

**AFFORDABLE CARE ACT
MATERNAL, INFANT AND EARLY CHILDHOOD
HOME VISITING PROGRAM**

**NEW YORK STATE
STATEWIDE NEEDS ASSESSMENT**

**New York State Department of Health
HRSA Award Number: 1 X02MC19384-01-00**

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I. Introduction

The New York State Department of Health was designated by the Governor as the lead entity for the State to accept and administer funds made available through the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program. The submission of a needs assessment is a required step in the process that has been established in order to receive the funding. The following assessment of the home visiting needs in New York State was prepared and submitted in response to a Supplemental Information Request issued by Health Resources and Services Administration (HRSA). The primary purpose of the needs assessment as stated in the HRSA Supplemental Information Request is to produce “a ‘first-cut’ assessment of the needs and resources in communities the State identifies as being at risk.” This initial home visiting needs assessment is evidence of New York State’s continuing collaborative efforts to strengthen home visiting services for families and children.

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.

The 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.

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.

Finally, but very importantly, the State received input from more than 200 individuals who have a commitment to home visiting in New York State. Home visiting stakeholders identified strengths of the home visiting programs in their communities, identified specific gaps and barriers to services unique to their communities, and provided valuable insight into how home visiting services in New York State can be strengthened.

For the purposes of this initial needs assessment, New York State has preliminarily identified counties in New York State deemed to be at risk per the terms of the Affordable Care Act and HRSA guidance. This initial needs assessment demonstrates New York State’s capacity to determine and summarize home visiting-related needs at the county level. In order to fully represent and reflect the varied geographic and socio-demographic needs of families living in New York State, the State will conduct a more refined need assessment at the zip code level. This subsequent assessment will result in identifying more specific at risk communities, and may

include identifying at risk communities outside of the counties identified through this initial assessment. A more refined needs assessment will be essential in informing the development of a tailored and effective Updated State Plan for home visiting services.

II. Process Used to Complete the Needs Assessment

New York State Home Visiting Work Group

To coordinate New York State's activities related to the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program, the State established a work group of representatives from State agencies that have responsibility for managing programs for women, children and families. The core membership of the work group are the relevant staff (e.g. program managers, data system managers, evaluators/researchers, etc.) from the Department of Health, Office of Children and Family Services, Office of Alcohol and Substance Abuse Services, and the Council for Children and Families. Staff from the Office of Mental Health, Office for the Prevention of Domestic Violence, Division of Criminal Justice Services, Department of Labor, and Education Department have contributed information and data relevant to their agencies' scope of work as it relates to home visiting programming and the needs of families. It is anticipated that the core membership of the Work Group will expand as New York develops its Updated State Plan for home visiting services. For example, the Office for the Prevention of Domestic Violence, which has been actively training staff of home visiting programs about domestic violence issues, will become an active member of the Work Group.

The agencies have a history of working together on a variety of issues and tasks related to improving services for families, and many of the agency representatives serve on statewide task forces, work groups and collaborative projects as part of their day-to-day program management responsibilities. For example, the Office for Children and Family Services and the Department of Health are partnering to develop a statewide child mortality review program which will result in improved information about the cause of death for children including deaths due to maltreatment. The creation of the Maternal, Infant and Early Childhood Home Visiting Program, and the accompanying requirement to conduct a statewide needs assessment on a broad range of indicators, afforded the State agencies an opportunity to work more closely together to identify at risk communities as a step toward developing a comprehensive home visiting program plan for New York State.

The work group has met several times and work group members regularly communicate via phone calls and emails to discuss the status of the statewide needs assessment. A primary task of the work group has been to identify the data that each agency has available to satisfy the requirements of the Supplemental Information Request for the Submission of the Statewide Needs Assessment. Data sets for the indicators listed in the Supplemental Information Request were forwarded to the Department of Health. The Department of Health completed the statewide data report and the data report for each at risk community in the state according to the guidance included in the Supplemental Information Request. Additional indicators of risk were included in both the statewide and individual community data reports at the recommendation of the Office of Children and Family Services, the Office of Alcohol and Substance Abuse Services and the

Department of Health. See the discussions (below) on data sources and methodology used to determine at risk communities for further information

Work group members reviewed the results of the statewide and community data reports and have concurred with the results (see letters of concurrence). The work group will continue to meet and collaborate on the subsequent refinement of this initial needs assessment and the development, submission and implementation of the state plan for home visiting services.

Collaboration with Stakeholders

Working closely with home visiting stakeholders in New York State has been, and continues to be, an integral component of the State's efforts to address families' needs for home visiting services. Many of the working relationships and collaborative efforts regarding the home visiting needs in New York State occurred prior to the passage of the Affordable Care Act and the corresponding creation of the Maternal, Infant and Early Childhood Home Visiting Program. A prime example of these collaborative efforts is the release of a white paper in 2007 entitled *Universal Prenatal/Postpartum Care and Home Visitation: The Plan for an Ideal System in New York State*. The paper was a product of two years of intensive research and discussion with a broad group of stakeholders that included representatives from State agencies, county health departments and a wide array of home visiting programs and advocacy organizations. The work group was convened and the development of the white paper was lead by the Schuyler Center for Analysis and Advocacy (SCAA), a statewide, not-for-profit, policy analysis and advocacy organization working to shape policies that improve health, welfare and human services in New York State through collaboration with many partners including civic, business, religious, human service and government agencies.

Along with State agency partners, SCAA assisted New York State Department of Health 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, members of the home visiting white paper work group and other interested parties.

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 and the services available for children and families residing in at-risk communities. A corresponding online survey (see attachment) was also widely disseminated to interested parties throughout the State. A discussion of the results of the conference calls and online survey is presented below.

Going forward, State agency partners and other stakeholders will be kept informed of the status of the home visiting needs assessment and the development of the state plan and additional opportunities will be made available to receive stakeholder input.

Process Used for Stakeholder Input

As referenced above, four conference calls were conducted to allow ample opportunity for stakeholders and interested parties to provide input. As previously mentioned, the calls were structured around a series of four questions designed to elicit information about the 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. See Summary of Stakeholder Input below for the specific questions. 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.

In addition to the conference calls, the same four questions were included in an online survey that was widely disseminated throughout the State. A total of 176 surveys were completed and submitted. The respondents represented 55 of the 62 counties in New York State. Respondents were asked to identify the type of program in which they worked: 36% worked in a home visiting program; 25% worked in a local or county government agency; 23% worked in a community-based health and human service agency; and 16% indicated working in another setting (e.g. school, private foundation, advocacy organization, etc.).

Summary of Stakeholder Input

The responses from the conference calls and the online surveys were compiled by staff at the Department of Health. An analysis of the comments reveals that several major themes and recommendations were identified by the respondents. These themes and recommendations are described below under each question that was posed during the conference calls and replicated in the online survey.

What are the biggest strengths of your communities' home visiting programs for families?

Conference call participants and survey respondents identified several strengths of the home visiting programs in their communities including:

- Having a centralized intake process in the community greatly enhances families' access to home visiting services.
- Concrete collaborative relationships among home visiting programs in a community result in better services for families. For example, a home visiting program that uses public health nurses provides education on health-related matters to paraprofessionals employed in another home visiting program.
- Home visiting programs that combine elements of several evidence-based programs are able to more fully address the needs of families.
- Efforts to increase the involvement of fathers with their families, and with the home visiting program, have strengthened the effectiveness of the services.

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- A collaborative spirit in the community among service providers and among the home visiting programs results in better outcomes for families. As one participant noted - “We all work together to meet needs of families.”
- Home visiting programs that are embedded in organizations that provide a broad range of social services are able to offer “wrap-around” services that provide additional support to families.
- Having a working relationship with an Early Intervention Program is an important connection for home visiting programs.
- Organizations that provide families with multiple points of entry into a home visiting program were successful in recruiting and engaging families into services.
- Programs are strengthened by providing high quality ongoing staff training.
- The provision of transportation to help clients access needed services, especially clients residing in rural areas, greatly enhances the effectiveness of the home visiting program.
- A strong partnership with community schools can result in more families being referred for home visiting services.
- Programs that have a presence at multiple sites in the community – e.g. prenatal care clinic, hospital, pediatric care setting, WIC clinic, etc. increase the likelihood of maintaining the continuity of care for families.

What at-risk populations are you having difficulty reaching? Any thoughts on how home visiting could be of assistance in reaching these families?

The responses to this question illustrate the diversity of the populations in need of home visiting services in New York State. Respondents identified the following populations that they have had difficulty in reaching and serving:

- Pregnant women not receiving prenatal care.
- Pregnant teens, teens with mental health issues and homeless teens.
- Immigrant and refugee populations from Central America, Africa and Mexico. Barriers included language, cultural expectations, trust, and access to translation services.
- Women with mental health, domestic violence and substance abuse issues.
- Families who move to a locality to be near an incarcerated family member.
- Members of gangs.
- Families that reside in rural areas of the state.
- Grandparents who are raising their grandchildren.
- Migrant workers, especially those who are transient.
- Native American population.
- Family members who are hearing impaired.

Suggestions about how home visiting programs can assist in reaching at-risk populations included:

- Increase referrals among home visiting programs so families do not have to endure long waits to access services.

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- Foster collaboration among community providers of health and social services to increase referrals to other needed services for families served by home visiting programs.
- Hire home visiting staff who are indigenous to the community and who are representative of the populations being served.
- Use technology to engage and maintain relationships with teens – e.g. social networking web sites, texting.
- For clients who are reluctant to have home visiting staff enter their home (e.g. women with domestic violence issues, teens, immigrants) arrange to meet clients in community settings at times.
- Establish working relationships with child protective services and foster care agencies so communication about families' situations and needs can be more fully addressed.
- Increase community outreach and education efforts to inform families about services they can access in their home and to reduce the stigma attached to asking for assistance.
- Establish partnerships with community schools to encourage referrals for home visiting services.
- Employ the services of MSWs to address the complex needs of families dealing with mental health, domestic violence and substance abuse issues.
- Create systems to better track when families move and to ensure that such families have continued access to home visiting services.
- Seek community resources to address identified unmet needs such as translation services for non-English speaking clients, and mental health and supportive services for teens.

Are the needs of at-risk pregnant women, children and families met in your community? If not, what are the gaps in services, and barriers to services for families within your community?

Since conference call participants and survey respondents were from virtually every type of community in New York State (urban, suburban and rural) it was expected that this question would generate a broad range of responses. The gaps and barriers to services that were identified included:

- Home visiting services are not available in large areas of New York State and, in some areas of the state where programs do exist, there are substantial waiting lists.
- Families living in poverty require assistance with basic needs such as food and shelter which makes the delivery of home visiting services additionally challenging.
- Severe housing deficiencies in communities (in New York City in particular) result in large numbers of transient clients who are difficult to retain in services since programs are largely limited to serve specific geographic areas/communities.
- Deficiencies in housing also results in extreme overcrowding for some families which makes the delivery of quality home visiting services more challenging.
- Lack of translation services for the many languages and dialects spoken by new immigrants from Central America, Mexico, and Africa.
- Absence of adequate services in communities to address all the needs of families – e.g. dental and mental health providers who take Medicaid.
- Lack of transportation is a major issue in rural areas.
- Lack of effective coordination among home visiting programs and with community providers of health and human services.

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- Eligibility requirements of some of the home visiting program models create barriers for some families' ability to access needed home visiting services.
- Increased chronic illnesses among family members (e.g. diabetes, asthma, hypertension, obesity, mental health, etc.) places increased demands on home visiting programs to address an increasingly broader and more complex set of needs.
- Decreased access to health care due to lack of physicians in some rural communities.
- Lack of appropriate child care which results in missed appointments for services.
- Large volume of reports of child abuse each year places a large strain on home visiting programs.
- Home visiting programs are experiencing difficulty in attracting and retaining qualified staff, especially bi-lingual staff.

How would you like to see NYS use the funding available under the Maternal, Infant and Early Childhood Home Visitation Program?

This question generated a great deal of discussion and respondents offered many varied and, at times, contradictory recommendations including:

- Create or integrate a home visiting model with increased flexibility, a central intake function, and with eligibility criteria based solely on a family's need not on income, location or characteristics of the family members (i.e. age, pregnancy/motherhood status).
- Ensure that the coordination of home visiting programs happens at the State agency level as well as at the community level.
- Make a real commitment to the home visiting program model, including increasing funding to effective home visiting programs (even if they are not determined to be evidence based).
- Fund only evidence-based home visiting program models use data to determine where the need for services is greatest.
- Increase funding to home visiting programs to help them attract and retain qualified staff.
- Create a mechanism for a central intake and seamless point of entry into home visiting services.
- Ensure that appropriate tools to screen families and assess needs are used in program models throughout the state.
- Research the various models of home visiting used in the state and determine the successful elements of each model. Use this research to create a "hybrid" home visiting program model that contains the components determined to be successful at achieving the desired outcomes for families.
- Create a stable funding stream to ensure the long-term sustainability and expansion of home visiting services.
- Eliminate geographic boundaries that are barriers to programs that attempt to continue serving clients who have moved out of the program's service area.
- Consider using multi-county service areas to accommodate needs of families residing in areas of low volume/rural areas of the state.
- Concentrate resources in areas of the state where the need is greatest; if resources are distributed across the state the impact will be reduced.

- Create programs that are designed to help families avoid the need for home visiting services (e.g. teach new parents basic life and parenting skills, crisis intervention services for teens, support for continued education and employment skills, day care, etc.).
- Create community coalitions that would be responsible for identifying resources for families, facilitating access to needed services, coordinating families' access to home visiting services, and reducing the duplication of home visits to families from different health and social service systems.

Coordination with Other Statewide Needs Assessments

Members of the New York State Home Visiting Work Group include staff from the State agencies responsible for managing the Title V Maternal and Child Health Block Grant Program (MCHBG), the New York State Head Start Collaboration Project, and Title II of the Child Abuse Prevention and Treatment Act (CAPTA). Work group meetings and discussions afforded agency representatives the opportunity to share information about the responsibilities and functions of their respective program area. In addition, the needs assessments associated with each initiative were reviewed for information relevant to the completion of the home visiting needs assessment. Summaries of the findings from the review of the needs assessments are presented below. Strategies for addressing the needs identified through the various statewide needs assessments will be an important component of New York State's home visiting state plan.

Title V Maternal and Child Health Block Grant Program (MCHBG)

The needs assessment that was submitted with Department of Health's 2011 Title V Maternal and Child Health Block Grant application to HRSA was the document reviewed to satisfy the requirement that the home visiting needs assessment take into account the Title V assessment.

The New York State Department of Health undertook a highly structured and multi-faceted process to assess the maternal and child health related needs in the state. The process included a detailed analysis of a wide range of data and outcome measures, forums and focus groups with providers and recipients of maternal and child health services, a review of needs assessments conducted by a variety of programs funded by the Department of Health to provide maternal and child health services, and a very widely disseminated online survey.

The Title V Needs assessment should also be considered within the context of the Department of Health's Prevention Agenda for the Healthiest State which established 10 statewide public health priorities with an emphasis on prevention strategies. The Prevention Agenda is 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.

One of the ten public health priorities in the State's Prevention Agenda is *Healthy Mothers, Healthy Babies, Healthy Children*. To measure progress toward improvements in this priority area, the Department of Health has identified a range of important health status measures that are employed by communities as a starting point for the development of locally-appropriate performance targets. The Prevention Agenda measures for *Healthy Mothers, Healthy Babies, Healthy Children* are:

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Indicator	Prevention Agenda 2013 Objective	US	NYS	White non-Hispanic	Black non-Hispanic	Asian non-Hispanic	Hispanic
HEALTHY MOTHERS/ HEALTHY BABIES/HEALTHY CHILDREN							
% early prenatal care (1 st trimester)	90%	83.9% (2005)	75.4% (2005)	77.0% (2004)	60.9% (2004)	66.9% (2004)	64.4% (2004)
% low birthweight births (<2500 grams)	5%	8.2% (2005)	8.3% (2005)	6.7% (2004)	12.9% (2004)	7.6% (2004)	7.4% (2004)
Infant mortality (per 1,000 live births)	4.5	6.9 (2005)	5.8 (2005)	4.6 (2004)	11.1 (2004)	3.4 (2004)	4.5 (2004)
Increase % of 2 year old children who receive recommended vaccines (4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 HepB)	90%	80.5% (2006)	82.4% (2006)	84.3% (2006)	NA	NA	80.3% (2006)
% of children with at least one lead screening by age 36 months	96%	-	77% (NYS excl. NYC) (2002 birth cohort)	NA	NA	NA	NA
Prevalence of tooth decay in 3 rd grade children	42%	53.0% (2004)	54.1% (2004)	NA	NA	NA	NA
Pregnancy rate among females aged 15-17 years (per 1,000)	28.0	44.4 (2002)	36.5 (2005)	14.5 (2004)	71.0 (2004)	11.6 (2004)	70.4 (2004)

The indicators for low birth weight infants and infant mortality mirror the indicators included in the Supplemental Information Request. New York State has also added indicators for prenatal care and teen birth to its home visiting needs assessment to identify at risk communities.

As previously stated, the Title V needs assessment addresses a very broad range of issues and received input from a large number of stakeholders representing a variety of perspectives. A major tool used to elicit feedback was an online survey that was designed to develop a better understanding of key informants' views on current Maternal and Child Health Services Block Grant (MCHSBG) priorities and the issues and problems that confront the three MCHSBG target populations: pregnant women, mothers and infants; children and adolescents ages 1-21; and, children and youth with special health care needs.

All told, 234 survey responses were received, 207 of which were determined to be complete and subject to analysis. Survey findings relevant to home visiting services or home visiting related issues included:

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- Home visiting was selected as one of the top five issues for pregnant women, mothers and infants by nearly 26% of respondents; if combined with related parent education and support and infant developmental screening, this result lends strong support for the Department's focus on parenting support activities of all kinds, including expansion of prenatal-perinatal home visiting services.
- Early and high quality prenatal care was the most frequently selected issue from this population group, with 54.7% of the respondents to this question picking it among the top five impacting the health of pregnant women, mothers and infants.
- One-quarter of respondents selected child abuse/neglect and teen pregnancy as among the five most important issues impacting children and adolescents, followed closely by developmental screening.
- Violence prevention was also noted by respondents as an issue affecting the health of children and adolescents in the State
- For children and youth with special health care needs, survey respondents' most frequently-cited issue was access to specialty care followed by community-based support and coordinated comprehensive care. Home visiting programs have a potential role in addressing providing support to families to address these needs.

Another aspect of the Title V needs assessment was receiving input from the Department of Health's Comprehensive Prenatal-Perinatal Services Networks (CPPSNs). The Department funds 16 CPPSNs that engage consortia of local health and human service providers and consumers to identify and address gaps in local and regional perinatal health and child health care and service delivery systems. The following themes and priorities related to home visiting were identified by the CPPSNs:

- Access to early, comprehensive, continuous prenatal care remains a high priority, but more targeted approaches are needed to reach high-risk women and increase rates of early entry into prenatal care.
- Addressing health disparities is a priority but reaching hard-to-reach populations requires true cultural competency. Programs need to know the city, neighborhood, language barriers, and literacy levels of the populations being targeted for services.
- Further attention for adolescent pregnancy prevention and support for teen parents and their babies is required, including: how to meet the developmental needs of both the teen parents and their babies.
- Child abuse and neglect was identified as a critical issue. Child abuse and neglect cannot be unlinked from infant mortality and morbidity. Non-punitive supportive services, preparedness for parenthood and parenting education are needed. Family violence and work to engage fathers also need to be addressed.

Title II of the Child Abuse and Prevention Treatment Act (CAPTA)

The Office of Children and Families Services is responsible for managing Title II of CAPTA for New York State. Specific information about existing home visiting programs and resources is included in the profiles of the at risk communities identified through the data reports and information about existing home visiting programs across the State also is included in this needs assessment (see attachment).

A review of the recent CAPTA needs assessments and other relevant assessments collected by the Office of Children and Family Services resulted in the following inventory of unmet needs to prevent child abuse and related findings:

- There is a need for increased efforts for the early and ongoing location and engagement of all family members (fathers in particular) in a child's life.
- Similar to racial and ethnic disparities for other health and human services outcomes, children of color are under represented in prevention services and over represented in the child welfare and juvenile justice systems.
- The development and dissemination of strategies to provide culturally-competent services and the delivery of training to programs to implement such strategies would strengthen child abuse prevention services.
- Early identification and specialized interventions for parents and children experiencing domestic violence, substance abuse and/or mental health issues are lacking in the State.
- There is a need for evidenced-based parenting programs that are designed to meet the needs of specific underserved segments of the population in the State (e.g. families with special needs, family members with disabilities, families residing in underserved rural areas, etc.).
- Efforts to increase the number and competence of parent advocates could strengthen child abuse prevention services.
- Adequate resources are unavailable to meet the need (volume and type) for respite services for families.
- Resources are insufficient to adequately meet the need for supervised visitation.
- Resources to meet the concrete needs of families (e.g. food, clothing, housing, transportation) are not consistently available throughout the State.
- There is a need for more information and support regarding the Child Support Enforcement process and corresponding parents' rights.
- There is a need for more services that address the literacy needs of family members, assistance with employment and job-readiness issues, and information about prenatal care.

New York State Head Start Collaboration Project

The New York State Council on Children and Families administers the New York State Head Start Collaboration Project with support from the federal Office of Head Start and the New York State Head Start Association. The Head Start Collaboration Project conducted a needs assessment survey of Head Start and Early Head Start programs throughout New York State in the spring of 2008. The needs assessment addressed the federally identified eight national priority areas: health care; education; services for children with disabilities; child care; services for children experiencing homelessness; welfare/child welfare; family literacy; and community services.

There are 178 Head Start grantee and delegate agencies in New York State and, at the time the survey was administered, there were 39 Early Head Start programs. For the purposes of completing this phase of the home visiting needs assessment, the 2009 Needs Assessment and Strategic Plan (based on the surveys conducted in 2008) was reviewed and the ensuing findings and comments regarding home visiting related issues are the result of that review. New York

State will review, where available, the needs assessments conducted by Head Start and Early Head Start programs in the communities identified at risk. Specific home visiting related needs from those assessments will be addressed in the subsequent home visiting needs assessment and state plan submitted by New York State.

Home visiting related needs and issues identified in the 2009 Head Start Collaboration Project's Needs Assessment and Strategic plan include:

- 30.2% of the responding programs reported having little or no contact with a home visiting program in their community.
- 14% of the respondents reported that a home visiting program was not available in their community.
- 30.2% of the programs reported exchanging information and referrals with home visiting programs.
- 16.3% of the respondents reported working together with a home visiting program.
- 9.3% of the respondents reported that they shared resources and had written agreements (e.g. memorandum of understanding) with home visiting programs.
- Several programs cited the need for parenting education on the importance of health care, especially preventive health care, and ways to promote health for children.
- Programs reported a higher degree of coordination with Child Protective Services than with other welfare/child welfare services (i.e. TANF, employment and training agencies, services supporting foster/adoptive parents).
- Programs cited a lack of funding for child care subsidies and other supports for families.
- A great concern cited by respondents is the lack of community literacy providers, mostly due to budget cuts.
- Respondents cited a lack of mental health services for children under five years old.

The Early Childhood Comprehensive Systems

The Early Childhood Comprehensive Systems (ECCS) planning initiative funded by the HRSA MCH Bureau involved three years of effort by a collaborative team of more than 50 participants. The team was co-convened by the Council on Children and Families and the Department of Health Title V Program, and included representatives from all relevant state agencies: Office of Children and Family Services, Office of Temporary and Disability Assistance, State Education Department, Office of Mental Health, Office of Alcoholism and Substance Abuse Services, Office of Mental Retardation and Developmental Disabilities, and the Department of State. The team included many provider and advocacy organizations, colleges and universities, and parents. With support from the ECCS grant, a professional facilitator was engaged to assist with a series of full-day meetings to assure that all participants were effectively engaged and contributing. This formal planning process also created opportunities for countless other communications with stakeholders, as the ECCS chairs were invited to participate in meetings, conferences, and other forums convened by many stakeholder organizations such as the New York State Child Care Coordinating Council, Prevent Child Abuse New York, Cornell University's Family Life Development Center, Schuyler Center for Analysis and Advocacy and many others.

This emphasis on a broad range of stakeholder input and involvement has continued and expanded through the state's Early Childhood Advisory Council (ECAC). A subgroup of the

Governor's Children's Cabinet, the ECAC includes over 40 individuals with early childhood expertise who represent early care and education, health care and public health, 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. Through its organizational structure, which includes a steering committee, general membership and several workgroups, there are many opportunities for members to engage and provide meaningful, ongoing input including input on New York State's home visiting service needs. The ECAC is co-chaired by the New York State Head Start Collaboration Director, and several Title V staff actively participate in the Council and its work groups. The ECAC has identified home visiting as one of its priority areas.

New York State American Indian Tribal Areas

The New York State Department Office of Indian Health collected needs assessments on maternal and child health needs from three American Indian Tribal health care providers in New York State – Oneida, Tonawanda and Tuscarora. The home visiting needs and related issues identified through these needs assessments included:

- Identification of home visiting as one of the top five priorities for pregnant women, mothers and infants.
- Identification of parent education and support as another top five priority for pregnant women, mothers and infants.
- Reduction of unintended and adolescent pregnancies was identified as an important maternal and child health priority.
- Provision of early and high quality prenatal care was identified as a priority.
- Elimination of disparities in health outcomes, especially with regard to low birth weight and infant mortality.
- Reduction of tobacco use and substance use among pregnant women.

Universal Prenatal/Postpartum Care and Home Visitation: The Plan for an Ideal System in New York State.

In October 2007 the Schuyler Center for Analysis and Advocacy (SCAA) released a white paper on home visiting entitled *Universal Prenatal/Postpartum Care and Home Visitation: The Plan for an Ideal System in New York State*. The paper was a product of two years of research and discussion, spearheaded by the SCAA, with a broad group of stakeholders including the State agencies represented on the New York State Home Visiting Work Group, county health officers and private organizations such as Prevent Child Abuse NY, Fight Crime - Invest in Kids, Nurse-Family Partnership, Healthy Families NY, Parent-Child Home Program, Comprehensive Prenatal-Perinatal Services Networks and other organizations and individuals with a commitment to quality home visiting services.

The paper described a system of services that would support new families by providing three components: universal prenatal care, postpartum screening, and comprehensive home visiting. Quoting from the paper's Executive Summary – "All new families in New York State should receive assistance from a model-neutral system of support and services that promote optimal health, mental health, family functioning and self-sufficiency.

The white paper envisioned and described a system that would serve all pregnant women, infants, and new families (including first-time parents and existing families with new babies). The system would include universal contact/screening of all pregnant women and new families; assessments for parent, child and family health, mental health, developmental, social, literacy and other service needs; early intervention and referrals to an array of coordinated supports and services; and, home visiting services of varying duration and intensity as needed. The system would utilize proven practices and, in high-need situations, evidence-based practices.

The organizations and individuals who were involved in the development of the white paper continue to meet and explore ways to work toward achieving the vision articulated in the paper.

Coordination with Other State Agencies

In addition to the coordinating activities of the State agencies represented on the New York State Home Visiting Work Group and the review of relevant needs assessments (Title V, Head Start, and CAPTA), coordination with other State agencies that is encouraged in the Supplemental Information Request was addressed by sharing a draft version of this needs assessment for review and comment. Specifically, State agency representatives who are responsible for overseeing the Family Violence Prevention and Services Act (Office on Children and Family Services), the STOP Violence Against Women funds (Office for the Prevention of Domestic Violence), and the State's Individuals with Disabilities Education Act Part B (State Education Department) and Part C (Department of Health) have been identified and have been, and will continue to be, engaged in the home visiting needs assessment and state plan development process.

III. Statewide Data Report

New York State is a large, populous and diverse state. It is important to have some knowledge about the current status and emerging trends about the residents of New York State to have a better understanding of the environment in which the home visiting needs of New Yorkers are being identified. What follows is a brief overview of New York State's population.

Description of New York State's Population

New York State is notable for the great diversity of both its geography and its people. According to the 2008 American Community Survey, New York State is home to more than 19 million people (19,490,297). 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).

Race and Ethnicity

New York's population reflects diverse race and ethnicity; we are more diverse than the nation as a whole. New York has higher percentages of non-Hispanic Black residents, Hispanic residents and non-citizen immigrant residents than the U.S. average. According to the American Community Survey conducted by the US Census Bureau, New York ranks second of all states in foreign born, with 21.7% 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.)

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.

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.

About 70% of Blacks and 43% of Hispanics/Latinos in the State reside in New York City. Among New York City residents, 45.7% reported their race as White alone, 25.6% reported Black or African American alone, 11.9 percent reported Asian alone, and 13.9 percent reported being Some Other Race. About 28% of New York City's population identifies themselves as Hispanic/Latino. Several counties outside of New York City have significant Hispanic/Latino populations, as well. In Rockland, Nassau, Orange, Suffolk, Sullivan and Westchester Counties, Hispanics/Latinos make up at least 9% of the population. 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%.

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

Language

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In addition to our great racial and ethnic diversity, there is also great diversity in languages spoken in New York. According to the 2008 American Community Survey, of the estimated 18,285,349 New Yorkers over age 5, an estimated 12,977,510 speak only English at home, while 5,307,839 speak a language other than English. Of those speaking a language other than English at home, 2,443,942 speak English less than “very well.” About 2,588,384 New Yorkers speak Spanish at home. The New York State Education Department found that, of the 2.7 million students attending school in New York, 8.0% were identified as having limited proficiency in English.

Population Density

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

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

Age

New York’s population is aging. The median age in the State has increased from 32.0 years in 1980, to 38.0 years in 2008. This represents an aging of the “Baby Boomers” born between 1946 and 1964, as well as a longer survival rate for the elderly. The expectations for length of life for New York State residents has increased, from 75.2 years for those born in 1991 to 80.8 years for those born in 2008.

Growth

According to the 2008 Census estimates, 19,490,297 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 2007 and 2008. 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%.

Households and Families

In 2008, there were 7,132,482 households in New York State. A family household, by Census definition, has at least two family members related by blood, marriage or adoption, one of which

is the householder. Families made up 64.2% of the households in New York in 2008. This figure includes married couple families (45.0%), female householders (14.5%), and male householders (4.7%). Non-family households made up 35.8% of all the households in New York State. The majority of the non-family households were people living alone. Households containing children under the age of 18 numbered 2,310,119 or 32.4%, and households with adults 65 and older numbered 1,821,159 or 25.5%.

Women of Childbearing Age

The population of women of childbearing age has been decreasing since 1990. In 2008, it is estimated there were 4,076,182 females between the ages of 15 and 44 in New York State. A total of 686,495 females were between the ages of 15 and 19. An additional 597,794 females were between the ages of 10 and 14.

Children

Of New York's 2008 population, 4.4 million (22.6%) were under age 18. The number of children under the age of 20 in 2008 was about 5 million (5,007,190) and approximately 43% of these children (2,144,445) live in New York City.

The U.S. Census Bureau estimates that the number of children ages 4 and under in New York City grew by an estimated 6% from 2000 to 2008. In the Rest of State, however, there was a 9% decline in population in this age group. Demographers attribute the growth in the youngest age groups to the influx of immigrant families in New York City, many of whom are of childbearing age. The Census Bureau estimated that Manhattan had a 20% gain in this age group; the Bronx had a 4.8% increase; Brooklyn a 2.3% increase; and Queens showed a 1.1% increase. Upstate rural counties lost the greatest number of infants and toddlers under age 5.

Immigration

New York has always served as a major gateway for immigration and as an entry point for many new New Yorkers and new Americans. The 2008 American Community Survey collected information on the characteristics of legal native and foreign-born populations living in New York State. The following estimates are based on the American Community Survey findings:

- New York had a foreign-born population of 4.2 million in 2008. This number represents 21.7% of the State's population, or about one in five people. Only California has a higher percentage (26.9%) of foreign-born residents. Nationally the foreign-born population is more than 304 million or 12.5% of the total population.
- There were approximately two million legal resident aliens and over two million naturalized citizens in New York.
- New York's immigrant population was very diverse, with no particular region or country having clear dominance.
- On average, 47% of the foreign born population speaks English less than "very well". Among foreign born New Yorkers who are not U.S. citizens, 56% speak English less than "very well."
- In New York State, the median household income for foreign-born individuals (\$54,918) was lower than the median income for households headed by natives (\$58,392).

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- About 13% of natives and 15% of foreign born individuals live below poverty in New York State. Nineteen percent of non-citizen foreign born individuals in New York live below poverty.
- New York was estimated to have the third highest number of illegal immigrants living in the state, behind California and Texas.

Poverty

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. According to the 2009 Current Population Survey, during 2008, 38.9 percent of the people in female-headed households with children lived below poverty in New York State. For a female-headed household with two children, the Federal Poverty Level would be an income of \$17,285 or less per year. Even at 200% of poverty, which includes 66 percent of female-headed families, the income level would be no more than \$34,570. In 2008, 881,000 of New York's children (21.3 percent) were living below poverty. This is slightly higher than the 19 percent in the nation as a whole.

In comparing poverty levels among age groups, there is a general decrease in poverty as individuals grow older, up until age 65. According to the 2008 American Community Survey, the percentages of those living in 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.

Education

According to the NYS Education Department, in the 2008-09 school year, 3.12 million students were enrolled in New York State's public schools. About 14 percent of the State's school children attend nonpublic schools.

In New York State, 72% of students who started 9th grade in 2005 graduated by June 2009, while 15.5% of those students were still enrolled. Graduation rates varied among students. Fifty-six percent of Black and American Indian Alaska Native students, 55% of Hispanic students, 80% of Asian Students and 83% of white students graduated as expected. Of students with disabilities, 42% graduated on time, while among students with limited English proficiency the rate was 39%.

Despite the heavy emphasis put on secondary and post-secondary education in our State, the percentage of students who do not complete high school is of significant concern. According to the 2008 American Community survey, in New York State, 25 percent of persons with less than a high school education live below poverty. Among females without a high school education, the percent below poverty is 30 percent. Educational attainment also has a major impact on median income. As educational level increases, so does income. A female with a bachelor's degree earns 80 percent more than a female with just a high school education.

Educational Attainment of Mothers

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

In New York State, 21.1% of women giving birth in 2008 had less than a high school education. Among African American and Hispanic women, the percentage is even higher (26.0% and 42.2%, respectively). Mothers in New York City were significantly more likely than mothers in the rest of the state (25.9% vs. 16.6%) not to have completed high school. The number of mothers without a high school diploma in the Bronx and Brooklyn alone was nearly equal to the number of mothers in the rest of the state outside New York City.

Data Sources Used to Complete the Statewide Data Report

The data used to complete the required statewide and community reports come from a variety of sources and at varying geographic units (zip code, county, region). Some of the data are reported through a statewide requirement (i.e. vital records), other data are reported through reporting requirements associated with specific funded initiatives (i.e. data reported by contract agencies), and some data are collected through surveying (i.e. substance abuse prevalence indicators). The table below provides an overview of the data sources for the required and additional indicators of at risk communities.

HRSA-Required Indicators	Source	Geographic Unit
Premature Births: # resident live births before 37 weeks/total # resident live births	Dept. of Health Vital Records	Zip Code/County
Low Birth Weight: # resident live births less than 2500 grams/# resident live births	Dept. of Health Vital Records	Zip Code/County
# infant deaths ages 0-1/1,000 live births	Dept. of Health Vital Records	Zip Code/County
# residents below 100% FPL/total # residents	U.S. Census	Zip Code/County
# reported index crimes/100,000 residents # crime arrests ages 0-16/10,000 juveniles age 0-16	Div. of Criminal Justice Services Uniform Crime Report	County
Domestic Violence # domestic violence victims/10,000	Div. of Criminal Justice Services Uniform Crime Report	County
Percent high school drop-outs grades 9-12	State Education Dept.	County
Prevalence rate: Binge alcohol use in past month		Region of NYS
Prevalence rate: Marijuana use in past month		Region of NYS

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Prevalence rate: Nonmedical use of prescription drugs in past month	Office of Alcohol and Substance Abuse Services	Region of NYS
Prevalence rate: Use of illicit drugs, excluding marijuana, in past month		Region of NYS
Percent: # unemployed and seeking work/total workforce	Dept. of Labor	County
Rate of reported of substantiated maltreatment – children in indicated reports of abuse/maltreatment per 1,000 age 0 – 17 in population	Office of Children and Family Services	County
Rate of reported substantiated maltreatment by type		

Additional NYS-Selected Indicators	Source	Geographic Unit
<u>Child maltreatment</u> # of unique children in CPS reports/10000 children aged 0-17 in population	Office of Children and Family Services	Zip Code/County
# of unique children admitted to foster care/10000 children aged 0-17 in population		Zip Code/County
<u>Prenatal, maternal, newborn, or child health</u>	Dept. of Health	
Late or no prenatal care	Vital Records	Zip Code/County
Adolescent births	Vital Records	Zip Code/County
Chlamydia	STD Control	Zip Code/County
Lead exposure/lead poisoning		County
<u>Substance Abuse</u>		
Admissions to certified chemical dependence programs – admissions per 10,000, all ages, all substances	Office of Alcohol and Substance Abuse Services	County
Drug-related hospital discharges/10,000	SPARCS	County

Statewide Data Report

In completing its statewide data report, New York State included and expanded upon the standard metrics selected by HRSA. New York State was able to use the standard metrics, as

designated in the Supplemental Information Request (SIR), with the following minor exceptions. It was not possible to report a rate for the indicator “Rate of reported substantiated maltreatment by type.” However, data regarding the number of cases (burden) of this indicator are included in the statewide and at risk community data reports (except for the reports for the five boroughs of New York City due to the fact that the data are not readily available by borough). Another minor deviation from the indicators listed in Appendix A of the SIR is for “crime arrests ages 0 -19.” New York State reports juvenile crime arrests for youth ages 0 to 16 and the data used for this indicator is for that age range. Additionally, the data for juvenile crime arrests do not include data from New York City. However, New York City data are included in the indicator for reported crimes.

It is important to note that New York State included data for both rate and burden (i.e. total number of events or cases) in its statewide and at risk community data reports. This is consistent with the targeting methodology utilized in other public health initiatives. The use of burden was deemed to be an essential element in identifying at risk communities. The use of both rate and burden recognizes the geographic diversity of New York State and the need to target limited resources to maximize population impact. In some cases, high rates alone represent a very small number of events or cases due to a small population base. Given that available funding will not be sufficient to address all areas of need in New York State, the number of cases for the indicators of risk in each county has been factored into New York’s analysis and identification of at risk communities.

New York State has included additional indicators of risk recommended by State agencies participating in the Home Visiting Work Group. The additional indicators add both breadth and depth to the State’s analysis of the comparative health of communities in the State and the factors that place families at high risk and who could benefit from home visiting services.

The additional indicators are:

- Substance Abuse
 - Rate of admissions to certified substance abuse treatment facilities
 - Rate of drug-related hospital discharges
- Child Maltreatment
 - Rate of Child Protective Services reports
 - Rate of foster care admissions
- Maternal, Infant and Child Health
 - Rate of late or no prenatal care
 - Rate of teen births
 - Rate of Chlamydia cases
 - Rate of exposure to lead

Finally, most of the data used in the statewide and at risk community data reports are available at the zip code level. For the purposes of this initial assessment, the data have been aggregated and analyzed at the county level. The one minor exception to the geographic availability of the data concerns the HRSA-required indicators for substance abuse. These data are reported at a

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regional level, but New York State was able to assign the regional prevalence date to the specific relevant county when completing the at risk community data reports. As discussed further in the next section, New York State intends to analyze the data at zip code level for the counties determined to be at risk and refine the needs assessment with the submission of the updated state plan for home visiting services. The New York statewide data report is below.

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	11.6	28,978
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	8.2	20,513
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	5.5	1,361
<u>Poverty</u> -# residents below 100% FPL/total # residents	14.5	2,692,202
<u>Crime</u> - # reported index crimes/1000 residents - # crime arrests ages 0-16/100,000 juveniles age 0-16 (*data from NYC not included)	2295.9 25.7*	448,554 5800*
<u>Domestic violence</u> - domestic violence victims per 10,000	39	76,600
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	2.9	32,318
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month	23.6 7.0 4.1	Not Applicable

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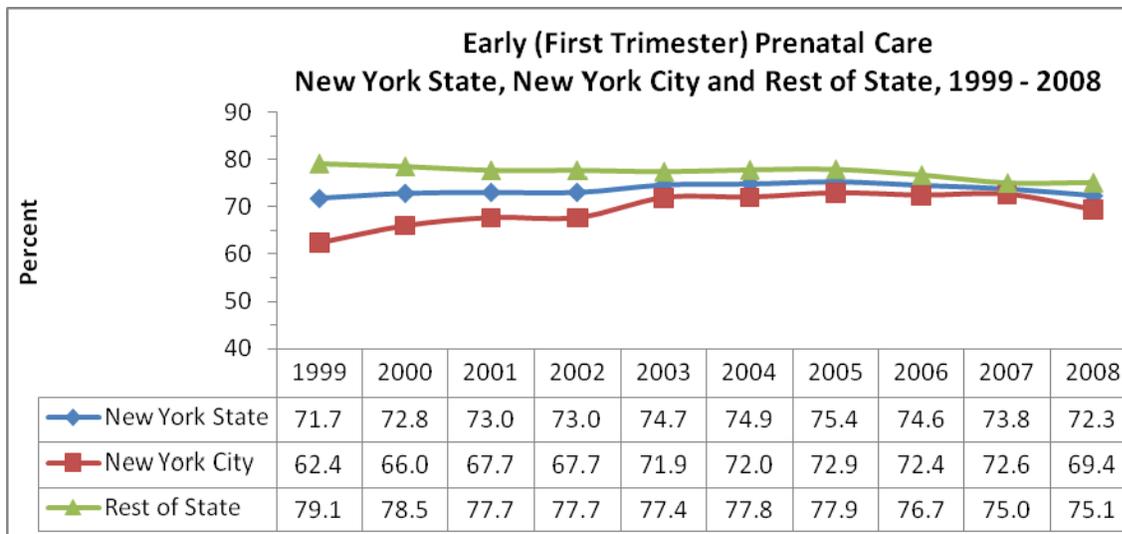
- Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	3.7	
<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	160	312,860
- Drug Related Hospital Discharges	32.5	63,592
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	5.3	514,200
<u>Child maltreatment</u>		
- Unique children in indicated CPS reports in 2009 (per 10,000 children age 0 -17 in population)	168.7	75,510
- Unique children in indicated CPS reports in 2009 by type of maltreatment		
Physical Abuse	---	8,171
Neglect	---	71,127
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children aged 0-17 in population)	483.7	216,420
- Unique children admitted to foster care in 2009 (rate per 10,000 children aged 0-17 in population)	28	12,529
<u>Other indicators of at risk prenatal, maternal, newborn, or child health -</u>		
- Late or no prenatal care	6.3	15,746
- teen births	7.0	17,487
- Chlamydia	454.6	88,437
- Lead exposure/lead poisoning	6.7	3,530

Trends in Major Home Visiting Related Indicators

The statewide data report was completed by using the most recent available data for each indicator and represents a point in time. To gain a fuller understanding of the impact of the major home visiting indicators on New Yorkers, it is important to view the indicators in the context of the recent related trends. Brief summaries of the most recent trends for the major home visiting related indicators in New York State are presented below.

Late or No Prenatal Care

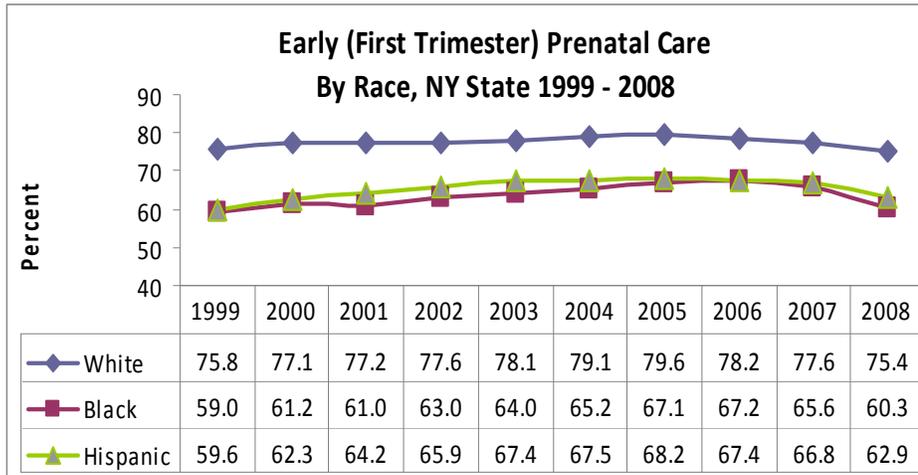
In 2008, the percent of women giving birth in New York State who received early prenatal care (first trimester) was 72.3%, a reduction from the 2007 percentage of 73.8%. The lower statewide rate was due to a reduced percentage of New York City women receiving early care. However, rates of early entry into prenatal care, overall, have been basically stable over the past decade (71.7% in 1999 and 72.3 in 2008), with some minor fluctuations. Regional rates, however, have been less stable. The rate for women outside of NYC was initially significantly higher than the rate for NYC women, but NYC rates of early entry to prenatal care have improved more than 10 percent over the past decade (from 62.4% to 69.4%), while rates for upstate women have fallen off slightly, resulting in far less regional disparity.



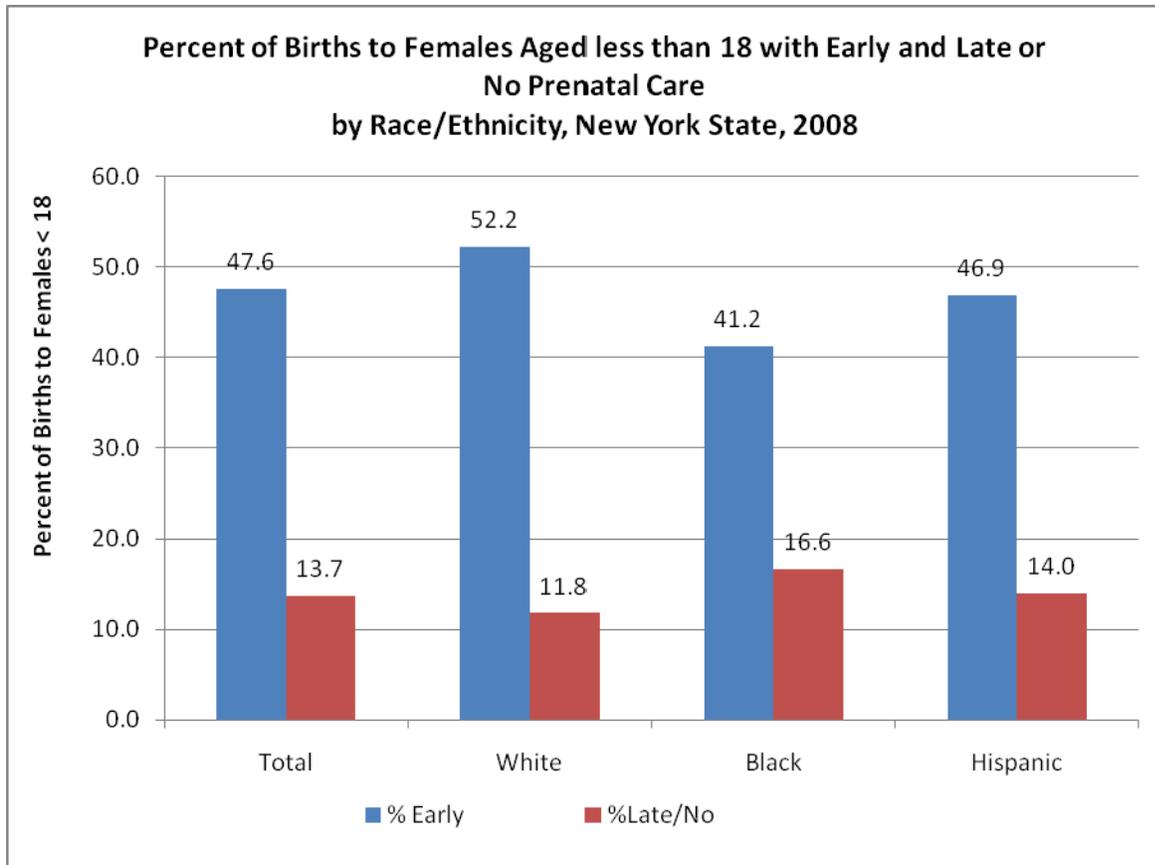
Note: Percent is based on births with known prenatal care utilization

Consistent with the slight decline in the statewide rate of early entry into prenatal care, compared to 2007, early prenatal care rates in 2008 were somewhat lower among all race/ethnicity groups. A significant race/ethnic disparity exists in the percentage of women receiving early care. Rates for white women (75.4%) were 25% higher than rates among Black (60.3%) and Hispanic (62.9%) women, while a decade ago the rate for

whites was 32% higher than the rate for Black or Hispanic women.

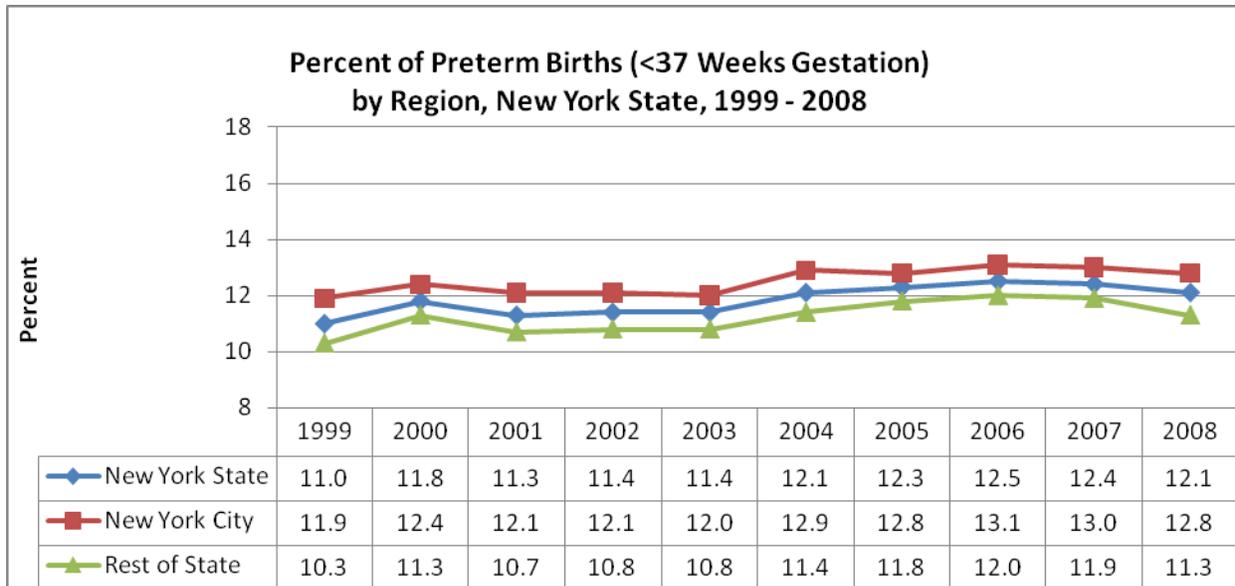


Women under the age of 18 are less likely than women in general to get prenatal care during the first three months of pregnancy. In 2008, just over 50 percent of women under the age of 18 received early prenatal care. The percent was lowest among Black (41%) and Hispanic (47%) teens. White teen girls were the most likely to receive early care (52%). Almost 14% of teen girls gave birth after receiving only late (the seventh month of pregnancy or later) or no prenatal care. About 17% of Black, 14% of Hispanic and 12% of white teen girls received late or no prenatal care before giving birth in 2008. Among women of all ages giving birth in New York State in 2008, 6% received late or no prenatal care.

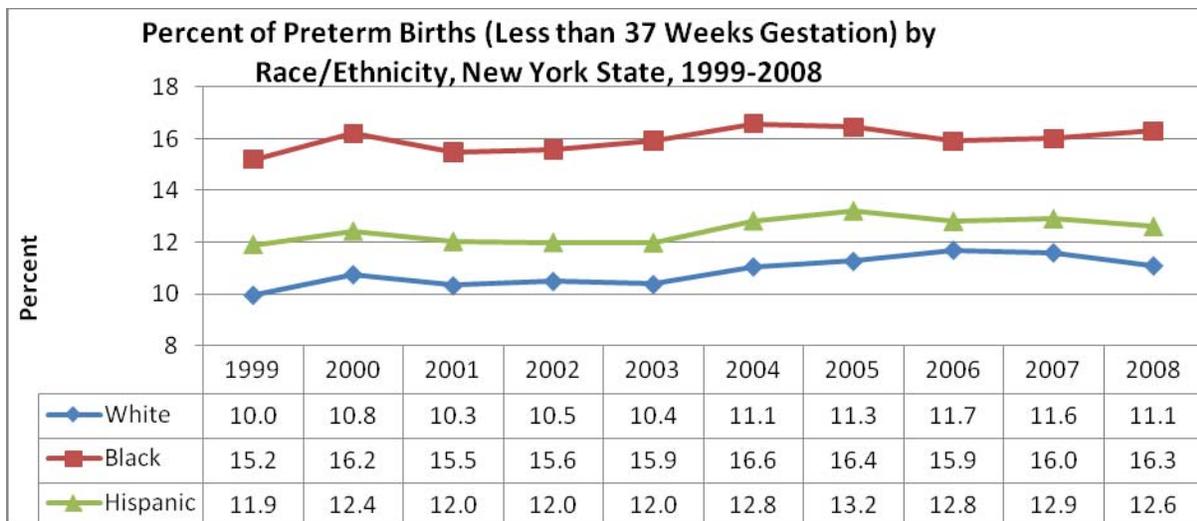


Premature Births

The preterm birth (less than 37 weeks gestation) rate in New York State decreased slightly between 2007 and 2008 from 12.4% to 12.1%. Small declines occurred in the rates in both New York City (13.0% to 12.8%) and the Rest of State (11.9% to 11.3%). The preterm birth rate in New York City has been consistently higher than rates in Rest of State during the past 10 years.



The percentage of Black women delivering at less than 37 weeks gestation was 16.3% in 2008, 47% higher than the 11.1% rate among white women. Hispanic women giving birth had a premature rate of 12.6% in 2008. This was 14% higher than the rate among white women but 23% lower than the rate for Black women. Disparities between Black, white and Hispanic births have persisted over the past ten years.

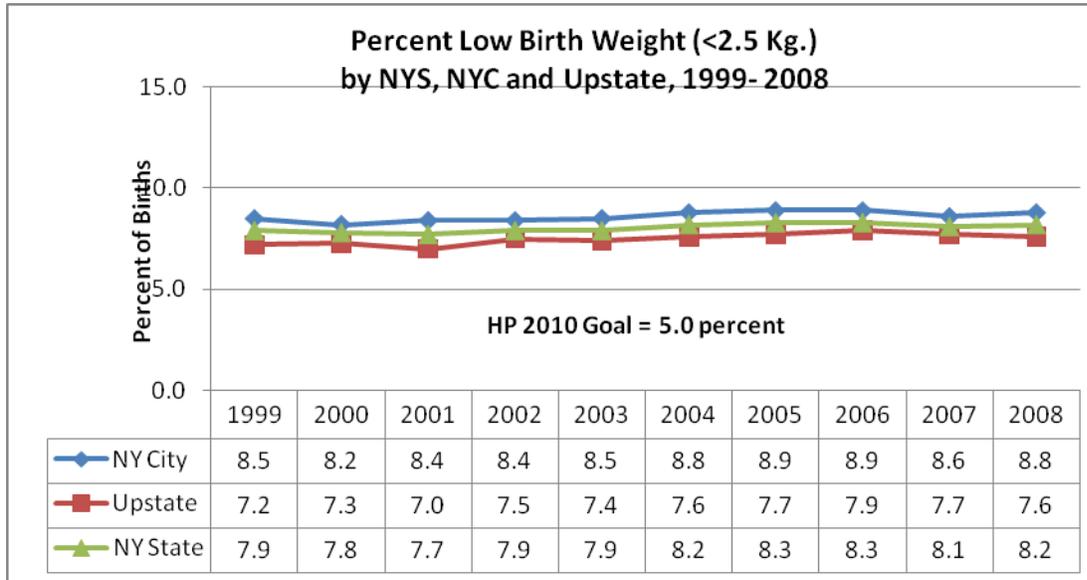


Low and Very Low Birth Weight Infants

New York State's low birth weight rate increased slightly in 2008, to 8.2% from 8.1% in 2007. The percentage of low birth weight births in 2008 was higher than the 1999 rate of 7.8% and 64% greater than the Healthy People 2010 goal of 5.0%. Nationally, 8.2% of births were low birth weight (2007).

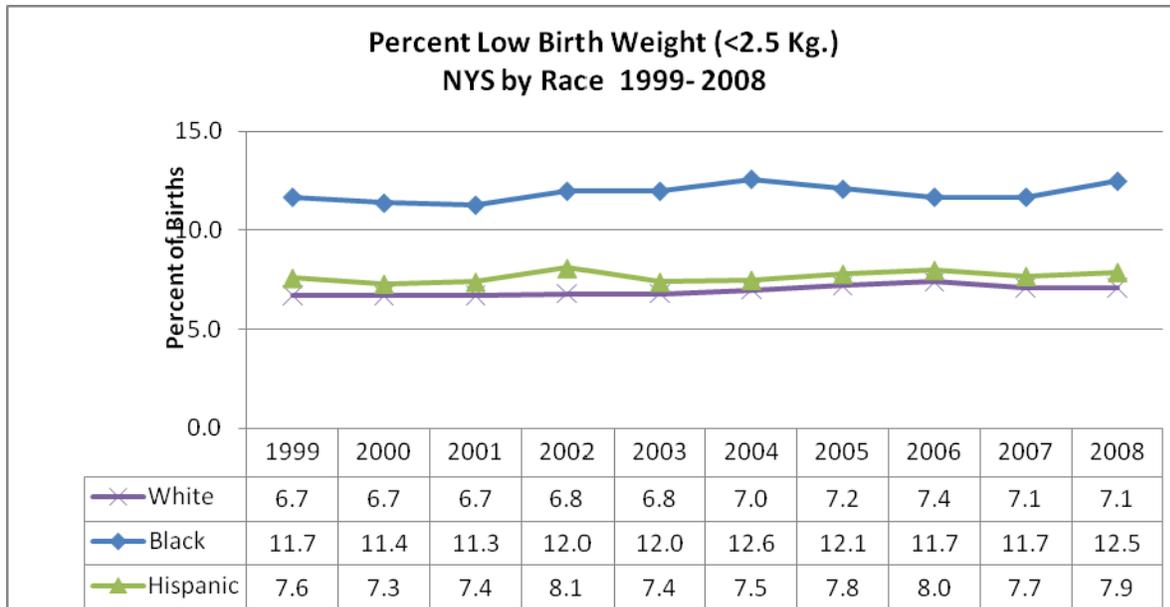
The percent of very low birth weight births (<1500 grams) in New York State was 1.5% in 2008. The rate has been virtually unchanged since 1999. The very low birth weight rate is 67% higher than the Healthy People 2010 goal of 0.9%.

Low birth weight rates have been consistently higher in New York City as compared to Rest of State. In New York City, the low birth weight rate in 2008 was 8.8%, compared to 7.6% in the rest of State.



In 2008, 12.5% of Black infants were less than 2500 grams at birth (low birth weight). This rate is 76% higher than the percentage for White infants (7.1%) and 58% higher than the percentage for Hispanic infants (7.9%). The 2008 low birth weight rate for Black infants increased about 7% from the 2007 rate of 11.7%. The low birth weight rate among Hispanic infants increased slightly from 7.7% to 7.9% between 2007 and 2008. During the past 10 year period, the low birth weight rate for Hispanic infants increased about 4%.

White infants were the least likely to be born with a low birth weight. In 2008, the percentage was 7.1%, unchanged from 2007. Prior to 2007, the rate had been steadily increasing throughout the decade and in 2006 was at its highest level. Consistent with national trends, the 2008 rate is still higher than the rate reported 10 years ago in 1999 (6.7%).



Important Note Related to Data: In 2008, New York City Vital Records adopted the NCHS standard birth certificate. This certificate has been used for births occurring in New York State outside of New York City since 2004. The use of the new birth certificate changes the way race data are collected for New York City recorded births. Beginning in 2008, respondents are able to check all races he/she thinks are appropriate. Prior to 2008, respondents would have to select one of 4 categories (White, Black, Asian or Other). There was no option for selecting multiple races. As a result of these changes, comparisons of race-related birth statistics between 2008 and prior years, although described, are problematic. Although no changes have occurred in the reporting of race on death records, 2008 race specific death rates that use total births as a denominator (such as infant deaths and neonatal deaths) are also impacted. New York State and New York City Departments of Health are meeting to discuss the impact of this change to better assess current performance.

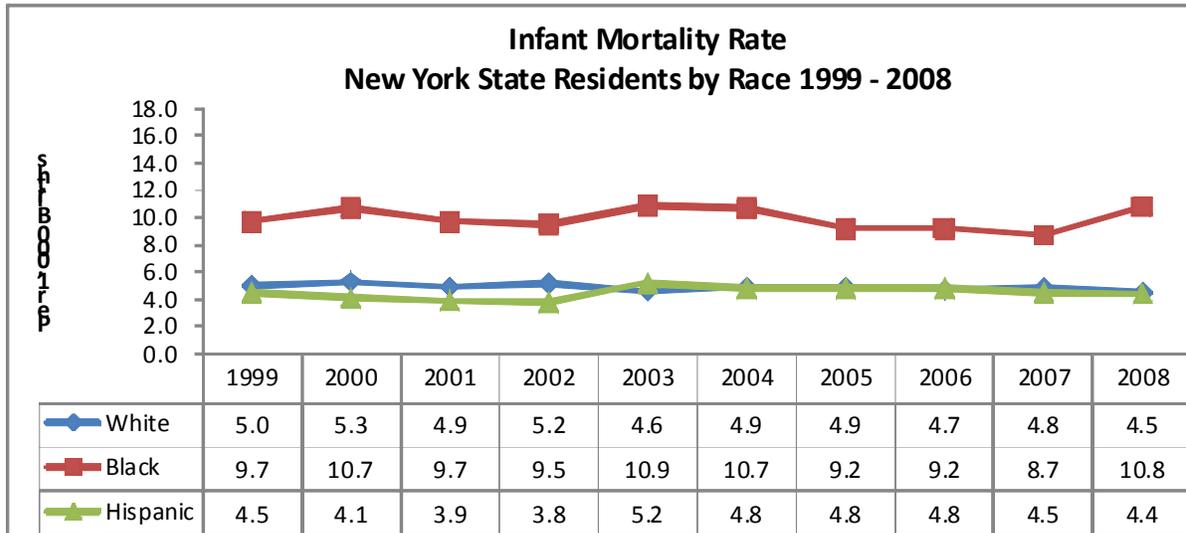
Infant Mortality

The 2008 infant mortality rate was 5.4 per 1,000 live births. The rate has declined the past four consecutive years to a record low for New York State. The New York State infant mortality rate declined most dramatically during the early 90's and at a slower pace in recent years.

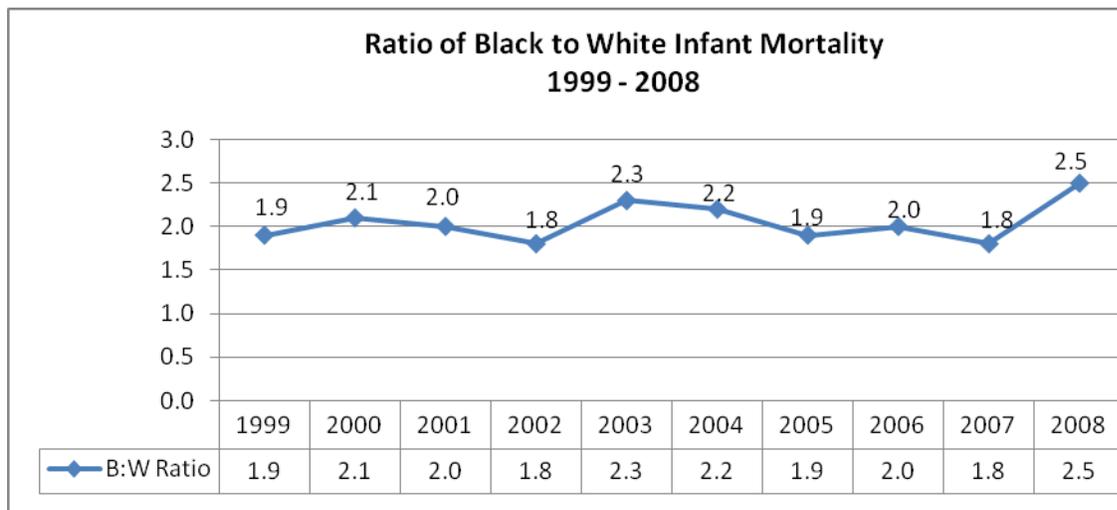
In 2008, the New York City infant mortality rate was unchanged from the 2007 rate of 5.1 per 1,000 live births, a record low for New York City. Among residents of Rest of State the rate decreased slightly in 2008, to 5.8 from 5.9 per 1,000 live births in 2007.

The infant mortality rate among Black infants, which had been improving over the past few years, increased between 2007 and 2008, from 8.7 to 10.8 per 1,000 live births. The 24% increase reversed the progress made in the past decade. The white infant mortality rate however, continued a downward trend, dropping from 4.8 in 2007 to 4.4 in 2008. Although infant mortality among Hispanic infants declined slightly between 2007 and 2008 (4.5 to 4.4 per 1,000 live births), the mortality rate was basically unchanged over the decade.

Hispanic and white infant mortality rates have continued to be about half the rate for Black infants. At 4.5 and 4.4 per 1,000, the rates for the white and Hispanic populations meet the Healthy People 2010 goal of 4.5 per 1,000 live births.

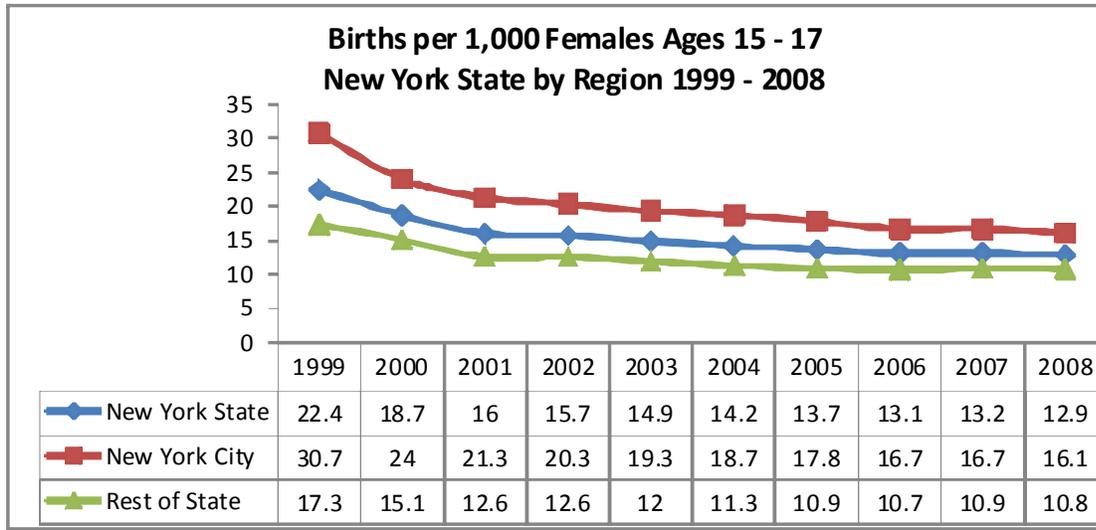


Even though rates have been declining, Black infant mortality rates are still significantly higher than rates for both whites and Hispanics. In 1990, the disparity between Black and white rates peaked when the Black/white ratio for infant mortality reached 2.7, meaning there were 2.7 Black infant deaths for every one white infant death per 1000 births. The ratio was based on rates of 16.0 and 6.0, respectively. Between 1991 and 1997 the Black/white ratio was reduced to 2.0. It has fluctuated in both directions between 1999 and 2008. In 2008, the ratio was 2.5 to 1 based on rates of 10.8 and 4.4 for Blacks and whites, respectively.



Adolescent Births

New York State’s birth rate for 15-17 year old girls is relatively low. The birth rate for this age group has been declining over the past 10 years. The birth rate for teenagers aged 15 – 17 declined between 2007 and 2008 to 12.9 per 1,000 teen girls. The 2008 rate of 12.9 was 42 percent lower than the 1999 decade high rate of 22.4 per 1,000 teen girls. The New York City rate, at 16.1 per 1,000, is higher than the Rest of State rate, which was 10.8 per 1,000 young women between the ages of 15 and 17.

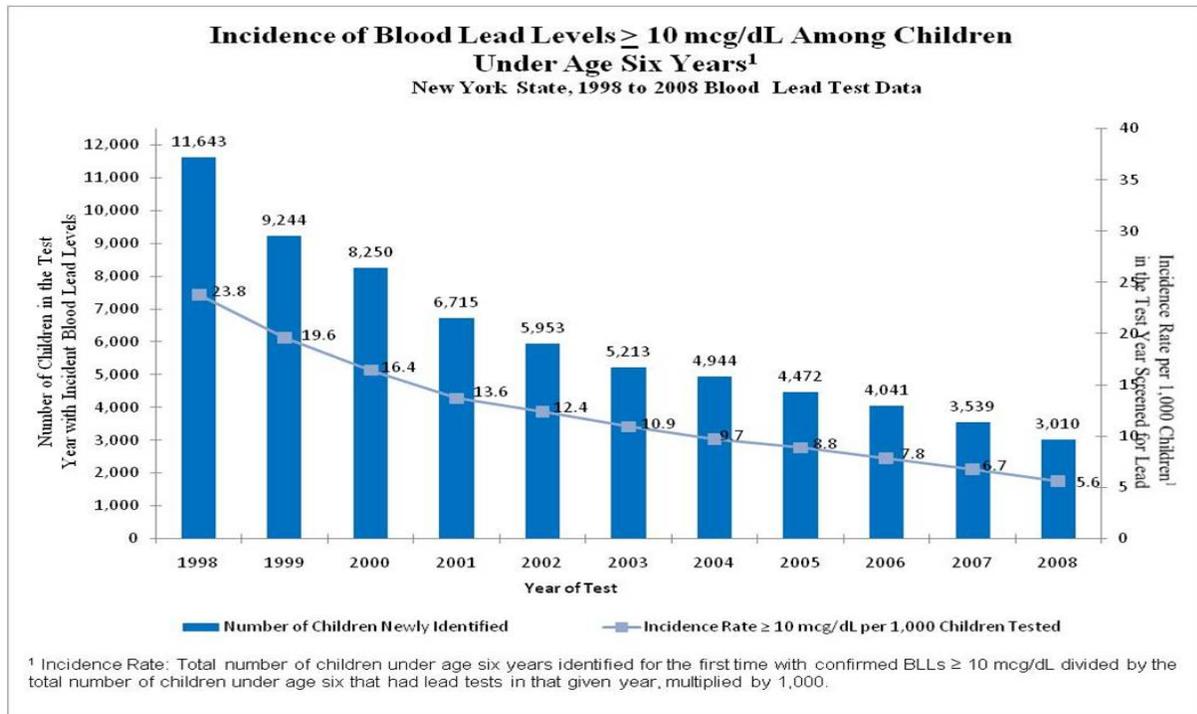


Chlamydia

In 2008, 88,460 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 females in 2008 was more than twice the rate for males (623.3 vs. 296.6). Young women had the highest rates of infection. Among females 15-19 in New York State, the infection rate was 3,749.6 per 100,000, and among females aged 20-24, the rate was 3290.3 per 100,000.

Incidence of Lead Poisoning

The incidence of elevated blood lead levels (EBLLs) among children under age six years is steadily declining across all blood lead level (BLL) categories. Incident data for 2008 show the continued, dramatic improvement in both the number and percent of children newly identified with confirmed BLLs \geq 10 mcg/dL, the current definition of lead poisoning established by the federal Centers for Disease Control (CDC) and Prevention. In 2008, 3010 children less than six years of age were newly identified with BLLs \geq 10 mcg/dL compared to 11,643 children in 1998. This represents a striking 74 percent decline in the number of children with EBLLs since 1998. A 76.5 percent decrease in the rate of incidence of lead poisoning was observed over the same time period, from 23.8 per 1,000 children tested in 1998 to 5.6 per 1,000 children tested in 2008.



The incidence of childhood lead poisoning varies across the state. For the three-year period from 2006 through 2008, 80 percent of children under age six years newly identified with BLLs \geq 10 mcg/dL resided in the thirteen highest incidence counties (ordered from high to low): Kings, Queens, Erie, Bronx, Monroe, New York, Onondaga, Westchester, Oneida, Orange, Nassau, Albany, and Richmond. Expanding this list to include nine additional counties (Suffolk, Rensselaer, Dutchess, Niagara, Ulster, Rockland, Fulton, Broome, Montgomery, Chautauqua, and Schenectady) accounts for a full 90% of incident cases.

Poverty

The indicator for children and youth (ages 0 to 17 years of age) living below poverty measures the percentage of children/youth living in families considered to have too little income to meet basic needs. Poverty in childhood is associated with a wide range of social, educational, health and future employment problems.

In 2007, the highest rates of child poverty occurred in three of the five counties of New York City: Bronx (38.1%), Kings (31.7%) and Manhattan (27.8%). The lowest poverty rates were found in the highly suburban counties such as Putnam (4.8%), Suffolk (6.6%), Nassau (5.6%), Saratoga (7.2%) and Westchester (9.4%). The child poverty rate in New York City (26.7%) was about twice as high as the rate in the rest of the state (13.7%).

Child poverty in New York State was about the same in 2007 as it was in 2000 (19.6% and 19.1%, respectively). During the same period, child poverty in New York City decreased slightly from 28.1% in 2000 to 27.6% in 2007. However, in the rest of the state, child poverty increased slightly from 12.6% in 2000 to 13.6% in 2007.

Crime

Over the past 18 years, the crime rate in New York State has declined steadily. The largest reductions in crime rate were reported for murder, robbery, burglary, and motor vehicle theft. Overall, the rate of index crimes per 100,000 residents declined 62% since 1990, the rate of violent crimes (murder, rape, robbery, and aggravated assault) dropped 66% and property crimes (burglary, larceny, and motor vehicle theft) fell 62%.

However, not all areas of the state have benefitted equally from the reduction in crime. The majority of violent crime incidents are reported within the five counties of New York City. It is noteworthy however, that violent crime within New York City has decreased by 74% since 1990. Violent crime outside New York City has not changed significantly during this time period. The counties outside New York City now account for 58% of the reported crime statewide, as compared to 38% in 1990.

A review of juvenile justice data between 2005 and 2007 reveals a decrease in nearly every category of juvenile justice system involvement. With the exception of juvenile justice arrests in New York City and the use of secure detention, contact points in the juvenile justice system saw a decline in volume over the three-year period.

Juvenile arrests outside of New York City decreased 13.8% from 2005 to 2007. All categories of juvenile arrest reported a decrease, with a 25.5% decrease in weapons offenses, a 15.8% decrease in drug arrest, a 10.9% decrease in property crime, and a 5.2% decrease in violent crime.

Juvenile arrests were on the rise between 2005 and 2007 in New York City. This increase was driven by a 26.4% increase in misdemeanor juvenile arrests from 5,264 in 2005 to 6,653 in 2007. Felony juvenile arrests decreased 7% over the same period, from 5,887 to 5,473.

Still, with over 35,000 arrests of youth under age 18 in jurisdictions outside New York City and a 26.4% increase in misdemeanor arrest in New York City from 2005 to 2007, juvenile crime remains a significant problem throughout New York State.

Domestic Violence

The New York State Office for the Prevention of Domestic Violence reports that New York State is experiencing an increase in indicators of domestic violence. Some of the upward trends identified between 2007 and 2009 continued through 2009, such as more claims from domestic violence and sexual assault victims filed with the Crime Victims Board and more public assistance applicants disclosing a current danger due to domestic violence.

Noted increases in indicators of domestic violence reported for 2009 include:

- A 21% increase in required orders of protection issued from 2008 and 26% increase from 2007.
- The number of applicants for public assistance who indicated danger due to domestic violence in 2009 was 20,909, a 17% increase from 2008 and a 41% increase from 2007.
- Crime victims' claims for financial reimbursement from domestic violence victims increased 25% from 2008 and 40% from 2007.

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- Non-residential domestic violence programs served 45,943 adults and children in 2009 which represents an increase of people served of 8% from 2008 and 13% from 2007.
- 89 intimate partner homicides were reported in 2009; counties outside of New York City reported 46 of these homicides. The numbers remained relatively stable from 2008 to 2009, but increased 24% statewide and 53% in counties outside of New York City from 2007.

School Drop-Out Rates

The statewide 2007/2008 reported drop-out rate was 2.9 percent which was a decrease from the prior year (3.1%). New York City's drop-out rate for 2007/2008 was 4 percent which was also down from the prior year (4.6%). The percentage of students reported as having dropped out in the state remained fairly stable at about 4% through the 1990s and into 2000/2001. The substantial increase in the dropout rate between 200/2001 and 2001/2002 years from 3.7% to 5.6%) was due to the State's implementation of a new information system for accounting for and enumerating drop-outs. It is noteworthy that in 2007/2008, just under 50% of students who dropped out of schools attended New York City public schools.

Substance Abuse

More than half (54%) of individuals admitted to certified treatment programs in New York State in 2007 reported having children; almost two thirds (65%) of females admitted for treatment in 2007 reported having children. There were more than 58,000 female admissions to substance abuse treatment in 2007 representing 27% of all non-crisis admissions in the state. The number and percent of female admissions have remained relatively stable since 2000.

More than 37,500 females admitted for treatment in 2007 reported having children under the age of 19. The percentage of female admissions who have children slightly decreased from 68% in 2000 to 65% in 2007. The majority of women that have children were admitted to outpatient programs (65%), followed by inpatient (20%), residential (9%), and methadone (7%). The most frequently reported primary substances of abuse among women with children under the age of 19 were alcohol (36%), crack/cocaine (28%), opioids (19%) and marijuana (14%).

More than one quarter (28% or 16,073 admissions) of females admitted to treatment in 2007 reported living with children. The percentage of women admitted who reported living with children has decreased from 32% in 2000 to 28% in 2007. Most of the women (76%) were admitted to outpatient programs and alcohol was the most frequently reported primary substance of abuse (37%). Three percent of female admissions in 2007 were pregnant at time of admission. Most were admitted to outpatient programs and marijuana was the most frequently reported substance of abuse.

Almost one quarter of female admissions who have children had an active case with child protective services at the time of admission during 2007. Fourteen percent of female admissions who have children that were admitted for treatment in 2007 had one or more children in foster care.

There were more than 12,000 adolescents (ages 12 to 17 years) admitted to substance abuse treatment in 2007 in New York State. Most of the admissions were to outpatient programs

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(80%), followed by residential (13%) and inpatient (7%). Adolescents represented 5.7% of total admissions in the state; nationally, adolescent represent 8% of all admissions.

The number of adolescent admissions, as well as the percent of adolescent admissions compared to total admissions, decreased from 2000 to 2007 (from 14,235 to 12,112 and from 7.1% to 5.7%, respectively).

Unemployment

New York State has experienced an increase in the unemployment rate over the past few years as have all states due to the downturn in the national economy. This is best demonstrated by a comparison of 2008 and 2009 unemployment statistics.

Region	2008 Rate	2009 Rate
New York State	5.3%	8.4%
New York City	5.4%	9.5%
Rest of State	5.2%	7.6%

These rates represent a total of almost 300,000 more people who were out of work in 2009 as compared to 2008 (813,400 and 514,300, respectively). The substantial negative impact of recent unemployment rates are further illustrated by the fact that the statewide unemployment rate in 2000 was just 4.5%

Child Maltreatment

Child abuse and maltreatment represent an impairment or imminent danger of impairment of a child's physical, mental or emotional condition due to the failure of the parent, guardian or other person legally responsible for the child to exercise a minimum degree of care toward the child. This can involve the failure to provide care regarding a child's basic needs, such as food, clothing, shelter, medical care, education, or proper supervision. It can also involve the parent or other legally responsible person's use of excessive corporal punishment, the abuse or misuse of drugs or alcohol, and abandonment of a child. The Statewide Central Register for Child Abuse and Maltreatment (SCR) receives reports concerning alleged incidents of abuse and maltreatment in families and in certain publicly licensed settings. A report becomes "indicated" when credible evidence is found that a child has experienced abuse or maltreatment.

The total number of reports of child abuse or maltreatment received by the SCR increased by 12% between 2000 and 2008, from 143,719 to 161,580. The increase in the number of reports was more pronounced in the rest of the state (from 88,702 to 102,831) than in New York City (from 55,017 to 58,749). Statewide, the number of reports of child abuse and maltreatment that were indicated rose from 45,937 in 2000 to 50,714 in 2008. In contrast to the regional trend in the overall number of reports, the increase in indicated reports from 2000 to 2008 was greater for New York City (from 19,414 to 23,717) than for the rest of the state (from 26,523 to 26,997).

An important indicator of the incidence of child abuse and maltreatment in New York State in a given year is the number of unique children in indicated reports per 10,000 children age 0-17 in the general population. While the rate of unique children in indicated reports increased across the

state between 2000 and 2008 (from 134 to 169 per 10,000 children), it increased more dramatically in New York City (from 131 to 172) than in the rest of the state (136 to 165). It should be noted, however, that the rate of unique children in indicated reports is affected by a number of factors in addition to the actual incidence of child abuse and maltreatment. Therefore, caution is required in drawing conclusions concerning differences between New York City and the rest of the state on this measure. For example, reports tend to rise for reasons unrelated to the actual incidence of abuse and maltreatment in a jurisdiction, such as a highly publicized case, a public awareness campaign or an addition to the list of mandated reporters. Also, higher rates of indicated abuse or maltreatment reports in some counties may reflect better reporting or reliance on a lower standard of evidence to indicate cases.

Summation of Trends

While it may be possible to identify positive trends in some of the individual indicators of risk, overall it is evident that a substantial number of families in New York State are at great risk for experiencing significant negative outcomes. It is also evident that significant and persistent racial/ethnic and geographic disparities exist among the negative outcomes experienced by families in New York State. Given the great diversity in New York State's population and geography, communities that are at greater risk for negative outcomes are located throughout New York State. The challenge for New York State has been, and continues to be, is how to break stagnant or downward trends in negative outcomes for families and individuals and, as importantly, how to maintain effective strategies and efforts to produce positive outcomes. As envisioned by the Affordable Care Act, and as implemented by New York State, home visiting services will one such strategy.

IV. Identification of At Risk Communities

Methodology Used to Identify At Risk Communities

For the purposes of this initial needs assessment, the geographic unit New York State used to define community and make the initial determination of at risk communities is county. There are 62 counties in New York State. Each county is well-defined with its own governance structure and varying service delivery systems based on population size, geographic area and resources. Since counties are well defined, it was decided that the logical approach to determining at risk communities for this initial needs assessment was to start at the county level. New York State intends to conduct a more refined needs assessment by using the same set of indicators at the zip code level (where zip code-level data are available). It is expected that this subsequent needs assessment will identify specific communities and neighborhoods within the counties where risk is greatest and may potentially include specific communities in counties other than the counties identified for this assessment. A refined needs assessment of this nature will more fully address the wide variety in geography and socio-demographic needs of New York's families and will result in an Updated State Plan that will be tailored to meet the specific needs of families residing in those communities.

Given the large number of indicators (23) used by New York State to identify at risk communities, it was decided that the best approach was to calculate a Z-score for the rates of all the indicators and a Z-score for the number of cases (burden) for all the indicators for each

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county. The Z-score allows for a standard score that indicates how many standard deviations the data are above or below the mean. The average Z-score was obtained for each county (where each indicator was treated with equal weight), thus providing a composite index for ranking the counties from highest to lowest in overall need, relative to the statewide value. This was repeated for both rates and cases so that counties could be prioritized by ranking with respect to both rates and overall burden. A Z-score with a positive value means that it is above the group mean; a Z-score with a negative value means that it is below the group mean.

The application of a Z-score methodology resulted in the following 4 groupings:

- Group 1* – Positive Z-score for both rate and burden
- Group 2* – Positive Z-score for burden but not for rate
- Group 3* – Positive Z-score for rate but not for burden
- Group 4* – Negative Z-score for both rate and burden

The counties identified in each grouping are:

Group 1

Albany	Monroe
Bronx	New York
Erie	Oneida
Kings	Onondaga

Group 2

Nassau	Richmond
Orange	Suffolk
Queens	Westchester

Group 3

Broome	Jefferson
Cattaraugus	Montgomery
Chautauqua	Niagara
Chemung	Orleans
Chenango	Oswego
Clinton	Schenectady
Columbia	Schuyler
Cortland	Seneca
Delaware	Sullivan
Franklin	Warren
Fulton	

Group 4

Allegany	Rensselaer
Cayuga	Rockland
Dutchess	St. Lawrence
Essex	Saratoga

Genesee	Schoharie
Greene	Steuben
Hamilton	Tioga
Herkimer	Tompkins
Lewis	Ulster
Livingston	Washington
Madison	Wayne
Ontario	Wyoming
Otsego	Yates
Putnam	

For the purposes of this initial needs assessment, the 14 counties identified in Group 1 and Group 2 have been identified as the at risk communities in New York State. These counties represent all 5 boroughs of New York City (Bronx, Kings, New York, Queens, and Richmond), the 3 counties in the immediate New York City metropolitan area (Nassau, Suffolk, and Westchester) and the upstate counties with urban centers (Orange/Newburgh, Albany/City of Albany, Oneida/Utica, Onondaga/Syracuse, Monroe/Rochester, and Erie/Buffalo).

Data Reports for the Initially-Identified At Risk Communities in the State

The same set of metrics used for the statewide data report was used to produce the data reports for each of the initial at risk communities. The data reports for the counties identified above in Group 1 and Group 2 are attached. In addition to the data reports, preliminary individual profiles of each initially-identified at risk county have been developed and are attached. The preliminary profiles include information about each county's population and demographics, detailed information about the home visiting programs that are present in the county, and recent maternal and infant health-related statistics for each county. The profiles also include several quotes from stakeholders from the county. These quotes provide the stakeholders' perspectives about the unique home visiting needs in their community.

The county profiles, along with the detailed information about other service programs supported by the State agency partner agencies in the initially-identified at risk counties demonstrate New York State's capacity to determine levels of need and identify available resources at the county level. The profiles and corresponding materials will serve as templates for the collection and depiction of need and resources for the specific at risk communities identified through the next needs assessment. These materials will be essential sources of information that will be utilized in developing the Updated State Plan for home visiting services. It is anticipated that the preliminary profiles for the at risk communities will be refined, enhanced and expanded during the next phase of the needs assessment as more specific information about at risk communities is compiled.

V. Capacity of Home Visiting Programs in New York State

New York State collected information about existing home visiting programs through a variety of means and from several sources. In addition to collecting information from the State agencies that directly fund home visiting programs, Office of Children and Family Services (OCFS) and the Department of Health (DOH), an environmental scan was conducted of existing home

visiting programs in New York State with a national or state affiliation to determine their current level of services, target areas and demographics of clients served. These programs include Building Healthy Children, Community Health Worker Program, Early Head Start, Head Start, Healthy Families New York, Healthy Start, Home Instruction for Parents of Preschool Youngsters, Nurse Family Partnership, Parents as Teachers, and Parent Child Home Program.

The Department of Health developed a survey tool (see attachment) to collect information about each program model, contacted state level representatives of the home visiting programs, or the local program directly in the case of HIPPY, and emailed them the survey for completion. The survey was designed to capture components of the program model used, services provided, communities targeted, families served, duration of services, and client demographics. Additional meetings were held with representatives from several programs to collect supplemental information. Summaries of the information collected on the home visiting programs operating in New York State are provided below.

Building Healthy Children (BHC) is an ACF funded Evidence-based Home Visiting program targeted to the city of Rochester. The program has been in existence for three years. BHC prioritizes services to low income, pregnant women under 21 years of age. It is a home-based primary prevention program that uses evidence-based interventions to improve children's health and development, family functioning, parenting skills, increase secure attachments between parent and child, address maternal mental health concerns, and reduce risk factors associated with child abuse and neglect. Evidence-based interventions include: Parents at Teachers (PAT), Child-Parent Psychotherapy (CPP), Interpersonal Psychotherapy (IPT), and Incredible Years (IY). This program also works at a community level to improve collaboration and strengthen the infrastructure to maximize the capacity and efficiency of home visitation. BHC serves 197 families per year.

The **Community Health Worker Program (CHWP)** is a paraprofessional home visiting program developed and administered by the Department of Health. The program has been in existence for over 20 years and currently operates in 23 sites throughout NYS targeted to communities with high rates of infant mortality, low-birth weight, preterm delivery, births to teenage mothers, and poverty. The program prioritizes services to women with late or no prenatal care and/or poor compliance with prenatal care and focuses on getting Medicaid-eligible pregnant women into early and consistent prenatal care and ensuring families receive primary and preventive health care services. Services are provided by trained paraprofessional Community Health Workers (CHWs) who live in or are familiar with the community, creating a bridge between providers of health, social and community services and the underserved and hard-to-reach populations within the community. CHWs are trained to provide basic health education and referrals for a wide range of services and to provide support and assistance in navigating the services system. CHWs provide outreach, education and monthly home visits during pregnancy and through the baby's first year of life. The ultimate goal is to assist families to develop the necessary skills and resources to improve their health status and family functioning in order to move towards self-sufficiency. CHWs are supervised by a nurse or social worker with clinical case management experience. An evaluation of the data submitted by CHW Programs for services provided in 2008 indicated that the programs had a positive impact on first trimester enrollment into prenatal care, Medicaid and WIC enrollment, and completion of

postpartum visits and pediatric visits. The program is funded by \$4.6 million and serves 3,500 annually.

Early Head Start (EHS) began in 1995 as part of the Head Start program to provide services to families with infants and toddlers. EHS serves low-income pregnant women and families with infants and toddlers from birth through age 3 and is designed to provide high-quality child and family development services that promote healthy prenatal outcomes, enhance the development of infants and toddlers, and promote family functioning. During weekly home visits parents are provided with information about parenting, health, and child development. Families are linked to other community services and resources and provided with social supports specific to their needs. EHS programs follow standards set by the Head Start Program Performance Standards on quality early childhood development programs, and tailor their approach to the communities they serve. An evaluation of EHS programs has shown EHS to have statistically significant positive impacts on standardized measures of children's cognitive and language development. Services generally fall into one of three program approaches, home-based, center-based, or mixed-approach combining both home and center based approaches. There are 64 EHS programs serving the state; however, data received from the survey of home visiting programs conducted for this needs assessment does not adequately distinguish between center-base and home-based EHS programs. The number of families home visited by EHS programs is reported by county where known.

The **Head Start (HS)** program was created in 1965 as part of the War on Poverty and is intended to provide comprehensive child development services to low-income children, their families, and communities, and focus on helping preschoolers develop the early reading and math skills necessary to be successful in school. HS programs promote school readiness by enhancing the social-emotional and cognitive development of children through the provision of educational, health, nutritional, social and other services to the children and families they serve. HS programs engage parents in their children's learning and help them in making progress toward educational, literacy and employment goals. HS is a federal program administered by local grantees that must adhere to national Head Start Performance Standards. HS services are responsive and tailored to the child's and family's needs and strengths. HS programs can be: center-based, with children enrolled in classroom settings and parents participating in at least 2 home visits annually; home-based in which HS staff work directly with children and parents in the home on a weekly basis and at least twice monthly group socialization activities; family child care in which services are provided in a child care setting; or, a combination program of center-based and home-based services. Each HS program conducts a community needs assessment to determine which services best fit the needs of families in the community. There are 178 Head Start sites in NYS; however, Head Start data received from the survey of home visiting programs conducted for this needs assessment does not adequately distinguish between center-base and home-based programs. The number of families home visited by HS programs is reported by county where known.

Healthy Families New York (HFNY) is an evidence-based, paraprofessional home visiting program that targets expectant parents and parents with infants less than 3 months of age considered at high-risk for child abuse and neglect. HFNY is associated with Healthy Families America (HFA). The program began in 1995 with 10 programs, and currently operates 37

programs in 44 sites throughout NYS, and is present in 20 counties and the 5 boroughs of NYC. HFNY is directed by the NYS Office of Children and Family Services. Families are screened and assessed for risk factors that are predictive of child abuse and neglect. The program prioritizes services to low income, single parents with a history of child abuse/child welfare services, substance abuse, late/no prenatal care, mental issues, and domestic violence. HFNY promotes the use of positive parenting skills that support and encourage children's cognitive and social development, links families to a medical provider, and refers families to additional services based on identified needs. Home visits are conducted by trained paraprofessionals who are reflective of the communities they serve. HFNY staff receives required training according to HFA standards. Home visitors provide families with support, education and linkages to community services with the goals of promoting positive parenting skills and parent-child interaction, preventing child abuse and neglect, ensuring optimal prenatal care and child health and development, and increasing parents' self sufficiency. Home visits are conducted biweekly during pregnancy and weekly during the first six months of the child's life. As families progress through the program, the frequency of home visits declines from biweekly, to monthly, to quarterly. Families are offered home visiting services until the child is in school or a Head Start program. HFNY has demonstrated outcomes through a randomized controlled trial at three sites, including sustained decreases in mothers' reports of serious physical abuse, sustained increases in positive parenting, and reductions in the rate of low birth weight deliveries and participation in special education programs. HFNY has also demonstrated lower rates of confirmed child protective services reports for young first-time mothers who enroll prenatally and for mothers with confirmed prior involvement with child protective services. The program is funded by \$23 million and serves nearly 6,000 families annually.

The Federal **Healthy Start** (FHS) program is a federally funded community-driven model of care established in 1991 to mobilize and coordinate community resources to reduce infant mortality. The goals of FHS are to: reduce racial and ethnic disparities in access to and utilization of health services; improve the local health care system; and, increase consumer participation in health care decisions. The program is administered by HRSA. Grantees are required to implement outreach, case management, health education, perinatal depression screening and referral, and interconceptional care strategies. There are five FHS programs in NYS (Rochester, Onondaga, Central Harlem, Brooklyn, and Queens/Nassau/Suffolk). Three of NY's FHS programs use home visiting/case management strategies to manage the care of pregnant and parenting (interconceptional) women. The FHS program provides home visits to a total of 1,262 families.

Home Instruction for Parents of Preschool Youngsters (HIPPO) is a national evidence-based program in existence since 1969. There is one HIPPO program in NYS, BronxWorks HIPPO which has been in operation since 1991. HIPPO prioritizes its services to low income, single-parent families with a history of child abuse/child welfare services who use tobacco, have children with low student achievement and developmental delays, current depression, history of domestic violence, and unemployment. HIPPO is a home-based program whose purpose is to provide parents with the tools they need to become successful first teachers, enabling them to prepare their children for success in kindergarten and beyond. To participate in HIPPO, families must have a child between 3 and 5 years of age at time of enrollment, and be willing to spend a minimum of 15 to 20 minutes a day, five days a week engaging the child in literacy skills

development activities in the home. Weekly home visits are conducted by paraprofessional parent educators for a minimum of 30 minutes per visit. The HIPPY curriculum is administered by parents who are trained by the parent educators over a 30-week period. Research by HIPPY USA and BronxWorks indicates that HIPPY has helped improve children's readiness for elementary school and has been a deciding factor in keeping parents engaged in their children's education through middle school. A special feature of BronxWorks HIPPY is that it is linked to a host of community services (i.e., local hospitals, community mental health centers, Legal Aid Society or Bronx Legal Services; literacy supports through branches of the NY Public Library, and adult education classes through the NYC Department of Education).

The **Nurse Family Partnership** (NFP) is a national, evidence-based nurse home visiting program for at-risk first-time mothers, their infants, and families. There are currently 3 NFP programs in NYS implemented by the Monroe County Health Department (Rochester), Onondaga County Health Department (Syracuse), and New York City Department of Health and Mental Hygiene (Bronx, Brooklyn, Manhattan, Queens, and Staten Island, and a targeted city-wide initiative) in targeted high-risk communities. The NYC program serves 9 sites through all 5 boroughs with a city-wide initiative targeted to teens in foster care, women and teens in homeless shelters, and women at the Rikers Island correctional facility. Home visits are conducted by trained registered nurses on average two times per month during pregnancy and until the infant's second birthday. Nurses carry a caseload of no more than 25 families. The program helps families improve maternal and child health, build a secure and nurturing relationship between parent and child, and reach education and employment goals. With each visit, nurses focus on personal health, environmental health, quality of care-giving for the child, maternal life-course development, social networks, and health and human service utilization. Through randomized controlled trials, NFP programs have consistently demonstrated such positive effects as improved prenatal health, increased intervals between births, fewer subsequent pregnancies, increased maternal employment, improved school readiness, and fewer childhood injuries. The NFP programs in NYS are funded by \$19 million, supporting 129 nurses and 19 supervisors, and serving 3,700 Medicaid-eligible families annually.

Parent as Teachers (PAT) is an evidence-based program that prioritizes services to pregnant women under 21 with a history of child abuse/child welfare services. The primary focus is on ameliorating or reducing behaviors and/or environmental conditions that contribute to child abuse/neglect and foster care placement. A secondary focus is on improving prenatal, health, and developmental outcomes for at-risk children. The program seeks to enroll clients early as possible, preferably prenatally, to maximize best possible birth outcomes. Working with families starting in the prenatal period and sustaining a long-term relationship of education and support, PAT programs can remain active in the life of a family until the youngest starts kindergarten. Parents become knowledgeable advocates for their children through their on-going relationship with their parent educator in home visits, combined with the opportunity to meet other parents in an educational group setting. PAT educators are trained to be aware of community resources and to facilitate linking families with necessary services. There are 56 PAT sites throughout NYS. There is no state director as these are stand-alone programs or are integrated into other home visiting programs such as HFNY, for example.

Parent Child Home Program (PCHP) is a national evidence-based home visiting program that prepares young children for school success by increasing language and literacy skills, enhancing social-emotional development and strengthening the parent-child relationship. PCHP is overseen by a national organization and has been in existence for over 45 years. Local PCHP sites implement a research-validated replication model according to national guidelines and training. The program targets families with 2 and 3 year olds who face multiple obstacles to educational and economic success. The program operates in 32 sites in NYS and prioritizes its services to low-income families challenged by limited parental education levels, literacy and language barriers, lack of transportation, and other barriers. These families include with a history of child abuse/child welfare services, domestic violence, and older children with low student achievement, as well as women with late/no prenatal care. The families served include 2-parent, single parent, teen parent, foster parent, and grandparent families. PCHP home visitors are paraprofessionals who receive 16 hours of training prior to beginning home visits, 2 hours of weekly group training and supervision, and as needed individual supervision throughout the year. Families receive twice-weekly home visits for a minimum of 92 home visits over a two-year period, linking families to early intervention, social and community services, and the next appropriate educational step for the child, such as pre-kindergarten and Head Start. A randomized controlled trial found that children who completed the full 2 years of PCHP graduated at an 84% rate from high school, 30% higher than the control group. In New York State, two PCHP programs are supported by the Children and Family Trust Fund, which is administered by NYS Office of Children and Family Services, as well as by partial funding through Title 1/McKinney Act funds for education of Homeless Children and Youth, and through BOCES and local school aid.

In addition to the home visiting program models described above, many of New York State's **county health departments** provide maternal and child health home visiting services for pregnant and/or postpartum women and infants. Traditionally, local health departments have offered home visits conducted by public health nurses to assess maternal health, perform a newborn physical examination, provide parenting education, assess the family's living environment and provide follow-up communication and referrals to appropriate health care, social support and education resources. Home visiting services of this nature gives families an early contact with the local health department and provides an opportunity to connect families with needed services, answer questions, and identify potential public health or safety threats in the home (e.g. unsafe conditions, lack of heat, potential lead exposures , etc.). Public health nurses also assist the mother in identifying and dealing with issues such as postpartum depression and provide child health assessment, care and nutrition education services. Home visits provided through county health departments tend to be limited and delivered on a short-term basis.

Further information about the home visiting programs in New York State is provided in the following attachments: preliminary profiles of the counties initially identified as being at risk communities; and, a chart that depicts the total number of families served and the total number of sites for each home visiting program model for all 62 counties in New York State. New York State has also compiled detailed information about the full range of programs supported by the Office of Children and Family Services and the Office of Alcohol and Substance Abuse Services for all the counties initially identified as at risk. Information about the services available in the

specific at risk communities identified through the subsequent refined needs assessment will be utilized during the development of the Updated State Plan.

As evidenced by the above-mentioned attachments and documents, a wealth of information has been gathered about home visiting programs and related services in New York State. Much of New York State's efforts during this initial phase of the home visiting needs assessment have been directed at collecting pertinent information from a variety of sources. The description of the process the State used to conduct the needs assessment reflects a multi-faceted and comprehensive endeavor that involved multiple partners, stakeholders and sources of data and information. By completing the statewide and county data reports, engaging State agency partners in the collection of home visiting-related information, reviewing relevant needs assessments, receiving input from more than 200 stakeholders statewide, and constructing detailed profiles of the services available in the at risk communities, New York State has the tools to determine the extent to which home visiting programs are meeting the needs of families and identify gaps and duplications in home visiting services.

These tools will be utilized in the next phase of the development New York State's assessment of the need for home visiting services. As previously stated, New York will next conduct a needs assessment at the zip code-level to identify specific communities determined to be at risk in New York State. Once specific sub-county communities are identified as being at highest risk, New York State will conduct a thorough review of the home visiting program models and other relevant services that are available in those communities, as well as a review of the number and types of families currently being served by home visiting programs in those communities. Until that review is completed and the results analyzed, it is premature to draw detailed conclusions regarding the adequacy of the available services and gaps and duplications in existing services for families.

This in-depth review of all the data and information that has been collected will be conducted in consultation with the members of the New York State Home Visiting Work Group. The results of this review and analysis will inform the development of the updated state plan for home visiting services. The results will also be coupled with the Work Group's review of the final HRSA guidance regarding the criteria for establishing evidence of effectiveness of home visiting models. It is anticipated that as a result of these efforts, the updated state plan will include specific action steps that will be designed to address clearly identified needs in the communities of New York State most in need of home visiting services. The updated plan will also provide a road map that will guide New York State's implementation of the ACA-funded home visiting program.

Another integral element of New York State's review of all the information gathered through this initial phase of the needs assessment is the careful consideration of the feedback the State received from home visiting stakeholders and the needs identified in the other assessments and documents that were collected. As described previously, many of the comments from stakeholders and issues identified in the other need assessments concerned the essential role that community collaboration and coordination of services plays in the delivery of effective home visiting services. Stakeholders also provided feedback on very specific gaps in services and systemic barriers to delivering effective home visiting services in their communities. This

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information, coupled with information that will be gathered from the Head Start/Early Head Start programs located in the at risk communities identified through the refined needs assessment process, will greatly inform the Updates State Plan for home visiting services.

VI. Capacity to Provide Substance Abuse Services

The New York State Office of Alcoholism and Substance Abuse Services (OASAS) plans, develops and regulates the state’s system of addiction prevention and treatment services. This includes 1,035 chemical dependence treatment programs that serve about 110,000 persons on any given day in a wide range of comprehensive services. Included in that total are 12 OASAS-operated Addiction Treatment Centers, which provide inpatient rehabilitation services to 10,000 persons per year. The table below shows the total number of chemical dependence treatment programs and certified capacities for the five major service categories for the initially-identified high risk counties and state wide.

OASAS-Certified Chemical Dependence Treatment Service Capacity

County	Crisis		Outpatient		Methadone		Inpatient Rehab		Residential	
	Progs.	Cap.	Progs.	Cap.	Progs.	Cap.	Progs.	Cap.	Progs.	Cap.
Albany	3	71	17	N/A	2	300	2	70	11	288
Bronx	6	165	37	N/A	18	9,665	3	91	19	1,224
Erie	4	55	32	N/A	3	980	4	141	9	316
Kings	7	114	47	N/A	19	7,900	2	110	14	860
Monroe	3	34	16	N/A	3	750	2	84	17	397
Nassau	3	58	43	N/A	4	900	1	30	2	42
New York	15	453	69	N/A	45	13,882	3	91	25	1,805
Oneida	1	25	4	N/A	0	0	1	68	5	105
Onondaga	4	39	13	N/A	1	500	3	122	7	227
Orange	2	30	15	N/A	1	300	3	114	3	82
Queens	5	193	30	N/A	9	2,389	2	79	13	1,258
Richmond	3	108	14	N/A	3	770	2	54	2	55
Suffolk	4	67	42	N/A	5	1,175	6	287	10	433
Westchester	2	82	35	N/A	6	2,035	4	160	4	211
Statewide	81	1,756	535	N/A	125	42,411	63	2,468	231	10,391

Source: OASAS Provider Directory System, September 10, 2010. Note: OASAS does not certify a capacity for outpatient services.

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Measures of the service system’s capacity to meet the estimated treatment needs in the initially-identified at risk counties in New York State are presented in the following two tables.

All Treatment Services

County	Prevalence	Certified Programs	Treatment Demand	Persons Treated	Demand Met
Albany	34,800	39	10,249	6,663	65.0%
Bronx	135,299	90	46,614	32,338	69.4%
Erie	99,238	61	28,558	14,642	51.3%
Kings	220,868	105	71,700	29,630	41.3%
Monroe	83,861	46	24,964	11,495	46.1%
Nassau	127,206	57	36,467	14,983	41.1%
New York	165,314	200	56,546	53,579	94.8%
Oneida	25,836	14	7,482	3,534	47.2%
Onondaga	48,874	32	13,892	7,210	51.9%
Orange	42,702	23	12,496	4,926	39.4%
Queens	181,688	62	55,299	21,665	39.2%
Richmond	28,600	16	8,161	3,134	38.4%
Suffolk	145,167	74	41,795	20,275	48.5%
Westchester	94,402	58	27,368	14,244	52.1%
Statewide	1,907,439	1,066	576,884	259,551	45.0%

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Outpatient Services

County	Prevalence	Certified Programs	Treatment Demand	Persons Treated	Demand Met
Albany	34,800	17	6,153	4,110	66.8%
Bronx	135,299	36	21,473	14,735	68.6%
Erie	99,238	34	17,685	11,677	66.9%
Kings	220,868	51	36,972	15,347	41.5%
Monroe	83,861	16	14,623	9,896	67.7%
Nassau	127,206	45	22,731	12,286	54.1%
New York	165,314	75	25,784	21,894	84.9%
Oneida	25,836	4	4,588	2,162	47.1%
Onondaga	48,874	14	8,844	5,129	58.0%
Orange	42,702	11	7,614	3,003	39.4%
Queens	181,688	32	31,876	9,738	30.6%
Richmond	28,600	6	5,170	1,489	28.8%
Suffolk	145,167	45	25,964	13,979	53.8%
Westchester	94,402	35	16,770	7,577	45.2%
Statewide	1,907,439	550	337,920	169,373	50.1%

Source: NYS OASAS Prevalence and Treatment Need Methodologies, 2008.

The major chemical dependence treatment service categories include crisis, outpatient, methadone, inpatient, and residential. Most services are planned for and delivered at the county level. Inpatient and certain residential services are considered regional resources and serve residents on a multi-county basis. For the purposes of the table above, only those services located in the identified counties are shown. The following is a brief description of the five major service categories.

Crisis Services: Chemical dependence crisis services manage the treatment of alcohol and/or substance withdrawal, as well as acute disorders associated with alcohol and/or substance use, resulting in a referral to continued care. These services are often provided early in a person's course of recovery and are relatively short in duration, typically in the three to five day range,

though outpatient medically supervised withdrawal from opiates using methadone may be up to 30 days. Crisis services include: medically managed detoxification; medically supervised withdrawal in either an inpatient/residential or outpatient setting; and medically monitored withdrawal.

Outpatient Services: Chemical dependence outpatient services assist individuals who suffer from chemical abuse or dependence and their family members and/or significant others. Outpatient services may be delivered at different levels of intensity responsive to the severity of the problems presented by the client. These services may be provided in a free-standing setting, or may be co-located in a variety of other health and human service settings. Sponsorship may be voluntary, proprietary, or county operated. Chemical dependence outpatient service categories include medically supervised outpatient and outpatient rehabilitation. The length of stay and the intensity of services as measured by frequency and duration of visits vary from one category of outpatient services to another and intensity will vary during the course of treatment within a specific category. In general, persons are engaged in outpatient treatment for up to a year and visits are more frequent earlier in the treatment process becoming less frequent as treatment progresses.

Methadone Services: Methadone Treatment is a medical service designed to manage heroin addiction. Methadone treatment programs (MTPs) administer methadone by prescription, in conjunction with a variety of other rehabilitative assistance, to control the physical problems associated with heroin dependence and to provide the opportunity for patients to make major life-style changes over time. Methadone treatment is delivered primarily on an ambulatory basis, with most programs located in either a community or hospital setting. Some specialized programs deliver services in a residential setting, while a few programs deliver services in correctional facilities.

Inpatient Services: Chemical dependence inpatient rehabilitation services provide intensive management of chemical dependence symptoms and medical management/monitoring of physical or mental complications from chemical dependence to clients who cannot be effectively served as outpatients and who are not in need of medical detoxification or acute care. While these services can be provided in a hospital, OASAS does not fund hospital inpatient rehabilitation services. In New York, these services are also provided by free-standing facilities and sponsorship may be voluntary not-for-profit, proprietary, or State-operated. Lengths of stay are primarily in the 20 to 40 day range.

Residential Services: Chemical dependence residential services assist individuals who suffer from chemical dependence, who are unable to maintain abstinence or participate in treatment without the structure of a 24-hour/day, 7 day/week residential setting, and who are not in need of acute hospital or psychiatric care or chemical dependence inpatient services. There are three levels of intensity of procedures offered by this service: intensive residential treatment and rehabilitation, community residential services, and supportive living services. Length of stay ranges from an average of four months in a community residential service to up to two years in the other residential service categories. In addition, there are a small number of residential rehabilitation services for youth (RRSY) programs designed for individuals up to age 21 years. All residential chemical dependence services provide the following procedures: counseling; peer

group counseling; supportive services; educational services; structured activity; recreation; and orientation to community services. Residential services seek to provide the necessary coping skills and self-sufficiency for an individual to initiate and maintain an abstinent life-style. Habilitative and rehabilitative procedures can be provided directly or through referral and are based on an individualized assessment and treatment plan.

Detailed information about the substance abuse treatment and counseling services provided in the communities determined to be at risk is available and will be an essential component in developing New York State's Updated Plan for home visiting.

VII. Summary and Next Steps

New York State was well positioned to collect and analyze the data required to complete the statewide and community data reports required by the SIR. With only three minor exceptions, data in the standard metric designated in the SIR were available; and where the data were not available in the form designated in the SIR, a comparable substitute metric was available and used. New York State also included 8 additional indicators of risk all of which had strong and reliable data sources.

As directed by the SIR, New York State completed the required statewide data report as well as data reports for all 62 counties in New York State using the designated indicators and the additional 8 indicators. This resulted in reports that calculated rates for a total of 23 indicators. Given the complexity of analyzing such a large number of rates and reviewing individual county rates in comparison to the statewide rates for 23 indicators, it was determined that using a Z-score methodology would yield the most useful tool for determining which communities are at risk in New York State.

As discussed in the needs assessment, New York State has a large and very diverse population coupled with a large and varied geography. New Yorkers are not evenly distributed across the State; there are very large metropolitan areas and sparsely populated rural counties. Because of this dynamic and the need to direct limited resources to communities in the State where the need is greatest based on the volume of population, New York State determined that it was essential to factor in the number of cases (burden) for each of the 23 indicators used to determine at risk communities. A Z-score methodology was used to identify at risk communities from the perspective of burden.

The results of the analysis of the rate and burden Z-scores for each county confirmed New York State's knowledge of the State's at risk communities. The counties that were identified as being at risk, for the purpose of this initial needs assessment, are the counties with the largest number of residents, the most diverse populations, or are urban areas or contain large urban centers. New York State will analyze the data that are available at the zip code level to more precisely identify the communities within the State that are at highest risk. A refined list of at risk communities (at a sub-county level) will be identified in the Updated State Plan for home visiting services.

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While there is an obvious need for more home visiting services to serve more families in need in the at risk communities, the need to build effective state and local coordination of home visiting services cannot be ignored. The existing home visiting program models currently in operation in New York State can effectively address certain specific needs of families, but no one model can adequately address all the issues that impact families' health, well-being and stability. As noted by home visiting stakeholders who contributed to this needs assessment, and as reiterated in the CAPTA and Head Start Collaboration Project needs assessments, families lack access to a wide scope of essential supports (e.g. housing, food, transportation, health care, mental health services, employment assistance, child care, etc.). When asked to identify the strengths of home visiting programs in their communities, stakeholders stated that collaboration among service providers in a community was essential in order to address families' multiple needs. As noted by one stakeholder "We all work together to meet the needs of families." This is the most concise summation of the strategy and challenge that New York State must address in constructing an effective home visiting system.

The next steps New York State will undertake to develop home visiting services and develop an Updated State Plan for home visiting services include:

- Conducting a refined needs assessment using zip code-level data, where available, for the same set of indicators used for the initial needs assessment.
- Analyzing the results of the refined needs assessment to identify specific communities/neighborhoods where the risks are greatest.
- Reviewing the results of this analysis with members of the New York State Home Visiting Work Group.
- Collaborating with the members of the Work Group to map the location of each State agency's relevant services in those high risk communities.
- Reviewing with Work Group members the guidance regarding the identification of the criteria for establishing evidence of effectiveness of home visiting models.
- Consulting with the Work Group members regarding the options available to New York State based on the results of all the steps listed above.
- Preparing an updated state plan for home visiting in consultation with the Work Group members.

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ATTACHMENT

Letters of Concurrence



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

September 17, 2010

Audrey M. Yowell, Ph.D., M.S.S.S.
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
16B-26
Rockville, Maryland 20857

Dear Dr. Yowell:

As Commissioner of the New York State Department of Health (Department) which administers the Title V program, I am writing to express my concurrence with New York State's initial statewide needs assessment submitted in response to the Supplemental Information Request for the *Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program*.

The initial needs assessment reflects the Department's commitment to supporting the effective implementation of home visiting programs to meet the diverse needs of children and families residing in at risk communities in New York State. The Department is committed to continuing its close working relationship with the other New York State partner agencies in completing the next phase of the needs assessment and developing an Updated State Plan for home visiting services.

Thank you for the opportunity to express my support for New York State's initial statewide needs assessment.

Sincerely,

Richard F. Daines, M.D.
Commissioner of Health



**New York State
Office of
Children & Family
Services**

www.ocfs.state.ny.us

David A. Paterson
Governor

Gladys Carrión, Esq.
Commissioner

Capital View Office Park
52 Washington Street
Rensselaer, NY 12144

September 17, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane, 16B-26
Rockville, Maryland 20857

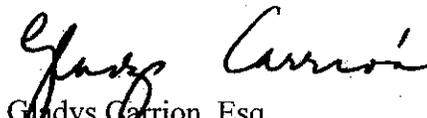
Dear Dr. Yowell:

As Commissioner of the New York State Office of Children and Family Services (OCFS), which administers Title II of CAPTA, I am writing to express my concurrence with New York State's initial statewide needs assessment submitted by the New York State Department of Health in response to the Supplemental Information Request for the *Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program*.

The initial needs assessment reflects OCFS's commitment to supporting the effective implementation of home visiting programs to meet the diverse needs of children and families residing in at risk communities in New York State. OCFS is committed to continuing its close working relationship with the Department of Health and the other New York State partner agencies in completing the next phase of the needs assessment and in developing an Updated State Plan for home visiting services.

Thank you for the opportunity to express my support of New York State's initial statewide needs assessment.

Sincerely,


Gladys Carrión, Esq.
Commissioner





Council on Children and Families

52 Washington Street * West Building, Suite 99 * Rensselaer, NY 12144 * Phone: (518) 473-3652 * Website: <http://www.ccf.state.ny.us>

September 17, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
16B-26
Rockville, Maryland 20857

Dear Dr. Yowell:

As Deputy Director of the New York State Council on Children and Families (CCF) and Director of New York State's Head Start Collaboration Project, I am writing to express my concurrence with New York State's initial statewide needs assessment submitted by the New York State Department of Health in response to the Supplemental Information Request for the *Affordable Care ACT Maternal, Infant and Early Childhood Home Visiting Program*.

The initial needs assessment reflects CCF's commitment to supporting the effective implementation of home visiting programs to meet the diverse needs of children and families residing in at risk communities in New York State. CCF is committed to continuing its close working relationship with the Department of Health and the other New York State partner agencies in completing the next phase of the needs assessment and in developing an updated state plan for home visiting services.

Thank you for the opportunity to express my support of New York State's initial statewide needs assessment.

Sincerely,

Robert Frawley
Deputy Director



David A. Paterson
Governor

Council Member Agencies

State Office for the Aging * Office of Alcoholism and Substance Abuse Services
Office of Children and Family Services * Division of Criminal Justice Services * State Education Department
Department of Health * Department of Labor * Office of Mental Health
Office for People with Developmental Disabilities * Office of Probation and Correctional Alternatives
Commission on Quality of Care and Advocacy for Persons with Disabilities * Office of Temporary and Disability Assistance



Deborah A. Benson
Executive Director



OASAS

Improving Lives.

NEW YORK STATE

OFFICE OF ALCOHOLISM & SUBSTANCE ABUSE SERVICES

Addiction Services for Prevention, Treatment, Recovery

GOVERNOR
David A. Paterson

COMMISSIONER
Karen M. Carpenter-Palumbo

September 17, 2010

Audrey M. Yowell, PhD, MSSS
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane
16B-269
Rockville, Maryland 20857

Dear Dr. Yowell:

As Commissioner of the New York State Office of Alcohol and Substance Abuse Services (OASAS), I am writing to express my concurrence with New York State's initial needs assessment submitted by the New York State Department of Health in response to the Supplemental Information Request for the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program.

The initial needs assessment reflects OASAS' commitment to supporting the effective implementation of home visiting programs to meet the diverse needs of children and families residing in at-risk communities in New York State. OASAS is committed to continuing its close working relationship with the Department of Health and the other New York State partner agencies in completing the next phase of the needs assessment and developing an updated State Plan for home visiting services.

Thank you for the opportunity to express my support of New York State's initial statewide needs assessment.

Sincerely,

Karen M. Carpenter-Palumbo
Commissioner

cc: M. A. DiChristopher
W. Phillips



September 17, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
16B-26
Rockville, Maryland 20857

Dear Dr. Yowell:

As Commissioner of the New York State Office of Mental Health (OMH), I am writing to express my support of New York State's initial statewide needs assessment submitted in response to the Supplemental Information Request for the *Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program*.

The initial needs assessment reflects New York State's commitment to supporting the effective implementation of home visiting programs to meet the diverse needs of children and families residing in at risk communities in New York State. OMH is committed to continuing its close working relationship with the other New York State partner agencies in completing the next phase of the needs assessment and developing an Updated State Plan for home visiting services.

Thank you for the opportunity to express my support for New York State's initial statewide needs assessment.

Sincerely,

Michael F. Hogan, Ph.D.
Commissioner



New York State Department of Health
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ATTACHMENT

Stakeholder Input Survey

Home Visiting Needs Assessment Stakeholder Survey

[Exit this survey](#)**1. Survey Background**

The "Patient Protection and Affordable Care Act"(ACA), signed into law on March 23, 2010, created the "Maternal, Infant & Early Childhood Home Visitation Program." This legislation provides a funding opportunity for states to improve health and developmental outcomes for at-risk children and families through a coordinated system of evidence-based only home visiting programs. States are required to conduct a statewide needs assessment that identifies communities with concentrations of premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn or child health; poverty; crime; domestic violence; high rates of high-school dropouts; substance abuse; unemployment; and child maltreatment.

New York State's funding level for FY2010, as stated in the funding announcement, is \$3,897,893. A portion of this funding (\$673,000) must support the existing Administration for Children and Families' evidence-based home visiting program located in Rochester. It is our understanding that in future years additional federal funding will be made available to help states implement their plans for home visiting programs. When the program is fully implemented it is expected to cover only 5%-10% of the State's need; a modest down payment on home visiting programs in NYS.

We are requesting input from stakeholders, such as yourself, to begin the statewide needs assessment process and would appreciate if you could answer the following questions. Please feel free to add comments that you think will help us in this undertaking. Thank you.

***1. To help us understand the diversity of strengths and needs among communities in New York State, indicate the county, or counties, that you are referring to when answering the subsequent questions.**

2. Indicate if you (choose one):

- work in a home visiting program
- work in county/local government (indicate type below e.g. social services, health, etc.)
- work in a community-based organization (indicate type below e.g. substance abuse, child abuse, etc.)
- receive home visiting services
- other (indicate below)

Type of county/local government agency or community-based organization or other

3. What are the biggest strengths of the home visiting programs for families in your community?

4. What at-risk populations are difficult to reach in your community? How could home visiting programs assist in reaching these populations?

5. Are the needs of at-risk pregnant women, children and families met in your community? If no, what are the gaps in services and barriers to services for families in your community?

6. How would you like to see New York State use the funding available under the Maternal, Infant & Early Childhood Home Visitation Program?

7. Other comments?

Done

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ATTACHMENT

Home Visiting Program Model Survey

**Home Visiting Needs Assessment
Program Profile**

Program Name:
National Affiliation:
State Lead:
State Agency Affiliation, if any:
Contact:

Funding Source(s) & Amount
Funding History during the past 5 years:
Number of programs in NYS:

contracts:
sites:

Program Model:

In existence at least three years:
Association with national org:
Research Base:
Demonstrated Outcomes:
Program Standards:
Program Curricula:
Staff qualifications: (see #1 below)

Direct Staff:
Supervisory Staff:
Other:

Supervision requirements:

Time in supervision:
Content of supervision:

Training requirements:
Monitoring/QI:

Services Provided:

Client eligibility criteria:

***Does program prioritize services to any of the following families
(check all that apply):***

- | | |
|---|---|
| <input type="checkbox"/> residing in targeted high need geographic areas | <input type="checkbox"/> single parents |
| <input type="checkbox"/> Low income | <input type="checkbox"/> late/no prenatal care |
| <input type="checkbox"/> Pregnant women under age 21 years | <input type="checkbox"/> poor compliance with prenatal care |
| <input type="checkbox"/> History of child abuse/child welfare services | <input type="checkbox"/> hx of mental health issues |
| <input type="checkbox"/> History or current substance abuse | <input type="checkbox"/> current depression |
| <input type="checkbox"/> Use of tobacco products | <input type="checkbox"/> hx of domestic violence |
| <input type="checkbox"/> Children with low student achievement | <input type="checkbox"/> parents with developmental delays |
| <input type="checkbox"/> Children with developmental delays or disabilities | <input type="checkbox"/> unemployment |
| <input type="checkbox"/> Families previously or currently serving in Armed Forces | |

Brief description of services provided:

Links to other community services/resources (List):

Known gaps/ unmet needs:

#1 Staff Qualifications: 1= none; 2= HS diploma/GED; 3= associate degree; 4= bachelor degree; 5= advanced degree

#1 Race Breakdown (% for each category): 1= White; 2= Black; 3= Native American; 4= Asian/Pacific Islander; 5= Other; 6= Unknown

#1 Ethnic Breakdown (% for each category): 1= Hispanic; 2= Non-Hispanic; 3= Unknown

#2 Age Breakdown (% for each category): 1= under 15; 2= 15-19 yo; 3= 20-24 yo; 4= 25-29; 5= 30-39; 6= 40 and over

#3 Income Breakdown (% for each category): 1= under \$10,000; 2= \$10,000 -19,999; 3= \$20,000 -29,999; 4= \$30,000 -39,999; 5= \$40,000 and over

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ATTACHMENT

**Data Reports for the Initially-Identified
At Risk Communities**

**NEW YORK STATE
 HOME VISITING NEEDS ASSESSMENT
 DATA REPORT FOR AT RISK COMMUNITY**

County: ALBANY

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	10.5	330
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	8.6	269
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	9.7	30
<u>Poverty</u> -# residents below 100% FPL/total # residents	10.62	29,745
<u>Crime</u> - # reported index crimes/1000 residents	3485.9	10,402
- # crime arrests ages 0-16/100,000 juveniles age 0-16	53.21	287
<u>Domestic violence</u> - domestic violence victims per 10,000	84.68	2,527
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	2.4	399
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month	24.2	Not Applicable
-Prevalence rate: Marijuana use in past month	10.3	
-Prevalence rate: Nonmedical use of prescription drugs in past month	4.7	
- Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	4.1	

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<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	248	7,394
- Drug Related Hospital Discharges	21.3	636
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	4.8	7,700
<u>Child maltreatment</u>		
-Unique children in indicated CPS reports in 2009 (rate per 10,000 children 0 -17 in population)	191.1	1,139
-Unique children in indicated CPS reports in 2009, by type of maltreatment		
- Physical Abuse	---	125
- Neglect	---	1,103
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children age 0-17 in population)	716	4,268
- Unique children admitted to foster care in 2009 (rate per 10,000 children age 0-17 in population)	28	168
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>		
- Late or no prenatal care	4.3	137
- teen births	6.6	208
- Chlamydia	423.6	1,264
- Lead exposure/lead poisoning	15.4	66

**NEW YORK STATE
 HOME VISITING NEEDS ASSESSMENT
 DATA REPORT FOR AT RISK COMMUNITY**

County: BRONX

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	13.7	3,149
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	10.0	2,309
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	6.1	141
<u>Poverty</u> -# residents below 100% FPL/total # residents	30.7	395,263
<u>Crime</u> - # reported index crimes/1000 residents - # crime arrests ages 0-16/100,000 juveniles age 0-16	2242.1 ---	31,329 ---
<u>Domestic violence</u> - domestic violence victims per 10,000	46.16	6,450
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	4	3,228
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	20.9 5.9 3.2 3.5	Not Applicable

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<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	279	39,051
- Drug Related Hospital Discharges	96.4	13,470
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	7.3	38,200
<u>Child maltreatment</u>		
- Unique children in indicated CPS reports in 2009 (rate per 10,000 children 0 -17 in population)	264	10,556
- Unique children in indicated CPS reports in 2009, by type of maltreatment		
- Physical Abuse	---	---
- Neglect	---	---
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children age 0-17 in population)	558	22,283
- Unique children admitted to foster care in 2009 (rate per 10,000 children age 0-17 in population)	59.1	2,362
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>		
- Late or no prenatal care	9.1	2,100
- teen births	11.1	2,555
- Chlamydia	1139.3	15,919
- Lead exposure/lead poisoning	4.4	301

**NEW YORK STATE
 HOME VISITING NEEDS ASSESSMENT
 DATA REPORT FOR AT RISK COMMUNITY**

County: ERIE

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	11.1	1,072
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	8.2	797
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	7.4	72
<u>Poverty</u> -# residents below 100% FPL/total # residents	12.2	112,358
<u>Crime</u> - # reported index crimes/1000 residents	3606.0	32,653
- # crime arrests ages 0-16/100,000 juveniles age 0-16	34.1	626
<u>Domestic violence</u> - domestic violence victims per 10,000	65.5	5,926
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	3.9	2,081
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month	28.5	Not Applicable
-Prevalence rate: Marijuana use in past month	8.4	
-Prevalence rate: Nonmedical use of prescription drugs in past month	4.9	
- Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	4.2	

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<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	189	17,157
- Drug Related Hospital Discharges	33.2	3,006
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	5.6	26,700
<u>Child maltreatment</u>		
- Unique children in indicated CPS reports in 2009 (rate per 10,000 children 0 -17 in population)	164	3,281
- Unique children in indicated CPS reports in 2009, by type of maltreatment		
- Physical Abuse	---	376
- Neglect	---	3,169
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children age 0-17 in population)	596	11,921
- Unique children admitted to foster care in 2009 (rate per 10,000 children age 0-17 in population)	22	433
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>		
- Late or no prenatal care	4.2	407
- teen births	8.9	870
- Chlamydia	521.7	4,723
- Lead exposure/lead poisoning	20.1	351

**NEW YORK STATE
 HOME VISITING NEEDS ASSESSMENT
 DATA REPORT FOR AT RISK COMMUNITY**

County: **KINGS**

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	12.6	5,241
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	8.6	3,590
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	5.4	223
<u>Poverty</u> -# residents below 100% FPL/total # residents	25.1	610,476
<u>Crime</u> - # reported index crimes/1000 residents - # crime arrests ages 0-16/100,000 juveniles age 0-16	2242.1 ---	57,557 ---
<u>Domestic violence</u> - domestic violence victims per 10,000	33.8	8,676
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	4.5	5,294
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	20.8 5.9 3.6 3.9	Not Applicable

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<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	154	39,654
- Drug Related Hospital Discharges	38.6	9,909
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	5.8	64,300
<u>Child maltreatment</u>		
- Unique children in indicated CPS reports in 2009 (rate per 10000 children 0 -17 in population)	150	9,776
- Unique children in indicated CPS reports in 2009, by type of maltreatment		
- Physical Abuse	---	---
- Neglect	---	---
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children age 0-17 in population)	346	22,605
- Unique children admitted to foster care in 2009 (rate per 10,000 children age 0-17 in population)	30.1	1,968
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>		
- Late or no prenatal care	8.8	3,693
- teen births	6.6	2,758
- Chlamydia	660.7	16,960
- Lead exposure/lead poisoning	6.5	687

**NEW YORK STATE
 HOME VISITING NEEDS ASSESSMENT
 DATA REPORT FOR AT RISK COMMUNITY**

County: MONROE

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	9.2	803
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	8.1	702
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	7.6	66
<u>Poverty</u> -# residents below 100% FPL/total # residents	11.1	79,311
<u>Crime</u> - # reported index crimes/1000 residents	3513.0	25,710
- # crime arrests ages 0-16/100,000 juveniles age 0-16	23.3	354
<u>Domestic violence</u> - domestic violence victims per 10,000	79.1	5,786
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	3.5	1,732
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month	23.4	Not Applicable
-Prevalence rate: Marijuana use in past month	6.5	
-Prevalence rate: Nonmedical use of prescription drugs in past month	4.4	
- Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	3.7	

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<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	152	11,173
- Drug Related Hospital Discharges	19.2	1,405
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	5.4	20,400
<u>Child maltreatment</u>		
- Unique children in indicated CPS reports in 2009 (rate per 10000 children 0 -17 in population)	120	1,972
- Unique children in indicated CPS reports in 2009, by type of maltreatment		
- Physical Abuse	---	321
- Neglect	---	1,959
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children age 0-17 in population)	497	8,157
- Unique children admitted to foster care in 2009 (rate per 10,000 children age 0-17 in population)	25	404
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>		
- Late or no prenatal care	2.9	260
- teen births	10.3	893
- Chlamydia	637.7	4,667
- Lead exposure/lead poisoning	16.7	233

**NEW YORK STATE
 HOME VISITING NEEDS ASSESSMENT
 DATA REPORT FOR AT RISK COMMUNITY**

County: NASSAU

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	11.2	1,688
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	7.9	1,183
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	5.3	79
<u>Poverty</u> -# residents below 100% FPL/total # residents	5.2	68,631
<u>Crime</u> - # reported index crimes/1000 residents	1597.0	21,607
- # crime arrests ages 0-16/100,000 juveniles age 0-16	13.2	370
<u>Domestic violence</u> - domestic violence victims per 10,000	14.6	1,976
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	0.9	727
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month	24.3	Not Applicable
-Prevalence rate: Marijuana use in past month	6.7	
-Prevalence rate: Nonmedical use of prescription drugs in past month	4.5	
- Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	3.4	

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<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	107	14,531
- Drug Related Hospital Discharges	16.7	2,259
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	4.7	32,800
<u>Child maltreatment</u>		
- Unique children in indicated CPS reports in 2009 (rate per 10000 children 0 -17 in population)	92	2,814
- Unique children in indicated CPS reports in 2009, by type of maltreatment		
- Physical Abuse	---	293
- Neglect	---	2,748
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children age 0-17 in population)	287	8,746
- Unique children admitted to foster care in 2009 (rate per 10,000 children age 0-17 in population)	14	431
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>		
- Late or no prenatal care	3.2	489
- teen births	3.9	584
- Chlamydia	193.5	2,618
- Lead exposure/lead poisoning	2.7	81

**NEW YORK STATE
 HOME VISITING NEEDS ASSESSMENT
 DATA REPORT FOR AT RISK COMMUNITY**

County: NEW YORK

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	12.4	2,519
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	8.7	1,770
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	4.7	95
<u>Poverty</u> -# residents below 100% FPL/total # residents	20.0	298,231
<u>Crime</u> - # reported index crimes/1000 residents - # crime arrests ages 0-16/100,000 juveniles age 0-16	2242.1 ---	36,525 ---
<u>Domestic violence</u> - domestic violence victims per 10,000	21.9	3,583
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	4	3,053
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	27.5 9.6 4.1 4.5	Not Applicable

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<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	255	41,500
- Drug Related Hospital Discharges	63.8	10,393
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	4.7	44,200
<u>Child maltreatment</u>		
- Unique children in indicated CPS reports in 2009 (rate per 10,000 children 0 -17 in population)	135	3,899
- Unique children in indicated CPS reports in 2009, by type of maltreatment		
- Physical Abuse	---	---
- Neglect	---	---
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children age 0-17 in population)	301	8,700
- Unique children admitted to foster care in 2009 (rate per 10,000 children age 0-17 in population)	35.3	1,021
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>		
- Late or no prenatal care	6.9	1,420
- teen births	5.1	1,032
- Chlamydia	667.7	10,878
- Lead exposure/lead poisoning	3.5	158

**NEW YORK STATE
 HOME VISITING NEEDS ASSESSMENT
 DATA REPORT FOR AT RISK COMMUNITY**

County: ONEIDA

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	12.6	331
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	7.8	205
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	7.3	19
<u>Poverty</u> -# residents below 100% FPL/total # residents	13.0	28,764
<u>Crime</u> - # reported index crimes/1000 residents	2826.8	6,534
- # crime arrests ages 0-16/100,000 juveniles age 0-16	52.5	222
<u>Domestic violence</u> - domestic violence victims per 10,000	65.1	1,504
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	2.4	343
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month	24.1	Not Applicable
-Prevalence rate: Marijuana use in past month	8.0	
-Prevalence rate: Nonmedical use of prescription drugs in past month	4.6	
- Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	3.9	

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<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	147	3,402
- Drug Related Hospital Discharges	16.2	374
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	5.3	5,900
<u>Child maltreatment</u>		
-- Unique children in indicated CPS reports in 2009 (rate per 10,000 children 0 -17 in population)	301	1,465
- Unique children in indicated CPS reports in 2009, by type of maltreatment		
- Physical Abuse	---	174
- Neglect	---	1,390
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children age 0-17 in population)	854	4,160
- Unique children admitted to foster care in 2009 (rate per 10,000 children age 0-17 in population)	53	256
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>		
- Late or no prenatal care	4.6	121
- teen births	10.3	269
- Chlamydia	325.3	752
- Lead exposure/lead poisoning	34.1	114

**NEW YORK STATE
 HOME VISITING NEEDS ASSESSMENT
 DATA REPORT FOR AT RISK COMMUNITY**

County: ONONDAGA

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	10.7	595
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	7.4	412
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	7.7	43
<u>Poverty</u> -# residents below 100% FPL/total # residents	12.2	54,208
<u>Crime</u> - # reported index crimes/1000 residents	2961.4	13,383
- # crime arrests ages 0-16/100,000 juveniles age 0-16	52.6	507
<u>Domestic violence</u> - domestic violence victims per 10,000	70.5	3,185
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	3.5	1,058
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month	24.1	Not Applicable
-Prevalence rate: Marijuana use in past month	8.0	
-Prevalence rate: Nonmedical use of prescription drugs in past month	4.6	
- Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	3.9	

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<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	184	8,378
- Drug Related Hospital Discharges	14.8	669
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	5.1	12,100
<u>Child maltreatment</u>		
-- Unique children in indicated CPS reports in 2009 (rate per 10,000 children 0 -17 in population)	174	1,815
- Unique children in indicated CPS reports in 2009, by type of maltreatment		
- Physical Abuse	---	207
- Neglect	---	1,775
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children age 0-17 in population)	670	6,978
- Unique children admitted to foster care in 2009 (rate per 10,000 children age 0-17 in population)	22	224
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>		
- Late or no prenatal care	3.3	186
- teen births	9.9	553
- Chlamydia	524.4	2,370
- Lead exposure/lead poisoning	12.6	137

**NEW YORK STATE
 HOME VISITING NEEDS ASSESSMENT
 DATA REPORT FOR AT RISK COMMUNITY**

County: ORANGE

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	9.7	524
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	7.5	404
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	4.4	24
<u>Poverty</u> -# residents below 100% FPL/total # residents	10.5	34,672
<u>Crime</u> - # reported index crimes/1000 residents	2267.7	8,704
- # crime arrests ages 0-16/100,000 juveniles age 0-16	23.5	206
<u>Domestic violence</u> - domestic violence victims per 10,000	36.2	1,389
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	2.6	721
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month	25.3	Not Applicable
-Prevalence rate: Marijuana use in past month	7.7	
-Prevalence rate: Nonmedical use of prescription drugs in past month	4.6	
- Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	3.6	

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<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	153	5,867
- Drug Related Hospital Discharges	29.5	1,132
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	5.3	9,600
<u>Child maltreatment</u>		
-- Unique children in indicated CPS reports in 2009 (rate per 10,000 children 0 -17 in population)	91	904
- Unique children in indicated CPS reports in 2009, by type of maltreatment		
- Physical Abuse	---	79
- Neglect	---	889
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children age 0-17 in population)	394	3,928
- Unique children admitted to foster care in 2009 (rate per 10,000 children age 0-17 in population)	18	180
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>		
- Late or no prenatal care	4.9	270
- teen births	6.6	356
- Chlamydia	216.8	832
- Lead exposure/lead poisoning	12.7	104

**NEW YORK STATE
 HOME VISITING NEEDS ASSESSMENT
 DATA REPORT FOR AT RISK COMMUNITY**

County: QUEENS

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	12.2	3,796
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	8.3	2,569
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	4.5	141
<u>Poverty</u> -# residents below 100% FPL/total # residents	14.6	321,102
<u>Crime</u> - # reported index crimes/1000 residents - # crime arrests ages 0-16/100,000 juveniles age 0-16	2242.1 ---	51,719 ---
<u>Domestic violence</u> - domestic violence victims per 10,000	25.7	5,933
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	3.8	3,845
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	20.1 4.8 3.4 3.2	Not Applicable

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<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	88	20,388
- Drug Related Hospital Discharges	21.1	4,867
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	4.9	54,300
<u>Child maltreatment</u>		
-- Unique children in indicated CPS reports in 2009 (rate per 10,000 children 0 -17 in population)	118	6,000
- Unique children in indicated CPS reports in 2009, by type of maltreatment		
- Physical Abuse	---	---
- Neglect	---	---
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children age 0-17 in population)	290	14,819
- Unique children admitted to foster care in 2009 (rate per 10,000 children age 0-17 in population)	25.4	1,294
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>		
- Late or no prenatal care	9.9	3,074
- teen births	5.4	1,692
- Chlamydia	506.1	11,675
- Lead exposure/lead poisoning	4.9	420

**NEW YORK STATE
 HOME VISITING NEEDS ASSESSMENT
 DATA REPORT FOR AT RISK COMMUNITY**

County: RICHMOND

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	11.7	675
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	8.4	481
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	3.5	20
<u>Poverty</u> -# residents below 100% FPL/total # residents	10.0	43,866
<u>Crime</u> - # reported index crimes/1000 residents - # crime arrests ages 0-16/100,000 juveniles age 0-16	2242.1 ---	11,025 ---
<u>Domestic violence</u> - domestic violence victims per 10,000	22.8	1,119
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	3.3	729
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	20.8 5.9 3.6 3.9	Not Applicable

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<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	199	9,763
- Drug Related Hospital Discharges	33.9	1,667
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	4.9	12,000
<u>Child maltreatment</u>		
- Unique children in indicated CPS reports in 2009 (rate per 10,000 children 0 -17 in population)	148	1,704
- Unique children in indicated CPS reports in 2009, by type of maltreatment		
- Physical Abuse	---	---
- Neglect	---	---
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children age 0-17 in population)	367	4,238
- Unique children admitted to foster care in 2009 (rate per 10,000 children age 0-17 in population)	26.9	311
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>		
- Late or no prenatal care	5.9	337
- teen births	5.6	325
- Chlamydia	201.9	993
- Lead exposure/lead poisoning	4.2	66

**NEW YORK STATE
 HOME VISITING NEEDS ASSESSMENT
 DATA REPORT FOR AT RISK COMMUNITY**

County: SUFFOLK

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	11.0	1,976
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	7.2	1,290
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	3.9	71
<u>Poverty</u> -# residents below 100% FPL/total # residents	5.9	83,171
<u>Crime</u> - # reported index crimes/1000 residents - # crime arrests ages 0-16/100,000 juveniles age 0-16	2100.1 11.8	31,963 393
<u>Domestic violence</u> - domestic violence victims per 10,000	50.6	7,699
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	1.6	1,623
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	24.3 6.7 4.5 3.4	Not Applicable

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<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	143	21,741
- Drug Related Hospital Discharges	20.6	3,135
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	4.9	39,600
<u>Child maltreatment</u>		
-- Unique children in indicated CPS reports in 2009 (rate per 10,000 children 0 -17 in population)	127	4,627
- Unique children in indicated CPS reports in 2009, by type of maltreatment		
- Physical Abuse	---	414
- Neglect	---	4,451
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children age 0-17 in population)	376	13,729
- Unique children admitted to foster care in 2009 (rate per 10,000 children age 0-17 in population)	14	516
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>		
- Late or no prenatal care	4.7	842
- teen births	5.2	934
- Chlamydia	206.8	3,147
- Lead exposure/lead poisoning	1.6	43

**NEW YORK STATE
 HOME VISITING NEEDS ASSESSMENT
 DATA REPORT FOR AT RISK COMMUNITY**

County: WESTCHESTER

Indicator	Rate	Burden
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	13.1	1,513
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	8.9	1,020
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	5.4	62
<u>Poverty</u> -# residents below 100% FPL/total # residents	8.7	78,967
<u>Crime</u> - # reported index crimes/1000 residents	1718.0	16,439
- # crime arrests ages 0-16/100,000 juveniles age 0-16	15.4	322
<u>Domestic violence</u> - domestic violence victims per 10,000	26.0	2,490
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	1.5	875
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month	21.0	Not Applicable
-Prevalence rate: Marijuana use in past month	5.3	
-Prevalence rate: Nonmedical use of prescription drugs in past month	3.5	
- Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	3.4	

New York State Department of Health
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<u>Other Indicators of Substance Abuse</u>		
- Admissions to certified chemical dependence programs	112	10,707
- Drug Related Hospital Discharges	30.8	2,947
<u>Unemployment</u>		
-Percent: # unemployed and seeking work/total workforce	4.7	23500
<u>Child maltreatment</u>		
-- Unique children in indicated CPS reports in 2009 (rate per 10,000 children 0 -17 in population)	109	2,551
- Unique children in indicated CPS reports in 2009, by type of maltreatment		
- Physical Abuse	---	258
- Neglect	---	2,415
<u>Other indicators of child maltreatment</u>		
- Unique children in CPS reports in 2009 (rate per 10,000 children age 0-17 in population)	324	7,598
- Unique children admitted to foster care in 2009 (rate per 10,000 children age 0-17 in population)	15	360
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>		
- Late or no prenatal care	4.7	541
- teen births	5.0	580
- Chlamydia	268.2	2,566
- Lead exposure/lead poisoning	4.9	131

New York State Department of Health
HRSA Award #: 1 X02MC19384-01-00

ATTACHMENT

Preliminary Profiles of the Initially-Identified At Risk Communities

The quotes noted for each county (where available) were from home visiting stakeholders who participated in one of the four conference calls conducted during the needs assessment process.

Albany County

“It is difficult to reach new immigrants and to determine their language translation needs”

“Our gaps are transportation, housing, child care and employment.”

Demographics:

Albany County has a population of close to 300,000 residents living in urban, suburban and rural areas of the county. Approximately one in five Albany County residents are under the age of 18; 52% are female, 12% black, 3.7% are of Hispanic or Latino origin, 79.3% are white (non-Hispanic), 4% are Asian, and as of 2009, 12.3% were living below the Federal poverty level.

According to 2009 Census population data, 5.2% of the Albany County population was under five years of age, 6.5% were foreign born, and 9.9% spoke a language other than English in the home.

Home Visiting:

Albany County Department of Health’s Public Health Nursing Program provides home visits to pregnant women, new parents, infants and children to coordinate needed health and support services. In addition, the nurse provides health education related to prenatal care, growth and development of infants and children, nutrition, safety in the home and available community resources. “Maternal and Perinatal Care,” services include assessment and surveillance, birth certificate review, health and nutrition education, and providing approximately 1,400 nursing home visits annually.

The County Department’s skilled nursing program in the Certified Home Health Agency (CHHA) provides health assessments and nursing visits for clients who require nursing skills such as medication management, catheter care, wound care or other procedures that call for this level of care. Albany County provided approximately 580 skilled home care visits to the homebound population in need of such services. In addition, physical therapists provided approximately 200 visits to the homebound population to address rehabilitation needs.

The Home Care Assessment Unit (HCAU) and Personal Care Aide Program (PCP) is a collaborative partnership between the Department of Social Services (DSS) and the Albany County Department of Health where a nursing assessment of Albany County residents who may benefit from personal care aides is conducted to assist clients in their desire to remain independent in their own homes. If personal care aids are deemed appropriate, nurses provide an orientation and supervision for the personal care aides who are assisting clients

with their personal care and light housekeeping tasks. Over 2000 assessments and aide supervision visits were conducted through these programs in 2008.

Albany County is also served by the following three statewide home visiting programs: Healthy Families New York (HFNY), Community Health Worker Program (CHWP), and Head Start (HS). These following programs served approximately 453 families throughout the county, providing home visits to prenatal women and children. The majority of women in the programs are low income, Hispanic, and between the ages of 20-29.

- Healthy Families Albany County, HFNY, provided home visits to 243 families in urban areas of Albany County. The population was 50% Black, 22% White, and 22% Hispanic; 59% of mothers between the ages of 20-29 (20-24=33%; 25-29=26%), with an additional 19% between the ages of 30-39. The average household income for all families was under \$10,000.
- Albany County Department of Health has a Community Health Worker Program (CHWP) grant funded by the NYS Department of Health. The CHWP utilizes trained paraprofessionals to provide in-home health visits to pregnant and postpartum women and their families. In 2009, they provided approximately 1,000 home visits to 210 high risk, low income women and their families throughout the county. The population was 43% Black and 29% White; 22% of mothers were between the ages of 15-19, and 63% between the ages of 20-29 (20-24=38%; 25-29=25%). All families were Medicaid eligible.
- Albany Community Action Partnership, formerly Albany County Opportunity, Inc., operates ACAP Head Start in Albany County. During the 2008-2009 school year Albany Community Action Partnership Head Start Program served 469 children and families in the center and in the Home-Based program. No distinction was made between the two programs.

Maternal and Infant Statistics:

In 2005, there were 4,088 pregnancies to Albany Co. residents resulting in 3,226 births. Seventy-four percent of women giving birth started care in the first trimester, 14% in the second trimester, 3% in the third trimester, 8.6% were unknown. Twenty one percent were on Medicaid and 1.5% were self-pay. Of these births, 7.5% were to teens aged 15-19, 69% were to white residents, 20% to black residents, 6% to Hispanic residents and 11% to others.

The low birth weight for Albany County residents was 8.6% in 2008. The LBW rate is well above the desired HP 2010 goal of 5%. Out of all the Albany County births, 10.5% were premature and there were 9.7 infant deaths per 1,000 births.

Bronx County

“It is difficult to reach undocumented pregnant women, they have a fear of systems and often show up at ER ready to give birth without any prenatal care.”

“The major gap is a lack of affordable housing, substandard housing and overcrowding, sometimes there are 3-4 people in a room with a new baby.”

Demographics:

The Bronx is the northernmost of the five boroughs of New York City. Located north of Manhattan and Queens, and south of Westchester County, the Bronx is the only borough located primarily on the mainland. In 2010, the Census Bureau estimated that the borough's population on July 1, 2009 was 1,397,287, inhabiting a land area of 42 square miles. This makes the Bronx the fourth-most-populated of the five boroughs, the fourth-largest in land area, and the third-highest in density of population.

The ethnic composition of this borough in the 2000 Census (simplifying official classifications) was 48.4% Hispanic and Latino of all races (including 4.4% solely Black or African-American and 3.7% of two or more races), 31.2% Black or African-American, 14.5% Whites, 2.9% Asians, 2.0% Multiracial and 0.9% Other (including Pacific Islanders and Native Americans, Alaskans or Hawaiians). According to the 2010 data, the number of Hispanic and Latinos has increased to 52% of the population, and 86% of speak Spanish.

In the Bronx, the median household income in 2008 was \$35,108 and 62% percent are high school graduates, and 23.8% were living below the federal poverty level, compared to NYS which has 13.7%.

Home Visiting:

The Bronx has many local or borough-wide home visiting programs, including Visiting Nurse, The Newborn Home Visiting Program, and Kings County Home Care, among others.

According to the New York City's Newborn Home Visiting Program's website, a 2005 study documents that 17% of mothers discharged from hospitals after childbirth lacked basic information regarding health insurance, breastfeeding and pediatric care. New York City's Newborn Home Visiting Program ensures that newborns get a healthy start by providing parents with guidance, information and support directly in their homes. Families will receive one to two visits after the birth of a child. A trained health worker comes to the home and offers information on infant health and development, child safety and household risks, answers questions about nutrition and breastfeeding, and links families to primary care and community services. The program is now available to new parents in 11 communities in Brooklyn, the Bronx and Manhattan.

Bronx County is served by the following six statewide home visiting programs: Nurse Family Partnership, Healthy Families New York (HFNY), Community Health Worker Program

(CHWP), Parent Child Home Program (PCHP), Home Instruction for Parents of Preschool Youngsters (HIPPY), Early Head Start (EHS), and Head Start). These programs served approximately 1,617 families throughout the county, providing home visits to prenatal women and children. The majority of women in the programs are low income, predominately Hispanic, and between the ages of 20-29.

- Visiting Nurse Service of New York, NFP provided home visits to 654 families. The population was 62% Hispanic, and the average income of households was \$10,500.
- HFNY served 377 families in 3 programs in the Bronx: South Bronx Healthy Families, Healthy Families Morris Heights, and Healthy Families Parkchester. Programs were similar with race and age categories. In South Bronx Healthy Families, 65% of the population was Hispanic with 20% of the mothers between the ages of 15-19 and 53% between 20-29 (20-24=32%; 25-29=21%). In Healthy Families Morris Heights, 90% were Hispanic, with 22% of mothers between the ages of 15-19 and 57% between 20-29 (20-24=31%; 25-29=26%). In Healthy Families Parkchester, 73% were Hispanic, 15% of mothers between the ages of 15-19 and 57% between 20-29 (20-24=23%; 25-29=34%). Average household income for all programs was less than \$10,000.
- CHWP served 385 families in 2 programs: the Morris Heights Health Center (targeting Highbridge and Mt. Eden, Morris Heights, Concourse, Claremont Village), and Urban Health Plan (targeting Morrisania, Tremont, Soundview, Hunts Point). The programs were similar with race and age categories. In Morris Heights, 89% were Hispanic with 58% of mothers between the ages of 20-29 (15% were between 15-19). In Urban Health Plan, 77% were Hispanic with 59% of women between the ages of 20-29 (23% were between 15-19). All families were Medicaid eligible.
- PCHP provided home visits to 123 families in 2 programs in the Bronx: Graham Windham/Bronx, and The Parent-Child Home Program-Inwood House. In Graham Windham/Bronx, the population was 72% Hispanic; 30% of mothers were between the ages of 20-29 (20-24=10%; 25-29=20%) with an additional 46% between the ages of 30-39; 58% of families earned less than \$10,000, and 31% earned between \$10,000-\$19,000. In The Parent-Child Home Program-Inwood, the population was 80% Hispanic; 60% of mothers between the ages of 15-19, and 40% between the ages of 20-24; 80% of the household income was less than \$10,000.
- Bronxwork HIPPY provided home visits to 78 families. The population was 58% Hispanic; 58% of mothers were between the ages of 20-29 (20-24=22%; 25-29=35%) with an additional 20% between the ages of 30-39. Of household income, 35% of families earned less than \$10,000, and 26% earned between \$10,000-\$19,000.
- Four EHS operated in the county: Kingsbridge Heights Community Center, Bronx Lebanon (new), Episcopal Social Services of NY, and Graham Windham/Bronx. Two of the four reported their numbers of families (243), but the data does not indicate whether they were home-based or center-based clients. No other information was reported.

- Twenty HS operated throughout the county, but only one provider, Kingsbridge Heights Community Center, reported families served; however, it is not known from the data if these clients were home-visited. No other information was reported.

Maternal and Infant Statistics:

The Bronx had the third highest number of live births (21,298) but the highest birth rate in New York City (NYC), at 16.0 live births per 1,000.

Regarding low birth weight and infant mortality in the Bronx, the percentage of low birth weight babies born in the Bronx increased slightly to 9.5% in 2003 – from 9.2% in 2002. The Morrisania community of the Bronx has the highest percentage of low birth weight babies in the borough – 12.1%. The Bronx has the highest infant and neonatal mortality rates in NYC: 8.6 per 1,000 births and 5.7 per 1,000 live births respectively. The Williamsbridge community of the Bronx had the highest infant mortality rate – 11.5 and neonatal mortality rate at 9.4.

The Bronx had the highest percentage of live births to women on Medicaid in the City – 67.4%. The Mott Haven community had the highest percentage of live births to mothers on Medicaid – 79.3%. In 2003, 93.5% of women who had live births had early and adequate prenatal care in the Bronx, 6.5% had no prenatal care (2nd highest in NYC). The Mott Haven community had the highest percentage of infants born to women with late or no prenatal care – 9.7%.

In 2003, 12.2 percent of the total live births were to teenagers in the Bronx – the highest percentage of teen births in NYC – higher than the NYC percentage of 7.1. The Mott Haven community district of the Bronx had the highest percentage of teen births at 16.4 percent. The Riverdale community district had the lowest percentage of teen pregnancies at 5.9 percent.

In 2008, the Bronx County increased slightly to 10% low birth weight, and 13.7% of babies born were premature. The infant death rate was 6.1 for every 1,000 births.

Erie County

“The Native American population here is very difficult to reach.”

“We have very complex needs with mental health and domestic violence issues and it complicates family situations, so we have started using MSWs.”

Demographics:

Erie County is a county located in the most western part of the state of New York. As of the 2009 population estimate (based on 2000 US census), the population was 909,247. The county seat is Buffalo.

In the 2000 census, the ethnic makeup of the county was 82.18% White, 13.00% Black or African American, 3.27% was Hispanic or Latino, 0.61% Native American, 1.46% Asian, 0.02% Pacific Islander, 1.42% from other races, and 1.31% from two or more races.

According to the 2009 population estimate (based on US Census), Erie County has 5.4% of its population under 5 years of age, 4.5% were foreign born, and 9% spoke a language other than English in the home.

Erie County has several Medicaid prenatal care providers including Women and Children’s Hospital of Buffalo, Sisters of Charity Hospital, the Community Health Center of Buffalo and the Northwest Buffalo Community Health Center (both federally qualified health centers.)

The Medicaid Managed Health Care programs have also been very active in trying to improve birth outcomes for at risk women. Independent Health, Univera, Blue Cross and Blue Shield, and Fidelis meet monthly to discuss issues and work collaboratively to solve problems. The insurance companies also provide some case management services to their pregnant members, primarily via the telephone.

Home Visiting:

Erie County has several local home visiting programs and the following five statewide home visiting programs: Healthy Families New York (HFNY), Community Health Worker Program (CHWP), Parent Child Home Program (PCHP), Early Head Start (EHS), and Head Start (HS). These programs served approximately 734 families throughout the county, providing home visits to prenatal women and children. The majority of women in the programs are low income, black, and between the ages of 15-24.

The three agencies that seem most active in providing these home visiting services are Buffalo Prenatal-Perinatal Network (BPPN) which operates the Community Health Worker Program and Healthy Family New York Program, Visiting Nurse Association of Western New York (VNA), and McAuley-Seton Home Care (part of the Catholic Health System.)

- The Buffalo Home Visiting Program, a HFNY program, provided home visits to 461 families in the city of Buffalo in Erie County. The population was 65% Black, with 71%

of mothers between the ages of 15-24 (15-19=34%; 20-24=37%). The average family income is less than \$10,000.

- The Buffalo Prenatal-Perinatal Network, CHWP, home visited 161 families in Buffalo. The population was 57% Black and 66% Hispanic with 70% of mothers between the ages of 15-24 (15-19=38%; 20-24=32%). All families were Medicaid eligible.
- PCHP served 73 families in 2 programs in Buffalo: the King Center, and the Jericho Road Ministries. King Center reported the population as 92% Black and 84% Hispanic with 57% of mothers between the ages of 20-29 (20-24=36%; 25-29=21%) with an additional 29% over 40; 50% of the household income was less than \$10,000, and 33% earned between \$30,000-\$39,000. The Jericho Road Ministries reported only the number of families served.
- The Community Action Organization of Erie County, Inc, EHS, served 39 families, but no other information was reported.
- Head Start operates three programs in the county: Bethel Head Start, Inc, CAO Head Start, and Holy Cross Head Start. No other information was reported.

Maternal and Infant Statistics:

Many of the Erie County agencies are facing or have endured significant funding reductions and loss of staff that provide these same type of services. Erie County's perinatal outcomes continue to be very poor, with among the highest rates of low birth weight babies, late or no prenatal care and infant deaths.

A major indicator of poor birth outcomes is poverty and in 2009, Buffalo was ranked as the third poorest city in the nation by the US Census Bureau. The scope and intensity of needs in Erie County are increasing, and the resources available to provide services to address those needs are shrinking.

In 2008, Erie County's low birth weight was 8.2%, above the HP 2010 5% goal, and their rate of premature infants was 11.1%. In addition, 7.4 infants out of every 1,000 births was premature.

Kings County

“Brooklyn has a transient population, severe housing issues, as families move they cannot be followed – they move out of catchment areas or neighborhoods.”

“Lack of appropriate child care, no trusted individual to leave child with so people do not go back to work, miss appointments, etc.”

Demographics:

Kings County is better known as Brooklyn, one of the five boroughs of New York City, with an estimated population of 2,567,098 in 2009 (US Census Bureau Estimate of April 2010). This was a 4% increase in population from the 2000 census. The racial composition of Brooklyn is as follows: 37% are Black or African-American, 35.3% are White persons of non-Hispanic/Latino origin, 0.3% are Native American Indian and/or Alaska Native persons, 0.1% are Native Hawaiian and Other Pacific Islander, 9% are Asian, and 18% are of Latino or Hispanic origin.

Approximately 37.3% of the population were foreign born (and another 3.4% were born in Puerto Rico, U.S. Island areas, or born abroad to American parents), 46.0% spoke a language other than English at home, and 27.8% had a Bachelor's degree or higher.

Home Visiting:

Kings County has a considerable selection of local or borough-wide home visiting programs for a range of patients, including, Visiting Nurse, Brooklyn Home Care, Nursing Sisters Home Visiting, Americare Certified Special Services, Inc., and Excellent Home Care Services, among others.

Kings County is served by the following eight statewide home visiting programs: Nurse Family Partnership, Healthy Families New York (HFNY), Community Health Worker Program (CHWP), Parent as Teachers (PAT), Parent Child Home Program (PCHP), Healthy Start, Early Head Start (EHS), and Head Start (HS). These programs served approximately 2,692 families throughout the county, providing home visits to prenatal women and children. The majority of women in the programs are low income, Black, and between the ages of 20-29.

- NFP served 559 families in 2 programs: Brooklyn Hospital Center, and SCO Family Services. In Brooklyn Hospital Center, 60% of families were Black, and the average household income was \$10,500. In SCO Family Services, only the number of clients served was provided (322). HFNY served 645 families in 4 programs in the Brooklyn communities East new York, Central Brooklyn, Bushwick, Flatbush and Bedford Stuyvesant: CAMBA's Healthy Families, Healthy Families Successful Start, Bushwick Bright Start, and Healthy Families Brookdale. All four programs were similar with race (predominately Black) and age (20-29)

- In CAMBA's Healthy Families program, 60% of families were Black with 48% of mothers between the ages of 20-29 (20-24=24%; 25-29=24%) and additional 32% between 30-39. In Healthy Families Successful Start, 85% were Black with 54% of mothers were between the ages of 20-29 (20-24=34%; 25-29=20%) with 19% between the ages of 15-19, and an additional 23% between 30-39. In Bushwick Bright Start, 94% were Hispanic with 57% of mothers between the ages of 20-29 (20-24=34%; 25-29=21%), and an additional 25% between 30-39. In Healthy Families Brookdale (a new program), 74% were Black with 54% of mothers between the ages of 20-29 (20-24=34%; 25-29=20%) with 20% between the ages of 15-19, and an additional 23% between the ages of 30-39. The average household income for most programs families was under \$10,000, with one program falling in between \$10,000-\$19,000.
- CHWP served 363 families in 2 programs in Brooklyn: CAMBA, and Brookdale University Hospital & Medical Center. CAMBA CHWP provided services in Brooklyn, Flatbush, and E. Flatbush; Brookdale Hospital CHWP provided services in E. Brooklyn. The population served by CAMBA was 69% Black, with 69% of mothers between the ages of 15-19. The population served by Brookdale Hospital was similar, 88% of the population was Black, 22% of mothers were between the ages of 15-19, and 56% between the ages of 20-29 (20-24=31%; 25-29=25%). All families were Medicaid eligible.
- Excellence Baby Academy, PAT, provided home visits to 30 families in Brooklyn. The population was mostly Black (90%); mothers were between the ages of 20-29 (54%) and 30-39 (50%), and the household income was under \$10,000 (54%) and between \$10,000 - \$19,000 (17%).
- PCHP served 212 families in 3 Brooklyn programs: Excellence Early Learning Academy, WPA's Parent-Child Home Program, and SCO Family Services of Brooklyn/Brownsville/East New York. The population for all four was predominately Black. Income was similar, but ages varied. In the Excellence Early Learning Academy, 83% of families were Black with 41% of mothers between 20-29 (20-24= 17%; 25-29=24%) and an additional 38% between 30-39; 67% of household income was under \$10,000 and 17% between \$10,000-\$19,000. In the WPA P-C Home Program, 65% were Black with 50% of mothers between the ages of 20-29 (20-24=25%; 25-29=25%); 55% of household income was below \$10,000 and 35% between \$10,000-\$19,000. In the SCO Family Services, 76% were Black with 60% of mothers being older, between the ages of 25-39 (25-29=25%; 30-39=35%), and an additional 37% over 40; 55% of household income was under \$10,000 and 19% between \$10,000-\$19,000.
- Healthy Start Brooklyn provided home visits to 703 families in Brooklyn. The population was 77% Black with 15% of mothers between the ages of 15-19, 25% between 20-23, and 35% between 25-29. Most all families (72%) fell below 100% of the federal poverty level. Several of these families may also be served by the other home visiting programs available in this borough.

- EHS operated seven programs in the county: Brooklyn Child and Family Services, Yeled V'Yalda Early Childhood Center, Inc., Bais Yaakov Faigeh Schonberger of Adas Yerem (new), Beth Rivkah Early Head Start, Brooklyn Bureau of Community Service, Yeshiva Kehilath Yakov Head Start, Inc., and SCO Family Services. Together home visited approximately 148 families. No other information was reported.
- HS operated thirty-four programs in the county. Only one program, United Talmudical Academy Head Start, reported the number of families served, but from the data, it is not clear if these were home-based or centered-based clients. No other information reported.

Maternal and Infant Statistics:

The infant mortality rates in Flatbush, East and Central Brooklyn, and Brownsville are higher than in New York City overall.

Low Birth Weight is a major cause of infant mortality. Low birth weight infants who survive their first year are at increased risk of neurological and developmental problems. In 2007, 4% of the total live births in Brooklyn were low birth weight babies (<2,500 grams). The highest rates of low birth weight occur in Brownsville and East Brooklyn – 12.1 and 11.4 respectively.

In 2007, Brownsville and East Brooklyn teen births accounted for approximately 1 in 7 of all live births. The percentages of live births to teens in these two community districts are roughly double the rate in NYC.

The percentage of women who smoked 3 months before pregnancy was 11.0% (every day), 6.5% (some days). During pregnancy the number decreased to 2.6%. The percentage of women who drank alcohol 3 months before pregnancy was 0.7 (7-13 drinks), 3.3% (4-6 drinks), 26.8 (1-3 drinks).

Monroe County

“We have difficulty finding women who are not connected to prenatal care, have mental health or substance abuse issues or have a history of trauma; home visiting will only work with true outreach and case finding.”

“Families of incarcerated who move where the prison are difficult to serve, decreased transportation in rural areas, difficult to reach fathers.”

Demographics:

According to 2000 census data, Monroe County has 735,343 residents and Rochester has a population of 219,773 within its city limits. Rochester is the third largest city in New York after NYC and Buffalo. The majority of Monroe County residents are White, while the population is more racially diverse in the City of Rochester. Between 2000 and (2005-07), the population distribution in Monroe County remained fairly stable. In the City, the proportion of the population that is African American increased from 39% to 41%, and the Latino population increased slightly from 13% to 14%.

Based on the 2009 population estimates (US Census 2000), approximately 75% are White (non Hispanic), 14.8% are Black/African American, 6.2% are Hispanic or Latino, and 2.8% are Asian, and 1.7% identified by two or more races.

In Monroe County, 5.8% of the population is under 5 years of age, 7.3% are foreign born, and 12.1% speak a different language than English at home.

Home Visiting:

There are 3 Medicare and Medicaid home health agencies in Monroe County. Each agency's services must be countywide. These agencies provide skilled nursing, rehabilitation therapy services, and aide services to fill a plan of care developed by a community health nurse and ordered by the patient's physician. The majority of CHHA services are short term, post-acute and have short term, rehabilitation and educational goals.

There are 46 licensed home health agencies which serve Monroe County. These agencies provide private duty nursing and aide services, and contract with the certified agencies to serve public insurance cases.

Monroe County has a number of medical and supportive services programs. In the City of Rochester, location of their highest risk population, there are approximately 25 programs that provide some type of support for pregnant women and women with infants. Monroe County also has a robust system of local home visiting programs, including, Healthy Moms, Baby Love/Strong, Perinatal Home Visiting Program, and Monroe Plan for Medical Care and Visiting Nurse.

- The Perinatal Home Visiting Program, PHVP, in the Department of Public Health, which offers services to pregnant women. Each woman who joins the program receives visits in her home from a Community Health Worker. The support and information provided by the Community Health Worker help women to have a healthy pregnancy. Visits are continued until the baby is one year of age. After delivery, the Community Health Worker discusses ways that parents can help their child to grow and develop.
- The County also has Peer Home Visiting, which uses peers to assess the risks of pregnant women and their care coordination, including referrals for needed services, intervention for behavioral and social issues, health care referral and transportation to medical appointments, Support services including counseling, financial help, and childbirth classes, etc.
- Monroe Plan for Medical Care is for any member and provides case management and support for members with high risk medical conditions or who are psychosocially at risk. A Perinatal Nurse, Maternal Child Health Specialist, and Behavioral Health staff offer support, education and linkages to health and community services for women and children. MP contracts with Baby Love to offer intensive outreach to those pregnant women with the highest social risk factors.

Monroe County is also served by four statewide home visiting programs: Nurse Family Partnership (NFP), Parent as Teachers (PAT), Building Healthy Children (BHC), and Early Head Start (EHS). These programs served approximately 744 families providing home visits to prenatal women and children. The majority of women in the programs were low income and predominately Black and ages varied.

- Monroe County Department of Public Health, NFP, provided home visits to 210 families in Rochester. The population was 52% Black and 21% White, and the average household income was \$7,500.
- PAT provided home visits to 40 families. Race, age, and income varied by zip codes.
- BHC provided home visits to 197 families in the county. The population was 66% Black with 44% of mothers between the ages of 15-19 and 55% between the ages of 20-24; 34% of household income was less than \$10,000 and 40% between \$10,000-\$19,000.
- Action for a Better Community, EHS, served 297 families throughout the county, but the data does not distinguish between home based and centered-based clients. No other information was reported.

Maternal and Infant Statistics:

Lower educational levels are associated with poorer health outcomes. Literacy levels have a profound impact on an individual's ability to manage their health. In Monroe County, 11% of adults ages 25-64 years old and 31% of adults aged 65 years and older do not have a high school diploma. Percentages are higher in the city compared to the suburbs.

Not having a high school diploma is also correlated with low birth weight. Mothers without a high school diploma in the Healthy Start zip codes (14605, 14606, 14607, 14608, 14609, 14611, 14613, 14619, 14621) have a 30% higher rate of low birth weight than high school graduates. In suburban Monroe County mothers without a high school diploma have 42% higher rates of low birth weight than high school graduates. Latinas living in the Healthy Start zip codes have the highest rate of less than high school education, followed by African Americans living in the city.

Two-thirds of women without a high school degree smoked, and were significantly more likely to be current smokers than women with a high school diploma /some college. Latinas (the group most likely to be without a high school diploma) and city residents were significantly more likely to be current smokers than whites and suburban residents.

According to the 2006 Monroe County Adult Health Survey, 18% of women 18-44 were at risk of an alcohol use disorder. Younger women (18-29) and non-Healthy Start area residents were significantly more likely than older women and residents of Healthy Start zip codes to be at risk; the majority of African American and Latinas said they never drank. The Healthy Start area has some of the highest density of liquor store-to-population in the city of Rochester and Monroe County as a whole.

In Monroe County poverty is concentrated in the Healthy Start area and the city as a whole. In 2008, one in five families in the Healthy Start area lived below the poverty level compared to 3% in the suburbs. Over two-thirds of female headed households with children in this area were below the poverty line.

Sixteen percent of Monroe County women 18-44 reported that they had at some time been a victim of intimate partner violence. Women with less than a college degree and residents of Healthy Start zip codes were significantly more likely to report having been a victim.

Nassau County

“In Nassau County, there are 15,000 births each year and approximately 1000 of those are at risk. We do not have enough home visiting programs in the county to serve all the families in need of services.”

Demographics:

Nassau is a suburban county on Long Island, east of New York City in the state of New York, within the New York Metropolitan Area. As of the 2000 census, the population was 1,334,544, with 447,387 households, and 347,172 families residing in the county. The racial makeup of the county was 73.95% White Non-Hispanic, 10.01% African American, 0.16% Native American, 4.73% Asian, 0.03% Pacific Islander, 3.57% from other races, and 2.12% from two or more races. Hispanic or Latino of any race were 10.09% of the population.

As of 2008, Nassau County was the second richest county per capita in the State of New York and the 10th richest in the nation, with a median household income of \$85,994. The per capita income for the county was \$32,151. However, they have several sections of poverty, for example, about 3.50% of families and 5.20% of the population are below the poverty line, including 5.80% of those under age 18 and 5.60% of those age 65 or over. Nassau County’s pockets of poverty include Freeport, Hempstead, Inwood, Long Beach, Roosevelt, Uniondale and Westbury.

Housing policies and community development may have an effect on social and health outcomes. Education, specifically school drop-out rates, teenage pregnancy rates, infant mortality rates also impact ability to seek and maintain education and henceforth employment. The AIDS Institute’s Community Needs Index, an index measuring high risk behavior in communities, is higher in these communities and contributes to social and health status. These selected communities tend to be ethnically and racially diverse.

Home Visiting:

Certified Home Health Agencies (CHHA) provide nursing services; home health aides; medical supplies and equipment; and physical, speech and occupational therapies. There are currently twenty-one agencies approved to operate in the county, which includes for-profit and not-for-profit agencies. CHHA’s also provide charity care at no cost or reduced charge for those without insurance and with incomes less than 200% of the federal poverty level. Besides home health services offered through the CHHAs, services are also provided by twelve long term home health care programs (LTHHCP) and six hospices.

Nassau County is served by the following three statewide home visiting programs: Community Health Worker Program (CHWP), Parent Child Home Program (PCHP), and Head Start (HS). These programs served approximately 467 families throughout the county, providing home visits to prenatal women and children. The majority of women in the programs are low income, Hispanic or Black, and between the ages of 20-29.

- Nassau County Health Department, CHWP, provided home visits to 178 families in Hempstead and Roosevelt. The population was mostly Black (43%) or Hispanic (47%); 35% of mothers were between the ages of 15-19, 46% between 20-29 (20-24=27%; 25-29=19%), and all families were Medicaid eligible.
- PCHP provided home visits to 180 families in 9 programs in Nassau County. Only two of the nine reported information: Youth & Family Counseling in Oyster Bay/E. Norwich, and Port Washington Public Library in Port Washington. Population for both programs was similar (mostly Hispanic): In Youth & Family Counseling in Oyster Bay/E. Norwich, 70% of the population was Hispanic; Port Washington, 87%. The ages of mothers varied between the two programs: In Oyster Bay/E. Norwich, the majority of mothers fell in the range of 20-29 (39%) and 30-39 (46%); Port Washington, the ages ranged from 25-29 (44%) and 40+ (25%). The household income for families in both programs was between \$10,000 -\$29,000.
- Downstate Healthy Start, Nassau, provided home visits to 109 families in Hempstead. The population was 86% Black; 25% of mothers were between the ages of 15-19, 51% were between the ages of 20-29 (20-24=34%; 25-29=17%), and an additional 20% e between 30-39; 70% of households earned less than \$10,000.
- Head Start operates four programs in Nassau County: Economic Opportunity Commission of Nassau County, Five Towns Head Start, Glen Cove Child Day Care Center, Inc., and Manhasset/Great Neck Head Start. No other information was reported.

Maternal and Infant Statistics:

Although access to private physicians improved with the advent of the Child Health Plus and Medicaid managed care programs, many beneficiaries are still unable to access primary care and rely on episodic emergency room or clinic care. Anecdotally, one reason is that many private physicians in the county will not accept Medicaid patients. A second reason is that many Medicaid managed care enrollees do not understand how to best access their managed care organization and are confused and challenged by the complexity of the health care system.

The percentage of high school graduates in Nassau County increased marginally from 84.0% in 1990 to 86.7%, in 2000. Residents with bachelor's degrees grew from 30.0% to 35.4% in NC in the same time period. By comparison, 27.4% of NYS residents had bachelor's degrees or higher. In 2008, infant death rates were 5.3 per 1,000 infant births in Nassau County. In Nassau County, 11.2 % of births in Nassau County were premature, and the county's low birth weight rate was 7.9%. 5.2% of Nassau County residents live below 100% of the Federal Poverty Level.

New York County (Manhattan)

“We have high infant mortality rate, chronic illnesses, (for example, diabetes, asthma, hypertension) low use of prenatal care, the need for mental health services, and lack of insurance.”

“We need more mental health and supportive services for teens”

Demographics:

Manhattan is one of the five boroughs of New York City. Located primarily on Manhattan Island at the mouth of the Hudson River, the boundaries of the borough are identical to those of New York County. It is the smallest, yet most urbanized of the five boroughs.

The County of New York is the most densely populated county in the United States, and one of the most densely populated areas in the world, with a 2008 population of 1,634,795 living in a land area of 22.96 square miles, or 71,201 residents per square mile. It is also one of the wealthiest counties in the United States, with a 2005 personal income *per capita* above \$100,000. While there is significant wealth in Manhattan, there are pockets of poverty too. Overall in the County, there are 25.07 % of people living below 100% of the Federal Poverty Line.

According to the 2005–2007 American Community Survey, Manhattan's population was 56.8% White (48.4% non-Hispanic White alone), 16.7% Black or African American (13.8% non-Hispanic Black or African American alone), 0.8% American Indian and Alaska Native, 11.3% Asian, 0.1% Native Hawaiian and Other Pacific Islander, 16.9% from some other race, and 2.4% from two or more races. 25.1% of the total population were Hispanic or Latino of any race.

Fifty six percent of the population had a Bachelor's degree or higher. 28.4% were foreign born and another 3.6% were born in Puerto Rico, U.S. Island areas, or born abroad to American parents. 38.8% spoke a language other than English at home.

Home Visiting:

New York County/Manhattan has several home visiting programs throughout its borough, including, Universal Home Visiting, Baby Steps, Newborn Home Visiting, Visiting Nurse, and HHC/ Health and Home Care, a Division of the New York City Health and Hospitals Corporation, that serves residents of Manhattan, Queens, and the Bronx. HHC also operates a Long-Term Home Health Care Program in Manhattan and the Bronx.

New York County/Manhattan is also served by seven statewide home visiting programs: Nurse Family Partnership (NFP), Healthy Families New York (HFNY), Community Health Worker Program (CHWP), Healthy Start , Parent Child Home Program (PCHP), Early Head Start (EHS), and Head Start (HS). These programs served approximately 1,780 families throughout

the county, providing home visits to prenatal women and children. The majority of women in the programs are low income, Black or Hispanic, and between the ages of 20-29.

- NFP provided home visits to 429 families in 3 programs in Manhattan: Visiting Nurse Services, Lower Manhattan; TCI, and Harlem Hospital. In VNS, Lower Manhattan, the population was 50% Hispanic; in TCI, the populations 59% Black. No information regarding population was given for Harlem Hospital. Ages of mothers was not specified in either of the programs. The average income for all programs was \$10,500.
- HFNY provided home visits to 511 families in 3 programs: Best Beginnings/Alianza Dominicana, Inc. serving the community of Washington Heights, Baby Steps Home Visiting Program serving the community of Central Harlem, and University Settlement Healthy Families serving the community of East Harlem. In Best Beginnings, the population was 97% Hispanic, with 21% of mothers between the ages of 15-19, 41% were between the ages of 20-29 (20-24= 21%; 25-29=20%) with an additional 33% between the ages of 30-39. In Baby Steps, the population was mostly Black at 58%, with 51% of the mothers were between the ages of 20-29 (20-24=26%; 25-29=25%); 29% were between 30-39. The majority of households in these two programs earned less than \$10,000. In University Settlement, the population was 70% Hispanic, with 54% of the mothers between the ages of 20-29 (20-24=31%; 24-29=23%) with an additional 23% between the ages of 30-39. Most household income in this program ranged from \$10,000-\$19,999.
- CHWP home visited 338 families in 2 programs: Harlem Hospital serving Central Harlem and No. Manhattan, and No. Manhattan Perinatal Partnership, serving E. Harlem. In Harlem Hospital, the population was 64% Black and 37% Hispanic; 60% of the mothers were between the ages of 20-29 (20-24=31%; 25-29=29%), with an additional 23% between the ages of 30-39. In No. Manhattan Perinatal Partnership, the population was 62% Hispanic and 22% Black, with 55% of mothers between the ages 20-29 (20-24=29%; 25-29=26%), with an additional 26% between the ages of 30-39. All families were Medicaid eligible.
- Central Harlem Healthy Start served 205 families. The population was 72% Black and 28% Hispanic; 50% of mothers were between the ages of 20-29 (20-24=24%; 25-29=26%), an additional 35% were between the ages of 30-39; 70% of households earned less than \$10,000.
- Graham Windham-Harlem, PCHP, served 51 families. The population was 51% Black, with 49% of mothers between the ages of 20-29 (20-24=22%; 25-29=27), and an additional 38% between the ages of 30-39. Of household income, 33% earned less than \$10,000, 31% earned between \$10,000-\$19,000, and 25% earned between \$20,000-\$29,000.
- EHS operated 10 programs throughout the county providing home visits to approximately 246 families. No other information was reported.
- HS operated approximately 40 programs. No other information was reported.

Maternal and Infant Statistics:

In 2007, there were 50.9 births per 1,000 females (age 15-44) in New York County.

In 2008, 12.4 % of births in New York County/Manhattan were premature and their low birth weight rate was 8.7%. The New York County infant mortality rate was 4.7 infant deaths per 1,000 births.

Also in Manhattan, the domestic violence rate was 14.6 per 10,000 victims in 2008.

Even though Manhattan is one of richest counties in the nation, twenty percent of Manhattan is living below 100% of the Federal Poverty Level.

Oneida County

“Transient/mobility issues create problems, can’t access clients who have moved out of the county. Families are difficult to track once they re-locate.”

“We are unable to find pregnant women not already in care, even with increased pregnancy rate in Utica.”

Demographics:

Oneida County is a county located in the central region of New York State. As of the 2000 census, the population was 235,469. The county seat is Utica.

In 2000, the racial makeup of Oneida county was 90.21% White, 5.74% African American, 0.23% Native American, 1.16% Asian, 0.02% Pacific Islander, 1.11% from other races, and 1.52% from two or more races. Hispanic or Latino of any race were 3.20% of the population. 21.7% were of Italian, 13.1% Irish, 12.1% German, 9.9% Polish, 8.5% English and 5.6% American ancestry according to Census 2000. 90.6% spoke English, 2.7% Spanish, 1.3% Italian, 1.2% Serbo-Croatian and 1.1% Polish as their first language.

The overall population of Oneida County is expected to decrease by 22.6%, but the trends among different age groups vary significantly. The number of women of childbearing age is estimated to decrease by more than 35% with the total loss of women of childbearing age projected to be 16,180.

The median age for males in Oneida County is expected to decrease from 36.5 in 2000 to 36.1 by 2010. It is expected to continue to decrease slightly before returning to near 2000 levels in 2030. The median age for females is expected to increase from 40.1 in 2000 to 41.8 in 2010 and will be 42.2 by the year 2030.

Home Visiting:

Oneida County is served by the following four statewide home visiting programs: Healthy Families New York (HFNY), Community Health Worker Program (CHWP), Early Head Start (EHS), and Head Start (HS). These programs served approximately 498 families throughout the county, providing home visits to prenatal women and children. The majority of women in the programs are low income, White, and between the ages of 15-24*. (*Information on race, age, and income was only provided for HFNY and CHWP).

- Healthy Families of Oneida County provided home visits to 197 families throughout the county. The population was 65% White; 28% of mothers were between the ages of 15-19, 42% were between 20-24. The average participant family earned \$10,000-\$19,000.
- Oneida County Public Health, CHWP, provided home visits to 207 families within Utica, Rome, Waterville, Camden, Blossvale, and New Hartford. The population was 58%

White, 29% Black; 39% of mothers were between the ages 15-19, and 33% between the ages of 20-24. All families were Medicaid eligible.

- Mohawk Valley Community Action Agency, Inc., EHS, provided 94 home visits to families. No other information reported.
- Mohawk Valley Community Action Agency, Inc., HS did not provide any information.

Maternal and Infant Statistics:

In Oneida County the birth rate for 15-17 year olds rose slightly each year from 2003 until a drop in 2007 resulted in an overall improvement of 8%.

Over the past nine years, there has been fluctuation in the percentages of infants who were born with low birth weight in Herkimer and Oneida Counties. However, similar to a nationwide trend, the average percentage of low birth weight babies in 2004-2007 is higher than the previous five year average.

From 2004-2007, the premature birth rates for the urban 13501 and 13502 zip codes were higher than for Oneida County, within which these zip codes are located, and higher than the CNY Region.

In 2008, Oneida County had 12.6% premature births and a low birth weight of 7.8%.

Also, in this County they had an infant death rate of 7.3 per every 1,000 births.

Onondaga County

“We have an increasing refugee population and it is difficult to access to translation services due to lack of funds.”

“Referrals and services are shrinking due to less staff, chaotic home situations, hard to get younger staff into field or bilingual staff.”

Demographics:

In 2000, Onondaga had a population of 458,336 – 84.78% white 9.38%, African American, 0.86%, Native American, 2.09, Asian, 0.03%, Pacific Islander, Hispanic and Latino of any race were 2.44%. Approximately 2,300 infants are born each year to Syracuse residents: 1,260 (55% white), 870 (38% African American), 170 (7% are of other races), and about 160 (7% are Hispanic of any race). The estimated population for 2008 is decreasing at 452,633.

Based on Onondaga County’s demographic data (Community Needs Assessment, 2010-2013) it is clear that a relatively small number of economically disadvantaged areas in Onondaga County bear a disproportionate amount of public health burdens, including infant mortality, sexually transmitted diseases, childhood lead poisoning, adolescent pregnancy, diabetes, and heart disease. Many of these areas are in the city of Syracuse, but there are others located throughout the county as well. Since 2000, the population of Syracuse has gotten smaller, younger, more racially diverse, and less educated. These trends are expected to continue, as is the likelihood that these individuals will experience poor health outcomes.

There is a substantial economic disparity between the City of Syracuse and the remainder of Onondaga County. In 1999, the median household income in Syracuse was \$25,000. The next lowest median household income of any town in the county was around \$40,000. For this reason, many of the available public health services target city residents, which could leave many poor rural residents without easy access. In 2007, nearly 69,000 Onondaga County residents, or 15.2% of the population, were eligible for Medicaid. Statewide, 32.6% of the population was eligible. The same year close to 8,000 children in Onondaga County were enrolled in Child Health Plus (NYSDOH Fiscal Management Group). In 2008, 12.7% of Onondaga’s population lived below 100% of the Federal Poverty Level.

Home Visiting:

Onondaga County has several home visiting programs including, Visiting Nurse, Partnership, CCH Home Care & Palliative Services, Gentiva, Regional Home Care Services, Inc., St. Camillus Health & Rehabilitation Center and St. Joseph’s Certified Home Health Care Agency, among others.

Onondaga County is served by four statewide home visiting programs: Nurse Family Partnership (NFP), Community Health Worker Program (CHWP), Healthy Start, Early Head Start (EHS), and Head Start (HS). These programs served approximately 872 families providing

home visits to prenatal women and children. The majority of families are White or Black. The majority of women were between the ages of 15-24.

- Onondaga County Health Department, NFP, and provided home visits to 122 families in Syracuse. The population was 40% Black and 33% White, with mothers being the average age of 17. All families were 200% of poverty level.
- Onondaga County Health Department, CHWP, provided home visits to 229 families throughout the county. The population was mostly White (54%), with a high percentage Black (43%); most mothers were between the ages of 15-24 (54%) and 25-29 (21%), and all were Medicaid eligible.
- Onondaga Healthy Start provided home visits to 572 families in Syracuse. The population served was mostly African-American (45%) or White (36%); and most of the women were between the ages of 15-24 (94%).
- EHS operates two programs: P.E.A.C.E (People's Equal Action and Community Effort, Inc) and P.E.A.C.E. Expansion. Together they served 1,057 families throughout the county; however, the data does not distinguish between home-based and centered-based clients. No other information reported.
- HS operates a program through P.E.A.C.E. but no information was reported.

Maternal and Infant Statistics:

Early (first trimester) entry into prenatal care is essential for a healthy pregnancy and healthy baby. In Onondaga County, 76.7% of pregnant women received early prenatal care from 2005 to 2007. This is similar to the Upstate New York rate of 76.4%, but is much lower than the national rate of 83.9% (2005), and the Healthy People 2010 Goal of 90%. The rate improves for women participating in WIC in Onondaga County. Nine out of 10 participants received early prenatal care from 2005 to 2007 compared with 85.1% in Upstate New York. Countywide, 3.8% of births from 2005 to 2007 were to women who received late or no prenatal care. This is similar to the Upstate New York rate of 4.0% (Vital Records, NYSDOH Bureau of Biometrics and Health Statistics).

There were 5,526 live births in Onondaga County in 2007 (Vital Records, NYSDOH Bureau of Biometrics and Health Statistics, 2007). Of these, 539 (9.8%) were to women age 19 years and younger, and 154 (2.8%) were to women age 40 and older. White mothers accounted for 71.6% of births, and 17.7% of births were to Black mothers. The remaining 10.7% of births were to women whose race was classified as "Other". Births to Hispanic women represented 5.6% of the total. Countywide, 45.6% of births met the definition for "out of wedlock."

In 2008, 7.4% of babies born in Onondaga County weighed less than 2,500 grams at birth. This percent of low birth weight babies is slightly less than that for New York State (8.1%), For babies born from 2005 through 2007, the county infant mortality rate per 1,000 live births is 6.6.

For Black infants, this rate is 14.5, compared to 5.2 for White infants. In Syracuse, the overall infant death rate is 8.3 per 1,000 live births, with 14.3 deaths per 1,000 live births among Black infants compared to 5.7 per 1,000 among White infants (OCHD Office of Vital Statistics).

In Syracuse, there is a disparity between African American rates (15.9) and White infant mortality rates (6.7) – the African American rate is more than three times greater than the Healthy People 2010 target of 4.5.

From 2004 to 2008, over 2,500 refugees have been resettled in Onondaga County. The largest numbers have come from Burma, Somalia, Liberia, and Sudan. Most of these individuals are settled in the Syracuse City area. A variety of challenges have been identified in meeting the healthcare needs of this population. Communicable diseases, child health and immunizations, mental health, and nutrition are specific issues that arise during the resettlement process.

Transportation and language are two major barriers that can prevent recent refugees from receiving the care they need. In addition to healthcare issues, some refugees also face the threat of violence in their neighborhoods.

Orange County

“No, the needs of at risk pregnant women and children are not being met. Referrals and services are shrinking due to less staff, chaotic home situations, and it is hard to employ younger staff and bilingual staff.”

Demographics:

In 2006 the population for Orange County was estimated at 376,392 – the highest population growth in NYS over the past decade. In 1990 and 2000, Orange County ranked as the 12th most populated county in the state. Orange County is comprised of 42 municipalities, including 3 cities, 20 towns, and 19 villages, with 61% of the population living in the towns and 21% in the villages. The median age of the population that has experienced the most rapid growth has been among Hispanics, which increased by 85% from 1990 to 2000.

According to the U.S. Census population estimates published by the New York State Data Center, Orange County is the fastest-growing county in New York State; from April 1, 2000 to July 1, 2007, the county’s population increased by an estimated 10.5%. Trends in population growth vary greatly by municipality -communities with estimated population growth rates of twenty percent or more from 2000-2007 include the towns of Minisink and Monroe, and the villages of Kiryas Joel, Maybrook, and Montgomery.

Poverty rates vary greatly throughout the county based on municipality. Poverty rates exceeding 25% for families with related children under 18 are found in Orange County’s three cities (Middletown, Newburgh, and Port Jervis), as well as in the town of Monroe, largely due to the impact of the village of Kiryas Joel, where the great majority of its 5,000 residents are Hasidic Jews and the poverty rate is more than 4 times the county average. According to 2008 census figures, Kiryas Joel has the highest poverty rate in the nation, more than two-thirds of residents live below the Federal Poverty Level and 40% receive food stamps.

Levels of poverty in the county also vary depending on race, ethnicity and family composition. Married couple families have the lowest overall poverty rates; the highest rates are seen in single mother families, and this rate exceeds 50% in single mother families with children under the age of five.

Housing units within the county increased an estimated 9.2% from 2000 to 2007. The majority of housing units in the county are owner occupied; however this also varies by municipality. Communities with 50% or more of their housing units consisting of pre-1950 construction include Cornwall, Highlands, and the county’s three cities of Middletown, Newburgh, and Port Jervis.

Home Visiting:

Orange County has several home visiting programs, including Visiting Nurse, The County's Public Health Nursing, Visiting Angels and others.

Orange County is served by the following four statewide home visiting programs: Healthy Families New York (HFNY), Community Health Worker Program (CHWP), Early Head Start, and Head Start (HS). These programs served approximately 318 families throughout the county, providing home visits to prenatal women and children with an average duration of 10 months. The majority of women in the programs are low income, Black, Hispanic, or White and between the ages of 15-29.

- HFNY provided home visits to 180 families in 2 sites in Orange County: Occupations Inc. Healthy Families program operates a HFNY site in Newburgh and Middletown. The population in Orange County is 34% Black and 42% Hispanic, with 100% of mothers between the ages of 15-19. In Middletown, the population was 28% White and 27% Black with 34% of the mothers between the ages of 15-19, 51% between 20-29 (20-24=24%; 25-29=27%). The average household income for program participants was between \$10,000-\$19,000.
- Orange County Department of Health, CHWP, uses trained paraprofessionals to perform outreach for case finding of at risk pregnant women, provide basic health education and case management for these clients, and make referrals, concentrating their home visiting efforts on 138 families in Middletown, Newburgh, and Port Jervis. The population was 51% White and 48% Hispanic; 21% of mothers were between the ages of 15-19, and 56% between the ages of 20-29 (20-24=37%; 25-29=19%), and all families were Medicaid eligible.
- Kiryas Joel Municipal Local Development Corp. provided services to 100 families in Kiryas Joel, but the data does not distinguish between home based and centered-based clients. No other information reported.
- Family Enrichment Network, Inc., HS, operates in Orange County, but no other information was reported.

Maternal and Infant Statistics:

In 2004-2006, 20,912 pregnancies were recorded for Orange County residents. There has been an overall decline in the pregnancy rate for females ages 15-44 in the county over the latest ten-year time period (1997-2006); this trend is consistent with that for Upstate. The pregnancy rate in the county is the second highest in the Hudson Valley Region (HVR) higher than the average for the region and Upstate and lower than the rate for NYS. Access too early and ongoing prenatal care is important to healthy birth outcomes for women of all ages.

The percentage of women who are receiving early prenatal care is well below *HP2010* targets (90%), and is lowest in teens, minority females, and geographically, in the cities of Middletown and Newburgh. Birth rates were relatively constant from 2004-2006, and are, like pregnancy rates, higher than the average for the HVR and Upstate. Birth rates are highest in Hispanic females. The city of Middletown has the highest birth rate in the county; the city of Newburgh has the highest percentage of births to teens (ages 17 and under) and Medicaid/Self Pay births.

Infant mortality rates in the county have also declined substantially since 2004, and the 2006 rate met the *HP 2010* target for the first time. Infant mortality (as a percentage of total births) is highest in Black/African American infants, which is consistent with state and national findings. In 2008, Orange County's low birth weight rates are 7.5%, highest in teens and in Black/African Americans.

Queens County

Demographics:

Queens County, is the easternmost of the five boroughs of New York City and has a population of 2,306,712 in July, 2009. The racial breakdown is: White Non-Hispanic (32.9%), Hispanic (25.0%), Black (20.0%), Other race (11.7%), Chinese (6.3%), Two or more races (6.1%), Asian Indian (4.9%), Korean (2.8%), Other Asian (1.9%), Filipino (1.4%), and American Indian (1.2%), and 46% are foreign born.

The populations in Queens are the most racially, ethnically and linguistically diverse of the five NYC boroughs. The percent of foreign born residents is 46.1%. Significant increases are shown in the Hispanic, Asian/Pacific Islander, and African American/Black populations. Asians and Latin Americans each account for 1/3rd of the foreign born population, while those from non-Hispanic Caribbean and Europe are approximately 1/6th.

Home Visiting:

Queens County is served by the following seven home visiting programs: Nurse Family Partnership (NFP), Healthy Families New York (HFNY), Community Health Worker Program (CHWP), Parent Child Home Program (PCHP), Healthy Start, Early Head Start (EHS), and Head Start (HS). These programs served approximately 1,229 families throughout the county, providing home visits to prenatal women and children. The majority of women in the programs are low income, Black or Hispanic, and between the ages of 20-29.

- Public Health Solutions, NFP, and provided 559 home visits to families in Queens. The population was 52% Hispanic, 23% Black, and 11% White. Average household income was \$10,500.
- Safe Space, HFNY, provided home visits to 96 families in the community of Jamaica in Queens. The population was 44% Black and 52% Hispanic; 56% of mothers were between the ages of 20-29, and 21% were between the ages of 30-39. The average household income for all families was under \$10,000.
- PCHP Queens @ SCO Family of Services home visited 100 families in Woodside. The population was 100% Hispanic with 27% of mothers between the ages of 25-29, and 49% between the ages of 30-39 (only 11% between 15-24).
- Safe Space, CHWP, provided home visits to 117 families in Jamaica. The population was mostly 52% Black and 35% Hispanic; 53% of mothers were between the ages of 20-29, and 22% between the ages of 30-39. All families were Medicaid eligible.

- Downstate Healthy Start, Queens, provided home visits to 109 families in South Jamaica and Far Rockaway. The population was 48% Black and 50% Hispanic; 53% of mothers were between the ages of 20-29 (20-24=28%; 25-29=25%), and an additional 30% were between 30-39; 56% of households earned less than \$10,000, and 29% earned from \$10,000-\$19,000.
- EHS provided at least 97 home visits to families in 4 programs in Queens: The Child Center of New York, The Child Center of New York, Expansion; Visiting Nurse Service of New York, and B' Above World Wide Institute (new). No other information was reported.
- HS provided 151 home visits to families in 6 programs in Queens: B' Above World Wide Institute (new), Child Center of New York, Committee for Early Childhood, Quick Start Head Start Day Care, Rockaway Community, and So. Jamaica Center for Children and Parents, Inc. Only one of the seven programs provided the number of families served (151); no other information was reported.

Maternal and Infant Statistics:

The infant mortality rate for three community districts, Jamaica/St. Albans, 8.7 infant deaths per 1,000 live births; Queens Village, 8.2 infant deaths per 1,000 live births, and The Rockaways, 7.8 infant deaths per 1,000 live births, significantly exceed the Queens IMR of 5.0 infant deaths per 1,000 live births and the NYC IMR of 5.4 infant deaths per 1,000 live births. These community districts exceed the NYC and Queens percent of preterm births, 8.6% and 8.2%, respectively, and low birth weight infants, <2,500 grams, 9.5% and 9.2%, respectively. However, in 2008, Queens had an IMR of 4.5 infant deaths per 1,000 births, and decreased their low birth weight to 8.3%.

The IMR for teenagers in Flushing (8.7/1,000 live births) and Jamaica (11.2/1,000 live births) are higher than the overall Queens and NYC rates. In five of the seven community districts, teenagers are also more likely to give birth to low birth weight and preterm infants than teenagers in the rest of Queens and NYC. Additionally, teenagers in all community districts are more likely to receive late or no prenatal care than in NYC overall.

In 2008, 9.7% of babies born were premature, and 7.5% had a low birth weight. However, the rate of premature births were 4.4 per 1,000 births.

Richmond County (Staten Island)

Demographics:

Staten Island is a borough of New York City located in the southwest part of the city. With a population of 491,730, Staten Island is the least populated of the five boroughs, but is the third largest in area at 59 sq miles.

According to the 2005–2007 American Community Survey Estimates, the borough's population was 76.6% White (67.4% non-Hispanic White alone), 10.6% Black or African American (9.5% non-Hispanic Black or African American alone), 0.4% American Indian and Alaska Native, 7.6% Asian, 0.0% Native Hawaiian and Other Pacific Islander, 6.0% from some other race and 1.1% from two or more races. 14.7% of the total population were Hispanic or Latino of any race. 20.9% of the population were foreign born. While the average median income is high at \$55,380, 9.5% percent of Staten Island residents live below the 100% of the Federal poverty line.

Home Visiting:

Richmond County is served by the following local or borough wide home visiting programs, including Visiting Nurse, Home Health Services, and Sisters of Charity Home Health Care, among others.

Richmond County has the following three statewide home visiting programs: Nurse Family Partnership (NFP), Healthy Families New York (HFNY), and Early Head Start (EHS). These programs served approximately 254 families throughout the county, providing home visits to prenatal women and children. The majority of women in the programs are low income, Black or Hispanic, and between the ages of 15-29.

- Richmond Home Needs Services, NFP, provided home visits to 95 families. The population was 29% Black and 49% Hispanic, and the household income average was \$10,500.
- Healthy Families Staten Island provided home visits to 127 families in the North Shore section of the borough. The population was 25% Black and 62% Hispanic, with 30% of the mothers between the ages of 15-19 and 43% between the ages of 20-29 (20=24=19%; 25-29=24%). The average household income was less than \$10,000 for program participants.
- Yeled V'Yalda Early Head Start provided home visits to 32 families. No other information was provided.

Maternal and Infant Statistics:

In 2008, Richmond County had a low birth rate of 7.7%, and had 11.7% of births were premature. In Staten Island/Richmond County the infant mortality rate is low at 7.5 for every 1,000 births.

There are 9.5% of county residents living below 100% of the Federal Poverty Level.

Regarding Domestic Violence, there were 23.1 Domestic Violence victims per every 10,000.

In 2009, there were 159 substance abuse admissions per every 10,000 residents. This includes all ages and all substances.

Suffolk County

Demographics:

Suffolk County has a total population estimated at 1,457,115 and is located on the eastern end of Long Island. This is a real challenge for service provision which emanates from the structural span of the region and the differences across both suburban and rural communities. The population is 85.1% white, 7.9% African American and 13% Hispanic. It is estimated that almost 17% of Suffolk's population is foreign-born. Many of these individuals are recent immigrants who are uninsured. Growing ethnic populations in Suffolk County include Hispanics, Arab-Americans, Haitians and West Indians.

Poverty is a growing concern in Suffolk County. The national poverty rate dropped for the first time in 2006, while Suffolk's rate climbed to 6.5% from 4.8% in 2005. The 2000 census indicates that 3.9% of Suffolk families, 13.5% of female-headed families, and 29% of female households with children under five lived below the poverty level.

There has been a growth in ethnic diversity in Suffolk over the last decade. There are twelve hamlets with higher minority populations than the overall Countywide rate, which consists of 13% Hispanics and 7.8% African Americans. In the towns with high minority populations (i.e., Wyandanch, North Amityville, Huntington Station, Central Islip, Brentwood, Patchogue, North Bellport, Mastic Beach, Riverhead, Hampton Bays and Bay Shore), approximately 55% of the residents have income between 125% and 200% of the Federal Poverty Level.

Home Visiting:

Suffolk County is served by the following five statewide home visiting programs: Healthy Families New York (HFNY), Community Health Worker Program (CHWP), Parent Child Home Program (PCHP), Healthy Start, Early Head Start (EHS), and Head Start (HS). These programs served approximately 962 families throughout the county, providing home visits to prenatal women and children. The majority of the families in the programs are low income, Black or Hispanic, and between the ages of 20-29.

- Healthy Families Suffolk, HFNY (new), provided home visits to 106 families in the communities of Brentwood, and Bayshore. The population was 78% Hispanic with 21% of mothers between the ages of 15-19, 55% between the ages of 20-29 (20-24=30%, 25-29=25%), and with an additional 24% from the ages of 30-39. The average household income for families range was \$10,000-\$19,000.
- CHWP provided 430 home visits to families in 2 programs in Suffolk County: the Suffolk County Health Department, and the Shinnecock Indian Nation. The Suffolk Co. Health Department provided services in Wyandanch, Amityville, Central Islip, Copiague, and Brentwood. The Shinnecock Indian Nation provided services on their reservation. In Suffolk Co. Health Department, CHWP, the population was 72% Hispanic; 18% of mothers were between the ages of 15-19, 54% between 20-29 (20-24=35%, 25-29=18%), with an additional 21% between 30-39. In Shinnecock, the population was 100% Native

American; 18% of mothers were between the ages of 15-19, 36% of mothers between 20-24, and 27% between 30-39. All families were Medicaid eligible.

- PCHP home visited 240 families in 8 programs throughout Suffolk County. Five programs reported. Population was mostly Hispanic; the average age of mothers varied by program, which ranged from 15-39. Majority of household income was below \$40,000.
- Downstate Healthy Start, Suffolk, provided home visits to 136 families in Bellport, Coram, Medford, and Patchogue. The population was 46% White and 40% Black; 60% of mothers were between the ages of 20-29 (20-24=35%; 25-29=25%), and an additional 21% were between 30-39; 75% of households earned less than \$10,000.
- EHS operates two programs: The Community Programs Center of Long Island, Inc., and the Long Island Child and Family Development Services. CPCLI home visited 50 families. No other information reported.
- HS operated two programs: The community Programs Center of Long Island, Inc., and Long Island Head Start. No other information reported.

Maternal and Infant Statistics:

In Suffolk County, there were 18,802 live births in 2005, a birth rate of 63.5 per 1,000 women ages 15-44. The percentage of births during 2003-2005 was; White - 65.4, Hispanic - 22.6, Black - 7.8, Asian - 3.9, and Native American - 0.2. Although Suffolk County's rate of early prenatal care is high, many women still do not enter prenatal care within the first trimester.

Approximately 1 in 8 infants, 13.2 percent of live births, was born to a woman receiving inadequate prenatal care in Suffolk County in 2005. Pregnant women who are in isolated areas, without means of transportation, adolescents, women of color, and uninsured women are less likely to seek early prenatal care. Uninsured pregnant women are less likely to seek prenatal care in the first trimester, and to receive the optimal number of visits during their pregnancy. They have a 31 percent higher likelihood of experiencing an adverse health outcome after giving birth (ACOG, 2008).

Black women in the County had the highest rates of both late or no prenatal care and inadequate prenatal care when compared to other ethnic categories. Hispanics and Native Americans followed closely behind with almost as high rates.

In 2008, the average infant mortality rates (per 1,000 births) was 3.9, and was highest for women under age 20 and those ages 40 and older compared to other age groups. They also had a low birth rate of 7.2% county wide.

Westchester County

“We have a collaborative spirit in community and among programs. Work together to meet needs of families.”

“There are huge areas in the county without home visiting services”

Demographics:

Westchester County is the 4th most populous county in New York State (outside of New York City) and encompasses a total area of 450.5 square miles and the total population is 949,041, according to the 2005-2007 American Community Survey (ACS) estimates (excluding people living in institutions, college dormitories, and other group quarters). Westchester County is predominantly white (68.3%). Just below a third (31.7%) of the county population are persons of color, including blacks (13.9%), Asians (5.5%), and other races. Overall, Hispanics represented 18.5% of the population.

According to 2008 data, the median income for a household of one person in the county was \$75,427 and the median income for a family of four was \$96,500. Westchester County ranks number two (number one being Manhattan) for wealthiest counties in New York State and the seventh wealthiest county nationally.

The county has been divided into six Health Planning Regions (HPRs) by the Westchester County Department of Health based on their demographic profiles and utilization patterns (East Central, Northeast, Northwest, West Central, Southeast, Southwest).

Home Visiting:

The Westchester County Department of Health provides health care services to county residents in their homes through the Certified Home Health Agency. Over 20,000 home health visits are made annually to county residents. Home health services include public health nursing, physical therapy, occupational therapy, speech/language therapy, medical social workers and home health aides. Home health services are available 24 hours a day, 7 days per week. County residents of all ages are eligible for home health services.

Westchester County is served by the following five statewide home visiting programs: Healthy Families New York (HFNY), Community Health Worker Program (CHWP), Parent Child Home Program (PCHP), Early Head Start (EHS), and Head Start (HS). These programs served approximately 496 families throughout the county, providing home visits to prenatal women and children. The majority of women in the programs are low income, Hispanic, and between the ages of 15-29.

- Westchester County Healthy Families, HFNY, provided home visits to 98 families in the community of Yonkers in Westchester County. The population was predominately Hispanic; 63% of mothers were between the ages of 15-24 (15-19=26%; 20-24=32%), with an additional 23% between the ages of 25-29. The household income for the majority of families was under \$10,000.
- Mt. Vernon Neighborhood Health Center, CHWP, provided home visits to 262 families in Mt. Vernon, Yonkers, and Greenburgh-White Plains. The population was 65% Hispanic; 52% of the mothers were between the ages of 20-29 (20-24=29%; 25-29=23%) with an additional 26% between 30-39 (18% were between 15-20). All families were Medicaid eligible.
- Westchester Jewish Community Services, PCHP, provided home visits to 119 families. The population was 59% Black; 37% of mothers were between the ages of 15-19, 26% between 20-24, and with 60% of the household income between \$20,000-\$39,000.
- Family Services of Westchester, Inc., EHS, provided home visits to 17 families. No other information provided.
- HS operates seven programs, but no other information was reported.

Maternal and Infant Statistics:

According to New York State Department of Health, the prenatal care started during the first trimester is defined as early prenatal care, and the prenatal care started during the third trimester is defined as late prenatal care. Among infants born in 2007, over one-quarter (26.3%) were born to women who delayed or sought no prenatal care (excluding cases with incomplete prenatal care information). About one-fifth (21.8%) of infants were born to mothers who delayed to have their prenatal care until the second trimester, 3.9% were born to mothers who started prenatal care during the third trimester, and 0.6% were born to mothers who did not seek prenatal care at all.

Young women were more likely to delay or not seek prenatal care. For example, among the infants born to mothers aged 10-17 years of age, 64.7% were born to mothers who did not have or delayed prenatal care. Among those born to mothers 18-19 years of age, 50.8% were born to mothers who did not have or delayed prenatal care. In comparison, the percentage of infants born to mothers aged forty and over who did not seek or delayed prenatal care was 21.1%. Black women were more likely to delay or seek no prenatal care compared to white women. 33.8% of infants born to black mothers had delayed prenatal care; 2.0% of those had mothers who did not receive any prenatal care. Women of Hispanic ethnicity were also more likely to delay or seek no prenatal care compared to white women. Among infants born to Hispanic mothers, 32.7% were born to mothers who did not seek prenatal care until the second trimester, 5.4% were born to mothers who did not seek care until the third trimester, and 0.7% was born to women who did not seek any prenatal care.

As level of education increased, the percentage of mothers who delayed or did not seek prenatal care decreased. Among infants born to women with less than a high school education, 44.0% were born to mothers who sought prenatal care in the second or third trimester. This percentage was 12.0% among those born to women with an advanced degree beyond college.

A total of 11,857 infants were born to Westchester County residents in 2008, with a birth rate of 12.8 live births per 1,000 people. Among these infants, the majority was born within the county, accounting for 74.7% of all the infants born to Westchester County residents.

As reported by the New York State Department of Health, a total of 16,701 pregnancies occurred during 2007 among Westchester women, with a pregnancy rate of 64.1 per 1,000 women (aged 10-49). The pregnancy rate varies by race and ethnicity. For example, the pregnancy rate among white non-Hispanic women was 43.4 per 1,000, compared to 81.4 per 1,000 among black non-Hispanic women and 115.5 per 1,000 among Hispanic women.

Among infants born in 2008, 8.9% were born with a birth weight between 1,500 to 2,499 grams, and 1.3% was born with a birth weight below 1,500 grams. The proportion of infants born with low birth weight (<2,500 grams) varied by race and ethnicity. Blacks had the highest proportion of low birth weight babies (13.9%). Hispanics had a slightly lower proportion of infants with low birth weight than whites (6.5% and 7.9%, respectively).

In 2008, 13.1% of all births were premature. Also in 2008, the County had a 5.4 infant death rate per every 1,000 births.

New York State Department of Health
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ATTACHMENT

Home Visiting Program Capacity Statewide

Counties	Home Visiting Sites Number of Families Served										Total Number of Families Served per County	Total HV Sites per County	
	CHWP	Healthy Start	HFNY	EHS	HS	NFP	PCHP	PAT	HIPPY	EBHV			
Albany	1		1		1							453	3
	210		243										
Allegany			1	1	1							116	3
			98	18									
Bronx	2		3	4	20	1	2		1			1617	33
	385		377			654	123		78				
Broome			1		1							805	2
			142					663					
Cattaraugus			1	1	1							177	3
			133	44									
Cayuga			1	1	1							130	3
			70	60									
Chautauqua	1			1	2							558	4
	216			69				273					
Chemung			1		1							203	2
			203										
Chenango				1	1							0	2
Clinton			1		1							92	2
			92										
Columbia				1	1							0	2
Cortland				1	1							0	2
Delaware			1		2							73	3
			73										
Dutchess	1		1	1	1							553	4
	262		148	143									
Erie	1		1	1	3		2					734	8
	161		461	39			73						

Counties	Home Visiting Sites Number of Families Served										Total Number of Families Served per County	Total HV Sites per County	
	CHWP	Healthy Start	HFNY	EHS	HS	NFP	PCHP	PAT	HIPPY	EBHV			
Essex				1	1								
				72								72	2
Franklin					1								1
												0	
Fulton					1								1
												0	
Genessee				1									1
												0	
Greene					1								1
												0	
Hamilton													0
												0	
Herkimer			1		1								2
			81									81	
Jefferson	1				1								2
	81											81	
Kings	2	1	4	7	34	2	3						53
	363	703	645	180		559	212	30				2692	
Lewis					1								1
												0	
Livingston	1				1								2
	216											216	
Madison			1	1	1								3
				65								65	
Monroe				1	2	1					1		5
						210		40			197	447	
Montgomery				1	1								2
												0	
Nassau	1	1			4			8					14
	178	109						180				467	

Counties	Home Visiting Sites Number of Families Served										Total Number of Families Served per County	Total HV Sites per County
	CHWP	Healthy Start	HFNY	EHS	HS	NFP	PCHP	PAT	HIPPY	EBHV		
Manhattan (New York)	2	1	3	10	40	3	1				1780	60
	338	205	511	246		429	51					
Niagara	2		1								453	3
	229		224									
Oneida	1		1	1	1						498	4
	207		197	94								
Onondaga	1	1		1	1	1					872	5
	229	521				122						
Ontario			1		3						99	4
			99									
Orange	1		2	1	3						318	7
	138		180									
Orleans				1	1						0	2
Oswego					1						0	1
Otsego			1	1	1						265	3
			104	161								
Putnam				1							0	1
				0								
Queens	1	1	1	4	6	2	1				1229	16
	117	109	96	97	151	559	100					
Rensselaer			1	1	1						264	3
			225	39								
Richmond			1	1	1	1					254	4
			127	32		95						
Rockland				2	2		4				124	8
				63			61					
Saratoga				1	1						156	2
				108	48							

Counties	Home Visiting Sites Number of Families Served										Total Number of Families Served per County	Total HV Sites per County	
	CHWP	Healthy Start	HFNY	EHS	HS	NFP	PCHP	PAT	HIPPY	EBHV			
Schenectady			1	2	3							569	6
			230	339									
Schoharie				1	1							0	2
Schuyler					1							0	1
Seneca			1									42	1
			42										
St. Lawrence	1				1							81	2
	81												
Steuben			1	1	2							369	4
			259	110									
Suffolk	2	1	1	2	2		8					962	16
	430	136	106	50	0		240						
Sullivan	1		1	1	1							311	4
	75		130	106									
Tioga			1		1							121	2
			121										
Tompkins				1	2							68	3
				68									
Ulster			1	1	1							279	3
			279										
Warren				1	1							24	2
				24									
Washington				1	1							108	2
				108									
Wayne				1	1							0	2
Westchester	1		1	1	7		1					496	11
	262		98	17			119						

Counties	Home Visiting Sites Number of Families Served										Total Number of Families Served per County	Total HV Sites per County
	CHWP	Healthy Start	HFNY	EHS	HS	NFP	PCHP	PAT	HIPPY	EBHV		
Wyoming				1							32	1
				32								
Yates				1							0	1
Total Sites State-wide	24	6	39	65	175	11	30	0	1	1		352
Total Families State-wide	4178	1783	5794	2384	199	2628	1159	1006	78	197	19406	