Maternal and Child Health Services Title V Block Grant

State Narrative for New York

Application for 2013 Annual Report for 2011

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I. General Requirements

A. Letter of Transmittal

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

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

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

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

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

•NYSDOH's Prevention Agenda (PA) development process: In April, 2008, former Commissioner Daines launched the PA for the Healthiest State, establishing 10 statewide public health priorities with an emphasis on prevention strategies. The PA was a call to action, asking hospitals, local health departments, and other health care and community partners to collaborate in planning to bring about measurable progress toward mutually-established goals related to two to three of the priorities. Across all the priority areas, the PA focuses on eliminating the profound health disparities that impact racial and ethnic minorities.

•A survey of stakeholders related to MCH needs and priorities NYSDOH's Needs Assessment leadership team developed a survey for key stakeholders to obtain their input related to the needs and priorities for the MCH populations in NYS. The survey included background information related to the MCH Block Grant, as well as specific information regarding current national outcome measures, performance measures and current state priorities. The survey was sent to over 183 MCH stakeholders, stakeholders in NYSDOH and other state agencies, as well as a substantial number of external partners, including perinatal consortia and regional perinatal centers, advocacy organizations, community based agencies servicing the MCH population, professional organizations and consumers.

•Regional forums for youth/young adults with special health care needs and families of children with special health care needs were conducted in February and March 2010 by the CSHCN Program to gather consumer input about the system of care for children and youth/young adults. The forums were facilitated to elicit information about the core Maternal and Child Health Bureau

performance measures
•A survey of families of children with special health care needs and youth representatives was developed to elicit feedback for the Maternal Child Health Block Grant application item 13, "Characteristics Documenting Family Participation in the CSHCN Program".
•Focus groups with adolescents and their families were conducted to inform the DOH about how young people get information about sexual health, where they go for sexual health care services, their experiences in accessing services and their unmet needs. The Adolescent Sexual Health Focus Group study was conducted by the DOH-funded adolescence Center of Excellence at Cornell University (and their partners at University of Rochester School of Medicine, NYS Center for School Safety and NYC Cornell Cooperative Extension).
•MCHBG Advisory Council discussions related to MCH needs and priorities, development of the MCH Block Grant needs assessment and application was an agenda item for several Council meetings. In addition, a special session of the Council was convened with an agenda exclusively focused upon a review of needs assessment activities and results and development of state priorities.
•Incorporation of local level stakeholder input to inform the state level assessment, including structured listening sessions with:
-the MCH committee of the NYS County Health Association which includes 17county members
-local perinatal networks which represent consortia of health and human service providers who address MCH issues at the local level. These networks also co-chair regional perinatal forums which are also co-chaired by regional perinatal centers. These forums provide a comprehensive picture of MCH needs, incorporating both the community and hospital perspectives; and,
-the NYC DOH and Mental Health MCH Bureau.
•In addition to these efforts to obtain input during the development of the application, a summary of the needs assessment and new state priorities were made available to key stakeholders, including the perinatal networks, the MCHBG Advisory Council, the MCH Committee of NYSACHO to provide any additional input for consideration prior to submission.
•The application was posted on the Department's website to obtain further information regarding development and implementation of the needs assessment.
•A summary of the needs assessment process was presented on June 17th ***/2013/2010 //2013//*** at the NY Perinatal Association Conference with an opportunity to comment.

/2013/ Additional //2013// activities to obtain public input into the block grant /2013 are ***//2013// described in more detail in the Needs Assessment Section.***

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

/2013/ In 2010-11, //2013// a major effort to obtain public input regarding MCH ***/2013/ needs and //2013//*** services related to the development of the state needs assessment and plan related to creation of the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) authorized under the Patient Protection and Affordable Care Act (ACA) of 2010. This historic legislation marks a significant commitment to promote and improve the health, development and well-being of at-risk children and families through evidence-based home visiting programs. NYS's MIECHV State Plan reflects over a year of intensive assessment and planning work, led by the DOH MCH Program and conducted in collaboration with a core group of state agency partners and many other stakeholders.

Fourteen counties were identified through the Needs Assessment as "at-risk" communities for NYS' MIECHV initiative. As part of the plan development process, a structured on-line survey was distributed to stakeholders in those 14 counties to further identify: community risk factors,

strengths and resources; characteristics of target populations; mechanisms for screening identifying and referring families to home visiting programs; and referral resources currently available and needed. In-person and conference call discussions were held with several stakeholder groups during the plan development process. Respondents include local home visiting programs as well as other stakeholder organizations. Through these processes, input was received from ***/2013/ other State agencies //2013//***, more than 100 community-based organizations, local government agencies and home visiting programs.

Parent representatives have meaningful roles on councils and task forces that provide input to DOH policy and programs, including the MCHBG Advisory Council, the Early Intervention Cooridnating Council, and the Lead Poisoning Prevention Advisory Council. In addition, DOH has ongoing communication and engagement with parent organizations. DOH staff met with parent support staff of Parent to Parent of NYS, the Family-to-Family Health Care Information and Education Center grantee, to affirm collaboration on family support activities and to obtain input on DOH programming related to CSHCN. ***/2013/ As you can see throughout this application, consumers, including parents, play a critical role in the ongoing work of the NYSDOH in improving health outcomes for New Yorkers.//2013//***

In addition to these efforts to obtain public input, NYSDOH continued a number of regular mechanisms to obtain public input related to MCH programs, including advisory council meetings, providers meetings, meetings with advocates and other activities. ***/2013/ In 2012, the NYSDOH is developing a NYS Improvement Plan, based on the PA that identifies public health priorities, establishes indicators to measure progress, and engages local health departments and other partners to address them. This initiative is led by a Committee appointed by the Public Health and Health Planning Council, consisting of NYS DOH staff, and key stakeholders.//2013//***

/2013/ Methods used to obtain input from providers and consumers regarding efforts to address disparities and improvements in supports and services to CSHCN are discussed Section IIB Needs Assessment Summary.//2013//

/2013/ The application will be available to //2013// key stakeholders, including the MCHBG Advisory Council and the MCH Committee of New York State Association of County Health Organizations (NYSACHO), to provide any additional input for consideration prior to submission. The application will also be posted on the Department's website.

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The NYSDOH's goal in the needs assessment process is to comprehensively review the needs of the MCH population; examine existing program priorities and realign those priorities to better address identified needs as resources permit; and, assess performance related to program priorities to ensure MCH programming results in improvements in the health and well being of the MCH populations. The needs assessment process was developed based upon three main components: stakeholder input; analysis of MCH data; and, information obtained from needs assessment cycles for specific MCH programs.

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

The NYSDOH makes every effort to assess the needs of its population on an ongoing basis to ensure that scarce resources are being well utilized. However, impacting health disparities requires a more comprehensive approach to the public health needs of NY's diverse population. NYS has made steady progress in several outcomes, but despite improvements, NYS is below Healthy People 2020 objectives for several measures, and health disparities continue to be significant. Addressing racial and ethnic disparities necessitates a more holistic, comprehensive approach that addresses the biological, behavioral, psychological, social and environmental factors that contribute to health outcomes across the lifespan. Moving towards a life-course perspective of MCH services requires a reframing of priorities and outcomes, focusing on families and communities and the factors and conditions that impact health.

Approaching public health from the life-course perspective highlights those areas for improvement, and provides a framework to promote healthy behaviors rather than focusing on the identification and treatment of health issues. The early years of a child's life, including a healthy start from birth, significantly impacts the child's health and well-being in later years. NYS has made steady progress in reducing infant and neonatal mortality, perinatal HIV transmission, and ensuring the delivery of very low birth weight babies in higher level hospitals. Breastfeeding rates have been steadily increasing over the past 10 years. High rates of newborn screening and follow up continue, including significant increases in newborn hearing screening and children identified with autism. Although infant mortality rates have been declining, Black non-Hispanic infant mortality rates are still significantly higher than rates for White non-Hispanics, Asian/Pacific Islander non-Hispanics and Hispanics. Rates of low birth weight remain unchanged. Trends in neonatal mortality mimic those of infant mortality. In 2010, the Black non-Hispanic neonatal mortality rate was 6.8 per 1,000 births, more than double the rate for White non-Hispanics, Asian/Pacific Islander non-Hispanics and Hispanics. Among infants born in 2010, 43.5 percent were exclusively fed breast milk in the delivery hospital. White non-Hispanic women exclusively breastfed at a higher rate than Black non-Hispanics, Asian/Pacific Islander non-Hispanic and Hispanic women.

NY has also generally made improvements in children's health measures related to lead, immunization, oral health, asthma, obesity and tobacco use have generally improved, though

data tends to fluctuate annually for children hospitalized due to asthma. Obesity in children and adolescents in NYS remains a significant public health problem. Currently, one third of NY's children are obese or overweight. The percent of children, including CSHCN, who have insurance coverage and a medical home have improved, though some other access and quality measures for primary and specialty care for CSHCN have been relatively unchanged. However, since the last MCHBG cycle, there have been significant changes in State capacity related to priorities. Reform in the State's public health insurance programs has been extensive with positive impacts. (Refer to Section IIA for further details on health care reform in NYS.)

Health disparities are also evident in NY's adolescents. Although NYS has had significant success in decreasing teen (15-17 years) birth rates, including a decrease in the rate for every race and ethnicity, disparities continue to exist. Hispanic teen girls had a birth rate of 23.2 per 1,000, 41 percent higher than the rate for Black non-Hispanics, and more than 4 times the rate for White non-Hispanics. Chlamydia morbidity has continued to increase since reporting began in 2000 making it the most commonly reported communicable disease.

The statewide rates of early prenatal care decreased slightly while adequacy of prenatal care and smoking in pregnancy saw a slight improvement, and alcohol use in pregnancy remain relatively unchanged. The percentage of preterm births declined slightly and births delivered by c-section declined between 2009 and 2010 to 34.5 percent, the first decline in more than a decade, though maternal mortality has increased.

A significant racial/ethnic disparity is evident in early prenatal care, as the rate for White non-Hispanic women was 29 percent higher than the rate among Black non-Hispanic, 11 percent higher than the rate among Asian/Pacific Islander non-Hispanic and 22 percent higher than the rate among Hispanic women. The percentage of Black non-Hispanic women delivering at less than 37 weeks gestation was 15.8 percent in 2010, 58 percent higher than the 10.0 percent among White non-Hispanic women. In 2010, 12.9 percent of Black non-Hispanic infants were less than 2500 grams at birth (low birthweight), 90 percent higher than the percentage for White non-Hispanic infants and 65 percent higher than the percentage for Hispanic infants. The racial disparity in maternal mortality in NY is dramatic. The 2010, Black non-Hispanic maternal mortality rate of 65.4 per 100,000 births and the White non-Hispanic rate of 12.8 per 100,000 births, result in a Black non-Hispanic-to-White non-Hispanic ratio of 5.1 to 1. These rates are based on 25 deaths among African American women and 15 deaths among Caucasians.

In spite of NY's continuing fiscal crisis, state funding continued to support key initiatives, including: family planning and school based health programs; home visiting; adolescent pregnancy prevention; perinatal regionalization; and, obesity, as well as others. The NYSDOH also received federal grants that support MCH initiatives, including home visiting, adolescent health initiatives, newborn hearing screening, autism, oral health, breastfeeding, immunization, obesity, and perinatal quality improvement. Significant investments have been made in quality improvement and developing initiatives to improve quality of MCH services.

Over the past year, the NYSDOH embarked on the development of a Public Health Improvement Plan with a vision of NY as the "healthiest state". Working collaboratively with the Public Health and Health Planning Council and key stakeholders, the NYSDOH is reviewing progress on priorities established through the Prevention Agenda, and developing priorities and outcomes, identifying evidence-based strategies and changes in policy and practice needed to accomplish improvements and key partners to implement needed changes identified in the Improvement Plan that will improve the health status of all NY's citizens.

Additionally, the NYSDOH continued to assess outcomes, and refocused efforts in the highest need areas of the state, and reviewed trends to better address health disparities. For example, resources to improve adolescent health using evidence-based strategies are targeted to areas of the state with the greatest need and burden. The same is true of the upcoming maternal and infant health initiative that will include the new federal maternal, infant and early childhood home

visiting funds.

A greater focus has been placed on the development of processes to obtain enhanced input from the people served, both directly at NYSDOH and on the part of providers directly connected to individuals served in order to improve services. With the focus on community involvement and diversity, Tile V staff developed an on-line survey that was disseminated to all DOH-funded MCH providers to obtain input regarding their outreach into the community, level of consumer involvement in the development of their services, as well as successes and challenges in serving the highest risk population in their catchment area. Those providers included LHDs, family planning providers, adolescent health providers, home visiting programs, a range of perinatal providers, those involved with smoking cessation, obesity prevention, children with special health care needs, among others. The majority obtained input through interviews, focus groups, membership on advisory boards, etc., and enhanced efforts to engage community agencies to reach disparate populations. In focusing specifically on CSHCNs, providers modified practices and procedures based on input from parents and young adults with special health care needs. In addition to more targeted activities, the NYSDOH is exploring other venues to reach the targeted populations, including social media and alternative communication such as Text4 for Baby.

The NYSDOH is committed to continuous efforts to identify needs, maximize resources and better meet the needs of underserved population in order to reach MCH goals and improve health disparities related to NY's population.

III. State Overview

A. Overview

/2013/ NYS is notable for the great diversity of its geography and its people. As of 2012, NY was the 3rd largest state after California and Texas, with a population of 19,378,102. NY leads the nation in numbers of immigrants from across the world. Since 2000, over 820,000 immigrants made NY their home while over 800,000 New Yorkers migrated to other parts of the nation. //2013//

/2013/ Cultural diversity is both a strength and challenge. NYS is geographically diverse, with both rural and urban areas. Population density often determines the number and types of health services in an area. In 2010 there were 411 persons per square mile in NYS, compared to 88 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 NY varies widely. NYC is 104 times more densely populated than the rest of the state. Manhattan has the highest population density at 69,467 persons per square mile, while Hamilton County in the Adirondack Mountain Range has the lowest density, with only 3 people per square mile. Sixty-four percent of NY's population live in the NY Metropolitan area; 43% in NYC alone. //2013//

/2013/ NY has a rich system of health care as well. According to a 2004 Center for Workforce Study, NY had over 61,000 active patient care physicians and is fourth in the country for the number of dentists in the state. However, physicians are more likely practicing in urban areas and only 9% are representative of minority populations. NY is also home to 51 Federally Qualified Health Centers, 231 hospitals with 134 of those certified to provide perinatal services, and numerous other health care resources as described later in this application. //2013//

/2013/ The changing landscape of NY's population, services and resources, as well as health care on the federal level, coupled with efforts to enhance and streamline health services in NYS has been the impetus for strategic planning processes for the NYSDOH. Under the direction of Commissioner Nirav Shah, NYSDOH leadership redefined the mission and vision of the NYSDOH to protect, improve and promote the health and well-being of all NYS residents through outcome-based, cost effective strategies that:
•Focus on opportunities to reinvent core functions and improve efficiency;
•Increase the effectiveness of statewide health infrastructure;
•Optimize resource acquisition and utilization; and,
•Reinvent the NYSDOH as a model performance-based organization.//2013//

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

In a state as large and diverse as NY, achieving the mission is a daunting task. This task ***/2013/continues to be //2013//***complicated by New York's economic and fiscal challenges. Both financial and human resources ***/2013/continue to be //2013//*** limited to accomplish the Department's core mission. Yet, despite these ***/2013/challenges//2013//***, DOH is committed to ensuring NY meets the needs of its most vulnerable maternal and child health population.

Maximizing resources and cultivating collaborative relationships is essential to /2031/achieving DOH's mission.*//2013//.* ***DOH works with the State's health care community to /2013/ improve the health of all New Yorkers, and //2013//*** ensure appropriate readiness and response to potential public health threats. DOH is also the principal State agency that interacts with the Federal and local governments, health care providers and program participants for the State's Medicaid (MA) program.

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

The Governor's Budgets for 2011 ***/2013/and 2012 //2013//***continues to reshape the health environment in New York through significant reforms of the Medicaid Program. The budget process brought together health care providers, labor, government and other Medicaid stakeholders to form the Governor's Medicaid Redesign Team (MRT). Tasked with identifying ways to provide critical health care services at lower costs and control unsustainable growth, the MRT recommended a series of proposals to fundamentally restructure New York's extensive Medicaid program. The ***/2013/ 2011 //2013//*** budget implemented a majority of the MRT recommendations resulting in a $2.3 billion reduction. ***/2013/ The Governor's 2012-13 budget builds on the success of this past year, including //2013//***major expansion of patient-centered medical homes, better control of home health care services, and care management for individuals with complex and continuing health needs.

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

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

/2013/ Work continues on //2013// several additional proposals of the MRT pertaining to the MCH population, including expanding current statewide patient-centered medical homes; MA changes related to family planning, including the proposal to move the Family Planning Benefit Program, an income expansion of MA eligibility approved through a MA waiver, to a state MA plan service; reducing inappropriate use of services such as C-section delivery and reforming malpractice and patient safety, including development of a NYS obstetrical patient safety workgroup.

/2013/ DFH staff are working with OHIP on additional MRT proposals to enhance services to the MCH population, including: development of a children's health home to provide enhanced care coordination for children with chronic physical and behavioral health needs; reimbursement to Local Health Departments (LHD)s for environmental and nursing follow-up services provided to children with lead poisoning; reimbursement for interpretation services for patients with limited English proficiency and communication services for people who are deaf and hard of hearing; expansion of Medicaid to include pre-diabetes counseling, lead poisoning prevention and asthma home visits; home blood pressure monitors for patients with uncontrolled hypertension; Medicaid enhancements to promote maternal and child health, including interconceptional health, breastfeeding

support and efficient use of HIT to improve care delivery; denial of Medicaid payment for elective c-section prior to 39 weeks gestation without medical indication; Medicaid coverage of intensive behavioral therapy for treatment of obesity and water fluoridation; and, statewide expansion of Nurse Family Partnership. //2013// Staff from the Division of Family Health, as well staff from other public health offices, are participating in the implementation committees of relevant MRT proposals.

Despite the need for the budgets to reduce a significant deficit, with some exceptions, maternal and child health programs were relatively successful in maintaining funding levels. The Governor has also supported specific health related efforts such as expanding fresh food access into urban areas. The Governor has indicated that he fully supports passage of reproductive rights legislation in the State to protect the fundamental right of reproductive freedom and a woman's right to make private health care decisions.

Under the direction of the Commissioner, Dr. Nirav Shah, who is appointed by the Governor, DOH meets its responsibilities through the Office of Health Insurance Programs (OHIP), the Office of Long Term Care (OLTC), the centers located in the Office of Public Health (OPH) and the Office of Health Systems Management (OHSM). In 2007, DOH established OHIP which consolidated operations of the State's public health insurance programs under the direction of the State MA Director. OHIP is responsible for developing and implementing strategies to improve access to health insurance coverage for the uninsured and providing for an integrated approach to oversight and administration of the MA program to strengthen coordination within the DOH and among State agencies. The establishment of OHIP marked the adoption of a new mission for MA, namely to expand coverage and access; to buy value with NY's heath care dollars; and, to advance system wide reform. OHIP is responsible for MA, Family Health Plus, Child Health Plus, Elderly Pharmaceutical Insurance Coverage, and the AIDS Drug Assistance Program. The OLTC oversees the integration of planning and program development for services related to long term care. The OPH and the OHSM are responsible for providing policy and management direction to the DOH's system of regional offices. ***/2013/ The Office of Minority Health now reports directly to the Commissioner to ensure high level involvement to the issue of health disparities.//2013//*** DOH staff located in regional offices conduct health facility surveillance, monitor public health, provide ***/2013/ technical assistance and monitor DOH contracted providers, provide //2013//*** direct services and oversee county health department activities. In addition, DOH also contracts with organizations, such as the Island Peer Review Organization (IPRO), to conduct monitoring and surveillance activities for programs such as the Early Intervention Program, ***/2013/ Family Planning Program and School Based Health Centers. //2013//*** The DOH is also responsible for five health care facilities that are engaged in patient care: the Helen Hayes Hospital in West Haverstraw, which offers specialty rehabilitation services, and four nursing homes for the care of veterans and their dependents in Oxford, NYC, Batavia and Montrose.

The OPH was established in 2007 to strengthen coordination among the DOH's public health programs and to ensure public health input into all the DOH's programs. OPH is made up of the Department's four principal public health centers:
•AIDS Institute;
•Center for Community Health;
•Center for Environmental Health; and,
•Wadsworth Center.

In addition, the Office of Public Health Practice (formerly the Office of Local Health Services in the Center for Community Health), the Health Emergency Preparedness Program, the Office of Public Health Informatics and Project Management and the CDC Senior Management Official in NY report to OPH. The purposes of the OPH are to:
•continue and increase coordination and integration across the department's public health centers and programs;
•assure that public health is fully represented at the departmental level including full incorporation

of public health principles into the redesign of the health care system and health insurance programs;
•keep New York active as an innovator in the emerging areas on the cutting edge of public health practice such as maternal and child health; chronic disease prevention; nutrition; environmental health; laboratory science; prevention and control of infectious diseases such as HIV, hepatitis C and others; genomics and informatics;
•coordinate public health activities with the Centers for Disease Control and Prevention, other federal agencies, other state health departments, and local health departments in New York;
•convene partners in the community, academia and the health care system to further public health goals; and,
•rebuild and strengthen the state and local public health infrastructure.

The Center for Community Health (CCH) works with communities to promote good public health for all New Yorkers. A priority of the CCH is to address the root causes of diseases, not just the diseases themselves, in order to make a longer term impact. Aiming programs at the problems of obesity, lack of exercise, poor diet and smoking, helps reduce illness and death from a variety of diseases including heart disease, cancer, diabetes mellitus and stroke--the nation's leading killers. Making sure children's homes are free of lead and that children are screened early in life for lead poisoning helps prevent a lifetime of underachievement and behavioral problems. ***/2013/ Promoting healthy behavior across the lifespan, and preconception health to better ensure women are healthy before pregnancy to improve birth outcomes are also significant priorities.//2013//***

The majority of deaths in NYS are not caused by inadequate access to health care (10%) but by behavioral (50%), environmental (20%), and genetic (20%) factors that can be addressed by public health actions. According to a report on Public Health in America produced by the U.S. Department of Health and Human Services in 1994, public health provides ten essential services:
•Monitor health status to identify community health problems;
•Diagnose and investigate health problems and health hazards in the community;
•Inform, educate, and empower people about health issues;
•Mobilize community partnerships to identify and solve health problems;
•Develop policies and plans that support individual and community health efforts;
•Enforce laws and regulations that protect health and ensure safety;
•Link people to needed personal health services and assure the provision of health care when otherwise unavailable;
•Assure a competent public health and personal health care workforce;
•Evaluate effectiveness, accessibility, and quality of personal and population-based health services; and,
•Research for new insights and innovative solutions to health problems.

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

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

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

NY's Title V program is located in the DFH in the CCH. DFH's primary focus is to improve the health of women, children and adolescents. Its programs touch new mothers, adolescents ***/2013/ including those //2013//*** considering sexual activity, children, ***/2013/including those//2013//*** with disabilities ***/2013/and special health care needs//2013//***, rape victims and children with lack of access to dental services. Programs promote healthy behaviors while also assuring access to quality health care. DFH provides access to primary medical and dental care and preventive health services for migrant farm workers and Native Americans living in reservation communities. DFH consists of the:
•Bureau of Maternal and Child Health;
•Bureau of Early Intervention;
•Bureau of Dental Health;
•Office of the Medical Director.

DFH works very closely with the other Divisions within CCH as well as with the major organizational segments of DOH whose work complements that of DFH, in particular the Office of Health Systems Management (OHSM) and the Office of Health Insurance Programs (OHIP). Division of Nutrition (DON), which includes the WIC program and various other nutrition and fitness programs, works closely with the DFH and OHIP in implementing both prenatal programs and children's programs to ensure that the nutritional needs of at risk pregnant and nursing women as well as infants and children are being met. The Division of Chronic Diesease and Injury Prevention (DCDIP) works closely with the DFH on programs such as the family planning program, which collects extensive annual data on Chlamydia testing for reproductive age women in NYS, with the cancer screening program in referral of women for screening and treatment for breast and cervical cancer. The DFH, DON and DCDIP are also collaborating on a major effort to promote exclusive breastfeeding in NYS. Ongoing communication and collaboration are essential to ensure messaging is consistent in areas such as preconception and interconceptional health, screening for intimate partner violence and substance use and abuse, among other topics of importance to Title V.

OHSM oversees all hospitals and licensed clinics as well as related services in NYS. These facilities, licensed under Article 28 of the Public Health Law to provide health care services, are frequently targeted by the Division's programs in RFPs as eligible awardees for contracts. Since the licensing and monitoring process carried out on an ongoing basis ensures that facilities obtain approval for provision of specific services, these facilities have a demonstrable range of services and quality of care level appropriate for many of the services and programs provided by the DFH. Further, the BMCH, in particular, within DFH, collaborates closely with OHSM in designation of hospitals for level of perinatal care, and in fact drafted the revisions of hospital regulations on

which these designations are based, as well as certifying hospitals as Sexual Assault Centers of Excellence (SAFE Centers). BMCH and DFH are consulted by OHSM whenever hospital or clinic closures are threatened, to ensure that sufficient service providers are available to meet the obstetric and perinatal needs within the region.

There has been a long and very close partnership between the MA programs and the maternal and child health programs in NYS. The DFH worked closely with OHIP over the past couple years on major initiatives of significance to the MCH population including the transition of the Prenatal Care Assistance Program to the MA Prenatal Care Program, revising prenatal care program policies and standards to conform with current standards of professional practice, streamlining enrollment of pregnant women from Fee for Service MA into Managed Care, improving the coordination of home visiting services, including the development of a Risk Summary form to better ensure providers are working with Managed Care Plans to address identification and referral of pregnant women at risk for poor birth outcomes, development and implementation of the new Ambulatory Patient Group reimbursement to ensure providers were adequately reimbursed for comprehensive services, and efforts such as submission of the 1115 MA Waiver to ensure NY can continue to provide comprehensive reproductive health services to eligible populations of the state. DFH is working closely with OHIP on an ongoing basis to ensure that guidelines for high quality care are in place, in addition to helping inform providers of changes, streamline application processes, and generally provide a systems level approach to implementation. ***/2013/The DFH and OHIP are currently collaborating on a focused prenatal care study to establish priority areas for improvement. The DFH will also work closely with the newly formed Office of Quality and Patient Safety (OOQPS) whose core mission is to improve the health, quality of care and patient safety of NYS residents, consistent with the NYSDOH Strategic Plan and MRT recommendations.//2013//***

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

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

Title V priorities align with DOH's overall priorities. Dr. Nirav Shah, the DOH Commissioner continues to stress the importance of restoring NY to national prominence in health care delivery and the need to reshape NY's health care system to serve New Yorkers more efficiently and cost effectively. Dr. Shah ***/2013/continues to support//2013//*** the need to maintain core public health programs in critical areas such as tobacco control, obesity prevention, and HIV AIDS prevention and services. As with the previous budget, there are several themes that run through all of the Department's budget proposals for the ***/2013/ 2012-13//2013//*** fiscal year including:
•preserving services that support the DOH's core mission of protecting and improving the public's health;
•achieving reforms that increase efficiency while maintaining quality;
•accountability and transparency;
•elimination of duplication of services;
•consolidation, streamlining and simplification;
•flexibility to target resources where they are needed most; and,
•use of innovation to reduce the State's greatest public health threats while at the same time helping to reduce the deficit.

Major priority areas of DOH closely align with the priorities of NY's Title V program including:
•Obesity Prevention - Overweight and obesity are now challenging smoking for the top public health threat in NYS. Currently, about 60 percent of adults and 35 percent of children and

adolescents in NYS are obese or overweight. The increase in overweight and obesity is dramatically increasing NY's risk for many chronic and debilitating conditions -- including heart disease, diabetes, hypertension, and some cancers. NY's approach to obesity as well as other chronic diseases uses the social-ecological model focusing on activities at all levels of influence (society, community, organizational, interpersonal and individual) in order to facilitate healthy choices and limit promoters of poor health. The obesity prevention agenda includes the promotion of exclusive breastfeeding, initiatives to increase exercise among children, decrease television viewing, and improve nutrition, including a calorie posting requirement, a ban on the use of trans fats in certain restaurants and food service establishments, and a ban on the sale of high-fat, high-sugar junk foods in schools.

•Tobacco prevention and control - Tobacco use continues to be NY's number one cause of preventable disease and death. Health care costs related to treating smoking-caused diseases total approximately $8 billion annually for NY alone, including $3 billion annually in Medicaid costs. Between 2000 and 2009, the adult smoking rate in NYS declined from 21.6 percent to 17.9 percent, resulting in 500,000 fewer smokers in only one year. Between 2000 and 2010, the high school smoking rate in NYS dropped from 27.1 percent to only 12.6 percent.

•Lead poisoning -- NY has made a commitment to end childhood lead poisoning in NYS. Childhood lead poisoning has decreased by 17 percent in upstate NY since 2005. The Childhood Lead Poisoning Primary Prevention Program is a priority of DOH to keep NY's children safe from this public health threat.

•HIV/AIDS and Sexually Transmitted Diseases -- DOH remains committed to addressing the AIDS/HIV epidemic and addressing sexually transmitted diseases.

•Targeting primary and preventive public health strategies that will decrease obesity rates, increase healthy eating and physical exercise, prevent childhood lead poisoning, expand access to cervical cancer vaccines, prenatal and postpartum home visiting, high-quality mammograms and public health education.

•Early Intervention Program (EIP) -- DOH continues to work on reforms to the program including a variety of administrative actions that would require preferred assessment tools, modified speech eligibility standards, and revised reimbursement rates. ***/2013/Significant reforms were enacted as part of the 2012-13 State Budget to improve coordination of care and reduce the local burden of the early intervention system for localities. These reforms, which will become effective in 2013, include a new requirement for service coordinators to notify regional OPDD, with parent consent, when children referred to the EIP might also be eligible for that system; elimination of local contracts with EIP providers, to be replaced by direct State-level provider agreements; the establishment of a State fiscal agent to manage provider billing and claiming to third party payors; and, expansion of the role of service coordinators to include timely implementation of children's Individual Family Services Plans and management of the transition process.//2013//***

•Ensuring there are health care professionals available to meet the primary and preventive health care needs in NY's underserved areas of the state;

•Ensuring that the Graduate Medical Education (GME) system provides the state with the value desired for the funds invested;

•No longer using MA to cross-subsidize commercial insurers, nor supporting deep discounts for hospital services their members use.

•Paying fair reimbursements that reflect the true costs of providing high-quality care through a work force whose needs are met fairly, redirecting MA dollars to those facilities that serve the bulk of the MA patients.

•Purchasing health care in the appropriate setting, using the highest standards at the best price, and starting with the patients that have multiple medical needs. With better coordination of care, patients with medically-complicated conditions will get better care, their conditions will be better managed, and the cost of their total care will be reduced.

•Expanding the managed long-term care programs which have been successful in coordinating and managing long-term care needs.

•Driving the implementation of health information technology, which is essential to improving health care quality, reducing bureaucratic barriers and saving health care dollars.

•Increasing efforts to root out MA fraud, which wastes precious resources and reduces our ability

to care for those in need.

/2013/Refer to Section IIIB Agency Capacity for a more comprehensive description of NY's MCH activities.//2013//

The Governor's proposed Budget for 2012 continues the historic health care reforms achieved over the last ***/2013/four//2013//*** years. DOH's efforts focus on achieving greater efficiency without creating barriers to enrollment for those eligible for MA services. In NY, MA is the largest single payer of health care, so through MA reform, DOH will have an opportunity to leverage changes in the health care system. These reforms fully support the mission of NY's Title V program in ensuring comprehensive primary and preventive health and support services to the maternal and child health population, including children with special health care needs.

NY also leads the nation in MA inpatient hospital spending. NYS ranks 4th on per enrollee inpatient hospital spending and spends almost twice the national average. To better serve patients in the right setting at the right price, NY has invested more than $600 million in outpatient care in the last ***/2013/three//2013//*** years. The investments include investments in hospital programs, including outpatient clinics, ambulatory surgery, and emergency room; physicians' fees; primary care; freestanding programs; and, mental hygiene enhancements.

Another critical component of NY's historic health care reform of the last ***/2013/four//2013//*** years has been the updating of the decade-old hospital reimbursement system and addressing the issue of potentially preventable hospital readmissions. Potentially preventable readmissions occur because the patient is discharged too soon or too sick or because of a lack of follow-up care in the community following the discharge. The 2010-11 Budget began reducing funding for preventable admissions and in 2012 begins to reinvest a portion of the savings in rewarding hospitals that reduce readmissions and in post discharge linkages. The budget also funded an additional 100 slots for Doctors Across NY -- 50 for physician loan repayment and 50 for physician practice support -- to improve access in medically underserved areas of the state.

DOH continues its efforts to make it easier for eligible individuals to access public health insurance programs. Since 2008, DOH has permitted self-attestation of income and residency at renewal for non-SSI related MA beneficiaries and Family Health Plus members. The 2010-11 budget permitted MA enrollees receiving community-based long-term care to attest to their income and residency at renewal. DOH ***/2013/is in the process of implementing//2013//*** a federal option called Express Lane eligibility that will allow children ***/2013/no longer eligible for Child Health Plus//2013//*** to transfer to MA.

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

The Affordable Care Act (ACA) at the federal level may significantly impact NY's public health programs and maternal and child health services, and support NY's efforts in this arena. Although DOH awaits specific guidance around some of these areas, the federal Patient Protection and ACA will assist DOH to achieve improved maternal and child health outcomes if DOH has the ability to obtain funding and support. DOH has already been awarded a small Community Transformation Grant from the Centers for Disease Control and Prevention (CDC) through the Communities Putting Prevention to Work (CPPW) initiative. The Title V staff is collaborating with the DCOD to implement this grant that will help support DOH's initiative to increase exclusive breastfeeding rates in NYS. DOH's plan for the use of Personal Responsibility Education Program funding ***/2013/has been approved and //2013//*** will support additional programs in the Comprehensive Adolescent Pregnancy Prevention program to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted

infections, including HIV/AIDS; and adult preparation subjects (financial literacy, parent child communication, career planning, etc). This funding will augment adolescent health services in the state. The OHIP has also obtained state plan approval to provide MA funding support to two Nurse Family Partnership programs in Monroe County and NYC as targeted case management programs. DOH was awarded Abstinence Education funds to support ***/2013/innovative activities//2013//*** focusing on adult mentorship and supervision of children 9 through age 12 years ***/2013/and plans on releasing a Request for Applications to award those funds later in 2012//2013//***.

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

The new federal law also contains measures that will enhance NY's already rich public health insurance system. The following are major highlights of those provisions impacting NYS.
•MA Expansion. Creates a new mandatory MA eligibility category for most adults and children with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. States are required to adopt a "modified adjusted gross income" (MAGI) test to further streamline eligibility determinations. The OHIP will be working with CMS to define the MAGI to ensure greater access for NY's uninsured or underinsured population. Eligibility for most non-disabled adults under age 65 will be based on this MAGI.
•NYS is already in compliance with the requirement that there be no resource test for most populations, including pregnant women, most families, children and single adults. That provision is required by the HCRA starting in 2014.
•State Health Insurance Exchange. ***//2013//In April 2012, Governor Cuomo signed an Executive Order to establish a statewide Health Exchange that will reduce the cost of coverage for individuals, small businesses, and local governments, and will be instrumental in establishing the first-ever comparative marketplace to bring down the cost of health insurance and help more than one million uninsured New Yorkers afford health coverage.//2013//***
•States are required to maintain income eligibility levels for CHIP through September 30, 2019. Low income children will continue to be covered in NY up to 400% of the FPL either through Child Health Plus, MA or the Exchange.

There are also provisions that will bolster NY's health care system, especially for underserved areas of the state, including:
•Community Health Centers. Creates a Community Health Center (CHC) Fund that provides mandatory funding for the CHC program, the National Health Service Corps and construction and renovation of community health centers. DOH is ensuring that CHCs are positioned to apply for grant funding to serve NY's populations whenever feasible.
•Increasing Primary Care and Public Health Workforce. Includes numerous provisions intended to increase the primary care and public health workforce by including amended and expanded health workforce programs authorized under Title VII (health professions) and Title VIII (nursing) of the Public Health Service Act. A variety of incentives are included to support education and training of pediatric specialists, oral health providers, and nurses. Title V staff are working with the OHSM staff to identify workforce shortages and support community partners to address these shortages where possible.

Recognizing the complexity of Health Care Reform, the Governor created the Governor's Health Care Reform Cabinet to manage the implementation of federal health care reform in NYS. The Cabinet will advise and make recommendations to the Governor on all aspects of federal health care reform and strategic planning to guide the implementation of the Patient Protection and AAC and the Health Care and Education Reconciliation Act. State agencies serving in the Cabinet

include: DOH, the Department of ***/2013/Financial Services//2013//***, the Division of the Budget, the Department of Civil Service, the Department of Taxation and Finance, the Department of Labor, the Office for Technology, the Office of Temporary and Disability Assistance, the Office of Mental Health, the Office for People with Developmental Disabilities, the Office of Alcoholism and Substance Abuse Services, the Office for the Aging, the Office of the Medicaid Inspector General, and the Office of Children and Family Services. The Deputy Secretary for Human Services, Technology and Operations, Deputy Secretary for Intergovernmental Affairs and Counsel to the Governor also serves in the Cabinet. In addition, the Governor has named an external advisory group to assist and advise the Cabinet on reform provisions and ensure stakeholder and public engagement. The advisory group includes organizations representing health care providers, consumers, businesses, organized labor, local governments, and health plans and health insurers, as well as health policy experts. In this way, NY can be better assured that changes and improvements will be made to improve the health outcomes of all New Yorkers.

NY has proceeded to implement the health reform law provision related to the establishment of a temporary statewide insurance pool for high risk individuals. Coverage through this program is available until January 2014 when more health insurance coverage options become available through a Health Insurance Exchange. In NYS, the preexisting condition pool is called the NY Bridge Plan which covers a broad range of services, including primary and specialty care, inpatient and outpatient hospital care and prescription drugs, as well as assistance from professional nurses and caseworkers to help members manage chronic conditions and maintain health. Eligibility is not based on income. Coverage for preexisting conditions begins right away, with no waiting period. ***/2013/In 2011, the Governor signed a law amending Insurance and Public Health Law relating to prescription drug coverage, pre-existing conditions and preventive health care, increased the age of dependent children for coverage, prohibited lifetime and annual coverage limits, among others, that ensured NYS will be in compliance with the ACA.//2013//***

A series of public forums were held on the establishment of health insurance exchanges in NYS. A wide array of stakeholders ***/2013/participated in//2013//*** the meetings including health care consumers, administrators, doctors, hospitals and other health care providers, insurers, producers, businesses, unions, academics and the general public. Stakeholders provided input related to key design options related to exchanges.

NY is also committed to ensuring all New Yorker's are insured and do not lose their insurance due to unnecessarily high premiums. To that end the former Governor signed legislation requiring health insurers and HMOs to make an application to the State Department ***/2013/of Financial Services//2013//*** to implement premium increases. DOH would have the opportunity to review the rate applications, as well as the underlying calculations, to ensure that the rates are justified and not excessive, and may approve, modify or disapprove the rate application. The law applies to all rate increases taking effect on or after October 1, 2010.

Through health care reform and investing in primary and preventive care, and strengthening NY's public insurance programs, as previously discussed, NY is striving to increase availability and accessibility of health care for historically underserved populations. In April, 2008, former Commissioner Daines launched the PA for the Healthiest State, establishing 10 statewide public health priorities with an emphasis on prevention strategies. The PA was a call to action, asking hospitals, LHDs 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 PA focuses on eliminating the profound health disparities that impact racial and ethnic minorities. The public health priorities include:

- Access to Quality Health Care
- Tobacco Use
- Healthy Mothers, Healthy Babies, Healthy Children
- Healthy Environment
- Physical Activity & Nutrition

• Community Preparedness
• Unintentional Injury
• Mental Health & Substance Abuse
• Chronic Disease
• Infectious Disease

LHDs recorded their efforts in Community Health Assessments (CHA) and Municipal Public Health Service Plans (MHSP), which were submitted to DOH in July of 2009 as part of requirements for receipt of state funding through Article 6 of the NY Public Health Law. Hospitals submitted their Community Service Plans (CSP) in mid-September, 2009. With input from community members and stakeholders, two or three Prevention Agenda priorities were selected for community action and a plan was developed. By coordinating their needs assessment and program planning activities, all participants are better able to meet the needs of their communities while avoiding duplicative efforts and achieving economies of scale. The goal is for LHDs and hospitals to develop shared visions of what must be addressed. DOH provided technical assistance on accessing county-specific data, using evidence-based prevention approaches, and monitoring their impacts. Community-based efforts were complemented by local and statewide policy initiatives to help achieve the prevention goals. Although Title V's major focus is Healthy Mothers, Healthy Babies, Healthy Children, all of the areas of focus impact health outcomes of the maternal and child health population. ***/2013/Efforts are underway to assess progress on the 2008-2012 PA toward the Healthiest State, identify new health priorities and develop a plan for multi-sector action on priority health issues.//2013//***

As demonstrated in the Needs Assessment Summary portion of NY's application, health disparities continue to exist in NYS, and addressing those factors leading to ethnic and racial disparities in health outcomes remains a DOH priority. Health disparities in NY often occur along the lines of race, ethnicity, nativity, language ability, socioeconomic status, and geography, among other factors. The geographic distribution of NYS also complicates issues related to disparities as there is a great variation between rural and urban areas, providing a sharp contrast among residents and their access to health care services. Small community-based providers in underserved areas of the state often do not have the level of expertise and infrastructure to support comprehensible public health programs.

All efforts discussed previously are devoted to improving health outcomes for all New Yorkers, including ethnically and culturally diverse individuals. The major focus of DOH's efforts include partnerships at the state, local and community level. A 2010 report developed for the DOH's Minority Health Council contained several strategies regarding eliminating disparities. The Title V program in NYS is working to operationalize these concepts to decrease the divide that exists among diverse groups in NYS. The report contained recommendations and promising strategies that NY could implement to potentially reduce disparities including:
•Leverage and expand core system and mission functions to assure an integrative approach for addressing health disparities
•Improve data collection, data systems, and mechanisms for monitoring and reporting disparities.
•Develop, implement and evaluate disparities interventions.
•Ensure leadership and stakeholder support for coordination of effort and institutionalize disparities-reduction work.

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

improve the health outcomes of NY's diverse community.

DOH has access to a wealth of data and information to identify issues related to maternal and child health outcomes and disparities. Although resources have always been targeted at high risk populations of the state, a more concerted effort is being made to ensure resources are going to the highest need areas. For example, although NY's outcomes in many areas are improving, in areas such as adolescent pregnancy, disparities continue to exist due to increasing numbers of immigrant and hard to reach adolescents. Extensive data analyses have been completed to target the highest need areas and provide better utilization of resources. DOH also provided statewide training to current and potential providers on evidence based programming and community coordination of resources, and outreached to providers in the hardest to reach areas to ensure there will be a pool of agencies positioned to apply for funds to address the need in the highest need areas of the state. In addition, all requests for applications now specifically identify high risk groups as a priority including specific minority populations, youth in foster care or those otherwise not engaged in the service system.

The Title V program also continues to prioritize resources and activities to address health disparities.

Targeted efforts at disparate populations include ***/2013/the adolescent and perinatal programs, where resources will be targeted to the highest need areas of NYS, and//2013//*** collaborative efforts with the NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigration Affairs and DOH's Refugee Health Program to address emerging state and national concerns about lead poisoning among refugee populations. DOH and OTDA jointly conducted an assessment of educational needs for LHDs and refugee resettlement agencies, resulting in a collaboration to translate basic low literacy lead educational materials for refugees and to develop a new video for local agencies. DOH worked with the Office of Children and Family Services to develop and disseminate materials on lead poisoning prevention for all child care providers throughout NYS.

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

DOH is also requiring funded providers to use, whenever possible, evidence-based or promising practices that have been tested or evaluated to produce desired outcomes on the target population. For example, in the comprehensive adolescent health request for applications released in 2010, only evidence-based practices were entertained for funding. NY also has a comprehensive system of perinatal regionalization, led by Regional Perinatal Centers (RPCs). This better ensures women at high risk for poor birth outcomes are referred to a hospital that has the capability to care for the women and her infant.

Title V staff communicate regularly with DOH regional staff as well as community providers. This allows issues such a lack of obstetrical coverage in certain areas of the state or issues with health outbreaks or medical coverage to come to the forefront.

DOH strives to better coordinate the state's data system and information technology to streamline and coordinate the flow of information. Through NY's Office of Health Technology Transformation, NY's health IT plan is being advanced in the public's interest and with clinical priorities and quality and population health improvement goals leading the way. The plan includes key organizational, clinical and technical infrastructure as well as cross cutting consumer, financial and regulatory strategies to better coordinate data flow and information sharing. Within the DFH, staff are working on the development of the Child Health Information Integration Project (CHI^2) that aims to develop an integrated data system that will improve quality of care (via timely accurate data), reduce medical errors, collect individual data for activities such as Newborn Hearing Screening, provide seamless flow of information between jurisdictions, link events of public health significance in a child's life (e.g. immunizations) and enable bi-directional data sharing.

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

B. Agency Capacity

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

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

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

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

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

DOH's ability to control lead poisoning is conferred by PHL SS1370-1376-a, which defines the State lead poisoning program, specifies lead screening and reporting requirements, and prohibits the manufacture, sale and use of specific products containing lead. The law also details abatement requirements where lead hazards exist, identifies enforcement agencies, and provides remedies for failure to act to abate lead hazards.

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

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

Succeeding sections in PHL Article 25 authorize the Commissioner to, among other important activities, screen newborns for inherited metabolic diseases (SS2500-a), HIV (SS2500-f) and hearing problems (SS2500-g). NY's Child Health Insurance Plan is detailed in PHL SS2510-2511, and the statewide Adolescent Pregnancy Prevention and Services (APPS) Program is authorized by PHL SS2515-2515-d. The Commissioner's extensive powers to affect prenatal care are enumerated in PHL ***/2013/SS2522-2528, 364-i and 365-k of Social Service Law.//2013//*** An important asset to Departmental efforts to monitor, evaluate and improve patient care and outcomes is provided by PHL SS2500-h, which authorizes development and maintenance of a statewide perinatal data system and sharing of information among perinatal centers.

DOH's Early Intervention (EI) Program, for children who may experience a disability because of medical, biological or environmental factors which may produce developmental delay, is authorized by PHL SSSS2540-2559-b, while programming to provide medical services for the treatment and rehabilitation of children with physical disabilities is authorized by PHL SS2580-2584.

Nutrition programming conducted on behalf of children in day care settings is authorized by PHL SS2585-2589, while PHL SS2595-2599 establishes the nutrition outreach and public education program to promote utilization of nutrition throughout the state. The makeup and operation of NY's Obesity Prevention Program is detailed in PHLSS2599-a-2599-d.

The ability of NYS to regulate hospitals, including ambulatory health facilities, is conferred by PHL Article 28, Hospitals, and is a prime determinant of DOH's capacity to promote and protect the

health of mothers and children. Among the specific provisions of ***/2013/PHL relating to hospitals is//2013//*** the NYS Health Care Reform Act (HCRA), which is codified as PHL SS2807-j-2807-t. A major component of NYS Health Care financing laws, HCRA governs hospital reimbursement methodologies and targets funding for a multitude of health care initiatives. The law also requires that certain third-party payers and providers of health care services participate in the funding of these initiatives through the submission of authorized surcharges and assessments.

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

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

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

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

Family Planning Program provides accessible reproductive health services in 51 agencies in 199 sites. Programs provide low-income, uninsured women with contraceptive education, counseling and methods to reduce unintended pregnancies and to improve birth spacing and outcomes. The program serves over 350,000 women and men per year. The Family Planning Extension Program (FPEP), added in 1998, provides up to 26 months of additional access to family planning services for women who were pregnant while on MA, and subsequently lost coverage. The Family Planning Benefit Program (FPBP) began in October 2002 and provides MA coverage for family planning services to individuals with incomes at or below 200 percent of the federal poverty level. Plans are underway to expand and streamline access to family planning services through MA redesign. ***/2013/Effective July 2012, FPBP will be a MA State service and include a presumptive eligibility period that ensures immediate access to services while awaiting eligibility determination. It will also include//2013//*** auto-enrolling women into the program who would have previously entered the FPEP, including undocumented immigrants.

Comprehensive Adolescent Pregnancy Prevention (CAPP) Initiative is a new initiative launched in January 2011 that integrates and replaces NY's previous adolescent health programs, and includes a significant focus on reducing racial and ethnic disparities. Through the CAPP initiative, DOH awarded more than $17.5 million in state grants to 50 community-based organizations that focus on the prevention of pregnancies, STDs and HIV among male and female adolescents age 10 to 21 years. Projects implement evidence-based sexuality education; ensure access to reproductive healthcare services; expand educational, social, vocational and economic opportunities; and engage adults to advance sustainable local community efforts to improve environments for young people. Personal Responsibility Education Program (PREP) initiative, supported through new federal funding ($3.4 million), focuses on implementation of evidence-based sexual health education and preparation of youth for successful transition to adulthood to reduce adolescent pregnancy, making it closely aligned with the DOH CAPP initiative described above. A state plan describing NYS's plans for use of this funding was approved in April, 2011 by the federal Administration on Children and Families (ACF). The majority of NYS' PREP funds were used to make eight additional CAPP awards to organizations that were "approved but not funded" through the 2011 CAP RFA, and to support an enhancement project targeting youth in foster care, which is being developed in consultation with OCFS.

/2013/Supporting Healthy Transitions to Adolescence//2013// is a new initiative supported by $2.99 million in federal funding through the federal Abstinence Education Grant Program. NYS previously declined this federal funding due to significant restrictions on use of the funding. Under revised guidance, states have considerable flexibility to target younger youth and to focus on elements of programming determined to meet the needs of the selected populations. NYS will utilize grant funds to support a new initiative that will fund community-based mentoring, counseling and adult supervision programs designed to delay the initiation of sexual behavior among young people, ages 9-12, residing in high-risk communities. ***/2013/A RFA for this initiative will be released in 2012.//2013//***

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

Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP) is a new initiative supported by a grant from HRSA designed to improve health and developmental outcomes for at-risk children through implementation of evidence-based home visiting programs. To receive funding, states were required to complete a number of steps including an initial funding application and a statewide needs assessment.
NY's MIECHVP targets high risk communities with gaps in home visiting services as defined by the state home visiting needs assessment, and in accordance with the requirements of a home visiting state plan recently issued by HRSA. To date NYS has been awarded $4,111,834 for FY 2010, ***/2013/and an additional $5,604,010 for 2011//2013//***. HRSA required NY to provide $673,000 annually of NYS' $4.1 million award to a Rochester project previously directly funded by the Administration for Children and Families.
The purpose of the statewide needs assessment was to identify communities with high rates of maternal, infant and child health risk indicators and the existing home visiting programs and supportive resources in those communities. With input and assistance from a group of state agency partners, the DOH collected and analyzed a set of 23 indicators based on HRSA criteria and additional state-defined criteria. For the initial needs assessment, county was used as the geographic unit of analysis.

MIECHVP will provide NY with an opportunity to maximize and coordinate the various models of home visiting services in NYS (listed below) to better serve the MCH population.

Community Health Worker Program (CHWP) - In 23 programs statewide, one-on-one outreach, education and home visiting services are provided to pregnant women who are at highest risk for poor birth outcomes, such as low birth weight infants or infant mortality. The CHWP is targeted towards specific communities with high rates of infant mortality, out-of-wedlock births, late or no prenatal care, teen pregnancies and births, and births to low-income women. ***/2013/Services are provided by trained paraprofessionals recruited from the target communities.//2013//***

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

Nurse Family Partnerships (NFP) is an evidence-based home visiting program that improves the health and self-sufficiency of low-income, first time parents and their children. NFP is a nurse-led model in which nurses promote the personal health of mothers, parental care of the child, environmental health, support systems for mother and infant, and parent's life course development. ***/2013/For 2010 and 2011//2013//***, the Office of Temporary and Disability Assistance provided DOH with $5,000,000 in federal TANF funding via a Memorandum of Understanding to expand NFP programs. The three approved programs funded to provide services are: the NYC Department of Health and Mental Hygiene, Onondaga DOH and Monroe County DOH NFP Programs. The OHIP has also obtained state plan approval to provide MA funding support to two of these programs in Monroe County and NYC as targeted case management programs. ***/2013/The enacted 2012-13 budget includes $2 million in TANF funding and $500,000 in local assistance funds to support NFP.//2013//***

Regional Perinatal Centers (RPC) - NYS's system of regionalized perinatal services includes a hierarchy of four levels of perinatal care provided by the hospitals within a region and led by a RPC. The regional systems are led by RPCs capable of providing all the services and expertise required by the most acutely sick or at-risk pregnant women and newborns. RPCs provide or coordinate maternal-fetal and newborn transfers of high-risk patients from their affiliate hospitals, and are responsible for support, education, consultation, and improvements in the quality of care in the affiliate hospitals within their regions. RPC quality assurance activities are supported by the Statewide Perinatal Data System that provides affiliate hospital data to them.
There are currently 134 birthing hospitals, including: 56 Level 1 hospitals; 25 Level 2 hospitals; 35 Level 3 hospitals; and, 18 hospitals constituting 15 RPCs. ***/2013/Through the NYS State Perinatal Collaborative, the DOH, RPC s and other key partners are working together on significant quality initiatives to improve birth outcomes.//2013//***

Newborn Metabolic Screening Program (NBSP) -- PHL 2500(a) requires that all newborns are screened for 46 congenital conditions, and ensures all screen positive infants receive follow-up.

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

Medicaid Prenatal Care provides comprehensive prenatal care for women up to 200% of the fpl based on in accordance with current standard of obstetrical care. ***/2013/Since 2012, comprehensive standards apply to all prenatal care providers serving Medicaid clients.//2013//*** The Medicaid Obstetrical and Maternal Services (MOMS) Program was developed to provide comprehensive prenatal care services to low-income women in rural settings. Prenatal care is provided in doctors' offices, while ancillary services such as health education, psychosocial and nutritional screening are provided by qualified Health Supportive Services Providers. Over 3,000 physicians are enrolled in the MOMS program. The Title V programs works closely with the OHIP to ensure women across NYS have access to prenatal care services.

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

Tobacco Control Program is a comprehensive, coordinated program that seeks to prevent initiation of tobacco use, reduce current use of tobacco products, eliminate exposure to secondhand smoke and reduce the social acceptability of tobacco use. The program consists of community and statewide activities supported by surveillance and evaluation. NYSDOH issues grants for programs such as local tobacco control, youth action, tobacco enforcement and prevention, and cessation. The NYS Smoker's Quitline (1-866-NY QUITS (1-866-697-8487)) continues to be a key evidence-based component of the program's cessation efforts.

School-Based Health Center Program (SBHC) -- Through 218 SBHCs sponsored by 543 community health and mental health services providers, the SBHCs provide primary and preventive medical and mental health care services to more than 158,000 students living in high-need areas. SBHCs are extension clinics of Article 28 hospitals and/or diagnostic and treatment centers that provide services in school settings.

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

Preventive Dentistry for High-Risk Underserved Populations Program addresses the problems of excessive occurrence of dental disease among children who reside in communities with a high proportion of persons living below 185 percent of the federal poverty level. The application of dental sealants, an extremely effective caries-prevention agent, in combination with a program of dental screening, referral and other preventive services significantly improves the dental health of children in underserved communities. Organizations providing preventive dental services under this program include LHDs, dental schools, hospitals and diagnostic and treatment centers, rural health networks and SBHCs. Previous contracts for this program end 6/30/11. A RFA was released in 2011 to fund the Preventive Dental Services Program to increase the prevalence of dental sealants in second and third grade children ***/2013/resulting in 30 new grant awards.//2013//***

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

Child and Adult Care Food Program (CACFP) improves the nutritional quality of meals and snacks served in participating day care programs by establishing minimum standards for items served, providing reimbursement for qualifying meals and snacks, and mandating ongoing monitoring of food service programs and training of program staff. The goal of CACFP is to ensure that nutritious and safely prepared meals and snacks are available to children age 18 and under and to functionally impaired adults and senior citizens participating in eligible day care programs.

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

Creating Healthy Places to Live, Work and Play -- Eat Well Play Hard Community Projects ended in September 2010. The DON and BCCDP collaborated on the development of a new community-based initiative. Twenty-two contractors maximize the impact on the prevention of obesity and type 2 diabetes by promoting the implementation of policies, systems and environmental change that will create healthy places for people to live, work, and play. Targeted

strategies include: increasing availability of places to be physically active; creating community landscapes conducive to physical activity; increasing the availability of fresh fruits and vegetables; and increasing the healthful quality of foods offered for sale.

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

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

Childhood Asthma Coalitions - 8 Regional Childhood Asthma Coalitions, ***/2013/identify high-risk populations for asthma and help manage care to improve health outcomes.//2013//***

Immunization Program works to prevent the occurrence and transmission of vaccine-preventable diseases by ensuring the delivery of vaccines to children and adults. The program assures that: all children have access to vaccines irrespective of financial status; adequate vaccine supplies are available for all primary health care providers; and that health care providers are aware of immunization standards of practice.

Child Mortality Review/SIDS Prevention Program - In collaboration with other state agencies, the program is working to develop a more comprehensive statewide child death review and prevention initiative. ***/2013/By partnering with these agencies the program helps coordinate child safety initiatives aimed at reducing the risk for future deaths.//2013//*** The program also provides public outreach and education about risk factors associated with SIDS. .

Lead Poisoning Prevention Program (LPPP) - The goal of the LPPP is to reduce the occurrence and consequences of childhood lead poisoning throughout the state. DOH, in collaboration with a wide range of partners, has developed a strategic plan for the elimination of childhood lead poisoning in NYS by 2010. Due to a significant decrease in funding from CDC, as well as CDC's refocusing of the program into a new Healthy Home and Community Environments model, major responsibility for the LPPP was transitioned to the Center for Environmental Health, with continued close collaboration by Title V staff. ***/2013/Significant CDC funding cuts present a major challenge to these efforts.//2013//***

Children with Special Health Care Needs (CSHCN) Program works closely with internal partners and LHDs, community-based and professional organizations to develop and implement systems initiatives to improve quality of services for children with special health care needs. The CSHCN Program has 55 contracts with LHDs to provide services to children with special health care needs birth to 21 and their families. With funding and technical assistance from the department, the local CSHCN Programs develop community-based resources to: assist families in accessing necessary health care and related services; promote "medical homes" for the provision of high-quality health care services that meet the needs of children and families; and, develop partnerships with families of children with special health care needs that involve them in program planning and policy development.

The CSHCN Program collaborates with DOH's Wadsworth Laboratories' Newborn Screening

Program, to support a statewide network of specialty centers that accept referrals of infants with positive newborn screens for endocrine, metabolic, cystic fibrosis or hemoglobinopathy disorders.

Physically Handicapped Children's Program (PHCP) operates in 40 of 58 counties in NYS. The program provides reimbursement for specialty health care for severe chronic illness or physically handicapping conditions in children. Medical equipment, office visits, hospitalizations, pharmaceuticals, and other health-related services can be reimbursed for children meeting county financial and medical eligibility criteria.

Early Intervention Program (EIP) is a statewide service delivery system for infants and toddlers (birth to three years) with disabilities and their families. Its mission is to identify and evaluate those children whose healthy development is compromised and provide appropriate interventions to improve child and family development. To be eligible for services, infants and toddlers must have a delay in one or more areas of development (physical growth or development, learning skills, speech and language development) or a physical or mental diagnosis that impacts on development (such as cerebral palsy or Down syndrome). The EIP, created in 1993, currently provides services to more than 70,000 infants and toddlers and their families statewide. ***/2013/The DOH has been awarded grants to improve awareness and identification of autism to ensure children are identified and receive services as early as possible.//2013//***

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

3) Capacity to Provide Culturally Competent Care

The NYS Office of Minority Health (OMH) was established by an amendment to the NYS PHL in 1992 and became operational in 1994. PHL SS 240-243 outlines the duties and responsibilities of the office, responsibilities and membership appointments of the NYS Minority Health Council, and specifies the contents of a minority health report which NYSDOH is required to prepare and distribute biennially. ***/2013/OMH is a statewide resource for effecting elimination of health disparities across all populations. Among the key goals is formation of partnerships with government systems, public/private sectors, communities and individuals to strengthen the health care delivery system and access to the services needed by all.//2013//*** Unequal access to high quality health care is a problem that has been documented for many racial and ethnic minorities. It has also been shown that when access is available, many populations face barriers which prevent them from utilizing health care. ***/2013/The Health Disparities Research Dissemination Project is a joint effort between OMH-HDP and the Minority Health Council focused on sharing findings of health disparities research with local community members.//2013//***

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

identify issues and plan effective public health interventions. Title V staff will continue to promote partnerships to improve the health outcomes of NY's diverse community.

DOH is also making a concerted effort to provide services and resources to the highest need areas of the state. For example, although New York's outcomes in many areas are improving, in areas such as adolescent pregnancy, disparities continue to exist due to increasing numbers of immigrant and hard to reach adolescents. Extensive data analyses have been completed to target the highest need areas and provide better utilization of resources. DOH also provided statewide training to current and potential providers on evidence based programming and community coordination of resources, and outreached to providers in the hardest to reach areas to ensure there will be a pool of agencies positioned to apply for funds to address the need in the highest need areas of the state. In addition, all requests for applications now specifically identify high risk groups as a priority including specific minority populations, youth in foster care or those otherwise not engaged in the service system. All programs developed by the Bureaus and Divisions within the Center for Community of Health work with the communities they serve to assure that their programs meet community needs. The following processes help to ensure ongoing improvements in cultural competency:

•The Request of Applications process used to select contractors requires applicants to demonstrate competence in serving the target populations including linguistic and cultural competency.
•DOH provides programs with health risk data, enabling programs to tailor their programs to the community. Data are provided by major race/ethnicity categories, when available, and at the lowest feasible geographic unit, e.g., zip code.
•All programs are required to include outreach plans and activities to ensure the services are reaching the high risk, diverse populations in their catchment areas. This includes the LHD CSHCNs programs as well.
•The Child Health Information Integration Project (CHI^2) that aims to develop an integrated data system that will improve quality of care, reduce medical errors, collect individual data for activities such as Newborn Hearing Screening, provide seamless flow of information between jurisdictions, link events of public health significance in a child's life (e.g. immunizations) and enable bi-directional data sharing. Ultimately health care providers will have access to child health information to ensure they have a complete picture of the child's health history and needs, which will benefit those high risk children who may access health care through a variety of settings and clinics.
•Programs use community-based organizations with diverse staff, representative of the racial and ethnic backgrounds of the communities.
•Programs that serve non-English speaking populations must have staff to deliver services who are fluent in the predominant foreign languages spoken in the community and/or provide access to a telephone language line.
•Programs are encouraged to hire staff that is from communities and populations served. For example, the CHWP uses paraprofessional home visitors indigenous to the communities and populations served.
•DOH funds Family Planning Advocates of NYS to work with family planning agencies, to enable them to develop strategies for providing more culturally and linguistically competent, reproductive health services, thereby increasing their reach into the targeted population.
•Written and outreach materials are translated, adapted and/or provided in alternate formats based on the needs and preferences of the population served.
•Programs actively engage the community on an ongoing basis. The SBHC program, for example, has a community advisory council that assures that the views of the community members are reflected in the polices priorities and plans. The Perinatal Networks have community coalitions that include community organizations, including individuals from the community served to guide program outreach and development.

C. Organizational Structure

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

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

/2013/To increase government efficiencies, Governor Cuomo created the Spending and Government Efficiency Commission (SAGE) to streamline State government. This Commission is charged with reviewing the State's organizational structure, identifying improvements, creating meaningful metrics, and identifying non-critical activities. The commission is in the process of analyzing the operations of State agencies and will be releasing recommendations later in 2012.//2013//

Four statewide government officers are directly elected including:
•The Governor, who heads the Executive Department, and Lieutenant Governor (who are elected on a joint ballot).
•The State Comptroller, who heads the Department of Audit and Control.
•The Attorney General, who heads the Department of Law.

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

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

Under the direction of the Commissioner, Nirav Shah, MD, MPH, who is appointed by the Governor, DOH meets its responsibilities through the Office of Health Insurance Programs (OHIP), the Office of Long Term Care (OLTC), the centers located in the Office of Public Health (OPH), and the Office of Health Systems Management (OHSM). The OHIP is responsible for Medicaid, Family Health Plus, Child Health Plus, Elderly Pharmaceutical Insurance Coverage, and the AIDS Drug Assistance Program. The OTLC oversees the integration of planning and program development for services related to long term care. The OPH and the OHSM provide policy and management direction to a system of regional offices, whose staff conduct health facility surveillance, monitor public health, provide direct services and oversee county health department activities. Additionally, DOH is responsible for five health care facilities. DOH has a workforce of 4,992 filled positions, with 29 percent of those positions employed in DOH's health care facilities.

The OPH led by Guthrie Birkhead, MD, MPH, brings together all DOH public health programs under one organizational mantle. The Office's programs include: the biomedical research, public

health science, and quality assurance of clinical and environmental laboratories of the Wadsworth Center; the counseling, education, prevention, health care and supportive services of the AIDS Institute; the protection of human health from environmental contaminants in air, water and food through regulation, research and/or education by staff of the Center for Environmental Health; the nutrition, health screening, immunization, tobacco control, maternal and child health programs and the public health surveillance and disease control activities of the Center for Community Health (CCH); the support and oversight of local health departments and the efforts to help build public health workforce capacity of the Office of Public Health Practice; and, the comprehensive all-hazards preparedness and response activities of the Office of Public Health Preparedness.

The programs providing services to the maternal and child health population are spread throughout the Department, but are mainly focused in the CCH. CCH responsibilities touch practically every aspect of public health in NYS. Under the direction of ***/2013/Bradley Hutton, MPH//2013//***, the Center conducts programming through four Divisions: the Division of Chronic Disease and Injury Prevention; the Division of Nutrition; the Division of Epidemiology; and, the Division of Family Health. Each addresses a major component of the Department's public health mission, and all are involved in carrying out MCHSBG-related activities.

The Division of Family Health (DFH), directed by ***/2013/Rachel de Long, MD, MPH//2013//*** (who also serves as the Director of the NYS Title V Program), promotes the health of families by assessing needs, promoting healthy behaviors and providing services to support families. ***/2013/Dr. de Long assumed the director position upon the retirement of Barbara McTague in 2011.//2013//*** The division's primary focus is to improve the health of women, children and adolescents. Its programs touch new mothers, adolescents including those considering sexual activity, children, including those with disabilities, rape victims and children with lack of access to dental services. Programs promote healthy behaviors while also assuring access to quality health care. The division provides access to primary medical and dental care and preventive health services for migrant farmworkers and Native Americans living in reservation communities. The Division provides the central focus for NYS's Title V MCH programming, and consists of three program bureaus and the Office of the Medical Director:

The Bureau of Maternal and Child Health (BMCH), has ***/2013/been led by Assistant Director Rudy Lewis since the director position was vacated by Dr. de Long. The BMCH//2013//*** administers a variety of programs that focus on the prevention of adverse health conditions and promotion of health and wellness in women, children and youth, ***/2013/and consists of the following functional units://2013//***

•Perinatal Health Unit is comprised of Article 28-based programs and community-based initiatives that support the direct delivery of clinical health care and supportive services to achieve outcomes related to the accessibility, quality, and sustainability of perinatal services for NY's women and babies. These programs have substantial commonalities in terms of their focus on improving birth outcomes. Consolidating these programs within a common unit facilitates the establishment and implementation of more consistent and effective systems and standards to address these common issues. Programs included in the Perinatal Health Unit are:

-Perinatal Regionalization, including Regional Perinatal Centers and affiliate hospitals, ***/2013/and the NYS Perinatal Quality Collaborative.//2013//***

-Maternal, Infant and Early Childhood Home Visiting Program

-Community Health Worker Program

-Healthy Mom, Healthy Baby home visiting ***/2013/systems initiative//2013//***

-Nurse Family Partnership

-Comprehensive Prenatal Perinatal Services Networks

-Growing Up Healthy Hotline

-Infertility Demonstration Program

-Osteoporosis Prevention and Education.

•The Adolescent Health Unit is comprised of community-based programs that focus on prevention and health promotion strategies to achieve outcomes related to healthy behaviors and health

outcomes at the personal, family and community levels. These programs have substantial commonalities in terms of primary and secondary prevention strategies, emerging federal priorities and funding opportunities, and local partnerships to promote and improve health. Consolidating these programs supports use of evidence-based prevention strategies across programs, allows for alignment and ongoing meaningful collaboration between programs with similar target groups and outcomes, and facilitates the establishment and implementation of more consistent systems for program management and improvement. The Adolescent Health Unit includes:
-Comprehensive Adolescent Pregnancy Prevention (CAPP) Program
-Personal Responsibility and Education Program
-***/2013/Supporting Healthy Transitions to Adolescence//2013//***
-ACT-for Youth Center of Excellence
-Adolescent HIV Prevention
-Act for Youth Healthy Transitions

The Community-Based Health Care Unit is comprised of programs that provide comprehensive family planning and reproductive health care services to underserved populations, and the largest School Based Health Center program in the country that provides primary and preventive health care services to many of NY's most vulnerable children and adolescents.
-Family Planning and Reproductive Health
-School Based Health Center program.
-***/2013/Sexual Violence Prevention and Rape Crisis Services.***
-Hospital Sexual Assault Forensic Examiner (SAFE) program.//2013//

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

The Bureau of Early Intervention, ***/2013/is co-directed by Brenda Knudson Chouffi and Donna Noyes, PhD, as the director position was vacated//2013//*** by Bradley Hutton, MPH. The Bureau is responsible for two major programs for young children with, or who may be at risk for, physical and cognitive disabilities. The EIP is a statewide service delivery system for infants and toddlers (birth to three years) with disabilities and their families. Its mission is to identify and evaluate those children whose healthy development is compromised and provide appropriate interventions to improve child and family development. The Bureau also administers DOH's Newborn Hearing Screening Program, as well as the MCH Autism Intervention Research Grant and the State Implementation Grant for Improving Services for Children with Autism Spectrum Disorders.

The Bureau of Dental Health, under the leadership of Jay Kumar, DDS, MPH, implements and monitors a broad range of statewide dental health programs that prevent, control and reduce dental diseases and other oral health conditions, and promote healthy behaviors. In addition to maintaining the focus on children, programs promote dental health among adult populations. The Bureau's dental health programs include:
•Preventive Dentistry for High-Risk Underserved Populations Program
•Supplemental Fluoride Program
•Dental Rehabilitation Program
•Preventive Dentistry Program for Deaf/Adolescent Children
•Dental Health Education
•Dental Public Health Residency Program
•Research and Epidemiology
•State Oral Disease Prevention Program
•School-Based Health Center Dental Program

The Office of the Medical Director provides medical leadership for the DFH. Under the direction of Marilyn Kacica, MD, MPH, physicians in the office provide medical consultation and support to all division programs; support policy development and programmatic initiatives; and provide advice on emerging medical issues. ***/2013/OMD leads the NYS Perinatal Quality Collaborative, an initiative of NY's Regional Perinatal Centers (RPCs), the DOH and the National Initiative for Children's Healthcare Quality. The goals are to improve maternal and newborn outcomes and increase patient safety by applying evidence-based system change interventions, and to establish capacity within RPCs for ongoing QI activities. The Obstetrical intervention focuses on reducing scheduled deliveries performed without indication in women 36 0/7 to 38 6/7 weeks gestation. The Neonatal intervention focuses on enteral feeding practices for neonatal care patients. Additional//2013//*** OMD programs include:

•/2013/Children with Special Health Care Needs;
•Physically Handicapped Children's Programs; and,
•Other cross-systems early childhood initiatives, including parenting education projects and the current federal Project LAUNCH grant. Consistent with the framework for public health MCH services, these programs and activities are characterized by a blend of public health approaches including population-based public and professional outreach and education, targeted care coordination and other enabling services, and gap-filling direct health care services.//2013//

•CHI2
•Child Mortality Review/SIDS Prevention Program
•Maternal Mortality Review Program
•American Indian Health Program
•Migrant and Seasonal Farmworker Health Program
•Statewide Systems Development Initiatives.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

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

/2013/Rachel de Long, M.D., M.P.H., was appointed//2013// the Director of the DFH and Director of the NYS Title V Maternal and Child Health Services Program in the DOH in December 2011 upon the retirement of Barbara McTague. ***/2013/Dr. de Long formerly served as Director of the Bureau of Child and Adolescent Health (BCAH), and then Bureau of Maternal and Child Health (BMCH) (formed due to a merger of the Bureau of Women's Health (BWH) and BCAH) since 2005, and served as BCAH's Medical Director from 2003 to 2004. Dr. de Long is on the faculty of the SUNY at Albany School of Public Health in the Department of Health Policy, Management, and Behavior. She earned a B.S. in Rural Sociology from Cornell University, M.D. from University of Wisconsin Medical School, and M.P.H. from SUNY Albany School of Public Health. She completed a medical internship in Family Practice at the Guthrie Clinic and residency in Preventive Medicine at SUNY Albany/NYSDOH, and is Board-Certified in Preventive Medicine and Public Health. Dr. de Long //2013//*** provides policy and program direction and administrative oversight for the Division's bureaus, including the Bureau of Maternal and Child Health, the Bureau of Dental Health, the Bureau of Early Intervention and the Office of the Division's Medical Director which

includes the Migrant Health and Indian Health Programs, ***/2013/as well as several quality initiatives.//2013//***

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

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

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

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

Christopher Kus, M.D., M.P.H., serves as Associate Medical Director for the DFH, and provides medical consultation to the Division. He is a graduate of Michigan State University and the Wayne State University School of Medicine. He received his M.P.H. from University of North Carolina at

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

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

/2013/Rudy Lewis, M.S., has served as the Assistant Director of the BMCH (formerly BWH) since 2007 and has extensive experience with MCH programs and worked in several areas, including prenatal care, family planning, and perinatal regionalization. He has extensive experience with surveillance and data systems, in the design, development and implementation of information systems for public health programs, and with program evaluation.//2013//

Susan Slade, RN, MS, is a very experienced clinical and public health nurse and public health administrator. She has worked in the NYSDOH since 1987, with over ten years of that time in the Bureau of Maternal and Child Health (formerly the Bureau of Child and Adolescent Health). Ms. Slade oversees several public health programs, including the Children with Special Health Care Needs Program and ***/2013/is leading the development of Children's Health Homes,//2013//*** as well as non categorical activities related to health care provider and parenting education. She's been involved with pediatric quality improvement initiatives related to developmental screening, standards development for pediatric specialty centers, and transition activities related to adolescents with special health care needs. In addition to being a licensed Registered Nurse, Ms. Slade is also a Certified Health Education Specialist.
Jayanth Kumar, DDS, MPH, is the Acting Director of the Bureau of Dental Health. He has served the Department since 1980 and most recently as Director of the Research and Epidemiology unit of the Bureau of Dental Health. He is also Associate Professor, School of Public Health, University at Albany. Dr. Kumar is a board-certified specialist in dental public health and a former director and president of The American Board of Dental Public Health. He has served as a consultant to many national and international organizations including the Centers for Disease Control & Prevention (CDC), National Institute of Dental & Craniofacial Research, NIH, Health Resources Services Administration (HRSA), the American Dental Association (ADA) and the National Research Council (NRC). He is project director for the Centers for Disease Control & Prevention's co-operative agreement to strengthen state's infrastructure. Dr. Kumar oversees the Department's fluoridation and other public health dental programs targeting high-risk underserved women and children, the supplemental fluoride program for preschool and school-aged children residing in non-fluoridated areas of the State, the Dental Rehabilitation Program for children with physically-handicapping malocclusions. Other Bureau activities and programs include Dental Health Education, the Dental Public Health Residency Program, research and epidemiology, the

oral health initiative, and targeted oral health service systems for women and children.

/2013/Brenda Knudson Chouffi and Donna Noyes were recently appointed Co-directors of the Bureau of Early Intervention as the position was vacated by Bradley Hutton, M.P.H. since his appointment as the Director of the CCH in 2011. Ms. Knudson Chouffi has been with BEI for 12 years, most recently as the Assistant Director of EIP. Donna Noyes joined the NYSDOH in 1989. Most recently, Dr. Noyes served as the Associate Director for Clinical Policy contributing to significant program development initiatives.//2013//

E. State Agency Coordination

As mentioned earlier, PHL SS2500 specifies that the Commissioner shall, "cooperate with other state departments having jurisdiction over matters affecting the health of mothers and children, to the end that existing activities may be coordinated and duplication of effort avoided. He shall cooperate with and stimulate local agencies, public and private, in promoting such measures and undertakings as may be designed to accomplish the purposes of this section." The Department has developed strong formal and informal relationships with other state agencies, local public health agencies, federally-qualified health centers, tertiary care facilities, academic institutions and the non-profit voluntary sector, all of which enhance the capacity of the Title V program to carry out its mission.

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

The State Education Department (NYSED) is a key partner in needs assessment and priority setting for services relating to the school-aged population. NYSED and DOH have formal planning structures related to youth risk behavior surveillance, comprehensive school health, ***/2013/HIV prevention,//2013//*** and workforce and scope of practice issues. NYSED also collaborates with NYSDOH on the Supplemental Fluoride Distribution Program. The Early Intervention Program and the Children with Special Health Care Needs Program regularly interact with SED's Vocational and Educational Services for Individuals with Disabilities (VESID) Program. NYSED is responsible for general supervision of all educational institutions in the State, for operating certain educational and cultural institutions, for certifying teachers, and for certifying or licensing practitioners of thirty-eight professions, including physicians and nurses. NYSED's supervisory activities include chartering all schools, libraries and historical societies; developing and approving school curricula; accrediting colleges and university programs; allocating state and federal financial aid to schools; and providing coordinating vocational rehabilitation services. The Youth Risk Behavior Surveillance System is administered by NYSED in collaboration with NYSDOH. We also work with the Education Department on issues such as placement of automated external defibrillators in schools, administration of fluoride rinse programs, healthcare/public health workforce matters, scope of practice issues, transition from early intervention to preschool programs, and approval of school-based primary care and dental care centers. Comprehensive School Health and Wellness Centers help school districts across the State create positive learning environments for their students. Schools that model and encourage students to engage in healthy behaviors create an atmosphere for academic success and individual growth.

The University at Albany School of Public Health is jointly sponsored by the University and the Department, which serves as the laboratory for graduate students working shoulder-to-shoulder with practicing professionals in the state health department and in local health departments. DOH and Title V staff serve as faculty and advisors to the school, and serve on the School's Continuing Education Advisory Board and on the advisory council for the North East Public Health

Leadership Institute. The Bureau of Maternal and Child Health maintains a ***/2013/Memorandum of Understanding//2013//*** with the SUNY School of Public Health that facilitates calling upon the resources of the school for training and education of professionals, such as ***/2013/perinatal hospitals,//2013//*** family planning providers, prenatal care providers, etc. Title V staff coordinate the MCH Graduate Assistant Program, under which twelve - fourteen graduate students per semester (fall, spring and summer) are supported by block grant funds to work on priority MCH research and planning projects. This arrangement attracts bright, motivated individuals who are interested in gaining theoretical and practical knowledge of public health and maternal and child health, enhances the Department's research capacity, and improves the availability of pertinent and timely educational offerings for practicing public health professionals in the region. The School of Public Health sponsors the Northeast Public Health Leadership Institute (NEPHLI). Several Title V staff have attended the Institute, and several graduates serve Title V in other states and at the New York City Department of Health. Title V staff and Dr. Birkhead serve on their advisory council.

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

Department Title V staff work with the Office of Children and Family Services (OCFS) on health care of children in foster care, ***/2013/family planning,//2013//***and on issues related to the health and safety of infants and children in child care. The Early Intervention Program collaborated with OCFS in the development of a guidance document entitled, "Protocols for Children in Foster Care Who Participate in the Early Intervention Program." In 2008 the Department and OCFS entered into a partnership to expand and improve child fatality review and prevention in NYS. The partnership works to improve the collection and examination of information generated by local fatality reviews. OCFS also sponsors, with partners such as DOH, the SUNY Distance Learning Project and the New York State Child and Family Trust Fund, monthly satellite broadcasts on child health and safety topics such as SIDS and Risk Reduction. ***/2013/OCFS is a critical partner in the DOH led MIECHV initiative.//2013//***

/2013/For the past 3 years,//2013// the State Legislature allocated funding from the federal Temporary Assistance to Needy Families (TANF) Block Grant to the Department of Health for. Nurse Family Partnership (NFP), an evidence-based home visiting program that improves the health and self-sufficiency of low-income, first time parents and their children. The three approved programs funded to provide services are: the NYCDHMH, Onondaga DOH and Monroe County DOH Nurse Family Partnership Programs. The Department has entered into a Memorandum of Understanding with the Office of Temporary and Disability Assistance (OTDA) to provide for the transfer of these funds to the Department.

2) State Agencies -- Multi-Agency Activities
/2013/The Department participates on the Fetal Alcohol Spectrum Disorders (FASD) Interagency Workgroup, led by OASAS, whose mission is to increase awareness and advance the effective prevention and treatment of FASD in NYS through interagency collaboration and coordination. Each participating agency is charged to examine policies, practices, regulations and laws, to determine how it can positively impact the goals of eliminating alcohol use during pregnancy.

The Council on Children and Families (CCF) facilitates collaboration among the child-serving state agencies and partners to create a high-quality and seamless system of care with shared accountability for cross-systems youth, who have complex, co-occurring medical, mental health, developmental, substance abuse and/or educational needs that require collaboration and coordination among multiple service systems.//2013//

The commissioners and directors of NYS's health, education and human services agencies

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

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

To respond to the federal requirement to establish or designate State Advisory Councils on Early Childhood Education and Care, New York established a new body-- the Early Childhood Advisory Council (ECAC). The ECAC includes individuals with early childhood expertise who represent early care and education, health care, child welfare, and mental health programs, as well as state agencies, advocacy organizations, foundations, higher education, unions, and others involved in the provision of services to young children and their families. The ECAC focuses on addressing the structural issues that have impeded the development of a comprehensive system of early childhood supports and services. The Director of ***/2013/the Title V program//2013//***, Dr. Rachel de Long, is an ECAC member, and several Title V staff participate on ECAC workgroups. ***/2013/The ECAC established the Promoting Healthy Development Work Group to address issues related to the healthy development of young children including: supporting professionals working with young children meet the social-emotional needs of young children; supporting early care and education efforts to promote good nutrition, increase physical activity, and prevent obesity; ensure that all children receive routine developmental screenings; work with the QI Work Group to develop program standards that support healthy development and identify resources to support programs efforts to meet those standards; and increase participation of early care and education programs in low-income communities in the Child and Adult Care Food Program.//2013//***

From 2003 through May of 2009, the Department's Title V Program was the recipient of a federal Early Childhood Comprehensive Systems (ECCS) grant. The early years of the grant focused on cross-systems strategic planning, and resulted in a comprehensive early childhood plan. Recent years have focused on incremental implementation of the plan, with a strong emphasis on building state level cross-systems infrastructure for early childhood work. The overarching goal of

the NYS ECCS plan is to support families and communities in nurturing the healthy development of children ages 0-5. The plan outlines goals, objectives and strategies within four cross-sector focus areas: Healthy Children, Strong Families, Early Learning, and Supportive Communities/ Coordinated System. A major emphasis and accomplishment in recent years has been to align the ECCS initiative with the work of the New York's Children's Cabinet, and most recently the Cabinet's Early Childhood Advisory Council, accomplished in part by transferring administration of the State's ECCS grant to the NYS Council on Children and Families in 2010. ***/2013/(The Council also administers and provides staff support to the ECAC.)//2013//*** In addition, significant progress has been made by ECCS partners across a wide range of program areas, including enrollment of young children in health insurance programs, expanded mental health screening for children, parent education projects, funding for universal pre-kindergarten, significant work to coordinate and expand home visiting programs to serve at-risk families, quality improvement projects to improve developmental screening of young children with medical homes, completion and dissemination of a comprehensive data report on the health and development of children birth to five years of age.

/2013/In 2009, DOH, with the CCF, OMH and OCFS, successfully applied to SAMHSA for a Project LAUNCH grant in partnership with Open Door Family Medical Centers, representing Westchester County's Community Network, a unique countywide wrap-around service system for children and families, to collaboratively enhance early childhood systems to demonstrate how different municipalities can support a holistic approach to childhood wellness. The goals of Project LAUNCH are consistent with ECCS goals to build cross system support for healthy development, including the social emotional development, of young children.//2013//

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

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

DOH, with the Center for Public Health Continuing Education at the School of Public Health at the University at Albany, the New York State Community Health Partnership and the New York State Association of County Health Officials, sponsors monthly Public Health Live Webcast Services (PHLive; formerly the Third Thursday Breakfast Broadcasts (T2B2). PHLive provides statewide continuing education opportunities covering a variety of emerging public health issues. This credit-bearing program is now hosted as a monthly Live Webcast, and subsequently archived. Interested parties can access the live programs by visiting the UA-SPH-CPHCE website: http://www.albany.edu/sph/cphce/phl.shtml. Continuing medical and nursing education credits are available.

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

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

First, the Department provides the bulk of its services through contracts with community-based providers, including hospitals, diagnostic and treatment centers, community-based organizations, colleges and universities. These contracts are specific about the services to be provided and the outcomes expected. All of the nearly 650 750 contracts maintained by the Division of Family Health to perform Title V and related services represent collaborations to provide high quality services to the people of the state, and the commitment of those contractors is extraordinary. The interactions of the Department with our service providers represent collaborative relationships of the highest order on behalf of health of our maternal and child population.

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

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

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

strategies to improve patient safety and prevent future deaths. DOH is working with a subgroup of the Expert Workgroup to develop clinical guidelines for the management of hypertension in pregnancy. ***/2013/The guidelines will be finalized in 2012.//2013//***

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

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

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

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

The Bureau of Dental Health held a series of regional oral health stakeholder meetings involving school dental health and Head Start/Early Head Start stakeholders for the purpose of needs assessment and discussing implementation of the statewide Oral Health Plan. Attendees received meeting summaries, membership in the Oral Health listserv, information about additional potential regional and statewide partnerships, and an invitation to participate in the newly formed statewide Oral Health Coalition. ***/2013/The Bureau will be working with key stakeholders to update New York's Oral Health Plan.//2013//*** The Dental Bureau also engaged an expert panel to consider the scientific evidence related to oral care during pregnancy and in early childhood and this panel participated in formulating practice guidelines for New York State dentists and obstetrical care providers. The guidelines have been distributed, and are available on the NYSDOH website at http://www.health.state.ny.us/prevention/dental/

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

F. Health Systems Capacity Indicators

In this section, New York will report on areas related to the Health Systems Capacity Indicators (HSCIs) that are priorities and have the ability to influence multiple indicators and measures. Data reported in many of the HSCI categories are relatively stable reflecting the strong public health and health care infrastructure in NYS. Several highlight the need to ensure access to ongoing comprehensive health care (HSCI 1, 2, 3, 4, 6, 7A and 7B) and to reduce racial, ethnic and economic disparities.

A major focus for NYSDOH is the elimination of health disparities and the achievement of health equity. Health disparities are differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes. Health disparities, inequalities, and inequities are important indicators of the health of a State and community, and provide information for decision making and intervention implementation to reduce preventable morbidity and mortality. Numerous indicators are analyzed in New York State by race and ethnicity in an effort to determine if certain groups are not benefiting equally from current interventions, and for planning future more effective systems change efforts and interventions. (Please refer to forms 17, 18 and 19 for annual reporting of HSCIs as well as NPMs, SPMs and State Priorities for further details.) As reflected in the Needs Assessment Summary section of this application, although New York State has made great strides in improving the health and well being of New Yorkers, disparities still exist in areas such as early prenatal care, prematurity, adolescent pregnancy, infant, neonatal and maternal mortality, among others.

A critical element of addressing health disparities and improving the health of all New Yorkers is to ensure access to comprehensive health care. Health Care Reform has provided New York with a unique opportunity to meet its goal of affordable, comprehensive health insurance and access to quality care for all New Yorkers. At this time, nearly 5 million New Yorkers are covered by public health insurance: Medicaid insures 4.5 million individuals while Child Health Plus insures nearly 400,000 children. Over 10.5 million New Yorkers have employer-sponsored health insurance. Approximately 2.7 million New Yorkers are uninsured: 2.3 million of these individuals are adults ages 19-64 years and approximately 340,000 are children.

New York's commitment to maximizing coverage through public insurance programs is longstanding, and the State has made steady progress over the last decade in both reducing the number of uninsured New Yorkers and filling the gaps in eroding employer-sponsored coverage. Over the past fifteen years, federal rules have gradually transformed Medicaid into a major health insurance program. This transformation began in 1996, when Medicaid eligibility was delinked from cash assistance, and continued in 1997 when federal legislation required states to coordinate eligibility and enrollment for Medicaid and the Children's Health Insurance Program (CHIP). When CHIP was reauthorized in 2009, states were given new tools to expedite enrollment in both CHIP and Medicaid. New York is one of the few states in the country that provide Medicaid coverage to childless adults and subsidizes coverage for children in families with incomes up to 400 percent of the federal poverty level (FPL). New York is home to the first, and one of the most robust Child Health Insurance Programs (Child Health Plus) in the nation.

Building on the facilitated enrollment program initiated in 2000, New York began a multi-year effort in 2007 to reach and enroll New Yorkers eligible for Medicaid, Family Health Plus (Medicaid for adults with incomes just above traditional Medicaid levels), and Child Health Plus (CHPlus). New York has been in the forefront of innovative approaches to ensuring health care coverage for all New Yorkers. Incorporating presumptive eligibility into the prenatal care program in the 1980s enabled low income women to receive services immediately while full Medicaid eligibility was under determination. Medicaid managed care legislation in 1998 extended family planning benefits for 26 months after the end date of a pregnancy to women who had previously been on Medicaid while pregnant but lost benefits when the pregnancy ended. The Family Planning Benefit Program (FPBP) was implemented in 2002 pursuant to New York's Medicaid 115 Waiver that expended eligibility for Medicaid family planning services to individuals with household incomes up to 200% of the FPL regardless of previous Medicaid eligibility or pregnancy status.

Medicaid currently provides health coverage for more than 4.5 million New Yorkers. New York Medicaid covers children under five up to 133% FPL, children aged six to 18 up to 100% FPL, pregnant women and infants up to 200% FPL, parents and young adults up to 83% FPL, and childless adults up to approximately 78% FPL. The Family Planning Benefit Program (FPBP) provides reproductive health care services to men and women of reproductive age up to 200% FPL. Elderly and disabled New Yorkers may in some cases receive coverage at slightly higher eligibility levels, as do children and adults participating in "waiver" programs, designed to meet their special health needs in a community-based, cost effective manner. Finally, New Yorkers with incomes too high to qualify for traditional Medicaid may be eligible to participate in Family Health Plus (FHPlus), a Medicaid-funded program that provides a somewhat more limited benefit package to parents and young adults (ages 19--20) with incomes up to 150% FPL and childless adults with incomes up to 100% FPL. Children with incomes above Medicaid thresholds are eligible for CHPlus, New York's CHIP program that offers coverage on a sliding scale basis with subsidies up to 400% FPL, and allows families with incomes over 400% FPL to buy into the program.

Several HSCIs relate to child health and the systems of care for New York's children and adolescents in poverty. NYS has been a national leader in developing systems to cover and provide quality care to low income children. New York provides health care coverage to nearly 2.2 million children. Slightly more than 1.8 million children are covered by Medicaid and 390,000 by Child Health Plus, representing more than 40% of New York's children. In order to improve New York's rates for immunization, primary and preventive care, including oral health, and management of chronic diseases, children need to be engaged in comprehensive, quality health care on an ongoing basis. In NYS, the vast majority of children enrolled in Medicaid and all children in CHPlus are enrolled in managed care plans. NYSDOH has in place a rigorous and dynamic system for quality assurance and improvement within health plans. Through its Quality Assurance Reporting Requirements (QARR), all health plans -- including Medicaid, CHPlus and commercial plans -- are required to annually report results of a set of standardized quality measures. These measures cover all areas of care and include a robust set of measures specific to children and adolescents, including well-child preventive visits from infancy through adolescence; annual dental visits; age-appropriate anticipatory guidance and counseling on specific topics including sexual activity, depression, tobacco use, alcohol and drug use, nutrition and physical activity; immunizations, blood lead testing and weight assessment; and appropriate management of both acute and chronic health care needs.
The results of the quality measures are used in publications including consumer guides to facilitate health plan selection. Results are also used to target quality improvement activities for Medicaid plans. Plans that perform poorly on any of the selected measures have to conduct a root cause analysis and action plan to improve their performance. Plans with positive performance relative to their peers are awarded financial incentives.

A 2006 study conducted by the Commonwealth Fund concluded that family-centered medical homes support ongoing comprehensive health care, helps eliminate barriers to care, creates greater access to preventive care services, and leads to better management of health as well as chronic conditions. In a family-centered medical home the pediatric care team works in partnership with a child and a child's family to assure that all of the medical and non-medical needs of the patient are met. Through this partnership the pediatric care team can help the child and family access, coordinate, and understand specialty care, educational services, out-of-home care, family support, and other public and private community services that are important for the overall health of the child and family. In 2009, New York State law authorized NYSDOH to incentivize the development of patient centered medical homes to improve health outcomes through better coordination and integration of patient care for persons enrolled in NYS Medicaid. Major medical home initiatives have become established within New York State Medicaid and Child Health Plus (CHPlus). In July 2010, NYSDOH began making incentivized payments to medical providers enrolled in Medicaid for offering a higher level of coordinated primary care, as recognized by the National Committee for Quality Assurance's (NCQA) Patient Centered Medical

Home.

Over the past year, New York also simplified documentation requirements for Medicaid, CHPlus, and Family Health Plus (FHPlus) by implementing a data file match process with the Social Security Administration (SSA) to verify U.S. citizenship status, identity and age. Applicants who include their Social Security Number on the application do not have to document their citizenship, identity and birth date. The SSA data match is used to electronically verify this information that removes the burden of proof from the family. Medicaid program coverage was also expanded for children ages 6-18 to 133% of the FPL.

New York State is also working towards the centralization of public insurance eligibility and renewals to alleviate the burden on families and better ensure consistent interpretation of polices. The Statewide Enrollment Center includes a single statewide telephone and mail-in renewal system and toll-free call center for New Yorkers outside of New York City seeking information and assistance enrolling in Medicaid, Family Health Plus, and Child Health Plus. Plans are also underway for the implementation of an Express Lane Eligibility strategy to assist in the transition of children from CHPlus to Medicaid at their CHPlus renewal, enabling them to seamlessly enroll in Medicaid without completing a new application.

In some areas of NYS, health care availability may be limited, or working parents may be unable to take time off from work to bring their children to health care appointments. To facilitate access to primary and preventive health services for children and adolescents, the NYSDOH established School Based Health Centers. NY has the largest School Based Health Center program in the country to serve as a safety net for the provision of primary and preventive health care in high need neighborhoods schools in NY. School Based Health Centers (SBHCs) are located in 220 schools in high need school districts across NY; 107 of the SBHCs are located in junior and senior high schools.

The NYSDOH is also committed to ensuring that oral health care becomes an integral part of health care for all individuals. New York has strongly supported efforts to increase oral health services to all citizens of the state. School Based Health Center Dental programs increases access to oral services to some of New York's most vulnerable populations. In New York, the percentage of Medicaid-eligible children and adolescents between 2 and 21 years of age having at least one dental visit during the year continues to increase. The proportion of low-income children and adolescents seeing a dentist during the year increased from 2009 to 2010 for all age groups. OHIP generates data on the utilization of dental services by Medicaid enrollees for monitoring trends in dental visits and the use of preventive and restorative services. The analysis of the Medicaid dental claims and encounters shows that children in fluoridated counties continue to experience fewer claims compared to that in less fluoridated counties.

Recognizing the importance of fluoridation to prevent caries, the DOH Medicaid Redesign Team (MRT) has made two recommendations for improving oral health services: 1) MA funding be made available to support costs of fluoridation equipment, supplies and staff time for public water systems in population centers (population over 50,000) where the majority of MA-eligible children reside; and 2) amend statute and regulation to allow for the practice of dental hygiene under a collaborative practice agreement rather than under the supervision of a licensed dentist. Work in the arena will continue in the upcoming year. Title V staff are directly involved in the development of these MRT proposals. Ensuring access to oral health services continues to be a NYSDOH priority. Any discussion related to health care includes consideration for oral health care services.

Children with special health care needs present even more significant challenges to ensuring comprehensive, coordinated care. New York is home to one of the largest Early Intervention Programs in the country. Established through law in 1992, the EIP provides services to infants and toddlers with developmental delay or disability ages 0 to three and their families. Approximately 70,000 infants and toddlers are served annually. New York's Children with Special Health Care Needs Program works closely with internal partners and local health

departments, and community-based and professional organizations to develop and implement systems initiatives to improve quality of services for children with special health care needs. (Refer to Needs Assessment Summary for information related to child and family input into services.) Despite supports and services offered in New York State (as detailed in other sections of this application), the NYSDOH seeks to further improve a comprehensive approach to the provision of services for CSHCN.

The Affordable Care Act provides states with the opportunity to provide Health Homes for Medicaid enrollees as an option in their Medicaid state plan. Health Homes are a model of care delivery designed to expand upon the traditional medical home model by enhancing coordination of primary, acute and behavioral health care and building linkages with community and social supports for individuals with chronic conditions. The provision of Health Homes for high need, high costs individuals enrolled in Medicaid, seeks to improve the quality of care and the experience of care while reducing costs. Implementation of the Health Homes for Adults is currently underway in NYS. Under the leadership of NY's Title V Program, and in collaboration with interagency and external partners, the NYSDOH is currently developing recommendations for Children's Health Homes. The recommendations for Children's Health Homes will be incorporated into a State Plan Amendment (SPA) submitted to the Centers for Medicare and Medicaid (CMS). Children's Health Homes tentatively will target those Medicaid enrolled individuals, birth to twenty years, with two or more chronic conditions, one serious, persistent mental illness, and selected single chronic conditions at risk for another, such as HIV/AIDS. It is anticipated that preliminary recommendations for Children's Health Homes will be completed in fall 2012.

With an eye to addressing health disparities across the lifespan, NYSDOH has undertaken considerable analysis of data trends and programming. For example, current Comprehensive Adolescent Pregnancy Prevention (CAPP) funding was targeted through the development and use of the Adolescent Sexual Health Needs Index (ASHNI). ASHNI is a ZIP-code level indicator that provides a single, multidimensional measure that incorporates multiple factors including the size of adolescent population, number of adolescent pregnancies and STD cases, and demographic and community factors that are significantly associated with adverse sexual health outcomes. As stated in the Needs Assessment Summary, although New York has had significant success in decreasing teen birth rates, including a decrease in the rate for every race and ethnicity, disparities continue to exit with Hispanic teen girls having the highest rate of teen births. As another example, a multi-dimensional needs index based on 23 indicators was developed for NY's MIECHV initiative, and will serve as a key indicator to target both home visiting and other community-based maternal and infant public health strategies.

NYSDOH also has embraced the systematic use of evidence-based public health strategies. For example, the Comprehensive Adolescent Pregnancy Prevention (CAPP) community-based projects supported by the NYSDOH focus on decreasing the incidence of adolescent pregnancy and STD/HIV and reducing racial and ethnic disparities among adolescents aged 10 to 21 by providing evidenced-based sexual health education; ensuring access to family planning; increasing skill-building opportunities; and promoting community efforts to improve adolescent sexual health. During the first year of the CAPP initiative, 2,869 Hispanic youth and 3,493 Black youth participated in evidence-based sexual health education programs. Forty of the 50 CAPP projects specifically focus on serving Hispanic youth. Funded programs are expected to have staff and Boards representative of racial and ethnic populations they serve, and that have experience serving minority populations.

New York supports a network of family planning providers targeted in the highest need, disparate areas of NYS. The program serves over 3540,000 women and men per year. The Family Planning Extension Program, added in 1998, provides up to 26 months of additional access to family planning services for women who were pregnant while on Medicaid, and subsequently lost Medicaid coverage. The Family Planning Benefit Program began in October 2002 and provides Medicaid coverage for family planning services to individuals with incomes at or below 200

percent of the federal poverty level. Plans are underway to expand and streamline access to family planning services through Medicaid redesign. Effective July 2012, FPBP will be a Medicaid State service and will include a presumptive eligibility period that will ensure immediate access to services while awaiting eligibility determination. The State Plan will also include auto-enrolling women into the program who would have previously entered the FPEP, including undocumented immigrants. Family planning programs funded by DOH reported that 26% (90,000) of all the clients served during the report period were of Hispanic origin. The NYSDOH was able to fund several additional CAPP projects through the federal Personal Responsibility Education Program (PREP) award. Planning is also underway for use of the federal Section 510 Abstinence Education Grant Program (AEGP) funds to support community projects for 9 to12 year-olds focused on adult mentoring and supervision to delay the onset of sexual activity. The NYSDOH will release a request for applications later in 2012.

The health of New York's mothers and babies is paramount. As noted, NYS provides expanded eligibility for public health insurance for pregnant women, with nearly 46% of all births covered by MA. At a systems-level, Title V staff work closely with the State MA program staff to implement comprehensive quality standards for prenatal care. Further discussion regarding present activities and future plans is presented in performance measures and Section IV E Health Status Indicators sections of this application.

A major effort to set the course for health and public health initiatives in NYS is the Prevention Agenda. The Prevention Agenda which was launched in 2008 identified the NYS's 10 public health priorities for a five year period, established indicators to measure progress, and charged local health departments, hospitals and other community partners to assess and prioritize local public health needs and take action together to address them. It also serves as a systems-level guide for the NYSDOH. These priority areas included:
- Access to quality health care
- Chronic disease
- Community Preparedness
- Healthy Environment
- Healthy mothers, healthy babies, healthy children
- Infectious disease
- Mental health and substance abuse
- Physical activity and nutrition
- Tobacco use
- Unintentional injury

Through the Prevention Agenda, local health departments were asked to work with hospitals to assess the needs in the community and develop collaborative strategies for improvements. Nearly five years have passed since the initiation of the Prevention Agenda, and therefore the NYSDOH is moving into the next phase of this initiative. The plan will consist of an assessment of progress on the 2008-2012 Prevention Agenda toward the Healthiest State, the identification of new public health priorities and a plan for multi-sector action for the next 5 years on priority health issues. The plan is being developed with input from key stakeholders throughout the state, including local public health, hospital associations, professional societies, business representatives, academia, managed care plans, community based organizations and a wide range of public health organizations. Tile V staff are closely involved in this process.

Developing a new five year public health plan for NYS that is coordinated with national and state health reform will help New York State focus attention and action on the most important causes of ill health and develop a coordinated plan for addressing them. The new plan will identify the state's public health priorities for 2013-2017 and establish measurable objectives, evidence based policies and improvement strategies, and time-framed targets for each priority. The plan will designate public and private organizations that have accepted responsibility for implementing strategies outlined in the state health improvement plan.

The NYSDOH is working in collaboration with the NYS Public Health and Health Planning Council's Ad Hoc Advisory Committee. When the plan is launched at the end of 2012, local health departments, hospitals and other stakeholders will be charged with conducting local planning efforts to assess needs, identify local priorities from among the state's list, and develop and implement action plans to address them. The state plan will be the resource document that they can use to shape their local plans.

In addition to providing important public health guidance to stakeholders across New York, developing an assessment and plan that includes these elements will enable the NYSDOH to advance toward accreditation. The first ever voluntary accreditation of state and local public health agencies was launched in 2011 by the national Public Health Accreditation Board. The goal of the program is to improve and protect the health of the public by advancing the quality and performance of state, local, tribal and territorial health departments. Accreditation provides an opportunity for health departments to measure performance against a set of nationally recognized practice focused and evidenced based standards. State health departments are required to complete three prerequisites before applying: a state health assessment, a state health improvement plan, and an internal strategic plan. Completing the state health improvement plan which will include a state health assessment will enable NYS to move forward with its application.

In order to best meet the needs of all New Yorkers, and remain a leader in the nation for public health, the NYSDOH must look towards the future and continually evaluate strategies and outcomes. NYSDOH continues to be committed to making New York "the healthiest state".

IV. Priorities, Performance and Program Activities

A. Background and Overview

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

As previously described in the Needs Assessment Summary section, New York' s priority setting process included a review of the needs of the MCH populations, ***/2013/input from maternal and child health stakeholders throughout NYS,//2013//*** an examination of existing program priorities and realignment of the priorities to address new identified needs to the extent that resource permit. Performance related to program priorities was assessed to ensure MCH programming results in real improvement in the health and well being of the MCH populations in NYS.

NY's progress on Federal and State Performance Measures and Outcome Measures are tracked on Forms 11 and 12.

A summary of the state's progress related to implementation of state priorities ***/2013/and outcomes measures//2013//*** is included in Section IV B.

Determining what should be identified as a state priority ***/2013/in NY's five-year application for 2011-2016//2013//*** and how those priorities should be ranked was based upon a number of factors including degree of stakeholder input identifying an issue as a priority; current capacity to meet identified needs, whether the need related to a health disparity / disparities, as well as other factors. The following are revised State Priorities for the 2011 through 2016 MCHBG grant cycle:

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

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

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

A summary of the state's progress related to addressing the State's outcome measures is as follows:

1. State Outcome Measure: The maternal mortality rate per 100,000 births - In 2010, the Department implemented a new Maternal Mortality Review Initiative, which builds on the previous DOH-funded Safe Motherhood Initiative. The Department redesigned the previous process, in which ACOG was funded to conduct reviews of a selected sub-set of maternal deaths on a voluntary basis, to a DOH-led comprehensive process to systematically review all maternal deaths, in conjunction with IPRO and an expert committee that includes representation from ACOG and other professional groups/experts. The updated initiative is intended to ensure a comprehensive review of factors leading to maternal deaths in New York State, and to have sufficient information to develop strategies and measures to decrease the risk of these deaths. The first meeting of the expert committee included a review of preliminary 2006-2008 data on 70 maternal deaths, ***/2013/showing leading causes of death to be: hypertension (20%), hemorrhage (19%) and embolism (17%). Chronic illness, obesity and prenatal risk factors were identified,//2013//*** resulting in identification of several priorities including management of hypertension, obesity and embolism/DVT for development of clinical guidelines. Management of hypertension during pregnancy was selected as the first topic for development.

/2013/During the past year//2013//, a multidisciplinary subcommittee and the Department worked with the OHIP, IPRO and the subcommittee to develop guidelines ***/2013/on the diagnosis, evaluation, and management of Hypertensive Disorders in Pregnancy.//2013//*** The full Expert Review Committee will have the opportunity to review and comment on the guidelines before they are issued by DOH.

2. State Outcome Measure: The percentage of elective deliveries both cesarean sections and inductions performed without appropriate indication between 36 and 38 6/7 weeks -To address concerns regarding elective preterm deliveries, the NYS Department of Health has implemented the New York State Perinatal Quality Collaborative (NYSPQC) - a joint initiative of the Department, New York's Regional Perinatal Centers (RPCs) and the National Initiative for Children's Healthcare Quality (NICHQ). The collaborative strives to improve maternal and newborn outcomes through the use of evidence-based healthcare improvement interventions to reduce the number of scheduled, elective deliveries performed without appropriate indication in women of 36 0/7 to 38 6/7 weeks gestation. Initial RPC Obstetrical Intervention teams activities include: collecting and submitting data on scheduled inductions and Caesarian deliveries without medical indication; revising admitting practices; employing "hard stop" processes to ensure that only elective deliveries with acceptable medical indicators are scheduled; and educating providers and patients. ***/2013/Significant progress has been shown including: a 67% decrease in scheduled deliveries without medical indication; an 86% decrease in inductions; a 62% decrease in c-sections; and, a 66% decrease in primary c-sections.//2013//***

The Neonatal learning collaborative focuses on optimizing early enteral nutrition in preterm babies in the NICU. Ultimately, the goals of the Learning Collaborative are to improve care in the participating RPCs, as well as care in their affiliate hospitals. Both arms of the collaborative utilize data collected by the Department to analyze success in achieving collaborative objectives. RPC teams will learn and apply formal strategies to expand their findings from these QI projects to perinatal hospitals in their regions through the RPC QI role with their affiliate.

/2013/Building on the initial success of these activities, the NYSDOH was awarded a competitive CDC Perinatal QI grant to expand activities to additional obstetrical hospitals, in partnership with the NYS Partnership for Patients.//2013//

B. State Priorities

As discussed previously, stakeholder perceptions of state priorities for the MCHBG five year needs were very aligned with priorities identified by the Department. The Department has already begun significant efforts to address these priorities.

The Department is very committed to reducing health disparities. This commitment is reflected in the priorities for the ***/2013/current 5-year//2013//*** MCHBG grant. Although health disparities have narrowed in several MCH performance areas, health disparities at unacceptable levels continue to persist. These disparities may be caused by a number of factors, including socioeconomic and environmental factors, barriers related to access and quality of care, differences in health literacy, immigration status, linguistic and cultural differences which create barriers to access to health care, health literacy, as well as a variety of other factors. Addressing these disparities must begin with data analysis at finer level of stratification, a process which is currently underway in the Department. Program services are increasingly targeted to communities with health disparities and poor outcomes. Programs must be representative of the communities they serve, both in terms of board members and staff that provide services. Existing programs are evaluated and modified if they are ineffective in addressing issues of health disparities. The following is a brief implementation status related to state priorities identified in the 2011 needs assessment.

1. State Priority: To improve access to early, adequate and high quality prenatal care, with a specific focus on eliminating health disparities - A major focus continues to be the expansion and enhancement of home visiting activities for high-risk pregnant women to improve birth outcomes, which includes a focus on identifying and engaging women early in pregnancy. This effort has including a number of initiatives, including the DOH-developed Healthy Mom-Healthy Baby ***/2013/systems-building//2013//*** initiative supporting local health departments serving six highest need counties; the Community Health Worker (CHW) program that provides outreach and paraprofessional home visiting services to pregnant women at high risk for poor birth outcomes; and, the Nurse Family Partnership (NFP) programs in three high-need communities. NYSDOH was designated as the State lead and has developed a comprehensive, statewide needs assessment and state plan related to the provision of evidenced-based home visiting services in response to the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visitation (MIECHV) implemented by HRSA. ***/2013/Funds have been awarded to expand home visiting programs in three target areas, and a RFA to award funds to support additional maternal and infant health initiatives in high risk communities in NYS will be released in 2013.//2013//*** MCH staff program have worked closely with the Department's Office of Health Insurance Programs (OHIP) related to a Medicaid Redesign Team (MRT) proposal to expedite enrollment of MA-eligible women into managed care plans to promote earlier entry into prenatal care and increase utilization of care management for high risk women ***/2013/and to support and assess implementation of comprehensive standards for MA prenatal care.//2013//***

2. State Priority: To improve access to comprehensive, high quality primary and preventive health care for children and adolescents, consistent with the medical home model, including children with special heath care needs --There has been a significant expansion in health insurance eligibility for children in NYS, including expansion of Child Health Plus (NYS S-CHIP program) to 400% FPL in 2009 and expansion of Medicaid (MA) coverage for children aged 6 to 18 to 133% FPL in late 2011. All MCHSBG-funded programs are expected to facilitate public insurance enrollment for eligible children. In particular, the Title V CSHCN program provides grant funds to local health departments that include assistance in helping families of CSHCN who are uninsured or underinsured access health insurance, including Medicaid waiver programs. Title V staff have worked with OHIP to advance policies to improve access to health care for children and CSHCN, including participation in MRT efforts related to expansion of Medicaid Managed Care to additional MA-eligible populations (including children and youth in foster care); expanding the state's Patient-Centered Medical Home Program; and, implementing Health Home (enhanced care coordination services) for high-need MA enrollees, ***/2013/including the development of Child Health Homes//2013//***. The Title V program continues to operate the largest School-Based Health Center Program in the nation, with over 50 hospitals and community health centers

sponsoring 218 clinics within schools across the state. Title V staff have implemented quality improvement initiatives related to improving pediatric care, including developmental screening, autism screening and follow-up, and blood lead screening.

3. State Priority: To eliminate disparities in birth outcomes especially with regard to low birth weight and infant mortality -- Improving birth outcomes requires a multi-pronged approach including clinical and community-based efforts. In the past decade, the NYSDOH MCH Program has worked to develop a highly structured, statewide system of regionalized perinatal care organized around regional perinatal centers (RPCs). RPCs provide care to the highest risk mothers and babies and provide quality improvement services to a network of affiliated hospitals offering varying levels of perinatal care. This year, the impact of perinatal regionalization on neonatal mortality among very low birth weight (VLBW) infants has been assessed. Regionalization has had a positive impact in NYS with VLBW babies more likely to be born at RPC and Level III hospitals and more likely to survive post-regionalization (2004-2006) than pre-regionalization (1996-2001). NYS's risk-adjusted VLBW neonatal mortality rate declined from 13.03 per 100 during 1996-2001 to 10.46 per 100 during 2004-2006. Improvements were noted by region, NYC (13.45/100 to 10.45/100) and Rest of State (12.49/100 to 10.47/100), and hospital level, RPCs (12.52/100 to 9.78/100) and Level IIIs (13.41/100 to 10.71/100). NYS is first among 10 states that met the 2010 goal of 90% of VLBW infants delivered at a Level III or higher hospital. ***/2013/NY's work in the MIECHV initiative other long standing community-based programs will support expansion of evidence-based home visiting services to improve birth outcomes.//2013//***

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

5. State Priority (revised) To reduce unintended pregnancies in adults and adolescents and improve adolescent sexual health and development, with a focus upon reducing health disparities - In January 2011, BMCH launched a new $17.5 million 5-year Comprehensive Adolescent Pregnancy Prevention CAPP initiative that includes a significant focus on implementation of evidence-based sexual health education and reducing racial and ethnic disparities. Grants were awarded to 50 community-based organizations that focus on the prevention of pregnancies, STDs and HIV among male and female adolescents ages 10 to 21 years. BMCH applied for and received federal funding for the Personal Responsibility Education Program (PREP) initiative which is closely aligned with CAPP and ***/2013/this funding supports//2013//*** additional awards to organizations that were approved but not funded under CAPP, as well as to supporting an enhancement project targeting youth in foster care. BMCH also applied for and received $2.99 million in federal funding for the Abstinence Education Grant Program (AEGP) which will support a new initiative that will fund community-based mentoring, counseling and adult supervision programs designed to delay the initiation of sexual behavior among young people, ages 9-12, residing in high-risk communities. ***/2013/An RFA to award this funding will be released in 2012. Through NY's Family Planning Program,//2013//*** funding was awarded in a competitive

application to 49 agencies operating more than 200 clinic sites to provide comprehensive family planning and reproductive health care services targeted to the highest need communities and populations to address health disparities. Services were expanded to several locations in the state. In addition to the clinical programs, the State is also supporting a new Statewide Center of Excellence (COE) for Family Planning and Reproductive Health Services that will partner with the Department of Health to develop and promote a comprehensive system of high quality family planning services. MCH Staff partnered with OHIP related to an MRT proposal to convert the state's programs that provide expanded access for family planning services from waiver programs to a State Medicaid plan service.

6. State Priority: To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women - NYS exceeds the Healthy People 2020 baseline and target goals of 26% and 21% respectively for this indicator. In 2010, 12.6% of high school students smoked cigarettes on one or more days during the past month (2010 YTS), compared to 2000, when 27.1% of high school students were smokers. The New York Tobacco Control Program (NYTCP) approach to tobacco control is built on the social norm change model, in which reductions in tobacco use are achieved by creating a social environment and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible. The success in reducing youth smoking is attributable to high tobacco product taxes, a statewide clean indoor air law, and DOH's comprehensive tobacco control effort. The program increases access to effective cessation services, including support for the NYS Smokers' Quitline, and supports media campaigns designed to increase public awareness of the dangers of tobacco use. NYTCP supports a range of local programs designed to build and support tobacco-free communities, including Reality Check, a youth engagement program which works to counter the tobacco industry influence in communities. Exposure to tobacco marketing in stores is a primary cause of youth smoking. Over the past year, NYTCP continues to focus on action to reduce the impact of tobacco industry marketing on youth.

7. State Priority: To improve oral health, particularly for pregnant women, mothers and children, and among those with low income - According to a Pew report titled The State of Children's Dental Health: Making Coverage Matter, New York State met five of eight policy benchmarks aimed at addressing children's dental health needs. The overall performance improved from a C grade in 2010 to a B grade in 2011. The Bureau of Dental Health (BDH) continues to grow its School-Based Health Center-Dental program, with programs in a quarter of high-risk schools offering preventive services. The Bureau awarded $1.5 million for 30 applications for preventive dental services in school-based/school-linked programs, with a primary objective to increase the prevalence of dental sealants in second and third grade children. BDH has completed the second year of the Oral Health, Physical Activity and Nutrition (OPAN) survey of 3rd grade children in upstate New York; over 5,000 3rd grade children have been screened for this project to date. BDH collaborated with OHIP related to developing Medicaid reimbursement for physicians, dentists, and nurse practitioners for the application of fluoride varnish to teeth in children younger than 7 years of age. BDH is educating and encouraging medical providers to incorporate oral health screening, anticipatory guidance, caries risk assessment, and where indicated, the application of fluoride varnish into well child visits as a routine standard of care for children, including development of a partnerships between WIC and local pediatricians to explore a WIC Fluoride Varnish Pilot Project Proposal. The BDH assisted the New York State Oral Health Coalition in re-establishing its Prenatal/Perinatal Committee to improve oral health education for pregnant women. ***/2013/BDH staff is collaborating with OHIP on a MRT proposals to support community fluoridation.//2013//***

8. State Priority: To eliminate childhood lead poisoning - The Department continues to address the problem of childhood lead poisoning through multiple primary and secondary prevention strategies. A major ***/2013/recent accomplishment was the//2013//*** promotion of lead testing through linkage of lead registry with the NYS Immunization Information System (NYIIS). This linkage will reinforce and promote timely lead testing by practitioners, and improve the Department's ability to survey screening rates, ***/2013/by allowing//2013//*** physician offices to

review lead test histories for their patients, submit reports of ***/2013/point-of-care//2013//*** lead tests, ***/2013/receive automatic reminders//2013//*** for testing or follow-up, ***/2013/and access to//2013//*** reports that enable providers, plans and state and local health departments to assess lead testing practices and target quality improvement activities. NYSDOH has issued new guidelines for the blood lead testing of refugee children and pregnant women ***/2013/and updated guidelines for counseling, testing and follow-up of children and pregnant women. This year, the program has been successfully transitioned to the Center for Environmental Health with continued collaboration with Title V. The reduction in Federal funding presents a significant challenge to NY's//2013//*** ability to address this priority.

9. State Priority: To improve diagnosis and treatment of asthma in the maternal and child health population - DOH continued to fund 11 regional asthma coalitions across NYS with the goal of reducing asthma related morbidity and mortality. The coalitions, representing organizations that serve a pediatric population disproportionately affect by asthma, continue to implement and spread education and systems changes intervention through participation in the NYS Asthma Outcomes Learning Network (AOLN), a quality improvement initiative led by the NYS Asthma program, with assistance from the National Initiative for Children's Health Care Quality (NICHQ). ***/2013/Among teams measuring ED visits for asthma, all reported a decrease in the percentage of patients served who had had an asthma-related ED visit in the past six months.//2013//*** Managed care plans and health practices which provide benefits and services to African Americans with asthma are implementing interventions to improve asthma outcomes in the Eliminating Disparities in Asthma Care (EDAC) initiative. A partnership has been established to work on the development of culturally/linguistically appropriate mobile phone information systems to provide asthma self management support to consumers. To increase access to quality asthma self-management support services, Medicaid has provided coverage for asthma self-management services when provide by a Certified Asthma Educator. DOH is leading an initiative to further develop the Certified Asthma Educator workforce and their integration into clinical practice, including an analysis to understand Certified Asthma Educator workforce supply.

10. State Priority: To increase the percentage of infants who are breastfed for at least six months - Significant cross organizational efforts to improve breastfeeding rates continue, including promoting the development of Baby Friendly Hospitals and breastfeeding quality improvement in hospitals through a structured, data-driven, breastfeeding quality improvement learning collaborative, a joint initiative with the NICHQ. ***/2013/Twelve hospitals that provide maternity care services outside of NYC were recruited and have been engaged in the NYS Breastfeeding QI in Hospitals (NYS BQIH) Learning Collaborative. The average prevalence of infants exclusively fed breastmilk across all hospitals in the project was 44.5% in August 2011, up from June 2010 baseline of 37.1%. NYCDOHMH also worked with 13 hospitals in NYC to improve support to breastfeeding mothers.//2013//*** DOH and Regional Perinatal Centers (RPCs) are offering the 18 hour Ten Steps to Successful Breastfeeding Online course to staff in 125 obstetrical hospitals in NYS. The NYSDOH WIC Program received a performance award of $1.6 million from the USDA to recognize its high rate of breastfeeding initiation. A statewide media campaign was funded, targeted to low income communities to increase awareness and support of breastfeeding, "Breastfeeding -For My Baby, For Me", which featured advertising via television, internet, bus shelters and bus interiors. Medicaid Prenatal Care Standards, revised in 2010, required providers to counsel and educate women during prenatal visits and immediately postpartum regarding infant feeding choices. The Maternity Information leaflet, required by state law, provides patients information on maternity-related procedures performed at each hospital. The law has now been expanded to also require that information on infant feeding practices at each hospital be included in this publication.

C. National Performance Measures

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	77.2	76.0	88.1	86.8	86.8
Numerator	3542	3238	15853	3300	3300
Denominator	4586	4263	17985	3800	3800
Data Source		Newborn Screening Program data set	Newborn Screening	Newborn Screening	Newborn Screening
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	88.5	89.4	90.3	91.1	92

Notes - 2011
As shown in the above table, the numerator is the number of closed cases with documentation of an evaluation, diagnostic testing and a diagnosis as appropriate. The denominator is the number of screen positive newborns for the year. The program follows all screen positive newborns to ensure they receive appropriate follow-up.

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

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

Notes - 2010
Data in the cells for 2007 and 2008 numerators and denominators represent only screen positives or referrals. In previous years, these numbers represented all newborns screened. For 2007-2008. as shown in the above table, the numerator is the number of cases closed and the denominator is the number of screen positive newborns for the year. The annual indicator is the number of closed cases divided by number of screen positive cases reported as a percent. A case is considered closed when all predetermined closure criteria are met, including the newborn

having an evaluation, any diagnostic testing, and a diagnosis has been made regarding the condition for which the newborn was referred. The program follows all screen positive newborns to ensure they receive appropriate follow-up, including an evaluation, diagnostic testing and a diagnosis as appropriate.

For 2009, the numerator is the number of referrals (previously called screen positives) plus the number of babies with a presumptive positive screen. Presumptive positive screens are those infants with slightly out of range results; a repeat specimen is required, and follow-up staff ensures a repeat sample is received, tested, and reported appropriately. Data for 2009 are cases opened and closed that calendar year. There are still instances where the annual indicator will increase as some infants have cases remaining open until a firm diagnosis is made by the clinician. The diagnosis may not be made by the clinician until the following year; therefore the 2009 data is provisional. 2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Notes - 2009
2009 data have been revised but are still considered provisional due to open cases where a firm diagnosis by the clinician has not been made.

Unlike in 2006, the numerator and denominator numbers in 2007 - 2009 represent only the infants screened positive, rather than all infants screened.

a. Last Year's Accomplishments
-Newborn screening (NBS) is performed by DOH's Wadsworth Center's NBS Program. In 2011, 242,210 infants were screened for 46 congenital conditions, including 30 core conditions, most secondary conditions, and HIV and Krabbe disease (both unique to NY). Screening for severe combined immunodeficiency was added to the panel on 9/29/2010.
-The 46 conditions include:
•Congenital adrenal hyperplasia
•Congenital hypothyroidism
•Sickle cell disease and other hemoglobinopathies
•HIV-1 exposure
•Homocystinuria
•Hypermethioninemia
•Maple syrup urine disease
•Phenylketonuria
•Tyrosinemia, types 1, 2, and 3
•Carnitine-acylcarnitine translocase deficiency
•Carnitine palmitoyltransferase deficiency, types 1 and 2
•Carnitine uptake defect
•2,4-Dienoyl-CoA reductase deficiency
•Long-chain 3-hydroxyacyl-CoA dehydrogenase deficiency
•Medium-chain acyl-CoA dehydrogenase deficiency
•Medium-chain ketoacyl-CoA thiolase deficiency
•Medium/short-chain hydroxyacyl-CoA dehydrogenase deficiency
•Mitochondrial trifunctional protein deficiency
•Multiple acyl-CoA dehydrogenase deficiency
•Short-chain acyl-CoA dehydrogenase deficiency
•Very long-chain acyl-CoA dehydrogenase deficiency
•Glutaric acidemia, type 1
•3-Hydroxy-3-methylglutaryl-CoA lyase deficiency
•Isobutyryl-CoA dehydrogenase deficiency
•Isovaleric acidemia
•Malonic acidemia
•2-Methylbutyryl-CoA dehydrogenase deficiency
•3-Methylcrotonyl-CoA carboxylase deficiency

•3-Methylglutaconic acidemia
•2-Methyl 3-hydroxybutyryl-CoA dehydrogenase deficiency
•Methylmalonic acidemia
•Mitochondrial acetoacetyl-CoA thiolase deficiency
•Multiple carboxylase deficiency
•Propionic acidemia
•Argininemia
•Argininosuccinic acidemia
•Citrullinemia
•Hyperammonemia/hyperornithinemia/homocitrullinemia
•Biotinidase deficiency
•Cystic Fibrosis (CF)
•Galactosemia
•Krabbe disease
•Severe combined immunodeficiency
-Infants screened in 2011 were confirmed with the following conditions:
•27 cases of amino acid disorders
•13 cases of congenital adrenal hyperplasia
•94 cases of primary congenital hypothyroidism
•32 cases of fatty acid oxidation disorders
•313 cases of hemoglobinopathies
•52 cases of organic acid disorders
•6 cases of biotinidase deficiency
•41 cases of CF
•9 cases of galactosemia
•6 cases of severe combined immunodeficiency
•3 infants were found to be at high risk for Krabbe disease.
-The NBS program followed all screen positive newborns to ensure they received appropriate follow-up. For each screen positive newborn, a phone call is made to the hospital of birth, primary care provider and appropriate specialist to report the abnormal screen. The specialists are located at Specialty Care Centers (SCCs) that are approved and monitored based on established clinical standards. A follow-up phone call is made to the specialist 1 week after notification to ensure that the infant has been located. Over a 13 week period, 3 sets of forms are sent to the specialists, birth hospital and primary care provider to gather data on the outcome of the diagnostic evaluation. A call is also made to the specialist four weeks after the newborn entered into care to determine the outcome of the diagnostic evaluation. When the final diagnosis is received, a review team meets to ensure that appropriate follow-up was done.
-Newborn screening educational materials were developed and maintained.
-Through the NY NBS and NY Mid-Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC) websites, individuals can access educational resources about genetics services or specialty care or identify clinical services providers, support groups and other services.
-DOH received a 3-year grant from HRSA entitled Effective Follow-up in Newborn Screening (EFU), which ends in 8/12, to improve NBS short-term follow-up via enhanced health information exchange. Specific activities include electronic data transmission, electronic submission of diagnostic data and electronic collection of long-term follow-up data.
-For many of the disorders on the newborn screen, genetic counseling is an important component of clinical management. MA coverage for genetic counseling provided by certified genetic counselors was instituted on 1/1/11.
-Prenatal Genetics Services were provided to 19,071 pregnant women in 2011. Clinical Genetics Services were provided to an additional 27,312 individuals through genetics services grantees in 2011 through genetic services grantees.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In 2011, DOH's Wadsworth Center's NBS Program screened 242,210 infants for 46 congenital conditions.			X	X
2. The NBS program followed all screen positive newborns to ensure they received appropriate follow-up.	X	X		
3. DOH received a grant from HRSA entitled Effective Follow-up EFU) in Newborn Screening. This 3-year grant ends in 8/12. Its goals are to improve NBS short-term follow-up via enhanced health information exchange.				X
4. NBS EFU staff worked with Natus, a software company, to develop specifications for an internet case management system (iCMS) to allow for electronic diagnostic entry and long-term follow-up.			X	X
5. DOH certifies specialty centers. The NBS Program and the Children with Special Health Care Needs Program continue to monitor standards for Endocrine, CF and Inherited Metabolic Diseases Specialty Centers.	X			X
6. For many of the disorders on the newborn screen, genetic counseling is an important component of clinical management. MA coverage for genetic counseling provided by a certified genetic counselor was instituted on 1/1/11.	X			X
7. Prenatal Genetics Services were provided to 19,071 pregnant women in 2011. Clinical Genetics Services were provided to an additional 27,312 individuals through genetics services grantees in 2011.	X	X	X	X
8. Through the NY NBS and NYMAC websites, individuals can access educational resources about genetics services or specialty care or identify clinical services providers, support groups and other services.		X	X	X
9.				
10.				

b. Current Activities

-Wadsworth Center conducts bloodspot screening on 100% of suitable specimens from NY's newborns for 46 conditions. More than 90% of referred infants are followed to confirmation.
-The NBS Program is reviewing unresolved cases to discuss ways to increase the percent of infants who receive timely follow-up.
-DOH continued work for the NBS EFU grant for enabling Health Information Exchange (HIE) and improving communications regarding child health information. EFU grant staff performed a data matching analysis of vital records data and newborn screening data and identified a group of unscreened infants. Using this data, the Program is developing a targeted education and outreach effort to decrease the number of unscreened infants.
-NY provides grant awards to 24 genetic centers across NYS to provide diagnostic services, laboratory testing, genetic counseling, and referral to treatment centers.
-NY is a member of NYMAC for Genetic and Newborn Services.
-DOH continued work from the CDC Cooperative Agreement for RuSH, the Registry and Surveillance System for Hemoglobinopathies.
-Hemoglobinopathy criteria for specialty centers were reviewed. Specialty Centers are being re-certified based on the resulting standards.
-DOH submitted a grant proposal to HRSA to fund a Critical Congenital Heart Disease NBS Demonstration Program.

c. Plan for the Coming Year

-The NBS Program will continue to screen all newborn blood spots that are received in suitable condition. Education and outreach will be initiated to decrease the number of samples received that are unsuitable. The program will continue to ensure appropriate follow-up of all screen positive newborns.

-The NBS Program will continue to investigate and improve on existing methods to screen for additional lysosomal storage disorders in the event that screening is mandated for these disorders, and will begin a pilot study to add secondary genetic testing for hemoglobinopathies. The Program will also continue to work with Endocrinologists to develop new diagnostic criteria for hypothyroidism.

-NBS EFU staff will continue to work with 67 target hospitals to roll out electronic data transmission. Staff will also implement use of the internet case management system for remote diagnostic entry with CF Specialty Centers, Severe Combined Immunodeficiency (SCID) Specialty Centers and Inherited Metabolic Disease (IMD) Specialty Treatment Centers.

-Article 28 hospitals will be monitored for their success as SCCs.

-NBS EFU staff will work with SCID and IMD Specialty Centers to define criteria and goals for long-term follow-up, and implement a long-term follow-up tracking module.

-NBS EFU staff will work with the CF Foundation Patient Registry to obtain existing data on SCC service utilization for program surveillance.

-NBS EFU staff will continue to work across DOH units to enable the design and development of a HIE infrastructure. This infrastructure will also be used to support and populate a virtual child health profile, accessible by authorized users in both the private and public sector to improve access to child health information by health care providers. NBS EFU staff will also continue to work with Child Health Information Integration (CHI²) staff to coordinate activities for design, development and implementation of a virtual child health profile.

-Individuals concerned with genetics or specialty care can access educational resources or identify clinical services providers, support groups and other public health resources through both the NY NBS and NYMAC websites: www.wadsworth.com/newborn; www.wadsworth.org/newborn/nymac

-Wadsworth Center will continue to operate a state-of-the-art clinical and environmental laboratory evaluation program to ensure that laboratories offering tests to NY residents meet appropriate quality requirements and can pass proficiency tests.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**242208**					
Reporting Year:	**2011**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	242208	100.0	21	20	20	100.0
Congenital Hypothyroidism (Classical)	242208	100.0	693	328	328	100.0

Galactosemia (Classical)	242208	100.0	15	9	6	66.7
Sickle Cell Disease	242208	100.0	83	68	68	100.0
Biotinidase Deficiency	242208	100.0	12	6	6	100.0
Congenital Adrenal Hyperplasia	242208	100.0	230	13	13	100.0
Cystic Fibrosis	242208	100.0	889	41	41	100.0
Homocystinuria	242208	100.0	11	0	0	
Maple Syrup Urine Disease	242208	100.0	9	4	4	100.0
beta-ketothiolase deficiency	242208	100.0	0	0	0	
Tyrosinemia Type I	242208	100.0	6	2	2	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	242208	100.0	20	5	5	100.0
Argininemia	242208	100.0	0	0	0	
Isovaleric Acidemia	242208	100.0	11	3	3	100.0
Propionic Acidemia	242208	100.0	46	10	10	100.0
Carnitine Uptake Defect	242208	100.0	4	0	0	
Glutaric Acidemia Type I	242208	100.0	1	0	0	
Isobutyryl-CoA Dehydrogenase Deficiency	242208	100.0	14	13	13	100.0
Sickle Cell Anemia (SS-Disease)	242208	100.0	161	139	139	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	242208	100.0	26	15	15	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	242208	100.0	1	0	0	
Other Hemoglobin Disorders	242208	100.0	48	43	43	100.0
Argininosuccinic Acidemia/Citrullinemia	242208	100.0	6	3	3	100.0
Short-Chain Acyl-CoA Dehydrogenase Deficiency	242208	100.0	14	13	13	100.0
Hemoglobin C Disease	242208	100.0	28	21	21	100.0
Malonic acidemia	242208	100.0	0	0	0	
Krabbe Disease	242101	100.0	45	3	3	100.0
Severe Combined Immunodeficiency	242208	100.0	201	16	16	100.0
Hyperammonemia/Hyperornithinemia/Homocitrullinemia	242208	100.0	1	0	0	
Carantine Palmitoyltransferase I Deficiency	242208	100.0	1	0	0	
Carantine Palmitoyltransferase II/Acylcarnitine translocase Deficiency	242208	100.0	9	0	0	
Medium/Short Chain Hydroxyacyl-CoA dehydrogenase Deficiency	242208	100.0	2	0	0	
Hydroxy-3-Methylglutaryl-CoA Lyase Deficiency	242208	100.0	58	26	26	100.0

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	66	66	60	62	59.6
Annual Indicator	59	59	59	59	64.4
Numerator					
Denominator					
Data Source		CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	65.7	66.3	67	67.6	68.3

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

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

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

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey

a. Last Year's Accomplishments
-According the 2009-2010 NS-CSHCN, 64.4% of NY families of CSHCN report they are shared partners in decision making about their child's health. The Data Resource Center for Child and Adolescent Health has indicated that outcomes for this measure are not comparable across the 2005-2006 and 2009-2010 survey years.
-DOH promotes shared family professional decision-making through medical homes and public health program activities. (The promotion of medical homes is described under National Performance Measure 03.)
-Approximately 73,000 Early Intervention Program (EIP) families were engaged in decision making via the Individualized Family Service Plan (IFSP) process. The IFSP outlines the families' concerns, priorities, resources and objectives for their child's development and the services needed to reach those objectives.
-Family representatives support state planning as members on the Lead Poisoning Prevention Program Advisory Council, Maternal Child Health Services Block Grant (MCHBG) Advisory Council and Early Intervention Coordination Council (EICC).
-Local CSHCN Program contractors based in local health departments link families to appropriate services for their child. The Resource Directory is a print and on-line tool that provides information for families about NYS programs and services for CSHCN. This tool is offered by local CSHCN Program contractors and is available on line on the DOH web.
-Title V staff participated in discussions related to Medicaid (MA) Redesign including proposals that relate to CSHCN. Families and advocacy organizations were also welcome to participate in regional forums for Medicaid Redesign.
-The local CSHCN Program work plan was revised to include this goal: CSHCN Program activities are responsive to the needs of family and youth. Required program activities include

eliciting consumer feedback about services provided and modifying activities, if needed, based upon consumer input.
-In September 2011, the CSHCN Program staff convened a workgroup to develop a family satisfaction questionnaire to be utilized by all local contractors to assess consumer satisfaction with program services. The workgroup consisted of six local CSHCN Program representatives, four state CSHCN Program staff and one parent representative of NYS Parent to Parent (NYSP2P). NYSP2P is the state's Family to Family Health Information Center. The purpose of the work group was to assist DOH in developing a standardized tool and to provide feedback about data collection and survey distribution procedures. A significant amount of time was spent creating drafts of the document to share with the work group during conference calls held in September and October 2011. The survey was designed to guide program planning and improvements. Further developments regarding the survey are discussed in this year's activities.
-In August 2011, CSHCN Program staff distributed NYSP2P information links to local CSHCN Program to share with families.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Local CSHCN Programs work with families to identify and refer them to appropriate services for their child.		X		X
2. DOH promotes shared family professional decision making through medical homes and public health program activities.	X	X		X
3. Early Intervention Program (EIP) families were engaged in decision making through the Individualized Family Service Plan (IFSP). The IFSP identifies family's concerns, priorities, and objectives for their child's development.		X		
4. Parents of CSHCN are represented on the MCHSBG Advisory, the Early Intervention Coordination, the Lead Poisoning Prevention Advisory Councils and serve as representatives on several other state level advisory groups.				X
5. Title V staff participated in MA redesign discussions that relate to CSHCN.				X
6. The CSHCN work plan was revised to include a goal for program activities that are responsive to the needs of families and youth.				X
7. The Resource Directory for CSHCN is posted on the DOH website and distributed free of charge to consumers and providers.			X	
8. The state CSHCN Program convened a workgroup of outside partners to assist in the development of CSHCN family satisfaction tool for statewide distribution.			X	X
9. Conference calls were held with family and youth representatives and local health departments (LHDs) concerning their ease of use of the systems of care and satisfaction with services.				X
10. CSHCN Program staff distributed NYSP2P information links to local CSHCN Program to share with families.			X	

b. Current Activities
-The Family Satisfaction Survey was finalized in collaboration with workgroup members. A webinar with LHDs was held to discuss implementation of the survey. Local CSHCN Program staff invited families participating in CSHCN programs to complete the survey online via Survey Monkey. A survey was mailed to families without internet access. The survey is being translated

into Spanish.
-DOH applied for HRSA funding to support a Critical Congenital Heart Disease (CCHD) Newborn Screening Demonstration Program. DOH received support for its application from NYSP2P, with a commitment to support the CCHD newborn screening program in reviewing and helping to distribute educational information regarding newborn screening for critical congenital heart disease.
-In 1/12, CSHCN Program staff distributed NYSP2P information links to local CSHCN Program for sharing with families.
-The DOH Early Hearing Detection and Intervention (EHDI) Program identified 20 parents of children with hearing loss and 10 professionals interested in establishing a NYS Chapter of Hands and Voices (HAV), a national parent professional collaborative offering unbiased support to families of children with significant hearing loss. The EHDI program contracted with National HAV to provide a national consultant to guide this parents and professionals in the formation of a NYS Chapter; the group has achieved provisional Chapter status.

c. Plan for the Coming Year
-Beginning in April 2012, NY CSHCN Program staff will review data collected regarding family satisfaction with local CSHCN Program contractors. An annual statewide report will be generated at the end of the grant cycle (September 30th), and individual reports will be created and shared with each local CSHCN Program. The statewide and local reports are designed as a quality improvement tool, providing feedback from families about how to improve the delivery of services. The survey may be revised as needed based upon review of data collection.
-CSHCN Program staff will host one conference call/webinar for LHDs on relevant topics, e.g. promotion of family-professional partnerships, provision of information about resources to make services easier for families to find and utilize.
-HAV of New York will continue to provide the EHDI program with status updates as they progress and will establish a permanent board, become a 501c3 non-profit organization
-Title V staff will continue to seek opportunities to involve families in decisions impacting supports and services.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	58	58	46	48	45.7
Annual Indicator	45.2	45.2	45.2	45.2	38.4
Numerator					
Denominator					
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2012	2013	2014	2015	2016
Annual Performance Objective	39.2	39.6	39.9	40.3	40.7

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

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

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

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
-Through NY's School Based Health Centers, children and adolescents, including CSHCN receive primary and preventive health care.
-New York State (NYS) is committed to principles of individualized, comprehensive and coordinated care within a medical home for all individuals. A medical home is very important for those individuals who have complex needs for which they may utilize the system often through multiple providers.
-In 2009, NY law authorized DOH to incentivize the development of patient centered medical homes (PCMH) to improve health outcomes through better coordination and integration of patient care for persons enrolled in NYS Medicaid (MA). Major medical home initiatives have become established within NYS MA and Child Health Plus (CHPlus), with a goal of all children in MA and CHPlus in PCMH by 2014.
-In July 2010, DOH began making incentivized payments to medical providers enrolled in MA for offering a higher level of coordinated primary care, as recognized by the National Committee for Quality Assurance's (NCQA) Patient Centered Medical Home (PCMH). Approximately, 1.3 million MA enrollees received their medical care from a PCMH as of December 31, 2011. An increase of 200,000 MA enrollees was seen from the third to fourth quarter of 2011. In 2011, the incentivized payments began for CHPlus providers. At the end of 2011, 97,000 children in CHPlus received their primary care from a PCMH. This number represents almost 32% of all CHPlus enrollees.
-The NS-CSHCN's 2009-2010 data indicated that 38.4% of families reported their children received care within a medical home. This is a 15% decrease from the 45.2 percent reported by families in the 2005-2006 NS-CSHCN. The MCHB core outcome for medical homes has been deemed comparable across the 2005-2006 and 2009-2010 surveys so it is unclear what accounts

for the decrease in the number of families reporting having a medical home. It is hoped that the use of incentivized payments for PCMH will influence a positive trend in medical home creation in NY and the data will reflect this in the next NS-CSHCN.
-DOH's Managed Care Plan Performance is measured annually by the Office of Health Insurance Programs (OHIP) for quality, access to care and consumer satisfaction. The 2011 report provided data collected for 2009 regarding its care coordination measure. Seventy-four percent of MA enrollees and 79% of commercial managed care plan enrollees reported their personal doctor "usually" or "always" seemed informed and up to date about care they received from other doctors or health care providers. This measure is reported annually for commercial plans and biannually for MA plans.
-NYS Department of Health (DOH) continues to fund Local Health Departments (LHDs) to provide information and referral services to CSHCN and their families, including assistance with obtaining health insurance and locating a primary care provider. As a proxy for medical home, the CSHCN Program assesses the number of children with a primary care provider as part of the initial contact when families request information and referral services from local programs. In 2010-2011, approximately 69% of CSHCN served by the program reported having a primary care provider. NY CSHCN Program contract managers are reviewing the data integrity and following up with local contractors to determine whether this percentage is an accurate portrayal of the presence of a primary care provider or is underreported.
-The CSHCN Program staff began discussions with technical staff about the type of reports needed to demonstrate annual statewide activity provided for CSHCN through contracts with LHD. The statewide report would be compiled from local CSHCN Programs quarterly reports.
-The Early Intervention Program (EIP) assesses the presence of a primary care provider and assists with linkages for insurance coverage as necessary.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Established NYS medical home initiatives within MA and CHPlus continue.	X			X
2. DOH continues payments to CHPlus and MA providers that meet NCQA standards of PCMH.				X
3. DOH measures Managed Care Plan Performance annually for quality, access to care and consumer satisfaction.				X
4. DOH continued funding to LHDs that provide information and referral services to CSHCN and families; assist them with obtaining health insurance coverage; locating a primary care provider/medical homes; and linking with community services.		X		X
5. DOH continued funding to LHDs to include consumer involvement in local programs.		X		X
6. The CSHCN Program began discussions with technical staff about the development of a statewide CSHCN Program report.				X
7. The EIP assesses the presence of a primary care provider and assists with linkages for insurance coverage as necessary.				X
8.				
9.				
10.				

b. Current Activities
-Funding has been identified for a new SBHC Center of Excellence that will provide support to enhance services offered through this program.
-The CSHCN Program designed reports based upon data collected from local programs that include demographics of population served; assistance needed; referrals made; and outcomes.

These reports have increased the capacity to monitor local programs regarding services provided to CSHCN and their families and will be used to provide improvements to local programs. The program work plan includes responsibility to assess for the presence of a primary care provider and to assist families with connections to health insurance and providers. The Title V Program, in collaboration with many internal and external partners, is leading the development of programmatic recommendations for Children's Health Home (HH) for NYS. The HH model provides reimbursement for enhanced care coordination for high need/high cost individuals enrolled in MA. A state plan amendment for adult HH was submitted to CMS and approved retroactive to January 1, 2012. A series of intensive working meetings began in 2012 to design the model to reflect considerations necessary for family-centered care coordination for children with special health care needs, including medical and behavioral conditions. A full set of preliminary recommendations is expected by Fall 2012.

c. Plan for the Coming Year

-CSHCN program staff will continue to monitor trends in state and national data regarding the presence of medical homes for CSHCN and to fund CSHCN Programs in LHDs to provide information and referral for CSHCN and their families. State program staff will review work plans and budgets, monitor performance through review of quarterly reports, and provide technical assistance as necessary.

-CSHCN program staff will build upon the CSHCN Program data collection and reporting process by considering the creation of reports for local CSHCN Program. This will provide state DOH staff with another tool for quality improvement.

-Title V program staff will work with OHIP to successfully implement a children's HH model. Important pediatric considerations include, but not limited to, identifying children early; recognizing the invaluable role of the family in their child's life; considering many transitions a child makes throughout childhood and adolescence, and planning for appropriate provider standards and quality measures. We anticipate that Title V staff will continue to be involved in implementation.

-School-Based Health Center (SBHC) programs will identify a revised set of quality indicators for the SBHC initiative. The goal is to identify indicators that define the primary services and outcomes that SBHCs achieve in providing primary and preventive care, chronic disease management, and mental health services for enrolled students. The corresponding intent of this exercise is to collect data from SBHCs for indicators that reflect the quality indicators utilized by the larger health care delivery system in NY (e.g. MA, Managed Care,and the NCQA. This data will help document the role SBHCs play in providing coordinated care and serving as the medical home for children with special health care needs.

-OHIP will continue rollout of incentives to expand MA/CHP enrollees receiving care in NCQA PCMH.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	70	72	64	64	62.7
Annual Indicator	62.1	62.1	62.1	62.1	56.8
Numerator					
Denominator					
Data Source		CSHCN	CSHCN	CSHCN	CSHCN

		survey	survey	survey	survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	57.9	58.5	59.1	59.6	60.2

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

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

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

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
-Approximately 8% of NY families of Children with Special Health Care Needs (CSHCN) reported their child was uninsured at some point during the year (NS-CSHCN 2009-2010). According to the NS-CSHCN 2009-2010, 38% of NY families reported their current insurance was inadequate to meet their child's needs. NY is slightly higher than the national average of 34.3%. Compared to the 2005-2006 NS-CSHCN, 3% more families reported their insurance was inadequate in the 2009-2010 NS-CSHCN.
-A January 2011 report from National Academy for State Health Policy entitled The Affordable Care Act and Children with Special Health Care Needs: An Analysis and Steps for State Policymakers explains that "while most CSHCN have insurance coverage, many have inadequate coverage because of non-covered benefits, limitations in duration and scope, and annual or lifetime limits, resulting in excessive out of pocket expenses or children not receiving the care they need." NY Families of CSHCN with private insurance feel the burden of these out-of-pocket costs that consume more of their personal budget.
-The staff of local CSHCN Programs asks families about the type of financial assistance they need during their encounter with families who contact the program. In 2011, 1,803 NY families responded to the inquiry about the types of financial assistance needed. The most common reasons why families requested financial assistance were: the service or item is not covered by their insurance (65.6 %); need help with insurance premium (17.5%); need help with copayment (6.7%) and need help with deductible (2.9%).
-In addition to NY public insurance programs, two public health programs, the CSHCN and

Physically Handicapped Children's Programs help families of CSHCN address their child's unmet needs.
-DOH provided grant funding to support 56 local CSHCN Programs' information and referral services. The CSHCN Program staff refers families to health insurance, cash assistance programs (SSI) and gap-filling programs. Upon initial contact with a family, the CSHCN Program inquires about the type of financial assistance families are seeking.
-DOH provided funding through the Physically Handicapped Children's Program (PHCP) for medical services to children, age birth to 21 years, with severe, chronic illnesses or physically handicapping conditions. The gap-filling reimbursement assists families of CSHCN pay for services that health insurance does not cover or only partially covers. The children may be uninsured or underinsured and must meet local program financial and medical eligibility requirements established by participating counties.
-In 2011, 220 children received a diagnostic evaluation and 1550 children received treatment services through the PHCP. In descending order, the major categories of services and percent of funds expended in 2011 are as follows: orthodontia (71%), medications (10%), therapy services (3.3%) medical-surgical services (3%), hearing aids (3%), and enteral formula (3%).
-The NY Early Intervention Program (EIP) provided comprehensive services, including services coordination, to infants and toddlers with developmental delay or disabilities. A child's insurance is billed first for these services; if the child's insurance is inadequate, the locality provides payment for the authorized services. Approximately 73,000 children and families received early intervention services in 2011.
-The Resource Directory for CSHCN is a comprehensive document for consumers and providers about state financial assistance programs and other supports for families. This document is available online and in print format in English, Spanish, Chinese, Russian and French. In 2011, there were 15,890 page views to one or more of the pages of the online document. In 2011, almost 11,000 copies of the printed document were distributed in the languages cited above.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DOH funds 56 local CSHCN Programs to provide information and referral services to assist families to locate insurance and/or financial assistance.		X		X
2. The staff of local CSHCN Programs asks families about the type of financial assistance they need during their initial encounter with families who contact the program.		X		
3. DOH PHCP provides reimbursement to providers for diagnostic evaluations and state aid reimbursement to localities for gap filling treatment services.		X		
4. Local EIPs will continue to provide reimbursement to EIP providers for authorized services not covered by insurance.	X			
5. DOH displays on-line versions of the Resource Directory for CSHCN in multiple languages for consumer and professional use.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
-PHCP is a voluntary local public health program financed by both (50%) State and Federal dollars. Although state funding has remained stable, four local programs discontinued their PHCP

services in 2011. Eighteen of 58 LHDs are now either not accepting new cases or have discontinued their programs, citing fiscal austerity as the reason for discontinuance of the voluntary program or ceasing acceptance of new children.
-Local CSHCN Program staff continues to look for other resources to assist these families, including reduced or free medication programs or community foundations. Local CSHCN Programs refer families to appropriate SSI and Medicaid (MA) waiver programs.
-Title V staff continue to participate in the MA Redesign process as the lead for development of recommendations for children's Health Homes (HH). In this model of health care coordination for high need/high cost MA children, each enrollee will be assigned a care coordinator. The care coordinator will ensure that services are arranged and coordinated, continuity of care and health promotion are supported, and patient outcomes are monitored so that changes in care if needed can be initiated. Also see NPM 03 Children's Health Home.
-Title V staff are monitoring the status of the ACA implementation including essential benefits package for children.
-Distribution of information to consumers and providers about the financial and supportive resources available to families continued during the reporting period.

c. Plan for the Coming Year
-DOH will continue to provide grant funding to support 55 local CSHCN Programs to assist families of CSHCN age birth to 21 years of age.
-LHDs will continue to receive state aid reimbursement for gap filling services. Local programs will continue to monitor why gap filling services are needed and provide this information to DOH.
-The CSHCN Program staff will continue to participate in the MA Redesign Process for children's HH, supporting the process through the submission of a MA State Plan Amendment. (See NPM 03)
-CSHCN staff will begin the process of updating the Resource Directory for CSHCN by reaching out to intra-agency and interagency contacts to review current information.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	82	91	92	92	91.5
Annual Indicator	90.6	90.6	90.6	90.6	65.6
Numerator					
Denominator					
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**

Annual Performance Objective	66.9	67.6	68.2	68.9	69.5

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

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

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

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
-Almost sixty-six (65.6%) percent of NY families reported they can easily access community-based services. In 2009-10 NS-CSHCN, NY scored slightly higher than the national average of 65.1%. However, there is room for significant improvement in family satisfaction with access to services.
-DOH provides grants to 56 local CSHCN Program contractors to help families access services for CSHCN from birth to twenty-one years of age. Local program staff link families to appropriate state and community health-related programs and services and help identify and resolve gaps and barriers to care for CSHCN. The programs are receiving year-3 funding (of a 5 year funding cycle)
-Title V staff streamlined the work plan requirements for local CSHCN programs to assure that all contractors are addressing a core set of program requirements.
-DOH provided funding to 57 local health departments (LHDs) to provide preventive outreach and education, and coordinate follow-up of medical, educational and environmental services for children identified with lead poisoning.
-The Early Intervention Program (EIP) provided service coordination to approximately 73,000 infants and toddlers and their families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. DOH provided year-3 funding (of a 5 year funding cycle) to 56 contractors for the CSHCN Program to link families to state/community health programs and services, and to identify and resolve gaps/barriers to care for children ages 0-21 years.		X		X
2. DOH provided year-two funding as part of a five year funding cycle to 57 LHDs for the Lead Poisoning Prevention Program	X	X	X	X

(LPPP) to coordinate follow-up medical, educational, and environmental services for children with lead poisoning.				
3. Title V staff streamlined the work plan requirements for local CSHCN programs to assure that all contractors are attesting to and working on a core set of program requirements.				X
4. DOH provided funding to LHDs for administration of the Early Intervention Program (EIP).				X
5. The Early Intervention Program (EIP) provided service coordination to approximately 73,000 infants and toddlers and their families.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

-Local CSHCN Programs provide quarterly data and narrative reports that are reviewed by Title V staff. Local CSHCN Programs located in rural counties have reported that families have to travel long distances, sometimes out of the county, to access providers who will accept Medicaid (MA). Several local programs have reported that there is a lack of dental, vision, and orthodontic providers enrolled in MA within their counties. One county reported a lack of MA enrolled primary care providers. These gaps in services will be reviewed by NY CSHCN Program staff in the coming year. (See Section c.)

-Title V staff are participating in the state's MA Redesign process, including active involvement in the "care management for all" goal. DOH wishes to have all MA enrollees in some form of care management within three years. The Health Home (HH) concept is a care management model being implemented for high cost/high cost MA enrollees. Adults who meet chronic medical and behavioral eligibility requirements are being actively enrolled in HH. Title V staff have taken the lead in convening a work group to develop recommendations for a Children's HH.

-The EIP continued to provide service coordination for referred and eligible infants and toddlers and their families.

c. Plan for the Coming Year

-Local CSHCN Program concerns about availability of MA primary care providers and specialists will be discussed during the development of recommendations for Children's HH, including requirements for provider networks. Providers and health plans that wish to apply as lead HHs will be required to have a network of providers that meet DOH standards. Strong HH networks will promote systems of care that are organized and have the ability to address behavioral, medical and social needs of the child.

-Title V staff will continue to monitor progress towards removal of barriers to care for CSHCN and transmit information to appropriate DOH and other state agencies to improve the systems of care.

-Title V staff will also continue to collaborate with OHIP in the implementation of Children's HH to enhance coordination of care for CSHCN.

-Title V staff will also continue to work with SBHCs and the SBHC COE to improve SBHC care for all children, including CSHCN.

-The CSHCN/PHCP contact list will be updated and provided to New York State Parent to Parent (P2PNYS) for posting on the Family to Family Health Information Center website.

-Early intervention service coordination will continue to be provided to those children referred and found eligible for the EIP.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	9	40	40	40	38.8
Annual Indicator	38.4	38.4	38.4	38.4	39.7
Numerator					
Denominator					
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	40.5	40.9	41.3	41.7	42.1

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

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

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

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments

-NY's performance on this core measure is equal to the national performance of 40%; progress on this measure has been maintained.
-The local CSHCN Programs receive grant funds to assist children, adolescents and families in obtaining information and referrals they need. Helping families with transition issues was an optional work plan activity for local contractors during this reporting period. The work plan with local contractors was revised by creating a transition goal, objectives and activities that were incorporated into the three remaining years of the contract cycle beginning October 1, 2011.
-The hand-held portable health summary developed by Title V Program staff and Youth Champions is available through the DOH Distribution Center for use by consumers and providers. Local CSHCN Programs are required to provide the portable health summary document to youth ages 14 or older and their families who contact their local program.
-During onsite visits with hospital Specialty Centers, state CSHCN Program staff inquired about transition planning for transfer of care from pediatric to adult providers. Providers described their transition planning efforts and some have noted reluctance on the part of adult providers to accept these complex patients. Some of the patients may remain with the pediatric provider beyond age 21 years depending upon the adult specialist's familiarity with the patient's condition.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The CSHCN Program work plan was revised to include transition activities as a required work plan deliverable beginning October 1, 2011.		X	X	X
2. Hand-held portable health summary continued to be available through the DOH Distribution Center for consumers and providers.			X	
3. Title V staff are involved in development of recommendations for pediatric HH.	X	X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
-All local CSHCN contractors are required to disseminate information about the Healthy Transitions website (http://www.healthytransitionsny.org) developed by Title V Program in collaboration with Youth Champions and offer the pocket sized health summary document to adolescents and their families who contact the program for assistance.
-Information about the Healthy Transitions website was disseminated to SBHCs to share with youth they serve.
-State CSHCN Program staffs continue to discuss transition plans during onsite visits to and conference calls with hospital Specialty Center providers.
-Title V staff are participating in NY's Medicaid (MA) redesign process, including discussion of recommendations related to HH for children. Transition of medical/behavioral care from pediatric to adult specialists and transfer of care coordination as youths become independent are being discussed. Recommendations concerning transition from a pediatric HH to an adult HH are be part of the discussions regarding the development of a HH for children.
-Title V staff are the DOH's project lead for the development of recommendations for pediatric Health Homes (HH). Staff reviewed the specifications for the adult model to identify what needs

to be considered for children and their families.

c. Plan for the Coming Year
-Transition activities will continue to be a required program element for local CSHCN contractors.
-The CSHCN Program staff will continue to participate with the Office of Health Insurance Programs in NY's MA Redesign process including the development of recommendations for HH for children. Following the review of recommendations, a state plan amendment for HH for children will be submitted to the Centers for Medicare and Medicaid (CMS).
-During the specialty center approval process, program staff will continue to discuss specialists' plans for transition of their pediatric patients to adult providers and offer Healthy Transitions website (http://www.healthytransitionsny.org) and Health Information Document tools to specialists for their use with transitioning adolescents and young adults.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	87	88	80	80	72.9
Annual Indicator	83	76.2	72.2	71.3	71.3
Numerator					
Denominator					
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	73.6	74.4	75.1	75.8	76.5

Notes - 2011
The National Immunization Survey rates have decreased, in part, due to changes in the survey methodology. Decreasing prevalence of families with land lines (the National Immunization

Survey is a telephone survey) and a small sample size contribute to the variability of the results. 2010 data are used as a proxy for 2011 data. It is estimated that final 2011 immunization data will be available from CDC in late 2012 or early 2013. NYS exceeds the HP 2020 baseline of 68% for the proportion of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and PCV vaccines but is below the target of 80%.

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Notes - 2009
2008 data are being used as a proxy for 2009.

a. Last Year's Accomplishments
-The Immunization Program provided vaccines through the NY Vaccines for Children (VFC) Program, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted local health departments with disease surveillance and outbreak control activities, and continued to expand the statewide immunization registry. CDC categorical grants and State and Local Assistance dollars were used to provide staffing in both central and regional DOH offices and to purchase vaccines. Local Health Departments (LHD) assist in recruiting VFC providers.
-Under the Assessment, Feedback, Incentives and eXchange (AFIX) initiative, LHD staff visited health care providers to assess their patients' medical records for compliance with immunization schedules. The information is entered in CDC-developed software (Comprehensive Clinic Assessment Software Application (CoCASA)). CoCASA calculates the providers' immunization rates and identifies opportunities for improvement in immunization practices. Over 390 AFIX visits were conducted last year and an ongoing AFIX evaluation project focuses on program quality improvement.
-Comprehensive Prenatal-Perinatal Service Networks (CPPSN) provided education and outreach to engage children into the health care system and to improve utilization of well child care. Some networks conducted outreach for Child Health Plus and other outreach and educational activities to ensure that parents are aware of the need for comprehensive immunization.
-Article 6 State Aid to Localities reimbursed LHDs for the infrastructure that supports immunization surveillance, tracking, parent and provider education, and special studies.
-The Community Health Worker Program (CHWP) educated parents about immunization, assessed the immunization status of all children in the program, referred and assisted families to obtain immunizations and followed up with families to assure they actually received the service. Assistance was given with insurance enrollment. In 2010, 87% of the children entering the program had up-to-date immunizations. Of the children who did not have complete immunizations, 84% received immunizations while in the program. Nurse Family Partnership programs also ensure children receive well child care including immunizations.
-The WIC program screens all infants and children until all marker immunizations are received. Infants and children who are not adequately immunized must be referred to a health care provider or immunization clinic.
-Child care providers in NY are required to check immunizations and refer as appropriate. Continued updates to the appropriate immunization schedules and number of doses necessary to bring children up-to-date have been made. Surveys of child care providers continued to assess vaccination rates in children attending child care settings and schools.
-The Perinatal Hepatitis B Program provided on-site record review for quality assurance and to monitor compliance with public health law at NY birthing hospitals. Site visits provided the opportunity to review hepatitis B birth dose policies and offer training to hospital staff regarding immunization of parents and health care personnel.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Bureau of Immunization provided vaccines through the NY Vaccines for Children Program, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted providers.		X	X	X
2. Under the AFIX Initiative, county staff visited pediatric providers and assess immunization records.			X	X
3. CPPSNs provided education and outreach to engage children into the health care system.		X	X	X
4. Article 6 State Aid to Localities reimbursed LHDs for the infrastructure that supports immunization surveillance, tracking, parent and provider education and special studies.			X	X
5. The CHWP educated parents about immunization, assessed the immunization status of children, referred and assisted families to obtain immunization, and followed-up with families to assure receipt of vaccines.		X	X	X
6. The WIC Program reviewed immunization records and infants and referred children who are not up-to-date are referred to health-care providers or immunization clinics.		X	X	X
7. The Perinatal Hepatitis B Program increased the universal birth dose in all birthing hospitals outside NYC to 78% by providing free vaccine for all children regardless of insurance coverage.			X	X
8. NYSIIS tracks childhood immunizations and experienced significant growth in this area along with increased numbers of registered and active pediatric providers.				X
9. Child care providers in NY are required to check immunizations and refer as appropriate. Surveys of child care providers continued to assess vaccination rates in children attending child care settings and schools.				X
10.				

b. Current Activities

-As part of the ongoing linkage of the NYS Immunization Information System (NYSIIS) to other child health data, enhancements were made in December 2011 to enable prompts and reports for blood lead reporting. In addition, legislation was passed in April 2011 authorizing the collection of individual newborn hearing screening test results. These additions enhance the utility of the overall NYSIIS application for families and providers. NYSIIS continues to grow towards a fully-functioning, comprehensive population-based system. Ninety-two percent (92%) of practices which immunize children are participating in the system. NYSIIS contains more than 4.1 million patients and 50.5 million immunizations. NYSIIS enables health care providers to identify and track under-immunized children and increase immunization rates. NYSIIS continues to work on system improvements including enhancing interoperability with other DOH reporting systems on child health issues as well as external data systems used at the provider practice organizations.
-The Perinatal Hepatitis B Birth Dose Program continues to be enhanced based on evidence from a best practices survey conducted in 2010-11.
-AFIX Initiative evaluations are being conducted to determine best practices in this arena among a diverse network of NY counties' health departments, and will serve to improve provider and patient immunization knowledge and rates.
-CPPSN, CHW and NFP Programs continue to promote well child care and immunization.

c. Plan for the Coming Year

-Further development and enhancement of NYSIIS is planned for the coming year, including enhancement of the clinical decision support tool used by health care providers to determine when a child is due or overdue for an immunization. Interoperability activities will also increase the capability and capacity for external health information exchange. Significant system modifications including the ability for providers to order vaccine on line will enable improved vaccine accountability. In addition, data is being assessed for completeness, accuracy and timeliness of reporting and will be used to determine areas of need for additional immunization related program activities.

-The Perinatal Hepatitis B Program has identified best practices by surveying all birthing hospitals that have a 90% and above birth dose vaccination rate. Additional studies were conducted in 2011 to address barriers for implementing the birth dose among hospitals with birth dose rates below the current state average of 76%. The Bureau of Immunization will now using this information to promote the universal birth dose of hepatitis B vaccine for all newborns in NY.

-A review of AFIX best practices and evaluation of the program will be completed and recommendations generated for use by local health departments to further improve immunization rates in NY.

-Daycare and other child care provider yearly survey forms will be updated to incorporate ongoing changes in the immunization schedules as appropriate. Spanish translation of forms will assist in improvement of timely and accurate reporting of immunization information. Online reporting of immunization information began in 2011-2012 with Head Start programs and will expand to day care centers and nursery schools for 2012-2013. Feasibility of online reporting of immunization information will be explored further to enhance reporting of immunizations.

-Immunization related information on childhood vaccines on the DOH immunization website, including safety related information, will be revise and increased to assist providers and parents to have children vaccinated in accordance with the Advisory Committee on Immunization Practices schedule.

-Community-based maternal and infant health programs, including home visiting, will continue to promote use of well child care and timely immunizations.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	11	11	12.5	12.3	12
Annual Indicator	13.2	12.9	12.1	11.2	11.2
Numerator	5277	5074	4687	4330	4330
Denominator	398693	392716	386720	386890	386890
Data Source		Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	11	10.9	10.8	10.6	10.5

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

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission. The NYS birth rate for teenagers aged 15 to17 was considerably lower than the national rate of 21.7 (2008).

Notes - 2009
Data for 2009 have been revised with final data.

a. Last Year's Accomplishments
-Vital Statistics data for 2010 demonstrated continued accomplishments and challenges in teen pregnancy and birth rates. The birth rate for teens aged 15 to17 declined to a new low of 11.2 per 1,000. While significant geographic, racial and ethnic disparities in teen birth rates exist, the magnitude of the disparities is declining.
-Findings from an Adolescent Sexual Health Symposium and a series of youth and parent focus groups were incorporated into the development of a RFA for a new teen sexual health initiative, which began 1/1/11. DOH awarded $17.5 million in grants to 50 community programs through the Comprehensive Adolescent Pregnancy Prevention (CAPP) initiative to provide adolescent pregnancy prevention programming, in areas with a high burden of adverse sexual health outcomes. CAPP, which replaced the former Community Based Adolescent Pregnancy Prevention and Adolescent Pregnancy Prevention Programs, is focused on a comprehensive and coordinated approach to reduce the risk of initial and repeat pregnancies, STDs and HIV among NY adolescents. The RFA used a new Adolescent Sexual Health Needs Index (ASHNI) to identify the highest burdened areas of NY. ASHNI is a ZIP code-level indicator which provides a single, multidimensional measure of community risk factors related to adolescent pregnancy and STDs. CAP grantees implement evidence-based sexuality education, ensure access to reproductive healthcare, expand educational, social, vocational and economic opportunities, and coordinate existing community resources.
-The CAPP initiative incorporates a technology component for family planning (FP) service providers to maximize the use of information communication technologies that are appropriate and consistent with current adolescent modes of communication. The efforts are focused on improving reproductive and FP service delivery and decreasing barriers for adolescents, raising awareness, providing information and improving clinical services. In addition, Columbia University was funded to provide statewide training to community health care providers to improve adolescent health care.
-DOH was awarded $3.1 million in Federal Personal Responsibility Education Program (PREP) funds to support additional CAPP programs selected through the RFA.
-DOH was awarded $2.8 million in Federal Section 510 Abstinence Education Grant Program (AEGP) funds to support a new Supporting Transitions to Adolescents initiative, which will support community projects for 9-12 year-olds focused on adult mentoring and supervision to delay the onset of sexual activity.
-The DOH-funded Assets Coming Together (ACT) for Youth Center of Excellence (COE) began monthly webinars and other trainings with CAPP providers on the implementation of evidence-based programs (EBPs) with fidelity, adaptation of EBPs; implementation of adult preparation topics; and community assessment. The new web site (nysyouth.net) launched as part of a media campaign has continued; and will be further enhanced to include additional information on adolescent health and related issues, including topics identified through youth feedback on the site.
-The DOH Adolescent Sexual Health Work Group (ASHWG) continued to focus on the development of a coordinated approach to improving sexual health outcomes for teens. ASHWG is comprised of staff from multiple DOH units.
-Fifty-one Family Planning (FP) agencies that operate 198 clinics throughout NY provided free or low cost FP and reproductive health care services to more than 71,000 teens (33,000 of these

teens were between the ages of 15 and 17).
-School Based Health Centers (SBHCs) are located in 220 schools in high need school districts across NY; 107 of the SBHCs are located in junior and senior high schools. These SBHCs continued to provide age-appropriate risk assessment and anticipatory guidance and health education pertaining to sexual activity to enrolled students. Some of these SBHCs provide reproductive health care services on-site, others refer students to community providers of reproductive health care services when needed.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DOH funded the CAPP initiative that emphasizes evidence-based comprehensive sexuality education, access to reproductive health services, multi-dimensional support for life skills development and community collaboration.		X	X	
2. Columbia University was funded to provide statewide training to community health care providers to improve adolescent health care.			X	
3. DOH was awarded $3.2 million in Federal PREP funds to support additional CAPP programs.		X	X	
4. DOH was awarded $2.8 million in Federal AEGP funds to support mentoring to support community projects in high-risk areas for 9-12 year-olds focused on adult mentoring and supervision to delay the onset of sexual activity.		X	X	
5. Funding has been provided to those CAPP programs that are FP service providers to maximize the use of information communication technologies that are appropriate and consistent with current adolescent modes of communication.		X	X	
6. The ACT COE began providing monthly webinars and other trainings with CAPP providers on the implementation of evidence-based programs with fidelity, adaptation of EBPs; implementation of adult preparation topics; and community assessment.				X
7. The DOH Adolescent Sexual Health Work Group continued to focus on the development of a coordinated approach to improving sexual health outcomes for teens.				X
8. DOH continued to support a statewide comprehensive FP and reproductive health care initiative that provides the full range of FDA-approved contraceptive methods to more than 350,000 uninsured, low income clients annually.	X	X	X	X
9. DOH continued to support 220 SBHCs located in high-need underserved communities across NY that provide more than 680,000 health care visits to more than 160,000 students annually.	X	X		
10.				

b. Current Activities
-CAPP programs began activities including implementing evidenced-based programs; ensuring access to FP; increasing skill-building opportunities for teens; and promoting community efforts to improve adolescent sexual health.
-Eight additional CAPP programs were funded through PREP.
-DOH submitted a proposal to use PREP funds to support 2 NYC foster care agency adolescent pregnancy prevention projects designed specifically for the needs of youth in foster care.

-AEGP funding will support a new competitive procurement to fund 15 programs to implement mentoring and adult-supervised programs for high-risk youth ages 9-12 to begin in 2012. RFA to be released in 2012.
-In partnership with the ACT COE and Cornell Cooperative Extension, DOH developed and distributed "Guidelines for Healthy Food and Beverages" for use by funded adolescent health programs.
-The FP COE provided training and technical assistance to funded FP programs with the intent of promoting a statewide standard of excellence for FP services including increasing the number of teens who receive services.
-MCHSBG staff participated in the development of a MA State Plan Amendment (SPA) to convert the current FP Benefit Program into a MA State Plan service. The SPA will include a period of presumptive eligibility (PE) where clients may receive family planning services while final MA eligibility is determined. The addition of PE to FPBP is expected to increase the number of teens who receive FP services.

c. Plan for the Coming Year
-Ongoing program activities to support a wide range of clinical and community-based services will continue, including CAPP, FP and SBHCs.
-The ACT for Youth COE will continue to provide training and technical assistance to the CAPP and CAPP-PREP programs on the implementation of evidence-based programming and will work with DOH to develop and conduct the evaluation for these projects. The COE will also provide training and technical assistance to community-based programs funded through the AEGP, and conduct the evaluation of these programs.
-DOH will implement the enhancement project targeting youth in foster care with PREP funds.
-Up to fifteen awards will be made through the federal AEGP to support community projects focused on the use of adult mentoring, supervision and counseling to support healthy transition to adolescence, including delaying the onset of sexual activity, for children aged 9 to12 years who reside in targeted high-need communities.
-Title V staff will continue to participate in the MA Redesign process relevant to FP services. Several recommendations to expand eligibility criteria that would result in more teens being able to access FP services will be considered.
-DOH will solicit proposals from applicants to serve as the Statewide COE for SBHCs. The creation of a COE will enhance DOH's ability to support the SBHC initiative including identifying and supporting best practices for the delivery of reproductive health care services in a SBHC setting.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	35	40	28	39	40.9
Annual Indicator	27.0	27.0	38.1	41.9	41.9
Numerator	10534	10534	3414		
Denominator	39014	39014	8960		
Data Source		NYS 3rd Grade Dental Survey	NYS 3rd Grade Dental Survey	NYS 3rd Grade Dental Survey	NYS 3rd Grade Dental Survey
Check this box if you cannot					

report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	42.7	43.2	43.6	44	44.4

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

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

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

2010 data have been updated and finalized since NYS's previous MCH block grant application submission.
Numerator and denominator data are not available.

Notes - 2009
2009 data are for NYS (excluding NYC).

a. Last Year's Accomplishments
-The number of schools with a school-based dental health (SBDH) clinic program remained fairly constant with 625 schools in 2010 and 619 schools in 2011. Services continue to be available at 28% of all schools eligible for a sealant program. The CDC has defined the eligibility criteria for targeting school-based sealant program as: urban areas where 50% of student population is participating in free or reduced lunch program; and, rural school districts having a median income at or below 235% federal poverty line.
-During the 2010-2011 school year, 22,503 children in high need areas received oral health screenings through BDH-funded SBDH programs, with 34.8% receiving protective sealants. Sealants were present in nearly 28% of children screened.
-The prevalence of dental sealants among 3rd grade children continues to increase. Based on the results of the 2010-2011 third grade survey in upstate NY schools, 42% had sealants, as compared to 38% in the 2002-2004 survey. A stratified analysis by income showed that sealants increased from 42.5% to 44.9% among high income students and from 28.9% to 38.4% among low income groups.
-Between 2009 and 2010, the number of Medicaid (MA)-eligible children aged 5-to-9-years-old (when sealants are most frequently applied), increased by 4.75%, with 46.1% of all 2010 MA beneficiaries receiving dental services. During the same time period, the number of sealant claims increased by 10.8%. These data indicate that either more children are having sealants applied or that some children may be appropriately receiving sealant application on multiple teeth.
-DOH was awarded a $200,000 annually HRSA school-based health center (SBHC) dental clinic grant to integrate oral health services into existing school-based health centers at North County Children's Clinic in rural Jefferson County. The grant runs for four years through August 31, 2015.

-An evaluation of the effectiveness of the Dental Health Certificate (DHC) in increasing access to dental care was completed. Based on a survey of school nurses, 24% of the DHCs were returned, with the highest return rate among children enrolling in Kindergarten. Identified barriers for completion of the certificate include the lack of a mandate for the certificate and issues related to dental providers (e.g., no dentists in the area and dentists not accepting new or MA patients). The NYS Oral Health Coalition is exploring several strategies to increase return rates and access to dental care, including mandating the dental certificate and authorizing completion of the certificate by Registered Dental Hygienists.
-Please refer to SPM 07 for additional accomplishments.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. SBDH clinics provided services at 619 schools.	X		X	
2. Oral health screening services were provided to 22,503 children in high need areas throughout NY through SBDH clinic programs.	X		X	
3. Contracts to provide SBDH services at high need schools throughout NY continued.			X	X
4. Information on the public website on finding a dental provider continued to be updated. http://www.nyssmiles.org/)				X
5. The 3rd grade oral health surveillance project at upstate NY elementary schools was completed. The 3rd grade surveillance project was initiated at NYC elementary schools.			X	X
6. An evaluation of the effectiveness of the DHC in increasing access to dental care was completed.			X	X
7. DOH was awarded a 3-year HRSA SBHC dental clinic grant to integrate oral health services into existing school-based health centers at North County Children's Clinic in Jefferson County.	X			X
8.				
9.				
10.				

b. Current Activities
-Oral health preventive services, including the application of sealants, continue to be provided to eligible students at schools in high need areas across NYS.
-BDH funds 31 programs for SBDH services and approved 27 other programs to provide dental health services in high risk, underserved areas of NYS. Between funded and unfunded, services are now available at 936 schools in high need areas.
-The 3rd grade oral health surveillance project is continuing at elementary schools in NYC. A report on the results of the 3rd grade survey for upstate NY counties is being prepared.
-Please refer to SPM 07 for additional current activities and plans for upcoming year.
-DOH is seeking guidance from Center for Medicare/Medicaid Services (CMS) on allowable MA administrative expenses for certain costs of community water fluoridation. BDH is working with Children's Dental Health Project and developed a background paper on why the use of MA funds for infrastructure development of public water fluoridation systems would be consistent with CMS guidelines.

c. Plan for the Coming Year
-Contracts with providers for promoting school-based and school-linked dental programs will continue. Training and technical assistance will be provided.

-BDH will develop a simple data reporting tool that can be easily administered and completed to capture data from both funded and unfunded school-based dental health programs on the number of children served and number receiving sealants. Data will be collected for the 2011-2012 school year.
-The Upstate portion of the 3rd grade oral health survey will be completed. The NYC component of the survey began in late 2011 and will continue throughout the coming year.
-DOH will continue to encourage implementation of policies and systems changes that promote twice a day tooth brushing with fluoride toothpaste; good oral health habits including appropriate feeding and snacking habits and healthy dietary practices, the provision of anticipatory guidance, risk assessment and fluoride varnish (FV) by child healthcare professionals and referral to dental providers as early as eruption of first tooth; encourage visits to a dental provider on a regular basis; increase the availability of fluoride through community water fluoridation or a supplemental fluoride program; promote school-based interventions ranging from the DHC, oral health education, dental sealants, case finding and referral to dental care providers; enhance access to affordable insurance coverage; ensure an adequate supply of oral health providers, especially in underserved areas; and integrate oral health as part of programs, policies and overall health screenings.
-BDH will continue to monitor the utilization of dental services by children and adolescents and the types of services received.
-The 2005 State Oral Health Plan will be updated with goals, objectives and strategies for addressing Title V and Healthy People 2020 oral health objectives.
-Title V Staff will continue to work with OHIP to implement the MRT recommendation to utilize MA funds to support infrastructure development of public water fluoridation systems in high population areas.
-Appropriate revisions will be proposed to amend the State Dental Practice Act to change the supervision requirements in the practice of dental hygiene for promoting preventive interventions in non-traditional settings.
-BDH will continue to advocate for interdisciplinary oral health training programs for child healthcare providers (e.g., pediatricians and nurse practitioners) to screen and provide preventative dental services and FV applications.
-BDH will work with MA managed care organizations to implement policy change to allow reimbursement of preventative dental services and FV applications by non-dental professionals.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	1	0.9	1.3	1.2	1
Annual Indicator	1.3	1.2	1.0	1.3	1.3
Numerator	48	43	37	47	47
Denominator	3597289	3604140	3633448	3531233	3531233
Data Source		Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1.3	1.3	1.2	1.2	1.2

Notes - 2011
The number of motor vehicle deaths is based on the definition used by the DOH Bureau of Biometrics and Health Statistics and includes pedestrians and cyclists. The definition changed in 2004; prior to that time, pedestrians and cyclists were not included.

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

Notes - 2010
The number of motor vehicle deaths is based on the definition used by the DOH Bureau of Biometrics and Health Statistics and includes pedestrians and cyclists. The definition changed in 2004; prior to that time, pedestrians and cyclists were not included.

2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Notes - 2009
2009 data have been revised with final 2009 data.
The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

a. Last Year's Accomplishments
-The Governor's Traffic Safety Committee (GTSC) coordinates statewide traffic safety activities. The GTSC is chaired by the Commissioner of the Department of Motor Vehicles (DMV), and as a state department is also housed in the DMV. The Committee acts as the state's official liaison with the National Highway Traffic Safety Administration.
-The Committee promotes and supports the state's highway safety program to provide for the safe transportation of people and goods on NY's roadways. GTSC staff manages the state highway safety program by reviewing and monitoring grant programs, coordinating special programs such as the Child Passenger Safety or the Drug Recognition Effort officer programs, and by providing guidance and oversight to state and local agencies. By statute, the Committee is comprised of the heads of the twelve state agencies with missions related to transportation and safety. The DOH Injury Prevention Program (IPP) Director represents the DOH Commissioner on the Committee.
-In July 2011, Governor Cuomo signed a new law to make texting while driving a primary traffic offense, giving law enforcement the power to stop motorists solely for using a handheld electronic device.
-In August 2011, Governor Cuomo signed a law to require state and local transportation agencies to consider "complete streets" designs that will make streets and roadways across the state safe and accessible to all New Yorkers. "Complete streets" design principles have been proven to reduce fatalities and injuries, and by taking them into consideration on future projects we will greatly improve the safety of pedestrians, bicyclists, and drivers of all ages and abilities. Under this law, "Complete Streets" design principles will be considered on NY/s Department of Transportation (DOT) projects and local and county projects which receive both federal and state funding and are subject to state DOT oversight. "Complete Streets" principles facilitate improved joint use of roadways by all users, including pedestrians, motorists, and bicyclists. Design features may include sidewalks, bicycle lanes, crosswalks, pedestrian control signalization, bus pull outs, curb cuts, raised crosswalks, ramps, and traffic calming measures.
-IPP was awarded two Centers for Disease Control and Prevention (CDC) grants related to child injury prevention and motor vehicle safety. The main goal of the first grant is to enhance the injury infrastructure in NY, with motor vehicle safety and childhood injury prevention as two of the four grant priorities. The second grant emphasizes the development of child injury prevention policy initiatives, with child occupant safety in a motor vehicle being one of the foci.

-IPP was awarded a GTSC grant to promote motor vehicle safety. Activities of this grant include child passenger safety, bicycle safety, and pedestrian safety
-Injury Prevention Program (IPP) and the Public Health Information Group (PHIG) have childhood and motor vehicle data available and are able to perform additional analyses for use in planning.
-IPP promoted toolkits and fact sheets to provide up-to-date data, best practices and evidence-informed programs to reduce unintentional injuries, particularly those that are traffic-related, for medical providers, researchers, educators and consumers. The toolkits include child passenger safety, Shaken Baby Syndrome prevention, fire safety, falls prevention, motorcycle safety, and bicycle safety.
-IPP continues to participate in child safety seat checks and bicycle helmet fitting events.
-The Community Health Worker (CHWP) has extensive child safety components, which stress car seat use and other infant safety measures. Parents enrolled in CHWP are also given extensive information about childhood safety. Homes are assessed for hazards and workers model positive parenting skills and behaviors.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. GTSC coordinates statewide traffic safety activities and manages the state highway safety program by reviewing and monitoring grant programs, coordinating special programs and by providing guidance and oversight to state and local agencies.			X	X
2. In July 2011, Governor Cuomo signed a new law to make texting while driving a primary traffic offense, giving law enforcement the power to stop motorists solely for using a handheld electronic device.			X	X
3. In August 2011, Governor Cuomo signed a law to require state and local transportation agencies to consider "complete streets" designs that will make streets and roadways across the state safe and accessible to all New Yorkers.			X	X
4. IPP received 2 CDC grants related to motor vehicle (MV) safety to enhance the injury infrastructure in NY and develop child injury prevention policy initiatives. MV safety and child occupant safety in a MV are among the grants' goals.			X	X
5. IPP was awarded a GTSC grant to promote MV safety. Activities of this grant include child passenger safety, bicycle safety, and pedestrian safety			X	X
6. The IPP and the PHIG have childhood and MV data available and are able to perform additional analyses for use in planning.				X
7. The IPP promoted toolkits and fact sheets with current data, best practices and evidence-informed programs to reduce unintentional injuries, particularly traffic-related, for medical providers, researchers, educators and consumers.		X		
8. The CHWP has extensive child safety components which stress car seat use and other infant safety measures.		X		
9.				
10.				

b. Current Activities
-During the first months of 2012, 65,000 motorists were ticketed for using an electronic device while driving.
-The Governor launched two Operation Hang Up campaigns to further reduce distracted driving.
-IPP hosted an Injury Community Planning Group meeting for traffic safety stakeholders to

enhance NY's injury infrastructure. The Child Injury Prevention Policy Subgroup (CIPS) also met. A major goal of CIPS is to educate decision makers/public health professionals about safety benefits for children ages 12 and under to ride properly restrained in the back seat of a motor vehicle. NY law requires children to be properly restrained but does not require them to be in the back seat.
-IPP works with the NY Child Passenger Safety Advisory Board to promote occupant restraint best practices for children ages 8-12 including riding properly and consistently restrained in the back seat of motor vehicles. The Sit, Click, Drive 'Tween Passenger Safety Toolkit resource contains educational materials, media items, outreach strategies and web-based resources for traffic safety/public health professionals to conduct school and community based activities promoting the consistent and proper use of appropriate restraints for 'tweens.
-A NY Injury Action Plan, including childhood and motor vehicle safety, is in development.
-A 1-day traffic safety symposium to share relevant data, evidence-informed strategies and best practices will be held to educate stakeholders about pedestrian safety.

c. Plan for the Coming Year
-The Injury Community Planning Group will continue to meet to enhance injury infrastructure in NY, including childhood and motor vehicle safety and the continued development of the NY Injury Action Plan.
-The Child Injury Prevention Policy Subgroup will continue to meet.
-The availability of the Sit, Click, Drive 'Tween Passenger Safety Toolkit will be announced and its use promoted to child passenger safety and public health professionals with support from the CPSAB and GTSC during National Child Passenger Safety Week
(September 16-22, 2012).
-IPP staff will collaborate with the NY Safe Routes to School Network, the NYS Association of Traffic Safety Boards, SAFE KIDS Worldwide and the NY Bicycle Coalition to promote helmet use at a variety of traffic safety and bicycling promotion events. IPP staff will work with these agencies to incorporate helmet distribution, helmet fitting and bicycle safety education at a variety of annual events. Event opportunities to incorporate bicycle helmet safety may include, but are not limited to Safe Kids Week, child passenger safety check up events, or "Bike to School Day" events.
-Community-based home visiting and other maternal and infant health initiatives will continue to emphasize injury prevention and motor vehicle safety.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	43	51	44.5	45.5	47.9
Annual Indicator	50	49.4	47.4	47.7	47.7
Numerator					
Denominator					
Data Source		National Immunization Survey - breastfeeding suppl	National Immunization Survey	National Immunization Survey	National Immunization Survey

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	48.3	48.8	49.3	49.8	50.2

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

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission. 2010 data represents the 2008 birth cohort.

Notes - 2009
2009 data have been revised with final 2009 data. Information was reported in 2009 for the 2006 birth cohort.

a. Last Year's Accomplishments
-The percentage of NYS mothers who breastfed their infants at 6 months (47.7%) was higher than the national percentage of 44.3%.
-Infant feeding data during birth hospitalization, taken from infant birth certificates, were analyzed. Hospitals were ranked using three indicators (percent of infants fed any breast milk, percent of infants fed exclusively breast milk, and percent of breastfed infants also fed formula in the hospital). Each hospital was informed of its performance relative to other hospitals, and were asked to examine their policies and procedures regarding supplemental in hospital formula feedings and the distribution of infant formula samples at the time of discharge. The NYC Department of Health and Mental Hygiene (NYCDOHMH) was involved in the communication to 8 NYC hospitals.
-A Breastfeeding (BF) Mothers' Bill of Rights; the NYS Model Hospital Breastfeeding Policy; and New York State Model Hospital Breastfeeding Policy: Implementation Guide were developed to increase compliance with State law and are available on the DOH public webpage: (http://www.health.ny.gov/community/pregnancy/breastfeeding/) The BF Mothers Bill of Rights was posted in 6 languages on the site.
-A webinar on these rights was provided for hospitals statewide; staff from 84% of maternity hospitals participated. Hospital policies required revision to incorporate the additional requirements included in the NY BF Mothers' Bill of Rights legislation. Hospitals were asked to submit their revised Hospital BF Policies for review; 131 of the 132 maternity hospitals did so.
-Ten Steps to Successful BF: An Online Course was offered to staff in 132 hospitals providing maternity care services; staff from all 132 hospitals completed the course which meets the staff education requirement for Baby Friendly Hospital Designation.
-Twelve hospitals outside of NYC have been engaged in the NY BF QI in Hospitals (BQIH) Learning Collaborative, a joint initiative with the National Initiative for Children's Healthcare

Quality (NICHQ). Ten of the 12 hospitals have discontinued distribution of formula samples, formula coupons, and educational materials provided by formula companies to BF mothers. Eight hospitals discontinued the practice as part of their NY BQIH work and two hospitals discontinued the practice prior to their participation in the NY BQIH Learning Collaborative. The average rate of exclusive BF across all hospitals in the project was 44.5% in August 2011, up from a June 2010 baseline of 37.1%. NYCDOHMH engaged 8 hospitals in NYC in a similar initiative.
-In 2011, DOH conducted a series of listening sessions across the state with WIC participants. WIC participants identified challenges in arranging worksite support for BF and in accessing information breastfeeding mothers would like to have for their employers, family members, and themselves as they return to work, and expressed how WIC staff can assist them in their efforts to continue breastfeeding in workplace. This formative research guided the development of the Return to Work Toolkit for Hourly Wage Earner .
-The DOH Office of Public Health (OPH) submitted recommendations to the NY Medicaid Redesign Team (MRT) for payment of specifically trained lactation counselors and to incentivize deliveries at Baby Friendly Hospitals. Structured breastfeeding education and lactation counseling is recommended by the US Preventative Services Task Force (USPTF) as an evidence-based intervention during pregnancy and postpartum to increase breastfeeding initiation, exclusivity and duration. It is estimated that 100% implementation will yield a cost savings of $33.67 million dollars.
-WIC provided an International Board of Certified Lactation Consultants exam preparation course which doubled the number of staff with this credential.
-The DOH Website revised the WIC pages to include BF promotion and support pages under WIC.
-WIC developed a Health Care Provider (HCP) BF Toolkit, Partnering with WIC for BF Success, as part of its public health detailing project; 5,000 toolkits were distributed to physicians' offices.
-CHWP provides home visiting services to high risk pregnant and parenting families. CHWPs provide a myriad of information and support, including support for breastfeeding.
-NFP provides supports and services to first time mothers. One of NFP's goals is to improve healthy behaviors by pregnant women and new mothers, including support for breastfeeding.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Using the SPDS, hospitals were ranked on three BF indicators (fed exclusively breastmilk, fed any breastmilk, and breastfed infants also fed formula in the hospital).				X
2. DOH and Regional Perinatal Centers continued offering the Ten Steps to Successful BF: An Online Course to staff at 132 hospitals providing maternity care statewide.			X	
3. The NY Model Hospital BF Policy: Implementation Guide were developed. Hospitals statewide were provided training on the policy, the implementation guide, and strategies to support improving maternity care practices.				X
4. The BF Mothers Bill of Rights was posted on the DOH website in six languages.		X		
5. The BQIH Learning Collaborative engaged hospitals in quality improvement work focused on maternity care practices.			X	X
6. NYCDOHMH recruited and engaged 8 hospitals to develop a culture that promotes exclusive BF.			X	X
7. DOH conducted listening sessions with WIC participants who identified challenges in arranging worksite support for BF, accessing information for employers, family, and themselves, and identified how WIC staff can assist them to BF at work.		X	X	X

8. OPH submitted two cost savings recommendations to MRT: payment for specifically trained lactation counselors and incentives for deliveries at Baby Friendly Hospitals.		X	X	X
9. WIC provided an International Board of Certified Lactation Consultants exam preparation course to local agency staff which doubled the number of staff with this credential.		X	X	X
10. WIC developed a HCP Breastfeeding Toolkit, Partnering with WIC for BF Success, as part of its public health detailing project.		X	X	X

b. Current Activities

-DOH has surveyed all 132 hospitals that provide maternity care services in NY to collect information regarding patient education and support, obstetric staff education and training, and general BF policies.
-DOH will continue to offer the Ten Steps to Successful BF: Online Course to 80 hospitals (excludes NYC and 12 BQIH Hospitals) providing maternity care in NY.
-The Return to Work Toolkit for Hourly Wage Earners will be completed and disseminated statewide through breastfeedingpartners.org and the DOH public webpage.
-Current hospital BF policies will be codified and compared with those collected during a 2009 review. Hospitals will be notified as to whether their policies include required NY components.
-NY MA will implement payment for specifically trained lactation counselors to provide BF education and counseling as recommended by the NY MRT.
-WIC will implement the revised Loving Support through Peer Counseling: A Journey Together. Regional DOH staff, WIC management teams and local agency staff will be trained through a series of trainings.
-The revised updated website, BF Partners, will include the Making It Work Toolkit for mothers returning to work.

c. Plan for the Coming Year

-Given the success of the NY BQIH demonstration project, a new cohort of 27 teams will be engaged in the quality improvement process.
-Widespread dissemination of the Return to Work Toolkit for Hourly Wage Earners is planned through posting to the DOH public webpage and breastfeedingpartners.org. WIC staff will be trained to use the toolkit to empower mothers to talk with employers about their BF needs during their pregnancy and upon returning to work.
-DOH will develop and implement web-based training for hospitals statewide to improve hospital reporting of feeding methods on the Electronic Birth Certificate.
-WIC will implement an initiative to promote and improve exclusive BF.
-WIC will develop best practices and follow up trainings for Loving Support through Peer Counseling: A Journey Together for a sustainable program.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	98.5	98.7	99.1	99.6	99.6
Numerator	247960	244630	244545	239116	239116
Denominator	251760	247928	246647	240169	240169

Data Source		Newborn Hearing Screening Program	Newborn Hearing Screening Program	Newborn Screening	Newborn Screening
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

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

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Notes - 2009
2009 data have been revised using final 2009 data.

a. Last Year's Accomplishments
-The percentage of NY newborns screened for hearing before hospital discharge (99.2%) far exceeds both Healthy People 2020 baseline (82%) and target (90.2%) indicators for screening newborn at no later than 1 month of age.
-State legislation was enacted on 1/11/11 which requires hospitals and other health care providers that perform or order newborn infant hearing screenings to report results through a statewide information system; authorizes the collection and storage of newborn infant hearing screening results and data in a statewide information system; and authorizes access to such data in order to increase newborn infant hearing screening rates and improve the completeness and accuracy of newborn infant hearing screening data. DOH was previously authorized to collect aggregate data on Newborn Hearing Screening (NBHS) results each quarter for all infants born in NY. The collection of aggregate data has significantly impacted DOH's ability to follow-up on infants who potentially have a hearing loss.
-DOH received grant funding from HRSA to expand and improve the NBHS program to assure quality developmental outcomes for infants identified with hearing loss.
-DOH received the first of three years of funding from the CDC for the Early Hearing Detection and Intervention (EHDI) Tracking, Surveillance, and Integration project. DOH is improving its mandated NBHS Program by linking existing child health data systems within DOH to better track individual level screening and audiologic data and referral information.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. State legislation was enacted on 1/11/11 which requires hospitals and other health care providers that perform or order newborn infant hearing screenings to report results through a statewide information system.				X
2. DOH received grant funding from HRSA to expand and improve the Universal NBHS and Intervention program to assure quality developmental outcomes for infants identified with hearing loss.			X	
3. DOH received CDC funding for the EHDI Tracking, Surveillance, and Integration project to improve its mandated Universal NBHS and Intervention Program.				X
4. Through this grant, DOH is improving this program by linking existing child health data systems within DOH to better track individual level screening and audiologic data and referral information.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

-DOH is actively involved in the implementation of the new legislation described in Section a. Revised regulations are in draft form. Work is underway to design requirements for the data systems for submission of data and storage in DOH's child information system.

-The American Academy of Pediatricians District II is collaborating with DOH to produce a 1 hour tutorial for pediatricians on EHDI concepts and practices. This will be available online and approved for continuing medical education credits. The tutorial includes: responsibilities, hearing loss's effect on speech and language development, basic screening procedures, follow-up procedures, and results reporting specific to NY.

-The NY EHDI advisory work group will reconvene. This group of parents, providers, professional organizations, and government officials will discuss regulatory changes, NY EHDI data system deployment, recent activities, and other topics related to early hearing.

-DOH is actively working with New York State Association of Speech Language Hearing Association regarding the development of training materials and training audiologists regarding the newborn hearing screening procedures and follow-up.

c. Plan for the Coming Year

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

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

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	8	8	8.5	8.4	7.4
Annual Indicator	8.9	7.1	7.5	7.9	7.9
Numerator	395000	310000	335000	350000	350000
Denominator	4437000	4373000	4465000	4418000	4418000
Data Source		Current Population Survey	Current Population Survey	Current Population Survey	Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	7.4	7.3	7.2	7.1	7

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available in early 2013.

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Notes - 2009
2009 data have been revised using 2009 final data.

a. Last Year's Accomplishments
-The percentage of NY children without health insurance (8%) is lower than that of the nation (9.8%).
-NY has made significant progress in providing access to health insurance for all uninsured children and teens. All uninsured children and teens are eligible for comprehensive and affordable health insurance through either Medicaid (MA) or Child Health Plus (CHPlus). Currently, approximately 83% of the state's uninsured children are eligible for subsidized coverage. The families of the remaining children are able to purchase insurance at full premium cost through the CHPlus program.
-In calendar year 2010, the number of uninsured children under age 19 in NY increased slightly, from an estimated 367,000 in 2009 to 382,405 in 2010. This remains a significant decrease from 2007 when approximately 434,000 children were uninsured.
-Infants aged 0-1 are eligible for MA if their household incomes are at or below 200% of the Federal Poverty Level (FPL). All infants born to women enrolled in MA are MA-eligible until the end of the month of their first birthday.
-Children aged 1 through 18 years of age are eligible for MA if their household incomes are at or

below 133% of the FPL for twelve months of continuous coverage, even if their household income exceeded eligibility levels during that year.
-Families with household incomes at or below 400% of the FPL are eligible for free or subsidized CHPlus, NY's Child Health Insurance Plan (CHIP). Families over 400% of FPL are eligible for participation at full premium.
-NY simplified documentation requirements for MA, CHPlus, and Family Health Plus (FHPlus) by implementing a data file match process with the Social Security Administration (SSA) to verify U.S. citizenship status, identity and age. Applicants who include their Social Security Number on the application do not have to document their citizenship, identity and birth date. The SSA data match is used to electronically verify this information.
-The CHPlus renewal application was translated into Chinese and Spanish and distributed to health plans and community-based Facilitated Enroller (FE) organizations.
-FEs provided application assistance to those who were seeking MA or CHPlus which accounted for over 430,000 applications submitted annually. FEs provide assistance to applicants in 60 languages. Currently, 41 community-based organizations and 15 health plans serve as FEs. All MCHSBG- funded programs are required to facilitate enrollment in insurance programs.
-All MCHSBG- funded programs are required to assist with enrollment in public insurance programs. The Community Health Worker Program (CHWP) assists any child or member of an enrolled family to access health insurance. Many Comprehensive Prenatal/Perinatal Services Networks (CPPSN) are facilitated enrollers for health insurance programs. Insurance status for students enrolled in school-based health centers (SBHC) is determined as part of the initial enrollment process. SBHC staff works with students/parents/guardians without insurance to connect them to MA and/or CHPlus. Children with special health care needs (CSHCN) whose families are referred to or contact the CSHCN Program are connected with MA and/or CHPlus if they do not have a source of insurance. Program staff follow up with families who receive information and referral to determine if they obtain insurance coverage for their children. CSHCN Program staff follows up with families who receive information and referral to determine if they obtain insurance coverage for their children.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Infants aged 0-1 are eligible for MA if their household incomes are at or below 200% of the FPL. All infants born to women enrolled in MA are MA-eligible until the end of the month of their first birthday.			X	X
2. Children aged 1 through 18 years of age are eligible for MA if their household incomes are at or below 133% of the FPL for twelve months of continuous coverage, even if their household income exceeded eligibility levels during that year.			X	X
3. Families with household incomes at or below 400% of the FPL are eligible for free or subsidized CHPlus, NY's CHIP. Families over 400% of FPL are eligible for participation at full premium.			X	X
4. NY simplified documentation requirements for MA, CHPlus, and FHPlus by implementing a data file match process with the SSA to verify U.S. citizenship status, identity and age.		X		
5. All MCHSBG- funded programs are required to facilitate enrollment in public insurance programs. Facilitated enrollers provided application assistance MA or CHPlus in 60 languages, accounting for over 430,000 applications submitted annually.		X	X	X
6. Many CPPSNs are facilitated enrollers for health insurance programs.			X	X
7. CSHCN whose families are referred to or contact the CSHCN		X	X	X

Program are connected with MA and/or CHPlus if they do not have a source of insurance.				
8. The CHWP assists any child or member of an enrolled family to access health insurance.		X		
9. Insurance status for students enrolled in SBHCs is determined as part of the initial enrollment process. SBHC staff works with students/parents/guardians without insurance to connect them to MA and/or CHPlus.		X		X
10.				

b. Current Activities

-NY provides health care coverage to nearly 2.2 million children. Slightly more than 1.8 million children are covered by MA and 390,000 by CHPlus. This represents more than 40% of NY's children.
-The NY Enrollment Center operates a consolidated call center for MA, CHPlus and FHPlus programs and processes mail-in and telephone MA renewals for some populations outside NYC who can attest to their income at renewal.
-MA program coverage was expanded for children ages 6-18 to 133% of the FPL.
-NY will implement an Express Lane Eligibility strategy to assist in the transition of children from CHPlus to MA at their CHPlus renewal, enabling them to seamlessly enroll in MA without completing a new application.
-NY enhanced the consumer web-based application assistance tools launched in 2011 developing a Spanish version of the ACCESS NY Public Health Insurance Eligibility Screening Tool.
-The FE program was re-procured in 2011 for contracts effective 1/1/12 to provide application assistance to those seeking MA or CHPlus. Currently, 41 community-based organizations and 14 health plans are FEs.
-The Connections to Coverage campaign increases awareness of public health insurance through partnerships with community-based organizations, faith groups, schools, health and human service providers and others across the state to link uninsured children and families to FE.
-MCHSBG-funded programs assist with public insurance enrollment to increase the number of insured children.

c. Plan for the Coming Year

-NYS plans to implement ex-parte renewal for children enrolled in CHPlus. Some children will be automatically renewed in CHPlus without the need to complete a renewal application as their income will be verified against an external source.
-Effective 11/1/12, the CHPlus program will be increasing covered benefits of children with autism spectrum disorders.
-Federal statute did not allow children with access to state health benefits to enroll in the Children's Health Insurance Program. A provision in the Affordable Care Act changed this prohibition to allow states to cover these children if they meet one of two maintenance of effort (MOE) provisions. New York is currently exploring this option to determine if we meet one of the two MOE requirements and if we wish to allow children with access to state health benefits to enroll in Child Health Plus.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2007	2008	2009	2010	2011

Data					
Annual Performance Objective	31	30	29	29	31.5
Annual Indicator	32.0	32.0	31.8	31.5	31.5
Numerator	63373	67108	71274	70636	70636
Denominator	198041	209713	224130	224243	224243
Data Source		PedNSS	PedNSS	PedNSS	PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	31.2	30.8	30.5	30.2	29.9

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available in early 2013.

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Notes - 2009
2009 data have been revised using final 2009 data.

a. Last Year's Accomplishments
-The WIC Program continued supporting the new food package. Soy beverages and whole grain tortillas were added to the acceptable foods list. Participants can "pay the difference" between the total value of their vegetables and fruits (V/F) purchases and WIC V/F checks, and the monthly check value increased to $10 from $8. WIC fully implemented the option allowing farmers to accept WIC V/F checks.
-Breastfeeding (BF) is a core strategy for obesity prevention. WIC funded its BF Peer Counselor Program statewide in all 94 local agencies. The DOH BF Workgroup continued to focus on support for BF in hospitals and worksites. Hospital specific BF data monitoring was initiated. NYS Department of Labor worksite guidelines for BF support were distributed to over 500 individuals including worksite contractors. Webinars/trainings sponsored by WIC and WIC Training Center were provided to contractors to enhance BF knowledge and rates. The Child and Adult Care Food Program (CACFP) implemented a BF Friendly Initiative. In its first year, 80 child care centers and 128 day care homes were designated as BF Friendly.
-Implementation of the BF Quality Improvement in Hospitals (BQIH) collaborative with 12 hospitals that demonstrated the highest percentage of formula supplementation continued.
-WIC received a $1.6 million U.S. Department of Agriculture (USDA) performance award for its high BF initiation rate. A statewide public media campaign targeted to low income communities to increase public awareness and support of BF women was implemented. The Partnering with WIC for BF Success Toolkit was developed for health care providers/hospitals to support families' BF efforts. (See NPM #11)
-Implementation of CACFP Healthy Child Meal Patterns continued, reaching 9,200 family day care homes and 4,700 day care centers serving 330,000 children.
-The Eat Well Play Hard in Child Care Settings (EWPHCCS) intervention continued in 274 low-income CACFP-participating child care centers to improve the nutrition and physical activity behaviors of pre-school age children and their parents/caregivers reaching 16,430 pre-school age children, family members, and center staff. It was selected as one of 4 USDA Supplemental

Nutrition Assistance Program Education Projects to participate in a Demonstration Project. An external research organization conducted an outcome and process evaluation of EWPHCCS; participation significantly increased children's daily consumption of vegetables, child-initiated vegetable snacking, at-home use of 1% or fat-free milk and showed a trend toward increased parental offering of vegetables as snacks.
-The Nutrition and Physical Activity Assessment for Child Care (NAP SACC) intervention continued in 20 counties reaching 60 child care centers, impacting 1026 center staff and 4991 children. In the 55 centers completing the intervention, 870 staff was trained impacting 4232 children.
-A Healthy Lifestyles Promotion Toolkit and policy was developed by and shared with local WIC agencies to promote healthy lifestyles through developing and implementing effective and meaningful activities for participants, their families and WIC staff.
-A new WIC logo and New Look of WIC Toolkit were launched. The logo is used on the DOH website and all new WIC materials. The toolkit guides staff on implementation of WIC core services and is a resource to ensure the agency is meeting the needs of WIC families.
-4 focus groups of women representing low wage earners who are or expected to be nursing mothers returning to work were convened to inform the development of a Return to Work Toolkit for that audience. The toolkit guides employers in complying with federal and state labor laws. Working with the WIC Program, focus groups were convened in urban, upstate urban and rural areas.
-The Obesity Prevention in Child Care Partnership proposed policies to eliminate sugar sweetened beverages, decrease screen media use and increase BF support. Accomplishments included physical activity and media reduction measures in proposed child care regulations; expansion of regulatory language on child care provider training to include specific obesity prevention topics; and, inclusion of obesity prevention competencies in the state's proposed Core Body of Knowledge: Core Competencies for Early Childhood Educators.
-A MA Redesign proposal supporting BF lactation counseling support during pregnancy and postpartum was submitted and included in the 2012-13 enacted budget.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. BF remained a core strategy for obesity prevention, with ongoing initiatives in hospitals, worksites, childcare, WIC and community-based settings. Implementation of the BQIH collaborative to improve exclusive BF continued.			X	X
2. WIC received a $1.6 million USDA performance award for its high BF initiation rate.				X
3. NY-WIC Program continued to support the new food package per the interim rule implemented in January 2009 which includes fruits & vegetables, whole grain cereals & breads, brown rice, tofu, canned & dried beans, reduced juice amts & low-fat milk.			X	
4. DOH implemented Healthy Child Meal Patterns for child care centers and day care homes participating in the CACFP, affecting more than 9,200 family day care homes and 4,700 day care centers serving 330,000 New Yorkers.			X	
5. DOH continued implementing the Eat Well Play Hard in Child Care Settings intervention, designed to improve the nutrition and physical activity behaviors of pre-school age children and influence food/activity practices in child care settings.		X	X	
6. Childhood obesity prevention activities continued to be implemented to prevent obesity through sustainable policy, systems and environmental changes in communities.		X	X	X

7. The Obesity Prevention in Child Care Partnership proposed policies to eliminate sugar sweetened beverages, decrease screen time and increase breastfeeding to improve child care settings in NY.				X
8. 4 focus groups representing low wage earners who are or expected to be nursing mothers returning to work were convened to inform development of a Return to Work Toolkit for nursing mothers returning to low wage jobs and their employers.			X	X
9. The Nutrition and Physical Activity Assessment for Child Care intervention continued in 20 counties reaching 60 child care centers, impacting 1026 center staff and 4991 children.				X
10. A MA Redesign proposal supporting breastfeeding lactation counseling support during pregnancy and postpartum was submitted and included in the 2012-13 enacted state budget.				X

b. Current Activities

-WIC is enhancing efforts to reduce obesity by supporting local agencies and staff training in: Breastfeeding (BF) Peer Counselor Programs, Participant-Centered Nutrition Education, Facilitated Group Discussions and Healthy Lifestyles. September 2012 is Celebrate Healthy Lifestyles Month. Agencies are encouraged to celebrate with healthy lifestyle activities using the Fit WIC Resource Book & Healthy Lifestyle Promotion Toolkit.
-CACFP continues to train child care centers and homes on the new Healthy Child Meal Pattern, and plans to expand to 235 more child care centers.
-The Hunger Prevention and Nutrition Assistance Program is expanding access to fresh produce, low-fat milk, lean meats and whole grains for families accessing emergency food services.
-The Obesity Prevention Program (OPP) works with partners to establish BF policy and environmental supports; focus on local and state-level interventions to increase intake of fruits and vegetables, decrease intake of sugar-sweetened beverages and high energy dense foods; and promote physical activity through environmental and policy changes.
-The Return to Work Toolkit is undergoing review and approval.
-Data analysis for the BQIH is underway and manuscripts are being prepared.
-The OPP and CACFP collaborated with ECAC to include obesity prevention standards in Quality Stars NY, including CACFP as the standard for meals and snacks, and standards for physical activity, screen time/content limits and breastfeeding support.

c. Plan for the Coming Year

Childhood obesity prevention activities will continue to be implemented through numerous avenues including: child nutrition programming; statewide coalitions; community-based contracts; statewide and local policy efforts; partnerships with health care and collaboration with state and federal partners. Plans for the coming year include:
-Strengthen policies and environments that promote and support breastfeeding.
-Increase screening and early recognition of overweight and obesity by pediatric healthcare providers.
-Provide local, county and statewide estimates of the prevalence of childhood obesity.
-Target resources to populations most at risk for childhood obesity.
-Identify best practices and promising interventions in child care, schools and communities to help prevent and reduce childhood obesity.
-Implement Creating Healthy Places grants in 22 targeted communities. The grantees are laying the groundwork, together with their community partners, for sustainable implementation of their 4 or more selected core activities. These activities will lead to outcomes that increase access to healthy physical activity and food options in targeted communities around NY.
-Implement the EWPHCCS in family day care homes to increase the number of CACFP-participating day care home providers who improve the nutrition and physical activity practices in their day care homes.

-Evaluate compliance with the Healthy Meal Pattern among CACFP-participating facilities. This data will be compared against menu observations before the Healthy Meal Pattern was implemented. CACFP will review Healthy Meal Pattern against the Institute of Medicine's recently issued recommendations regarding the CACFP Meal Pattern (CACFP: Aligning Dietary Guidelines for All, IOM: 2010).
-Track WIC participants' consumption of vegetables, fruits and whole grains; TV and screen time; meal time TV; and milk consumption.
-Provide education, technical assistance and support in the development and advancement of legislation promoting access to healthier food and beverage options and increased opportunities for physical activity.
-Provide technical and resource support for the implementation Quality Stars NY health standards including nutrition, physical activity, screen time/content limits and breastfeeding support.
-Promote the adoption of the CACFP meal pattern as the licensing standard for meals and snacks in child care.
-Promote expansion of CACFP to child care programs in low income areas to ensure nutritious meals and snacks are served.
As a result of the significant improvements in exclusive breastfeeding demonstrated through the BQIH collaborative, further expansion to NY's remaining 125 hospitals providing maternity care will commence.
Dissemination of the Return to Work Toolkit through the www.breastfeedingpartners.org DOH website will be accomplished.
The MARedesign proposal for BF Lactation Counseling Support will be implemented as part of the 2012-13 enacted state budget.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	14	14	13	12	8.1
Annual Indicator	13.7	8.2	7.6	7.2	7.2
Numerator					
Denominator					
Data Source		PRAMS	PRAMS	PRAMS	PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	7.1	7	6.9	6.8	6.8

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

Notes - 2010

Data source is the Pregnancy Risk Assessment and Monitoring Survey (PRAMS). Numerator and demonminator data are not available. Data reported for 2006 and 2007 were for NYS (excluding NYC). CDC recently provided statewide statistics for this indicator. Statewide 2006 and 2007 data are therefore now available. The comparable statewide percentages for 2006 and 2007 are 8.5% and 9.1% accordingly. 2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Notes - 2009
Numerator and denominator data are not available (survey data). Previous data reported for 2006-2007 were for NYS (Excluding NYC). CDC has recently provided statewide statistics for this indicator. The comparble NYS percentages for 2006 and 2007 are 8.5% and 9.1%, respectively. 2009 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-From 2004 to 2011, the statewide percentage of women smoking during the last 3 months of pregnancy declined dramatically from 12.9% to 7.6% statewide. In NYC, the percentage has decreased from 7.6% to 3.3%. The upstate percentage has decreased from 15.6% to 11.9%.
-Efforts to reduce smoking in pregnant women are a part of DOH's multi-pronged efforts to reduce smoking in the general public. These efforts included a coordinated set of evidence-based activities implemented primarily by the Tobacco Control Program, in partnership with other public health programs, including Title V programs, and other external partners:
Community Partnerships worked to change the community environment to support the tobacco free norm.
-Youth Action partners worked with youth activists to change community norms and de-glamorize and de-normalize tobacco use.
-Cessation Centers worked with health care organizations and providers to implement systems to screen patients for tobacco use and provide help.
-Statewide media and counter marketing educated New Yorkers about the health risks of tobacco use and the dangers of second hand smoke, motivating tobacco users to stop, and promoting use of the NY Smokers' Quitline and Quitsite (1-866-NY-QUITS, www.nysmokefree.com).
Educational materials for pregnant women were disseminated. Counter-marketing efforts sought to expose marketing practices of the tobacco industry, de-glamorize tobacco use, and build and sustain a tobacco-free norm.
-Effective January 1, 2010, Medicaid (MA) now provides coverage for smoking cessation counseling for pregnant and postpartum women and adolescents to age 21. Smoking cessation counseling complements existing MA covered benefits for prescription and non-prescription smoking cessation products and programs. Education and outreach activities to prenatal care providers were conducted to inform them of this new coverage.
-MA prenatal care providers promote healthy behaviors during pregnancy. Prenatal care providers provide information regarding the impact of smoking on the pregnant woman and the fetus and have developed various programs to deal with smoking, including individual counseling and referrals to group or other programs that support smoking cessation.
-All school-based health centers (SBHCs) screened for tobacco use as part of the initial health assessment of all teenage student who enroll in them. Students (and in particular pregnant female students) who use tobacco are either referred to a tobacco cessation program within the community or receive such services directly from SBHC staff.
-The priorities of the Comprehensive Prenatal-Perinatal Services Networks (CPPSN) included developing and implementing programs to reduce the number of women who smoke or use other substances during pregnancy. Networks provided education and training to health and human services providers on ways to assist women to enhance healthy behaviors, including smoking cessation. Activities included the promotion at the local level of Baby and Me Tobacco Free Smoking Cessation Programs, Text Message Smoking Cessation Support for Teens, and online training on Smoking Cessation for Women.
-The Community Health Worker Program (CHWP) provided education for pregnant and postpartum women to increase their understanding of behaviors that pose a risk to health,

including the use of tobacco, and provision of appropriate referrals for those women seeking assistance in this area, including accompanying them to care, if necessary. NFP also promotes healthy behaviors in first time mothers, including smoking cessation.
-Family Planning (FP) Programs screened for tobacco use and referred for smoking cessation.
-All Migrant and Seasonal Farm Worker Health programs and American Indian Health Program (AIHP) providers screened for tobacco use and made appropriate referrals.
-School-based dental health (SBDH) center staff screened all enrollees, including pregnant adolescents, for tobacco-use, provided counseling and made appropriate referrals.
-Local Women, Infants, and Children (WIC) agencies are required by policy to screen all prenatal, postpartum and breastfeeding participants regarding their use of tobacco.
-Consumer input in all program areas is garnered through satisfaction surveys, education and training programs, and support groups such as Baby and Me Tobacco Free Smoking Cessation Programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Prenatal care providers provided information on the impact of smoking and developed programs to deal with smoking, including individual counseling and referrals to group or other programs that support smoking cessation.		X	X	
2. MA prenatal care providers provided information regarding the impact of smoking on the pregnant woman and the fetus and MA covers cessation counseling and prescription and non-prescription smoking cessation products.			X	
3. CPPSN provided education and training to health and human services providers on ways to assist women to enhance healthy behaviors, including smoking cessation.			X	
4. CHWP staff provided education for pregnant and postpartum women to increase their understanding of behaviors that pose a risk to health, including the use of tobacco, and provision of appropriate referrals.			X	
5. Migrant and Seasonal Farm Worker Health programs and AIHP providers screened for tobacco use and made appropriate referrals.	X	X	X	
6. SBHC staff screened all enrollees, including pregnant adolescents, for tobacco-use, provided counseling and made appropriate referrals.	X			
7. Local Women, Infants and Children (WIC) agencies are required by policy to screen all prenatal, postpartum and BF participants regarding their use of tobacco.	X	X		
8. Education and outreach activities to prenatal care providers and community based programs were conducted to inform them of MA coverage for smoking cessation for pregnant and postpartum women and adolescents to age 21.		X		X
9. Consumer input occurs through satisfaction surveys, education and training programs, and support groups such as Baby and Me Tobacco Free Smoking Cessation Programs.		X		
10.				

b. Current Activities
-The multi-pronged activities described for the 2010-2011 year have continued.
-Consumer input continues to occur through satisfaction surveys, education and training

programs and support groups such as Baby and Me Tobacco Free Smoking Cessation Programs.
-The Tobacco Control Program contracts with an independent evaluator to evaluate programmatic efforts.
-Education and outreach activities to prenatal care providers to inform them of MA coverage for smoking cessation for pregnant and postpartum women and adolescents up to age 21 continue.
-The 10/20/11 NY Medicaid Redesign Team (MRT) recommendation to Address Health Disparities included an analysis that an investment of $10 per person per year in prevention programs has potential annual savings of $1.3 billion. These programs have delivered results in lowering rates of diseases that are related to smoking, nutrition and physical activity. The evidence shows that implementing these programs reduces rates of type 2 diabetes and high blood pressure by 5% within 2 years. The MRT to Address Health Disparities also included the recommendation to provide MA coverage for a dedicated preconception visit for all women and adolescents of reproductive age on MA, particularly those women and teens with chronic health conditions that have high potential for adverse impact on pregnancy.

c. Plan for the Coming Year
-The multi-pronged activities described for the 2010-2011 and 2011-2012 years will continue.
-Consumer input will continue through satisfaction surveys, education and training programs, and support groups such as Baby and Me Tobacco Free Smoking Cessation Programs.
-Education and outreach activities to promote the availability of Medicaid coverage for smoking cessation for pregnant and postpartum women and adolescents to age 21 will continue to ensure that as many pregnant women as possible who use tobacco receive counseling and associated services.
-The Division of Family Health will support the 2011 MRT recommendations to Address Health Disparities for prevention programs and preconception health for all women and adolescents of reproductive age on MA, particularly those women and teens with chronic health conditions that have high potential for adverse impact on pregnancy.
-The Tobacco Control Program conducts several media campaigns each year motivating smokers to quit by using graphic and emotionally evocative messages that demonstrate the health and social consequences of smoking, including the effects on infants, children, women and families.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	4.1	4	3.8	3.8	4.2
Annual Indicator	3.9	3.3	4.2	4.6	4.6
Numerator	54	46	58	63	63
Denominator	1396874	1403050	1366144	1366278	1366278
Data Source		Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events					

over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	4.5	4.5	4.4	4.4	4.3

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

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Notes - 2009
2009 data have been revised using final 2009 data.

a. Last Year's Accomplishments
-Suicide is the third leading cause of death for young people ages 10-24 in NYS. The suicide rate among this age range increased between 2007 and 2010.
-Under the leadership of the NY Office of Mental Health (OMH), in collaboration with numerous partners and stakeholders, NY has mounted a major Suicide Prevention (SP) Initiative. Prevention of youth suicide is a critical priority of this initiative.
-OMH evaluated the existing evidence based SP, Intervention and Postvention programs from the Substance Abuse and Mental Health Services Administration's (SAMSHA) National Registry of Evidence-Based Programs and Practices and the SP Resource Center/American Foundation for SP best practice registry to determine how they might be used in the agency's Comprehensive SP Strategy.
-OMH continued its work with schools and communities in SP, intervention and postvention.
-OMH received a SAMHSA Garrett Lee Smith (GLS) grant award on July 29, 2011 to launch a Youth SP Program. This initiative will focus on 4 interventions: (1) building youth SP capacity through the development of 4 regional training centers at existing child service agencies; (2) providing early identification/gatekeeper training for caregivers through these centers; (3) improving suicide risk assessments, management and treatment for providers using evidence based practices; and (4) providing resiliency training for adolescents. Cultural competence to ethnic, sexual orientation and military culture issues will be built into each intervention. Upon notification of this grant award, OMH began to develop MOUS and contracts with the 4 Youth SP Centers and 4 counties identified in the grant application.
-The NYS DOH Injury Prevention Program (IPP) and the Public Health Information Group have suicide data available and are able to perform additional analyses for planning purposes. The IPP has and will continue to work closely with OMH, providing updated data and reviewing research opportunities.
-The IPP disseminated fact sheets targeted to medical providers, researchers, educators and consumers to provide up-to-date data, best practices and evidence-informed programs to reduce self-inflicted injuries. The fact sheets are posted on the DOH website and available in hard copy upon request.
-Effective 7/1/11, School-Based Health Centers (SBHCs) are able to bill Medicaid (MA) for mental health counseling provided by licensed clinical social workers or by licensed master social workers. This new funding stream will strengthen SBHCs' ability to provide on-site mental health services to students including routine psycho-social assessments and individual and group counseling.
-DOH continues to fund a statewide network of rape crisis programs for the provision of services to victims of rape and for the development and implementation of sexual violence primary prevention initiatives.
-Rape Crisis Programs provided 4,267 multi-session educational programs to 57,927 young people at schools, colleges and community locations. They also provided 393 professional

trainings to 4,332 professionals including law enforcement officers, school personnel, social workers, district attorneys and health care providers. Topics included prevention of bullying, healthy relationships, gender roles, self-esteem, communication skills, role of bystander and other prevention topics.
-DOH released the NY Sexual Violence Prevention Plan with the goal of fostering leadership and strengthening coordination of efforts at the State level to decrease sexual violence; increase the capacity of local organizations to effectively implement evidence-based and promising strategies to prevent sexual violence; and, create a respectful society changing social norms to empower youth and adults to intervene with peers when necessary to prevent sexual violence.
-A Research Brief on Teen Dating Violence and other information on healthy relationships are available on the DOH-funded ACT for Youth Center of Excellence web site: actforyouth.net.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Under the leadership of OMH, in collaboration with numerous partners and stakeholders, NY has mounted a major SP Initiative. Prevention of youth suicide is a critical priority of this initiative.			X	X
2. OMH evaluated evidence based SP, Intervention and Postvention programs from SAMSHA and the SP Resource Center/American Foundation for SP for use in OMH Comprehensive SP Strategy.			X	X
3. OMH continued its work with schools and communities in suicide prevention, intervention and postvention.		X		
4. OMH received a GLS grant for a Youth SP Program to develop Youth SP Centers, early identification/gatekeeper and resiliency training, and improving provider suicide risk assessments, management and treatment.		X		X
5. OMH began to develop MOUS and contracts with the 4 Youth SP Centers and 4 counties identified in the grant application.		X		X
6. The IPP and the Public Health Information Group make suicide data available and are able to perform additional analyses for use in planning.			X	X
7. The IPP disseminated fact sheets targeted to medical providers, researchers, educators & consumers to provide up-to-date data, best practices & evidence-informed programs to reduce self-inflicted injuries. Fact sheets are posted on the DOH web.		X		X
8. SBHCs were able to bill MA for mental health counseling provided by licensed clinical social workers or by licensed master social workers.	X			
9. DOH continues to fund a statewide network of rape crisis programs, which provide services to victims of rape & the development and implementation of sexual violence primary prevention initiatives. DOH released the NY Sexual Violence Prevention Plan.		X		X
10.				

b. Current Activities
-OMH staff began implementation of its GLS grant. The 4 Youth SP Centers initiated services and staff received clinical training. Needs assessments were conducted in the 4 selected counties. Training related to military families was conducted in collaboration with the NY National Guard.

Lifelines Curriculum training was held for schools in the 4 targeted counties. Staff completed the grant's continuation application and identified 6 additional counties for service intervention.
-Staff from the Bureau of Occupational Health, IPP, OMH and the University of Rochester Medical Center (URMC) met to discuss potential collaborative projects related to suicide prevention. The IPP hosted an Injury Community Planning Group meeting to enhance injury infrastructure in NY. Staff from OMH and URMC with interest in the prevention of suicide attended the meeting. A NY Injury Action Plan, which will include suicide prevention, is in development.
-All SBHCs continued to address the mental health needs of enrolled students, either directly or by referral. Services include individual mental health assessment, treatment and follow-up, crisis intervention, short and long-term counseling, group and family counseling, and psychiatric evaluation and treatment. SBHCs report that provision of mental health services increased during the reporting period. Establishment of the MA funding stream for mental health counseling will enhance SBHCs' ability to provide such services on-site.

c. Plan for the Coming Year
-OMH will expand its Youth SP Program to six additional counties.
-The Bureau of Occupational Health, IPP and the URMC will continue to meet to further suicide prevention initiatives in NY.
-The Injury Community Planning Group will continue to meet to enhance the injury infrastructure in NY, including SP and continue development of the NY Injury Action Plan.
-All SBHCs will continue to address the mental health needs of enrolled students, either directly or by referral. Services may include individual mental health assessment, treatment and follow-up, crisis intervention, short and long-term counseling, group and family counseling, and psychiatric evaluation and treatment. SBHCs will be monitored through regular reports and site visits to ensure mental health services are available with on-site or by referral. The ability to bill MA for mental health services by licensed and master's level social workers may encourage more SBHCs to offer this service on-site.
-Services for victims of rape will continue through the local Rape Crisis Programs across NY.
-The Sexual Violence Primary Prevention Committee will continue to work with DOH on implementation of the NY Sexual Violence Prevention Plan.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	92	92	94	94	91
Annual Indicator	89.7	90.0	90.6	90.5	90.5
Numerator	3252	3281	3356	3270	3270
Denominator	3627	3646	3704	3614	3614
Data Source		Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	91.3	91.7	92	92.4	92.8

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

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Notes - 2009
2009 data have been revised using final 2009 data.

a. Last Year's Accomplishments
-NY already exceeds both the Healthy People 2020 baseline and target goals (75% and 82.5% respectively) for this indicator.
-NY has been a national leader in the development of a statewide system of perinatal regionalization. All obstetrical hospitals have been designated by DOH as a Level I, II, III or Regional Perinatal Center (RPC) based on standard criteria included in state regulation. Regulations require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers and newborns.
-RPCs remain the hubs of the perinatal regionalization system. RPCs conduct Quality Assurance visits at affiliate hospitals and work to improve perinatal quality and outcomes, including review of complex cases. RPCs also conduct on-site educational programs to enhance affiliates ability to provide quality perinatal services.
-90.5% of all very low birth weight (VLBW) infants were delivered at RPC and Level III facilities. Conversely, 9.5% of VLBW infants were delivered at Level I and II hospitals.
-The very high percentage (over 90%) of deliveries of high-risk newborns at appropriate level hospitals demonstrates the effectiveness of perinatal regionalization.
-The Statewide Perinatal Data System (SPDS) -- NYS's electronic birth certificate - captures data on why VLBW infants were born at lower level hospitals. The majority of these births are due to unavoidable events, such as inability to transfer the woman to a higher level hospital due to advanced stage of labor or instability of the patient.
-RPCs conduct numerous activities to obtain consumer/parent/family input and to enhance provider/parental relationships; these activities include, but are not limited to: development of Family Advisory Councils to improve outcomes; the use of the Press-Ganey Satisfaction Survey; monthly Neonatal Intensive Care Unit (NICU)-Avatar patient satisfaction surveys; provider "call-backs" to parents after NICU discharge; provision of CPR instruction to all parents of infants discharged from the NICU; and formation of Perinatal Bereavement Teams, Bereavement Support Groups and Teen Prenatal Parenting groups.
-In 2010, DOH initiated the New York State Obstetric and Neonatal Quality Collaborative (NYSONQC), subsequently renamed NYS Perinatal Quality Collaborative (NYSPQC). NYSPQC is a perinatal collaboration among DOH, the RPCs and the National Initiative for Children's Health Care Quality (NICHQ) to implement evidence based interventions for improving neonatal and maternal outcomes. During 2011 the NYSPQC Obstetric team focused on reducing scheduled late preterm deliveries, including scheduled inductions and cesarean deliveries, without documented medical indication at 36 0/7 to 38 6/7 weeks gestation while the Neonatology team focused on optimizing early enteral nutrition in preterm newborns of <31 weeks gestational age in the NICU. The first meeting of the NYSPC Obstetrical QI team was held on 9/28/10 and the first Neonatal Quality Improvement team meeting was held on 2/8/11.
-Continued implementation of a range of public health (PH) initiatives including the system of perinatal regionalization; efforts to increase access to early and continuous prenatal care; community-based programs that target high-risk areas to identify and address gaps in needed services; and home visiting programs, such as the Nurse Family Partnership (NFP), Healthy

Families New York (HFNY) and the Community Health Worker Program (CHWP), to improve birth outcomes.
-As part of the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative, DOH developed a state plan based on a needs assessment process to identify high risk communities and target expansion of evidence-based home visiting programs.
-The Division of Family Health (DFH) partnered with the Office of Health Insurance Programs (OHIP) in implementation of Medicaid Prenatal Care and the Healthy Mom-Healthy Baby (HM-HB) home visiting programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Through the hospital system of perinatal regionalization, quality assurance visits are conducted to improve perinatal quality and outcomes, including review of complex cases and whether cases should have been transferred to regional centers.		X		
2. RPCs conducted educational program at affiliates and through grand rounds on programs such as stabilization of VLBW and ELBW infants in preparation for transfer, to prepare affiliates for emergency cases.		X		
3. Consumer/patient/family input occurs at the RPCs and affiliates through family advisory councils, satisfaction surveys, provider call-backs, support groups, and education and training programs.		X		
4. DOH staff continued to collaborate with the RPCs, and the NICHQ to implement interventions designed to improve perinatal outcomes (NYSONQC).				X
5. DOH has implemented a range of PH initiatives to improve perinatal outcomes in NY, including home visiting programs to increase access for early and continuous prenatal care.		X		X
6. DOH developed a state plan for the federal MIECHV funds based on a needs assessment process to identify high risk communities.		X		
7. The Division of Family Health (DFH) partnered with the Office of Health Insurance Programs (OHIP) in implementation of Medicaid Prenatal Care and the Healthy Mom-Healthy Baby (HM-HB) home visiting programs.			X	X
8.				
9.				
10.				

b. Current Activities
-RPCs remain the hubs of the perinatal regionalization system and conduct QI visits at affiliate hospitals and work to improve perinatal quality and outcomes, including review of complex cases. RPCs also continue to conduct on-site educational programs to affiliates.
-RPCs and affiliates continue activities cited above to obtain consumer input.
-DOH's oversight role to identify and address appropriateness of care issues continues. In 10/11, NY received a CDC State-Based Perinatal Quality Collaborative
Grant award for 10/1/11-9/30/14 for the NYS Perinatal Quality Collaborative (NYSPQC). NYSPQC will expand the work begun through the NYSONQC initiative. DOH is working with the RPCs to continue and expand obstetric and neonatal interventions to perinatal affiliate hospitals throughout NY to improve specifically identified perinatal outcomes.
-Abstracts regarding neonate enteral feeding have been submitted on behalf of NYSONQC

Neonatal Initiative for presentation at the 4/28/12-5/1/12 meeting of the Pediatric Academic Societies.
-DOH will continue to support PH initiatives to increase access to prenatal care; to support community-based programs that target high-risk areas to identify and address gaps in needed services; and the assessment and referral of high-risk women to appropriate level of services.
-Initial MIECHV funds have been awarded to expand NFP and HFA/HFNY programs in three high need communities and a RFA to award remaining funds will be released in 2012.

c. Plan for the Coming Year
-DOH staff will continue to work closely with the RPCs and affiliate hospitals to monitor and support effective use of the established system of perinatal regionalization.
-Consumer/parent/family input will continue at RPCs and affiliates through family advisory councils, satisfaction surveys, provider call-backs, support groups, and education and training programs.
-DOH will continue the NYSPQC with the RPCs to implement selected obstetric and neonatal interventions designed to improve perinatal outcomes. NYSPQC will expand the obstetric interventions for reducing scheduled deliveries without medical indication in women of 36 0/7 to 38 6/7 weeks gestation to perinatal affiliate hospitals throughout NY; and to optimize early enteral nutrition in newborns of <31 weeks gestational age.
-DOH will maintain efforts related to access to prenatal care services and community-based initiatives designed to identify and engage pregnant women in early and continuous prenatal care.
-DFH will continue to partner with OHIP to implement the Medicaid (MA) Prenatal Care and the Healthy Mother-Healthy Baby (HM-HB) home visiting programs. HM-HB programs will continue to pilot the use of the Prenatal Care Risk Screening form for early identification and communication of risk status to MA managed care plans. These programs will also work to ensure the development of countywide systems of perinatal care and the assessment and referral of high-risk women to appropriate level of services.
-DFH will support the NY Medicaid Redesign Team (MRT) recommendations to address health disparities which include recommendations for prevention programs for all women and adolescents of reproductive age on Medicaid, particularly those women and teens with chronic health conditions which a have high potential for adverse impact on pregnancies.
-NY's work in the MIECHV and other community-based maternal and infant health initiatives will support evidence-based home visiting services, further coordination of services, and maximization of resources to improve birth outcomes.
-The statewide Growing Up Healthy Hotline (GUHH) will continue to link women to needed services, with periodic public awareness media campaigns conducted to direct women to the hotline.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	78	79	80	81	74
Annual Indicator	73.8	72.3	73.3	73.2	73.2
Numerator	174949	165813	167503	169190	169190
Denominator	236903	229467	228517	231137	231137
Data Source		Vital Records	Vital Records	Vital Records	Vital Records

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	74.8	75.5	76.2	77	77.7

Notes - 2011
The denominator is the total number of births for which prenatal care initiation is known and excludes births where trimester of entry into prenatal care is unknown. 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Notes - 2010
The denominator is the total number of births for which prenatal care initiation is known and excludes births where trimester of entry into prenatal care is unknown. 2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Notes - 2009
2009 data have been revised using final 2009 data.

Denominator excludes births where trimester when prenatal care began is unknown

a. Last Year's Accomplishments
-The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester has been relatively unchanged since 2008. NY is performing above the Healthy People 2020 baseline of 70.8% for this indicator.
-NY's maternal and infant health programs employ a comprehensive, multi-level strategy which integrates broad-based systems approaches involving regional and local planning; one-on-one outreach and support; population-based education; public health insurance and clinical practice standards; and extensive surveillance to support public health planning and clinical quality improvement efforts.
-In 2011, DOH conducted 35 focus groups with adolescents and young adults to determine attitudes toward health and supports needed to be healthy. Participants emphasized the need for community opportunities to engage in healthy behaviors; increased awareness and understanding of the importance of being healthy; and increased awareness of health disparities. Results will inform NY's maternal and infant health strategies.
-The Growing Up Healthy Hotline (GUHH) is available 24/7, provides information and referral in English and Spanish and in other languages via the AT&T language line, and is used in media campaigns to promote early and continuous access to prenatal care and other services. In 2011 GUHH responded to 53,130 calls including 3,391 calls requesting referral and information related to pregnancy testing and/or prenatal care, and 3,694 calls related to health insurance.
-Medicaid (MA) prenatal care providers encouraged early enrollment in prenatal care and provided presumptive MA eligibility to ensure women were able to begin prenatal care immediately pending eligibility determination. All MA-enrolled Article 28 prenatal care providers are required to perform presumptive eligibility determinations and assist with completion of the full MA application and MA managed care plan selection.
-15 Comprehensive Prenatal-Perinatal Services Networks (CPPSNs) use local toll-free numbers, web sites, and resource directories to provide pregnant women with information and referral to prenatal care services. CPPSNs identify gaps and barriers to the service system, and in collaboration with community stakeholders, work to improve accessibility and the quality of local perinatal service systems.

-23 Community Health Worker Programs (CHWP) conducted outreach to engage pregnant women in early and consistent prenatal care and ensure access to needed services. In 2011, the CHWP served 3,386 families. 96% of women not already in prenatal care were assisted to obtain this care within 1 month of program entry. 78% of pregnant women enrolled in the CHWP entered prenatal care in the first trimester, 18% in the second and 3% in third.
-6 Healthy Mom-Healthy Baby programs continued to engage key stakeholders to develop county perinatal health systems to identify high-risk pregnant women early in pregnancy, assess their risks and healthcare needs and refer them to appropriate services including home visiting.
-Through a Memorandum of Understanding (MOU) with the NY Office of Temporary and Disability Assistance (OTDA), DOH supports the expansion/enhancement of the state's 3 Nurse Family Partnership (NFP) programs to provide home visiting services to TANF-eligible pregnant women. In 2011, the NFP programs served 841 TANF-eligible women.
-Through the Affordable Care Act - Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant, a 5-year initiative, NY developed the Updated State Plan for a State Home Visiting Program which identified the high-need communities to be served (Erie, Monroe and Bronx counties) and evidence-based home visiting models to be supported (NFP and Healthy Families NY) based on FY10 funding level.
-School-based Health Centers (SBHC) provided pregnancy testing and reinforced the need for early prenatal care for parents choosing to continue pregnancy.
-Family Planning Programs (FPP) made early referrals for women testing positive for pregnancy, thereby improving rates for early access to prenatal care in the population served.
-Through the Community Action for Prenatal Care Program (CAPC), CAPC lead agencies coordinate a comprehensive service network, recruit pregnant women into prenatal care and case management through enhanced outreach and referrals from community agencies, link substance-using women to treatment programs, navigate client to appointments, and engage in community planning.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The GUHH, available 24/7, provided information and referral in multiple languages via the AT&T language line. The number is used in media campaigns to promote early and continuous access to prenatal care and other services.			X	
2. CPPSN programs have local toll-free numbers, resource directories, and websites to provide pregnant women with information and referral to prenatal care.			X	
3. 35 preconception health focus groups were conducted across the state with adolescents and young adults to determine attitudes toward health and supports needed to be healthy.			X	X
4. MA prenatal care providers encouraged early enrollment in prenatal care, and provided presumptive MA eligibility to ensure that women were able to begin prenatal care immediately pending determination of MA eligibility.	X			
5. SBHCs provided pregnancy testing and reinforced the need for early prenatal care. Access is provided either on-site or through referral to the back-up facility.	X			
6. FPP made early referrals for women testing positive for pregnancy, thereby improving rates for early access to prenatal care in the populations served.	X			
7. DOH is supporting NFP programs in Monroe and Bronx Co. & HFNY programs in Erie & Bronx Co. to provide evidence-based home visiting (HV) services to high risk families. NY's 3 NFP		X	X	X

programs delivered HV services to TANF eligible pregnant 1st time moth				
8. Outreach efforts conducted through the CHWP and consumer awareness strategies implemented through the CPPSNs continued with a central focus on identifying and engaging women to seek early and continuous prenatal care.		X	X	
9. Through CAPC lead agencies coordinate a comprehensive service network, recruit pregnant women into prenatal care & case management via enhanced outreach & referrals from community agencies.		X		
10. DOH's 6 Healthy Mom-Healthy Baby programs continued to engage key stakeholders to develop county perinatal health systems to identify, assess and refer high-risk pregnant women to services early in their pregnancies.				X

b. Current Activities

-The Title V program continues to collaborate with OHIP to ensure comprehensive prenatal care services are available to high risk populations.
-DOH continues to support the CPPSNs, CHWP, Healthy Mom-Healthy Baby and Nurse Family Partnership programs. An RFA for the next 5-year cycle of community-based maternal and infant health programs, including MIECHV, will be released this summer. A companion RFP will be released to support a new MIH Center of Excellence.
-Under the HRSA-funded First Time Motherhood/New Parents Initiative, DOH is supporting 6 CPPSN programs to convene key stakeholders to increase awareness of CDC's Recommendations to Improve Preconception Health and Health Care. Programs will develop community action plans to increase consumer awareness of preconception health.
-DOH is entering into an agreement with the National Healthy Mom -- Healthy Baby Coalition to implement the national Text4baby initiative in NY.
-Contracts are being established with 2 NFP programs in Bronx and Monroe counties and 4 HFNY projects in Bronx and Erie counties under the MIECHV initiative. This initiative uses evidence-based home visiting programs to help improve birth outcomes for high-risk pregnant women and their babies; improve children's health and development; and strengthen family functioning.
-Through its MOU with OTDA, DOH continues to support NY's 3 NFP programs through TANF funding to provide nurse home visiting services to TANF-eligible pregnant women.

c. Plan for the Coming Year

-DOH will continue to promote early entry to prenatal care through outreach and case finding strategies to identify high risk pregnant women early and ensure engagement in comprehensive, quality prenatal care. Outreach efforts through CHWPs, consumer awareness strategies through CPPSNs, and systems development strategies through HMHBs will continue to focus on identifying and engaging high-risk women in early and continuous prenatal care.
-DOH will support implementation of community-based maternal and infant health programs through the upcoming MIH RFA.
-A Request for Proposals will be released as a companion to the MIH-RFA to establish a new MIH Center of Excellence to support MICHC and MIECHV grantees with the provision of technical assistance, training and coordination of data management and evaluation activities.
-DOH will promote the Text4baby initiative through its maternal and infant health partners. A targeted media campaign will be implemented. Customization of messages will allow DOH to include state-specific information and referral resources including the GUHH.
-Public health programs that serve at-risk adolescents - SBHC, FP and Community-Based Adolescent Pregnancy Prevention Programs - include provisions for preventive health services, pregnancy prevention, and, when needed, prompt referral of pregnant teens to prenatal care.
-The statewide GUHH will continue to link women to needed services, with periodic public

awareness media campaigns conducted to direct women to the hotline.
-MCH and MA staff will collaborate to ensure compliance with MA prenatal care standards.
-Title V staff will continue to participate in NYS's ongoing MA Redesign initiative to support development and implementation of potential recommendations related to improving access to prenatal care for all high risk populations.

D. State Performance Measures

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					64.9
Annual Indicator		62.4	64.3	64.6	64.6
Numerator		58091	58055	59319	59319
Denominator		93114	90226	91838	91838
Data Source		Vital Records	Vital Records	Vital Records	Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	65.6	66.2	66.9	67.5	68.2

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

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-While NY experienced a 2% improvement in this measure from 2008-2009, the disparity remained significant, with 64.3% of infants born to Black and Hispanic women receiving prenatal care beginning in the first trimester in 2009, as compared to 73.3% of infants born to all women.
-State law requires all Medicaid (MA) enrolled Article 28 prenatal care providers to perform presumptive eligibility determinations and assist with completion of the full MA application and managed care plan selection, allowing women to immediately receive care while awaiting full MA eligibility determination.
-Through the MIECHV grant, DOH developed an Updated State Plan for a State Home Visiting Program with input from over 100 community-based organizations, local government agencies and home visiting programs in the 14 high-risk communities identified in DOH's needs assessment. Stakeholders identified community and population characteristics which contribute to poor maternal and infant health outcomes. The Plan identifies Erie, Monroe and Bronx counties as the high-need communities to be served and Nurse Family Partnership (NFP) and Healthy Families NY (HFNY) as the evidence-based home visiting models to be supported in year 1. A MOU with the Office of Children and Family Services has been established to support administration of MIECHV HFNY programs. A priority of DOH's hv initiatives is to promote healthy behaviors, including engaging women into early prenatal care.
-Comprehensive Prenatal Perinatal Services Networks (CPPSN) facilitate access to comprehensive prenatal care targeting at-risk pregnant women not engaged in health care or other supportive services, particularly African American and Hispanic women.

-Community Health Worker Programs (CHWP) provide outreach and home visiting services to high-risk pregnant women. In 2011, CHWP served 3,386 clients, including 99.9% female, 33% Black and 44% Hispanic. CHWPs are indigenous to the communities served. Outreach targets local health departments, WIC sites, cultural/ethic organizations, community centers, local department of social services, door-to-door canvassing, health fairs, community events, and places where high-risk populations may congregate such as laundromats, markets, churches, hair salons, transit stops, housing projects, and community centers.
-Healthy Mom-Healthy Baby (HM-HB) programs support development of organized community systems of perinatal health and home visiting services. The goal is to improve birth outcomes for MA eligible pregnant and postpartum women and newborns through early identification, outreach, risk assessment, and referral to appropriate services including home visiting.
-Through an MOU with the Office of Temporary and Disability Assistance (OTDA), DOH supports enhancement/expansion of NY's 3 NFP programs to provide home visiting services to TANF-eligible first-time mothers. Nurse home visitors received OTDA training on determining TANF eligibility.
-In 2010, DOH received approval from CMS for a MA State Plan Amendment to provide MA reimbursement for Targeted Case Management (TCM) activities of NFP programs in Monroe County and NYC. TCM includes assessment of medical, education, social and other needs; development of a care plan to engage in preventive health practices; and referral, follow-up and assistance in accessing needed services. NFP programs began MA billing in 1/11. MA billing data show 42% of clients served were Black and 40% Hispanic.
-DOH conducted 35 preconception focus groups with 333 adolescents and young adults ages 12 to 29 from diverse racial and ethnic groups including 56% African American and 20% Hispanic. When asked their thoughts on being healthy, participants expressed the need for increased: community opportunities to engage in healthy behaviors; understanding of the importance of being healthy; and awareness of health disparities. Results will inform NY's maternal and infant health strategies.
-Public awareness materials are available to promote early entry into prenatal care. All materials are printed in multiple languages, tested with populations they are targeting, and disseminated to better reach the target population.
-The statewide Growing Up Healthy Hotline (GUHH) links women to needed services, and is staffed 24/7 with both English and Spanish-speaking trained tele-counselors, a TTY for the hearing impaired, and the AT&T Language Line which extends access to callers speaking over twenty additional languages.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MA Article 28 prenatal care providers must perform presumptive eligibility determinations & assist with completion of the MA application & managed care plan selection, allowing women to immediately receive care while awaiting determination.	X			X
2. CPPSNs are community-based organizations whose goal is to organize the service system at the local level to improve early and continuous prenatal care, targeting at-risk pregnant women not engaged in services.		X	X	X
3. CHWPs provide outreach and home visiting services to pregnant women who are at highest risk for poor birth outcomes.		X	X	
4. HM-HB programs support development of organized community systems of perinatal health and home visiting services to identify pregnant and postpartum women early, provide outreach, assess risk, and make appropriate referrals.	X	X	X	X
5. The MIECHV initiative establishment, expansion/enhancement of evidence-based home visiting programs (NFP or HFNY) in		X	X	X

high-need communities.				
6. DOH conducted 35 focus groups with 333 adolescents and young adults ages 12 to 29 from diverse racial and ethnic groups including 56% African American and 20% Hispanic. Results will inform NY's maternal and infant health strategies.		X		X
7. Through an MOU with the OTDA, DOH supports enhancement/expansion of NY's 3 NFP programs to provide home visiting services to TANF-eligible first-time mothers.	X	X		
8. NFP programs began MA billing in 1/11 for TCM activities. MA billing data show 42% of clients served were Black and 40% Hispanic.		X	X	
9. Public awareness materials are available to promote early entry into prenatal care. All materials are printed in multiple languages, tested with populations they are targeting, and disseminated to better reach target populations.		X		
10. The statewide GUHH linked women to needed services. and is staffed 24/7 with both English and Spanish-speaking trained tele-counselors, a TTY and the AT&T Language Line providing access to over 20 additional languages.		X		

b. Current Activities

-Title V staff participate in NYS's MA Redesign process, including membership on implementation workgroups related to improving access to and encouraging entry into early prenatal care and engaging women into managed care.

-The current state budget includes TANF funding to support NFP programs and will allow for continued support of NY's 3 NFP programs to provide nurse home visiting services to TANF-eligible first time mothers.

-Contracts are currently being established under the MIECHV initiative to support NFP programs in Monroe and Bronx counties, and HFNY programs in Erie and Bronx counties. Through periodic home visits, home visitors will assess pregnant women's and families' health and social support needs; provide information to promote positive birth outcomes, and make referrals to needed services including early prenatal care. Studies show that home visiting has significant health benefits, including early and continuous prenatal care.

-DOH will promote Text4baby through its maternal and infant health partners. Customization of messages will allow DOH to include state-specific information and referral resources such as the GUHH.

-Under the First Time Motherhood/New Parents Initiative, 6 CPPSNs are convening community stakeholders to develop and implement preconception health community action plans. Action plans will propose evidence-based and promising practices to increase awareness of and supports for preconception health and use of healthcare services.

c. Plan for the Coming Year

-Activities and services noted in the "Accomplishments" and "Current Activities" sections will continue.

-DOH will issue a Maternal and Infant Health (MIH) Request for Applications (RFA), a redesign of the current CHWP, CPPSN and HMHB programs. Through the RFA, DOH will establish Maternal and Infant Community Health Collaboratives (MICHC) in high-need communities to develop community-wide systems of integrated and coordinated evidence-based and/or best practice strategies targeted to high-need women and infants, designed to achieve a set of performance standards including: enrollment in health insurance; engagement in health care and other supportive services; identification of risk factors and coordinated referrals and follow-up; and promotion of community supports and opportunities to be engaged in and maintain healthy behaviors. The MIH RFA will also procure an expansion of DOH's MIECHV initiative, supporting establishment or enhancement/expansion of additional NFP or HFNY programs in the 14 high-

need communities identified in the MIECHV needs assessment and as indicated in the MIECHV State Plan. MIECHV currently supports 6 programs in 3 high-need communities. It is expected that 2 to 4 additional NFP and/or HFNY programs will be supported effective 1/1/13.
-A Request for Proposals will be released as a companion to the MIH-RFA to establish a new MIH Center of Excellence to support MICHC and MIECHV grantees including provision of technical assistance, training and coordination of data management and evaluation activities.
-A Text4baby media campaign will be developed, with targeted media in areas with the highest rates of adverse birth outcomes. Customization of messages will allow DOH to include state-specific messages and referral resources such as the 24/7 GUHH. It is expected that the campaign will run in fall 2012 and continue through spring of 2013.
-DOH participates on the NY Parenting Education Partnership which is currently developing resources to be distributed to all new parents to promote positive parenting through knowledge and skill development in accessing appropriate resources and supports, and build stronger parent-child relationships.
-Through the MA Redesign process, DOH is developing an initiative to demonstrate effective and efficient use of Health Information Technology (HIT) between hospitals/health care systems and community-based health organizations to improve delivery for women and infants through use of uniform screening criteria for perinatal risks. The intent is to coordinate services, reduce fragmentation and redundancy, increase patient's access to health records and care engagement, improve quality and reduce costs. It is expected that identifying and addressing risks in a timely manner can contribute to significant reductions in MA costs while improving health outcomes. Title V staff are leading this workgroup.

State Performance Measure 2: *The percentage of Medicaid enrolled children between the ages of 3 and 6 years who had a well-child and preventive health visit in the past year*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					79.5
Annual Indicator		81	79	79	80
Numerator					
Denominator					
Data Source		NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	79.9	80.4	80.9	81.4	83.7

Notes - 2011
These data represent children in this age group who are enrolled in the Managed Care type of Medicaid coverage which includes 87% of all children. Information on children enrolled in

Medicaid fee-for-service is not included.

Numerator and denominator data are not available (survey data).

Notes - 2010
These data represent children in this age group who are enrolled in the Managed Care type of Medicaid coverage which includes 87% of all children. Information on children enrolled in Medicaid fee-for-service is not included. Comparison between 2007/2008 and 2009/2010 are not possible due to the fact that different methods of data collection were used in developing the measure rate.

2009 data are used as a proxy for 2010. This indicator is collected on a biannual basis. Numerator and denominator data are not available (survey data).

Notes - 2009
These data represent children in this age group who are enrolled in the Managed Care type of Medicaid coverage which includes 87% of all children. Numerator and denominator data are not available (survey data).

a. Last Year's Accomplishments
-DOH annually monitors the level of access and availability of Primary Care Physician (PCP) panels (number of primary care physicians in a practice) serving the MMC and Child Health Plus (CHPlus) populations. To do this, the Office of Health Insurance Programs (OHIP) analyzes the number of enrollees in a county compared to the number of PCPs. As specified in the 1115 waiver Terms and Conditions for the Partnership Plan and in the MMC contract, DOH established limits of panel size that plan practices are required to meet. Providers are also monitored for access and availability to see if the practice meets acceptable time standards for appointment availability by type of visit (urgent, non-urgent sick, routine and well child care). This is done by using a 'secret shopper' methodology of calling the practice and posing as an enrollee who needs one of the four types of visit. If the proportion of calls that are given a visit within the acceptable time frame is 75% or less, the plan must submit a plan of correction.
-DOH conducted Article 44 operational on-site surveys which included a review of provider networks to insure that there are sufficient numbers of PCPs/pediatricians for preventive well child visits for children enrolled in MMC.
-Health plans which participate in MMC have pursued several quality improvement activities to increase their well child preventive health visit rates including the following: contacting parents of children who have not had a well-child visit to urge them to schedule an appointment; contacting the non-compliant child's PCP and asking them to reach out to family to schedule an appointment; offering gift cards or other incentives to encourage members to schedule a visit; and publishing articles in member newsletters and on the health plans' websites to remind parents of the importance of a well child visit for this age group.
-One health plan conducted a Performance Improvement Project to improve the rate of immunizations which included educating the parent on the importance of childhood preventive visits.
-The measure "well-child visits in the 3rd, 4th, 5th and 6th year" was included in the 2011 Quality Incentive methodology. The Quality Incentive uses quality measures of Effectiveness of Care, Access and Availability and Use of Services. Other measures in the incentive include consumer satisfaction, rates of Preventive Quality Indicators and compliance measures. Plans are ranked by overall points and receive payments of 2.5%, 1.5%, or .5% per member per month premium increase. For the 2011 Quality Incentive, six plans did not receive any incentive increase.
-Community-based programs, such as the Community Health Worker Program and Nurse Family Partnership promote healthy behavior in families, including the promotion of primary and preventive care for children.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Health plans which participate in MMC pursued several quality improvement activities to increase their well child preventive health visit rates. (see 2-6 below).		X		
2. Health plans contacted PCPs who have non-compliant patients.		X		
3. Health plans offered gift cards or other incentives to encourage members to schedule visits.		X		
4. Health plans contacted non-compliant members.		X		
5. Health plans published information on the importance of well child visits in their newsletters and on their websites.			X	
6. DOH monitored access and availability of PCPs which serve the MMC and CHPlus populations.				X
7. DOH conducted Article 44 operational on-site surveys which included a review of provider networks to insure that there are sufficient numbers of primary care physicians/pediatricians for preventive well child visits for children enrolled in MMC.				X
8. DOH monitored the number of PCPs/pediatricians serving the 3- to 6-year old population.				X
9. The measure “well-child visits in the 3rd, 4th, 5th and 6th year” was included in the 2011 Quality Incentive methodology.				X
10.				

b. Current Activities

-DOH annually monitors the level of access and availability of PCP panels serving the MMC and CHPlus populations. Any plan with a score of less than 75% is required to submit an action plan to improve the measure result.

-DOH is conducting Article 44 operational on-site surveys which include review of provider networks to insure that there are sufficient numbers of PCPs/pediatricians for preventive well child visits.

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

-Community-based programs, such as the Community Health Worker Program and Nurse Family Partnership promote healthy behavior in families, including the promotion of primary and preventive care for children.

c. Plan for the Coming Year

-DOH will conduct annual monitoring of the level of access and availability of PCP panels serving the MMC and CHPlus populations. Any plan with a score of less than 75% will be required to submit an action plan to improve these measures.

-DOH will conduct Article 44 operational on-site surveys which include review of provider networks to insure that there are sufficient numbers of PCPs/pediatricians for preventive well child visits.

-Health plans will pursue quality improvement activities to increase their well child preventive health visit rates for children age three to six including the following: contacting parents of children who have not had a well-child visit and urging them to schedule an appointment;

contacting non-compliant children's PCPs and asking them to reach out to families to schedule an appointment; offering gift cards or other incentives to encourage members to schedule a visit; and publishing articles in member newsletters and on the health plans' websites to remind parents of the importance of well child visits for this age group.
-Community-based programs, such as the Community Health Worker Program and Nurse Family Partnership promote healthy behavior in families, including the promotion of primary and preventive care for children.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					1.9
Annual Indicator		1.9	1.9	1.9	1.9
Numerator		13	13	12.9	12.9
Denominator		6.8	6.9	6.8	6.8
Data Source		Vital Records	Vital Records	Vital Records	Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1.9	1.8	1.8	1.8	1.8

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013. Data are based on rates of low birthweight for White non-Hispanic and Black non-Hispanic births.

Notes - 2010
White and Black race groups do not include Hispanics.
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Notes - 2009
White and Black race groups do not include Hispanics.

a. Last Year's Accomplishments
-NYS has been a national leader in the development of a statewide system of perinatal regionalization. All obstetrical hospitals have been designated by DOH as a Level I, II, III or Regional Perinatal Center (RPC) based on standard criteria included in state regulation. Regulations require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers and newborns.
-Approximately 90.5% of all very low birth weight (VLBW) infants were delivered at RPC and Level III facilities. Conversely, less than 9.5% of VLBW infants were delivered at Level I and II hospitals. The trend towards delivery of over 90% of high-risk newborns at appropriate level hospitals suggests the effectiveness of perinatal regionalization.
-The Statewide Perinatal Data System (SPDS) captures data on why VLBW infants were born at lower level hospitals; the majority of these births are due to unavoidable events, such as inability to transfer the woman to a higher level hospital due to advanced stage of labor.
-DOH oversees a range of community-based public health initiatives to improve early and continuous prenatal care for high-risk women not currently engaged in health care, particularly African Americans and Hispanic, including: Comprehensive Prenatal-Perinatal Service Networks (CPPSN) which identify gaps and barriers to the service system, and in collaboration with

community stakeholders, work to improve accessibility and the quality of the local perinatal service system; Community Health Worker Programs (CHWP) which provide outreach and home visiting services to pregnant women who are at highest risk for poor birth outcomes; and Healthy Mom-Healthy Baby (HM-HB) programs which support development of organized community systems of perinatal health services through early identification, outreach, risk assessment, and referral to appropriate services including home visiting.
-In 2011, CHWP served 3,386 clients, including 99.9% female, 33% Black and 44% Hispanic. CHWPs are indigenous to the communities served.
-Through a Memorandum of Understanding (MOU) with the NY Office of Temporary and Disability Assistance (OTDA), DOH supports the expansion/enhancement of the state's 3 Nurse Family Partnership (NFP) programs to provide home visiting services to TANF-eligible pregnant women. In 2011, the NFP programs served 841 TANF-eligible women.
-Through a MA State Plan Amendment, DOH provides MA reimbursement for Targeted Case Management (TCM) activities to NFP programs in Monroe County and New York City. MA billing data show 42% of clients served were Black and 40% Hispanic in 2011.
-Through the Maternal and Infant Early Childhood Home Visiting (MIECHV) grant, DOH developed an Updated State Plan for a State Home Visiting Program with input from over 100 community-based organizations, local government agencies and home visiting programs in the14 high-risk communities identified in DOH's MIECHV needs assessment. The Plan identifies Erie, Monroe and Bronx counties as the communities to be served and NFP and Healthy Families NY (HFNY) as the evidence-based home visiting models to be supported beginning in year 1, with additional funds to be awarded through the forthcoming RFA.
-DOH conducted 35 preconception focus groups with a total of 333 adolescents and young adults ages 12 to 29 from diverse racial and ethnic groups including 56% African American and 20% Hispanic. When asked their thoughts on being healthy, participants expressed the need for increased: community opportunities to engage in healthy behaviors; understanding of the importance of being healthy; and awareness of health disparities. Results will inform NY's maternal and infant health strategies.
-Public awareness materials are available to promote early entry into prenatal care.
-The statewide Growing Up Healthy Hotline (GUHH) links women to needed services.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Public health initiatives were implemented, including perinatal regionalization, to increase access to early & continuous prenatal care, targeting high-risk areas to identify & address gaps in needed services & improve perinatal outcomes in NY.		X		X
2. RPCs conducted quality assurance visits to affiliate hospitals to improve perinatal quality and outcomes, including review of complex cases and determination as to whether cases should have been transferred to regional centers.		X		X
3. HM-HB programs support development of organized community systems of perinatal health services through early identification, outreach, risk assessment, and referral to appropriate services.		X	X	X
4. CPPSNs in collaboration with community stakeholders, worked to improve accessibility and the quality of the local perinatal service system.		X	X	X
5. CHWP provided outreach and home visiting services to pregnant women who are at highest risk for poor birth outcomes.		X	X	
6. DOH supported NY's 3 NFP programs to provide nurse home visiting services to TANF-eligible first time mothers.		X	X	

7. Through a MA State Plan Amendment, DOH provides MA reimbursement for TCM activities to NFP programs in Monroe County and NYC. MA billing data show 42% of clients served were Black and 40% Hispanic in 2011.		X		X
8. Public awareness materials were available to promote early entry into prenatal care.		X		
9. DOH conducted 35 focus groups across the state with adolescents and young adults to determine attitudes towards health and supports needed to be healthy.		X	X	
10. DOH developed an Updated State Plan for a State Home Visiting Program under the MIECHV initiative.		X	X	X

b. Current Activities

-Regional Perinatal Centers (RPCs) remain the hubs of the perinatal regionalization system. RPCs conduct QA visits at affiliate hospitals and work to improve perinatal quality and outcomes, including review of complex cases. RPCs conduct educational programs on-site to prepare affiliates for emergency cases.
-DOH's oversight role to identify and address appropriateness of care issues continues.
-NY was awarded a CDC State-Based Perinatal Quality Collaborative Grant for a NY Perinatal Quality Collaborative. DOH is working with RPCs to expand obstetric and neonatal interventions to affiliate hospitals to improve specifically identified perinatal outcomes.
-TANF funding will continue to support NY's 3 NFPs to provide nurse home visiting services to TANF-eligible first time mothers.
-MIECHV funds have been awarded to NFPs in Monroe and Bronx counties and HFNYs in Erie and Bronx counties under NY's MIECHV State Plan. An RFA to award additional funds will be released in 2012.
-DOH will promote Text4baby. A targeted media campaign will be developed. Customization of messages will allow for state-specific information and referral resources such as the GUHH.
-Under the First Time Motherhood/New Parents Initiative, 6 CPPSNs are convening stakeholders to develop and implement community action plans to increase awareness of and supports for preconception health through evidence-based and promising strategies.

c. Plan for the Coming Year

-DOH staff will continue to work closely with RPCs and affiliate hospitals to monitor and support effective use of the established system of perinatal regionalization.
-Consumer/parent/family input will continue at RPCs and affiliates through family advisory councils, satisfaction surveys, provider call-backs, and education and training programs.
-DOH will continue the NYSPQC with RPCs to implement selected obstetric and neonatal interventions designed to improve perinatal outcomes. NYSPQC will expand obstetric and neonatal interventions to affiliate hospitals, including current interventions for reducing scheduled deliveries without medical indication in women of 36 0/7 to 38 6/7 weeks gestation; and to optimize early enteral nutrition in newborns of <31 weeks gestational age.
-DOH will support implementation of community-based maternal and infant health programs awarded through an upcoming RFA. The MIH RFA will also procure expansion of DOH's MIECHV initiative, supporting establishment, enhancement or expansion of NFP or HFNY programs in high-need communities.
-A Request for Proposals will be released as a companion to the MIH-RFA to establish an MIH Center of Excellence to support community-based grantees including provision of technical assistance, training and coordination of data management and evaluation activities.
-A Text4baby media campaign will be implemented. Customization of messages will allow DOH to include state-specific messages and referral resources such as the 24/7 GUHH.
-Through the MA Redesign process, DOH is developing an initiative to demonstrate effective and efficient use of Health Information Technology between hospitals/health care systems and community-based health organizations to improve delivery for women and infants through use of

uniform screening criteria for perinatal risks. The intent is to coordinate services, reduce fragmentation and redundancy, increase patient's access to health records and care engagement, improve quality and reduce costs. Title V staff are leading this workgroup.

State Performance Measure 4: *The percentage of high school students who were overweight or obese*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					26.3
Annual Indicator		27.2	26.6	26.6	25.7
Numerator					
Denominator					
Data Source		YRBS	YRBS	YRBS	YRBS
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	26.1	25.8	25.5	25.3	25

Notes - 2011
Data are from the 2011 Youth Risk Behavior Suvey. Numerator and denominator data are not available (survey data).

Notes - 2010
2009 data are being used as a proxy for 2010. The YRBS is conducted bi-annually. The next survey was in 2011 with results available in 2012. Numerator and denominator data are not available (survey data).

DOH also collects data on the percentage of students in Pre-Kindergarten, Kindergarten and grades 2, 4, 7 and 10 in NYC (exclusive of NYC) who are overweight or obese: (32.0% for 2008-2010). The source of this data is the DOH Student Weight Status Category Report.

a. Last Year's Accomplishments
-The national percentage of high school students who were overweight or obese (27.8%) based on the 2009 YRBS data is slightly higher than the percentage for NY (26.6%). These figures are based on self-reported information (often underestimated). NY's student weight status category reporting surveillance is based on directly measured data. The percentage of public school students in grades 7 and 10 exclusive of NYC for the period of 2008 through 2010 was substantially higher at 34.0%.
-Funding is distributed directly and in combination with other programs to prevent obesity and related chronic diseases with intervention investments in child care, school, communities and health care settings. The program continued to use evidence- and practice-based chronic disease prevention interventions promoting policy systems and environmental approaches for sustainable change are used in each setting with an emphasis on reaching populations experiencing the greatest health disparities.
-In the first year of the Healthy Schools New York (HSNY) initiative, implemented by eighteen contractors to school districts with free/reduced price meal participation of 50% or more, the work scope changed as a result of the removal of Tobacco Prevention and Control funding. As a result, tobacco-free policy work was discontinued. The work scope was narrowed to a focus on school policies supporting physical education and physical activity.
-In the first year of implementation, the statewide center for obesity prevention, policy research and training for healthy eating and active living, Designing a Strong and Healthy New York (DASH-NY), provided multiple statewide training events for DOH contractors and NY residents. Training emphasizing environmental, policy and systems approaches to increasing physical

activity and healthy eating included Developing and Implementing Food Procurement Policy; Local Strategies to Reduce Sugar Sweetened Beverage Consumption; Land Use in Economic Development Strategies ; Using Planning and Zoning in NY to Promote Healthy Living; and Educating Decision Makers: Local Strategies to Sustain Prevention Projects in Public Health. Trainings are archived and remain available for access.
-Obesity is a significant public health issue and, as such, is an important component of preconception health. DOH received a First Time Motherhood -- New Parents Initiative three-year HRSA grant (September 1, 2010 to August 31, 2013) to improve perinatal health outcomes and strengthen resources available for new parents. Goals of this initiative include increasing awareness of the importance of preconception health, influencing preconception health behaviors among low income Black women and men, and promoting positive health behaviors among high-risk Black adolescents. DOH has conducted 23 focus groups with 237 adolescents to determine their views on living a healthy lifestyle and future health. Participants expressed a desire for more supportive home, school and community environments which encourage positive behaviors, and provide more information and communication.
-A Medicaid (MA) Redesign proposal for Intensive Behavioral Therapy for Obesity in Children and Adolescents was submitted in this period. The proposal described a staged approach beginning with assessment of obesity and discussion of healthy behaviors at the annual well visit regardless of weight status; increased reimbursement for the provision of childhood and adolescent obesity treatment that is consistent with both the American Medical Association (AMA) Expert Committee Recommendations Step-Wise approach and the U.S. Preventive Services Task Force (USPSTF) Grade B Recommendations (Stage 1: Prevention Plus; Stage 2: Structured Weight Management; Stage 3: Comprehensive Multidisciplinary Intervention). The proposal was accepted for implementation in State Fiscal Year 2013-14.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The statewide center for obesity prevention, policy research and training around healthy eating and active living, DASH-NY, delivered obesity prevention training (policy, system and environmental changes) to NY residents and DOH contractors.				X
2. The HSNY delivered technical assistance/training to school districts with the purpose of establishing or improving policies for physical activity and physical education.			X	X
3. The Obesity Prevention Program distributed funding directly and in combination with other programs to prevent obesity and related chronic diseases with intervention investments in child care, school, communities and health care settings.				X
4. DOH received a 3-year First Time Motherhood – New Parents Initiative HRSA grant to improve perinatal health outcomes and strengthen resources available for new parents.				X
5. DOH has conducted 23 focus groups with 237 adolescents to determine their views on living a healthy lifestyle and future health. Participants expressed a desire for more supportive home, school and community environments.				X
6. A MA Redesign proposal was submitted for intensive behavioral therapy for obesity for children and accepted for implementation in State Fiscal Year 2013-14.				X
7.				
8.				
9.				
10.				

b. Current Activities
-Over 70 contractors from multiple initiatives include improving physical activity and nutrition for children and adolescents. Policy, systems and environmental changes are used to support healthy eating including breastfeeding, increased opportunities for physical activity, or a combination thereof, across a variety of settings (child care, schools, communities, and health care) to achieve improved health outcomes.
-DASH-NY continues to coordinate and support an obesity prevention advisory group, write policy briefs on various obesity reduction/healthy eating/active living topics and provides training to stakeholders.
-SBHCs are required to document the weight of enrolled students based on Body Mass Index-for-age percentile.
-Contractors for obesity prevention in pediatric health care settings which will deliver guideline-concordant care for the assessment, prevention and treatment of child and adolescent overweight and obesity have been identified and established.
-HSNY contractors received training on improving access to physical activity opportunities and increasing compliance with physical education regulations.
-Collection of directly-measured weight status data from selected school districts continues.

c. Plan for the Coming Year
-Full implementation of the Obesity Prevention in Pediatric Health Care Settings as a learning collaborative to ensure the delivery of guideline-concordant care for the assessment, prevention and treatment of child and adolescent overweight and obesity is expected.
-A school district local wellness policies surveillance system will be established in partnership with the NY State Education Department. Policies will be rated for their strengths and areas for improvement. The resulting information can be compared with school district-level student weight status category reporting survey results and school health initiatives to observe changes over time.
-The HSNY work scope will be expanded to address selected nutrition issues not covered by the Healthy Kids Hunger Free Act including sufficient time for lunch; fundraising standards that do not include food or limit foods sold for fundraising; prohibited use of foods and beverages as reward or punishment; and limited frequency of classroom celebrations.
-Results of the 23 focus groups conducted as part of the First Time Motherhood -- New Parents Initiative (see Section a.) will inform a social marketing campaign. In addition, community action planning will be conducted in six high need counties; these efforts will bring together community stakeholders to identify barriers and develop strategies to promote preconception health to high risk populations, including adolescents.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					5.2
Annual Indicator		5.6	5.3	4.6	4.6
Numerator		64.3	58.3	48.6	48.6
Denominator		11.4	11	10.6	10.6
Data Source		Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Is the Data Provisional or				Final	Provisional

Final?					
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	4.5	4.5	4.4	4.4	4.3

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

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-NY has experienced a continuous decline in adolescent pregnancy rates over the past two decades. NY's rate of adolescent pregnancy is the sixth lowest in the U.S. According to a report from the National Center for Health Statistics, when adjusted for race and ethnicity, NY has the second lowest pregnancy rate for Black adolescents and the fifth lowest for Hispanic adolescents. Despite this positive trend, NY continues to have striking regional and racial/ethnic disparities in adolescent pregnancy rates.
-Adolescent pregnancy and birth rates are among the most racially and ethnically disparate public health outcomes that DOH monitors. Pregnancy and STD rates are consistently almost three times higher for Black and Hispanic teens than for white teens. Racial and ethnic disparities in teen pregnancy rates continue, although the actual magnitude of the disparity is decreasing. Rates for all race/ethnicity groups continue to decline.
-DOH funds 50 Comprehensive Adolescent Pregnancy Prevention (CAPP) community-based projects that focus on decreasing the incidence of adolescent pregnancy and STD/HIV and reducing racial and ethnic disparities among adolescents aged 10 to 21 by providing evidenced-based sexual health education; ensuring access to family planning; increasing skill-building opportunities; and promoting community efforts to improve adolescent sexual health. During the first year of the CAPP initiative, 2,869 Hispanic youth and 3,493 Black youth participated in evidence-based sexual health education programs.
-Forty of the 50 CAPP projects specifically focus on serving Hispanic youth. Funded programs are expected to have staff and Boards representative of racial and ethnic populations they serve, and that have experience serving minority populations.
-Eligible target communities for the CAPP procurement were identified through the Adolescent Sexual Health Needs Index (ASHNI). ASHNI is a ZIP-code level indicator that provides a single, multidimensional measure that incorporates multiple factors including the size of adolescent population, number of adolescent pregnancies and STD cases, and demographic and community factors that are significantly associated with adverse sexual health outcomes.
-Family planning programs funded by DOH target activities to underserved populations. Grantees reported that 26% (90,000) of all the clients served during the report period were of Hispanic origin.
-DOH funds Columbia University to provide professional education and resources statewide for community healthcare providers to improve care for adolescents.
-DOH was awarded $3.1 million in Federal Personal Responsibility Education Program (PREP) funds to support additional CAPP programs.
-DOH was awarded $2.8 million in Federal Section 510 Abstinence Education Grant Program (AEGP) funds to support community projects for 9 to12 year-olds focused on adult mentoring and supervision to delay the onset of sexual activity.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DOH funds 50 CAPP community-based projects that focus on decreasing the incidence of adolescent pregnancy and STD/HIV		X	X	

and reducing racial and ethnic disparities among adolescents aged 10 to 21.				
2. 2. 40 of 50 CAPP projects specifically focus on serving Hispanic communities. Funded programs are expected to have staff and Boards representative of racial and ethnic populations they serve, and that have experience serving minority populations.		X	X	
3. Eligible communities for CAPP were identified using ASHNI, a ZIP-code level indicator that provides a measure incorporating multiple factors including demographic/community factors significantly associated with adverse sexual health outcomes.			X	
4. DOH funded Columbia University to provide professional education and resources statewide for community healthcare providers.				X
5. DOH was awarded $2.8 million in Federal Section 510 AEGP funds to support community projects for 9 to12 year-olds focused on adult mentoring and supervision to delay the onset of sexual activity.		X		
6. DOH was awarded $3.1 million in Federal PREP funds to support additional CAPP programs.		X		
7.				
8.				
9.				
10.				

b. Current Activities

-CAPP and CAPP-PREP program activities that focus on decreasing the incidence of adolescent pregnancy and STD/HIV and reducing racial and ethnic disparities among adolescents aged 10 to 21 will continue. Activities include implementation of evidenced-based education programs; ensuring access to family planning; increasing skill-building opportunities for teens; and promoting community efforts to improve adolescent sexual health.

-DOH will fund fifteen programs that focus on mentoring, and adult-supervised activities for preteen youth ages 9 to 12 who reside in targeted high-need communities to support a healthy transition into adolescence. Funding for this initiative is through the AEGP.

-DOH-funded family planning providers' performance regarding increasing the number of adolescent clients and clients from racial/ethnic minority communities will be monitored. Training around best practices for improving program performance in these areas will be developed and provided.

c. Plan for the Coming Year

-NY's comprehensive approach to adolescent pregnancy prevention targeting high-risk youth across NY as described above will continue, with an emphasis on decreasing disparities.

-Training and technical assistance will be provided to DOH-funded family planning providers on best practices to increase the number of teen clients and clients from racial/ethnic minority communities.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	**2007**	**2008**	**2009**	**2010**	**2011**

Performance Data					
Annual Performance Objective	5	5	5	5	12.5
Annual Indicator	13.8	13.8	14.9	12.6	12.5
Numerator					
Denominator					
Data Source		YRBS	YRBS	NYS Youth Tobacco Survey	YRBS
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	12.3	12.2	12.1	12	11.8

Notes - 2011
Data are from the 2011 Youth Risk Behavior Survey. Numerator and denominator data are not available (survey data).

Notes - 2010
2010 data are from the NYS 2010 Youth Tobacco Survey. Numerator and denominator data are not available (survey data).

Notes - 2009
2009 data are from the 2009 (biannual)Youth Risk Behavior Survey. Numerator and denominator data are not available (survey data).

a. Last Year's Accomplishments
-The percentage of high school students in NYS who smoke has declined steadily from 16.2% in 2006 to 12.6% in 2010.
-NY exceeds both the Healthy People 2020 baseline and target goals of 19.5% and 16% respectively for this measure.
-The percentage of NY high school students who smoke (12.6%) is 26% lower than the comparable national rate of 17.2% indicated in the National Youth Tobacco Survey (NYTS).
-NY's cigarette excise tax is $4.35 per pack, which is the highest in the nation. Raising the price of cigarettes discourages youth smoking.
-NY law requires that all tobacco products be kept behind the counter.
-Enforcement of a strong indoor air law continued, banning smoking in public places, including restaurants and bars.
-Over 170 municipalities in NY have passed smoke-free outdoor air policies at locations such as parks, playgrounds and beaches. The Tobacco Control Program (TCP) continued to fund Reality Check Partners to engage youth to counter the tobacco industry and its marketing practices. These 16 programs engage middle and high school youth in activities aimed at de-glamorizing and de-normalizing tobacco use in their communities. NY also funded local Tobacco Control Community Partnerships (TCCP) in every county of the state. These partnerships work to advance community polices that support the tobacco-free norm. This is accomplished by implementing a coordinated set of strategies to build public, political and organizational support for tobacco control policies. By effectively educating and mobilizing the public, and educating government and organizational policy-makers, communities become receptive to or even demand strong tobacco control policies. Through these Community Transformation strategies, Community Partnerships and Reality Check contractors advance community policies to help realize our vision of all New Yorkers living in a tobacco-free society.
-Medicaid (MA), MA Prenatal Care Program, Women, Infants, and Children and Community Health Worker (CHW) programs assess prenatal clients for tobacco use and refer to or provide smoking cessation and other counseling/health teaching.
-Comprehensive Prenatal-Perinatal Service Networks (CPPSN) create awareness of the dangers of smoking, particularly during pregnancy.
-NY makes smoking cessation assistance available through a toll-free hotline, which provides free coaching and nicotine replacement therapy to eligible callers. The purchase of smoking cessation

products is available through MA.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Fund Youth Action Partners to engage youth to counter the tobacco industry & its marketing practices. 16 programs engage middle & high school youth in activities aimed at de-glamorizing & de-normalizing tobacco use in their communities.			X	
2. Continue to operate in every county of the state to advance community policies that support & reinforce the tobacco-free norm. Partnerships engage local stakeholders, educate community leaders & the public & mobilize the community.			X	
3. The TCP funded contractors' work with local leaders to educate them on the tobacco-related public health problems that can be addressed by local communities.			X	
4. MA Prenatal Care, WIC and the CHW Programs continued to assess prenatal clients for tobacco use and refer to or provide smoking cessation and other counseling/health teaching.		X		
5. NY continued to make smoking cessation assistance available through a toll-free hotline, which provides free coaching and nicotine replacement therapy to eligible callers.		X	X	
6. CPPSNs continued to create awareness of the dangers of smoking, particularly during pregnancy.		X	X	
7.				
8.				
9.				
10.				

b. Current Activities

-DOH continues to implement successful programs outlined in the "Accomplishments" section.
-The TCP continued work supported by federal stimulus funding to reduce youth smoking prevalence and tobacco product sales to minors by reducing the impact of retail tobacco product marketing on youth. This is accomplished by Community Partnership and Youth Action contractors which implement a set of educational activities to increase awareness of the impact that tobacco product marketing and tobacco retailer density have on youth smoking. Although the goal of having State legislation adopted was not met this year, this work remains the top policy priority for the NY TCP.
-Comprehensive Adolescent Pregnancy Prevention programming includes development of healthy attitudes and values as one of the adult preparation topics, allowing new opportunities to discuss tobacco usage.
-Twenty-three (23) Preconception Health focus groups were conducted with 237 adolescents to determine their understanding of health habits and their impact on future childbearing.

c. Plan for the Coming Year

-DOH will continue to implement a comprehensive TCP as outlined in the two sections above.
-The policy priority for the TCP in the coming year will be to educate communities and policy makers so they are receptive to local and statewide policies that protect children from tobacco marketing.
-Title V will continue to collaborate with Division of Chronic Disease Prevention, which is the DOH lead organizational unit for smoking-related public health programming.

-Smoking cessation messages will continue to be incorporated into Title V programs.
-Results of the Preconception Health focus groups will be incorporated into a social marketing campaign and perinatal health programming. Strategies for improving preconception health will include reduction of health hazards including tobacco use among persons of childbearing age.

State Performance Measure 7: *The percentage of Medicaid enrolled children and adolescents between the ages of 2-21 years who had at least one dental visit within the last year*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					41.4
Annual Indicator		37.3	40.2	41.0	41.8
Numerator		667090	746153	797681	835106
Denominator		1790400	1854115	1946654	1996387
Data Source		Burea of MA Statistics	Bur of MA Statistics	Bur of MA Statistics	Bur of MA Statistics
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	41.8	42.2	42.6	43.1	43.5

Notes - 2011
This indicator is based on information from both Managed Care and Fee-for- Sevice Medicaid Programs.

Notes - 2010
This indicator is based on information from both Managed Care and Fee-for- Sevice Medicaid Programs.

a. Last Year's Accomplishments
-In NY, the percentage of MA-eligible children and adolescents between 2 and 21 years of age having at least one dental visit during the year continues to increase. In 2010, 42.6% of eligible children had at least one dental visit, exceeding the national average of 36.2%.
-The proportion of low-income children and adolescents seeing a dentist during the year increased from 2009 to 2010 for all age groups. During 2011, 54% of children and adolescents aged 2 through 18 years participating in MA Managed Care (MC) Programs had at least one dental visit within the year.
-The percentage of children and adolescents aged 2 through 18 years covered under the CHPlus MC Programs who saw a dentist during the year increased by 11 percentage points from 52% in 2010 to 63% in 2011.
-The Office of Health Insurance Programs (OHIP) generates data on the utilization of dental services by MA enrollees for monitoring trends in dental visits and the use of preventive and restorative services. The analysis of the MA dental claims and encounters shows that children in fluoridated counties continue to experience fewer claims compared to that in less fluoridated counties.
-The above mentioned data are used for updating the state oral disease burden document titled The Impact of Oral Disease in NYS and the State Oral Health Plan.
-The DOH Medicaid Redesign Team (MRT) has made two recommendations for improving oral health services: 1) MA funding be made available to support costs of fluoridation equipment, supplies and staff time for public water systems in population centers (population over 50,000)

where the majority of MA-eligible children reside; and 2) amend statute and regulation to allow for the practice of dental hygiene under a collaborative practice agreement rather than under the supervision of a licensed dentist.
-An analysis of the use of emergency departments (ED) and ambulatory surgery facilities for the treatment of early childhood caries (ECC) was completed. Both ECC-related visits by children under 6 years of age and related treatment charges have substantially increased from 2004 through 2008. These data support the need for policies promoting anticipatory guidance, risk assessment and early dental visits.
-School-Based Dental Health (SBDH) programs operated at 619 schools during the 2010-2011 school year with services available at 30% of all schools eligible for a sealant program.
-The Bureau of Dental Health (BDH) conducted a survey of 3rd grade children selected from a sample of schools annually to assess oral health status of school age children and monitor progress toward oral health objectives. To assist county health departments in assessing the oral health status and needs of local residents, their utilization of dental services, the availability of dental providers and to develop their respective Municipal Public Health Service Plans, county-level data are routinely provided. Data include the results of the 3rd grade surveillance project, age-specific MA claims for a wide variety of dental procedures, and the Children's Oral Healthcare Access Atlas on the location of dental offices and identification of dentists accepting MA.
-To better identify barriers to the utilization of dental services, school nurses were surveyed to obtain feedback on the effectiveness of the dental health certificate (DHC) and reported barriers faced by parents in obtaining dental care for their children. The lack of dental providers in geographic areas and unwillingness of providers to accept MA were found to be the major barriers to care.
-DOH was awarded a $200,000/year HRSA school-based health center (SBHC) dental clinic grant for a four year period to integrate oral health services into existing SBHCs. DOH is collaborating with North County Children's Clinic in rural Jefferson County on the project.
-NY MA approved payment for fluoride varnish (FV) in 2009 with FV applications promoted in physician offices. A pilot project targeting children less than 3 years of age at the Albany Medical Center WIC Program was initiated in 2011.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitoring of the utilization of dental services by low-income children and adolescents participating in the MA Program continued.			X	X
2. Evaluation of the effectiveness of the DHC in identifying children in need of treatment services and facilitating their entry into dental care was completed.			X	X
3. BDH conducted a survey of 3rd grade children selected from a sample of schools annually to assess oral health status of school age children and monitor progress toward oral health objectives.			X	X
4. An analysis of the use of EDs and ambulatory surgery facilities for the treatment of early childhood caries (ECC) was completed			X	X
5. Targeted outreach and education to underserved low-income age groups was conducted.		X	X	X
6. DOH was awarded a $200,000/year HRSA SBHC dental clinic grant for a four year period to integrate oral health services into existing school-based health centers.	X			X
7. The MRT made 2 recommendations to improve oral health: use MA funds to support water fluoridation in population centers where most MA-eligible children reside and allow for practice of			X	X

dental hygiene under a collaborative practice agreement.				
8. The WIC Fluoride Varnish Pilot Project was initiated.	X	X		X
9.				
10.				

b. Current Activities
-BDH continues to focus on promoting healthy behaviors, reducing barriers to care and utilizing personal and population-based oral health services and to partner with local health departments, perinatal and rural health networks, educational institutions, and professional and provider organizations.
-Thirty-one contracts were funded for school-based oral health screenings and sealants in high need, underserved areas. BDH also approved 27 other programs to provide dental health services. Between funded and unfunded, services are now available at 936 schools in high need areas.
-The 3rd grade oral health surveillance project is continuing at elementary schools in NYC. A report on the results of the 3rd grade survey for upstate NY counties is being prepared.
-An evaluation of the effectiveness of the DHC in increasing access to dental care was completed. Based on a survey of school nurses, 24% of DHCs were returned, with highest return rates for children enrolling in Kindergarten. Identified barriers for completing the DHC include the lack of a mandate and availability of dental providers.
-Plans to evaluate the effectiveness of the WIC Fluoride Varnish Project and formulate recommendations for expansion to additional WIC sites are underway.
-Recommendations for improving the effectiveness of the DHC are being formulated.

c. Plan for the Coming Year
-DOH will continue to encourage implementation of policies and systems changes that promote twice a day tooth brushing with fluoride toothpaste; good oral health habits including appropriate feeding and snacking habits and healthy dietary practices, the provision of anticipatory guidance, risk assessment and FV by child healthcare professionals and referral to dental providers as early as eruption of first tooth; encourage visits to a dental provider on a regular basis; increase the availability of fluoride through community water fluoridation or a supplemental fluoride program; promote school-based interventions ranging from the DHC, oral health education, dental sealants, case finding and referral to dental care providers; enhance access to affordable insurance coverage; ensure an adequate supply of oral health providers, especially in underserved areas; and integrate oral health as part of programs, policies and overall health screenings.
-Initiatives described under "Current Activities" will continue.
-The utilization of dental services by children and adolescents and the types of services received will continue to be monitored.
-The 2005 State Oral Health Plan will be updated with goals, objectives and strategies for addressing Title V and Healthy People 2020 oral health objectives.

State Performance Measure 8: *Percentage of children who were tested for lead two or more times before the age of three.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					51
Annual Indicator		47.5	50.5	53.0	53.0

Numerator		116544	125763	133960	133960
Denominator		245402	249182	252662	252662
Data Source		NYS Lead Program	NYS Lead Program	NYS Lead Program	NYS Lead Program
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	51.5	52	52.5	53	53.5

Notes - 2011
Data are reported for children turning three years of age in the year reported – i.e., data reported for 2010 are for children born in 2007. Data is statewide, including NYC.
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Notes - 2010
This is a new performance measure that replaces and updates a previous measure that captured the percentage of children tested for lead at least once by age two years. The measure was revised to align with the state universal lead testing requirements that all children be tested for lead at both ages one year and two years, and to align with current statewide surveillance reports. While there are several separate metrics currently tracked for lead testing in state surveillance reports, this measure is the best stand-alone composite measure of performance in this area.

Data are reported for children turning three years of age in the year reported – i.e., data reported for 2010 are for children born in 2007. Data is statewide, including NYC.
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-In accordance with state regulations for lead testing at ages one and two, lead surveillance data for 2010 demonstrates an almost 5% (4.9%) increase in the number of children tested for lead two or more times by age three years. The application of strong policy and program efforts has resulted in this improvement.
-Revisions to state regulations, effective June 2009, authorized physician laboratories and limited services registrant laboratories to conduct blood lead testing using point-of-care testing devices.
-Enhanced ease of obtaining a blood lead test has contributed to improved testing rates. Authorized providers can obtain a blood lead in their office/clinic instead of sending the parent and child out with a prescription to get a blood lead test.
-Reporting mechanisms for point-of-care laboratories has been streamlined. In 2009, Public Health Law (PHL) was amended to authorize linkage of the DOH childhood blood lead registry (LeadWeb) and the NYS Immunization Information System (NYSIIS). In September 2010, the linkage was completed and a NYSIIS lead module was implemented. This module allows providers using point-of-care testing devices to enter lead test results in NYSIIS that are reported to DOH. Providers can see a child's lead testing history in NYSIIS; this helps to reinforce compliance with blood lead testing as per PHL and regulations.
-Responsibility for activities related to childhood lead poisoning was shared in the DOH between two major program areas, the Lead Poisoning Prevention Program (LPPP), located in the Center for Community Health (CCH), Division of Family Health, Bureau of Maternal and Child Health, and the Bureau of Community Environmental Health and Food Protection, located in the Center for Environmental Health (CEH). With the Centers for Disease Control and Prevention's restructuring of its LPPP into a Healthy Homes and Lead Poisoning Prevention initiative that addresses a variety of environmental health and safety concerns, CCH and CEH began preparing for transitioning the administration of the NYS LPPP to CEH to be completed by December 31, 2011.
-Effective 9/1/11, CEH received a Healthy Homes (HH) grant to develop a comprehensive and

holistic approach to addressing a broad range of housing hazards associated with lead poisoning, asthma, and injury prevention. This replaced the longstanding CDC funding for lead poisoning prevention. CEH staff will assume the administrative lead for the management of the lead registry, contract management, public education and outreach, and quality improvement activities of the LPPP. Although the scope of the program was expanded by CDC, the annual federal funding for the project was reduced 45% from the previous year. This funding reduction resulted in a loss of seven staff directly working in the program. Title V staff continued to provide clinical input regarding issues associated with the identification and management of children and pregnant women at risk for or exposed to lead.
-Local health departments (LHD) continued to receive grant funds to support statewide to improve lead testing of children as part of a comprehensive lead poisoning prevention program, and to contract with three Regional Lead Resource Centers (RLRCs) in five teaching hospitals throughout NY to provide expert clinical support, education and outreach LHDs and health care providers to improve lead testing and other preventive practices.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Physician laboratories and limited services registrant laboratories conduct blood lead testing in the office/clinic setting using point-of-care testing devices due to 2009 revisions to state regulations.	X			
2. DOH implemented the NYSIIS lead module that allows providers using point-of-care testing devices to enter lead test results in NYSIIS.				X
3. Providers can see a child's lead testing history in NYSIIS; this helps to reinforce compliance with blood lead testing as per PHL and regulations.	X			
4. DOH CCH and CEH began transitioning the administration of the NYS LPPP to CEH.				X
5. DOH CEH began planning efforts to implement the Healthy Homes grant to develop a comprehensive and holistic approach to addressing a broad range of housing hazards associated with lead poisoning, asthma, and injury prevention.				X
6. DOH provided grant funds to support local health departments (statewide to improve lead testing of children as part of a comprehensive lead poisoning prevention program.	X			X
7. DOH contracted with 3 RLRCs in 5 teaching hospitals throughout NY to provide expert clinical support, education and outreach LHDs and health care providers to improve lead testing and other preventive practices.			X	X
8.				
9.				
10.				

b. Current Activities
-Reminders for risk assessment, lead testing & follow-up implemented were in NYSIIS to promote lead testing by providers. Providers receive prompts regarding whether their one-and two-year-old patients are due or overdue for a lead test.
-LPPP provides funds to LHDs to improve lead testing of children & contracts with 3 RLRCs in 5 hospitals to provide support, education & outreach to LHDs/providers.
-LPPP created/released NYSIIS reports for LHDs & health plans to assess provider performance related to lead testing & to assist outreach to providers with low testing rates. Health care

providers can access reports on their patients.
-OHIP & LPPP staff developed a contract requirement for managed care plans requiring an annual assessment of enrollees' lead testing status.
-LPPP staff completed updated Guidelines for the Identification & Management of Lead Exposure in Children, posted them on the DOH website and in NYSIIS, and notified LHDs/RLRCs of its availability.
-Updated Guidelines for the Prevention, Identification & Management of Lead Poisoning in Pregnant and Postpartum Women were completed. Dissemination is in process. Input for guideline development was incorporated from RLRCs and ACOG.
-Transition of the lead program from CCH to CEH was completed on 12/31/11. LHDs, RLRCs, and other partners were notified.
-CDC will manage the cooperative agreement with HH grantees until 9/1/12 when CDC will provide technical support but no funding for HH and lead poisoning surveillance.

c. Plan for the Coming Year
-Partnerships established within the Childhood Lead Poisoning Primary Prevention Program, Healthy Neighborhood and the LPPP will be reviewed, consolidated, streamlined, and expanded upon to allow for a comprehensive HH Program. For example, CEH will explore the collaboration of the RLRCs and NY Occupational Health Centers to expand the services provided to consumers and health care providers to include the HH concept.
-Contracts with LHDs and RLRCs for the prevention, identification and follow up of lead exposure in children will be continued.
-In partnership with ACOG, the Guidelines for the Prevention, Identification and Management of Lead Poisoning in Pregnant and Postpartum Women will be distributed to its members via newsletter and web posting.
-LPPP staff will begin work with NYSIIS staff and the vendor to develop the capacity to accept electronic blood lead test results along with immunizations in a file submitted by a health care provider (replacing manual data entry) and additional quality improvement enhancements.
-LPPP staff will work with the NYSIIS vendor to create on-line tutorials to instruct users how to generate lists and aggregate clinical performance reports.
-CEH staff will collaborate with internal partners in the Medicaid Redesign Team (MRT): Lead Inspection Reimbursement initiative. Staff is developing a cost saving proposal to pay for the environmental lead investigations for Medicaid eligible children who meet the criteria for such investigations.
-It is unclear at this time how activities in the LPPP and HH programs will be maintained at their current levels after September 1, 2012 when CDC will provide technical support but no funding for HH and lead poisoning surveillance.

State Performance Measure 9: *Hospitalization Rate for Asthma in Children Ages 0 to 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					31
Annual Indicator		28.4	31.1	26.7	26.7
Numerator		12509	13781	11552	11552
Denominator		4408016	4424083	4324929	4324929
Data Source		SPARCS	SPARCS	SPARCS	SPARCS
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	26.5	26.4	26.3	26.2	26

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

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-DOH implemented and monitored the Asthma Program through collaboration with a network of partners, to include its agency-wide, multi-disciplinary internal infrastructure to address asthma, and the Asthma Partnership of NY, a public/private collaboration.
-DOH maintained a comprehensive asthma surveillance system. The system served to monitor the burden of asthma; strengthen the use of data for targeting, monitoring, and evaluating interventions and developing programs; and influence policy. Population--based asthma measures and population-subset asthma measures were analyzed. A public asthma website was available with updated data, including: asthma surveillance reports; asthma prevalence; asthma hospital discharge data by age, county, and ZIP code; Emergency Department (ED) visits by age, county, ZIP code, and asthma mortality data by age and county (www.health.state.ny.us/statistics/ny_asthma).
? The Clinical Guideline for the Diagnosis, Evaluation and Management of Adults and Children with Asthma, a NY consensus asthma guideline decision support tool, and the Asthma in the Primary Care Setting course, both based on the National Asthma Education and Prevention Program (NAEPP), Expert Panel Report (EPR)-3 Asthma Guideline (http://www.nhlbi.nih.gov/guidelines/asthma/index.htm), were made available at no cost to all health care providers, educators and health plans throughout NY. Over 6,000 hard copies of the guideline tool were distributed. The tool was also available electronically for download at the DOH website. The Asthma in the Primary Care Setting course was made available on DVD and online at: http://jeny.ipro.org/files/Asthma. Over 1,000 copies of the DVD were distributed, and 34 clinicians completed the course online (bringing the total to 400).
-A competitive procurement process to fund NY Regional Asthma Coalitions (RACs) was executed. To strategically distribute resources to areas and populations of high need, county-level asthma burden data (hospital discharge and ED visit) was utilized to define funding-eligible geographic areas. The RACs will identify high risk populations within their regions, convene and engage local stakeholders, and apply a population-based, systems change approach that translates the NAEPP EPR-3 Guideline into practice. The RACs aim to increase the quality of life among individuals living with asthma and to decrease the number of asthma-related hospitalizations, ED visits, urgent care visits and school/work days lost.
-The Eliminating Disparities in Asthma Care (EDAC) collaborative was implemented in Central Brooklyn to identify key strategies for reducing racial/ethnic disparities in asthma care and outcomes. Six teams, representing a health plan-practice partnership comprise the EDAC workgroup. The intervention is based on the Institute for Health Care Improvement's (IHI) "Breakthrough Series" (BTS) evidence based methodology (www.ihi.org). Participating teams conducted an initial Assessment of Chronic Illness Care (www.improvingchroniccare.org); tested and implement system changes within and across their organizations; and reviewed and reported monthly progress.
-The Asthma Outcomes Learning Network (AOLN), based on the IHI BTS methodology, continued to engage 11 teams, representing organizations serving a pediatric population disproportionately affected by asthma. Among teams measuring ED visits for asthma, all reported a decrease in the percentage of patients served by their organization who had had an asthma-related ED visit in the past six months. Teams learned to: test and implement system changes within and across organizations; measure outcomes; evaluate results; review and report progress. Innovations implemented included: use of asthma registries; use of asthma flow sheets with embedded NAEPP EPR-3 recommendations; installation of asthma follow up reminder systems; use of asthma action plans; building community linkages.
-An analysis of the NY Certified Asthma Educator (AE-C) workforce was completed by the

University at Albany Center for Health Workforce Studies to examine supply, distribution, demographics, and practice characteristics of AE-Cs in NY.
-To increase access to culturally/linguistically appropriate self management tools, the Asthma Program partnered with an external organization with expertise in developing web-based tools and mobile phone applications to support asthma self management to develop a pilot to test existing tools.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. An agency wide organizational approach was utilized to manage the DOH Asthma Program, fostering a multi-disciplinary, sustainable infrastructure to address the complex problem of asthma.				X
2. NY has an extensive network of asthma partners organized under the Asthma Partnership of NY, a public/private collaboration to mobilize all planning, implementation, and evaluation efforts to improve asthma outcomes in NY.				X
3. DOH maintained and expanded a sophisticated asthma surveillance system.				X
4. The DOH Asthma Program implemented and monitored the EDAC in partnership with Brooklyn-based health care practices and managed care health plans.			X	X
5. A competitive procurement process to fund RACs to convene and engage local stakeholders and apply a population-based, systems change approach that translates the NAEPP EPR-3 Guideline into practice was executed.			X	X
6. The DOH Asthma Program implemented AOLN in collaboration with the RACs to improve asthma care and management and reduce the disparities gap.			X	X
7. An analysis of the NY Certified Asthma Educator workforce was completed.				X
8. The DOH Asthma Program worked with partners to increase access to culturally and linguistically appropriate asthma self management tools.			X	
9.				
10.				

b. Current Activities
-Funding for RACs has been awarded to areas of high need, defined by county-level asthma burden data. This change in distribution of resources is to strategically target areas with high asthma-related ED and hospital discharge rates. Interventions are aimed at decreasing the number of asthma-related hospitalizations, emergency department visits, and school/work days lost.
-Guided by the findings of the AE-C workforce analysis, education is being provided on the Asthma Self Management Training services benefit and certification. Efforts to expand the workforce and its integration into clinical practice settings continue.
-Updated, comprehensive asthma surveillance data is continuously made available via the DOH public website and the printed NY Asthma Surveillance Summary Report; NY BRFSS Asthma Call-Back Survey Summary Report for 2006-10 is being finalized.
-A pilot program to test a mobile information system to inform users around appropriate steps following an asthma-related ED visit is being designed in collaboration with partners.
-RACs will engage in the 2012 AOLN; they will bring together health care and community

systems to implement evidence-based interventions aimed at improving asthma care and health outcomes.
-Implementation and monitoring of the Eliminating Disparities in Asthma Care collaborative continues.
-Staff is drafting a proposed benefit to provide reimbursement for asthma home-based services, as recommended by the NY Medicaid Redesign Team (MRT).

c. Plan for the Coming Year
-The NY MRT Disparities Workgroup put forth a recommendation to expand Medicaid (MA) to include reimbursement for asthma home-based services. The DOH Asthma Program is coordinating the drafting and implementation of this proposed benefit, with anticipation of implementation in 2013. Multi-modal home-based asthma services are recommended by the NAEPP, EPR-3. The proposed service, to be provided in the home setting, includes asthma assessment and education related to patient self-management and control of environmental triggers and the provision of multiple low-cost products for remediation of triggers.
-The RACs will complete and implement individual strategic plans, outlining system change interventions to be implemented to improve asthma care and eliminate disparities in asthma outcomes for their communities. Utilizing local and state data, specific target populations will be identified for these interventions, ensuring that resources are directed to systems and populations with a high burden of asthma. Performance across a core set of required measures will be monitored on a monthly basis utilizing the IHI Extranet Improvement Tracker.
-DOH will maintain and expand its sophisticated asthma surveillance system, to include updating of asthma surveillance reports and asthma data housed on the DOH public website. Asthma information briefs will be released to the public on a regular schedule during this time period, with the goal of providing information for action based on the NAEPP, EPR-3 recommendations.
-The EDAC collaborative will close with the convening of an outcomes conference to review best practices and final results. Best practice interventions and tools for eliminating disparities in asthma care and health outcomes will be disseminated to managed care organizations and healthcare practices throughout the state.
-The Clinical Guideline for the Diagnosis, Evaluation and Management of Adults and Children with Asthma, a NY consensus asthma guideline decision support tool, and the Asthma in the Primary Care Setting course will continue to be made available. DOH will explore the possibility of creating a mobile application for health care providers based on the decision support tool.

State Performance Measure 10: *The percentage of infants who were exclusively fed breast milk between birth and hospital discharge*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					43.1
Annual Indicator		42.0	42.7	43.5	43.5
Numerator		95496	96080	95511	95511
Denominator		227604	224903	219503	219503
Data Source		Statewide Perinatal Data System	Statewide Perinatal Data System	Statewide Perinatal Data System	Statewide Perinatal Data System
Is the Data				Final	Provisional

Provisional or Final?					
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	43.6	44	44.4	44.8	45.4

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

Notes - 2010
The denominator includes all live born infants, excluding infants who were admitted to the NICU or transferred in or out of the hospital. Method infant is fed is recorded on the Certificate of Live Birth, and is defined as the period between birth and discharge from the hospital, up until 5 days of age (when NYS law requires report of live births). Infants are classified as being fed exclusively breast milk if they were fed only breast milk, and no other liquids or solids except for drops or syrups consisting of vitamins, minerals or medications.
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-The Breastfeeding(BF)Mothers' Bill of Rights was posted on the DOH website in 6 languages.
-Twelve hospitals that provide maternity care services outside of NYC were recruited and have been engaged in the NYS Breastfeeding Quality Improvement in Hospitals (NYS BQIH) Learning Collaborative, a joint initiative with NICHQ. Ten out of 12 hospitals have discontinued distribution of formula samples, formula coupons, and educational materials provided by formula companies to breastfeeding mothers at time of discharge. Eight hospitals discontinued the practice as part of their NYS BQIH work and two hospitals had discontinued the practice prior to their participation in the NYS BQIH Learning Collaborative. The average prevalence of infants who were exclusively fed breast milk across all hospitals in the project was 44.5% in August 2011, up from a June 2010 baseline of 37.1%. NYCDOHMH also recruited and worked with 13 hospitals in NYC to improve maternity care practices to support breastfeeding mothers.
-Ten Steps to Successful BF: An Online Course was offered to staff in 132 hospitals providing maternity care services. Staff from all 132 hospitals completed the course which meets the staff education requirement for Baby Friendly Hospital Designation. There was an 81% completion rate among the 1040 distributed course codes (823 accessed and 669 completed).
-The Division of Chronic Disease Prevention submitted recommendations to the NYS Medicaid Redesign Team (MRT) for payment of specifically trained lactation counselors and an incentive for deliveries at Baby Friendly Hospitals.
-Infant feeding data from hospitals (excluding NYC) was analyzed using the Statewide Perinatal Data System (SPDS). Hospitals were ranked using three indicators (percentages of infants fed exclusively breast milk, fed any breast milk, and breastfed infants also fed formula in the hospital). Each hospital was informed of its performance relative to other hospitals.
-Hospitals statewide were asked to examine their policies and procedures regarding supplemental in hospital formula feedings and the distribution of infant formula samples at the time of discharge.
-The New York State Model Hospital BF Policy and the New York State Model Hospital BF Policy Implementation Guide were developed to increase compliance with New York State Codes, Rules, and Regulations (NYCRR) Title 10.405.21 Perinatal Services and the NYS BF Mothers' Bill of Rights. Hospitals statewide were provided webinar training with staff from 113/135 (84%) hospitals attending. Hospitals were advised to ensure that their Hospital BF Policy was consistent with NY Hospital regulations and legislation. The New York State Model Hospital BF Policy was provided as a guide. Hospitals were asked to submit their written hospital BF policies in September 2011. The New York State Model Hospital BF Policy and accompanying Implementation Guide are located on the DOH public webpage :

(http://www.health.ny.gov/community/pregnancy/breastfeeding/)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The BF Mothers' Bill of Rights was posted on the DOH website in 6 languages.		X		
2. Using SPDS data, hospitals were ranked based on 3 BF indicators (newborn infants fed exclusively breast milk, fed any breast milk and breastfed infants supplemented with formula) and informed of its relative performance.				X
3. Hospitals statewide were asked to examine their policies and procedures regarding supplemental in hospital formula feedings and the distribution of infant formula samples at the time of discharge.				X
4. DOH and RPCs continued offering the Ten Steps to Successful Breastfeeding: An Online Course to staff at 132 hospitals providing maternity care services across the state.		X		
5. DOH engaged 12 hospitals in the NYS BQIH Learning Collaborative to improve policies, systems, and practices consistent with the recommended Ten Steps to Successful BF.			X	X
6. The Division of Chronic Disease Prevention submitted two cost savings recommendations to MRT: payment for specifically trained lactation counselors and incentives for deliveries at Baby Friendly Hospitals.		X	X	X
7. The NYS Model Hospital BF Policy and NYS Model Hospital BF Policy Implementation Guide were developed. Hospitals received training on these documents and strategies to improve maternity care practices.				X
8. NYCDOHMH recruited and engaged 13 hospitals to improve maternity care practices and develop a culture that promotes exclusive BF.			X	X
9.				
10.				

b. Current Activities

-DOH has surveyed the 132 hospitals that provide maternity care services in NYS to collect information regarding patient education and support, obstetric staff education and training, and general BF policies.
-DOH will continue to offer the Ten Steps to Successful BF: Online Course to 80 hospitals (excludes NYC hospitals and 12 BQIH Hospitals) providing maternity care in NYS.
-The NYS BQIH demonstration project has officially concluded. Data analyses are being conducted to identify areas of significant improvement.
-Hospital BF rates are updated yearly and posted to the NYSDOH webpage.
-131 of 132 hospitals providing maternity care have resubmitted their hospitals breastfeeding policy to DOH. The one hospital that did not submit indicated that its policy was not revised.
-Hospital BF policies will be codified and compared with a 2009 review. Hospitals will be notified of inclusion of required components and hospitals informed of their inclusion of the required components.
-The Change Package, Data Measurement Plan, and additional tools developed for the BQIH will be updated for dissemination to all hospitals in NYS providing maternity care services.
-Successes from the CPPW Breastfeeding Initiatives are in the process of being showcased

nationally and through scholarly publication.

c. Plan for the Coming Year

-Given the success of the NYS BQIH, an additional cohort of 27 hospitals will be recruited this year to engage in 15-month learning collaborative to improve maternity care practices.
-Collaboration will continue among Title V staff, Divisions of Nutrition and Chronic Disease and the NYCDOHMH to educate providers, assist hospitals with the implementation of baby friendly policies and practice, and to link women with home visiting programs to educate and assist with support for BF.
-Staff will continue to work with NYS Medicaid staff to develop the details and specifications of the breastfeeding education and lactation counseling benefit by specifically trained lactation counselors, consistent with United States Preventative Task Force recommendations for interventions during pregnancy and after birth to promote and support BF.

E. Health Status Indicators

A review of trends of several Health Status Indicators (HSIs) is included in Section IIB Needs Assessment Summary of this application. In this current section, New York will report on the category of priorities that will cross various HSIs and measures.

Several of the HSIs are related to the demographics of New York State. According to the 2010 Census estimates, 19,378,102 people live in New York State. The population residing in the State, excluding New York City experienced a slight gain between 2009 and 2010 while the New York City population declined. Between 2009 and 2010, the overall statewide population declined slightly. There were 242,914 births in New York State in 2010. Of these, 120,003 (49 percent) were to residents of New York City and the remaining 122,911 were to residents of New York State, excluding New York City (Rest of State). This is 6,678 fewer births than occurred in 2009. Both New York City and Rest of State residents experienced a decline in the number of births.

The majority of births occurred to women between the ages of 20 and 39 (89 percent). Women aged 45 plus had 843 live births and women under fifteen had 185. In 2010, births to White mothers accounted for 66 percent of all births while births to Black mothers represented 18 percent of the total. Sixteen percent of births were in the "other" category. This includes births to persons of multiple races, as well as all other races. Twenty-four percent of total births were Hispanic. Out-of-wedlock births accounted for 41.8 percent of total births. Mothers 17 years of age and younger were more likely (97 percent) to be unmarried compared to mothers aged 25 or older (31 percent). Out-of-wedlock births were also more common among Black (70.7 percent) and Hispanic (65.6 percent) mothers.

New York's population is ever changing with large increases in both the Asian non-Hispanic and Hispanic populations. Asian non-Hispanic New Yorkers were the fastest growing population group in the state between 2000 and 2010, and made up about seven percent of the New York State population in 2010. The NYS Hispanic population increased by 19 percent from 2000 to 2010, the second largest percentage increase among all racial/ethnic groups. There were 3,416,922 Hispanics living in New York in 2010, approximately 18 percent of the total state population. The Black non-Hispanic population decreased approximately one percent from 2000 to 2010 and was 14 percent (2,783,857) of the total New York State population in 2010.

The percentage of NYS's overall population that was living in poverty increased slightly from 15.8 percent in 2009 to 16.0 percent in 2010. The percentage of New York State families living in poverty increased as well, from 12.5 percent in 2009 to 12.6 percent in 2010. This is the second

consecutive yearly increase for both of these indicators. More than 25 percent of all NYS Hispanics and one-third of Hispanic children were living below the federal poverty level in 2010, compared with only 9 percent of White non-Hispanics and 11 percent of White non-Hispanic children, respectively. Poverty has disproportionately affected Black non-Hispanic New Yorkers almost 21 percent of all Black non-Hispanic and 29 percent of Black non-Hispanic children lived below the federal poverty level in 2010, compared to only 9 percent of White non-Hispanics and 11 percent of White non-Hispanic children.

Poverty is highly associated with poor health outcomes, especially for women and children. Families headed by single females, and single-female headed households with children are more likely than other families to be living below poverty. According to the 2011 Current Population Survey, during 2010, 43.0 percent of persons in female-headed households with children lived below poverty in New York State.

Prior to the recent leveling off of poverty rates among children, New York State had made much progress in reducing child poverty. In 2000, New York's child poverty rate was at its lowest level in 21 years, largely because the State had increased employment among its most economically needy families. In 2010, 1,080,000 of New York's children (24.6 percent) were living below poverty. This is higher than the 22.0 percent in the nation as a whole, but below the 2009 percentage of 25.0 percent. About 43 percent of children in New York State were living below 200 percent of poverty in 2010. According to the 2009 American Community Survey, the percentages of those living in households earning less than 100 percent of the poverty level were: 20.3 percent for children birth to under age 5, 18.6 percent for 5 to 17 year-olds, 15.8 percent for 18 to 34 year olds, 10 percent for 35-64 year olds, and 11.8 percent for those over 65.

Ensuring comprehensive health care for all New Yorker's, regardless of income, is a priority of New York State. This has been discussed in Section III. F. Health Systems Capacity Indicators.

As stated previously, a major focus for NYSDOH is on health disparities and the achievement of health equity. Several HSI relate to pregnancy and birth outcomes. Based on a population as a whole, New York is making great strides in improving birth outcomes. However, New York also breaks down indicators by race and ethnicity in an effort to determine if certain groups are not benefiting equally from current and future interventions. (Please refer to forms 20 and 21 for annual reporting of Health Status Indicators.) Black women fare significantly worse in several areas. They have higher rates of prematurity and low birth weight, higher rates of maternal death and enter prenatal care later in their pregnancies.

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

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

NYS has also been a national leader in the development of a statewide system of perinatal regionalization. NYS has a well-organized system of regionalized perinatal care that ensures that appropriate hospital care is provided to women and their newborns. A system of regionalized

perinatal services includes a hierarchy of three levels of perinatal care provided by the hospitals within a region and led by a Regional Perinatal Center (RPC). All obstetrical hospitals have been designated by the Department as a Level I, II, II or Regional Perinatal Center (RPC) based on standard criteria included in state regulation. Regulations require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers and newborns.
Women at highest risk for poor birth outcomes are referred to RPCs and supportive health and social services. Research strongly supports regionalization as a means of improving birth outcomes.

The NYSDOH has made significant efforts to improve birth outcomes through the development, implementation and oversight of a number of programs and initiatives that collectively aim to provide a comprehensive, integrated set of services to support optimal perinatal outcomes. Efforts made to ensure that all VLBW babies are born at facilities with services commensurate with their more complex needs have resulted in the vast majority of these babies being born at Level III hospitals and Regional Perinatal Centers. Regionalization has had a positive impact in NYS with VLBW babies more likely to be born at RPC and Level III hospitals and more likely to survive post-regionalization (2004-2006) than pre-regionalization (1996-2001). NYS's risk-adjusted VLBW neonatal mortality rate declined from 13.03 per 100 during 1996-2001 to 10.46 per 100 during 2004-2006. 90.5% of all very low birth weight (VLBW) infants were delivered at RPC and Level III facilities. Conversely, 9.5% of VLBW infants were delivered at Level I and II hospitals. Recognizing the need for current data to assess public health outcomes and needs, the NYSDOH, in conjunction with the perinatal regionalization effort, developed the Statewide Perinatal Data System (SPDS) that captures birth data and is used for public health and quality improvement purposes. Data such as the VLBW data discussed above are easily culled from SPDS. All obstetrical hospitals in NYS have access to their birth data and RPCs have access to their affiliate hospital de-identified birth data for quality improvement purposes.

Building on the system of perinatal regionalization, the NYSDOH embarked on a systems-changing quality improvement process, using data to measure outcomes and the RPC leadership and expertise to work with the NYSDOH to improve birth outcomes. Initiated in 2012, the New York State Obstetrical and Neonatal Quality Collaborative (NYSONQC) - a joint initiative of the Department, New York's Regional Perinatal Centers (RPCs) and the National Initiative for Children's Healthcare Quality (NICHQ), strives to improve maternal and newborn outcomes through the use of evidence-based healthcare improvement interventions to reduce the number of scheduled, elective deliveries performed without appropriate indication in women of 36 0/7 to 38 6/7 weeks gestation. Seventeen (17) RPCs are participating in the quality improvement initiative. Initial RPC Obstetrical Intervention teams activities include: collecting and submitting data on scheduled inductions and Caesarian deliveries without medical indication; revising admitting practices; employing "hard stop" processes to ensure that only elective deliveries with acceptable medical indicators are scheduled; and educating providers and patients. Significant progress has been shown including: a 67% decrease in scheduled deliveries without medical indication between 36 and <39 week gestation; an 86% decrease in inductions; a 62% decrease in cesarean sections; and, a 66% decrease in primary cesarean sections.

In 2011, the NYSDOH was awarded a CDC Perinatal Quality Improvement grant which will provide support to expand these activities to additional obstetrical hospitals. Leveraging these resources, NYSDOH also forged a partnership with the NYS Partnership for Patients (CMS funded Hospital Association of NYS and Greater NY Hospital Association joint grant) focusing on reducing scheduled deliveries between 36 and 38 6/7 weeks gestation. Through this joint initiative, this effort will be expanded to all additional 116 obstetrical hospitals in NYS.

Every maternal death is a tragedy, and Black women die at a much higher rate than non-Black women. In 2011, utilizing a public health approach to decreasing maternal deaths, the NYSDOH implemented a new Maternal Mortality Review (MMR) Initiative, which builds on the previous DOH-funded Safe Motherhood Initiative. The Department redesigned the previous process, in which ACOG was funded to conduct reviews of a selected subset of maternal deaths on a

voluntary basis, to a DOH-led comprehensive process to systematically review all maternal deaths, in conjunction with the State's quality improvement organization, Island Peer Review Organization (IPRO), and an expert committee that includes representation from ACOG and other professionals/experts. The updated initiative is intended to ensure a comprehensive review of factors leading to maternal deaths in New York State, and to have sufficient information to develop strategies and measures to decrease the risk of these deaths. The first meeting of the expert committee included a review of preliminary 2006-2008 data on maternal deaths that was based on an initial review of 70 maternal deaths obtained from the New York Patient Occurrence and Tracking System (NYPORTS) from 2006 to 2008. This review showed the leading causes of death to be: hypertension (20%), hemorrhage (19%) and embolism (17%). A history of chronic illness and prenatal risk factors was frequently found in the mothers, and in 59% of the cases, the mother was obese.

This discussion resulted in identification of several priorities for this initiative, including the development of clinical guidelines for the management of hypertension, obesity and embolism/DVT. Management of hypertension during pregnancy was selected as the first topic for development. During the past year, a multidisciplinary subcommittee of the Expert Workgroup, and the Department worked with the OHIP, IPRO and the subcommittee to develop guidelines. The subcommittee is developing a guidance document on Hypertensive Disorders in Pregnancy that will summarize existing guidelines for the diagnosis, evaluation, and management of hypertensive disorders in pregnancy. The guidance document is intended for healthcare providers, including obstetricians, midwives, anesthesiologists, nurses, and other health care providers who care for pregnant women in a variety of clinical settings. The full Expert Review Committee will have the opportunity to review and comment on the guidelines before they are issued by the Department.

A variety of public health strategies engage high risk pregnant women in early prenatal care. These include: Community Health Worker Program, Nurse Family Partnership for high risk first-time mothers early in pregnancy, and Healthy Mom -- Healthy Baby Prenatal and Postpartum Home Visiting Program, designed to establish a county system of perinatal health services and the new federal Maternal and Infant Early Childhood Home Visiting (MIECHV). All are targeted to communities with high rates of poor birth outcomes as well as maternal, infant and child health risk indicators. The Department also funds perinatal networks in high risk communities that are designed to improve the local system of perinatal care.

New York has had much success, but with the ever changing landscape of NY's population, it is imperative to continuously re-evaluate achievements and initiatives, considering available evidence, and develop systems and strategies to best meet the needs of the target population. Therefore, the NYSDOH is developing a new Maternal and Infant Health (MIH) initiative that will be funded through a competitive bid process. The goal of the MIH initiative is to improve maternal and infant health outcomes for high-need women of childbearing age and their families, while reducing racial, ethnic and economic disparities in those outcomes. High-need women include those who are low-income or uninsured; racial, ethnic and linguistic minorities; women with multiple social or economic stressors; underserved immigrants; victims of domestic violence; individuals impacted by mental health issues, alcoholism and/or substance abuse; women with unintended or unwanted pregnancies; and women with disabilities. These women on average attend fewer prenatal visits and are more likely to experience poorer pregnancy outcomes. Their families are more likely to be without a medical home and are less likely to access consistent, comprehensive preventive and primary care services.

Through the MIH initiative, the Department seeks to improve key perinatal outcomes, reduce associated disparities and maximize the use of limited public health resources through a critical re-structuring of current community-based maternal and infant health public health programs. The Department endeavors to drive and support innovation to ultimately build a practice base of evidence that is implemented and tested through continuous quality improvement. The Department is committed to targeting limited public health resources to populations and

communities with the highest need where impact will be greatest to improve population health outcomes and reduce health disparities. To accomplish this, the MIH Request for Applications incorporates the following key guiding models, principles and approaches within a comprehensive public health framework:
- A performance management approach to measuring, monitoring and improving health outcomes. Performance management is the practice of actively using performance data to improve the public's health. The performance management framework centers on a clear and focused aim and the strategic use of performance standards to guide the development and implementation of specific improvement strategies.
- A life course model promotes optimal women's health throughout the reproductive lifespan. The life course model looks at health as an integrated continuum and suggests a complex interplay of multiple determinants, considering the impact of social, environmental, biological, behavioral and psychological factors on individuals throughout their lives. It builds on recent social science and public health literature that posits that each life stage influences the next and that social, economic and physical environments interacting across the life course impact individual and community health. A life course perspective recognizes that as many as half of all pregnancies are unintended, underscores the importance of promoting a woman's health regardless of her pregnancy plans, and expands the focus on improving pregnancy outcomes from prenatal care alone to include preconception and inter-conception care and wellness.
- A social ecological model approach recognizes health as a function of individuals and the environments in which they live -- including family, peer, neighborhood, work place, community and societal influences. A social ecological model identifies and addresses health determinants at multiple ecologic levels to strengthen individual knowledge and skills; enhance social networks and supports; change organizational practices; mobilize communities; and influence policy.

By redesigning an approach to community perinatal services, focusing in the highest need populations in the State, and building community capacity and buy-in to improve birth outcomes, the NYSDOH will embark on a major effort to reducing MCH disparities. The MIH RFA will be released in 2012.

A priority of the NYSDOH is to ensure access to comprehensive family planning and reproductive health services. As stated in Section II B Needs Assessment Summary, Hispanic teen girls had a birth rate of 23.2 per 1,000, 41 percent higher than the rate for Black non-Hispanics, and more than 4 times the rate for White non-Hispanics. Chlamydia morbidity has continued to increase since reporting began in 2000 making it the most commonly reported communicable disease (HSI05). In order to decrease teen births, unwanted pregnancies, to reduce, identify and treat sexually transmitted diseases such as Chlamydia, there must increase access to reproductive health services.

New York has a rich system of providing reproductive health services to our most vulnerable population. The NYS Family Planning Program in the Division of Family Health, Bureau of Maternal and Child Health provides comprehensive reproductive health care, including contraceptive education, counseling and methods as well as counseling and testing for HIV and sexually transmitted diseases to help contain major threats to public health, to assist low income, uninsured and underinsured women, racial and ethnic minorities, adolescents and men in determining their reproductive futures and in avoiding STIs and unintended pregnancy. Fifty-one Family Planning (FP) agencies that operate 198 clinics throughout NY provided free or low cost FP and reproductive health care services to more than 71,000 teens (33,000 of these teens were between the ages of 15 and 17). The Bureau of STD Control administers STD clinics throughout NYS and oversees a significant public awareness and education campaign targeted to NY's most vulnerable individuals.

NY also has the largest School Based Health Center program in the country to serve as a safety net for the provision of primary and preventive health care in high need neighborhoods schools in NY. School Based Health Centers (SBHCs) are located in 220 schools in high need school districts across NY; 107 of the SBHCs are located in junior and senior high schools. These

SBHCs continued to provide age-appropriate risk assessment and anticipatory guidance and health education pertaining to sexual activity to enrolled students. Some of these SBHCs provide reproductive health care services on-site; others refer students to community providers of reproductive health care services when needed.

An important NYSDOH initiative is the Comprehensive Adolescent Pregnancy Prevention (CAPP) Initiative, a new initiative implemented in 2011 that integrates and replaces previous adolescent health programs that implement evidence-based sexuality education; ensure access to reproductive services; expand educational, social, vocational and economic opportunities; and, engage adults to advance community efforts to improve environments for young people. DOH was awarded funding for the Personal Responsibility Education Program initiative that focuses on implementation of evidence-based sexual health education and preparation of youth for successful transition to adulthood to reduce adolescent pregnancy. Funding through the Abstinence Education Grant Program will support a new initiative that will fund community-based mentoring, counseling and adult supervision programs designed to delay the initiation of sexual behavior among young people, ages 9-12, residing in high-risk communities. The CAPP initiative also incorporates a technology component for family planning service providers to maximize the use of information communication technologies that are appropriate and consistent with current adolescent modes of communication. The efforts are focused on improving reproductive and family planning service delivery and decreasing barriers for adolescents, raising awareness, providing information and improving clinical services. In addition, Columbia University was funded to provide statewide training to community health care providers to improve adolescent health care.

A significant goal of the NYSDOH is to streamline processes within the public health insurance programs to increase access to primary and preventive health services, especially to disparate populations. DFH staff has played an integral role in the Medicaid Redesign processes. NY continues to strive to expand enrollment in the Medicaid managed care program by requiring many of the high need populations which were previously exempted or excluded to enroll in a managed care plan. The Medicaid Managed Care Program provides an organized system of care, an accountable entity and the ability to coordinate and manage care. As part of this effort, the expedited enrollment of pregnant women into managed care will promote better management of health and psychosocial risks leading to improved birth outcomes. Work continues on several additional proposals of the MRT pertaining to the MCH population, including expanding current statewide patient-centered medical homes; Medicaid changes related to family planning, including the proposal to move the Family Planning Benefit Program, an income expansion of Medicaid eligibility approved through a Medicaid waiver, to a state Medicaid plan service; reducing inappropriate use of services such as C-section delivery and reforming malpractice and patient safety, including development of a NYS obstetrical patient safety workgroup.
DFH staff are working with OHIP on MRT proposals to enhance services to the MCH population, including development of a children's health home for coordinated, comprehensive medical and behavioral health care to children with special needs through care coordination and integration that assures access to services, improves health outcomes, reduces preventable hospitalizations and emergency room visits, and promotes use of health information technology (HIT).

Through the Medicaid Redesign process, NYSDOH is also developing an initiative to demonstrate effective and efficient use of Health Information Technology (HIT) between hospitals/health care systems and community-based health organizations to improve delivery for women and infants through use of uniform screening criteria for perinatal risks. The intent is to coordinate services, reduce fragmentation and redundancy, increase patient's access to health records and care engagement, improve quality and reduce costs. It is expected that identifying and addressing risks in a timely manner can contribute to significant reductions in MA costs while improving health outcomes.

It is clear that achieving NYS's public health and health care goals cannot be realized without addressing health disparities. The NYSDOH remains committed to collecting accurate, quality

data on the health status of populations as important prisms through which public health interventions, quality of care, utilization of health services, health outcomes and satisfaction with health care services can be assessed and compared over time. The NYSDOH will continue to develop and support initiatives that help reduce health disparities, with the goal of ensuring that all New Yorkers have access to the resources and services they need to be healthy.

F. Other Program Activities

With the exception of injuries to young children, all MCH activities fall within State priorities for the MCHBG 2011-2016 grant cycle. Injury prevention for young children continues to be a priority for the Department, however, it could not be subsumed readily under the new priorities. Department efforts to address injury prevention in children and adolescents are described in ***/2013/various performance measures.//2013//***

The Bureau of Maternal and Child Health supervises the operation of the toll-free Growing Up Healthy Hotline (1-800-522-5006 and TTY 800-655-1789). The hotline provides information to pregnant women, mothers, children and adolescents on over thirty topics, and helps to ensure access to needed maternal and child health services. It operates 24 hours per day/seven days per week, with both English- and Spanish-speaking trained tele-counselors. Answering services are contracted to the Association for the Blind and Visually Impaired, Goodwill Inc., a not-for-profit telecommunications group that specializes in community information and referral services. A requirement of the contract is that callers will be immediately connected to an information specialist, with no busy signal or answering tape, at least 94% of the time. The contractor actually achieves 98%, which is one of the best performances in the nation. In order to maximize its usefulness, the Growing Up Healthy Hotline provides services for the hearing-impaired and to people who are not English- or Spanish-speaking through the AT&T Language Line, extending access to referral services to callers speaking over twenty additional languages.
In 2011 the Growing Up Healthy Hotline provided information to 43,130 callers on a variety of maternal and child health issues, including information on eligibility for programs and the location of the nearest services. Of these, 3,391 were for provision of pregnancy-related information and services. Six percent (2,708) of calls required handling in languages other than English. Of these calls, 2,143 were from Spanish-speaking callers and 565 of the calls were in languages other than English or Spanish. Seventy-eight percent of callers were female, 19% male, and 3% unknown. There was a 20% decrease in the total number of calls to the hotline in 20109 compared to 2011 and a 30% decrease compared to 2009. It is important to note that calls to the hotline for WIC inquiries declined from 27,832 calls in 2010 to 21,001 in 2011. The reason for the decrease of 6,831 WIC calls is unknown however it accounts for 63% of the overall decrease in Growing Up Healthy Hotline calls in 2011.

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

Last year, callers requested assistance in the following areas: adult insurance 1.1%, Child Health Plus 2.2%, child/adult care food program 2.8%, dental/orthodontia 0.1%, early intervention 2.2%, educational materials 0.2%, Family Health Plus 0.8%, family planning 2.4%, farmer's market 9%, food and nutrition programs 0.7%, health department programs 1%, immunizations 0.1%, Medicaid for adults 5%, Medicaid for children 1.1%, newborn screening 0.5%, pregnancy care 7.8%, social services 2.9%, summer food program 4.3%, WIC 48.7%, WIC complaints 1.9%, and other 4%. Twelve callers asked about perinatal depression information and services.

The hotline number is published in local telephone directories and used in public information

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

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

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

G. Technical Assistance

Programs have not identified any technical assistance needs for this cycle. We do, however, reserve the option to request technical assistance as necessary during the year.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	41036806	40508072	41036806		40033023	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	336529505	337120805	144502296		62208171	
4. Local MCH Funds *(Line4, Form 2)*	313430367	323234192	301048616		271491225	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	173450785	253341008	404365207		314762086	
7. Subtotal	864447463	954204077	890952925		688494505	
8. Other Federal Funds *(Line10, Form 2)*	75196798	73646798	63259202		57643011	
9. Total *(Line11, Form 2)*	939644261	1027850875	954212127		746137516	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	70606837	67384532	47653244		37033896	
b. Infants < 1 year old	38939501	45243057	35366730		17701104	
c. Children 1 to 22 years old	109314803	110836789	127701617		93767071	
d. Children with Special Healthcare Needs	566769437	652809843	612613715		503301337	
e. Others	70749273	70444023	64329713		34804474	
f. Administration	8067612	7485833	3287906		1886623	
g. SUBTOTAL	864447463	954204077	890952925		688494505	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		270000	
b. SSDI	93713		101303		85000	
c. CISS	0		0		0	
d. Abstinence Education	0		2991440		2841809	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	1724830		900000		806338	
j. Education	50238349		23765113		23867174	
k. Home Visiting	0		0		5604010	
k. Other						
DHHS ACF	0		0		3102520	
DHHS HRSA	0		6624047		844588	
DHHS PHS Title X	0		11644517		10290042	
DHHS SAMSA	0		850000		850000	
Medicaid Match	8546452		8646452		9081530	
DHHS ACF TANF	0		4500000		0	
DHHS ACF	0		3236330		0	
HRSA	1131973		0		0	
TANF	2500000		0		0	
Title X	10961481		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011	FY 2012	FY 2013

	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	581216529	668679951	633765886		491943772	
II. Enabling Services	59929280	61322226	49755348		36683291	
III. Population-Based Services	88451645	87046529	85056641		72912918	
IV. Infrastructure Building Services	134850009	137155371	122375050		86954524	
V. Federal-State Title V Block Grant Partnership Total	864447463	954204077	890952925		688494505	

A. Expenditures

Completion of Budget Forms: Please refer to budget columns on Forms 2, 3, 4, and 5 for a summary of state, local, federal and program income as it contributes to the MCH Partnership.

Principles for Allocation: Also, please refer to the Principles for Allocation of Maternal and Child Health Services Block Grant Funds in the block grant

Historical Note: Budgeted and expended amounts are shown on Form 3 within Line 1 only based on guidance provided by HRSA in FFY 2006. The total Federal allocation is committed to program services.

Program managers prepare a report on the population served by pyramid level. Expenditure reports are generated for the appropriate period and distributions by population and pyramid level are then calculated.

For FFY09, total partnership expenditures were 1.31% less than the budgeted allocation. A number of factors contributed to this reduction: the MCHSBG allocation was $592,411 less than the application budget amount; the implementation of new and enhanced initiatives was delayed; and, NYS's response to its budget deficit resulted in state funding reductions of numerous appropriations.

/2013/For FFY11, partnership expenditures were $954,204,077, approximately 10% greater than what was budgeted. This is primarily due to the reported program income from counties for their early intervention services. //2013//

B. Budget

The FFY 2011 partnership budget is $ 864,447,463. NYS's allocation of $336,529,505 demonstrates a continued obligation of funds above our statutory maintenance of effort level from FY1989 of $58,268,752. This level of state funding budgeted includes a State Match ($3 state for every $4 federal) of $30,777,603 for the $41,036,806 of Federal MCH Block Grant funds and an overmatch of $305,751,902.

This budget reflects New York State's commitment to Title V programs and services. New York more than meets the maintenance of effort requirements of Section 505 (a) (4) and match

requirements for FFY 2011 which assures continuation of essential maternal and child health services.

Obvious variances in the FY 2011 amount from the FY 2010 amount can be attributed to increased levels of review and assessment of the populations being served and the type of service being provided by initiative; and, in light of the state's budget situation, ensuring that resources are being targeted for unmet needs. For example, the American Indian Health program, for which 50 percent of their state funding is attributable to maternal and child health, had previously been identified as "Population-based Services". Under NYS Public Health Law, the state provides for the ambulatory medical care of Native Americans living on reservations in NYS, as such, the majority of the services are "Direct Health Care". This discrepancy was identified and corrected. The Department has increased efforts to identify and match state dollars for appropriate initiatives; a result of this has been a decrease or elimination of those dollars in the MCHSBG application. Although these dollars are no longer included, the maternal and child health related services continue to be provided by the state at the same level. The re-evaluation of service delivery has resulted in a budget that more closely aligns with the FY2009 expenditures being reported.

The MCHSBG Advisory Council assists the Department in determining program priorities and is instrumental in seeking public input into the application process. The "Principles and Guidelines for the Use of Block Grant Funds", developed and revised as necessary by the Advisory Council, continues to be used. Effort is made to match funding to the level of unmet need, and to address the four layers of the MCH pyramid and the three target populations. Because funded programs often take more than one structural approach to targeted needs and populations, program appropriations are proportioned out to reflect percentage of effort in infrastructure-building, population-based services, enabling services and direct health care services. Program appropriations also take into account the "30-30-10" requirements of Title V. The State more than meets "30-30-10 Requirements" for 30% allocation to primary and preventive care to children ($13,634,547, 33.23%), for 30% for children with special health care needs ($12,467,244, 30.38%) and under 10% for administration ($2,274,958 or 5.54%) for block grant distribution.

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

The state share for MCH services is considerable, more than meeting the requirements for state match. New York State-funded programs dedicated to MCH include:

Early Intervention; Family Planning; Genetic Screening and Human Genetics; Immunization, Vaccine Distribution and State Aid for Immunization; Lead Control and Prevention, Lead Poisoning Prevention and Lead Regional Resource Centers; Physically Handicapped Children's Treatment Program; Migrant and Seasonal Farmworker Health Program; Community Health Worker; Comprehensive Prenatal-Perinatal Services Networks, Perinatal Regionalization; Statewide regional perinatal systems; Infertility services; School-Based Health Centers; SIDS and Infant Death, Child's Asthma Program, Diabetes (Type II) Prevention in Children Program, HPV

Vaccine, Growing Up Health Hotline, Healthy Mom, Healthy Babies Home Visitation Program, State HIV-related appropriations included in previous applications as match are no longer being included as those dollars are used as match for other federal grants. However, services continue to be a component of the NYS MCH related programming.

The methodology used to identify State expenditures for MCH-related programs has also not changed from prior years:

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

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

Federal sources of MCH targeted dollars other than the block grant included: Centers for Disease Control and Prevention (Lead, Immunization, Public Health Information Infrastructure; Oral Health), Department of Education, IDEA Part C; Family Planning Title X; STD/fertility; SPRANS Grants; HRSA -- Ryan White HIV/AIDS Treatment Modernization Act of 2006; Oral Health; SSDI Funds; TANF Funds; Early Childhood Comprehensive Systems planning grant.

/2013/The FFY2013 partnership budget is $688,494,505. While this is 27.8% less than FFY2012, the commitment to support MCH services in NYS continues. The state's allocation of $62,208,171 meets the statutory maintenance of effort level, $58,268,752, and the match requirement of $30,024,768 ($3 state for every $4 federal) for the $40,033,023 grant anticipated for FFY13. The overmatch reflected in this application is considerable less than previous years however the state's funding for the MCHS initiatives remains fairly consistent.

The 27.8% difference in the FY2013 and FY2012 amount is attributable to two changes: (1) the department's efforts to maximize funding by identifying initiatives eligible for match funding resulting in a decrease in the overmatch demonstrated in the grant; and, (2) changes in reimbursement to the counties for general public health services. The department reimburses counties for defined basic health services at a prescribed percentage of the county's net cost. Until June 2012, counties were also reimbursed for certain optional services. As a result of the elimination of optional service reimbursements, state aid funding will decrease and fiscal information from counties on the optional services cost will no longer be collected.

For FFY13, NYS will continue federal MCH funding for the following initiatives: American Indian Health Community Health Workers, Asthma Coalitions, Children with Special Health Care Needs including Physically Handicapped Children's Diagnostic and Evaluation Program, Community-Based Adolescent Pregnancy Prevention, Family Planning, Genetics Program and Newborn Metabolic Screening, SUNY School of Public Health MCH Graduate Assistantships, Health Communications, Child Mortality Review, Lead Poisoning Prevention, Migrant and Seasonal Farm Worker Health, Dental Technical

Assistance Center, Osteoporosis Prevention, Parent and Consumer Focus Groups, Public Health Information/Community Assessment infrastructure, Preventive Dentistry Initiatives, Dental Residency, Dental Supplemental Fluoride Program, School-Based Health Centers, STD Screening and Education; and, Diabetes Prevention in Children.

The following NYS funded initiatives continue to be included in the MCHS budget for FFY13: Assets Coming Together for Youth (ACT) Center of Excellence, Childhood Asthma, Childhood Lead Poisoning Prevention including Safe Housing and Resource Centers, Comprehensive Adolescent Pregnancy Prevention, Family Planning, Genetic Services, Healthy Heart, American Indian Health, Maternal Mortality, Migrant Health, Osteoporosis Prevention and Education, Physically Handicapped Children's Treatment, School-based Health Centers and Keeping Kids Alive/Sudden Unexplained Infant Deaths.

As in prior years, additional state funded initiatives have been identified as potential sources to leverage increased funding for dwindling resources and increasing needs. For FFY13, the following initiatives are not included in the MCHSBG application budget but continue to be NYS funded and remain a component of the state's maternal and child health services: HIV related counseling and testing, Early Intervention, Community Health Worker Program, Comprehensive Prenatal Perinatal Services Networks, "Growing Up Healthy" Hotline, Perinatal Regionalization, Statewide Perinatal Data Systems, Healthy Mom Healthy Babies Home Visiting, Nurse Family Partnerships, Immunization, Infertility and General Public Health Work support to counties. Collectively, the state appropriations for these initiatives total approximately $243 million. //2013//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.