transitions website and curriculum to students in a NYC school. The video vignette “Scheduling an Appointment” resulted in an engaging and interactive exchange with students, which revealed that students need to establish a basic foundation in the topic of health care transition and to gradually build their knowledge base and confidence level. The website and its corresponding video vignettes can be a successful resource for schools to address gaining independent skills to help youth transition to adult health care.

Table 4a - National Performance Measure 6 Summary

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. DOH staff continued to promote the use of the transition website with local Children with Special Health Care Needs programs and other public health partners. Applicability and dissemination through other public health programs, including the Bureau of Maternal and Child Health’s adolescent health programs, will be further explored. | | X | X | X |

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 2. A hand-held portable health summary continued to be available through the DOH Distribution Center for distribution to consumers and providers who serve youth and young adults with special health care needs. | | | X | |

b. Current Activities

- The Children with Special Health Care Needs (CSHCN) Program is exploring ways to spread the health care transition website and resources with other DOH programs and activities. Staff provided the New York-Mid-Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC) with information regarding the Healthy Transitions website. CSHCN staff will participate in a NYMAC conference where a breakout session about the transition website will be featured.
- The workplan template for local CSHCN programs includes transition activities.
- Title V staff are participating in NYS’s Medicaid Redesign process, including discussion of potential recommendations related to CSHCN. Staff has been assigned to relevant implementation work groups and is contributing to the development of additional proposals.

c. Plans for the Coming Year

- Children with Special Health Care Needs (CSHCN) staff will continue to explore the use of the transition website with other DOH public health programs and promote the transition link from the DOH website.
- The 2011-2012 workplan template for local CSHCN programs includes a goal related to promoting youth transition. Local CSHCN Programs, as part of their workplan deliverables, will be asked to offer the website as a resource tool when assisting youth aged 14 years and older and their families.
- A hand-held portable health summary will continue to be available through the DOH Distribution Center for distribution to consumers and providers who serve youth and young adults with special health care needs.
- The CSHCN Program staff will continue to participate with the Office of Health Insurance Programs in the Medicaid Redesign process, including discussions related to enhancing access to and coordination of services to CSHCN.

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

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|------------------------------|------------------------------|------------------------------|
| Annual Performance Objective | 86 | 87 | 88 | 80 | 80 |
| Annual Indicator | 83.5 | 83 | 76.2 | 72.2 | 72.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | National Immunization Survey | National Immunization Survey | National Immunization Survey |
| Is the Data Provisional or Final? | Final | Final | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 72.9 | 73.6 | 74.4 | 75.1 | 75.8 |

Notes 2010

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 (confidence interval 4.7%). 2009 data are used as a proxy for 2010 data. It is estimated that final 2010 immunization data will be available from CDC in late 2011 or early 2012. 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%.

a. Last Year's Accomplishments

- The percent of NYS children in this age range who were fully immunized was slightly higher than the national percentage of 71.9%.
- The Immunization Program provided vaccines through the NYS Vaccines for Children (VFC) Program; assessed immunization rates and worked to improve them; provided technical assistance to providers; disseminated educational materials; assisted local health departments with disease surveillance and outbreak control activities; and continued to expand the statewide immunization registry. CDC categorical grants and State and Local Assistance dollars were used to provide staffing in both central and regional offices and to purchase vaccines. Local health departments assist in recruiting VFC providers.
- Under the Assessment, Feedback, Incentives and eXchange (AFIX) initiative, local health department staff visited health care providers to assess their patients' medical records for compliance with immunization schedules. The information is entered in CDC-developed software (Comprehensive Clinic Assessment Software Application (CoCASA)). CoCASA calculates the providers' immunization rates and identifies opportunities for improvement in immunization practices.
- Comprehensive Prenatal-Perinatal Service Networks provided education and outreach to engage children into the health care system. Some networks conducted outreach for Child

Health Plus and other outreach and educational activities to ensure that parents are aware of the need for comprehensive immunization.

- Article 6 State Aid to Localities reimbursed local health departments for the infrastructure that supports immunization surveillance, tracking, parent and provider education, and special studies.
- The Community Health Worker Program educated parents about immunization, assessed the immunization status of all children in the program, referred and assisted families to obtain immunizations, and followed up with families to assure they actually received the service. Assistance with insurance enrollment was also provided. In 2009, 72% of the children entering the program had up-to-date immunizations. Of the children who did not have complete immunizations, 86% received immunizations while in the program. A total of 90% had complete immunizations.
- Chapter 53-Laws of 2008 required DOH to update Medicaid standards for prenatal care, requiring all providers to comply with standards that incorporate evidence-based procedures and integrate standards from the American Congress of Obstetricians and Gynecologists and the American Academy of Pediatrics, and reflect expert consensus regarding care, including immunization.
- The WIC program screens all infants and children until all marker immunizations are received. Infants and children who are not adequately immunized must be referred to a health care provider or immunization clinic. Revisions to the immunization components of the WIC program were started.
- Child care providers in NYS are required to check immunizations and refer as appropriate. Continued updates to the appropriate immunization schedules and number of doses necessary to bring children up-to-date have been made. Surveys of child care providers continued to assess vaccination rates in children attending child care settings and schools.
- Legislation was passed in April 2009 authorizing the linkage between the statewide childhood lead registry (LeadWeb) and NYS Immunization Information System (NYSIIS). Enhancements to NYSIIS were made to display the blood lead test result history for children under age six and accept lead test reports from physician office laboratories through a NYSIIS lead reporting module. Roll out to providers occurred in September 2010. It is anticipated that this system will prompt and reinforce lead testing of patients, and provide a tool for DOH and local health departments to systematically identify children who have not been tested for lead to target quality improvement and compliance activities. Future plans include adding lead to the reports and prompts currently in NYSIIS to assist with follow up and encourage proper screening and complete reporting.
- The Perinatal Hepatitis B Program provided on-site record review for quality assurance and to monitor compliance with public health law at NYS birthing hospitals. Site visits provided the opportunity to review hepatitis B birth dose policies and offer training to hospital staff regarding immunization of parents and health care personnel.

Table 4a - National Performance Measure 7 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Bureau of Immunization provided vaccines through the NYS Vaccines for Children Program, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted providers. | | X | X | X |
| 2. Under the Assessment, Feedback Incentives and eXchange (AFIX) Initiative, county staff visited pediatric providers and assess immunization records. | | | X | X |
| 3. Comprehensive Prenatal-Perinatal Service Networks provided education and outreach to engage children into the health care system. | | X | X | X |
| 4. Article 6 State Aid to Localities reimbursed local health departments for the infrastructure that supports immunization surveillance, tracking, parent and provider education and special studies. | | | X | X |
| 5. The Community Health Worker Program educated parents about immunization, assessed the immunization status of children, referred and assisted families to obtain immunization, and followed-up with families to assure receipt of vaccines. | | X | X | X |
| 6. The Women, Infants and Children (WIC) program reviewed immunization records and referred infants and children who were not up-to-date to health-care providers or immunization clinics. | | X | X | X |
| 7. The Perinatal Hepatitis B Program has increased the universal birth dose in all birthing hospitals outside NYC to 78% by providing free vaccine for all children regardless of insurance coverage. | | | X | X |
| 8. The NYS Immunization Information System, which tracks childhood immunizations, has experienced both significant growth in this area and increased numbers of registered and active pediatric providers. | | | | X |

b. Current Activities

- The NYS Immunization Information System (NYSIIS) was launched in February 2008 and has continued to experience tremendous growth since its inception. Ninety-two percent (92%) of practices which immunize children are participating in the system. NYSIIS contains more than 3.7 million patients and 43.4 million immunizations. As the statewide, web-based immunization information system, NYSIIS enables health care providers to identify and track under-immunized children and increase immunization rates. NYSIIS continued to work on improvements in the Lead module and worked with others in DOH to enhance potential intra-operability with other DOH department-based reporting systems on child health issues.
- The Perinatal Hepatitis B Birth Dose Program continues to be enhanced based on evidence from a best practices survey conducted in 2010.
- Assessment, Feedback Incentives and eXchange (AFIX) Initiative evaluations are currently being conducted to determine best practices in this arena among a diverse network of NYS

counties health departments. This will serve to improve provider and patient immunization knowledge as well as immunization rates.

c. Plans for the Coming Year

- NYSIIS continues to grow towards a fully-functioning, comprehensive population-based system. Further development and enhancement of the system is planned for the coming year, including integration with other internal child health data systems and increased capacity for external health information exchange. In addition, data is being assessed for completeness, accuracy and timeliness of reporting and will be used to determine areas of need for additional immunization related program activities.
- The Perinatal Hepatitis B Program has identified best practices by surveying all birthing hospitals that have a 90% and above birth dose vaccination rate. The Bureau of Immunization is now using this information to promote the universal birth dose of hepatitis B vaccine for all newborns in NYS. Additional studies and interventions are planned to address barriers for implementing the birth dose among the remaining 17% of hospitals with birth dose rates below 60%.
- Review of Assessment, Feedback, Incentives and eXchange (AFIX) best practices and evaluation of the program will be completed and recommendations generated for use by local health departments to further improve immunization rates in NYS.
- Daycare and other child care provider yearly survey forms will be updated to incorporate ongoing changes in the immunization schedules as appropriate. Spanish translation of forms will assist in improvement of timely and accurate reporting of immunization information. Feasibility of online reporting of immunization information will be explored further to enhance reporting of immunizations.
- Revise and increase immunization related information on childhood vaccines on the DOH immunization website, including safety related information, to assist providers and parents to have children vaccinated in accordance with the Advisory Committee on Immunization Practices schedule.
- Comprehensive Prenatal-Perinatal Service Networks will continue to provide education and outreach to engage children into the health care system.
- The Community Health Worker Program will continue to educate parents about immunization, assess the immunization status of all children in the program, refer and assist families to obtain immunization
Due to significant funding cuts by the CDC and a refocusing of lead to a Healthy Homes model, the lead program will be transitioned to the DOH Center for Environmental Health.

National Performance Measure 08: *The Birth Rate (per 1,000) for teenagers aged 15 through 17 years.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|------------------|------------------|-------------|
| Annual Performance Objective | 12 | 11 | 11 | 11 | 11 |
| Annual Indicator | 13.1 | 13.2 | 12.9 | 12.1 | 12.1 |
| Numerator | 5,214 | 5,277 | 5,074 | 4,687 | 4,687 |
| Denominator | 398,091 | 398,693 | 392,716 | 386,720 | 386,720 |
| Data Source | | | Vital Statistics | Vital Statistics | |
| Is the Data Provisional or Final? | Final | Final | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 12 | 11.9 | 11.7 | 11.6 | 11.5 |

Notes 2010

2009 data has been updated and finalized since NYS's previous MCH block grant application submission. The NYS birth rate for teenagers aged 15 to17 was considerably lower than the national rate of 21.7 (2008). 2009 data are used as a proxy for 2010 data. 2010 data will be available by May 2012.

a. Last Year's Accomplishments

- Vital Statistics data for 2009 demonstrated continued accomplishments and challenges in teen pregnancy and birth rates. The birth rate for teens aged 15 to17 declined to a new low of 12.1 per 1,000. While significant geographic, racial and ethnic disparities in teen birth rates exist, the magnitude of the disparities is declining.
- Fifty-one family planning agencies with 189 clinics provided free or low cost contraceptive services to nearly 343,000 women, including nearly 100,000 teens.
- Several projects to support the use of emergency contraception (EC) were conducted, including collaboration with ACOG for education and media campaigns to reach OB/GYN providers, supplemental funding to family planning providers and school-based health centers (SBHCs) to distribute EC, and development of educational materials for the public and pharmacists.
- A preconception care packet, including a checklist and Preconception Care Guide, was developed in collaboration with the ACOG NY, Region II, and distributed to over 16,000 obstetricians/gynecologists, nurse practitioners, and pediatricians specializing in adolescent health. The materials encourage medical professionals to ask women about reproductive intentions at every visit, assess risk of an unplanned pregnancy, and counsel women on appropriate health behaviors to optimize pregnancy outcomes.
- The Community Based Adolescent Pregnancy Prevention program (CBAPP) provided pregnancy prevention services in targeted high risk zip codes. CBAPP employed a comprehensive model that includes: sexual health education to delay onset of sexual activity and reduce risky sexual behavior; educational, recreational and vocational opportunities as alternatives to sexual activity; and access to family planning services.

- Additional funds (formerly used for abstinence-only programs) were utilized to enhance and expand CBAPP.
- The Adolescent Pregnancy Prevention and Services Program (APPS) continued to provide education, case management, prenatal support and parenting education to teens in high need communities.
- The DOH Adolescent Sexual Health Work Group (ASHWG) continued to focus on development of a coordinated approach to improving sexual health outcomes for teens. ASHWG is comprised of staff from multiple DOH units.
- The ACT for Youth COE began monthly webinars with CBAPP and APPS providers on relevant topics relating to teen pregnancy prevention, male involvement in pregnancy prevention, needs of youth in foster care, gang involvement, and community assessment.
- Findings from an Adolescent Sexual Health Symposium and a series of focus groups held in 2008 were incorporated in the development of a new RFA released in the fall 2010 for a new teen sexual health initiative that emphasizes evidence-based comprehensive sexuality education, access to reproductive health services, multi-dimensional support for life skills development and community collaboration.
- The new web site (nysyouth.net) launched as part of a media campaign has continued; and will be further enhanced to include additional information on adolescent health and related issues, including topics identified through youth feedback on the site.
- Comprehensive Prenatal/Perinatal Services Networks conduct community education and outreach activities to improve the reproductive health of all women, including teens.
- The Rape Crisis Program worked with the Sexual Violence Primary Prevention Committee to review the DOH Sexual Violence Prevention Plan. DOH provided funding to rape crisis providers across NYS to support activities related to the primary prevention of sexual violence.
- SBHCs are located in high-need underserved communities across the state. Age-appropriate risk assessment and anticipatory guidance and health education pertaining to sexual activity are part of the initial assessment and annual comprehensive physical exam for students enrolled in a SBHC. When indicated, these students have access, either onsite or through referral, to family planning services and pregnancy testing.
- DOH released an RFA to solicit the NYS Family Planning Program for the next five year funding cycle. Fifty-four awards were made as follows: 51 to providers; one for infertility and teratogen counseling, one to develop a Center of Excellence and one for data management. The statewide network of family planning and reproductive health care providers continue to provide comprehensive services to NYS's most vulnerable populations.

Table 4a - National Performance Measure 8 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Fifty-one family planning agencies with 189 clinics provided free or low cost contraceptive services to nearly 343,000 women, including nearly 100,000 teens. | X | X | X | X |

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 2. A preconception care package was developed and distributed to 16,000 OB/GYNs, nurse practitioners, and pediatricians to assess risk of an unplanned pregnancy, and counsel women on appropriate health behaviors to optimize pregnancy outcomes. | | | X | |
| 3. The Community Based Adolescent Pregnancy Prevention program provided pregnancy prevention health education services in targeted high risk zip codes to delay onset of sexual activity and reduce risky sexual behavior. | X | X | X | X |
| 4. The Adolescent Pregnancy Prevention and Services Program continued to provide education, case management, prenatal support and parenting education to teens in high need communities. | | | | |
| 5. SBHCs are located in high-need underserved communities across the state. Age-appropriate risk assessment and anticipatory guidance, and health education on sexual activity are part of exams for students enrolled in a SBHC. | X | X | | |
| 6. DOH formed an Adolescent Sexual Health Work Group to develop a coordinated approach to improving sexual health outcomes for teens. | | | | X |
| 7. The Comprehensive Adolescent Pregnancy Program (CAPP), a new teen sexual health initiative that will emphasize evidence-based comprehensive sexuality education, access to reproductive health services, multi-dimensional support for life skills development and community collaboration, was developed. | | | | X |
| 8. DOH developed and launched a media campaign that includes sexual health promotion messages that address pregnancy, STD, and HIV. The campaign includes a new youth-friendly sexual health web site (www.nysyouth.net) | | | | X |

b. Current Activities

- DOH completed a procurement to award \$17.5 million in grants to 50 community programs to provide adolescent pregnancy prevention programming in areas with a high burden of adverse sexual health outcomes and Columbia University to provide statewide training to community health care providers to improve adolescent health care. This Comprehensive Adolescent Pregnancy Program (CAPP) replaced CBAPP and APPS. The RFA used a new Adolescent Sexual Health Needs Index (ASHNI) to identify the highest burdened areas of NYS. ASHNI is a ZIP code-level indicator which provides a single, multidimensional measure of community risk factors related to adolescent pregnancy and STDs.
- DOH was awarded \$3,236,330 in Federal Personal Responsibility Education Program (PREP) funds to support additional CAPP programs

- DOH received \$2,991,440 in Federal Section 510 Abstinence Education Grant Program (AEGP) funds to support community projects for 10-to-14-year-olds focused on adult mentoring and supervision to delay the onset of sexual activity.
- DOH completed a procurement to fund Rape Crisis Sexual Violence Prevention Programs to provide direct services to victims of rape and sexual assault and sexual violence prevention activities to adolescents.
- Title V staff participate in NYS's Medicaid Redesign process, including membership on implementation work groups and contribution to potential new recommendations related to improving access to family planning services for teens and adults.

c. Plans for the Coming Year

- Ongoing program activities to support a wide range of clinical and community-based services will continue.
- The ACT for Youth COE will provide training and technical assistance to the CAPP and CAPP-PREP programs on the implementation of evidence-based programming and ensure the selection of curricula related to the target audience; and will work with DOH to develop and conduct the evaluation for these projects. The COE will also provide training and technical assistance for community-based programs funded through the AEGP, and conduct the evaluation of these programs.
- PREP funds will support additional local grants to organizations that were "approved but not funded" through the recent CAPP RFA. Funds will also support an enhancement project targeting youth in foster care, to be developed in consultation with NYS Office of Children and Family Services.
- An RFA is currently under development for the AEGP. Fifteen awards will be made to support community projects focused on the use of adult mentoring, supervision and counseling to support healthy transition to adolescence, including delaying the onset of sexual activity, for children aged 9 to 12 years who reside in targeted high-need communities
- Thirty new performance measures were added to the NYS Family Planning Program to enhance quality improvement activities in seven areas: outreach and access, effective contraceptives, STI screening and treatment, cancer services, adolescent sexual health, program accessibility and program management.
- A COE will be developed to provide training and technical assistance to Family Planning Program providers and to facilitate the use of best practices. During its first year, the COE will develop a needs assessment that will be used to survey providers and develop appropriate activities.
- Work will continue to develop approaches in preconception health including cross-agency collaborations with other programs and DOH Bureaus.
- The Family Planning Extension Program (FPEP) expands Medicaid (MA) benefits for 26 months after the end of a pregnancy to women who had previously been on MA while pregnant. The Family Planning Benefit Program (FPBP), which is based on NY's 1115 waiver, provides MA coverage for family planning services for individuals with household incomes up to 200% of the FPL who are U.S. citizens or have satisfactory immigration status, regardless of previous MA eligibility or pregnancy. Additional recommendations adopted through NYS's MA Redesign process in 2011 will convert NYS's 1115 waiver into a State Plan service and streamline FPEP and FPBP into a single program that includes auto-enrollment of women following pregnancy and the addition of presumptive eligibility for

Family Planning services coverage. Additional changes may be considered as part of the continued MA Redesign process including presumptive eligibility processes to expedite initiation of MA coverage.

- Title V staff will continue to participate in the MA Redesign process.

National Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2009 Upstate Only | 2010 Upstate Only |
|--|-------------|-------------|--|--|--|--|
| Annual Performance Objective | 30 | 35 | 40 | 28 | 40 | 39 |
| Annual Indicator | 27 | 27 | 27 | 27 | 38.1 | 40.5 |
| Numerator | 10534 | 10534 | 10534 | 10534 | 3414 | 1043 weighted data |
| Denominator | 39014 | 39014 | 39014 | 39014 | 8960 | 2575 weighted data |
| Data Source | | | NYS 3 rd Grade Oral Health Surveillance Project | NYS 3 rd Grade Oral Health Surveillance Project | NYS 3 rd Grade Oral Health Surveillance Project | NYS 3 rd Grade Oral Health Surveillance Project |
| Is the Data Provisional or Final? | | | Final | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 | |
| Annual Performance Objective | 40.9 | 41.3 | 41.7 | 42.1 | 42.5 | |

Notes 2010

The NYS 3rd Grade oral health surveillance project is currently in progress. 2006-2009 data is statewide data. Final 2009 and 2010 provisional data include upstate NY data only (excludes NYC.) It is anticipated that 2010 and 2011 data will be combined to increase the sample size and that this data will be released by the end of 2011.

a. Last Year's Accomplishments

- Dental sealants are shown to be an effective intervention in preventing dental decay in permanent molars. For more than 25 years, DOH has promoted school-based dental sealant programs in targeted areas in order to improve the oral health status of children and reduce disparities in dental caries disease.
- The number of schools with a school-based dental health clinic program increased 12% from 2009 (560 schools) to 2010 (625 schools), with services now available at 28% of all schools eligible for a sealant program.
- During the 2009-2010 school year, 59,000 children in high need areas throughout NYS were provided oral health services through school-based dental health clinic programs, with 36.2% receiving protective sealants.

- The prevalence of dental sealants among 3rd grade children continues to increase. Based on provisional data, over 40% of children screened in the third grade survey in upstate NY schools (excluding NYC) during the 2009-2010 school year had sealants, compared to 38% in the 2002-2004 survey. A stratified analysis by income showed that sealants increased from 42.5% to 47.8% and 28.9% to 36.4% among high income and low income groups respectively.
- Between 2007 and 2009, the number of Medicaid-eligible children aged 5-to-9-years-old, when sealants are most frequently applied, increased by 4.4%. During the same time period, the number of sealant claims increased by 11.8%. This data indicates that either more children are having sealants applied or that some children may be receiving more than one sealant application.

Table 4a - National Performance Measure 9 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. School-based dental health clinics provided services at 625 schools | X | | X | |
| 2. Oral health services were provided to 59,000 children in high need areas throughout NYS through school-based dental health clinic programs. | X | | X | |
| 3. Contracts to provide school-based dental services at high need schools throughout NYS continued. | | | X | X |
| 4. Information on finding a dental provider was updated on the public website. (http://www.nyssmiles.org/) | | X | | |
| 5. The 3 rd grade oral health surveillance project at upstate NY elementary schools continued. | | | X | X |

b. Current Activities

- Oral health preventive services, including the application of sealants, continue to be provided to eligible students at 625 schools in high need areas across NYS.
- According to NYS Education Law §903, public schools are to ask for a Dental Health Certificate for students, at the time of school entry and in grades Kindergarten, 2, 4, 7, and 10 declaring their dental health condition. While medical certificates are required for students, this new law also encourages students to obtain dental health certificates and is an important step in bringing awareness to the importance of oral health. A pilot project to determine the effectiveness of the Dental Health Certificate in increasing access to dental care for students entering grades Kindergarten, 2, and 4 is presently underway. The Dental Health Program continues to update information on finding dental providers on the public website (<http://www.nyssmiles.org/>).
- The 3rd grade oral health surveillance project is continuing at upstate elementary schools and plans are being finalized to initiate the project in NYC schools.
- Forty-one (41) applications have been received in response to a Request for Applications for school-based dental sealant programs issued in early 2011.
- Applications for school-based dental health clinics in high risk, underserved areas of NYS are under review; up to 30 projects will be funded.

c. Plans for the Coming Year

- New contracts will be executed for school-based dental health clinics and sealant programs. Training for new contractors will be held.
- An evaluation study on the effectiveness of the Dental Health Certificate in increasing access to dental services will be conducted; the study will utilize the results from the pilot project to determine the effectiveness of the certificate in increasing access to dental care for students entering grades Kindergarten, 2, and 4.

National Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|---------------|---------------|---------------|---------------|---------------|
| Annual Performance Objective | 1.1 | 1 | 0.9 | 1.3 | 1.2 |
| Annual Indicator | 1.3 | 1.3 | 1.2 | 1.0 | 1.0 |
| Numerator | 50 | 48 | 43 | 37 | 37 |
| Denominator | 3,916,635 | 3,597,289 | 3,604,140 | 3,633,448 | 3,633,448 |
| Data Source | Vital Records | Vital Records | Vital Records | Vital Records | Vital Records |
| Is the Data Provisional or Final? | | | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 1 | 1 | 1 | 1 | 1 |

Notes 2010

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. 2009 data are used as a proxy for 2010. 2010 data will be available in May 2012.

a. Last Year's Accomplishments

- Childhood Injury Prevention Projects have sustained successful coalitions for injury prevention at the local level, reaching out to diverse segments of the community to ensure that the populace is well informed on issues related to childhood injury prevention.
- The Bureau of Injury Prevention (BIP) performed traffic-related research and conducts surveillance of passenger, bicycle and pedestrian safety in NYS.
- The BIP continued to represent DOH on the Governor's Traffic Safety Committee.
- The BIP completed development of toolkits and fact sheets for medical providers, researchers, educators and consumers to provide up-to-date data, best practices and evidence-informed programs to reduce unintentional injuries, including traffic-related injuries. The toolkits include child passenger safety, Shaken Baby Syndrome prevention, fire safety, falls prevention, and bicycle safety. The toolkits are available on the DOH website (<http://www.health.ny.gov>) and in hard copy upon request.

- Partnerships with other agencies and organizations with a focus on childhood injury prevention continued to thrive, promoting a coordinated message.
- A supplemental grant award received from the Centers for Disease Control and Prevention is supporting the development of a child injury prevention policy initiative. A Child Injury Prevention Policy Subgroup of the larger Injury Community Planning Group met to discuss and prioritize policy initiatives of importance to reduce the risk of injury in NYS families with children aged 0 to 19 years. A Child Injury Policy Plan was drafted including the relevant data, evidence-informed strategies, best practices, a prioritized list of policies, and a related timeline.
- The Emergency Medical Services for Children Project continued to compile data to assist providers in prevention activities and in further enhancing the pediatric trauma care system. 2005 NYS data show that motor vehicle crashes accounted for 19.8% of all pediatric trauma cases and are responsible for the largest percentage of all pediatric dead-on-arrival cases (about 35%).
- The Community Health Worker (CHWP), Medicaid Prenatal Care, and Medicaid Obstetrical and Maternal Services Programs all have extensive child safety components, which stress car seat use and other infant safety measures. Parents enrolled in CHWP are also given extensive information about childhood safety. Homes are assessed for hazards and workers model positive parenting skills and behaviors.
- American Indian Nations with CHWPs all have formalized car seat education components. Health clinics serving the Nations promoted vehicle safety during individual health education/risk reduction encounters. Last year, a vehicular accident provided the impetus for tribal members to place more emphasis on the management of alcohol/substance abuse, and the promotion of vehicle safety and risk reduction.
- Medicaid prenatal programs have an extensive health education agenda, including infant and child safety, use of safety seats, burn prevention and other causes of infant injuries.
- All school-based health centers provided screening for psychosocial and health risk assessment beginning with the initial visit. Additionally, age appropriate anticipatory guidance is provided in a typical encounter which includes student and family education about safety issues and injury prevention.
- DOH launched the Keeping NY Kids Alive program to expand and improve local multidisciplinary teams that review and prevent child deaths. In collaboration with the Office of Children and Family Services, the program is focusing on the increasing the number of county based child death review teams, expanding the number and scope of cases reviewed, standardizing data collection and submissions and enhancing local prevention measures and system improvements.

Table 4a - National Performance Measure 10 Summary

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Childhood Injury Prevention Projects have sustained successful coalitions for injury control at the local level, reaching out to diverse segments of the community to ensure that the populace is well informed on issues. | | | X | X |

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 2. The Bureau of Injury Prevention performed traffic related research and conducts surveillance of passenger, bicycle and pedestrian safety in NYS and represents DOH on the Governor's Traffic Safety Committee. | | | X | X |
| 3. The Emergency Medical Services for Children Project continued to compile data to assist providers in prevention activities and in further enhancing the pediatric trauma care system. Motor vehicle crashes account for 19.8% of all pediatric trauma cases. | | | X | X |
| 4. The Community Health Worker (CHW), Medicaid Prenatal Care, and Medicaid Obstetrical and Maternal Services Programs all have extensive child safety components, which stress car seat use and other infant safety measures. Parents enrolled in CHWPs are given extensive safety information. | | X | X | X |
| 5. American Indian Nations with CHWPs all have formalized car seat education components. Other reservation clinics promote vehicle safety during individual health education/risk reduction encounters. | | X | X | X |
| 6. All school-based health centers provided screening for psychosocial issues and complete health risk assessment beginning with the initial visit. Additionally, age appropriate anticipatory guidance is provided to students and families which included education about safety issues and injury prevention. | X | X | | |
| 7. DOH launched the Keeping NY Kids Alive program which will expand and improve local multidisciplinary teams that review and prevent child deaths, was launched. | | | X | X |

b. Current Activities

- The Bureau of Injury Prevention is promoting toolkits and fact sheets to provide up-to-date data, best practices and evidence-informed programs to reduce unintentional injuries, particularly those that are traffic-related, for medical providers, researchers, educators and consumers. The toolkits include child passenger safety, Shaken Baby Syndrome prevention, fire safety, falls prevention, and bicycle safety.
- Partnerships with other agencies and organizations with a focus on childhood injury prevention continue to thrive, promoting a coordinated message.
- A supplemental grant award from the Centers for Disease Control and Prevention is supporting the development of a child injury prevention policy initiative.
- Regional workshops on childhood injury prevention policies and tools for policy promotion were held throughout NYS during April and May 2011.
- A Child Injury Prevention Policy Subgroup of the larger Injury Community Planning Group meets to discuss implementation of the Child Injury Policy Plan.
- DOH periodically meets with the Office of Children & Family Services to foster collaboration and discuss ways to develop local child death review teams and improve child death.

c. Plans for the Coming Year

- The BIP will continue to conduct a Childhood Injury Prevention Campaign. Partners participating in the Child Injury Prevention Policy Subgroup will provide expertise and support in the implementation of the strategic plan.
- A one-day traffic safety symposium will be held to educate stakeholders about pedestrian safety. Relevant data and evidence-informed strategies and best practices will be shared with the participants.
- DOH will continue to collaborate with the Office of Children & Family Service to discuss ways to improve child death reviews and identify issues and opportunities to prevent these deaths from occurring in the future.

National Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|------------------------------|------------------------------|------------------------------|------------------------------|------------------------------|
| Annual Performance Objective | 40 | 43 | 51 | 44.5 | 45.5 |
| Annual Indicator | 50.0 | 50.0 | 49.4 | 47.4 | 47.4 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | National Immunization Survey | National Immunization Survey | National Immunization Survey | National Immunization Survey | National Immunization Survey |
| Are the Data Provisional or Final? | Final | Final | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 47.9 | 48.3 | 48.8 | 49.3 | 49.8 |

Notes 2010

2008 data has been finalized from previous submission. 2009 data is for 2007 birth cohort. 2009 data are used as a proxy for 2010 data. It is estimated that final 2010 data will be available from CDC in 2012.

a. Last Year’s Accomplishments

- The percentage of NYS mothers who breastfed their infants at 6 months (47.4%) was higher than the national percentage of 43%. NYS exceeds the HP 2020 baseline of 43.4% of mothers who breastfeed their infants at 6 months of age, but is still below the HP 2020 target of 60.5%
- The *Breastfeeding Mothers’ Bill of Rights* law which specifies the rights of pregnant women and new mothers prenatally, after delivery and upon discharge from the birthing facility was passed in 2010.
- Infant feeding data from hospitals (excluding NYC) was analyzed using the Statewide Perinatal Data System. Hospitals were ranked using three indicators (breastfeeding initiation, exclusive breastfeeding, and formula supplementation of breastfed infants), and

each was informed of its performance relative to other hospitals. The written breastfeeding policies and procedures, as specified in state regulation, were collected from all hospitals providing maternity care services in the state, and reviewed to determine compliance with the 32 components required by NYS regulations. Each hospital was informed about its individual compliance.

- In 2009, DOH surveyed all 138 hospitals that provide maternity services in NYS to collect information regarding patient education and support, obstetric staff education and training, and general breastfeeding policies. The study identified several differences in breastfeeding practices at hospitals providing maternity services. Recognition of these differences will be used to inform policy decisions and training opportunities for obstetric staff across NYS.
- NY-WIC (overseen by the Division of Nutrition's (DON) Bureau of Supplemental Food Programs) continues to support redesigned WIC food packages, which were implemented in January 2009. Extended food benefits are available to the breastfeeding mother for the first year of breastfeeding (instead of six months).
- The WIC contract includes requirements for local agencies to promote and support breastfeeding and participant-centered nutrition education as priority core services. These services include support from WIC staff members trained in lactation counseling and peer counseling services for pregnant women and new mothers. Other support services include the availability of breast pumps for breastfeeding mothers who are returning to work/school or have other special needs and the www.breastfeedingpartners.org website which provides information and resources for peer counselors and breastfeeding mothers.
- NY- WIC received a performance award of \$1.6 million from the USDA to recognize its high rate of breastfeeding initiation. About 74% of WIC mothers initiated breastfeeding, compared to the national rate of 62% and 39 % breastfeed for at least six months, compared to 27% for the US. A statewide media campaign was funded, targeted to low income communities, to increase awareness and support of breastfeeding. A six-week breastfeeding campaign, "*Breastfeeding...For My Baby. For Me.*", featuring advertising via television, internet, bus shelters and bus interiors resulted in over 2000 hits per week on the website page and nearly 30,000 hits for the TV ads placed on YouTube, 375 ads posted in bus shelters and 2285 ads in bus interiors. A survey of WIC participants found 43% of those who saw at least one ad came into WIC because of the ad. A Toolkit on Partnering with WIC for Breastfeeding Success, containing breastfeeding resources including how to create a breastfeeding-friendly practice, was developed for health care providers/hospitals to encourage and support breastfeeding.
- Medicaid Prenatal Care standards, revised in 2010, require providers to counsel and educate woman during prenatal visits and immediately postpartum regarding infant feeding choices, and should support breastfeeding by counseling the patient regarding the nutritional advantages of human breast milk and should provide her with information regarding the benefits of breast feeding for both the mother and infant.
- The CHWP provided home visiting services to high risk pregnant and parenting families. For the 2009-10 program year, 47% of CHWP mothers breast-fed at six months.
- CPPSNs promote breastfeeding in a variety of ways including working with local WIC programs to promote breastfeeding through PSAs, distributing information on the benefits of breastfeeding to community residents, promoting the "business case" for breastfeeding to local businesses, working with other agencies to support breastfeeding, and providing referrals to certified breastfeeding specialists.

Table 4a - National Performance Measure 11 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. NYS enacted the <i>Breastfeeding Mothers' Bill of Rights</i> law which requires pregnant women and new mothers to be informed about the benefits of breastfeeding and obtain specific supports from health care providers and health care facilities on May 1, 2010. | | | X | |
| 2. Using data from the Statewide Perinatal Data System, hospitals were ranked by quintile scores on three breastfeeding indicators (breastfeeding initiation, exclusive breastfeeding, and formula supplementation of breastfed infants). Each hospital was informed of its performance relative to other hospitals. | | | | X |
| 3. WIC continued to support the redesigned WIC food packages which were implemented in January 2009, following DOH goals and the American Academy of Pediatrics recommendation that breastfeeding continue for 1 year and beyond. | | | X | X |
| 4. WIC continued to develop and implement strategies to enhance breastfeeding support and participant centered nutrition education, which are WIC priority core services. | | | X | |
| 5. DOH and Regional Perinatal Centers began offering the <i>Ten Steps to Successful Breastfeeding Online Course</i> (18-hour course) to staff in 125 obstetrical hospitals across NYS. | | | X | |
| 6. For the Breastfeeding Quality Improvement in Hospitals Learning Collaborative with the National Institute for Children's Health Care Quality (NICHQ), DOH recruited 12 hospitals and NYC Department of Health and Mental Hygiene (DOHMH) recruited 8 hospitals to develop a culture within the hospital to promote exclusive breastfeeding. | | | X | X |
| 7. The <i>Breastfeeding Mothers' Bill of Rights</i> was posted on the DOH website in 6 languages. | | | X | |
| 8. A collaborative effort among DOH Divisions and Offices and the NYC DOHMH began to educate and implement baby friendly policies and practices, link women with home visiting programs, and assist with support for breastfeeding. | | | X | X |

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 9. The Partnering with WIC for Breastfeeding Success Toolkit was developed for health care providers/hospitals to support families in their breastfeeding efforts. This toolkit, developed for health care providers/hospitals to support families in their breastfeeding efforts, contains breastfeeding resources, including how to create a breastfeeding-friendly practice. | | | X | |
| 10. The Child and Adult Care Food Program successfully implemented a Breastfeeding Friendly Initiative. In its first year of implementation, 80 child care centers and 128 day care homes were designated as “Breastfeeding Friendly.” | | | X | X |

b. Current Activities

- DOH and Regional Perinatal Centers offer the 18-hour *Ten Steps to Successful Breastfeeding Online Course* to staff in 125 obstetrical hospitals in NYS.
- DOH is recruiting 12 hospitals located outside NYC for the Breastfeeding Quality Improvement in Hospitals Learning Collaborative, a joint initiative with the NICHQ. The NYC DOHMH is recruiting 8 hospitals in NYC for a similar initiative. The goal is to recruit teams from the hospitals to develop a culture to promote exclusive breastfeeding.
- The *Breastfeeding Mothers’ Bill of Rights* was posted on the DOH website in six languages.
- WIC agencies receive technical assistance and ongoing training to ensure quality breastfeeding promotion and support services. The DON continues to invest substantially in breastfeeding promotion and has allocated over \$5 million in contracts for Breastfeeding Peer Counselor Programs.
- The return to work project to support WIC breastfeeding mothers and their employers when breastfeeding mothers return to work/school is being planned and implemented.
- CHWs receive training and on-going education on topics appropriate to the needs of at-risk pregnant and parenting women and their families, including breastfeeding. Activities include client education early in their pregnancies about the benefits of breastfeeding, encourage meeting with a lactation consultant in order to learn techniques, and ongoing support after birth.
- CPPSNs continue to promote and support breastfeeding.

c. Plans for the Coming Year

- Collaboration will continue among DOH’s DFH, including the Office of the Medical Director, and the Bureau of Maternal and Child Health, the Division of Nutrition, the Division of Chronic Disease and Injury Prevention, and the NYC DOHMH to educate providers, assist hospitals with the implementation of baby friendly policies and practices, and to link women with home visiting programs during the perinatal period to educate and assist with support for breastfeeding.
- Through the *Communities Putting Prevention to Work* grant, DOH aims to further improve hospital policies and practices, promote hospital compliance with NYS regulations and laws,

and increase staff skills and knowledge. This includes supporting the training for hospital staff to become Certified Lactation Counselors, and training WIC staff to increase their knowledge and skills in supporting and educating mothers of their rights. Website resources will be developed for women, health care providers and employers to increase their access to current information and resources on breastfeeding, and in particular, providing support for nursing women in the workplace.

- The Maternity Information Leaflet, required by state law, provides patients information on maternity-related procedures performed at each hospital. The law has now been expanded to also require that information on infant feeding practices at each hospital (breastfeeding initiation, exclusive breastfeeding, and formula supplementation of breast-fed infants) be included in this publication.
- WIC continues to fund and require a Breastfeeding Coordinator who has completed the 40-hour lactation course (CLC/Certified Lactation Counselor), in addition to peer counselors, be available at all WIC clinics to provide breastfeeding education and lactation support. WIC offers CLC training to local WIC staff statewide.

National Performance Measure 12: *The percentage of newborns who have been screened for hearing before hospital discharge.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-----------------------------------|-----------------------------------|-----------------------------------|
| Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 97.9 | 98.5 | 98.7 | 99.1 | 99.1 |
| Numerator | 242,212 | 247,960 | 244,630 | 244,545 | 244,545 |
| Denominator | 247,352 | 251,760 | 247,928 | 246,647 | 246,647 |
| Data Source | | | Newborn Hearing Screening Program | Newborn Hearing Screening Program | Newborn Hearing Screening Program |
| Is the Data Provisional or Final? | | | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

Notes 2010

2009 data are used as a proxy for 2010 data. 2010 data will be available in late 2011.

a. Last Year's Accomplishments

- The percentage of NYS newborns screened for hearing before hospital discharge (99.1%) far exceeds both Healthy People 2020 baseline (82%) and target (90.2%) indicators for screening at age no later than age 1 month.
- DOH received grant funding from HRSA to expand and improve the Universal Newborn Hearing Screening and Intervention Program to assure quality developmental outcomes for infants identified with hearing loss. Letters were sent to all 140 birthing facilities in NYS, comparing individual hospital performance to statewide performance and the Joint

Committee on Infant Hearing benchmarks. Six hospitals were required to submit corrective action plans to DOH. Staff completed a review of the policies and procedures submitted by these hospitals and, in some cases, conducted follow up conference calls or visits to the hospitals.

- DOH received the third year of three years of funding from the Centers for Disease Control and Prevention for the Early Hearing Detection and Intervention Tracking, Surveillance, and Integration project. Through this project, DOH is improving its mandated Universal Newborn Hearing Screening and Intervention Program by linking existing child health data systems within the Department to better track individual level screening and audiologic data and referral information.

Table 4a - National Performance Measure 12 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. DOH received grant funding from HRSA to expand and improved the Universal Newborn Hearing Screening and Intervention program to assure quality developmental outcomes for infants identified with hearing loss. | | | X | |
| 2. Existing child health data systems within DOH are being linked to better track individual level screening and audiologic data and referral information. | | | | X |

b. Current Activities

- State legislation was enacted on January 11, 2011 which requires hospitals and other health care providers that perform or order newborn infant hearing screenings to report results through a statewide information system; authorizes the collection and storage of newborn infant hearing screening results and data in a statewide information system; and authorizes access to such data in order to increase newborn infant hearing screening rates and improve the completeness and accuracy of newborn infant hearing screening data. DOH was previously authorized to collect, and all birthing facilities are required to provide, aggregate data on newborn hearing screening results each quarter for all infants born in NYS. The collection of aggregate data significantly impacted DOH’s ability to follow up on infants who potentially have a hearing loss.
- DOH is actively involved in the implementation of the new legislation. The work to design requirements for the data systems for submission of data and storage in DOH’s child information system is underway. The Statewide Perinatal Data System, NY's (outside of NYC) Web application for capturing birth certificate information, was recently enhanced to capture information on individual level newborn hearing screenings performed prior to discharge, including date, equipment used, and results for each ear if performed, and reason if not performed.

c. Plans for the Coming Year

- DOH will continue to be actively involved in implementing the legislation over the coming year. The work to design requirements for the data systems for submission of data, and storage in the Department’s child information system will continue.

- DOH is preparing a Notice of Proposed Rulemaking seeking to change regulations for the Newborn Hearing Screening and Intervention Program for the first time since regulations were adopted in 2000. These revised regulations will include changes needed to collect individual level data and other corrections, which have been learned over the last decade of working closely with hospitals to improve screening performance to support improved practices by facilities, to support improved practices by facilities.

National Performance Measure 13: *Percent of children without health insurance.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------------------------------|-------------------------------------|-------------------------------------|
| Annual Performance Objective | | | 8 | 8.5 | 8.5 |
| Annual Indicator | | | 7.1 | 7.5 | 7.5 |
| Numerator | | | 310,000 | 335,000 | 335,000 |
| Denominator | | | 4,373,000 | 4,465,000 | 4,465,000 |
| Data Source | | | US Census Current Population Survey | US Census Current Population Survey | US Census Current Population Survey |
| Is the Data Provisional or Final? | | | Final | Final | Provisional |
| | 2011 | 2012 | 2012 | 2014 | 2015 |
| Annual Performance Objective | 7.4 | 7.4 | 7.3 | 7.2 | 7.1 |

Notes 2010

2009 data are used as a proxy for 2010 data. It is estimated that 2010 data will be available by the end of 2011.

a. Last Year's Accomplishments

- The percentage of NYS children without health insurance (7.5%) is 25% lower than that of the nation (10%). The National Survey of Children's Health states that 22.8% of NYS children are inadequately insured as compared to 23.5% nationally.
- NYS has made significant progress in providing access to health insurance for all uninsured children and teens. All uninsured children and teens are eligible for comprehensive and affordable health insurance through either Medicaid (MA) or Child Health Plus (CHPlus). Currently, approximately 86% of NYS's uninsured children are eligible for subsidized coverage. Families of the remaining children are able to purchase insurance at full premium cost through the CHPlus program.
- In 2008, NYS expanded CHPlus up to 400% FPL with state only dollars. In 2009, NYS received federal approval for this expansion. This approval provided federal matching funds retroactive to September 2008, and included two new exceptions to the six month waiting period for those children between 250% and 400% FPL whose families dropped their employer-based coverage. These exceptions are as follows: the child is age five or under and the child's portion of the family's employer based health insurance premium is more than 5% of the gross household income.

- In calendar year 2009, the number of uninsured children under age 19 in NYS increased slightly, from an estimated 343,000 in 2008 to 367,000 in 2009. However, this remains a significant decrease from 2007 when approximately 434,000 children were uninsured.
- NYS has witnessed a steady increase in children's enrollment in MA and CHPlus since January 2008. Enrollment of children in MA and CHPlus grew by 151,000 children between January 2008 and September 2009 (most recent data available for combined enrollment). More than 102,000 of these children have been enrolled since the expansion in September 2008.
- NYS now provides health care coverage to 2.1 million children. Slightly more than 1.7 million children are covered by MA and another 390,000 by CHPlus. This represents more than 40% of NYS's children.
- In 2010, MA coverage was extended to all 18 to 20 year olds leaving foster care until their 21st birthday.
- Effective November 1, 2009, CHPlus coverage limitations were removed for inpatient and outpatient mental health and substance abuse services, providing for greater access and parity with other medical benefits.
- With passage of Chapter 484 of the laws of 2009, Section 365-k of the Social Services Law was revised to require all facilities licensed under Article 28 of the Public Health Law that provide prenatal care services to perform presumptive eligibility determinations and assist women in submitting appropriate documentation to the local social services district.
- NYS further simplified the application process for public health insurance by eliminating the face-to-face interview requirement for MA on April 1, 2010. To reflect the elimination of the face-to-face requirement, NY revised the ACCESS NY Health Care Application, the application used for CHPlus, MA, and Family Health Plus (FHPlus). NYS also launched a web-based eligibility screening tool and "fill and print" application. These tools allow consumers to determine which program they may be eligible for, refer them for application assistance, and/or guide them through completing and determining where to submit an application.
- Facilitated enrollers (FEs) provide application assistance to those who are seeking MA or CHPlus and account for over 430,000 applications submitted annually. FEs provide assistance to applicants in 60 languages. Currently, 41 community-based organizations and 15 health plans serve as FEs.
- Many Comprehensive Prenatal/Perinatal Services Networks are FEs for health insurance programs.
- Children with special health care needs (CSHCN) who do not have a source of insurance are assisted by the CSHCN Program to enroll in an insurance program.
- The Community Health Worker Program assists any child or member of an enrolled family to access health insurance and tracks success rates.
- NYS partnered with community-based organizations, faith groups and health and human service providers to launch a statewide outreach campaign, "Connections to Coverage," to promote the availability of public health insurance coverage for all uninsured children and eligible adults and to link families with uninsured children to facilitated enrollment in their communities.

Table 4a -National Performance Measure 13 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Infants aged 0-1 are eligible for Medicaid (MA) if their household incomes are at or below 200% of the Federal Poverty Level (FPL). All infants born to women enrolled in MA are MA-eligible until the end of the month of their first birthday. | | | X | X |
| 2. Children aged 1 through 5 years of age are eligible for MA if their household incomes are at or below 133% of the FPL for twelve months of continuous coverage, even if their household income exceeded eligibility levels during that year. Children aged 6 through 18 are eligible for MA at 100% of the FPL. | | | X | X |
| 3. Families with household incomes at or below 400% of the FPL are eligible for free or subsidized Child Health Plus (CHPlus), NYS’s CHIP. Families over 400% of FPL are eligible for participation at full premium. | | | X | X |
| 4. Facilitated enrollers are available statewide to assist families with public insurance enrollment processes. All MCHSBG-funded programs are required to facilitate enrollment in insurance programs. | | X | X | X |
| 5. Many Comprehensive Prenatal/Perinatal Services Networks are facilitated enrollers for health insurance programs. | | | X | X |
| 6. Children with special health care needs who do not have a source of insurance are assisted by the Children with Special Health Care Needs Program to enroll in an insurance program. | | X | X | X |
| 7. The Community Health Worker Program assists any child or member of an enrolled family to access health insurance. | | X | | |
| 8. The insurance status for all students enrolled in school-based health centers is determined as part of the initial enrollment process. A facilitated enroller works with students/parents/guardians with no insurance to connect them to CHPlus and MA. | | X | | X |

b. Current Activities

- Local children with Special Health Care Needs programs in 55 localities link uninsured children to insurance. Program staff follows up with families who receive information and referral to determine if they obtain insurance coverage for their children.
- School-based health clinics address health system gaps by eliminating barriers that may prevent youth from receiving needed health care. Youth without insurance are connected to FEs.
- The Community Health Worker Program assists any child or member of an enrolled family to access health insurance.
- NY simplified documentation requirements for Medicaid (MA), Child Health Plus (CHPlus), and Family Health Plus (FHPlus) by implementing a data file match process with the Social

Security Administration (SSA) to verify U.S. citizenship status, identity and age. Applicants who include their Social Security Number on the application do not have to document their citizenship, identity and birth date. The SSA data match is used to electronically verify this information.

- The CHPlus renewal application was translated into Chinese and Spanish and distributed to health plans and community-based FE organizations.
- The NYS Enrollment Center (EC) will begin processing MA renewals for populations outside NYC who can attest to their income at renewal in 2011. The EC will process mail-in and telephone renewals and run a consolidated call center for MA, CHPlus and FHPlus programs.

c. Plans for the Coming Year

- In late 2011, MA program coverage will be expanded for children aged 6 to 18 to 133% of the Federal Poverty Level. The Children’s Health Insurance Program Reauthorization Act allows states to rely on findings from an Express Lane agency to conduct simplified eligibility determinations and facilitate enrollment into MA and Children’s Health Insurance Programs. NYS plans to use the authority under Express Lane Eligibility (ELE) to seamlessly transition children and teens moving between MA and CHPlus at renewal at the time the MA expansion takes effect. NYS included a provision in the 2010-2011 Enacted Budget to allow the use of ELE at application and renewal to enroll uninsured children into public health insurance.
- NYS will enhance consumer application assistance tools launched in February 2011 and develop a Spanish version of the ACCESS NY Public Health Insurance Eligibility Screening Tool.
- The “Connections to Coverage” campaign, created to increase awareness of public health insurance, will continue to partner with community-based organizations, faith groups, schools, health and human service providers and others across the state to link uninsured children and families to facilitated enrollment in their communities.
- MCHSBG-funded programs will continue to facilitate public insurance enrollment to increase the number of children with coverage.
- In 2011, the Family Health Plus program will be expanded to cover parents and young adults aged 19 to 20 whose household incomes are up to 160% of the FPL. This expansion will have the largest impact on 19-to-20-year-olds living on their own; this age group is more likely to lack health insurance coverage than other age groups.

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

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 32 | 31 | 30 | 29 | 30 |
| Annual Indicator | 32.0 | 32.0 | 32.0 | 31.8 | 31.8 |
| Numerator | 63,874 | 63,373 | 67,108 | 71,274 | 71,274 |
| Denominator | 199,608 | 198,041 | 209,713 | 224,130 | 224,130 |
| Data Source | | | PedNSS | PedNSS | PedNSS |
| Is the Data Provisional or Final | Final | Final | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 31.5 | 31.2 | 30.8 | 30.5 | 30.2 |

Notes 2010

Data source is the Pediatric Nutrition Survey (PedNSS). 2009 data are used as a proxy for 2010 data. 2010 data will be available in early 2012.

a. Last Year's Accomplishments

- The NY Women's, Infants and Children Program (WIC) continued supporting the new WIC food package. In 2010, soy beverages and whole grain tortillas were added to the acceptable foods list. WIC allowed participants to "pay the difference" between the total value of their vegetables and fruits (V/F) purchases and their WIC V/F checks. V/F check monthly value increased to \$10 from \$8 for women. WIC fully implemented the option allowing farmers to accept WIC V/F checks.
- Breastfeeding (BF) has been identified as a core strategy for obesity prevention. WIC funded its successful BF Peer Counselor Program statewide in all 94 local agencies. The DOH BF Workgroup continued to focus on support for BF in hospitals and worksites. Hospital specific BF data monitoring began. NYS Department of Labor worksite guidelines for BF support were distributed to over 500 individuals including worksite contractors. Webinars and trainings sponsored by WIC and the WIC Training Center were provided to contractors to enhance BF knowledge and rates. The Child and Adult Care Food Program (CACFP) successfully implemented a BF Friendly Initiative. In its first year of implementation, 80 child care centers and 128 day care homes were designated as "BF Friendly."
- In March 2010, WIC received a \$1.6 million United States Department of Agriculture performance award for its high BF initiation rate. The award funded a statewide public media campaign, targeted to low income communities, to increase public awareness and support of BF women. The Partnering with WIC for BF Success Toolkit was developed for health care providers/hospitals to support families in their BF efforts. (See NPM #11)
- CACFP continued to implement its new Healthy Child Meal Patterns; a total of 9,200 family day care homes and 4,700 day care centers serving 330,000 children implemented these new meal patterns.
- CACFP continued to implement the Eat Well Play Hard in Child Care Settings (EWPHCCS) intervention in 274 low-income CACFP-participating centers last year to improve the

nutrition and physical activity behaviors of pre-school age children, and their parents/caregivers and influence food and activity practices in child care settings. EWPHCCS nutritionists reached 16,430 pre-school age children, family members, and center staff. EWPHCCS was selected as one of four USDA SNAP-Ed Projects to participate in a FFY 2010 Demonstration Project in Models of SNAP-Ed and Evaluation. The grant funded an external research organization to conduct an external outcome and process evaluation of the program, and to evaluate the DOH outcome evaluation of EWPHCCS. The NYS and external program evaluations have been completed with final results projected to be released in May 2011.

- The Obesity Prevention Program (OPP) coordinated implementation of the Nutrition and Physical Activity Assessment for Child Care (NAP SACC) intervention in 20 counties. NAP SACC activities were accomplished through a variety of contractors including the Early Care and Learning Council, Eat Well Play Hard (EWPH) Community Projects, and EWPHCCS participating child care centers. The NAP SACC intervention was implemented in 60 child care centers representing 1026 center staff and 4991 children. In the 55 centers completing the intervention, 870 staff was trained and 4232 children were reached.
- From 2006-10, EWPH Community Projects facilitated the implementation of 681 environmental and systems changes in targeted settings across 22 counties. Examples included: assisting school and district wellness committees to implement policies supporting healthy snacks, consistent food standards across the school campus, and increasing physical activity opportunities; increasing the number of schools and day care centers switching to low-fat milk and incorporating other healthier menu options; and starting farmers' markets in low-income communities.
- WIC developed and shared the Healthy Lifestyles Promotion Toolkit and policy with WIC local agencies to promote healthy lifestyles through developing and implementing effective and meaningful activities for participants, their families and WIC staff.
- WIC launched a new program logo and the New Look of WIC Toolkit. The new logo is used on the DOH website and all newly developed WIC materials. The toolkit guides staff through implementation of WIC core services and is a resource to ensure the agency is meeting the needs of WIC families.

Table 4a - National Performance Measure 14 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The NY-WIC Program continued to support the new WIC food package per the interim rule implemented in January 2009 which includes fruits and vegetables, whole grain cereals and breads, brown rice, tofu, canned and dried beans, reduced juice amounts, and low-fat milk for all participants over the age of two years. | | | X | |
| 2. DOH implemented Healthy Child Meal Patterns for child care centers and day care homes participating in the Child and Adult Care Food Program, affecting more than 9,200 family day care homes and 4,700 day care centers serving 330,000 New Yorkers. | | | X | |

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 3. DOH continued implementation of the Eat Well Play Hard in Child Care Settings intervention, designed to improve the nutrition and physical activity behaviors of pre-school age children and influence food and activity practices in child care settings. | | X | X | |
| 4. The DOH Obesity Prevention Program (OPP) coordinated the implementation of the Nutrition and Physical Activity Assessment for Child Care intervention in 20 counties in the state. | | X | | X |
| 5. The Eat Well Play Hard Community Projects facilitated the implementation of more than 475 environmental and systems changes in targeted settings across 22 counties in NYS. | | | | X |
| 6. The OPP continued work on interventions to increase the consumption of fruits and vegetables; decrease the consumption of sugar-sweetened beverages; and promote physical activity through environmental and policy changes. | | | X | |
| 7. Childhood obesity prevention activities continued to be implemented to prevent obesity through sustainable policy, systems and environmental changes in communities. | | X | X | X |

b. Current Activities

- PedNSS data continues to be collected and analyzed. The OPP conducts surveillance and evaluation on key risk factors for obesity. Collection of BMI on Kindergarten, school and high-school age children in selected school districts continues.
- WIC is enhancing current efforts to reduce obesity by supporting local agency core services and ongoing staff training in: BF Peer Counselor Programs, Participant-Centered Nutrition Education, Facilitated Group Discussions and Healthy Lifestyles. WIC has declared September 2011 Celebrate Healthy Lifestyles Month. Local agencies are encouraged to celebrate with healthy lifestyle activities using the Fit WIC Resource Book and Healthy Lifestyle Promotion Toolkit.
- CACFP continues to train participating child care centers and homes on the new Healthy Child Meal Pattern, and plans to expand EWPHCCS to 235 more child care centers.
- The Hunger Prevention and Nutrition Assistance Program is expanding access to fresh produce, low-fat milk, lean meats and whole grains for families accessing emergency food services.
- The OPP continues working with partners to establish BF policy and environmental supports; focus on local and state-level interventions to increase intakes of fruits and vegetables, decrease intakes of sugar-sweetened beverages and high energy dense foods; and promote physical activity through environmental and policy changes.

c. Plans for the Coming Year

- Childhood obesity prevention activities will continue to be implemented through numerous avenues including: child nutrition programming; statewide coalitions; community-based

contracts; statewide and local policy efforts; partnerships with health care and collaboration with state and federal partners. Plans for the coming year include:

- Strengthen policies and environments that promote and support breastfeeding.
- Increase screening and early recognition of overweight and obesity by pediatric healthcare providers.
- Provide local, county and statewide estimates of the prevalence of childhood obesity.
- Target resources to populations most at risk for childhood obesity.
- Identify best practices and promising interventions in child care, schools and communities to help prevent and reduce childhood obesity.
- Implement Creating Healthy Places grants in 22 targeted communities. The grantees are laying the groundwork, together with their community partners, for sustainable implementation of their four or more selected core activities. These activities will lead to outcomes that increase access to healthy physical activity and food options in targeted communities around New York State.
- Implement the Eat Well Play Hard in Child Care Settings in family day care homes to increase the number of Child and Adult Care Food Program (CACFP)-participating day care home providers who improve the nutrition and physical activity practices in their day care homes.
- Evaluating compliance with the Healthy Meal Pattern among CACFP-participating facilities. This data will be compared against menu observations before the Healthy Meal Pattern was implemented. CACFP will review Healthy Meal Pattern against the Institute of Medicine's (IOM) recently issued recommendations regarding the CACFP Meal Pattern (CACFP: Aligning Dietary Guidelines for All, IOM: 2010).
- Track WIC participants' consumption of vegetables, fruits and whole grains; TV and screen time; meal time TV; and milk consumption.
- Provide education, technical assistance and support in the development and advancement of legislation promoting access to healthier food and beverage options and increased opportunities for physical activity.
- Continue funding initiatives targeted to immigrants, including CHALK (Choosing Healthy & Active Lifestyles for Kids), a collaboration between NY Presbyterian Hospital/Columbia University Medical Center and a community coalition. This 5-year Center for Best Practices grant began in 2008. CHALK's goals are to reduce the prevalence of childhood obesity and its related morbidity in Northern Manhattan communities that are predominately Latino (Dominican majority) and 50% foreign-born and to promote a culture and create an environment in which healthy lifestyles are integral to the lives of children. CHALK is initially focusing on developing and disseminating a social marketing message that promotes healthy lifestyles while identifying barriers and resources to healthy living.

National Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy*

| | | | | | |
|---------------------------------------|------|------|-------|-------------|-------------|
| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 15 | 14 | 14 | 13 | 13 |
| Annual Indicator | 12.2 | 13.7 | 8.2 | 8.2 | 8.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | PRAMS | PRAMS | PRAMS |
| Is the Data Provisional or Final? | | | Final | Provisional | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 8.1 | 8 | 8 | 7.9 | 7.8 |

Notes 2010

Data source is the Pregnancy Risk Assessment and Monitoring Survey (PRAMS). Data reported for 2006 and 2007 were for NYS (excluding NYC). CDC recently provided statewide statistics for this indicator. Statewide 2006 and 2007 data are therefore now available. The comparable statewide percentages for 2006 and 2007 are 8.5% and 9.1% accordingly. 2008 data are used as a proxy for 2009 and 2010. 2009 data will be available in August 2011. In comparing data from the NYC and Upstate PRAMS surveys for 2008, women giving birth in upstate NY in 2008 were more likely to smoke during the last 3 months of pregnancy as compared to women residing in NYC (11.9% and 3.6% respectively).

a. Last Year's Accomplishments

- Efforts to reduce smoking in pregnant women are a part of DOH's multi-pronged efforts to reduce smoking in the general public. These efforts included a coordinated set of evidence-based activities implemented primarily by the tobacco control program, in partnership with other public health programs, including Title V programs, and other external partners:
 - Community Partnerships worked to change the community environment to support the tobacco free norm.
 - Youth Action partners worked with youth activists to change community norms and de-glamorize and de-normalize tobacco use.
 - Cessation Centers worked with health care organizations and providers to implement systems to screen patients for tobacco use and provide help.
 - Statewide media and counter marketing educated New Yorkers about the health risks of tobacco use and the dangers of second hand smoke, motivating tobacco users to stop, and promoting use of the NYS Smokers' Quitline and Quitsite (1-866-NY-QUITS, www.nysmokefree.com). New and existing educational materials for pregnant women were disseminated.
 - Counter-marketing efforts sought to expose marketing practices of the tobacco industry, de-glamorize tobacco use, and build and sustain a tobacco-free norm.
- Medicaid prenatal care providers promoted healthy behaviors during pregnancy. Prenatal care providers provide information regarding the impact of smoking on the woman and the fetus and have developed various programs to deal with smoking, including individual

counseling and referrals to group or other programs that support smoking cessation. Medicaid covers smoking cessation products and programs.

- All school-based health centers screened for tobacco use as part of the initial health assessment of all teenage student who enroll in them. Students (and in particular pregnant female students) who use tobacco are either referred to a tobacco cessation program within the community or receive such services directly from SBHC staff.
- The Comprehensive Prenatal-Perinatal Services Networks' priorities included developing and implementing programs to reduce the number of women who smoke or use other substances during pregnancy. Networks provided education and training to health and human services providers on ways to assist women to enhance healthy behaviors, including smoking cessation.
- The Community Health Worker Program provided education for pregnant and postpartum women to increase their understanding of behaviors that pose a risk to health, including the use of tobacco, and provision of appropriate referrals for those women seeking assistance in this area, including accompanying them to care, if necessary.
- Family Planning Programs screened for tobacco use and referred for smoking cessation.
- All Migrant and Seasonal Farm Worker Health programs and American Indian Health Program providers screened for tobacco use and made appropriate referrals.
- School-based dental health center staff screened all enrollees, including pregnant adolescents, for tobacco-use, provide counseling and make appropriate referrals.
- Local Women, Infants, and Children (WIC) agencies are required by policy to screen all prenatal, postpartum and breastfeeding participants regarding their use of tobacco.

Table 4a - National Performance Measure 15 Summary

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Prenatal care providers provided information on the impact of smoking on the woman and the fetus and developed programs to deal with smoking, including individual counseling and referrals to group or other programs that support smoking cessation. | | X | X | |
| 2. The Comprehensive Prenatal-Perinatal Services provided education and training to health and human services providers on ways to assist women to enhance healthy behaviors, including smoking cessation. | | | X | |
| 3. The Community Health Worker Program provided education for pregnant and postpartum women to increase their understanding of behaviors that pose a risk to health, including the use of tobacco, and provision of appropriate referrals. | | | X | |
| 4. Migrant and Seasonal Farm Worker Health programs and American Indian Health Program providers screened for tobacco use and made appropriate referrals. | X | X | X | |
| 5. School-based dental health center staff screened all enrollees, including pregnant adolescents, for tobacco-use, provided counseling and made appropriate referrals. | X | | | |

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 6. Local Women, Infants and Children (WIC) agencies are required by policy to screen all prenatal, postpartum and breastfeeding participants regarding their use of tobacco. | X | X | | |
| 7. Medicaid prenatal care providers promoted healthy behaviors during pregnancy by providing information regarding the impact of smoking on the woman and the fetus and developing various programs to deal with smoking. | | | X | |

b. Current Activities

- The multi-pronged activities described for the 2009-2010 year have continued.
- Tobacco Control Program contracts with an independent evaluator to evaluate programmatic efforts.
- Education and outreach activities to prenatal care providers on changes to Medicaid (MA) reimbursement for smoking counseling for pregnant women and broader changes to MA Prenatal Care Standards and Ambulatory patient Group (APG)-based reimbursement continue (see HSCI 04 and HSCI 05). Effective January 1, 2010, MA covers smoking cessation counseling for pregnant and postpartum women and adolescents to age 21. Smoking cessation counseling complements existing MA covered benefits for prescription and non-prescription smoking cessation products.

c. Plans for the Coming Year

- The multi-pronged activities described for the 2009-2010 and 2010-2011 years will continue.
- The promotion of the availability of Medicaid reimbursement to ensure that as many pregnant women as possible use tobacco receive counseling and associated services will continue.
- The Tobacco Control Program is planning a media campaign entitled “Premie” showing the effects of smoking on pregnancy.

National Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---------------------------------------|-------------|-------------|---------------|---------------|---------------|
| Annual Performance Objective | 4.1 | 4.1 | 4 | 3.8 | 3.8 |
| Annual Indicator | 3.7 | 3.9 | 3.3 | 4.2 | 4.2 |
| Numerator | 51 | 54 | 46 | 58 | 58 |
| Denominator | 1,385,081 | 1,396,874 | 1403050 | 1,366,144 | 1,366,144 |
| Data Source | | | Vital Records | Vital Records | Vital Records |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 4.2 | 4.1 | 4.1 | 4 | 4 |

Notes 2010

2009 data are used as a proxy for 2010 data. 2010 data will be available in May 2012.

a. Last Year's Accomplishments

- Bureau of Injury Prevention and the Public Health Information Group have suicide data available and are able to perform additional analyses for use in planning.
- The NYS Office of Mental Health (OMH) was given the lead in all suicide prevention activities in NYS. OMH continued to make available its prevention campaign. Title V programs have access to the campaign and associated materials.
- OMH funded community mental health services that include suicide prevention and crisis hotlines.
- Teen alcohol use is correlated with suicide attempts. The NYS Office of Alcohol and Substance Abuse Services continued to make available its campaign entitled "Underage drinking: Not a minor problem." The package includes fact sheets and resource directories. Title V programs have access to the campaign and associated materials.
- The School-Based Health Center (SBHC) Program includes an evaluation for suicide risk as a part of the initial health assessment and whenever indicated, crisis intervention visits. Mental health services, including crisis intervention, were available through the school-based health center or by referral. Referrals are also made for more intensive consultation or treatment. School staff, family members and other students are also offered consultation and education. Approximately 25% of SBHC visits indicated emotional problems as a primary reason for the visit.
- An OMH initiative continued to operate expanded school-based mental health services in five schools. This initiative provides a range of psychological support, education, consultation and treatment for students and families, co-located with a comprehensive school-based health center. School staff education and support was also an integral component of the model.
- DOH established MA reimbursement for mental health counseling to children and adolescents through age 20 provided by licensed clinical social workers and licensed Master's degree level social workers at hospitals and free standing clinics, including individual brief counseling, individual comprehensive counseling, and family counseling.
- Assets Coming Together (ACT) for Youth focuses community attention on asset-building activities for youth as a way of reducing risk-taking behaviors. Through these community collaborations, ACT for Youth has developed youth forums on violence abuse and risky sexual behaviors, as well as peer education materials, conflict resolution training to train peer mediators, and mentoring programs.
- NYS continued implementation of the Lesbian, Gay, Bisexual and Transgendered Health Initiative. Over half of the grantees under this initiative are focused on issues related to gay and lesbian youth and including alcohol, substance abuse and self-inflicted injuries. Data from other states indicate that gay, lesbian and bisexual youth are approximately four times more likely to attempt suicide than their heterosexual counterparts.
- The Sexual Violence Primary Prevention Committee (SVPPC), as part of a needs assessment being conducted, reviewed data associated with other forms of violence as risk factors for victimization or perpetration of sexual violence. Studies show that over one half of rapes and sexual assaults occur to women between the ages of 12 and 24. While it is difficult to document the true prevalence of sexual violence, studies indicate that one in six of adult females and 1 in 33 of adult males have been victims of rape or attempted rape. More than half of all rapes of females occurred among women younger than 18; 22% occurred among females younger than 12. In approximately 8 out of 10 cases (83%) the victim knew the

perpetrator. Victims of sexual violence are left with emotional scars such as fear, anger and anxiety which can lead to depression or suicide attempts. DOH continues to fund a statewide network of rape crisis programs for the provision of services to victims of rape and for the development and implementation of sexual violence primary prevention initiatives.

Table 4a - National Performance Measure 16 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Bureau of Injury Prevention and the Public Health Information Group make suicide data available and are able to perform additional analyses for use in planning. | | | X | X |
| 2. The Office of Mental Health (OMH) was given the lead in all suicide prevention activities in the state. OMH continued to make available their prevention campaign. Title V programs have access to the campaign and associated materials. | | | X | X |
| 3. Teen alcohol use is correlated with suicide attempts. The NYS Office of Alcohol and Substance Abuse Services continued to make available its campaign entitled, “Underage drinking: Not a minor problem.” | | | X | X |
| 4. OMH continued to operate an expanded school-based mental health initiative in five schools. This initiative co-located a comprehensive mental health services clinic with school-based health centers. | X | X | X | X |
| 5. Assets Coming Together (ACT) for Youth focused community attention on asset-building activities as a way of reducing risk-taking behaviors. Through these community collaborations, ACT for Youth has developed youth forums on violence/abuse. | | | X | X |
| 6. The School-Based Health Center Program includes an evaluation for suicide risk as a part of the initial health assessment and whenever indicated, crisis intervention visits. Mental health services were available through the school-based health centers or by referral. | X | X | | |
| 7. NYS continued implementation of the Lesbian, Gay, Bisexual and Transgendered Health Initiative. | | | X | X |
| 8. There is continued collaboration with the Bureau of Chronic Disease Prevention and Adult Health, Bureau of Injury Prevention, Office of Mental Health and Office of Children and Family Services. | | | X | X |
| 9. The Sexual Violence Primary Prevention Committee continued to work towards the ultimate goal of stopping sexual violence before it occurs. | | X | X | X |

b. Current Activities

- Programming as described in the “Accomplishments” section has continued.
- Addressing mental health issues for NYS’s adolescents continues to be a priority of Title V. Title V will continue to collaborate with partners in suicide prevention.
- The Bureau of Injury Prevention disseminated fact sheets targeted to medical providers, researchers, educators and consumers to provide up-to-date data, best practices and evidence-

informed programs to reduce self-inflicted injuries. The fact sheets are posted on the DOH website and available in hard copy upon request.

c. Plans for the Coming Year

- The Division of Family Health will continue to promote the mental health services in Title V programs and continue to collaborate with the Division of Chronic Disease and Injury Prevention, Bureau of Injury Prevention, Office of Mental Health, Office of Children and Family Service and other key stakeholders in activities to prevent adolescent suicide.
- The Sexual Violence Primary Prevention Committee will continue to work towards the ultimate goal of stopping sexual violence before it occurs. Potential activities to accomplish this include developing or partnering with existing mentoring programs or other skill-based activities that address healthy sexuality and dating relationships: addressing social and cultural influences; creating policies that address sexual harassment; and looking at existing social norms and developing messages that promote healthy attitudes toward women, masculinity, relationships, and sexuality.
- School-based health centers (SBHCs) will continue to screen for emotional and mental health issues as part of the initial health assessment conducted with all students who enroll in SBHCs. All SBHCs are required to address the mental health needs of student enrollees, either directly through licensed mental health staff within the SBHC, or through referrals with community-based providers of mental health services. Funding for the SBHC program initiative will be re-solicited during the coming year (for contracts starting July 1, 2012). As in the previous solicitation, screening for mental health needs, as well as the delivery of, or referral to, mental health services will remain a core component of SBHC services.

National Performance Measure 17: *The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|---------------|---------------|---------------|
| Annual Performance Objective | 91 | 92 | 92 | 94 | 94 |
| Annual Indicator | 88.6 | 89.7 | 90.0 | 90.6 | 90.6 |
| Numerator | 3,345 | 3,252 | 3,281 | 3,356 | 3,356 |
| Denominator | 3,774 | 3,627 | 3,646 | 3,704 | 3,704 |
| Data Source | | | Vital Records | Vital Records | Vital Records |
| Is the Data Provisional or Final? | Final | Final | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 91 | 91.3 | 91.7 | 92 | 92.4 |

Notes 2010

2009 data have been finalized since previous submission. 2009 data are used as a proxy for 2010. 2010 data will be available in May 2012.

a. Last Year's Accomplishments

- NYS already exceeds both the Healthy People 2020 baseline and target goals (75% and 82.5% respectively) for this indicator.

- NYS has been a national leader in the development of a statewide system of perinatal regionalization. All obstetrical hospitals have been designated by DOH as a Level I, II, III or Regional Perinatal Center (RPC) based on standard criteria included in state regulation. Regulations require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers and newborns.
- While RPCs and Level III hospitals accounted for 64.7% percent of all births in 2009, approximately 90% of all very low birth weight (VLBW) infants were delivered at RPC and Level III facilities. Conversely, less than 10% of VLBW infants were delivered at Level I and II hospitals, which accounted for approximately 35% of all newborn deliveries in the state in 2009. The trend towards delivery of high-risk newborns at appropriate level hospitals suggests the effectiveness of perinatal regionalization.
- The Statewide Perinatal Data System captures data on why VLBW infants were born at lower level hospitals; the majority of these births are due to unavoidable events, such as inability to transfer the woman to a higher level hospital due to advanced stage of labor.
- A range of public health initiatives including the system of perinatal regionalization; efforts to increase access to early and continuous prenatal care; community-based programs that target high-risk areas to identify and address gaps in needed services; and home visiting programs, such as the Nurse Family Partnership, Healthy Families New York and the Community Health Worker Program, have all been critical in achieving these improvements. DOH was also a successful applicant for the new federal Maternal and Infant Early Childhood Home Visiting (MIECHV) funds. These efforts have effectively combined medical and community-based interventions to improve perinatal outcomes in NYS.

Table 4a - National Performance Measure 17 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. DOH implemented a range of public health initiatives, including the system of perinatal regionalization, to increase access to early and continuous prenatal care, targeting high-risk areas to identify and address gaps in needed services and improve perinatal outcomes in NYS. | | X | | X |
| 2. Quality assurance visits were conducted to affiliate hospitals to improve perinatal quality and outcomes, including review of complex cases and whether cases should have been transferred to regional centers. | | X | | |
| 3. DOH staff continued to collaborate with the Regional Perinatal Centers, the National Initiative for Children's Healthcare Quality (NICHQ) and an external expert advisory group to implement interventions designed to improve perinatal outcomes. | | | | X |
| 4. The Division of Family Health continued to partner with the Office of Health Insurance Programs in implementation of Medicaid Prenatal Care and the Healthy Mom-Healthy Baby home visiting programs. | | | X | X |
| 5. DOH was a successful applicant for the new federal MIECHV funds. | | X | | X |

b. Current Activities

- Regional Planning Centers (RPC) remain the core component of the perinatal regionalization system. Affiliation agreements among hospitals guide maternal and infant consultation and transfers.
- RPC staff conducts quality assurance visits to affiliate hospitals and work with them to improve perinatal quality and outcomes, including review of complex cases and whether cases should have been transferred. RPCs also conduct educational programs on-site at affiliates and through grand rounds presentations on programs such as stabilization of VLBW and ELBW infants in preparation for transfer, to prepare affiliates for emergency cases.
- DOH has an oversight role to identify and address appropriateness of care issues that may occur, in ensuring moderate to high-risk pregnant women and newborns continue to receive care at the appropriate perinatal level, and that perinatal networks function properly with RPCs providing oversight of affiliates within their network.
- DOH is currently working with RPCs, the NICHQ and an external expert advisory group to develop and implement obstetric and neonatal interventions designed to improve specifically identified perinatal outcomes. In consultation with RPCs, DOH has begun implementation of an obstetric intervention to reduce scheduled near term deliveries (36-38 weeks) without medical indication.
- DOH is developing a state plan for the MIECHV funds based on a needs assessment process to identify high risk communities.

c. Plans for the Coming Year

- DOH staff will continue to work closely with the Regional Planning Centers (RPC) and affiliate hospitals to monitor and support effective use of the established system of perinatal regionalization
- DOH will continue to collaborate with the RPCs, the National Initiative for Children's Healthcare Quality and an external expert advisory group to implement selected obstetric and neonatal interventions designed to improve perinatal outcomes, including the current obstetric intervention to reduce scheduled deliveries prior to 39 weeks without medical indication.
- DOH will maintain efforts related to access to prenatal care services and community-based initiatives designed to identify and engage pregnant women in early and continuous prenatal care.
- The Division of Family Health will continue to partner with the Office of Health Insurance Programs to implement of Medicaid (MA) Prenatal Care and the Healthy Mom-Healthy Baby (HM-HB) home visiting programs. HM-HB programs will pilot the use of the Prenatal Care Risk Screening form for early identification and communication of risk status to MA managed care plans. These programs will also work to ensure the development of countywide systems of perinatal care and the assessment and referral of high-risk women to appropriate level of services.
- NYS's work in the Maternal and Infant Early Childhood Home Visiting (MIECHV) initiative will support further coordination of services, and maximization of resources to improve birth outcomes.
- The statewide Growing Up Healthy Hotline links women to needed services, with periodic public awareness media campaigns conducted to direct women to the hotline.

National Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|---------------|---------------|---------------|
| Annual Performance Objective | 77 | 78 | 79 | 80 | 81 |
| Annual Indicator | 74.6 | 73.8 | 72.3 | 73.3 | 73.3 |
| Numerator | 174,078 | 174,979 | 165,813 | 167,503 | 167,503 |
| Denominator | 233,441 | 236,903 | 229,467 | 228,517 | 228,517 |
| Data Source | | | Vital Records | Vital Records | Vital Records |
| Is the Data Provisional or Final? | Final | Final | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 74.0 | 74.8 | 75.5 | 16.2 | 77 |

Notes 2010

2009 data has been finalized since the previous submission. 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. 2009 data are used as a proxy for 2010 data. 2010 data will be available in May 2012. NYS is performing above the Healthy People 2020 baseline of 70.8% for this indicator.

a. Last Year's Accomplishments

- NYS's perinatal programs employ a comprehensive, multi-level strategy which integrates broad based systems approaches involving regional and local planning; one-on-one outreach and support through home visiting programs to assess and address the needs of residents in high risk communities; population-based education, media and informational resources; public health insurance and clinical practice standards; and, extensive surveillance work to support public health planning and clinical quality improvement efforts.
- The 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, and is used in media campaigns to promote early and continuous access to prenatal care and other services. In 2010, GUHH responded to 53,978 calls including 6,807 phone calls requesting referral and information related to pregnancy testing and/or prenatal care.
- The CPPSNs have local toll-free numbers, web sites, and resource directories to provide pregnant women with information and referral to prenatal care. CPPSNs identify gaps and barriers to the service system, and, in collaboration with the community stakeholders, work to increase accessibility and the quality of the local perinatal service system. Networks co-chair regional perinatal forums in collaboration with RPCs, which combine community-based and clinical perspectives to prioritize and address regional MCH issues such as access to prenatal care, breastfeeding and other priority MCH issues.
- MA prenatal care providers encouraged early enrollment in prenatal care and provided presumptive MA eligibility to ensure that women were able to begin prenatal care immediately pending determination of MA eligibility.

- A variety of public health strategies engaged high risk pregnant women in early prenatal care. These include: CHWP, NFP and Healthy Mom-Healthy Baby Prenatal and Postpartum Home Visiting Program, designed to establish a county system of perinatal health services. DOH is developing a state plan for new federal Maternal and Infant Early Childhood Home Visiting (MIECHV) funds, based on an extensive needs assessment process to identify communities with high rates of maternal, infant and child health risk indicators and the existing home visiting programs and supportive resources in those communities. All programs are targeted to communities with highest needs. NYS's work in the MIECHV will support further coordination of services, and maximization of resources to improve birth outcomes.
- The 3 NFP programs served 490 women.
- DOH continued to support 23 CHWPs statewide. CHWPs conduct outreach to engage pregnant women into prenatal care and ensure the family has access to other services. CHWs are indigenous to the communities they serve. The CHWP served 3,524 families, including 2,304 infants and 1,456 children. Of those women who were not already in prenatal care, 96% were assisted to obtain prenatal care within 1 month of entry to the program. Of the total number of pregnant women, 77% entered prenatal care in the first trimester, 18% in the second, and 3% in third.
- SBHCs provided pregnancy testing and reinforced the need for early prenatal care.
- Family Planning Programs made early referrals for women testing positive for pregnancy, thereby improving rates for early access to prenatal care in the populations served.
- The Community Action for Prenatal Care Program, a collaboration between Title V and the AIDS Institute, seeks to decrease negative birth outcomes, including perinatal HIV transmission, by conducting street outreach and referral to high risk communities to engage high risk, substance using pregnant women into prenatal care.
- The Title V Program collaborated with MA to develop updated prenatal standards for all pregnant women enrolled in MA. New legislation was enacted to address the impact of the APG payment methodology on MA reimbursement for prenatal care services; eliminate PCAP designation, certification, and associated rates; and, ensure a comprehensive quality model of care for all pregnant women in MA. The legislation also required that all MA-enrolled Article 28 prenatal care providers perform presumptive eligibility determinations and assist with completion of the full MA application and MA managed care plan selection. All prenatal care providers must provide prenatal care services to pregnant women determined presumptively eligible for MA but not yet enrolled.

Table 4a - National Performance Measure 18 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The GUHH, available 24/7, provided information and referral in multiple languages via the AT&T language line. The number is used in media campaigns to promote early and continuous access to prenatal care and other services. | | | X | |
| 2. The statewide DOH-supported CPPSNs have local toll-free numbers, web sites, and resource directories to provide pregnant women with information and referral to prenatal care. | | | X | |

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 3. Medicaid prenatal care providers encouraged early enrollment in prenatal care, and provided presumptive Medicaid eligibility to ensure that women were able to begin prenatal care immediately pending determination of Medicaid eligibility | X | | | |
| 4. Community Health Worker Programs conducted outreach to engage pregnant women into prenatal care and ensure family access to services. Community health workers are indigenous to the communities they serve and provide education, referrals and follow-up through home visits. | | X | X | |
| 5. School-based health centers provided pregnancy testing and reinforced the need for early prenatal care. Access is provided either on-site or through referral to the back-up facility. | X | | | |
| 6. The Family Planning Program made early referrals for women testing positive for pregnancy, thereby improving rates for early access to prenatal care in the populations served. | X | | | |
| 7. The Title V Program collaborated with Medicaid to develop updated prenatal standards for all pregnant women enrolled in Medicaid to ensure a comprehensive, high quality model of care for all pregnant women who qualify for Medicaid. | | X | | |
| 8. Through collaboration with the Office of Temporary and Disability Assistance, three certified NFP programs delivered home visiting services to pregnant women with incomes up to 200% FPL. The three NFP programs reached 490 women. | | X | | |
| 9. Outreach efforts conducted through the Community Health Worker Program and consumer awareness strategies implemented through the Comprehensive Prenatal-perinatal Service Network continued with a central focus on identifying and engaging women to seek early and continuous prenatal care. | | X | | |

b. Current Activities

- The updated Medicaid (MA) prenatal standards became effective in November 2009. Standards include evidence-based practices that integrate updated standards and guidance from ACOG and the AAP and reflect expert consensus on appropriate care for high-risk pregnant women. The Title V program continues to collaborate with OHIP to ensure that comprehensive prenatal care services are available to high risk populations.
- DOH continues to support the Growing Up Healthy Hotline.
- DOH continues to support the Comprehensive Prenatal-Perinatal Service Networks and Community Health Worker Program. An RFA for the next five-year funding cycle for these programs is being developed
- New state funding allowed DOH to support a Healthy Mother-Healthy Baby program in six counties with at least 50,000 females aged 15 to 44 years, high rates of low birth weight, adolescent pregnancy and births, and neonatal intensive care unit admissions for MA clients.

Six local health departments are funded to engage key stakeholders plan and implement countywide systems of care.

- Through collaboration with the Office of Temporary and Disability Assistance, funds to support the three certified Nurse Family Partnership programs in NYS to deliver home visiting services to pregnant women with incomes up to 200% FPL were allocated to DOH through an MOU.
- A targeted media campaign to promote early prenatal care and the availability of MA prenatal care services in high-risk communities will launch later this year.

c. Plans for the Coming Year

- DOH will continue to promote early entry to prenatal care through outreach and case finding strategies to identify high risk women early and ensure engagement in comprehensive, quality prenatal care. Outreach efforts conducted through the Community Health Worker Program and consumer awareness strategies implemented through the Comprehensive Prenatal-Perinatal Service Networks programs will continue with a central focus on identifying and engaging women to seek early and continuous prenatal care.
- DOH will continue to assist the Healthy Mother-Healthy Baby (HM-HB) contractors to establish county systems of perinatal health services targeting highest risk pregnant and postpartum women and infants. HM-HB will outreach to organizations serving women of childbearing age to identify pregnant women, particularly those not engaged in prenatal care. Home visits will be provided to screen women for eligibility for comprehensive home visiting programs, provide basic health education, and to make referrals to needed services. Families in need will have access to more intensive sustained home visiting services, where available.
- The Nurse Family Partnership initiative will continue to engage high risk first-time mothers early in pregnancy.
- DOH will begin implementing its state plan for new federal Maternal and Infant Early Childhood Home Visiting (MIECHV) funds. The plan is being developed during the current year based on an extensive needs assessment process to identify communities with high rates of maternal, infant and child health risk indicators and the existing home visiting programs and supportive resources in those communities. NYS's work in the MIECHV will support further coordination of services, and maximization of resources to improve birth outcomes.
- Public health programs that serve at-risk adolescents - including School-Based Health Center (SBHC), Family Planning, and Community-Based Adolescent Pregnancy Prevention programs - include provisions for preventive health services, pregnancy prevention, and, when needed, prompt referral of pregnant teens to prenatal care.
- The statewide Growing Up Healthy Hotline will continue to link women to needed services, with periodic public awareness media campaigns conducted to direct women to the hotline.
- MCH and Medicaid staff will continue their collaboration to implement prenatal care standards.
- Title V staff will continue to participate in NYS's ongoing MA Redesign initiative to support development and implementation of potential recommendations related to improving access to prenatal care for all high risk populations.

D. State Performance Measures

State Performance Measure 1: *The percentage of infants born to Black and Hispanic women receiving prenatal care beginning in the first trimester.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|------------------|------------------|------------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | 62.4 | 64.3 | 64.3 |
| Numerator | | | 58,091 | 58,055 | 58,055 |
| Denominator | | | 93,114 | 90,226 | 90,226 |
| Data Source | | | Vital Statistics | Vital Statistics | Vital Statistics |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 64.9 | 65.6 | 66.2 | 66.9 | 67.5 |

Notes 2010

2009 data are used as a proxy for 2010. 2010 data will be finalized in May 2012.

a. Last Year's Accomplishments

- NYS experienced a 3% improvement in this measure from 2008-2009.
- NYS has undertaken major efforts to improve access to prenatal care. OHIP, in collaboration with the DFH, revamped NYS's Prenatal Care Assistance Program (PCAP), which provided prenatal care to women up to 200% FPL. Chapter 53-Laws of 2008 established MA payment methodology based on Ambulatory Patient Groups, for MA services in outpatient clinics, ambulatory surgery, emergency departments. The legislation also required DOH to update standards for prenatal care and eliminated the PCAP program, requiring all providers to comply with standards that incorporate evidence-based procedures and integrate standards from ACOG and the AAP, and reflect expert consensus regarding prenatal care. Chapter 484 of the Laws of 2009 require all MA enrolled Article 28 prenatal care providers to perform presumptive eligibility determinations and assist with completion of the full MA application and managed care plan selection, allowing women to immediately receive care while awaiting full MA eligibility determination.
- DOH also oversees programs to improve early and continuous prenatal care targeted to high need areas of the state and populations with poor birth outcomes including:
 - CPPSNs utilize innovative and collaborative perinatal outreach strategies to target key high risk populations, particularly African American women, to raise awareness of prenatal care and infant mortality with the attempt to eliminate disparities in maternal and child health.
- The Community Health Worker Program (CHWP) provides outreach and home visiting services to pregnant women who are at highest risk for poor birth outcomes. In 2010, CHWP case managed 3,524 clients: 99/9% were female, 32% were Black/African American and 41% were Hispanic. CHWPs are indigenous to the communities they serve and target households with incomes less than 200 percent of poverty; racial, ethnic and linguistic

minorities; women with multiple social or economic stressors; undeserved immigrants; teenagers, victims of domestic violence; rurally isolated or homeless families, and individuals with patterns of substance abuse. Outreach strategies may include outreach to agencies and organizations such as local health departments, WIC sites, churches, cultural/ethnic organizations, community centers, local Department of Social Services, etc. for the purpose engaging women into prenatal care. CHWs conduct case finding through community outreach, including door-to-door canvassing, participate in health fairs and other community events that focus on public education, health screening. Outreach strategies may include, but not be limited to, the following places where high-risk populations may congregate: laundromats, supermarkets/bodegas, hair/nail salons train/subway/bus stations, housing projects, faith-based organizations, shelters, and community centers.

- The Healthy Mom-Healthy Baby Prenatal and Postpartum Home Visiting program (HMHB) is implemented in local health departments serving six highest need counties of the state. The purpose of HMHB is to engage high risk women into prenatal care, better ensure that risks are addressed and to enhance and coordinate home visiting services in the target area.
- One-time funding of \$7 million under TANF supports the Nurse Family Partnership (NFP) program to improve outcomes for first time mothers. The three certified NFPs in NYS have been funded based on number of TANF eligible women to be served.
- DOH was awarded new federal Maternal and Infant Early Childhood Home Visiting (MIECHV) funding and has submitted a needs assessment to identify communities with high rates of maternal, infant and child health risk indicators and the existing home visiting programs and supportive resources in those communities. NYS’s work in the MIECHV will support further coordination of services, and maximization of resources to improve birth outcomes.
- Public awareness materials are available to promote early entry into prenatal care. All materials are printed in multiple languages, tested with populations they are targeting, and disseminated to better reach the target population.
- The statewide Growing Up Healthy Hotline links women to needed services, and is staffed 24/7 with both English- and Spanish-speaking trained tele-counselors, a TTY for the hearing impaired, and the AT&T Language Line extends access to referral services to callers speaking over twenty additional languages.

Table 4b - State Performance Measure 1 Summary

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Standards for prenatal care were updated to require all providers to comply with standards that incorporate evidence-based procedures and integrate standards from the American Congress of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP). | | | | X |
| 2. All Medicaid (MA) enrolled Article 28 prenatal care providers are required to perform presumptive eligibility determinations and assist with completion of the full MA application and managed care plan selection, allowing women to immediately receive care while awaiting full Medicaid determination. | X | | | X |

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 3. The Community Health Worker Program provided outreach and home visiting services to pregnant women who are at highest risk for poor birth outcomes. | | X | | |
| 4. The Healthy Mom-Healthy Baby Prenatal and Postpartum Home Visiting program was implemented in local health departments serving six highest need counties of the state. | X | X | | |
| 5. DOH was awarded new federal Maternal and Infant Early Childhood Home Visiting funding which will support further coordination of services, and maximization of resources to improve birth outcomes in high risk communities. | | X | X | X |
| 6. The Nurse Family Partnership program improved outcomes for first time mothers. | X | X | | |
| 7. Title V staff participated in NYS's Medicaid Redesign process. | | | X | |
| 8. Public awareness materials promoted early entry into prenatal care. | | X | | |
| 9. The statewide Growing Up Healthy Hotline linked women to needed services. | | X | | |

b. Current Activities

- Activities and services noted in the “Accomplishments” section have continued.
- As stated previously, DOH is the recipient of a new federal grant from Health Resources and Services Administration for the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting initiative to support the development and implementation of evidence-based home visiting programs in high-risk communities. DOH has completed a needs assessment that has identified the high need areas of the state, and is currently developing a required Home Visiting State Plan that will coordinate existing evidence based home visiting programs and/or develop new evidence based models in these high need areas.
- Title V staff participate in NYS’s Medicaid Redesign process, including membership on implementation work groups and contribution to potential new recommendations related to improving access to and encouraging entry into early prenatal care and engaging women into managed care.

c. Plans for the Coming Year

- Activities and services noted in the “Accomplishments” and “Current Activities” sections will continue.
- A media campaign encouraging women to access prenatal services will be developed and implemented in areas with the highest rates of adverse perinatal outcomes. It is anticipated that the campaign, which will instruct women to call the 24/7 Growing Up Healthy Hotline for information, will begin in the fall of 2011 and run through the winter of 2012.
- The Bureau of Maternal and Child Health will complete and release a comprehensive Request for Applications to restructure its perinatal strategies. This new integrated, comprehensive perinatal health initiative will be improve targeting to highest need areas of NYS and incorporate evidence-based and promising strategies to reduce disparities and improve perinatal health outcomes.

- DOH will implement a state plan, which is currently under development, for the Maternal, Infant, and Early Childhood Home Visiting initiative.

State Performance Measure 2: *The percentage of Medicaid enrolled children between the ages of three and six years who had a well-child and preventive health visit in the past year.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|---|-------------|-------------|-------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | 81% | 81% | 79% | 79% |
| Numerator | | 18,856 | | 188,633 | 188,633 |
| Denominator | | 23,029 | | 238,595 | 238,595 |
| Data Source | | QARR (Quality Assurance Reporting Requirements) | | QARR | QARR |
| Is the Data Provisional or Final? | Final | | Final | | Final |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 79.5 | 79.9 | 80.4 | 80.9 | 81.4 |

Notes 2010

Data in this table applies to children enrolled in Medicaid managed care plans only (87% of Medicaid-enrolled children). Information on children enrolled in Medicaid fee-for-service is not included. Comparison between 2007/2008 and 2009/2010 are not possible due to the fact that different methods of data collection were used in developing the measure rate. A hybrid method of data collection was used in 2007/2008 while an administrative method was used in 2009. This indicator is collected on a biannual basis. 2009 data are used as a proxy for 2010.

a. Last Year's Accomplishments

- DOH annually monitors the level of access and availability of Primary Care Physician (PCP) panels (number of primary care physicians in a practice) serving the Medicaid (MA) managed care and Child Health Plus populations. To do this, the Office of Health Insurance Programs analyzes the number of enrollees in a county compared to the number of PCPs. As specified in the 1115 waiver Terms and Conditions for the Partnership Plan and in the MA managed care contract, DOH established limits of panel size that plan practices are required to meet. Any plan with a score less than 75% is required to submit an action plan to improve these measures. Providers are also monitored for access and availability to see if the practice meets acceptable time standards for appointment availability by type of visit (urgent, non-urgent sick, routine and well child care). This is done by using a 'secret shopper' methodology of calling the practice and posing as an enrollee who needs one of the four types of visit. If the proportion of calls that are given a visit within the acceptable time frame is 75% or less, the plan must submit a plan of correction.
- DOH conducted Article 44 operational on-site surveys which include review of provider networks to insure that there are sufficient numbers of primary care physicians/pediatricians for preventive well child visits for children enrolled in MA management care.

- Health plans which participate in MA management care have pursued several quality improvement activities to increase their well child preventive health visit rates including the following: contacting parents of children who have not had a well-child visit to urge them to schedule an appointment; contacting non-compliant child’s PCPs and asking them to reach out to family to schedule an appointment; offering gift cards or other incentives to encourage members to schedule a visit; and publishing articles in member newsletters and on the health plans’ websites to remind parents of the importance of a well child visit for this age group.

Table 4b - State Performance Measure 2 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Health plans contacted non-compliant members. | | X | | |
| 2. Health plans contacted Primary Care Physicians (PCP) who have non-compliant patients. | | X | | |
| 3. Health plans offered gift cards or other incentives to encourage members to schedule visits. | | X | | |
| 4. Health plans published information on the importance of well child visits in their newsletters and on their websites. | | | X | |
| 5. DOH monitored access and availability of PCPs who serve the 3 to 6 year old population. | | | | X |
| 6. DOH monitored the number of PCPs/pediatricians serving the 3- to 6-year old population. | | | | X |

b. Current Activities

- DOH annually monitors the level of access and availability of Primary Care Provider (PCP) panels serving the Medicaid managed care and Child Health Plus populations. Any plan with a score less than 75% is required to submit an action plan to improve these measures.
- DOH is conducting Article 44 operational on-site surveys which include review of provider network to insure that there are sufficient numbers of PCPs/pediatricians for preventive well child visits.
- Health plans are pursuing quality improvement activities to increase their well child preventive health visit rates including the following: contacting parents of children who have not had a well-child visit to urge them to schedule an appointment; contacting non-compliant child’s PCPs and asking them to reach out to family to schedule an appointment; offering gift cards or other incentives to encourage members to schedule a visit; and publishing articles in member newsletters and on the health plans’ websites to remind parents of the importance of a well child visit for this age group.
- One health plan will continue conducting a Performance Improvement Project to improve the rate of immunizations which includes educating the parent on the importance of childhood preventive visits.

c. Plans for the Coming Year

- DOH will conduct annual monitoring of the level of access and availability of Primary Care Physician (PCP) panels serving the Medicaid managed care and Child Health Plus populations. Any plan with a score less than 75% is required to submit an action plan to improve these measures.
- DOH will conduct Article 44 operational on-site surveys which include review of provider network to insure that there are sufficient numbers of PCPs/pediatricians for preventive well child visits.
- Health plans will pursue quality improvement activities to increase their well child preventive health visit rates including the following: contacting parents of children who have not had a well-child visit and urge them to schedule an appointment; contacting non-compliant child's PCPs and asking them to reach out to family to schedule an appointment; offering gift cards or other incentives to encourage members to schedule a visit; and publishing articles in member newsletters and on the health plans' websites to remind parents of the importance of a well child visit for this age group.
- One health plan will continue conducting a Performance Improvement Project to improve the rate of immunizations which includes educating the parent on the importance of childhood preventive visits.

State Performance Measure 3: *The ratio of Black infant low birth weight rate to the White infant low birth weight rate.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|---------------|---------------|---------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | 1.9 | 1.9 | 1.9 |
| Numerator | | | 13.0 | 13.0 | 13.0 |
| Denominator | | | 6.8 | 6.9 | 6.9 |
| Data Source | | | Vital Records | Vital Records | Vital Records |
| Is the Data Provisional or Final? | | | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 1.9 | 1.9 | 1.8 | 1.8 | 1.8 |
| | | | | | |

Notes 2010

White and Black race groups do not include Hispanics. 2009 data are used as a proxy for 2010. 2010 data will be finalized in May 2012.

a. Last Year's Accomplishments

- NYS has been a national leader in the development of a statewide system of perinatal regionalization. NYS has a well-organized system of regionalized perinatal care that ensures that appropriate hospital care is provided to women and their newborns. A system of regionalized perinatal services includes a hierarchy of three levels of perinatal care provided by the hospitals within a region and led by a Regional Perinatal Center (RPC).
- All obstetrical hospitals have been designated by DOH as a Level I, II, III or RPC based on

standard criteria included in state regulation. Women at highest risk for poor birth outcomes are referred to RPCs and supportive health and social services. Research strongly supports regionalization as a means of improving maternal and infant outcomes. Regulations require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers and newborns.

- While RPCs and Level III hospitals accounted for 64.7% percent of all births in 2009, approximately 90 percent of all very low birth weight (VLBW) infants were delivered at RPC and Level III facilities. Conversely, less than 10% of VLBW infants were delivered at Level I and II hospitals, which accounted for approximately 35% of all newborn deliveries in NYS in 2009. The trend towards delivery of high-risk newborns at appropriate level hospitals suggests the effectiveness of perinatal regionalization. The Statewide Perinatal Data System also captures data as to why VLBW infants were born at lower level hospitals; the majority of such births are due unavoidable events, such as inability to transfer the woman to a higher level hospital due to advanced stage of labor.
- DOH also oversees a range of public health initiatives to improve early and continuous prenatal care including:
 - Comprehensive Prenatal-Perinatal Services Networks are community-based organizations whose mission is to organize the service system at the local level.
 - The Community Health Worker Program provides outreach and home visiting services to pregnant women who are at highest risk for poor birth outcomes.
 - The Healthy Mom-Healthy Baby Prenatal and Postpartum Home Visiting program is implemented in local health departments serving six highest need counties of NYS.
 - One-time funding of \$7 million under Temporary Assistance for Needy Families (TANF) supports the Nurse Family Partnership (NFP) program to improve outcomes for first time mothers. The three certified NFPs in NYS have been funded based on the number of TANF eligible women to be served.
- Public awareness materials are available to promote early entry into prenatal care.
- The statewide Growing Up Healthy Hotline links women to needed services.

Table 4b - State Performance Measure 3 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Public health initiatives were implemented, including the system of perinatal regionalization, to increase access to early and continuous prenatal care, targeting high-risk areas to identify and address gaps in needed services and improve perinatal outcomes in NYS. | | X | | X |
| 2. Quality assurance visits were conducted to affiliate hospitals to improve perinatal quality and outcomes, including review of complex cases and determination as to whether cases should have been transferred to regional centers. | | X | | |

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 3. The Division of Family Health partnered with the Office of Health Insurance Programs in implementation of Medicaid Prenatal Care and the Healthy Mom-Healthy Baby (HM-HB) home visiting programs. | | | X | X |
| 4. Comprehensive Prenatal-Perinatal Services Networks pursued their goal of organizing the service system at the local level to improve early and continuous prenatal care | | | | X |
| 5. The three certified. Nurse Family Partnership programs improved outcomes for first time mothers. | X | X | | |
| 6. Public awareness materials were available to promote early entry into prenatal care. | | X | | |
| 7. The statewide Growing Up Healthy Hotline linked women to needed services. | | X | | |

b. Current Activities

- Activities and services in the “Accomplishments” section continue.
- DOH is developing a state plan for the Maternal, Infant, and Early Childhood Home Visiting Program federal home visiting funds.
- RPCs remain the core component of the perinatal regionalization system. RPCs provide oversight of affiliates. Affiliation agreements among hospitals guide maternal and infant consultation and transfers.
- RPC staff conducts quality assurance visits to affiliate hospitals and works with them to improve perinatal quality and outcomes, including review of complex cases and whether cases should have been transferred. RPCs conduct educational programs on-site at affiliates and grand rounds presentations to prepare affiliates for emergency cases (e.g., stabilization of VLBW infants in preparation for transfer).
- DOH has an oversight role to identify and address appropriateness of care issues that may occur in ensuring that moderate to high-risk pregnant women, fetuses and newborns continue to receive care at the appropriate perinatal level, and that perinatal networks function properly.
- DOH works with RPCs, National Initiative for Children’s Healthcare Quality (NICHQ) and an external expert advisory group to develop and implement obstetric and neonatal interventions to improve specifically identified perinatal outcomes. In consultation with RPCs, DOH has begun implementing an obstetric intervention to reduce scheduled near term deliveries (36-38 weeks) without medical indication.

c. Plans for the Coming Year

- Activities and services noted in the “Accomplishments” section will continue.
- DOH will implement a state plan, which is currently under development, for new federal home visiting funds.
- The Bureau of Maternal and Child Health will complete and release a comprehensive Request for Applications to restructure its perinatal strategies. This new integrated, comprehensive perinatal health initiative will improve targeting to highest need areas of NYS

and incorporate evidence-based and promising strategies to reduce disparities and improve perinatal health outcomes.

- DOH will continue to work closely with the Regional Perinatal Centers (RPC) and affiliate hospitals to monitor and support effective use of the established system of perinatal regionalization
- DOH will continue to collaborate with the RPCs, the National Initiative for Children’s Healthcare Quality (NICHQ) and an external expert advisory group to implement selected obstetric and neonatal interventions designed to improve perinatal outcomes, including the current obstetric intervention to reduce scheduled deliveries prior to 39 weeks without medical indication.
- DOH will maintain efforts related to access to prenatal care services and community-based initiatives designed to identify and engage pregnant women in early and continuous prenatal care.
- The Division of Family Health will continue to partner with the Office of Health Insurance Programs in implementation of Medicaid Prenatal Care and the Healthy Mom-Healthy Baby (HM-HB) home visiting programs. HM-HB programs will pilot the use of the Prenatal Care Risk Screening form for early identification and communication of risk status to MA managed care plans. These programs will also work to ensure the development of countywide systems of perinatal care and the assessment and referral of high-risk women to appropriate level of services.
- A media campaign encouraging women to access prenatal services will be developed and implemented in areas of NYS with the highest rates of adverse perinatal outcomes. It is anticipated that the campaign, which will instruct women to call the 24/7 Growing Up Healthy Hotline for information, will begin in the fall of 2011 and continue through the winter of 2012.

State Performance Measure 4: *The percentage of high school students who were overweight or obese (i.e., at or above the 85th percentile for body mass index, by age and sex.)*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------------------------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | 27.2 | 27.2 | 26.6 | 26.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | Youth Risk Behavioral Survey (YRBS) | YRBS | YRBS | YRBS |
| Is the Data Provisional or Final? | | Final | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 26.3 | 26.1 | 25.8 | 25.5 | 25.3 |

Notes 2010

The YRBS is conducted biannually. Numerator and denominator data from this survey are not available. The next survey will be conducted in 2011 with results available in 2012. 2009 data are used as a proxy for 2010.

a. Last Year's Accomplishments

- The goals of DOH adolescent obesity prevention efforts are to increase fruit and vegetable consumption, decrease consumption of foods of minimal value, increase physical activity before, during and after the school day, and decreasing television and other screen time viewing. These goals are achieved through policy, systems and environmental changes in a variety of settings and programs.
- The primary focus of the Overweight and Obesity Prevention Program is the prevention of childhood obesity by increasing physical activity and improving healthy eating, including breastfeeding, among residents of NYS. The program distributed funding directly and in combination with other programs to prevent obesity and related chronic diseases with intervention investments in child care, school, communities and health care settings. The program continued to use evidence- and practice-based chronic disease prevention interventions promoting policies, systems and environmental approaches for sustainable change are used in each setting with an emphasis on reaching populations experiencing the greatest health disparities.
- The Strategic Alliance for Health program continued its work with four NYS counties to create healthier communities through sustainable, innovative, evidence and practice-based community health promotion and chronic disease prevention efforts that promote policy, system, and environmental change. These counties work with schools and the community to encourage physical activity, healthy eating, and tobacco-free choices in order to reduce the burden of diabetes, cardiovascular disease, and obesity. Targeted at risk populations include those from specific racial and ethnic groups, those limited by income and insurance coverage, those with high chronic disease rates, and individuals with disabilities.
- Three programs (Healthy Heart, Overweight and Obesity Prevention and Tobacco Prevention and Control) combined funds for a new initiative (Healthy Schools New York) aimed at school health. Eighteen contractors from across NYS were selected for and began receiving funding to work in schools around policies supporting healthful nutrition, physical activity and a tobacco-free campus.
- The Healthy Heart Program wrapped up funding for local organizations that worked in schools statewide to improve policy and environmental supports for nutrition and physical activity. Physical activity improvements included increasing active time during physical education, increasing the number of children walking or bicycling to school, increasing opportunities for physical activity, improving or maintaining recess times, and prohibiting the use of physical activity as a punishment. Nutrition policies that were adopted included: increasing the availability of low-fat milk, increasing the number of healthful options sold in school stores and vending machines, prohibiting the use of food for reward or punishment, and prohibiting the sale of unhealthy foods as fund raising activities.
- Two programs (Healthy Heart and Overweight and Obesity Prevention) combined funding for a new initiative, Designing a Strong and Healthy New York. (DASH-NY), which supports a statewide center for obesity prevention, policy research and training around

healthy eating and active living. The training emphasized environmental, policy and systems approaches to increasing physical activity and healthy eating.

- Two bureaus (Community Chronic Disease Prevention and Nutrition Risk Reduction) combined funding for a new initiative: Creating Healthy Places to Live, Work and Play. Twenty-two contractors across the state were selected for and began receiving funding to work in communities and worksites around policies and systems changes supporting healthful nutrition and physical activity.
- DOH also collects data on the percentage of students in Pre-Kindergarten, Kindergarten and grades 2, 4, 7 and 10 in NYs (exclusive of NYC) who are overweight or obese: The source of this data is the DOH Student Weight Status Category Report. The first report of the new Student Weight Status Category Reporting Surveillance was released. Reported student weight status data, which is directly measured, was reported in aggregate. The percentage of students in Pre-Kindergarten, Kindergarten and grades 2, 4, 7 and 10 in NYS (exclusive of NYC) who were overweight or obese was 32.0% for the period 2008-2010.

Table 4b - State Performance Measure 4 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Two programs (Healthy Heart and Overweight and Obesity Prevention) combined funding for a statewide center for obesity prevention, policy research and training around healthy eating and active living (Designing a Strong and Healthy New York). | | | | X |
| 2. Two bureaus (Community Chronic Disease Prevention and Nutrition Risk Reduction) combined funding for the Creating Healthy Places to Live, Work and Play initiative. | | | X | X |
| 3. Three programs (Healthy Heart, Overweight and Obesity Prevention and Tobacco Prevention and Control) combined funding for a new initiative aimed at school health (Healthy Schools New York). | | | X | X |
| 4. The Strategic Alliance for Health program continued its work with four NYS counties to create healthier communities through sustainable, innovative, evidence and practice-based community health promotion and chronic disease prevention efforts that promote policy, system, and environmental change. | | | X | X |
| 5. The Overweight and Obesity Prevention Program distributed funding directly and in combination with other programs to prevent obesity and related chronic diseases with intervention investments in child care, school, communities and health care settings | | | | |
| 6. The first report of the new Student Weight Status Category Reporting Surveillance was released. | | | X | X |
| 7. A training schedule for new contractors was developed. | | | | X |
| 8. Information and resources were provided through listserves to contractors working on obesity prevention. | | | | X |

b. Current Activities

- At least 63 contractors from multiple initiatives include improving physical activity and nutrition for children and adolescents (i.e., Strategic Alliance for Health; Healthy Schools New York; Creating Healthy Places to Live, Work and Play; Healthy Eating and Active Living by Design (HEALD); Childhood Obesity Prevention and Designing a Strong and Healthy New York. (DASH-NY)
- Each contractor uses policy, systems and environmental changes to support healthful nutrition including breastfeeding, increased opportunities for physical activity, or a combination thereof, across a variety of settings (child care, schools, communities, and health care) to achieve improved health outcomes.
- Twelve HEALD contractors are funded to reduce risk of cardiovascular disease.
- The 22 Creating Healthy Places contractors work to reduce the risk of both obesity prevention and type 2 diabetes.
- DASH-NY, a statewide obesity prevention, research and training center, coordinates and supports an obesity prevention advisory group, writes policy briefs on various obesity reduction/healthy eating/active living topics and provides training to stakeholders.
- NYS continues to mandate physical education in schools and that all students complete a mandated, semester-long course in health.
- Public school districts outside NYC continue to report student weight status category data biennially.
- SBHCs are required to document the weight of enrolled students based on Body Mass Index-for-age percentile.

c. Plans for the Coming Year

- Funding for Healthy Schools New York, Creating Healthy Places to Live, Work and Play, Strategic Alliance for Health, Healthy Eating and Active Living by Design, and Designing a Strong and Healthy New York will continue.
- Contractors for obesity prevention in pediatric health care settings to promote the delivery of guideline-concordant care for the assessment, prevention and treatment of child and adolescent overweight and obesity will be established.
- Healthy Schools New York contractors will receive training on improving school nutrition and increasing compliance with physical education regulations.
- Creating Healthy Places to Live, Work and Play, Strategic Alliance for Health, and Healthy Eating and Active Living by Design contractors will receive training on environmental, policy and systems approaches to increasing physical activity and healthy eating.
- Collection of weight status data from school districts will continue.
- Obesity is a significant public health issue and, as such, is an important component of preconception health. DOH received a First Time Motherhood – New Parents Initiative three-year HRSA grant (September 1, 2010 to August 31, 2013) to improve perinatal health outcomes and strengthen resources available for new parents. Goals of this initiative include increasing awareness of the importance of preconception health, influencing preconception health behaviors among low income Black women and men, and promoting positive health behaviors among high-risk Black adolescents. DOH has conducted 23 focus groups with 237 adolescents to determine their views on living a healthy lifestyle and future health. Participants expressed a desire for more supportive home, school and community

environments which encourage positive behaviors, and provide more information and communication. Results of the focus groups will inform a social marketing campaign. In addition, community action planning will be conducted in six high need counties; these efforts will bring together community stakeholders to identify barriers and develop strategies to promote preconception health to high risk populations, including adolescents.

State Performance Measure 5: *The ratio of the Hispanic teen (ages 15-17) pregnancy rate to the non-Hispanic White teen (ages 15-17) pregnancy rate.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|---------------|---------------|---------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | 5.6 | 5.3 | 5.3 |
| Numerator | | | 64.3 | 58.3 | 58.3 |
| Denominator | | | 11.4 | 11.0 | 11.0 |
| Data Source | | | Vital Records | Vital Records | Vital Records |
| Is the Data Provisional or Final? | | | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 5.2 | 5.2 | 5.1 | 5.1 | 5 |

Notes 2010

2009 data are used as a proxy for 2010. 2010 data will be finalized in May 2012.

a. Last Year's Accomplishments

- NYS has experienced a continuous decline in adolescent pregnancy rates over the past two decades. NYS has the 8th lowest rate of adolescent pregnancy in the U.S. According to a report from the National Center for Health Statistics, when adjusted for race and ethnicity, NYS has the second lowest rate for Black adolescents and the sixth lowest for Hispanic adolescents. The two racial/ethnic groups in NYS with the highest teen pregnancy rates (Black non-Hispanic and Hispanics) have both seen substantial declines over the last decade. From 2000 to 2009, the teen pregnancy rates among Hispanic teens declined from 78.5 per 1,000 teens aged 15-17 in 2000 to 58.3 in 2009.
- Additional funds (formerly used for abstinence-only programs) were utilized to enhance and expand Community-based Adolescent Pregnancy Prevention Programs (CBAPP).
- The Adolescent Pregnancy Prevention and Services (APPS) Program continued to provide education, case management, prenatal support and parenting education to teens in high need communities.
- A Request for Applications (RFA) was released for the Comprehensive Adolescent Pregnancy Prevention (CAPP) initiative which was developed to replace APPS and CBAPP. A key goal of this adolescent sexual health initiative is to reduce racial and ethnic disparities in pregnancy rates and other sexual health outcomes with preference given to applicants that proposed to serve communities with high disparities, have staff and Boards representative of racial and ethnic populations they propose to serve, and have experience serving minority populations. This initiative will emphasize: evidence-based comprehensive sexuality education; access to reproductive health services; multi-dimensional support for life skills

development; and, community collaboration. The concept for this program was revised by lessons learned from previous adolescent health initiatives; and, information gathered at 27 youth focus groups held in 2008 to learn how young people across NYS acquire information about sexual health and access services and treatment; information gleaned from an Adolescent Sexual Health Symposium held in 2008.

- The DOH Adolescent Sexual Health Work Group (ASHWG) continued to focus on development of a coordinated approach to improving sexual health outcomes for teens. ASHWG is comprised of staff from multiple DOH units.
- The ACT for Youth Center of Excellence began monthly webinars with CBAPP and APPS providers on relevant topics related to teen pregnancy prevention, male involvement in pregnancy prevention, needs of youth in foster care, gang involvement, and community assessment.
- The new web site (nysyouth.net) launched as part of a media campaign continued; it will be further enhanced to include additional information on adolescent health and related issues, including topics identified through youth feedback on the site.
- Comprehensive Prenatal/Perinatal Services Networks conducted community education and outreach activities to improve the reproductive health of all women, including teens.
- The Rape Crisis Program worked with the Sexual Violence Primary Prevention Committee to review the DOH Sexual Violence Prevention Plan. DOH provided funding to rape crisis providers across NYS to support activities related to the primary prevention of sexual violence.
- Two hundred and thirty (230) school-based health centers (SBHC) are located in high-need underserved communities across the state. Age-appropriate risk assessment, anticipatory guidance and health education pertaining to sexual activity are part of the initial assessment and annual comprehensive physical exam for students enrolled in a SBHC. When indicated, students have access, either onsite or through referral, to family planning services and pregnancy testing.
- DOH released an RFA to solicit the NYS Family Planning Program for the next 5 year funding cycle. Fifty-four awards were made: 51 to family planning providers; one for infertility and teratogen counseling, one to develop a COE and one a for data management. The statewide network of Family Planning providers provided comprehensive services to NYS's most vulnerable populations.

Table 4b - State Performance Measure 5 Summary

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Adolescent Pregnancy Prevention and Services (APPS) Program continued to provide education, case management, prenatal support and parenting education to teens in high need communities. | | X | | X |
| 2. Additional funds were utilized to enhance and expand Community-based Adolescent Pregnancy Prevention Programs (CBAPP). | | X | | |

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 3. The Comprehensive Adolescent Pregnancy Prevention (CAPP) initiative was developed to replace the APPS and Community-based Adolescent Pregnancy Prevention CBAPP programs. A key goal of this initiative is to reduce racial and ethnic disparities in pregnancy rates and other sexual health outcomes. | | X | X | |
| 4. The DOH Adolescent Sexual Health Work Group (ASHWG) continued to focus on development of a coordinated approach to improving sexual health outcomes for teens. | | | | X |
| 5. Two hundred thirty (230) school-based health centers located in high-need underserved communities across NYS provided age-appropriate risk assessment, anticipatory guidance, and health education pertaining to sexual activity as part of the initial assessment and annual comprehensive physical exam for enrolled students. Students have access, either onsite or through referral, to family planning services and pregnancy testing. | X | X | | |
| 6. Comprehensive Prenatal/Perinatal Services Networks conducted community education and outreach activities to improve the reproductive health of all women, including teens. | | X | X | X |

b. Current Activities

- DOH awarded more than \$17.5 million in grants to 50 community-based organizations to implement CAPP projects in NYS and an organization to provide professional education and resources statewide for community healthcare providers. The community projects focus on prevention of pregnancy, sexually transmitted diseases and HIV among male/female adolescents aged 10 to 21. Twenty of the 50 projects specifically focus on serving Hispanic communities.
- The CAPP initiative focuses on decreasing the incidence of adolescent pregnancy and STD/HIV and reducing racial and ethnic disparities among adolescents aged 10 to 21 by providing evidenced-based sexual health education; ensuring access to family planning; increasing skill-building opportunities; and, promoting community efforts to improve adolescent sexual health.
- The RFA used ASHNI to identify eligible target communities and prioritize the selection of funded projects. ASHNI is a ZIP-code level indicator that provides a single, multidimensional measure that incorporates multiple factors including the size of adolescent population, number of adolescent pregnancies and STD cases, and demographic and community factors that are significantly associated with adverse sexual health outcomes.
- Title V staff are participating in NY’s Medicaid Redesign process, including membership on implementation work groups and contribution to potential new recommendations related to improving access to family planning services for teens and adults.

c. Plans for the Coming Year

- Ongoing program activities to support a wide range of clinical and community-based services will continue. DOH will continue to focus on improving the sexual health needs of NYS youth in its adolescent sexual health programs and decreasing health disparities among Hispanic and other disparate adolescents and young adults. A key goal of initiatives described below will be to reduce racial and ethnic disparities in pregnancy rates and other sexual health outcomes for adolescents and young adults
- Title V staff will continue to actively participate in the Adolescent Sexual Health workgroup.
- DOH will continue to fund the CAPP initiative. The ACT for Youth Center of Excellence (COE) will provide training and technical assistance to the CAPP and CAPP-PREP programs on the implementation of evidence-based programming with fidelity and ensure the selection of appropriate curricula related to the target audience; and will work with DOH to develop and conduct the data collection, analysis and evaluation for these projects. The COE will also provide training and technical assistance for community-based programs funded through the AEGP and conduct the evaluation of these programs.
- DOH was awarded \$3,236,330 in federal Personal Responsibility Education Program (PREP) funds. PREP funds will support organizations that were “approved but not funded” through the recent CAPP RFA. Funds will also support an enhancement project targeting youth in foster care, to be developed in consultation with NYS Office of Children and Family Services.
- DOH was awarded \$2,991,440 in Federal Section 510 Abstinence Education Grant Program (AEGP) funds to support community projects for 10- to 14-year-old youth focused on adult mentoring and supervision to delay the onset of sexual activity. An RFA is currently under development for the AEGP. Fifteen awards will be made to support community projects focused on the use of adult mentoring, supervision and counseling to support healthy transition to adolescence, including delaying the onset of sexual activity, for children aged 9 to 12 who reside in targeted high-need communities.
- A five year grant funding cycle for the NYS Family Planning Program will begin in January 2011. Thirty new performance measures were added to enhance quality improvement activities in seven areas: outreach and access, effective contraceptives, STI screening and treatment, cancer services, adolescent sexual health, program accessibility and program management.
- A COE will be developed to provide training and technical assistance to Family Planning Program providers and to facilitate the use of best practices. The COE will develop a needs assessment that will be used to survey providers and develop appropriate training and technical assistance activities. In addition, the COE will focus on maximizing resources and improving clinic efficiency.
- Title V staff will continue to participate in the Medicaid Redesign process.

State Performance Measure 6: *Percent of High School Students Who Smoked Cigarettes in the Last Month*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|-------------|----------------------|
| Annual Performance Objective | 5 | 5 | 5 | 5 | 5 |
| Annual Indicator | 16.2 | 13.8 | 13.8 | 14.8 | 12.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | YRBS | YRBS | Youth Tobacco Survey |
| Is the Data Provisional or Final? | | | Final | Final | Final |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 12.5 | 12.3 | 12.2 | 12.1 | 12 |

Notes: The numerator and denominator are not available (survey data). Data source for 2008 and 2009 is the Youth Risk Behavior Survey (YRBS).

a. Last Year's Accomplishments

- NYS exceeds both the Healthy People 2020 baseline and target goals of 19.5% and 16% respectively for this measure.
- The percentage of NYS high school students who smoke (12.6%) is 26% lower than the comparable national rate of 17.2% indicated in the National Youth Tobacco Survey.
- NYS's cigarette excise tax is \$4.35 per pack, which is the highest in the nation. Raising the price of cigarettes discourages youth smoking.
- NYS law requires that all tobacco products be kept behind the counter
- Enforcement of a tough indoor air law continued, banning smoking in public places, including restaurants and bars.
- The Tobacco Control Program continued to fund Youth Action Partners to work with youth to become activists in the movement to change community norms related to tobacco use. These 16 programs engage middle and high school youth in activities aimed at de-glamorizing and de-normalizing tobacco use in their communities.
- NYS also funded local Tobacco Control Community Partnerships in every county of the state. These partnerships work to change the community environment to support the tobacco-free norm. Partnerships engage local stakeholders, educate community leaders and the public, and mobilize the community to strengthen tobacco-related policies to restrict the use and availability of tobacco products and tobacco product promotion and limit opportunities for exposure to second hand smoke.
- The Tobacco Control Program funded contractors' work with local leaders to educate them on the public health benefits of passing local ordinances on smoking in public places, removing tobacco products from the reach of youth, and reducing tobacco advertising in areas frequented by youth.

- Medicaid, Prenatal Care, Women, Infants, and Children and Community Health Worker programs assess prenatal clients for tobacco use and refer to or provide smoking cessation and other counseling/health teaching.
- Comprehensive Prenatal-Perinatal Service Networks create awareness of the dangers of smoking, particularly during pregnancy.
- NYS makes smoking cessation assistance available through a toll-free hotline, which provides free coaching and nicotine replacement therapy to eligible callers. The purchase of smoking cessation products is available through Medicaid.

Table 4b - State Performance Measure 6 Summary

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Tobacco Control Program continued to fund Youth Action Partners to work with youth to become activists in the movement to change community norms related to tobacco use. These 16 programs engage middle and high school youth in activities aimed at de-glamorizing and de-normalizing tobacco use in their communities. | | X | | |
| 2. Tobacco Control Community Partnerships continued to operate in every county of the state to change the community environment to support the tobacco-free norm. Partnerships engage local stakeholders, educate community leaders and the public, and mobilize the community to strengthen tobacco-related policies to restrict the use and availability of tobacco products and tobacco product promotion and limit opportunities for exposure to second hand smoke. | | | X | |
| 3. The Tobacco Control Program funded contractors' work with local leaders to educate them on the public health benefits of passing local ordinances on smoking in public places, removing tobacco products from the reach of youth, and reducing tobacco advertising in areas frequented by youth. | | | X | |
| 4. Medicaid Prenatal Care, WIC and the Community Health Worker Programs continued to assess prenatal clients for tobacco use and refer to or provide smoking cessation and other counseling/health teaching. | | X | | |
| 5. NYS continued to make smoking cessation assistance available through a toll-free hotline, which provides free coaching and nicotine replacement therapy to eligible callers. | | X | X | |
| 6. Comprehensive Prenatal-Perinatal Service Networks continued to create awareness of the dangers of smoking, particularly during pregnancy. | | X | X | |

b. Current Activities

- DOH continues to implement successful programs outlined in the "Accomplishments" section.

- In February 2010, the tobacco control program received federal stimulus funding to reduce youth smoking prevalence and tobacco product sales to minors by reducing the impact of retail tobacco product marketing on youth. This is accomplished by Community Partnership and Youth Action contractors which implement a set of educational activities to increase awareness of the impact that tobacco product marketing and tobacco retailer density have on youth smoking.
- Comprehensive Adolescent Pregnancy Prevention programming includes development of healthy attitudes and values as one of the adult preparation topics, allowing new opportunities to discuss tobacco usage.
- Twenty-three (23) preconception health focus groups were conducted with 237 adolescents to determine their understanding of health habits and their impact on future childbearing.

c. Plans for the Coming Year

- DOH will continue to implement successful programs as outlined in the two sections above.
- Title V will continue to collaborate with Division of Chronic Disease and Injury Prevention, which is the DOH lead organizational unit for smoking-related public health programming.
- Smoking cessation messages will continue to be incorporated into Title V programs.
- Results of the Preconception Health focus groups will be incorporated into a social marketing campaign and perinatal health programming.

State Performance Measure 07: *The percentage of Medicaid enrolled children and adolescents between the ages of two and twenty-one years who had at least one dental visit within the last year.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|--|--|--|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | 37.3 | 40.2 | 41 |
| Numerator | | | 667,090 | 746,153 | 797,681 |
| Denominator | | | 1,790,400 | 1,854,115 | 1,946,654 |
| Data Source | | | Bureau of Medicaid Statistics & Program Analysis | Bureau of Medicaid Statistics & Program Analysis | Bureau of Medicaid Statistics & Program Analysis |
| Is the Data Provisional or Final? | Final | Final | Final | Final | Final |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 41.4 | 41.8 | 42.2 | 42.6 | 43.1 |

Notes 2010

This table includes children enrolled in both managed care and fee-for-service Medicaid programs.

a. Last Year’s Accomplishments

- National survey data show dental disease remains a significant problem for children in Medicaid and that the rate of dental disease has decreased for older children, but not among 2- to 5-year-olds. Nationally, only one in three children in Medicaid visited a dentist in the prior year, compared to more than half of privately insured children. Nationwide, the proportion of low-income children receiving any dental care is far below the Healthy People 2010 target of 66 percent. In a 2009 survey of state Medicaid programs, identifying a dentist who accepts Medicaid remained the most frequently reported barrier to children seeking dental services.
- In NYS, the percentage of Medicaid-eligible children and adolescents between 2 and 21 years of age having at least one dental visit during the year increased by nearly 6 percentage points from 2005 to 2009. In 2005, 35.3% of eligible children had at least one dental visit compared to 40.2% in 2009, exceeding the national average of 36.2%.
- The proportion of low-income children and adolescents seeing a dentist during the year increased from 2005 to 2009 for all age groups. Two to four year olds had the largest increase in dental visits during the five-year period, increasing by 7.3 percentage points from 22.2% to 29.5%, followed by 5- to 9-year-olds who experienced a 6.8 percentage point increase from 43.4% to 50.2%.
- During 2010, 52% of children and adolescents aged 2 through 18 years and 42% of 19- to 21-year-olds participating in Medicaid Managed Care Programs had at least one dental visit within the year. When a Managed Care Plan does not offer dental care as part of its benefit package, enrollees have access to dental services through fee-for-service options (Medicaid, Child Health Plus).
- The percentage of children and adolescents aged 2 through 18 years covered under Medicaid Managed Care who saw a dentist during the year increased by 8 percentage points from 44% in 2007 to 52% in 2010.

Table 4b State Performance Measure 7 Summary

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Monitoring of the utilization of dental services by low-income children and adolescents participating in the Medicaid Program continued. | | | X | X |
| 2. The dental health certificate was implemented at the start of the 2009 school year. Plans were initiated in 2010 to evaluate the effectiveness of the dental health certificate in identifying children in need of treatment services and in facilitating their entry into dental care. | | | X | X |
| 3. Targeted outreach and education to underserved low-income age groups was conducted. | | X | X | X |

b. Current Activities

- The utilization of dental services by children and adolescents and the types of services received continue to be monitored.
- There are currently 49 school-based dental providers serving 692 school sites in NYS serving 28,536 children.
- Thirty school-based health center dental programs are funded to provide dental sealants on 3rd grade children.
- According to NYS Education Law §903, public schools are to ask for a Dental Health Certificate of students, at the time of school entry and in grades K, 2, 4, 7, and 10 declaring their dental health condition. While medical certificates are required for students, this new law also encourages students to obtain dental health certificates and is an important step in bringing awareness to the importance of oral health. A pilot project to determine the effectiveness of the Dental Health Certificate in increasing access to dental care for students entering grades Kindergarten, 2, and 4 is presently underway.
- NYS Medicaid began providing coverage for fluoride varnish application in October 2009.
- Fluoride varnish is being promoted in physician offices. DOH is assisting the New York City Department of Health and Mental Health in developing training programs and resources for managed care organizations. A pilot project targeting children under three years of age receiving services at the Albany Medical Center WIC Program is being developed. A pediatric physician from AMC will be at the WIC site one day a week to provide oral health assessments, risk reduction education, and fluoride varnish application. The project is expected to start by August 2011.
- More than 16,000 children enrolled in the Physically Handicapped Children's Program are receiving orthodontic treatment for physical malocclusions.

c. Plans for the Coming Year

- Initiatives described under "Current Activities" will continue.
- Reports on Medicaid claims data for 2010 will be produced and comparisons made to previous years with respect to the receipt of dental services.
- Based on these findings and notable age differences in the proportion of children and adolescents receiving dental services, targeted outreach and education to specific age groups will be undertaken to increase utilization levels.

State MCHBG Performance Measure 8: *The percentage of children who were tested for lead two or more times by age three years.*

| Annual Objective and Performance Data | | | 2008 | 2009 | 2010 |
|--|-------------|-------------|------------------|------------------|------------------|
| Annual Performance Objective | | | 48 | 50 | 55 |
| Annual Indicator | | | 47.5 | 50.5 | 50.5 |
| Numerator | | | 116544 | 125763 | 125763 |
| Denominator | | | 245402 | 249182 | 249182 |
| Data Source | | | NYS Lead Program | NYS Lead Program | NYS Lead Program |
| Is the Data Provisional or Final? | | | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 51 | 51.5 | 52 | 52.5 | 53 |

Notes 2010

This is a new performance measure that replaces and updates a previous measure that captured the percentage of children tested for lead at least once by age two years. The measure was revised to align with the state universal lead testing requirements that all children be tested for lead at both ages one year and two years, and to align with current statewide surveillance reports. While there are several separate metrics currently tracked for lead testing in state surveillance reports, this measure is the best stand-alone composite measure of performance in this area.

Data are reported for children turning three years of age in the year reported – i.e., data reported for 2009 are for children born in 2006. Data are statewide, including NYC. 2009 data are used as a proxy for 2010. 2010 data will be available in May 2012.

a. Last Year’s Activities

- NYS Public Health Law and implementing regulations require universal blood lead testing of all children at ages one and two years, and a risk assessment at least annually, with blood lead testing as indicated, for children up to age six years.
- Preliminary statewide surveillance data for 2009 demonstrate continued improvements in the proportion of children receiving blood lead screening tests at or around age one year (68%) and age two years (65.4%). Improvements in the number of children with two tests by age three years are noted. For children born in 2006, 50.5% had two tests by age three years as compared to 47.5% of children born in 2005. The number of children not tested at least once by three years of age decreased from 12.1 in 2008 to 10.1 in 2009. 2010 data is not yet available.
- Revisions to state regulations, effective June 2009, authorized physician office laboratories and limited service registrant laboratories to conduct blood lead testing using point of care testing devices. These regulations support in office testing to help improve access to blood lead tests for children and also require reporting of these results to DOH
- The Lead Poisoning Prevention Program (LPPP) provided grant funding and technical support to local health department (LHD) lead poisoning prevention programs, including a

strong emphasis on improving local lead screening rates. LPPP staff reviewed and provided technical assistance to counties on annual workplans and quarterly reports to assure effective strategies to increase lead testing rates were implemented.

- The LPPP contracted with three Regional Lead Resource Centers (RLRCs) in five teaching hospitals throughout NYS to provide expert clinical support, education and outreach for LHDs and health care providers to improve lead testing and other preventive practices.
- Public Health Law was amended in 2009 to authorize the linkage of the NYS Immunization Information System (NYSIIS) with the statewide DOH childhood blood lead registry (LeadWeb). In 2009, LPPP began work with the NYSIIS vendor to initiate the development of the linkage between NYSIIS and LeadWeb. In September 2010, the link was activated and a lead module was implemented that streamlines electronic reporting of office-based lead testing. Providers using point-of-care lead testing devices enter test results into NYSIIS. Data exchange of blood lead test information occurs between NYSIIS and LeadWeb.
- In July 2010, an electronic health alert was provided to health care providers via the DOH Health Commerce System to warn their patients to avoid use of non-prescription chelation products offered over the Internet. An article regarding the over-the-counter chelation therapy agents was placed in the July 2010 DOH Medicaid Update newsletter.

Table 4b - State Performance Measure 8 Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Grant and technical support was provided to local health departments statewide to improve lead testing of children as part of comprehensive local lead poisoning prevention programs. | X | | | X |
| 2. The Lead Poisoning Prevention Program contracted with three Regional Lead Resource Centers (RLRCs) in five teaching hospitals throughout NYS to provide expert clinical support, education and outreach for local health departments and health care providers to improve lead testing and other preventive practices | | | X | X |
| 3. Public Health Law was amended in 2009 to authorize the linkage of the NYS Immunization Information System with the statewide DOH childhood blood lead registry (LeadWeb) as a tool to improve lead testing rates. In September 2010, the link was activated and a lead module was implemented that streamlines electronic reporting of office-based lead testing. | | | X | X |

b. Current Activities

- Staff conducted webinars about NYSIIS lead module for LHDs and providers.

- Written instructions for NYSIIS prompts to provide reminders for risk assessment, lead testing, and follow up are under development. Programming of these prompts will begin this year.
- Staff developed a policy document about the use of portable lead testing devices which was sent to LHDs and posted on the DOH Web site.
- Staff worked with a State University of NY School of Public Health intern to perform a needs assessment about factors that influence health care provider behavior when screening for, treating, and preventing lead poisoning in children.
- Guidelines for the lead testing of refugee children and pregnant women were developed and disseminated to LHDs for use and distribution to providers.
- Enhanced functions in LeadWeb were implemented to identify refugee children to assist in tracking their lead testing status.
- Articles on lead poisoning prevention and contractors' use of safe work practices were developed for a DOH Community Health newsletter.
- Guidelines for prevention/management of lead poisoning in pregnant women were updated and finalized and are awaiting DOH approval.
- Title V staff are working with DOH OHIP to address CHPlus coverage for office-based lead testing.
- Title V staff participate in NYS' Medicaid (MA) Redesign process, including discussions related to lead poisoning prevention and screening services. Nearly 80% of children with lead poisoning in NYS are MA-eligible.

c. Plans for the Coming Year

- Significant cuts in NYS's CDC grant and refocusing of CDC priorities to a Healthy Homes focus resulted in some staff being moved to other grants, and restructuring and reprioritizing the Lead Poisoning Prevention Program. Due to CDC's Healthy Homes focus, the entire lead program is being transitioned incrementally to the DOH's Center for Environmental Health (CEH). Planning for a comprehensive and holistic healthy homes approach to address the broad range of housing deficiencies and hazards associated lead poisoning, asthma, and injury prevention will be promoted. Title V staff will work closely with CEH staff to facilitate this transfer.
- The program will continue to facilitate appropriate use of portable "point of care" lead testing technology to reduce key barriers to lead testing and assure reporting of lead test results from all laboratories.
- The link between the NYS Immunization Information System (NYSIIS) and the statewide DOH childhood blood lead registry (LeadWeb) will be maintained and enhanced. Complete written instructions for reports to be developed in NYSIIS will further support quality improvement in lead testing rates. Once developed, the reports will provide local health departments (LHD) and health plans with tools to assess health care provider performance related to lead testing and assist with targeting outreach efforts to providers with low lead testing rates.
- Contracts will continue with a statewide network of Regional Lead Resource Centers to provide clinical support, education and outreach for LHDs and pediatric health care providers to improve lead testing and other preventive practices.
- DOH staff will finalize and disseminate a reference tool for health care providers about risk assessment and lead testing of children, including follow up and management of those

children with elevated blood lead levels. Guidelines for obstetrical providers about risk assessment and lead testing of pregnant women, including follow up and management of women with elevated blood lead levels and their newborns will also be distributed.

- DOH staff will continue to provide grant and technical support to LHDs statewide to improve lead testing of children as part of comprehensive local lead poisoning prevention programs. LHDs will be provided with current local data to support targeting and monitoring of local strategies, including expanded LeadWeb reporting functionality, as well as annual work plan guidance, oversight, and technical assistance to assure effective strategies are utilized to improve local testing rates.
- Educational messages and materials for the public and parents will continue and expand to increase the demand for lead testing.
- Title V staff will continue to participate in the Medicaid Redesign process.

State Performance Measure 9: *The rate of hospitalizations for asthma among children and adolescents ages 0-17 years per 10,000 children and adolescents ages 0-17.*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | 28.4 | 31.1 | 31.1 |
| Numerator | | | 12,509 | 13,781 | 13,781 |
| Denominator | | | 4,408,016 | 4,424,083 | 4,424,083 |
| Data Source | | | SPARCS | SPARCS | SPARCS |
| Is the Data Provisional or Final? | | | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 31.0 | 30.9 | 30.7 | 30.6 | 30.5 |

Notes 2010

2009 data are used as a proxy for 2010. 2010 data will be available in May 2012.

a. Last Year's Accomplishments

- The NYS Asthma Outcomes Learning Network is a quality improvement initiative led by the NYS Asthma Program with assistance from National Initiative for Children’s Healthcare Quality. This initiative aims to strengthen the capacity of the asthma coalitions and their partners to improve asthma care processes and outcomes for children in a variety of settings. Eleven asthma care improvement teams, representing organizations that serve a pediatric population disproportionately affected by asthma, implemented an education and systems change intervention through this initiative. Teams represented schools, School-Based Health Centers (SBHC), Emergency Departments (ED), hospital in-patient units, and primary care practice settings.
- ED data and asthma hospital discharge data from SPARCS were used to create zip code level data for all 62 NYS counties; this data continued to be made available through the DOH public website for use by regional asthma coalitions, local health departments, health plans, etc. Regional asthma coalitions successfully utilized this surveillance data to assess, plan, target, monitor and evaluate their asthma interventions.

- The Clinical Guideline for the Diagnosis, Evaluation and Management of Asthma, a NYS consensus asthma guideline decision support tool, was disseminated through various venues. It was made available electronically, in a downloadable format, on the DOH website. Hard copies were available for order from the DOH Distribution Center and distributed through the regional asthma coalitions and at partnership meetings and trainings. The tool promotes the translation of the asthma guideline into practice among health care providers, educators, and health plans.
- The NYS Asthma Program continued work with partners to promote the expanded asthma self management training (ASMT) services Medicaid (MA) benefit. Initial efforts to increase awareness that asthma education services provided by a Certified Asthma Educator (AE-C) are a billable service reimbursable by NYS MA were targeted at MA plans and MA providers. Additionally, targeted outreach and education to AE-Cs in NYS who meet MA licensure requirements was conducted. Web sessions were developed and presented to provide accurate and detailed information to the field.
- A home-based intervention which connected an existing community-based program with managed care plans was conducted to improve targeting of in-home services to people with poorly controlled asthma and to facilitate the integration of environmental management into routine asthma care. The program was designed and implemented through a partnership between the NYS Asthma Control Program, four managed care plans and the Erie County Department of Health Healthy Neighborhoods Program.
- A partnership with MA managed care plans and health care practices in Brooklyn was established to implement a medical home initiative to reduce asthma health care disparities. The goal of the Eliminating Disparities in Asthma Care (EDAC) project is to develop, implement and evaluate healthcare system change interventions which improve asthma control and reduce disparities among African Americans enrolled in managed care plans that serve MA recipients.
- While asthma care and management has significantly improved over the last 10 years, hospitalization rates have recently increased. Using this data, the regional asthma coalition program has been redesigned to specifically target the highest risk areas (high ED and hospitalization rates) in NYS. While the DOH continued to fund 11 regional asthma coalitions across NYS with the goal of reducing asthma-related morbidity and mortality, the scale of this program has been reduced to accommodate reduced funding.

Table 4a - State Performance Measure 9 Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Asthma Coordinator continued to play a pivotal role in coordinating asthma prevention and control efforts across DOH. | | | | X |
| 2. DOH continued to make asthma information available on the DOH intranet, the public website, and also by hard copy. The public website includes information on asthma surveillance, interventions, asthma care and asthma-related patient materials. | | | X | X |

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 3. The NYS Asthma Outcomes Learning Network quality improvement initiative supported the improvement of asthma care processes and outcomes for children in a variety of settings. | | X | X | X |
| 4. User-friendly asthma treatment guidelines were available through the Asthma Program. The finalized Clinical Guidelines build on the National Asthma Education and Prevention Program /National Instituted of Health guidelines. | | | X | X |
| 5. The Asthma Program is partnering with an outside organization to develop of culturally and linguistically appropriate self management support information systems. | | | X | X |
| 6. The DOH Asthma Control Program is developing processes to increase access to asthma self-management support services individuals with asthma. | | | X | X |
| 7. The NYSDOH continued fund regional asthma coalitions across NYS in an effort to reduce asthma-related morbidity and mortality. | | X | X | X |
| 8. The Eliminating Disparities in Asthma Care project brought managed care plans and health care practices together to implement a medical home initiative to reduce asthma health care disparities among the African American population. | | X | X | X |

b. Current Activities

- The 11 asthma care improvement teams, representing organizations that serve a pediatric population disproportionately affected by asthma, continue to implement and spread education and systems change interventions through participation in the NYS Asthma Outcomes Learning Network.
- Managed care plans and health care practices which provide benefits and services to African Americans with asthma are implementing interventions to improve asthma health outcomes for the target population in the Eliminating Disparities in Asthma Care initiative.
- A partnership has been established to work on the development of culturally/linguistically appropriate mobile phone information systems to provide asthma self management support to consumers.
- DOH is developing an RFA to fund regional asthma coalitions across NYS in an effort to continue to reduce asthma-related morbidity and mortality.
- An evaluation of the in-home services initiative is being completed to make the business case for expansion of the program.
- An evaluation of the SBHC Improvement Collaborative is being completed to identify best practices for improving care around comprehensive physical exams, asthma care and obesity care in NYS SBHCs.
- An analysis of the NYS Certified Asthma Educator workforce is being conducted to increase understanding of workforce supply and integration into clinical practice.

- Surveillance staff are finalizing the *2006-2008 NYS BRFSS Asthma Call-Back Survey Summary Report* for circulation.

c. Plans for the Coming Year

- DOH will administer contracts to regional asthma coalitions across NYS to support efforts to continue to reduce asthma-related morbidity and mortality in counties with high asthma-related hospitalization and Emergency Department visit rates.
- A finalized plan will be implemented, based on the outcome of the Certified Asthma Educator workforce analysis, to expand quality and access to asthma self management services for New Yorkers with asthma and their families.
- Asthma surveillance staff will produce and disseminate the 2011 NYS Asthma Surveillance Summary Report.
- Culturally and linguistically appropriate web and mobile phone-based asthma self management support tools and information systems will be finalized and provided to New Yorkers with asthma. Products will focus on increasing knowledge and limiting exposure to environmental triggers and on targeting messaging around appropriate steps following an asthma-related ED visit.
- The Asthma Outcomes Learning Network will expand to include at least eight new improvement teams which will implement initiatives aimed at improving asthma care and health outcomes in a variety of community and health care settings across the state.
- A summary report of the School-based Health Center (SBHC) Improvement Collaborative evaluation will be developed and distributed to NYS SBHCs and stakeholders throughout the state.
- Updated, comprehensive asthma surveillance data will continue to be made available via the DOH public website and the printed NYS Asthma Surveillance Summary Report.
- The Eliminating Disparities in Asthma Care initiative will continue implementation in the six health care practice sites.

State Performance Measure 10: *The percentage of infants who were exclusively fed breast milk in the delivery hospital*

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|--|-------------|-------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | 42 | 42.7 | 42.7 |
| Numerator | | | 95,496 | 96,080 | 96,080 |
| Denominator | | | 227,604 | 224,903 | 224,903 |
| Data Source | | | Statewide Perinatal Data System (SPDS) | SPDS | SPDS |
| Are the Data Provisional or Final? | | | Final | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 43.1 | 43.6 | 44 | 44.4 | 44.8 |

Notes 2010

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. 2009 data are used as a proxy for 2010. 2010 data will be available in May 2012.

a. Last Year's Accomplishments

- The *Breastfeeding Mothers' Bill of Rights* law, which went into effect May 1, 2010, was passed, which specifies the rights of pregnant women and new mothers to be informed about the benefits of breastfeeding, and to obtain specific supports from health care providers and health care facilities during pregnancy, after delivery and after discharge from the birthing facility. The *Bill of Rights* was posted on the DOH website in 6 languages.
- In an effort to improve awareness of the importance of maternity care practices in affecting breastfeeding, especially exclusive breastfeeding during the birth hospitalization, infant feeding data from hospitals (excluding NYC) were analyzed using the Statewide Perinatal Data System. Hospitals were ranked by quintile scores on three breastfeeding indicators (breastfeeding initiation, exclusive breastfeeding, and formula supplementation of breastfed infants). Each hospital was informed of its performance relative to other hospitals.
- In 2009, the 138 hospitals that provide maternity services in NYS were surveyed electronically by DOH. Information regarding patient education and support, obstetric staff education and training, and general breastfeeding policies was collected. The study identified several differences in breastfeeding practices at these hospitals. Recognition of these differences will be used to inform policy decisions and training opportunities for obstetric staff across the state. In preparation for this training, hospital staff was surveyed to determine the best staff education options related to breastfeeding.
- The written breastfeeding policies and procedures, as specified in NYS regulations, were also collected from all hospitals providing maternity care services and reviewed to determine compliance with NYS regulations. Each hospital was informed about its compliance with each component of the regulations.
- The WIC providers promote and support breastfeeding and participant-centered nutrition education as priority core services. Implementation of these core services is monitored by state staff through the new Local Agency Compliance and Self Assessment (LACASA) process. These services include support for pregnant women and new mothers from WIC staff members trained in lactation counseling and peer counseling services. The literature shows that peer counseling is one of the most successful interventions for increasing breastfeeding among low-income women. Other support services include the availability of breast pumps for mothers who are returning to work/school or have other special needs and the www.breastfeedingpartners.org website which provides information and resources for peer counselors and breastfeeding mothers.
- In March 2010, NY WIC received a performance award of \$1.6 million from the United States Department of Agriculture "*in recognition of the State agency's outstanding achievement in the highest breastfeeding rates among WIC participants.*" The performance award funded a statewide public media campaign, targeted to low income communities, to

increase public awareness and support of breastfeeding women. A Toolkit on Partnering with WIC for Breastfeeding Success, which contained breastfeeding resources, was developed for health care providers/hospitals to support families in their breastfeeding efforts.

- Medicaid Prenatal Care standards, which were revised in 2010, require providers to counsel and educate woman during prenatal visits and immediately postpartum regarding infant feeding choices, the nutritional advantages of human breast milk and provide information regarding the benefits of breast feeding for both the mother and infant.
- The Community Health Worker Program (CHWP) provides home visiting services to high risk pregnant and parenting families. Pregnant women are counseled about the benefits of exclusive breastfeeding. For the 2009-10 program year, the percentage of CHWP mothers who breast-fed at six months was 47.4%. The program exceeds the HP 2020 baseline of 43.4% of mothers who breastfeed their infants at 6 months of age, but is still below the HP 2020 target of 60.5%
- Comprehensive Prenatal-Perinatal Service Networks promote breastfeeding in a variety of ways including working with local WIC programs to promote breastfeeding through PSAs, distributing information on the benefits of breastfeeding to community residents, promoting the “business case” for breastfeeding to local businesses, working with other agencies to support breastfeeding, and providing referrals to certified breastfeeding specialists.

Table 4a - State Performance Measure 10 Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. NYS enacted the <i>Breastfeeding Mothers’ Bill of Rights</i> law on May 1, 2010 which requires pregnant women and new mothers to be informed about the benefits of breastfeeding and obtain specific supports from health care providers and health care facilities. | | | X | |
| 2. The <i>Breastfeeding Mothers’ Bill of Rights</i> was posted on the DOH website in 6 languages. | | | X | |
| 3. Using data from the Statewide Perinatal Data System, hospitals were ranked by quintile scores on three breastfeeding indicators (breastfeeding initiation, exclusive breastfeeding, and formula supplementation of breastfed infants). Each hospital was informed of its performance relative to other hospitals. | | | | X |
| 4. WIC continued to develop and implement strategies to enhance breastfeeding support and participant centered nutrition education, which are WIC priority core services. | | | X | |
| 5. DOH and Regional Perinatal Centers began offering the <i>Ten Steps to Successful Breastfeeding Online Course</i> (18-hour course) to staff in 125 hospitals providing maternity care services across NYS. | | | X | X |
| 6. DOH recruited 12 hospitals for the Breastfeeding Quality Improvement in Hospitals Learning Collaborative with the National Institute for Children’s Health Care Quality (NICHQ) to improve policies, systems and practices consistent with the recommended ten steps to improve breastfeeding support. | | | X | X |

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 7. Medicaid Prenatal Care standards, which were revised in 2010, require providers to counsel and educate woman during prenatal visits and immediately postpartum regarding infant feeding choices, the nutritional advantages of human breast milk and provide information regarding the benefits of breast feeding for both the mother and infant | | | X | X |
| 8. A collaborative effort among DOH Divisions and Offices and the NYC Department of Health and Mental Hygiene began to educate and implement baby friendly policies and practices. | | | X | X |
| 9. The 138 hospitals that provide maternity services in NYS were surveyed electronically by DOH to obtain information regarding patient education and support, obstetric staff education and training, and general breastfeeding polices. Identified differences in breastfeeding practices at these hospitals will inform policy decisions and training opportunities for obstetric staff across NYS. | | | X | X |
| 10. A Toolkit on Partnering with WIC for Breastfeeding Success, which contained breastfeeding resources, was developed for health care providers/hospitals to support families in their breastfeeding efforts. | | | X | |

b. Current Activities

- Hospital-specific breastfeeding rates for all hospitals are updated yearly and posted on the DOH public website. Those with high exclusive rates were recognized by the DOH Commissioner.
- DOH is providing the 18-hour *Ten Steps to Successful Breastfeeding Online Course* free-of-charge to staff in 125 hospitals providing maternity care services in NYS.
- DOH is engaging 12 hospitals located outside NYC for the Breastfeeding Quality Improvement in Hospitals Learning Collaborative, a joint initiative with NICHQ. NYCDHMH. Teams from the hospitals implement maternity care practices that support exclusive breastfeeding.
- DOH developed Model Hospital Breastfeeding Policy Guidelines consistent with NYS Perinatal Rules and Regulations (Title 10-405.21) and the *Breastfeeding Mother’s Bill of Rights*. Hospitals statewide were trained on the Model Hospital Breastfeeding Policy and Implementation Guide.
- DOH will again collect written Hospital Breastfeeding Policies from hospitals providing maternity care services to assess compliance with NYS laws and regulations.
- CHWs receive training and on-going education on topics appropriate to the needs of at-risk pregnant and parenting women and their families, including breastfeeding. Activities include client education early in their pregnancies about the benefits of breastfeeding, encourage meeting with a lactation consultant in order to learn techniques, and ongoing support after birth.
- CPPSNs continued to promote breastfeeding.

c. Plans for the Coming Year

- Collaboration will continue among Title V staff, the Division of Nutrition the Division of Chronic Disease and Injury Prevention, and the NYC Department of Health and Mental Hygiene to educate providers, assist hospitals with the implementation of baby friendly policies and practices, and to link women with home visiting programs to educate and assist with support for breastfeeding.
- Through the Communities Putting Prevention to Work (CPPW) funded Breastfeeding Quality Improvement initiative, DOH aims to further improve hospital policies and practices, promote hospital compliance with NYS regulations and laws, and increase staff skills and knowledge. Policies will be reviewed to determine compliance with State regulations, and each hospital will be informed of its compliance.
- The Change Package, Data Measurement Plan and other resources developed for the Breastfeeding Quality Improvement in Hospitals Learning Collaborative will be revised based on project experience and redeployed with additional hospitals engaged in breastfeeding quality improvement.
- The Maternity Information Leaflet, required by state law, provides patients information on maternity-related procedures performed at each hospital. The law has now been expanded to also require that information on infant feeding practices at each hospital (breastfeeding initiation, exclusive breastfeeding, and formula supplementation of breast-fed infants) be included in this publication.
- WIC agencies receive technical assistance and ongoing training opportunities to ensure quality breastfeeding promotion and support services. The DON continues to invest substantially in breastfeeding promotion and has allocated over \$5 million in FFY2011 contracts for Breastfeeding Peer Counselor Programs.
- WIC continues to fund and require that a Breastfeeding Coordinator, who has completed the 40-hour lactation course (CLC/Certified Lactation Counselor), in addition to peer counselors, be available at all WIC clinics to provide breastfeeding education and lactation support. WIC offers CLC training to local WIC staff statewide.
- WIC's updated www.breastfeedingpartners.org website, which provides information and resources for peer counselors and breastfeeding mothers, will be implemented.
- CHWPs will continue to promote breastfeeding to their clients, and to ensure they get the support they need.
- OHIP performs periodic analyses of data and information, including breastfeeding, through prenatal care chart reviews and birth certificate validation studies to assess quality of MA prenatal care through Managed Care. In the prenatal chart review, OHIP reviews evidence/documentation that breastfeeding was discussed with the pregnant woman and again postpartum, including a discussion of recommending 6 months exclusivity. Infant feeding at the end of the hospital stay is a question that is included in the Birth Certificate validation study using hospital records. OHIP will continue their periodic reviews and reinforce good practice with the Medicaid population.

Section IV E. Health Status Indicators

The MCH Program's ability to maintain or improve HSIs, interpretation of new data and strategies for the impacting upon the HSIs is described in the Needs Assessment Summary. A major focus for NYSDOH is on health disparities and the achievement of health equity. Numerous indicators are broken down by race and ethnicity in an effort to determine if certain groups are not benefiting equally from current interventions. Please refer to forms 20 and 21 for annual reporting of Health Status Indicators.

1A – NYS's low birth weight rate was unchanged between 2008 and 2009, at a rate of 8.2% which is greater than the Healthy People 2020 goal of 7.8%. New York's experience mirrors the national trend; in 2009, 8.2% of births nationally were low birth weight.

Through a multipronged approach, DOH is committed to improving birth outcomes. Within the Title V Program, and in collaboration with a wide range of internal and external partners, the Department administers a number of programs and initiatives that collectively aim to provide a comprehensive, integrated set of services to support optimal perinatal outcomes for both mothers and babies. These programs are located in the Division of Family Health and are part of an integrated effort to reduce health disparities in affected communities by increasing access to and utilization of comprehensive and continuous early prenatal care and other services through early identification, enrollment and referral of pregnant women into prenatal care, home visiting and other needed services.

A variety of public health strategies engage high risk pregnant women in early prenatal care. These include: Community Health Worker Program, Nurse Family Partnership for high risk first-time mothers early in pregnancy, and Healthy Mom – Healthy Baby Prenatal and Postpartum Home Visiting Program, designed to establish a county system of perinatal health services. Over the past year, DOH was awarded funding through the new federal Maternal and Infant Early Childhood Home Visiting (MIECHV), and is developing a state plan for funds, based on an extensive needs assessment process to identify communities with high rates of maternal, infant and child health risk indicators and the existing home visiting programs and supportive resources in those communities. NYS's work in the MIECHV will support further coordination of services, and maximization of resources to improve birth outcomes. The Department also funds perinatal networks in high risk communities that are designed to improve the system of perinatal care.

The Medicaid Prenatal Care Program provides comprehensive prenatal care to women up to 200% of the FPL based on evidence-based procedures and practices appropriate to the needs of pregnant women who qualify for Medicaid coverage, regardless of provider or delivery system. The program integrates updated standards and guidance from ACOG and the AAP, and reflect expert consensus regarding appropriate care for low-income, high-risk pregnant women.

NYS has also been a national leader in the development of a statewide system of perinatal regionalization. NYS has a well-organized system of regionalized perinatal care that ensures that appropriate hospital care is provided to women and their newborns. A system of regionalized perinatal services includes a hierarchy of three levels of perinatal care provided by the hospitals within a region and led by a Regional Perinatal Center (RPC). Women at highest risk for poor

birth outcomes are referred to RPCs and supportive health and social services. Research strongly supports regionalization as a means of improving birth outcomes.

1B – When low birth weight rates for total births are compared to those for singleton births, the rates among singletons are consistently better. Very low and low birth weight births occur more frequently during multiple births. There has been an increase in the past decade in multiple births, due in part to advances in the technology of assisted reproduction, where multiple births are more common. From 1999 through 2009 there was a slow rise in the percentage of all babies born who were either twins or higher order multiples. In 1999 the rate of non-singleton babies born was 3.5%, and in 2009 the rate was 4.0%, an increase of 14.3%. The singleton LBW rate of 6.2 percent in 2009 represents a slight decrease from 2008, but is still higher than the rather steady rate of 5.9 – 6.1 percent from 1998 – 2003. Issues such as access to comprehensive prenatal care, substance use and other issues can impact birth outcomes. As stated in 1A, within the Title V Program, and in collaboration with a wide range of internal and external partners, the Department administers a number of programs and initiatives that collectively aim to provide a comprehensive, integrated set of services to support optimal perinatal outcomes for both mothers and babies. These programs are part of an integrated effort to reduce health disparities in affected communities by increasing access to and utilization of comprehensive and continuous early prenatal care and other services through early identification, enrollment and referral of pregnant women into prenatal care, home visiting and other needed services.

DOH recognizes that to improve birth outcomes, efforts need to be made to improve the health of women prior to pregnancy as it significantly impacts birth outcomes. In 2010, HRSA awarded DOH a *First Time Motherhood – New Parents Initiative* grant to increase awareness of preconception/interconceptional health to improve perinatal outcomes, with a focus on the promotion of positive health behaviors among high-risk Black adolescents in order to address the issue of health disparities in birth outcomes. To date, adolescent focus groups were conducted to determine attitudes toward health and inform DOH's future plans. The Department is working with local providers in 6 high-risk communities (Erie, Monroe, Onondaga, Albany, Westchester and Bronx counties) to develop local action plans to identify existing preconception health resources and supports, gaps in services and strategies to increase community awareness of preconception health, and utilization of local resources to promote preconception health/care. These communities represent areas of the state with the most disparate birth outcomes.

New York State has also been a national leader in the development of a statewide system of perinatal regionalization. All obstetrical hospitals have been designated by the Department as a Level I, II, III or Regional Perinatal Center (RPC) based on standard criteria included in state regulation. Regulations require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers and newborns.

2A – The percent of very low birthweight births (<1500 grams) in New York State was 1.5% in 2009. The rate has been virtually unchanged since 1999, and higher than the Healthy People 2020 goal of 1.4%. The VLBW rate has shown little variation over the past decade. As stated in Health Status Indicator 1B, the Title V Programs has made significant efforts to improve birth outcomes through the development, implementation and oversight of a number of programs and initiatives that collectively aim to provide a comprehensive, integrated set of services to support

optimal perinatal outcomes. Efforts made to ensure that all VLWB babies are born at facilities with services commensurate with their more complex needs have resulted in the vast majority of these babies being born at Level III hospitals and Regional Perinatal Centers. Regionalization has had a positive impact in NYS with VLBW babies more likely to be born at RPC and Level III hospitals and more likely to survive post-regionalization (2004-2006) than pre-regionalization (1996-2001). NYS's risk-adjusted VLBW neonatal mortality rate declined from 13.03 per 100 during 1996-2001 to 10.46 per 100 during 2004-2006. Improvements were noted by region, NYC (13.45/100 to 10.45/100) and Rest of State (12.49/100 to 10.47/100), and hospital level, RPCs (12.52/100 to 9.78/100) and Level IIIs (13.41/100 to 10.71/100). NYS is first among 10 states that met the 2010 goal of 90% of VLBW infants delivered at a Level III or higher hospital. An analysis of mortality rates among VLBW babies has been conducted. Preliminary findings indicate a substantial decrease in mortality rates for babies in the birthweight group since implementation of New York's perinatal regionalization initiatives.

2B – When comparing low birth weight rates for total births to those for singleton births, the rates among singletons are consistently better. The percent of singleton very low birth weight births (<1500 grams) in NYS has decreased slightly since 2006, but remained relatively consistent since that time. Very low and low birth weight births occur more frequently during multiple births. The ten-year trends of very low birth weight for both singleton and total births are similar, and have been basically unchanged over the past 10 years.

New York State's has also been a national leader in the development of a statewide system of perinatal regionalization to better ensure that high risk mothers and babies receive the most appropriate level of care to improve perinatal outcomes. The percentage of very low birth weight infants delivered at facilities for high-risk deliveries has increased significantly from 84.6% in 2002 to approximately 90% in 2009~~8~~, which is most likely the result of the State's strong regionalized approach to birthing hospitals as described previously. While RPCs and Level III hospitals accounted for 64.7% percent of all births in 2009, approximately 90 percent of all very low birth weight (VLBW) infants were delivered at RPC and Level III facilities. Conversely, less than 10% of VLBW infants were delivered at Level I and II hospitals, which accounted for approximately 35% of all newborn deliveries in NYS in 2009. The trend towards delivery of high-risk newborns at appropriate level hospitals suggests the effectiveness of perinatal regionalization. The Statewide Perinatal Data System also captures data as to why VLBW infants were born at lower level hospitals; the majority of such births are due unavoidable events, such as inability to transfer the woman to a higher level hospital due to advanced stage of labor.

White – Black disparities remains an issue for LBW as well as VLBW. As stated in other sections of this application, the Title V Program, and in collaboration with a wide range of internal and external partners, the Department administers a number of programs and initiatives that collectively aim to provide a comprehensive, integrated set of services to support optimal perinatal outcomes for both mothers and babies. These programs are part of an integrated effort to reduce health disparities in affected communities by increasing access to and utilization of comprehensive and continuous early prenatal care and other services through early identification, enrollment and referral of pregnant women into prenatal care, home visiting and other needed services.

Preconception health is also a focus of DOH as the health of women prior to pregnancy significantly impacts birth outcomes. In 2010, HRSA awarded DOH a *First Time Motherhood – New Parents Initiative* grant to increase awareness of preconception/interconceptional health to improve perinatal outcomes, with a focus on the promotion of positive health behaviors among high-risk Black adolescents, a specific target of this project to improve issues related to health disparities. To date, adolescent focus groups were conducted to determine attitudes toward health and inform DOH's future plans.

3A – The death rate for unintentional injuries among children aged 14 years and younger has decreased from 4.3 per 100,000 in 2008 to 3.4 in 2009. As stated in National Performance Measure #10, the Department's Bureau of Injury Prevention has devoted significant effort in promoting efforts to decrease these injuries. The Bureau's Childhood Injury Prevention Projects have built successful coalitions for injury prevention at the local level, reaching out to diverse segments of the community to ensure that the community is well informed on issues related to childhood injury prevention. The Bureau of Injury Prevention has developed and disseminated toolkits and fact sheets for medical providers, researchers, educators and consumers to provide up-to-date data, best practices and evidence-informed programs to reduce unintentional injuries, including traffic-related injuries. The toolkits include child passenger safety, Shaken Baby Syndrome prevention, fire safety, falls prevention, and bicycle safety. The toolkits are available on the DOH website (<http://www.health.ny.gov>) and in hard copy upon request. DOH also received a supplemental grant award from the Centers for Disease Control and Prevention that is supporting the development of a child injury prevention policy initiative. A Child Injury Prevention Policy Subgroup of a larger Injury Community Planning Group met to discuss and prioritize policy initiatives of importance to reduce the risk of injury in NYS families with children aged 0 to 19 years, and are drafting a Child Injury Policy Plan to include relevant data, evidence-informed strategies, best practices, a prioritized list of policies, and a related timeline for implementation.

Title V Programs such as the Community Health Worker Program and prenatal care programs all have extensive child safety components, which stress car seat use and other infant safety measures. Parents who are enrolled in the Community Health Worker Program are also given extensive information about childhood safety. American Indian Nations with Community Health Worker Programs all have formalized child safety education including car seat education components. Other reservation clinics promote child safety during individual health education/risk reduction encounters.

Over the past year, DOH launched the Keeping NY Kids Alive program to expand and improve local multidisciplinary teams that review and prevent child deaths. In collaboration with the Office of Children and Family Services, the program is focusing on the increasing the number of county based child death review teams, expanding the number and scope of cases reviewed, standardizing data collection and submissions and enhancing local prevention measures and system improvements.

3B - The death rate for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes has decreased slightly since 2007. In 2008, the rate was 1.2 per 100,000 and 1.0 in 2009. As stated in National Performance Measure #10, the Department's Bureau of

Injury Prevention has devoted significant effort in promoting efforts to decrease these injuries. The Bureau's Childhood Injury Prevention Projects have built successful coalitions for injury prevention at the local level, reaching out to diverse segments of the community to ensure that the community is well informed on issues related to childhood injury prevention. The Bureau of Injury Prevention has developed and disseminated toolkits and fact sheets for medical providers, researchers, educators and consumers to provide up-to-date data, best practices and evidence-informed programs to reduce unintentional injuries, including traffic-related injuries. The toolkits include child passenger safety, Shaken Baby Syndrome prevention, fire safety, falls prevention, and bicycle safety. The toolkits are available on the DOH website (<http://www.health.ny.gov>) and in hard copy upon request. The Bureau of Injury Prevention also performed traffic-related research and conducts surveillance of passenger, bicycle and pedestrian safety in NYS.

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3C – The death rates for unintentional injuries due to motor vehicle crashed among youth aged 15 through 24 years decreased significantly between 2005 (14 per 100,000) and 2008 (8.6), but increased to 9.5 in 2009. As discussed previously, the Division of Chronic Disease and Injury Prevention, Bureau of Injury Prevention identifies and monitors where and why injuries occur across the state and develops programs to prevent them. It consists of unintentional injury prevention, violence prevention and injury surveillance programs. The Childhood Injury Prevention Project continued work with the injury prevention coalitions established at the local level reaching out to diverse segments of the community to ensure the populace is well informed on issues related to childhood injury prevention. The Bureau of Injury prevention also performed

traffic related research and conducted surveillance of passenger, bicycle and pedestrian safety in NYS. New York has spearheaded policies and programs such as New York's Graduated Driver's License program that has specific restrictions for drivers under 18 years of age and the school based education programs that promote awareness and driver safety.

4A – The rate of nonfatal injuries among children aged 14 years and younger has declined significantly since 2005. In 2008 the rate was 253 per 100,000 which decreased to 244.7 in 2009. As stated in previous HSIs, the Division of Chronic Disease and Injury Prevention, Bureau of Injury Prevention identifies and monitors where and why injuries occur across the state and develops programs to prevent them. The Bureau of Injury Prevention has a long history of collaborating with groups, organizations and agencies to determine their needs and the needs of the public to decrease fatal and nonfatal injuries. In response to their requests the Bureau is completed the development of five tool kits and 48 fact sheets to provide up to date data, best practices and evidence-informed programs to reduce unintentional injuries, particularly traffic related, for medical providers, researchers, educators and consumers. The toolkits include Shaken Baby Syndrome prevention, fire safety, falls prevention, child passenger safety, and bicycle safety. The toolkits are available on the department website and in hard copy upon request.

Partnerships with other groups, agencies and organizations with a focus on childhood injury prevention continue to thrive promoting a coordinated message. A supplemental grant award from the CDC is supporting the development of a child injury prevention policy initiative. A symposium was held in winter 2010 for practitioners describing the problem of child injuries and introduce the toolkits. A second symposium was held in spring 2010 to educate practitioners and provide the tools necessary to develop strategies for childhood policy promotion on the state and local level.

In December 2008, the WHO/UNICEF and the CDC issued reports about the problem of childhood unintentional injuries in the world and the US. In response to the reports, the Bureau of Injury Prevention developed the Child Injury Prevention Project to assist LHDs, hospitals, providers, caregivers and parents in preventing unintentional childhood injuries. These injuries are preventable and the Bureau is sharing the evidence-based strategies with the public, LHDs and hospital staff to reduce the risk of injury and disability. Key strengths of the program include strong partnerships with community and state level organizations with a focus on children and their families, such as OCFS, NYS Safe Kids Coalition, and the Governor's Traffic Safety Committee.

4B - The rate for nonfatal injuries among children aged 14 years and younger due to motor vehicle crashes has decreased steadily 2006. In 2009, the rate decreased from 25.8 per 100,000 in 2008, to 23. The Department's Bureau of Injury Prevention has devoted significant effort in promoting efforts to decrease these injuries. The Bureau's Childhood Injury Prevention Projects have built successful coalitions for injury prevention at the local level, reaching out to diverse segments of the community to ensure that the community is well informed on issues related to childhood injury prevention. Title V Programs such as the Community Health Worker Program and prenatal care programs all have extensive child safety components, which stress car seat use and other infant safety measures. Parents who are enrolled in the Community Health Worker

Program are also given extensive information about childhood safety. American Indian Nations with Community Health Worker Programs all have formalized car seat education components. Other reservation clinics promote vehicle safety during individual health education/risk reduction encounters. Whenever possible, child safety messages are integrated into Department programs to maximize the impact of these messages.

4C - The rate for nonfatal injuries due to motor vehicle crashed among youth aged 15 through 24 years has decreased significantly since 2006. There was a slight decrease in 2009 (103 per 100,000) as compared with 104.4 in 2008. As stated previously, the Division of Chronic Disease Prevention and Adult Health, Bureau of Injury Prevention identifies and monitors where and why injuries occur across the state and develops programs to prevent them. It consists of unintentional injury prevention, violence prevention and injury surveillance programs. The Childhood Injury Prevention Project continued to work with the injury prevention coalitions established at the local level reaching out to diverse segments of the community to ensure the populace is well informed on issues related to childhood injury prevention. The Bureau of Injury prevention performed traffic related research and conducted surveillance of passenger, bicycle and pedestrian safety in NYS. New York has spearheaded policies and programs such as New York's Graduated Driver's License program that has specific restrictions for drivers under 18 years of age and the school based education programs that promote awareness and driver safety. The Bureau also represents the Department on the Governor's Traffic Safety Committee. In the coming year, the Department is also planning a one-day traffic safety symposium will be held to educate stakeholders, including adolescents, young adults and community members, about the risk of sustaining a traumatic brain injury from a motor-vehicle related incident. Relevant data and evidence-informed strategies and best practices will be shared with the participants.

5A – The rate of Chlamydia increased significantly between 2005 and 2009. The rate in 2008 was 33.7 per 100,000, increasing to 36.1 in 2009. In 2009, 92,075 cases of Chlamydia were reported in New York State, making it the most commonly reported communicable disease. Chlamydia morbidity has continued to increase since reporting began in 2000. Women are disproportionately affected by Chlamydia. The case rate per 100,000 population for females in 2009 was more than twice the rate for males (649.1 vs. 308.4). Young women had the highest rates of infection. Among females 15-19 in New York State, the infection rate was 3,908.8 per 100,000, and among females aged 20-24, the rate was 3435.8 per 100,000.

New York has a rich system of providing reproductive health services to our most vulnerable population. The NYS Family Planning Program in the Division of Family Health, Bureau of Maternal and Child Health provides comprehensive reproductive health care, including contraceptive education, counseling and methods as well as counseling and testing for HIV and sexually transmitted diseases to help contain major threats to public health, to assist low income, uninsured and underinsured women, racial and ethnic minorities, adolescents and men in determining their reproductive futures and in avoiding STIs and unintended pregnancy. The Family Planning Program served more than 349,000 women and men in 2009, including 58% minority and 85% under 150% of the Federal Poverty Level.

The Title V Programs also supports an array of adolescent health programs, as previously discussed. The Comprehensive Adolescent Pregnancy Prevention (CAPP) Initiative is a new

initiative that integrates and replaces previous adolescent health programs that implement evidence-based sexuality education; ensure access to reproductive services; expand educational, social, vocational and economic opportunities; and, engage adults to advance community efforts to improve environments for young people. DOH was awarded funding for the Personal Responsibility Education Program initiative that focuses on implementation of evidence-based sexual health education and preparation of youth for successful transition to adulthood to reduce adolescent pregnancy. The Abstinence Education Grant Program is a new initiative that will fund community-based mentoring, counseling and adult supervision programs designed to delay the initiation of sexual behavior among young people, ages 9-12, residing in high-risk communities.

The Bureau of STD Control administers STD clinics throughout NYS and oversees a significant public awareness and education campaign targeted to NY's most vulnerable individuals.

5B - The rate of Chlamydia increased significantly in 2006, and has remained relatively consistent since that time. The rate for women 20- 44 years in 2008 was 10.6 per 100,000, increasing to 11.1 in 2009. In 2009, 92,075 cases of Chlamydia were reported in New York State, making it the most commonly reported communicable disease. As stated previously, Chlamydia morbidity has continued to increase since reporting began in 2000. Women are disproportionately affected by Chlamydia. The case rate per 100,000 population for females in 2009 was more than twice the rate for males (649.1 vs. 308.4). Young women had the highest rates of infection. Among females 15-19 in New York State, the infection rate was 3,908.8 per 100,000, and among females aged 20-24, the rate was 3435.8 per 100,000.

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The Comprehensive Adolescent Pregnancy Prevention (CAPP) Initiative is a new initiative that integrates and replaces previous adolescent health programs that implement evidence-based sexuality education; ensure access to reproductive services; expand educational, social, vocational and economic opportunities; and, engage adults to advance community efforts to improve environments for young people. The Bureau of STD Control administers STD clinics throughout NYS and oversees a significant public awareness and education campaign targeted to NY's most vulnerable individuals.

6A – As stated in the Needs Assessment section of New York's 2011 application, these data demonstrates the diversity that is New York. According to the 2009 Census estimates, 19,541,453 people live in New York State. Both the population residing in Rest of State and New York City's population experienced a modest gain between 2008 and 2009. Population

trends indicate that, after a slight downward trend in the late 70's and early 80's, New York's population rose, and then leveled off. New York was the second most populous state until the late 1990's, when its population growth slowed to less than 1%. New York is now the third most populous state, behind California and Texas. Six percent of the US population lives in New York. New York City contains 43% of the State's population, with over 8 million people (8,363,710).

New York's population reflects diverse race and ethnicity as it is more diverse than the nation as a whole. New York has higher percentages of non-Hispanic Black residents, Hispanic residents and non-citizen immigrant residents than the U.S. average. According to the American Community Survey conducted by the US Census Bureau, New York ranks second of all states in foreign born, with 21.7% of its total population or 4,236,768 people being foreign born in 2008. Almost 90% of New York's non-citizen immigrants live in New York City, with Queens County being the most diverse county in America. (As of the 2008 American Community Survey, immigrants comprise 47.4% of its residents.)

This diversity necessitates the focus on ensuring that programs and activities developed and implemented by the Department are targeted to the maternal and child health population served and are not only available, but are accessible by being ethnically and culturally sensitive. Initiatives such as the Prevention Agenda emphasize at the local and state level, the importance to developing service systems that will improve health outcomes for all and decrease health disparities.

6B – These data elucidate the diversity of New York's children. As stated in the Needs Assessment section of this application, between 1990 and 1998, there had been small shifts in the ethnic composition of New York's population, with the population of New York City being more racially and ethnically diverse than the rest of the State. The 1999 New York State population under age 24 was 72% white, 22% African American, and 18% Latino. Approximately 6% were identified as Asian/Pacific Islander.

In 2000, the Census, in an effort to reflect the growing diversity in the US, gave respondents the option of selecting one or more race categories to indicate their racial identities. Because of this change, data from the 2000 Census cannot be compared to earlier censuses. The six single race categories (White, Black or African American, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, and Some Other Race) and the two or More Races category are exclusive categories. The majority of New Yorkers (96.9%) reported only one race; 3.1% identified themselves as being of more than one race.

The 2008 American Community Survey uses the same race categories as the 2000 Census. According to the 2008 American Community Survey, the largest group (67.2%) reported White alone, while Black or African American alone represented 15.9 percent of New Yorkers. 7.5% reported being Some Other Race. 7.0% stated they were Asian alone, and 0.4% reported they were American Indian or Alaska Native. Native Hawaiian or Other Pacific Islander accounted for only 0.03% of those reporting.

Hispanics accounted for the majority of the Some Other Race category. Of New York State residents who selected Some Other Race, 93.4 percent identified themselves as Hispanic. Hispanics represent 16.7% of New York State's total population. In New York City, 28% indicated they were Hispanic. Four out of 10 Hispanics did not identify themselves with one of the five specific race alone categories or two or more races category. Of those New Yorkers identifying themselves as Hispanic, 44.2 said they were Some Other Race. Between 2000 and 2008, the Hispanic population increased from 13.9% to 16.7% of New York's total population. The percentage of Black or African Americans remained at 15.9% and the percentage of Asians increased from 5.5% to 6.9%.

As stated numerous times in this application, by expanding access to the public health insurance programs and developing and implementing health and supportive services in highest need areas of the state, New York is committed to providing quality services to the children, youth and adolescents of New York that are culturally and ethnically sensitive to the needs of the diverse population to ultimately address health disparities and improve health outcomes.

7A – There were 246,592 births in New York State in 2009. Of these, 121,745 (49%) were to residents of NYC and the remaining 124,847 were to Upstate, NY residents. This is 3,063 fewer births than occurred in 2008. Most all of the decline in the number of births was among New York City residents. In 2009, births to white mothers accounted for 66 percent of all births and births to Black mothers represented 18 percent of the total. Sixteen percent of births were in the “other” category. This includes births to persons of multiple races, as well as all other races. Births to Hispanic mothers accounted for almost 24 percent of all births. The majority of births occurred to women between the ages of 20 and 39 (89%). Out-of-wedlock births accounted for 41.1 percent of total births. This is slightly less than in 2008 when 41.2percent of births were out-of-wedlock. Mothers 17 years of age and younger were more likely (96%) to be unmarried compared to mothers aged 25 or older (30%). Out-of-wedlock births were also more common among Black (70.6%) and Hispanic (65.5%) mothers. Disparities between Black, white and Hispanic births have persisted over the past ten years.

The diversity of age as well as race present significant challenges to New York State. Addressing adolescent pregnancy is a priority of the Department and the Title V program. Adolescents are less likely to seek early prenatal care, therefore risking poor birth outcomes, and are also more likely to live in poverty. New York's adolescent health initiatives and comprehensive family planning program as discussed, in this application, strive to address this issue. New York State's perinatal programs employ a comprehensive, multi-level strategy, which integrates broad based systems approaches, involving county and local planning efforts, with one-on-one outreach through home visiting programs to assess, intervene and address the perinatal health needs of residents in high risk communities.

To address health disparities in birth outcomes, within the Title V Program, and in collaboration with a wide range of internal and external partners, the Department administers a number of programs and initiatives that collectively aim to provide a comprehensive, integrated set of services to support optimal perinatal outcomes for both mothers and babies. These programs are part of an integrated effort to reduce health disparities in affected communities by increasing access to and utilization of comprehensive and continuous early prenatal care and other services

through early identification, enrollment and referral of pregnant women into prenatal care, home visiting and other needed services. New York State has also been a national leader in the development of a statewide system of perinatal regionalization. All obstetrical hospitals have been designated by the Department as a Level I, II, III or Regional Perinatal Center (RPC) based on standard criteria included in state regulation. Regulations require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers and newborns.

7B – Refer to HIS 7A for information.

8A – The 2009 infant mortality rate was 5.3 per 1,000 live births, declining the past five years to a record low for NYS. The infant mortality rate declined most dramatically during the early 90's and at a slower pace in recent years. NYS has exceeded the Healthy People 2020 goal for infant mortality (6.0), and is working toward meeting NYS's 2013 Prevention Agenda Objective of no more than 4.5 infant deaths per 100,000 live births.

Hispanic and White infant mortality rates have continued to be about half the rate for Black infants. The infant mortality rate among black non-Hispanic infants declined from 11.8 in 2008 to 10.9 in 2009. The 2009 white non-Hispanic infant mortality rate was unchanged from 2008 at 4.2 per 1,000 and 24% lower than in 2000. Asian/Pacific Islander non-Hispanic infants experienced the lowest rate of infant mortality in 2009, at 2.4 per 1,000 live births. Infant mortality among Hispanic infants, at 4.5 per 1,000 in 2009. Even though rates have been declining, Black infant mortality rates are still significantly higher than rates for white non-Hispanics, Asian/Pacific Islander non-Hispanics and Hispanics.

NY's neonatal mortality rate mimics that of infant mortality. The postneonatal mortality rate in NYS has changed very little over the past decade. The disparities in rates between Blacks and Whites and Hispanics that were seen in both infant and neonatal mortality rates are also seen in postneonatal mortality.

Within the Title V Program, there are specific projects to monitor and analyze infant mortality data to guide the development of priorities and interventions. Based on 2005-2007 vital statistics data, the top five causes of infant death including conditions originating in the perinatal period (56.4%), congenital anomalies (18.7%), sudden infant death syndrome (4.1%), accidents (non-motor vehicle injuries) (2.6%) and diseases of the heart (1.4%) accounted for 83% of all infant deaths. Based on an 11-year report on child deaths, communicable and chronic disease and unknown causes account for much of the remaining 17% of deaths. Driven by these data, in addition to enhanced prenatal activities, efforts to reduce infant mortality have focused on promotion of safe sleep and reduction of SIDS, including extensive risk reduction education for SIDS and other sleep related deaths, and work with local child fatality review and data collection activities to better understand the contributing factors to sleep related, other accidental deaths and homicides. In addition, the Title V program collaborates with other partner programs including WIC, Injury Prevention, and others to address factors that contribute to infant mortality.

The Title V program, in collaboration with the state's Office of Children and Family Services (OCFS), implemented the Keeping NY Kids Alive program that will expand and improve the quality of the child fatality review process. The initiative will assist in improving the skills of

local officials who work in the child fatality review process to promote improved community services delivery and the development of local public health risk reduction and safety focused prevention programs.

8B – Refer to HSI 8A for information.

9A - New York’s commitment to its citizens, including children 0 through 19 years of age, is demonstrated by the significant supports and services available to New York’s most vulnerable population. Through their various health and human service programs offered by the Department, as well as sister agencies, such as health care services funded by public insurance programs, family planning and reproductive health care, and the array of adolescent health initiatives, including youth development activities, New York strives to support its youth to decrease health disparities, reach the high risk populations, such as those children living in poverty and foster care, and foster self sufficiency and youth development in order that all youth become healthy, productive citizens.

The comprehensive strategy of the Children’s Agenda aims to provide the groundwork for healthy and successful lives for all New York’s children. To respond to the federal requirement to establish or designate State Advisory Councils on Early Childhood Education and Care, New York established a new body— the Early Childhood Advisory Council (ECAC). The ECAC includes individuals with early childhood expertise who represent early care and education, health care, child welfare, and mental health programs, as well as state agencies, advocacy organizations, foundations, higher education, unions, and others involved in the provision of services to young children and their families. The ECAC focuses on addressing the structural issues that have impeded the development of a comprehensive system of early childhood supports and services. The Director of the Bureau of Maternal and Child Health, Dr. Rachel de Long, is an ECAC member and several other Title V staff participate on ECAC workgroups.

From 2003 through May of 2009, the Department’s Title V Program was the recipient of a federal Early Childhood Comprehensive Systems (ECCS) grant. The early years of the grant focused on cross-systems strategic planning, and resulted in a comprehensive early childhood plan. Recent years have focused on incremental implementation of the plan, with a strong emphasis on building state level cross-systems infrastructure for early childhood work. The overarching goal of the NYS ECCS plan is to support families and communities in nurturing the healthy development of children ages 0-5. The plan outlines goals, objectives and strategies within four cross-sector focus areas: Healthy Children, Strong Families, Early Learning, and Supportive Communities/ Coordinated System. A major emphasis and accomplishment in recent years has been to align the ECCS initiative with the work of the Early Childhood Advisory Council, accomplished in part by transferring administration of the state’s ECCS grant to the NYS Council on Children and Families in 2010.

9B – As stated in the Needs Assessment section of NY’s 2011 application, New York’s population reflects diverse race and ethnicity as it is more diverse than the nation as a whole. New York has higher percentages of non-Hispanic Black residents, Hispanic residents and non-citizen immigrant residents than the U.S. average. New York’s commitment to its citizens, including children 0 through 19 years of age, is demonstrated by the significant supports and services available to New York’s most vulnerable population. Through their various health and

human service programs offered by the Department, as well as sister agencies, such as health care services funded by public insurance programs, family planning and reproductive health care, and the array of adolescent health initiatives, including youth development activities, New York strives to support its youth to decrease health disparities, reach the high risk populations, such as those children living in poverty and foster care, and foster self sufficiency and youth development in order that all youth become healthy, productive citizens.

10 – These data show that a large majority of New York’s children aged 0 through 19 years resides in urban and metropolitan areas of the state, with a much smaller number in rural New York State. Population density often determines the number and types of health services that an area can support. The US Census shows that in 2000 there were 401.9 persons per square mile in New York State, compared to 79.6 persons per square mile in the US. New Yorkers are more likely to live in urban areas than residents of other states. Population density within New York varies widely. New York City is 104 times more densely populated than the rest of the state. New York City comprises over 40% of New York State’s population, and the counties immediately north of New York City (Orange and Westchester Counties) and Long Island (Nassau and Suffolk Counties) comprise an additional 21% of the state’s population. Other population centers are Buffalo (Erie County), Rochester (Monroe County), Syracuse (Onondaga County) and Albany (Albany County). Many areas of New York are also rural. Twenty-six percent of New Yorkers live in rural areas, compared to 36% nationwide.

This presents a significant challenge in ensuring quality services are available in diverse areas of the state, while maximizing limited resources. The Department often uses Vital Records data to identify areas where significant needs and health disparities exist. Areas are rank ordered on multiple indicators through zip code level analyses of rates of adverse outcomes to ensure provision of services to residents living in the highest risk communities, with the intent of reducing health disparities and improving outcomes. Vital Records and program data are routinely assessed to determine the impact on stated goals and to identify areas for quality improvements efforts. For example, adolescent health initiatives are targeted to the highest areas of risk including teen pregnancy rate, STIS, among others.

Department funded providers are also required to identify areas of need within high risk areas, identify gaps, barriers and challenges, and address those issues for their programs services. These issues may include proximity of services to the population served, and marketing those services to the high risk population.

11- These data highlight New York’s challenge of addressing supports and services for those individuals at or below 200% of fpl. Approximately 50% of New Yorkers are at 200% of the fpl and below. 20% of these individuals are at 100% of fpl or below. Poverty is highly associated with poor health outcomes, especially for women and children. Poverty is most common in families headed by single females, and single-female headed households with children are more likely than other families to be living below poverty. This is true regardless of race or ethnicity. New York is committed to ensuring programs and services are available to provide health care and support for New York’s most vulnerable children and families. In 2008, New York took a bold step towards ensuring universal coverage for children in the State when, prior to federal funding support, it increased the income eligibility threshold for Child Health Plus from 250 to

400 percent of the federal poverty level, making an additional 70,000 children eligible for subsidized health insurance coverage. In addition, the State expanded Family Health Plus for adults with children and for young adults (ages 19 and 20) to 160 per cent of the federal poverty level. Medicaid coverage for foster care children was also extended through age 20 to address the long standing problems children in foster care have had in transitioning to adulthood and independence. The state has also made substantial process in streamlining the Medicaid eligibility process.

Birth spacing and timing of births are significant in improving birth outcomes and allowing adolescents and women determine their reproductive future. Delaying pregnancy may help women in poverty further their education and become more gainfully employed. Comprehensive family planning and reproductive health care services provide comprehensive reproductive health care services throughout NYS.

Title V program has worked diligently with the Medicaid program to increase access to reproductive health services for Medicaid eligible women. In 1996, the Medicaid managed care legislation expanded Medicaid benefits for 26 month after the end of a pregnancy to women under 185 percent of the federal poverty level who had previously been on Medicaid while pregnant and subsequently lost coverage. In addition, in 2006, the MCH program and OHIP collaborated in developing and implementing the state's waiver to expand family planning services for individuals up to 200 percent of the federal poverty level. Medicaid prenatal care services and the array of home visiting services offered in New York (as discussed previously) provide supports and services to better ensure improved birth outcomes and provide support to mothers, children and families. Additional recommendations adopted through the state's MRT process in 2011 will convert NYS's 1115 waiver into a State Plan service, and streamline FPEP and FPBP into a single program that includes auto-enrollment of women following pregnancy and the addition of presumptive eligibility for Family Planning services coverage.

12 – Poverty is highly associated with poor health outcomes, especially for women and children. Poverty is most common in families headed by single females, and single-female headed households with children are more likely than other families to be living below poverty. This is true regardless of race or ethnicity. Given this, NY continues its commitment to reduce rates of teen pregnancy and out-of-wedlock births and to provide poor heads of households with jobs. According to the 2010 Current Population Survey, during 2009, 40.7 percent of the people in female-headed households with children lived below poverty in NYS. /2012/ In 2000, the rate was at its lowest level in 21 years, largely because NY had increased employment among its most economically needy families. In 2009, 71,000 children (25.0 percent) were living below poverty, slightly higher than the 20.1 percent in the nation as a whole, and an increase over the 20.3% living in poverty in 2008.

According to the 2009 American Community Survey, the percentages of households earning less than 100% of the poverty level were: 20.3% for children birth to under age 5, 18.6% for 5 to 17 year-olds, 15.8% for 18 to 34 year olds, 10% for 35-64 year olds, and 11.8% for those over 65. The percentage of NYS's population was living in poverty increased from 14.2% in 2008 to 15.8% in 2009, and families living in poverty increased from 11.4% in 2008 to 12.5% in 2009.//2012//

NY is committed to ensuring services are available to provide health care and support for NY's most vulnerable families. In 2008, NY took a bold step towards ensuring universal coverage for children when, prior to federal funding support, it increased the income eligibility threshold for Child Health Plus from 250 to 400 percent of the federal poverty level, making an additional 70,000 children eligible for subsidized health insurance coverage. In addition, the State expanded Family Health Plus for adults with children and for young adults (ages 19 and 20) to 160 per cent of the federal poverty level. Medicaid coverage for foster care children was also extended through age 20 to address the long standing problems children in foster care have had in transitioning to adulthood and independence. The state has also made substantial process in streamlining the Medicaid eligibility process.

Title V staff monitor access to services on a local level and work with OHIP to identify and solve access issues. DOH's public health home visiting (HV) services provide community outreach and direct services to high-risk families. These programs promote well baby care visits, assisting women with keeping these visits after the baby is born. The CHW, NFP and HMHB HV programs ensure that high-risk pregnant women and new mothers are identified and engaged in HV services. These efforts will be further developed through NYS's federal MIECHV initiative. (Refer to HSCI 04 for further details.)

NY has the largest SBHC program in the country to serve as a safety net for the provision of primary and preventive health care in high need neighborhoods schools in NY. Medicaid prenatal care services and the array of HV services provide supports and services to better ensure improved birth outcomes and provide support to mothers, children and families.

Section IV F. Other Program Activities

With the exception of injuries to young children, all MCH activities fall within priorities for the MCHBG 2011-2016 grant cycle. Injury prevention for young children continues to be a priority for the Department, however, it could not be subsumed readily under the new priorities. Department efforts to address injury prevention in children and adolescents are described in Section 3 of the needs assessment.

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

In 2009~~10~~ the Growing Up Healthy Hotline provided information to 53,978 callers on a variety of maternal and child health issues, including information on eligibility for programs and the location of the nearest services. Of these, 6,807 were for provision of pregnancy-related information and services. Less than six percent (3,017) of calls required handling in languages other than English. Of these calls, 2,874 were from Spanish-speaking callers and 143 of the calls were in languages other than English or Spanish. Seventy-seven percent of callers were female, and 23+ percent male. There was a 14+ percent decrease in the total number of calls to the hotline in 2010~~09~~ compared to 2009 and a 13 percent decrease compared to 2008. . It is important to note that in 2010 calls to the hotline for WIC inquiries declined from 33,687 calls in 2009 to 27,832 in 2010. The reason for the decrease of 5,855 WIC calls is unknown however it accounts for 11 percent of the overall decrease in Growing Up Healthy Hotline calls in 2010.

Another possible reason for the decrease in calls may be more use of the Internet to gain information. The implementation of United Way's 2-1-1 call hotline in New York State may have had an impact also. The 2-1-1 hotline number connects people in need to agencies and other organizations that can help them, specializing in providing emergency food, shelter and clothing and crisis counseling, services which may be utilized more since the economic downturn and loss of jobs.

Last year, callers requested assistance in the following areas: adult insurance 0.86 percent, Child Health Plus 2.4 percent, child/adult care food program 1.6 percent, dental/orthodontia 0.9 percent, early intervention 1.7 percent, educational materials 0.3 percent, Family Health Plus .9 percent, family planning 2 percent, farmer's market 4.8 percent, food and nutrition programs 1.6 percent, health department programs 0.9 percent, immunizations 0.2 percent, Medicaid for adults 2.9 percent, Medicaid for children 1 percent, newborn screening

0.5%, pregnancy testing 0.1%, pregnancy care 12.8%, rape crisis 0.3%, social services 1.7%, summer food program 2.9%, WIC 54.8%, WIC complaints 1.3%, and other 3.2%. Twelve callers asked about perinatal depression information and services.

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

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

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

Section V Budget Narrative

A. Expenditures

For each maternal and child health related initiative identified for the partnership, percentages for the types of services and the population are provided by program managers. The Federal allocation and State Budget appropriations are used to determine the level of funding for types of service and population to be served for the application. Expenditure reports for the budget period are generated and the percentages are applied to the initiative expenditures to determine population and service values.

Although the MCHSBG award was 2.3% less than anticipated, New York State expenditures exceeded the budget by 11.5%. Increases in state and local expenditures were within 5% of the budgeted amount; however, reported Program income exceeded the budget by 36%. This inordinate increase was primarily due to the delayed reporting by one of the Early Intervention counties. For individuals served, the variance between budgeted and expended was in children with special health care needs and also attributable to Early Intervention reporting. The difference in the types of services budget and expenditures is also predominately attributable to Early Intervention reported expenditures for direct health care services. The expenditures for infrastructure were 14% less than budgeted and attributable to state reimbursement to counties for general public health support.

B. Budget

The FFY 2012 total partnership budget is \$ 890,952,925. New York State's allocation of \$301,048,616 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 (\$3 state for every \$4 federal) of \$30,777,603 for the \$41,036,806 of Federal MCH Block Grant funds anticipated and an overmatch of \$270,271,013.

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 2012 which assures continuation of essential maternal and child health services.

Obvious variances in the FY 2012 amount from the FY 2011 amount can be attributed to increased levels of review and assessment of the populations being served and the type of service being provided by initiative; and ensuring that resources are being targeted for unmet needs. The Department's continuing efforts to identify and match state dollars for appropriate initiatives has resulted in a decrease or elimination of those dollars in the MCHSBG application. However, the maternal and child health related services continue to be provided by the state at the same level. The MCHSBG Advisory Council assists the Department in determining program priorities and is instrumental in seeking public input into the application process. The "Principles and Guidelines for the Use of Block Grant Funds", developed and revised as necessary by the Advisory Council, continues to be used. Effort is made to match funding to the level of unmet need, and to address the four layers of the MCH pyramid and the three target populations. Because funded programs often take more than one structural approach to targeted needs and

populations, program appropriations are proportioned out to reflect percentage of effort in infrastructure-building, population-based services, enabling services and direct health care services. Program appropriations also take into account the "30-30-10" requirements of Title V. The State more than meets "30-30-10 Requirements" for 30% allocation to primary and preventive care to children (\$13, 867,166; 33.8%) for 30% for children with special health care needs (\$14,003,000; 34.1%) and under 10% for administration (\$1,932,599, 4.7%) 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; Infant and Child Mortality Review; Lead Poisoning Prevention; Migrant and Seasonal Farmworker Health; Statewide Dental Technical Assistance Center; Osteoporosis Prevention; Parent and Consumer Focus Groups; Public Health Information/Community Assessment infrastructure; Preventive Dentistry Initiatives; the Dental Residency Program; Dental Supplemental Fluoride Program, School-Based Health Centers; STD Screening and Education; and, Diabetes Prevention in Children.

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:

Family Planning; Genetic Screening and Human Genetics; Immunization, Vaccine Distribution and State Aid for Immunization; Lead Control and Prevention, Lead Poisoning Prevention and Lead Regional Resource Centers; Physically Handicapped Children's Treatment Program; Migrant and Seasonal Farmworker Health Program; Perinatal Regionalization; Infertility services; School-Based Health Centers; SIDS and Infant Death, Child's Asthma Program, Diabetes (Type II) Prevention in Children Program, Growing Up Health Hotline, Healthy Mom, Healthy Babies Home Visitation Program and Safe Motherhood.

State HIV-related, Early Intervention, Community Health Worker, Comprehensive Prenatal-Perinatal Services Networks and Regional Preinatal Systems appropriations included in previous applications as match/overmatch are no longer being included as those dollars are used to leverage other federal funding. 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 and reporting processes to permit proper and complete recording of the utilization of available funds.
- Identifying codes are assigned to record these transactions by object of expense within each cost center.

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; SPRANS Grants; HRSA -- Ryan White HIV/AIDS Treatment Modernization Act of 2006; Oral Health; SSDI Funds; TANF Funds; Maternal, Infant and Early Childhood Home Visiting; Personal Responsibility Education; and, Abstinence Education.

Although there is a three percent increase in the FFY12 budget, this is attributable only to Program Income. This is based on current trend and anticipation that the transition to a new Early Intervention data system will result in more timely submission of claims. State funding reductions are a result of exclusion of additional initiatives identified above to leverage other funding and marginal appropriation decreases. The state's methodology for reimbursement to counties for assistance with health services has been restructured. Effective July 1, 2011, the state will no longer pay a percentage of the counties' cost for optional services.

TITLE V BLOCK GRANT APPLICATION
FORMS (2-21)
STATE: NY
APPLICATION YEAR: 2012

- FORM 2 - MCH BUDGET DETAILS
- FORM 3 - STATE MCH FUNDING PROFILE
- FORM 4 - BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED AND SOURCES OF FEDERAL FUNDS
- FORM 5 - STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES
- FORM 6 - NUMBER AND PERCENTAGE OF NEWBORN AND OTHERS SCREENED, CASE CONFIRMED, AND TREATED
- FORM 7 - NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V
- FORM 8 - DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE XIX
- FORM 9 - STATE MCH TOLL-FREE TELEPHONE LINE DATA
- FORM 10 - TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT STATE PROFILE FOR FY 2011
- FORM 11 - NATIONAL AND STATE PERFORMANCE MEASURES
- FORM 12 - NATIONAL AND STATE OUTCOME MEASURES
- FORM 13 - CHARACTERISTICS DOCUMENTING FAMILY PARTICIPATION IN CHILDREN WITH SPECIAL HEALTH CARE NEEDS
- FORM 14 - LIST OF MCH PRIORITY NEEDS
- FORM 15 - TECHNICAL ASSISTANCE (TA) REQUEST AND TRACKING

- FORM 17 - HEALTH SYSTEM CAPACITY INDICATORS (01 THROUGH 04,07,08) - MULTI-YEAR DATA
- FORM 18
 - MEDICAID AND NON-MEDICAID COMPARISON
 - MEDICAID ELIGIBILITY LEVEL (HSCI 06)
 - SCHIP ELIGIBILITY LEVEL (HSCI 06)
- FORM 19
 - GENERAL MCH DATA CAPACITY (HSCI 09A)
 - ADOLESCENT TOBACCO USE DATA CAPACITY (HSCI 09B)
- FORM 20 - HEALTH STATUS INDICATORS 01-05 - MULTI-YEAR DATA
- FORM 21
 - POPULATION DEMOGRAPHICS DATA (HSI 06)
 - LIVE BIRTH DEMOGRAPHICS DATA (HSI 07)
 - INFANT AND CHILDREN MORTALITY DATA (HSI 08)
 - MISCELLANEOUS DEMOGRAPHICS DATA (HSI 09)
 - GEOGRAPHIC LIVING AREA DEMOGRAPHIC DATA (HSI 10)
 - POVERTY LEVEL DEMOGRAPHIC DATA (HSI 11)
 - POVERTY LEVEL FOR CHILDREN DEMOGRAPHICS DATA (HSI 12)

FORM 2
MCH BUDGET DETAILS FOR FY 2012

[Secs. 504 (d) and 505(a)(3)(4)]

STATE: NY

1. FEDERAL ALLOCATION

(Item 15a of the Application Face Sheet [SF 424])
 Of the Federal Allocation (1 above), the amount earmarked for:

\$ 41,036,806

A. Preventive and primary care for children:

\$ 13,867,166 (33.79%)

B. Children with special health care needs:

\$ 14,003,000 (34.12%)

(If either A or B is less than 30%, a waiver request must accompany the application)[Sec. 505(a)(3)]

C. Title V administrative costs:

\$ 1,932,599 (4.71%)

(The above figure cannot be more than 10% [Sec. 504(d)])

2. UNOBLIGATED BALANCE (Item 15b of SF 424)

\$ 0

3. STATE MCH FUNDS (Item 15c of the SF 424)

\$ 144,502,296

4. LOCAL MCH FUNDS (Item 15d of SF 424)

\$ 301,048,616

5. OTHER FUNDS (Item 15e of SF 424)

\$ 0

6. PROGRAM INCOME (Item 15f of SF 424)

\$ 404,365,207

7. TOTAL STATE MATCH (Lines 3 through 6)

(Below is your State's FY 1989 Maintenance of Effort Amount)

\$ 58,268,752

\$ 849,916,119

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL)

(Total lines 1 through 6. Same as line 15g of SF 424)

\$ 890,952,925

9. OTHER FEDERAL FUNDS

(Funds under the control of the person responsible for the administration of the Title V program)

| | |
|--------------------------|----------------------|
| a. SPRANS: | \$ <u>0</u> |
| b. SSDI: | \$ <u>101,303</u> |
| c. CISS: | \$ <u>0</u> |
| d. Abstinence Education: | \$ <u>2,991,440</u> |
| e. Healthy Start: | \$ <u>0</u> |
| f. EMSC: | \$ <u>0</u> |
| g. WIC: | \$ <u>0</u> |
| h. AIDS: | \$ <u>0</u> |
| i. CDC: | \$ <u>900,000</u> |
| j. Education: | \$ <u>23,765,113</u> |
| k. Other: | |

| | |
|-------------------------|----------------------|
| <u>DHHS ACF TANF</u> | \$ <u>4,500,000</u> |
| <u>DHHS ACF</u> | \$ <u>3,236,330</u> |
| <u>DHHS HRSA</u> | \$ <u>6,624,047</u> |
| <u>DHHS PHS Title X</u> | \$ <u>11,644,517</u> |
| <u>DHHS SAMSA</u> | \$ <u>850,000</u> |
| <u>Medicaid Match</u> | \$ <u>8,646,452</u> |

10. OTHER FEDERAL FUNDS (SUBTOTAL of all Funds under item 9)

\$ 63,259,202

11. STATE MCH BUDGET TOTAL

(Partnership subtotal + Other Federal MCH Funds subtotal)

\$ 954,212,127

FORM 3
STATE MCH FUNDING PROFILE

[Secs. 505(a) and 506(a)(1-3)]

STATE: NY

| | FY 2007 | | FY 2008 | | FY 2009 | |
|--|----------------|----------------|----------------|----------------|----------------|----------------|
| | BUDGETED | EXPENDED | BUDGETED | EXPENDED | BUDGETED | EXPENDED |
| 1. Federal Allocation <i>(Line1, Form 2)</i> | \$ 41,621,706 | \$ 41,629,217 | \$ 41,629,217 | \$ 40,842,301 | \$ 41,629,217 | \$ 41,036,806 |
| 2. Unobligated Balance <i>(Line2, Form 2)</i> | \$ 0 | \$ 0 | \$ 0 | \$ 0 | \$ 0 | \$ 0 |
| 3. State Funds <i>(Line3, Form 2)</i> | \$ 351,809,825 | \$ 347,801,378 | \$ 351,565,000 | \$ 337,067,557 | \$ 390,311,698 | \$ 360,267,459 |
| 4. Local MCH Funds <i>(Line4, Form 2)</i> | \$ 242,471,037 | \$ 245,642,140 | \$ 361,355,556 | \$ 357,876,779 | \$ 309,987,228 | \$ 315,619,141 |
| 5. Other Funds <i>(Line5, Form 2)</i> | \$ 0 | \$ 0 | \$ 0 | \$ 0 | \$ 0 | \$ 0 |
| 6. Program Income <i>(Line6, Form 2)</i> | \$ 268,918,266 | \$ 182,431,876 | \$ 189,548,660 | \$ 179,051,322 | \$ 174,723,376 | \$ 187,342,102 |
| 7. Subtotal | \$ 904,820,834 | \$ 817,504,611 | \$ 944,098,433 | \$ 914,837,959 | \$ 916,651,519 | \$ 904,265,508 |
| (THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP) | | | | | | |
| 8. Other Federal Funds <i>(Line10, Form 2)</i> | \$ 42,076,539 | \$ 39,471,805 | \$ 40,337,744 | \$ 40,337,744 | \$ 46,143,937 | \$ 43,118,307 |
| 9. Total <i>(Line11, Form 2)</i> | \$ 946,897,373 | \$ 856,976,416 | \$ 984,436,177 | \$ 955,175,703 | \$ 962,795,456 | \$ 947,383,815 |
| (STATE MCH BUDGET TOTAL) | | | | | | |

FORM 3
STATE MCH FUNDING PROFILE
[Secs. 505(a) and 506(a)(1-3)]
STATE: NY

| | FY 2010 | | FY 2011 | | FY 2012 | |
|--|----------------|------------------|----------------|----------|----------------|----------|
| | BUDGETED | EXPENDED | BUDGETED | EXPENDED | BUDGETED | EXPENDED |
| 1. Federal Allocation <i>(Line1, Form 2)</i> | \$ 41,043,769 | \$ 40,947,507 | \$ 41,036,806 | \$ | \$ 41,036,806 | \$ |
| 2. Unobligated Balance <i>(Line2, Form 2)</i> | \$ 0 | \$ 0 | \$ 0 | \$ | \$ 0 | \$ |
| 3. State Funds <i>(Line3, Form 2)</i> | \$ 363,695,631 | \$ 373,396,439 | \$ 336,529,505 | \$ | \$ 144,502,296 | \$ |
| 4. Local MCH Funds <i>(Line4, Form 2)</i> | \$ 299,499,317 | \$ 327,468,560 | \$ 313,430,367 | \$ | \$ 301,048,616 | \$ |
| 5. Other Funds <i>(Line5, Form 2)</i> | \$ 0 | \$ 0 | \$ 0 | \$ | \$ 0 | \$ |
| 6. Program Income <i>(Line6, Form 2)</i> | \$ 176,715,455 | \$ 240,879,389 | \$ 173,450,785 | \$ | \$ 404,365,207 | \$ |
| 7. Subtotal | \$ 880,954,172 | \$ 982,691,895 | \$ 864,447,463 | \$ 0 | \$ 890,952,925 | \$ 0 |
| (THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP) | | | | | | |
| 8. Other Federal Funds <i>(Line10, Form 2)</i> | \$ 45,901,844 | \$ 44,374,026 | \$ 75,196,798 | \$ | \$ 63,259,202 | \$ |
| 9. Total <i>(Line11, Form 2)</i> | \$ 926,856,016 | \$ 1,027,065,921 | \$ 939,644,261 | \$ 0 | \$ 954,212,127 | \$ 0 |
| (STATE MCH BUDGET TOTAL) | | | | | | |

FORM NOTES FOR FORM 3

We reduced overmatching, thereby ensuring that state funds are available for matching purposes as needed in other areas. Although the State match was reduced, the overall partnership amount, which includes state, local and revenue contributions remained at the same level due to an increase in projected related revenue. Although these dollars are no longer reflected in this form, the maternal and child health related services continue to be provided by New York State at the same level as previous years.

FIELD LEVEL NOTES

1. **Section Number:** Form3_Main
Field Name: FedAllocExpended
Row Name: Federal Allocation
Column Name: Expended
Year: 2010

Field Note:

Expenditures reflect award amount.

2. **Section Number:** Form3_Main
Field Name: FedAllocExpended
Row Name: Federal Allocation
Column Name: Expended
Year: 2009

Field Note:

Expenditures equal to grant award amount

3. **Section Number:** Form3_Main
Field Name: ProgramIncomeExpended
Row Name: Program Income
Column Name: Expended
Year: 2010

Field Note:

Program income budget was based on estimate of reported data; One large county had a reporting lag due to transition to new data systems management.

FORM 4
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: NY

| | FY 2007 | | FY 2008 | | FY 2009 | |
|---|----------------|----------------|----------------|----------------|----------------|----------------|
| | BUDGETED | EXPENDED | BUDGETED | EXPENDED | BUDGETED | EXPENDED |
| I. Federal-State MCH Block Grant Partnership | | | | | | |
| a. Pregnant Women | \$ 48,860,325 | \$ 45,117,681 | \$ 64,999,538 | \$ 61,029,725 | \$ 76,287,545 | \$ 70,922,081 |
| b. Infants < 1 year old | \$ 185,488,271 | \$ 104,879,584 | \$ 129,744,213 | \$ 128,292,591 | \$ 46,193,308 | \$ 44,833,643 |
| c. Children 1 to 22 years old | \$ 54,289,250 | \$ 97,346,038 | \$ 116,647,102 | \$ 107,617,387 | \$ 125,026,052 | \$ 108,881,991 |
| d. Children with Special Healthcare Needs | \$ 531,129,829 | \$ 498,360,642 | \$ 496,870,196 | \$ 486,426,590 | \$ 540,975,612 | \$ 580,974,370 |
| e. Others | \$ 39,812,117 | \$ 43,678,763 | \$ 97,300,581 | \$ 93,049,666 | \$ 112,109,458 | \$ 89,425,117 |
| f. Administration | \$ 45,241,042 | \$ 28,121,903 | \$ 38,536,803 | \$ 38,422,000 | \$ 16,059,544 | \$ 9,228,306 |
| g. SUBTOTAL | \$ 904,820,834 | \$ 817,504,611 | \$ 944,098,433 | \$ 914,837,959 | \$ 916,651,519 | \$ 904,265,508 |

II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).

| | | | |
|-------------------------|---------------|---------------|---------------|
| a. SPRANS | \$ 0 | \$ 150,000 | \$ 150,000 |
| b. SSDI | \$ 100,000 | \$ 100,000 | \$ 100,000 |
| c. CISS | \$ 0 | \$ 0 | \$ 140,000 |
| d. Abstinence Education | \$ 3,675,827 | \$ 3,614,500 | \$ 0 |
| e. Healthy Start | \$ 0 | \$ 0 | \$ 0 |
| f. EMSC | \$ 0 | \$ 0 | \$ 0 |
| g. WIC | \$ 0 | \$ 0 | \$ 0 |
| h. AIDS | \$ 0 | \$ 0 | \$ 0 |
| i. CDC | \$ 2,380,573 | \$ 1,837,125 | \$ 1,939,252 |
| j. Education | \$ 25,623,183 | \$ 25,550,992 | \$ 23,636,568 |
| k. Other | | | |
| Medicaid Match | \$ 0 | \$ 0 | \$ 9,758,117 |
| Title X-Fam Planning | \$ 0 | \$ 0 | \$ 10,420,000 |
| Title X (Family Plan) | \$ 10,296,956 | \$ 9,085,127 | \$ 0 |
| III. SUBTOTAL | \$ 42,076,539 | \$ 40,337,744 | \$ 46,143,937 |

FORM 4
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: NY

| | FY 2010 | | FY 2011 | | FY 2012 | |
|---|----------------|----------------|----------------|----------|----------------|----------|
| | BUDGETED | EXPENDED | BUDGETED | EXPENDED | BUDGETED | EXPENDED |
| I. Federal-State MCH Block Grant Partnership | | | | | | |
| a. Pregnant Women | \$ 77,507,975 | \$ 72,021,720 | \$ 70,606,837 | \$ | \$ 47,653,244 | \$ |
| b. Infants < 1 year old | \$ 67,645,380 | \$ 71,848,320 | \$ 38,939,501 | \$ | \$ 35,366,730 | \$ |
| c. Children 1 to 22 years old | \$ 121,371,304 | \$ 108,027,577 | \$ 109,314,803 | \$ | \$ 127,701,617 | \$ |
| d. Children with Special Healthcare Needs | \$ 506,821,678 | \$ 621,643,203 | \$ 566,769,437 | \$ | \$ 612,613,715 | \$ |
| e. Others | \$ 94,488,959 | \$ 96,538,075 | \$ 70,749,273 | \$ | \$ 64,329,713 | \$ |
| f. Administration | \$ 13,118,876 | \$ 12,613,000 | \$ 8,067,612 | \$ | \$ 3,287,906 | \$ |
| g. SUBTOTAL | \$ 880,954,172 | \$ 982,691,895 | \$ 864,447,463 | \$ 0 | \$ 890,952,925 | \$ 0 |

II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).

| | | | |
|-------------------------|---------------|---------------|---------------|
| a. SPRANS | \$ 150,000 | \$ 0 | \$ 0 |
| b. SSDI | \$ 568,638 | \$ 93,713 | \$ 101,303 |
| c. CISS | \$ 0 | \$ 0 | \$ 0 |
| d. Abstinence Education | \$ 0 | \$ 0 | \$ 2,991,440 |
| e. Healthy Start | \$ 0 | \$ 0 | \$ 0 |
| f. EMSC | \$ 0 | \$ 0 | \$ 0 |
| g. WIC | \$ 0 | \$ 0 | \$ 0 |
| h. AIDS | \$ 0 | \$ 0 | \$ 0 |
| i. CDC | \$ 1,334,619 | \$ 1,724,830 | \$ 900,000 |
| j. Education | \$ 23,831,850 | \$ 50,238,349 | \$ 23,765,113 |
| k. Other | | | |
| DHHS ACF TANF | \$ 0 | \$ 0 | \$ 4,500,000 |
| DHHS ACF | \$ 0 | \$ 0 | \$ 3,236,330 |
| DHHS HRSA | \$ 0 | \$ 0 | \$ 6,624,047 |
| DHHS PHS Title X | \$ 0 | \$ 0 | \$ 11,644,517 |
| DHHS SAMSA | \$ 0 | \$ 0 | \$ 850,000 |
| Medicaid Match | \$ 9,503,861 | \$ 8,546,452 | \$ 8,646,452 |
| HRSA | \$ 0 | \$ 1,131,973 | \$ 0 |
| TANF | \$ 0 | \$ 2,500,000 | \$ 0 |
| Title X | \$ 0 | \$ 10,961,481 | \$ 0 |
| Title X-Fam Planning | \$ 10,512,876 | \$ 0 | \$ 0 |
| III. SUBTOTAL | \$ 45,901,844 | \$ 75,196,798 | \$ 63,259,202 |

FORM NOTES FOR FORM 4

None

FIELD LEVEL NOTES

1. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: PregWomenBudgeted
Row Name: Pregnant Women
Column Name: Budgeted
Year: 2012
Field Note:
This year's budgeted amount reflects adjustments to the local share's state aid to localities "preventive health care" services being directed for children birth through age twenty. County reporting will not capture expenditures for pregnant women.
2. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: PregWomenBudgeted
Row Name: Pregnant Women
Column Name: Budgeted
Year: 2009
Field Note:
adjust \$1 for rounding
3. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_1_22Expended
Row Name: Children 1 to 22 years old
Column Name: Expended
Year: 2010
Field Note:
Budget estimate was a projection based on available data at that time. One of the state's largest county was experiencing difficulties with the transition of their data system to a new fiscal administrator.
4. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_1_22Expended
Row Name: Children 1 to 22 years old
Column Name: Expended
Year: 2009
Field Note:
Delayed start for new initiatives and state appropriation reductions resulted in underexpenditures.
5. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNExpended
Row Name: CSHCN
Column Name: Expended
Year: 2010
Field Note:
This is also a result of one of the state's large county experiencing difficulties with the transition of their data system to a new administrator. The budget projection was based on available data at that point in time.
6. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNExpended
Row Name: CSHCN
Column Name: Expended
Year: 2009
Field Note:
Expenditures for Children with Special Healthcare Needs exceeds the budgeted amount by 7.4%. The 2009 budgeted amount is a projection of expenditures rather than actual expenditures. The 2009 expenditures increase was most likely due to the timing of claim submissions for the Early Intervention Program where reported local share and program income were up 18%.
7. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersExpended
Row Name: All Others
Column Name: Expended
Year: 2009
Field Note:
State appropriations reductions, delayed start of new initiatives and delayed claiming for some initiatives resulted in underexpenditures for this fiscal year.
8. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AdminExpended
Row Name: Administration
Column Name: Expended
Year: 2009
Field Note:
Budget calculation for Local administrative budget inadvertently doubled.

FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: NY

| TYPE OF SERVICE | FY 2007 | | FY 2008 | | FY 2009 | |
|--|----------------|----------------|----------------|----------------|----------------|----------------|
| | BUDGETED | EXPENDED | BUDGETED | EXPENDED | BUDGETED | EXPENDED |
| I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.) | \$ 587,681,132 | \$ 545,637,112 | \$ 479,686,457 | \$ 468,968,888 | \$ 542,289,899 | \$ 567,918,281 |
| II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.) | \$ 171,011,137 | \$ 124,847,808 | \$ 111,547,731 | \$ 103,589,315 | \$ 72,957,273 | \$ 69,242,156 |
| III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.) | \$ 70,123,615 | \$ 68,531,654 | \$ 118,240,385 | \$ 113,204,948 | \$ 110,605,239 | \$ 91,433,990 |
| IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.) | \$ 76,004,950 | \$ 78,488,037 | \$ 234,623,860 | \$ 229,074,808 | \$ 190,799,108 | \$ 175,671,081 |
| V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.) | \$ 904,820,834 | \$ 817,504,611 | \$ 944,098,433 | \$ 914,837,959 | \$ 916,651,519 | \$ 904,265,508 |

FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: NY

| TYPE OF SERVICE | FY 2010 | | FY 2011 | | FY 2012 | |
|--|----------------|----------------|----------------|----------|----------------|----------|
| | BUDGETED | EXPENDED | BUDGETED | EXPENDED | BUDGETED | EXPENDED |
| I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.) | \$ 549,101,044 | \$ 681,730,785 | \$ 581,216,529 | \$ | \$ 633,765,886 | \$ |
| II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.) | \$ 73,676,681 | \$ 68,342,121 | \$ 59,929,280 | \$ | \$ 49,755,348 | \$ |
| III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.) | \$ 114,544,747 | \$ 109,677,635 | \$ 88,451,645 | \$ | \$ 85,056,641 | \$ |
| IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.) | \$ 143,631,700 | \$ 122,941,354 | \$ 134,850,009 | \$ | \$ 122,375,050 | \$ |
| V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.) | \$ 880,954,172 | \$ 982,691,895 | \$ 864,447,463 | \$ 0 | \$ 890,952,925 | \$ 0 |

FORM NOTES FOR FORM 5

None

FIELD LEVEL NOTES

1. **Section Number:** Form5_Main
Field Name: DirectHCBudgeted
Row Name: Direct Health Care Services
Column Name: Budgeted
Year: 2012
Field Note:
Increase in direct health care services attributable to increased program income reporting for Early Intervention and the reassessment of American Indian Health services as direct health care.
2. **Section Number:** Form5_Main
Field Name: DirectHCExpended
Row Name: Direct Health Care Services
Column Name: Expended
Year: 2010
Field Note:
Budget estimate was a projection based on available data at the time of grant application completion. One of the state's largest county's difficulties with their transition to a new data systems administrator delayed reporting. This also had an impact on program income.
3. **Section Number:** Form5_Main
Field Name: EnablingBudgeted
Row Name: Enabling Services
Column Name: Budgeted
Year: 2011
Field Note:
The enabling services budget for FY11 is 18.6% less than the FY10 budget and 13% less than FY09 expenditures. Variances can be attributed to increased levels of review and assessment of the populations being served and the type of service being provided by initiative. Also, the Department has increased efforts to identify and match state dollars for appropriate initiatives; a result of this has been a decrease or elimination of those dollars in the MCHSBG application. Although these dollars are no longer reflected in this form, the maternal and child health related services continue to be provided by New York State at the same level as previous years.
4. **Section Number:** Form5_Main
Field Name: PopBasedExpended
Row Name: Population-Based Services
Column Name: Expended
Year: 2009
Field Note:
State appropriation reductions and delayed start of new initiatives.
5. **Section Number:** Form5_Main
Field Name: InfrastrBuildExpended
Row Name: Infrastructure Building Services
Column Name: Expended
Year: 2010
Field Note:
Local government expenditures were less than anticipated. The methodology used to calculate the budget has been revised to more closely reflect anticipated expenditures. Also, the implementation of the new Comprehensive Adolescent Pregnancy prevention program was delayed which resulted in underexpenditures.

FORM 6

NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED, AND TREATED

Sect. 506(a)(2)(b)(iii)

STATE: NY

Total Births by Occurrence: 245,282

Reporting Year: 2010

| Type of Screening Tests | (A) Receiving at least one Screen (1) | | (B) No. of Presumptive Positive Screens | (C) No. Confirmed Cases (2) | (D) Needing Treatment that Received Treatment (3) | |
|---|---|-----|---|--------------------------------------|---|-----|
| | No. | % | | | No. | % |
| Phenylketonuria | 245,282 | 100 | 30 | 16 | 16 | 100 |
| Congenital Hypothyroidism | 245,282 | 100 | 889 | 247 | 247 | 100 |
| Galactosemia | 245,282 | 100 | 16 | 9 | 9 | 100 |
| Sickle Cell Disease | 245,282 | 100 | 70 | 36 | 36 | 100 |
| Other Screening (Specify) | | | | | | |
| Biotinidase Deficiency | 245,282 | 100 | 15 | 8 | 8 | 100 |
| Congenital Adrenal Hyperplasia | 245,282 | 100 | 401 | 15 | 15 | 100 |
| Cystic Fibrosis | 245,282 | 100 | 1,065 | 66 | 66 | 100 |
| Maple Syrup Urine Disease | 245,282 | 100 | 18 | 1 | 1 | 100 |
| Tyrosinemia | 245,282 | 100 | 12 | 0 | 0 | |
| Other | 245,282 | 100 | 40 | 13 | 13 | 100 |
| Very Long-Chain Acyl-CoA Dehydrogenase Deficiency | 245,282 | 100 | 11 | 4 | 4 | 100 |
| Argininosuccinic Acidemia | 245,282 | 100 | 7 | 4 | 4 | 100 |
| Carnitine Uptake Defect | 245,282 | 100 | 13 | 3 | 3 | 100 |
| Multiple Carboxylase Deficiency | 245,282 | 100 | 53 | 3 | 3 | 100 |
| Glutaric Acidemia Type I | 245,282 | 100 | 8 | 1 | 1 | 100 |
| Sickle Cell Anemia (SS-Disease) | 245,282 | 100 | 146 | 72 | 72 | 100 |
| Medium-Chain Acyl-CoA Dehydrogenase Deficiency | 245,282 | 100 | 37 | 16 | 16 | 100 |
| Short-Chain Acyl-CoA Dehydrogenase Deficiency | 245,282 | 100 | 20 | 10 | 10 | 100 |
| Hemoglobin C Disease | 245,282 | 100 | 15 | 9 | 9 | 100 |
| Krabbe Disease | 245,282 | 100 | 40 | 2 | 2 | 100 |
| Homocystinuria/Hypermethioninemia | 245,282 | 100 | 24 | 0 | 0 | |
| Carnitine Palmitoyltransferase II/Carnitine Acylcarnitine Translocase Deficiencies | 245,282 | 100 | 29 | 1 | 1 | 100 |
| Long-Chain 3-Hydroxyacyl-CoA Dehydrogenase/Mitochondrial Trifunctional Protein Deficiencies | 245,282 | 100 | 1 | 0 | 0 | |
| Medium Short-Chain Hydroxyacyl-CoA Dehydrogenase Deficiency | 245,282 | 100 | 3 | 0 | 0 | |
| Isovaleric Acidemia/2 Methylbutyryl-CoA Dehydrogenase Deficiency | 245,282 | 100 | 14 | 0 | 0 | |
| Hydroxy-3-Methylglutaryl-CoA Lyase/Methylcrotonyl-CoA Carboxylase Deficiencies & 3 Methylglutaconic | 245,282 | 100 | 115 | 30 | 30 | 100 |
| Severe Combined Immunodeficiency | 245,282 | 100 | 172 | 5 | 5 | 100 |
| Hyperammonemia/Hyperomithinemia/Homocitrullinemia | 245,282 | 100 | 11 | 0 | 0 | |

Screening Programs for Older Children & Women (Specify Tests by name)

- (1) Use occurrent births as denominator.
- (2) Report only those from resident births.
- (3) Use number of confirmed cases as denominator.

FORM 7
NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V
(BY CLASS OF INDIVIDUALS AND PERCENT OF HEALTH COVERAGE)

[Sec. 506(a)(2)(A)(i-ii)]

STATE: NY

| Number of Individuals Served - Historical Data by Annual Report Year | | | | | |
|---|------------------|------------------|------------------|------------------|------------------|
| Types of Individuals Served | 2005 | 2006 | 2007 | 2008 | 2009 |
| Pregnant Women | 387,368 | 381,744 | 388,110 | 391,034 | 385,884 |
| Infants < 1 year old | 254,293 | 251,865 | 244,832 | 246,824 | 250,282 |
| Children 1 to 22 years old | 5,743,127 | 5,461,706 | 5,644,950 | 5,583,705 | 5,456,881 |
| Children with Special Healthcare Needs | 446,071 | 459,476 | 554,740 | 542,758 | 486,192 |
| Others | 486,792 | 473,315 | 485,170 | 511,395 | 434,102 |
| Total | 7,317,651 | 7,028,106 | 7,317,802 | 7,275,716 | 7,013,341 |

Reporting Year: 2010

| Types of Individuals Served | TITLE V | PRIMARY SOURCES OF COVERAGE | | | | |
|--|-----------------------------|------------------------------------|----------------------------|--------------------------------|-----------------------|--------------------------|
| | (A) Total Served | (B) Title XIX % | (C) Title XXI % | (D) Private/Other % | (E) None % | (F) Unknown % |
| Pregnant Women | 378,814 | 45.7 | 0.0 | 51.6 | 1.7 | 0.9 |
| Infants < 1 year old | 247,880 | 44.9 | 0.8 | 51.6 | 1.7 | 0.9 |
| Children 1 to 22 years old | 5,560,739 | 40.3 | 6.9 | 45.3 | 7.5 | 0.0 |
| Children with Special Healthcare Needs | 570,508 | 43.3 | 3.1 | 40.8 | 4.9 | 8.0 |
| Others | 690,441 | 23.4 | 0.0 | 59.9 | 16.7 | 0.0 |
| TOTAL | 7,448,382 | | | | | |

FORM NOTES FOR FORM 7

None

FIELD LEVEL NOTES

1. **Section Number:** Form7_Main
Field Name: PregWomen_XIX
Row Name: Pregnant Women
Column Name: Title XIX %
Year: 2012
Field Note:
The estimate is based on the percentage of live births to women with medicaid as their primary financial coverage. (2009 Vital Records Data)
2. **Section Number:** Form7_Main
Field Name: PregWomen_Private
Row Name: Pregnant Women
Column Name: Private/Other %
Year: 2012
Field Note:
The estimate is based on the percentage of live births to women with private and other government as their primary financial coverage. (2009 Vital Records Data)
3. **Section Number:** Form7_Main
Field Name: PregWomen_None
Row Name: Pregnant Women
Column Name: None %
Year: 2012
Field Note:
The estimate is based on the percentage of live births to women with self-pay as their primary financial coverage. (2009 Vital Records Data)
4. **Section Number:** Form7_Main
Field Name: PregWomen_Unknown
Row Name: Pregnant Women
Column Name: Unknown %
Year: 2012
Field Note:
The estimate is based on the percentage of live births to women with unknown as their primary financial coverage. (2009 Vital Records Data)
5. **Section Number:** Form7_Main
Field Name: Children_0_1_XIX
Row Name: Infants <1 year of age
Column Name: Title XIX %
Year: 2012
Field Note:
The estimate is based on the percentage of live births to women with Medicaid as their primary financial coverage. (2009 Vital Records Data)
6. **Section Number:** Form7_Main
Field Name: Children_0_1_XXI
Row Name: Infants <1 year of age
Column Name: Title XXI %
Year: 2012
Field Note:
This estimate is based on the percentage of children less than one who are covered by Child health Plus (2009 Child Health Plus enrollment data).
7. **Section Number:** Form7_Main
Field Name: Children_0_1_Private
Row Name: Infants <1 year of age
Column Name: Private/Other %
Year: 2012
Field Note:
The estimate is based on the percentage of live births to women with private and other government as their primary financial coverage. (2009 Vital Records Data)
8. **Section Number:** Form7_Main
Field Name: Children_0_1_None
Row Name: Infants <1 year of age
Column Name: None %
Year: 2012
Field Note:
The estimate is based on the percentage of live births to women with self-pay as their primary financial coverage. (2009 Vital Records Data)
9. **Section Number:** Form7_Main
Field Name: Children_0_1_Unknown
Row Name: Infants <1 year of age
Column Name: Unknown %
Year: 2012
Field Note:
The estimate is based on the percentage of live births to women with unknown as their primary financial coverage. (2009 Vital Records Data)
10. **Section Number:** Form7_Main
Field Name: Children_1_22_XIX
Row Name: Children 1 to 22 years of age
Column Name: Title XIX %
Year: 2012
Field Note:
The estimate is based on the percentage of children less than 19 who are covered by Medicaid. 6.6% of children on Medicaid are also covered by private insurance. (2010 Current Population Survey data) enrollment data).
11. **Section Number:** Form7_Main
Field Name: Children_1_22_XXI
Row Name: Children 1 to 22 years of age
Column Name: Title XXI %
Year: 2012
Field Note:
The estimate is based on the percentage of children ages 1-22 covered by Child Health Plus (2009 Child Health Plus enrollment data)
12. **Section Number:** Form7_Main
Field Name: Children_1_22_Private

Row Name: Children 1 to 22 years of age

Column Name: Private/Other %

Year: 2012

Field Note:

This estimate is based on the percentage of children under age 19 who have private health insurance or other insurance only. The percentage excludes children with both private insurance and another type of insurance who are counted under another category. If children with multiple forms of insurance were included, the percentage would be 58.5%. (2010 Current Population Survey)

13. Section Number: Form7_Main

Field Name: Children_1_22_None

Row Name: Children 1 to 22 years of age

Column Name: None %

Year: 2012

Field Note:

The estimate is based on the percentage of children under age 19 who have no health insurance. (Current Population Survey-2010)

14. Section Number: Form7_Main

Field Name: AllOthers_XIX

Row Name: Others

Column Name: Title XIX %

Year: 2012

Field Note:

The estimate is based on the percentage of persons aged less than 65 who are covered by Medicaid. 4.0% of children on Medicaid are also covered by private insurance. (2010 Current Population Survey data)

15. Section Number: Form7_Main

Field Name: AllOthers_Private

Row Name: Others

Column Name: Private/Other %

Year: 2012

Field Note:

This estimate is based on the percentage of persons under age 65 who have private health insurance or other insurance only. The percentage excludes persons with both private insurance and another type of insurance who are counted under another category. If children with multiple forms of insurance were included, the percentage would be 62.5%. (2010 Current Population Survey)

16. Section Number: Form7_Main

Field Name: AllOthers_None

Row Name: Others

Column Name: None %

Year: 2012

Field Note:

The estimate is based on the percentage of persons under age 65 who have no health insurance. (Current Population Survey-2010)

FORM 8
DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE
XIX
(BY RACE AND ETHNICITY)
[Sec. 506(A)(2)(C-D)]
STATE: NY

Reporting Year: 2009

I. UNDUPLICATED COUNT BY RACE

| | (A) Total All Races | (B) White | (C) Black or African American | (D) American Indian or Native Alaskan | (E) Asian | (F) Native Hawaiian or Other Pacific Islander | (G) More than one race reported | (H) Other and Unknown |
|---------------------------|---------------------------|--------------|-------------------------------------|---|--------------|---|---------------------------------------|-----------------------------|
| DELIVERIES | | | | | | | | |
| Total Deliveries in State | 240,235 | 158,041 | 43,693 | 6,046 | 16,502 | 0 | 0 | 15,953 |
| Title V Served | 240,235 | 158,041 | 43,693 | 6,046 | 16,502 | 0 | 0 | 15,953 |
| Eligible for Title XIX | 111,315 | 61,360 | 28,386 | 2,765 | 8,945 | 0 | 0 | 9,859 |
| INFANTS | | | | | | | | |
| Total Infants in State | 246,592 | 162,564 | 44,682 | 6,156 | 16,771 | 0 | 0 | 16,419 |
| Title V Served | 246,592 | 162,564 | 44,682 | 6,156 | 16,771 | 0 | 0 | 16,419 |
| Eligible for Title XIX | 112,814 | 62,100 | 28,911 | 2,801 | 9,033 | 0 | 0 | 9,969 |

II. UNDUPLICATED COUNT BY ETHNICITY

| | (A) Total NOT Hispanic or Latino | (B) Total Hispanic or Latino | (C) Ethnicity Not Reported | HISPANIC OR LATINO (Sub-categories by country or area of origin) | | | | |
|---------------------------|--|------------------------------------|----------------------------------|--|----------------|-----------------------|--|-------------------------------|
| | | | | (B.1) Mexican | (B.2) Cuban | (B.3) Puerto Rican | (B.4) Central and South American | (B.5) Other and Unknown |
| DELIVERIES | | | | | | | | |
| Total Deliveries in State | 182,146 | 58,089 | 0 | 0 | 0 | 0 | 0 | 58,089 |
| Title V Served | 182,146 | 58,089 | 0 | 0 | 0 | 0 | 0 | 58,089 |
| Eligible for Title XIX | 69,954 | 41,361 | 0 | 0 | 0 | 0 | 0 | 41,361 |
| INFANTS | | | | | | | | |
| Total Infants in State | 187,396 | 59,196 | 0 | | | | | 59,196 |
| Title V Served | 187,396 | 59,196 | 0 | | | | | 59,196 |
| Eligible for Title XIX | 71,024 | 41,790 | 0 | | | | | 41,790 |

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM (OPTIONAL)
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: NY

| | FY 2012 | FY 2011 | FY 2010 | FY 2009 | FY 2008 |
|--|---------|---------|---------|---------|---------|
| 1. State MCH Toll-Free "Hotline" Telephone Number | | | | | |
| 2. State MCH Toll-Free "Hotline" Name | | | | | |
| 3. Name of Contact Person for State MCH "Hotline" | | | | | |
| 4. Contact Person's Telephone Number | | | | | |
| 5. Contact Person's Email | | | | | |
| 6. Number of calls received on the State MCH "Hotline" this reporting period | 0 | 0 | 0 | 0 | 0 |

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: NY

| | FY 2012 | FY 2011 | FY 2010 | FY 2009 | FY 2008 |
|--|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| 1. State MCH Toll-Free "Hotline" Telephone Number | (800) 522-5006 | (800)522-5006 | (800) 522-5006 | (800) 522-5006 | (800)522-5006 |
| 2. State MCH Toll-Free "Hotline" Name | The Growing Up Healthy Hotline | The Growing Up Healthy Hotline | The Growing Up Healthy Hotline | The Growing Up Healthy Hotline | The Growing Up Healthy Hotline |
| 3. Name of Contact Person for State MCH "Hotline" | Michael Acosta | Michael Acosta | Michael Acosta | Michael Acosta | Michael Acosta |
| 4. Contact Person's Telephone Number | (518) 474-1911 | (518)474-3664 | (518) 474-1911 | (518) 474-1911 | (518)474-1911 |
| 5. Contact Person's Email | maa04@health.state.ny.us | maa04@health.state.ny.us | maa04@health.state.ny.us | | |
| 6. Number of calls received on the State MCH "Hotline" this reporting period | 0 | 0 | 53978 | 61518 | 69506 |

FORM NOTES FOR FORM 9

None

FIELD LEVEL NOTES

1. **Section Number:** Form9_Main

Field Name: calls_2

Row Name: Number of calls received On the State MCH Hotline This reporting period

Column Name: FY

Year: 2010

Field Note:

In 2010 the GUHH provided information to 53,978 callers on a variety of maternal and child health issues, including information on eligibility for programs and the location of the nearest services. Of these, 6,807 were for provision of pregnancy-related information and services. Less than 6% (3,017) of calls required handling in languages other than English. Of these calls, 2,874 were from Spanish-speaking callers and 143 of the calls were in languages other than English or Spanish. 77% of callers were female, and 23% male. There was a 14% decrease in the total number of calls to the hotline in 2010 compared to 2009 and a 13% decrease compared to 2008. It is important to note that in 2010, calls to the hotline for WIC inquiries declined from 33,687 in 2009 to 27,832 in 2010. The reason for the decrease of 5,855 WIC calls is unknown which accounts for 11% of the overall decrease in GUHH calls in 2010.

FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE FOR FY 2012
[Sec. 506(A)(1)]
STATE: NY

1. State MCH Administration:
(max 2500 characters)

The New York State Department of Health's Division of Family Health administers the Title V program in New York State. The Title V program supports activities designed to improve the health status of women, particularly those of reproductive health age, infants, children and adolescents, including those with special health care needs. Funds support public health/infrastructure, population-based, enabling and gap-filling personal health care services for those with limited access to high quality, continuous health care. The Division of Family Health encompasses three Bureaus (Maternal and Child Health, Dental Health, and Early Intervention), and is supported by the Office of the Medical Director. The Division also provides leadership for the State Systems Development Initiative (SSDI), the American Indian Health Program, MCH Graduate Student Assistantship Program, and the Migrant and Seasonal Farmworker Health Program. All programs work closely with the Department's Office of Health Insurance Programs (OHIP), which oversees the state's Medicaid program, and the Office of Health Systems Management, which licenses and monitors hospitals and clinics throughout the state.

Block Grant Funds

| | |
|--|------------------------------|
| 2. Federal Allocation (Line 1, Form 2) | \$ <u>41,036,806</u> |
| 3. Unobligated balance (Line 2, Form 2) | \$ <u>0</u> |
| 4. State Funds (Line 3, Form 2) | \$ <u>144,502,296</u> |
| 5. Local MCH Funds (Line 4, Form 2) | \$ <u>301,048,616</u> |
| 6. Other Funds (Line 5, Form 2) | \$ <u>0</u> |
| 7. Program Income (Line 6, Form 2) | \$ <u>404,365,207</u> |
| 8. Total Federal-State Partnership (Line 8, Form 2) | \$ <u>890,952,925</u> |

9. Most significant providers receiving MCH funds:

| |
|---|
| <u>Family Planning Programs</u> |
| <u>Comprehensive Adolescent Pregnancy Prevention Prog</u> |
| <u>Lead Poisoning Prevention & Education Services</u> |
| <u>School-Based Health Centers</u> |

10. Individuals served by the Title V Program (Col. A, Form 7)

| | |
|-------------------------------|------------------|
| a. Pregnant Women | <u>378,814</u> |
| b. Infants < 1 year old | <u>247,880</u> |
| c. Children 1 to 22 years old | <u>5,560,739</u> |
| d. CSHCN | <u>570,508</u> |
| e. Others | <u>690,441</u> |

11. Statewide Initiatives and Partnerships:

a. Direct Medical Care and Enabling Services:
(max 2500 characters)

School-based health centers, family planning and reproductive health, regional perinatal centers, community health workers, nurse/family partnership, MIECHVP and home visiting, primary health and dental care for migrant and season farmworkers and their families, genetic services, care coordination, children with special health care needs program, services to native american women and children, physically handicapped children diagnosis and evaluation, dental rehabilitation program and patient education, translation and transportation.

b. Population-Based Services:
(max 2500 characters)

Childhood lead poisoning prevention, newborn genetics and hearing screening, population-based health education campaigns, including prenatal outreach and education, breastfeeding promotion, the Growing Up Healthy Hotline, injury prevention, immunization, health information media, overweight prevention, nutrition and physical activities programs for children and adolescents, comprehensive adolescent pregnancy prevention, Personal Responsibility Education Program, abstinence, youth development, minority health community coalitions, and migrant health outreach & education.

c. Infrastructure Building Services:
(max 2500 characters)

Statewide Perinatal Data System, maternal mortality review, NYS Neonatal and Obstetrical Quality Collaborative, hospital discharge data system (SPARCS) and quality assurance reporting, statewide immunization registry (NYSIIS), surveillance and public health information, state systems development initiative, child health information integration, community health assessments, public health workforce development, evaluation and monitoring, contract management, emergency preparedness, standards and guidelines development. Education-related activities include the Preventive Medicine and Dental Public Health residency programs, public health nurse continuing education, the MCH Graduate Assistantship program, monthly satellite broadcasts, the Statwide Oral health Technical Assistance Center, participation in regional training centers, national meetings and organizations.

12. The primary Title V Program contact person:

13. The children with special health care needs (CSHCN) contact person:

Name Barbara L. McTague
 Title Director, Division of Family Health
 Address Empire State Plaza Tower Room 890

Name Susan Slade
 Title CSHCN Director
 Address Empire State Plaza Tower Room 890

City Albany
State NY
Zip 12237
Phone (518) 473-7922
Fax (518) 473-2015
Email blm01@health.state.ny.us
Web www.health.state.ny.us

City Albany
State NY
Zip 12237
Phone (518) 408-1526
Fax (518) 474-7054
Email sjs11@health.state.ny.us
Web www.health.state.ny.us

FORM 11
TRACKING PERFORMANCE MEASURES
[SECS 485 (2)(2)(B)(iii) AND 486 (A)(2)(A)(iii)]
STATE: NY

Form Level Notes for Form 11

None

PERFORMANCE MEASURE # 01

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

| | Annual Objective and Performance Data | | | | |
|--|---------------------------------------|-------|------------------------------------|-------------------|-------------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 100.0 | 77.2 | 76.0 | 88.1 | 88.1 |
| Numerator | 252,014 | 3,542 | 3,238 | 15,853 | 15,853 |
| Denominator | 252,014 | 4,586 | 4,263 | 17,985 | 17,985 |
| Data Source | | | Newborn Screening Program data set | Newborn Screening | Newborn Screening |
| Check this box if you cannot report the numerator because | | | | | |
| 1. There are fewer than 5 events over the last year, and | | | | | |
| 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| <small>(Explain data in a year note. See Guidance, Appendix IX.)</small> | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #1

Field Name: PM01

Row Name:

Column Name:

Year: 2010

Field Note:

Data in the cells for 2007 and 2008 numerators and denominators represent only screen positives or referrals. In previous years, these numbers represented all newborns screened. For 2007-2008, as shown in the above table, the numerator is the number of cases closed and the denominator is the number of screen positive newborns for the year. The annual indicator is the number of closed cases divided by number of screen positive cases reported as a percent. A case is considered closed when all predetermined closure criteria are met, including the newborn having an evaluation, any diagnostic testing, and a diagnosis has been made regarding the condition for which the newborn was referred. The program follows all screen positive newborns to ensure they receive appropriate follow-up, including an evaluation, diagnostic testing and a diagnosis as appropriate.

For 2009, the numerator is the number of referrals (previously called screen positives) plus the number of babies with a presumptive positive screen. Presumptive positive screens are those infants with slightly out of range results; a repeat specimen is required, and follow-up staff ensures a repeat sample is received, tested, and reported appropriately. Data for 2009 are cases opened and closed that calendar year. There are still instances where the annual indicator will increase as some infants have cases remaining open until a firm diagnosis is made by the clinician. The diagnosis may not be made by the clinician until the following year; therefore the 2009 data is provisional. 2009 data are used as a proxy for 2010. 2010 data will be available in late 2011.

2. Section Number: Form11_Performance Measure #1

Field Name: PM01

Row Name:

Column Name:

Year: 2009

Field Note:

2009 data have been revised but are still considered provisional due to open cases where a firm diagnosis by the clinician has not been made.

Unlike in 2006, the numerator and denominator numbers in 2007 - 2009 represent only the infants screened positive, rather than all infants screened.

3. Section Number: Form11_Performance Measure #1

Field Name: PM01

Row Name:

Column Name:

Year: 2008

Field Note:

Unlike in 2002 through 2006, the numerator and denominator numbers in 2007 and 2008 represent only the infants screened positive, rather than all infants screened.

PERFORMANCE MEASURE # 02

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

| | Annual Objective and Performance Data | | | | |
|--|---------------------------------------|------|--------------|--------------|--------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 64 | 66 | 66 | 60 | 62 |
| Annual Indicator | 60.3 | 59 | 59 | 59 | 59 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | CSHCN Survey | CSHCN Survey | CSHCN Survey |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. (Explain data in a year note. See Guidance, Appendix IX.) | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 59.6 | 60.2 | 60.8 | 61.4 | 62 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_Performance Measure #2
Field Name: PM02
Row Name:
Column Name:
Year: 2010
Field Note:
 Data reported for 2007, 2008 and 2009 are from the National Survey of Children with Special Health Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010 data. 2010 data will be available in the fall of 2011. Nationally, 57.4% of families with CSHCN report satisfaction with the services they need.
- Section Number:** Form11_Performance Measure #2
Field Name: PM02
Row Name:
Column Name:
Year: 2009
Field Note:
 Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey
- Section Number:** Form11_Performance Measure #2
Field Name: PM02
Row Name:
Column Name:
Year: 2008
Field Note:
 Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey

PERFORMANCE MEASURE # 03

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

| Annual Objective and Performance Data | | | | | |
|--|------|------|--------------|--------------|--------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 55 | 58 | 58 | 46 | 48 |
| Annual Indicator | 51.7 | 45.2 | 45.2 | 45.2 | 45.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | CSHCN survey | CSHCN survey | CSHCN survey |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. (Explain data in a year note. See Guidance, Appendix IX.) | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| Annual Objective and Performance Data | | | | | |
|---------------------------------------|------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 45.7 | 46.1 | 46.6 | 47 | 47.5 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_Performance Measure #3
Field Name: PM03
Row Name:
Column Name:
Year: 2010
Field Note:
 Data reported for 2007, 2008 and 2009 are from the National Survey of Children with Special Health Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010 data. 2010 data will be available in the fall of 2011. NYS is below the national average of 47.1%, as well as the target for the HP 2020 goal of 54.8% of CSHCN (under age 18) who have access to a medical home. However, NYS exceeds the HP 2020 target for CSHCN who receive their care in family-centered, comprehensive, coordinated systems. For children 0 – 11years, the HP 2020 target is 22.4%, and for children 12-17 years of age the target is 15.2%
- Section Number:** Form11_Performance Measure #3
Field Name: PM03
Row Name:
Column Name:
Year: 2009
Field Note:
 Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.
- Section Number:** Form11_Performance Measure #3
Field Name: PM03
Row Name:
Column Name:
Year: 2008
Field Note:
 Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

PERFORMANCE MEASURE # 04

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

| | Annual Objective and Performance Data | | | | |
|--|---------------------------------------|------|--------------|--------------|--------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 68 | 70 | 72 | 64 | 64 |
| Annual Indicator | 59.1 | 62.1 | 62.1 | 62.1 | 62.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | CSHCN survey | CSHCN survey | CSHCN survey |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. (Explain data in a year note. See Guidance, Appendix IX.) | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 62.7 | 63.3 | 64 | 64.6 | 65.2 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #4

Field Name: PM04

Row Name:

Column Name:

Year: 2010

Field Note:

Data reported for 2007, 2008 and 2009 are from the National Survey of Children with Special Health Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010 data. 2010 data will be available in the fall of 2011. Nationally, 62% of families have adequate insurance to pay for services they need.

2. Section Number: Form11_Performance Measure #4

Field Name: PM04

Row Name:

Column Name:

Year: 2009

Field Note:

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

3. Section Number: Form11_Performance Measure #4

Field Name: PM04

Row Name:

Column Name:

Year: 2008

Field Note:

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

PERFORMANCE MEASURE # 05

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

| Annual Objective and Performance Data | | | | | |
|--|------|------|--------------|--------------|--------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 80 | 82 | 91 | 92 | 92 |
| Annual Indicator | 75.3 | 90.6 | 90.6 | 90.6 | 90.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | CSHCN survey | CSHCN survey | CSHCN survey |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. (Explain data in a year note. See Guidance, Appendix IX.) | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| Annual Objective and Performance Data | | | | | |
|---------------------------------------|------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 91.5 | 92.4 | 93.3 | 94.2 | 95.1 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_Performance Measure #5
Field Name: PM05
Row Name:
Column Name:
Year: 2010
Field Note:
 Data reported for 2007, 2008 and 2009 comes from the National Survey of Children with Special Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010. 2010 data will be available in the fall of 2011. Nationally, 89.1% of families report that community-based service systems are organized so they can easily use them.
- Section Number:** Form11_Performance Measure #5
Field Name: PM05
Row Name:
Column Name:
Year: 2009
Field Note:
 Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.
- Section Number:** Form11_Performance Measure #5
Field Name: PM05
Row Name:
Column Name:
Year: 2008
Field Note:
 Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

PERFORMANCE MEASURE # 06

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

| Annual Objective and Performance Data | | | | | |
|--|------|------|--------------|--------------|--------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 7 | 9 | 40 | 40 | 40 |
| Annual Indicator | 5.8 | 38.4 | 38.4 | 38.4 | 38.4 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | CSHCN survey | CSHCN survey | CSHCN survey |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. (Explain data in a year note. See Guidance, Appendix IX.) | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| Annual Objective and Performance Data | | | | | |
|---------------------------------------|------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 38.8 | 39.2 | 39.6 | 39.9 | 40.3 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #6

Field Name: PM06

Row Name:

Column Name:

Year: 2010

Field Note:

Data for 2007, 2008 and 2009 comes from the National Survey of Children with Special Health Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010 data. 2010 data will be available in the fall of 2011. Nationally, 41.2% of youth indicated they received this service.

2. Section Number: Form11_Performance Measure #6

Field Name: PM06

Row Name:

Column Name:

Year: 2009

Field Note:

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

3. Section Number: Form11_Performance Measure #6

Field Name: PM06

Row Name:

Column Name:

Year: 2008

Field Note:

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

PERFORMANCE MEASURE # 07

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

| Annual Objective and Performance Data | | | | | |
|--|------|------|------------------------------|------------------------------|------------------------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 86 | 87 | 88 | 80 | 80 |
| Annual Indicator | 83.5 | 83 | 76.2 | 72.2 | 72.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | National Immunization Survey | National Immunization Survey | National Immunization Survey |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. (Explain data in a year note. See Guidance, Appendix IX.) | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| Annual Objective and Performance Data | | | | | |
|---------------------------------------|------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 72.9 | 73.6 | 74.4 | 75.1 | 75.8 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #7

Field Name: PM07

Row Name:

Column Name:

Year: 2010

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 (confidence interval 4.7%). 2009 data are used as a proxy for 2010 data. It is estimated that final 2010 immunization data will be available from CDC in late 2011 or early 2012. 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%.

2. Section Number: Form11_Performance Measure #7

Field Name: PM07

Row Name:

Column Name:

Year: 2009

Field Note:

2008 data are being used as a proxy for 2009.

3. Section Number: Form11_Performance Measure #7

Field Name: PM07

Row Name:

Column Name:

Year: 2008

Field Note:

Data from the National Immunization Survey. Numerator and Denominator data are not available. Data are for the time period 1-08-12-08.

PERFORMANCE MEASURE # 08

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

| | Annual Objective and Performance Data | | | | |
|--|---------------------------------------|---------|---------------|---------------|---------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 12 | 11 | 11 | 12.5 | 12.3 |
| Annual Indicator | 13.1 | 13.2 | 12.9 | 12.1 | 12.1 |
| Numerator | 5,214 | 5,277 | 5,074 | 4,687 | 4,687 |
| Denominator | 398,091 | 398,693 | 392,716 | 386,720 | 386,720 |
| Data Source | | | Vital Records | Vital Records | Vital Records |
| Check this box if you cannot report the numerator because | | | | | |
| 1. There are fewer than 5 events over the last year, and | | | | | |
| 2. The average number of events over the last 3 years is fewer | | | | | |
| than 5 and therefore a 3-year moving average cannot be | | | | | |
| applied. | | | | | |
| (Explain data in a year note. See Guidance, Appendix IX.) | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 12 | 11.9 | 11.7 | 11.6 | 11.5 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #8

Field Name: PM08

Row Name:

Column Name:

Year: 2010

Field Note:

2009 data has been updated and finalized since NYS's previous MCH block grant application submission. The NYS birth rate for teenagers aged 15 to17 was considerably lower than the national rate of 21.7 (2008). 2009 data are used as a proxy for 2010 data. 2010 data will be available by May 2012.

2. Section Number: Form11_Performance Measure #8

Field Name: PM08

Row Name:

Column Name:

Year: 2009

Field Note:

Data for 2009 have been revised with final data.

PERFORMANCE MEASURE # 09

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

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------|--------|-----------------------------|-----------------------------|-----------------------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 30 | 35 | 40 | 28 | 39 |
| Annual Indicator | 27.0 | 27.0 | 27.0 | 38.1 | 40.5 |
| Numerator | 10,534 | 10,534 | 10,534 | 3,414 | 1,043 |
| Denominator | 39,014 | 39,014 | 39,014 | 8,960 | 2,575 |
| Data Source | | | NYS 3rd Grade Dental Survey | NYS 3rd Grade Dental Survey | NYS 3rd Grade Dental Survey |

Check this box if you cannot report the numerator because
 1. There are fewer than 5 events over the last year, and
 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 40.9 | 41.3 | 41.7 | 42.1 | 42.5 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_Performance Measure #9
Field Name: PM09
Row Name:
Column Name:
Year: 2010
Field Note:
 The NYS 3rd Grade oral health surveillance project is currently in progress. 2006-2009 data is statewide data. Final 2009 and 2010 provisional data include upstate NY data only (excludes NYC.) It is anticipated that 2010 and 2011 data will be combined to increase the sample size and that this data will be released by the end of 2011.
- Section Number:** Form11_Performance Measure #9
Field Name: PM09
Row Name:
Column Name:
Year: 2009
Field Note:
 2009 data are for NYS (excluding NYC).
- Section Number:** Form11_Performance Measure #9
Field Name: PM09
Row Name:
Column Name:
Year: 2008
Field Note:
 2002-2004 data are being used as a proxy for 2007.

PERFORMANCE MEASURE # 10

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

| Annual Objective and Performance Data | | | | | |
|--|-----------|-----------|---------------|---------------|---------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 1.1 | 1 | 0.9 | 1.3 | 1.2 |
| Annual Indicator | 1.3 | 1.3 | 1.2 | 1.0 | 1.0 |
| Numerator | 50 | 48 | 43 | 37 | 37 |
| Denominator | 3,916,635 | 3,597,289 | 3,604,140 | 3,633,448 | 3,633,448 |
| Data Source | | | Vital Records | Vital Records | Vital Records |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. (Explain data in a year note. See Guidance, Appendix IX.) | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| Annual Objective and Performance Data | | | | | |
|---------------------------------------|------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 1 | 1 | 1 | 1 | 1 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_Performance Measure #10
Field Name: PM10
Row Name:
Column Name:
Year: 2010
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. 2009 data are used as a proxy for 2010. 2010 data will be available in May 2012.
- Section Number:** Form11_Performance Measure #10
Field Name: PM10
Row Name:
Column Name:
Year: 2009
Field Note:
 2009 data have been revised with final 2009 data.
 The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.
- Section Number:** Form11_Performance Measure #10
Field Name: PM10
Row Name:
Column Name:
Year: 2008
Field Note:
 The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

PERFORMANCE MEASURE # 11

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

| Annual Objective and Performance Data | | | | | |
|---|------|------|--|------------------------------|------------------------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 40 | 43 | 51 | 44.5 | 45.5 |
| Annual Indicator | 50 | 50 | 49.4 | 47.4 | 47.4 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | National Immunization Survey - breastfeeding suppl | National Immunization Survey | National Immunization Survey |
| <p>Check this box if you cannot report the numerator because</p> <p>1. There are fewer than 5 events over the last year, and</p> <p>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.</p> <p>(Explain data in a year note. See Guidance, Appendix IX.)</p> | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| Annual Objective and Performance Data | | | | | |
|---------------------------------------|------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 47.9 | 48.3 | 48.8 | 49.3 | 49.8 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_Performance Measure #11
Field Name: PM11
Row Name:
Column Name:
Year: 2010
Field Note:
 2008 data has been finalized from previous submission. 2009 data is for 2007 birth cohort. 2009 data are used as a proxy for 2010 data. It is estimated that final 2010 data will be available from CDC in 2012.
- Section Number:** Form11_Performance Measure #11
Field Name: PM11
Row Name:
Column Name:
Year: 2009
Field Note:
 2009 data have been revised with final 2009 data. Information was reported in 2009 for the 2006 birth cohort.
- Section Number:** Form11_Performance Measure #11
Field Name: PM11
Row Name:
Column Name:
Year: 2008
Field Note:
 2008 data are based on the 2006 birth cohort.
Data Source: National Immunization Survey - breastfeeding supplement

PERFORMANCE MEASURE # 12

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

| | Annual Objective and Performance Data | | | | |
|--|---------------------------------------|---------|-----------------------------------|-----------------------------------|-------------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 97.9 | 98.5 | 98.7 | 99.1 | 99.1 |
| Numerator | 242,212 | 247,960 | 244,630 | 244,545 | 244,545 |
| Denominator | 247,352 | 251,760 | 247,928 | 246,647 | 246,647 |
| Data Source | | | Newborn Hearing Screening Program | Newborn Hearing Screening Program | Newborn Screening |
| Check this box if you cannot report the numerator because | | | | | |
| 1. There are fewer than 5 events over the last year, and | | | | | |
| 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| (Explain data in a year note. See Guidance, Appendix IX.) | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #12

Field Name: PM12

Row Name:

Column Name:

Year: 2010

Field Note:

2009 data are used as a proxy for 2010 data. 2010 data will be available in late 2011.

2. Section Number: Form11_Performance Measure #12

Field Name: PM12

Row Name:

Column Name:

Year: 2009

Field Note:

2009 data have been revised using final 2009 data.

PERFORMANCE MEASURE # 13

Percent of children without health insurance.

| Annual Objective and Performance Data | | | | | |
|--|-----------|-----------|---------------------------|---------------------------|---------------------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 8.5 | 8 | 8 | 8.5 | 8.4 |
| Annual Indicator | 8.4 | 8.9 | 7.1 | 7.5 | 7.5 |
| Numerator | 380,000 | 395,000 | 310,000 | 335,000 | 335,000 |
| Denominator | 4,547,000 | 4,437,000 | 4,373,000 | 4,465,000 | 4,465,000 |
| Data Source | | | Current Population Survey | Current Population Survey | Current Population Survey |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. (Explain data in a year note. See Guidance, Appendix IX.) | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| Annual Objective and Performance Data | | | | | |
|---------------------------------------|------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 7.4 | 7.4 | 7.3 | 7.2 | 7.1 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #13

Field Name: PM13

Row Name:

Column Name:

Year: 2010

Field Note:

2009 data are used as a proxy for 2010 data. It is estimated that 2010 data will be available by the end of 2011.

2. Section Number: Form11_Performance Measure #13

Field Name: PM13

Row Name:

Column Name:

Year: 2009

Field Note:

2009 data have been revised using 2009 final data.

PERFORMANCE MEASURE # 14

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

| | Annual Objective and Performance Data | | | | |
|--|---------------------------------------|---------|---------|---------|-------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 32 | 31 | 30 | 29 | 29 |
| Annual Indicator | 32.0 | 32.0 | 32.0 | 31.8 | 31.8 |
| Numerator | 63,874 | 63,373 | 67,108 | 71,274 | 71,274 |
| Denominator | 199,608 | 198,041 | 209,713 | 224,130 | 224,130 |
| Data Source | | | PedNSS | PedNSS | PedNSS |
| Check this box if you cannot report the numerator because | | | | | |
| 1. There are fewer than 5 events over the last year, and | | | | | |
| 2. The average number of events over the last 3 years is fewer | | | | | |
| than 5 and therefore a 3-year moving average cannot be | | | | | |
| applied. | | | | | |
| (Explain data in a year note. See Guidance, Appendix IX.) | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 31.5 | 31.2 | 30.8 | 30.5 | 30.2 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number: Form11_Performance Measure #14

Field Name: PM14

Row Name:

Column Name:

Year: 2010

Field Note:

Data source is the Pediatric Nutrition Survey (PedNSS). 2009 data are used as a proxy for 2010 data. 2010 data will be available in early 2012.

- Section Number: Form11_Performance Measure #14

Field Name: PM14

Row Name:

Column Name:

Year: 2009

Field Note:

2009 data have been revised using final 2009 data.

PERFORMANCE MEASURE # 15

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

| | Annual Objective and Performance Data | | | | |
|--|---------------------------------------|------|-------|-------------|-------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 15 | 14 | 14 | 13 | 12 |
| Annual Indicator | 12.2 | 13.7 | 8.2 | 8.2 | 8.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | PRAMS | PRAMS | PRAMS |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. (Explain data in a year note. See Guidance, Appendix IX.) | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 8.1 | 8 | 8 | 7.9 | 7.8 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_Performance Measure #15
Field Name: PM15
Row Name:
Column Name:
Year: 2010
Field Note:
 Data source is the Pregnancy Risk Assessment and Monitoring Survey (PRAMS). Data reported for 2006 and 2007 were for NYS (excluding NYC). CDC recently provided statewide statistics for this indicator. Statewide 2006 and 2007 data are therefore now available. The comparable statewide percentages for 2006 and 2007 are 8.5% and 9.1% accordingly. 2008 data are used as a proxy for 2009 and 2010. 2009 data will be available in August 2011. In comparing data from the NYC and Upstate PRAMS surveys for 2008, women giving birth in upstate NY in 2008 were more likely to smoke during the last 3 months of pregnancy as compared to women residing in NYC (11.9% and 3.6% respectively).
- Section Number:** Form11_Performance Measure #15
Field Name: PM15
Row Name:
Column Name:
Year: 2009
Field Note:
 2008 NYS PRAMS data are being used as a proxy for 2009. 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 comparable NYS percentages for 2006 and 2007 are 8.5% and 9.1%, respectively. 2009 data will be available in August of 2011.
- Section Number:** Form11_Performance Measure #15
Field Name: PM15
Row Name:
Column Name:
Year: 2008
Field Note:
 Data from 2008PRAMS - NYS exclusive of NYC data. Numerator and denominator data are not available (survey data).

PERFORMANCE MEASURE # 16

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

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------|-----------|---------------|---------------|---------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 4.1 | 4.1 | 4 | 3.8 | 3.8 |
| Annual Indicator | 3.7 | 3.9 | 3.3 | 4.2 | 4.2 |
| Numerator | 51 | 54 | 46 | 58 | 58 |
| Denominator | 1,385,081 | 1,396,874 | 1,403,050 | 1,366,144 | 1,366,144 |
| Data Source | | | Vital Records | Vital Records | Vital Records |

Check this box if you cannot report the numerator because
 1. There are fewer than 5 events over the last year, and
 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 4.2 | 4.1 | 4.1 | 4 | 4 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #16

Field Name: PM16

Row Name:

Column Name:

Year: 2010

Field Note:

2009 data are used as a proxy for 2010 data. 2010 data will be available in May 2012.

2. Section Number: Form11_Performance Measure #16

Field Name: PM16

Row Name:

Column Name:

Year: 2009

Field Note:

2009 data have been revised using final 2009 data.

PERFORMANCE MEASURE # 17

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

| | Annual Objective and Performance Data | | | | |
|---|---------------------------------------|-------|---------------|---------------|---------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 91 | 92 | 92 | 94 | 94 |
| Annual Indicator | 88.6 | 89.7 | 90.0 | 90.6 | 90.6 |
| Numerator | 3,345 | 3,252 | 3,281 | 3,356 | 3,356 |
| Denominator | 3,774 | 3,627 | 3,646 | 3,704 | 3,704 |
| Data Source | | | Vital Records | Vital Records | Vital Records |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. <i>(Explain data in a year note. See Guidance, Appendix IX.)</i> | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 91 | 91.3 | 91.7 | 92 | 92.4 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_Performance Measure #17
Field Name: PM17
Row Name:
Column Name:
Year: 2010
Field Note:
 2009 data have been finalized since previous submission. 2009 data are used as a proxy for 2010. 2010 data will be available in May 2012.
- Section Number:** Form11_Performance Measure #17
Field Name: PM17
Row Name:
Column Name:
Year: 2009
Field Note:
 2009 data have been revised using final 2009 data.
- Section Number:** Form11_Performance Measure #17
Field Name: PM17
Row Name:
Column Name:
Year: 2008
Field Note:
 2007 data are being used as a proxy for 2008.

PERFORMANCE MEASURE # 18

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

| | Annual Objective and Performance Data | | | | |
|--|---------------------------------------|---------|---------------|---------------|---------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | 77 | 78 | 79 | 80 | 81 |
| Annual Indicator | 74.6 | 73.8 | 72.3 | 73.3 | 73.3 |
| Numerator | 174,078 | 174,949 | 165,813 | 167,503 | 167,503 |
| Denominator | 233,441 | 236,903 | 229,467 | 228,517 | 228,517 |
| Data Source | | | Vital Records | Vital Records | Vital Records |
| Check this box if you cannot report the numerator because | | | | | |
| 1. There are fewer than 5 events over the last year, and | | | | | |
| 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| (Explain data in a year note. See Guidance, Appendix IX.) | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 74 | 74.8 | 75.5 | 76.2 | 77 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_Performance Measure #18
Field Name: PM18
Row Name:
Column Name:
Year: 2010
Field Note:
 2009 data has been finalized since the previous submission. 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. 2009 data are used as a proxy for 2010 data. 2010 data will be available in May 2012. NYS is performing above the Healthy People 2020 baseline of 70.8% for this indicator.
- Section Number:** Form11_Performance Measure #18
Field Name: PM18
Row Name:
Column Name:
Year: 2009
Field Note:
 2009 data have been revised using final 2009 data.

 Denominator excludes births where trimester when prenatal care began is unknown
- Section Number:** Form11_Performance Measure #18
Field Name: PM18
Row Name:
Column Name:
Year: 2008
Field Note:
 Denominator excludes births where trimester when prenatal care began is unknown.

FORM 11
TRACKING PERFORMANCE MEASURES
[SECS 485 (2)(2)(B)(iii) AND 486 (A)(2)(A)(iii)]
STATE: NY

Form Level Notes for Form 11

None

STATE PERFORMANCE MEASURE # 1 - REPORTING YEAR

The percentage of infants born to Black and Hispanic women receiving prenatal care beginning in the first trimester.

| Annual Objective and Performance Data | | | | | |
|---------------------------------------|------|------|---------------|---------------|---------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | | | | | |
| Annual Indicator | | | 62.4 | 64.3 | 64.3 |
| Numerator | | | 58,091 | 58,055 | 58,055 |
| Denominator | | | 93,114 | 90,226 | 90,226 |
| Data Source | | | Vital Records | Vital Records | Vital Records |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| Annual Objective and Performance Data | | | | | |
|---------------------------------------|---|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 64.9 | 65.6 | 66.2 | 66.9 | 67.5 |
| Annual Indicator | Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period. | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_State Performance Measure #1
Field Name: SM1
Row Name:
Column Name:
Year: 2010
Field Note:
 2009 data are being used as a proxy for 2010; 2010 data will be available in May 2012.

STATE PERFORMANCE MEASURE # 2 - REPORTING YEAR

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

| Annual Objective and Performance Data | | | | | |
|---------------------------------------|-------|-------|--|--|--|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | _____ | _____ | _____ | _____ | _____ |
| Annual Indicator | _____ | _____ | 81 | 79 | 79 |
| Numerator | _____ | _____ | _____ | _____ | _____ |
| Denominator | _____ | _____ | _____ | _____ | _____ |
| Data Source | | | NYS Quality Assurance Reporting Requirements | NYS Quality Assurance Reporting Requirements | NYS Quality Assurance Reporting Requirements |
| Is the Data Provisional or Final? | | | | Final | Final |

| Annual Objective and Performance Data | | | | | |
|---------------------------------------|---|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 79.5 | 79.9 | 80.4 | 80.9 | 81.4 |
| Annual Indicator | Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period. | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_State Performance Measure #2

Field Name: SM2

Row Name:

Column Name:

Year: 2010

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. Comparison between 2007/2008 and 2009/2010 are not possible due to the fact that different methods of data collection were used in developing the measure rate.

2009 data are used as a proxy for 2010. This indicator is collected on a biannual basis. Numerator and denominator data are not available (survey data).

2. Section Number: Form11_State Performance Measure #2

Field Name: SM2

Row Name:

Column Name:

Year: 2009

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. Numerator and denominator data are not available (survey data).

3. Section Number: Form11_State Performance Measure #2

Field Name: SM2

Row Name:

Column Name:

Year: 2008

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).

2007 data are being used as a proxy for 2008. This indicator is collected on a biannual basis.

STATE PERFORMANCE MEASURE # 3 - REPORTING YEAR

The ratio of the Black infant low birth weight rate to the White infant low birth weight rate

| | Annual Objective and Performance Data | | | | |
|-----------------------------------|---------------------------------------|------|---------------|---------------|---------------|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Annual Performance Objective | | | | | |
| Annual Indicator | | | 1.9 | 1.9 | 1.9 |
| Numerator | | | 13 | 13 | 13 |
| Denominator | | | 6.8 | 6.9 | 6.9 |
| Data Source | | | Vital Records | Vital Records | Vital Records |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---|------|------|------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 1.9 | 1.9 | 1.8 | 1.8 | 1.8 |
| Annual Indicator | Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period. | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_State Performance Measure #3
Field Name: SM3
Row Name:
Column Name:
Year: 2010
Field Note:
 2009 data are being used as a proxy for 2010; 2010 data will be available in May of 2012. White and Black race groups do not include Hispanics.
- Section Number:** Form11_State Performance Measure #3
Field Name: SM3
Row Name:
Column Name:
Year: 2009
Field Note:
 White and Black race groups do not include Hispanics.
- Section Number:** Form11_State Performance Measure #3
Field Name: SM3
Row Name:
Column Name:
Year: 2008
Field Note:
 White and Black race groups do not include Hispanics.

FORM 16
STATE PERFORMANCE AND OUTCOME MEASURE DETAIL SHEET
STATE: NY

SP() # 1

PERFORMANCE MEASURE:

The percentage of infants born to Black and Hispanic women receiving prenatal care beginning in the first trimester.

STATUS:

Active

GOAL

Increase the percentage of Black and Hispanic women receiving early prenatal care.

DEFINITION

Percentage of births to Black non-Hispanic and Hispanic women who started prenatal care during their first trimester.

Numerator:

Number of births to Black non-Hispanic and Hispanic women who started prenatal care during their first trimester.

Denominator:

Number of births to Black non-Hispanic and Hispanic women (excluding births with unknown prenatal care start dates).

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

NYS Vital Records

SIGNIFICANCE

It is essential that women, especially high risk women, receive early prenatal care where their needs can be assessed, and they can be provided with necessary health and psychosocial supports. While health disparities related to early entry prenatal care have improved somewhat in the last decade, they still remain significant, highlighting the specific importance of monitoring prenatal care for minority populations.

SP() # 2

PERFORMANCE MEASURE:

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

STATUS:

Active

GOAL

To increase the percent of children in the 3-6 age group who have an annual preventive health visit

DEFINITION

The percentage of Medicaid enrolled children ages 3-6 years with a well child and preventive health visit in the past year.

Numerator:

Number of medicaid enrolled children (ages 3-6) who have had a well child preventive health visit

Denominator:

Number of medicaid enrolled children (ages 3-6) years.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

Source: The NYS Quality Assurance Reporting Requirements (QARR)- report of managed care plan performance. Data only include information for enrollees in managed care programs.

SIGNIFICANCE

Having health insurance alone does not assure access to or utilization of necessary health care services. Well child preventive visits are an essential component of high quality health care.

SP() # 3

PERFORMANCE MEASURE:

The ratio of the Black infant low birth weight rate to the White infant low birth weight rate

STATUS:

Active

GOAL

To reduce the disparity between the White and Black low birth weight rates.

DEFINITION

Ratio of Black to White low birth weight rates

Numerator:

The percent of Black infants born weighing less than 2500 grams

Denominator:

The percent of White infants born weighing less than 2500 grams

Units: 1 **Text:** Ratio

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

NYS Vital Records

SIGNIFICANCE

Elimination of health disparities is a high priority for the Department and the Governor and permeates the work of the department. The Black low birth weight rate in NYS is about double the rate of the White rate.

SP() # 4

PERFORMANCE MEASURE:

The percentage of high school students who were overweight or obese

STATUS:

Active

GOAL

To reduce the percentage of adolescents who are overweight or obese

DEFINITION

The percentage of high school students who were overweight or obese (i.e., at or above the 85th percentile for body mass index, by age and sex)

Numerator:

The number of high school students with BMIs above the 85th percentile by age and sex.

Denominator:

The number of high school students

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

The NYS Youth Risk Behavior Survey

SIGNIFICANCE

Research indicates that adult morbidity and mortality are increased by childhood obesity, even if the condition does not persist into adulthood. However, in general, overweight and obesity tend to track or persist from childhood into adolescence and adulthood. The older the child/adolescent and the greater the obesity, the more likely that child/adolescent obesity will persist.

SP() # 5

PERFORMANCE MEASURE:

The ratio of the Hispanic teen (ages 15-17) pregnancy rate to the non-Hispanic White teen (ages 15-17) pregnancy rate

STATUS:

Active

GOAL

To reduce the disparity in teen pregnancy rates between Hispanic and non-Hispanic White teen girls.

DEFINITION

The ratio of the Hispanic teen (ages 15-17) pregnancy rate to the non-Hispanic White teen (ages 15-17) pregnancy rate

Numerator:

The rate of pregnancies (including abortions, spontaneous fetal deaths, and births) to Hispanic females aged 15-17 years old.

Denominator:

The rate of pregnancies (including abortions, spontaneous fetal deaths, and births) to non-Hispanic White females aged 15-17 years old.

Units: 1 Text: Ratio

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

Vital Records are the source for data on mothers' age and pregnancies. Population numbers are estimated by the Bureau of Biometrics, NYS Health Department.

SIGNIFICANCE

Adolescent sexual activity can have life-changing or life-threatening consequences; unintended pregnancy and infection with sexually transmitted diseases or HIV. Teen parenting is associated with non-completion of high school. While NYS has been successful in reducing teen pregnancies over the past decade, rates of pregnancy among Hispanic teens is more than double the rate for White teens.

SP() # 6

PERFORMANCE MEASURE:

Percent of High School Students Who Smoked Cigarettes in the Last Month

STATUS:

Active

GOAL

To reduce smoking among adolescents.

DEFINITION

The rate of current smoking among high school students.

Numerator:

The number of high school students that reported smoking at least one cigarette during the last month.

Denominator:

The number of high school students

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

The New York State Youth Risk Behavior Survey

SIGNIFICANCE

Tobacco is an addictive substance. Tobacco causes more disease and death in NYS than any other pathogen. Tobacco causes 30% of all cancer deaths, 82% of all deaths due to pulmonary disease, and 21% of deaths due to chronic cardiac disease. More than 1,500 fire deaths and 4,600 injuries in the US are attributable to cigarettes. Most (89%) of adult smokers initiated their habit while young, under the age of 18. 71% of adult smokers reported that they began smoking daily before age 18.

SP() # 7

PERFORMANCE MEASURE:

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

STATUS:

Active

GOAL

To increase dental visits among children and adolescents living in low income households.

DEFINITION

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

Numerator:

Medicaid enrolled children and adolescents(ages 2-21) who had at least one dental visit in the last year

Denominator:

Medicaid enrolled children and adolescents (ages 2-21)

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

Source: The NYS Quality Assurance Reporting Requirements (QARR)- report of managed care plan performance. Data only include information for enrollees in managed care programs.

SIGNIFICANCE

Tooth decay, the most common chronic childhood disease impacts children's functioning, including eating, growth and speaking and learning. In the US, children are estimated to lose over 51 million school hours annually because of dental problems and dental visits.

SP() # 8

PERFORMANCE MEASURE:

Percentage of children who were tested for lead two or more times before the age of three.

STATUS:

Active

GOAL

To identify all children who have been exposed to high levels of lead.

DEFINITION

Percentage of children who were tested for high lead levels two or more times before the age of three.

Numerator:

Number of children in the birth year cohort who have been screened two or more times for high blood lead levels before the age of three.

Denominator:

Number of children in the birth year cohort

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

NYS Heavymetals and Childhood Lead Registry, the data base for the NYS Childhood Lead Poisoning Prevention Program, is the source for these data. The NYSDOH Bureau of Biometrics provides population estimates.

SIGNIFICANCE

Childhood lead poisoning is a serious health problem that can have devastating permanent effects on children's physical, social, behavioral and cognitive development, with serious social and economic repercussions for society as a whole.

SP() # 9

| | |
|--------------------------------------|--|
| PERFORMANCE MEASURE: | Hospitalization Rate for Asthma in Children Ages 0 to 17 years. |
| STATUS: | Active |
| GOAL | To reduce asthma morbidity among children. |
| DEFINITION | Rate of asthma hospitalizations per 10,000 children ages 0 to 17. Numerator: Number of hospitalizations for asthma (ICD9 493)among children ages 0 to 17. Denominator: Number of children ages 0 to 17 Units: 10000 Text: Rate |
| HEALTHY PEOPLE 2010 OBJECTIVE | 1-9. Hospitalization for ambulatory-care-sensitive conditions 1-9a. Reduce hospitalization rates for pediatric asthma (persons under age 18 years) to no more than 17.3 per 10,000 persons aged less than 18 years. |
| DATA SOURCES AND DATA ISSUES | The NYS SPARCS Data System is the source for the hospitalization data. The NYSDOH Bureau of Biometrics provides population estimates. |
| SIGNIFICANCE | Increased asthma prevalence among children and the associated morbidity due to exacerbations and persistent symptoms present a huge burden to affected individuals and their families. In the US, over 10 million school days are lost annually by children with asthma. Consequently lost productivity of their parents was almost \$1M. Patients with inadequately controlled severe asthma have high expenditures in health care costs, especially in terms of hospitalizations. The social and economic burdens of asthma can be alleviated through appropriate asthma prevention and management strategies. |

SP() # 10

PERFORMANCE MEASURE:

The percentage of infants who were exclusively fed breast milk between birth and hospital discharge

STATUS:

Active

GOAL

To increase the rate of infants who are exclusively fed breast milk

DEFINITION

The percentage of infants who were exclusively fed breast milk between birth and hospital discharge

Numerator:

The number of in-born infants, excluding those transferred to the neonatal intensive care unit, who are exclusively fed breast milk between birth and discharge

Denominator:

The total number of in-born infants who are not transferred to neonatal intensive care unit.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

Statewide Perinatal Data System

SIGNIFICANCE

The U.S. Surgeion General recommends that babies be fed only breast milk for the first six months of their lives. The public health benefits of breastfeeding have long been recognized. Human milk is uniquely adapted to the nutritional needs of infants and provides for optimal growth and development. Breast milk is easy to digest and contains antibodies that help reduce the infants risk of infection.

SO() # 1

OUTCOME MEASURE:

Maternal Mortality Rate per 100,000 Live Births

STATUS:

Active

GOAL

To reduce the number of maternal deaths

DEFINITION

Deaths from causes related to pregnancy

Numerator:

Number of deaths occurring to women from causes related to pregnancy (ICD 9: 630 through 676)

Denominator:

Number of Live Births

Units: 100000 **Text:** Rate

HEALTHY PEOPLE 2010 OBJECTIVE

Reduce the maternal mortality rate to no more than 3.3 per 100,000 live births

DATA SOURCES AND DATA ISSUES

Source: Vital Records Issues: Maternal death as cause of death are under reported. More aggressive case ascertainment results in what appear to be higher rates.

SIGNIFICANCE

Due to general improvement in social and economic conditions and medical practices, maternal deaths are rare occurrences. However, in recent years in both the U.S. and in New York State, the rate of maternal deaths has been increasing. New York State is revising its protocol for maternal mortality reviews with a focus upon prevention of future deaths. It is critical to continue to track the rate of maternal deaths to determine whether this effort will have a positive effect on reducing mortality.

SO() # 2

OUTCOME MEASURE:

The percentage of elective deliveries, both cesarean sections and inductions, performed without appropriate indication between 36 and 38 6/7 weeks gestation

STATUS:

Active

GOAL

To reduce the rate of elective deliveries performed without indication

DEFINITION

Rate of elective deliveries per 100 performed without appropriate indication among women between 36 and 38 6/7 weeks gestation.

Numerator:

Number of elective deliveries performed without appropriate indication among women between 36 and 38 6/7 weeks gestation.

Denominator:

Number of elective deliveries performed among women between 36 and 38 6/7 weeks gestation.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

Statewide Perinatal Data System

SIGNIFICANCE

Cesarean section rates have risen nationally over the past decade. Between 1996 and 2005, the national c-section rate rose by 46% due, in part, to increases in the percent of women having first time c-section deliveries and a reduction in the percentage of vaginal births after c-section. The c-section rate in NYS reflects the national trend.

FORM 16
STATE PERFORMANCE AND OUTCOME MEASURE DETAIL SHEET
STATE: NY

SP() # 1

PERFORMANCE MEASURE:

The percentage of infants born to Black and Hispanic women receiving prenatal care beginning in the first trimester.

STATUS:

Active

GOAL

Increase the percentage of Black and Hispanic women receiving early prenatal care.

DEFINITION

Percentage of births to Black non-Hispanic and Hispanic women who started prenatal care during their first trimester.

Numerator:

Number of births to Black non-Hispanic and Hispanic women who started prenatal care during their first trimester.

Denominator:

Number of births to Black non-Hispanic and Hispanic women (excluding births with unknown prenatal care start dates).

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

NYS Vital Records

SIGNIFICANCE

It is essential that women, especially high risk women, receive early prenatal care where their needs can be assessed, and they can be provided with necessary health and psychosocial supports. While health disparities related to early entry prenatal care have improved somewhat in the last decade, they still remain significant, highlighting the specific importance of monitoring prenatal care for minority populations.

SP() # 2

PERFORMANCE MEASURE:

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

STATUS:

Active

GOAL

To increase the percent of children in the 3-6 age group who have an annual preventive health visit

DEFINITION

The percentage of Medicaid enrolled children ages 3-6 years with a well child and preventive health visit in the past year.

Numerator:

Number of medicaid enrolled children (ages 3-6) who have had a well child preventive health visit

Denominator:

Number of medicaid enrolled children (ages 3-6) years.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

Source: The NYS Quality Assurance Reporting Requirements (QARR)- report of managed care plan performance. Data only include information for enrollees in managed care programs.

SIGNIFICANCE

Having health insurance alone does not assure access to or utilization of necessary health care services. Well child preventive visits are an essential component of high quality health care.

SP() # 3

PERFORMANCE MEASURE:

The ratio of the Black infant low birth weight rate to the White infant low birth weight rate

STATUS:

Active

GOAL

To reduce the disparity between the White and Black low birth weight rates.

DEFINITION

Ratio of Black to White low birth weight rates

Numerator:

The percent of Black infants born weighing less than 2500 grams

Denominator:

The percent of White infants born weighing less than 2500 grams

Units: 1 **Text:** Ratio

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

NYS Vital Records

SIGNIFICANCE

Elimination of health disparities is a high priority for the Department and the Governor and permeates the work of the department. The Black low birth weight rate in NYS is about double the rate of the White rate.

SP() # 4

PERFORMANCE MEASURE:

The percentage of high school students who were overweight or obese

STATUS:

Active

GOAL

To reduce the percentage of adolescents who are overweight or obese

DEFINITION

The percentage of high school students who were overweight or obese (i.e., at or above the 85th percentile for body mass index, by age and sex)

Numerator:

The number of high school students with BMIs above the 85th percentile by age and sex.

Denominator:

The number of high school students

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

The NYS Youth Risk Behavior Survey

SIGNIFICANCE

Research indicates that adult morbidity and mortality are increased by childhood obesity, even if the condition does not persist into adulthood. However, in general, overweight and obesity tend to track or persist from childhood into adolescence and adulthood. The older the child/adolescent and the greater the obesity, the more likely that child/adolescent obesity will persist.

SP() # 5

PERFORMANCE MEASURE:

The ratio of the Hispanic teen (ages 15-17) pregnancy rate to the non-Hispanic White teen (ages 15-17) pregnancy rate

STATUS:

Active

GOAL

To reduce the disparity in teen pregnancy rates between Hispanic and non-Hispanic White teen girls.

DEFINITION

The ratio of the Hispanic teen (ages 15-17) pregnancy rate to the non-Hispanic White teen (ages 15-17) pregnancy rate

Numerator:

The rate of pregnancies (including abortions, spontaneous fetal deaths, and births) to Hispanic females aged 15-17 years old.

Denominator:

The rate of pregnancies (including abortions, spontaneous fetal deaths, and births) to non-Hispanic White females aged 15-17 years old.

Units: 1 Text: Ratio

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

Vital Records are the source for data on mothers' age and pregnancies. Population numbers are estimated by the Bureau of Biometrics, NYS Health Department.

SIGNIFICANCE

Adolescent sexual activity can have life-changing or life-threatening consequences; unintended pregnancy and infection with sexually transmitted diseases or HIV. Teen parenting is associated with non-completion of high school. While NYS has been successful in reducing teen pregnancies over the past decade, rates of pregnancy among Hispanic teens is more than double the rate for White teens.

SP() # 6

PERFORMANCE MEASURE:

Percent of High School Students Who Smoked Cigarettes in the Last Month

STATUS:

Active

GOAL

To reduce smoking among adolescents.

DEFINITION

The rate of current smoking among high school students.

Numerator:

The number of high school students that reported smoking at least one cigarette during the last month.

Denominator:

The number of high school students

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

The New York State Youth Risk Behavior Survey

SIGNIFICANCE

Tobacco is an addictive substance. Tobacco causes more disease and death in NYS than any other pathogen. Tobacco causes 30% of all cancer deaths, 82% of all deaths due to pulmonary disease, and 21% of deaths due to chronic cardiac disease. More than 1,500 fire deaths and 4,600 injuries in the US are attributable to cigarettes. Most (89%) of adult smokers initiated their habit while young, under the age of 18. 71% of adult smokers reported that they began smoking daily before age 18.

SP() # 7

PERFORMANCE MEASURE:

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

STATUS:

Active

GOAL

To increase dental visits among children and adolescents living in low income households.

DEFINITION

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

Numerator:

Medicaid enrolled children and adolescents(ages 2-21) who had at least one dental visit in the last year

Denominator:

Medicaid enrolled children and adolescents (ages 2-21)

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

Source: The NYS Quality Assurance Reporting Requirements (QARR)- report of managed care plan performance. Data only include information for enrollees in managed care programs.

SIGNIFICANCE

Tooth decay, the most common chronic childhood disease impacts children's functioning, including eating, growth and speaking and learning. In the US, children are estimated to lose over 51 million school hours annually because of dental problems and dental visits.

SP() # 8

PERFORMANCE MEASURE:

Percentage of children who were tested for lead two or more times before the age of three.

STATUS:

Active

GOAL

To identify all children who have been exposed to high levels of lead.

DEFINITION

Percentage of children who were tested for high lead levels two or more times before the age of three.

Numerator:

Number of children in the birth year cohort who have been screened two or more times for high blood lead levels before the age of three.

Denominator:

Number of children in the birth year cohort

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

NYS Heavymetals and Childhood Lead Registry, the data base for the NYS Childhood Lead Poisoning Prevention Program, is the source for these data. The NYSDOH Bureau of Biometrics provides population estimates.

SIGNIFICANCE

Childhood lead poisoning is a serious health problem that can have devastating permanent effects on children's physical, social, behavioral and cognitive development, with serious social and economic repercussions for society as a whole.

SP() # 9

PERFORMANCE MEASURE:

Hospitalization Rate for Asthma in Children Ages 0 to 17 years.

STATUS:

Active

GOAL

To reduce asthma morbidity among children.

DEFINITION

Rate of asthma hospitalizations per 10,000 children ages 0 to 17.

Numerator:

Number of hospitalizations for asthma (ICD9 493) among children ages 0 to 17.

Denominator:

Number of children ages 0 to 17

Units: 10000 **Text:** Rate

HEALTHY PEOPLE 2010 OBJECTIVE

1-9. Hospitalization for ambulatory-care-sensitive conditions

1-9a. Reduce hospitalization rates for pediatric asthma (persons under age 18 years) to no more than 17.3 per 10,000 persons aged less than 18 years.

DATA SOURCES AND DATA ISSUES

The NYS SPARCS Data System is the source for the hospitalization data. The NYSDOH Bureau of Biometrics provides population estimates.

SIGNIFICANCE

Increased asthma prevalence among children and the associated morbidity due to exacerbations and persistent symptoms present a huge burden to affected individuals and their families. In the US, over 10 million school days are lost annually by children with asthma. Consequently lost productivity of their parents was almost \$1M. Patients with inadequately controlled severe asthma have high expenditures in health care costs, especially in terms of hospitalizations. The social and economic burdens of asthma can be alleviated through appropriate asthma prevention and management strategies.

SP() # 10

| | |
|--------------------------------------|---|
| PERFORMANCE MEASURE: | The percentage of infants who were exclusively fed breast milk between birth and hospital discharge |
| STATUS: | Active |
| GOAL | To increase the rate of infants who are exclusively fed breast milk |
| DEFINITION | <p>The percentage of infants who were exclusively fed breast milk between birth and hospital discharge</p> <p>Numerator: The number of in-born infants, excluding those transferred to the neonatal intensive care unit, who are exclusively fed breast milk between birth and discharge</p> <p>Denominator: The total number of in-born infants who are not transferred to neonatal intensive care unit.</p> <p>Units: 100 Text: Percent</p> |
| HEALTHY PEOPLE 2010 OBJECTIVE | |
| DATA SOURCES AND DATA ISSUES | Statewide Perinatal Data System |
| SIGNIFICANCE | The U.S. Surgeion General recommends that babies be fed only breast milk for the first six months of their lives. The public health benefits of breastfeeding have long been recognized. Human milk is uniquely adapted to the nutritional needs of infants and provides for optimal growth and development. Breast milk is easy to digest and contains antibodies that help reduce the infants risk of infection. |

SO() # 1

OUTCOME MEASURE:

Maternal Mortality Rate per 100,000 Live Births

STATUS:

Active

GOAL

To reduce the number of maternal deaths

DEFINITION

Deaths from causes related to pregnancy

Numerator:

Number of deaths occurring to women from causes related to pregnancy (ICD 9: 630 through 676)

Denominator:

Number of Live Births

Units: 100000 **Text:** Rate

HEALTHY PEOPLE 2010 OBJECTIVE

Reduce the maternal mortality rate to no more than 3.3 per 100,000 live births

DATA SOURCES AND DATA ISSUES

Source: Vital Records Issues: Maternal death as cause of death are under reported. More aggressive case ascertainment results in what appear to be higher rates.

SIGNIFICANCE

Due to general improvement in social and economic conditions and medical practices, maternal deaths are rare occurrences. However, in recent years in both the U.S. and in New York State, the rate of maternal deaths has been increasing. New York State is revising its protocol for maternal mortality reviews with a focus upon prevention of future deaths. It is critical to continue to track the rate of maternal deaths to determine whether this effort will have a positive effect on reducing mortality.

SO() # 2

OUTCOME MEASURE:

The percentage of elective deliveries, both cesarean sections and inductions, performed without appropriate indication between 36 and 38 6/7 weeks gestation

STATUS:

Active

GOAL

To reduce the rate of elective deliveries performed without indication

DEFINITION

Rate of elective deliveries per 100 performed without appropriate indication among women between 36 and 38 6/7 weeks gestation.

Numerator:

Number of elective deliveries performed without appropriate indication among women between 36 and 38 6/7 weeks gestation.

Denominator:

Number of elective deliveries performed among women between 36 and 38 6/7 weeks gestation.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES

Statewide Perinatal Data System

SIGNIFICANCE

Cesarean section rates have risen nationally over the past decade. Between 1996 and 2005, the national c-section rate rose by 46% due, in part, to increases in the percent of women having first time c-section deliveries and a reduction in the percentage of vaginal births after c-section. The c-section rate in NYS reflects the national trend.

VIII. GLOSSARY

A. ACRONYMS AND ABBREVIATIONS

| | |
|--------|---|
| AAP: | American Academy of Pediatrics |
| ACA: | Affordable Care Act |
| ACF: | Administration for Children and Families |
| ACOG: | American Congress of Obstetricians and Gynecologists |
| ACT: | Assets Coming Together |
| ADA: | American Dental Association |
| AE-C: | Certified Asthma Educator |
| AEGP: | Abstinence Education Grant Program |
| AFIX: | Assessment, Feedback, Incentives eXchange Initiative |
| AHECs: | Area Health Education Centers |
| AMCHP: | Association of Maternal and Child Health Programs |
| APG: | Ambulatory Patient Group |
| APN: | Association of Perinatal Networks |
| APPS: | Adolescent Pregnancy Prevention Program |
| ARRA: | American Recovery and Reinvestment Act |
| ASD: | Autism Spectrum Disorders |
| ASHNI: | Adolescent Sexual Health Needs Index |
| ASHWG: | Adolescent Sexual Health Work Group |
| ASMT: | Asthma Self Management Training |
| ASTHO: | Association of State and Territorial Health Officials |

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|-------------------------|--|
| AT&T: | American Telephone and Telegraph |
| BCCDP: | Bureau of Community Chronic Disease Prevention |
| BDH: | Bureau of Dental Health. |
| BEI: | Bureau of Early Intervention |
| BF: | Breastfeeding |
| BIP: | Bureau of Injury Prevention |
| BMCH: | Bureau of Maternal and Child Health |
| BRFSS: | Behavioral Risk Factor Surveillance System |
| BWH: | Bureau of Women's Health |
| CACFP: | Child and Adult Care Feeding Program |
| CAPP: | Comprehensive Adolescent Pregnancy Program |
| CBAPP: | Community-Based Adolescent Pregnancy Prevention Program |
| CCF: | Council on Children and Families |
| CCH: | Center for Community Health |
| CCSI: | Coordinated Children's Services Initiative |
| CDC: | Center for Disease Control and Prevention |
| CDLC: | Child Development Learning Collaborative |
| CEH: | Center for Environmental Health |
| CF: | Cystic Fibrosis |
| CHA: | Community Health Assessment |
| CHC: | Community Health Center |
| CHI ² /CHI2: | Child Health Information Integration project |
| CHIP: | Children's Health Insurance Program (Child Health Plus is New York's CHIP) |

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|----------|--|
| CHPlus: | Child Health Plus |
| CHWP: | Community Health Worker Program |
| CISS: | Comprehensive Integrated Services Systems |
| CLC: | Certified Lactation Counselor |
| CMR: | New York State Congenital Malformations Registry |
| CMS: | Center for Medicare/Medicaid Services |
| CoCASA: | Comprehensive Clinic Assessment Software Application |
| COE: | Center of Excellence |
| CCF: | New York State Council on Children and Families |
| CPPSN: | Comprehensive Prenatal/Perinatal Services Network |
| CPPW: | Communities Putting Prevention to Work |
| CSP: | Community Service Plans |
| DASH-NY: | Designing a Strong and Healthy New York |
| DCDI: | Division of Chronic Disease and Injury Prevention |
| DFH: | Division of Family Health |
| DOH: | New York State Department of Health |
| DON: | Division of Nutrition |
| DPCP: | Diabetes Prevention and Control Program |
| DRP: | Dental Rehabilitation Program |
| EC: | Emergency Contraception |
| ECAC: | Early Childhood Advisory Council |
| ECCS: | Early Childhood Comprehensive Systems |
| ED: | Emergency Department |
| EFU: | Effective Follow-up |

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|----------|---|
| ELE: | Express Lane Eligibility |
| EICC: | Early Intervention Coordinating Council |
| EIP: | Early Intervention Program |
| EMSC: | Emergency Medical Services for Children |
| EWPHCCS: | Eat Well/Play Hard in Child Care Settings |
| FES: | Facilitated Enrollers |
| FHPlus: | Family Health Plus |
| FPBP: | Family Planning Benefit Program |
| FPEP: | Family Planning Extension Program |
| FPL: | Federal Poverty Level |
| GME: | Graduate Medical Education |
| GUHH: | Growing Up Healthy Hotline |
| HEALD: | Healthy Eating and Active Living by Design |
| HCRA: | Health Care Reform Act |
| HIE: | Health Information Exchange |
| HIN: | Health Information Network |
| HIPAA: | Health Insurance Portability and Accountability Act |
| HM-HB: | Healthy Mom-Healthy Baby |
| HMO: | Health Maintenance Organization |
| HRSA: | Health Resources and Services Administration |
| HSCI: | Health Systems Capacity Indicators |
| HRI: | Health Research, Incorporated |
| HSIs: | Health Status Indicators |

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|-----------|--|
| HV: | Home Visiting |
| IFSP: | Individualized Family Service Plan |
| IMD: | Inherited Metabolic Disease |
| IMR: | Infant Mortality Rate |
| IOM: | Institute of Medicine |
| IPRO: | Island Peer Review Organization |
| IT: | Information Technology |
| LeadWeb: | Statewide DOH Childhood Blood Lead Registry |
| LEAH: | Leadership Education in Adolescent Health |
| LHD: | Local Health Department |
| LPPP: | Lead Poisoning Prevention Program |
| LPPPAC: | Lead Poisoning Prevention Program Advisory Council |
| MA: | Medicaid (also known as Title XIX) |
| MAGI: | Modified Adjusted Gross Income |
| MC: | Managed Care |
| MCH: | Maternal and Child Health |
| MCHSBG: | Maternal and Child Health Services Block Grant (also known as Title V) |
| MCHSBGAC: | Maternal and Child Health Services Block Grant Advisory Council |
| MCO: | Managed Care Organization |
| MHSP: | Municipal Public Health Service Plan |
| MOE: | Maintenance of Effort |
| MRT: | Medicaid Redesign Team |
| MIECHV: | Maternal, Infant and Early Childhood Home Visiting |

MIECHVP: Maternal, Infant, and Early Childhood Home Visiting Program

MMC: Medicaid Managed Care

MOMS: Medicaid Obstetrical and Maternal Services Program

MOU: Memorandum of Understanding

MUA: Medically Underserved Area

NA: Needs Assessment

NACP: National Asthma Control Program

NBHS: Newborn Hearing Screening

NBS: Newborn Screening

NBS EFU: Newborn Screening Effective Follow-up

NCQA: National Committee for Quality Assurance

NEPHLI: Northeast Public Health Leadership Institute

NFP: Nurse Family Partnership

NICHQ: National Initiative for Children's Healthcare Quality

NICU: Neonatal Intensive Care Unit

NRC: National Research Council

NYC: New York City

NYCDOHMH: New York City Department of Health and Mental Hygiene

NYCRR: New York Code, Rules and Regulations

NYMAC: New York Mid-Atlantic Consortium for Genetic and Newborn Services

NYS: New York State

NYSACHO: New York State Association of County Health Officials

NYSDOH: New York State Department of Health

NYSIIS: New York State Immunization Information System

NYSOHC: New York State Oral Health Coalition

NYSONQC: New York State Obstetrical and Neonatal Quality Collaborative

NYPORTS: New York Patient Occurrence Reporting and Tracking Systems

NYTCP: New York Tobacco Control Program

OASAS: New York State Office of Alcoholism and Substance Abuse Services

OCFS: New York State Office of Children and Family Services

OHIP: Office of Health Insurance Programs

OLTC: Office of Long Term Care

OMD: Office of the Medical Director

OMH: New York State Office of Mental Health or the Office of Minority Health.
(Definition depends on context)

OPDV: New York State Office for the Prevention of Domestic Violence

OPH: Office of Public Health

OPP: Obesity Prevention Program

OSC: New York State Office of the State Comptroller

OTDA: New York State Office of Temporary Disability Assistance

PCAP: Prenatal Care Assistance Program

PCP: Primary Care Physician

PHCP: New York's Physically Handicapped Children's Program

PHL: New York State Public Health Law

PHLive: Public Health Live Webcast Services

PPO: Preferred Provider Organization

PRAMS: Pregnancy Risk Assessment Monitoring System

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|---------------|---|
| PREP: | Personal Responsibility Education Program |
| QARR: | Quality Assurance Reporting Requirements |
| QI: | Quality Improvement |
| RFA: | Request for Applications |
| RLRC: | Regional Lead Resource Center |
| RPC: | Regional Perinatal Center |
| SAMSHA: | Substance Abuse and Mental Health Services Administration |
| SBHC: | School-Based Health Center |
| SCAA: | Schuyler Center for Analysis and Advocacy |
| SED/NYSED: | New York State Education Department |
| SAFE Centers: | Sexual Assault Forensic Exam Centers of Excellence |
| SIDS: | Sudden Infant Death Syndrome |
| SNAP: | Supplemental Nutrition Assistance Program |
| SPARCS: | Statewide Planning and Research Cooperative System |
| SPDS: | New York's Statewide Perinatal Data System |
| SPH: | School of Public Health |
| SPRANS: | Special Project of Regional and National Significance |
| SSDI: | State Systems Development Initiative |
| STD: | Sexually Transmitted Disease |
| STI: | Sexually Transmitted Infections |
| SVPPC: | Sexual Violence Primary Prevention Committee |
| TA: | Technical Assistance (See Technical Assistance below) |
| TANF: | Temporary Assistance for Needy Families |

Title V: Maternal and Child Health Services Block Grant

Title XIX: Medicaid

Title XXI: State's Children's Health Insurance Program (CHIP or Child Health Plus)

TTY: Text Telephone

UNICEF: United Nations Children's Fund

USDA: United States Department of Agriculture

VESID: Vocational and Educational Services for Individuals with Disabilities Program

V/F: Vegetables and Fruits

VFC: Vaccines for Children Program

VLBW: Very Low Birth Weight

WIC: Women, Infants, and Children

WHO: World Health Organization

YRBS: Youth Risk Behavior Survey

YTS: Youth Tobacco Survey

B. DEFINITIONS

Definitions of Terms Contained in the Application Template, Including Charts and Forms

Administration of Title V Funds: The amount of funds the State uses for management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Carryover (as used in Forms 2 and 3): The unobligated balance from the previous year's MCH Block Grant Federal Allocation.

Care Coordination Services for CSHCN: Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. [Title V Sec. 501(b)(3)]

Case Management Services: *For pregnant women*: those services that assure access to quality prenatal, delivery and postpartum care. *For infants up to age one*: those services that assure access to quality preventive and primary care services. [Title V Sec. 501(b)(4)]

Federal Allocation (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3): The monies provided to the States under Federal Title V Block Grant in any given year.

Infants: Children under one year of age who are not included in any other class of individuals

Local Funding (as used in Forms 2 and 3): Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income: An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services/Types of Services: Major kinds or levels of health care services covered under Title V activities:

Direct Health Services: Services which are generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room. The health professionals may include primary care physicians; registered dietitians; public health or visiting nurses; nurses certified for obstetric and pediatric primary care; medical social workers; nutritionists; dentists; subspecialty physicians who serve children with special health care needs; audiologists; occupational therapists; physical therapists; speech and language therapists; and specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school

health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services: Services that allow or provide for access to and the derivation of benefits from the array of basic health care services. Enabling services include transportation; translation services; outreach; respite care; health education; family support services; purchase of health insurance; case management; and coordination with Medicaid, WIC and education. These services are especially essential for low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, access without these enabling services is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Infrastructure Building Services: Services which are the base of the MCH Pyramid of Health Services and form its foundation. They include activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems. These systems include development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. Systems of care should be family centered, community-based and culturally competent.

Population-Based Services: Preventive interventions and personal health services which are developed and available for the entire maternal and child health population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or a health maintenance organization, and whether or not they are insured.

Other Federal Funds (as used in Forms 2 and 3): Federal funds other than Title V Block Grant that are under the control of the person responsible for the administration of the Title V program.

Others (as used in Forms 4, 7, and 10): Women of childbearing age who are not pregnant, women over age 21, and any other persons defined by the State who are not infants or children.

Performance Indicator: The statistical or quantitative value that expresses the result of a performance objective

Performance Measure: A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or assist in leading to, a

specific health outcome within a community or jurisdiction, generally within a specified time frame (e.g., The rate of women in [State] who receive early prenatal care in 20___. This performance measure will assist in leading to [health outcome measure of] reducing the rate of infant mortality in the State).

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3): Funds collected by State MCH agencies from sources generated by the State's MCH program; these include insurance payments, Medicaid reimbursements, HMO payments, etc.

State Funds (as used in Forms 2 and 3): The State's required matching funds (including overmatch) in any given year.

Total MCH Funding: All the MCH funds administered by a State MCH program, which includes the sum of the *Federal* Title V Block Grant allocation, the *Applicant's* funds (carryover from previous year's MCH Block Grant allocation: unobligated balance), the *State* funds (total matching funds for Title V allocation: match and overmatch), the *Local* funds (total of MCH dedicated funds from local jurisdictions within State), *Other* Federal funds (monies other than Title V Block Grant that are under the control of the person responsible for administration of Title V program), and *Program Income* (those collected by State MCH agencies from insurance payments, Medicaid, HMO's, etc.)

Definitions of Selected Terms Used Within the Application

Ambulatory Patient Groups (APGs): The new payment methodology for most Medicaid outpatient services. APG methodology will be used to reimburse for outpatient clinic, ambulatory surgery and emergency department services.

Article 6: Refers to Article 6 of the New York State Public Health Law, which sets forth the conditions under which local health departments are reimbursed for general public health work

Assessment, Feedback, Incentives eXchange Initiative (AFIX): A program under which county health department staff visit private pediatricians to assess the immunization records of their patients.

Center for Community Health (CCH): a Division within the New York State Department of Health Office of Public Health. The Division of Family Health is located within the CCH.

Children with Special Health Care Needs (CSHCN): *For budgetary purposes:* Infants or children from birth through 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *For planning and systems development:* Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Culturally Competent: The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in policy development, administration and provision of those services

Division of Family Health: A Division within the New York State Department of Health and Center for Community Health that is responsible for administration of Title V and Title V-related activities

Family-Centered Care: A system or philosophy of care that incorporates the family as an integral component of the health care system.

Health Care Reform Act (HCRA): A New York State law passed in 1996 and renewed in 2000 that authorizes financing of health services, graduate medical education, insurance coverage for the uninsured and rural health networks

Health Information Network (HIN): A New York State Department of Health intranet containing community health data which is accessible to local county health departments and state staff

Health Research, Incorporated (HRI): Health Research, Inc. is authorized to accept funding on behalf of the New York State Department of Health. In this capacity, HRI receives Federal funding from a variety of sources to support public health programming and research.

Infant Mortality Rate (IMR): The rate per 1,000 at which infants under the age of one year die

Medical/Health Home: The New York State Department of Health uses the American Academy of Pediatrics (AAP) definition of medical/health home. The medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family-centered, coordinated and compassionate. Care should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them. These characteristics define the medical/health home and describe care that has traditionally been provided by pediatricians in the office setting. In contrast, care provided by emergency departments, walk-in clinics, and or urgent care facilities is often less effective and more costly. (American Academy of Pediatrics, Volume 90, Number 5, November 1992.)

Needs Assessment: A study undertaken to determine the service requirements within a jurisdiction. For purposes of maternal and child health, the study is aimed at determining:

- 1) What is essential in terms of the provision of health services,
- 2) What is available, and
- 3) What is missing.

OHIP: The New York State Department of Health Office of Health Insurance Programs houses Medicaid, Child and Family Health Plus and Managed Care in the Division of Coverage and Enrollment in an effort to make transitions among health insurance programs more seamless.

Outcome Measure: The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal.

Performance Measurement: The collection of data on, recording of, or tabulation of results or achievements, usually with the intent of comparing with a benchmark figure

Physically Handicapped Children's Program (PHCP): An insurance type program for children with special health care needs to assure access to specialty care for medically and financially eligible children. PHCP operates within the context of the broader Children with Special Health Care Needs Program.

Pregnancy Risk Assessment Monitoring System (PRAMS): A data system which collects population-based information on maternal knowledge, attitudes and behavior, service access and utilization, and possible physical and emotional stressors during pregnancy from a sample of women who have recently given birth

Preventive Services: Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions

Primary Care: The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and overall management of an individual's or family's health care services

Quality Assurance Reporting Requirements (QARR): An annual analysis of quality performance of managed care plans in New York State. The annual report includes measures such as childhood immunization, blood lead testing, HIV testing of pregnant women, well child care, cancer screening and the treatment of chronic diseases such as asthma and diabetes, and results of standardized consumer satisfaction surveys for commercial population.

Risk Factors: Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term.

Statewide Planning and Research Cooperative System (SPARCS): A data system which collects information on every hospital discharge in New York State

Technical Assistance (TA): The process of providing recipients with expert assistance of specific health related or administrative services that include: systems review planning; policy options analysis; coordination coalition building/training; data system development; needs assessment; performance indicators; health care reform wrap-around services; CSHCN program

development/evaluation; public health managed care quality standards development; public and private interagency integration; and identification of core public health issues

Text Telephone (TTY): A special device that enables people who are deaf, hard of hearing, or speech-impaired to use telephone to communicate by typing messages back and forth to one another instead of talking and listening