

B. Five Year Needs Assessment Document

1. Process for Conducting Needs Assessment

Goals and Vision

The Department's goal in the need assessment process is to comprehensively review the needs of the MCH populations; to examine existing program priorities and realign those priorities to address new identified needs to the extent that resources permit; and, to clearly assess performance related to program priorities to ensure MCH programming results in real improvement in the health and well being of the MCH populations in New York State. This review includes not only MCH programming supported by federal MCH funding, but also the substantially greater MCH programming that is supported by state funding. In addition, the Needs Assessment is an important resource for information for stakeholders and consumers interested in MCH services in the state, providing comprehensive quantitative and qualitative information regarding the state's MCH programs and performance. As a result, in the past, New York State has produced and updated some components of the needs assessment on an annual basis, particularly quantitative data, in support of the informational needs of the MCH community.

Leadership

The DOH team developing the five year needs assessment was lead by Barbara McTague, Director of the Division of Family Health and the State's Title V Director. Ms. McTague was assisted in this role by Wendy Shaw, Associate Director of the Division. Both Ms. McTague and Ms. Shaw have decades of experience in management of a wide variety of MCH programming. Additional members of the leadership team included the following individuals:

- The MCHBG Advisory Council provided significant guidance, especially in the area of establishing state priorities.
- New York's Title V program relies heavily on the Department's Public Health Information Group (PHIG) in development of the annual needs assessment. Under the guidance of the Director of PHIG, Michael Medvesky, Pamela Sheehan provides her considerable analytic skills to development of updates to data from a wide variety of data sets.
- Helen Burmaster, the Title V Coordinator assisted in coordinating meetings of the MCHBG Advisory Council and assignments related to development of the needs assessment and of the MCH needs assessment survey.
- Robert Walsh, a part-time employee of the SDOH with substantial MCH and data analysis experience, assisted in development of significant areas in the needs assessment, including the analysis efforts related to the MCH needs assessment survey.
- Additional members of the management team of the Division of Family Health included Dr. Marilyn Kacica, Director of the Division's Office of the Medical Director, Dr. Rachel Delong, Director of the Department's new Bureau of Maternal and Child Health, Dr. Jayanth Kumar, Acting Director of the Bureau of Dental Health, Bradley Hutton, Director of the Bureau of Early Intervention and Susan Slade, who directs the program area which includes the Division's Children with Special Health Care Needs (CSHCN) program. The management team provided information related to how the needs assessment cycle, from

identification of need to identification of priorities and efforts to achieve those priorities, is addressed within their program areas.

- Other DOH internal partners provided information regarding MCH programming within their purview.
- DOH Executive staff reviewed and provided input into the MCH needs assessment and application.

Methodology

Needs assessment of the maternal and child health population is a continuous and ongoing process, and is one that is critical to developing and updating priorities and monitoring progress of programs. Stakeholder input, related to the five year needs assessment, as well to specific MCH populations and program areas, provides an additional and often uniquely compelling perspective on the needs of the MCH population. Analysis of data from a wide variety of sources, including MCH Program data, provides a substantial window on needs of the MCH population, both for the state overall, and for specific populations or geographic areas. Finally, programs providing services to MCH populations have undergone their own strategic needs assessment cycles, from assessment of need and capacity, to identification of priorities, developing program plans and performance measures to address those priorities and identifying or reallocating resources to implement the plans. All of these methods of assessment were incorporated in the Department's needs assessment process and were synthesized to develop the state's priority needs. This process is described in detail below.

Stakeholder 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, NYSDOH 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 Title V Block Grant Application include the following:

- The Department's Prevention Agenda development process;
- A survey of stakeholders related to MCH needs and priorities;
- Regional forums for youth/young adults with special health care needs and families of children with special health care needs;
- A survey of families of children with special health care needs and youth representatives;
- Focus groups with adolescents and their families;
- MCHBG Advisory Council discussions related to MCH needs and priorities; and,
- Incorporation of local level stakeholder input to inform the state level assessment, including structured listening sessions with:
 - the MCH committee of the New York State Association of County Health Officials,
 - Comprehensive Prenatal-Perinatal Services Networks (CPPSN); and,
 - the New York City Department of Health and Mental Health, Bureau of Maternal, Infant and Reproductive Health (BMIRH).

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

In addition, to the specific efforts described above that provided public input related to MCH needs and priorities, the Department has a significant number of regular mechanisms to obtain public input related to MCH program 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 below.

Summary of Public Comment

A summary of the needs assessment (See Appendix A attached) and a list of new state priorities and performance measures was sent to key stakeholders for final input. The summary was sent to the MCH Committee of the New York State Association of County Health Officials (NYSACHO), Comprehensive Prenatal-Perinatal Services Networks and to members of the MCHBG Advisory Council. Comments were received from ten perinatal networks and from four members of the Council. For the most part, the comments indicated that the needs assessment was comprehensive, and that the new State priorities appropriately reflected the highest priority MCH concerns in New York State. Additional specific comments are as follows:

- One commenter appreciated that low birth weight versus infant mortality was selected; it was hoped that New York State will help move the federal government to consider using low birth weight and prematurity as the indicators for future Healthy Start Funding.
- One commenter expressed concerns about overreliance on survey results for selection of priorities, although it was pointed out that there were significant other venues for public input.
- One commenter indicated that she was delighted to see exclusive breastfeeding for 6 months as a state priority. The same commenter questioned if the late preterm birth measure could be combined with Priority 3 related to health disparities. While we concurred that there are health disparities in late preterm birth was three, we included late preterm birth as an outcome measures due to its negative impact across racial ethnic groups.
- One commenter expressed the concern that the maternal mental health system of care is somewhat fragile in New York State and identified the need to do more work to strengthen the maternal mental health system of care, potentially through use of Title V funds.
- One commenter felt that it was important to reference home visiting in Priority 1 related to prenatal care.
- One commenter responded positively that oral health was again in the top ten priorities but indicated that preventive oral treatment of children starts with oral care for the pregnant mother, and that WIC, MOMS and Medicaid prenatal programs need to take a more active part in the solution of the problem.

New York State Prevention Agenda

In April, 2008, Commissioner Daines launched the Prevention Agenda for the Healthiest State, establishing 10 statewide public health priorities with an emphasis on prevention strategies. The Prevention agenda was a call to action, asking hospitals, local health departments, and other health care and community partners to collaborate in planning to bring about measurable progress toward mutually-established goals related to two to three of the priorities. Across all the

priority areas, the Prevention Agenda focuses on eliminating the profound health disparities that impact racial and ethnic minorities. The public health priorities include:

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

Local Health Departments (LHDs) recorded their efforts in Community Health Assessments (CHA) and Municipal Public Health Service Plans (MHSP), which were submitted to the Department in July of 2009 as part of requirements for receipt of state funding through Article 6 of the NY Public Health Law. Hospitals submitted their Community Service Plans (CSP) in mid-September, 2009. With input from community members and stakeholders, two or three Prevention Agenda priorities were selected for community action and a plan was developed. By coordinating their needs assessment and program planning activities, all participants will be better able to meet the needs of their communities while avoiding duplicative efforts and achieving economies of scale. The goal is for local health departments and hospitals to develop shared visions of what must be addressed.

A special section of the Department's public Web site has been designated to support the Agenda and the needs of partners in their effort. Key indicators with measurable five year objectives were established to track progress. Visitors can access recent statistics, information about evidenced based programs and best practices in each area, as well as information related to cost effectiveness. A new data source called the Prevention Quality Indicators (PQI) was used in many of the assessments. These are a set of measures developed by the federal Agency for Healthcare Research and Quality (AHRQ) to assess the quality of and access to outpatient care for ambulatory care sensitive conditions. The PQI provided invaluable zip code level information that enhances collaborative efforts. Detailed information about the Prevention Agenda can be found at: http://www.health.state.ny.us/prevention/prevention_agenda/index.htm. A highly successful follow up meeting was held with counties to provide them with additional information related to evidence based approaches and best practices to move forward with Prevention Agenda implementation.

While all the above public health priorities are important to the health and well-being of the MCH population targeted by the Title V program, the "Healthy Mothers, Healthy Babies, Healthy Children" priority is most immediately relevant, and the needs assessments produced by local health departments and hospitals that selected this priority will provide a central focus for our efforts to understand the nature and extent of locally-determined needs. To measure progress toward improvements in this priority area, the Department has identified a range of important health status measures that will be employed by communities as a starting point for the development of locally-appropriate performance targets:

Indicator	Prevention Agenda 2013 Objective	US	NYS	White non-Hispanic	Black non-Hispanic	Asian non-Hispanic	Hispanic
HEALTHY MOTHERS/ HEALTHY BABIES/HEALTHY CHILDREN							
% early prenatal care (1 st trimester) ⁵	90%†	83.9% (2005)	75.4% (2005)	77.0% (2004)	60.9% (2004)	66.9% (2004)	64.4% (2004)
% low birthweight ⁵ births (<2500 grams)	5%†	8.2% (2005)	8.3% (2005)	6.7% (2004)	12.9% (2004)	7.6% (2004)	7.4% (2004)
Infant mortality (per 1,000 live births) ⁶	4.5†	6.9 (2005)	5.8 (2005)	4.6 (2004)	11.1 (2004)	3.4 (2004)	4.5 (2004)
Increase % of 2 year old children who receive recommended vaccines (4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 HepB) ⁷	90%	80.5% (2006)	82.4% (2006)	84.3% (2006)	NA	NA	80.3% (2006)
% of children with at least one lead screening by age 36 months ⁸	96%	-	77% (NYS excl. NYC) (2002 birth cohort)	NA	NA	NA	NA
Prevalence of tooth decay in 3 rd grade children ⁹	42%†	53.0% (2004)	54.1% (2004)	NA	NA	NA	NA
Pregnancy rate among females aged 15-17 years ¹⁰ (per 1,000)	28.0	44.4 (2002)	36.5 (2005)	14.5 (2004)	71.0 (2004)	11.6 (2004)	70.4 (2004)

Because they planned together, hospitals and local health departments tended to pick the same four key priorities: Access to Quality Health Care, Chronic Disease, Physical Activity and Nutrition and Tobacco Use. Response to the Healthy Mothers, Healthy Babies, Healthy Children Priority was more limited with 35 counties or collaborating counties and 19 hospitals collaborating around this priority. This was discussed with the members of the New York State Association of Counties MCH Committee. The members of that committee indicated that the MCH arena was a major priority, and that they felt that MCH issues were subsumed in larger categories, for example, obesity. In some cases, MCH committee members indicated that while MCH issues were of high priority for them, entities with which they collaborated related to selecting MCH priorities might have had other priority concerns. However, taken together, the responses for the above major priority areas provided substantial input related to local MCH needs.

Maternal and Child Health Service Block Grant Needs Assessment Survey

One of the many elements for the needs assessment strategy for the 2011-2016 program periods was to develop a better understanding of key informants' views on current MCHSBG priorities and the issues and problems that confront the three MCHSBG target populations: pregnant

women, mothers and infants; children and adolescents ages 1-21; and, children and youth with special health care needs. It was determined that a tightly-framed internet survey could obtain useful and cost-effective feedback to help inform decisions regarding the priorities and issues that should be addressed over the next five years. Survey methods and results are discussed below.

Identifying Stakeholders to Participate in the Survey

The first step in the survey development process was to identify a pool of potential respondents with in-depth knowledge of MCHSBG target populations and experience in meeting their needs. In September, 2009, all Bureau Directors within the Division of Family Health, the Directors of other Divisions within the Center for Community Health, and program contacts within the Wadsworth Laboratories and elsewhere in the Department were requested to provide a list of stakeholders who should be involved in our needs assessment process and subsequent planning. From an exhaustive list of potential stakeholders obtained from these sources, a workgroup composed of the DFH Director, Associate Director and DFH Bureau and Office Directors selected 183 whose input was viewed as essential.

The stakeholders selected for the survey included the Commissioners and Directors of all 58 county and city health departments, the 10 members of the MCHSBG Advisory Council, the state's 15 regional perinatal centers and 16 perinatal networks, 23 advocacy groups such as the March of Dimes and the Health Care Association of New York, 12 professional organizations like the American Congress of Obstetricians and Gynecologists, the American Academy of Pediatrics and the NYS Dental Association, 4 health foundations, 12 American Indian Nations, 10 universities and 6 consumer groups. In addition, the survey was sent to 16 Department staff and 5 other state agencies. A complete listing of survey addressees is provided in Appendix I.

Developing the Survey Instrument

A prime consideration in the design of the survey instrument was to ensure ease of completion to maximize return rates from the busy professionals to whom the survey was addressed. We reviewed a large number of surveys employed by other state MCH agencies and consulted several to obtain the benefit of their experiences. After further review and discussion, the Department workgroup determined that the best survey approach would be to ask stakeholders to rank the Department's current ten state MCHSBG priorities, and then to select five particular issues or problems they felt impacted heavily on each of the three MCHSBG populations. The survey instrument provides a lengthy list of issues for each population group and offered participants the opportunity to identify issues that were not included among the list. A wrap-up question at the end of the survey asked respondents to identify emerging issues not addressed elsewhere in the survey. The instrument was tested by NYSDOH staff for ease and speed of completion prior to release. A copy of the survey tool is located in Appendix II.

Conducting the Survey

An e-mail was sent to each survey participant with background information on current federal and state MCHSBG priorities, links to DOH information resources, including our 2010 MCHSBG Application, and a request to click on a link to the Department's Survey Monkey web site, <https://www.surveymonkey.com/s/BNYLBG5>, to begin the survey. After a reminder e-mail was sent to improve response rates, the survey was closed. When results were first tabulated, it was recognized that additional follow-up would be needed to improve response rates among

certain stakeholder classes, particularly local health departments, so the survey was reopened with another e-mail request to the stakeholder list. The survey was closed again. A copy of the survey e-mail solicitation is included in Appendix III.

Results of the Survey

All told, 234 survey responses were received, 207 of which were determined to be complete and subject to analysis. Responses exceeded participant invitations because a number of consumer group contacts shared the survey solicitation with other individuals, mainly parents of CSHCN, and a few county health departments shared the invitation within their agencies, so that multiple staff participated in the survey. When the responses were sorted, it was possible to estimate response rates for two key stakeholder groups to assess representativeness. Fully 89% (52/58) of county and city health departments responded, with 56 individual respondents representing them. Of the ten members of the MCHSBG Advisory Council, seven returned complete surveys. Below we compare and contrast the responses of these stakeholder groups with those of the total survey population to determine if there are significant response differences that need to be accounted for in our analysis of results.

Ranking of NYS MCHSBG Priorities

Survey participants were provided a list of the current MCHSBG priorities as they are stated in last year's application:

New York State MCHSBG Priorities

1. To improve access to high-quality health services for all New Yorkers, with a special emphasis on prenatal care and primary and preventative care, which includes attention to mental health issues and which serves those with special health care needs;
2. To improve oral health, particularly for pregnant women, mothers and children, and among those with low income;
3. To prevent and reduce the incidence of overweight for infants, children and adolescents;
4. To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality;
5. To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;
6. To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women;
7. To reduce unintended and adolescent pregnancies;
8. To ensure the availability of comprehensive genetics services statewide, including follow-up on positive newborn screening tests, specialty services and genetic counseling for affected families;
9. To reduce the rate of violence across all age groups, including inflicted and self inflicted injuries and suicides in 15- to 19-year-olds;
10. To improve parent and consumer participation in the Children with Special Health Care Needs Program, as evidenced by parent scores.

Participants were asked to rank these priorities from one to ten, with one signifying most important and ten, least important. Because these rankings are ordinal rather than interval, the aggregate results are presented as summary measures rather than true means. A lower rating average therefore signifies higher ranking of a priority. Chart 1 below, which condenses the

wording of priorities for presentation purposes, indicates that the 205 respondents who completed this question selected “Access to Health Services” as the most important priority, with “CSHCN Parent Participation” considered of least importance.

Given the tremendously different dimensions of these two priorities, this ranking comes as no surprise. What is interesting about this chart is the importance respondents gave to the need for the Department to address health disparities, in addition to our need to attend to obesity prevention, an important factor in development of chronic diseases among our young people, particularly those in minority or economically disadvantaged populations. Acknowledgement of the need to confront the problem of unintended and adolescent pregnancies is longstanding in New York State, and it is obvious that our tobacco, alcohol and substance use informational activities have kept the public health and health provider communities aware of the issue’s importance to the health of the MCH population. Given the general inattention given to oral health concerns across the country, it is heartening to see that respondents considered oral health to be among the highest priority issues that should be addressed. The relatively low priority afforded violence, asthma, genetics services and CSHCN parent participation is probably a reflection of the focus of those issues. As for genetics services, its low rating might be seen as the result of general awareness that New Yorkers enjoy among the best such services in the country. Priority rankings in the main group were constant across key stakeholder groups; consonance of results is far more apparent than differences.

Chart 1

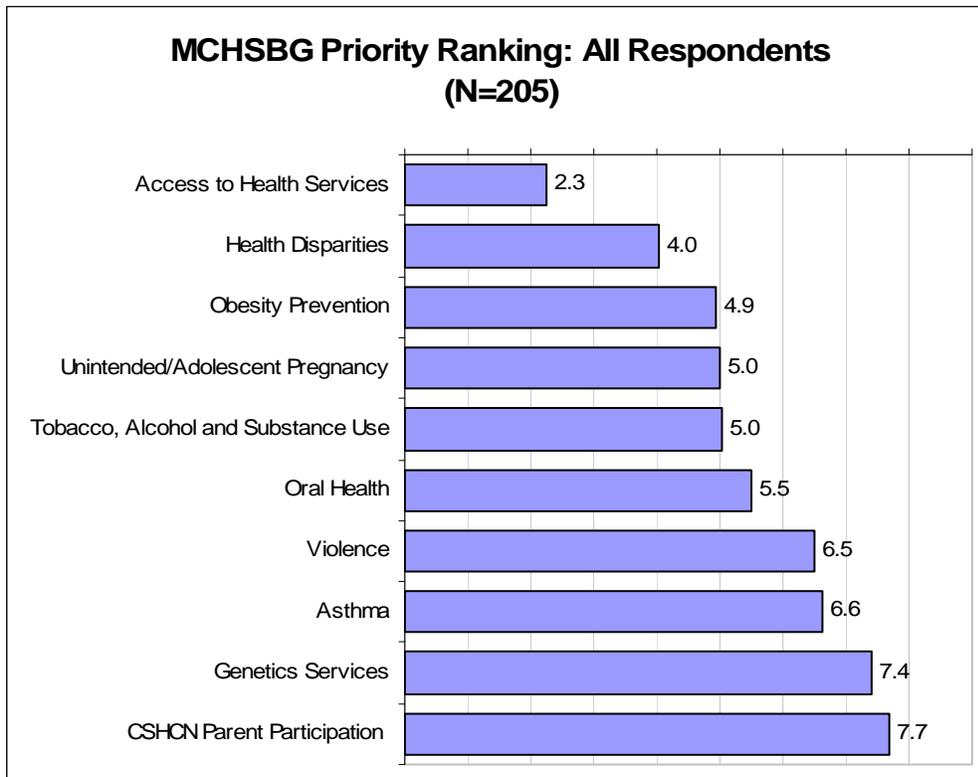
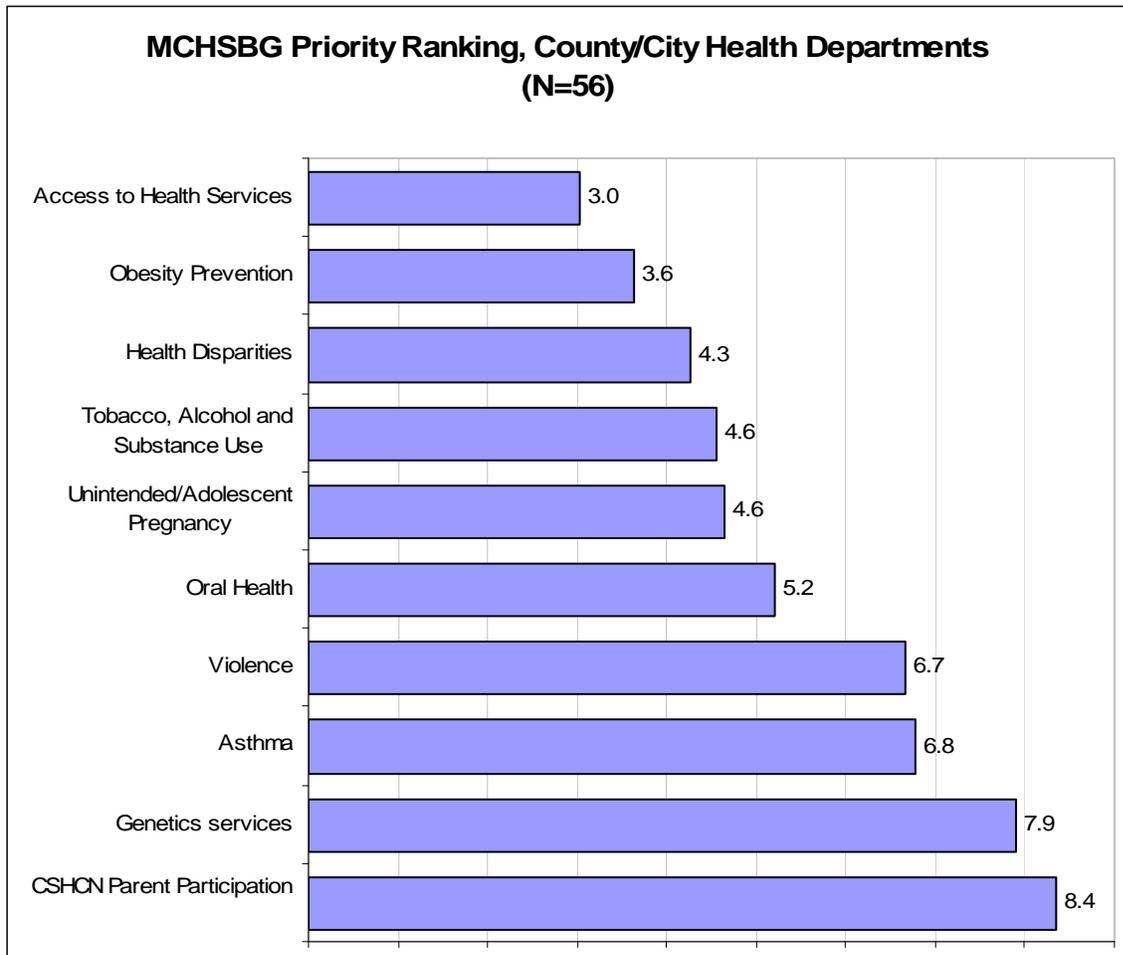


Chart 2 shows that when we restrict responses to those from County health departments and the NYC DOHMH, a very similar ranking emerges, with obesity prevention and tobacco, alcohol and substance use issues moving up slightly in importance, while the bottom four priorities remain in the same positions. County and city health department have been very busy in recent years with initiatives promoting good nutrition and greater physical activity, so their obesity prevention ranking is fully expected.

Chart 2



A slightly different pattern of priorities is noted in the responses of the members of the MCHSBG Advisory Council, as Chart 3 demonstrates below. Oral health increases in prominence, but overall, very little distinguishes the Council's ratings from those of the entire survey population, except for the fact that obesity prevention drops to sixth place among priorities. Of course, the small number of responses here means that one respondent can swing ratings dramatically, a fact that makes the similarity of these results with those of larger survey population that much more remarkable.

Chart 3

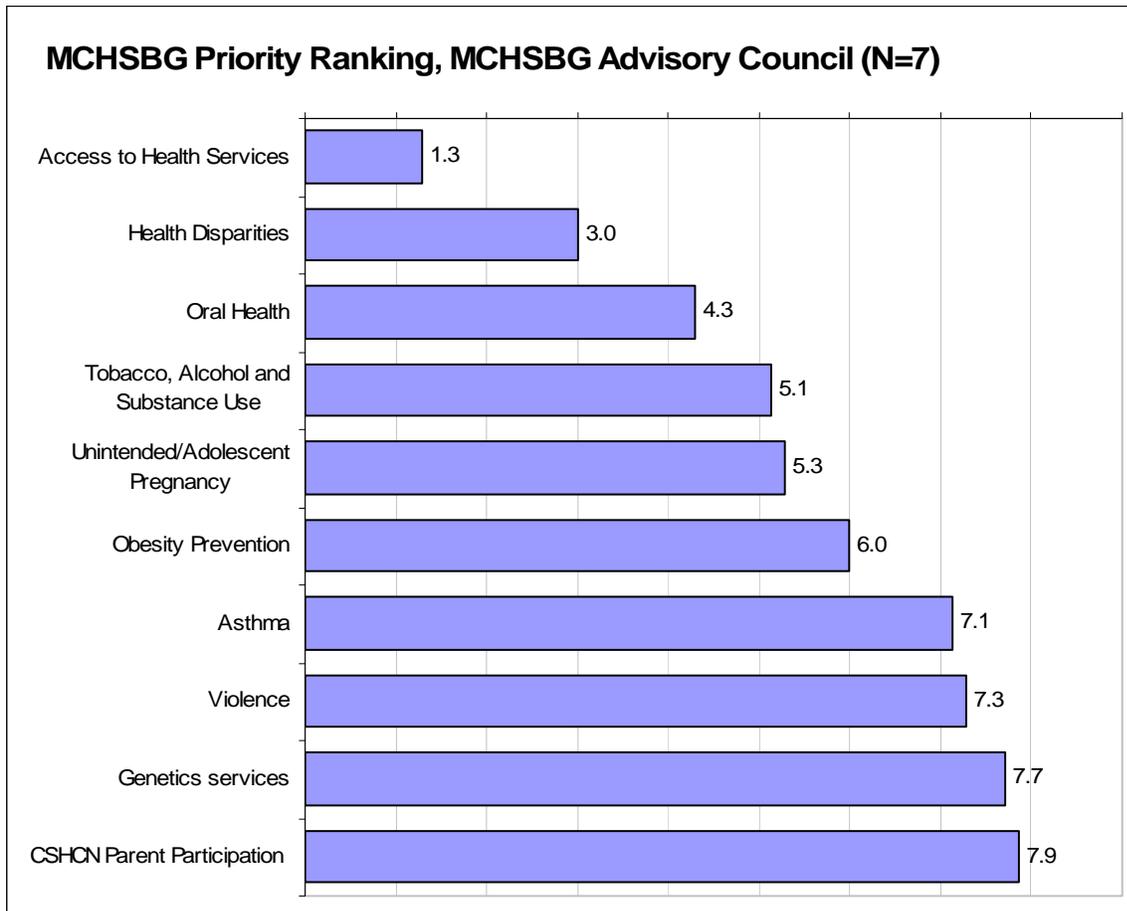


Chart 4, on the following page, reveals the priority rankings of five respondent groups that accounted for 152 of the 205 responses to this question: community-based organizations (CBOs), health care providers, MCHSBG Advisory Council members, county/city health departments and NYSDOH staff. Again, the overall pattern of rankings remains intact, with the obesity prevention priority showing the largest preference discordance among the groups. The MCHSBG Advisory Council and CBOs afforded the priority a lower ranking than did county/city health departments, health providers and NYSDOH staff, but otherwise ranking within groups reflects that of the entire survey population.

To gauge whether respondents' geographic orientation impacted results, we looked at how those representing themselves as reflecting statewide or county/borough concerns responded to the priority question. Those with a county/borough orientation were further divided into urban and rural to see if important differences arose among them. All in all, we could discern no essential differences between those with different geographic orientations.

Chart 4

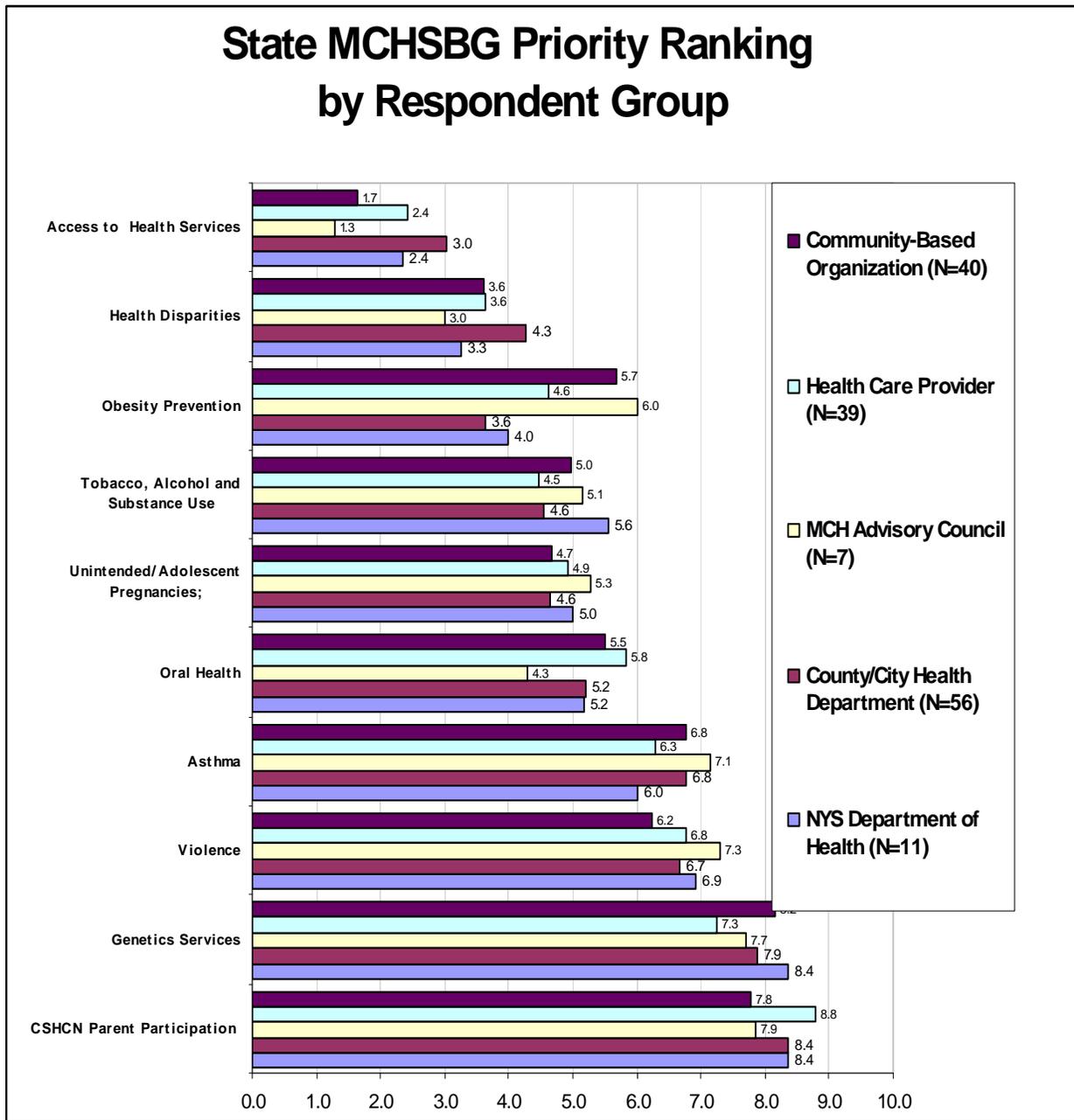
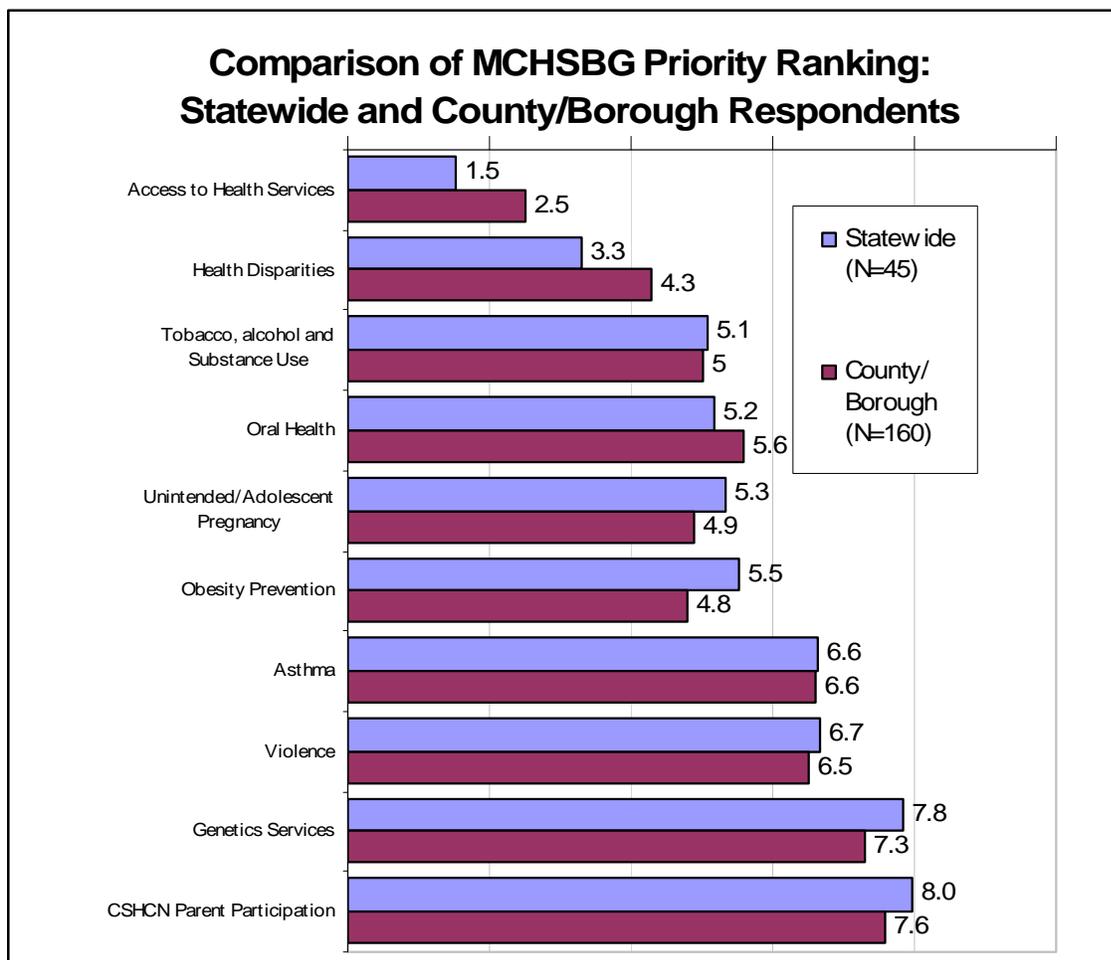


Chart 5 shows that respondents with a statewide orientation ranked access to health services very high, with an average rating of 1.5, and demonstrated elevated attention to health disparities and oral health relative to respondents who selected county/borough as their area of focus. For their part, county/borough respondents were more concerned about unintended/adolescent pregnancy and obesity prevention than their counterparts with statewide perspective. For both groups, the bottom four priorities were identical to those of the total survey population.

Chart 5



Issues Impacting the Health of MCHSBG Populations

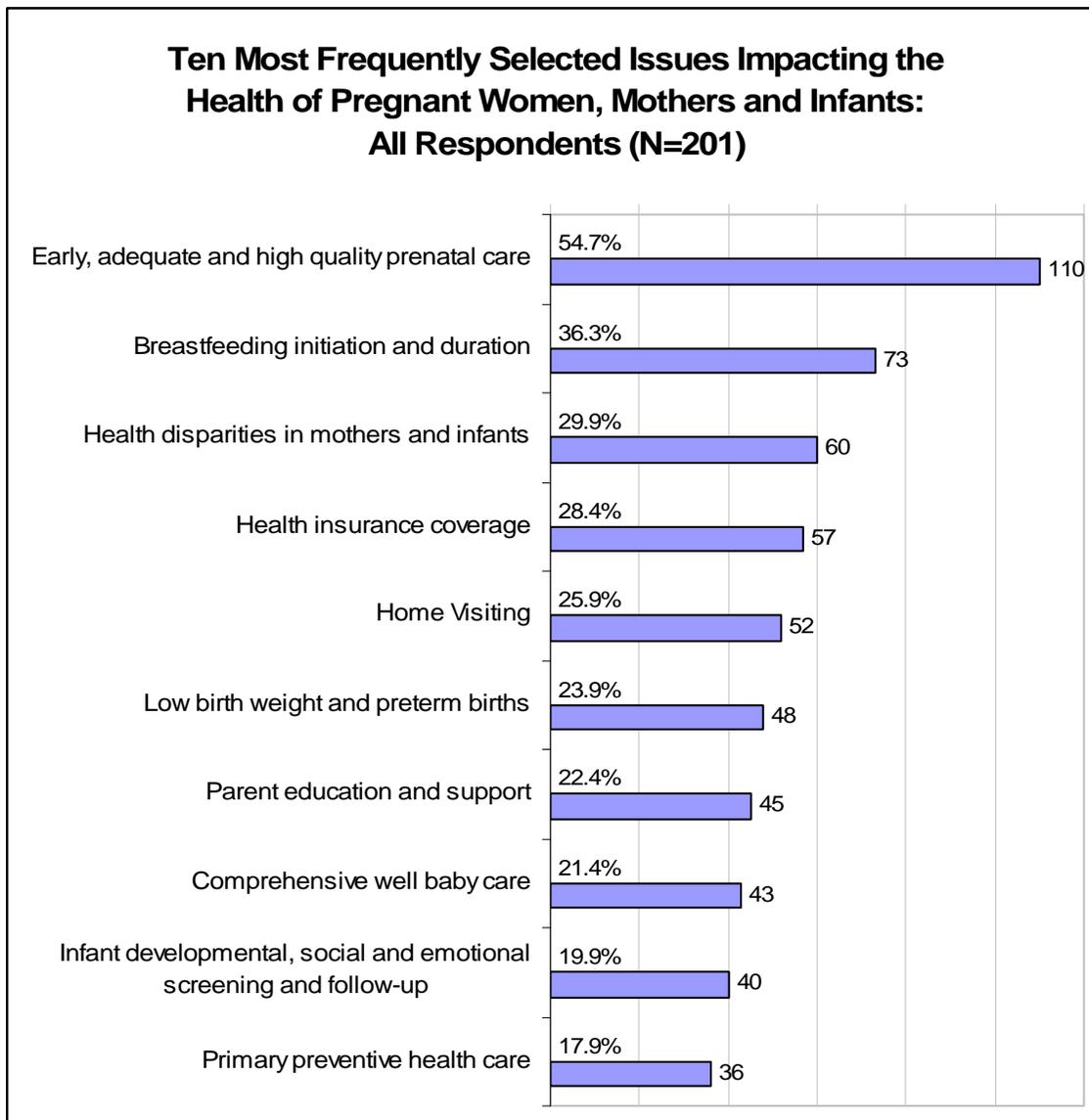
Because of the congruity of results between stakeholder groups in their responses to the MCHSBG priority ranking question, we feel confident that that the results accurately reflect the opinions of the broad survey population as well as those of the specific stakeholder groups to whom the survey was targeted. Accordingly, discussion of survey results pertaining to the importance of various issues impacting the health of the three MCHSBG target populations will be restricted to responses from the total respondent population. A principal aim with this section of the survey was to move respondents beyond the confines of the MCHSBG priority list to determine if there were important matters not addressed there, and, therefore, to help move us toward new priorities. A secondary concern was to understand whether respondents would affirm the validity of one or more of the current MCHSBG priorities. On questions 5, 6 and 7 of the survey, recipients were presented a lengthy list of issues and problems (see survey tool for details) and were asked to select the top five affecting each of the three target populations. If recipients could not find a suitable issue on the list, they were provided the opportunity to enter one for each population group. Results for the three population groups follow below:

1) Pregnant Women, Mothers and Infants

As Chart 6 demonstrates, *prenatal care* was the most frequently selected issue, with 110, or 54.7% of the 201 respondents to this question picking it among the top five impacting the

health of this population group. Other important issues selected included *breastfeeding* and *disparities*, lending support to current MCHSBG priorities. *Health insurance coverage* was the fourth most- often cited issue, and if taken together with *health insurance adequacy*, which garnered another 31 selections (but was not among the top ten) , health insurance was noted by more than 43% of respondents. Interestingly, *home visiting* was selected as one of the top five issues by nearly 26% of respondents; if combined with related *parent education and support* and *infant developmental screening*, this result lends strong support for the Department’s focus on parenting support activities of all kinds, including expansion of prenatal-perinatal home visiting services. The remainder of issues selected by respondents appears to support current MCHSBG priorities, most particularly access to health services. Seven respondents entered *Other*, but their entries either repeated issues listed or were unresponsive, addressing children with special health care needs.

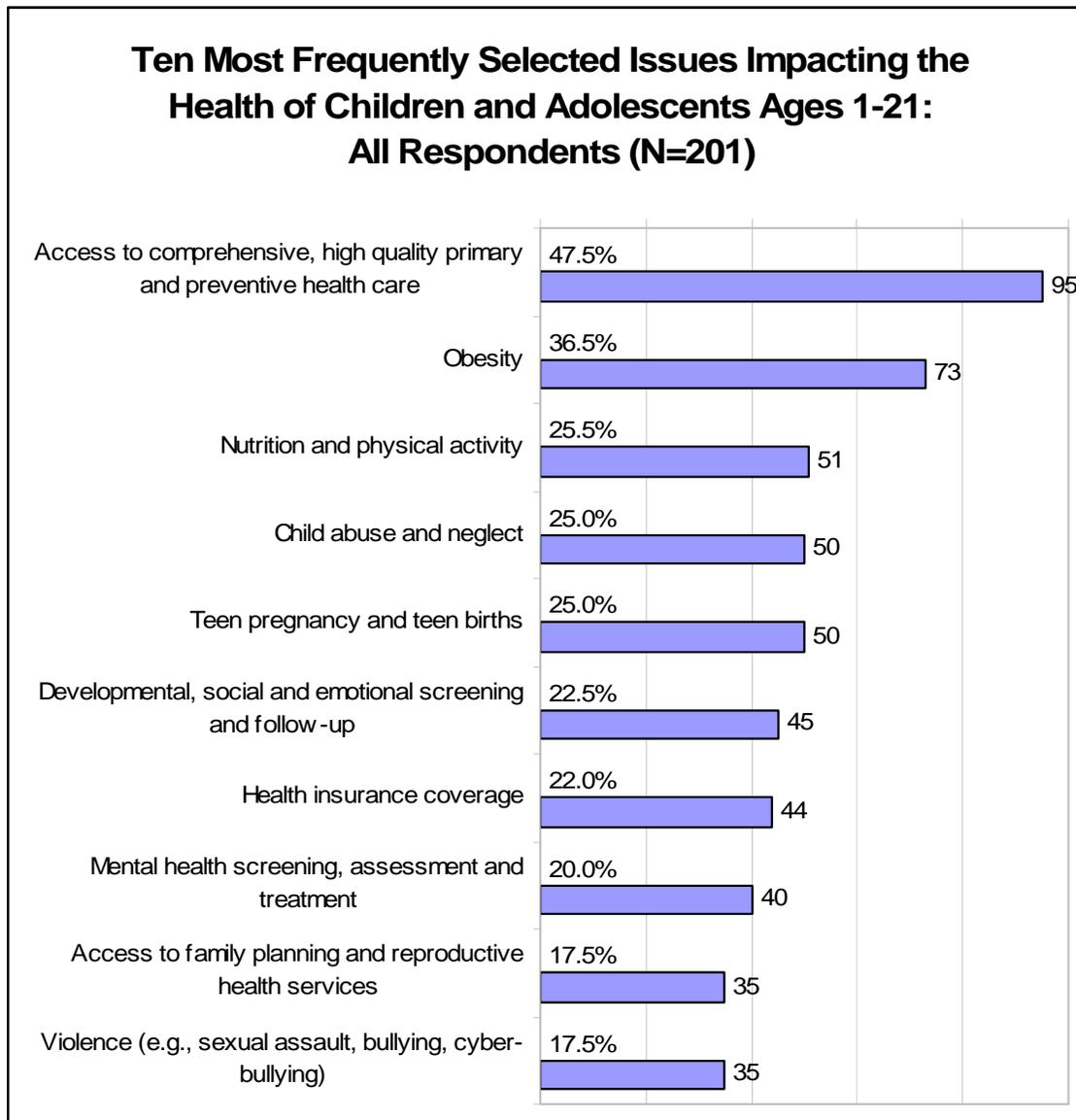
Chart 6



2) Children and Adolescents 1-21

For issues impacting the health of children and adolescents, *access to primary and preventive care* was the predominant issue for respondents, as shown in Chart 7. *Obesity* and the related *nutrition/physical activity* issues combined as top five choices of 62% of respondents. One-quarter of respondents selected *child abuse/neglect* and *teen pregnancy* as among the five most important issues, followed closely by *developmental screening* and *health insurance*.

Chart 7

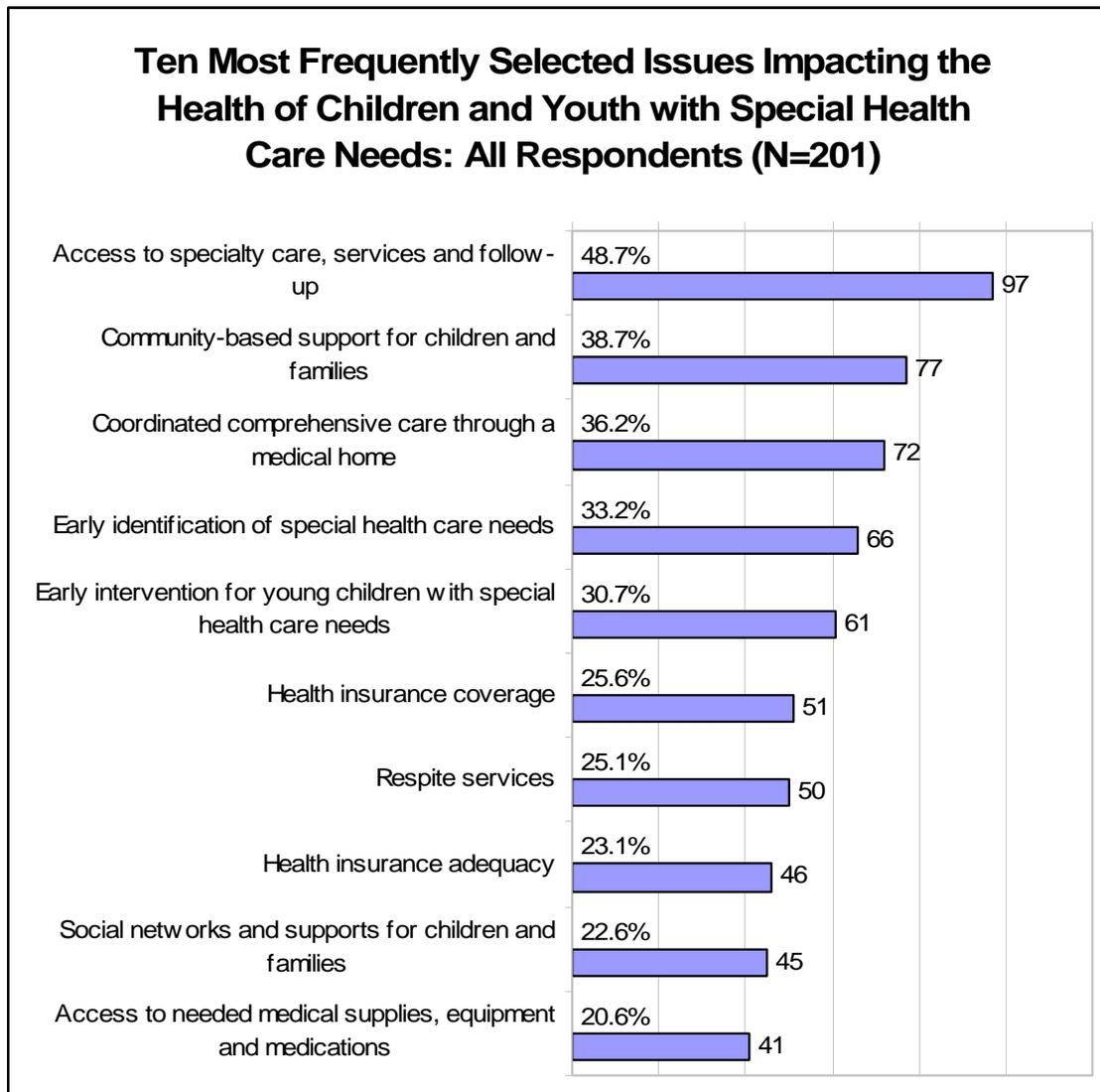


The remainder of the ten most frequently selected issues is in accord with our current MCHSBG priorities, especially those regarding *access to care* and *violence prevention*. Only seven respondents chose to offer open-ended issues, but most were unresponsive to this question, as they either restated issues listed or related to children with special health care needs, the subject of the next issues identification exercise.

3) Children and Youth with Special Health Care Needs.

Access to specialty care was the most frequently-cited issue among those responding to this question, followed by *community-based support* and *coordinated comprehensive care*, issues that affirm the results of the detailed feedback obtained from parents of clients of our CSHCN, PHC and Early Intervention programs, and provide support to our intensive efforts to ensure that all CSHCN and their families benefit from high-quality services. The remaining issues selected

Chart 8

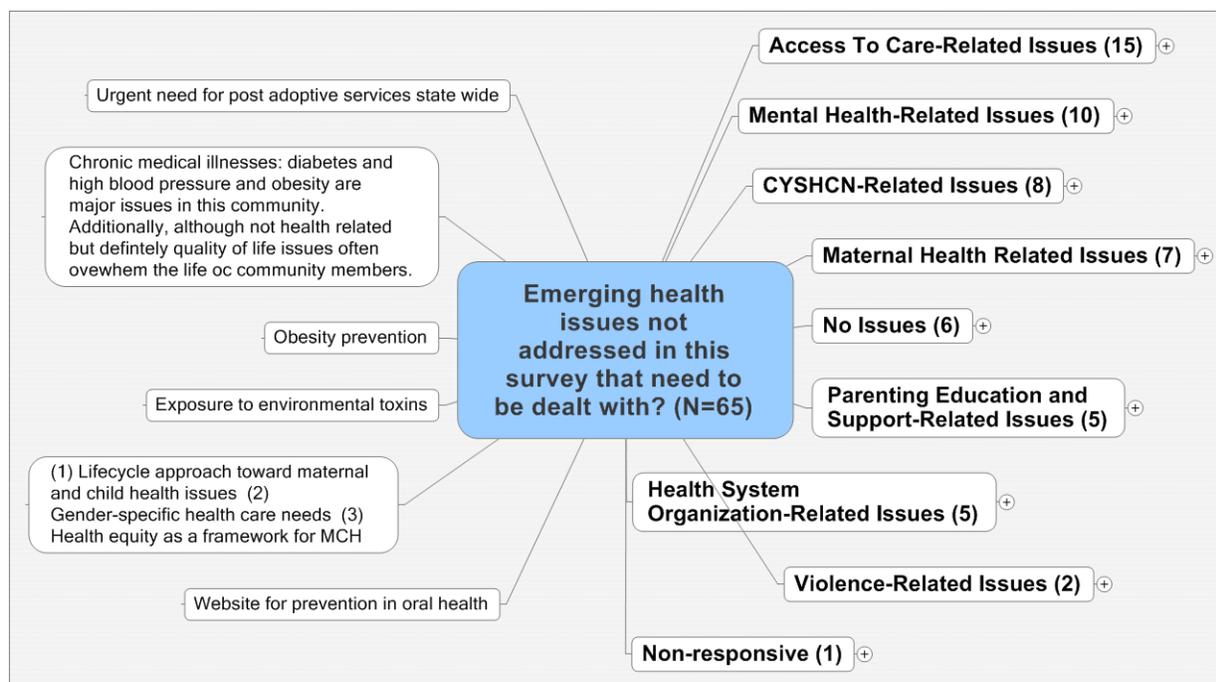


further reinforce the validity of the service strategies employed by our programs aimed at CSHCN and their families.

Emerging Health Issues

The last question of the survey asked respondents to identify emerging health issues that had not been addressed in the survey. A total of 65 responses were received and arranged into affinity groups using concept-mapping software (Mindmanager). The results are illustrated below, and a detailed review of all responses received is appended to this document. Issues related to the

many dimensions of *access to care* were foremost among those identified by respondents: concern for immigrant families was apparent, and concerns about access to primary and specialty medical providers were frequent. Lack of childbirth alternatives, including midwifery services, was cited by a number of respondents, and health insurance-related access issues were also identified.



Mental health matters figured importantly for respondents, with perinatal depression, shortages of child psychiatrists and other mental health professionals among the more common concerns. One respondent expressed concern about eligibility requirements hindering access to MH services, while another emphasized the relationship between stress and a host of adverse outcomes. Among the *CYSHCN* issues noted were problems related to the aging of children with disabilities, the lack of OB/GYN care for adolescent and young adult CYSHCN, and problems accessing quality services in rural counties. *Maternal health* concerns included maternal mortality, cesarean section rates, and environmental exposure to teratogens. *Parenting education and support* issues covered safe infant sleep practices and health literacy training needs. *Health system* concerns centered on the need for better coordination and continuity of care, i.e. horizontal and vertical integration, as well as avoidance of service duplication. *Violence* concerns covered child abuse and inter-teen violence, both addressed by the issues lists. Six responses were unique and are highlighted above.

Regional Forums for Youth/Young Adults with Special Health Care Needs and Families of Children with Special Health Care Needs

In February and March 2010, the CSHCN Program held regional forums for youth/young adults with special health care needs and families of children with special health care needs 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 (consumer partnership in decision making and satisfaction with services, medical

home, adequate insurance, organization of systems for ease of use, and transition) that are identified in the Block Grant application. Public forums for families were held in four regions of the state (Capital, Central, Western and Metropolitan). Seventeen families attended the public forums. A youth forum, in which five youth/young adults participated, was held in the Metropolitan region. A youth forum was planned in three other regions of the state; however, three of the four forums were cancelled due to lack of any youth respondents in the region. Qualitative data from the family forums was coupled with quantitative data specified in the performance indicators of the 2005-2006 National Survey of CSHCN to reflect a statewide needs assessment for children with special health care needs.

Consumer concerns raised during the forums include difficulty in obtaining Medicaid-funded transportation to doctor’s appointments; access to Medicaid enrolled providers and specialists, including primary care, dental, and mental health; health care provider and Medicaid Service Coordinators’ lack of knowledge about community resources related to special health care needs services; and, the need for additional training of these providers about the needs of these children and families. The consumers in the Central Region explained that some children are not able to utilize public transportation. Some consumers indicated the number of allowable services/visits under Medicaid for PT, OT and mental health were inadequate and others stated the need to bear out-of-pocket expenses for services and equipment not covered by Medicaid. Consumers also mentioned issues associated with the Medicaid prior approval process for durable medical equipment. Many consumers felt the coordination of their child’s care rested primarily with the parents rather than the provider. Consumers also pointed out the lack of transition resources to find adult health care, get a job, find housing and learn life skills as challenges. Peer mentoring was suggested as a possible strategy to overcome these challenges. Parents of CSHN also responded to the general survey related to MCH priorities as described above.

Survey of Families of Children with Special Health Care Needs and Youth Representatives

In addition, annually, a survey of family representatives is distributed to elicit feedback for the Maternal Child Health Block Grant application item (Form 13), “Characteristics Documenting Family Participation in the CSHCN Program”. The surveys were distributed to 17 Family Champions as well as the 17 consumer participants in the forums. Five individuals have responded (response rate of 14.7%). The raw individual scores were compiled and averaged for each of the six items of Form 13. Scores are rounded to the nearest whole number. A score of 2 represents the characteristic is “Mostly Met” and 3 indicates the item is “Completely Met”. The total score of 14 is lower than last year’s total score of 18. However, a small sample size should be viewed with caution when assessing trends in data over time. A copy of the survey is included in Appendix. The results for family participation in the CSHCN Program are as follows:

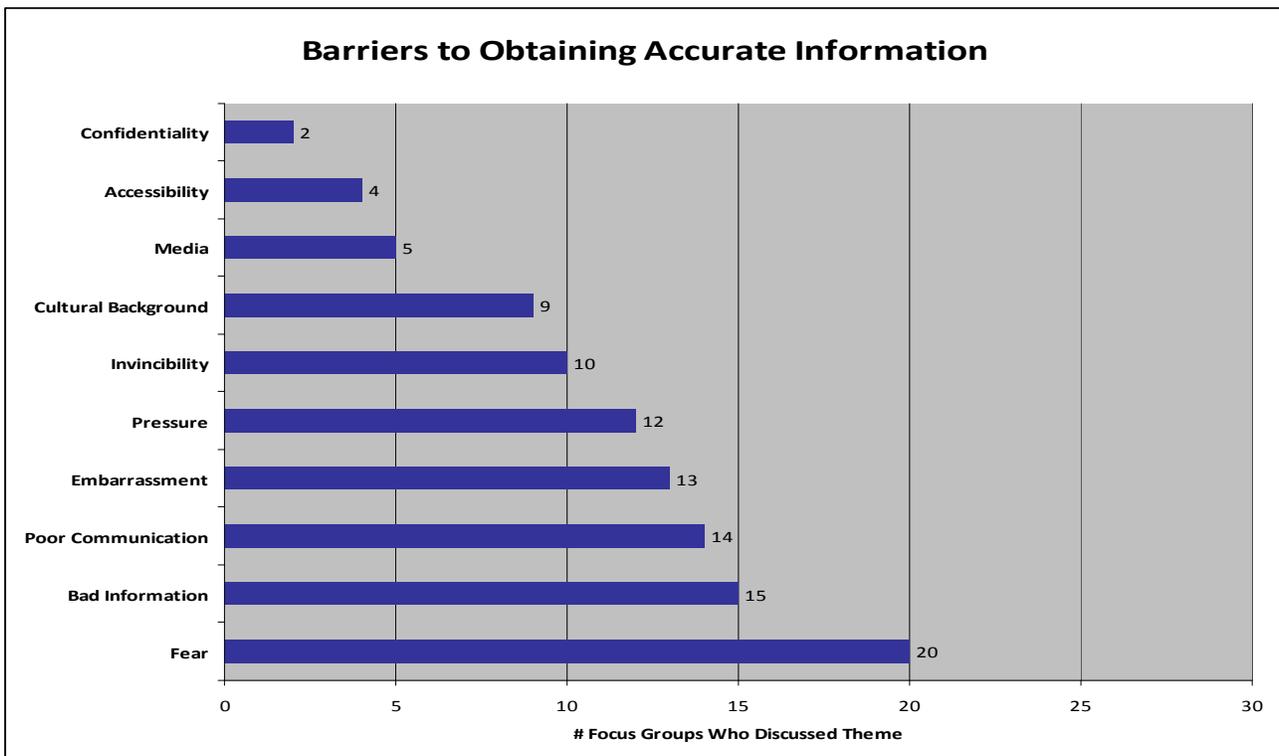
	Score
1. Family members participate on advisory committee or task forces and are offered training, mentoring, and reimbursement, when appropriate.	<u>2.2</u>
2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.	<u>2.0</u>
3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.	<u>2.2</u>
4. Family members are involved in service training of CSHCN staff and providers.	<u>2.5</u>

5. Family members hired as paid staff or consultants to the State CSHCN Program (a family member is hired for his or her expertise as a family member). 2.3
6. Family members of diverse cultures are involved in all of the above activities. 2.5

Total 13.7

Focus Groups of Adolescents and Families

In the fall of 2008 with the analysis completed and presented in early 2009, an Adolescent Sexual Health Focus Group study was conducted by the DOH-funded adolescence Center of Excellence (COE) at Cornell University (and their partners at University of Rochester School of Medicine, NYS Center for School Safety and New York City Cornell Cooperative Extension). This study was designed 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. Twenty-seven focus groups with 291 participants (age 13-21) were held statewide with consideration given to geographic and participant characteristics, including gender/gender identity and race/ethnicity.



Demographic breakdown of non-pilot group participants were 50.4% male, 48.3% female, and 1.3% transgender. Five percent of youth reported they were not currently in school, while the remaining participants were in the following grades: 8th - 3.4%, 9th - 17.6%, 10th - 18.0%, 11th - 26.2%, and 12th - 29.6%. Racial/ethnic breakdown was 25% Hispanic, 56.8% - Black, 23.5% - White, 18% - Other (includes multiracial and specific ethnic affiliations), 5.1% - American Indian or Alaska Native, and 3.4% - Asian. Participants were asked where they most commonly got their information as indicated in the chart below:

They were also asked to identify the barriers to receiving accurate information.

Recommendations included:

- Offer more extensive sexual health education, with schools identified as the most logical vehicle for this;
- Increase access to sexual health information and services, including into already existing community centers and organizations;
- Make resources more visible in the community;
- Improve communication between parents and their children by providing information to parents;
- Focus on media, such as launching a media campaign, instituting greater media controls, or developing a reliable and accessible Internet website "*that teaches everything*"; and,
- Develop a mechanism for information to be transmitted by clearly reliable sources, such as from medical professionals, speakers who easily connect with youth, and/or the Department of Health.

Many of these recommendations are being implemented through our current media campaign, the launch of [nysyouth.net](http://www.nysyouth.net), the enhanced focus on sexuality education in schools within the pregnancy prevention programming and our upcoming health care provider education. A copy of the report from the symposium is available on the ACT for Youth Center of Excellence (COE) website at <http://www.actforyouth.net/>.

The COE also conducted focus groups with parents, guardians, grandparents and other adults in NYS to assess parent needs for talking with their adolescents about sexual health and as a follow up to the focus group project with adolescents. Fifteen statewide parent focus groups were held during June 2009. Preliminary results of the groups have been released. Five groups (with 42% of participants) were conducted in Spanish. The analysis of these focus groups will determine whether the adults in the group endorsed, elaborated, and/or contradicted the youth focus group recommendations regarding what they want to ask/discuss with their parents.

Major findings from these focus groups include the need to:

- Inform parents about the normative changes in physical development that occur as their children mature through adolescence to empower them as sex educators.
- Improve parental knowledge of youths' psychosocial development to assist them to support youths' health sexual and reproductive development.
- Increase general information about STIs and HIV such as how these infections/diseases are transmitted and prevented and how to prevent pregnancy, as well as use of contraceptives including practical guidance in demonstrating how to put on a condom.
- Normalize the process in which youth develop their sexual identity, including how to "talk to children if they are confused about their sexuality".
- Emphasize the importance of teaching youth about sex in the context of healthy romantic relationships. This includes helping youth understand "the emotional elements of sex", including love, marriage, "that sex isn't just the physical act," "is serious and powerful," and can include caring, trust, and responsibility.

Input from the Maternal and Child Health Services Block Grant Advisory Council

The New York State Department of Health established the Maternal and Child Health Services Block Grant Advisory Council in 1983, following the enactment of Chapter 884 of the New York State Laws of 1982. The Council serves in an advisory role to the Department regarding the administration of funds under Title V of the Social Security Act. The Council assists the department in determining the program priorities and in soliciting public input for the preparation of annual applications.

By statute, the Council is composed of twelve individuals, six of whom are appointed by the Governor, three of whom are appointed by the Temporary President of the Senate and three of whom are appointed by the Assembly Speaker. Also by law, members are to include representatives of local government, the not-for-profit sector, and the community.

The Council members, in their advisory capacity, bring a wealth of experience, information and concern to the table. Advisory Council members carefully consider the testimony offered by individuals presenting at the meetings, and often bring new information encountered in their daily professional lives in formulating their recommendations to the Commissioner and the Governor.

Development of the Maternal and Child Health Block Grant needs assessment and application was an agenda item for several of Council meetings. In addition, a 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. The Council provided valuable recommendations related to the establishment of priorities. Members of the MCHBG Advisory Council were also asked to respond to the Maternal and Child Health Service Block Grant Needs Assessment Survey. The results are described above.

In addition, in this five year grant cycle, Maternal and Child Health Services Block Grant Advisory Council has re-affirmed its “Principles and Guidelines for the Use of Block Grant Funds.” This document has continued relevance to allocation decisions to ensure maximum benefit from New York’s allocation.

Principles of Allocation of the Maternal and Child Health Block Grant Funds
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- I. Programs must support functions and be consistent with the purposes of Title V, the Maternal and Child Health Services Block Grant.
- II. In general, MCHSBG funds must support needed functions for which adequate funds are not available through other sources. However, availability of these funds should be determined on a case-by-case basis considering criteria established below.
- III. MCHSBG funds should be targeted so as to render the greatest public health benefits while maximizing limited resources. Criteria for targeting include:
 - Identification of populations at greatest risk or need based on geographic, demographic, social, cultural and economic factors;
 - Mortality and morbidity;
 - Availability of effective and cost-effective interventions;
 - Ability to measure program outcomes; and,
 - Inadequate funding from other sources to meet the need.

- IV. These funds should be used to augment, not supplant, other funding sources and when possible, should support demonstration projects and coordination activities that can later be maintained by other funding sources.
- V. Block Grant funds should not be used to support basic research.
- VI. Block grant funds should be directed toward preventive services as much as possible. When funds must be allocated for personal health care services because of demonstrated need and lack of any other funding sources, preventive services must be incorporated into these services.
- VII. Block Grant funds should be allocated in a manner consistent with Federal and State requirements and be consistent with the Public Health Priorities of New York State.
- VIII. Block Grant funds should not be used to support established public health services.

**Incorporation of local level stakeholder input to inform the state level assessment
New York State Association of County Health Officials (NYSACHO)**

NYSACHO is the organization linking together the 58 local health departments that comprises New York's municipal public health system. Membership consists of health commissioners, public health directors, deputy commissioners, and directors of patient services from county and city health departments. Through its members and staff, NYSACHO seeks to build upon its strong collaborative partnerships with the Department and other academic and health related organizations in designing and implementing effective public health policies. As the operational arm of the public health system, local health departments understand the unique needs of their communities. As such, they are essential voices at the planning table in developing policies that are realistic, effective, and appropriate in scale. NYSACHO work is conducted through a number of standing and ad hoc committees related to different public health subject areas, one of which is related to Maternal and Child Health.

County health department response to the MCH needs assessment survey was previously described. MCH staff in the Division of Family Health conducted a telephone meeting with members of the MCH Committee to obtain additional insight related to the survey results. The meeting generally confirmed the results of the survey, including the high ranking related to access to care and the need to develop additional strategies to address access issues.

Comprehensive Prenatal-Perinatal Services Networks (CPPSNs)

The Department funds 16 CPPSNs that engage consortia of local health and human service providers and consumers to identify and address gaps in local and regional perinatal health and child health care and service delivery systems. Division of Family Health and Bureau of Maternal and Child Health staff met with staff from the Comprehensive Prenatal-Perinatal Services Networks (CPPSN) at an Association of Perinatal Networks (APN) meeting held April 20, 2010 and engaged in an active dialogue discussing current and future priorities related to perinatal health. Strengths, capacity, gaps and priorities were discussed in the context of current perinatal, reproductive and other MCH-related programs and initiatives, as well as the broader MCHBG needs assessment. The requirements of the MCHBG Needs Assessment and the MCHBG structure and service levels pyramid were reviewed as a framework for the discussion.

Through these discussions, the following themes and priorities were identified:

- The underlying importance of maintaining and strengthening community and regional infrastructure and partnerships. Comprehensive Prenatal-Perinatal Services Networks (CPPSNs) are positioned to support and further develop local infrastructure. Networks can support infrastructure and partnerships to: identify and respond to needs, both known and emerging; connect needs to resources and coordinate services; mobilize stakeholders for local action; and, establish strong communication networks and promote consistent messaging.
- Networks voiced support for an increased focus on outcome driven work and evidence-based strategies. Additional community level data, including race and ethnicity data, could support further targeting of activities. More feedback on what works will help drive ongoing improvement.
- At the same time, flexibility is important in order to identify and be responsive to emerging issues. Need to balance innovation and flexibility and a “big picture” focus with attention to specific priorities.

Access to early, comprehensive, continuous prenatal care:

- This remains a high priority, but more targeted approaches are needed to reach high-risk women and increase rates of early entry into prenatal care.
- The number of women utilizing Medicaid prenatal care programs must also be increased, and we need to ensure high-risk women are engaged in appropriate services.
- Early scheduled deliveries (inductions and C-sections) was noted as an issue of concern. Patient (consumer) education is one important component of addressing this problem.

Attention to issues of cultural competency, including urban and rural cultural differences:

- The culture in New York City and even across different boroughs within NYC may be different from upstate, especially from rural areas.
- Addressing health disparities is a priority but reaching hard-to-reach populations requires true cultural competency. Programs need to know the city, neighborhood, language barriers, and literacy levels of the populations being targeted for services. They also need to understand what target populations see as their needs and issues, and to “drill down” to qualitative information from people to understand if there is a “problem”, how it is perceived, and why it exists.

Further attention for adolescent pregnancy prevention and support for teen parents and their babies, including:

- How to meet the developmental needs of both the teen parents and their babies;
- Understanding of what is going on in communities that affects life choices related to early parenting. In some communities and cultural groups, this is not necessarily perceived as a problem. To address this effectively may require a shift in focus from pregnancy prevention to preconception/interconception care to meet people where they are.
- Programs need to address understanding relationships- what to expect from a partner, both as a dating partner and as parents. A life course approach is needed.

Further attention to child well being and special needs:

- Child abuse and neglect was identified as a critical issue that may be a gap in current MCHBG programming. Child abuse and neglect can't be unlinked from infant mortality and

morbidity. Non-punitive supportive services, preparedness for parenthood and parenting education are needed. Family violence and work to engage fathers also needs to be addressed. The importance of considering these as health issues was addressed.

The New York City Department of Health and Mental Health, Bureau of Maternal, Infant and Reproductive Health

The NYCDOHMH Bureau of MIRH had submitted their responses to the on-line survey. Staff reviewed the State priorities and Division of Family Health conducted a telephone meeting with the NYCDOHMH Assistant Commissioner BMIRH. The purpose of the call was to obtain additional insight related to NYCDOHMH concerns related to State MCHBG priorities. Information was shared regarding several major priorities of the NYCDOHMH that overlapped the current State priorities. The integration of reproductive health services into the primary care setting is imperative. This integration promotes a lifespan approach to reproductive health care by not only better ensuring improved access to reproductive health services, but in developing the linkage between primary health care and an individual's reproductive health, including management of chronic diseases that may impact later pregnancies and birth such as obesity, diabetes and other chronic diseases. This also relates to adolescent health services. Adolescent health services, including the prevention of teen pregnancy and access to quality adolescent and reproductive health services continues to be a priority. Pregnant adolescents who go on to deliver their babies have higher rates of complications and suffer economic and psychosocial impacts as a result of the pregnancy. Teenage pregnancies are associated with increased rates of alcohol and substance abuse, lower educational level, and reduced earning potential in teen fathers.

Ensuring access to mental health services, especially for pregnant and parenting women is essential as well. Mental health services are not always readily available for this population and can have significant impact on both maternal and infant well being.

The promotion of exclusive breastfeeding is also a priority of the NYCDOHMH as breastfeeding has been demonstrated to have significant health benefits for the mother as well as the infant. Through ongoing public awareness and promoting exclusive breastfeeding in the hospital setting, the goal is to encourage all women to breastfeed their infants exclusively for at least the first six months of age. Significant challenges still exist for breastfeeding support for women following discharge from the hospital.

Obesity is of course a significant public health issue requiring attention on many levels as it is a complex issue requiring behavioral change as well as access to healthy foods and increase physical activity.

Finally, the maternal mortality review process in New York City continues to raise the significance of public health issues, such as obesity and chronic disease, and its impact on birth outcomes.

The Assistant Commissioner added that she believes that the partnership between the NYCDHMH and the State Department of Health has never been stronger and is encouraged with

our ongoing work on issues such as adolescent health, breastfeeding and now, maternal mortality.

Other Efforts to Obtain Input into MCH Service Delivery

The Department, as the Title V agency, has been very successful in coordinating with other state agencies that serve the MCH population such as the State Education Department, the Office of Children and Family Services, the Office of Temporary and Disability Assistance, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Office of Alcohol and Substance Abuse Services, among others. In addition, the Title V program has been particularly effective in working with the Department's Office of Health Insurance Programs and Office of Health Systems Management to ensure access to comprehensive, high quality services that are appropriately reimbursed. The following are examples of the Department's ongoing efforts to obtain input into MCH service delivery.

The Early Childhood Comprehensive Systems

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

This emphasis on a broad range of stakeholder input and involvement has continued and expanded through the state's Early Childhood Advisory Council (ECAC). A subgroup of the Governor's Children's Cabinet, the ECAC includes over 40 individuals with early childhood expertise who represent early care and education, health care and public health, child welfare, and mental health programs, as well as state agencies, advocacy organizations, foundations, higher education, unions, and others involved in the provision of services to young children and their families. Through its organizational structure, which includes a steering committee, general membership and several workgroups, there are many opportunities for members to engage and provide meaningful, ongoing input. Specific projects linked to the ECAC, including the current Project LAUNCH initiative, have further expanded stakeholder networks. Project LAUNCH, which involved substantial coordination with the State's Office of Mental Health, specifically brings the perspective of a rich and growing network of local stakeholders in Westchester County, including local health and mental health agencies, community health centers and other health care providers, early care and education providers, family support specialists and families.

The ECAC is currently considering additional ways to seek and incorporate family and consumer input in its work.

Perinatal Health

The Title V staff in the Division of Family Health worked collaboratively with the Department's Office of Health Insurance Program (OHIP) to craft the new legislation related to the delivery of Medicaid reimbursed prenatal care, and, during 2008-2009, worked with OHIP and internal and external stakeholders to develop updated prenatal standards of care for all pregnant women enrolled in Medicaid. The Title V program also continues to work closely with OHIP to implement and monitor the new law. This effort is further described in Section 3 of the needs assessment.

In 2009, the Division of Family Health, in collaboration with the National Initiative for Children's Health Care Quality and the RPCs, launched the New York State Obstetric and Neonatal Quality Collaborative (NYSONQC) to improve maternal and neonatal outcomes and eliminate disparities. Through NYSONQC, Regional Perinatal Centers, the highest level hospitals in NYS related to the provision of perinatal care, will implement quality improvement interventions designed to improve maternal and newborn patient safety. The goal of NYSONQC is to bring together leaders in perinatal health to partner to explore opportunities to use evidence based information to improve patient outcomes.

The Association of Perinatal Networks (APN) is an organization of the 18 perinatal networks (16 funded by NYSDOH) serving New York State. Its mission is to improve perinatal, maternal and child health throughout New York State, and to support the work of the individual perinatal networks. CPPSNs engage consortia of local health and human service providers and consumers to identify and address gaps in local and regional perinatal health care and service delivery systems. The APN meets quarterly, with the Department staff attending and providing informational updates with dialogue related to specific issues. At a recent meeting, the APN provided input for both the MCHBG application and the home visiting needs assessments the Department is completing.

Childhood Obesity Prevention

A number of opportunities for stakeholder input on strategies for childhood obesity prevention have been utilized. Both the Division of Nutrition and the Division of Chronic Disease and Injury Prevention within the Department of Health solicit input related to childhood obesity prevention from such stakeholders as program contractors, statewide associations, child care providers, schools, the health care community, public health agencies and the community-at-large. The New York State Council on Food Policy, of which the NYSDOH is a lead member, held listening sessions throughout the state to gather feedback on what nutrition and food related issues should be addressed by the Council, and how best to address them. The Division of Nutrition Obesity Prevention Council, with representatives from several USDA funded child nutrition programs, provides guidance and feedback on division-wide policies, practices and positions relating to childhood obesity. In the Fall of 2009, the Division of Chronic Disease and Injury Prevention held a statewide strategic planning meeting with over 100 stakeholders. This forum provided an opportunity to review and respond to a comprehensive plan that will guide the state in preventing chronic disease and obesity. Specific program efforts, such as the Eat Well

Play Hard in Child Care Settings intervention, Fit WIC Project, the Hunger Prevention and Nutrition Assistance Program and the Just Say Yes To Fruits and Vegetables Project have utilized focus groups and participant surveys to obtain consumer input.

Lead Poisoning Prevention

The Department engages multiple stakeholders to update and implement the action plan. NYS's Advisory Council on Lead Poisoning Prevention meets several times each year to discuss issues relevant to the development and implementation of the statewide plan and make recommendations. The council reports annually to the Governor and the Legislature about the progress in eliminating lead poisoning in NYS. The program also meets with external stakeholders, including the Statewide Coalition to End Lead Poisoning. In 2009, DOH participated in a series of stakeholder meetings convened by the Governor's Office to obtain input on primary and secondary prevention priorities and strategies. In June 2009, Governor David Paterson issued Executive Order No. 21, which established a new Governor's Task Force on the Prevention of Lead Poisoning. The Task Force, comprised of Governor's office staff and state agencies, is charged with developing and implementing specific coordinated strategies to reduce childhood exposure to lead.

The program also obtains input from local health departments (LHDs) and Regional Lead Resource Centers, which are the frontline providers of lead prevention and follow up services.

Asthma

The NYS Asthma Plan was collaboratively developed with key state and national partners. NYSDOH convened statewide partners and national experts in asthma and chronic care improvement to participate in re-visioning the State Asthma Plan, and the *Framework for Improving Asthma Outcomes in NYS* was developed. A critical element of this framework is an enduring public/private collaboration to include people with asthma, providers, plans, purchasers, and public health partners. Guided by common vision and shared goals, the Asthma Partnership of NY is responsible for overseeing the implementation of the State Asthma Plan, to include continuous review and modification of the goals, objectives, and activities through analysis of data, evaluation findings and progress towards meeting process and outcomes measures.

School Based Health Centers

New York State has one of the largest school based health center programs in the country. The program has a long standing practice of soliciting SBHC stakeholder input and collaboration. The NYSDOH has established a relationship with the NYS Coalition of SBHCs which represents primary program stakeholders, and is comprised of virtually every SBHC sponsor organization in the State. A stakeholders workgroup was convened to strengthen communication between the NYSDOH and key staff of the facilities that sponsor SBHCs. This workgroup allowed our stakeholders to identify needs, challenges and barriers faced in operating the clinics, as well as to collaborate on innovative ideas to address these issues. As a result of the original workgroup a quality improvement sub-workgroup was formed in 2007 and participated in a SBHC quality improvement initiative led by NYSDOH.

Adolescent Sexual Health

In 2009, the Department convened a symposium on adolescent sexual health through its contract with the COE. The symposium included youth, national and state experts on adolescent sexual health and key stakeholders to review research and best practices, and make recommendations for future programming. Dr. Jonathan Klein, Associate Executive Director of the American Academy of Pediatrics, provided the professional leadership for this event through his role with the COE. The attendance of several adolescents was supported in this event, providing a venue for direct feedback from adolescents related to effective strategies.

The COE formed a youth network that develops materials for the Department and advises on issues important to and relevant to youth in New York State. Communication strategies are also diverse, using social networking sites (e.g., Face book), monthly meetings (with a NYC group) and interaction with groups who have invited COE staff to attend meetings. The COE provided input to all areas of the website (www.nysyouth.net) development. During the initial preparation for the Adolescent Sexual Health Media Campaign, the COE spoke with youth from across the state about the content of the website addressing sexual health.

The Sexual Violence Primary Prevention Committee meets quarterly to provide input to the DOH on the development of a comprehensive primary prevention and evaluation plan. The Committee is comprised of key state and community partners in the prevention of sexual violence.

Children with Special Health Needs

The CSHCN Program supports a cadre of family and youth representatives (a.k.a. Family Champions and Youth Advisors) that provide input on resources and tools being developed and the system of care for children and youth with special health care needs. The **Family Champions Project** engages parents of children with special health care needs in training on planning, policy and advocacy. In 2007, the Department added a **Youth Advisory Committee (YAC)** which was formed to advise the NYSDOH Children with Special Health Care Needs (CSHCN) Program on what youth need to transition successfully to adulthood in terms of employment, medical care and independent living. YAC members also provided information regarding their experiences with having a medical home and suggested methods for distributing materials and information to assist with the transition process. The YAC will give the youth an opportunity to develop their leadership skills and to be heard on issues that affect them directly. These consumers, who submit an application to become a family or youth representative, are racially and ethnically diverse and represent all regions of the state. They receive orientation and training about the mission of the CSHCN Program and its activities and the MCHBG process of needs assessment, program planning, implementation and evaluation. In 2010, four family forums and one youth forum were held this to provide input into the MCHBG needs assessment.

Dental Health

The Bureau of Dental works closely with the New York State Oral Health Coalition (NYSOHC), a statewide coalition of oral health providers, advocates, individuals, institutions, agencies and organizations sharing a common interest in oral health and access to care. Standing committees address access to care, workforce, public policy, communications, research and surveillance, and fluoridation. Presentations on current Bureau activities, initiatives and plans are routinely

provided to the Steering Committee, Standing Committees and full membership and feedback and input from all Coalition members is regularly sought.

Standing Committee members provide input to: improve access to high quality, comprehensive and continuous oral health services; promote best practices; assess workforce capacity issues and identify strategies to address workforce needs; identify oral health indicators and gaps in oral health surveillance, methods for the dissemination of data, potential data partners, and strategies for addressing data and evaluation needs; development of policies that have the greatest potential to reduce the burden of oral disease, improve access and enhance the quality and efficiency of oral health care; and, promote fluoridation and counteract misinformation about fluoridation.

Under the HRSA Targeted Oral Health Service Systems (TOHSS) grant, meetings are held with key representatives of maternal and child health and social service programs, such as the WIC Programs, Healthy Families NY, Head Start and Early Head Start, Council on Children and Families and Perinatal Networks, to obtain input into the oral health education needs of staff and the families they serve. These meetings have resulted in specific training programs, resources, and materials being developed, as well as mechanisms established for obtaining periodic feedback and input from program staff and parents on the usefulness of trainings and resources provided to date and the need for any additional resources, education materials and trainings.

Methods for Assessing Three MCH Populations

As described above in the Needs Assessment Methodology section, the needs assessment process was developed based upon three main components: stakeholder input related to the five year needs assessment, as well to specific MCH populations and program areas; analysis of MCH data from a wide variety of sources, including MCH program data; and, information obtained from needs assessment cycles for specific MCH programs. Stakeholder input related to the five year needs assessment was designed, where possible, not only to provide input in the needs and priorities for the general MCH population, but also the needs and priorities of the three MCH populations. For example, in the key stakeholder survey described above, respondents were asked to rank current state priorities and to select their top priorities for each of the three MCH population groups. In some cases, stakeholder input was obtained for a specific population group, for example, the forums and survey conducted to obtain input related to the needs of children and youth with special health care needs and their families. In addition, Section 3 below “Assessment of Strengths and Needs of the Maternal and Child Health Population Groups and Desired Outcomes” was reorganized in this application in separate sections for each MCH population group. Performance measures, outcome measures, health status measures, progress towards meeting Healthy People 2010 objectives, as well as substantial additional data generated by the Department to paint a clearer picture of each population group’s strengths and weaknesses was provided. Data for each population group is followed by a description of capacity related to the population, including current MCH programming within the population group. This included a description of the needs assessment cycle in key priority areas, including an assessment of strengths and weaknesses. This wealth of information, informed by qualitative information obtained through a variety of vehicles such as forums, focus groups, structured input of key stakeholders and contractors, provides a comprehensive understanding of the needs and priorities of each MCH population.

Methods for Assessing State Capacity

The state's capacity assessment described in Section 4 below is not only an inventory of services provided, but includes an evaluation of quantitative data and qualitative information related to the accessibility, affordability and quality of maternal and child health services provided in the state. This section will describe, in brief, the qualitative and quantitative methods used to assess the state's MCH capacity.

Assessing Capacity with regard to Direct Medical Services

Comprehensive assessment of the maternal and child health population's ability to access high quality health care and determination of gaps in the health care delivery system takes place at both the state and local level.

Section 3 below of the needs assessment includes a wealth of data, including national health system capacity indicators or performance measures, and several additional measures that the state routinely tracks to assess capacity. For example, statewide, assessment activities utilize vital records and the Statewide Perinatal Data System to assess access to prenatal care and births by level of facility. Statewide Planning and Research Cooperative System (SPARCS) data, which are data on hospital discharges, are used to assess hospitalizations for ambulatory care sensitive conditions such as asthma and source of payment at time of service or delivery. Program data and registries are used to monitor immunization and lead screening rates statewide, access to WIC and family planning services, and linkages to Early Intervention, specialty care and care coordination. In addition, MCH programs regularly assess other environmental factors, such as population shifts, to be able to better address

MCH staff has a close working relationship with the Office of Health Insurance Programs and has access to a wealth of information about the State's public insurance programs, including information related to benefits, enrollment and quality improvement. This relationship, in addition to providing an environmental context for provision of MCH services which are highly dependent upon Medicaid funding for support, also has resulted in collaborative expansions of services. For example, the Division of Family Health collaborated with the Medicaid programs to develop a Medicaid waiver to expand income eligibility for Medicaid reimbursed family planning services and collaborated with the Child Health Insurance Program (CHIP) to expand the Medicaid benefit package to provide coverage for medical orthodontia. The Medicaid Program and the MCH Program intensively collaborated related to the shift of publicly insured population to managed care arrangements and are currently working closely related to the elimination of the preferred model of prenatal care to provision of comprehensive prenatal care provided through all Medicaid reimbursed providers.

In addition, the MCH Program works closely with the Office of Health Systems Management (OHSM) which is responsible for oversight of the state's system of hospitals and clinics, to address a variety of issues, including designation of birthing hospitals and birthing hospital capacity, as well as coordination related to facility closures which could have a detrimental impact on MCH medical services. Further, MCH Programs contract with many hospitals and clinics in the State to conduct special services, such as School-Based Health and Family Planning, which provides a direct window on capacity issues. Information on state capacity for provision of hospital and clinic-based services is also provided through hospital associations that

keep in close touch with their member organizations and apprise DOH of issues related to access to or accessibility of services to segments of the MCH population, as they affect their member agencies.

The MCH Program also coordinates very closely with other areas of the Department which has facilitated the identification and address emerging needs related to capacity. For example, the Division of Family Health and the Bureau of Immunization collaborated closely during the H1N1 pandemic to address an identified capacity need to increase the number of family health physicians and obstetricians, as well as clinics providing prenatal care, that would directly immunize pregnant women. This collaboration included education of providers and pregnant women related to the importance of immunization. The MCH Program also worked with its regional perinatal centers to ensure that they were fully aware of treatment protocols and national and state guidelines and other information to ensure it could work with their affiliate hospitals and improve their capacity and quality for H1N1 care. Division of Family Health staff participated in a Department group which that identified a need to ensure adequate capacity for treatment of pregnant women and children in New York State hospitals outside of New York City in the event of a large scale emergency. As a result, the Division of Family Health, Office of the Medical Director, developed a Pediatric and Obstetric Tool Kit that serves as a resource and provides tools for hospitals to expand their capacity for emergency response.

MCH Programs are also in close communication with the Department's Division of Health Facility Planning, the area of the Department charged with reviewing and addressing direct care capacity issues and receives and reviews the results of workforce studies related to key professionals in the MCH field, for example, physicians, including specialists such as pediatricians and obstetricians, dentists and others. In addition, the Division of Family Health has worked collaboratively with this Division to address identified work force issues statewide and in specific communities.

Local sources of information are also important to assess capacity. Local Health Departments (LHDs) are required to perform Community Health Assessments (CHA) and Municipal Public Health Service Plans (MHSP) which were submitted to the Department for review. Hospitals are similarly required to submit Community Service Plans (CSP).

The Department has various mechanisms in place to obtain input related to capacity from its funded programs, for example, from its Comprehensive Prenatal-Perinatal Services Networks (CPPSNs) who engage consortia of local health and human service providers and consumers to identify and address gaps in local and regional perinatal and child health care and service delivery systems and are uniquely positioned to work with the MCH Program to identify and address capacity issues.

Finally, and most importantly, consumer input is key to obtaining on the ground information regarding capacity. The Behavioral Risk Factor Surveillance Survey and Pregnancy Risk Assessment Monitoring Survey provide insight related to capacity. The new Children with Special Health Care Needs data system and the national State and Local Area Integrated Telephone Survey (SLAITS) fill a gap in our knowledge of the capacity of the health care system

to serve that population. Special focused studies, focus groups, forums and other opportunities further inform efforts to assess capacity.

Assessing Capacity with regard for Enabling Services

The New York State Department of Health has a strong capacity to provide enabling services through its programs, contractors, and partners. State Title V efforts, in collaboration with contractors and partners, are essential to reducing and eliminating barriers to accessing care. The Department has the capacity and infrastructure to collect appropriate data and perform data analysis to assess the provision of enabling services.

The Growing Up Healthy Hotline (GUHH) links families with over state twenty programs and services (including WIC, prenatal care, insurance, family planning etc). A GUHH operator helps families identify services they need and provides information on how to locate providers and services in their area. The GUHH provides information and referrals 24 hours a day, seven days a week in English, Spanish and other languages, as well as providing access via a Tele Typewriter. Data is collected on the number of calls per year, the gender and language of the caller, the county calling from and the call type. Additionally, DOH staff monitors how the hotline is being used in response to specific Department initiatives. For example, the GUHH data can be utilized to assess the effect of a media campaign on call volume.

Many of the Department's programs assess the insurance status of families and children upon program entry and link individuals whenever necessary to health insurance. This assessment and linkage function is part of the Early Intervention and Children with Special Health Care Needs (CSHCN) Programs, Family Planning Programs and others. This function is a critical piece in helping individuals and families access primary/preventive care, specialty/subspecialty care, and habilitation/rehabilitation services.

The Bureau of Maternal and Child Health administers annual grants to Local Health Departments (LHDs) to support local CSHCN Programs. These programs provide community education and outreach, information and referral services to families of CSHCN and provide information to DOH about local met and unmet needs of CSHCN. The state CSHCN Program reviews the number and types of referral services provided annually to families of CSHCN. These referrals include linkages to insurance, support groups, counseling, transportation and others.

Several of the state's child-serving programs offer respite services, a key enabling service for families caring for children with special health care needs. These programs include some Medicaid waivers and the Early Intervention Program (EIP). In 2008, respite was provided to over 10,000 individuals via the Office of Mental Health and Office of Mental Retardation and Developmental Disabilities Medicaid Waiver programs. The EIP provides respite funds through state contracts with local health departments (LHD). Respite services may be authorized as part of the child's Individualized Family Service Plan. Other family services that may be authorized through the EIP include family support groups and family training.

Transportation to medical appointments is a key enabling service. The type of transportation needed varies by geographic location, depending upon whether the consumer may be located in

an urban or rural area. Medical transportation for those insured by Medicaid is provided either by the managed care organization (if it is part of the contract) or by fee-for-service Medicaid. The Department monitors the number and expenditures of medical transportation. In 2008, over 350,000 medical trips were paid for by Medicaid. This number does not include subways, buses or individual driver reimbursement. The EI Program also reimburses for transportation to child services.

Case management and supportive services are provided to New York's CSHCN through several programs. The **Early Intervention Program** provides service coordination to infant and toddlers with disabilities and their families. The EIP initial service coordinator works with families to help develop the Individualized Family Service Plan, and an ongoing service coordinator helps to ensure that services are provided in accordance with the plan. The Department provides grants to support local CSHCN programs with 56 local health departments that provide information and referral services to families of CSHCN. Some local CSHCN Programs provide short term case management to families of CSHCN. New York has several **Medicaid waiver** programs that provide care coordination and services to CSHCN and their families.

All Title V programs are required to examine barriers to health care in the populations they serve, whether financial, cultural, geographic, institutional or personal, and to institute measures to minimize or eliminate those barriers in collaboration with other stakeholders. All Title V and Title V-related programs are also required to have extensive linkages and referral networks, thus assuring that care is delivered at the appropriate level of specialty and in the appropriate community or regional setting. Programs that provide services for vulnerable populations, such as pregnant women, infants, young children, and youth, especially those serving racial or ethnic minorities, the poor, migrants, linguistic minorities, or children with special health care needs, are especially targeted for enabling services. Need for additional services and capacity to provide these services is assessed on an ongoing basis through contract monitoring and ongoing close contact with service providers.

Examples of these enabling services include special programs such as the Community Health Worker Program, which targets pregnant and parenting low income women, often minorities or recent immigrants, and their families, and provides home visiting, health education, and support to overstressed pregnant women; the Migrant Health program, which provides special on-site, culturally and linguistically appropriate health care as well as transportation to off-site visits as needed; and special dental case management programs for rural areas that reduce no-show rates and encourage enrollment of additional dental providers in Medicaid.

Assessing Capacity with regard for Population-Based Services

The need for population-based services may surface on a statewide or community level based upon a health need that can be prevented, controlled or ameliorated through a public health intervention that is safe, accepted, economical and effective. These needs may become known through the analysis of vital statistics or hospital discharge data, use of registry data, analysis of calls to toll-free hotlines, the administration of population based knowledge and attitude and behavior studies, focus groups or other types of special studies.

New York State has a significant capacity for population based services. For many of these population based services, for example newborn screening and newborn hearing screening, immunization and blood lead screening, data are carefully tracked to assess the size of the population reached in comparison to need, as well as to assess impact upon subpopulations and geographic areas. Programs, in addition, to obtaining data related to population reach also review performance and outcome measures to assess the success of population based programs. Sections 3 and 4 of the needs assessment provide extensive descriptions of several of these population based services, as well as data regarding the success of those programs to reach the population in need.

Assessing Capacity with regard for Infrastructure-Building Services

The protection and promotion of the public's health is not possible without adequate public health infrastructure. Public health agencies must have the ability to collect and maintain appropriate data, perform adequate needs assessment, appropriately evaluate public health issues and programs, develop meaningful policies and standards, effectively engage their communities, coordinate existing resources, ensure quality, and to adequately train the public health workforce. The Department has not undertaken a formal Capacity Assessment for State Title V (CAST –V) to assess our internal infrastructure for MCH services, however, there has been a substantial effort to review and improve MCH infrastructure in a variety of arenas. The strong partnerships and communication channels MCH Programs have are described in Section 2 of the needs assessment below. The physical infrastructure of the agency remains strong in terms of adequate physical space, computer equipment and other materials sources, however, like many states, New York State is in a significant fiscal crisis, and the impact of the inability to fill state funded MCH items is beginning to have an effect. The fiscal crisis also has had some impact upon staff competencies because travel for state MCH staff has been significantly restricted, and staff are often unable to attend meetings or conferences that would enhance their MCH Program knowledge.

The Division of Family Health is responsible for development and oversight of public health activities related to a broad range of maternal and child health issues that are core to the Department's mission and the Title V Program/Maternal and Child Health Services Block Grant (MCHSBG). The Director of the Division is the State Title V Director. To proactively respond to current staffing challenges and to improve MCH programming, the Division has been reorganized to consolidate the Bureau of Women's Health and the Bureau of Child and Adolescent Health into a new Bureau of Maternal and Child Health. While both Bureaus have made significant progress in implementing high priority public health programs and achieving Department goals, there is a need for both Bureaus to be continually responsive to changes in population needs, the health care system and scientific evidence base, within the context of available resources. A number of programs were outdated and are in the process of significant updating or restructuring. In many areas, there were missed opportunities to improve the efficiency and impact of programs that have similar goals, target populations, and functions. Broadly, there is a need to shift from a categorical program administration approach to one that is driven by priority outcomes and implementation of effective, evidence-based public health strategies, and to make better use of data to inform meaningful, ongoing improvement at all steps of program and policy design and implementation.

Combining the BWH and BCAH with a reorganization of management structure and program areas provides an opportunity to maximize existing human resources and skills at multiple organizational levels, and to align programs with similar target populations, outcomes and functions to improve overall program efficiency and impact.

Data Collection and Analysis

The Department's capacity for data analysis for surveillance, program planning and analysis is strong. New York's Title V program receives substantial support from the Office of Public Health, Public Health Information Group (PHIG) in development of the annual needs assessment and in ongoing assessment of MCH needs and capacity. The Division of Family Health, in which the state's Title V program is primarily located, has over 600 contractors who have successfully competed to provide services to maternal and child populations. Each is required to perform an assessment of needs in their target population, as well as assess current resources and strengths, in order not to duplicate existing services. The Department, through its Act for Youth Center of Excellence supported training on the asset based community development process, including needs assessment and resource identification. Over 3,000 community organizations were invited to attend face- to- face trainings that occurred throughout the state. The training is now available on the Act for Youth website.

The Division of Family Health has taken steps to develop discrete MCH Epidemiology capacity by co-locating existing staff with expertise in epidemiology, biostatistics and geocoding. This function is supplemented through the use of graduate students from the State University at Albany School of Public Health who receive stipends, school credit and on the job experience for public internship. Staff works on priority data analyses, such as factors contributing to increases in caesarian births and inductions, perinatal period of risk analysis, breastfeeding, reviewing data from quality improvement efforts and a variety of other efforts. Although this has been a significant improvement in MCH epidemiology capability, the effort has been somewhat hampered by our inability to obtain additional staff to support this function.

The MCH Program, with the support of the Department's Information Services Group, has developed new data systems to support data analysis capability related to significant MCH areas, such as the Statewide Perinatal Data System (SPDS) and the Neonatal Intensive Care Unit Data systems, with the SPDS being required to be implemented in all birthing hospitals in the state and the NICU in all birthing hospitals with a neonatal unit. Availability of these data systems has significantly enhanced the Department's ability to assess performance at the hospital level, regional level and statewide level, as well as has provided the data support needed by Regional Perinatal Centers to improve their own and their affiliate hospital performance.

Many MCH program areas have assessed their capacity for data analysis in the past several years and have significantly enhanced their capabilities in this arena. The Department's Lead Poisoning Prevention Program (LPPP) is a good example, although several other MCH programs had parallel improvements in their data analysis capability. (Other efforts are described in Section 3 of the needs assessment.) In 2006, the Department transitioned local health lead programs from the previous local PC-based system (LeadTrac) to the new statewide Web-based system (LeadWeb). The Program comprehensively reviewed the quality of data from laboratories in Leadweb for completeness, timeliness and quality to assess problems and to

improve data collection from the point of collection. In addition, the data system was enhanced to make the data more accessible to local health departments to help them improve screening and follow up of lead poisoned children and to assist them in assessing needs and performance to improve their program. There was also a significant effort to link blood lead level results with address information and geocoded data to support expanded geographic analysis. The program is also improving data at the state level, working with stakeholders to understand the key data analysis questions and how routine data analysis could be better aligned with program priorities. Lastly, the system is being connected with other data systems such as immunization and Medicaid to improve lead screening and program performance.

The integration of child health data has been supported for many years by the Statewide Systems Development Initiative (SSDI) funded through the HRSA MCH Bureau. The SSDI Project has developed infrastructure that provides relevant data and information to assure program and policy development for maternal and child health (MCH). The SSDI has assisted in the development and implementation of the department's Child Health Information Integration Project to improve data linkages among multiple data sources for child health information, and continues to support and foster the CHI² initiative. The Child Health Information Integration, a project lead by the Division of Family Health, Office of the Medical Director, will enable the integration of datasets within various Department of Health (DOH) programs serving children in New York. An integrated information system has the potential to dramatically increase the public health benefit and efficiency of the many governmental programs overseen by DOH. External partners including healthcare providers and Regional Health Information Organizations will have access to better child health data leading to improved patient care.

Quality Improvement

The Department has assessed and substantially enhanced its MCH program quality improvement efforts as well. Examples of major quality improvement projects that have been implemented are described below and are discussed Section 3 in detail:

- In 2009, the Division of Family Health in collaboration with the National Initiative for Children's Health Care Quality and the RPCs launched the New York State Obstetric and Neonatal Quality Collaborative (NYSONQC) to improve maternal and neonatal outcomes and eliminate disparities. Through NYSONQC, RPCs will implement quality improvement interventions designed to improve maternal and newborn patient safety.
- The Division of Family Health, in conjunction with the state's Office of Children and Family Services (OCFS), has developed an initiative to expand and improve the quality of the child fatality review process to promote improved community services delivery and the development of local public health risk reduction and safety focused prevention programs.
- In an effort to improve exclusive breastfeeding rates in maternity hospitals in New York, the Division of Chronic Disease Prevention and Adult Health and the Division of Family Health collaborated to analyze infant feeding data from hospitals (excluding New York City) using the Statewide Perinatal Data System, and hospitals were ranked on three breastfeeding indicators (breastfeeding initiation, exclusive breastfeeding, and formula supplementation of breastfed infants). Each hospital was informed of their performance relative to other hospitals.
- The Division of Family Health School Based Health Center Program in collaboration with the National Initiative for Children's Health Care Quality (NICHQ) developed an

improvement project around three established School Health Program quality of care indicators: comprehensive physical exams (including age-appropriate screening and follow-up), obesity and asthma.

Policy and Standard Development

Title V Programs collaborate both internally and externally to identify the need for new policy and standard development. The Title V Program has strong capacity for policy and standards development. Examples of this are as follows:

- Collaboration between the Division of Family Health and the Office of Health Insurance Programs has resulted in the development of updated, comprehensive prenatal care standards which will help ensure increased access and improved quality of services for all pregnant women who qualify for Medicaid to comprehensive high quality, prenatal and postpartum care.
- The CSHCN Program, in conjunction with the Newborn Screening Program ensures a statewide network of Article 28 hospital-based specialty centers that accept newborn screening referrals upon receipt of a positive newborn screen. These centers of excellence provide comprehensive, multidisciplinary evaluation and management of children by clinical specialists and sub-specialists. The Division of Family Health has been revising standards for these centers.
- The Bureau of Early Intervention has developed guidelines to ensure high-quality, consistent and effective service delivery to eligible children and their families. These guidelines address recommended clinical practices for developmental surveillance, assessment and intervention with children age birth to three years. There are six guidelines on the topics of 1) Autism/Pervasive Developmental Disorders, 2) Communication Disorders, 3) Down Syndrome, 4) Motor Disorders, 5) Hearing Loss, and 6) Vision Impairment. Each guideline consists of three separate publications (a technical report, a report of the recommendations, and a quick reference guide). The four most recent guidelines include evidence tables and, including the books, are provided on compact discs. Guidelines are disseminated to early intervention providers, municipalities, parents and others upon request. The Bureau is procuring a vendor to update the Autism and Communication Disorders guidelines using ARRA funds.

Program Monitoring

Through a combination of central and regional office staff, the state has a strong infrastructure for supporting program monitoring. Programs are grouped by region within New York State and assigned to central and regional office staff for oversight with each program having a central and regional office contract manager. Central office staff manages policy communication and is available to the program for technical assistance on program and budget issues. Regional office staff conduct on-site technical assistance as necessary, and a comprehensive monitoring visit on a periodic basis, usually, once every three years. Reports are issued as a result of site visits, indicating when corrective action is needed for specific program. Programs are reviewed for program compliance with regulations, standards and guidelines. A standardized work plan including clear, measurable objectives and benchmarks has been instituted for most programs. Programs are required to report on progress on a quarterly basis. Programs have data systems that capture information related to program performance, some of which can be very sophisticated depending upon the size of the program. Many programs have specific mechanisms

such as standing phone calls, annual meetings, trainings and other venues to provide ongoing communication with providers. In addition to program level communication, the Division of Family Health conducts a monthly phone call with regional staff to ensure that they have a comprehensive picture of issues and priorities to be addressed, and to provide a communication vehicle related to significant concerns that transcend specific programs. In addition to monitoring efforts through regional staff, some large programs, such as Early Intervention, conduct program monitoring through external peer review agencies.

Data Sources

In this assessment cycle, the needs of the maternal and child health population have been ascertained through a variety of methods and data sets, including statewide, program-specific, registry-specific, hospital-based, survey-generated, and community-based data sets, and via public input. Many of the data sets are available on the Department's intra-net Health Information Network or HIN, on the HPN or Health Provider Network, and most are on our public website www.health.state.ny.us as a part of the Community Health Data Set. Most data are available on the county level, and many on the sub-county or zip code level. Following is the list of data sources, which are described in some detail in the Data Sources section of Part Two, Section II, Part B.1: This data is supplemented by a variety of methods for obtaining stakeholder input as previously described.

- Census data, including the census Bureau's *Current Population Survey (CPS)*
- Vital Statistics data
- Statewide Perinatal Data System (SPDS) which includes the core (birth certificate), quality improvement, and NICU modules.
- DOH Registries: including the, Congenital Malformations, Newborn Screening, Communicable Disease, Sexually Transmitted Disease, HIV/AIDS Cancer, Heavy Metals (lead), Trauma and Immunization Registries.
- Provider-Generated or Program-Generated Data, including data sets maintained by programs such as WIC, Medicaid, the Immunization Program, the Family Planning Program, the Childhood Lead Poisoning Prevention Program, the Early Intervention the Preventive Dentistry Program, the Children with Special Health Care Needs Program, the Dental Rehabilitation Program, and the Community Health Worker Program.
- Medicaid enrollment and utilization Data
- Medicaid provider performance reports such as the Quality Assurance Reporting Requirements (QARR) system
- Hospital Discharge Data, including emergency room discharge data
- Special Studies: Including the Pregnancy Risk Assessment Monitoring System (PRAMS), Youth Risk Behavior Study (YRBS), and Behavioral Risk Factor Surveillance System (BRFSS)
- *National, State and Local Area Integrated Telephone Survey of Children with Special Health Care Needs (SLAITS CSHCN Survey)*
- Local Community and County Health Assessment Data
- State Education Department registry of licensed professionals.

Linkages between Assessment, Capacity and Priorities

In this MCH grant cycle, Section 3 of the needs assessment was organized into sections related to the three MCH populations groups. Each of the sections incorporated relevant data, including

relevant national capacity and performance measures, state level data and program data. Each section also described current capacity to serve that population, as well as needs that had been identified through a variety of venues, for example, through review of program level data, input from contractors, county health departments, advisory bodies and other stakeholders. Each section also describes strategic efforts currently underway to address identified needs of the population. When supplemented by qualitative information provided through public input as described above, a clear picture of the needs, capacity and priorities within each MCH population is obtained. The Department has effective and ongoing communication with stakeholders regarding need and priorities. Public input related to needs and priorities was, for the most part congruent with needs and priorities that had already been identified.

Dissemination

In addition to the significant efforts previously described to obtain input during the development of the application, efforts will be made to widely disseminate the needs assessment. This included a standardized form that was used to obtain comments related to the needs assessment. Dissemination activities include:

- A summary of the needs assessment and related priorities was made available to key stakeholders, including the perinatal networks, the MCHBG Advisory Council and the MCH Committee of NYSACHO, to provide any additional input for consideration prior to submission.
- A summary of the needs assessment process was presented made on June 17th at the New York State Perinatal Association Conference with an opportunity to comment.
- The application was also posted on the Department's website to obtain further comments and obtain information regarding development and implementation of the needs assessment. Key stakeholders who participated in the survey were notified when the final application was available for review.

Strengths and Weaknesses of the Process

The multilayered methods for obtaining structured input from stakeholders, while difficult, in light of resource considerations, provided an additional, external context for assessing needs and developing priorities. The survey of key stakeholders to gain their opinions about the needs and strengths of the target population helped provide a broader perspective related to MCH needs and made the process more inclusive, creating a sense of more ownership of the process and the need to address MCH needs for those who participated. The reorganization of the needs assessment into sections related to the three MCH populations groups, incorporating data, as well as information related to capacity and identified need, and strategic efforts to address need provided a clear picture of the needs for each population. In addition, the blending and synthesis of public input, quantitative and qualitative data and program data and other information provided a comprehensive, rounded assessment of the needs and priorities of the MCH populations.

While not a weakness, the strength of the process, the extensive information related to needs and capacity for MCH populations, both quantitative and qualitative, made it an extremely complex effort to synthesize and present the information to provide an understandably yet comprehensive account of the MCH Program in New York State.

2. Partnership Building and Collaboration Efforts

The New York State Department of Health has multiple collaborations and partnerships formed around maternal and child health needs assessment, planning and policy and program development and evaluation. Several of these partnerships were previously described in the section “Other Efforts to Obtain Input into MCH Services. The following are examples of internal and external partnerships and collaborations relating to specific initiatives and program areas.

Early Childhood Comprehensive Systems Initiative (ECCS)

From the beginning, NYSDOH collaborated with its sister agency, the **New York State Council on Children and Families (CCF)**, to lead and coordinate the Early Childhood Comprehensive Systems (ECCS) initiative. CCF was uniquely positioned to coordinate this cross-systems effort as an independent state agency charged with coordinating the activities of the state’s health, human service and education state agencies. CCF co-chaired the planning phase of the ECCS initiative with NYSDOH, and this collaboration was subsequently formalized through a subcontract to CCF of a major portion of NY’s ECCS grant. Through this subcontract, CCF, in ongoing partnership with NYSDOH and many other public and private partners, coordinated ECCS implementation through May 2009. Following HRSA’s expansion of the eligibility criteria for the ECCS grant in the most recent funding cycle to allow organizations other than Title V programs to apply, with the Department’s support, CCF directly applied and was awarded the grant from HRSA and has continued to coordinate implementation of the ECCS initiative in partnership with DOH.

By design, the ECCS initiative and subsequent work of the **Early Childhood Advisory Council (ECAC)** have established and strengthened partnerships with a large number of public and private partners, including partnerships with other state agencies, other public health programs, and many non-governmental agencies. In particular, these initiatives have facilitated continued strong working relationships between the Title V Program and the New York Office of Children and Family Services Division of Child Care Services (the child care licensing agency for New York State), as demonstrated through regular ongoing communication and consultation between our programs on projects ranging from development of standards for administration of medications in child care, to enhancing assessment of children’s blood lead testing status and environmental inspections for lead hazards in home-based child care settings, to current ECAC work focusing on promoting best practice standards for obesity prevention within child care settings. More recently, the collaborative work on both the ECAC and Project LAUNCH has served to strengthen partnerships with the state’s Office of Mental Health, including for example current projects to develop positive parenting education messages and strengthen capacity of early childhood providers to support young children’s social-emotional development.

In addition, this work has strengthened state-federal partnerships. New York’s longstanding partnership with HRSA’s MCH Bureau through our Title V Program has been further enhanced through CCF’s role in these initiatives, to which CCF brings a long history of strong experience and leadership in other aspects of early childhood systems work such as early learning, parent education and family support. New York’s ECCS work directly facilitated a new state-federal partnership with SAMHSA through the current Project LAUNCH initiative.

Child Health Information Integration Project

The integration of child health data has been supported for many years by the HRSA funded Statewide Systems Development Initiative (SSDI). The SSDI Project has developed infrastructure that provides relevant data and information to assure program and policy development for maternal and child health (MCH). SSDI staff collaborates with the department's information systems managers and information system units to expand the linkages among the MCH data systems. The SSDI has assisted in the development and implementation of the department's Child Health Information Integration Project (CHI²) to improve data linkages among multiple data sources for child health information, and continues to support and foster the CHI² initiative.

The CHI² project has established both internal and external feedback mechanisms to gather input from stakeholders. Within the Department of Health (DOH), the project has established multiple workgroups to ensure a balanced approach to the development of the system. These include an overall CHI² workgroup, a Guidance Team, and the Requirements Workgroup.

The cross-functional Requirements Workgroup includes program and IT representatives from the programs and systems that will be part of the first phase of CHI², including Immunization Program (NYSIIS), Early Intervention (NYEIS), Newborn Bloodspot Screening, Newborn Hearing Screening, Neonatal Intensive Care Unit (NICU), Statewide Perinatal Data System (SPDS) and Vital Records, Lead Screening. In addition, the workgroup includes representatives from the Office of Health Information Technology Transformation (OHITT) and the Office of Health Insurance Programs (OHIP) to ensure alignment with other DOH strategies and initiatives. CHI² also is closely intertwined with the Newborn Screening Effective Follow-up project, which is funded by HRSA.

Family Planning

The Family Planning Program collaborates with the DOH Division of Chronic Disease Cancer Services Program (CSP) to increase access to screening and diagnostic services to uninsured and underinsured women. The CSP has provided reimbursement to family planning providers for diagnostics and screening for breast and cervical cancer since 2002. Family planning clients with an abnormal finding on a clinical breast exam or Pap test are eligible for follow up testing through the CSP. In recent years, the New York State budget allocated funding to the CSP for HPV vaccine and an increasing portion of this funding was distributed to Family Planning providers for the purchase and administration of the vaccine to eligible clients. In addition, the DOH Bureau of STD control and the Centers for Disease Control and Prevention provide funding to ensure family planning agencies are in conformance with Federal Region II and CDC Chlamydia screening criteria. In 2008, nearly 200,000 Chlamydia tests were performed by family planning clinics throughout the state. Through collaboration with the NYSDOH AIDS Institute, funding is provided to Family Planning providers to support HIV testing of clients.

There is ongoing communication with the DOH Office of Health Systems Management regarding establishment and closure of clinic sites. In addition, the DOH Family Planning program collaborates with the Office of Health Insurance Programs to ensure that reimbursement rates to providers keeps pace with the latest in contraceptive technology. Recently rates were negotiated to increase reimbursement for more effective methods such as IUDs and Implanon.

These enhanced rates encourage providers to prescribe more effective contraceptive methods for their clients

Special funding from the Federal Office of Population Affairs supports collaboration with the New York State Department of Corrections to provide family planning services to women preparing for release from correctional facilities. The initiative's objective is to provide women with education, contraceptive methods, and referrals for services as they are released to communities. Three female prisons in the state are participating in the project.

Perinatal Health

Perinatal program staff works closely with many partners to advance strategies to improve outcomes for mothers and babies. Specific recent examples include:

- The Department has entered into a Memorandum of Understanding with the Office of Temporary and Disability Assistance (OTDA) to award \$5 million in TANF funding to the three Nurse Family Partnerships programs in the state. Funding is for a two-year period and will allow the NFP programs to expand services to TANF eligible first-time mothers. The Department will administer the program and OTDA will provide training and technical assistance on TANF certification.
- The Department participates in the interagency Fetal Alcohol Syndrome Disorder Taskforce, along with the Office of Alcohol and Substance Abuse Services, Office of Children and Families Services and OTDA. The taskforce is currently developing strategies to promote consumer and provider awareness of FASD.
- In collaboration with the Bureau of Maternal and Child Health, the Association of Regional Perinatal Programs and Networks (ARPPN) initiated the Statewide Perinatal Data System Epidemiology Work Group, to examine the quality and reliability of data being entered in the State Perinatal Data System (SPDS). The workgroup has conducted data analysis for quality improvement purposes, looking at specific indicators. The Bureau of Maternal and Child Health and the Bureau of Biometrics and Health Statistics have worked to address data definition and analysis issues raised by the Epidemiology Work Group.
- In 2009, the Department initiated an important collaboration with the National Initiative for Children's Health Care Quality (NICHQ) and the Regional Perinatal Centers to launch the NYS Obstetric and Neonatal Quality Collaborative (NYSONQC) to improve maternal and neonatal outcomes and eliminate disparities in birthing hospitals in the state. Through NYSONQC, RPCs will implement quality improvement interventions designed to improve maternal and newborn patient safety. The goal is to bring together leaders in perinatal health in NYS to explore opportunities to use evidence based information to reduce undesirable patient outcomes.

Childhood Obesity

Addressing the issue of childhood overweight and obesity requires the involvement of federal, state, and local partners. A key federal partner is the United States Department of Agriculture, Food and Nutrition Service (USDA/FNS), which provides funding for the Special Supplemental Nutrition Program for Women, Infants and Children and the Child and Adult Care Food Program. These programs serve low-income families in community and child care settings. The Centers for Disease Control (CDC), another key federal partner, provides a grant to New York State for the Overweight and Obesity Prevention Program. The CDC provides technical

assistance on implementation of evidence-based interventions, fosters state-to-state sharing of best practices, and supports surveillance and evaluation efforts. The New York State Council on Food Policy provides a framework for addressing barriers to improving access to healthy food choices, as well as capitalizing on those opportunities that have been identified from their statewide listening forums.

State level partners include the NYS Department of Agriculture and NYS Education Department, as well as numerous professional organizations such as the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, and health-related coalitions such as the NYS Healthy Eating and Physical Activity Alliance.

A newly formed DOH Breastfeeding Workgroup represents a partnership between the DOH and the NYS Breastfeeding Coalition, the New York City Department of Health and Mental Hygiene, and the State University at Albany School of Public Health. The partnership, which includes the Division of Chronic Disease Prevention, the Division of Nutrition and the Division of Family Health within DOH is collaborating on improving hospital performance related to support of breast feeding. In addition, materials are being developed for distribution to hospitals and providers as part of a Commissioner's Call to Action to improve breastfeeding

Lead Poisoning Prevention

Within the DOH, the Lead Poisoning Prevention Program (LPPP) collaborates extensively with the Center for Environmental Health's Bureau of Community Environmental Health and Food Protection, that oversees environmental lead poisoning prevention and remediation activities. Working partnerships occur with many other DOH programs to address ongoing activities and emerging issues. Regular partners include the Bureau of Occupational Health, the Bureau of Toxic Substance Assessment, the Environmental Public Health Tracking (EPHT) Program, the Early Intervention Program, Wadsworth Center (the state's public health laboratory), the Refugee Health Program, and the Office of Health Insurance Programs.

The program partners with many other state agencies addressing children or housing for needs assessment, planning, implementation and monitoring of the Department's plan to eliminate lead poisoning. Selected examples of recent partnerships include:

- A project with NYS Office of Temporary and Disability Assistance Bureau of Refugee and Immigration Assistance (BRIA) to produce a video to information refugee resettlement workers and refugee and immigrant communities about lead poisoning prevention and the importance of blood lead testing;
- Collaboration with the NYS Office of Children and Family Services (OCFS) Division of Child Care Services to update lead educational material for child care providers and to implement an updated medical form for children in child care that includes expanded fields and information regarding state lead testing requirements.
- Work with the NYS Division of Housing and Community Renewal and state HUD Lead Hazard Control grantees to identify communities of concern and target resources to appropriate housing.

In June 2009, Governor Paterson issued Executive Order No. 21, to establish a Governor's Task Force on the Prevention of Lead Poisoning. The Task Force, comprised of Governor's office

staff and state agencies, will develop and implement specific coordinated strategies to reduce childhood exposure to lead. This Task Force has provided a forum and impetus for further advancing a variety of interagency efforts to eliminate childhood lead poisoning.

Asthma

New York State has over 1000 partners who share the common goal to improve asthma outcomes. Partners are organized under the Asthma Partnership for New York (APNY), a public-private collaboration that includes statewide, regional, and local representatives. Statewide partners include the American Lung Association, Pediatric and Family Medicine professional societies, the NYS Health Plan Association, the Community Health Center Association, and the NYS and NYC Departments of Education. Regional partners include 11 Regional Asthma Coalitions, the NYS Asthma Outcomes Learning Network, and the NYC Asthma Partnership. Local partners are organized around special projects/initiatives such as the NYS Consensus Asthma Guidelines Expert Panel and NYS School-Based Health Center asthma quality improvement collaborative. The APNY was established to mobilize all partner efforts to plan, implement and evaluate population-based and patient-centered strategies to improve asthma outcomes. The APNY Steering Committee is composed of a broad, representative group of partners including: people with asthma, parent advocates, providers, health plans, public health, schools, city/regional coalitions, professional societies/associations, and the business community.

The NYSDOH applies a cross-organizational response to asthma. The State Asthma Plan is implemented through a collaborative effort of core teams representing surveillance, environmental health, and health care delivery and quality, and community interventions. Interventions such as the SBHC quality improvement collaborative are carried out through a partnership between the Bureau of Community Chronic Disease Prevention and the Division of Family Health. An in-home services pilot project and an initiative aimed at eliminating disparities in asthma health care in NYC are being implemented in collaboration with the NYSDOH Office of Health Insurance Programs, Division of Quality and Evaluation.

The 11 Regional Asthma Coalitions provide the infrastructure to target interventions across the state, particularly in areas with the greatest asthma disparities. Each coalition has a governance and membership structure ranging between 60-80 partners. Coalitions partner on the local level with schools, daycare facilities, clinics, pediatric practices, health plans, and community-based organizations to promote and sustain system change interventions.

NYSDOH staff provides technical assistance to Regional Asthma Coalitions on using state and local data to: identify populations with greatest asthma disparities to target interventions and monitor the impact; engage appropriate partners to address their local asthma burden; identify evidence based interventions; and, evaluate impact. Coalitions continually assess the local asthma burden and engage appropriate partners in the solution.

Adolescent Pregnancy Prevention

For over a decade, the Adolescent Health Unit within the Division of Family Health/Center for Community Health has collaborated with the AIDS Institute's Adolescent HIV Prevention Services Unit to coordinate adolescent sexual health activities through each unit's funded programs. This partnership has fostered a comprehensive approach to improving the sexual

health needs of young people throughout NYS and a foundation for the recent integration of the Adolescent HIV Prevention Services unit into the Adolescent Health Unit, within the recently-created Bureau of Maternal and Child Health.

In November 2006, the DOH launched the Adolescent Sexual Health Work Group (ASHWG) to promote a statewide environment conducive to every adolescent (ages 10 -24) achieving optimal sexual health. The ASHWG is comprised of program representatives whose shared vision and expertise promote and improve the sexual health of adolescents. The work group is comprised of representatives from the AIDS Institute, Office of Health Insurance Programs, Office of Minority Health, Bureau of Maternal and Child Health, Bureau of STD Control, Bureau of Communicable Disease Control, and Division of Family Health Office of the Medical Director.

The Department supports the ACT for Youth Center of Excellence which promotes a standard of excellence among youth-serving organizations statewide. The COE works with organizations to enhance awareness of regional issues and positive youth development approaches. The COE provides technical assistance and training; promotes consistency in planning and evaluation; and, assists the Department and its State level partners in formulating its “Positive Youth Development” policy agenda. The COE maintains a website for research briefs on adolescent health topics. Webinars on adolescent topics are conducted through the website and archived for future viewing.

A representative from the Bureau of Maternal and Child Health is a member of the Child Welfare/ Juvenile Justice Subcommittee of the Children’s Cabinet Advisory Board. This subcommittee addresses the issues of disconnected youth with a focus on youth aging out of foster care and leaving juvenile detention. This group will be focusing on pregnancy prevention and the specific needs of youth in foster care. A representative from the AIDS Institute represents the DOH on the Subcommittee for Children of Incarcerated Parents. Staff from the Adolescent Health Unit (AHU) participate in the Office for the Prevention of Domestic Violence (OPDV) Advisory Group.

Staff from the AHU are members of the NYS Youth Development Team. The team is comprised of representatives from multiple State and private agencies concerned with promoting youth development to improve outcomes for NYS children and youth. Over 11 years, the Team has provided leadership to integrate positive youth development practices into NYS services and supports for youth, families, schools and communities. The Team is guided by a cross-system Steering Committee with representatives from thirteen state agencies. Membership includes representation from a diverse population, including agencies working with foster care youth, LGBTQ youth and immigrant youth.

The New York State Education Department (SED) receives annual funding from the AIDS Institute through a Memorandum of Understanding (MOU) to provide training and technical assistance to NYS schools on the development, implementation, and evaluation of HIV education programs statewide. The goal is to build capacity of schools to develop and implement comprehensive health education programs for students. This model of comprehensive health for youth supports the development of life skills such as critical thinking, decision-making, conflict resolution and problem solving. Activities incorporate the CDC focus on the expansion of

HIV/AIDS prevention education to include STIs, teen pregnancy prevention and appreciation of diversity and support of healthy youth development norms.

Young people ages 13-17, involved in the Adolescent HIV Prevention funded after-school and out-of-school programs in NYC, participated in a NIH study conducted by the COE. Three-hundred thirty-one youth participated in the baseline survey with 301 (91%) youth participating in 6 and 12 month follow-up. Approximately 43% of the participants reported having had sex at least once prior to the survey; with the average age at first sex at 13.8 years. Sexually active youth enrolled in programs associated with NYSDOH were more likely to report having used a condom during last the sex, underscoring the importance and impact of programming that promotes protective practices. Findings suggest that efforts to enhance programs that promote youth development hold considerable promise for addressing specific risks for HIV/AIDS and changing social conditions contributing to health disparities.

School Health

Medicaid is the primary source of third-party revenue for School Based Health Centers (SBHCs) in New York State, and changes or modifications to Medicaid policy often have a direct impact on SBHCs and their sustainability. To support sustainability of SBHCs, program staff have worked extensively with the Department's Office of Health Insurance Programs (OHIP) for many years around a wide range of reimbursement policies and issues affecting SBHCs, including the establishment of a fee for service carve-out from Medicaid Managed Care for SBHC services and proposal of new reimbursement to support mental health services provided by social workers. Most recently staff has collaborated around the implementation of the new Medicaid payment methodology referred to as Ambulatory Patient Groupings (APGs). As various concerns or system problems were identified by SBHC stakeholders and DOH staff, program staff worked closely with OHIP to address issues related to the impact on SBHCs and assisted in the development of a SBHC APG training that addressed how this new methodology would impact SBHCs both financially and procedurally.

Immunizations are an important part of primary care and an integral service provided by SBHCs. Program staff works closely with the Bureau of Immunization to assure that SBHCs are meeting all NYSDOH mandates and practice guidelines. The program staff collects data via quarterly SBHC reports regarding immunization practice in SBHCs.

In recognition of the obesity epidemic amongst our children in New York State, and the key role that SBHC practitioners can play in addressing this problem, program staff has collaborated with the DOH Obesity Prevention Program staff to implement quality improvement activities about obesity prevention, assessment and management in SBHCs. Asthma is another prevalent health care concern in our SBHCs. Because of this, program staff has a long standing collaborative relationship with the Asthma program in order to ensure best practices in our SBHCs around Asthma treatment, management and prevention.

A quality improvement project for SBHCs was developed including funding for the National Initiative for Children's Health Care Quality (NICHQ) and development of a tailored improvement project around three established School Health Program quality of care indicators: comprehensive physical exams (including age-appropriate screening and follow-up), obesity and

asthma. Improvement efforts were focused across the Care Model for Child Health and encouraged testing and implementing changes in all six areas of the care model: decision support, family and self management support, use of community resources, delivery system design, and clinical information design. Staff from CSHCN and the School Health programs worked together throughout the project to provide participating teams the support and technical assistance necessary to facilitate their meeting project deliverables.

Early Intervention

The Department maintains several key partnerships at the state and national level for the EIP. At the national level, the Department is an active member in the Infant and Toddler Coordinators Association (ITCA), an organization representing the interests of State Part C programs. The Director of the Department's Bureau of Early Intervention is the President of ITCA for 2010. ITCA has recently begun to strengthen its relationship with other national organizations such as the Association of Maternal and Child Health Programs (AMCHP).

At the state level, the Department partners with numerous other state agencies with an interest in the EIP, including the State Education Department, which oversees the Preschool Special Education Program and School Age Special Education services, the Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Mental Health, Office of Children and Family Services, Office of Alcohol and Substance Abuse Services, and State Insurance Department. Each of these state agencies has a representative on the EICC whose charge includes assuring the coordination of services in New York for young children served through the EIP.

In 2009, these state agencies collaborated under the leadership of OMRDD on the New York State Interagency Task Force on Autism Spectrum Disorders (ASD) whose charge was to improve interagency coordination of services, maximize the impact and effectiveness of services and agency functions, elevate New York's ASD competency, and identify opportunities for government to partner more effectively with private enterprise in support of individuals with ASD. The Task Force issued a final report in January 2010 with 27 recommendations in five core areas including early identification, better coordination of services, lifelong service delivery, increased dissemination of information, and coordinated research.

The Department also maintains key relationships with other organizations in the state with an interest in EIP. These include organizations representing local municipal interests such as the New York State Association of Counties (NYSAC) and New York State Association of County Health Officials (NYSACHO); organizations representing early intervention providers such as the New York State Alliance for Children with Special Needs, Interagency Council for Mental Retardation and Developmental Disabilities, Cerebral Palsy Association of New York State, and Agencies for Children's Therapy Services; professional organizations representing individual therapists such as the New York State Speech-Hearing and Language Association, American Academy of Pediatrics, New York State Association of Applied Behavioral Analysts, New York State Physical Therapy Association and New York State Occupational Therapy Association; and agencies representing families such as Zero to Three, Autism Speaks and Just Kids Family Foundation.

Dental Health

The Division of Family Health, Bureau of Dental Health has in place several collaborative partnerships with state, federal, and private and public entities to promote increased access to oral health care for the MCH population and greater utilization of dental services. The Bureau provided administrative and technical support to the New York State Oral Health Coalition (NYSOHC) during its formative years of development and continues to support the work of the Coalition through active participation on the Steering Committee and Standing Committees. Representatives from Rural Health Networks, Perinatal Networks, Area Health Education Centers, Head Start programs, Community Health Centers, schools of dentistry and dental hygiene participate. The Bureau collaborates with the Bureau of Public Water Supplies and the Rural Water Association on the inspection of public water plants with fluoridated water and training water plant operators on maintaining optimal fluoride levels and reporting requirements. The Bureau also collaborates with the Office of Health Insurance Programs on the provision of orthodontic services through the Dental Rehabilitation, Medicaid and Child Health Plus programs, the development of resources on fluoride varnish for providers and consumers, data reports and analyses of Medicaid claims, and workforce issues. Collaborative partnerships are operational with advocacy groups, programs, agencies and organizations serving the MCH population for the provision of trainings and resources and development of low literacy materials for client use. Ongoing communication is maintained with numerous programs within the Department of Health, other State Agencies and community partners in order to enhance collaborations. The Bureau works in partnership with the NYS Dental Association, the NYS Dental Foundation and the State Education Department on identifying and making available to school districts the names and locations of dental care providers for completion of the school dental health certificate.

Children with Special Health Care Needs

The Department has longstanding partnerships with professional and family organizations that include the American Academy of Pediatrics, District II, New York State and New York State Academy of Family Physicians, the Family to Family Health Information Center and the Leadership Education in Neurodevelopmental Disabilities (LEND) Program. On March 26, 2009, the CSHCN Program staff provided an annual Title V overview and update to the LEND fellows. On April 23, 2009, the LEND fellows visited the Department to discuss their research projects with Title V staff.

3. Assessment of Strengths and Needs of the Maternal and Child Health Population and Desired Outcomes

New York State has the world's eleventh largest economy and is home to 54 Fortune 500 companies, 310 academic institutions, and hundreds of leading businesses – including companies in the biotech, high tech and financial industries. New York City is the country's second largest metropolis and one of the leading hubs for manufacturing and industry.

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

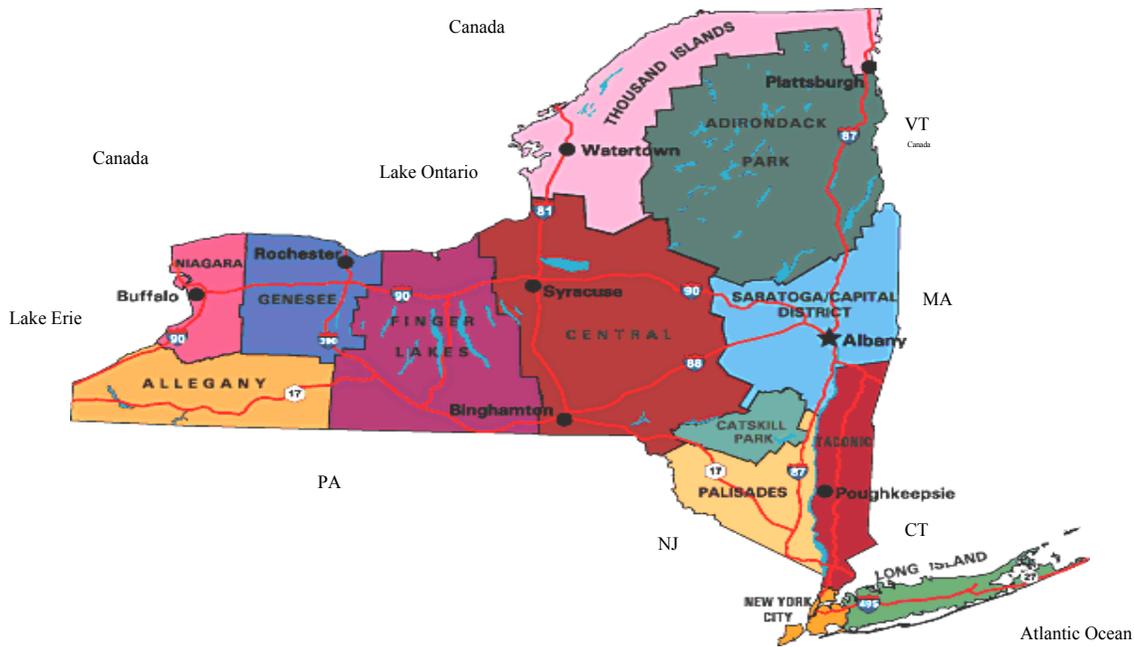
Texas. Six percent of the US population lives in New York. New York City contains 43% of the State's population, with over 8 million people (8,363,710).

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

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

Population density often determines the number and types of health services that an area can support. The US Census shows that in 2000 there were 401.9 persons per square mile in New York State, compared to 79.6 persons per square mile in the US. New Yorkers are more likely to live in urban areas than residents of other states. Population density within New York varies widely. New York City is 104 times more densely populated than the rest of the state. New York County (Manhattan) has the highest population density at 52,808 persons per square mile, while Hamilton County in the Adirondack Mountain Range has the lowest density, with only 3 people per square mile. New York City comprises over 40% of New York State's population, and the counties immediately north of New York City (Orange and Westchester Counties) and Long Island (Nassau and Suffolk Counties) comprise an additional 21% of the state's population. Other population centers are Buffalo (Erie County), Rochester (Monroe County), Syracuse (Onondaga County) and Albany (Albany County).

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



While there is great disparities among New York State residents – across geographic, economic and social sectors – some of the health related issues facing New Yorkers cut across those divides and affect the population as a whole, while other maternal and child health issues continue to show significant health disparities.

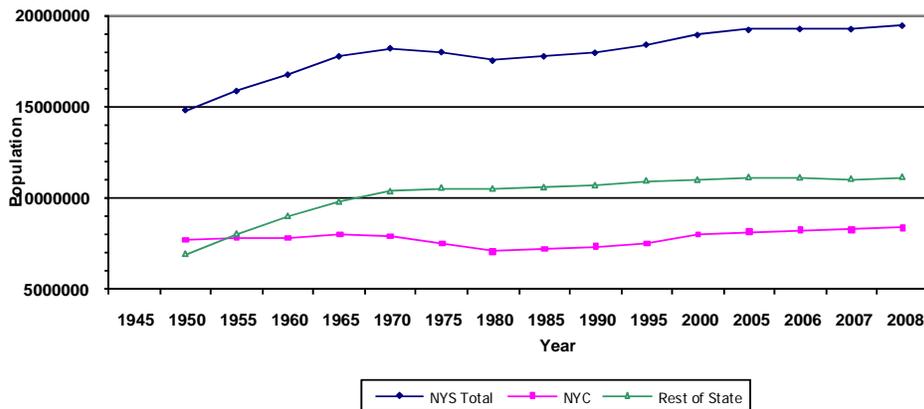
Population Age: New York’s population is aging. The median age in the State has increased from 32.0 years in 1980, to 38.0 years in 2008. This represents an aging of the “Baby Boomers” born between 1946 and 1964, as well as a longer survival rate for the elderly. The expectations for length of life for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

Population Growth: According to the 2008 Census estimates, 19,490,297 people live in New York State. Both the population residing in Rest of State and New York City’s population experienced a modest gain between 2007 and 2008. Population trends indicate that, after a slight downward trend in the late 70’s and early 80’s, New York’s population rose, and then leveled off. New York was the second most populous state until the late 1990’s, when its population growth slowed to less than 1%.

Population of New York State, 1950-2008			
<i>Source: US Census Bureau</i>			
Year	New York State	New York City	Rest of State
1950	14,830,192	7,891,957	6,938,235
1960	16,782,304	7,781,984	9,000,320
1970	18,241,584	7,895,563	10,346,021
1980	17,558,165	7,071,639	10,486,526
1985	17,795,916	7,232,980	10,562,936
1990	17,990,455	7,322,564	10,667,891
1995	18,439,500	7,510,600	10,928,900
1996	18,506,400	7,542,500	10,963,900
1997	18,571,800	7,575,000	10,996,800
1998	18,637,800	7,609,200	11,028,600
1999	18,705,695	7,643,800	11,061,900
2000	18,976,457	8,008,278	10,968,179
2001	19,074,843	8,055,166	11,019,677
2002	19,157,532	8,084,316	11,073,216
2003	19,190,115	8,085,742	11,104,373
2004	19,227,088	8,104,079	11,123,009
2005	19,254,630	8,143,197	11,111,433
2006	19,306,183	8,214,424	11,091,757
2007	19,297,729	8,274,527	11,023,202
2008	19,490,297	8,363,710	11,126,587

Population of New York State 1950-2008

Source: US Census Bureau



Households and Families: In 2008, there were 7,132,482 households in New York State. A family household, by Census definition, has at least two family members related by blood, marriage or adoption, one of which is the householder. Families made up 64.2% of the

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

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

Children: Of New York's 2008 population, 4.4 million (22.6%) were under age 18. The number of children under the age of 20 in 2008 was about 5 million (5,007,190), broken down by age groups as shown in *Table 2*. Approximately 43% of these children (2,144,445) live in New York City.

Child Population in NYS 1990, 2000, 2006-2008					
Source: US Census Bureau					
Age in Years	Number in 1990	Number in 2000	Number in 2006*	Number in 2007*	Number in 2008*
<1	1,255,764	1,239,417	244,832	246,824	250,282
1-4			975,475	949,864	958,213
5-9	1,178,006	1,351,857	1,192,659	1,157,034	1,173,057
10-14	1,140,177	1,332,433	1,285,336	1,243,567	1,222,588
15-19	1,230,127	1,287,544	1,385,081	1,396,874	1,403,050
Total Birth-20	4,804,074	5,211,251	5,083,383	4,994,163	5,007,190
Total in NYC	1,888,075	2,153,450	2,160,085	2,021,130	2,144,445

*Bureau of Census estimates.

The U.S. Census Bureau estimates that the number of children ages 4 and under in New York City grew by an estimated 6% from 2000 to 2008. In the Rest of State, however, there was a 9% decline in population in this age group. Demographers attribute the growth in the youngest age groups to the influx of immigrant families in New York City, many of whom are of childbearing age. The Census Bureau estimated that Manhattan had a 20% gain in this age group, the Bronx had a 4.8% increase, Brooklyn a 2.3% increase, and Queens showed a 1.1% increase. Upstate rural counties lost the greatest number of infants and toddlers under age 5: Greene and Schoharie Counties lost 14% each, while Orleans County lost 13%.

Race and Ethnicity:

In 2000, the Census, in an effort to reflect the growing diversity in the US, gave respondents the option of selecting one or more race categories to indicate their racial identities. Because of this change, data from the 2000 Census cannot be compared to earlier censuses. The six single race categories (White, Black or African American, American Indian or Alaskan Native, Asian,

Native Hawaiian or Other Pacific Islander, and Some Other Race) and the two or More Races category are exclusive categories. The majority of New Yorkers (96.9%) reported only one race; 3.1% identified themselves as being of more than one race.

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

Of New York State residents who selected Some Other Race, 93.4 percent identified themselves as Hispanic. Hispanics represent 16.7% of New York State's total population. In New York City, 28% indicated they were Hispanic. Four out of 10 Hispanics did not identify themselves with one of the five specific race alone categories or two or more races category. Hispanics accounted for the majority of the Some Other Race category. Of those New Yorkers identifying themselves as Hispanic, 44.2 said they were Some Other Race.

About 70% of Blacks and 43% of Hispanics/Latinos in the State reside in New York City. Among New York City residents, 45.7% reported their race as White alone, 25.6% reported Black or African American alone, 11.9 percent reported Asian alone, and 13.9 percent reported being Some Other Race. About 28% of New York City's population identifies themselves as Hispanic/Latino. Several counties outside of New York City have significant Hispanic/Latino population, as well. In Rockland, Nassau, Orange, Suffolk, Sullivan and Westchester Counties, Hispanics/Latinos make up at least 9% of the population. Between 2000 and 2008, the Hispanic population increased from 13.9% to 16.7% of New York's total population. The percentage of Black or African Americans remained at 15.9% and the percentage of Asians increased from 5.5% to 6.9%.

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

New York State Population Breakdowns by Race						
<i>Source: 2008 American Community Survey</i>						
Race Categories	New York Population		New York Hispanic Population			
	Number	% Total Pop.	Number	% of Total Population	% of Total Hispanics	% of Race Category
One Race	19,101,381	98.0	3,097,569	15.9	95.4	16.2
▪ White	13,092,844	67.2	1,450,252	7.4	44.6	11.1
▪ Black or African American	3,101,231	15.9	239,170	1.2	7.4	7.7
▪ American Indian/Alaska Native	72,575	0.4	21,745	.1	0.7	30.0
▪ Asian	1,361,955	7.0	15,483	.1	0.5	1.1
▪ Native Hawaiian/Other Pacific Islander	5,908	.03	678	.00	.00	11.5
▪ Some Other Race	1,466,868	7.5	1,370,241	7.0	42.2	93.4
▪ Two or More Races	388,916	2.0	150,958	0.8	4.6	38.8
TOTAL	9,490,297	100	3,248,527	16.7	100	16.7

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

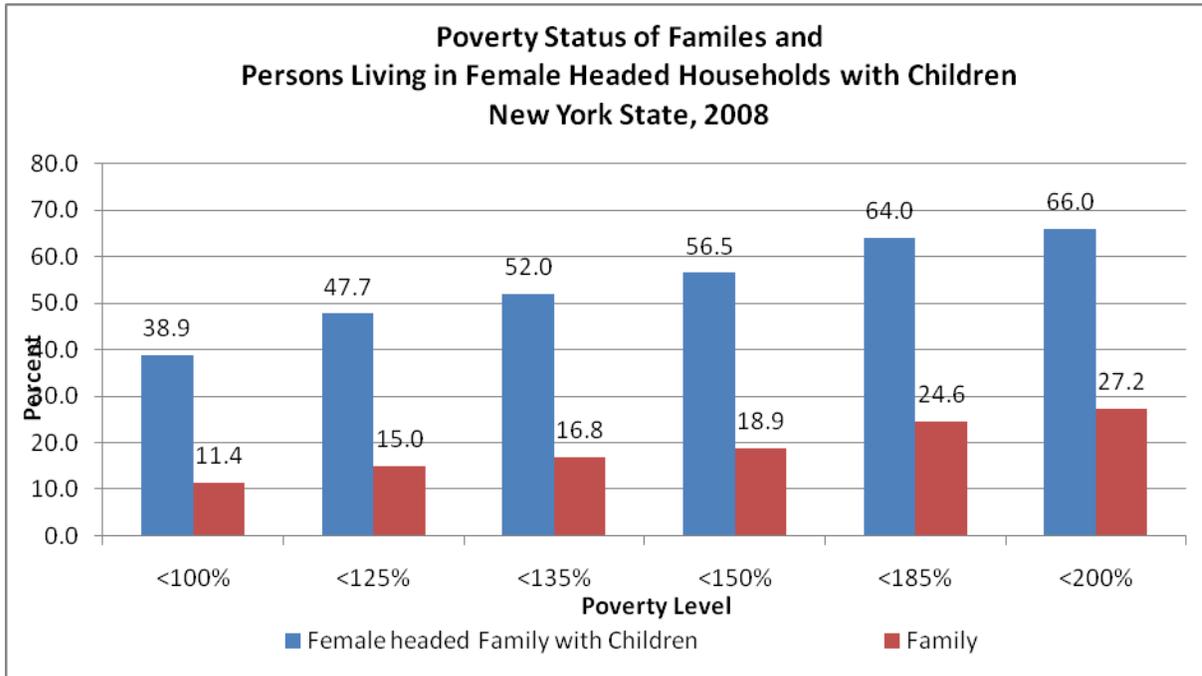
- New York had a foreign-born population of 4.2 million in 2008. This number represents 21.7% of the State's population, or about one in five people. Only California has a higher percentage (26.9%) of foreign-born residents. Nationally the foreign-born population is more than 304 million or 12.5% of the total population.
- There were approximately two million legal resident aliens and over two million naturalized citizens in New York.
- New York had more naturalized citizens than the country as a whole, probably because more of New York's immigrants come from countries that tend to naturalize and more are long-term immigrants, who are also more likely to naturalize.
- New York's immigrant population was very diverse, with no particular region or country having clear dominance.

- Of the estimated 4.2 million immigrants in New York:
 - About 832,806 or ~20% came from Europe;
 - About 1,083,658 or ~26% came from Asia;
 - About 161,368 or ~3.8% were from Africa;
 - About 11,811 or ~0.3% were from Oceania;
 - About 1,023,995 or ~24% came from the Caribbean;
 - About 475,665 or ~11% were from Central America;
 - About 588,576 or ~14% were from South America; and
 - About 58,127 or ~1.4% were from Canada.
- The largest single country of birth was the Dominican Republic, with about 403,749 or ~9.5%;
- About 235,254 or ~5.6% were from Mexico;
- About 141,738 or ~3% from India
- About 379,087 or ~9% were from China;
- About 35,348 or ~1% were from Israel
- About 234,367 or ~5% were from Jamaica; and
- About 103,987 or ~2% were from Russia.
- On average, 47% of the foreign born population speaks English less than “very well”. Among foreign born New Yorkers who are not U.S. citizens, 56% speak English less than “very well.”
- In New York State, the median household income for foreign-born individuals (\$54,918) was lower than the median income for households headed by natives (\$58,392).
- About 13% of natives and 15% of foreign born individuals live below poverty in New York State. Nineteen percent of non-citizen foreign born individuals in New York live below poverty.
- New York was estimated to have the third highest number of illegal immigrants living in state, behind California and Texas.

Poverty

- Poverty is highly associated with poor health outcomes, especially for women and children. Poverty is most common in families headed by single females, and single-female headed households with children are more likely than other families to be living below poverty. This is true regardless of race or ethnicity. Given this, New York continues its commitment to reduce rates of teen pregnancy and out-of-wedlock births and to provide poor heads of households with jobs. According to the 2009 Current Population Survey, during 2008, 38.9 percent of the people in female-headed households with children lived below poverty in New York State. For a female-headed household with two children, the Federal Poverty Level would be an income of \$17,285 or less per year. Even at 200% of poverty, which includes 66 percent of female-headed families, the income level would be no more than \$34,570. In 2008, 881,000 of New York’s children (21.3 percent) were living below poverty. This is slightly higher than the 19 percent in the nation as a whole.
- In comparing poverty levels among age groups, there is a general decrease in poverty as individuals grow older, up until age 65. According to the 2008 American Community Survey, the percentages of those living in households earning less than 100% of the poverty

level were: 20.3% for children birth to under age 5, 18.6% for 5 to 17 year-olds, 15.8% for 18 to 34 year olds, 10% for 35-64 year olds, and 11.8% for those over 65.



Source: Current Population Survey, Annual Social and Economic Supplement 2009

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

In 2008-2009, funding for education in New York was from several sources. Specifically, 47.1 percent was from the State, 46.4 percent from local school districts and 6.6 percent from the federal government (Educational Statistics for New York State, Table 11 – Total Expenditures and State Funds and Table 12 Federal Aid for Education, NYS Department of Education). Data for fiscal year 2007 indicate the per-pupil expenditures in New York State were \$15,536. The average for the U.S. as a whole was \$9,603. With a rank of 1 being the best and 51 the worst, New York ranked 2nd in the US for per-pupil expenditure, reflecting the high priority of education in New York State (U.S. Department of Education, National Center for Education Statistics, Common Core of Data (CCD), "National Public Education Financial Survey (NPEFS)," fiscal year 2007).

After an 11-year upward trend, total enrollment in elementary and secondary schools in NYS is declining. The table below illustrates current enrollment trends.

Table Elementary And Secondary Public And Non-Public School Enrollment New York State 2000-01 Through 2010-11				
Sector/Grade Group	2000-01	2008-09	2009-10a/	2010-11a/
Total	3,324,100	3,132,357	3,102,000	3,072,000
K-6	1,855,456	1,635,020	1,627,000	1,619,000
7-12	1,468,644	1,497,337	1,475,000	1,453,000
Public		2,691,444b/	2,669,000b/	2,647,000b/
K-6	2,828,362b/	1,398,898b/	1,396,000b/	1,393,000b/
7-12	1,562,045b/	1,292,546b/	1,273,000	1,254,000b/
Nonpublic	1,266,317b/	440,913	433,000	425,000
K-6	495,738	236,122	231,000	226,000
7-12	293,411	204,791	202,000	199,000
	202,327			
Nonpublic Enrollment As a Percent of Total	14.9%	14.1%	14.0%	13.8%

Source: NYS Department of Education, Education Statistics for NYS, January 2010

a/ Estimated

b/ Includes Charter School enrollment.

Note: It should be noted that public school enrollment figures reported above do not include students in special classes for handicapped children operated by Boards of Cooperative Educational Services (BOCES). The number of full-time students in BOCES classes has decreased from 17,058 in 1970-71 to 16,079 in 2008-09.

The Distribution of NYS Enrollment by race and type of school are in the chart below.

Percent Distribution Of Public School Students a/ By Racial/Ethnic Origin				
New York State				
2008-09				
Location	2008-09			
	Black	Hispanica/	Other	White
			Minoritiesb/	
"Big Five" Cities				
Buffalo	56.8%	14.9%	4.4%	24.0%
New York	31.0	39.8	14.9	14.3
Rochester	64.7	21.7	2.9	10.7
Syracuse	54.3	11.0	5.2	29.5
Yonkers	25.8	50.5	6.2	17.5
Total "Big Five"	33.1	38.2	13.8	14.8
Rest of State	8.9	9.8	4.9	76.5
TOTAL STATE	18.6	21.2%	8.5%	51.7%

a/ "Hispanic" includes Mexican, Central American, South American, Cuban, Puerto Rican, Latin American and other Spanish-speaking origin.

b/ "Other Minorities" includes American Indian, Alaskan Native, Asian and Pacific Islander, Multi-Racial

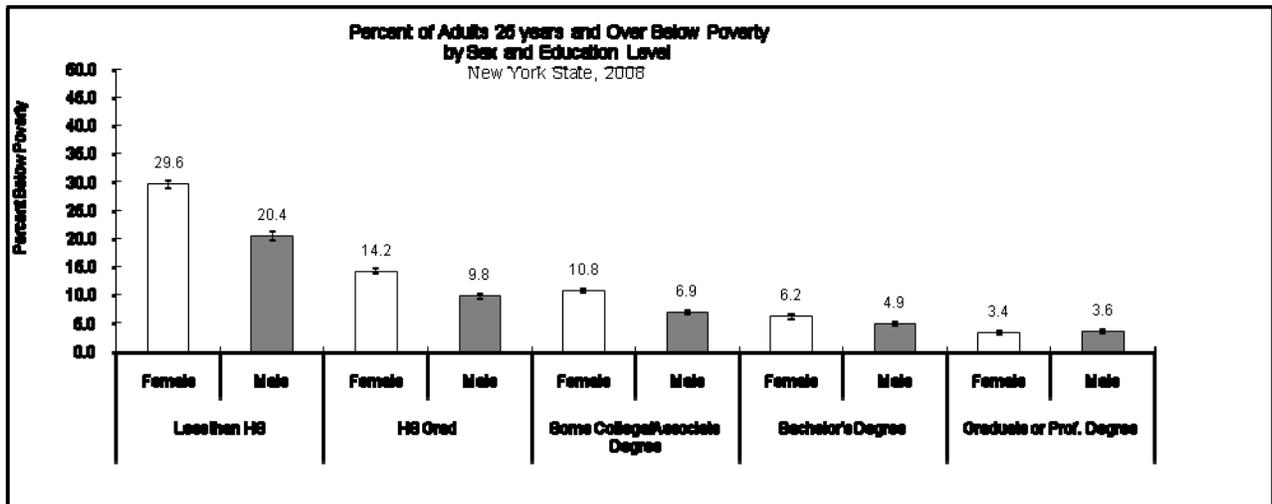
Source: New York State Department of Education, NYS Education Statistics, January, 2010

According to the National Center for Educational Statistics, during the 2007-2008 school year, there were 13.1 pupils per teacher in New York State's public schools, compared to the US average of 15.5 pupils per teacher. Class sizes in New York State public schools ranged from an average of 22 students in elementary school classes to about 23 students in high school regents classes (NYS 2007-2008 School Report Card).

In New York State, 72% of students who started 9th grade in 2005 graduated by June 2009, while 15.5% of those students were still enrolled. Graduation rates varied among students. Fifty-six percent of Black and American Indian Alaska Native students, 55% of Hispanic students, 80% of Asian Students and 83% of white students graduated as expected. Of students with disabilities, 42% graduated on time, while among students with limited English proficiency the rate was 39%. These data are also reported in the NYS School Report Card of September 01, 2008.

Despite the heavy emphasis put on secondary and post-secondary education in our State, the percentage of students who do not complete high school is of significant concern. According to the 2008 American Community survey, in New York State, 25 percent of persons with less than a high school education live below poverty. Among females without a high school education, the percent below poverty is 30 percent. The chart below presents education attainment by poverty level and sex for adults over the age of 25.

Educational attainment also has a major impact on median income. As educational level increases, so does income. A female with a bachelor’s degree earns 80 percent more than a female with just a high school education. Men earn more than their female counterparts with the same education. In fact, males with less than a high school education have a higher median income than females with a high school diploma.



Source: US Census Bureau, American Community Survey 2008 - (S1501) Educational Attainment

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

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

Public Health Insurance: In 2007, the Department established the Office of Health Insurance Programs which consolidated operations of the State’s public health insurance programs under the direction of the State Medicaid Director. The establishment of OHIP marked the adoption of a new mission for Medicaid, namely to expand coverage and access; to buy value with New York’s health care dollars; and, to advance system wide reform. Over the past several years, New York has transitioned towards a fairer, more transparent and straightforward system that

better rewards quality and efficiency. For the purposes of reimbursement reform, the State's mantra has been "the right care, in the right setting at the right price".

In 2007, New York began the critical process of reforming Medicaid's inpatient reimbursement system and transforming Medicaid into a more prudent, value driven health purchaser. In the 2007-08 Budget, the Legislature reduced inpatient rates by \$225 million as a first step in bringing inpatient reimbursement in line with inpatient costs. Most of this funding was reallocated to hospital clinics, community clinics and doctors and practitioners. Outdated outpatient payment methods and rates that had been frozen for over a decade at levels below the cost of providing care acted as a deterrent for physicians to accept Medicaid and for hospitals to treat patients in an outpatient setting. Clinics that serve a large proportion of Medicaid patients struggled financially as a result of reimbursement rates that had not kept pace with inflation or changes in medical practices. Fees paid to physicians and other practitioners were also well below reasonable market rates, making it difficult to ensure patient access to care. To incentivize the provision of enhanced primary and preventive care, the State embarked upon a multiyear commitment to modernize the outpatient payment methodology and to invest over \$600 million in ambulatory care reform.

Recognizing that comprehensive reform meant not only changing the price paid for Medicaid services, but also meant eliminating the "one size fits all" outpatient clinic payment methodology, the Department selected an innovative new payment methodology called Ambulatory Patient Groups or APGs. The APG methodology, unlike the previous flat rate methodology, responds to acuity of patients, as well as changes in the standard of care, and reimburses more specifically for diagnosis and services delivered. The new reimbursement system provides a wealth of information related to specific diagnoses of and services provided to Medicaid patient seen in outpatient clinics that was previously unavailable. Implementation of APGs began in outpatient hospitals clinics and in ambulatory surgical centers in December 2008 and will be implemented in free standing clinics effective September 1, 2009.

Medicaid was also significantly underpaying physicians and other practitioners. To remedy this situation and to encourage the participation of more physicians in Medicaid fee-for-service, the State provided funding to permit a 40% increase in the fees paid to physicians, nurse practitioners, midwives and other practitioners effective January 1, 2009. This funding also supported a 10% add on to the fees paid to office based physicians in Health Professional Shortage Areas (HPSAs) and for weekend and after hours appointments in clinics and office based settings.

In addition, to improve the health of enrollees and prevent more costly hospital admissions and treatment, the State has added asthmas and diabetes education, social worker counseling, cardiac rehabilitation, smoking cessation and screening and brief intervention and referral to treatment (SBIRT) for substance abuse to its list of covered services. Over time, these investment are expect to more than pay for themselves in the form of a reduction in medical costs. In addition, the state will implement a program to incentivize the development of patient centered medical homes. Hospitals and doctors that coordinate and integrate their patients care in accordance with medical home standards will receive additional payments. The State Plan Amendment for medical home incentive payments have been approved for office based physicians, nurse

practitioners, freestanding clinics and federally qualified health centers and will be implemented approximately July 1, 2010.

In 2008, New York took a bold step towards ensuring universal coverage for children in the State when, prior to federal funding support, it increased the income eligibility threshold for Child Health Plus from 250 to 400 percent of the federal poverty level, making an additional 70,000 children eligible for subsidized health insurance coverage. In addition, the State expanded Family Health Plus for adults with children and for young adults (ages 19 and 20) to 160 percent of the federal poverty level. Medicaid coverage for foster care children was also extended through age 20 to address the long standing problems children in foster care have had in transitioning to adulthood and independence.

The state has also made substantial process in streamlining the Medicaid eligibility process. A critical need was to eliminate administrative processes that served as barrier to enrollment. To address this need, the state made landmark changes by eliminating the requirements for face-to-face interviews and finger imaging, as well as the resource test for non-SSI applicants. This built on changes made in previous years related to eliminating several eligibility rules for single adults and childless couples such as the requirement for drug and alcohol screening. As a result of these administrative simplifications, Medicaid retention rates increased from 60 to 70 per cent and total Medicaid enrollment has also increased by 142,000 in 2008 alone.

Over the past several years, NY has implemented initiatives to increase access and enrollment. For example, authorized medical providers and community-based organizations provide application assistance as “Facilitated Enrollers (FEs).” FEs are able to determine a child presumptively eligible for MA or CHP for a limited time if they appear eligible for coverage based upon uniform criteria. In June 2009, NY received federal approval to waive the six-month waiting period for families with a child under five, or any child whose family must contribute more than 5 percent of their income to purchase insurance. Going forward, the State plans to strengthen the enrollment and renewal process through the establishment of a statewide enrollment center that will include a single, statewide telephone and mail-in renewal system and a toll-free call center for New Yorkers seeking information about, or assistance enrolling in, Medicaid, Family Health Plus or Child Health Plus.

Pregnant women and infants under one year of age, at or below 200% of the Federal Poverty Level (FPL) are eligible for Medicaid. Pregnant women with income of less than 100% FPL are eligible for the full array of ambulatory Medicaid services including, but not limited to, primary care, dental health and eye care as well as other supports and services offered to the Medicaid population. Those with incomes above 100% FPL but less than, or equal to 200% FPL are eligible for coverage for Medicaid Prenatal Care only. Pending approval from the Federal government, income limits for Medicaid eligibility will be increased. Women with incomes up to 120% FPL will be eligible for full Medicaid services. Women with incomes above 120% FPL and up to and including 230% FPL will be eligible for prenatal care services under Medicaid.

NYS is one of eight states participating in a program funded by the Robert Wood Johnson Foundation to increase enrollment and retention of children eligible for MA and SCHIP but are not enrolled. The program, “Maximizing Enrollment for Kids” seeks to help states improve

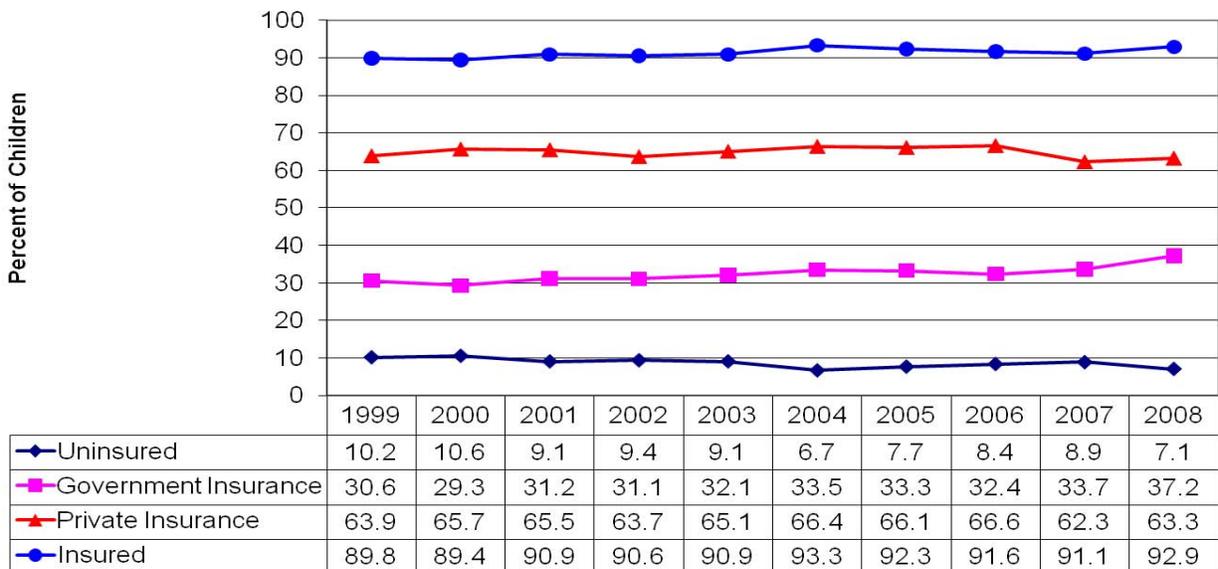
systems, policies and procedures to increase the proportion of eligible children enrolled and retained in MA and SCHIP. New York will explore the potential of enrolling more children by simplifying the enrollment process and using publicly available screening tools to make it easier for families to apply for coverage. NY will be partnering with community-based organizations, faith groups and health and human service providers for a “Connections to Coverage” campaign to link uninsured children to facilitated enrollment in their communities.

Expanded Medicaid Eligibility for Immigrants: In New York, qualified immigrants formerly subject to the five year ban on Medicaid eligibility and immigrants who are Permanently Residing in the United States Under Color of Law (PRUCOL) may be eligible for state-only Medicaid and Family Health Plus, so long as they meet all financial eligibility and other rules to be eligible for benefits under these programs. Immigrants who are determined to be class members may also be eligible for reimbursement of payment of doctors’ and other health care provider bills for care and services received on or after September 12, 1997 and August 5, 2004.

Health Insurance: The 2008 rate of uninsured New York State residents under the age of 65 was 15.8%, which compares favorably with the national rate of 17.3% without health insurance in 2008. In 2008, 49 percent of all obstetrical deliveries were paid for by private insurance and about 2% were self-pay. The remaining 49% were funded by some type of government (47%) or other insurance (2%).

According to the Current Population Survey, in recent years the number and percent of children under the age of 18 in New York State who are insured has increased incrementally. More children under the age of 18 were insured in 2008 than in 1999 (92.9% vs. 89.8%). The percent of these children covered by government insurance increased over 20 percent since 1999 (increased from 30.6% in 1999 to 37.2% in 2008). This figure is expected to undergo even further improvement in the coming years, as coverage under Child Health Plus has been extended to children with incomes under 400 percent FPL. Nationally, 9.9% and in New York State, 7.1% of children under age 18 were uninsured in 2008.

**Health Insurance Coverage Status
by Type of Insurance for Children less than 18 Years Old
New York State, 1999 - 2008**

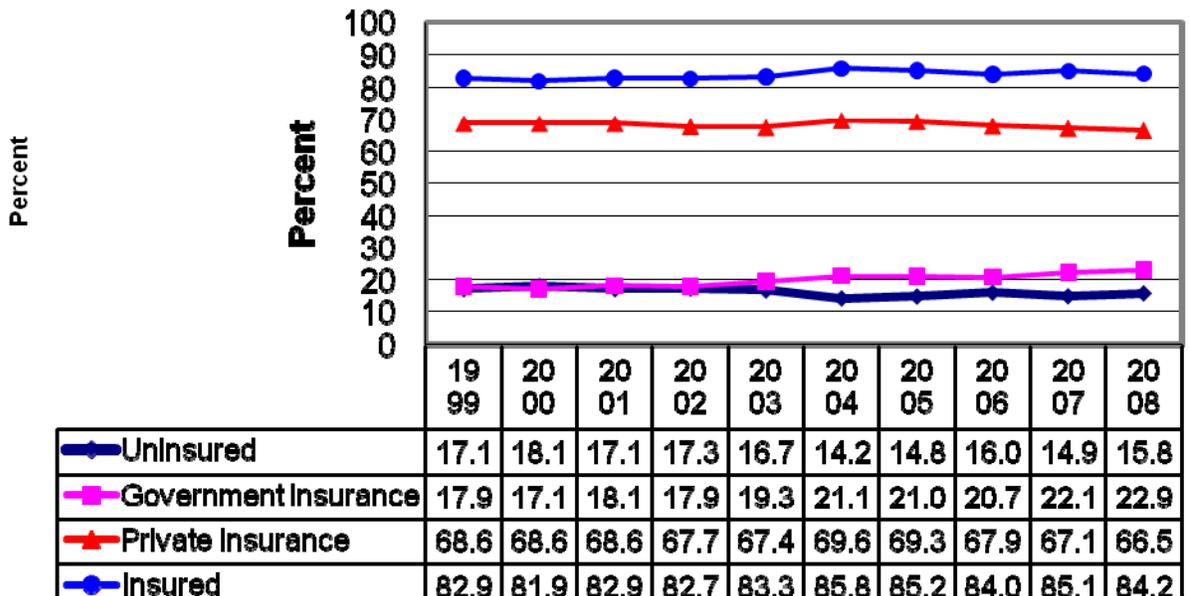


Source: Current Population Survey (CPS) 2008 Annual Social and Economic Supplement-Health Insurance Table HI-5

Note: Government Insurance includes plans funded by governments on the federal, state, or local level.

Private Insurance includes plans provided through an employer, union or purchased by an individual from a private insurer. An individual can be covered by both private and government insurance.

**Health Insurance Coverage Status
by Type of Insurance for Persons Under Age 65 Years of Age
New York State, 1999 - 2008**



Note: Government Insurance includes plans funded by governments on the federal, state, or local level.

Private Insurance includes plans provided through an employer, union or purchased by an individual from a private insurer. Persons can be covered by both Private and Government Insurance.

Source: US Census Bureau, Health Insurance Table HI-6

Until recently, it has been difficult to estimate the number of uninsured within each county in the state. Recently, however, the US Census Bureau has developed a model-based methodology to estimate health insurance coverage for counties and states. Utilizing this methodology and data

from the 2008 Annual Social and Economic Supplement to the Current Population Survey (CPS), NYSDOH staff has prepared county level uninsured estimates for NYS. According to these estimates 9.2% of New York State's children under the age of 19 were uninsured in 2007. The percent of children uninsured varied widely throughout New York State. The counties with the highest percentages of uninsured children were Hamilton (20.8%), Putnam (15.3%) and Otsego and Sullivan (12.7%). The lowest rates of uninsured children were in the counties of Monroe (5.5%), Chemung (5.7%), and Oswego (5.8%).

Overall Health: According to the United Health Foundation, the American Public Health Association and the Partnership for Prevention, which regularly assess the overall healthiness of the nation, New York ranked 25th in overall healthiness in 2009. In 2008, the ranking was 24th and in 2005, 29st. Reasons for the improved ranking include New York's ready access to primary care, high per capital public health funding and a low rate of cancer deaths in the state as compared to other states.

Access to Primary Care: According to the latest available National Survey of Children's Health, 2007, 57 percent of New York's children had a medical home (defined as care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective).

Ninety-six percent had a preventive medical visit in the past year and about 81 percent had a preventive dental visit in the past year. Both of these percentages were higher than the national averages for these indicators.

More New Yorkers are establishing a medical home under a managed care plan. In 1998, 29.1% of New Yorkers enrolled in the Medicaid program received their care through enrollment in managed care. By April of 2010, about 84% or 2,736,595 of the 3,263,506 Medicaid-eligible people in the State received their care through a managed care plan. Percentages are higher for New York City (87%) when compared to rates for the State outside New York City (77%).

Access to Dental Care: New York State, with 83.6 dentists per 100,000 population, was well above the national rate of 63.6 and ranked 4th in the nation in dentists per capita. The per capita ratio of dental hygienists was slightly higher than the national rate. However, the distribution of dentists and dental hygienists is geographically uneven. There are many rural and inner city areas in the State where shortages of dentists and dental hygienists exist, where specialty services may not be available, and where the number of dental professionals treating underserved populations is inadequate.

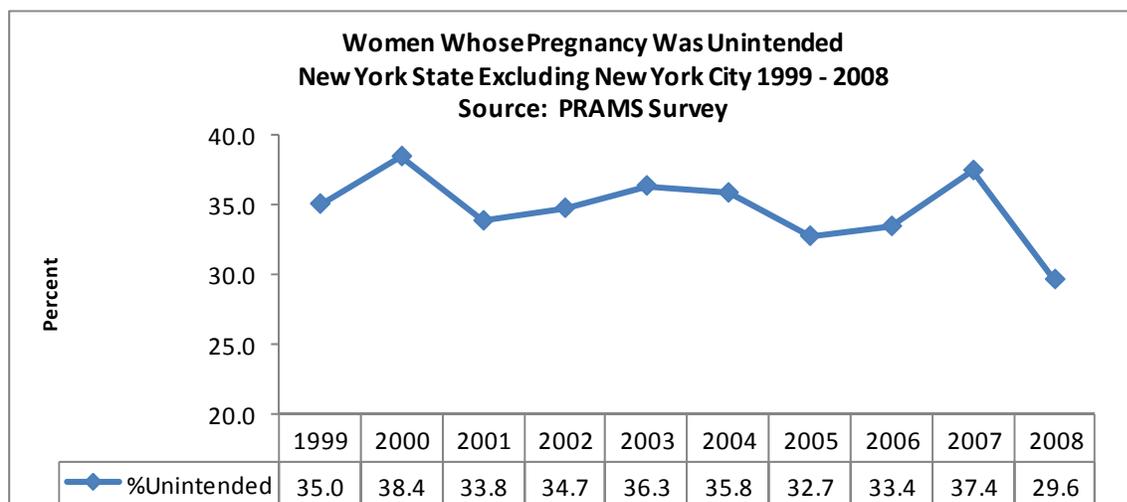
The demand for dentists, based on current employment levels, is projected to increase by 3.1% from 10,220 jobs in 2002 to 10,530 in 2012. During the same time period, the demand for both dental hygienists and dental assistants are both projected to increase by nearly 30%. In 2006, of the 15,291 dentists licensed to practice in New York State, 49% were enrolled in Medicaid. During the same time period, however, only 3,996 dentists statewide (26%) had at least one claim paid by Medicaid. Of the 3,996 dentists submitting at least one claim, 91% (3,638) had \$1,000 or more in Medicaid claims during 2006.

Those who are most vulnerable to dental disease are those of low income, those with less education, those who do not have access to preventive dental care, and those with special health care needs or chronic conditions.

Even the comprehensive coverage New York offers under public and private dental insurance is not enough to guarantee access. Other factors, such as the geographic location, transportation, the availability and distribution of dentists and pediatric dental specialists, and parent and patient knowledge and attitudes play a significant role in access to dental care, especially for the poor. According to the Behavioral Risk Factor Surveillance System, in 2008, 74.2% of New York State respondents indicated that they had seen a dentist in the last year. Among Blacks and Hispanics, 68.8% and 73.3% had visited a dentist during 2008.

A. Pregnant Women, Mothers and Infants

Family Planning and Reproductive Health



In 2008, about 30% of new mothers responding to the PRAMS survey in New York State excluding New York City indicated their pregnancy was unwanted or mistimed. This rate was the lowest ever recorded since the PRAMS survey began in 1993 and considerably lower than the 2007 rate of 37.4%. About 70% of women reported that they wanted their pregnancy either when it occurred (52.2%), or earlier (18.2%).

In New York City in 2007, 36% of moms responding to the PRAMS survey indicated that their pregnancy was not wanted or was wanted later. This rate held steady compared with 2006, when 35.9% reported that their pregnancies were unintended at this time. NOTE: A statewide PRAMS file is expected from CDC, but has not yet been received. Until it is available, Upstate and NYC PRAMS data must be reported separately. Changes in the percentages for these sub-groupings from year to year are generally not significant. The small number of respondents within these categories results in large confidence intervals and thus fluctuation in the rates from year to year.

<i>Responses to Question on Intendedness of Pregnancy PRAMS Survey 2000 to 2008 (NYS Excluding NYC)*</i>									
Response:	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total reporting pregnancy was unwanted or mistimed Of those that were:	38.4%	33.8%	34.7%	36.3%	35.8	32.7	33.4	37.4	29.6
Under age 20	76.4%	77.5%	81.7%	66.1%	77.9	63.4	75.6	62.7	54.3
Unmarried	67.9%	60.1%	63.2%	63.2%	59.5	54.5	56.3	59.0	53.1
African American	64.8%	56.6%	62.3%	71.1%	66.5	55.7	75.8	60.1	55.6
On Medicaid	57.9%	56.6%	57.2%	57.6%	56.1	48.1	48.1	59.0	46.5
Less than a high school education	51.2%	57.1%	51.9%	53.2%	54.3	48.9	40.3	46.0	54.3
Total reporting pregnancy was wanted when it occurred	44.5%	44.6%	44.1%	45.0%	42.4	46.4	47.9	46.6	52.2
Total reporting pregnancy was wanted earlier	17.2%	21.6%	21.2%	18.7%	21.8	20.8	18.7	16.0	18.2

In comparing New York City PRAMS responses to Upstate responses:

Comparison of Rest of State and New York City PRAMS Responses – Eligible Quarters in 2005 to 2007								
	2005		2006		2007		2008	
Timing of Pregnancy	Upstate	NYC	Upstate	NYC	Upstate	NYC	Upstate	NYC
Wanted Sooner	20.9%	18.0%	18.7%	19.4%	16.0%	20.3%	18.2%	n.a.
Wanted Later	26.6%	31.0%	26.5%	30.1%	29.7%	28.1%	22.1%	n.a.
Wanted Then	46.4%	44.2%	47.9%	44.7%	46.6%	43.7%	52.2%	n.a.
Did not want	6.2%	6.7%	6.9%	5.8%	7.8%	7.9%	7.5%	n.a.

Unintended Pregnancy (not wanted or wanted later)	32.7%	37.8%	33.4%	35.9%	37.5%	36.0	29.6%	n.a.
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Family Planning and Reproductive Health Services

Based on 2008 data, New York State is achieving the Healthy People 2010 intended pregnancy objective of 70% for women giving birth. Of New York women with unintended pregnancies who delivered live born infants, 55% reported that they were not using contraceptive methods when they became pregnant. Consistent with national data, significant health disparities exist in NYS with 54.3% of women under the age of 20; 53.1% of unmarried women; 55.6% of African American women; 46.5% of women receiving Medicaid benefits, and 54.3% of women with less than high school educations reporting that their pregnancies were unintended.

Adolescent pregnancy is an area where considerable health disparities exist. Among African American and Hispanic teens in the 15-19 age groups, pregnancy rates are more than double that of White teens. In 2008, the White teen pregnancy rate was 40.7 per 1,000 white adolescents, less than half the rate for Black (97.6) and Hispanic (103.3) adolescents.

To address the issue of unintended pregnancy and improving reproductive health, the New York State 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 to assist low income, uninsured and underinsured women, racial and ethnic minorities, adolescents and men in determining their reproductive futures and in avoiding unintended pregnancy. The Family Planning Program served more than 340,000 women and men in 2008, including 58% minority and 89% under 150% of the Federal Poverty Level.

The program services include:

- Offering basic primary care preventive and treatment services such as breast examinations, cervical cancer screening and hypertension screening to low income women who would otherwise be unable to obtain care.
- Providing counseling and testing for HIV and sexually transmitted diseases to help contain major threats to public health.
- Ensuring access to preventive and primary health services for women and their partners.
- Providing health education in community settings, including schools to educate children about reproductive health; to prevent adolescent pregnancy by promoting abstinence, and to promote access to reproductive and preventive health services.

There are currently 49 family planning agencies providing services in 189 sites, including four mobile units providing services statewide. In addition, there is one Natural Family Planning Services provider, and one Infertility education and referral program. All programs are administered according to the Federal Title X Guidelines for Family Planning Services. The Family Planning Program collects detailed information during each visit, including client characteristics, purpose of visit, medical and counseling services provided, and referrals. All

providers are required to participate in the data management information system, which collects client-specific information on all clients seen in the program. This information is used to identify trends in utilization of family planning services, to assess success in meeting stated program and Title X objectives, and to focus on improving program performance.

In addition, the program collaborates closely with the Medicaid program to increase access to reproductive health services for Medicaid eligible women. In 1996, the Medicaid managed care legislation expanded Medicaid benefits for 26 month after the end of a pregnancy to women under 185 percent of the federal poverty level who had previously been on Medicaid while pregnant and subsequently lost coverage. The MCH program and the Department's OHIP collaborated closely in implementing this program, which, with the advent of the Family Planning Benefit Program described below, increasingly became of the avenue for undocumented women to receive extended family planning benefits that are reimbursed with state funds. In addition, in 2006, the MCH program and OHIP collaborated in developing and implementing the state's waiver to expand family planning services for individuals up to 200 percent of the federal poverty level.

The Family Planning Program has undertaken a number of special initiatives. Funding was provided by the State in 2007 to support a continuing series of initiatives and services related to emergency contraception (EC), including collaboration with the American College of Obstetricians and Gynecologists (ACOG) for education efforts and media campaigns to reach OB/Gyns and supplemental funding to family planning providers to purchase EC for clients. In addition, the State has provided substantial funding for access to the HPV vaccine which is primarily being implemented through the State's Family Planning Program. Through the federal Office of Population Affairs, services were expanded to serve hard to reach populations that could benefit from these services. Expansion projects conduct activities designed to engage historically underserved populations (which may include minorities, adolescents, males, substance abusers, the homeless, immigrants, individuals in the criminal justice system and persons with disabilities. This has led to several strong collaborations, for example, with the state's Division of Correctional Services, to provide reproductive services to women being discharged from those facilities.

As a specific quality improvement project, in 2008 the School Health Program engaged in an ongoing collaboration with NYC DOHMH and NYCDOE to improve access to quality reproductive health care services in high school-based SBHCs in NYC. In addition, NYSDOH has identified additional funds to support the purchase of emergency contraception for SBHCs serving high schools statewide. Collaboration on the NYC project includes supporting NYCDOHMH in their efforts to increase resources and provide training and technical assistance for the provision of on-site, quality, comprehensive reproductive health care to adolescents at more than 40+ high school-based SBHCs in the city, including purchase of contraceptives. NYSDOH is collaborating closely with NYCDOE/DOHMH on this project, including steps to align the project with the NYSDOH SBHC Quality Improvement initiative, with the hope that this project may inform the development of additional reproductive health-related clinical measures and guidelines for SBHCs statewide, and the consideration of the varying needs of other upstate communities.

The Guttmacher Institute indicates that in 2006, New York State is second in the country in funding for publicly supported family planning services from all sources, including Medicaid. Strengths of the program include a well established network of comprehensive family planning programs in every county in the state that provides important capacity for providing services statewide. In addition, significant collaboration with a wide variety of community-based agencies, local and civic organizations, lay and professional interested parties and other government entities builds capacity and enhances the provision of outreach and access for intended clientele. The MCH Program has a very positive track record in working with OHIP related to a variety of issues, including Medicaid reimbursement, for example, in obtaining separate reimbursement of Implanon and IUDs within the APG payment methodology.

Despite this significant commitment to supporting family planning, The Guttmacher Institute also estimates that New York State is reaching only 41 percent of women in the state needing public support for family planning services. A key challenge for the program is that available funding has not kept pace with the increased costs of doing business for family planning providers making it difficult to hire and maintain clinical staff. Although state funding has increased over the past several years, federal Title X which provides substantial support to the Program has remained flat. Efforts to ensure coverage for the significant population of undocumented women in the State have been hampered by current limitations in access to the FPEP program. In addition, new federal requirements placed upon the state's Medicaid waiver in the last renewal period, coupled with requirements of the Deficit Reduction Act that requires proof of citizenship, have significantly impacted upon access to the waiver program, particularly among adolescents who do not have the means to obtain this documentation without jeopardizing confidentiality.

The provision of comprehensive family planning services remains one of the most effective ways to prevent unintended pregnancies. To decrease unintended pregnancies, family planning programs must increasingly focus their attention and resources upon those groups more likely to experience unintended pregnancies by increasing access to services and more effective methods of contraception; identifying and addressing issues which create barriers to access to contraception; providing assistance in enrolling clients in public health insurance programs; offering flexible and extended hours of operation; and, providing culturally competent care. The Family Planning Program prioritizes providing services in targeted zip codes in New York State where rates for unintended pregnancy, and vital indicators related to poor birth outcomes are high, as well as underserved rural communities.

The DOH is about to release a new Request for Applications for the upcoming five year contract cycle. This RFA will focus on targeting funding to the areas of highest need.

The Department is expanding its contract with Cornell University, the Department's Center of Excellence for Adolescent Health, who is in turn subcontracting with the Columbia University School of Public Health, to perform an intensive data analysis of the Department's Family Planning Program, including conducting focus groups to assess changes that need to be made to improve program performance. The Program will also collaborate with OHIP to identify factors impeding access to reproductive health services for Medicaid enrollees. The Program will also look for opportunities to collaborate with FQHCs to obtain information related to mandated

family planning services offered through their clinics to develop a more complete picture of family planning services accessible in the state.

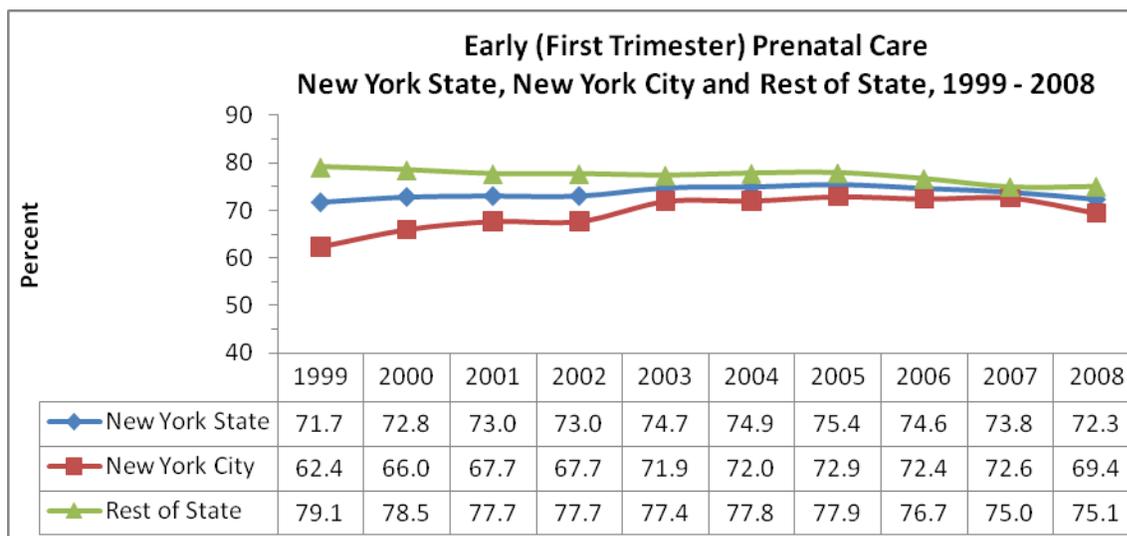
Perinatal Health

Important Note Related to Data: In 2008, New York City Vital Records adopted the NCHS standard birth certificate. This certificate has been used for births occurring in New York State outside of New York City since 2004. The use of the new certificate changes the way race data are collected for New York City recorded births. Beginning in 2008, respondents are able to check all the races he/she thinks are appropriate. Prior to 2008, respondents would have to select one of 4 categories (White, Black, Asian or Other). There was no option for selecting multiple races.

As a result of these changes, comparisons of race related birth statistics between 2008 and prior years, although described, are problematic. Although no changes have occurred in the reporting of race on death records, 2008 race specific death rates that use total births as a denominator (such as infant deaths and neonatal deaths) are also impacted.

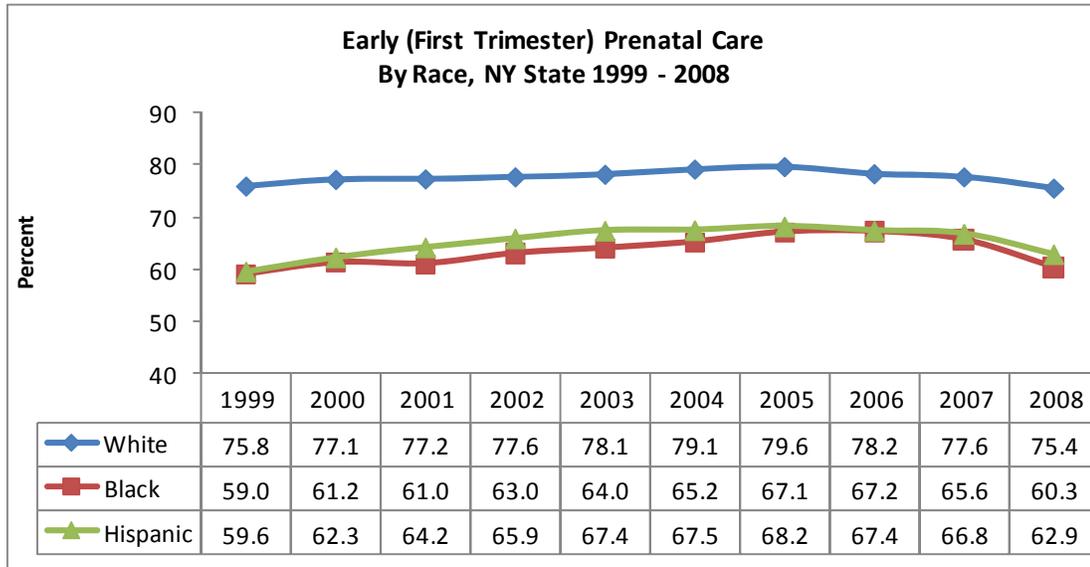
The New York State and New York City Department of Health are meeting to discuss impact of this change to better assess current performance.

In 2008, the percent of women giving birth in New York State who received early prenatal care (first trimester) was 72.3%, a reduction from the 2007 percentage of 73.8%. The lower statewide rate was due to a reduced percentage of New York City women receiving early care. However, rates of early entry into prenatal care, overall, have been basically stable over the past decade (71.7% in 1999 and 72.3 in 2008), with some minor fluctuations. Regional rates, however, have been less stable. The rate for women outside of NYC was initially significantly higher than the rate for NYC women, but NYC rates of early entry to prenatal care have improved more than 10 percent over the past decade (from 62.4% to 69.4%), while rates for upstate women have fallen off slightly, resulting in far less regional disparity. These rates do not meet the Healthy People 2010 goal of 90 percent first trimester entry to prenatal care.



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

Consistent with the slight decline in the statewide rate of early entry into prenatal care, compared to 2007, early prenatal care rates in 2008 were somewhat lower among all race/ethnicity groups in NYS. A significant, though declining, race/ethnic disparity exists in the percentage of women receiving early care. Rates for white women (75.4%) were 25% higher than rates among Black (60.3%) and Hispanic (62.9%) women, while a decade ago the rate for whites was 31-32 percent higher than the rate for Black or Hispanic women.



Prenatal Care – Medicaid/Non Medicaid Comparison

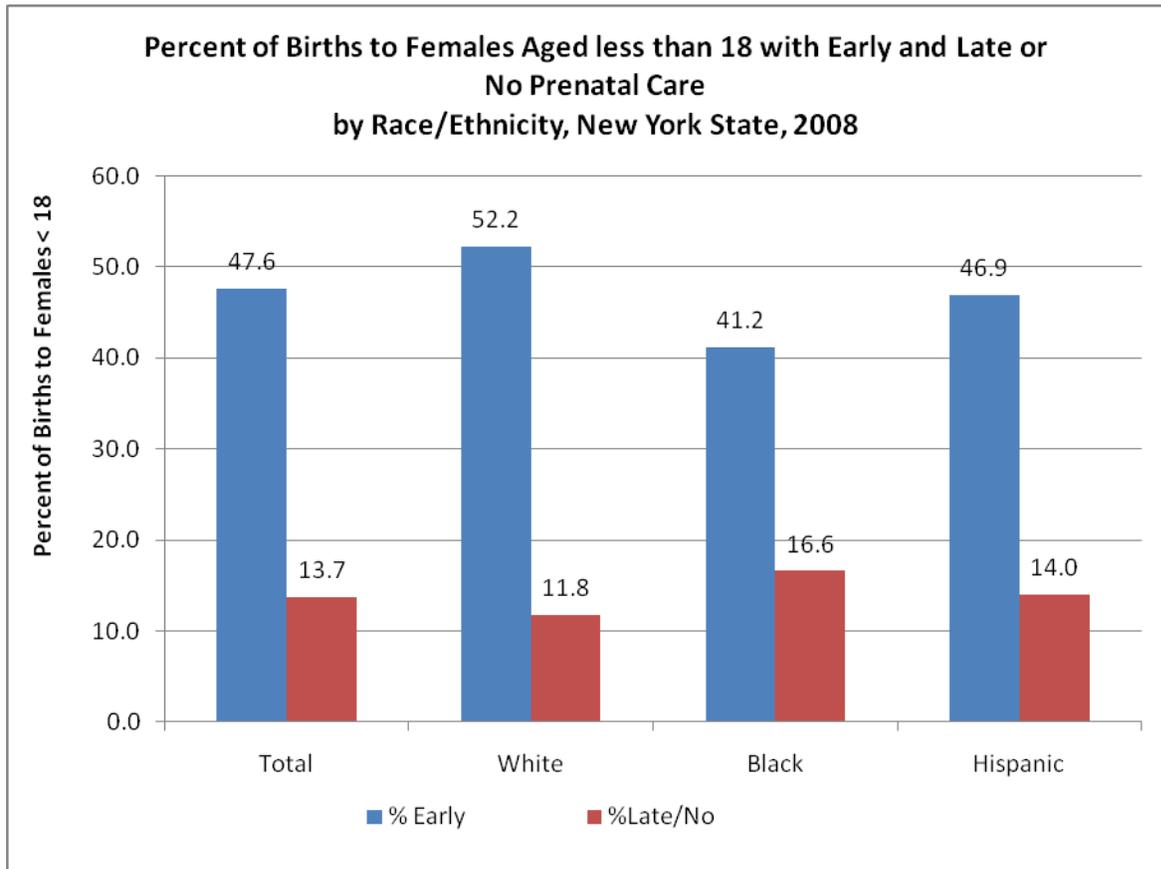
There is a significant disparity in the percentage of infants born to pregnant women receiving prenatal care in the first trimester in the Medicaid versus non-Medicaid population.

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	60.4	81.9	72.2

Prenatal Care Among Teens: Women under the age of 18 are less likely than women in general to get prenatal care during the first three months of pregnancy. In 2008, just over 50

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



Adequacy of Prenatal Care: The Kotelchuck Index is a calculation based on the number of prenatal care visits received by pregnant women ages 15 to 44 who had a live birth during the reporting year, expressed as a percentage of observed-to-expected number of prenatal visits. Adequate prenatal care is defined as completion of greater than 80% of expected visits, based on their timing of entry to prenatal care.

The Kotelchuck index for New York State women aged 15-44 giving birth in 2008 was 65.5. This was an increase over what was reported in 2007 (58.0). Indices were higher among women residing in Rest of State (69.0) as compared to women residing in New York City (61.7) and higher for White women (69.0) as compared to Black (52.7) and Hispanic women (57.8). However, both geographic (NYC vs. ROS) and racial/ethnic disparities have been reduced over the past decade.

Adequacy of Prenatal Care as demonstrated by Kotelchuck Index											
New York State Births											
1999 through 2008											
Year →		'99	'00	'01	'02	'03	'04	'05	'06	'07	'08
Region	New York City	57.6	57.6	56.6	56.5	57.8	59.9	59.5	59.8	58.0	61.7
	Rest of State	73.8	72.3	69.7	69.9	67.6	72.7	73.2	71.8	68.9	69.0
	Total NYS	66.9	65.6	63.5	63.6	63.1	66.4	66.5	65.9	63.5	65.5
Race	White	71.5	70.1	68.0	68.6	66.6	70.2	70.7	69.7	67.4	69.0
	Black	52.9	53.4	50.6	51.8	49.8	53.0	53.6	54.1	51.2	52.7
	Hispanic	56.2	56.1	55.0	57.1	55.8	57.8	57.9	57.0	54.3	57.8

Location of Prenatal Care: PRAMS responses indicate that 70.5% of women residing in NYS (excluding NYC) in 2008 received their prenatal care in physicians' offices (private MDs or health maintenance organizations). Other sources of care were hospital clinics (13.0%), community health centers (6.7%) and health department clinics (6.2%).

Women participating in the 2007 NYC PRAMS Survey were most likely to get their care from a hospital clinic (40.7%) or from an MD/HMO (49.5%).

Content of Care: PRAMS questions on prenatal care elicited responses to indicate that most women received educational information during their pregnancy on nutrition, drinking, smoking, and HIV testing. According to the 2008 survey, of the 90.4% of women who reported that their prenatal care provider talked to them about HIV testing, 96.4% went on to be tested during their pregnancy. Of the 9.6% who were not talked to about HIV testing, 57.1% report being tested. Between 2002 and 2008, women were asked if they could identify the reason folic acid is important in a multiple choice question. The percent of women answering this question correctly has ranged between 91 and 87 percent. In 2008, 85.7% answered correctly.

Use of Alcohol and Tobacco during Pregnancy: Smoking during pregnancy can cause stillbirth, low birthweight, SIDS and other serious pregnancy complications. About 21% of women who responded to the NYS (excluding NYC) PRAMS survey in 2008 reported they had smoked in the three months prior to pregnancy (down from 23% in 2007), and though most reported they stopped smoking while they were pregnant (11.9% in 2008 reported smoking in the last three months), many reported they returned to smoking (16.1%) after their pregnancy. The percentage of those that smoked after pregnancy, however, was consistently lower than the

percentage that smoked before pregnancy. About 3% reported their infants were exposed to second-hand smoke. According to the 2007 NYC PRAMS Survey, 4.7% of NYC moms answering smoked during their pregnancies and 11.3% were smokers before they became pregnant.

Drinking alcohol during pregnancy is associated with fetal alcohol syndrome, a birth defect that is 100 percent preventable by not drinking alcohol during pregnancy. Women sampled in the NYS (excluding NYC) PRAMS survey reported that they reduced the use of alcohol during pregnancy. In 2008, 52% reported drinking alcohol in the three months prior to pregnancy, but only 7% drank alcohol during the last three months of pregnancy. This percentage has been relatively unchanged since 2005, but represents an improvement over the 8.2% reporting drinking while pregnant in 2002.

Oral Health and Pregnancy: Evidence is emerging to show that poor oral health may be associated with adverse pregnancy outcomes. Several studies have shown the associations between periodontal disease and increased risk for preterm labor and low birth weight babies. Visits to a dentist during pregnancy are recommended to avoid the consequences of poor oral health. In New York State (exclusive of NYC) in 2008, 45% percent of pregnant women, as estimated from PRAMS, used dental services during their pregnancies. White women (57.4%) were more likely to have used dental services during their pregnancy than Black women (32%) and women of “other” races (52%).

Because of the concern about the potential effect of poor oral health prior to and during pregnancy, and because of potential effects of maternal oral health on early childhood caries, and because there are no national standards for the oral health care of women during pregnancy, New York convened an expert panel of obstetricians, dentists and pediatricians to formulate guidelines for the oral care of women during pregnancy and the prevention of early childhood caries. The guidelines were released in the Fall 2005 and were disseminated through professional meetings, patient and professional educational materials and teleconferencing. The Bureau of Dental Health was able to obtain a March of Dimes grant to complete the teleconferencing and web broadcasts.

Maternal Conditions in Pregnancy: Please see the chart that follows for a summary of maternal behaviors and other findings from the PRAMS data.

Tracking of Selected PRAMS Responses, 1999 – 2008										
New York State excluding New York City										
Percent of mothers who reported that...	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08
...they drank alcohol during pregnancy	7.2	6.5	6.7	8.2	6.2	6.2	7.0	7.6	7.2	7.3
...they smoked prior to pregnancy	28.0	27.1	24.8	23.3	25.6	28.4	23.0	22.3	23.4	21.4
...they smoked during pregnancy	15.7	17.0	14.4	14.6	14.6	15.6	12.9	12.2	13.7	11.9
...they smoked after pregnancy	22.8	22.4	20.6	19.3	19.2	21.6	17.5	16.9	17.9	16.1
...they experienced physical abuse during preg'cy	5.0	3.7	4.2	4.4	3.4	3.2	2.8	3.2	3.0	2.3%
...their pregnancy was unwanted or wanted later	35.1	38.4	33.8	34.7	36.3	35.8	32.7	33.4	37.5	29.6
...they initiated breastfeeding	67.0	69.1	68.6	72.1	71.6	72.4	72.9	76.1	73.9	73.3
...they put their babies to sleep on their side.	25.1	20.2	15.3	15.0	14.3	16.3	17.9	13.6	15.1	11.9
...back	56.7	66.3	68.5	69.4	70.9	69.5	67.2	71.9	70.5	75.1
...stomach	18.2	13.3	15.9	15.1	14.4	14.1	14.3	14.2	14.3	12.5
...their babies were exposed to 2 nd hand smoke	6.8	9.9	9.4	7.7	5.3	6.5	4.1	5.6	3.4	3.3
...knew that folic acid can prevent birth defects	81.3	92.0	90.5	90.7	90.7	86.4	87.7	88.1	86.8	85.7

Mental Health During Pregnancy: In 2008, 34.4% of those responding to the PRAMS (Upstate only) survey reported that it was “one of the happiest times of [their] life.” 2.6% reported that it was “one of the worst times of [their] life.” Most reported that it was somewhere in between:

- 42.7% reported that it was “a happy time with a few problems;”
- 15.7% responded that it was a “moderately hard time;”
- 5.1% reported that it was a “very hard time.”

In 2008, 2% of PRAMS respondents in NYS outside of NYC reported they experienced physical abuse during pregnancy while 4% reported abuse during the 12 months before they were pregnant. In 2007, 3% reported abuse prior to pregnancy and 4% reported abuse during their pregnancy. Data from the 2007 the NYC PRAMS indicates that 3.6% of respondents reported they were abused before their pregnancy and 3.3% during their pregnancy.

Following is a comparison of data from the New York City and Upstate PRAMS surveys for 2005-2007 (earlier data was unavailable for NYC due to low response rates).

In comparing New York City PRAMS responses to Upstate responses:

- Upstate residents were much more likely to receive their prenatal care from a private physician or health maintenance organization as compared to New York City residents (71.4% and 49.5% respectively) in 2007.

- Women giving birth in Upstate New York in 2007 were more likely to smoke during the last 3 months of pregnancy as compared to women residing in New York City (13.7% and 4.7% respectively).
- Women giving birth in New York City in 2007 were more likely to initiate and continue breastfeeding after one month as compared to women residing in Upstate New York.
- Women giving birth in Upstate New York (70.5) were more likely to put their babies on their back to sleep than women in NYC (57.6%) in 2007.

	2005		2006		2007		2008	
<u>Source of Prenatal Care</u>	Upstate	NYC	Upstate	NYC	Upstate	NYC	Upstate	NYC
Hospital Clinic	15.7%	41.6%	13.0%	43.7%	12.6%	40.7%	13.1%	n.a.
MD/HMO	70.3%	48.0%	72.2%	47.2%	71.4%	49.5%	70.5%	n.a.
Other	3.7%	1.7%	5.4%	2.4%	2.4%	1.8%	3.6%	n.a.
Neighborhood Clinic	n.a.	8.8%	n.a.	6.7%	n.a.	8.1%	n.a.	n.a.
Health Department Clinic	3.8%	n.a.	3.4%	n.a.	5.3%	n.a.	6.2%	n.a.
Community Health Center	6.3%	n.a.	6.1%	n.a.	8.3%	n.a.	6.7%	n.a.
<u>HIV</u>	Upstate	NYC	Upstate	NYC	Upstate	NYC	Upstate	NYC
HIV Education Received	93.0%	85.3%	91.5%	87.6%	88.0%	88.6%	90.4%	n.a.
<u>Smoking</u>	Upstate	NYC	Upstate	NYC	Upstate	NYC	Upstate	NYC
Smoked 3 Mo Before Pregnancy	23.0%	12.3%	22.3%	10.7%	23.4%	11.3%	21.4%	n.a.
Smoked Last 3 Mo of Pregnancy	12.9%	5.4%	12.2%	3.9%	13.7%	4.7%	11.9%	n.a.
<u>Domestic Violence</u>	Upstate	NYC	Upstate	NYC	Upstate	NYC	Upstate	NYC
Abuse Before Pregnancy	3.3%	4.9%	3.2%	3.7%	4.0%	3.6%	3.6%	n.a.
Abuse During Pregnancy	2.8%	3.7%	5.1%	3.2%	3.0%	3.3%	2.3%	n.a.
<u>Breastfeeding</u>	Upstate	NYC	Upstate	NYC	Upstate	NYC	Upstate	NYC
Initiated	72.9%	82.7%	76.1%	84.3%	73.9%	86.5%	73.3%	n.a.
At 1 month	56.4%	69.1%	62.3%	71.6%	61.5%	87.0%	63.1%	n.a.
<u>Sleeping Position</u>	Upstate	NYC	Upstate	NYC	Upstate	NYC	Upstate	NYC
Side	17.9%	19.7%	13.6%	21.9%	15.1%	17.3%	11.9%	n.a.

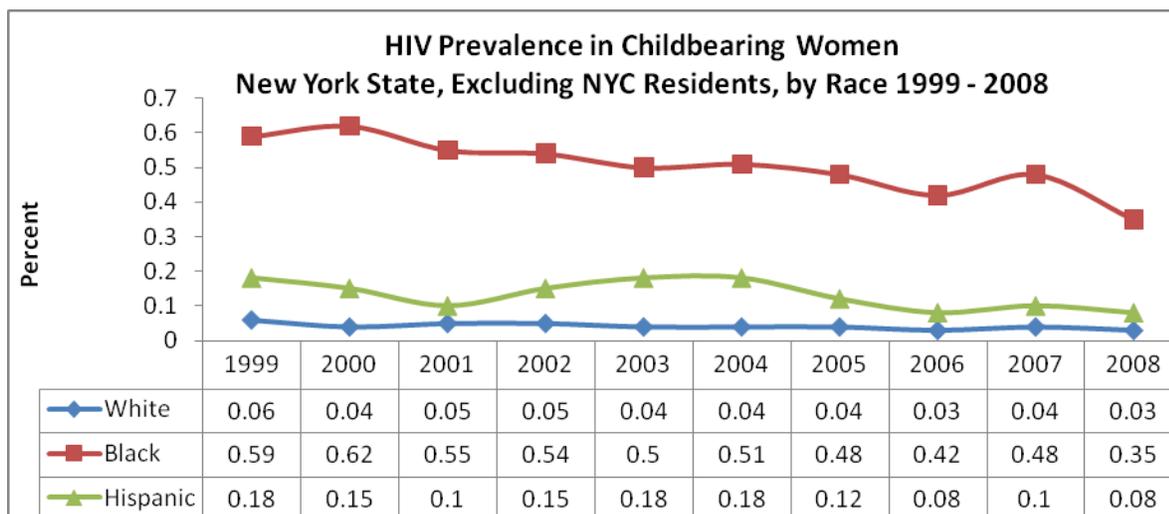
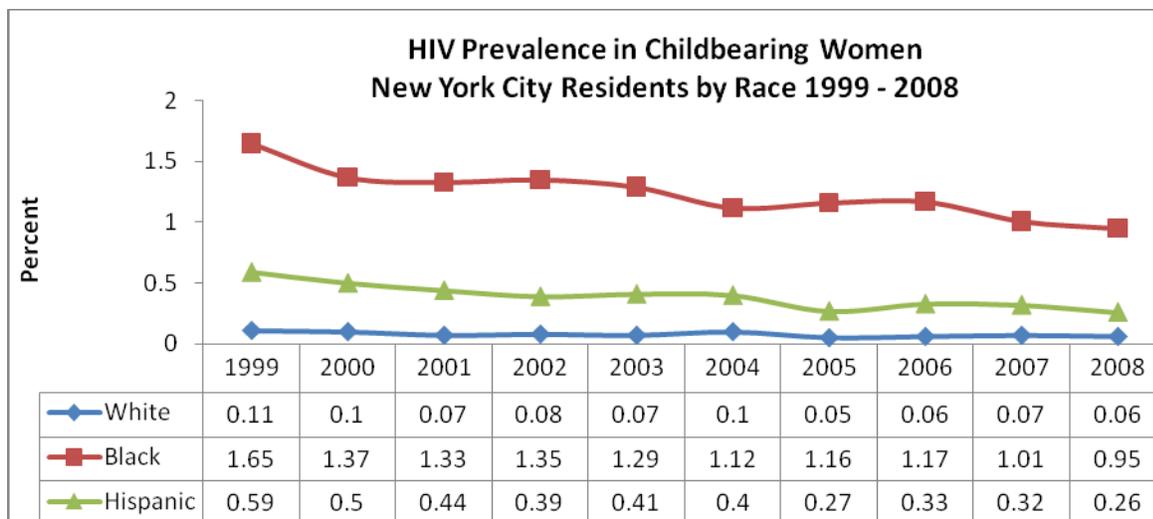
Back sometimes or always	67.2%	62.5%	71.4%	62.6%	70.5%	57.6%	75.1%	n.a.
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Perinatal HIV Transmission: Since 1990, there has been a 74% decline in HIV infected women giving birth in New York State. Specifically, the number of HIV infected women giving birth in the state went from 1,898 in 1990 to 488 in 2008. As of December 2007, women represented 33% of persons living with HIV in the State. The percent of all women presenting for delivery who were tested for HIV during pregnancy was 95% in 2008, up from 89% in 2000 and 46.7% in 1999. Prenatal care enrollment among HIV-positive women is high. The percent of HIV-infected women who gave birth that were known to have received some prenatal care was 94% in 2008.

Currently in New York, perinatal HIV counseling and testing are a standard of prenatal care. In 1996, the Department promulgated regulations requiring HIV counseling with testing recommended for all women in prenatal care in regulated facilities (licensed clinics, hospitals, and managed care plans). The Department worked with the American College of Obstetricians and Gynecologists, the New York State Academy of Family Physicians and the American Academy of Pediatrics to establish HIV counseling and testing as the standard of care. Compliance is monitored through chart review by a professional review agent, through the Quality Assurance Reporting Requirements (QARR) submission to the Office of Managed Care, and by own public health program nurses.

As a result of various State initiatives, perinatal HIV transmission rates declined dramatically from 1997 through 2008. In 1997, the perinatal HIV transmission rate was 10.9 percent with 97 HIV-infected infants born. In 2000, it was 3.7 percent (28 HIV-infected infants). In 2008, the rate was 1.3 percent, resulting in 6 HIV-infected infants. The percent of HIV-infected mothers and/or HIV-exposed infants who received prenatal, intrapartum or neonatal ARV to reduce HIV transmission increased from 64% in 1997 to 98% in 2008.

Perinatal prevalence rates are significantly higher in African American and Hispanic/Latina women and significantly higher in New York City residents.



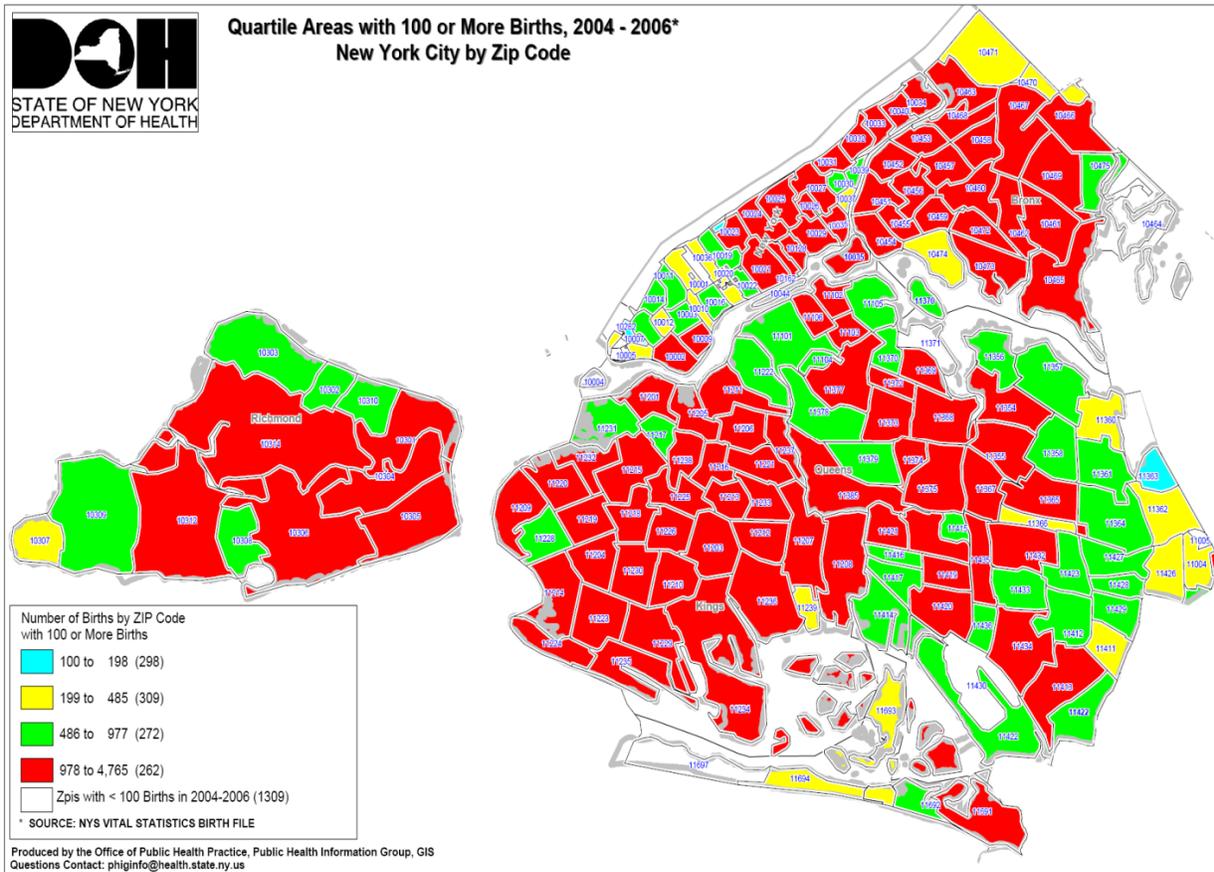
Perinatal Health Programs

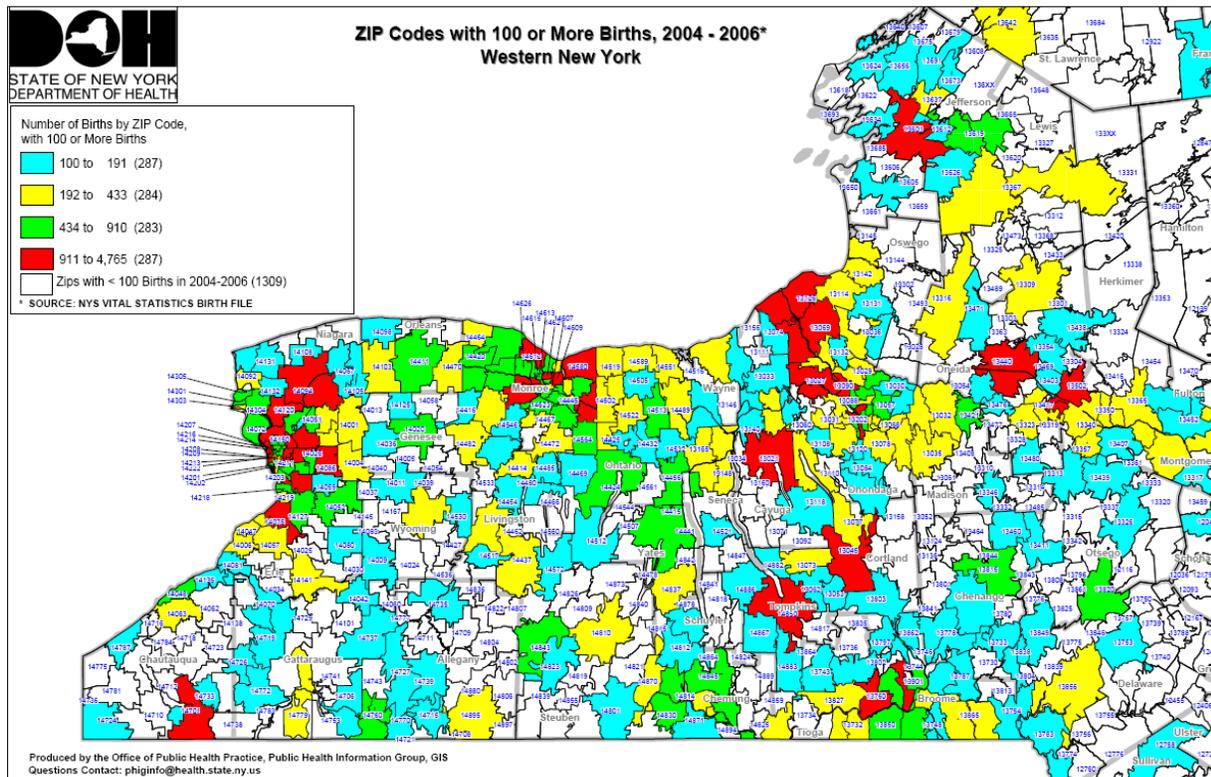
New York State’s perinatal programs employ a comprehensive, multi-level strategy, which integrates broad based systems approaches, involving county and local planning efforts, with one-on-one outreach through home visiting programs to assess, intervene and address the perinatal health needs of residents in high risk communities.

Perinatal Health Programs employ extensive use of Vital Records data to identify areas where significant needs and health disparities exist. Areas are rank ordered on multiple indicators through zip code level analyses of rates of adverse outcomes to ensure provision of services to residents living in the highest risk communities, with the intent of reducing health disparities and improving outcomes. Vital Records and program data are routinely assessed to determine the impact on stated goals and to identify areas for quality improvements efforts. For purposes of targeting perinatal programs to areas appropriate to the number of births, zip code-specific maps

are produced on birth density by state, region, and individual areas. As shown in the next figure, where zip codes are color-coded by birth density, in New York City boroughs almost any neighborhood would reach sufficient density for a program target, while in the Western region, seen in the next figure, there are relatively few zip codes that had even 100 births in the three year period used for calculating birth density areas.

Maps such as these are also produced for targeting of programs to areas of with specific issues, e.g., high rates of infant mortality, low birthweight, cesarean sections, late preterm deliveries, etc. The areas of need are reviewed in conjunction with the birth density areas to determine where programs can best be targeted, when funding is available for implementation of programs.





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, Bureau of Maternal and Child 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.

- Comprehensive Prenatal-Perinatal Services Networks (Networks)** target communities at highest risk for adverse outcomes, as identified through vital statistics indicators including: high rates of adolescent pregnancies and births, low birth weight, infant mortality, access to late or no prenatal care, out of wedlock births and births to mothers on Medicaid. The sixteen (16) Networks employ a systems-based approach to improving maternal and child health in the communities they serve by identifying gaps in services and working with health and human service providers to address those needs. Networks also conduct provider and consumer education on a range of maternal and child health topics including: H1N1, the expansion of Medicaid prenatal care, breastfeeding, the importance of folic acid, preconception health, perinatal depression, use of alcohol and tobacco and the impact of oral health on pregnancy outcomes. The Comprehensive Prenatal-Perinatal Services Networks perform need assessment of their target communities every three years. Networks develop multi level strategies involving community stakeholders in response to identified needs and barriers. North Country Prenatal/Perinatal Council for example, identified a lack of

Obstetrical/ prenatal care providers in Jefferson County in 2008 as the cause for a drop in the rate of early entry into prenatal care and worked with the Department and regional partners to address the issue.

Networks participate with Regional Perinatal Centers (RPCs) in regional perinatal forums, which combine community-based and hospital-based perspectives to address maternal and child health issues of regional importance. Along with RPCs, Networks co-chair regional perinatal forums in their respective regions and participate in the development of regional action plans to address identified needs. Networks are expected to play a key role in the planning and implementation phases of the Healthy Mom-Health Baby Home Visiting Program described below.

Home visiting programs: The Department is making an increasing investment in home visiting designed to improve birth and child outcomes. These programs include:

- **Healthy Mom-Healthy Baby program** is a new program which is supported by state funds and is being implemented in the six counties with at least 50,000 females 15-44 years of age, high rates of low birth weight, adolescent pregnancy and birth rates and neonatal intensive care unit admission rates for Medicaid client. Local health departments are funded to engage key stakeholders in planning and implementing countywide systems of care that includes hospitals, clinicians and community-based organizations to develop coordinated systems of care; conduct outreach to identify women and families in need of prenatal care and other services; develop infrastructure; coordinate referrals between home visiting programs and other services that exist within the community; and, provide home visiting services, as needed. The MCH Program is closely collaborating with OHIP related to this initiative and is piloting a standardized prenatal risk screening form, developed collaboratively by OHIP and the MCH program in the Healthy Mom – Healthy Baby Program. OHIP is actively working to ensure engagement of managed care plans in these community programs to ensure that managed care plans receive timely notification of pregnant women; are aware of those women's clinical and psychosocial risks, and, are employing plan resources to manage those risks. The Healthy Mom Healthy Baby programs are currently assessing county level systems which impact perinatal outcomes.
- The **Nurse Family Partnership** is a national evidenced-based nurse home visiting model that seeks to improve the health and self-sufficiency of low-income, first-time parents and their children. NFP nurses promote mothers' personal health, parents' care of the child, environmental health, family and friend support of the mother and parents' life course development. Nurses address these through assessment, education, promotion of behavioral change, and referral of families for needed health and human services. Through collaboration with the Office of Temporary and Disability Assistance, \$5 million in funds to support the three credited Nurse Family Partnership (NFP) programs in the state to deliver home visiting services to pregnant women with incomes up to 200% FPL were allocated to the Department of Health through a Memorandum of Understanding. The OHIP has also obtained state plan approval to provide Medicaid funding support to two of these programs in Monroe County and New York City as targeted case management programs.

- **Community Health Worker** Programs in 23 communities conduct extensive one-on-one outreach to identify and engage pregnant women not already enrolled in prenatal care to improve maternal and newborn outcomes, and ensure the family has access to other needed services. Community health workers provide advocacy, assist clients to navigate the health care delivery system to obtain access to prenatal care and medical home for pregnant women and their families and provide education, referrals and follow-up through monthly home visits. Community health workers are indigenous to and familiar with the communities they serve and provide a bridge between families and services needed to improve outcomes in those areas. Community Health Worker Programs routinely respond to changing demographics in their communities, including changes caused by economic factors such as loss of businesses, and changes due to increased immigrant and undocumented populations.

Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

New York State has established a home visiting needs assessment work group comprised of the relevant staff from the State agencies that will contribute data and other information for the needs assessment. The work group process will foster the State's ability to locate, gather and assemble the data and information required for the needs assessment in a timely and comprehensive manner. The work group will also create the mechanism to manage and address any obstacles that may arise as the needs assessment proceeds.

The State agencies responsible for completing the Title V MCH Block Grant, Head Start Act, and Title II of CAPTA needs assessments will be working together to complete the ACA home visiting needs assessment. The work group approach will afford the State the opportunity to use applicable components of the home visiting needs assessment to satisfy similar components of the other assessments. Working in this manner may also create the potential that each of the required needs assessments will be enhanced by the larger and more comprehensive perspective of needs assessment required by the ACA. The challenge for the work group will be to ensure the timely completing of each needs assessment as required by the funding agencies.

In anticipation of the needs assessment requirement, State agency representatives have had several meetings and discussions primarily to identify the available data. To guide the needs assessment process, a more formal work group will be established. The core membership of the work group will be the relevant staff (e.g. program managers, data system managers, evaluators/researchers, etc.) from the Department of Health, Office of Children and Family Services, Office of Alcohol and Substance Abuse Services, and the Council for Children and Families. Additional members will include relevant staff from the Office of Mental Health, Office for the Prevention of Domestic Violence, Division of Criminal Justice Services, Department of Labor, State Education Department, Developmental Disabilities Planning council, and other appropriate State agency stakeholders. Staff from the Department of Health's Office of Health Insurance Programs which oversees the State's Medicaid, managed care and family/child health insurance programs will participate on the work group as well and will provide key data and information about utilization and quality indicators for relevant services received by low-income individuals and families and corresponding health care provider capacity in the State.

The State agencies and the Schuyler Center for Analysis and Advocacy (SCAA), a state advocacy group that has actually promoted home visiting in the state, have been meeting on a regular basis in anticipation of conducting the needs assessment and a good deal of the preliminary planning work has been completed. The State agencies compiled a list of stakeholders comprised of relevant programs funded by the agencies (e.g. home visiting programs such as Community Health Worker Program, Healthy Families NY, Healthy Start and Nurse Family Partnerships, child abuse prevention programs, substance abuse prevention and treatment programs, early childhood development programs, etc.), inter-agency coordinating groups (e.g. Early Childhood Advisory Council), local health departments, advocacy groups, families, members of the home visiting work group and other interested parties. A series of conference calls will be convened to elicit qualitative information about the needs of and the services available for children and families residing in at-risk communities, and the unmet needs in these communities.

The Department has also developed a survey in conjunction with other State agencies and stakeholders, to better assess the capacity and nature of home visiting programs in the state. Feedback will also be elicited through an on-line survey. This qualitative information will supplement the quantitative data and provide a fuller picture of needs and services for at-risk families in New York State.

Preconception Care: The Department has been promoting preconception health to improve birth outcomes. The “kick off” of this multi-pronged initiative occurred in June 2006 when the Department sponsored a two- day meeting to introduce the concept of the importance of preconception health. The meeting included panel discussions and information from leaders in the field such as Dr. Hani Atrash from the Centers for Disease Control and Prevention (CDC), and agencies and programs that provide services to New York’s reproductive age men and women, such as programs in the Department that address AIDS/HIV, chronic disease, sexually transmitted diseases, the Office of Mental Health, and the Office of Alcoholism of Substance Abused Services among others. This meeting established the message that the focus of the Department’s and others efforts needed to move to address health behaviors and disease management well before a pregnancy occurs.

Recognizing the challenge with physicians and other health care providers having sufficient time to participate in in-person training programs, the Department in conjunction with the University at Albany School of Public Health developed a satellite videoconference targeted to medical professionals across the state to reinforce the importance of preconception health. The audience had the opportunity to call in questions to experts providing the program and the session was placed online for viewing after the program.

The Department also partnered with the American Congress of Obstetricians and Gynecologists – NY (ACOG) on the development of preconception health materials. In collaboration with ACOG and a workgroup of obstetricians across the state, the *Preconception Care: A Guide to Improved Pregnancy Outcomes* was developed and disseminated to all obstetricians/ gynecologists, family practice physicians, pediatricians specializing in adolescent health, midwives and nurse practitioners throughout the state and posted on the Department’s website. A laminated card was also distributed that serves as an easy reference guide for medical professionals serving women of reproductive age. The laminated card consisted of a

“preconception checklist” that included information on genetic issues, infectious diseases, environmental toxins, medical assessment, lifestyle changes and the need to assess any complications from a previous pregnancy, as well as web sites for further information. The preconception care packet was distributed to over 16,000 obstetricians/gynecologists, nurse practitioners, and pediatricians. The materials are designed to encourage medical professionals to ask women about reproductive intentions at every visit, assess risk of an unplanned pregnancy, and counsel women on appropriate health behaviors to optimize pregnancy outcomes.

The Department developed the *Preconception Health Cafe* an innovative web-based course for consumers and paraprofessionals that provides information regarding the importance of preconception health and discusses maximizing opportunities to integrate components of preconception health into public health strategies. The course is available to all family planning providers, prenatal care assistance programs, community health worker programs, adolescent pregnancy prevention programs and any other organization having access to the Internet at <http://www.albany.edu/sph/coned/women.htm>.

The Department worked with a Center for Women in Government fellow to review national best practices related to preconception. The Department is incorporating aspects of this review in its planning for preconception health initiatives.

Perinatal Depression: The Department has devoted considerable effort in the development of outreach and education materials about perinatal depression with input from women who have experienced the condition. Over 40 community stakeholders collaborated on development and implementation, including local health and mental health departments.

A media campaign was developed, as well as a consumer pamphlet and a provider fact sheet. These materials and media kits were distributed to perinatal networks, obstetrical hospitals, local health departments and other interested stakeholders to extend the influence of the media campaign in other areas of the state. The campaign was replicated by perinatal networks in Albany, Buffalo, Rochester and Queens.

The Department worked very closely with Office of Mental Health (OMH) in developing the provider fact sheet. The fact sheet contained information on symptoms and referral resources, and was intended to prepare providers for the media campaign. The fact sheet was disseminated (under joint signature of the commissioners of the DOH and OMH) to obstetricians, pediatricians, family practitioners, local health and mental health departments, managed care organizations, and prenatal care providers in the extended Capital Region (11 counties.) Local prenatal care providers began using the perinatal depression screening tools with their patients. Materials developed through this grant are posted on the Department’s web site at: <http://www.health.state.ny.us/nysdoh/perinatal/en/index.htm>. Guidelines for conducting perinatal depression screening by community health workers have been developed and disseminated to the 24 Community Health Worker Programs.

Fetal Alcohol Spectrum Disorder (FASD)

Title V staff participate in interagency projects to address specific perinatal issues. A FASD Interagency Workgroup promotes coordination among State agencies to design and support a comprehensive system of care to eliminate alcohol use during pregnancy and improve the lives

of New Yorkers affected by prenatal alcohol exposure. Representatives include: Council on Children and Families, Office of Children and Family Services, Office of Mental Retardation/Developmental Disabilities, Office of Alcoholism and Substance Abuse Services, and the DOH.

Growing Up Healthy Hotline (GUHH) is available 24/7, 365 days a year to provide information and referral in English and Spanish to callers seeking services. The hotline provides information and referral in several other languages via the AT&T language line. The GUHH number is used in media campaigns to promote early and continuous access to prenatal care and other services. In 2009, GUHH tele-counselors responded to 60,999 calls on topics, including prenatal care, family planning, WIC services and Child Health Plus.

Prenatal Outreach Media Campaigns: The Department has run in the past and will be running a targeted media campaign in 2010 to promote Medicaid prenatal care services to high-risk pregnant women. Radio and print advertising will encourage women to call the Growing Up Healthy Hotline for more information on prenatal care services and local prenatal care providers. The intent is to increase early entry into prenatal care and increase access to services.

Perinatal Health programs are required to assess community need and develop and revise strategies based on identified need, including development of outreach and media campaigns.

Clinical Initiatives: The MCH Program has been involved in a number of clinical initiatives related to perinatal care, including standards and associated reimbursement for prenatal care services; regionalization of perinatal inpatient services, along with associated quality improvement activities in conjunction with Regional Perinatal Centers; and, implementation of a new maternal mortality review process. The two latter efforts are described in the section related to improving birth outcomes. The MCH Program is also working extensively with the Division of Chronic Disease, Division of Nutrition and the NYCDOHMH to improve the state's performance related to breastfeeding which is described below.

As was described previously, new legislation (Chapter 484 of 2009), was enacted that made significant changes to the delivery of prenatal care in New York State. The legislation was developed to address the impact of the new Ambulatory Patient Group (APG) payment methodology on Medicaid reimbursement for prenatal care services delivered in the Prenatal Care Assistance Program (PCAP), a preferred provider model supported through Medicaid reimbursement rates developed in the 1980's that was originally designed to provide quality, comprehensive care to high-risk pregnant women. Prior to implementation of the new APG reimbursement methodology, PCAP Medicaid rates had not been increased for many years, which resulted in reimbursement that was increasingly inadequate to provide services consistent with the current standard of care, particularly in light of the increased acuity of women presenting for prenatal care. APGs are designed to pay for actual services delivered to pregnant women, which allows reimbursement to adjust to changes in the standard of care, as well the acuity of the individual patient, and provides substantially better information regarding service delivery than the previous flat rates.

The new legislation eliminated the PCAP model based upon preferred provider status and special rates and instead required a universal standard of prenatal care that would be required for all

women receiving prenatal care in the Medicaid Program, not just those receiving services in PCAP clinics. In addition, the legislation expanded access to presumptive eligibility for pregnant women beyond those clinics that were formerly PCAP clinics, to all licensed clinics in the state with prenatal care on their operating certificate. The Title V program worked collaboratively with the Department's Office of Health Insurance Program (OHIP) to craft the new legislation and during 2008-2009, worked with OHIP and internal and external stakeholders to develop updated prenatal standards of care for all pregnant women enrolled in Medicaid. The Title V program also continues to work closely with OHIP to implement and monitor the new law.

The updated prenatal standards, effective November 2009, incorporate new evidence-based procedures and practices appropriate to the needs of pregnant women who qualify for Medicaid coverage, regardless of provider or delivery system. They integrate updated standards and guidance from the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), and reflect expert consensus regarding appropriate care for low-income, high-risk pregnant women. The standards provide a comprehensive model of care, including but not limited to: comprehensive prenatal risk assessments; prenatal diagnostic and treatment services; HIV counseling and services; dental care; immunizations; lead poisoning prevention, testing and services; nutritional counseling; screening for genetic disorders; and, testing for fetal well-being.

Important new benefits for pregnant women with Medicaid coverage include: diabetes and asthma self-management training, smoking cessation counseling, and mental health counseling services provided by certain licensed social workers. In addition, all women enrolled in Medicaid are presumed eligible for one medically necessary postpartum home health care visit benefit. These comprehensive changes will improve the quality of prenatal/postpartum care provided to pregnant women who receive care under the Medicaid program.

The Department's perinatal health strategy employs a model of comprehensive prenatal care, outreach and education, home visiting, access to needed services, and perinatal regionalization as essential components in the goal of improving birth outcomes among high-risk women. Through initiatives such as perinatal networks, regional perinatal forums, and the Healthy Mothers, Health Babies initiative, the Department increasingly is working to improve access and quality of perinatal care, at the community systems level. The Department is expanding its efforts related to home visiting, which will potentially further expand when federal home visiting funding becomes available. Over the past decade, the Department has developed a strong system of regionalized perinatal care (described below in the section on birth outcomes) which it has been developing over the past decade. The Department has melded the community-based perspective of perinatal needs, and the hospital-based perspective, by having the perinatal networks and regional perinatal centers co-chair regional perinatal forums.

The MCH Program also has a very strong collaboration with the Office of Health Insurance Programs and the Office of Health Systems management in the perinatal arena. The collaboration with OHIP has resulted in the updated prenatal care standards as described above, which ensures increased access for all pregnant women who qualify for Medicaid to comprehensive high quality, prenatal and postpartum care. There have been a number of collaborative strategic efforts in the last few years related to improving perinatal health for the

Medicaid populations, including developing and implementing new legislation and standards related to prenatal care and the development of the risk referral form and implementation of the Healthy Mom, Healthy Baby Program. Staff from the MCH Program and OHIP continue to collaborate closely and have a standing biweekly meeting to ensure coordination and to jointly work on strategies to improve perinatal care. The MCH Program has also closely collaborates with the Office of Health System Management, the organization in the Department which is responsible for oversight of the State's hospitals and clinics. This collaboration, for example, has led to the development of an improved model of maternal mortality surveillance which is currently being implemented. With leadership from the Deputy Commissioner of the Office of Public Health, an internal group within the Department involving members from key organizations such as OHIP and OHSM, convene to review perinatal health data and to consider activities to strengthen the perinatal health program.

Although the Department has many strengths in the perinatal arena, many of the Department's programs were developed in the late 1980's and early 1990's and are in need of significant retooling. While there has been steady improvement in several perinatal health indicators over the past decade, significant health disparities exist. Capacity in this area is closely related to that described for HSCI #04. Medicaid populations generally fare less favorably than privately insured populations for this and other perinatal health measures. The Department has also been limited in its efforts to promote preconception health due to the lack of funding resources, although efforts are continuing, including coordination with other areas of the Department to incorporate preconception health messages into their programming. Although in the past the Department has developed media materials and campaigns to promote the identification of women at risk for perinatal depression and referral to appropriate resources, there is no funding to support specific initiatives or public awareness campaigns related to perinatal depression.

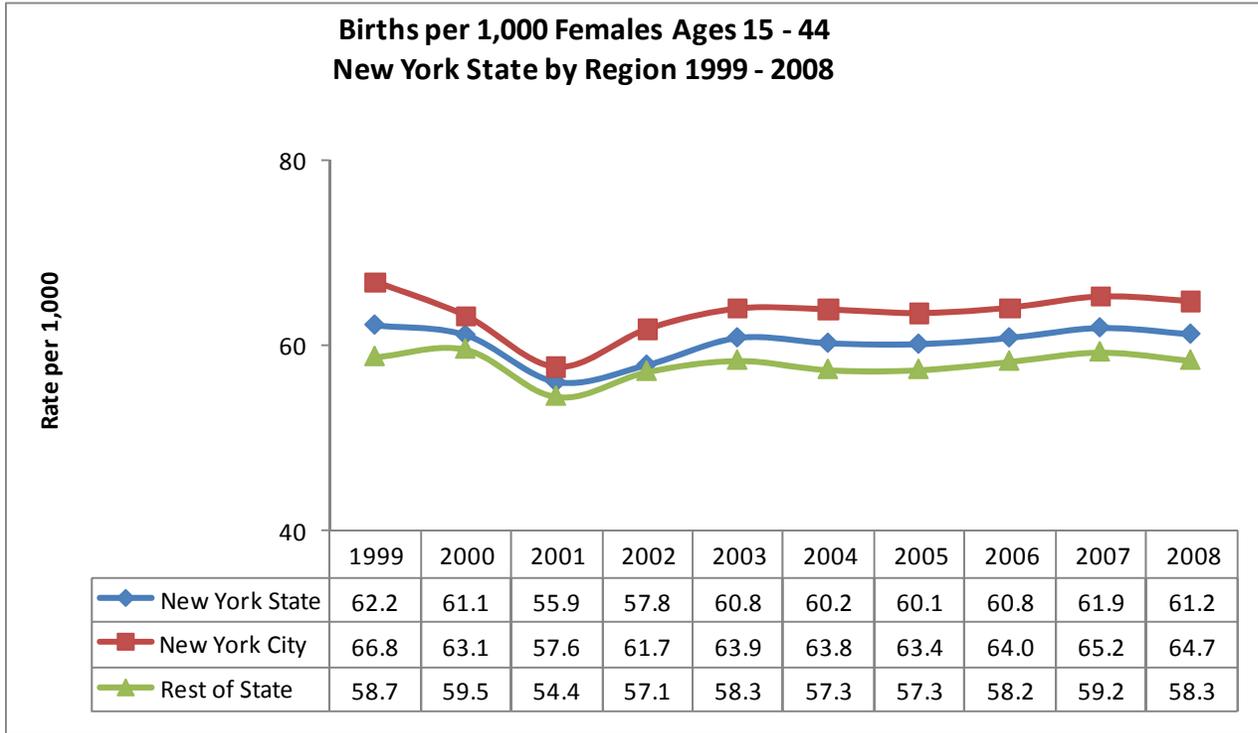
Birth Outcomes

Births: There were 249,655 births in New York State in 2008. Of these, 121,759 (48.8%) were to residents of NYC and the remaining 127,896 were to Upstate NY residents. This is 3,007 fewer births than occurred in 2007. The numbers of births decreased among both New York City and Upstate New York residents. In 2008, births to white mothers accounted for 66 percent of all births and births to Black mothers represented 18 percent of the total. Fifteen percent of births were in the "other" category. Births to Hispanic mothers accounted for almost 24 percent of all births. This includes births to persons of multiple races, as well as all other races. The majority of births occurred to women between the ages of 20 and 39 (89%). Women aged 45 plus had 819 births and women under fifteen had 242. Out-of-wedlock births accounted for 41.2 percent of total births. This is slightly more than in 2007 when 40.5 percent of births were out-of-wedlock. Mothers 17 years of age and younger were more likely (95%) to be unmarried compared to mothers aged 25 or older (30%). Out-of-wedlock births were also more common among Black (70.6%) and Hispanic (65.5%) mothers.

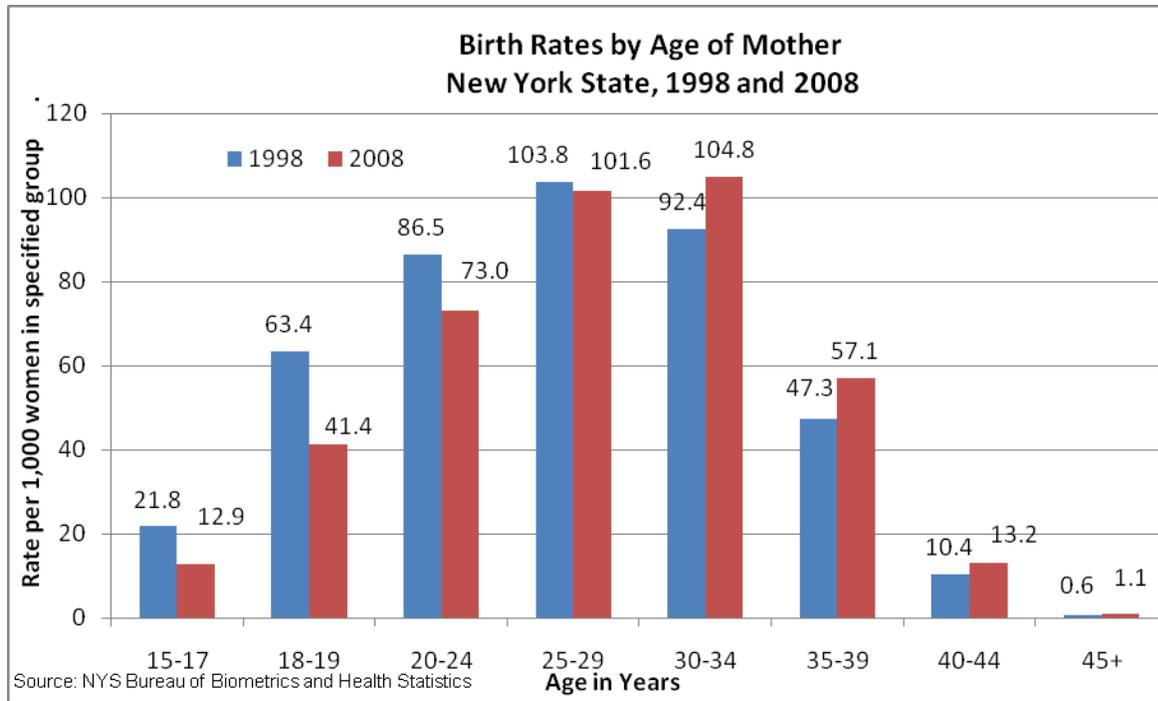
Category	2008 Births by Mother's Age										
	Total	<15	15-17	18-19	20-24	25-29	30-34	35-39	40-44	45+	N.S.
All Births	249,655	242	5,074	12,171	50,924	66,181	65,527	38,991	9,689	819	37
Sex											
Male	128,180	128	2,657	6,223	25,990	34,004	33,786	20,015	4,932	428	17
Female	121,467	114	2,416	5,948	24,934	32,171	31,741	18,976	4,757	391	19
Not Stated	8	0	1	0	0	6	0	0	0	0	1
Race¹											
White	164,869	115	2,754	7,280	32,096	42,788	45,278	27,255	6,699	582	22
Black	45,562	102	1,720	3,539	11,763	11,742	9,278	5,616	1,677	122	3
Other	38,080	25	575	1,276	6,778	11,342	10,739	5,960	1,272	108	5
Not Stated	1,144	0	25	76	287	309	232	160	41	7	7
Ethnicity											
Hispanic	59,897	109	2,215	4,660	15,752	16,560	12,294	6,553	1,631	116	7
NonHispanic	189,758	133	2,859	7,511	35,172	49,621	53,233	32,438	8,058	703	30
Marital Status											
Out of Wedlock	102,799	240	4,840	10,657	33,310	26,865	15,833	8,387	2,470	197	0
Married	143,863	2	213	1,453	17,224	38,697	48,747	29,907	7,018	592	10
Not Stated	2,993	0	21	61	390	619	947	697	201	30	27
Mother's Education											
< 12 Years	20,935	128	2,235	2,816	6,535	4,777	2,696	1,351	357	32	8
12 Years	28,218	0	267	2,647	9,364	7,582	4,862	2,702	736	50	8
13-15 Years	34,077	0	16	916	8,057	10,578	8,418	4,820	1,176	88	8
16 Years	21,376	0	0	2	1,250	5,938	8,089	4,891	1,131	72	3
17+ Years	20,614	0	0	0	205	4,597	9,240	5,433	1,062	76	1
Not Stated	124,435	114	2,556	5,790	25,513	32,709	32,222	19,794	5,227	501	9

¹ Beginning in 2008, births recorded in NYS Exclusive of NYC and births recorded in NYC

Fertility Rates: After declining from 2000-2001 to 55.9 per 1,000 females aged 15 to 44 years, the fertility rate in New York State has been generally increasing with some fluctuations in recent years. In 2008, the rate was 61.2/1,000. The rate in New York City, at 64.7 per 1,000, was higher than the rate for Rest of the State (58.3 per 1,000). Rates in both New York City and Rest of State were slightly lower than the 2007 rates.

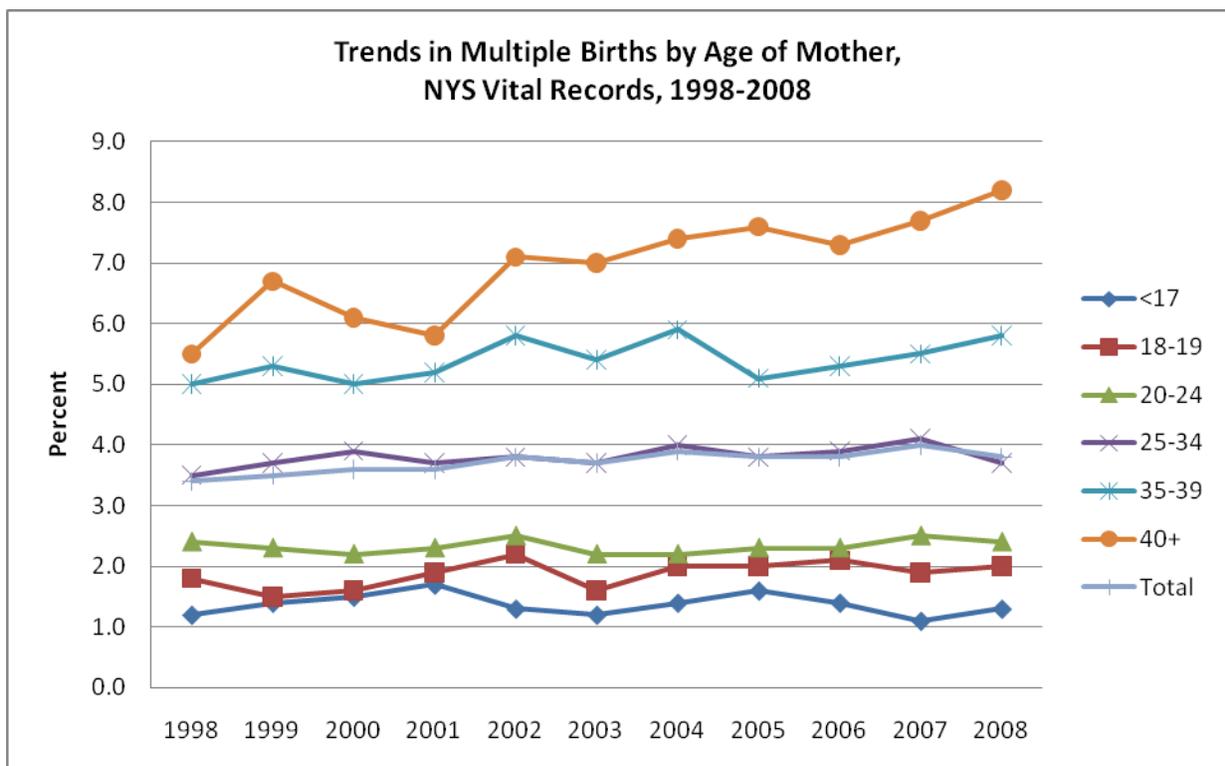


When comparing rates in New York State by age for the time periods 1998 and 2008, some interesting trends emerge. Between 1998 and 2008 birth rates among women aged 15-29 have all declined. Women aged 15-17 and 18-19 experienced the steepest reduction. Among women aged 25-45+, however, the birth rate has increased. In 2008, women aged 30-34 experienced the highest birth rate compared to all other age groups. In 1998, the 25-29 year old age group had the highest birth rate.



Multiple Births: From 1998 through 2008 there was a slow rise in the percentage of all babies born who were either twins or higher order multiples. In 1998 the rate of non-singleton babies born was 3.4%, and in 2008 the rate was 3.8%, a rise of 11.8%. This rise was not uniform across all age groups, with older women (40+) having the highest rate in each year, as well as the largest increase (from 5.5% to 8.2%, an increase of 49%), and teens <18 having both the lowest rate annually, and the lowest increase (from 1.2% to 1.4%).

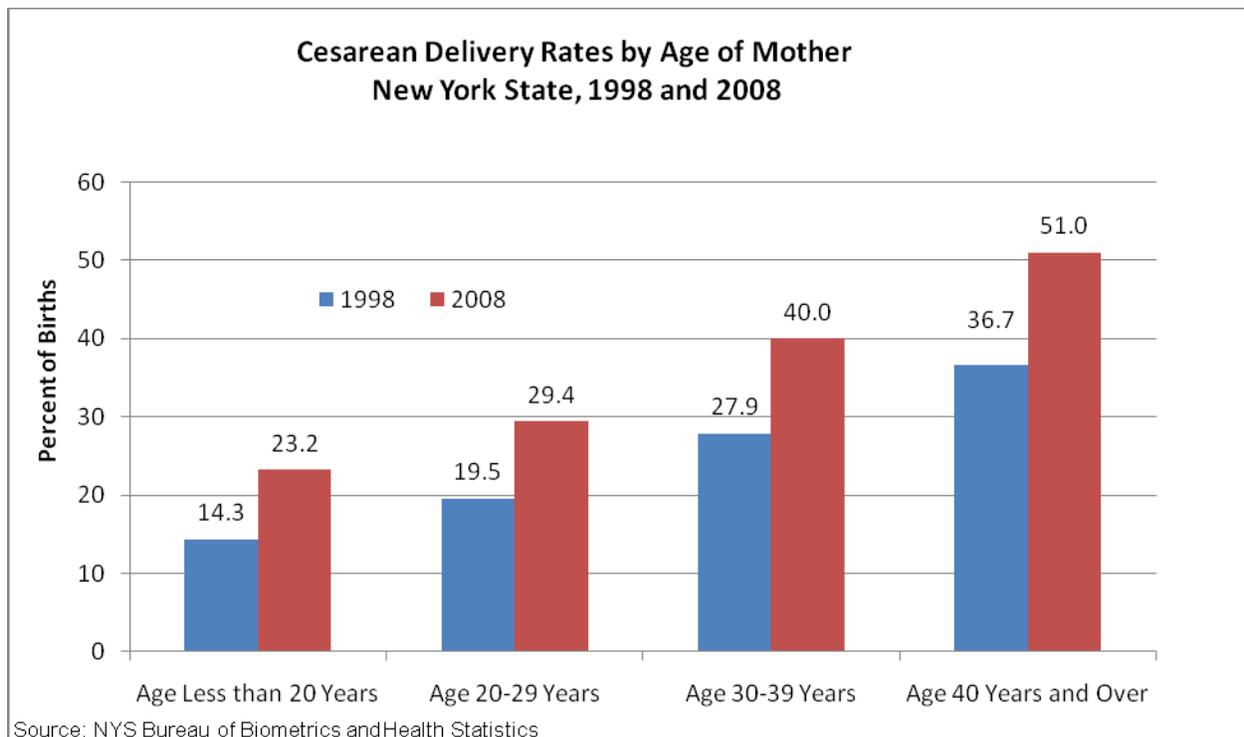
Among 2008 births, white women had the highest rates of non-singleton babies, followed fairly closely by Black women. Hispanic women and women of other races had rates that were approximately 30% less than rates for whites.



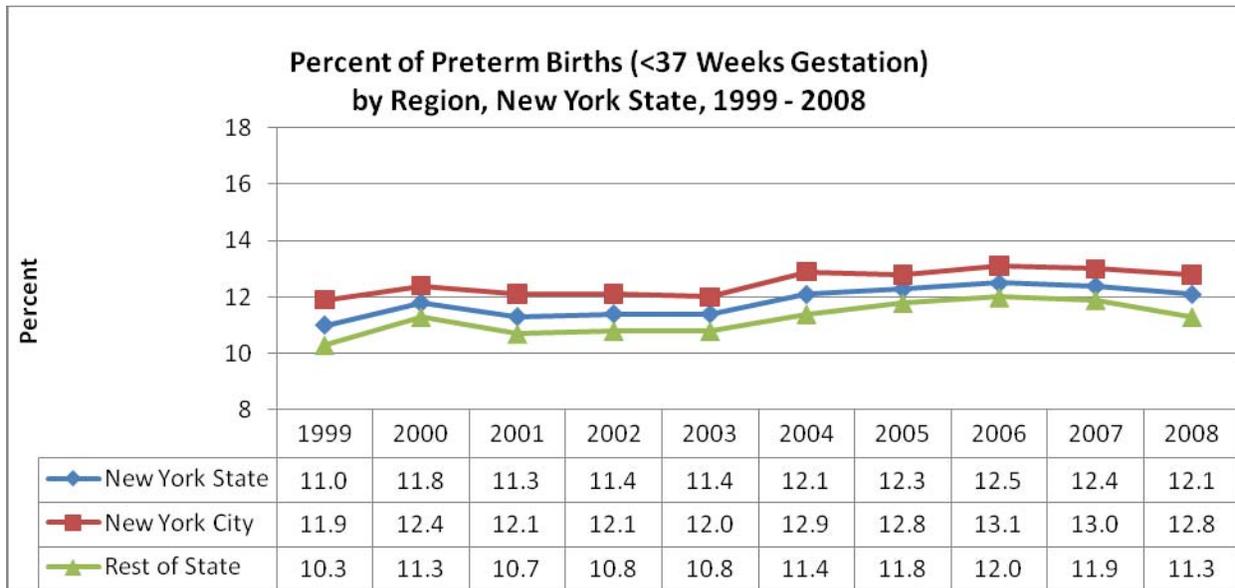
Cesarean Delivery Rates: As in the nation as a whole, the percent of births delivered by c-section in New York State has been steadily increasing over the past decade, from 23.1% of births in 1998 to the current rate of 34.1% of all births, an increase of 48% over this period. Nationally, the percent of all births delivered by c-section was 32% in 2007, a new record high, which represents a 53% increase over the past decade.

Deliveries by c-section have increased within all age groups. Women over the age of 40 experienced the highest cesarean delivery rate (51.0%) in 2008, a 39% increase over the 1998 rate. Women less than 20 years of age experienced the largest relative percentage increase (62%) between 1998 and 2008, although they had the lowest rate of cesarean delivery compared to other age groups. About 23% of women under the age of 20 giving birth in 2008 were delivered by cesarean, compared to over 50 percent of women age 40 and above.

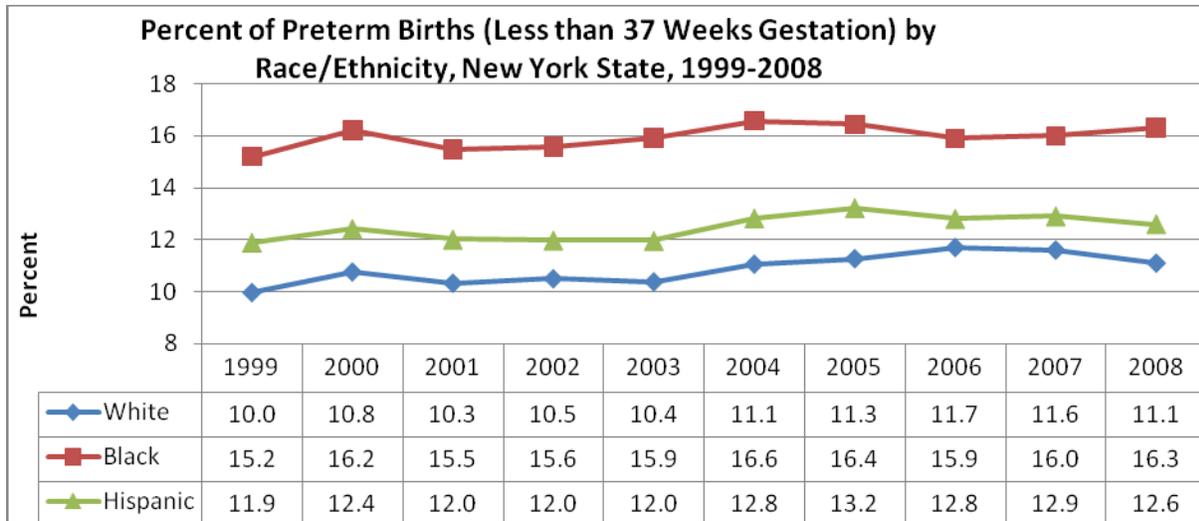
Babies delivered prior to 39 weeks, and in particular those delivered between 34 and (up to but not including) 37 weeks (34-36+) have emerged as an increasing concern, particularly when delivery prior to term is not medically indicated.



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

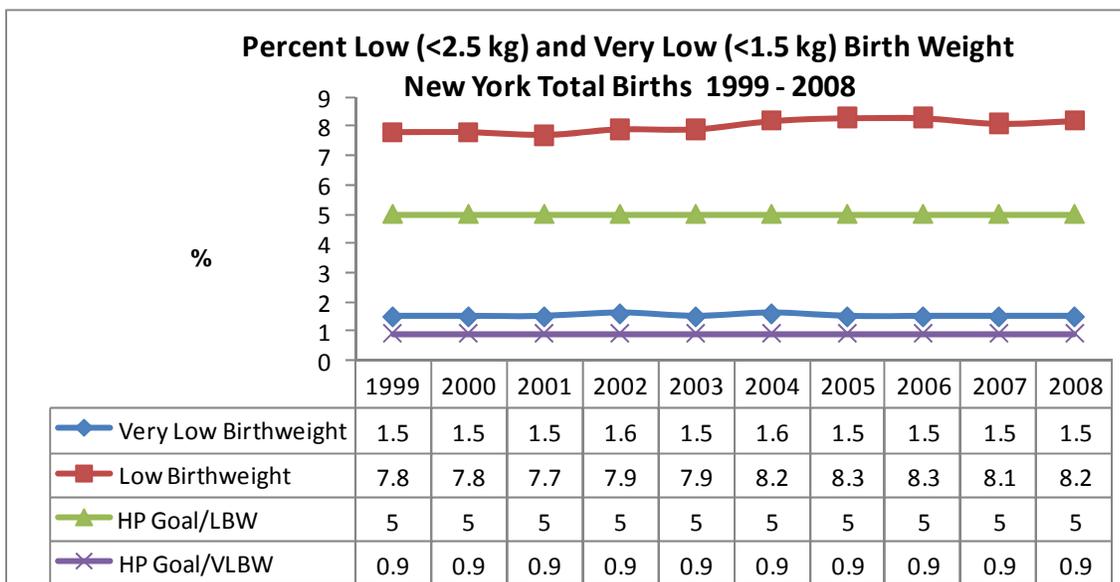


The percentage of Black women delivering at less than 37 weeks gestation was 16.3% in 2008, 47% higher than the 11.1% rate among white women. Hispanic women giving birth had a premature rate of 12.6% in 2008. This was 14% higher than the rate among white women but 23% lower than the rate for Black women.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



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

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



According to the National Center for Health Statistics, some reasons for the lack of improvement in the rate of low birthweight births are increases in multiple births, obstetric interventions such

as induction of labor and cesarean delivery, older maternal age and increased use of infertility therapies (National Vital Statistics Reports, Vol.55, No.1, September 29, 2006).

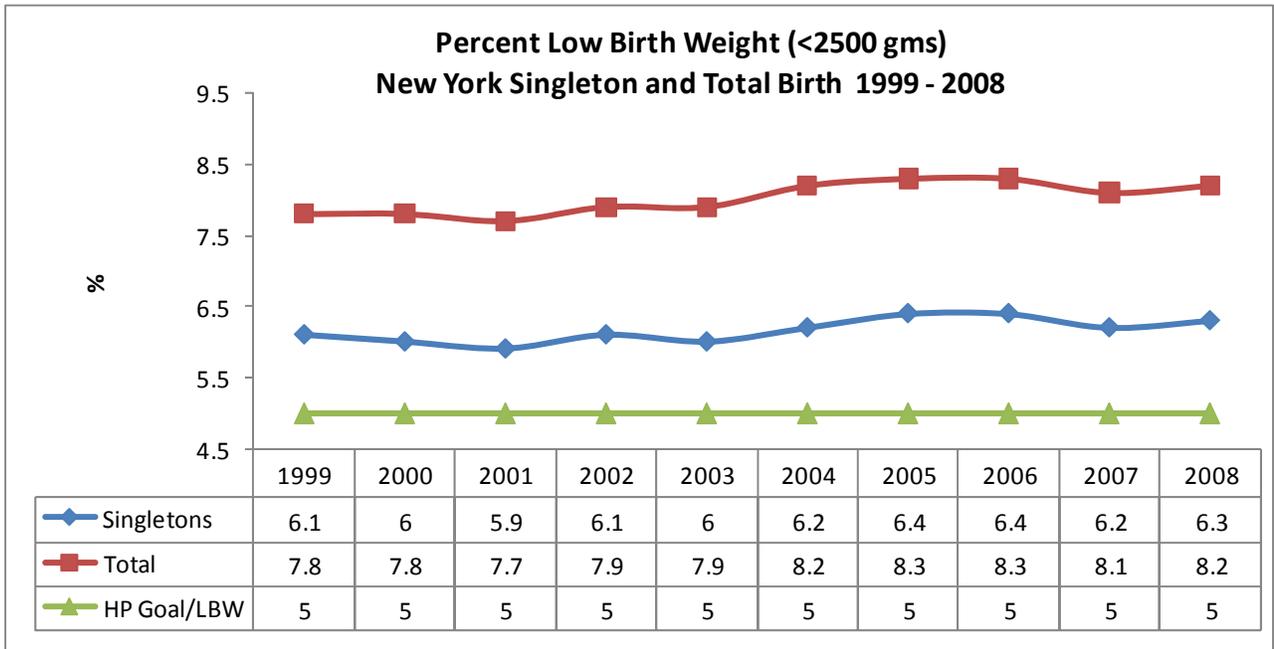
New York State's has been a national leader in the development of a statewide system of perinatal regionalization. All obstetrical hospitals have been designated by the Department as a Level I, II, III or Regional Perinatal Center (RPC) based on standard criteria included in state regulation. Regulations require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers and newborns. While RPCs and Level III hospitals accounted for 64 percent of all births in 2008, approximately 90 percent of all very low birth weight (VLBW) infants were delivered at RPC and Level III facilities. Conversely, less than 10 percent of VLBW infants were delivered at Level I and II hospitals, which accounted for approximately 36 percent of all newborn deliveries in the state in 2008. The trend towards delivery of high-risk newborns at appropriate level hospitals suggests the effectiveness of perinatal regionalization. The Statewide Perinatal Data System also reports reasons why VLBW infants were born at lower level hospitals and the majority are due unavoidable events, such as inability to transfer the woman to a higher level hospital due to advanced stage of labor.

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

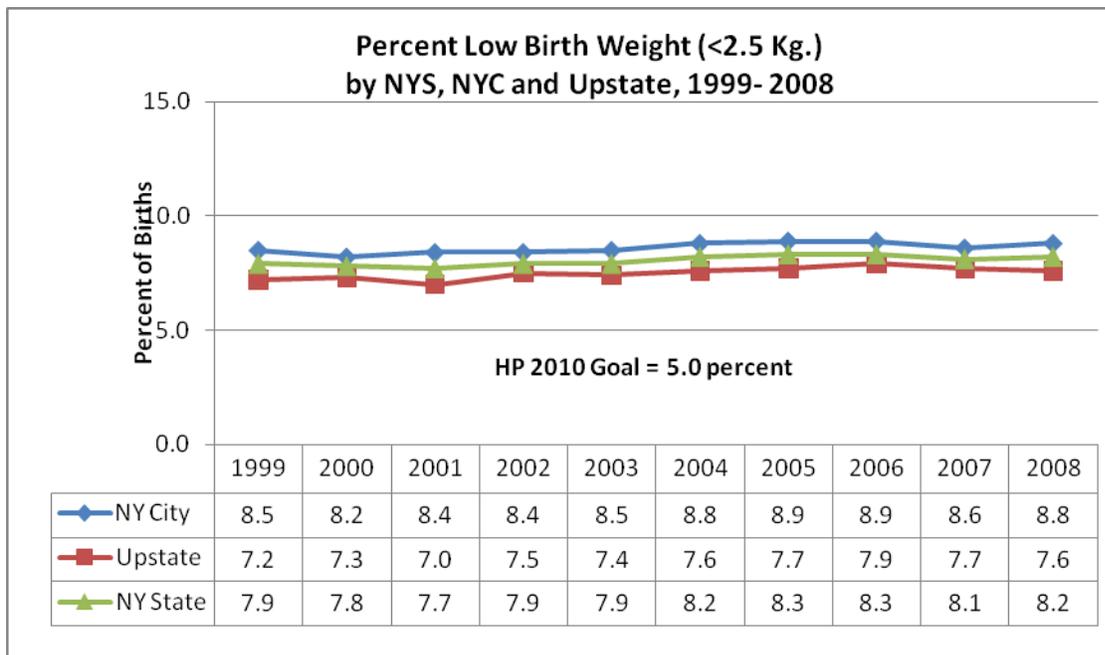
Annual Objective and Performance Data	2002	2003	2004	2005	2006	2007	2008
Annual Performance Objective	83	85	87	88	89	92	92
Annual Indicator	84.6	86.2	87.2	87.1	88.6	89.7	90.0
Numerator	3,401	3,436	3,453	3,281	3,345	3,252	3,281
Denominator	4,018	3,986	3,962	3,765	3,774	3,627	3,646

When low birthweight rates for total births are compared to those for singleton births, the rates among singletons are consistently better. Very low and low birthweight births occur more frequently during multiple births. There has been an increase in the past decade in multiple births, as previously discussed, due in part to advances in the technology of assisted reproduction, where multiple births are more common.

WIC participants in New York State were ranked 22nd among the states for the percentage of low birthweight births. In 2008, the percentage of low birth weight births was 8.9% among NYS WIC participants, compared to 9.0% of WIC participants nationwide.



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



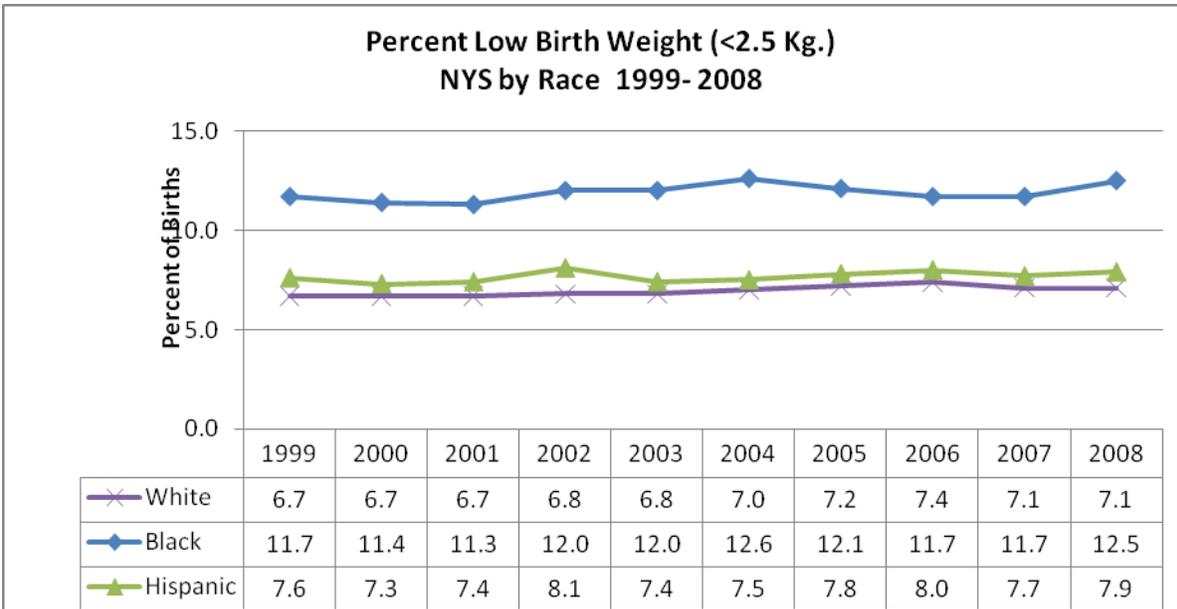
Lowbirthweight – Medicaid/non-Medicaid: The percent of low birth weight has decreased slightly from 2006 for the entire NYS population (8.3) and also decreased in the Non-Medicaid population (8.2) but the rate has remained consistent at 8.6 for the Medicaid population.

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

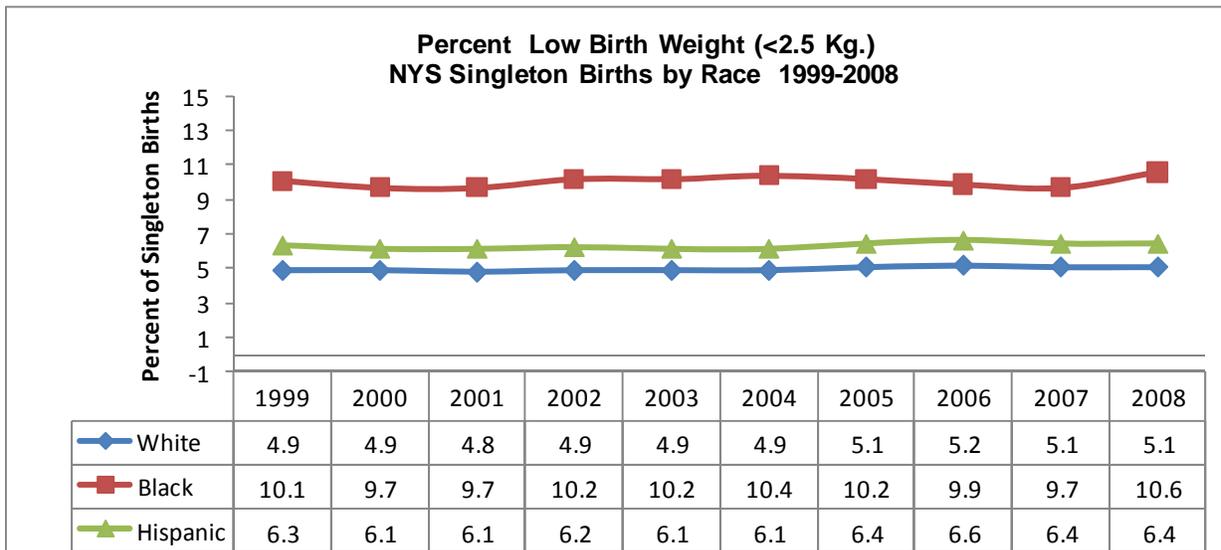
POPULATION					
INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid and all MCH populations in the State</i>	YEAR	DATA SOURCE	MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (<2,500 grams)	2008	Payment source from birth certificate	8.6	7.8	8.2

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

White infants were the least likely to be born with a low birthweight. In 2008, the percentage was 7.1%, unchanged from 2007. Prior to 2007, the rate had been steadily increasing throughout the decade and in 2006 was at its highest level. Consistent with national trends, the 2008 rate is



higher than the rate reported 10 years ago in 1999 (6.7%).



Trends in singleton low birthweight rates were basically flat for all race/ethnicity groups. Although there were small fluctuations in the rates over the ten-year period 1999-2008, the percentages of singleton births that were low birthweight in 2008 were within a few tenths of a percentage point of what they were in 1999 among Whites, Blacks and Hispanics.

Ratio of Black-to-White Low Birth Weight Rates: Disparities in low birthweight rates have shown no improvement during the past 10 years. These disparities may be measured in the ratio of the Black low birthweight rate to the white low birth weight rate. The 2008 Black/white ratio was 1.8 based on rates of 12.5% and 7.1% respectively. The ratio was higher than in 2007

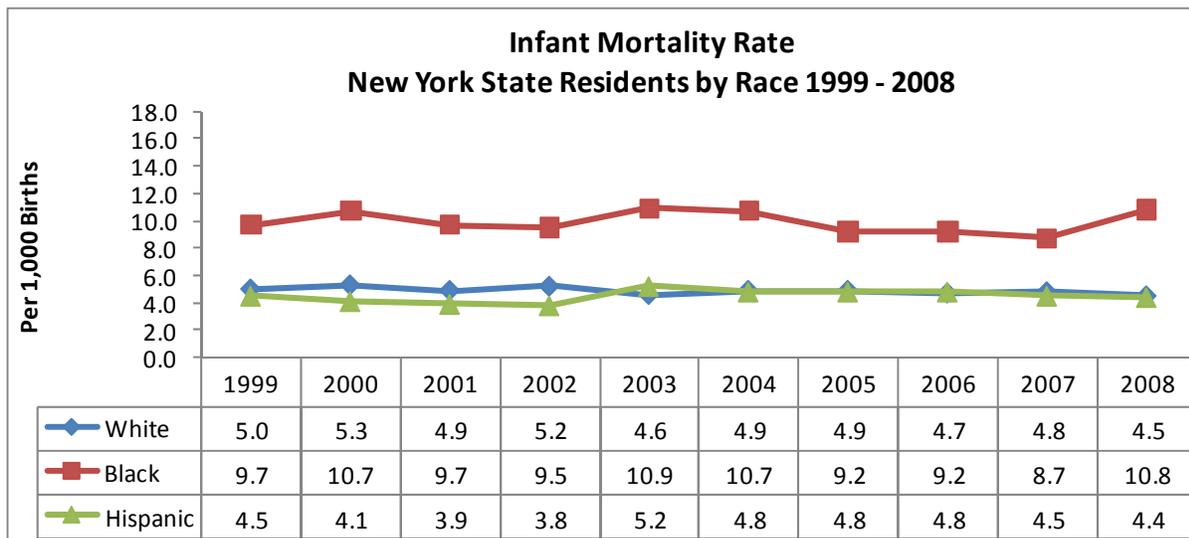
Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

There is a substantial disparity in the infant mortality rate for the Medicaid versus the non-Medicaid population.

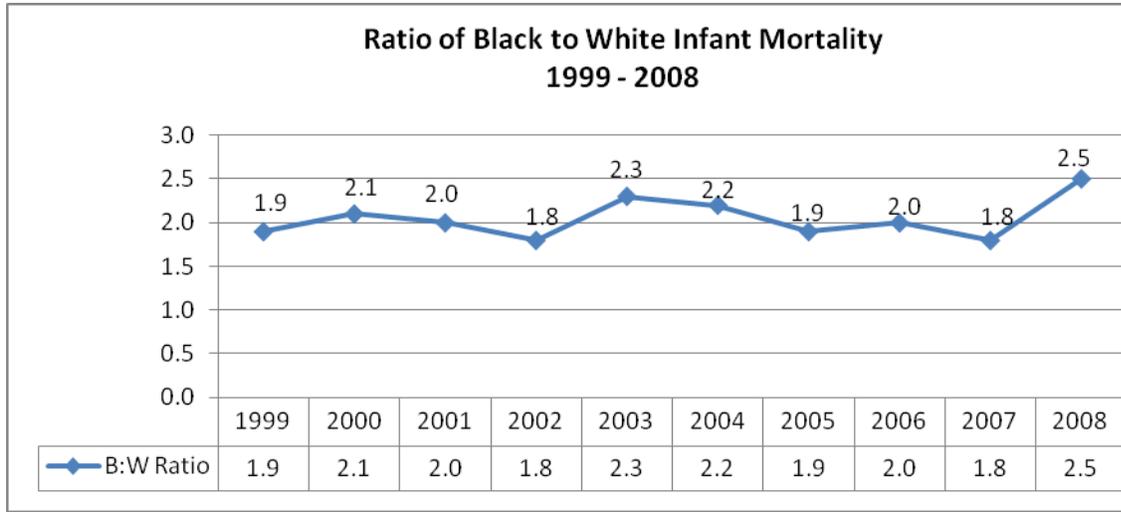
INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2008	payment source from birth certificate	7.4	5.1	5.4

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

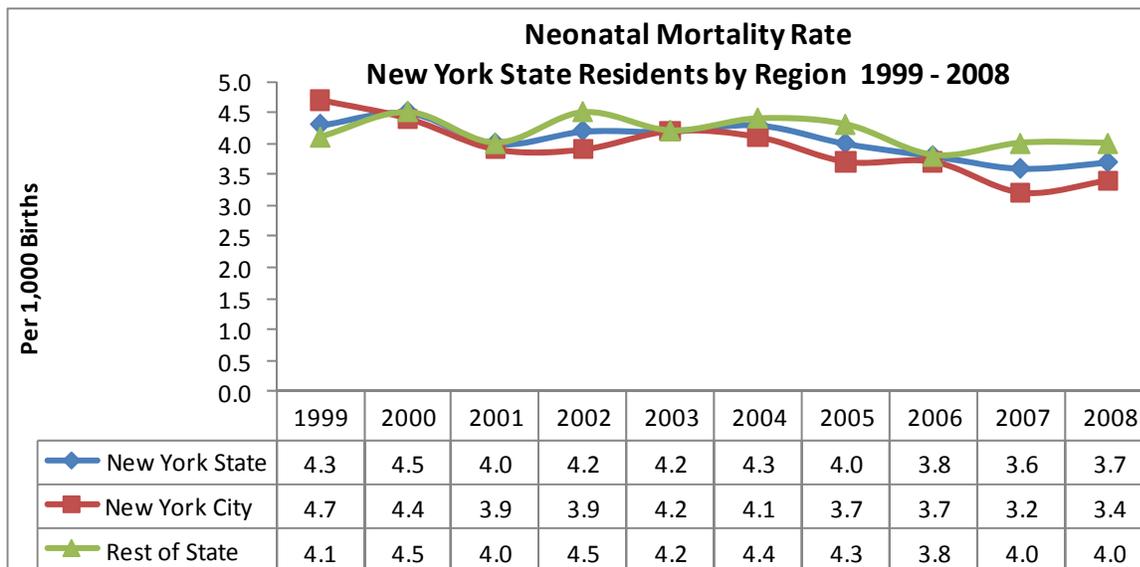
Hispanic and white infant mortality rates have continued to be about half the rate for Black infants. At 4.5 and 4.4 per 1,000, the rates for the white and Hispanic populations meet the Healthy People 2010 goal of 4.5 per 1,000 live births.



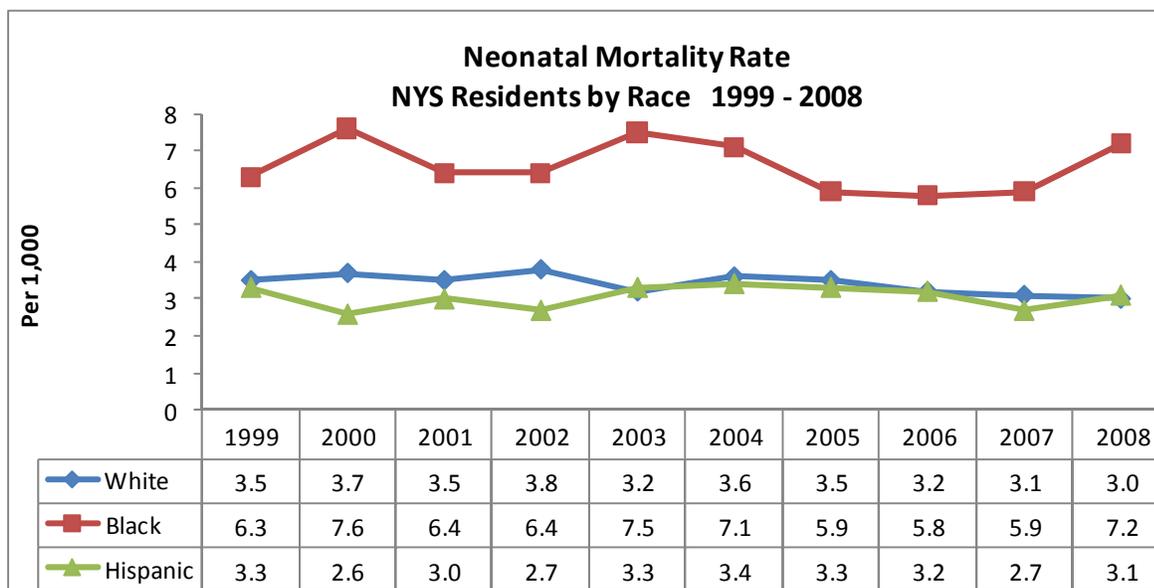
Disparities: Even though rates have been declining, Black infant mortality rates are still significantly higher than rates for both whites and Hispanics. In 1990, the disparity between Black and white rates peaked when the Black/white ratio for infant mortality reached 2.7, meaning there were 2.7 Black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



Neonatal Mortality: Trends in neonatal mortality mimic those of infant mortality. Between 1999 and 2008, neonatal mortality declined 14% to 3.7 per 1,000 live births. The 2008 neonatal mortality rate was slightly higher than the 2007 rate of 3.6 per 1,000 live births. The New York City neonatal mortality rate, at 3.4 in 2008, has been reduced by 28 percent since 1999, when it was 4.7 per 1,000 live births. Rates have declined more modestly in the Rest of State. Since 1999, the rate has declined by 2 percent to 4.0 per 1,000 live births in 2007. In 2000, New York City's rate dropped below the rate for the Rest of State and has been either equal to or lower than the rate for the Rest of State since that time.



In 2008, the Black neonatal death rate was 7.2 per 1,000 births, more than double the rate for whites (3.0 per 1,000 live births), and Hispanics (3.1 per 1,000 live births). The Black/white neonatal mortality ratio was 2.4 in 2008.



New York's Regionalized System of Perinatal Care

In addition to the programs described above, New York State has a well organized system of regionalized hospital perinatal services that ensures that appropriate care is provided to women and their newborns. Significant changes in the delivery and structuring of care in New York State's hospitals that were negatively impacting care resulted in the Department's Division of Family Health, Bureau of Women's Health spearheading an effort to redesignate all birthing hospitals for their level of perinatal care. Redesignation was completed in 2002, and revised perinatal regulations specifying the requirements for hospitals related to their level of care were promulgated in 2005. Oversight for this system now resides in the Division of Family Health, Bureau of Maternal and Child Health, with support of the Division's Office of the Medical Director with respect to quality improvement efforts, including the revamped maternal mortality review process described below.

Regional perinatal centers (RPCs), the highest level hospitals in this system, are required to enter into agreements with affiliate hospitals for the provision of a variety of services intended to improve perinatal outcomes. In addition to provision of specialty care and transportation of high risk women and newborns, RPCs coordinate the delivery of care in their network and provide many quality improvement services, including consultations, training and education, data collection and analyses, case review and quality of care visits to each affiliate. State appropriated funding is currently provided to RPCs to support them in their quality improvement role. RPCs play a critical role in implementing evidenced based interventions, patient safety and reducing maternal and newborn morbidity and mortality. There are currently 137 birthing hospitals in

New York State, including: 58 Level 1 hospitals, 25 Level 2 hospitals, 36 Level 3 hospitals, and 18 hospitals constituting 16 Regional Perinatal Centers.

In conjunction with this effort, a decision was made to invest resources in developing an on-line data system that would make data available on a more timely basis for the Department and hospitals for monitoring and quality improvement purposes. The resulting system, known as the Statewide Perinatal Data System, is web-based and modular in design, with the core module built around the electronic birth certificate, with additional information needed for quality improvement. An additional module was built to capture data on high risk newborns admitted to neonatal intensive care units. Regulations promulgated in 2006, require that all obstetrical hospitals enter data in the core module and hospitals with a level 2 designation or higher utilize the NICU module. Staff from the MCH Program and RPCs and representative affiliate hospitals have been meeting to discuss issues related to the data and use of the data related to quality improvement. Staff is also analyzing the data from both the core and NICU modules related to a variety of issues, including accuracy and completeness of the data.

Work has also begun in using the system of regionalized care and the supporting data systems to drive quality improvement in the state's birthing hospitals. The Division of Family Health was able to provide seed funding to RPCs to initiate quality improvement projects. Several of these projects addressed significant perinatal health concerns such as preterm birth. With the assistance of the Division staff, one of the projects related to reducing central line infections in the NICU, was able to garner significant resources from the Department's hospital acquired infections program, resulting in significant expansion of the project in RPCs and in affiliate hospitals.

In addition, in 2009, the Division of Family Health, in collaboration with the National Initiative for Children's Health Care Quality and the RPCs, launched the New York State Obstetric and Neonatal Quality Collaborative (NYSONQC) to improve maternal and neonatal outcomes and eliminate disparities. Through NYSONQC, RPCs will implement quality improvement interventions designed to improve maternal and newborn patient safety. The goal of NYSONQC is to bring together leaders in perinatal health to explore opportunities to use evidence based information to improve patient outcomes. NYSONQC will build on existing maternal and newborn quality improvement and safety initiatives and will promote the development of standardized, reproducible maternal and newborn care methods that will reduce preventable undesirable outcomes. NYSONQC will use evidenced based information, including data and established quality improvement activities, to develop patient safety practices which can be reproduced throughout perinatal hospitals. Reducing preterm birth will be a major focus of this initiative, as well as improving neonatal care. Division staff is also participating in the March of Dimes Big 5 initiative which is also developing initiatives and evidenced based approaches to address the increase in preterm birth.

New York State has a number of strengths related to improving birth outcomes, including those mentioned above in the perinatal health section. The State has a strong system of perinatal regionalization, with a specific funded function of the regional perinatal centers related to quality improvement in affiliate hospitals in their network. The State has also developed data systems that support quality improvement both in the obstetrical and neonatal arenas. The system of

regionalized care has resulted in a significant drop in high risk babies being delivered in lower level hospitals from 82% in 2002 to 90% in 2008.

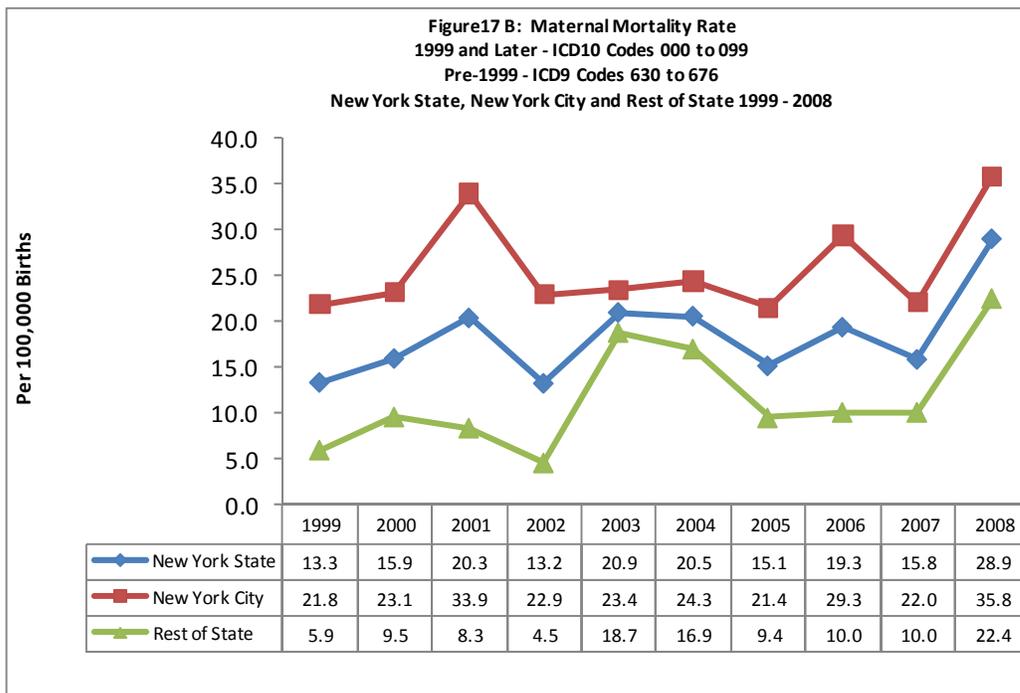
In a paper commissioned by the Maternal & Child Health Bureau (MCHB) developed by Jeff Koshel, a consultant hired by federal Maternal and Child Health Bureau, among states with more than 10 percent of births to African American women in 2007,

- New York had the *lowest non-Hispanic black infant mortality rate* (11.7/1,000) during 2003-2005;
- New York had the *lowest non-Hispanic white infant mortality rate* (4.65/1,000) during this same period; and
- New York had the *lowest neo-natal and post neo-natal infant mortality rates* in 2007.

Mr. Koshel attributed this to New York's multifaceted strategy to improve birth outcomes by implementing: (1) an aggressive program of providing outreach, comprehensive prenatal care and other support services to pregnant women and new mothers, (2) a comprehensive regionalized system of care that included redesignation of all obstetrical hospitals for level of perinatal care in accordance with current ACOG/AAP guidelines for perinatal services, (3) statewide perinatal data system that is readily accessible to hospitals for quality improvement and to public health staff for monitoring (4.) use of community based groups to improve perinatal care in their catchment area, including collaborative relationships with hospitals and other medical providers in regional forums, and (5) extensive family planning and STD treatment and monitoring programs. The paper also emphasizes that under New York's community-based regionalization model, community agencies and hospitals in New York are involved in providing a plethora of services to low income women of child bearing age, with special emphasis on New York City, which accounts for 70 percent of the births to mothers on Medicaid.

It also states that , in all likelihood, New York can make further gains in reducing infant mortality by matching or exceeding what other large states have accomplished in increasing the percentage of women entering prenatal care early in their pregnancies, placing more emphasis on providing the adequate number of prenatal care visits, and reducing smoking among pregnant women.

Despite these strengths, the State does not have resources to provide the necessary infrastructure to support the quality improvement collaborative. Progress is being made in this arena due to the ability of the Division of Family Health to identify or leverage funding support to enter into a contract with NICHQ and to provide RPCs and affiliates participating in the quality collaborative with some funding support. In addition, while there has been substantial progress in developing the data sets to support quality improvement, there remain a number of problems that need to be addressed with limited resources, including: upgrading outdated software; administrative streamlining of data sets to eliminate duplicate entry and improve quality of data entry; assessing the quality and completeness of existing data; and, linkage of data sets, such as birth, death, SPARCS, etc. to obtain a more comprehensive understanding to support quality improvement. Issues related to confidentiality of vital records data and timely access to NYC vital records data (NYC is a federally designated VR district separate from the State and is required under State



law to develop their own SPDS) continue to hamper access to data for quality improvement purposes, although dialogue continues to address these issues.

Most importantly, while there has been some statewide progress in addressing poor birth outcomes such as infant and neonatal mortality, significant health disparities persist.

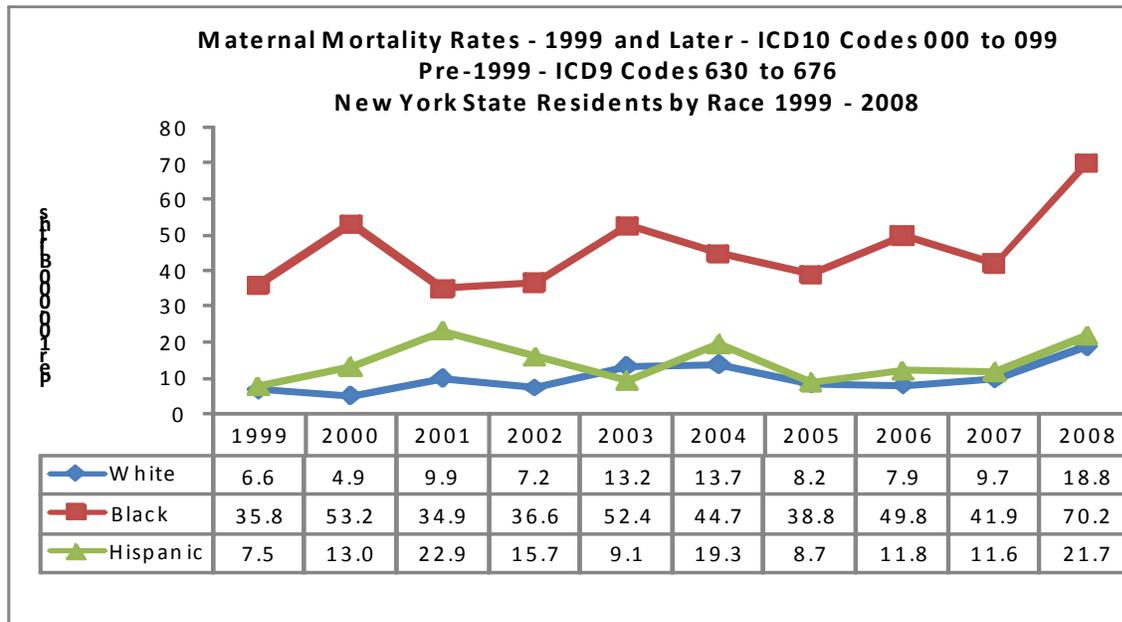
Maternal Mortality: Maternal mortality in New York State reached the rate of 28.9 per 100,000 live births in 2008. Both New York City and Rest of State experienced significant increases compared to 2007. The rate in the Rest of State more than doubled and in New York City, the rate increased 63%. The 2008 NYS rate is substantially higher than the 2007 NYS rate of 15.8 per 100,000 and the 2008 U.S. maternal mortality rate of 13.0 per 100,000, and is more than 6 times the Healthy People 2010 goal of 4.3 per 100,000.

Maternal mortality varied considerably during the past decade. The statewide rate has ranged from the current high of 28.9 in 2008 to a low of 13.2 per 100,000 live births in 2002. Among New York City residents, the 2008 rate of 35.8 was the highest in the decade while the lowest was in 2005 at 21.4 per 100,000 live births. Residents living outside of New York City experienced the lowest rates of maternal mortality. Their rates ranged from a high of 22.4 in 2008 to a low of 4.5 per 100,000 live births in 2002.

One reason for the wide fluctuation in the maternal mortality rate is the rarity of the occurrence. The small numbers of deaths that occur each year create great swings in rates. In 2008, there were 73 maternal deaths in New York State; 44 in New York City and 29 in Rest of State. In 2007, there were 40 deaths; 27 in New York City and 13 in Rest of State.

Possible explanations for the increase are the increasing rate of caesarean deliveries and induced preterm births and an increased percentage of obesity among pregnant women. These factors are known to increase the risk for medical complications during delivery. Improved reporting with better case identification is also thought to be a factor.

The racial disparity in maternal mortality in New York is dramatic and exceeds the differences seen in infant mortality and low birth weight. In 2008, the Black maternal mortality rate of 70.2 per 100,000 births and the white rate of 18.8 per 100,000 births, result in a Black to white ratio of 3.7 to 1. These rates are based on 32 deaths among African American women and 31 deaths among Caucasians. The rate for Hispanics in 2008 was 21.7 per 100,000 live births based on 13 deaths.



Maternal Mortality Review

Since 2003, the Department has provided funding to ACOG for maternal mortality reviews. There have been a number of positive achievements resulting from this collaboration, including the development of a well designed maternal review protocol, as well as a number of outreach and education activities, including a maternal mortality grand rounds program in hospitals. In addition, ACOG collaborated with the NYSDOH and the NYCDOHMH to address specific issues identified through maternal mortality reviews, for example, issuance of a postpartum hemorrhage alert to all hospitals.

However, hospital reporting of a maternal death was voluntary in this program, and it was estimated that only a small number of deaths are being reviewed, resulting in missed opportunities to develop prevention strategies to prevent future deaths. As a result, the Department will conduct maternal mortality reviews in the future, and hospital participation will be mandatory. The Department's Division of Family Health and Office of Health Systems Management, are collaborating related to this effort. In addition, case identification will be significantly improved by reviewing all deaths within one year of having a live birth or fetal death to determine whether the deaths were pregnancy related, and, if so, what factors contributed to the death. To identify as many cases of maternal death as possible, the Department will use a variety of approaches, including:

- Maternal deaths identified through NYPORTS, the Department system for reporting of sentinel events
- Identification from death certificates, through the check box on the death certificate to indicate whether the woman has been pregnant within the past 12 months.
- Identification from SPARCS for ICD codes related to maternal death
- Linkages of infant birth, maternal death and SPARCS files using key indicators.
- Deaths identified through other venues such as through health care providers, the news media or informal means.

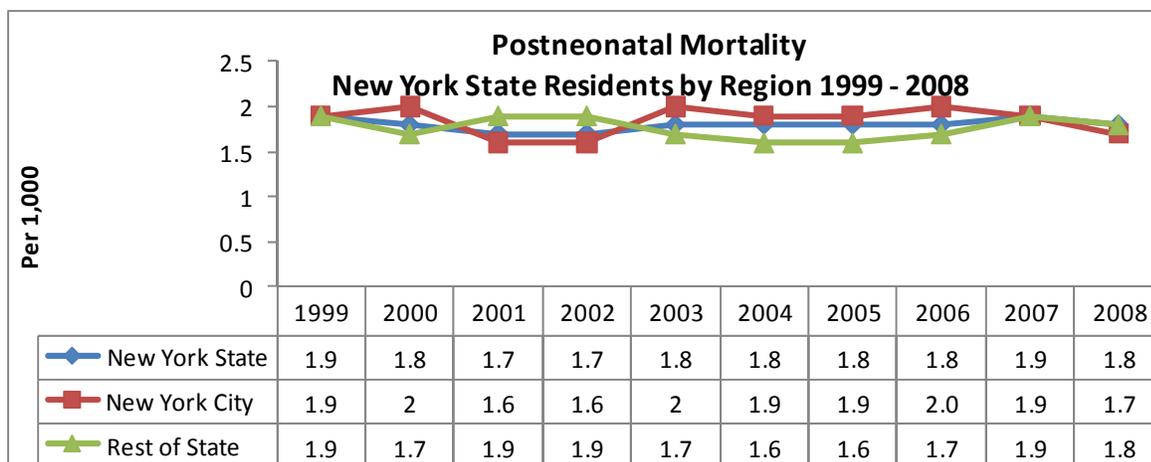
The Department’s MMRP will emphasize a public health approach to maternal mortality reviews which includes:

- Descriptions of the populations most at risk for maternal death;
- Understanding the scope of factors impacting maternal death including medical, non-medical and other social and economic factors;
- Education of stakeholders in maternal health including women, health and human service providers, policy makers and advocates for women’s health;
- Recognition of the supports and services needed on the individual and community level to improve birth outcomes; and,
- Development of recommendations and interventions to reduce maternal deaths in New York State and the role that all providers and key stakeholders can play in achieving this outcome.

The Department will convene an expert review committee that will consist of a diverse group of health care providers, ACOG, state agencies, hospital associations, and others. The expert committee will review the results of maternal mortality reviews and will provide recommendations related improvement opportunities. The Department will work with its RPCs and regionalized structure, ACOG, hospitals associations and others to implement committee recommendations.

NYCDOHM has had a comprehensive maternal mortality surveillance process for a number of years. The Department is collaborating closely with the NYCDOHMH related to this initiative.

Postneonatal Mortality Rate: The postneonatal mortality rate in New York State has changed very little over the past decade. Between 1999 and 2008, it has fluctuated between 1.7 and 1.9 per 1,000 live births. In 2008 the postneonatal mortality rate was 1.8 per 1,000 live births Statewide, 1.7 in New York City and 1.8 in Rest of State.



The disparities in rates between Blacks and Whites and Hispanics that were seen in both infant and neonatal mortality rates are also seen in postneonatal mortality. Black post-neonatal mortality increased by 17.9 percent between 2007 and 2008 and was more than double the rates for White (1.4/1,000) and Hispanic (1.4/1,000) infants. The Black/white postneonatal mortality ratio was 2.6 to 1 in 2008.

Sudden Infant Death Syndrome: The table below illustrates the relationship between occurrence of SIDS deaths as a subset of total infant and postneonatal deaths. The table also contains PRAMS Survey responses indicating mothers who reported putting their infants to sleep on their backs. It is widely believed that changing infant sleep position to backs exclusively has greatly reduced the SIDS rate from 0.6 per 100,000 population in 1998 to 0.4 per 100,000 in 2008. Total SIDS deaths in New York State declined from 100 in 1998 to a low of 23 in 2004. Between 2005 and 2008 the number of deaths attributed to SIDS increased each year from 49 in 2005 to 74 in 2008. SIDS related deaths now account for about 16.8% percent of all postneonatal deaths. In 1998, SIDS was the cause for 21.4% of these deaths.

Proportion of Post-Neonatal Deaths that Are SIDS, % Moms Reporting Back-to-Sleep, 1998- 2008					
<u>Year</u>	All deaths < 1 Year	Post-neonatal deaths	SIDS deaths	% SIDS of Post-Neonatal Deaths	% PRAMS Moms responding that they put their infants on their back to sleep
1998	1607	467	100	21.4%	53.0%
1999	1571	478	74	15.5%	56.7%
2000	1436	443	74	16.7%	66.3%
2001	1450	447	74	16.6%	68.5%
2002	1489	436	57	13.1%	69.4%
2003	1450	458	51	11.1%	70.9%
2004	1503	445	23	5.2%	69.5%
2005	1414	431	49	11.4%	67.2%
2006	1391	454	61	13.4%	71.9%
2007	1382	473	63	13.3%	70.5%
2008	1359	440	74	16.8%	75.1%

Infant/Child Mortality Review

Sudden Infant Death Syndrome (SIDS) is a leading cause of death among New York infants one month to one year of age. During 2008, 74 deaths were classified as SIDS, a slight increase over

the 63 that occurred in 2007. According to the 2008 PRAMS Survey, 75.1% of mothers reported putting their babies on their back to sleep. This represents a 4.6% increase over 2007 and the highest level in recent history. The department contracts with State University of NY Research Foundation to operate its SIDS program. The program functions as the New York State Center for Sudden Infant Death located at SUNY Stony Brook with 4 subcontracted regional offices. The programs conducted 125 educational programs and 50 public awareness programs. During the early part of 2008 the department worked closely with the Center on replacing the department's SIDS risk reduction information cards with a new, more attractive product that also incorporated other safe sleep recommendations. The Center also released health education materials about the dangers of placing infants to sleep in adult beds. The Center maintains membership in 25 coalitions addressing infant mortality risk reduction.

The Division of Family Health has primary responsibility for these activities. The Division has worked with the State Office of Children and Family Services (OCFS) on safe sleep messages and materials. OCFS released several safe sleep initiatives targeted toward lower socio-economic clientele. Statewide training efforts continued. Police, firefighters, emergency medical personnel and public health nurses were educated on appropriate responses to SIDS.

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

A specific project is in progress to assess "Perinatal Periods of Risk" statewide and by county. Preliminary multi-year analysis of infant mortality data for New York State (excluding New York City) has identified young maternal age, Black race and lower educational attainment as risk factors for infant mortality. These findings will further inform ongoing program development in this area.

Keeping NY Kids Alive: The Division of Family Health developed this initiative in conjunction with the OCFS to expand and improve the quality of the child fatality review process. The initiative will assist in improving the skills of local officials who work in the child fatality review process to promote improved community services delivery and the development of local public health risk reduction and safety focused prevention programs. Specifically the program will (1) promote the development of new child fatality review teams by offering technical assistance

support to local agencies, as they develop and implement child fatality review and prevention efforts as a community-based process to assess and improve services to protect children and adolescents; (2) help refine the practices used by local teams by assisting them with continuous self assessment, effective use of data, and evaluating feedback from communities; (3) support expanded use of the child fatality review process in translating data into policy. Policies concerning other adverse events (e.g., morbidity) affecting the maternal and child health population may also be supported; (4) promote collaboration among local agencies to increase effectiveness of efforts to improve child health and safety and reduce duplication of effort and (5) support operation of a state level multidisciplinary group (6) serve on local fatality review teams as experts on Sudden Infant Death Syndrome (SIDS) and other sleep related infant injury deaths as staff availability permits and infant case(s) are reviewed and (7) directly conduct statewide risk reduction activities and services for SIDS and other sleep related infant injury related deaths.

During a review of our Sudden Infant Death Syndrome (SIDS) program the department identified the need to not only strengthen activities related to SIDS, but to expand the program to address other factors related to child deaths less than 18 years old. The department's death certificate data indicates over 1,500 children of age 28 days through 18 years die annually in New York State (NYS), and approximately 40% of these deaths are categorized as accidents, homicides and suicides. An additional 12% of deaths are categorized as sudden and unexpected infant deaths, "ill defined" or "unknown and unspecified." Additionally, about 1,000 deaths occur each year among infants under 28 days of age. Child fatality rates remain higher in minority communities, especially among Black children.

An examination of information contained in death records revealed that insufficient information existed about child deaths to immediately expand the scope of our SIDS program to reduce the risk of other causes of child deaths.

The program priorities will be to increase the number of county child fatality review teams, expand the types of deaths they review from mostly child abuse and neglect cases to other types of possibly preventable deaths including infant sleep related deaths, accidents and suicides and collect standardized data from these reviews. Also, we will begin to establish a system of mini-grants to enable local officials to act on their findings to prevent future deaths. The program will support operation of a state level multidisciplinary group that will analyze data and recommend changes in state programs and new legislation to improve the health and safety of children. The program will utilize efficient methods to provide educational information to the public and professionals about risk factors that contribute to infant deaths and assure affected families are connected with appropriate follow-up services.

Teams will utilize the National Center for Child Death Review data collection system. The system allows local and state users to enter case data, access and download their data and download standardized reports via the Internet. Users are able to complete data analysis and develop their own reports. The Department is currently utilizing its competitive process to seek applications for a contractor to help us build a Keeping NY Kids Alive program that will implement the priorities listed above.

Breastfeeding

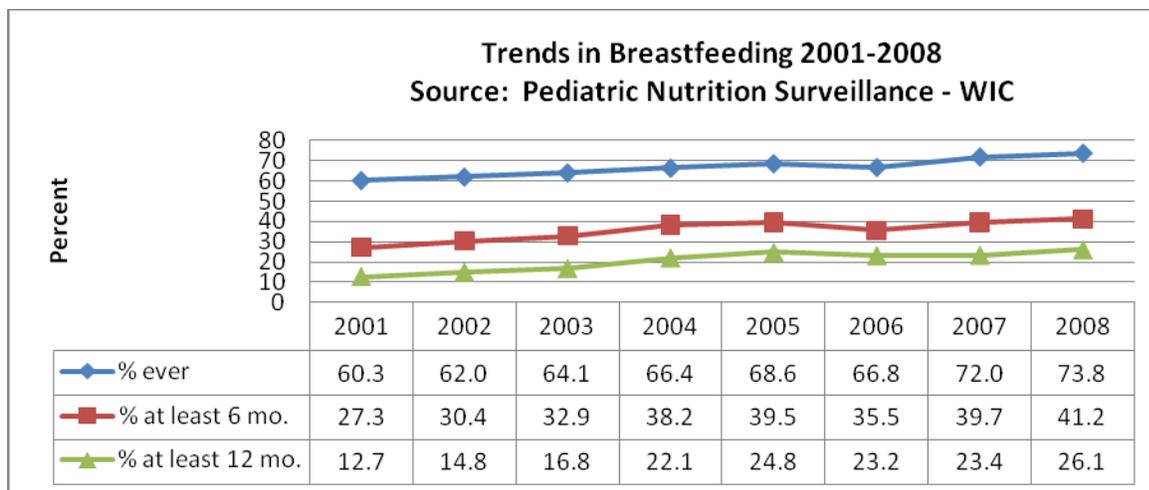
New York uses PRAMS data to track breastfeeding trends. PRAMS data show that since 1998, rates of breastfeeding initiation and breastfeeding at one month postpartum have improved.

Highlights from the PRAMS 2008 (New York State – excluding NYC) data are as follows:

- Breastfeeding rates have shown slight but steady improvement over the last few years.
- Breastfeeding rates drop by one month postpartum.
- Mothers with more than 12 years of education were more likely to breastfeed.
- Marriage increases the likelihood that mothers will initiate breastfeeding and continue to breastfeed past the immediate postpartum period.
- Of the 24% that chose not to breastfeed in 2008, 42% stated that they did not do so because they did not like breastfeeding, and 19% indicated that they didn't breastfeed because they had other children to care for. About 12% said they had to return to work or school, 7% said they had other household duties.
- Among women who initiated breastfeeding and then stopped, 45% said they were not producing enough milk, 40% said breast milk alone did not satisfy their baby and 26% said their nipples were sore.

Breastfeeding Initiation and Duration for PRAMS Respondents New York State Excluding New York City 1998 – 2008 <i>Source: PRAMS data</i>										
<i>Year></i>	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
PRAMS – Initiation	65.4%	69.1%	68.6%	72.1%	71.6%	72.4%	72.9%	76.1%	73.9%	73.3%
PRAMS –1 m Postpartum	50%	57.1%	55.3%	57.6%	57.4%	56.3%	59.5%	62.3%	61.5%	63.1%

In 2008, the percent of WIC moms who reported they ever breastfed increased to a record high rate of 73.8%. The percentage of WIC moms continuing to breastfeed for at least 6 months also increased to an all time high rate (41.2%) in 2008. About 26% of WIC Moms breastfed for at least 12 months.

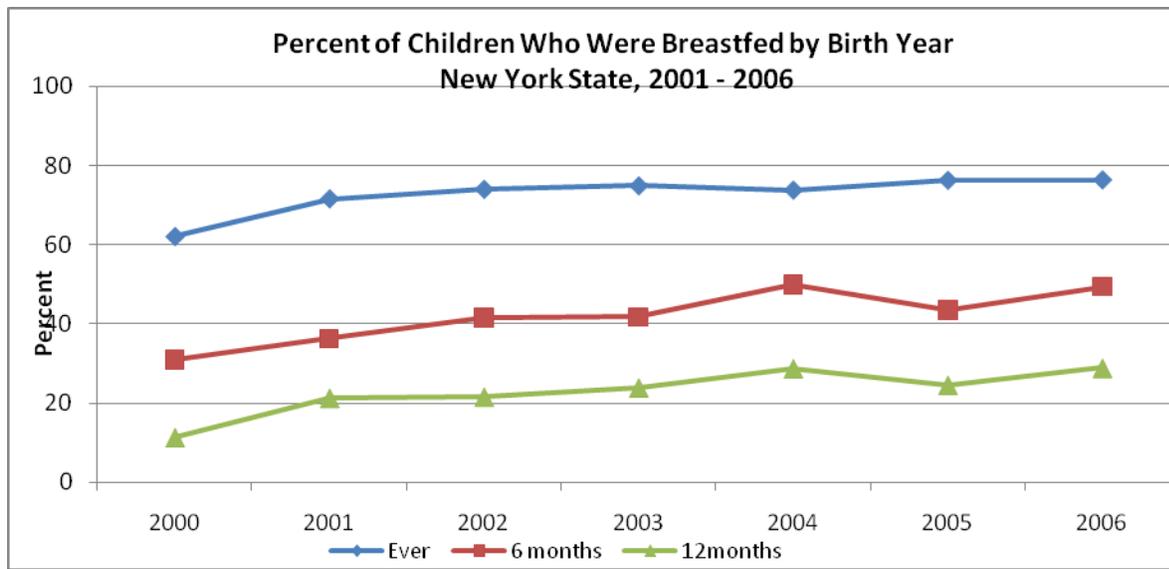


National Immunization Survey Data on Breastfeeding: Each year since 1994, the CDC National Immunization Program, in partnership with CDC’s National Center for Health Statistics, has conducted the National Immunization Survey (NIS) within all 50 states, District of Columbia, and selected geographic areas within the states. Since January 2003, breastfeeding questions have been asked of all survey respondents selected to participate in the National Immunization Survey (NIS). All data collected on breastfeeding in this survey relates to the child about whom immunization data is being collected. Beginning with the 2006 survey, NIS breastfeeding data are being presented according to the year of the child’s birth rather than the year the information was collected. As a result, information collected from the 2008 survey pertains to children born in 2006. In previous reports these data would have been reported as 2008 data. The change was made to make it easier to evaluate interventions and progress toward goals.

The following NIS results were collected as part of the NIS Breastfeeding Supplement and provide breastfeeding rates for children born in 2006 in New York State, New York City and nationwide:

- Of children born in 2006 in New York State, 76.4 percent were ever-breastfed. Children born to women in New York City were more likely to have been breastfed (82.4%) as compared to infants statewide. Nationally, 73.9% of infants born in 2006 were ever breastfed.
- About 43% of children born nationally and in New York State in 2006 were being breastfed when they were 6 months of age. Rates were higher among New York City children (53.6%). The American Academy (AAP) of Pediatrics recommends that infants be breast-fed exclusively for the first 6 months of life; 9.6 percent of children in New York State and 13.6% of children nationally met this recommendation. In New York City 10.7% of children were exclusively breast-fed at 6 months of age.

New York State’s breastfeeding rate, at 76.4%, meets the national *Healthy People 2010* objective of 75% of mothers initiating breastfeeding.



	2001	2002	2003	2004	2005	2006
Ever Breastfed	70.3+/-4.8	74.0+/-3.9	74.9+/-3.5	73.8+/-4.9	76.3+/-4.6	76.4+/-4.1
Breastfed at 6 months	36.3+/-5.3	41.6+/-4.1	41.8+/-3.9	50.0+/-4.6	43.5+/-5.1	49.4+/-5.0
Breastfed at 12 months	21.3+/-4.2	21.6+/-3.3	23.9+/-3.2	28.8+/-5.8	24.6+/-4.3	28.9+/-4.5

Source: National Immunization Survey, Breastfeeding Supplement, 2008

Programs to Promote Breastfeeding

The U.S. Surgeon General recommends that babies be fed only breast milk for the first six months of their lives. The public health benefits of breastfeeding have long been recognized. Human milk is uniquely adapted to the nutritional needs of infants and provides for optimal growth and development. Breast milk is easy to digest and contains antibodies that help reduce the infant's risk of infection. Breastfed infants are at reduced risk for asthma, respiratory infections, obesity, diabetes and other chronic illnesses throughout their lifetimes. Breastfeeding also benefits the mother, reducing postpartum bleeding, promoting an earlier return to pre-pregnancy weight, and reducing the risks of breast and ovarian cancers. Breastfeeding yields both health and economic benefits to the family and society.

Within the Department, there has been extensive collaboration among the Department's Division of Chronic Disease, Division of Family Health and Division of Nutrition, as well as with the NYCDOHMH to educate providers, assist hospitals with the implementation of baby friendly policies and practices, and to link women with home visiting programs during the perinatal period to educate and assist with support for breastfeeding.

In an effort to improve exclusive breastfeeding rates in maternity hospitals in New York, infant feeding data from hospitals (excluding New York City) was analyzed using the Statewide Perinatal Data System. Hospitals were ranked by quintile scores on three breastfeeding indicators (breastfeeding initiation, exclusive breastfeeding, and formula supplementation of breastfed infants). Each hospital was informed of their performance relative to other hospitals. The written breastfeeding policies and procedures, as specified in state regulation, were collected from all hospitals providing maternity care services in the state. The policies were reviewed to determine compliance with the 32 components required by State regulations, and each hospital was informed on their individual compliance with each component of the regulations. In addition, DOH is recruiting 12 hospitals located outside NYC for the Breastfeeding Quality Improvement in Hospitals Learning Collaborative, a joint initiative with the NICHQ. The NYC DOH is recruiting 8 hospitals located in NYC for a similar initiative. The purpose will be to recruit teams from these hospitals to develop a culture within the hospital to promote exclusive breastfeeding.

The Maternity Information Leaflet, required by state law, provides patients information on maternity related procedures performed at each hospital. It has now been expanded to also require that information on infant feeding practices at each hospital (breastfeeding initiation, exclusive breastfeeding, and formula supplementation of breast-fed infants) be included.

In 2009, the Department electronically surveyed all 138 hospitals that provide maternity services in NYS. Information regarding patient education and support, obstetric staff education and training, and general breastfeeding polices was collected. The study identified several differences in breastfeeding practices at hospitals providing maternity services in NYS. Recognition of these differences will be used to inform policy decisions and training opportunities for obstetric staff across the state. In preparation for such training, hospital staff was surveyed to determine the best staff education options related to breastfeeding. The Department and Regional Perinatal Centers are offering the *Ten Steps to Successful Breastfeeding Online Course* (18-hour course) to staff in 125 obstetrical hospitals across NYS.

Through the *Communities Putting Prevention to Work (CPPW)* funded Breastfeeding Quality Improvement initiative, the Department aims to further improve hospital policies and practices, promote hospital compliance with NYS regulations and laws, and increase staff skills and knowledge. This includes supporting the training for one staff per participating hospital to become a Certified Lactation Counselor, and training WIC staff to increase their knowledge and skills in supporting and educating mothers of their rights provided under NYS's *Nursing Mothers in the Workplace Act*. Website resources will be developed for women, health care providers and employers to increase their access to current information and resources on breastfeeding, and in particular, providing support for nursing women in the workplace. This initiative is supported by American Recovery and Reinvestment Act of 2009 funding through the CDC.

In January 2009, the NYS WIC Program (overseen by the Division of Nutrition's Bureau of Supplemental Food Programs) became the first program in the country to implement newly redesigned WIC food packages. In following the Department's goals and the American Academy of Pediatrics (AAP) recommendation that breastfeeding continue for 1 year and

beyond, WIC took into consideration the mother and infant to design a food package to meet their combined nutritional and energy needs. Extended food benefits are available to the exclusively breastfeeding mother for the first year of breastfeeding (instead of six months). The breastfeeding infant food packages (6 months and older) delay the introduction of juice and cereal, and provide baby vegetables, fruits and meats as further incentive for mothers to continue breastfeeding. By providing this support, mothers may be more likely to initiate and continue breastfeeding. When mothers do not plan to exclusively breastfeed, a “partial breastfeeding” option is available after the infant turns 1 month old. As a result, the food package is adjusted according to the amount of formula the infant receives.

The new food packages coincided with WIC’s initiatives to enhance breastfeeding support and provide participant centered nutrition education. The Division of Nutrition (DON) has invested substantially in breastfeeding promotion. The program now requires that a Certified Lactation Counselor, in addition to peer counselors, be available at all WIC clinics to provide breastfeeding education and lactation support. Fully, \$5 million in peer counseling programs have been implemented to improve breastfeeding rates among women receiving WIC.

NYS WIC offers Certified Lactation Counselor (CLC) training to local WIC staff, and participates in a pilot to expand CLC training to hospital staff statewide. These services include support from WIC staff members trained in lactation counseling and peer-counseling services for pregnant women and new mothers. The literature shows that peer counseling is one of the most successful interventions for increasing breastfeeding among low-income women. Other support services include the availability of breast pumps to mothers who are returning to work or have other special needs. The www.breastfeedingpartners.org website was developed specifically to answer mothers’ questions and provide additional training to peer counselors.

The USDA gave \$1.6 million to NYS WIC to recognize its high rate of breastfeeding initiation. About 74% of NYS WIC mothers initiated breastfeeding, compared to the national rate of 62% for WIC mothers; 41% of NYS WIC mothers breastfeed for at least six months, compared to 27% for the US. DON will initiate a new public awareness campaign to support breastfeeding women supported with WIC Breastfeeding Performance Bonus Award. To build general community awareness of how WIC provides support for breastfeeding families, WIC will launch a campaign that will include TV ads, radio and print, including bus sides, shelters and billboards. Materials will be produced and distributed that health care providers can use in educating women on the benefits of breastfeeding. These materials will include information on resources that will help support families in their breastfeeding efforts.

In recognition of the importance of breastfeeding, the NYS Legislature enacted and the Governor signed into law the *Breastfeeding Mothers’ Bill of Rights*, which specifies the rights of pregnant women and new mothers to be informed about the benefits of breastfeeding, and to obtain specific supports from health care providers and health care facilities during pregnancy, after delivery and after discharge from the birthing facility. The new law subsequently went into effect on May 1, 2010.

The *Breastfeeding Mothers’ Bill of Rights* was posted on the DOH website in 6 languages.

New WIC agencies receive intensive assistance to ensure quality breastfeeding promotion and support services, including implementation of Breastfeeding Peer Counselor Programs. Public Health Detailing expanded statewide, training WIC staff to visit local health care providers and offer materials on breastfeeding support, peer counseling and other services at WIC clinics.

B. Children and Adolescents

Access to Care

Public Insurance Programs

National 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	2004	2005	2006	2007	2008	2009
Annual Performance Objective	9	9	8.5	8.0	8	8.5
Annual Indicator	7.1	7.7	8.4	8.9	7.1	7.1
Numerator	396,000	347,000	380,000	395,000	310,000	310,000
Denominator	4,604,000	4,534,000	4,547,000	4,437,000	4,373,000	4,373,000
Is the Data Provisional or Final?		Final	Final	Final	Final	Provisional
	2010	2011	2012	2013	2014	2015
Annual Performance Objective	8.4	8.2	8	8	8	6

In 2008, New York took significant steps towards ensuring universal coverage for children in the State when, prior to federal funding support, it increased the income eligibility threshold for Child Health Plus from 250 to 400 percent of the federal poverty level, making an additional 70,000 children eligible for subsidized health insurance coverage. The State expanded Family Health Plus for adults with children and for young adults (ages 19 and 20) to 160 per cent of the federal poverty level. Medicaid coverage for foster care children was also extended through age 20 to address the long standing problems children in foster care have had in transitioning to adulthood and independence. In addition, there were several efforts previously described to increase access and decrease disenrollment.

With expansion of Child Health Plus (the State's SCHP program) to 400 percent of the federal poverty level in September 2008, all uninsured children and teens are eligible for comprehensive and affordable health insurance through Medicaid and Child Health Plus. More than 90 percent of the state's uninsured children are eligible for subsidized coverage. and the remaining children are able to buy into the Child Health Plus program.

New York has witnessed a steady increase in children's enrollment since January 2008. Enrollment of children in Medicaid and Child Health Plus grew by 151,000 children between January 2008 and September 2009 (most recent data available for combined enrollment). More

than 102,000 of these children have been enrolled since the expansion in September 2008. Today, New York provides health care coverage to 2.1 million children. Slightly more than 1.7 million children are covered by Medicaid and another 390,000 by Child Health Plus. This represents more than 40 percent of the state's children. The number of uninsured children in New York continues to decline. The number of uninsured children under the age of 19 in New York State decreased from 395,000 in 2007 to 310,000 in 2008. This decline is directly attributable to increased access to insurance.

In addition, Medicaid rates for children's health measures generally have steadily increased over time and often surpass national average rates.

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006	2007	2008	2009
Annual Indicator	74.9	74.7	76.5	80.7	76.9	72.7	77.6	76.3
Numerator	81,213	103,303	110,535	116,132	111,874	108,995	117,580	116,490
Denominator	108,485	138,216	144,460	143,968	145,432	149,958	151,439	152,710

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

A related measure is collected for Medicaid Managed Care (MMC) Plans through the state's Quality Assurance Reporting Requirements (QARR). For 2007, 98% of the children continuously enrolled in MMC had at least one well child visit between birth and 15 months, and 79% had five or more well child visits by 15 months. These rates were above the 2003 measurement year of 96% and 78% respectively, however, the methodology differences between these two years make the results not comparable. The majority of infants enrolled in Medicaid in New York State are served through managed care, rather than fee-for-service.

Child Health Plus is exclusively a managed care product. Data on provision of well child visits for children aged 15 months is reported by plans through the state's Quality Assurance Reporting Requirements (QARR). For children continuously enrolled in Child Health Plus plans, the percent of children with at least one well child visit by age 15 months rose from 98% in 2003 to 99% in 2007. A more meaningful measure of capacity and performance used for QARR is a subset of this group, the percent of children with five or more well child visits in the first 15 months, which increased from 79% in 2003 to 88% in 2007

Improving the quality and frequency of preventive care for children is a priority of the state's Medicaid and Title V programs and for Medicaid managed care plans in NYS. Plans' quality improvement efforts address barriers including: delays in processing newborn Medicaid identification numbers; lack of provider reminder systems; non-standardized medical record documentation; and, lack of member/parent understanding of the importance of well child visits. Health plans educate members and providers through newsletters and reminder mailings, annual

'birthday cards' as reminders to members and physician profiling to identify members who are due for a preventive visit. Health plans have encouraged their providers to use standardized forms to document well child visits, conduct on-site visits to review records for compliance; and, some plans have offered providers financial incentives to improve their well child visit rates.

Division of Family Health staff monitor access to programs and services on a local level and work with the DOH Office of Health Insurance Programs to identify and solve access issues. The DOH's public health home visiting services provide community outreach, and direct services to high-risk women and families. These programs promote well baby care visits, assisting women with keeping these visits after the baby is born. The Community Health Worker Program and the Nurse Family Partnership program helps ensure new mothers have a well baby visit within four weeks of delivery. The Healthy Mom/Healthy Baby Prenatal and Postpartum Home Visiting program will perform birth certificate reviews to identify high-risk women and outreach to engage high-risk women in home visiting services and keep their well baby appointments.

School-Based Health Care

New York State has one of the largest school based health center programs in the nation, with services provided by 55 Article 28 sponsoring providers (i.e., a licensed hospital or diagnostic and treatment center) at 222 sites. The School-Based Health Center (SBHC) Program within the Division of Family Health, Bureau of Maternal and Child Health was established to improve the accessibility to quality comprehensive primary and preventive medical and mental health care to students (Pre-K through 12) residing in high-need, underserved areas. SBHCs are primary care clinics located within school buildings, established as a partnership between an Article 28 sponsoring provider and a school district. Establishment of SBHCs in the areas of highest need addresses the fundamental barriers that typically prevent access to health care: geographic, financial, transportation, social, cultural, and the lack of parental availability. SBHCs provide a unique access point by enabling children to receive needed services in the place they spend a good part of their day.

A growing body of literature demonstrates the value of School Based Health Centers in providing cost-effective primary and preventive care services to at-risk children and youth, and improving health and life outcomes for that population. A significant proportion of NYS children and youth do not receive recommended basic primary and preventive health care services. Having health insurance alone does not assure access to or utilization of necessary health care services. SBHCs fill important gaps in the current health care system by eliminating barriers that may prevent or delay some children and youth from receiving needed health care, including: inability of parents to take time off from work to attend health care visits, lack of health insurance, lack of primary care providers, fear of revealing undocumented immigrant status, family disorganization and distance/transportation issues.

All school-based health centers (SBHCs) provide psychosocial assessment as part of the initial assessment and visit, the annual comprehensive physical examination and at follow up visits, when indicated. Students and families are offered individualized education regarding safety issues and abuse, and when indicated, mental health services are made available on site or by referral. Potential abuse and neglect cases are reported. SBHC staff follows up on all referrals for mental health services and behavioral issues. Over 171,000 students have access to mental

health services through school-based health centers; 63% of school-based health center sites in New York State provided onsite mental health services, and 37% provided mental health services through referral.

School-based health centers conduct routine risk assessments that include questions about tobacco and alcohol use. Students are counseled and educated accordingly. Referral is available for consultation/intervention where onsite services are not provided.

Key strengths of the program include the strong partnership with the Office of Health Insurance Programs. This has been critical to the SBHC Program's capacity to effectively address questions and barriers related to reimbursement. A parallel partnership with the Department's Office of Health Systems Management has served to support regulatory oversight of the program, including the establishment of new clinics and closing of clinics, when needed. The Department also has a strong partnership with the NYCDOHMH/NYCDOE related to improving access and quality of services through school based health centers in NYC.

With input from a group of SBHC stakeholders, three key priorities were identified for strengthening the SBHC program: quality improvement, sustainability, and increased communication, training and technical assistance for SBHC providers. Since that time, the School Health program has worked with the stakeholders group and other providers to accomplish several critical improvements in each of these priority areas.

Program staff have worked extensively with the Department's Office of Health Insurance Programs (OHIP) related to reimbursement policy and impact upon SBHCs. NYSDOH is also working with the Coalition to identify issues that are affecting the sustainability of SBHCs, and efforts are underway to collaborate on their development of targeted trainings around Medicaid eligibility billing practices and other areas of SBHC operation in an effort to build and strengthen the framework needed for future sustainability.

A quality improvement project for SBHCs was developed with support in part from CSHCN's NY-ICS grant. As a result of this partnership, we were able to collaborate with the National Initiative for Children's Health Care Quality (NICHQ) and tailor an improvement project around three established School Health Program quality of care indicators: comprehensive physical exams (including age-appropriate screening and follow-up), obesity and asthma. Improvement efforts were focused across the Care Model for Child Health and encouraged testing and implementing changes in all six areas of the care model: decision support, family and self management support, use of community resources, delivery system design, and clinical information design. Twenty-five SBHC teams have participated in a series of trainings, learning sessions, and individualized coaching/TA sessions.

Childhood Immunization Levels and Vaccine Preventable Diseases: Childhood immunization has had a major effect on reducing and eliminating some important causes of illness and death among children. Monitoring immunization levels is one of the key strategies that will increase immunization rates in under-immunized populations, and helps the Department to evaluate current public health strategies to increase immunization rates. The state passed

legislation requiring reporting of all children's immunizations to a central registry, starting 1/1/08, which is expected to significantly improve monitoring efforts.

Between 2007 and 2008, the Hepatitis B case rate decreased to 0.9 per 100,000. This rate is considerably lower than the 2002 high of 4.6 per 100,000. Since 2002, the case rate has declined steadily.

During 2003 and 2004 there was a significant increase in the number of pertussis cases reported nationwide and in New York State. The case rate in New York State went from 2.4/100,000 in 2002 to 11.3/100,000 in 2004. The number and rate of pertussis cases in New York State declined significantly in 2005, and fluctuated in both directions between 2005 and 2008, but remained lower than the rate in 2004. There were 567 pertussis cases reported in 2008, or 2.9 per 100,000 New York State residents.

The Advisory Committee on Immunization Practice (ACIP) has now recommended that adolescents aged 11-18 receive further immunization against pertussis. The US Food and Drug administration has approved two new vaccines for a booster immunization.

Cases of Vaccine-Preventable Diseases, New York State, 2002-2008														
<i>Year></i>	2002		2003		2004		2005		2006		2007		2008	
Disease	Case s	Rate *												
Hepatitis B	867	4.6	314	1.6	255	1.3	233	1.2	204	1.1	211	1.1	171	0.9
HiB**	205	1.1	222	1.2	226	1.2	222	1.2	247	1.3	254	1.3	258	1.3
Measles	91	---	7	.04	5	0.0	7	0.0	10	-	8	-	31	0.2
Mumps	7	---	15	0.1	26	0.1	47	0.2	70	0.4	43	0.2	38	0.2
Pertussis	447	2.4	1217	6.4	2165	11.3	772	4.0	1195	6.2	699	3.6	567	2.9

***Rate is per 100,000**

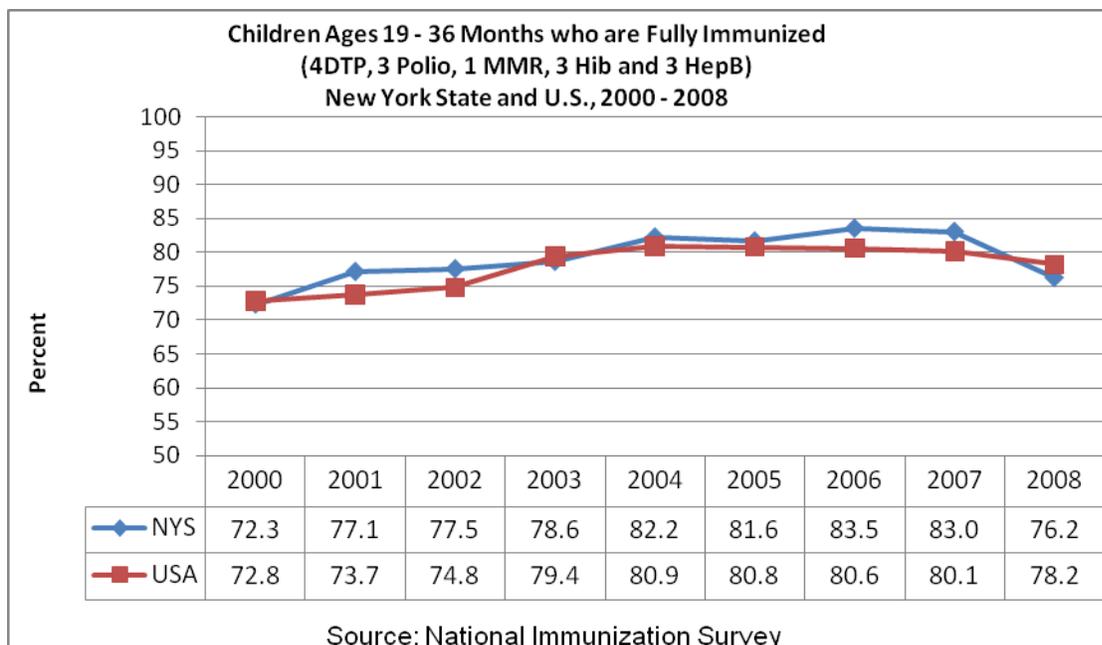
*****Haemophilus influenza B***

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.*

The National Immunization Survey (NIS) rates have decreased, in part, due to changes in the survey methodology. Decreasing prevalence of families with land lines (the NIS is a telephone survey) and a small sample size contribute to the variability of the results (confidence intervals are in the 4–6% range).

Annual Objective and Performance Data	2002	2003	2004	2005	2006	2007	2008
Annual Performance Objective	77	79	81	85	86	87	88
Annual Indicator	75.3	78.8	82.2	81.6	83.5	83	76.2
Numerator							
Denominator							
Is the Data Provisional or Final?					Final	Final	Final

The percentage of New York children aged 19-36 months who are fully immunized, reversed direction and dropped to only 76.2% in 2008. The rate was almost 7 percentage points below the 2007 rate of 83% and is below the Healthy People 2010 goal of 80% for childhood immunization. New York State's childhood immunization rate was also below the 2008 nationwide rate of 78.2%. One factor contributing to the reduced coverage, compared to 2007, was the shortage of Hib vaccine and the recommendation to defer the routine Hib vaccine booster dose administered at age 12--15 months.



The New York State Department of Health's (NYSDOH) Bureau of Immunization is committed to promoting the health of New York State children by reducing and/or eliminating the number of vaccine preventable diseases that affect the State's children. The Bureau of Immunization's goal is 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 for all primary health care providers; and, that health care providers are aware of immunization standards of practice.

As part of this effort, the New York State legislature passed the Immunization Registry Law which, as of January 1, 2008, requires health care providers to report all immunizations administered to persons less than 19 years of age, along with the person's immunization histories, to the New York State Department of Health using the recently launched statewide web-based [immunization information system \(IIS\)](#). This includes all vaccines administered in accordance with the Advisory Committee on Immunization Practices (ACIP) recommended schedule, as well as any additional vaccines administered to persons less than 19 years of age after January 1, 2008. Once fully implemented, this system, known as the New York State Immunization Information System (NYSIIS), will be the official source of New York State immunization information.

The goal of the new immunization information system is to establish a complete, accurate, secure, real-time immunization medical record that is easily accessible and promotes public health by fully immunizing all individuals appropriate to age and risk.

An immunization information system provides numerous benefits to all those involved in the health care of children, contributing to a higher immunization rate and a healthier population.

- Providers have access to consolidated and accurate immunization records of their patients; receive clinical decision support in complying with an increasingly complex vaccination schedule; and, can use an efficient tool to manage their vaccine inventory.
- Parents and caregivers get reminders when an immunization has been missed. Up-to-date information on a child's vaccination history helps to prevent over-immunization.
- Schools will be able to save time in complying with safety and health regulations.
- Public health systems use the information to control vaccine preventable diseases.

Recognizing the significant challenge presented to providers in entering immunization data within 14 days, the Department provided statewide training, webinars and ongoing technical assistance and other supports for physicians and their staff to implement the system. PHL also required all historical immunization information reported to NYSIIS for any patient less than 19 years of age receiving a vaccination after January 1, 2008. To assist providers with building the historical database, several activities were initiated including:

- Uploading information already contained in one of the previously existing regional immunization registries to the NYSIIS application database;
- Obtaining and uploading vital record birth certificate information, including the hepatitis B immunization administered at birth, for children who were born in New York State outside of New York City after January 1, 2004;
- Encouraging and facilitating historical downloads from provider electronic data systems; and;
- Allowing additional time during the first year of implementation to report patient immunization histories as long as the provider initiates and maintains reporting of active immunizations administered.

NYSIIS, in conjunction with the recent legislative mandate, strongly supports the NYSDOH Bureau of Immunization's objective to meet the Center for Disease Control's (CDC) Healthy People 2010 goal of 95% of children less than six years of age enrolled in an IIS with two or

more shots. The close partnership between the Department and statewide providers will better facilitate the successful implementation of the system.

NYSISS was launched in February of 2008 and continued to experience tremendous growth during 2009. Eighty percent (80%) of providers who immunize children are participating in the system. NYSIIS contains more than 3 million patients and 35 million immunizations. AS the statewide, web-based immunization information system, NYSISS enables health care providers to identify and track under-immunized children and increase immunization rates.

Implemented in 1994, the Vaccines for Children (VFC) Program was designed to improve vaccination coverage levels by providing vaccines at no cost to VFC-eligible children through public and private providers enrolled in the program. The VFC Program allows the government to buy vaccines at a discount and distribute them to states, which then distribute them to private physicians' offices and public clinics to give to children who meet the eligibility requirements.

The New York Vaccines for Children (NY VFC) program provides vaccines for Medicaid-enrolled, Native American, underinsured and uninsured children. Over 2,000 provider sites in the state are enrolled and active in NY VFC. In addition to administering the VFC program, the Immunization Program assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted local health departments with disease surveillance and outbreak control activities, and continued to expand the statewide immunization registry. CDC categorical grants and State and Local Assistance dollars were used to provide staffing in both central and regional offices and to purchase vaccines. Local health departments assist in recruiting VFC providers. Article 6 State Aid to Localities reimbursed local health departments for the infrastructure that supports immunization surveillance, tracking, parent and provider education and special studies.

Over 90% of two year-old children in New York State (outside New York City) are vaccinated in private doctor's offices, instead of public clinics. Under the Assessment, Feedback, Incentives and eXchange (AFIX) initiative, local health department staff visit health care providers to assess the medical records of their patients for compliance with immunization schedules. The information is entered in CDC-developed software called, the Comprehensive Clinic Assessment Software Application (CoCASA). CoCASA calculates the providers' immunization rates and identifies opportunities for improvement in immunization practices.

Other Department programs educate about the importance of immunization. Comprehensive Prenatal/Perinatal Services Networks provide education and outreach to engage children into the health care system. Some networks conducted outreach for Child Health Plus and other outreach and educational activities to ensure that parents are aware of the need for comprehensive immunization. Medicaid funded prenatal clinics educate parents about the need for preventive services, including immunization. The Community Health Worker Program educates parents about immunization, assesses the immunization status of all children in the program and refers and assists families get their children immunized. Assistance is given with insurance enrollment. In 2008, 76% of the children entering the program had up-to-date immunizations. Of the children who did not have complete immunizations, 91% received immunizations while in the program. In WIC, all infants and children are screened until all marker immunizations are

received. Infants and children not adequately immunized must be referred to a health care provider or immunization clinic. Child care providers in NYS are required to check immunizations and refer as appropriate. Up-to-date immunizations were provided to over 600 children in migrant day care settings in NYS.

New York State Department of Health (NYSDOH) created the Perinatal Hepatitis B Hospital Birth Dose Initiative in 2003 to aid in the elimination of hepatitis B virus (HBV) transmission. Children who are infected under 1 year of age have a 90% chance of developing chronic infection with sequelae such as liver cirrhosis and primary hepatocellular carcinoma. Complete vaccination at birth reduces the risk of infection and sequelae by 95%, and infants who receive the vaccine at birth are more likely to complete the series compared to children who begin the series at 1 to 2 months of age. The NYSDOH Bureau of Immunization provides the vaccine at no cost to all enrolled birthing hospitals that have a universal birth dose policy and standing orders to vaccinate all newborns regardless of the parent's insurance coverage.

Despite 100% enrollment of all birthing hospitals in the Universal Birth Dose Initiative by 2008, the proportion of infants receiving the birth dose in some hospitals remains far below the Healthy People 2010 goal of 90%. The average percent of infants vaccinated with the birth dose in New York State for 2008 was 70.81% (Range 0 to 98.50%; Median 79.10%) and in 2009 was 75.38% (Range 0 to 98.82%; Median 83.82%) according data from the New York State Immunization Information System (NYSIIS).

The Birth Dose Initiative continually seeks to improve compliance with recommendations for the administration of hepatitis B vaccine (Hep B). In April 2008, the Bureau of Immunization conducted a survey of birthing hospitals to assess barriers to vaccine administration and to influence the adoption of practices expected to increase the proportion of vaccinated infants.

The Bureau of Immunization continually strives to expand access to the hepatitis B birth dose and vaccines in general, and to educate the community and providers regarding the importance of immunization and vaccine safety. Ongoing workshops, webinars and onsite training are conducted at with birthing hospital staff, county perinatal hepatitis B coordinators and obstetrical and pediatric providers in the community. The Bureau of Immunization consults with several NYSDOH programs to promote the universal birth dose, including the Office of Health Insurance Programs and CDC National Center for Immunization and Respiratory Diseases (NCIRD).

Childhood Lead Poisoning: Despite dramatic declines in the incidence and severity of elevated blood lead levels among young children, childhood lead poisoning remains a significant public health issue in New York State. New York State has the highest number and proportion of old housing stock, and has more new cases of lead poisoning among young children annually, than any other state in the nation. At the same time, significant geographic, economic and racial/ethnic disparities persist, as the problem of childhood lead poisoning is increasingly concentrated within specific communities that are challenged by a combination of poverty and old housing. Childhood lead poisoning is a serious health problem that can have devastating permanent effects on children's physical, social, behavioral and cognitive development, with serious social and economic repercussions for society as a whole. And while the results of lead

poisoning are thought to be irreversible, exposure to lead is completely preventable. As a result of these collective factors, the prevention and elimination of childhood lead poisoning has been identified by both the Department of Health and the Governor as one of the state's highest child health priorities.

Young children are at the highest risk for lead poisoning. Exposure to lead is associated with a range of serious health effects on young children, including: anemia, hearing loss, diminished skeletal growth and delayed pubertal development, dental caries, hypertension, osteoporosis, pregnancy complications and low birth weight. Lead exposure is an important cause of preventable brain injury and neurodevelopmental dysfunction and associated detrimental effects on children's cognitive and behavioral development, including measurable declines in IQ. Routine screening and prompt and effective intervention have been shown to prevent some of the more advanced effects of lead poisoning, such as seizures and severe kidney and nervous system damage. However, long term effects of chronic lead exposure on IQ and other cognitive and behavioral outcomes appear to be irreversible, underscoring the critical importance of primary prevention action.

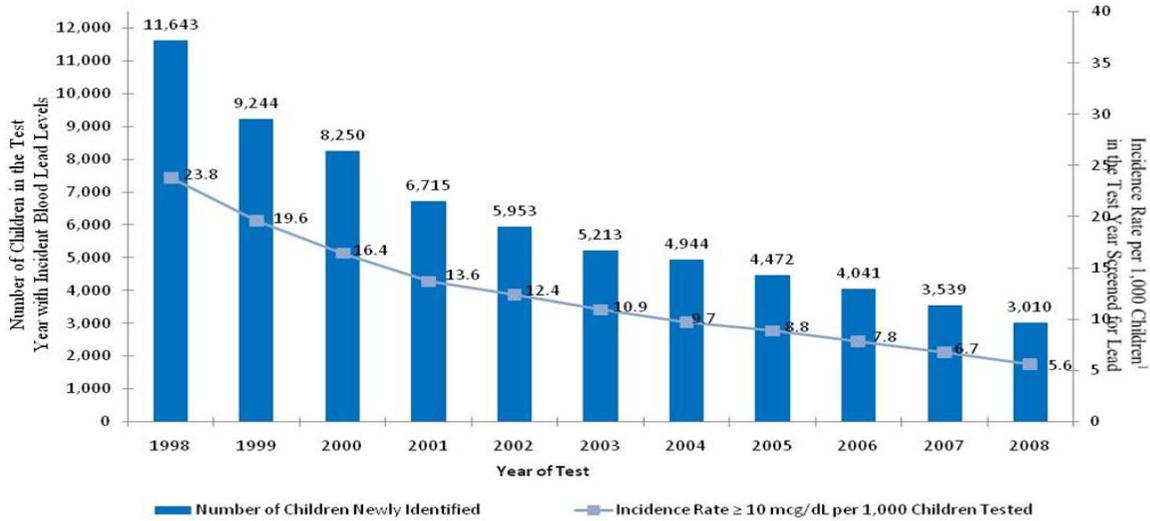
The Centers for Disease Control and Prevention (CDC), along with the President's Task Force on Environmental Health Risks and Safety Risks for Children, have called for the elimination of childhood lead poisoning (defined as blood lead levels at or above 10 mcg/dL among children age 6 years and younger) by 2010. A growing body of research indicates that children's development can be adversely affected at blood lead levels (BLLs) below the CDC-defined action level of 10 mcg/dL, further highlighting the need for primary prevention efforts.

The analysis and application of data are important tools used by the DOH to assess the extent of the problem, identify high-risk communities and populations with the highest need for interventions, and monitor and evaluate the effectiveness of interventions. An annual surveillance report summarizes the status of childhood testing and lead poisoning in NYS, including New York City (NYC), for children less than six years of age and six to less than eighteen years. Data highlight the progress made and areas needing further efforts.

Incidence of Lead Poisoning: The incidence of elevated blood lead levels (EBLLs) among children under age six years is steadily declining across all blood lead level (BLL) categories. Incident data for 2008 show the continued, dramatic improvement in both the number and percent of children newly identified with confirmed BLLs \geq 10 mcg/dL, the current definition of lead poisoning established by the federal Centers for Disease Control (CDC) and Prevention. In 2008, 3,010 children less than six years of age were newly identified with BLLs \geq 10 mcg/dL compared to 11,643 children in 1998. This represents a striking 74 percent decline in the number of children with EBLLs since 1998. A 76.5 percent decrease in the rate of incidence of lead poisoning was observed over the same time period, from 23.8 per 1,000 children tested in 1998 to 5.6 per 1,000 children tested in 2008.

Incidence of Blood Lead Levels ≥ 10 mcg/dL Among Children Under Age Six Years¹

New York State, 1998 to 2008 Blood Lead Test Data

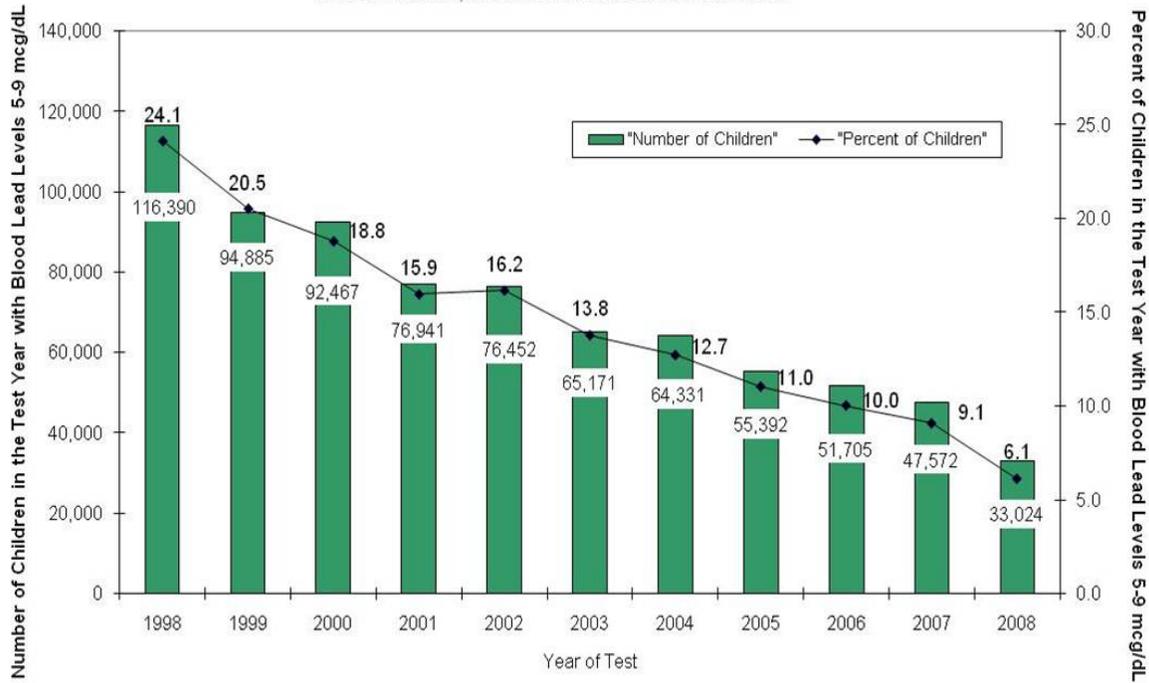


¹ Incidence Rate: Total number of children under age six years identified for the first time with confirmed BLLs ≥ 10 mcg/dL divided by the total number of children under age six that had lead tests in that given year, multiplied by 1,000.

The number and proportion of children with blood lead levels 5 - 9 mcg/dL are also declining. A growing body of scientific evidence highlights concerns about the harmful effects of blood lead levels below 10 mcg/dL, the blood lead level established by the Centers for Disease Control and Prevention (CDC) as the definition of lead poisoning and the trigger for individual-level medical and public health interventions. In 2008, a total of 33,024 children under the age of six years had blood lead levels of 5 - 9 mcg/dL, representing 6.1 percent of all children under age six who were tested for lead that year. Trend data show that the number and percent of children with blood lead levels in this range are declining over time, paralleling declines in elevated blood lead levels.

Number and Percent of Children Under Age Six Years with Blood Lead Levels of 5 - 9 mcg/dL

New York State, 1998 to 2008 Blood Lead Test Data ¹



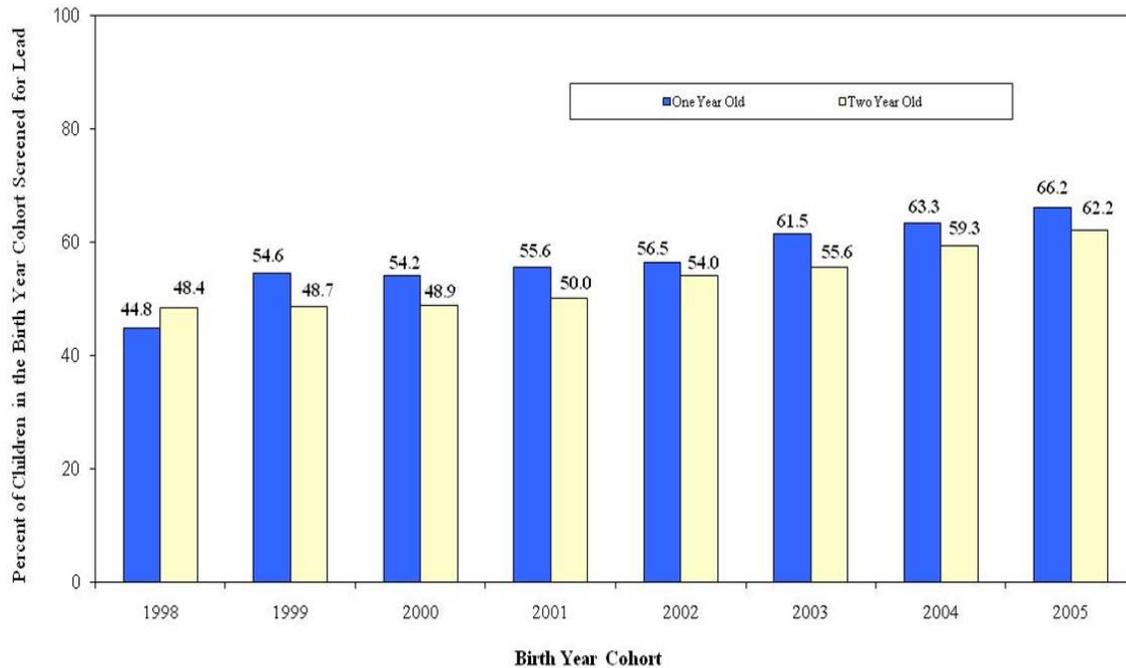
¹ The number of children with a BLL of 5-9 mcg/dL divided by the number of children that had a lead test in that given year multiplied by 100. Values reported below 10 mcg/dL are subject to increased measurement error and should not be interpreted as an absolute value.

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

Blood lead testing (screening): New York State Public Health Law and implementing regulations require health care providers to test all children for lead at or around ages one year and two years. Lead testing rates continue to increase in NYS. Approximately 66 percent of children born in 2005 were tested for lead at or around age one year, compared to 45 percent of children born in 1998. Similarly, lead testing rates for children at or around two years are improving. Sixty-two percent of children born in 2005 were tested for lead at or around age two, compared to 48 percent of children born in 1998. Although lead testing rates for two-year old children remain below the rates for one-year-old children, that gap appears to be narrowing. More work is needed to further improve lead testing rates among both one and two year olds.

Percent of Children Tested for Lead At or Around Age One Year and At or Around Age Two Years¹

New York State, 1998 - 2005 Birth Cohorts (1998 to 2008 Blood Lead Test Data)²

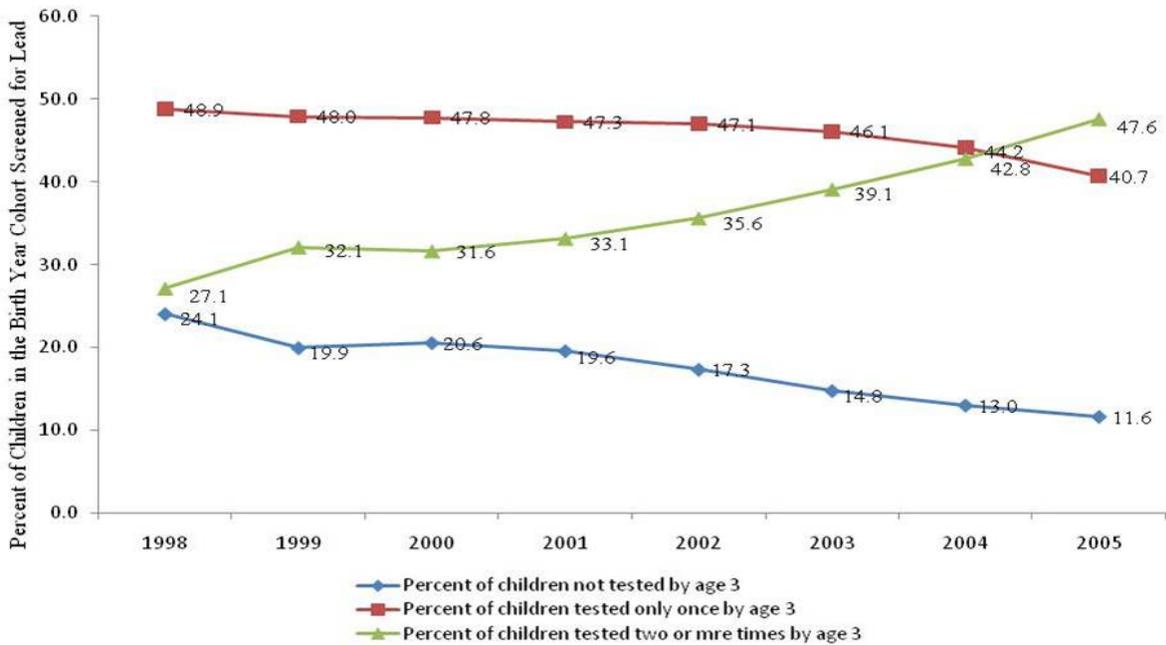


¹ At or around age one year is defined as 9 months to < 18 months and at or around age two years is defined as 18 months to < 36 months.

² Birth Cohorts beyond 2005 are not included in this analysis because those children had not yet reached 36 months of age by 2008.

Additional analysis identifies more specific patterns of lead testing. The percent of children who receive two or more blood lead screening tests by age three years continues to improve. The percent of children tested for lead two or more times by age three years increased by almost 76 percent, from 27.1 percent of children born in 1998 to 47.6 percent of children born in 2005. In contrast, the percent of children never tested for lead by three years declined by 52 percent, from 24.1 percent of children born in 1998 to 11.6 percent of children born in 2005, while the percent of children tested only once for lead by age three years declined by 17 percent, from 48.9 percent of children born in 1998 to 40.7 percent of children born in 2005.

Lead Testing Patterns Among Children Under Age 3 Years
 New York State, 1998 - 2005 Birth Cohorts, (1998 to 2008 Blood Lead Test Data)¹



¹ Birth Cohorts beyond 2005 are not included in this analysis because those children had not yet reached 36 months of age by 2008.

Lead Poisoning Prevention Efforts

In response to the CDC's charge, DOH has taken a leadership role to develop and implement a strategic plan to eliminate of childhood lead poisoning in NYS by 2010. This plan, *Eliminating Childhood Lead Poisoning in New York State by 2010*, was published in 2004. This state plan is a companion to the strategic plan developed by New York City DOH and Mental Hygiene (NYDOHMH) for its municipality. The plan guides the work of DOH and partner organizations' to eliminate childhood lead poisoning in NYS. Within the DOH, the Lead Poisoning Prevention Program (LPPP) within the Division of Family Health Bureau of Maternal and Child Health collaborates closely with the Center for Environmental Health's Bureau of Community Environmental Health and Food Protection to eliminate childhood lead poisoning in NYS.

The capacity to address the problem of lead poisoning in NYS includes the following factors:

Strong executive state leadership to support public health action. In creating the Governor's Task Force on the Prevention of Childhood Lead Poisoning, the Governor committed NYS to eradicate lead poisoning and focused increased efforts on prevention. The Task Force's preliminary report issued in December 2009 recommended nine actions. These actions included cross agency efforts for connecting primary prevention programs with clean energy and weatherization programs, and enhancing procedures to ensure that family-based child care environments are assessed for lead hazards. A final report is expected by November 2010. The

creation of the Governor's Task Force has received strong support from members of the state Senate and Assembly and key external stakeholders.

Strong state public health law (PHL) provides the authority and framework for the Department's LPPP. New York State's PHL requires an Advisory Council, provides authority to promote regulations for lead testing and reporting, gives authority for abatement of lead poisoning conditions, bans the manufacture and sale of painted toys and furniture that exceed a specified lead content limit, and allows linkages of the lead registry with the immunization system. These laws give the Commissioner the authority to promulgate regulations that guide the LHDs, health care providers and laboratories' work in lead poisoning prevention and follow-up, and environmental assessment and abatement.

Strong local health infrastructure to provide frontline prevention and intervention services.

Article 6 of the state PHL provides the authority for basic public health services in local health departments (LHDs). Through funding provided by state aid to localities, community outreach and education, lead testing and follow-up, and environment investigations are supported. The Department's Lead Poisoning Prevention Program (LPPP) in the Division of Family Health, Bureau of Maternal and Child contracts with LHDs enhance the local public health infrastructure to provide a comprehensive lead poisoning prevention program. Additional regulations define specific responsibilities for LHDs regarding identification and follow-up of children with lead poisoning. Supplemental grant funding to support local LPPPs is administered through the state LPPP.

The Division of Family Health's Bureau of Maternal and Child Health also provides grants to support a **statewide network of Regional Lead Resource Centers (RLRCs)**. The expert practitioners of these centers provide outreach, education, consultation, and technical assistance to health care providers and LHDs on lead testing and management of children and pregnant women with lead poisoning. The experts of the RLRCs partner with state DOH to support prevention activities by providing input into public and professional educational resources and working with the DOH on emerging lead clinical practice issues.

The Department's **capacity for data analysis for surveillance, program planning and analysis** is strong. The state's electronic lead registry (LeadWeb) maintained by the BMCH stores all testing data to support identification and tracking of children with lead poisoning at state and local levels. This data helps generate individual and aggregate reports to support local follow-up activities and inform state planning for targeting activities and resource distribution to LHDs for lead poisoning prevention grants and the primary prevention grants.

DOH uses a comprehensive public health approach to prevent and eliminate childhood lead poisoning. This includes engaging stakeholders; assessing needs through quantitative and qualitative data; providing public education; promoting childhood lead testing; data surveillance and analysis; and laboratory reporting, assurance of timely, comprehensive medical and environmental management for children with lead poisoning and policy and program activities to advance lead poisoning prevention. Across all areas, universal population-based strategies are balanced with intensive strategies targeted to the communities and populations at highest risk,

and emphasis is placed on establishing and maintaining strong partnerships with a range of federal, state and local agencies, organizations and other stakeholder groups.

Secondary prevention strategies are essential to prevention efforts. Early identification of elevated blood lead levels (EBLLs) through routine blood lead testing is essential to coordinate follow-up services, minimize harmful effects and prevent further exposure to lead. As noted above, under current NYS regulations, providers are required to test all children using blood lead tests at or around age one year and at or around age two years. Health care providers are also required to assess all children age 6 months to 6 years at least once annually for lead exposure using a risk assessment tool, with blood lead testing for all children found to be at-risk based on those assessments.

With grant and State Aid funding from DOH, LHDs coordinate follow-up services for children with EBLLs to minimize the adverse effects of lead and to reduce further exposure to lead in their environments. Health care providers, families, LHDs and the state DOH work together to assure that children with EBLLs receive these services. Specific follow-up services vary by blood lead level category. All children with blood lead levels greater than or equal to 10 mcg/dL require risk reduction education, nutritional counseling and follow-up testing to monitor blood lead levels. Effective June 22, 2009, changes in state regulation expanded environmental inspections and comprehensive medical follow-up services to more children with EBLLs by lowering the blood lead level threshold requiring such services from 20 mcg/dL to 15 mcg/dL, which exceeds the national standard of 20 mcg/dL, established by the CDC. In 2008-2009, \$7.2 million in Lead Poisoning Prevention Grant funding was distributed to LHDs.

With ongoing input from a formal Advisory Council of diverse stakeholders, the Department implements an action plan that includes the following priorities:

- 1. Continuation and expansion of surveillance activities to guide, target, and monitor lead poisoning prevention activities.*

Annual lead surveillance reports have been expanded to incorporate additional age-specific blood lead testing measures, descriptions of incidence patterns for multiple categories of blood lead levels and additional demographic and geographic analyses.

Underlying this data analysis work has been an effort to refine the statewide Web-based lead registry and data system that supports timely and accurate analysis of childhood blood lead data. In 2006, LHD lead programs transitioned from the previous local PC-based system (LeadTrac) to the new statewide Web-based system (LeadWeb). In 2007 and 2008, efforts focused on linking blood lead level results with address information and geocoding data to support expanded geographic analysis, and implementing new case coordination and environmental management modules for LHD tracking of follow-up services. Exploration of the feasibility of integrating automated geo-coding functionality in the lead registry will continue in 2010-2011. Several enhancements to LeadWeb were implemented in 2009 and 2010. One is the creation of several static reports, including statistical summary reports by blood lead level or by children needing confirmatory or follow-up testing. Another enhancement is creating dynamic reports to allow LHDs to create customized reports from a

drop-down menu. Regular conference calls with LHD programs and an ongoing focus group of LHD representatives provided invaluable input throughout the LeadWeb enhancement process. A LeadWeb report to track blood lead testing of refugee children birth to 18 yrs. will be completed in 2010.

To improve the surveillance system and identification and follow up for children with elevated lead test results, the Department monitors the timeliness and completeness of blood lead tests reported to the statewide Lead registry. The LPPP developed a policy regarding evaluating a clinical laboratories' compliance with timely reporting of blood lead tests results and has instituted a protocol to monitor the results on an annual basis. Those clinical laboratories who fail to meet the minimum standards for timeliness of reporting are required to submit a corrective action plan. Those facilities with continued compliance issues are referred to the Clinical Laboratory Evaluation Program. In addition, The LPPP has devised an electronic mechanism to alert staff when LHDs do not accept an EBLL for their follow up in LeadWeb. Staff monitors this alert system daily to assure that EBLLs are accepted by LHDs.

2. *Expanding education of the public, parents and professionals to promote both primary and secondary lead prevention practices.*

In 2008, DOH convened a work group to provide input on the development and distribution of new educational materials for parents and health care providers of children with blood lead levels below 10 mcg/dL. The material entitled "What Your Child's Blood Lead Test Means" was issued to NYS health care providers emphasizing the follow-up of children with blood lead levels below 10 mcg/dL and included the new educational material for use with their patients.

Changes to the lead poisoning prevention page on the public website have improved navigation and highlighted key information and materials for specific audiences. In addition to the information for consumers, there are content areas specifically identified for health care providers, child care providers, and laboratories. Laws and regulations, data reports and educational materials are included in the web page as well as information about prevention.

Most recently, the Department opted in to a national media campaign developed by HUD, EPA and the National Coalition to End Lead Poisoning. The campaign targets parents and the public to raise awareness about childhood lead poisoning, and to recognize and take action to address potential lead hazards. TV and radio ads have been customized to include NYS information. The campaign was launched in May 2010 and will run for approximately 18 months.

3. *Improving lead testing and follow-up of for children.*

DOH actions to support use of portable blood testing devices is a key strategy for reducing barriers to lead testing and increasing lead testing rates. The Department issued state regulations effective June 20, 2009 to authorize lead testing in private physician office laboratories and limited service clinic laboratories, and to require reporting of blood lead test

results from these facilities. In September 2009, the state's Medicaid Program began providing reimbursement to physicians' office and limited service clinic laboratories for point-of-care blood lead testing.

Amendments to state public health law enacted through the 2009 state budget authorize linking the NYS Immunization Information System (NYSIIS) and the statewide registry of children's blood lead levels (LeadWeb). Once implemented, this will populate childhood lead testing information in NYSIIS to make information more available to health care providers. The linkage will support clinical and public health quality improvement actions to increase lead testing. NYSIIS will provide a mechanism for physicians conducting blood lead testing in their office using CLIA waived portable analysis devices to report the results from those tests to the state. Implementation is scheduled for summer 2010.

4. *Expansion of primary prevention strategies to identify and reduce lead hazards before children become lead poisoned.*

The 2007-08 State Budget amended NYS Public Health Law and appropriated new funding totaling \$3 million to support a primary prevention pilot program to develop and implement local primary prevention plans in targeted high-incidence communities. Based on analysis of 2005 childhood lead poisoning incidence data, seven counties (Erie, Monroe, Onondaga, Oneida, Albany, Orange and Westchester) and New York City were targeted in the first year. Based on 2005 data, these localities account for 80% of the newly identified cases of childhood lead poisoning each year, and each contains at least one targeted high-incidence ZIP code. Target counties received grant funding to develop and implement local childhood lead poisoning primary prevention plans in/near the target areas, including identification and inspection of high-risk properties, community involvement, capacity building, and enforcement. LHDs collaborate with code enforcement officials, local housing authorities and other community partners to accomplish this work.

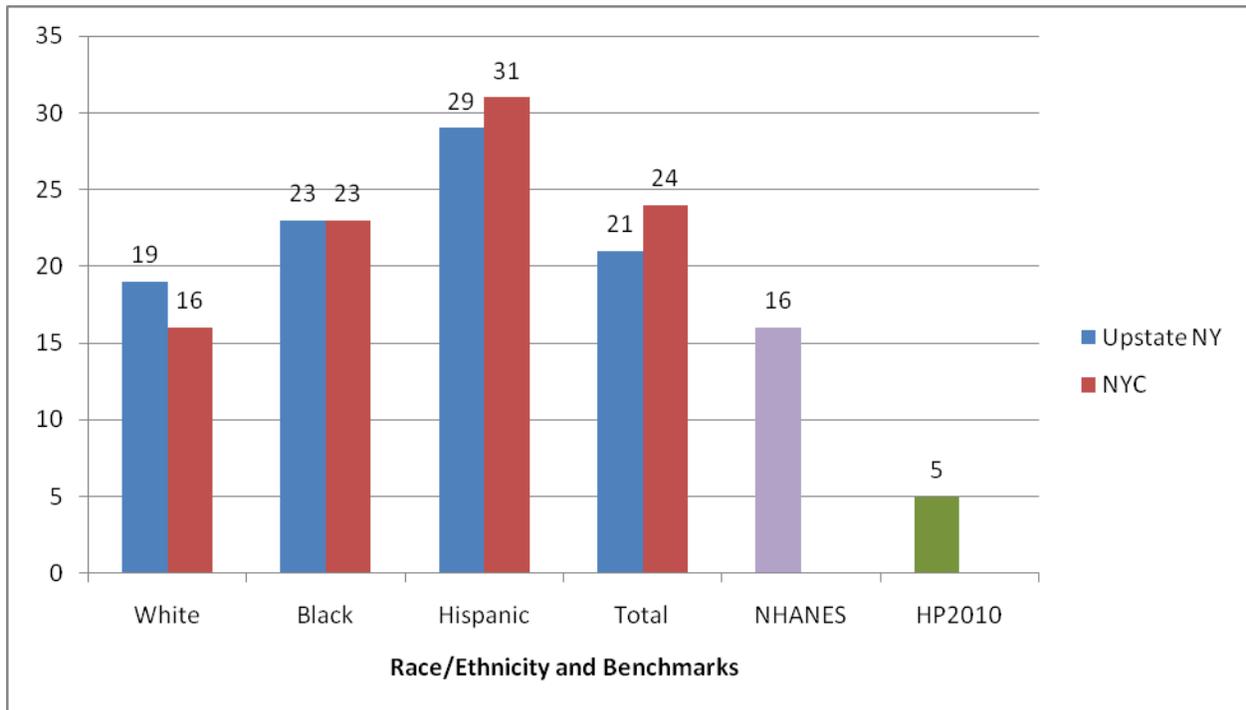
The Primary Prevention program was expanded in 2008 to allow for four additional counties, bringing the number of funded primary prevention projects to twelve. As part of the DOH's sustainability plan, the primary prevention pilot project was made permanent through amendments to Public Health Law in 2009, and has grown to 15 counties in 2009-2010. The DOH will work with the National Center for Healthy Housing to evaluate the projects with the highest incidence of lead poisoning. The lessons learned from the pilot prevention projects will be used to shape the primary prevention activities throughout the state in 2010 and 2011.

Childhood Overweight: There is growing concern about the national epidemic in childhood overweight and adult obesity. Research indicates that adult morbidity and mortality are increased by childhood obesity, even if the condition does not persist into adulthood.

The prevalence of obesity among elementary school children in New York State has increased dramatically between 1988 and 2003-2004. Based on measured height and weight in 2003, 24% of elementary school children (grades K-5) in New York City were obese. In 2004, 21% of third grade school children in Upstate New York were obese. These prevalence rates greatly exceed

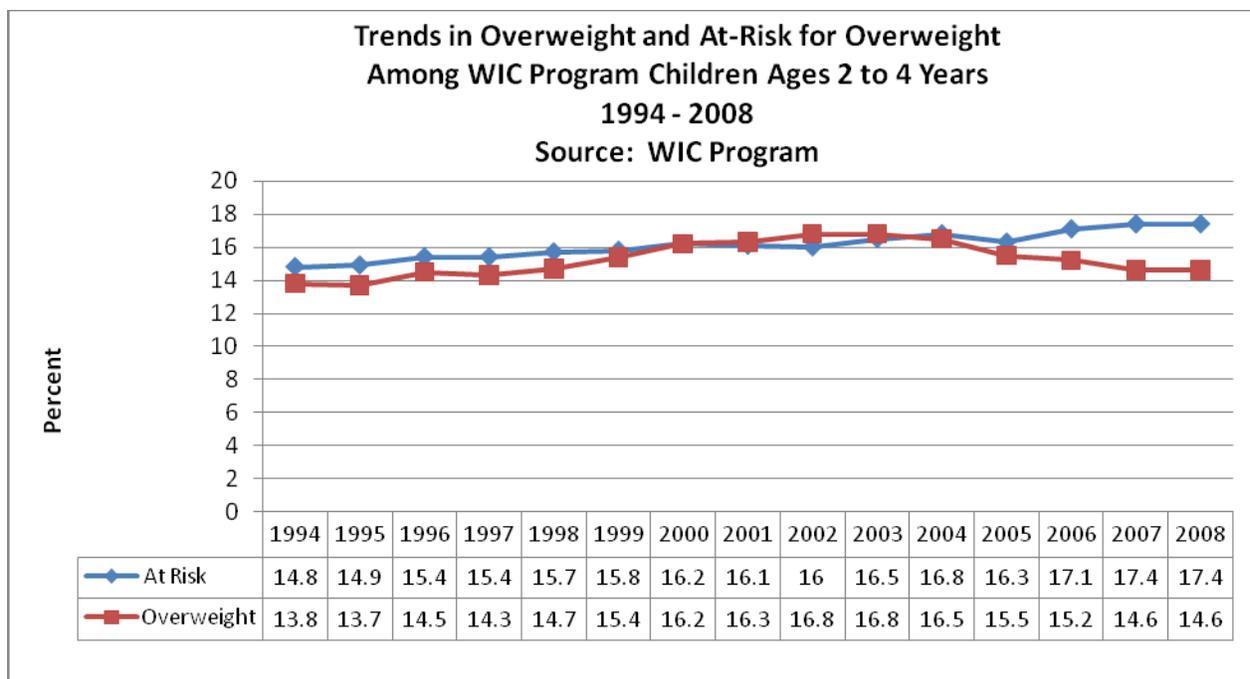
the prevalence reported for the U.S. (15.8%) in NHANES 1999-2002, and the Healthy People 2010 target of 5%. In both New York City and upstate NY, prevalence rates differed across racial/ethnic categories; Hispanics have the highest rates (29.3% and 31.1%), with rates for non-Hispanic Whites the lowest (18.7% and 15.9%), and rates for non-Hispanic Blacks in between (22.5% and 22.8%, respectively).

Proportion of elementary school children in upstate NY and New York City who are obese:



Source: Upstate NY, Grade 3 Oral Health, Physical Activity, and Nutrition Survey, 2004. New York City; Am J Public Health, 2004; 94: 1498. U.S.: NHANES, 1999-2002, J Am Med Assn 2004;291:2847-2850. The Department has just completed an updated survey for Upstate New York but data is not yet available.

For preschool-age children in New York State, data are only available for children from low-income families enrolled in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Between 2007 and 2008, the recent trend toward higher rates of overweight has leveled off. Still, however, 14.6% of the two- to four-year-olds participating in New York’s WIC Program were overweight and another 17.4% were at risk for overweight. This is down 13% from the 2003 high of 16.8%, but still an 11% increase since 1990.



At risk of overweight= BMI greater than 85th percentile, less than the 95th percentile

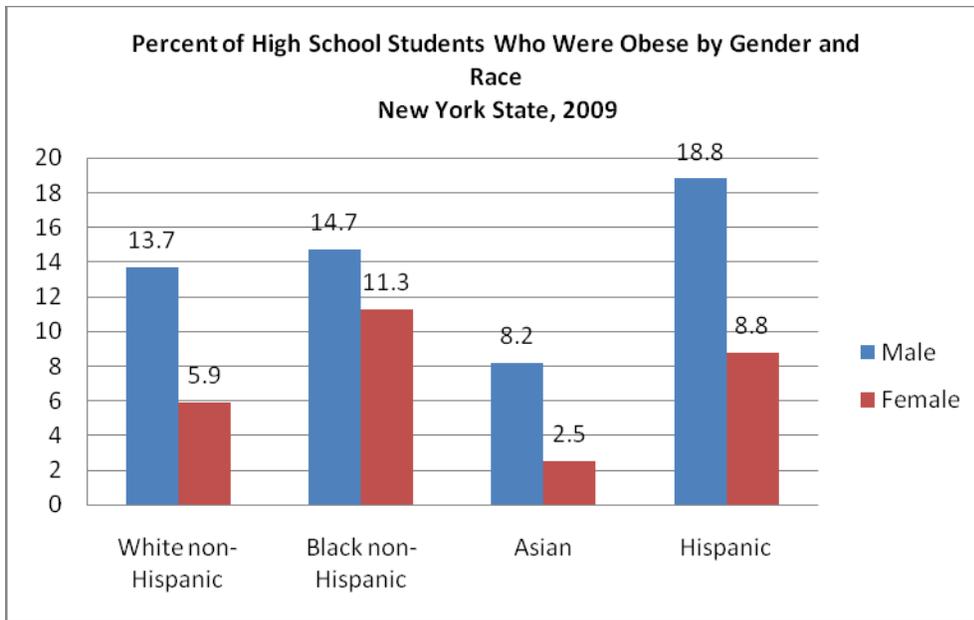
Overweight= BMI greater than or equal to the 95th percentile

Both measured by age- and sex-specific 2000 CDC growth charts

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

Annual Objective and Performance Data	2004	2005	2006	2007	2008	2009
Annual Performance Objective	34	33	32	31	30	29
Annual Indicator	33.4	31.8	32.0	32.0	32.0	32.0
Numerator	64,151	62,903	63,874	63,373	67,108	67,108
Denominator	192,060	197,807	199,608	198,041	209,713	209,713
Is the Data Provisional or Final		Final	Final	Final	Final	Provisional

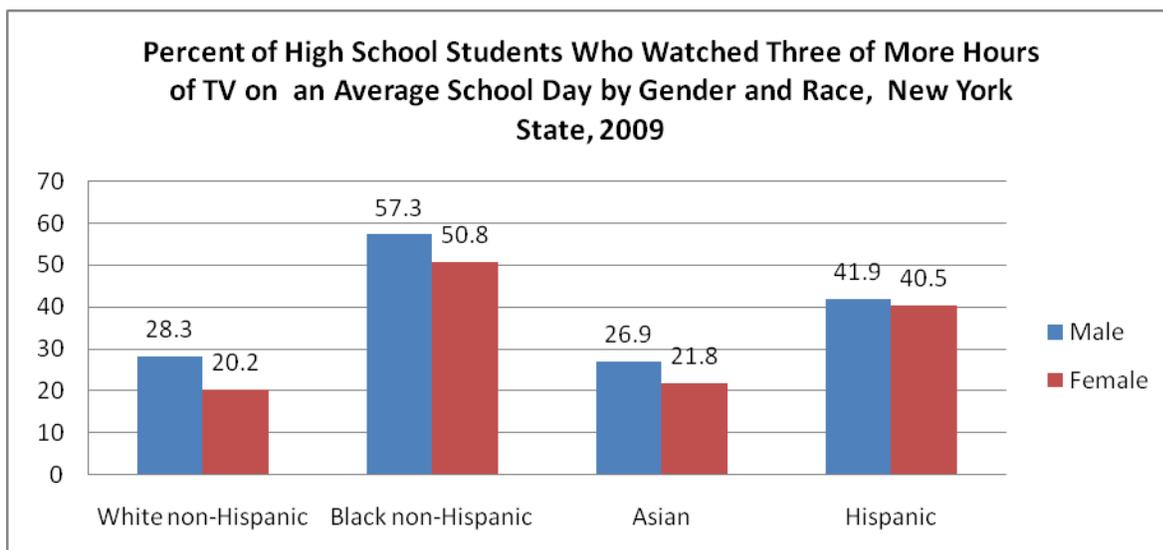
Data from the 2009 YRBS found that 11.1% of adolescents are obese (BMI \geq 95%). This is up slightly from the 10.9% rate in 2007 but an improvement over 2003 when 12.9 percent of high school students were obese. Adolescent males were more likely to be obese than females and African American adolescents were more likely to be obese than white adolescents. Hispanics males were the most likely of high school students to be obese (18.8%).



Source: YRBS

Current research suggests there is a relationship between TV watching and obesity. The American Academy of Pediatrics (AAP) recommends that children younger than two years of age be discouraged from viewing television, and that viewing for children two years and older be limited to no more than one to two hours per day of high quality educational shows (American Academy of Pediatrics, 2001).

Among high school students, about 51% of Black non-Hispanic females and 57% of Black non-Hispanic males watched three hours or more of TV per weekday. Among Hispanic male and female high school students, slightly more than 40% reported watching more than 3 hours of TV daily. White and Asian students were the least likely (less than 30%) to report watching more than 3 hours of TV on weekdays.



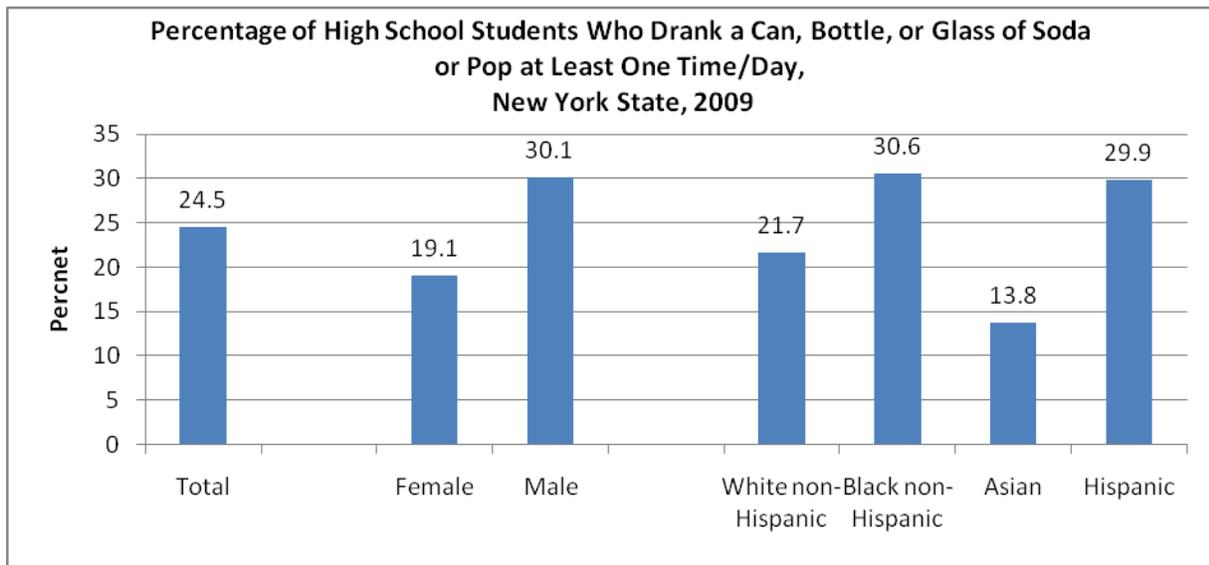
Source: YRBS

Adolescents also reported the amount of time they spent playing video and computer games on an average school day. Twenty-nine percent of high school students reported playing these games for 3 or more hours per day during an average school week. Males were more likely (32%) to report 3 hours or more of playing time as compared to females (26%).

Younger children are also at risk for watching too much TV. A random sample of third grade children surveyed in upstate NYS in 2004 revealed that 18.4% watched more than 2 hours per day. Among WIC participants aged 2 up to 5 years, 22% watched more than 2 hours per day of TV in 2009. Twenty percent of children and 20% of adults usually or always snacked while watching TV and 38% had a TV in their bedroom (Dennison et al., 2002).

Obesity and Soft Drink Consumption: Studies have linked soft drink consumption with obesity in children and adolescents. A study conducted by the National Heart, Lung, and Blood Institute (NHLBI), which followed over 2,000 girls from ages 9-10 years until 18-19 years of age, found their average soda consumption increased almost 300% over the 10 years of the study. Soda was the only beverage that was associated with increased obesity (BMI). Several studies have also found soft drink intake was associated with lower intakes of milk, calcium, and other nutrients.

The Youth Risk Behavior Survey also collects information about soda consumption. In 2009, almost 25% of New York State high school students reported drinking a can, bottle or glass of soda every day. Daily soda consumption was most common among male students (30.1%) and Black non-Hispanic (30.6%) and Hispanic (29.9%) students. Asian (12.8%) students were the least likely to consume soda daily. These percentages are similar to what was reported in 2007.



Source: Youth Risk Behavior Survey, 2009

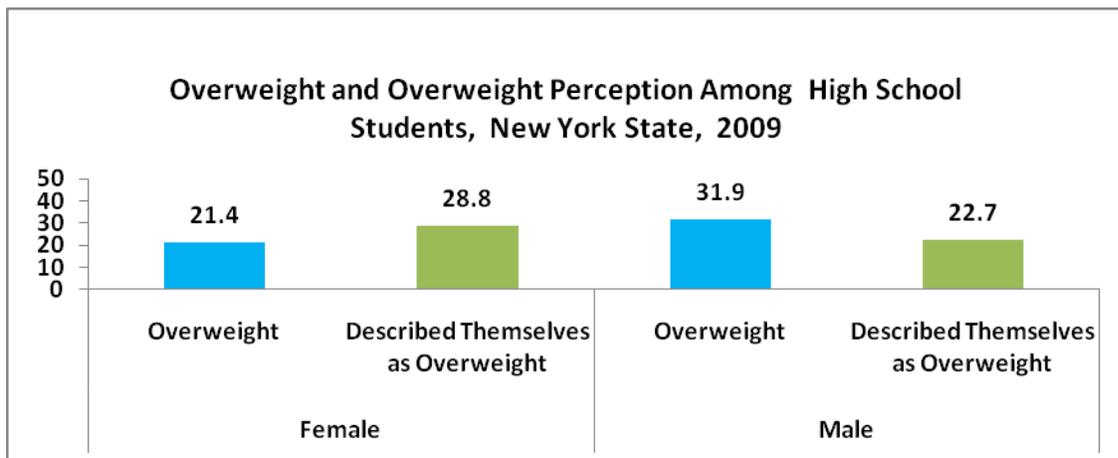
As part of the Department's strategic plan to address obesity, the Governor proposed a sugar sweetened beverage tax that would impose an additional sales tax of 18% levied on certain high

calorie, low nutrition beverages like non-dietetic soft drinks, sodas, and fruit drinks that contain less than 70% of natural fruit juice. Sugar-sweetened beverages are the largest single source of added sweeteners in the US diet. Americans consume an average of 36 gallons of sugar-sweetened soft drinks annually. Obese and overweight adults are more likely to consume soda than normal weight adults. An estimated \$6.1 billion is spent annually on obesity-related health problems in New York State. In New York, 81% of this cost is paid for by publically funded health care programs - Medicaid and Medicare. This means that obesity costs each NYS family \$899 per year for public and private health care programs.

Since price influences food purchasing behavior, an increase in the cost of sugar-sweetened beverages will reduce purchasing and consumption, thereby reducing the risk for overweight and obesity and decreasing health complications associated with overweight and obesity. Increasing the tax on sugar sweetened beverages will decrease consumption of sugar sweetened beverages, will improve weight status and health, and will raise revenue for health related programs. The bill, however, was not passed in the current legislative session.

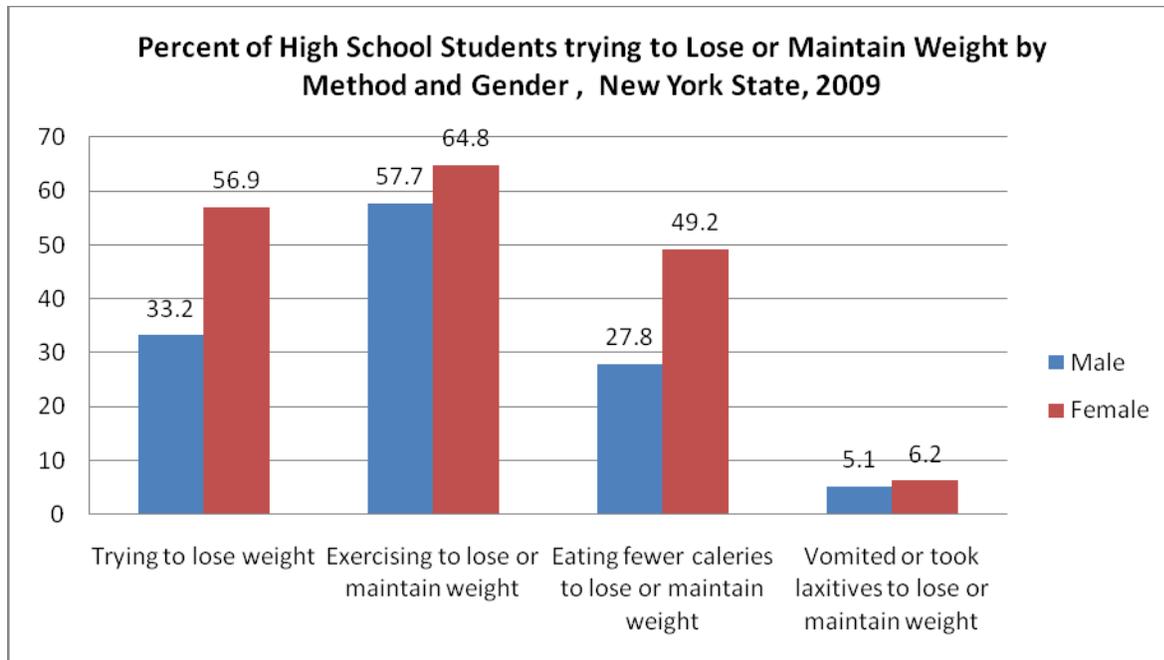
Eating Disorders: Other weight-related health issues that impact adolescents are eating disorders. The National Institute of Mental Health estimates there are 5-10 million people in the US with eating disorders, which include anorexia, bulimia, binge eating disorder and other conditions. Eating disorders cause more deaths than any other mental disorder. Females are much more likely to suffer from an eating disorder than males. Only 5- 15 percent of people with anorexia or bulimia are males. One characteristic of persons with an eating disorder is a perception that they are overweight when they are not.

According to the 2009 YRBS, 28.8 percent of female high school students described themselves as slightly or very overweight when, based on their self reported height and weight data, only 21.4 percent were overweight or obese. Among males the reverse was true. While 31.9% reported height and weight information that fell in the overweight or obese weight category, only 22.7% considered themselves to be slightly or very overweight.



Note: Overweight is defined as above the 85th percentile for body mass index, by age and sex

Among New York State high school students in 2009, 33.2% of males and 56.9% of females reported they were trying to lose weight. While most used methods such as exercise or eating fewer calories, 5.1% of males and 6.2% of females vomited or took laxatives to lose or maintain their weight.



Physical Activity: According to the 2009 YRBS, 42.3% of adolescents were estimated to have participated in physical activity for at least 60 minutes on at least five or more of the past seven days. Males (50.5%) were more likely than females (34.3%) to report this level of physical activity.

While 92 percent of students said they attended physical education class at least once per week, only 15 percent reported having a daily PE class. Half of both male and female students (59.5%) reported that they played on a sports team. Males were somewhat more likely (66.1%) to play on a sports team as compared to females (53.3%).

Childhood Nutrition: The New York State Department of Health administers several nutrition programs through its Division of Nutrition that are targeted to reducing hunger and promoting healthy eating and physical activity.

The **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 foods provided through the WIC Program are lower in fat and higher in fiber, and include vegetables and fruit, lower fat milk, and whole grain breads and cereals, with some substitutions available for cultural preferences.

The NYS WIC program provides services via 94 local agency direct service providers at over 450 WIC clinic sites. The program serves approximately 520,000 participants monthly, which is 36 percent of the WIC-eligible women, infants and children in New York State.

The NYS WIC program has also been proactive in developing initiatives that will aid in encouraging participants to transition to healthier lifestyles, and have a positive impact on decreasing obesity and overweight. These initiatives include:

- FitWIC, a program in which all WIC local agency staff are trained in exercises that can help encourage participants to increase physical activity in any environment;
- Breastfeeding Peer Counseling to provide support and encouragement to increase breastfeeding initiation and duration;
- The Healthy Lifestyles initiative to support the development of strategies to motivate participants and their families to adopt healthier lifestyles through increased physical activity and improved eating habits, and;
- Public Health Detailing in which WIC representatives make personal connections with health care providers in their communities, providing information on the WIC program and the services it offers.

The **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. At this time, more than 9,100 family day care homes and 4,000 day care centers serving 290,000 New Yorkers participate in CACFP. The program provides direct funding for qualifying meals and snacks served in child day care centers, outside school hours programs, emergency or homeless shelters, and family day care homes. The program also provides nutrition expertise and consultation, training, program resources, and enforces program guidelines through on-site program reviews.

CACFP also administers an obesity prevention initiative, **Eat Well Play Hard in Child Care Settings (EWPHCCS)** 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. EWPHCCS nutritionists reached nearly 13,000 pre-school age children, family members, and child care center staff (unduplicated count) with lessons on eating more fruits and vegetables, consuming more low-fat milk and dairy products, and being more physically active as part of a healthy lifestyle.

In 15 communities statewide, **Eat Well Play Hard (EWPH) Community Projects** have implemented sustainable policy and environmental changes to assure children and their families are exposed to consistent nutrition and physical activity recommendations. EWPH Community Projects have: facilitated changes to child care and school physical activity and nutrition practices; implemented farm-to-school/child care programs; established community gardens and farmers markets; worked to increase use of local parks; and partnered with planners to make communities more walkable.

The **Hunger Prevention and Nutrition Assistance Program (HPNAP)** works with emergency food relief organizations (EFROs), food banks, food pantries, soup kitchens and emergency

shelters to provide meals to those in need of emergency food. Almost 35 percent of New York State's residents have incomes at or below 200 percent of the federal poverty level and periodically need emergency foods in addition to food support provided by SNAP (USDA Food Stamp Program). Children receive approximately 40 percent of all emergency meals distributed through HPNAP-supported food pantries. With HPNAP and other funding, 166 million meals were distributed in 2009 through the network of more than 2,500 EFROs in the state. HPNAP funding supplements other food donations and is used for purchasing more healthy foods (i.e. fruits and vegetables, low fat milk).

The **Just Say Yes to Fruits and Vegetables Program (JSY)** promotes increased consumption of fruits and vegetables for low-income families. JSY nutritionists provide free nutrition education sessions and food demonstrations at food pantries, shelters, WIC clinics, farmers markets, summer food sites and other community settings for food stamp clients. Nutrition education sessions focus on increased awareness of the benefits of a healthy diet including a variety of fruits and vegetables. In 2008-09, JSY nutritionists conducted 1,061 workshops, providing nutrition education to 12,805 food stamp eligible clients.

The New York State Education Department (SED) administers the **National School Lunch, School Breakfast and Summer Nutrition Programs**. Approximately 1,800,000 children participate in the School Lunch Program, with over 530,000 children participating in the School Breakfast Program. The Summer Nutrition Program provides meals to over 300,000 children daily. Several initiatives, such as the Fruit and Vegetable Program, focus on improving the quality of the food provided through school meals and promoting healthy eating. In collaboration with the Department, SED disseminated Activ8Kids! School Nutrition and Physical Activity Toolkit as a resource to help all New York's schools take actions towards improving nutrition and physical activity environments within school settings. Currently, the WIC program provides services to a monthly average of 482,686 participants through 101 local agency direct service providers. Due to funding limitations, the program currently serves approximately 51 percent of the WIC-eligible women, infants and children in New York State. Funds received totaled approximately \$477 million.

Approximately 1,800,000 children participate in the School Lunch Program, and an additional 250,000 children participate in the Child and Adult Care Food Program (CACFP). Food Stamps reach about 800,000 children.

Respondents to WIC participant surveys reported an increase in the number of children drinking low fat or skim milk from 5.4% in 1998 to 8.9% in 2000. Responses on numbers of fruits and vegetables consumed per day increased in the same time period from 2.8 to 3.0 servings of fruit and from 1.6 to 1.7 servings of vegetables a day. While improvement is encouraging, this is still below the recommended servings per day.

The epidemic of overweight and obesity has become one of the most critical public health threats for New Yorkers and Americans. This epidemic has affected all age groups, boys and girls, men and women, and reached across racial/ethnic and socioeconomic groups. Obesity rates increased slightly during the 1970's, but escalated for both children and adults during the 1980's and 1990's. Obesity among children and adolescents has tripled over the past three decades. While

the rate of increase may be slowing among adults, there are no signs that the epidemic of childhood obesity is significantly abating. In fact, overweight and obesity are increasing problems in young children, setting the stage for the obesity epidemic to continue far into the future. As a result, for the first time in history, children are predicted to have a shorter life expectancy than their parents.

The root causes of the obesity epidemic—poor nutrition and physical inactivity—will become the leading underlying causes of preventable deaths in the U.S. The costs, both financial and personal, associated with obesity are also increasing, in part, because obesity leads to higher rates of many diseases, including heart disease, stroke, diabetes, cancer, asthma, arthritis, disability and a number of psychological conditions, including depression. Increasingly, many of these diseases, previously associated only with adulthood, are also being seen in overweight and obese children. Along with the risks for life-shortening chronic diseases, being overweight in a society that stigmatizes this condition contributes to poor mental health associated with serious shame, self-blame, low self-esteem and depression.

Stopping the obesity epidemic will not be easy, but there are precedents for success in other public health endeavors. It will require the input, hard work, skills, talents and perseverance of many people, a wide array of organizations and groups, including the medical, educational, non-profit and business communities, academia and government. While there is a role for individual behavior change, population focused prevention efforts require both decreasing environmental barriers to and supporting healthy food choices and physically active lifestyles. A multifaceted public health policy campaign is needed, with special attention to selected groups, including Hispanics, Blacks, and Native Americans, and communities experiencing health disparities and social and physical environments unsupportive of healthy eating and physical activity.

To address this important issue in New York State (NYS), the State Department of Health coordinated a strategic planning process involving a broad array of stakeholders and experts represented by the 33-member steering committee, six workgroups, two site-specific workgroups and 14 community forums held throughout New York State.

The first *New York State Strategic Plan for Overweight and Obesity Prevention*, was published in early 2005. It is only the first step toward achieving the vision that all New Yorkers will achieve and maintain a healthy weight. Implementing the proposed strategies will require continued and sustained commitment from a wide array of stakeholders. The [New York State Strategic Plan for Overweight and Obesity Prevention](#) identifies evidence-based strategies and promising approaches that can be replicated. Interventions that address the need for changing policies and environments to promote and provide options for healthy eating and more physical activity are highlighted.

Priority areas of the strategic plan are based on their potential for:

- Increasing the perception of overweight and obesity as major public health threats
- Increasing early recognition of healthy weight, overweight, and/or excessive weight gain
- Promoting, supporting, and maintaining systemic and sustainable changes needed to make healthy eating and physical activity easy for everyone
- Expanding and improving surveillance and program evaluation

- Increasing initiation, exclusivity and duration of breastfeeding during infancy
- Increasing lifelong physical activity
- Improving lifelong healthy eating
- Decreasing exposure to television and other recreational screen time.

The NYS Council on Food Policy has identified four key food policy issue areas, with objectives and strategies outlined for each. The Department has identified nutrition and physical activity as one of ten priority areas in the Prevention Agenda Toward the Healthiest State; and the NYS Strategic Plan for Overweight and Obesity, developed with broad stakeholder involvement, provides a blueprint for addressing childhood obesity prevention.

These plans are being used to direct resources and implement prevention strategies. The nutrition programs administered by the Department, such as the WIC and Child and Adult Care Food Programs, are implementing new interventions and policies to address the issues and strategies identified in the plans. The recent capacity building trainings for local health units provided training, and assisted with the development of action plans based on the input/assessment of key community partners. Many of the counties used these action plans to prepare for funding opportunities offered by the state (e.g. Creating Healthy Places; Comprehensive School Health Policies etc.) The new Creating Healthy Places RFA represents a unique reallocation of existing resources that pools funding from two Divisions and three programs to establish community-based grants focused on addressing obesity prevention.

The action plan is being 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. Future implementation plans include:

- 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; Establish 20 community-based grants through the Creating Healthy Places RFA to implement
- 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.

The Department has a number of programs addressing childhood obesity that have been realigned consistent with these strategic efforts, including:

- The **Overweight and Obesity Prevention Program** aims to increase physical activity and improve nutrition among New York residents. The program's current primary focus is the prevention of childhood obesity.
- The **Healthy Heart Program** is collaboratively funding schools across New York State to implement policies and practices to reduce tobacco use and increase physical activity and

healthy eating. Schools with a higher percentage of students eligible for free and reduced school lunch are priority. The Healthy Heart, Tobacco Prevention and Control, and Obesity Prevention Programs are collaborating to fund this set of school contractors. The Programs developed and released a request for applications from which they are funding 18 catchment areas in NYS. The contractors will be funded for five years to work in primarily high need schools in their catchment areas. Each contractor will work with 5 – 6 school districts per year. Technical advisors from each program will be working with the contractors. The Program reached over a 1000 schools to improve the nutrition and physical activity environment. However, there are 7,600 schools in New York State. The new collaboration between DOH programs extends the reach of our work in schools, but still does not allow us to reach all schools in New York State.

- **The Student Weight Status Initiative is a new approach to assess childhood obesity throughout the state is being implemented to:**
 - Increase screening and early recognition of overweight and obesity by pediatric healthcare providers
 - Collect, aggregate and report weight status data for public schools and school districts
 - Provide local, county and statewide estimates of the prevalence of childhood obesity
 - Target resources to populations most at risk for childhood obesity
 - Identify what is working in schools and communities to help prevent and reduce childhood obesity.
- **Model Guidelines on Nutrition, Physical Activity and Media for After-School Settings:** New York is one of 10 states selected to receive a grant from the National Governors Association to develop and disseminate model guidelines on nutrition, physical activity and media use in after-school care settings. Recognition will be given to after-school programs that adopt and implement the model childhood obesity prevention guidelines.
- **The Diabetes Prevention and Control Program** collaborates with local, state and national partners to reduce and eliminate the burden of diabetes in New York State. Since its inception, the DPCP has transitioned from a focus on the control of diabetes complications to a comprehensive public health approach including prevention of type 2 diabetes and the promotion of healthy lifestyles across the lifespan. The DPCP has identified three goals to align with CDC's and national diabetes program framework:
 - Prevent type 2 diabetes
 - Prevent complications, disabilities and the disease burden associated with diabetes
 - Eliminate diabetes-related health disparities.

To achieve these goals, the DPCP implements strategies within the following priority areas:

- Public awareness and education
- Children and diabetes in schools and childcare settings
- Healthcare practice
- Access to care
- Sustainability and policy, systems and environmental change
- Public health tracking and evaluation.

- **The Eat Well Play Hard Program** is a childhood obesity prevention initiative previously described that is incorporated into large-scale public health food and nutrition programs that serve low-income preschool children and their families in targeted communities. EWPH strategies are integrated into each program's food policies, nutrition education efforts, staff training, and marketing and outreach efforts. The core strategies for the EWPH intervention aim to:
 - Increase developmentally appropriate physical activity
 - Increase consumption of 1% or fat-free milk and low-fat dairy products
 - Increase consumption of fruits and vegetables
 - Decrease TV and screen time
 - Increase the initiation and duration of breastfeeding.

A total of 15 community projects cover 22 counties and involve a variety of settings including daycare centers, WIC clinics, schools, and after-school programs. The statewide goal for these projects is to establish sustainable, local collaborative partnerships that focus on creating environmental, policy and practice changes to increase healthy eating and physical activity at the community level.

- **The Special Supplemental Nutrition Program for Women, Infants and Children (WIC)** supports the EWPH objectives through state policies and resources provided to WIC local agency staff and participants, such as encouraging low-fat dairy products for participants over age two, incorporating physical activity into clinic education and actively supporting breast feeding.
- **The Child and Adult Care Food Program** is recognized as the gold standard for nutrition and food service in daycare centers. The Program currently serves more than half of all eligible daycare programs, including all Head Start centers in the state.
- **The Hunger Prevention and Nutrition Assistance Program** ensures that the state's emergency food system supports EWPH objectives by establishing policies and resources for emergency food relief organizations, such as food banks, food pantries, soup kitchens and shelters. Examples of these efforts include:
 - The HPNAP policies require that at least 10 percent of HPNAP food funds are spent on fresh produce and a minimum of two percent are spent on non-flavored low-fat or non-fat fluid milk.
 - Food recovery projects, food banks, and other contractors are increasing the availability of fresh produce, including locally grown produce, in food pantries, soup kitchens and emergency shelters by collecting leftover produce on farms, participating in Community Supported Agriculture, operating gardens and delivering fresh produce to low-income areas.
 - Just Say Yes to Fruits and Vegetables is a Food Stamp Nutrition Education Program designed to increase access to and consumption of fruits and vegetables by individuals and families receiving food stamps and WIC benefits.

Several systems are in place to track prevalence of childhood overweight and obesity, and assess needs related to the prevention of childhood obesity. The primary surveillance system used to track overweight and obesity levels of children participating in the WIC Program, conducted in collaboration with the Centers for Disease Control, is the Pediatric Nutrition Surveillance System (PedNSS). In 2008, 14.6% of the two- to four-year-old children participating in New York's WIC Program were obese. This is down 12% from the 2003 high of 16.6%, but still an 11% increase since 1990. Data for 2009 are preliminary estimates. The PedNSS also collects information on behaviors related to childhood obesity prevention, such as breastfeeding and TV viewing rates. The PedNSS data is analyzed annually and provides insight into trends in overweight and obesity and disparities among racial-ethnic groups.

Other efforts to assess need related to childhood obesity prevention include Community Health Assessments completed by Local Health Units, school BMI reporting, the Nutrition and Physical Activity Self-Assessment for Child Care, and evaluation of program outcomes.

Despite the efforts to realign resources with the strategic effort, the inability to extend successful pilot projects to prevent childhood obesity due to resource limitations prevents expansion of successful interventions from reaching and serving more New Yorkers. In the WIC Program, expansion of the Breastfeeding Peer Counselor Program, implementation of a new food package and an emphasis on client centered counseling will address some of the identified needs, however WIC is not an entitlement program, and therefore, is not available to all low-income families. Identified as a promising practice by national organizations, the Eat Well Play Hard in Child Care Settings intervention, is limited in the number of child care centers reached because of lack of adequate resources.

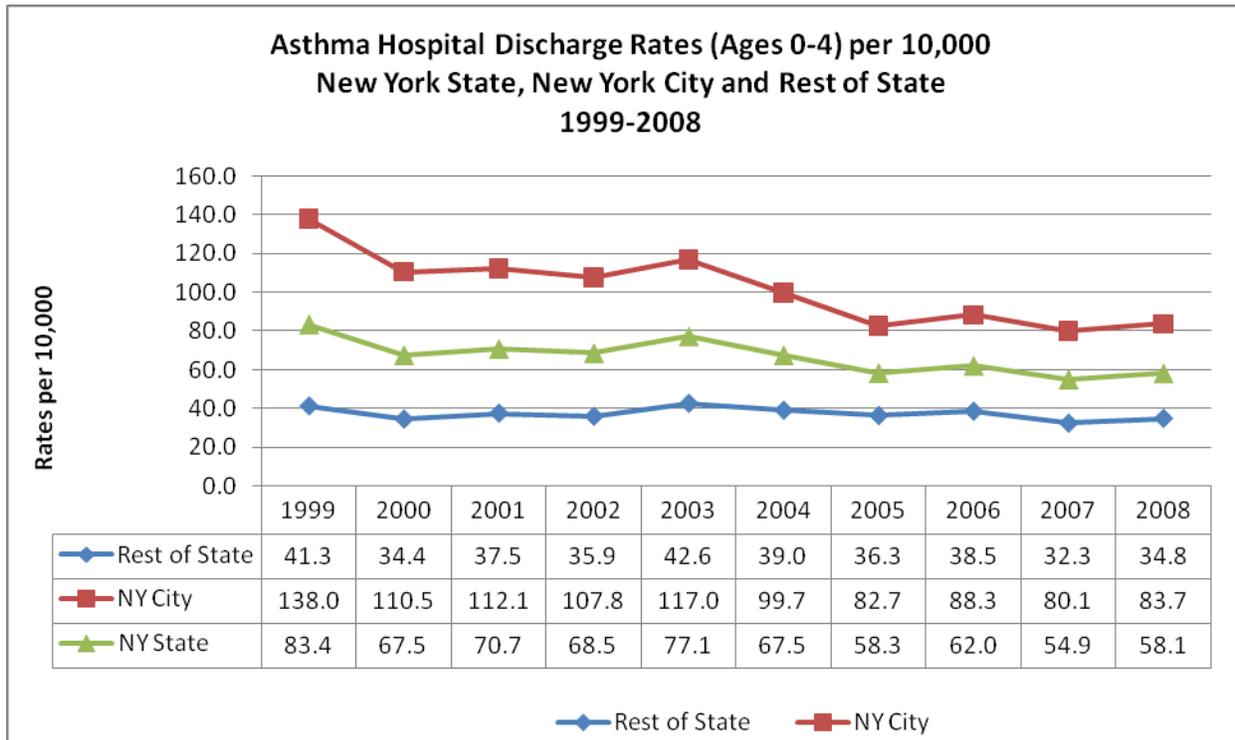
The community based approach has yielded results in counties that have had the benefit of funding (e.g. Healthy Heart, Steps to a Healthier NY, Eat Well Play Hard). In 2010, the department provided capacity building training to local health units and their key partners. The local health units developed an action plan with their key partners and were able to offer mini-grants to help their communities begin implementation of the action plan. Ideally, being able to offer on-going technical assistance and funding to all 62 counties to implement childhood obesity strategies would go a long way in reducing health disparities and improving lifestyle choices for all New Yorkers.

The newly offered Creating Healthy Places RFA combines funding and staff expertise from several program areas to offer grants to 20 counties to implement sustainable policies, systems and environmental changes related to healthy eating and physical activity. Four identified core community strategies will lead to population wide efforts that will accelerate improvements in individual health behaviors and health outcomes.

Asthma

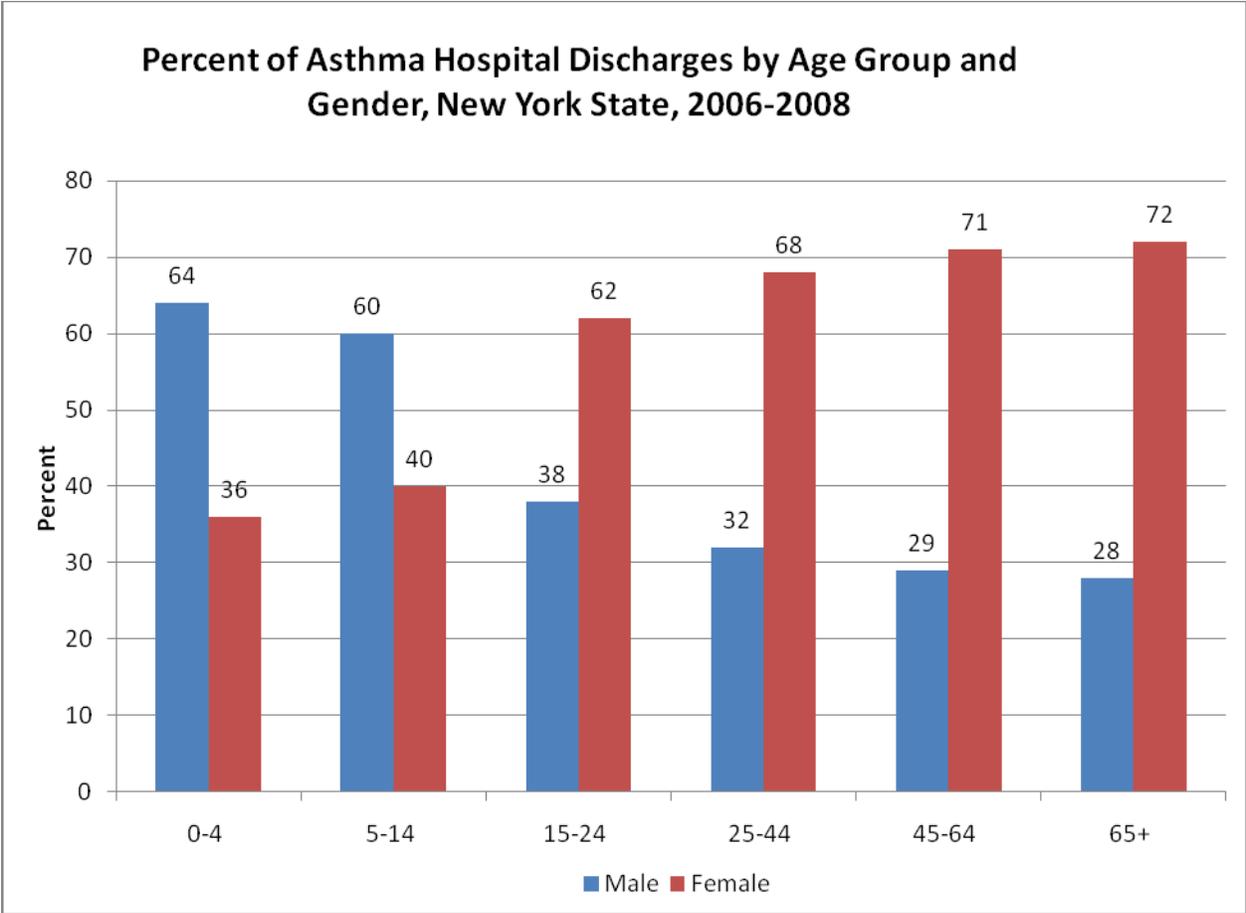
Asthma Hospitalizations: Since the 1999 high rate of 83.4 per 10,000, asthma hospitalization rates for children aged birth to four-years-old have declined 30 percent to 58.1 per 10,000 in 2008. Over the past ten year period the rate fluctuated in both directions reaching a record low rate of 54.9 per 10,000 in 2007 and then increasing slightly in 2008.

The asthma hospitalization rate in New York City for children aged 0 to four continued to be more than double the rate among 0 to 4 year old children residing in Rest of State. Between 2007 and 2008, the rates for children residing in both New York City and Rest of State increased slightly.



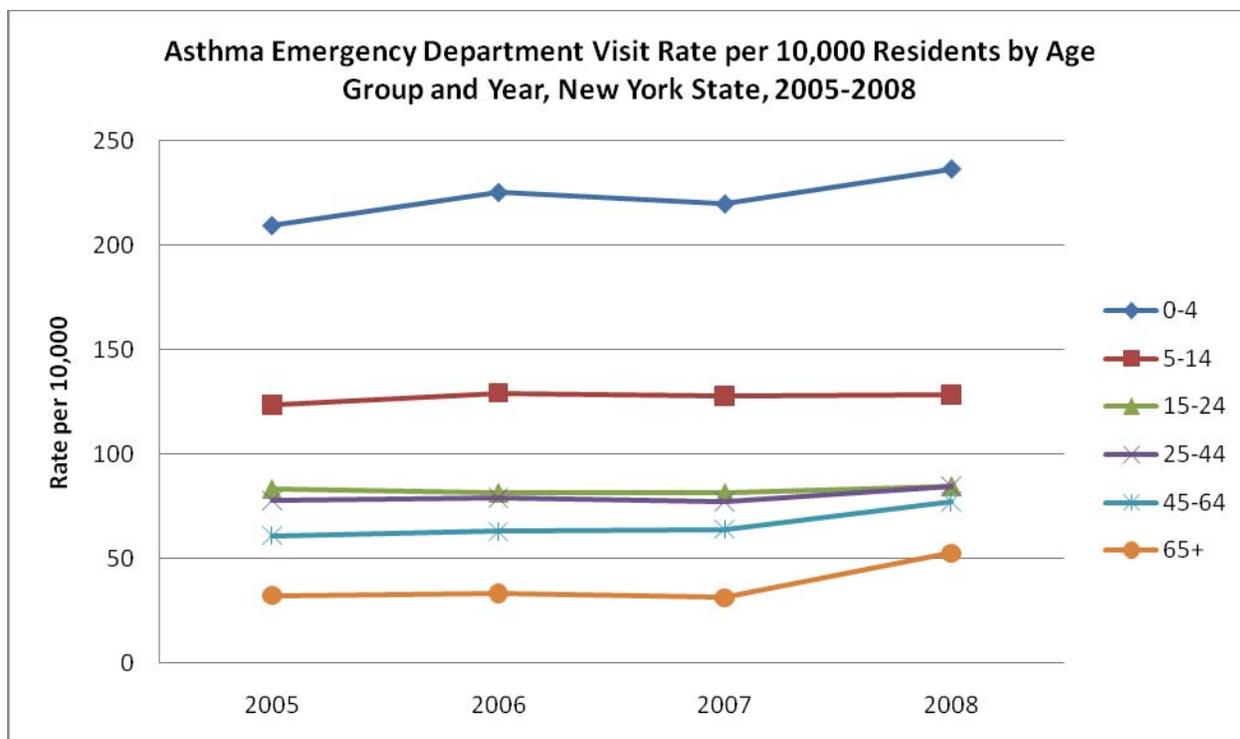
There is an interesting age and gender-related pattern in asthma hospitalizations. At ages under 15, there is a higher proportion of males than females among all asthma hospital discharges (0-4 years: males-64%, females-36%; 5-14 years: males-60%, females-40%).

In contrast, for those aged 15 years and older, females had a higher proportion of asthma hospital discharges compared to males (15-24 years: males-38%, females-62%; 25-44 years: males-32%, females- 68%; 45-64 years: males-29%, females-71%; 65+ years: males-28%, females-72%). This is especially significant for women during child bearing years because asthma can cause complications during pregnancy and must be monitored closely. Use of inhaled corticosteroids (ICS) prior to pregnancy has been shown to decrease physician visits, whereas not using ICS prior to pregnancy was associated with an increase in physician and ER visits (Schatz M, Leibman C. *Annals Allergy Asthma Immunology*. 2005 Sep;95(3):234-8.)



Asthma is a condition that results in a large number of emergency department (ED) visits.

In 2008, children aged 0-4 had the highest ED visit rate (236.6 per 10,000) compared to all other age groups. Children aged 5-14 had the second highest rate at 128.4 per 10,000. Between 2005 and 2008, the asthma ED rate increased for all age groups.



The Behavioral Risk Factor Surveillance System asks about asthma in the annual survey of adults in New York State. Beginning in 2006, NYS added questions to this survey about asthma prevalence and demographic characteristics for children. Based on responses to these questions, asthma prevalence estimates for current asthma in children have been calculated for the 2006-2008 time period. During 2006-2008, current asthma prevalence among children in NYS was 11.0%.

Children who lived in New York City had slightly higher current asthma prevalence (11.2%) compared to children in the Rest of State (10.9%). However, this difference was not statistically significant.

During this time, current asthma prevalence was higher in boys (11.4%) than in girls (10.5%) but this difference was not statistically significant.

Children aged 5-9 years had the highest current asthma prevalence (14.3%), while children aged 0-4 years had the lowest current asthma prevalence (7.5%). The difference in current asthma prevalence rates between these two age groups was statistically significant.

The prevalence of current asthma was lower in both Non-Hispanic White (8.7%) and Hispanic (11.1%) children in 2006-2008 compared to Non-Hispanic Black children (17.3%). The difference in current asthma prevalence rates between non-Hispanic Black children and non-Hispanic White children was statistically significant.

Children who lived in households with an annual income greater than or equal to \$75,000 had the lowest current asthma prevalence (8.4%), while children living in households with annual

incomes of \$15,000-\$24,999 had the highest current asthma prevalence (16.5%). Current asthma prevalence among children in households with an annual income less than \$15,000 was significantly higher than among children in households with an annual income greater than or equal to \$75,000 (Table 6-1).

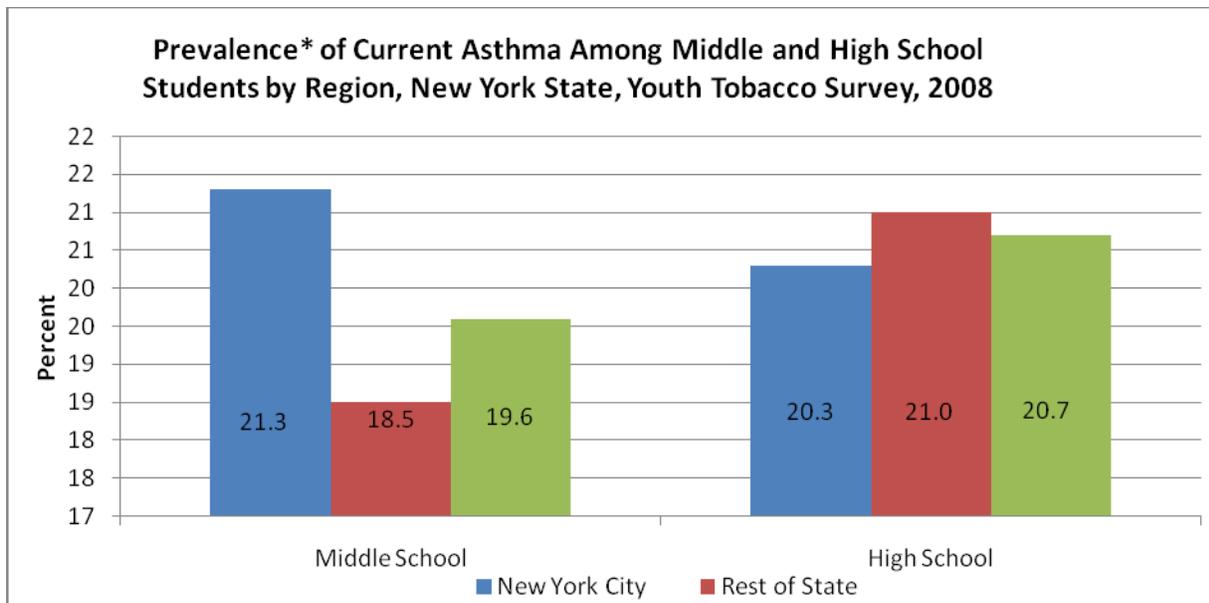
Table Prevalence of Current Asthma Among Children (0-17 Years) by Sociodemographic Characteristics, New York State, BRFSS, 2006-2008

	Weighted Current Prevalence (%)	95% CI
New York State	11.0	9.8-12.1
Region		
New York City	11.2	8.8-13.6
Rest of State	10.9	9.6-12.1
Gender		
Male	11.4	9.8-13.0
Female	10.5	8.9-12.1
Age Group (years)		
0-4	7.5	5.4-9.5
5-9	14.3	11.8-16.9
10-14	12.5	10.0-14.9
15-17	9.5	7.5-11.4
Race and Ethnicity		
Non-Hispanic White	8.7	7.7-9.8
Non-Hispanic Black	17.3	13.2-21.3
Non-Hispanic Other	11.8	7.8-15.7
Hispanic	11.1	8.2-14.0
Household Income		
<\$15,000	15.6	10.8-20.4
\$15,000-\$24,999	16.5	12.2-20.9
\$25,000-\$49,999	11.1	8.6-13.5
\$50,000-\$74,999	8.8	6.4-11.3
≥\$75,000	8.4	7.0-9.9

**Parent/Guardian is self-reported proxy for children.*

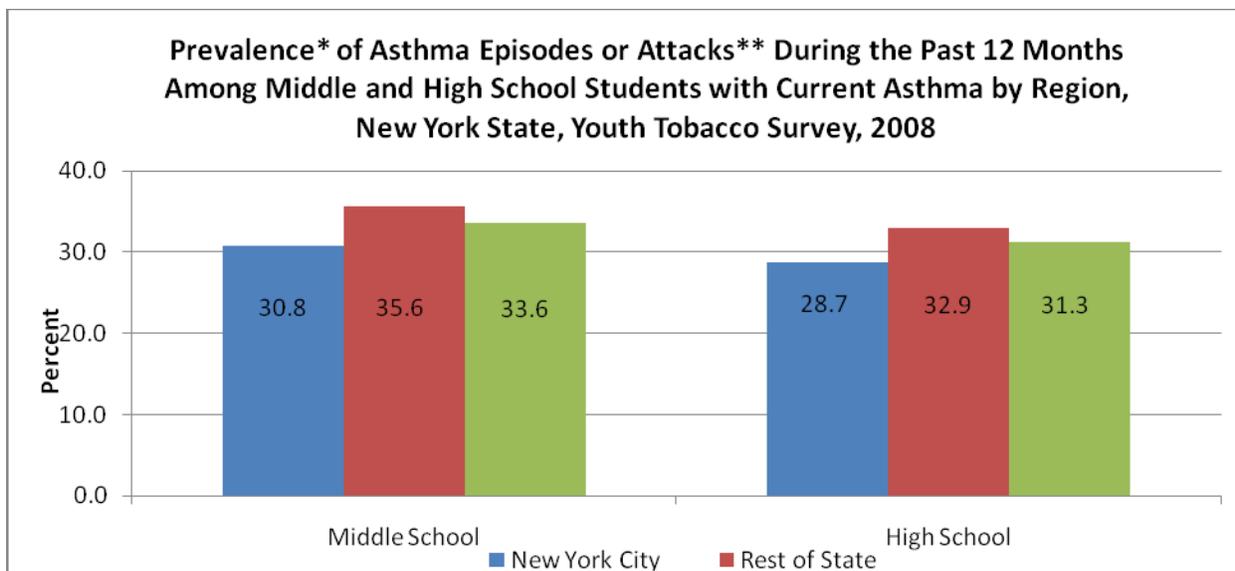
In 2008, the Youth Tobacco Survey (YTS), a survey administered in New York State bi-annually to middle school and high school students in grades 6 through 12, added several questions related to current asthma and asthma attack/episode information. According to the 2008 YTS, 19.6% of middle school students and 20.7% of New York State high school students reported having

current asthma. High school students residing in Rest of State were somewhat more likely to report current asthma compared to their New York City counterparts. In middle school, New York City students were the most likely to report current asthma.



Source: 2008 New York State Youth Tobacco Survey

Among students with current asthma, middle school students were more likely to suffer an attack or episode during the past year. Middle school students residing in Rest of State (35.6%) reported the highest percentage of attacks. About 29% of New York City high school students and 33% of Rest of state high school students reported attacks.



Source: 2008 New York State Youth Tobacco Survey

The New York State Asthma Control Program (NYSACP) is a comprehensive, statewide initiative that applies a systematic evidence-based approach in public health surveillance, environmental and occupational health, health care delivery and quality and community interventions to improve outcomes and reduce disparities among New Yorkers with asthma. The 2006-2011 New York State Asthma Plan (NYSAP) was collaboratively developed with key state and national partners. It serves as a blueprint for improving the lives of all New Yorkers with asthma, regardless of age, race/ethnicity, gender, socioeconomic status or geographic area.

The NYSAP includes five strategic goals: 1) seamless, evidence-based, patient/family-centered care exists for all New Yorkers with asthma; 2) disparities in diagnosis, treatment and outcomes are eliminated; 3) asthma-friendly communities exist; 4) NYS policy makers, health care providers and consumers will increase awareness and implement appropriate control based on data, and 5) a statewide public/private collaboration exists to shape, implement and monitor action to improve asthma outcomes. The NYSAP has been endorsed by the NYSDOH Commissioner and statewide partners, with commitment to support and participate in its implementation and ongoing evaluation and revisions.

The NYSDOH applies a cross-organizational response to asthma. The State Asthma Plan is implemented through a collaborative effort of core teams representing surveillance, environmental health, and health care delivery and quality, and community interventions. Interventions such as the SBHC quality improvement collaborative are carried out through a partnership between the Bureau of Community Chronic Disease Prevention and the Division of Family Health. An in-home services pilot project and an initiative aimed at eliminating disparities in asthma health care in NYC are being implemented in collaboration with the NYSDOH Office of Health Insurance Programs, Division of Quality and Evaluation.

Based on the identified needs and description of the burden of asthma in NYS, six goals have been outlined for the NYS Asthma Control Program: 1) Reduce asthma hospitalizations and emergency department visits among NYS children and adults; 2) Reduce Disparities in asthma diagnosis, treatment and outcomes among those disproportionately affected by asthma; 3) Increase and support asthma self-management education among New Yorkers with current asthma; 4) Equip and activate schools, daycare facilities, communities, health care providers, homes and workplaces with information, evidence-based tools and systems to improve asthma control; 5) Strengthen NY's public/private collaboration of partners to improve the effectiveness, reach and impact of NY's action to control asthma; and 6) Maintain, and expand statewide asthma surveillance system to track disease, inform policy makers and partners, and assess the effectiveness of the Statewide Asthma Control Program.

To address these goals, an extensive range of evidence-based interventions is being implemented and evaluated in a variety of settings and populations. Strategies to address the need and meet the goals are as follows:

- Publish *Asthma Surveillance and Summary Report* updated every 2 years.
- Support Regional Asthma Coalitions to target local problem and implement local solutions
- Update the NYS consensus asthma guideline clinical decision support tool based on the national guidelines every 2 years

- Implement NYS SBHC Asthma Improvement Collaborative and translate findings to all SBHCs in NYS
- Increase influenza vaccination rates among high-risk pediatric population
- Add new teams each year to NYS Asthma Outcomes Learning Network
- Implement the NYS asthma self-management education legislation and develop the Certified Asthma Educator workforce
- Develop and implement the NYS Asthma Self-management toolkit
- Evaluate business case for in-home services program
- Expand coaches education program
- Provide statewide asthma education in a variety of setting
- Coordinate a statewide asthma and influenza campaign
- Support Asthma Partnership of NY expansion and development of subcommittees to address priority activities
- Establish and implement comprehensive evaluation plan, monitor outcomes and modify the state plan as needed
- Maintain and expand existing surveillance system and assess new data for asthma surveillance.

The Asthma Partnership of NY is responsible for the implementation and ongoing monitoring of the NYSAP; there is a continuous review by the partnership to modify goals, objectives and activities through analysis of surveillance data, program evaluation findings and progress toward reaching each goal of the NYSAP. The Asthma Program's statewide partners and national experts will be convened once again in 2011 for the third re-visioning of the NYSAP to result in the 2012-2017 NYSAP to result in the 2012-2017 NYSAP.

New York State has over 1000 partners who share the common goal to improve asthma outcomes. Partners are organized under the Asthma Partnership for New York (APNY), a public-private collaboration that includes statewide, regional, and local representatives. Statewide partners include the American Lung Association, Pediatric and Family Medicine professional societies, the NYS Health Plan Association, the Community Health Center Association, and the NYS and NYC Departments of Education. Regional partners include 11 Regional Asthma Coalitions, the NYS Asthma Outcomes Learning Network, and the NYC Asthma Partnership. Local partners are organized around special projects/initiatives such the NYS Consensus Asthma Guidelines Expert Panel and NYS School-Based Health Center asthma quality improvement collaborative. The APNY was established to mobilize all partner efforts to plan, implement and evaluate population-based and patient-centered strategies to improve asthma outcomes.

The APNY Steering Committee is composed of a broad, representative group of partners including: people with asthma, parent advocates, providers, health plans, public health, schools, city/regional coalitions, professional societies/associations, and the business community. Guided by common vision and shared goals, the Asthma Partnership of NY is responsible for overseeing the implementation of the State Asthma Plan, to include continuous review and modification of the goals, objectives, and activities through analysis of data, evaluation findings and progress towards meeting process and outcomes measures.

The NYS Asthma Control Program successfully connects and leads statewide partners in defining asthma problems; examining and applying evidence-based science to address problems; prioritizing, aligning and implementing intervention strategies; and, evaluating results. The 11 Regional Asthma Coalitions provide the infrastructure to target interventions across the state, particularly in areas with the greatest asthma disparities. Each coalition has a governance and membership structure ranging between 60-80 partners. Coalitions partner on the local level with schools, daycare facilities, clinics, pediatric practices, health plans, and community-based organizations to promote and sustain system change interventions. NYSDOH staff provides technical assistance to Regional Asthma Coalitions on using state and local data to: identify populations with greatest asthma disparities to target interventions and monitor the impact; engage appropriate partners to address their local asthma burden; identify evidence based interventions; and evaluate impact. Coalitions continually assess the local asthma burden and engage appropriate partners in the solution.

The NYS Asthma Outcomes Learning Network is a large-scale systems change intervention aimed at reducing disparities in asthma care and management across a variety of settings where individuals with asthma spend a significant amount of time. This intervention is led by the NYS Asthma Control Program and the Regional Asthma Coalitions with assistance from NICHQ. Local and state data is used to identify high risk areas in each region and recruit organizations in those areas for participation in this 12-month intervention.

The NYS SBHC Improvement Collaborative is aimed at improving asthma care process and outcomes by implementing evidence-based system changes based on the Chronic Care Model. The project methodology is based on the Institute for Health Care Improvement's Breakthrough Series and NYS's experience in implementing past improvement collaborative. The intervention is being implemented through collaboration with the Asthma Control Program, the Division of Family Health and NICHQ.

The NYSACP's highly sophisticated surveillance system is maintained to use multiple sets of data for targeting, monitoring, and evaluating interventions, developing programs, and influencing policy. The following data sets are among those used to survey the burden of asthma among children NYS: vital statistics, SPARCS-inpatient hospital discharge data, BRFSS child prevalence, BRFSS random child selection module , BRSS Child ACS, Medicaid Encounter Claims, YRBS, YTS, and Asthma ED visit data. Data sets to be included over the course of the next five years include: EBRFSS, Child Health Plus, and SPARCS Diagnostic and Treatment Center data.

- The *NYS Asthma Surveillance and Summary Report* serves as the NYS asthma burden document and is produced biennially (most recently published in October of 2009). The report is mailed to approximately 600 asthma partners, including NYSDOH staff, other state agencies, legislative staff, local health departments, and managed care program directors, Regional Asthma Coalitions, the Asthma Partnership of New York, and the CDC. The report is made available on the NYSDOH public website.
- Population-based information for NYS residents is being collected annually through the NYS BRFSS and asthma surveillance staff will develop and circulate a *2006-2008 NYS BRFSS Asthma Call-Back Survey Summary Report* in 2010.

- State and county level asthma hospitalization and mortality indicators are contained in the Community Health Data Set and the County Health Assessment Indicator Reports on the NYSDOH Public Website. These sites are utilized by local health departments and hospitals for community health assessment. The Prevention Quality Indicator (PQI) Tool on the NYSDOH public website allows local partners to review a number of ambulatory care indicators. Users can generate asthma hospitalization rates at the ZIP code level; pediatric asthma hospitalization rates will be added to the next version of the PQI Tool. Asthma hospitalization rates for children 0-17 years of age will be tracked as part of the Prevention Agenda Toward the Healthiest State launched by NYSDOH in 2008.
- The NYS Asthma Control Program has been conducting evaluation on asthma activities, programs, and interventions across NYS. These include the evaluation of the NYS Regional Asthma Coalitions, the NYS Asthma and Influenza Vaccination Campaign, and the NYS Asthma Outcomes Learning Network. The NYS Asthma Plan was revised and the overall program logic model developed with key stakeholders. A comprehensive set of key performance indicators has been selected. A 4-year program evaluation plan is in development under the direction of the Asthma Evaluation Team. The team will plan for the findings of the evaluation to support annual and long-range planning.

Adolescent Health and Development

Adolescent Pregnancy Rates: Adolescent pregnancy is highly correlated with lack of educational attainment and lasting disadvantage in earning power and economic potential. Teens are less likely to eat correctly, gain sufficient weight during pregnancy, or get early, continuous prenatal care. Teen moms are at greater risk than women over age 20 for pregnancy complications like premature labor, anemia and high blood pressure. The risks are even greater for teens under 15 years of age.

Onset of Sexual Activity: There is a relationship between age of sexual initiation, number of partners, frequency of sexual activity, history of sexual abuse, and a myriad of other risk factors particular to adolescents. In New York State, the 2009 Youth Risk Behavior Survey (YRBS) found the percentage of teens that have experienced sexual intercourse increases with age, from 26.4% of ninth graders to 61.8% of 12th graders. Although these numbers are cause for great concern, they are less than the national average of 31.6% of ninth graders and 62.3% of 12th graders (2009 YRBS). Of New York students responding, 6.2% reported having had sexual intercourse for the first time before the age of 13 as compared to the national rate of 5.9%; 31.5% of New York State high school students describe themselves as currently sexually active, compared to 34.2% nationally.

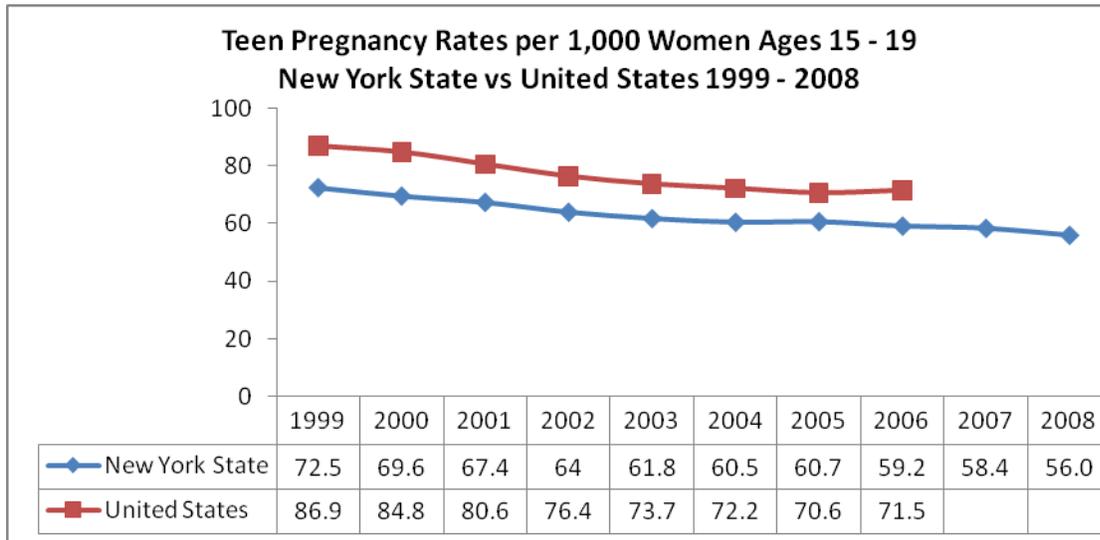
Contraceptive Use: There is often a significant period of time between initiation of sexual intercourse and the choice and utilization of an effective method of contraception. According to the 2009 YRBS:

- The percentage of sexually active New York teens reporting condom use during their last sexual intercourse was 67.7, up from 63.3% on the 1999 survey but below the 70.7% reported in the 2005 survey.
- New York State adolescent males reported a lower use of condoms during their last sexual intercourse than did adolescent females – 67.6% of adolescent males (compared to 67.6% in

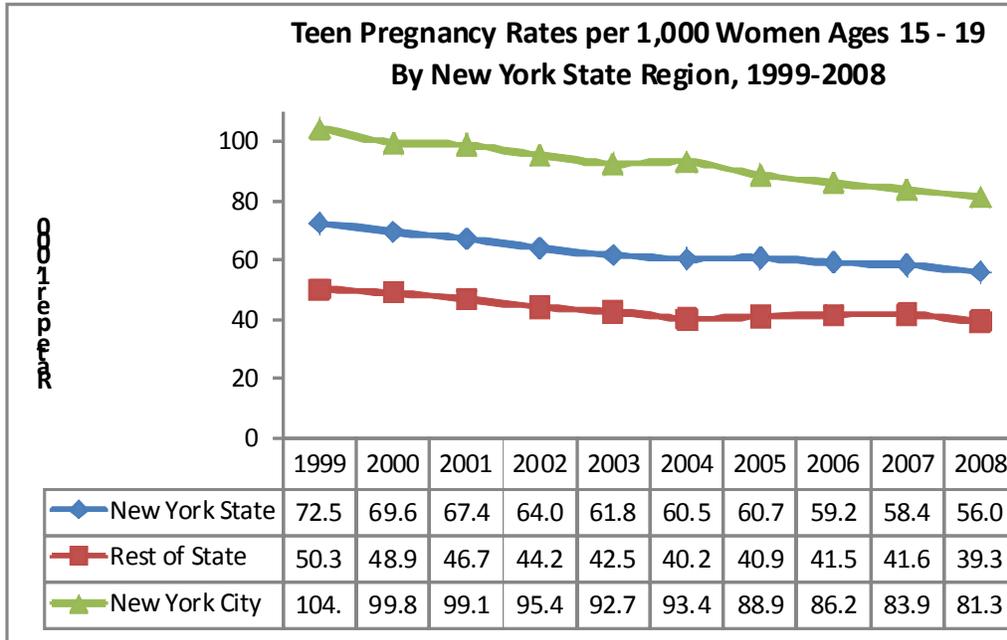
1999 and 72.5 in 2007) and 68.4% of adolescent females (compared to 58.9% in the 1999 survey and 61.9% in the 2007 survey) reported using condoms during their last intercourse.

- In New York State, 17.0% of high school students reported using birth control pills during their last sexual intercourse.
- 26.8% of the adolescent males responding to the survey and 17.7% of adolescent females who responded reported alcohol or drug use at last sexual intercourse. Use of alcohol is generally associated with reduced inhibitions and has a negative statistical correlation with effective use of contraceptives. These data for the 2007 survey were at levels of 26.8% for males and 19.3% for females.
- Although 58.0% of New York State high school students in 2009 reported they never had sex, 8.8% of male students and 3.3% of female students reported having their first sexual intercourse before the age of 13.
- Black high school students were the most likely to report ever having had sexual intercourse (51.7%), followed by Hispanic students (48.2%), White students (39.9%) and Asian students (13.8%). These rates are similar to what was reported in 2007.

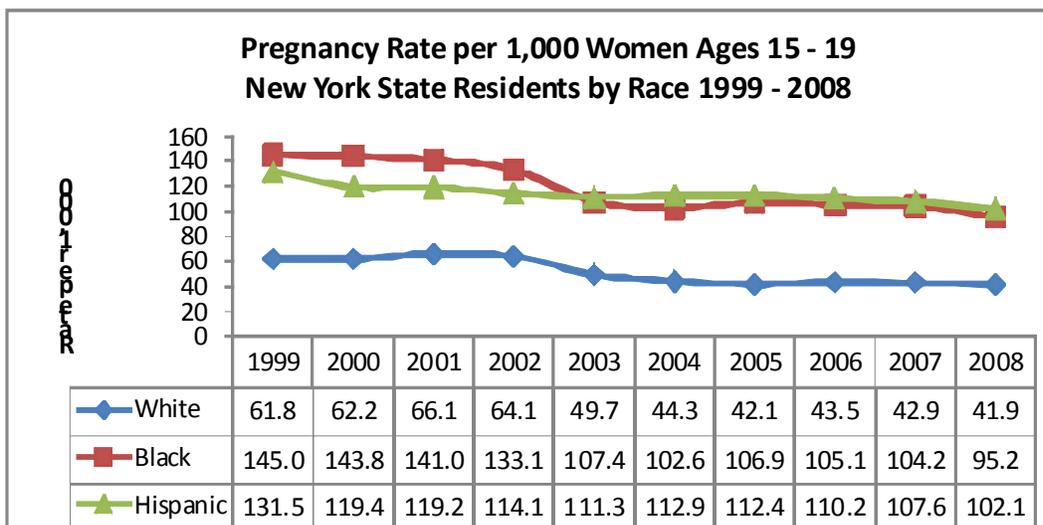
New York’s adolescent pregnancy rate is lower than the national average. However, New York is continuing to address this issue in an effort to make even further gains in decreasing pregnancies in this age group.



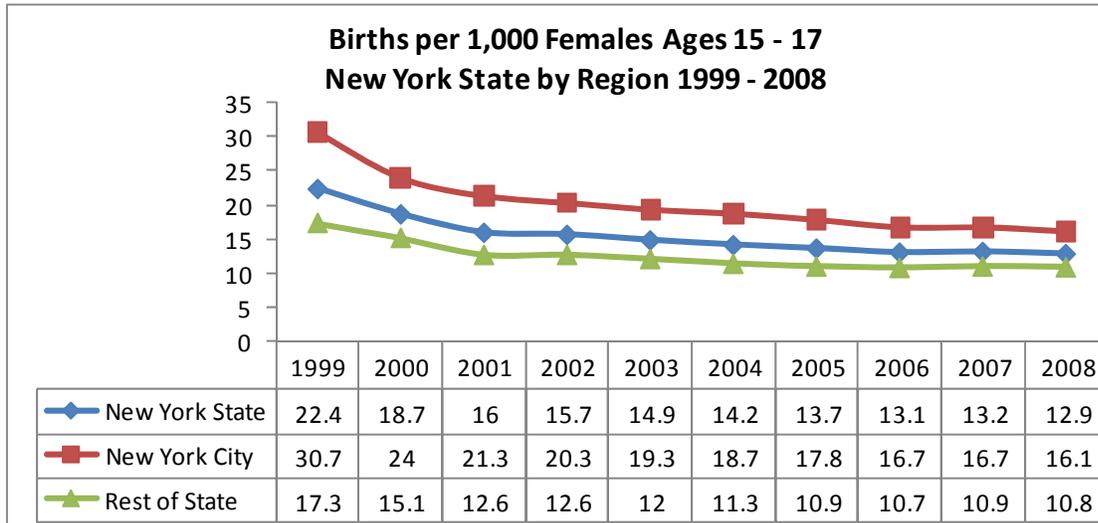
Since 1999, the pregnancy rate for girls aged 15-19 has been decreasing; the 2008 rate of 56.0 per 1,000 is 23% lower than the 1999 rate of 72.5 per 1,000. The teen pregnancy rate in NYC is approximately double the rate in the rest of the state.



Racial and ethnic disparities in teen pregnancy rates continue, although the actual magnitude of the disparity is decreasing. In 2008, the White teen pregnancy rate was 41.9 per 1,000 white teen girls, less than half the rate for Black (95.2) and Hispanic (102.1) teen girls. Rates for all race/ethnicity groups continue to decline. The Black/white ratio of teen pregnancy rates was 2.3 to 1 in 2008.



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



Sexually Transmitted Diseases and HIV: Unprotected, high-risk sexual behavior places individuals at risk for sexually transmitted diseases and HIV. If undiagnosed and untreated, there can be lifelong consequences, including infertility and death. Genital sores caused by syphilis make it easier to transmit and acquire HIV infection sexually. There is an estimated 2- to 5-fold increased risk of acquiring HIV infection when syphilis is present.

HIV/AIDS: As of December 2008, 641 children under 13 and 1,833 children ages 13-19 were living with HIV or AIDS in New York State. Approximately half of these children were males and half were female. About 90% of these cases are attributable to perinatal HIV transmission. Children between the ages of 0 and 19 represent about 2.0% of New Yorkers living with HIV and AIDS. About 90% of High School students over the past decade reported they have ever been taught in school about AIDS or HIV infection. Overall, in 2007, 89% of students reported receiving AIDS/HIV related education, with rates highest among white students at 90%, and at about 85% among Black and Hispanic students.

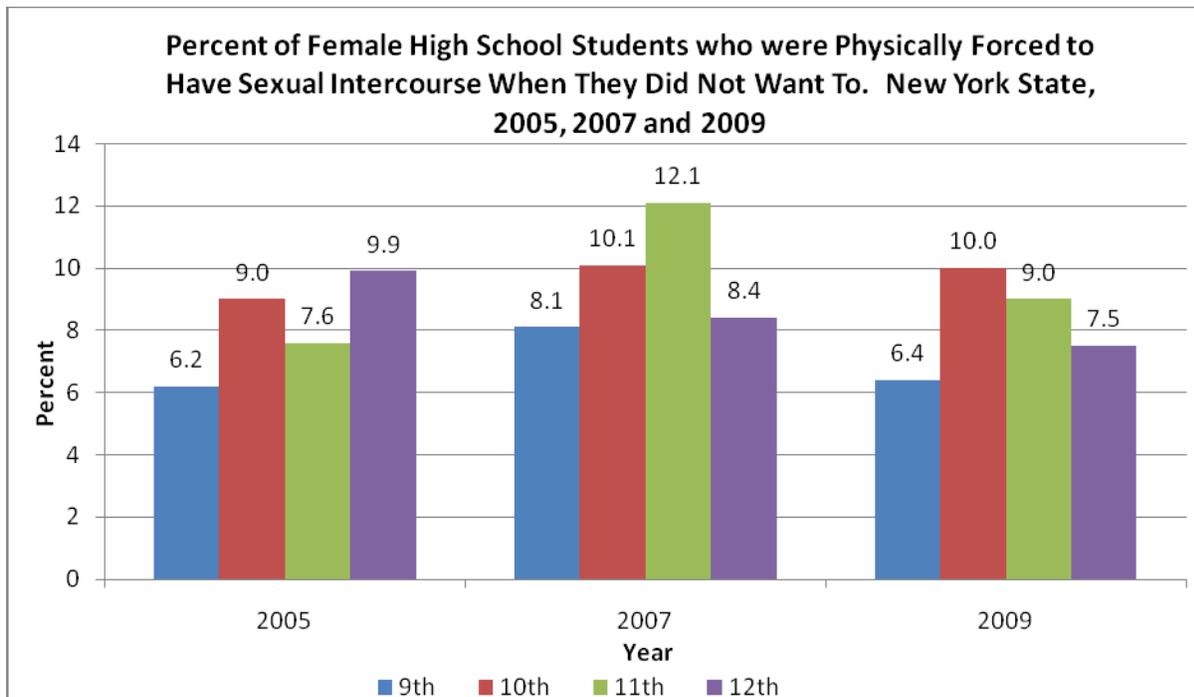
Chlamydia: In 2008, 88,460 cases of Chlamydia were reported in New York State, making it the most commonly reported communicable disease. Chlamydia morbidity has continued to increase since reporting began in 2000. Women are disproportionately affected by Chlamydia. The case rate per 100,000 population for females in 2008 was more than twice the rate for males (623.3 vs. 296.6). Young women had the highest rates of infection. Among females 15-19 in New York State, the infection rate was 3,749.6 per 100,000, and among females aged 20-24, the rate was 3290.3 per 100,000.

Syphilis and Gonorrhea: In 2008, there were 2,576 cases of early stage syphilis in New York State. This was an increase over the 2,222 cases reported in 2007. The bulk of the cases were in New York City and among males. In 2008, 25 cases of congenital syphilis were reported statewide. Of the 25 cases, 19 were reported in New York City and 6 were reported in the rest of the state.

Gonorrhea is the second most commonly-reported STD in New York State. In 2008, 17,120 cases of gonorrhea were reported statewide. The case rate of 90.2 per 100,000 population was slightly lower than the 2007 rate of 93.3 per 100,000. Overall, rates of gonorrhea by sex were similar with 95.9 cases per 100,000 males and 84.9 cases per 100,000 females. Gonococcal infection rates were highest among adolescent and young adults. Statewide, age-specific rates by sex were highest among 20-24 year old males (409.5 per 100,000) and 15-19 year old females (504.1 per 100,000).

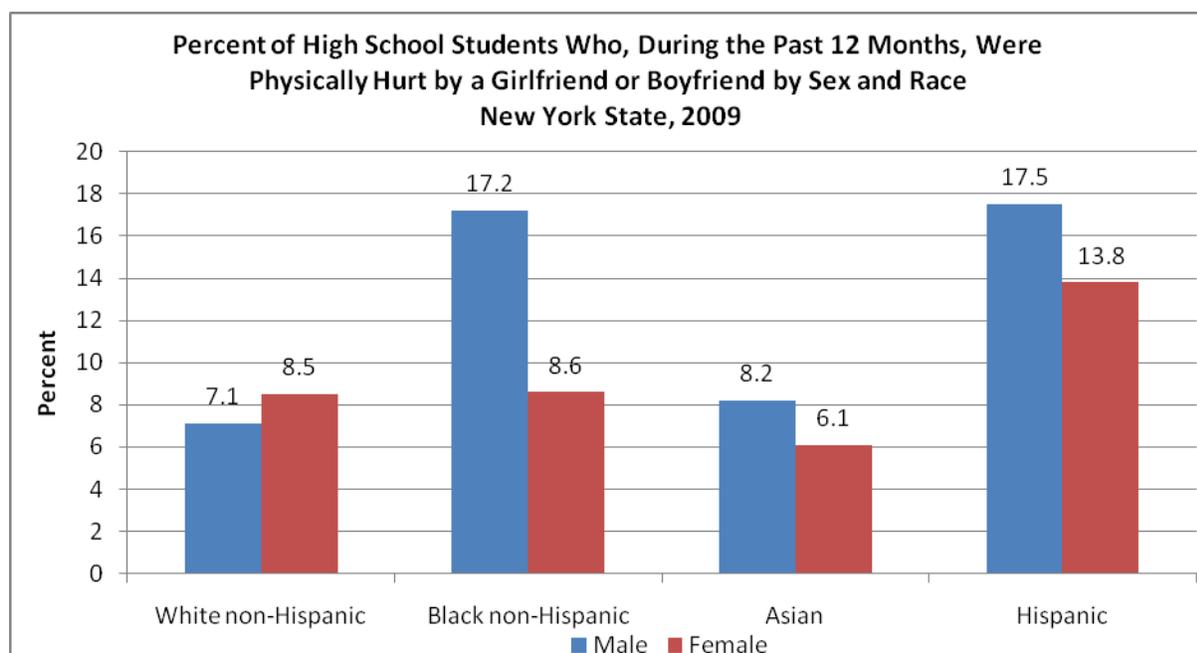
Sexual Assault: According to the U.S. Department of Justice, one of every six American women has been the victim of an attempted or completed rape in her lifetime. About 44 percent of rape victims are women under age 18. Girls 15-19 are four times more likely than the general population to be victims of rape, attempted rape or sexual assault. (Making the Grade on Women’s Health: A National and State-by-State Report Card, 2004 – Fact Sheet: the Health of Teenagers, www.nwlc.org).

According to the 2009 New York State Youth Risk Behavior Survey, about 8% high school students reported they have been forced to have sex when they did not want to in their lifetime. Among males, 6.9% and females 8.3%, reported being physically forced to have sex.



Source: Youth Risk Behavior Survey – 2005, 2007 and 2009

The 2009 Youth Risk Behavior Survey also asked students about physical abuse. About eleven percent of New York high school students reported they were physically hurt (hit, slapped or physically hurt on purpose) by a girlfriend or boyfriend in the past 12 months. Rates were highest among Black and Hispanic males and females. Males were more likely (11.2%) to report physical abuse by a girlfriend or boyfriend as compared to their female (9.6%) counterparts.



- In New York City, the category of homicide is the leading cause of death (26.2%) for the 10-19 age group.
- The 2009 YRBS shows that males in New York were almost three times more likely to carry a weapon to school than females (6.6% vs. 2.4%).
- 6.4% of students responding to the 2009 YRBS reported that they had missed school because they felt unsafe at school or on the way to school, females at the rate of 6.6% and males at the rate of 5.9%.
- 7.5% of students reported being threatened or injured with a weapon while on school property. More males were threatened than females (9.9% vs. 4.7%). Ninth graders were more likely to be threatened or injured than seniors (8.1% vs. 6.7%).
- About a third of the students (29.6%) reported participating in a physical fight. Ninth graders were again more likely to report this behavior than seniors (34.9% vs. 24.5%). 10.6% of students reported being slapped or being physically hurt by a boyfriend or girlfriend. 8.3% of females and 6.9% of males reported being forced to have sexual intercourse when it was not wanted.
- Eighteen percent of students reported ever being bullied on school property during the past 12 months. White females were the most likely to report being bullied (22.7%) followed by white males (18.4%).
- 22.6% of students reported feeling sad or hopeless almost every day for 2 weeks or more. The rate for females (28.3%) was higher than for males (16.5%). 13.3% of students seriously considered attempting suicide. Females were more likely to have considered this than males

(15.1% vs. 11.0%). 7.4% reported attempting suicide one or more times. Females and males attempted at about the same rate (7.2% for males vs. 7.3% for females). 2.8% needed medical care.

- Suicide is the fourth leading cause of death among New York State 10- to 19-year-olds. Suicide accounts for 8.1% of deaths in this age group, and when New York City is excluded, it represents 9.0 of deaths in the rest of the state.
- The 2009 Youth Risk Behavior Survey offers a great deal of information about high school students across the State. A summary of these data follows:

Youth Alcohol and Substance Use: Of respondents to the 2009 YRBS, 41.4% of all students reported having had at least one drink of alcohol in the past 30 days; 20.9% had their first drink before age 13. In 2007, these data were at 43.7% and 22.9%, respectively. Binge drinking (five or more drinks of alcohol in a row on one or more days in the last 30 days) in 2009 was reported by 26.6% of males and 20.7% of females. In 2005, 25.7% of males and 23.8% of females reported binge drinking.

The use of drugs other than alcohol was consistently higher for males than for females. The 2009 survey findings regarding drug use were as follows:

- *34.7% of students reported they had tried marijuana, compared to 35.2% in 2007;*
- *20.9% used marijuana one or more times in the last 30 days, compared to 18.6% in 2007;*
- *7.2% of students reported using cocaine, compared to 7.0% in 2007;*
- *10.8% of students reported they had sniffed glue or breathed the contents of aerosol cans to get high, compared to 11.9% in 2007;*
- *3.9% used heroin one or more times during their life, compared to 3.4% in 2007.*
- *4.8% reported using methamphetamines, compared to 4.4% in 2007;*

Source: New York City Youth Risk Behavior Survey – 2005

Adolescent Health and Development Programs

Adolescent health and development is a major priority within the state's maternal and child health infrastructure. This work represents the Department's efforts to integrate pregnancy, STD and HIV prevention programming. Pregnancy at too early an age disrupts normal adolescent development and often results in significant academic, social and economic costs for the mother, father and child. Adolescent mothers are more likely to drop out of school, remain unmarried and live in poverty. Adolescent fathers are more likely to have lower economic stability, educational attainment and relationships that are more turbulent. The lost social, educational and vocational opportunities and perpetual poverty for the teen mother father shape personal development, relationships, career and educational prospects.

Since its peak in 1993, NYS has had a 39% decline in adolescent pregnancy rates. Despite this trend, New York State continues to have striking regional and racial/ethnic disparities in adolescent pregnancy rates. Pregnancy rates in NYC are at least double the rest of the state. Pregnancy rates are consistently more than double for Black and Hispanic teens than for white teens. Continuous public health efforts must address the regional and racial disparities and risky sexual behaviors that lead to both teen pregnancy and HIV/STDs. Unhealthy adolescent sexual behaviors often continue into adult life, contributing to unintended pregnancies and transmission of HIV and STDs.

The Department addresses adolescent sexual health through the following initiatives in the Division of Family Health, Bureau of Maternal and Child Health:

- The **Community-Based Adolescent Pregnancy Prevention Program (CBAPP)** was established in 1995 to reduce the rate of pregnancy among teens residing in targeted communities. The program began with ten targeted zip codes and has expanded to 237 in 2009. The three program strategies are to provide comprehensive sexual health education to promote abstinence, delay the onset of sexual activity and reduce the practice of risky sexual behaviors among adolescents; expand educational, recreational, vocational and economic opportunities for teens to provide alternatives to sexual activity and develop skills leading to higher earning power and reducing the need for public assistance; and, provide access to comprehensive family planning and reproductive health care services to prevent pregnancies, STIs and HIV.
- The **Adolescent Pregnancy Prevention and Services (APPS)** program was transferred to the DOH from the state Office of Children and Family Services (OCFS) in 2008. The purpose of the APPS program is to address adolescent pregnancy prevention, coordination/community awareness, self-sufficiency and healthy child development. Previous OCFS procurements used Temporary Assistance to Needy Families (TANF) resources to support projects the program.
- **Adolescent HIV Prevention Services (AHPS)** was created in 1994 to expand and strengthen HIV/AIDS prevention services for young people and to support these services with a comprehensive statewide strategy for program development, delivery, and evaluation. Currently, AHPS provides funding to 25 community and school-based programs for HIV prevention and support services to young people age 13-24. Programs deliver services through a variety of strategies including peer education and outreach, performing arts, adventure based learning, parent education, service learning and social marketing. The service providers funded by AHPS serve a diverse cross-section of adolescents and young adults (ages 13 to 24) including heterosexual youth; young people who are lesbian, gay, bisexual or transgender; young men of color who have sex with men; and young people from various socio-economic, racial, and ethnic groups.
- NYSDOH has infused the principles of positive youth development into all of the adolescent sexual health programs. Using this approach, agencies seek opportunities for young people to learn, meet challenges, develop self-confidence and improve their communities. A program that uses a positive youth development approach works with young people to help them realize their full potential.
- The **Assets Coming Together for Youth (ACT) Center of Excellence (COE)** was created to work with youth-serving organizations to provide technical assistance, training and serve as a clearinghouse for resources and best practices to assure consistent services of the highest quality. The COE is the Family Life Development Center of Cornell University in partnership with University of Rochester, NYS Center for School Safety, and Cornell Cooperative Extension of NYC. The COE serves as a resource for research, information and guidance, and forms a bridge between policy and guidance, principles and practice for the Department, its state level partners and communities. The COE is an active member of the Youth Development Team and provides assistance and guidance to many of its member agencies.

- **The Rape Crisis Program** Since 1982, NYSDOH has supported direct services to victims of rape and sexual assault and primary prevention efforts to reduce the incidence of rape and sexual assault. NYSDOH contracts with Rape Crisis Centers to provide crisis intervention and primary prevention education in every county in NYS. The DOH is in the process of adding a primary prevention education component that will assure primary prevention activities across the State through community education and coalition building.

Adolescents and young adults, age 15 to 24 yrs, have the highest rates of gonorrhea and *Chlamydia* in NYS. In 2009, the number of *Chlamydia*, gonorrhea and syphilis cases among young people (ages 15- 24) represented 64% of the total cases reported in the State (while young people ages 15-24 represent only 14% of the total population of NYS). Sexual transmission accounts for an increasing proportion of new HIV infections and STIs are a major factor fueling the HIV epidemic, particularly among young people of color.

STIs and unintended pregnancies are negative outcomes of sexual behavior. HIV infection among young people is largely a result of sexual behavior among men who have sex with men. For newly diagnosed HIV cases among youth in NYS reported in 2007, men who have sex with men account for 52% of the cases among youth age 13 to 19, and 60% of the cases among young people age 20 to 24.

Sexual violence against adolescents and young adults can result in severe physical and psychological problems, following the violent episode and persisting long-term. Results from the U.S. Department of Justice National Violence Against Women Survey (2007) demonstrate that among survivors of sexual assault, 21.6% of women and 48% of men were younger than 12 years old when the first sexual assault occurred, and another 32.4% of women and 23% of men were between 12-17 years. In a comprehensive study conducted with 1,300 NYC high school students, one in six participants (16.2%) reported having experienced sexual and dating violence in their lives. This is higher than the national average of 7-10%. Dating violence is a serious and under-reported problem in the United States.

In the fall of 2008, a study was conducted by the DOH-funded COE at Cornell University (and their partners at University of Rochester School of Medicine, NYS Center for School Safety and New York City Cornell Cooperative Extension). This study was designed 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. Twenty-seven focus groups with 291 participants (age 13-21) were held statewide with consideration given to geographic and participant characteristics, including gender/gender identity and race/ethnicity.

In 2009, the Department convened a symposium on adolescent sexual health through its contract with the COE. The symposium included youth, national and state experts on adolescent sexual health and key stakeholders to review research and best practices, and make recommendations for future programming. Dr. Jonathan Klein, Associate Executive Director of the American Academy of Pediatrics, provided the professional leadership for this event through his role with the COE. The symposium and focus groups provided extensive input from experts and stakeholders to the NYSDOH for future initiatives. Adolescents requested quality, accurate comprehensive sexuality education in schools; and, for the adults in their lives, to be better

informed to provide and support this education. Adolescents and researchers recommended a new approach to sexuality education to convey accurate messages about avoiding pregnancy and STDs/HIV infection, within a broader context including information about healthy relationships and sexual activity, effective communication and decision making. Stakeholders and researchers emphasized the need to provide community health care providers with information and resources on current and emerging adolescent sexual health issues.

The COE formed a youth network that develops materials for the Department and advises on issues important to and relevant to youth in New York State. Communication strategies are also diverse, using social networking sites (e.g., Face book), monthly meetings (with a NYC group) and interaction with groups who have invited COE staff to attend meetings. The COE provided input to all areas of the website (www.nysyouth.net) development. During the initial preparation for the Adolescent Sexual Health Media Campaign, the COE spoke with youth from across the state about the content of the website addressing sexual health.

The COE conducted focus group with parents, guardians, grandparents and other adults in NYS to assess parent needs for talking with their adolescents about sexual health and as a follow up to the ASH focus group project with adolescents. Fifteen statewide parent focus groups were held during June 2009. Five groups (with 42% of participants) were conducted in Spanish.

The COE sponsored a training series for DOH-funded youth-serving providers that highlighted curricula focused on building skills and knowledge necessary for healthy relationships among adolescents designed especially for work with young people who are at risk for early and unplanned pregnancy, who are pregnant, or who are already parenting. The COE has also developed youth forums on violence, abuse and risky sexual behaviors; peer education for violence prevention; conflict resolution training to train peer mediators; and mentoring programs. The COE also provided information to youth serving providers on self-injurious behavior through their website and list serve. The COE updated an article on the ACT for Youth website on non-suicidal self-injury in adolescence and how to proactively address this issue. The COE is providing information on gang-related violence among youth to all adolescent sexual health providers.

Ongoing discussions occur with the Young People's Committee of the New York State HIV Prevention Planning Group (PPG) concerning identified needs of young people relating to their sexual health. Recommendations from the PPG were used to create an educational palm card (in English and Spanish) to be distributed by pharmacies to customers who purchase emergency contraception. The content was developed with input from the PPG's Young People's Committee, Emerging Issues Committee, AIDS Institute, Bureau of Women's Health and Bureau of STD Control. The palm card provides an HIV/STD-related educational message, the New York State HIV/AIDS Information Hotline number and the CDC HIV/STD Testing Resources web site. The palm card also provides toll-free phone numbers for information regarding free, anonymous HIV testing. As of March 2010, over 550 independent and chain pharmacy stores have placed orders and over 47,000 palm cards have been mailed to pharmacies throughout the State.

In November 2006, the DOH launched the Adolescent Sexual Health Work Group (ASHWG) to promote a statewide environment conducive to every adolescent (ages 10 -24) achieving optimal sexual health. The ASHWG is comprised of program representatives whose shared vision and expertise promote and improve the sexual health of adolescents. The work group is comprised of representatives from the AIDS Institute, Office of Health Insurance Programs, Office of Minority Health, Bureau of Maternal and Child Health, Bureau of STD Control, Bureau of Communicable Disease Control, and Division of Family Health Office of the Medical Director.

Within the DOH, the ASH Work Group provides a cross-programmatic forum for assessing and developing strategic responses to identified needs. The Work Group has formed three committees to assess issues related to adolescent sexual health and carry out specific initiatives:

- Access Committee: Identifies ways to increase adolescent access and utilization of sexual and reproductive health services and to reduce barriers to these services
- Prevention/Education Committee: Identifies resources to educate the public and providers and creates resources to promote comprehensive sexual health education
- Surveillance Committee: Utilizes current data to raise awareness of adolescent sexual health issues, to plan and evaluate program and service delivery and to promote policy development

The Surveillance Committee has developed an indicator, calculated at the zip code level, to provide a single, multi-dimensional measure related to adolescent pregnancy and sexually transmitted diseases (STD). The ASH Community Needs Index considers a variety of factors related to these outcomes, including the size of adolescent population, burden (number) of adolescent pregnancies and STD cases, and number of specific demographic and community factors (education, economic, and race/ethnicity indicators) associated with adverse sexual health outcomes. The index identifies high need target communities to prioritize the need for projects and determine the amount of funding projects are eligible to receive in future funding cycles. These high need areas are consistent with areas identified in other programs and are concentrated in the upstate urban areas and specific areas within New York, Bronx, Queens and Kings Counties.

The rich array of community-based programs provides key statewide capacity for effectively addressing needs in this area. In some cases, program restructuring and enhancement is being implemented to more effectively address persistent and emerging needs. Structurally, in the next funding cycle, the CBAPP and APPS programs will be integrated into a single comprehensive adolescent pregnancy prevention initiative that maintains the strengths of both existing programs while incorporating stronger requirements for the implementation of evidence-based educational programming and emphasizing the targeting of services to the highest need areas statewide.

As noted, the new initiative will begin January 1, 2011 and will be targeted to high need communities, with an increased focus on implementation of evidence-based programming. Program outcomes will emphasize core components of comprehensive sexuality education, access to reproductive health services, support for life skills development and a transition through developmental milestones into young adulthood. The CAPP proposal focuses on primary prevention efforts to promote healthy behaviors to decrease adolescent pregnancy and STD rates and secondary prevention efforts for early detection and healthy outcomes. The

initiative will have an enhanced emphasis on reducing disparities through contracting with organizations that are representative of high-need populations and communities.

The ASHWG Workgroup has established additional cross-programmatic priorities, including:

- Development and implementation of guiding principles for adolescent-funded providers on sexual health education.
- Development and maintenance of an inventory of NYSDOH publications relevant to adolescent sexual health, along with the identification of current information and gaps, best practices and new media for sexual health education to share innovative practices with providers and develop new materials/methods.
- Development and application of a community-level needs index that reflects multiple dimensions of key factors including the size of adolescent population, actual burden (number) of adolescent pregnancies and STD cases, and a number of specific demographic and community factors (education, economic, and race/ethnicity indicators) that are significantly associated with adverse sexual health outcomes.
- Collaborative development and implementation of a multi-phasic media campaign focused on comprehensive adolescent sexual health to address the common behaviors that contribute to adolescent pregnancy, STDs and HIV.

A draft strategic adolescent sexual health framework is being developed by the ASH Work Group Leadership Team with representatives from all DOH adolescent sexual health programs. The intent is to identify the components/steps to accomplish a cross-programmatic statewide plan for comprehensive adolescent sexual health to decrease the incidence of unintended pregnancy, STDs and HIV for adolescents and young adults. The framework will promote a statewide environment conducive to every adolescent and young adult to achieve optimal sexual health.

The strategic framework will serve as a blueprint for work within the DOH and with partners outside of the Department to achieve a comprehensive plan. The following framework goals will guide the strategies and activities to:

- Ensure an infrastructure that provides access to quality care for adolescent sexual health
- Improve the quality of sexual health care services for adolescents and young adults
- Increase knowledge and impact sexual health behaviors through comprehensive sexual health education and public information that is reflective of youth input.

Collaborative efforts among programs have guided procurements to improve the sexual health of adolescents and young adults in NYS. The CAPP procurement is aligned with both CBAPP and APPS initiatives to promote healthy adolescent development, enhance life options and skills and prevent initial and repeat adolescent pregnancies.

In coordination with this broader strategic planning infrastructure and framework, key activities have been implemented through specific program initiatives, including:

- The AIDS Institute Adolescent HIV Prevention procurement, “Sexual Health Promotion for Young People through Youth Leadership and Community Engagement,” was released in the fall of 2009. This Request for Applications (RFA) will support sixteen community-based programs designed to address the HIV, STI (sexually transmitted infection) and unintended pregnancy prevention needs of young people (ages 13-24) through youth leadership,

community engagement and community change. The goals of this RFA are to reduce HIV infection, sexually transmitted diseases (STDs) and unintended pregnancies among youth by creating communities that support and promote optimal sexual health for young people.

- A RFA to award funding for adolescent pregnancy prevention funding through a comprehensive initiative that integrates the current CBAPP and APPS programs is under final development, as described above. In preparation for the new adolescent HIV Prevention RFA that begins June 1, 2010 the Adolescent Health staff and the COE are working to develop a multi-level evaluation plan to assess the impact of the newly funded programs. This five year initiative presents unique opportunities for longitudinal evaluation that will identify individual-level and community-level changes. The evaluation plan builds on the strong infrastructure developed by the DOH and COE for data gathering, management and analysis and for utilizing evaluation findings to improve programs. This comprehensive evaluation will inform each of the adolescent health unit initiatives.
- A large scale, statewide media campaign has been implemented in two phases. The first phase, launched in 2008, focused primarily on STD prevention and testing. The second phase, launched in 2010, includes broad adolescent sexual health promotion and prevention messages, and includes a call to action that directs youth to a new Web site (nysyouth.net) that was developed through the COE, with significant input from youth stakeholders. The Web site will be an ongoing resource for youth after the current campaign ends.
- Addressing adolescent sexual health care needs by increasing access to and the utilization of reproductive and sexual health care services is a public health priority. An upcoming procurement will include a component that will expand NYSDOH's capacity to improve the quality of sexual health care services that are provided to adolescents across New York State. This will be achieved by providing professional educational opportunities and resources state-wide for community health care providers (physicians, nurse practitioners and physician assistants) who serve adolescents in primary and specialty care settings through community based training, online educational opportunities and the dissemination of current and emerging health information, clinical tools and other resources.

Since 2006, there have been major changes in the use of funds to support prevention of sexual violence in communities. The DOH has worked with local programs to transition from a focus exclusively on intervention in cases of rape and sexual violence to one that includes primary prevention education programs, by facilitating training and technical assistance and supporting the establishment of community coalitions, in conformance with CDC requirements. The Sexual Violence Primary Prevention Committee meets quarterly to provide input to the DOH on the development of a comprehensive primary prevention and evaluation plan. The Committee is comprised of key state and community partners in the prevention of sexual violence. The ACT for Youth Center of Excellence is another key strength for programming in this area.

The Rape Crisis and Sexual Violence Prevention Program released a RFA, focusing on direct services to Victims of Rape and Sexual Assault and Community-Based Sexual Violence Prevention. The Sexual Violence Prevention component will require applicants to plan, implement and evaluate primary prevention activities in their catchment area. Applicants may propose primary prevention education programs engaging local youth-serving agencies, schools, colleges/universities, and other venues where youth gather; or a community mobilization effort through developing local coalitions to influence factors that lead to sexual violence.

The Office of Mental Health (OMH) is working with NYSDOH to ensure child mortality reviews are conducted in every county and gaps in service identified help shape youth violence prevention programs (including suicide prevention and anti-bullying and the impact on suicide prevention) in communities. Office of Mental Health trained some counties on youth violence prevention programs so they can train school districts in SAFETALK (suicide awareness for everyone), TELL, ASK, LISTEN, and Keep Safe, and Applied Suicide Intervention Skills training (ASIST). OMH provides Post-intervention services and policy direction for schools on suicide prevention. These trainings are also offered to county offices including the county health departments, probation, DSS and youth bureaus routinely, and as part of the state plan for suicide prevention.

DOH/Title V staff continued to collaborate with our state Office of Alcoholism and Substance Abuse Services (OASAS) on substance abuse and alcohol-related prevention policy. Beginning in 1999, OASAS involved multiple human service agencies at the county level in identifying alcohol and substance abuse risk and protective factors, and in strengthening and expanding local partnerships for alcohol and substance abuse prevention. OASAS continued to promote its nationally recognized *Underage Drinking: Not a Minor Problem* Media Campaign, which includes helpful information for youth, parents, colleges and communities. Title V programs promoted the campaign to health care providers. OASAS is conducting the first ever statewide assessment of youth (7th -12th grade) risk and protective factors for problem behavior. These factors predict levels of substance use, school drop-out, violence, delinquency and gambling, behaviors that are also measured by the survey. Surveys were administered in sampled schools every two years starting in the Fall of 2008. Participating NYS counties, schools, service providers and prevention coalitions will be able to compare their risk and protection factor levels to county and state norms, then tailor their prevention service plans to better support healthy youth development.

Youth Tobacco Use: Tobacco use is a major risk factor in adolescents. According to the 2006 New York State Youth Tobacco Survey, the current use of cigarettes among middle school and high school students is approximately 4.1% and 16.3% respectively. Among high school students, the current use of cigarettes for white, Black and Hispanic students was 20.1%, 7.9% and 13.4%, respectively.

The Youth Risk Behavioral Risk Survey (YRBS) also queries students about smoking. During the past decade, there has been significant progress in reducing teen smoking.

- Of students participating in the Youth Risk Behavior Survey in New York in 2009, 37.2% reported they had tried smoking sometime in their life. This is down slightly from 45.4% in 2009 and 45% lower than the 68.1% reporting this in 1997.
- The percentage of high school students who reported smoking a whole cigarette before the age of 13 was about 8% in 2009, less half of the 22.7% reporting smoking by age 13 in 1997.
- The current smoking rate (smoking one or more cigarettes in the last 30 days) among NYS high school students in 2009 of 14.8% was 55% lower than the 1997 rate of 32.9%.
- In 2009, Hispanic students had the highest current smoking rate (20.8%), followed by White (14.9%), Asian (9.1%) and Black students (7.7%). Both White and Black students have

reduced their smoking rates by at least 50% since 1997. The rate among Hispanic students, however, has been increasing since 2005 when it was 12.3% to the current high rate of 20.8%.

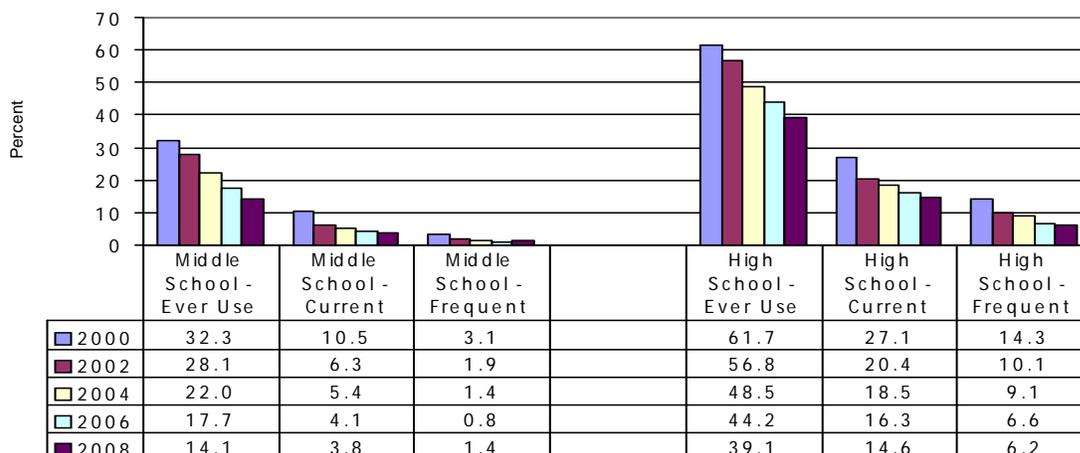
- Female students had a higher current smoking rate (12.7%) than Male students (16.2%) in 2009. Both males and females have cut their smoking rates in half since 1997.
- Of current student smokers in 2009, 38.8 percent of students tried to quit during the past 12 months.

Among New York City high school students in 2005, 11.2 percent of students reported smoking on one or more of the past 30 days. White students were the most likely to report smoking (29.3%) followed by Hispanic (11.4%) and Black (7.3%) students. In addition to their current smoking habits, New York City high school students were asked if they think they will be smoking 5 years from now. About 13 percent answered yes. Among white students the percent was even higher (18.6%). Of Black and Hispanic NYC high school students, 11.0 and 12.9% respectively, predicted they would be smoking 5 years from now.

The Youth Tobacco Survey (YTS) is also administered in New York State on a biannual basis to students in sixth through twelfth grades, and supplements information obtained through YRBS. The YTS estimates tobacco use, exposure to environmental tobacco smoke, knowledge and attitudes about tobacco, access to tobacco products by minors, counter-marketing and tobacco cessation in middle and high school students. The results of the 2000, 2002, 2004, 2006 and 2008 YTS show important declines in youth tobacco use. Among New York State middle school students, current use of tobacco declined from 10.5% in 2000 to 3.8% in 2008. High school students had a decline in current use (from 27.1% to 14.6%), frequent use (from 14.3% to 6.2%) and ever use (61.7% to 39.1%).

Middle & High School Ever, Current, & Frequent Use of Cigarettes

Source: NYS Youth Tobacco Survey, 2000, 2002, 2004, 2006 and 2008



Tobacco Control Program

The New York State Department of Health's Tobacco Control Program envisions all New Yorkers living in a tobacco-free society and works to reduce the morbidity and mortality, and alleviate the social and economic burden caused by tobacco use in New York. This mission is achieved through the following statewide and local actions:

- Changes to the community environment that support the tobacco-free norm and reduce the social acceptability of tobacco use;
- Cessation interventions that promote cessation from tobacco use and increase access to and delivery of tobacco dependence treatment;
- Health communications to decrease the social acceptability of tobacco use and educate community members and decision makers about the hazards and costs of tobacco use, as well as effective strategies to prevent and reduce tobacco use;
- Surveillance and evaluation to monitor program progress and improve program quality;
- Statewide coordination of these strategies.

Preventing and reducing tobacco use are extremely important public health actions that can be taken to improve the health of New Yorkers. Tobacco use and dependence is the leading preventable cause of morbidity and mortality in New York State (NYS) and in the U.S. Cigarette use alone results in an estimated 443,000 deaths each year in the U.S., including 25,400 deaths in New York State. Second-hand smoke kills another 2,600 New Yorkers every year. There are 389,000 children alive today who will die prematurely from smoking. More than half a million New Yorkers currently suffer from serious smoking caused diseases, at a cost of \$8.17 billion in health care expenditures annually. The list of illnesses caused by tobacco use is long and contains many of the most common causes of death, including heart disease and stroke, many forms of cancer, and lung and vascular diseases.

Program Objectives related to the MCH population include:

- By the year 2013, reduce the prevalence of smoking in New Yorkers so that:
 - The percent of adults who smoke is no more than 10%* (Baseline: 18.2%, BRFSS, 2006)
 - The percent of adolescents who smoked in the past month is no more than 10.0%.** (Baseline: 16.3%, New York State Youth Tobacco Survey, 2006)
 - 41 per 100,000 for females* (Baseline: 53.9 per 100,000, NYS Cancer Registry, 2000-04)

* Healthy People 2010 Objective

** Since Healthy People 2010 Objective was met, a new objective was set as part of the Tobacco Control Plan.

Program's strategic plan: To reduce tobacco use and the addiction, disease, and premature death it causes, the NY TCP must intervene by dismantling the environmental structures that support and promote tobacco use, preventing the susceptible host from initiating tobacco use, motivating the user to quit, and protecting the nonuser from secondhand smoke. Modifying the agent and constraining the vector are areas the NY TCP will have to address in order to make additional progress.

The strategies to achieve program objectives are described in One Million Fewer Smokers by 2010 (PDF, 4.17MB, 12pg.) These include the following efforts:

- Mass media, public relations and media advocacy to motivate tobacco users to stop, promote smoke-free homes, promote effective tobacco control community policies, expose tobacco industry propaganda, and reduce the social acceptability of tobacco use
- Work with health care organizations and providers to implement systems to screen patients for tobacco use and prompt providers to offer advice and assistance to quit. The Department provides cessation support and services through the NYS Smokers' Quitline and other venues
- Use the most current research findings to drive program activities
- Work collaboratively with state and national partners to ensure program goals are met.
- Community action that de-normalizes tobacco use, decreases the social acceptability of tobacco use, and establishes and supports a tobacco-free norm.

New York State cigarette excise tax is \$2.75 per pack, which is the fourth highest in the nation. Raising the price of cigarettes discourages youth smoking. New York state law requires that all tobacco products be kept behind the counter which further discourages youth access. Enforcement of a tough indoor air law continued, banning smoking in public places, including restaurants and bars. New York makes smoking cessation assistance available through a toll-free hotline, which provides free coaching, and nicotine replacement therapy to eligible callers and purchase of smoking cessation products is available through Medicaid.

The Division of Chronic Disease Prevention and Adult Health Tobacco Control Program funded contractors' work with local leaders to educate them on the public health benefits of passing local ordinances on smoking in public places, removing tobacco products from the reach of youth, and reducing tobacco advertising in areas frequented by youth. The Tobacco Control Program continues to fund Youth Action Partners to work with youth to become activists in the movement to change community norms related to tobacco use. These 16 programs engage middle and high school youth in activities aimed at de-glamorizing and de-normalizing tobacco use in their communities. The State also funds local Tobacco Control Community Partnerships in every county of the state. These partnerships work to change the community environment to support the tobacco-free norm. Partnerships engage local stakeholders, educate community leaders and the public, and mobilize the community to strengthen tobacco-related policies to restrict the use and availability of tobacco products and tobacco product promotion and limit opportunities for exposure to second hand smoke. Medicaid Prenatal Care, WIC and the Community Health Worker Programs assess prenatal clients for tobacco use and refer to or provide smoking cessation and other counseling/health teaching.

In February 2010, the tobacco control program received federal stimulus funding to reduce youth smoking prevalence and tobacco product sales to minors by reducing the impact of retail tobacco product marketing on youth. This is accomplished by Community Partnership and Youth Action contractors implementing a set of educational activities to increase awareness of the impact that tobacco product marketing and tobacco retailer density have on youth smoking.

Leading Causes of Death for Children: The leading causes of death for children, birth to 19 years in 2008 for New York State, New York City, and the rest of the state are reflected on the table that follows.

The figures show:

- Among children aged 1-9, unintentional injury is the most likely cause of death in both New York City (19.9%) and New York State-excluding NYC (22.1%). Homicide and legal intervention remains in the top five causes of death for this age group.
- Unintentional injuries are the leading cause of death among children ages 10 to 19 years in New York State – excluding New York City (39.7%) followed by homicide and legal intervention (10.7%). In New York City, the category of homicide and legal intervention is the leading cause of death (26.2%) for this age group while unintentional injuries (20.2%) were next most common cause of death.
- Suicide is the fourth leading cause of death among New York State 10- to 19-year-olds. Suicide accounts for 8.1% of deaths in this age group, and when New York City is excluded, it represents 9.0 of deaths in the rest of the state.

LEADING CAUSES OF DEATH, 2008					
FOR CHILDREN BIRTH TO AGE 19 YEARS and TOTAL POPULATION					
New York State Children					
All Ages			Under Age 1		
Cause	Number	Percent	Cause	Number	Percent
All Causes	147,469	100.0	All Causes	1,359	100.0
Diseases of the heart	49,137	33.3	Cond Orig in Perinatal Period	722	53.1
Malignant Neoplasms	35,101	23.8	Congenital Anomalies	260	19.1
CLRD	6,841	4.6	SIDS	74	5.4
Cerebrovascular disease	5,883	4.0	Unintentional Injuries	34	2.5
Unintentional Injuries	4,988	3.4	Gastritis, Enteritis, et al	23	1.7
Ages 1 – 9 Years			Ages 10 – 19 Years		
Cause	Number	Percent	Cause	Number	Percent
All Causes	349	100.0	All Causes	663	100.0
Unintentional Injuries	74	21.2	Unintentional Injuries	214	32.3
Malignant Neoplasms	51	14.6	Homicide & Legal Intervention	110	16.6
Congenital Anomolies	50	14.3	Malignant Neoplasms	60	9.0
Homicide and legal intervention	19	5.4	Suicide	54	8.1
Diseases of the Heart	15	4.3	Diseases of the Heart	35	5.3

New York State – Exclusive of New York City					
All Ages			Under Age 1		
Cause	Number	Percent	Cause	Number	Percent
All Causes	94,468	100.0	All Causes	739	100.0
Diseases of the Heart	28,073	29.7	Cond Orig in Perinatal Period	386	52.2
Malignant Neoplasms	22,863	24.2	Congenital Anomalies	140	18.9
CLRD	5,214	5.5	SIDS	62	8.4
Cerebrovascular disease	4,323	4.6	Unintentional Injuries	18	2.4
Unintentional Injuries	3,401	3.6	Septicemia	12	1.6
Ages 1 – 9 Years			Ages 10 – 19 Years		
Cause	Number	Percent	Cause	Number	Percent
All Causes	208	100.0	All Causes	411	100.0
Unintentional Injuries	46	22.1	Unintentional Injuries	163	39.7
Malignant Neoplasms	29	13.9	Homicide & Legal Intervention	44	10.7
Congenital Anomalies	28	13.5	Malignant Neoplasms	37	9.0
Homicide & Legal Intervention	11	5.3	Suicide	37	9.0
Diseases of the Heart	10	4.8	Diseases of the Heart	22	5.4
New York City					
All Ages			Under Age 1		
Cause	Number	Percent	Cause	Number	Percent
All Causes	53,001	100.0	All Causes	620	100.0
Diseases of the Heart	21,064	39.7	Cond Orig in Perinatal Period	336	54.2
Malignant Neoplasms	12,238	23.1	Congenital Anomalies	120	19.4
Pneumonia	2,272	4.3	Unintentional Injuries	16	2.6
CLRD	1,627	3.1	Gastritis, Enteritis, et al	14	2.3
Diabetes Mellitus	1,607	3.0	SIDS	12	1.9
Ages 1 – 9 Years			Ages 10 – 19 Years		
Cause	Number	Percent	Cause	Number	Percent
All Causes	141	100.0	All Causes	252	100.0
Unintentional Injuries	28	19.9	Homicide & Legal Intervention	66	26.2
Malignant Neoplasms	22	15.6	Unintentional Injuries	51	20.2
Congenital Anomalies	22	15.6	Malignant Neoplasms	23	9.1
Homicide & Legal Intervention	8	5.7	Suicide	17	6.7
CLRD	6	4.3	Diseases of the Heart	13	5.2
			Congenital Anomalies	13	5.2

Risk for Unintentional Injuries: According to the survey, more than four out of five (80.5%) students who rode bicycles in the past 12 months reported they never or rarely wore a bike

helmet. Students at highest risk were younger (83.9% of ninth graders vs. 77.9% for seniors), and male students were less likely to wear helmets (84.0%) than female students (76.4%). About 12% reported on the survey that they never or rarely wore seatbelts when in a car driven by someone else. Twenty-three percent reported this behavior in 1997. Eight percent reported they had driven a car or other vehicle when drinking alcohol; males were more likely to report doing so than females (10.9% vs. 5.2%).

The Division of Chronic Disease Prevention and Adult Health, Bureau of Injury Prevention identifies and monitors where and why injuries occur across the state and develops programs to prevent them. It consists of unintentional injury prevention, violence prevention and injury surveillance programs. The most recent data available shows that injuries are the leading cause of death for New Yorkers ages 1-44 years and are among the top causes of death for all other age groups. Almost 7,000 New Yorkers die every year because of injury. Approximately 125 children between 0-19 years of age die because of a motor vehicle-related incident each year. Additionally, injuries are consistently among the leading causes of hospitalization for New Yorkers of all age groups. More than 150,000 individuals are injured severely enough to require hospitalization annually. Approximately 2,677 children between the ages of 0-19 years are injured severely enough in a motor vehicle-related incident to require hospitalization annually. Another 1.5 million injured New Yorkers are seen in emergency departments every year. Approximately 27,788 children between 0-19 years are treated and released from an emergency department each year for a motor vehicle-related injury.

Childhood Injury Prevention Program

The Childhood Injury Prevention Project thrived during the 2009-10 grant year with successful injury prevention coalitions established at the local level reaching out to diverse segments of the community to ensure the populace is well informed on issues related to childhood injury prevention. The Bureau of Injury prevention performed traffic related research and conducted surveillance of passenger, bicycle and pedestrian safety in NYS. The Bureau continued to represent the Department on the Governor's Traffic Safety Committee.

The Bureau of Injury Prevention has a long history of collaborating with groups, organizations and agencies to determine their needs and the needs of the public. In response to their requests the Bureau is completing development of five tool kits and 48 fact sheets to provide up to date data, best practices and evidence-informed programs to reduce unintentional injuries, particularly traffic related, for medical providers, researchers, educators and consumers. The toolkits include Shaken Baby Syndrome prevention, fire safety, falls prevention, child passenger safety, and bicycle safety. The toolkits will be available on the department website and in hard copy upon request.

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

and provide the tools necessary to develop strategies for childhood policy promotion on the state and local level.

A Child Injury Prevention Policy Subgroup of the larger Injury Community Planning Group has met to discuss and prioritize policy initiatives of importance to reduce the risk of injury in NYS families with children from 0-19 years. A Child Injury Policy Plan is being developed including the relevant data, evidence-informed strategies and best practices and prioritized list of policies and timeline.

In December 2008, the WHO/UNICEF and the CDC issued reports about the problem of childhood unintentional injuries in the world and the US. In response to the reports, the Bureau of Injury Prevention developed the Child Injury Prevention Project to assist LHDs, hospitals, providers, caregivers and parents in preventing unintentional childhood injuries. These injuries are preventable and the Bureau is sharing the evidence-based strategies with the public, LHDs and hospital staff to reduce the risk of injury and disability.

Key strengths of the program include strong partnerships with community and state level organizations with a focus on children and their families, such as OCFS, NYS Safe Kids Coalition, and the Governor's Traffic Safety Committee. Grant funding support is limited and therefore continued support for the Child Injury Prevention project may not be sustainable in the long term, however, identification of new funding streams is ongoing.

The Bureau of Injury Prevention will continue to conduct a Childhood Injury Prevention Campaign. As requested by stakeholders in LHDs and other community-based organizations, regional training workshops will be conducted in four locations across the state during 2011. The purpose of the workshops will be to educate practitioners about the usefulness of policy measures to support evidence-informed interventions and best practices to reduce the risk of childhood injury. Partners participating in the Child Injury Prevention Policy Subgroup (CIPPS) will provide expertise and support by encouraging their local offices to participate. The CIPPS will complete a Child Injury Policy Plan to guide future efforts for addressing child policy initiatives.

A one-day traffic safety symposium will be held to educate stakeholders about the risk of sustaining a traumatic brain injury from a motor-vehicle related incident. Relevant data and evidence-informed strategies and best practices will be shared with the participants.

Oral Health

Cleft Lip and Palate: During 2002-2006, 1595 children (over 300 per year) in this state, at a rate of 12.9 per 10,000 live births, were born with cleft lip, palate or both.

The prevalence of Cleft lip and palate is somewhat higher among males as compared to females and among non-Hispanic Whites. New York has an effective mechanism for identifying, recording, and referring these infants for treatment. Cleft lip and palate are eligible conditions under the Physically Handicapped Children's Program (PHCP) and the Dental Rehabilitation component of PHCP.

**Prevalences of Oral Clefts (BPA=749.x) per 10,000 live births
by birth year, sex & race, New York State, 2002-2006**

Birth year	Total children	Total Prevalence	Male	Female	Prevalence Ratio (M\F)	Non Hispanic White	Non Hispanic Black	Hispanic	Other & Unknown Race	Mothers Age <35yrs	Mothers Age >=35yrs
2002	332	13.2	14.8	11.6	1.3	14.2	9.6	12.9	15.0	12.8	15.2
2003	317	12.5	13.6	11.4	1.2	12.9	9.5	12.6	14.8	12.4	13.2
2004	290	11.8	12.3	11.2	1.1	13.2	7.5	12.2	10.9	12.5	8.8
2005	314	12.9	12.8	13.1	1.0	13.4	8.9	12.9	17.7	13.5	10.9
2006	342	13.9	13.4	14.4	0.9	15.5	10.7	12.0	15.7	13.0	17.5
All	1595	12.9	13.4	12.3	1.1	13.8	9.2	12.5	14.8	12.8	13.1

Oral Health Status of Children: According to a survey of 3rd grade children conducted during 2002-2004 by the New York State Health Department in collaboration with many partners, the prevalence of dental caries was 54.1%. The estimated percent of children with untreated caries was 33.1%. The *Healthy People 2010* target for caries experience and untreated caries for 6-8 year old is 42% and 20% respectively. Consistently, both caries experience and untreated caries were more prevalent in the low-income group, and the use of sealants was low. Therefore, the Department has prioritized low income schools for targeting prevention interventions.

Health Systems Capacity Indicator 7B: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Annual Objective and Performance Data	2002	2003	2004	2005	2006	2007	2008
Annual Indicator	35.8	35.2	36.3	38.9	44.3	46.4	47.8%
Numerator	124,393	134,265	140,454	144,365	159,486	166,217	174,234
Denominator	347,546	381,935	386,892	370,657	360,268	358,116	364,167

The percentage of EPSDT-eligible children 6 through 9 years of age receiving dental services has increased each year since 2003. However, despite improvements in the provision of dental services to low income children, NYS remains below the *Healthy People 2010* target of 56%. New York State is committed to achieving optimum oral health for all New Yorkers.

National Performance Measure 9: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth*

Annual Objective and Performance Data	2003	2004	2005	2006	2007	2008	2009
Annual Performance Objective	50	60	40	30	35	40	28
Annual Indicator	38.2	27.0	27.0	27.0	27.0	27.0	27.0
Numerator	10,534	10,534	10,534	10,534	10,534	10,534	10,534
Denominator	39,014	39,014	39,014	39,014	39,014	39,014	39,014
Is the Data Provisional or Final?		Final			Provi-sional	Provi-sional	Provi-sional

Notes - 2010

2004 data is being used as a proxy for 2009. Data are from the 2002-2004 New York State Oral Health Surveillance System which surveyed 10,534 students from 272 schools. A new survey is currently being conducted, and therefore the 2009 data should be available in late 2010.

Tooth decay, the most common chronic childhood disease impacts children’s functioning, including eating, growth and speaking and learning. In the US, children are estimated to lose over 51 million school hours annually because of dental problems and dental visits. In a report titled Oral Health in America, the Surgeon General concluded that a “silent epidemic” of oral and dental diseases is affecting some population groups. The report noted profound disparities in oral health among poor children.

Even though dental sealants are effective in preventing dental decay, their rate of utilization among children and adolescents is below the Healthy People 2010 objective and Maternal and Child Health Block Grant Performance Measure of 50%. Nationally, the prevalence of dental sealants among 6-19 year old children is about 32%. A survey of third grade children in New York State showed that the prevalence of dental sealant was 27%, which is below the Maternal and Child Health Block Grant Performance Measure of at least 50% of children with a dental sealant on a molar tooth.

Significant disparities were found by geographic area and socioeconomic status in the prevalence of dental caries, untreated decay, and sealants. Low income children and children in inner cities and rural areas are more likely to have caries and untreated decay and are least likely to receive dental sealants. The use of dental sealants was also found to be significantly higher among children in schools with a dental sealant program (68%) compared to those in schools without a program (33%).

The application of dental sealants is a reimbursable expense under the New York State Medicaid Program and can be applied to children between five and fifteen years of age and, if needed, reapplied every three years. An analysis of 2006 Medicaid claims data showed that approximately 6% of all Medicaid-eligible 8-9 year old children had received sealants. The mean number of sealant claims per child was not uniform across New York counties and varied from a low of 0 claims in Hamilton County to a high of 0.4 claims in Otsego County (maximum is 4).

For more than 25 years, the Department of Health has promoted school-based dental sealant programs in targeted areas to increase the prevalence of sealants. Currently, a total of 42 school-based dental health center programs provide oral health education, dental examinations, prophylaxis, sealants and referrals for needed treatment services to children at 625 schools in high need areas throughout the State. This represents services being available at 24.2% of all schools eligible for a sealant program. The Centers for Disease Control and Prevention (CDC) has developed criteria for targeting school-based dental sealant programs to reach the greatest number of children in high need areas most affected by dental caries and untreated decay, and least likely to have sealants. School-based dental sealant programs target schools in urban areas where 50% or more of the student population is participating in the free or reduced-cost lunch program. In rural school districts, sealant programs are targeted to schools in which the median family income is at or below 235% of the federal poverty level. An analysis of elementary school lunch and median family income data from the National Center for Education Statistics of the U.S. Department of Education was conducted to assess the number of schools that meet the CDC criteria. Based on these criteria, of the 4,669 elementary schools in New York State, 2,316 (50%) are eligible for sealant programs.

To assess the attitude of dentists toward the use of sealants, analysis of a survey of private dentists in general practice was conducted. Several actions were identified to promote utilization of dental sealants among private dentists. These include expansion of school-based sealant programs, increasing awareness about sealants through education campaigns for parents, and targeting high risk children, the last two of which can be accomplished through expanding school-based sealant programs.

A Request for Applications (RFA) for school-based dental sealant programs in underserved, high need areas of the state is under review and is anticipated to be issued early summer 2010. The Bureau plans to issue an RFA to promote the use of dental sealants, and establish and execute contracts with new providers for the creation of school-based dental and sealant programs. A grant application to HRSA is pending for the purchase of dental equipment. If the HRSA grant application is funded, then the Bureau will be able to support additional projects. Webinars will be conducted to provide training for dental hygienists regarding the use of dental equipment.

In addition, 31 projects are funded in high need underserved areas for preventive oral health services focused on maternal and child health populations. The majority of projects provide preventive dental services to children through school-based and school-linked dental programs and ensures that more children have a dental home and access to comprehensive dental treatment programs. A HRSA supported grant focuses on increasing access to, and utilization of, dental services by children. The state Dental Rehabilitation Program provides access to orthodontic services for children with physically-handicapping malocclusions.

Despite dramatic improvements in the oral health of residents during the past 50 years, oral diseases still affect a large proportion of the population. Recognizing that new vehicles for promoting oral health and preventing disease, improving the utilization of effective preventive measures and dental services, forging and sustaining public and private partnerships, and improving the measurement and tracking of oral diseases and risk factors are essential for controlling chronic diseases, the Bureau of Dental Health has worked collaboratively with a wide

variety of stakeholders to develop a comprehensive strategic plan to promote oral health and prevent disease. The *Oral Health Plan for New York State* serves as a blueprint for achieving optimal oral health for all New Yorkers.

The Oral Health Plan that was developed in collaboration with the New York State Public Health Association and stakeholders from across the state is in the final year of implementation and is in the process of being evaluated for the accomplishment of all goals and objectives. Evaluation results, findings from the analysis of oral health data, plus ongoing collaborations with community partners and stakeholders will be used to craft a new Oral Health Plan for the next five years. The new plan will address the needs identified above, as well as any additional needs identified by stakeholders.

The report *Oral Health Plan for New York State* serves as a blueprint for achieving optimal oral health for all New Yorkers. The New York State County Health Assessment Indicator (CHAI) Reports consist of a series of tables presenting selected indicators of oral health for all counties in New York State. Additionally, all local county health departments, hospitals, public health partners and other key stakeholders currently working together on the implementation of the State's Prevention Agenda will be provided complete data sets and reports generated from the joint Bureau of Dental Health-American Dental Association Workforce Project and requested to provide feedback. The reports and data sets will serve to guide the State and community partners in identifying oral health disparities, gaps in dental services, and high risk population groups and in developing targeted interventions and plans to best address the oral health needs of vulnerable New Yorkers.

A report titled *The Impact of Oral Disease in New York State* provides an overview of the oral health status of New Yorkers and disparities in oral health and is available on the Department's public website.

To assist in implementation of the Plan, the oral health infrastructure was strengthened by formation of the New York State Oral Health Coalition and by inclusion of oral health objectives in the State's Prevention Agenda. The New York State Oral Health Coalition is comprised of individuals representing themselves and individuals representing institutions, agencies, or organizations who share a common interest in oral health and access to care. The Sub-Committee meets regularly to implement sections of the plan relating to access to oral health care. Strategies for improving access to dental care are addressed in the NYS Oral Health Plan and by the Oral Health Coalition's Access to Care Sub-Committee. The Sub-Committee meets regularly to implement sections of the plan relating to access to oral health care.

The Department will continue to work closely with the NYSOHC, community partners and key stakeholders on implementation of the final year of the current Oral Health Plan, as well as on future activities and initiatives. The NYSOHC established six different standing committees focused around specific goals and objectives, with committee members working toward the accomplishment of all listed objectives. The NYSOHC has been a valuable resource in enabling the State to move forward in meeting many of its oral health goals and objectives. Issues related to the dental workforce and several preventive strategies remain to be addressed. New

collaborations and the oral health training programs provided during the past two to three years have also contributed to accomplishment of many Plan objectives.

Several statewide initiatives were recently implemented to ensure that children have opportunities and resources needed to achieve and maintain optimal oral health. ***The Prevention Agenda for the Healthiest State*** includes decreasing dental caries disease among third grade children as a public health priority. To increase access to oral health care for children and identify at risk children in need of treatment services, NYS passed legislation effective with the start of the 2008-09 school year requiring public schools to request a dental health certificate for students entering grades K, 2, 4, 7, and 10. The Bureau compiled a list of dental clinics willing to accept referrals from schools and a website was developed <http://www.nyssmiles.org> for public information.

The school dental health certificate is opening the doors for many low income children in accessing dental care and establishing a dental home.

The State Medicaid Program approved quarterly applications of fluoride varnish by dental and child health care professionals for children under seven years of age. This change should result in more low income infants and children receiving oral health services and timely identification and treatment of early signs of dental caries disease. State Oral Disease Prevention Program and Targeted Oral Health Services Systems. Both of these grant-funded programs target the MCH population for increased access to and use of dental services and the reduction of disparities in oral health. To assess the availability of dentists, the Bureau of Dental Health in collaboration with the Primary Care Office and the American Dental Association, is developing a Children's Oral Health Atlas. It will facilitate the identification of Dental Health Professional Shortage areas.

Oral health needs assessments are conducted by gathering and utilizing a variety of data from diverse sources. Data sources include surveys of third grade and Head Start children. Plans are underway to expand the survey of 3rd grade children to include New York City and additional schools in Upstate New York. Data will be made available to community partners and local health departments in order to better target oral health services to those most in need. Data from the third grade survey will be analyzed and a report will be provided to counties. A number of other data sources are reviewed. Where possible, data are further stratified by age, race/ethnicity and county or major metropolitan area to identify disparities in oral health status, utilization, or access to care. Access to dental care and the geographic location of practicing dentists and dentists active in the Medicaid Program are available from a special joint project undertaken with the American Dental Association.

Grant funding from the CDC and HRSA (CDC State Oral Disease Prevention Program and HRSA Targeted Oral Health Services Systems grants) makes it possible for the State to continue to target the MCH population for increased access to and use of dental services and to reduce disparities in oral health. These grant-funded programs target the MCH population for increased access to and use of dental services and the reduction of disparities in oral health.

The State's HRSA TOHSS-funded program is providing critical oral health education to key community partners to encourage dental care during pregnancy and reduce or prevent the risks ECC among infants and young children.

Fluoridation reaches to about 12.5 million New York State residents. Another 100,000 low income children receive the benefits of fluoride through the Supplemental Fluoride Education and Rinse Program. Existing school-based preventive dental programs reach about 27% of all eligible schools and are helping the State move closer toward meeting the national objectives. The recent expansion of the Medicaid program to include fluoride varnish is expected to increase the dental visits by age 1.

While there are many strengths, the following barriers hamper our progress:

- In the absence of a statewide mandate to implement fluoridation, it is challenging to promote fluoridation in counties with large proportions of the population not covered by fluoridation such as Nassau, Suffolk, Rockland, Ulster, Albany, Oneida and Tompkins.
- The ability to expand school-based preventive dental programs into all high need areas of the state is not possible at this time.
- The uneven distribution of dentists, inadequate number of participating dentists in the Medicaid program, and those willing to treat young children and pregnant women make it difficult to improve access to care for certain population groups. Public health clinics are experiencing difficulties in recruiting and retaining practitioners. This is compounded by the declining number of newly licensed dentists, high educational debt and aging of the dental workforce.

Based on analyses of the most recently available data from previously referenced sources and input from community partners and stakeholders, the following needs were identified:

- assessing the adequacy of laws and regulations to maintain and expand the fluoridation program;
- increasing the use of oral health services by pregnant women and the provision of education on the risks and prevention of Early Childhood Caries (ECC);
- increasing age one dental visits by low income infants;
- improving oral health and reducing the burden of oral disease among preschoolers and school-aged children;
- expanding school-based dental preventive and sealant programs into more high need schools;
- expanding the State Doctor's Across New York DANY Loan Repayment Program to include dentists in future budget years when the fiscal climate improves in New York State; and,
- encouraging more dental care professionals to provide a dental home for Medicaid and Child Health Insurance Program beneficiaries.

Children and Youth with Special Health Care Needs

Newborn Screening

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006	2007	2008
Annual Performance Objective		100	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100	100	77.2	76.0
Numerator	253,545	254,018	250,209	246,243	252,014	3,542	3,238
Denominator	253,545	254,018	250,259	246,243	252,014	4,586	4,263
Is the Data Provisional or Final?	Final						
	2009	2010	2011	2012	2013		
Annual Performance Objective	100	100	100	100	100		
Annual Indicator	76.0						
Numerator	3,238						
Denominator	4,263						
Is the Data Provisional or Final?	Provisional						

Notes 2010 - 2007, 2008, and 2009 numerator and denominator data represent only newborns who have screened positive, unlike previous years, where these numbers represent all newborns screened. For 2007-2009, 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.

Sickle Cell Disease: The Newborn Screening Program screens for Sickle Cell Disease and Trait. The report of 2008 achievements is located on Form 11, National Performance Measure 01. Of over 252,793 infants screened in 2008, 144 screened positive for Sickle Cell Disease, and of these, 124 were confirmed positives.

Sickle Cell Disease affected at least 2,844 New York Medicaid patients in 2005. As a result of Medicaid Drug Utilization Review, it was noted that Hydroxyurea, a drug approved by the Food and Drug Administration for the prevention of sickle cell crises, has been underutilized. As a result, the Medicaid program, in order to draw attention to the underutilization of this drug, wrote to providers of patients with sickle cell disease who were not receiving the drug to inform providers of the availability and efficacy of this drug.

Wadsworth Center continues to conduct bloodspot screening on 100% of the state's newborns for conditions listed. 98% of referred infants are followed to confirmation. 249,271 infants were screened in 2009 for all 45 conditions, which include the 29 core conditions and most of the secondary conditions plus HIV and Krabbe disease, both of which are unique to NYS. Screening is performed by Wadsworth Center's Newborn Screening Program at the NYSDOH.

- All newborns with a specimen submitted are tested for all 45 congenital conditions on bloodspots, including:
 - Congenital adrenal hyperplasia (CAH)
 - Congenital hypothyroidism (CH)
 - Sickle cell disease and other hemoglobinopathies
 - Exposure to HIV-1
 - 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 academia
 - Malonic academia
 - 2-Methylbutyryl-CoA dehydrogenase deficiency
 - 3-Methylcrotonyl-CoA carboxylase deficiency
 - 3-Methylglutaconic academia
 - 2-Methyl 3-hydroxybutyryl-CoA dehydrogenase deficiency
 - Methylmalonic academia
 - Mitochondrial acetoacetyl-CoA thiolase deficiency
 - Multiple carboxylase deficiency
 - Propionic academia
 - Argininemia
 - Argininosuccinic academia
 - Citrullinemia
 - Hyperammonemia/hyperornithinemia/homocitrullinemia

- Biotinidase deficiency
- Cystic Fibrosis
- Galactosemia
- Krabbe Disease

The Genetic Services Program in Wadsworth Center is in the process of developing an assay to detect severe combined immunodeficiency syndrome.

Of children screened in 2009, there were 20 cases of amino acid disorders including PKU; 11 cases of congenital adrenal hyperplasia; 141 cases of primary congenital hypothyroidism; 20 cases of fatty acid oxidation disorders including MCAD; 271 cases of hemoglobinopathies; 42 cases of organic acid disorders including 3-MCC; 13 cases of biotinidase deficiency; 71 cases of cystic fibrosis, and 6 cases of galactosemia. Two infants were found to be at high risk for Krabbe disease.

NYS provides grant awards to 24 genetic centers in all areas of the state to provide diagnostic services, laboratory testing, genetic counseling, and referral to treatment centers. Prenatal Genetics Services were provided to 23,417 pregnant women in 2009. Another 23,609 individuals received Clinical Genetics Services through genetics services grantees. New York is a member of the New York Mid-Atlantic Consortium for Genetic and Newborn Services (NYMAC) which is charged to ensure that individuals with heritable disorders and their families have access to quality care and appropriate genetic expertise and information. NYMAC has formed 2 work groups with a focus on educating about genetics and newborn screening (NBS).

Newborn Screening Follow Up: The Department is committed to ensuring the early identification, treatment and follow up of children with special health care needs. The CSHCN Program, in conjunction with the Newborn Screening Program ensures a statewide network of Article 28 hospital-based specialty centers that accept newborn screening referrals upon receipt of a positive newborn screen. These centers of excellence provide comprehensive, multidisciplinary evaluation and management of children by clinical specialists and sub-specialists. Title V staff also monitor active cases to ensure that infants with positive results receive follow-up.

The Title V Program was awarded the Effective Follow-up in Newborn Screening (NBS EFU) Grant from HRSA for enabling health information exchange (HIE) and improving communications regarding child health information. These are the goals of this project.

1. Improve the newborn screening short-term follow-up system through enhanced health information exchange among the newborn screening program, birthing hospitals, medical home/community-based practices, and subspecialists.
2. Develop and implement a system of long-term follow-up (LTFU) for Cystic Fibrosis (CF) and the inherited metabolic diseases (IMD).
3. Integrate NBS short and long-term data and information exchange activities within an interoperable, standard model for meaningful HIE.
4. Design, develop and implement a virtual child health profile (in conjunction with the CHI² project)

The existing system does not have the ability to identify unscreened newborns since it has no linkage with any other state registry of infants. In addition, it can be difficult to locate potentially affected newborns due to inaccurate or incomplete contact information, possibly resulting in unreported and untreated disease for these newborns. Location of these infants often takes countless hours of staff time. The current paper-driven system of determining the diagnostic status of the screen-positive newborns also has some inherent problems, resulting in incomplete or inaccurate diagnosis information. The NBSP has no capabilities for long-term follow-up at this time, and lacks the ability to share information electronically with other public health programs.

The initiative will improve collection of newborn screening and follow data. Child health outcomes will also be improved by more effectively tracking and monitoring ongoing treatments through long-term follow-up. The initiative will provide a solution that enables the improvement of data quality, timeliness and availability, while reducing duplicate entry and introduction of human error. It will also improve the communications and systems available to hospitals, providers and clinics that deliver information to DOH, and facilitate the sharing of health data across DOH internal systems. The initiative will also enable the timely sharing of accurately matched child data records, providing a comprehensive picture of a child's medical history and ensuring more complete testing and follow-up. It will provide public health officials with information in making population-based decisions about programs and policies, and enable the measurement of health program success.

Work accomplished through this grant activity enables newborn screening data to be accessed by the Statewide Perinatal Data System (SPDS), the NYS Immunization Information System (NYSIIS), the New York Early Intervention System (NYEIS), and the Newborn Hearing Screening System initially to ensure continuity of care for individuals identified by the NBSP and improve communication to the medical home and other clinical providers.

In the pursuit of improved Short-term Follow-up for Newborn Bloodspot Screening, NBS EFU is working with pilot hospitals across New York State for the implementation of a Remote Demographic Entry (RDE) module. This module allows hospitals to electronically submit demographic information on newborns to the Department of Health (DOH) rather than recording the information by hand on bloodspot collection (Guthrie) cards. This process allows the DOH labs to receive clear demographic information (no interpretation of handwriting) and pulls data directly from the hospital information system, eliminating the need for duplicate effort. Reporting based on the RDE allows the DOH to track which specimens they should be receiving and ensure better quality of both demographic information and bloodspot specimens, through early identification of quality issues. Reporting also benefits the hospital, as they can track what specimens have been received, which specimens have not yet been received, identify quality issues, and receive results electronically.

In pursuit of improved Long-term Follow-up, NBS EFU is working closely with Specialty Treatment centers for the identification of diagnostic criteria for Remote Diagnostic Entry (RDx) and identification of Long-term Follow-up criteria (LTFU). NBS EFU is currently working with Cystic Fibrosis Specialty Treatment Centers across New York State for the development of an

initial model for RDx and LTFU. Following the work with the CF Centers, NBS EFU will be working with Specialty Treatment Centers for Inherited Metabolic Disorders, and identifying RDx and LTFU criteria for implementation with those centers.

For the achievement of health information exchange (HIE) and the development of a virtual child health profile, NBS EFU is working closely with multiple organizations within DOH, as well as external stakeholders. NBS EFU is coordinating with the Office of Health Information Technology Transformation and associated RHIOs for the implementation of bidirectional HIE based on the Newborn Screening Use Case put forth by the US Department of Health and Human Services.

In addition, the NBS EFU and CHI² projects (described below) are working cooperatively for the first phase of the CHI² child health profile. NBS EFU is facilitating the integration of systems that collect child data from birth through one year for CHI², and participating in the development of requirements and design for the creation of CHI² focused on the child from birth to three years of age.

The Newborn Screening Effective Follow-up Project has generated a great deal of interest in the medical community, as well as within the Department of Health. Participation in our Remote Demographic Entry pilot has been actively pursued by several prominent NYS hospitals, and we have had enthusiastic participation from the Cystic Fibrosis Specialty Centers. Within the DOH, we have cross-program participation from areas such as immunization, hearing and early intervention, and through our close partnership with the CHI² project, have gained significant support and momentum for the furthering of the project goals.

Challenges to the NBS EFU goals include the lack of funds for the efforts of stakeholders in conjunction with NBS EFU activities, including additional hospital resources required for initial implementation efforts and learning curve, resources for system changes required for standardization of data sets for HIE (individual source systems), and the cost of EMR/EHR implementation by individual providers for access and integration with CHI².

An additional challenge faced by NBS EFU in conjunction with the CHI² initiative will be addressing the regulatory and legislative barriers to the type of data sharing that can enable a comprehensive child health profile, while maintaining the security and privacy of the individual patient. A Legal Workgroup is being convened to begin addressing these issues.

NBS EFU is approaching implementation over the course of a three year plan. Year One is primarily focused on Short-term Follow-up goals, including the implementation of Remote Demographic Entry and Remote Diagnostic Entry modules, partnering with hospitals and specialty treatment centers. Year Two focuses heavily on the implementation of bidirectional health information exchange based on the Newborn Screening Use Case (working closely with OHITT and RHIOs), the completion of system design for the virtual child health profile and the start of implementation. Year Two also will include implementation of the Long-term Follow-up module with Cystic Fibrosis Specialty Treatment Centers, and analysis of lessons learned for future rollouts. Year Three efforts will wrap up the implementation of Long-term Follow-up with

Since October 2001, all facilities caring for newborn infants are required to have in place a newborn hearing screening program, regardless of the size of the facility or Neonatal Infant Care Unit (NICU) status. There are a total of 144 hospitals/birthing centers approved and regulated by the NYSDOH.

The general requirements for new born hearing screening program include:

- Conducting inpatient infant hearing screening prior to discharge from the facility;
- Communicating results of infant hearing screenings to parents by designated personnel, including provision of written materials supplied by the Department;
- Conducting follow-up infant hearing screening or providing referrals to obtain follow-up screening on an outpatient basis for those infants who fail or do not receive infant hearing screening prior to discharge from the facility;
- Referring infants who are suspected of having a hearing loss to the Early Intervention Program for appropriate evaluation and early intervention services; and ,
- Reporting of aggregate data on newborn hearing screening to the Department on a quarterly basis.

Reimbursement for newborn hearing screening is available through Medicaid fee-for-service, Medicaid managed care and private insurance. The Department has received two NBHS Grants.

The Division of Family Health, Bureau of Early Intervention receives grant funding from HRSA to expand and improve the Universal Newborn Hearing Screening and Intervention (UNHS) program to assure quality developmental outcomes for infants identified with hearing loss. The focus of the grant is to improve the follow-up of infants who have positive screening test for potential hearing loss in hospitals/birthing centers across the state. The project is focusing on identifying problem points in the newborn hearing screening and early intervention program, developing small changes in the system, and piloting the changes with a small number of hospital/birthing centers in the state. The changes that show positive effect will then be introduced and implemented in hospital/birthing centers in New York. In addition, in Sept. 2009, a supplemental award of this grant was provided to expand the activities associated with loss to follow up.

Most recently, letters were sent to all 144 birthing facilities in New York State, comparing individual hospital performance to statewide performance and the Joint Committee on Infant Hearing benchmarks. Fifteen hospitals were required to submit corrective action plans to the Department. Staff completed a review of the policies and procedures submitted by the hospitals and, in some cases, conducted follow up conference calls or visits to the hospitals.

The Bureau of Early Intervention has received funding from the CDC for the Early Hearing Detection Intervention Grant. The activities associated with this grant are to enhance NYS Universal Newborn Hearing Screening (UNBS) Program tracking and surveillance system to accurately identify, match and collect unduplicated, individual identifiable data at the program level as part of the CDC EHDI process to evaluate NYS's progress in meeting the Healthy People 2010 goals. The grant will also assist the Department in developing and enhancing the capacity of the UNHS Program to integrate with other state systems that provide screening, tracking, and surveillance programs identifying children with special needs.

The Department is authorized to collect, and all birthing facilities are required to provide, aggregate data on newborn hearing screening results each quarter for all infants born in New York State. The collection of aggregate data significantly impacts the Department's ability to follow up on infants who potentially have a hearing loss. As a result, the Department is seeking state legislation that will require hospitals and other health care providers that perform or order newborn infant hearing screenings to report results through a statewide information system; authorize the collection and storage of newborn infant hearing screening results and data in a statewide information system; and, authorize 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.

If legislation is enacted as proposed above, the Department will be actively involved in implementing the legislation over the coming year. Much of the work to design requirements for the data systems for submission of data, and storage in the Department's child information system has been completed, but cannot be built until legislation is enacted. The Department also is preparing a Notice of Proposed Rulemaking seeking to change regulations for the Newborn Hearing Screening and Intervention program for the first time since regulations were adopted in 2000. These revised regulations will include changes needed to collect individual level data and other corrections to support improved practices by facilities that have been learned over the last decade of working closely with hospitals to improve screening performance.

Children with Special Health Care Needs Programs

The Department's programs for children with special health care needs assists individual children ages birth to twenty one years of age and their families. The Division of Family Health, Early Intervention Program (EIP) and Children with Special Health Care Needs (CSHCN) Program have core responsibilities for serving this population. The EIP and CSHCN Programs work closely with other programs, including the Newborn Screening Program, the Newborn Hearing Screening Program and the Dental Bureau to identify and treat children with special health care needs.

The Department is committed to ensuring the early identification, treatment and follow up of children with special health care needs. The CSHCN Program, in conjunction with the Newborn Screening Program ensures a statewide network of Article 28 hospital-based specialty centers that accept newborn screening referrals upon receipt of a positive newborn screen. These centers of excellence provide comprehensive, multidisciplinary evaluation and management of children by clinical specialists and sub-specialists. The specialty center types are Cystic Fibrosis, Endocrine, Inherited Metabolic Diseases and Hemoglobinopathy. In January 2009, the Hemoglobinopathy Specialty Center standards were updated and approved. The CSHCN and Wadsworth Center staffs are reviewing applications for these centers. The review and approval process ensures that each hospital that applies as a specialty center meets the minimum criteria to treat children with hemoglobinopathy disorders.

The state CSHCN Program's goals are to improve access to quality services for CSHCN birth to 21 years; to promote family centered systems of care; and, to provide linkages with gap-filling services that meet the needs of CSHCN. The EIP's goal is to enhance the development of infants

and toddlers with disabilities and developmental delays and to assist families in meeting their children's needs. The EIP serves children under the age of three years. Program priority setting for children with special needs involves utilization of the results of the public input process, state and local data from the EIP and CSHCN Program, and responding to statutory and regulatory requirements.

A major priority involves the early identification of children with special needs and referral to appropriate services. The EIP has the major responsibility in this area. All children referred with a suspected disability are entitled to receive a multidisciplinary evaluation to determine their eligibility for early intervention services. Children with a diagnosed condition receive an evaluation to help plan early intervention services. In November 2009, the Department launched a ten-month quality improvement project with community pediatricians to improve early identification of CSHCN and referral of these children to the EIP through performance of developmental surveillance and screening within primary practice (See QI section below for further detail on this project).

Improving ease of use of services for families of CSHCN is another key priority. Many families of CSHCN have difficulty navigating the complex systems of care for their children and making transitions from one program/system to the next. The Department provides annual grants to LHDs to fund local CSHCN Programs that assist families in navigating the community systems of care. Through contracts with 56 LHDs, CSHCN Programs link families of CSHCN to appropriate state and community health-related programs and services, and identify and resolve gaps/barriers. In addition, the state CSHCN Program has developed strategies to meet information needs by developing resources and tools that are available in print form and on the Department's website. Conference calls with staff of local CSHCN Programs are held to provide resource information and to keep current staff up to date and help new staff obtain knowledge of state and community resources.

In 2008, the CSHCN Program revised the "Resource Directory for Children and Young Adults with Special Needs" to provide information to families so they could more easily navigate NYS' system of care. This is the third major revision of the directory since its inception over ten years ago. This directory is a compilation of all the state's public programs, their eligibility, services offered and contact information. During 2009, the directory was translated and reprinted in Spanish, French, Russian and Chinese. The CSHCN Program created a three page, 8.5 by 11 inch paper sized, Health Summary to assist families to keep track of their child's health information. The document includes fields to record allergies, medical conditions and special needs instructions, immunizations and health care provider contact information. The tool's format was designed in accordance with Family Champions' feedback that requested pages that could be inserted into a binder. This tool is available on the Department's website, http://nyhealth.gov/community/special_needs/docs/health_summary.pdf.

The Department uses quantitative and qualitative data to assess the needs of CSHCN birth to 21 years. The National Center for Health Statistics State and Local Integrated Telephone Survey 2005-2006 National Survey of Children with Special Health Care Needs (hereafter referred to as

the “National Survey”¹ provides data about New York’s population of CSHCN. The number and percent of children and youth with special health care needs ages birth to 17 is 572,503 and 12.7%.

In 2009, the CSHCN Program served over 8,000 children and their families. Insurance status is assessed at the time a referral is made for a child and family. Program data for 2009 indicated insurance status of those served as follows: 32 % have private insurance; 28.3% have Medicaid; 28.4 % have Child Health Plus; and, 6% do not have insurance. Another 3% of children have SSI. Local CSHCN Programs assist families to obtain insurance if uninsured or obtain gap-filling services when necessary. In 2009, the number and percent of referrals of children with special health care needs to the following programs for assistance with access to health care services were:

Medicaid:	292 children or 3.6%
SSI:	267 or 3.29%
Child Health Plus:	125 or 1.26%
Gap-filling Program:	2704 or 33.3% (PHCP Treatment Program)
	1180 or 14.5% (PHCP D and E Program)

Although almost 93% of NYS’ CSHCN have some form of health insurance², approximately one-third (34.7%) of NYS families of CSHCN reported their insurance coverage was not adequate to meet their child’s needs. In NYS, all SSI beneficiaries are categorically eligible for Medicaid, which is a more generous health care insurance package than the Physically Handicapped Children’s Program, a gap-filling program for CSHCN described below. In 2008, 2% of the children upon entry in the CSHCN Program had SSI. Children with special health care needs who have severe, handicapping conditions and who contact the CSHCN Program are referred to SSI. In 2009, 267 children were referred to SSI and 211 of those children successfully obtained SSI (79%). The assessment and referral activity of the CSHCN Program is significant as it demonstrates that staff recognizes the benefit SSI can provide families and accurately refer those children most likely to be determined eligible for SSI. SSI provides income to help families obtain needed services to care for their disabled child. The CSHCN Program will continue to fund and provide technical support to local CSHCN Program contracts that support staff to perform information and referral activities.

In addition, there are Medicaid waiver programs that help families with severely disabled children who cannot meet the income and resource requirements of Medicaid obtain access to Medicaid, and also some services that are not generally provided through Medicaid, such as respite, home adaptations and vehicle modifications. The CSHCN and EI Programs, as appropriate, refer families to these waiver programs. To support access to Medicaid waivers, the CSHCN Program has developed a resource directory for children and young adults with special health care needs that includes descriptions of the waiver programs and contact information

¹ U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The National Survey of Children with Special Health Care Needs Chartbook 2005-2006. Rockville, Maryland: U.S. Department of Health and Human Services, 2008.

² Ibid.

The BMCH also oversees the state Physically Handicapped Children's Program (PHCP). PHCP is a public health gap-filling program that provides reimbursement of medical services for children birth to 21 years who are uninsured or have inadequate insurance. As PHCP is administered by local health departments and county participation is voluntary, there is variability in the medical and financial eligibility requirements and amount of assistance provided. The Department made available \$3,685,000 in state aid through the Physically Handicapped Children's Program for medical services to children birth to 21 years with severe, chronic illnesses or physically handicapping conditions.

The gap-filling reimbursement is for services that insurance will not cover or do not cover fully. The children may be uninsured or underinsured and meet local program financial and medical eligibility requirements. In 2009, 639 children received diagnostic evaluation through the PHCP and 2,689 children received treatment services under PHCP. In descending order, the three major categories of service and percent of funds expended are as follows: 1) orthodontia (72 %), drugs (9%), and metabolic foods and formula (4%). The CSHCN Program monitors the reasons why gap filling services are needed. The most common reasons for which families request PHCP assistance include: service is not covered (39 %), need help with copayment (4.9%), need help with premium (7.9%), need help with deductible (0.7%) and items exceeds the benefit package (4%).

In May 2009, the Center for Community Health, Division of Family Health, Bureau of Dental Health and Bureau of Maternal and Child Health and Office of Health Insurance Program's Division of Coverage and Enrollment held a planning meeting to discuss orthodontic coverage for children with severe handicapping malocclusions under Child Health Plus. The Physically Handicapped Children's Program (PHCP) has been providing coverage for orthodontic services for children with severe, handicapping malocclusions who have private insurance and CHP yet inadequate dental insurance. In 2009, 72% of PHCP expenditures were for orthodontia services. Medicaid reimburses for orthodontic services for eligible children with severe, handicapping malocclusions. OHIP was supportive of the Title V request to include orthodontic coverage under CHP. Orthodontic coverage by CHP for severe, handicapping malocclusions was included in the Governor's executive budget for 2010-2011.

During the public forums held February through April 2010 to inform the Maternal and Child Health Block Grant needs assessment process, families identified an inadequate number of authorized mental health, occupational therapy and physical therapy visits as a challenge. At the forums, families explained they had to pay out-of-pocket for services their child needed and identified the financial burden of these expenditures. These reports are consistent with National Survey data, in which almost 17% of NYS families reported spending over \$1,000 per year on out-of-pocket costs for their child's special health care needs and almost 18%³ reported the child's conditions caused a financial burden. Families reported out-of-pocket expenses for durable medical equipment. The most often requested gap-filling services from the PHCP were: orthodontia, drugs, and metabolic food and formulas.

³ Ibid.

In all areas of the state, finding a specialist that would take Medicaid was a priority concern for families. During the forums, families reported that physicians that do take Medicaid are overbooked and this resulted in long wait times for appointments. According to National Survey data, almost 14%⁴ of NYS CSHCN have an unmet need for specific health care services. During the forums, families reported long wait times for receipt of durable medical equipment after prior approval. The families and youth also discussed the need for medical transportation; in some regions of the state.

Ensuring the provision of quality care within a medical home for children with special health care needs is a major priority for the Department and CSHCN Program. Local CSHCN Programs assist with assessing whether a child has insurance and a primary care provider and making referrals when needed. Community based quality improvement initiatives are aligned with the pediatric primary care providers and medical home concepts are stressed, including the importance of family involvement in decision-making. Title V staff have collaborated with the DOH Office of Health Insurance Programs on the new Medical Home incentive program for clinics and health care providers who provide care to Medicaid beneficiaries in accordance with medical home standards set by the National Committee for Quality Assurance. In April 2010, OHIP staff conducted a presentation for all Bureau staff on this program to identify opportunities for supporting implementation once the state plan amendment is approved by the Centers for Medicare and Medicaid Services.

AAP awards **Community Access to Child Health (CATCH)** grants to pediatricians to plan community-based initiatives to increase access to children's health care. Priority is given to proposals that promote medical homes for underserved children and represent new initiatives within the community. Funds can only be used for planning not implementation.

Title V staff collaborated with a New York City CATCH grantee to convene a community meeting to foster medical home implementation for CSHCN. Nineteen stakeholders, including representatives from family organizations (Parent to Parent of NYS), community practitioners and hospital providers and state and local agencies serving CSHCN attended. Discussion focused on barriers and perceptions related to medical home implementation and recommendations to consider for enhancing medical homes. Recommendations included training for pediatricians to learn about community agencies, their range of services and how to collaborate and coordinate care with these agencies. Toolkits, web site information or a 1-800- number for this information were deemed potentially helpful. Subsequent to this meeting, the CATCH recipient has become a regional leader in the Child Development Learning Collaborative (CDLC) that supports developmental and autism screening within a medical home.

In response to longstanding complaints about the turnaround time for durable medical equipment (DME) requests, NY's Medicaid Program sought to strengthen the DME request and receipt process. In 2007, along with the Chair of the Assembly and Senate Health Committees and industry stakeholders, the DOH convened a workgroup to address DME coverage requirements, access criteria and turnaround time. Since the commencement of the workgroup, the prior

⁴ Ibid.

authorization requirements for certain types of DME have been eliminated and the process has been streamlined for other types of equipment.

New York State reduced the turnaround time for review of a DME request to two business days which far exceeds regulatory requirements. In addition to improving its own DME operations, New York Medicaid has demanded improvements in vendor performance by introducing report cards that document vendor turnaround times. These cards provide a comparative analysis of vendor performance, thereby motivating vendors to improve their performance relative to their peers. These Medicaid reforms should have a significant positive effect on improving access to DME for CSHCN.

During the public forums, families noted a lack of transition resources and training as a challenge. This challenge was identified by the National Survey in which 38.4% of NYS families reported their youth with special needs receives services necessary to make transitions to all aspects of adult life, including adult health care, work and independence. Youth and young adults with special health care needs reported they wanted to have education about safe sex so they could make informed choices. Families indicated their positive impression of the transition documents designed by BMCH (H.I.Doc and Health Insurance Fact Sheet) for youth and suggested these documents be widely disseminated.

The transition of youth and young adults with special health care needs to adult health care is a major priority area for the CSHCN Program based upon consumer input and National Survey data. The Department has engaged and trained a diverse group of Youth Advisors to help identify resources they need to develop skills and utilize tools to make a successful transition to adult health care providers. These young adults were brought together in the Albany area on April 20-21, 2007 for the first YAC meeting. Reflections from this session indicated that the youth were inspired by the individuals who presented and learned the importance of self-advocacy, perseverance and networking. They were interested in knowing more about accessibility on college campuses, independent living centers, their rights as a person with a disability, and how to drive with a disability that causes limited movement of the hands. The second day of the session focused on specific transition issues. Youth stated that the following would be helpful:

- a list of services that are available to help them live independently;
- information about Medicaid and how it works;
- updates on new technology,
- opportunities for learning life skills and social skills;
- information about good adult physicians who accept their insurance plans;
- someone to take care of their medical and medication needs;
- getting a job;
- learning from the examples of people who have already transitioned;
- making a slow transition from pediatrician to adult provider;
- getting a better understanding what it means to transition;
- having wheelchair accessible housing; and,
- lists of doctors that specialize in their particular illnesses.

In response to consumer concerns about the importance of having adequate insurance that pays for necessary services and understanding how to access insurance options as youth age off their parent's private insurance or access public options on their own, the CSHCN Program developed a Health Insurance Fact Sheet that provides information to young adults about insurance options (Medicaid and Medicaid Buy-In, Family Health Plus, and Healthy New York) and other programs (Supplemental Security Income). With input from Youth Advisors, the CSHCN Program also developed the Health Information Document (H.I. Doc). H.I. Doc is a portable, pocket-sized tool that youth can use to organize important health information and contacts.

With support from its federal Integrated Community Systems grant, the CSHCN Program contracted with the Research Foundation of New York, SUNY Upstate, to develop a youth oriented, interactive website to help youth develop transition skills necessary to move from pediatric to adult health care. This website entitled, <http://www.healthytransitionsny.org> offers youth the opportunity to learn many new skills, i.e. making a doctor's appointment, managing medications, speaking up at a doctor's visit, setting health goals and finding community resources, through viewing brief videos and using online resources and tools. Youth advisors provided feedback about the development of this transitions website by logging onto the website, testing its operation, and providing input. The CSHCN Program has planned for sustainability of the project through teacher training in two schools of the Central Region and one school in Metropolitan region. It is anticipated these teachers will utilize the <http://www.healthtransitionsny.org> tools in their curriculum for students with disabilities

The CSHCN Program employs a Family Specialist, the parent of a young adult with special health care needs. The Family Specialist represented the family perspective in program planning, provided presentations about family involvement and engaged other family members to become involved in a cadre of family leaders by offering support and guidance. Our Family Champions continue to be a vital source of information and support for CSHCN and their families as well as for the Medical Home Unit and the Division of Family Health.

Parents also have a major role in the policy and program development in the Early Intervention Program. Early Intervention conducts parent policy development training and the Early Intervention Parent Workgroup addresses a variety of service delivery issues. New family representatives, identified through the Title V Program's Family Champions group, were appointed to the MCHBG Advisory Council and the Lead Poisoning Prevention Advisory Council. Families continued to serve as representatives on several state-level advisory groups, including the Emergency Medical Services for Children (EMSC) committee, the Early Intervention Coordinating Council (EICC) and the Commissioner's Cross Systems Committee, an interagency group that addresses the needs of children with multiple issues (medical, developmental, mental and behavioral conditions).

The strengths of the CSHCN Program are in the state and local infrastructure that have the knowledgeable staff to help address family information needs. A challenge is the lack of integration between the data from the gap-filling program and the CSHCN information and referral program. In addition, the variable participation in the PHCP by local health departments across the state (some are not participating and others are not accepting new children) and the

variations in scope of conditions and services covered results in uneven assistance provided to children and their families.

Early Intervention Program

Society has a compelling interest in the development of young children. Evidence from both research and practice shows a strong link between early childhood experience and a wide range of both short and long-term life outcomes. Early childhood is a critical period of human development, across all developmental domains. Infants and toddlers raised in healthy, secure, nurturing environments have better outcomes across a range of domains and systems, and the roles of families and communities are essential in nurturing children's healthy development.

Part C of the Individuals with Disabilities Education Act established the Early Intervention Program (EIP) to provide a comprehensive system of early intervention services for infants and toddlers with disabilities and their families. The Department of Health is designated as the lead agency responsible for general administration, supervision and oversight of New York State's EIP. The EIP serves a critical function of identifying children at an early age whose development is compromised and providing services to ideally catch up their development to match those of typically developing peers, but also equally important, to obtain the best possible outcomes for children who may have lifelong disabilities. The EIP provides for appropriate interventions to improve child health and development through a wide range of therapeutic and supportive home and community-based services such as speech, physical therapy, and occupational therapy.

The EIP is administered locally by 57 counties and New York City. Children that are referred to the Program receive a timely evaluation. If a child is found eligible, an Individualized Family Service Plan (IFSP) is developed and services are provided. Municipalities are required to contract with a sufficient number of approved evaluators, service coordinators and service providers to ensure that services are available to eligible children and families. Currently, the EIP provides services to more than 74,000 children annually through approximately 2,100 providers (agencies and individuals) approved to deliver early intervention services to eligible children. Since the implementation of the EIP, the Department has provided each municipality with an annual allocation for use for respite services.

The EIP has evolved into a large, comprehensive statewide service delivery system that is the largest early intervention system in the nation and the third largest funded program within the Department of Health after Medicaid and WIC. In New York State, 4.3% of children under the age of three are enrolled in the Early Intervention Program, while nationally only 2.7% of children are enrolled in the program.

The EIP is financed through a combination of commercial third party, Medicaid, and state and county funds totaling approximately \$700 million. Commercial third party insurance covers approximately 1% of total costs; Medicaid coverage is provided for all early intervention services under the Medicaid Plan. In 2007-08, however, only \$13 million of the total expenditures for early intervention were paid by third party payers as compared with \$280 million by the Medicaid, \$180 million by the State, and \$192 million by counties. The

Department receives a federal grant from the U.S. Department of Education, Office of Special Education Programs, of approximately \$24 million to administer the EIP (Individuals with Disabilities Education Act, Part C). Of these funds, \$13.1 million is allocated to support local administrative activities via contracts with the local health departments.

IDEA and Public Health Law require the Department establish and maintain a state Early Intervention Coordinating Council (EICC) to advise and assist in administration of the EIP. Members of the EICC must be appointed by the Governor. The EICC is actively involved in development of policies and procedure and standards and guidelines for the program. The program also has active parent involvement. Family representatives are also key stakeholders in the EICC. Five of the 27 members are family representatives and EICC committees are appointed to have equal representation of providers, families, state agency and municipal representatives. The EI Program plans and delivers the EIP Training Project for parents several times annually. This nationally-renowned leadership-training project helps parents of various diverse backgrounds to learn more about opportunities for parent involvement with the EIP. The training sessions provide information, resources, and skill-building activities designed to increase advocacy and leadership skills. The training is currently conducted twice a year, in different parts of NYS, over three separate weekends.

The EIP has also allocated \$800,000 of its ARRA-Early Intervention funding to expand family initiatives over the two year period ending in 2011. This funding will be used to develop a Web site (www.eifamilies.com) to include information and communication with all of the 70,000 families in the EIP, with links to existing programs sponsored by other state agencies, a blog which will allow readers to post commentary, news, or questions in an interactive format, learning opportunities through links to existing Web-based learning modules, and support opportunities through links to state and national Parent Centers. In addition to the Web site, the Early Intervention Partners Training Project will be expanded by conducting a third session of three additional weekends for each of the two years, conducting a Partners seminar to learn of successful leadership accomplishments and/or current status of former Partners graduates and by translating all material and handouts into Spanish.

The Bureau has developed guidelines to ensure high-quality, consistent and effective service delivery to eligible children and their families. These guidelines address recommended clinical practices for developmental surveillance, assessment and intervention with children age birth to three years. There are six guidelines on the topics of 1) Autism/Pervasive Developmental Disorders, 2) Communication Disorders, 3) Down Syndrome, 4) Motor Disorders, 5) Hearing Loss, and 6) Vision Impairment. Each guideline consists of three separate publications (a technical report, a report of the recommendations, and a quick reference guide). The four most recent guidelines include evidence tables and, including the books, are provided on compact discs. Guidelines are disseminated to early intervention providers, municipalities, parents and others upon request. The Bureau is procuring a vendor to update the Autism and Communication Disorders guidelines using ARRA funds.

The EIP monitors the quality of services delivered to children in the program through a contract with the Island Peer Review Organization (IPRO) to complete programmatic reviews of the 2,000 providers and 58 municipalities in the program. IPRO completes on-site visits of municipalities every three years and of all providers every 1-5 years depending on the volume of

children that they serve and other risk criteria. The on-site visits include staff interviews, and a review of policies and procedures and child records. Beginning this year, the reviews will also include interviews of a random sample of families. IPRO generates a report of findings and the reviewed entity often has to complete a corrective action plan to address deficiencies. Focused reviews are conducted to follow upon on issues requiring corrective action. Additionally, the peer review agent, through a subcontract with local experts, has conducted clinical record reviews of children receiving autism services.

The program is required by the U.S. Department of Education's Office of Special Education Programs to measure its performance through fourteen indicators reported through a Statewide Performance Plan (SPP) and Annual Performance Report (APR). The SPP details plans for improvement in the 14 indicators for a six year period ending with the 2010-11 year and each APR reports on the state's performance on indicators for each of the six years.

These indicators include several process measures reflecting the experience entitled to children and families in the program such as the percentage of children who receive an initial Individualized Family Service Plan within 45 days of referral to the EIP, and the percentage of children whose services are initiated within 30 days of the initial IFSP meeting. The indicators also include measures of child and family outcomes in the program which were developed as part of a broader national effort to better measures standardized outcomes in this program which provides an incredibly diverse array of services to children and families with varied developmental concerns and needs.

The Department is engaged in the design, development, implementation, and support of a new information system for the administration and management of the statewide Early Intervention Program called the New York Early Intervention System (NYEIS). NYEIS will support the full range of management and administration activities of the Early Intervention Program to include initial referral and intake, evaluation, eligibility determination, Individual Family Service Plan (IFSP) development, services authorization and delivery and all financial aspects, as well as management and reporting tools to assist both county and state EIP personnel in the program's administration.

In addition to enhancing parent initiatives and updating Clinical Practice Guidelines, ARRA funding will be used to support the development and implementation of a revised rate reimbursement methodology; enhanced training and technical assistance for municipalities; conversion of existing curriculum to on-line web-based training; development and implementation of a preferred list of evaluation tools; translation and printing of publications; and, support for the evolution and maintenance of the NYEIS system.

Each year, children are increasingly identified at an earlier age when the program can better improve outcomes. For example, the average age of enrollment in the EIP for children with an autism spectrum disorder decreased from 23 months old several years ago to 20 months in the most recent program year. Also, since the enactment of legislation requiring universal newborn hearing screening, the average age of enrollment in the program for child with some hearing loss has decreased from 15 months to 6 months of age.

Unfortunately, the size and scope of the program and the limited federal financial participation makes the financing a continued strain on the State and localities' budgets. As a result, the Department has convened a Reimbursement Advisory Panel to review the reimbursement methodology used in the program, and each year several proposals are revealed in the Governor's proposed budget to enact programmatic reforms and other cost savings measures to make the program financially viable for many years to come.

As lead agency for New York State's Early Intervention Program (EIP) under Part C of the Individuals With Disabilities Education Act and Title V Children with Special Health Care Needs Program, the Department manages one of the State's largest service delivery systems for children with autism spectrum disorders (ASD) and their families, and is engaged in a variety of efforts to improve service delivery for children and youth with ASDs. During 2008-09, New York State provided early intervention services to 4,486 toddlers diagnosed with ASD, at a cost of nearly \$90 million. The Department is the recipient of a State Implementation Grant for Improving Services for Children and Youth with ASD and other Developmental Disabilities.

The goals of this project are to increase the proportion of pediatricians and other primary care providers that perform screening for ASD among all children at 18 and 24 months of age; train health care and special education professionals on the use of best practice applied behavior analysis (ABA) and other intensive behavior interventions; implement a quality improvement review tool to monitor the quality of ABA provided to children with ASD and their families statewide; and, implement a web-based family support initiative for parents of children with ASD to help improve their knowledge, satisfaction, access to care, and quality of their child's transition between various components of the system.

The Department is adopting new regulations, effective June 3, 2010, to establish standards and reimbursement rates for the use of paraprofessionals in the delivery of intensive behavioral interventions using ABA to children in the EIP. These new regulations will require agencies who deliver ABA services to children in the EIP to adhere to rigorous requirements for the delivery of ABA services, including supervision and training of behavior aides. It is anticipated that these new standards and rates will improve both the capacity and quality of ABA services for children in the EIP.

The Department maintains an ongoing training program on its evidence-based clinical practice guidelines on assessment and intervention with young children with ASDs (the first guideline of its kind ever to be issued on this topic), and is issuing a competitive request for proposals to update the guideline to reflect new findings from science on effective practices for early identification, evaluation, and treatment of children with ASD. Department staff have worked closely with New York State's University Centers for Excellence in Disabilities on autism-related activities, including presentations to LEND programs and development and submission of a proposal to AUCD to establish benchmarks for the early identification, evaluation, and diagnosis of children with ASD.

Department staff served on an interagency task force convened by the Office of Mental Retardation and Developmental Disabilities (OMRDD) under its Autism Platform, to examine how New York supports people diagnosed with ASDs and develop strategies to improve

interagency coordination of services, maximize the impact and effectiveness of services and agency functions, elevate New York's ASD competency, and identify opportunities for public-private partnerships to improve services for individuals with ASDs and their families. Areas of focus include early identification of children with ASD, better coordination of State services, increased dissemination of ASD information, coordinated ASD research, and lifelong service delivery. A final report detailing the work of this Task Force and recommendations is available on the OMRDD website, http://www.omr.state.ny.us/autism/hp_autism_platform.jsp. An outgrowth of this initiative is a new interagency website, New York ACTS, http://www.omr.state.ny.us/nyacts/nyacts_events.jsp, maintained by OMRDD in partnership with members of the interagency task force, including the Department, designed to serve as a centralized resource on ASD related events and activities.

4. MCH Program Capacity by Pyramid Levels

a. Direct Health Care Services

Health Workforce: A priority of the Department is to ensure the availability of a cadre of health care professionals throughout the state. National health care reform efforts have focused largely on expanding health insurance coverage to the uninsured or underinsured, which will likely increase the number of individuals seeking health care. This may exacerbate a physician workforce shortage that already exists in some areas of New York State.

In 2009, the Center for Workforce Studies, School of Public Health, University at Albany, conducted a study to analyze New York State physician supply and demand. In 2006, there were 79,451 licensed physicians in New York State. Seventy-nine percent (62,770) were active patient care physicians. Of the active patient care physicians, 72 percent practiced in downstate New York (New York City, Long Island and Westchester County), and 91 percent practiced in urban communities. The ratio of physicians per patient was highest in the New York City region, with 387 active patient care physicians per 100,000 population, with the lowest ratio being in the Mohawk Valley, with 165 physicians per 100,000 population. More than 19,000 physicians reported one of the primary care specialties (family medicine, general internal medicine, and general pediatrics) as their specialty. Between 2002 and 2006, the number of primary care physicians per 100,000 population grew in all regions of New York except Central New York, Mohawk Valley, North Country, and Western New York.

In a February 2010 report to the New York State legislature (Doctors Across New York), it was reported that general surgeon physicians had decreased by 14 percent over the past five years and there were seven counties in New York State without obstetricians/gynecologists. The same report found that the number of dentists registered to practice dentistry in New York State declined from 16,872 in 1997 to 15,291 in 2006. There are currently 13,552 dentists in active practice in New York State with an average age of 52 years. Approximately 24 counties have emerging shortages, with only one dentist per every 3,000 people. However, there has been a growth in a different fraction of the health care sector in New York. New licenses issued to nurse practitioners and physicians' assistants have increased substantially, while the growth of licensed midwives has varied year to year, with overall growth minimal.

The demographics of physicians in New York is changing as well. In 2006, active patient care physicians were predominantly male (70 percent), however, female physicians were significantly younger than their male counterparts, reflecting the growing number of women entering the profession. 70 percent of active patient care physicians were non-Hispanic Whites. 10 percent of the physician workforce was Black/African American, Hispanics/Latinos, and American Indians while 35 percent of New York's population is Black/African American, Hispanics/Latinos, and American Indians.

There are also emerging issues with the public health work force as well that will challenge the Department and local health departments to meet New York's public health need. A 2000 United State Health and Human Services Administration study found New York State had approximately 73 public health workers per 100,000 population as compared to 158 per 100,000 population for the entire country. A 2007 study conducted by the Association of State and Territorial Officials (ASHTO) reported that the median age of the state public health workforce is 47, whereas the median age of the overall American workforce is 40.8. New York's average age increased from 46 in 2003 to 53 in 2007. 70% of public health sector employees are classified as "knowledge workers", requiring specialized education, training or skills, while only 32% of the private sectors workers are knowledge workers. A 2005 ASTHO study found that government agencies are facing a major leadership crisis with some public health agencies facing leadership turnovers of 50% or higher. Finally, a national survey determined that 80% of the current national workforce lacks any formal training in public health. These data highlight emerging trends in types of health care and public health professionals available to meet the need of New York's rural and diverse populations.

The Federal government assists New York with workforce development and more equitable distribution of health resources through several Health Resources and Services Administration (HRSA) programs. New York State is also developing resources to ensure New Yorker's have access to quality health care and public health services as follows:

- 410 funded health care sites including 162 Community Health Center Only sites; 66 Community Health Centers/Health Care for the Homeless Sites; 57 Community Health Centers/Health Care for the Homeless/Public Housing/Migrant Health Center sites; 44 Community Health Center/School Based Health Center sites; 23 Community Health Center/Migrant Health Center sites; 17 Community Health Center/Health Care for the Homeless/ School Based Health Center sites; 9 Health Care for the Homeless and Public Housing sites; 2 Community Health Center/Public Housing/School Based Health Center sites; and 30 additional unidentified sites;
- 270 currently and formerly obligated National Health Services Corps loan repayment and scholarship clinicians, including 192 primary care physicians, nurse practitioners, physician assistants, and midwives, 59 dentists, 9 social workers, 7 psychiatrists, and 4 dental hygienists;
- the State Office of Rural Health with funding as follows:
 - three rural health services outreach grants;
 - one state rural hospital flexibility grant resulting in 11 grants to Critical Access Hospitals;
 - one small hospital improvement grant resulting in 19 grants to rural hospitals;
 - two small health care provider quality improvement grants;
 - three rural health network development grants; and,

- one rural health network planning grant.
- nine training grants to improve workforce diversity;
- 56 scholarship and loan programs for disadvantaged and/or financially needy students in health professions;
- 101 training grants to improve access to health care for the underserved;
- 12 training grants to improve public health;
- five projects training maternal and child health professionals;
- a Workforce Information and Analysis State Center for Excellence;
- one EMS for Children State Partnership grant;
- three Ryan White Part A Emergency Relief Assistance and three Minority AIDS Initiative (MAI) awards in the City of New York, Dutchess and Nassau/Suffolk Counties;
- a Statewide Ryan White Part B grant for HIV/AIDS care, including the AIDS Drug Assistance Program;
- 44 organizations receiving Ryan White Part C grants for Early Intervention Services, Capacity Development and Planning;
- 12 Ryan White Part D HIV/AIDS programs for children, youth and families;
- one Ryan White Part F AIDS Educational Training Center;
- 21 Ryan White Part F Special Projects of National Significance (SPNS) grants;
- 24 organizations (Ryan White Part F) providing oral health services to people living with HIV/AIDS;
- a grant for HIV/AIDS care, including the AIDS Drug Assistance Program; and,
- one traumatic brain injury grant.

New York also provides funding to address health care professional shortages. Doctor's Across New York (DANY) is a fully state-funded program aimed at increasing access to health care in underserved regions of the state. The **Physician Loan Repayment Program** of DANY provides up to \$150,000 in loan repayment in exchange for a 5 year service obligation. There are 2 components of this program:

- Residency Program Loan Repayment Tracks – teaching hospitals are eligible to apply for loan repayment positions on behalf of physicians who complete training in primary care or specialty tracks and subsequently practice in underserved area(s)
- Physician Loan Repayment - hospitals and other health care facilities licensed by NYSDOH or operated or licensed by municipal and county governments and private physician practice organizations and individual physicians may apply for loan repayment guarantees to practice in underserved areas.

DANY also has a **Practice Support** program that has 2 components including:

- Practice Support to Establish or Join Practices - Physicians are eligible to apply for funds to support the costs of establishing or joining practices in underserved communities.
- Practice Support to Recruit New Physicians - General hospitals and other health care providers are eligible to apply for funds to recruit new physicians to provide services in underserved communities.

DANY is presently funding 41 Physician Loan Repayors and 42 Practice Support program recipients.

New York State has approximately 180 **federally-designated primary care shortage areas and facilities** that contain 2.2 million underserved populations and 4.6 million total population, mostly residing in rural and inner-city areas. Access to care in rural areas is especially variable. Providers are usually clustered in small cities and towns, but are caring for residents whose homes are scattered over larger geographic areas. Access problems can be exacerbated by a shortage of health personnel and by fiscal constraints of rural health care facilities. HCRA 2000 continued numerous provisions designed to assist rural areas and rural hospitals. To help to ameliorate these issues, the Department is charged with applying for health professional shortage designation and re-designation on behalf of communities seeking the designation.

The **New York State Council on Graduate Medical Education** has been involved in developing policies that support the education of primary care physicians, expanding opportunities for training of physicians who are under-represented minorities, and expanding use of community-based ambulatory care sites as training sites for physicians. In addition, New York's **Area Health Education Centers** are expanding opportunities for training students in primary care and for engaging students in health careers.

As the designated **Primary Care Organization (PCO)**, the State Health Department sponsors or collaborates with several programs designed to increase the health workforce in underserved areas of New York State. These include the federally-funded **National Health Service Corps** loan repayment and scholarship programs and the state-funded scholarship program, the **New York State Regents Scholarship Program in Medicine and Dentistry**, and the **Doctors Across New York** program to support that all provide financial support and incentives for health care professionals to practice in underserved areas of the state. Additional programs administered by the PCO include:

- **Limited Medical and Dental Licensing Program**- assists foreign-born dentists and physicians obtain limited licenses in exchange for service obligations. Process about 250 each year and provide employment verifications for 675 each year.
- **State-30 J-1 visa waiver program**- process, obtain approvals for and provide 30 annual waivers to non-resident physicians in exchange for service in underserved areas. Monitor their service obligations.
- **ARC visa waiver program** - provide an average of 4 to 5 waivers similar to State-30 except limited to ARC counties, and monitor their service obligations.
- **Other Visa Waiver and non-immigrant clinician issues** – work with HHS and federal visa authorities to assist non-immigrant alien clinicians secure visa waivers and work authorizations to serve in underserved areas.

The **National Health Service Corps**, with two program components, is highly competitive. The **National Health Services Corps Loan Repayment Program** pays for up to four years of education at varying amounts. There is one year of obligated service for each year of assistance. The **National Health Services Corps Scholarship Program** pays tuition, fees, books, supplies, equipment and a monthly stipend. The program will pay for up to four years of assistance, with one year of obligated service for every year of assistance. The **Regents Scholarships in Medicine and Dentistry Program** gives disadvantaged minority candidates priority in accessing

up to \$5,000 annually in tuition, fees, books, supplies and equipment for up to four years, with one year of obligated service for each year of assistance.

Finally, under the Health Care Reform Act (HCRA), funding is designated to **encourage education of minorities in health professions**, and monies are available for **loan repayment**.

Title V staff work with staff in the Office of Health Systems Management's Division of Health Facility Planning and key stakeholders in the field to identify potential shortage issues, such as obstetrical and dental shortages, and ensure hospitals and health care providers in the field are aware of the resources offered to address potential shortages.

The Department also funds and administers a number of health care programs to reach underserved areas of the state and populations ordinarily hard to engage into the health care system. All of these programs strive to increase access to comprehensive, high-quality, primary and preventive care, improve access for vulnerable and underserved populations, and to strengthen the safety net within communities to address the needs of the vulnerable populations at risk for poor health outcomes. In addition to the wealth of health care resources in New York State, the following initiatives specifically promote access to quality care for New York's pregnant women, mothers, infants and children:

The **Family Planning and Reproductive Health Care Program** provides comprehensive reproductive health care services throughout New York State. 49

family planning agencies with 189 clinics provide free or low cost contraceptive services to nearly 343,000 women, including nearly 100,000 teens. These providers serve as a "safety net" for many of New York's underserved adolescents, women and men, providing primary and preventive health care in addition to family planning services. The program also supports initiatives targeted to high risk populations and to help address issues with disparities as follows:

- The Department funds four Family Planning Benefit Program (FPBP) Coordinators across the state to provide outreach, information and technical assistance to family planning providers on engaging individuals into the programs and streamlining processes to decrease barriers to care.
- Immigrant Women's Project of Family Planning Advocates of NY (FPA) – The diverse make-up of New York's population presents significant challenges to engaging and providing health care services. While many individuals can find the complex health care system difficult to navigate, the addition of language, financial and cultural barriers can make the process more challenging if language and cultural issues are involved. Family planning clinics are often the sole source of health care for uninsured and underinsured women. The Department funds FPA to offer training to family planning agencies, to enable them to develop strategies for providing more culturally and linguistically competent, reproductive health services.
- Family Planning Services for Incarcerated Women - The Department, in collaboration with the Department of Correctional Services (DOCS), provides family planning services, including health education and referrals, to inmates nearing their release dates from prison (Albion Correctional Facility, Bedford Correctional Facility, and Taconic Correctional Facility) to assure women will have access to birth control and information on health and reproductive health care issues prior to release into the community.

School-based Health Centers (SBHCs) were originally established in New York as demonstration projects under Chapter 198 of the Laws of 1978, with SBHCs jointly approved by the Commissioners of Health and Education. The school-based health centers were made permanent by Chapter 170 Laws of 1994 which granted establishment authority to the Commissioner of Health as Article 28 facilities (hospitals or diagnostic and treatment centers). New York State has one of the largest SBHC program in the nation. There are more than 200 school-based health centers sponsored by 55 community health and mental health services providers. Collectively, these SBHCs provide primary and preventive medical and mental health care services to more than 170,000 students living in high-need areas. New York establishes these centers only in areas of high need for services and under the auspices of an Article 28 facility. The Department also authorizes freestanding school-based dental services under this same provision of law.

The **Medicaid Prenatal Care Program** was created in 2009 after the passage of new legislation (Chapter 484 of 2009) that made significant changes to the delivery of prenatal care in New York State. The new legislation eliminated the Prenatal Care Assistance Program (PCAP) model based upon preferred provider status and special rates and instead required a universal standard of prenatal care that would be required for all women receiving prenatal care in the Medicaid Program, not just those receiving services in PCAP clinics. In addition, the legislation expanded access to presumptive eligibility for pregnant women beyond those clinics that were formerly PCAP clinics, to all licensed clinics in the state with prenatal care on their operating certificate. The Title V program worked collaboratively with the Department's Office of Health Insurance Program (OHIP) to craft the new legislation and during 2008-2009, worked with OHIP and internal and external stakeholders to develop updated prenatal standards of care for all pregnant women enrolled in Medicaid. The Title V program also continues to work closely with OHIP to implement and monitor the new law.

New York State has a long-established system of regionalized perinatal care with highly specialized **Regional Perinatal Centers (RPCs)** in each region of the state. These Centers provide tertiary level clinical care, prenatally and during the intrapartum and postpartum period, to high-risk mothers and newborns. They help ensure that high-risk mothers and newborns receive appropriate levels of care by working with their affiliate hospitals to provide quality improvement oversight, including monitoring of perinatal morbidity and mortality and providing education and technical assistance to physicians and others. The regionalized system of care facilitates access to the appropriate level of care and expertise for all high risk mothers and babies.

Several New York home visiting initiatives work to address barriers to care and engage women into early and continuous prenatal care and their families into primary and preventive health care. 23 Department funded **Community Health Worker Programs** conduct extensive one-on-one street outreach to identify and engage pregnant women not already enrolled in prenatal care to improve maternal and newborn outcomes, providing ongoing education and information on issues of importance to pregnant women and families, and ensure the family has access to other needed services. The **Community Access for Prenatal Care (CAPC) program** conducts street outreach to engage high-risk substance using, HIV positive pregnant women into prenatal

care in targeted zip codes of the South Bronx, Central Brooklyn, Northern Manhattan, and Buffalo. New York is home to three **Nurse Family Partnership Programs** that promote mothers' personal health, parents' care of the child, environmental health, family support of the mother and parents' life course development. Nurses address these through assessment, education, promotion of behavioral change, and referral of families for needed health and human services. **Healthy Mom-Healthy Baby Program** is New York's newest state-funded home visiting program and is being implemented in the six high need counties. Local health departments are funded to engage key stakeholders in planning and implementing countywide systems of care that includes hospitals, clinicians, community-based organizations to develop coordinated systems of care, conduct outreach to identify women and families in need of prenatal care and other services, develop infrastructure, coordinate referrals between home visiting programs and other services that exist within the community, and provide home visiting services, as needed. A major priority of the program as well is to engage pregnant women into New York's Managed Care system, thereby providing access to all the supports and services offered through Managed Care.

The **American Indian Health Program** clinics provide access to primary medical care, dental care, and preventive health services for approximately 25,000 Native Americans living within reservation communities. The program provides funding for services to enrolled members of nine recognized American Indian nations in New York State. The nine nations are: Tonawanda, Tuscarora, Onondaga, Shinnecock, Unkechaug, Cayuga, St Regis Mohawk, Seneca and Oneida. The nation clinics, located on tribal lands, are the medical home for many of the nation members. Each clinic provides primary preventive care and dental services. Any specialty care must be referred off site to physicians in the surrounding community.

New York's **Migrant and Seasonal Farmworker (MSFW) Health Program** seeks to provide an estimated 30,000 MSFWs and their family's access to high quality, culturally and linguistically appropriate health and social support services, focusing primarily on removal of barriers to access and linkage to needed services. Typically, about 20,000 individuals receive medical and/or support services annually; with about two-thirds being adults (>18yrs) and one-third children (0-18yrs).

The **Rape Crisis and Sexual Violence Prevention Program** provides direct advocacy, counseling and support services to victims of rape and sexual assault, as well as community-based Sexual Violence Prevention through community awareness and primary prevention education programs, engaging local youth-serving agencies, schools, colleges/universities, and other venues where youth gather; or through community mobilization efforts through developing local coalitions to influence factors that lead to sexual violence.

Children with Special Health Care Needs (CSHCN) are children age birth to 21 who have, or are suspected of having, a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. Serving CSHCN is a key priority of the Title V program. Program components include:

- Grant contracts to support local CSHCN programs with 56 local health departments (LHDs) and one community-based organization; these local programs provide information and referral services to families of CSHCN and assist the Department in assessing local needs.
- In conjunction with the Wadsworth Newborn Screening (NBS) Program, oversight of a statewide network of 166 hospital-based specialty centers that accept referrals of infants with positive newborn screens for endocrine, metabolic, or hemoglobinopathy disorders, or cystic fibrosis. Approved centers have the capacity to provide multi-disciplinary diagnosis and treatment for children with these conditions.

The **Physically Handicapped Children's Program (PHCP)** was implemented in 1925 and is administered by LHDs. PHCP has two components:

- **Diagnosis and Evaluation (D & E) Program** reimburses health care providers for the diagnosis and development of a treatment plan for eligible children. D & E services are approved by LHDs and paid directly to the providers by the Department up to 100% of the maximum rate allowed by Medicaid.
- The **Treatment Program** reimburses specialty providers for the ongoing treatment of CSHCN who are medically and financially eligible in their county of residence. Treatment services are approved and paid by LHD programs and reimbursed by the Department to LHDs at the rate of 50%. There are no contracts; providers submit vouchers to receive reimbursement.

Dental rehabilitative services are available both under the Medicaid Program and the Physically Handicapped Children's Program. Screening clinics are provided in Article 28 facilities in New York City. In other areas of the state, the Department has implemented a new process for the Dental Rehabilitation Program in Upstate counties that bypasses screening clinics and allows initial evaluations to be done by the child's orthodontist. In all participating counties outside of New York City, children who are financially eligible for services have direct access to orthodontists who perform screening exams and request authorization for the services through NYSDOH. Additional Diagnostic and Evaluation funds are used for non-Medicaid recipients who sought services under the Physically Handicapped Children's Program.

Early Intervention (EI): New York has one of the strongest Early Intervention Programs in the nation with 4.3% of infants and toddlers under age 3 being served each year. Children and their families receive a broad set of services as a result of significant state and local resources committed to the program.

Preschool and School Supportive Health Program: For Medicaid-eligible children ages three through twenty, Medicaid also reimburses counties and school districts for the provision of a wide array of medically-related services in the students' individualized educational programs.

Several federal **Home- and Community-Based Services Medicaid Waivers** allow the State to provide non-traditional services in the community to populations of special needs children who qualify for institutional placement. There are waivers specifically for physically disabled children and for developmentally disabled children who would not otherwise qualify for Medicaid coverage.

Federally Qualified Health Centers/Community Health Centers: As the state primary care agency, the Department of Health is a partner to a three-way **Cooperative Agreement** with the US Public Health Service and the Community Health Care Association of New York State (CHCANYS), the organization representing the bulk of the Federal 330 contractors in New York. This cooperative agreement provides the basis for mutual support of primary care development. Community Health Centers are often contractors for DOH initiatives under MCH, Family Planning, School-based Health Center and the Primary Care Initiatives. CHCANYS and Department staff will assist localities with obtaining designation as a medically underserved area or a health professional shortage designation.

Private Sector Resources: New York remains a world center for commerce, learning, finance and the arts. In a time of increasing government fiscal restraint and increasingly complex social and health issues, private sector resources are increasingly called upon to help improve the health of communities. Businesses hold great purchasing power as suppliers of employee benefits and purchasers of health insurance coverage. Business and unions have helped to set the health care agenda and to assist New York in meeting goals for health insurance enrollment, as well. To enhance its competitiveness in national and international markets, and to retain its international stature in business, education, the arts, research and development, continued collaboration from all sectors, including business and private concerns, is expected, enlisted and enjoyed. The New York State Department of Health regularly partners with the private sector to address issues related to health, education and public health and safety.

b. Enabling Services

The New York State Department of Health has a strong capacity to provide enabling services through its programs, contractors, and partners. State Title V efforts, in collaboration with contractors and partners, are essential to reducing and eliminating barriers to accessing care.

A major barrier to health and supportive services in New York State can be the inability of the population to understand the information and messaging. The diversity in New York State necessitates ensuring information is provided in a variety of means and different languages. All materials developed for the maternal and child health population are translated into at least six top languages as identified through the census data. New York State regulation requires all hospitals have a language assistance program to ensure hospital staff have ongoing education regarding ethnic and cultural diversity and the patients are provided information in a format and manner that is understandable to them. All Department-funded contractors that have outreach and education programs (e.g., Comprehensive Prenatal Perinatal Services Networks, Family Planning and Reproductive Health Care Programs, etc.) are required to address the linguistic and cultural needs of the high risk communities in their catchment areas. The Children with Special Health Care Needs (CSHCN) program requires that each county has an outreach and education plan that addresses the unique needs of the populations served, and all materials are available in languages understandable to those populations. For those CSHCN programs with lending libraries, materials must be available in a variety of languages as well as audio/visual formats to meet the needs of diverse populations. The Early Intervention Program requires providers to provide information in the dominant language of the family, meaning the language or mode of communication normally used by the parent of an eligible or potentially eligible child, including

Braille, sign language, or other mode of communication. The newly revised Medicaid prenatal care standards also require that prenatal care providers should ensure outreach and health education is provided in a manner understandable to the woman and they should 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

Transportation may also become a barrier to services for some of New York's citizens. New York's Medicaid program provides transportation to medical appointments, including public transportation and car mileage. The Physically Handicapped Children's Program (PHCP) provides transportation to medical appointments. The Early Intervention Program provides transportation necessary to enable the child and the child's family to receive early intervention services. Transportation may be provided directly, by contract, or through reimbursement of the parent for the use of a private vehicle or for other reasonable transportation costs, including public transportation, tolls, and parking fees.

New York offers strong supports to underserved families in New York through the generous public health insurance programs (see Infrastructure-building services section). Families of CSHCH however have specific challenges due to the significant medical needs of their children. New York has developed mechanisms to support families in accessing necessary medical services. PHCP may reimburse the parent for co-payments charged to the parent on behalf of the PHCP-eligible individual. Under the EIP, the municipality also pays all co-payments and deductibles to meet any requirement of an insurance policy or health benefit plan in accessing funds applied to payment for early intervention services. Therefore, children with disabilities in these programs will continue to have access to needed services without the barrier of parents' inability to pay co-pays or deductibles.

Families of children with special health care needs (CSHCN) can experience significant issues in accessing health care services, navigating the sometimes complex service system and generally require additional supports and services to maintain health and family functioning. The Department is fully committed to providing these supports and services in a variety of ways.

Case management and supportive services are provided to New York's CSHCN through several programs. The **Early Intervention Program** provides service coordination to infant and toddlers with disabilities and their families. Through the **Children with Special Health Care Needs Program**, the Department provides grants to support local CSHCN programs with 56 local health departments that provide information and referral services to families of CSHCN. New York has several **Medicaid waiver** programs that provide care coordination and services to CSHCN and their families including:

- Bridges to Health Home and Community-based Medicaid Waiver for Children in Foster Care;
- Care at Home Medicaid Waiver for Developmentally Disabled Children;
- Care at Home for Physically Disabled Children;
- Home and Community-based Services Waiver for Children and Adolescents with Serious Emotional Disturbances;
- Home and Community Based Waiver for Individuals with Traumatic Brain Injury;

- Home and Community Based Services Waiver – Long Term Home Health Care Program; and,
- Home and Community-based Services Waiver for Persons, Including Children, with Mental Retardation and/or Development Disabilities.

Service/care coordinators/ case managers strive to ensure that families are provided necessary information to access the myriad of health and human services in New York State. That includes family support and respite services. Through the Office of Mental Retardation and Developmental Disabilities, families caring for children and individuals at home with disabilities can access family support services, including respite, recreation, family reimbursement for certain services, counseling information, referral, transportation and a range of other services.

Through the Early Intervention Program, family training is provided to enhance a family's ability to care for their child with disabilities, and, since the implementation of the program, the Department has provided each municipality with an annual allocation for use for respite services, using funds available from the Federal Part C grant. Beginning in SFY 2006-07, reimbursement of respite services was transitioned from federal to state funding. A new state general fund appropriation was enacted at the time, in part due to declining federal grant funds for early intervention. At the same time, respite was also transitioned from being an expense that was reimbursed 100% by the State to one that is paid 50% by the State and 50% by counties, up to annual allocation cap for each county and for the state.

The **Early Intervention Partners Training Project** is for parents of young children with disabilities to help them become more actively involved in Early Intervention Program leadership activities. The training sessions provide information, resources, and skill-building activities designed to increase parent advocacy and leadership skills as well as increase their ability to advocate for their child and understand the service system in New York State.

In 2008, the CSHCN Program revised the **“Resource Directory for Children and Young Adults with Special Needs”** to provide information to families so they could more easily navigate NYS' system of care. The resource directory is available in several languages, and is on-line on the Department's public web site.

c. Population-Based Services

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

impaired and to people who are not English- or Spanish-speaking through the AT&T Language Line, extending access to referral services to callers speaking over twenty additional languages.

In 2009 the Growing Up Healthy Hotline provided information to 61,518 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, 7,918 were for provision of pregnancy-related information and services. Less than five percent (3,062) of calls required handling in languages other than English. Of these calls, 2,958 were from Spanish-speaking callers and 104 of the calls were in languages other than English or Spanish. Seventy-nine percent of callers were female, and 21% male. There was an 11% decrease in the total number of calls to the hotline in 2009 compared to 2008 and a 1.7% increase compared to 2007.

Last year, callers requested assistance in the following areas: adult insurance 0.6%, Child Health Plus 2.8%, child/adult care food program 1.6%, dental/orthodontia 0.9%, early intervention 1.7%, educational materials 0.3%, Family Health Plus .9%, family planning 2%, farmer's market 4.8%, food and nutrition programs 1.6%, health department programs 0.9%, immunizations 0.2%, Medicaid for adults 2.9%, Medicaid for children 1%, newborn screening 0.5%, pregnancy testing 0.1%, pregnancy care 12.8%, rape crisis 0.3%, social services 1.7%, summer food program 2.9%, WIC 54.8%, WIC complaints 1.3%, and other 3.2%. Twelve callers asked about perinatal depression information and services.

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

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

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

New York is committed to promoting access to early prenatal care through statewide outreach. The Department implemented a statewide, multimedia prenatal care promotion campaign in May and June of 2010 using television, radio, and print media, including posters; bus sides, shelters and interiors; and subway interiors. The materials advertised the toll-free and TTY hotline numbers. The benefits of prenatal care and access to prenatal care services under Medicaid are broadly promoted and women are given the toll-free Growing Up Healthy hotline number to call for a link to local services. The Department's experience has been that the more media coverage there is, the greater the use of the hotline. As a result of the media campaign there is typically a 60-75% increase in the number of calls requesting information on prenatal care compared to similar periods without media campaigns.

New York also has a toll-free hotline for **Child Health Plus** calls, which is linked to take rollover calls from the National Governor's Association hotline. The Child Health Plus hotline provides the public with more in-depth information about eligibility for Medicaid and Child Health Plus. The number for the Child Health Plus hotline is 1-800-698-4KIDS or 1-800-698-4543.

Local health departments and local departments of social services often get phone calls directly from the residents of their municipality. Local departments of health and social services are generally very active in providing information and referral services on a county level, as are the Comprehensive Prenatal/Perinatal Services Networks. Local agencies also have access to hotline numbers and directories in order to handle calls for residents outside of their districts.

A cross-program media campaign aimed at promoting **adolescent sexual health** was successfully launched in April 2010, to run through at least mid-June. The "Take Control" campaign targets sexually active adolescents aged 15-19 with internet, radio, print and transit advertising, as well as a text-messaging component. The campaign was developed by the Division of Family Health, Bureau of Maternal and Child Health, in collaboration with the Bureau of STD Control, the AIDS Institute, the Bureau of Marketing and Creative Communications, and the New York City DOHMH.

Messaging promotes the use of both contraception and condoms and encourages young people to be tested for HIV and STDs. As the call to action, advertising directs the public to www.nysyouth.net, a Website developed by the DOH-funded ACT for Youth Center of Excellence, the ACT Youth Network and the NYS DOH. Nysyouth.net promotes NYS-specific resources and information for adolescents and young adults regarding: sexual health; decision-making and communication; pregnancy, STD and HIV prevention, including information on contraceptive methods; access to confidential testing and, other reproductive health care services; and other related sexual health topics.

There is also a text-messaging component to receive periodic messages throughout the campaign. The website averaged over 50,000 page views per week in the first month since its launch. The website is being expanded to provide other adolescent health information and information related to adolescent rights. This website is unique as much of the content is developed by adolescents.

The Assets Coming Together for Youth (ACT) Center of Excellence (COE) was created to work with youth-serving organizations to provide technical assistance, training and serve as a clearinghouse for resources and best practices to assure consistent services of the highest quality. The COE is the Family Life Development Center of Cornell University in partnership with University of Rochester, NYS Center for School Safety, and Cornell Cooperative Extension of NYC.

In 1999, the Office of Minority Health created the **State-Community Partnerships Program** for minority health improvement. Through this coalition-focused, asset-based, neighborhood-specific program, twenty three (20) community coalitions have been funded to address community-specific health disparities to promote access to primary and preventive health care.

Using the Spectrum of Prevention framework (this framework is made up of six complementary levels to effect community level change: strengthening individual knowledge and skills; promoting community education; educating providers; fostering coalitions and networks; changing organizational practices; and, influencing policy legislation), these coalitions impact minority health in each of the six levels. The current cohort consists of three community coalitions providing services in Westchester, Manhattan and Onondaga counties.

The Minority Male Wellness and Screening Program conducts outreach to minority men with health screening opportunities and valuable information about preventive health. The programs also raise awareness among providers about minority men's health issues and ways to prevent and improve the early detection of men's health problems. Populations being served by the New York City Department of Health and Mental Hygiene Office of Minority Health are minority males (Latino men, African American men, American Indian men and Asian-Pacific Islander men) associated with faith based organizations across New York City.

The Latino Health Outreach Program provides outreach opportunities to engage more Latinos in the health care system. Populations being served by the four projects across New York State include Latinos across the life cycle (children, adolescents, adults and seniors) who are not engaged at all, or engaged sporadically, with the health care system, and immigrants from countries where Spanish is the primary language.

The **Newborn Screening Program** in the Department's Division of Genetic Disorders performs more than 11 million tests annually for more than 40 congenital diseases and the human immunodeficiency virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS). The tests are conducted on the quarter of a million babies born each year in New York State. The program obtains samples, tracks findings, provides education and follows up on infants needing additional evaluation or treatment.

The purpose of testing newborns is to permit early detection and treatment of these conditions that, if untreated, lead to mental retardation or other disability. In 2009, 249,271 infants were screened for genetic disorders by NYSDOH's Wadsworth Center Newborn Screening Program. All (100%) newborns in NYS are tested for all 45 congenital conditions. The Newborn Screening Program consistently achieves 100% follow-up on confirmed cases. Local health units can and do use Article 6 State Aid reimbursement to pay for follow-up visits by public health nurses or bill insurance companies for these services. Children identified through the metabolic screening process are referred to Children with Special Health Care Needs Specialty Centers. NYSDOH is in the process of certifying/re-certifying various specialty centers.

Clinical genetics services, including follow-up genetics counseling for families of children with inborn metabolic errors are available through the **Genetics Program**. The Wadsworth Center for Laboratories and Research administers programs that cover services to families statewide. Prenatal Genetics Services were provided to 23,417 pregnant women in 2009, and another 23,609 individuals received Clinical Genetics Services through genetics services grantees.

In 1999, the New York State Legislature passed and Governor Pataki signed a bill requiring **Universal Newborn Hearing Screening** in birthing hospitals in New York State. In 2000, the

Department convened an Ad Hoc Work Group on Newborn Hearing Screening. This group advised the Department on the development of policies and procedures for newborn hearing screening, tracking, and follow-up as necessary to ensure successful expansion of the program statewide. Final regulations were published for implementation in August 2001.

The Department receives grant funding from HRSA to expand and improve the Universal Newborn Hearing Screening and Intervention (UNHS) program to assure quality developmental outcomes for infants identified with hearing loss. Recently, letters were sent to all 144 birthing facilities in New York State, comparing individual hospital performance to statewide performance and the Joint Committee on Infant Hearing benchmarks. Fifteen hospitals were required to submit corrective action plans to the Department. Staff completed a review of the policies and procedures submitted by the hospitals and, in some cases conducted follow up conference calls or visits to the hospitals.

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

The Department is authorized to collect, and all birthing facilities are required to provide, aggregate data on newborn hearing screening results each quarter for all infants born in New York State. The collection of aggregate data significantly impacts the Department's ability to follow up on infants who potentially have a hearing loss. New York State is the only state that does not collect individualized newborn infant hearing screening data. As a result, the Department is seeking state legislation that will require hospitals and other health care providers that perform or order newborn infant hearing screenings to report results through a statewide information system; authorize the collection and storage of newborn infant hearing screening results and data in a statewide information system; and, authorize 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.

If legislation is enacted as proposed above, the Department will be actively involved in implementing it over the coming year. Much of the work to design requirement for the data systems for submission of data and storage in the Department's child information system has been completed, but cannot be built until legislation is enacted. The Department also is preparing a Notice of Proposed Rulemaking seeking to change regulations for the Newborn Hearing Screening and Intervention program for the first time since regulations were adopted in 2000. These revised regulations will include changes needed to collect individual level data and other corrections to support improved practices by facilities that have been learned over the last decade of working closely with hospitals to improve screening performance.

The **Adolescent Pregnancy Prevention and Services (APPS) Program** was transferred to the Department on July 1, 2008 through the SFY08 budget/Article VII bill to coordinate administration of the APPS and other adolescent health programs within the department to enhance pregnancy prevention programming. The APPS program addresses four statewide

outcomes: adolescent pregnancy prevention, coordination/community awareness, self-sufficiency, and healthy child development. The **Community-Based Adolescent Pregnancy Prevention Program (CBAPP)** provides comprehensive sexual health education to promote abstinence, delay the onset of sexual activity and reduce the practice of risky sexual behaviors among adolescents; expand educational, recreational, vocational and economic opportunities for teens to provide alternatives to sexual activity and develop skills leading to higher earning power and reducing the need for public assistance; and provide access to comprehensive family planning and reproductive health care services to prevent pregnancies, STIs and HIV. A 5-year grant funding cycle for the new Comprehensive Adolescent Pregnancy Prevention initiative will begin January 2011. This new initiative will combine the current Community Based Adolescent Pregnancy Prevention and APPS programs.

Immunization Services: The **Immunization Program** provided vaccines through the **NYS Vaccines for Children Program**, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted local health departments with disease surveillance and outbreak control activities, and continued to develop a statewide immunization registry. CDC categorical grants and State funds were used to provide staffing in both central and regional offices. Both CDC and State dollars were used to purchase vaccines and support local immunization activities at county health departments. Laboratory reports of Hepatitis B surface antigen-positive mothers are follow-up to ensure that their infants received appropriate vaccinations and treatment.

Over 90% of two year-old children in New York State (outside New York City) are vaccinated in private doctor's offices, not public clinics. Under the **Provider-Based Immunization Initiative**, county staff visit pediatricians and assess the medical records of their patients. The information is then keyed into a computer using CDC-developed software, the Clinical Assessment Software Application, (CASA). CASA calculates the providers' immunization rate and enables them to improve their vaccination protocols, when necessary.

The New York State legislature passed the Immunization Registry Law which, as of January 1, 2008, requires health care providers to report all immunizations administered to persons less than 19 years of age, along with the person's immunization histories, to the Department using the recently launched statewide web-based immunization information system (IIS). Once fully implemented, this system, known as the New York State Immunization Information System (NYSIIS), will be the official source of New York State immunization information. The goal of the new immunization information system is to establish a complete, accurate, secure, real-time immunization medical record that is easily accessible and promotes public health by fully immunizing all individuals appropriate to age and risk.

Childhood Lead Poisoning Prevention: The **Childhood Lead Poisoning Prevention Program** coordinates efforts to prevent, detect and treat childhood lead poisoning; educates the public and health professionals about prevention, early detection and appropriate medical management of childhood lead poisoning; ensures that families of children with lead poisoning are given appropriate advice and assistance in locating and eliminating sources of lead within the child's environment; and, collects and analyzes statewide data on the extent and severity of childhood lead poisoning.

In New York, blood lead testing is done primarily by the child's medical provider. The Childhood Lead Poisoning Prevention Program has contracts with 58 local health departments to provide prevention programs and provide care coordination. The Department contracts with three teaching hospitals to serve as Regional Lead Resource Centers. Local health departments and State Health Department District Offices provide environmental assessments and assure lead hazards are corrected.

SIDS Prevention: The Department contracts with State University of NY Research Foundation to operate a statewide SIDS prevention program. The program functions as the New York State Center for Sudden Infant Death located at SUNY Stony Brook with 4 subcontracted regional offices. The programs conducted 125 educational programs and 50 public awareness programs. The Center also released health education materials about the dangers of placing infants to sleep in adult beds. The Center maintains membership in 25 coalitions addressing infant mortality risk reduction.

Childhood Overweight Prevention: Eat Well, Play Hard was initiated in 1997 as a comprehensive response to the childhood overweight epidemic. The program's three-part strategy has been incorporated into all New York State Department of Health nutrition programs. To reduce the prevalence of overweight among New York State children, Eat Well, Play Hard promotes:

- Increasing developmentally-appropriate physical activity;
- Increasing the consumption of 1% or lower fat milk and low-fat dairy products; and
- Increasing the consumption of fruits and vegetables.

Eat Well, Play Hard later became a part of New York's obesity prevention program. This program also includes other strategies and programs such as Just Say "Yes" to Vegetables, Steps to a Healthier New York, the Hunger Prevention and Nutrition Program, Minority Health Mini-Grants, Healthy Heart, Team Nutrition Training Grants, Obesity Prevention through Physical Activity and Nutrition, and the Statewide Strategic Plan for Overweight and Obesity Prevention. Eat Well, Play Hard also sponsors physical activities such as bike trips. These initiatives are under the supervision of the Division of Chronic Disease Prevention and Adult Health and the Division of Nutrition.

New interventions focus on improving the health and fitness of young children and preventing the development of overweight among preschool children by targeting the environment where children spend an increasing amount of time: preschools, child care and Head Start centers. During 2009, the Eat Well Play Hard Community Projects facilitated the implementation of more than 300 environmental and systems changes in targeted settings across 22 counties in New York State. Examples include assisting school and district wellness committees around the state in implementation of policies that support healthy snacks, consistent food standards across the school campus, and increased physical activity opportunities; increased the number of schools and day care centers that have switched to low-fat milk and incorporated other healthier menu options; and implemented new farmers' markets in low-income communities.

The Department is also addressing obesity by strengthening its **Breastfeeding promotion** initiative. Some of these activities are listed below:

- The NYS Legislature enacted and the Governor signed into law the *Breastfeeding Mothers' Bill of Rights*, which specifies the rights of pregnant women and new mothers to be informed about the benefits of breastfeeding, and to obtain specific supports from health care providers and health care facilities during pregnancy, after delivery and after discharge from the birthing facility. The new law subsequently went into effect on May 1, 2010.
- In an effort to improve exclusive breastfeeding rates in maternity hospitals in New York, infant feeding data from hospitals (excluding New York City) was analyzed using the Statewide Perinatal Data System and shared with hospitals for benchmarking and quality improvement. The Department is offering the *Ten Steps to Successful Breastfeeding Online Course* (18-hour course) to staff in all obstetrical hospitals across NYS.
- In January 2009, the NYS WIC Program (overseen by the Division of Nutrition's Bureau of Supplemental Food Programs) became the first program in the country to implement newly redesigned WIC food packages. In following the Department's goals and the American Academy of Pediatrics (AAP) recommendation that breastfeeding continue for 1 year and beyond, WIC took into consideration the mother and infant to design a food package to meet their combined nutritional and energy needs. Extended food benefits are available to the exclusively breastfeeding mother for the first year of breastfeeding (instead of six months). The new food packages coincided with WIC's initiatives to enhance breastfeeding support and provide participant centered nutrition education.

The Department of Health's formerly funded the American Congress of Obstetricians and Gynecologists-NY (ACOG) Safe Motherhood initiative, a voluntary maternal death review process. In order to ensure review of all maternal deaths in the state, the Department has initiated the **Maternal Death Review Program** (MDRP), a process that is mandatory on the part of hospitals, and will include a data matching component to review those deaths not identified by hospitals. All cases will be reviewed to identify the pregnancy related deaths, defined as the death of a woman while pregnant or within 1 year of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to, or aggravated by her pregnancy or its management, but not from accidental or incidental causes. Information gleaned from these reviews will be presented to an Expert Workgroup to develop recommendations for improvement to prevent deaths in the future.

Health Information Materials: As in past years, the **Bureau of Health Media and Marketing** planned, developed, produced, distributed and/or evaluated MCHSBG-related materials and campaigns. The following is a partial listing of recent projects. For a complete list, please visit the Department's website:

http://www.health.state.ny.us/nysdoh/publication_catalog/n_zpub.htm#oral_health

- After a Sexual Assault (brochure)
- Anabolic Steroids and Sports
- Antibiotic Resistance (professional brochure, viral prescription order forms and prescription pads)
- Are You and Your Baby in Danger? (brochure)
- As I Grow (new parent developmental guide and video)

- Asthma: Don't Let Asthma Knock the Wind Out of Your Child (statewide campaign, brochures in English, Spanish, French, Chinese, Russian and low-literacy versions; posters in English and Spanish; TV and radio spots; prescription form)
- Berenstain Bears Tobacco Use Prevention Initiative (booklets in English and Spanish for all second graders)
- Booster Seat Demonstration Project (activity book, jungle, CD-ROM, tambourine, sunglasses)
- Breast is Best (brochure)
- Breast is Best...Unless you have HIV (poster)
- Child and Adult Care Food Program (brochures and posters in English and Spanish)
- Condom Comebacks...Things to do instead of doin' it. (wheel)
- Dental Sealants Work Hard (stickers)
- Dental Sealants at Work (handout)
- Ear Infections in Children (brochure)
- Early Prenatal Care (poster)
- Eat Well, Play Hard (nutrition and activity campaign for children)
- Eat at Moms (for WIC on breastfeeding)
- Emergency Contraception (brochure)
- Fall Prevention for Children Birth to Three (brochure)
- Female Circumcision (brochure)
- Folic Acid Awareness Week (informational campaign)
- Get Mouthy! (Oral Health Issues for Teens)
- Guidelines for Oral Health Care during Pregnancy and Early Childhood (for providers)
- Having A Baby (booklet in English and Spanish)
- Help Your Baby To A Healthy Start (brochure)
- How to Have a Healthy Baby (brochure)
- If you do drugs, your baby's health can go up in smoke (poster)
- Important News for Pregnant Women (poster on HIV testing)
- Life! Pass it On! (brochure on organ donation)
- Maternity Information Law (brochure given to each mother upon registering for hospital maternity services)
- Molly and Michael Molar (about dental sealants)
- Moms Like You (for pregnant teens)
- Mr. Fluoride Beats the Sugar Bugs (about fluoride supplements)
- Newborn Hearing Screening Education (4 brochures and 7 posters in English, Spanish, Chinese, Creole, Russian, Urdu and Bengali)
- No One Deserves to Be Abused (poster)
- Oral Health is Important (for Kids with HIV/AIDS)
- Oral Health Plan for New York State
- Parents Resource Directory for Families of Children with Special Health Care Needs (English, Spanish, French, Russian, Mandarin Chinese and Urdu)
- Pedestrian Safety (formative research/focus groups)
- Physician and Parent Guidelines for the Treatment of Otitis Media (brochure)
- Pregnancy Care calendar – Updated to include Oral Health

- Pregnant? WIC can help you eat right from the start (poster)
- Protect Your Baby from Smoke (brochure)
- Sale of BIDs (poster)
- Scooter Safety (brochure)
- Shaken Baby Syndrome (brochure, information kit, poster- see our website)
- Take Folic Acid Every Day (emery boards with countertop display holder)
- Welcome to Parenthood (packet given to every new mother after delivery, English and Spanish)
- WellNYS Weekend (health screening fact sheets)
- A Whale of a Smile (stickers)
- Your Baby is Special and So Is Your Breastmilk (brochure)
- Your Guide to a Healthy Birth (booklet, English and Spanish)

d. Infrastructure-Building Services

New York has a well developed quality infrastructure for health insurance, with linkages to essential public health services, health information, education and collaboration among agencies.

Health Insurance Initiatives: Improving and sustaining access to high-quality, continuous primary health care and treatment services are critical to improving health outcomes for all New Yorkers and achieving the Department’s public health and maternal and child health priorities. The hallmarks of success will be prevention, early intervention, and continuity of care through establishing and maintaining a “medical home” for every New Yorker. Success will also depend on the actual delivery of appropriate, high-quality, comprehensive health services to people in need, and requires practitioners to be knowledgeable about and practice good preventive and therapeutic medicine.

In a report recently released by the New York State Insurance Department, it was found that New York had an uninsured rate of 18.1 percent for adults ages 19 to 64 vs. 20.4 percent nationally. The report also states that among working citizens in New York age 18 to 64, the number of uninsured is 1.61 million. New York State’s uninsured are largely working adults or their dependents or individuals from low-income families: nearly two-thirds of the uninsured have family income no greater than 200 percent of the federal poverty level (FPL). Over 80 percent of the uninsured are workers or their dependents. Coverage patterns vary in New York City and in the rest of the state. New York City has a greater share of uninsured people than does the rest of the state. Residents outside New York City are more likely to have employer-sponsored insurance and are less likely to have public coverage or to be uninsured. Many uninsured New Yorkers are eligible for existing public health insurance.

While employer-sponsored insurance coverage is the dominant form of coverage for employees, almost one-third of employees do not have employer-sponsored insurance. **The Healthy NY program** offers an option to both small business owners and lower income working individuals to obtain health insurance at rates that are more affordable than market rates. Created as part of the Health Care Reform Act of 2000, the Healthy NY program was initiated in 2001 and has 160,000 enrolled members as of the end of 2009. With eligibility limited to uninsured workers

and their families, it is a state sponsored program with standard, streamlined benefit packages and state-funded reinsurance.

In 2007, New York State initiated the Partnership for Coverage to examine options for ensuring access to affordable, quality health insurance coverage for all New Yorkers. New York has demonstrated an ongoing commitment to health insurance coverage, especially through New York's public health insurance programs that provide comprehensive health care coverage to 3.7 million people or 21.4% of all non-elderly New Yorkers. Through the Partnership for Coverage, the Department, in collaboration with the State Insurance Department, was charged with developing, evaluating and recommending proposals for achieving affordable, quality health insurance coverage for all New Yorkers.

The incentives to address the problem of the uninsured are strong. The health and financial implications of going without insurance coverage are serious. A lack of insurance has been shown to lower access to care and limit the use of preventive services. The evidence strongly indicates that lack of coverage has adverse effects on the overall population's health as well. Being uninsured can create major financial burdens for families and is also a major contributor to personal bankruptcy. In addition, a large uninsured population leads to inappropriate use of certain types of health care services and puts financial strains on the health care delivery system.

The recent economic downturn serves to increase these pressures. While the most recent available data are not current enough to measure the impact of the recession, research does indicate that increases in the unemployment rate significantly decrease health insurance coverage. The largest impact on coverage is for adults, as many children (all those up to 400 percent of the FPL) will be eligible for Medicaid, CHIP or fully state-financed coverage, but public coverage eligibility for adults is much more limited. As public program costs increase and demand for public support for safety net hospitals providing care to a larger uninsured population increase as well, financial pressures mount on state and local governments. This is occurring at the same time as overall state general revenues are falling due to the recession

The high number of immigrants in New York State may also account for the number of uninsured New Yorkers. There has been misunderstanding among the documented immigrant communities regarding use of Medicaid and Child Health Plus being used to "count against" immigrants as having used public services (a "public charge"). The Department and Immigration and Naturalization Service (INS) has issued statements to try to correct this misinformation about public charge, and the Medicaid Program has also provided guidance to local districts on this ruling.

Certain groups of undocumented immigrants in New York are entitled to government coverage including:

- Uninsured children are eligible for Child Health Plus under the state-financed portion of the program;
- Anyone accessing care at an emergency room are eligible for emergency Medicaid; and,
- Poor, undocumented immigrant women are eligible for prenatal care using state-only funds.

In May 2000, the United States Court of Appeals for the Second Circuit, in Manhattan, ruled that undocumented immigrant women are not entitled to federally-financed prenatal care. This ruling overturned a 1991 Federal District Court (Lewis v. Grinker) ruling that ordered the federal government to provide prenatal care (care of the unborn) for undocumented immigrants. The children born of those pregnancies, who are US citizens, are still automatically eligible for one full year of Medicaid benefits after their birth. The Court of Appeals sent the ruling back to a lower court for a decision as to how to carry out this ruling, which would affect approximately 13,000 women. It was decided that undocumented immigrant women would continue to receive prenatal care until the lower court provided guidelines. To ensure undocumented women would continue to receive prenatal care, New York passed Chapter 16 of the Laws of 2002 that amended the Social Services Law to continue to provide prenatal care coverage through the program called the Prenatal Care Assistance Program (PCAP) as a State-only funded program. This became effective February 1, 2002. This practice continues under the newly redesigned Medicaid Prenatal Care Program in New York State.

Ensuring access to health care coverage for the uninsured and underinsured remains a very high priority in New York State. New York State's Title V Program will continue to work with the Office of Health Insurance Programs (OHIP), which oversees the State's Medicaid program, to address access to care through public insurance programs as described in the following section.

Transforming New York's Public Health Insurance Programs: In 2007, the Department established OHIP which consolidated operations of the State's public health insurance programs under the direction of the State Medicaid Director. The establishment of OHIP marked the adoption of a new mission for Medicaid, namely to expand coverage and access; to buy value with New York's health care dollars; and, to advance system wide reform. Over the past several years, New York has transitioned towards a fairer, more transparent and straightforward system that better rewards quality and efficiency. New York believes that these changes will result in improvements in quality and outcomes, reduced costs, and better overall health system performance.

In 2007, New York began the critical process of reforming Medicaid's inpatient reimbursement system and transforming Medicaid into a more prudent, value driven health purchaser. In the 2007-08 Budget, the Legislature reduced inpatient rates by \$225 million as a first step in bringing inpatient reimbursement in line with inpatient costs. Most of this funding was reallocated to hospital clinics, community clinics and doctors and practitioners. Outdated outpatient payment methods and rates that had been frozen for over a decade at levels below the cost of providing care acted as a deterrent for physicians to accept Medicaid and for hospitals to treat patients in an outpatient setting. Clinics that serve a large proportion of Medicaid patients struggled financially as a result of reimbursement rates that had not kept pace with inflation or changes in medical practices. Fees paid to physicians and other practitioners were also well below reasonable market rates, making it difficult to ensure patient access to care. To incentivize the provision of enhanced primary and preventive care, the State embarked upon a multiyear commitment to modernize the outpatient payment methodology and to invest over \$600 million in ambulatory care reform.

Recognizing that comprehensive reform meant not only changing the price paid for Medicaid services, but also meant eliminating the “one size fits all” outpatient clinic payment methodology, the Department selected an innovative new payment methodology called Ambulatory Patient Groups or APGs. The APG methodology, unlike the previous flat rate methodology, responds to acuity of patients, as well as changes in the standard of care, and reimburses more specifically for diagnosis and services delivered. The new reimbursement system provides a wealth of information related to specific diagnoses of and services provided to Medicaid patient seen in outpatient clinics that was previously unavailable. Implementation of APGs began in outpatient hospitals clinics and in ambulatory surgical centers in December 2008 and will be implemented in free standing clinics pending approval by CMS retroactive to September 1, 2009.

Medicaid was also significantly underpaying physicians and other practitioners. To remedy this situation and to encourage the participation of more physicians in Medicaid fee-for-service, the State provided funding to permit a 40% increase in the fees paid to physicians, nurse practitioners, midwives and other practitioners effective January 1, 2009. This funding also supported a 10% add on to the fees paid to office based physicians in Health Professional Shortage Areas (HPSAs) and an add-on for weekend and after hours appointments in clinics and office based settings.

In addition, to improve the health of enrollees and prevent more costly hospital admissions and treatment, the State has added asthmas and diabetes education, social worker counseling, cardiac rehabilitation, smoking cessation and screening and brief intervention and referral to treatment (SBIRT) for substance abuse to its list of covered services. Over time, these investment are expect to more than pay for themselves in the form of a reduction in medical costs. In addition, the state will implement a program to incentivize the development of patient centered medical homes. Hospitals and doctors that coordinate and integrate their patients care in accordance with medical home standards will receive additional payments. The State Plan Amendment for medical home incentive payments has been approved by CMS for office based physicians and nurse practitioners, freestanding clinics and FQHCs, but not as yet for hospital based clinics. Implementation is planned for approximately July 1, 2010.

In 2008, New York took a bold step towards ensuring universal coverage for children in the State when, prior to federal funding support, it increased the income eligibility threshold for Child Health Plus from 250 to 400 percent of the federal poverty level, making an additional 70,000 children eligible for subsidized health insurance coverage. In addition, the State expanded Family Health Plus for adults with children and for young adults (ages 19 and 20) to 160 percent of the federal poverty level. Medicaid coverage for foster care children was also extended through age 20 to address the long standing problems children in foster care have had in transitioning to adulthood and independence.

The state has also made substantial process in streamlining the Medicaid eligibility process. A critical need was to eliminate administrative processes that served as barrier to enrollment. To address this need, the state made landmark changes by eliminating the requirements for face-to-face interviews and finger imaging, as well as the resource test for non-SSI applicants. This built on changes made in previous years related to eliminating several eligibility rules for single adults

and childless couples such as the requirement for drug and alcohol screening. As a result of these administrative simplifications, Medicaid retention rates increased from 60 to 70 per cent and total Medicaid enrollment has also increased, by 142,000 in 2008 alone.

Over the past several years, NY has implemented initiatives to increase access and enrollment. For example, authorized medical providers and community-based organizations provide application assistance as “Facilitated Enrollers (Fes).” FEs are able to determine a child presumptively eligible for MA or CHP for a limited time if they appear eligible for coverage based upon uniform criteria. In June 2009, NY received federal approval to waive the six-month waiting period for families with a child under five, or any child whose family must contribute more than 5 percent of their income to purchase insurance. Going forward, the State plans to strengthen the enrollment and renewal process through the establishment of a statewide enrollment center that will include a single, statewide telephone and mail-in renewal system and a toll-free call center for New Yorkers seeking information about, or assistance enrolling in, Medicaid, Family Health Plus or Child Health Plus.

Pregnant women and infants under one year of age, at or below 200% of the Federal Poverty Level (FPL) are eligible for Medicaid. Pregnant women with income of less than 100% FPL are eligible for the full array of ambulatory Medicaid services including, but not limited to, primary care, dental health and eye care as well as other supports and services offered to the Medicaid population. Those with incomes above 100% FPL but less than, or equal to 200% FPL are eligible for coverage for Medicaid Prenatal Care only. Pending approval from the Federal government, income limits for Medicaid eligibility will be increased. Women with incomes up to 120% FPL will be eligible for full Medicaid services. Women with incomes above 120% FPL and up to and including 230% FPL will be eligible for prenatal care services under Medicaid.

The Family Planning Extension Program: Women and adolescents residing in New York State and insured by Medicaid during their pregnancy who lose Medicaid eligibility for any reason are eligible for up to 26 months of family planning benefits immediately following their pregnancy. These women are eligible whether their pregnancy ended in miscarriage, live birth, stillbirth or induced termination. Approved under a Centers for Medicare and Medicaid Services (CMS) 1115 waiver, at present the program is only available from the Department’s contracted Family Planning Providers. The federal Medicaid Program supports 90% of the cost of family planning services for eligible women. The benefit package includes all services normally provided by family planning programs for their patients.

The federal government approved the state's Medicaid waiver to expand family planning services for more than 800,000 New Yorkers, and on October 1, 2002. The **Family Planning Benefit Program** expands family planning eligibility based solely on the countable income being below 200% of the Federal Poverty Level, regardless of previous Medicaid eligibility or pregnancy. Both men and women are eligible. New York is one of a limited number of states that have pursued this approach. Under the waiver, Federal Medicaid will support 90% of the cost of contraceptive services for eligible women and men and the State pays the other 10%. No local share is required of the counties.

Pregnant women and infants under age one who have countable income at or below 200% of the Federal Poverty Level are eligible for Medicaid. New legislation (Chapter 484 of 2009), was enacted that made significant changes to the delivery of prenatal care in New York State. The legislation was developed address the impact of the new Ambulatory Patient Group (APG) payment methodology on Medicaid reimbursement for prenatal care services delivered in the Prenatal Care Assistance Program (PCAP), a preferred provider model supported through Medicaid reimbursement rates developed in the 1980's that was originally designed to provide quality, comprehensive care to high-risk pregnant women. Prior to implementation of the new APG reimbursement methodology, PCAP Medicaid rates had not been increased for many years, which resulted in reimbursement that was increasingly inadequate to provide services consistent with the current standard of care, particularly in light of the increased acuity of women presenting for prenatal care. APGs are designed to pay for actual services delivered to pregnant women, which allows reimbursement to adjust to changes in the standard of care, as well the acuity of the individual patient, and provides substantially better information regarding service delivery than the previous flat rates. The new legislation eliminated the PCAP model based upon preferred provider status and special rates and instead required a universal standard of prenatal care that would be required for all women receiving prenatal care in the Medicaid Program, not just those receiving services in PCAP clinics. In addition, the legislation expanded access to presumptive eligibility for pregnant women beyond those clinics that were formerly PCAP clinics, to all licensed clinics in the state with prenatal care on their operating certificate. The Title V program worked collaboratively with the Department's Office of Health Insurance Program (OHIP) to craft the new legislation and during 2008-2009, worked with OHIP and internal and external stakeholders to develop updated prenatal standards of care for all pregnant women enrolled in Medicaid. The Title V program also continues to work closely with OHIP to implement and monitor the new law.

The updated prenatal standards, effective November 2009, incorporate new evidence-based procedures and practices appropriate to the needs of pregnant women who qualify for Medicaid coverage, regardless of provider or delivery system. They integrate updated standards and guidance from the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), and reflect expert consensus regarding appropriate care for low-income, high-risk pregnant women. The standards provide a comprehensive model of care, including but not limited to: comprehensive prenatal risk assessments; prenatal diagnostic and treatment services; HIV counseling and services; dental care; immunizations; lead poisoning prevention, testing and services; nutritional counseling; screening for genetic disorders; and, testing for fetal well-being. Important new benefits for pregnant women with Medicaid coverage include: diabetes and asthma self-management training, smoking cessation counseling, and mental health counseling services provided by certain licensed social workers. In addition, all women enrolled in Medicaid are presumed eligible for one medically necessary postpartum home health care visit benefit. These comprehensive changes will improve the quality of prenatal/postpartum care provided to pregnant women who receive care under the Medicaid program.

On August 9, 1999, Chapter 412 of the laws of 1999 was signed into law requiring the Department to ensure timely enrollment of newborns whose mothers are in receipt of Medicaid, into the Medicaid program. Effective July 1, 2000, all hospitals were required to provide the

Department the certificate of birth information to facilitate Medicaid enrollment for the newborn. In this way, Medicaid coverage is assured for babies during the first year of life, a critical time for many babies born to low-income families. Enrollment is facilitated via the Statewide Perinatal Data System (SPDS), or, in New York City, the Electronic Birth Record System (EBRS), which was implemented in January 2008.

Medicaid provides comprehensive health care to both medically needy and categorically eligible children in the State under the aegis of **EPSDT**, known in New York as the **Child/Teen Health Program (C/THP)**. Using a broad definition of medical necessity, Medicaid covers medical, mental health and substance abuse in a rich service package. EPSDT standards were developed based on the American Academy of Pediatrics Guidelines as the standard of care, except in cases where State law contravenes.

Medicaid Managed Care: More New Yorkers than ever before are receiving care through managed care providers. Mandatory Medicaid managed care represents the single greatest effort the State has made to ensure that every New Yorker with Medicaid has access to high-quality primary care in a “medical home” model. This ensures that more care takes place within the context of the primary and preventive care setting, with less reliance on more expensive and less continuous forms of care, including the emergency rooms.

Health Plans participating in Child Health Plus are required to submit New York’s **Quality Assurance Reporting Requirements (QARR)** reports annually. Among other measures, the QARR contains measures of preventive care and health outcomes related to maternal, infant, child and adolescent health.

According to the Quality Assurance Reporting Requirements (QARR) Report, there have been significant advances in the quality of care for individuals in Medicaid managed care. With over ten years of QARR data, the Department has seen a trend in which the difference between the historically under-served Medicaid population and those individuals with private insurance has narrowed or disappeared with respect to primary care access and receipt of preventive services. There has been continuous improvement in usage of screening mammograms, cervical cancer testing, and immunizations. In addition, with respect to care of people with chronic diseases like asthma, heart disease and diabetes, there has been an improvement in the delivery of recommended interventions that will positively impact health outcomes. The Department, providers and plans are engaged in prioritizing areas for further quality improvement, which is further advancing the health status of New Yorkers.

The Child Health Plus Program: Child Health Plus provides free or low-cost private health insurance to children from age one month to age 19 in low-income working families who are not eligible for Medicaid. The program is paid for through a combination of state funding and federal funding under Title XXI, the State Child Health Insurance Program (SCHIP). The program encourages parents to seek routine primary and preventative care, resulting in healthier children. Effective September 1, 2008, the household income eligibility level for subsidized Child Health Plus enrollment increased from 250 percent to 400 percent of the Federal Poverty Level (FPL). More than 90 percent of the state’s uninsured children are eligible for subsidized coverage under Child Health Plus and the remaining children are able to buy into the program. New York has seen a steady increase in numbers enrolled (enrollment grew by 151,000 children since January

2008, with 102,000 of these children being enrolled since the program's expansion in September 2008) with a corresponding drop in numbers of uninsured children.

In June 2009, New York received federal approval and support for the Child Health Plus expansion. This approval provided federal matching funds for the expansion going back to September 2008, and included two new exceptions to the six month waiting period for children in families whose household income is between 251 percent and 400 percent of the FPL that dropped employer-based insurance during the six month period prior to the date of application. Now, no child under the age of five or any child whose family must contribute more than 5 percent of their income to purchase employer sponsored health insurance will be subject to the waiting period.

In addition to expanding access to coverage, New York has made it easier to apply for, and keep coverage, and launched a statewide outreach campaign, Connections to Coverage, to promote the availability of public health insurance coverage for all children and eligible adults. This campaign brought information on New York's health insurance programs to more than 40,000 families across the state.

New York is also striving to provide health care services to its most vulnerable citizens. In 2009, Medicaid coverage was automatically extended for all 18, 19 and 20 year olds leaving foster care until their 21st birthday.

Medicaid for Children and Pregnant Women: Please note that as of 2008, Child Health Plus A is called simply "Medicaid" and Child Health Plus B is called simply "Child Health Plus."

The most current information may be found on the NYSDOH website at http://www.health.state.ny.us/nysdoh/chplus/who_is_eligible.htm

The chart below shows how much income can be received in a month and the amount of resources (if applicable) that can be retained and still qualify for Medicaid. The income and resource (if applicable) levels depend on the number of family members who live in one residence.

2010 Income & Resource Levels*					
	Medicaid Standard for Singles People, Couples without Children & Low Income Families		Net Income for Families; and Individuals who are Blind, Disabled or Age 65+		Resource Level (Individuals who are Blind, Disabled or Age 65+ ONLY)
	Annual	Monthly	Annual	Monthly	
1	\$8,479	\$707	\$9,200	\$767	\$13,800
2	\$10,584	\$883	\$13,400	\$1,117	\$20,100
3	\$12,593	\$1,050	\$15,410	\$1,285	\$23,115
4	\$14,622	\$1,219	\$17,420	\$1,452	\$26,130
5	\$16,719	\$1,394	\$19,430	\$1,620	\$29,145

2010 Income & Resource Levels*					
	Medicaid Standard for Singles People, Couples without Children & Low Income Families		Net Income for Families; and Individuals who are Blind, Disabled or Age 65+		Resource Level (Individuals who are Blind, Disabled or Age 65+ ONLY)
	Annual	Monthly	Annual	Monthly	
6	\$18,253	\$1,522	\$21,440	\$1,787	\$32,160
7	\$19,869	\$1,656	\$23,450	\$1,955	\$35,175
8	\$21,943	\$1,829	\$25,460	\$2,122	\$38,190
9	\$23,131	\$1,928	\$27,470	\$2,289	\$41,205
10	\$24,321	\$2,027	\$29,480	\$2,457	\$44,220
For each additional person, add:		\$99	\$2,010	\$168	\$3,015

*Effective January 1, 2010 - Income and Resource Levels are subject to yearly adjustments.

Medicaid and PCAP Final 2009 Income Eligibility Levels (Effective 2/1/2009)									
Age Categories for Children	Monthly Income by Family Size								Each Additional Person, Add:
	1	2	3	4	5	6	7	8	
Children under 1 year Pregnant Women*	\$1,805	\$2,429	\$3,052	\$3,675	\$4,299	\$4,922	\$5,545	\$6,169	\$624
Children 1-5 year	\$1,201	\$1,615	\$2,030	\$2,444	\$2,859	\$3,273	\$3,688	\$4,102	\$415
Children 6-18 year	\$903	\$1,215	\$1,526	\$1,838	\$2,150	\$2,461	\$2,773	\$3,085	\$312

*Pregnant women count as two.

Child Health Plus Final 2009 Family Contributions by Income and Household Size (For Enrollment Effective On or After 7/1/2009)									
Premium Categories	Monthly Income by Family Size*								Each Additional Person, Add:
	1	2	3	4	5	6	7	8	
Free Insurance	\$1,443	\$1,942	\$2,441	\$2,939	\$3,438	\$3,937	\$4,435	\$4,934	\$499
\$9 per child per month (Maximum of \$27 per family)	\$2,004	\$2,696	\$3,388	\$4,080	\$4,772	\$5,464	\$6,155	\$6,847	\$692
\$15 per child per month (Maximum of \$45 per family)	\$2,257	\$3,036	\$3,815	\$4,594	\$5,373	\$6,153	\$6,932	\$7,711	\$780

\$30 per child per month (Maximum of \$90 per family)	\$2,708	\$3,643	\$4,578	\$5,513	\$6,448	\$7,383	\$8,318	\$9,253	\$935
\$45 per child per month (Maximum of \$135 per family)	\$3,159	\$4,250	\$5,341	\$6,432	\$7,523	\$8,613	\$9,704	\$10,795	\$1,091
\$60 per child per month (Maximum of \$180 per family)	\$3,610	\$4,857	\$6,104	\$7,350	\$8,597	\$9,844	\$11,090	\$12,337	\$1,247
Full Premium* per Child per Month	Over \$3,610	Over \$4,857	Over \$6,104	Over \$7,350	Over \$8,597	Over \$9,844	Over \$11,090	Over \$12,337	

*The full premium varies, depending on the health plan chosen by the family.

The Family Health Plus Program: In 2000, the federal Centers for Medicare and Medicaid Services approved an amendment to the Partnership 1115 Waiver, which enabled New York to establish the **Family Health Plus Program**. Like the **Child Health Plus Program**, this program offers comprehensive health insurance at no cost to low-income, uninsured New York State residents who are not income-eligible for Medicaid due to income or resources. However, unlike the Child Health Plus Program, Family Health Plus is a Medicaid funded program and it is for adults only. To qualify, the individuals must be between the ages of 19 and 64 and not meet the criteria for Medicaid but meet the following income criteria:

Parent(s) living with a child under the age of 21 will be eligible if the gross family income is up to:

- 120% of the Federal Poverty Level (FPL) as of January 1, 2001;
- 133% FPL as of October 1, 2001; and,
- 150% FPL as of October 1, 2002.

Individuals without dependent children in their households will qualify with gross incomes up to 100% FPL.

The 2007-2008 state budget made changes to Family Health Plus, similar to the changes in Medicaid and Child Health Plus. Self-attestation of residence and income will be allowed at renewal, and, there will be 12-month guaranteed continuous coverage for adults to reduce gaps in service.

Maximum Gross Annual Income Guide Effective January 1, 2010			
Family Size	Yearly Income	Monthly Income	Weekly Income
Single Adult	\$10,830	\$ 903	\$208
Couples with No Children	\$14,570	\$ 1,215	\$280
Parents/Guardians Living with at Least 1 Child Under 21			
Family Size 2	\$21,855	\$1,822	\$420
Family Size 3	\$27,465	\$2,289	\$528
Family Size 4	\$33,075	\$2,757	\$636
Family Size 5	\$38,685	\$3,224	\$743
Family Size 6	\$44,295	\$3,692	\$851
Family Size 7	\$49,905	\$4,159	\$959
For each additional person add:	+\$ 5,610	+\$ 468	+\$ 107

NOTE: Income levels change annually a guide.

The Family Health Plus managed care benefit package is similar to that of Child Health Plus, covering:

- physician services;
- inpatient and outpatient health care;
- prescription drugs and smoking cessation products;
- laboratory tests and x-rays;
- vision, speech and hearing services;
- rehabilitative services (some limits may apply);
- durable medical equipment;
- radiation, chemotherapy, and hemodialysis;
- emergency room visits and emergency ambulance services;
- behavioral health and chemical dependence treatment services (some limits may apply);
- hospice services;
- diabetic supplies and equipment; and
- dental services (if offered by the plan).

A toll-free help-line is currently available at 1-877-934-7587 or 1-877-9FHPLUS.

Coordination: Under these initiatives and expansions, the Department is striving to make the transitions between these systems seamless to the consumer in every way possible. Facilitated enrollers provide outreach and application assistance to Medicaid, Child Health Plus and Family Health Plus programs and a joint Medicaid-Child Health Plus-Family Health Plus-WIC application has been implemented. To facilitate children's retention of their primary care provider, most Child Health Plus providers are also Medicaid managed care providers. Many of the Family Health Plus providers participate in Medicaid managed care, as well. Quality is also

being monitored in a coordinated fashion, with plans participating in New York's public insurance program required to submit reports annually.

NYS is also one of eight states participating in a program funded by the Robert Wood Johnson Foundation to increase enrollment and retention of children eligible for MA and SCHIP but are not enrolled. The program, "Maximizing Enrollment for Kids" seeks to help states improve systems, policies and procedures to increase the proportion of eligible children enrolled and retained in MA and SCHIP. New York will explore the potential of enrolling more children by simplifying the enrollment process and using publicly available screening tools to make it easier for families to apply for coverage. NY will be partnering with community-based organizations, faith groups and health and human service providers for a "Connections to Coverage" campaign to link uninsured children to facilitated enrollment in their communities.

The Title V programs continue to have a role in outreach, enrollment, standards development, quality assurance and evaluation. Title V staff work closely with staff from OHIP in updating programs and standards (e.g., Medicaid Prenatal Care Program and Family Planning Benefit Program).

- Medicaid has also utilized fee enhancement as an approach to promoting access to quality care. The **Preferred Physicians and Children's Program (PPAC)** has been in operation for over ten years and has brought and retained thousands of highly qualified pediatricians, family practitioners and nurse practitioners into Medicaid.
- Medicaid has collaborated extensively for several years with the State Office of Children and Family Services to improve access to health care services for children in Foster Care by upgrading the eligibility process, revamping policies and procedures, sharing Foster Care Medicaid data with counties, and troubleshooting the child care agency rate-setting process. Title V staff have been involved, as well. Many major improvements to care have resulted for this special needs population.

The **Healthy New York Insurance Program** is available to pay health insurance premiums for employers with 50 or fewer employees who have not offered health insurance to their employees for at least one year. In addition, individuals whose employers do not offer health insurance coverage or who lost their coverage may purchase comprehensive health insurance directly through the Healthy New York Program. All of the State's Health Maintenance Organizations (HMOs) are required to offer the Healthy New York standardized, steam-lined, low-cost managed care benefits package. There are different eligibility requirements for individuals, small businesses and sole proprietors. Eligibility requirements may be viewed from this website: <http://www.ins.state.ny.us/website2/hny/english/hnyec.htm>

The **Medicaid Buy-In program** offers Medicaid coverage to people with disabilities who are working, and earning more than the allowable limits for regular Medicaid, the opportunity to retain their health care coverage through Medicaid. This program allows working people with disabilities to earn more income without the risk of losing vital health care coverage.

New York in 1992 passed a landmark **community ratings** law that established subsidies for insurance companies serving the individual and small groups market. This law allows insurers

that serve these markets to draw down donations to a pool to cover costs of serving a disproportionate number of sick enrollees due to adverse selection.

On July 29, 2009, the Governor signed into law Chapter 240 of the Laws of 2009, which permits young adults to continue or obtain coverage under their parent's health insurance policy through the age of 29 years if the individual does not have access to employer-sponsored health insurance. It is anticipated that this will increase access for thousands of New Yorkers who previously did not have access to basic health care insurance.

The **Catastrophic Insurance Program** assists low-income, uninsured New Yorkers facing devastating medical bills. HCRA also created a new **Individual Health Insurance Program** to defray the cost of premiums for people with incomes below 200% FPL, and a **Cancer and Children Initiative** provided grant funds to expand access and quality of cancer services and for specialty cancer and children's hospitals. The **AIDS Drug Assistance Program** helps employed persons with HIV or AIDS purchase expensive medications that they need to control their illness.

Health Services Infrastructure - Since most of the maternal and child health services delivered in this State are not delivered directly by the New York State Department of Health, not only is State infrastructure important, but the local infrastructure is also critical to the delivery of high-quality services. The Department employs various mechanisms to ensure that services are coordinated and resources are maximized. The Department's ability to keep apprised of local conditions and to ensure the stability of the MCH infrastructure is supported by the Public Health Law, strong regulations, its regional offices of health, its data collection and data analysis capacity, technical assistance capacity, and through oversight of contracts and letters of agreements with local providers of service.

Local Health Departments: County health departments continue to play an essential role in the assurance of high-quality, accessible maternal and child health services. They assessed the needs of their local communities, worked with their communities to design and implement programs that meet those needs, and evaluated the effects on their communities.

Under New York State Public Health Law, the **58 local health departments** extend the powers of the state health commissioner. Each of the 57 non-New York City counties have a county health department, while all five counties in New York City are covered by the New York City Department of Health. The county health departments provide community health assessment, family health services, health education and disease control services. Most also provide environmental services. Counties that do not provide their own environmental services rely on the State Health Department's District Office in their area. Most counties in New York also operate certified home health agencies or licensed home health care agencies, through which they provide a variety of home-based services, including skilled nursing, home health aide, therapies, early intervention, maternal and child health and disease control visits. Most counties also operate diagnostic and treatment centers licensed under Article 28 of the New York State Public Health Law. The trend has been for counties to either divest personal care services or ensure that they are competitive in the market environment. There is also an emerging trend toward streamlining the administrative structures of local agencies. As a result, a handful of

New York's local health agencies have combined with other county agencies, such as mental health or social services.

Under **Article 6 of the New York State Public Health Law**, local health departments perform comprehensive community health assessment and subsequently produce a county-wide (or in the case of New York City, a city-wide) Municipal Public Health Service Plan (MPHSP). These local plans explicitly address the needs of the maternal and child health population in sections on health education, infant mortality prevention, child health, family planning, chronic disease prevention, injury control, disease control and nutrition. The Title V program staff provide technical assistance to local health units in plan development and participate in the review and approval process, as well as in monitoring of the implementation of the plans. Because local health departments know their local systems and community needs, the Plans address coordination across public and private resources, and across the continuum of primary, secondary and tertiary care. Local health departments play a critical role in fostering local collaborations.

Relationships with local health departments are coordinated through the **Office of Public Health Practice** (formerly known as the Office of Local Health Services), the unit that also administers the local assistance/state aid program. Collaboration between the counties and the State and between agencies on the local level is yielding better use of data, better local plans, and more attention to outcomes of public health activities.

Perinatal Regionalization/Tertiary Care Centers/Regional Perinatal Centers: New York State has a long-established system of regionalized perinatal care with highly specialized **Regional Perinatal Centers (RPCs)** in each region of the state. These Centers provide tertiary level clinical care to high-risk mothers and newborns, and also serve as important contact points for the Department in interactions with the health care community. They help ensure that high-risk mothers and newborns receive appropriate levels of care by working with their affiliate hospitals to provide quality improvement oversight, including monitoring of perinatal morbidity and mortality and providing education and technical assistance to physicians and others. The RPCs have helped the Department address important public health issues such as H1N1, perinatal HIV, breast-feeding promotion, cesarean prevention, and collection, improved reporting, and use of perinatal data.

The Regional Perinatal Centers not only serve as the hub for consultation and transport within a network, but lead quality improvement activities within their network. The implementation of the Statewide Perinatal Data System (described under Information Infrastructure) has been closely tied to Perinatal Regionalization. The Regional Perinatal Centers are key to the development of a system for quality improvement within an affiliate network. SPDS is an important source for data for those activities. The Centers have responsibility for data quality within the network, including responsibility for training and technical assistance to affiliate hospitals. During 2002, Regional Perinatal Centers received their final designations as to level of perinatal care. Workplan guidance was developed and disseminated to all Regional Perinatal Centers in order that they gain a clearer understanding of their roles as leaders in regionalization. The Department worked with the Regional Perinatal Centers to enhance their understanding of the provision of quality improvement activities among their affiliate network and promoted their

leadership in the Regional Perinatal Forums to work with community collaborators in promoting improved perinatal outcomes within their regions.

Public Health Workforce: The New York State Public Health Workforce Task Force, established by the Public Health Council in 2005, requested that the Center for Workforce Studies at the University at Albany School of Public Health work with the New York State Association of Counties to conduct a local workforce enumeration study.

The Task Force has used the results of the study to identify priority needs and enact strategies to address those needs. Recruitment and retention of workers has emerged as one need to address, but the Task Force also addressed workplace incentives, career ladders, training and education, and additional leadership development.

While the Task Force was dissolved in late 2008, the New York State Department of Health (NYSDOH) Office of Public Health Practice (OPHP) has continued to work with many of its subgroups to address public health workforce issues. These initiatives include:

- **Public Health Educator Continuing Education** - The Department collaborated with academic and practice partners as part of the Strengthening Academic/ Practice Partnerships workgroup of the Task Force to implement new continuing education requirements for health educators employed in local health departments throughout the state. Health educators are responsible for planning, implementing, and evaluating educational programs for health professionals and the general public that will improve the health status of local communities. New changes to the State Sanitary Code require public health educators employed in local health departments and hired after August 20, 2008 to complete 15 hours of continuing education in their first year of employment. NYSDOH worked with a group of faculty and practicing health educators to develop a core curriculum of distance-accessible trainings that will help health educators meet this new requirement. The curriculum was made available through the NYSDOH's Learning Management System, NYLearnsPH.com, on December 15, 2008.
- **Public Health Educator Evaluation** - With partners, the Department also supported efforts to build on work of the public health educator continuing education project. A recently retired NYSDOH employee, who has over 30 years of experience in developing and evaluation training and education programs, conducted an evaluation of the public health educator core curriculum and the new State Sanitary Code changes requiring public health educators to complete 15 hours of continuing education within their first year of employment. A survey of all newly hired public health educators that completed this requirement was created and launched on February 19, 2010. Sixteen public health educators from local health departments across the state, including rural, urban and suburban populations, completed the survey. Results of the survey revealed that the requirement was easy to understand and to complete, the LMS was effective in facilitating the completion of the program and the included courses enhanced competencies of public health education.
- **Public Health Educator Self-Assessment Tools** - Continuing to build on this project, an associate professor of community health at Kingsborough Community College, and member of the public health educator work group, is working with OPHP staff to create self-assessment tools for public health educators to identify strengths and address areas in need of improvement. The self-assessment tools are for completion by public health educators

serving in local health departments. Those who complete the self-assessments are linked to a tailored curriculum of distance-accessible trainings via the NYSDOH Learning Management System, which will be identified and vetted by the consultant.

- **Public Health Nurse Continuing Education** - Also as part of the Strengthening Academic/ Practice Partnerships workgroup, the Office of Public Health Practice worked with academic and practice partners to implement new continuing education requirements for public health nurses employed in local health departments throughout the state. Public health nurses work with individuals, groups, families and populations to improve the overall health of communities. They help plan and implement public health programs, provide instruction to individuals, families and other groups regarding health issues, arrange for immunizations and health screening, and are involved in helping to contain the spread of disease in communities. New changes to the State Sanitary Code require Public Health Nurse 2 and Supervising Public Health Nurse titles employed in local health departments and hired after August 20, 2008 to complete 15 hours of continuing education in their first year of employment. A group of faculty and practicing public health nurses, as well as representatives from NYSDOH, worked together to develop a core curriculum of distance-accessible trainings that will help public health nurses meet this new requirement. The Public Health Nurse 2 curriculum was made available through the NYSDOH's Learning Management System (LMS), NYLearnsPH.com, on October 19, 2009. The curriculum for Supervising Public Health Nurses is still under development; however a majority of the program has been available on the LMS since April 2010.
- **Leadership Development:** The Leadership Development workgroup developed three self-assessment tools to identify strengths and address areas in need of improvement in public health leadership. The self-assessment tools are for completion by local health department workers in leadership positions at three levels: entry, middle, and senior. Those who complete the self-assessments are linked to a tailored curriculum of distance-accessible trainings via the NYSDOH Learning Management System. A recently retired NYSDOH employee, who has more than 30 years of experience in developing and evaluating training and education programs, vetted distance-accessible courses for inclusion in the senior-level leadership curriculum. The three leadership self-assessment tools are accessible via the NYSDOH Learning Management System. To date nearly 400 learners have selected or had a Leadership role assigned to them, 218 Entry Level Leaders, 109 Mid-level Leaders and 70 Senior Level Leaders. Of these 168 Entry, 93 Mid and 56 Senior Level leaders have completed assessments. NYSDOH is developing a hand-held card to provide information about the self-assessments, as well as instructions as to how to access them on the LMS. These cards will be distributed to all local health departments in an effort to make the tools more widely available to public health leaders.

Assessment of MCH Home Visiting: The Title V director is currently engaging in a needs assessment process related to home visiting. In collaboration with the Office of Children and Family Services, the state agency that administers healthy Families New York, a plan has been developed to do a comprehensive needs assessment, identifying gaps, barriers and plans to address those gaps.

New York State has established a home visiting needs assessment work group comprised of the relevant staff from the State agencies that will contribute data and other information for the

needs assessment. The work group process will foster the State's ability to locate, gather and assemble data and information required for the needs assessment in a timely manner. The work group will also create the mechanism to manage and address any obstacles that may arise as the needs assessment proceeds. The State agencies responsible for completing the Title V MCH Block Grant, Head Start Act, and Title II of CAPTA needs assessments will be working together to complete the ACA home visiting needs assessment. The work group approach will afford the State the opportunity to use applicable components of the home visiting needs assessment to satisfy similar components of the other assessments. Working in this manner may also create the potential that each of the required needs assessments will be enhanced by the larger and more comprehensive perspective of needs assessment required by the ACA.

New York State agencies that have responsibility for managing programs for children and families residing in communities at risk have a tradition of working together to ensure the effective coordination and delivery of needed services. The creation of the ACA Maternal, Infant and Early Childhood Home Visiting Program, and the accompanying requirement to conduct a statewide needs assessment on a broad range of indicators, affords the State agencies an opportunity to work more closely together to identify at-risk communities and construct a comprehensive home visiting program for New York State.

In anticipation of the needs assessment requirement, State agency representatives have had several meetings and discussions primarily to identify the available data. To guide the needs assessment process, a more formal work group will be established. The core membership the work group will be the relevant staff (e.g. program managers, data system managers, evaluators/researchers, etc.) from the Department of Health, Office of Children and Family Services, Office of Alcohol and Substance Abuse Services, and the Council for Children and Families. Additional members will include relevant staff from the Office of Mental Health, Office for the Prevention of Domestic Violence, Division of Criminal Justice Services, Department of Labor, State Education Department, Developmental Disabilities Planning Council, and other appropriate State agency stakeholders. Staff from the Department of Health's Office of Health Insurance Programs which oversees the State's Medicaid, managed care and family/child health insurance programs will participate on the work group as well and will provide key data and information about utilization and quality indicators for relevant services received by low-income individuals and families and corresponding health care provider capacity in the State.

Schuyler Center for Analysis and Advocacy (SCAA) will work with the State agency work group to help solicit input from a broad range of stakeholders from around New York State. The State agencies and SCAA have been meeting on a regular basis in anticipation of conducting the needs assessment and a good deal of the preliminary planning work has been completed. A list of stakeholders comprised of relevant programs funded by the agencies (e.g. home visiting programs such as Community Health Worker Programs, Healthy Families NY, Healthy Start and Nurse Family Partnerships, child abuse prevention programs, substance abuse prevention and treatment programs, early childhood development programs, etc.), inter-agency coordinating groups (e.g. Early Childhood Advisory Council), local health departments, advocacy groups, families, members of the home visiting white paper work group and other interested parties has been completed. A series of conference calls will be held to elicit feedback from the

stakeholders. The conference calls will be structured around questions, developed by the work group, designed to elicit qualitative information about the needs of and the services available for children and families residing in at-risk communities. Feedback will also be elicited through an on-line survey. This qualitative information will supplement the quantitative data and provide a fuller picture of needs and services for at-risk families in New York State.

The protection and promotion of the public's health is not possible without adequate public health infrastructure. Public health agencies must have the ability to perform adequate needs assessment, to appropriately evaluate public health issues and programs, to develop meaningful policies and standards, to engage their communities, to coordinate existing resources, to ensure quality, and to adequately recruit and train the public health workforce.

The Department is able to assess the adequacy of the infrastructure for maternal and child health services through:

- Establishing and maintaining regular multi-directional communication with local health departments, local contractors, our regional offices, other units within the State Health Department and other State and Federal agencies;
- Regularly and frequently monitoring the quality and the content of local health assessments, public health service plans and contractor workplans;
- Monitoring the ability of the Department's programs, contractors and county health departments to effectively achieve the desired results;
- Monitoring and auditing the use of available resources, including available technical assistance;
- Periodically reassessing the Department's internal controls system for areas of vulnerability; and,
- Performing special assessments relative to the ability of local agencies to perform essential public health services.

Information Infrastructure: The Department of Health continued to improve accessibility of local data, both on the internet-based public website and on the Department's intra-net, the **Health Information Network (HIN)**. More and better data are constantly becoming available via electronic means. This application has been posted on the Department's public website since 1997.

The following is a screenshot from the Department's public website. Statistics and data, on the lower right side of the screen, result in an alphabetic listing of numerous data sources, including Community Health Assessments, Vital Statistics Data, hospital discharge data, etc.

The screenshot shows the New York State Department of Health website. The browser address bar displays <http://www.nyhealth.gov/>. The page header includes the text "NEW YORK STATE" and "Department of Health Information for a Healthy New York". Navigation links include "A-Z Index", "En Español", "Help", "Contact", and "Home".

Health News

JANUARY 12, 2009
State, National Public Health Leaders to Explore Strategies to Eliminate Minority Health Disparities at First Statewide Summit
 More than 200 state and national public health leaders are meeting Tuesday and Wednesday at New York's first statewide Summit on Minority Health Disparities to begin the development of a comprehensive action plan to eliminate minority health disparities in New York State.

JANUARY 9, 2009
Media Advisory: Public Health Experts Share Strategies For Eliminating Health Disparities
 News media may attend parts or all of the two-day Summit on Minority Health Disparities, which will bring together leaders of public health, health care, and advocacy organizations from across the state to begin the initial steps in the development of a comprehensive action plan to eliminate health disparities in New York State.

JANUARY 7, 2009
State Health Commissioner Commemorates Millionth Call to Smokers Quitline
 If your New Year's resolution is to stop smoking, the New York State Smokers Quitline at 1-866-NYQUITS (1-866-697-8487) can help you reach that goal.

Current Issues

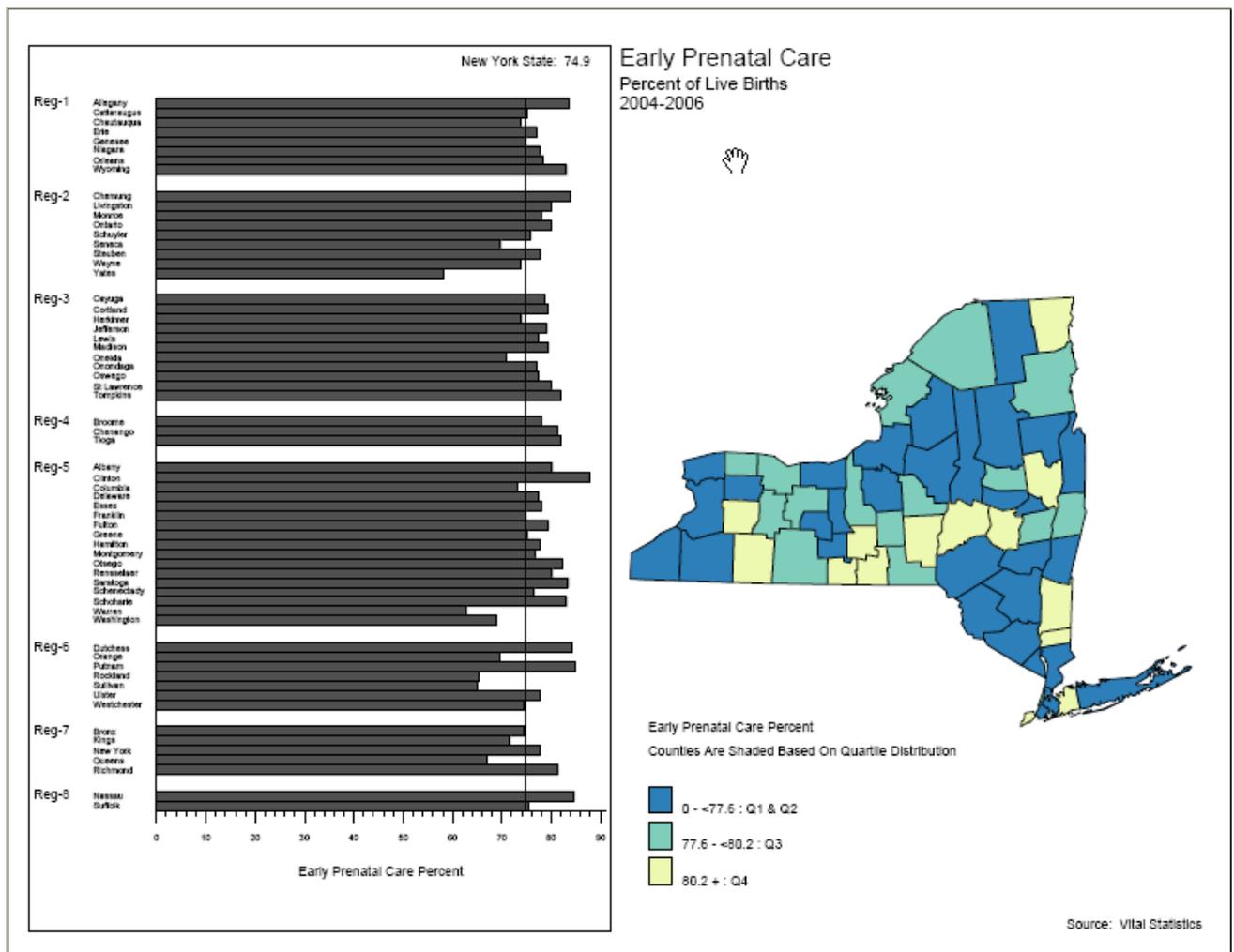
- Healthy Steps to Albany
- Prevention Quality Indicators
- Prescription Drug Prices
- Prevention Agenda Toward the Healthiest State
- Smokers' Quit Line - 1-866-NY-QUITS
- Influenza (Flu)
- Home Health and Hospice Profile
- Immunization Information System
- Lead Poisoning Prevention
- Partnership for Coverage
- Child Health Plus

Search
 Search this site:

Site Contents

- Birth, Death, Marriage & Divorce Records
- Health Insurance Programs
- Employment Opportunities
- Forms
- Family & Community Health
- Health Care Professionals & Patient Safety
- Hospitals, Nursing Homes & Other Health Care Facilities
- Diseases & Conditions
- Health & Safety in the Home, Workplace & Outdoors
- Healthy Lifestyles & Prevention
- Laws & Regulations
- Statistics & Data
- Events & Training

Data can be obtained on a county-specific basis on a wide variety of indicators, and even zip code specific information is available on the state's Health Information Network/Health Provider Network, which is accessible by Department staff and most health care providers, as well as others. County-specific information can be easily compared to all other counties, to allow localities to judge their progress in relation to other comparable areas (see below). In addition, the MCHBG Application and Report is posted annually on the website for easy access by the public, and it contains a significant amount of perinatal data and information, including trends on a number of indicators.



Statewide Perinatal Data System: The **Statewide Perinatal Data System** collects all data required for completion of the birth certificate in all areas of the state outside of New York City (which is a separate Vital Records reporting area), and information on all Neonatal Intensive Care Unit admissions throughout the state, including New York City. New York City implemented its own internet-based system for collection of birth certificate information on 1/1/08, using the SPDS to inform their efforts. New York City is currently developing the reporting functionality of their system, in collaboration with staff from the Division of Family Health. It is anticipated that the NYC-based reports for the core module data will be comparable, and therefore able to be combined into a single statewide report.

The SPDS system enables the regional centers to coordinate data analysis for their regions and to help their affiliated hospitals and others in the community (such as perinatal networks) to use data for needs assessment, planning and quality improvement activities. All of the standardized reports are available on-line to each (Upstate only, currently) birthing hospital and to RPCs for all of their affiliate hospitals.

The Statewide Perinatal Data System (SPDS) provides a wealth of information useful for monitoring achievement of the Department's goals. The system is an internet-based, secure

network consisting of all data from the Electronic Birth Certificate collected from hospitals and free-standing birth centers within the State as well as additional quality of care-related data elements. The system is used to assess birth outcomes at three levels: within hospitals, in integrated health care systems and in the community (however defined). It enables the Department to identify, in near real-time, health care delivery and public health problems. It provides a powerful tool for quality assurance and quality improvement. At the same time that electronic birth certificate information is being collected, the system also collects the content of prenatal care, breastfeeding status on discharge from the hospital, maternal depression during pregnancy and periodontal disease during pregnancy. The development of the Statewide Perinatal Data System required regulatory amendments. New regulations were proposed and adopted, as well as new statutory language to allow inclusion of the zip code and medical record number in de-identified affiliate hospital datasets provided to the RPCs to enable follow-back on records and analysis of geographic trends and information within their networks.

Indicators of maternal and child health are built into the **Quality Assurance Reporting Requirement (QARR) System** for monitoring managed care and Child Health Plus providers. Title V works closely with the Office of Managed Care to make health plan performance data available to county health departments so that they may monitor the delivery of care to the population within their county.

The **State Systems Development Initiative, (SSDI)** continues to support the development and implementation of the **Child Health Information Integration Project (CHI²)**. The CHI² project will provide an open-systems/industry-standard, easily supportable operational architectural framework that enables the NYSDOH to integrate systems containing child specific data. The new framework will provide data sharing capability and receive data from emerging electronic medical records systems and RHIOS that the department is supporting through the HEAL-NY grants. The framework will allow for bi-directional sharing of integrated child data held by the department with health care providers, hospital systems and local health departments in a manner consistent with public health laws, for the purpose of providing high quality health care to their patients.

The goals of CHI² is to develop an integrated data system that will improve quality of care (more timely non-duplicate and accurate patient information for diagnosis and treatment), benefit private healthcare providers, provides feedback to healthcare providers, reduce medical errors, collect individual level data for major activities such as Newborn Hearing Screening or School Based Health Centers, provide a seamless flow of information between jurisdictions, link events of public health significance in a child's life(e.g. immunizations, lead tests, early intervention services asthma events) and to enable bi-directional data sharing between provider's electronic medical record systems, hospital information systems, RHIOs and public health programs.

The CHI² Project is working in conjunction with other Department Health Information Exchange planning initiatives for the exchange of data elements in a standardize manner, utilizing various methods, including a service-oriented architecture within the framework of web services executed utilizing an enterprise service bus.

A three phase approach and schedule will be used for the implementation of CHI²; Phase 1 is Start-up/Define, Phase 2 is Design/Build and Phase 3 is Operationalize. The initial data systems that CHI² will focus and concentrate on integrating are Statewide Perinatal Data System- birth certificate component (SPDS), Newborn Hearing Screening, Neonatal Intensive Care Unit Module, Newborn Bloodspot Screening, Immunization (NYSIIS), New York Early Intervention (NYEIS) and Lead (Lead WEB).

Other system integration for consideration include: SPDS (non-birth certificate component), WIC (WICsys), eMEDNY, Child Health Plus, Statewide Planning and Research Cooperative System (SPARCS) and Congenital Malformation Registry.

MCH and Public Health Education Infrastructure - The New York State Preventive Medicine Residency Program trains five physicians annually, preparing them for leadership careers in state and local health departments. The program seeks to reduce health disparities among New Yorkers by increasing the number of well-trained public health physicians to address the needs of high-risk populations. This two-year residency program for physicians consists of an academic year, leading to a Masters in Public Health degree, and a practicum year, during which public health residents complete projects throughout the New York State Department of Health and affiliated sites. Many of the residents go on to employment at the New York State Department of Health and other public health agencies in important maternal and child health positions. They include the former director of the Division of Family Health, the director of the Bureau of Maternal and Child Health, and the medical directors of the Division of Family Health, the Immunization Program and the Hospital Epidemiology Program.

The **Dental Public Health Residency Program** continued its accreditation status and continued to collaborate with other sites in New York State. Dental residents are involved in numerous studies and projects. Current residents are working on analysis Behavioral Risk Factor Surveillance System and Statewide Planning and Regional Cooperative System data and conducting an oral health surveillance project involving 3rd grade school children.

Area Health Education Centers (AHECs): The **State University of New York at Buffalo**, Division of Family Medicine is developing **Area Health Education Centers (AHECs)**. The Centers work to recruit, retain, and support health professionals to practice in communities with health provider shortages. They do so by developing opportunities and arranging placements for future health professionals to receive their clinical training in underserved areas, by providing continuing education and professional support for professionals in these communities and by encouraging local youth to pursue careers in health care.

Universities and Schools of Public Health: The **University at Albany School of Public Health** is unique in that it is jointly sponsored by a university and a state health department. The New York State Department of Health serves as the laboratory for the University at Albany School of Public Health, with graduate students working shoulder-to-shoulder with practicing professionals in the state health department or in local departments. A number of DOH and Title V staff serve as faculty and advisors to the school. Title V staff also serve on the School's **Continuing Education Advisory Board**, providing approvals for continuing medical and nursing education. Title V has utilized the School of Public Health as the continuing medical

education provider for its annual Breastfeeding Grand Rounds, and for forums on public health genetics, HIV/AIDS, the dental public health residency, home visiting, women's health and female circumcision. Among the other offerings through continuing education are: social marketing, environmental health, Hepatitis C, substance abuse, and occupational health and safety.

Title V staff in the Division of Family Health coordinate the **MCH Graduate Assistant Program**, under which 14-15 University at Albany School of Public Health 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 supports the Department of Health's mission through attracting bright and motivated individuals who are interested in gaining both theoretical and practical knowledge of public health and maternal and child health. The use of students also 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 University at Albany's School of Public Health sponsors the **Northeast Public Health Leadership Institute (NEPHLI)**, serving the northeast corner of the US. Several Title V staff have attended the Institute. Several graduates of the Institute also serve Title V in other states and at the New York City Department of Health. Title V staff from New York and other states serve on the NEPHLI Advisory Council.

University Affiliated Programs: New York is fortunate to be home to three **University-Affiliated Programs** which offer **Leadership Education in Neurodevelopmental Disabilities (LEND)**. The three are located at the **University of Rochester**, the **Westchester Institute at Valhalla**, and **Jacobi/Albert Einstein Medical Center**. LEND Programs provide for leadership training in the provision of health and related care for children with developmental disabilities and other special health care needs and their families. The Department works with the LENDs on a variety of issues related to children with special health care needs. The Department's Title V staff participates on the Community Advisory Board for the Westchester Institute for Human Development (WHID) LEND Program. Annually, the Title V staff provide an overview of the MCHBG and services to the MCH population to LEND fellows. In April 2010, the WHID LEND fellows visited the Department of Health to share highlights of their LEND research projects with DOH and Developmental Disabilities Planning Council staff.

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. Prevention, coordination and communication are stressed.

Statewide Satellite Broadcasts: The Department of Health, with 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 **Third Thursday Breakfast Broadcasts (T2B2)**. T2B2 provides continuing education opportunities covering a variety of

public health issues. Local site coordinators in each county health department coordinate local logistics. Out-of-state attendees can locate sites by visiting the University at Albany's website: www.albany.edu/sph/coned/t2b2site.html. Continuing medical and nursing education credits are available.

The Office of Children and Family Services also sponsors monthly satellite broadcasts on child health and safety topics such as SIDS and risk reduction in conjunction with partners such as DOH, the SUNY Distance Learning Project, and the New York State Child and Family Trust Fund.

As a follow-up to the **Minority Health Disparities Conference** in 2009, the Office of Minority Health has initiated a webinar series to spotlight minority populations in New York State. The webinars, which feature presenters with practical experience designing and implementing programs with the minority group highlighted, are being scheduled as follows: April 15 (Asian Americans); May 12 (American Indians); May 20 (African Americans); May 26 (Hispanics/Latinos).

Web-Based Education and Materials: The Department's websites, both internal and public, are linked to a variety of health-related sites. In addition, the Department's partnership with the University at Albany School of Public Health and the New York – New Jersey Public Health Training Center broaden the availability of high-quality web-based course and materials available to NYSDOH and Title V staff.

Infrastructure for Collaboration - The Department of Health continued to support a variety of **regional and local collaboratives** to improve needs assessment, identify and build local capacity, outreach to hard-to-reach segments of the population, and assure quality. The common thread among these efforts is community engagement and commitment to collaboration and coordination in the use of resources. Examples of such efforts include: Comprehensive Prenatal Perinatal Services Networks, Rural Health Networks, community assessment and joint planning initiatives, Comprehensive Planning for Youth Services, Partners for Children, Local Early Intervention Coordinating Councils, the affiliation networks of the regional perinatal centers, regional EMS councils, Infant Mortality Review Community Councils, HIV/AIDS Prevention Planning Groups, and many more. The RPCs and CPPNS jointly sponsor Regional Perinatal Forums, which bring together health, ancillary and non-health services providers in each region of the state to take a proactive appropriate to improving pregnancy outcomes.

Voluntary and Professional Organizations: DOH strives to maintain positive and collaborative relationships with several not-for-profit, voluntary groups who share concerns for the health and well-being of mothers, infants, children and women of childbearing age. The Department's Title V program has active relationships/collaborations with:

- American Academy of Family Practice, New York State Chapter;
- American Academy of Pediatrics –NY District II;
- American College of Nurse Midwives, New York State Chapter;
- American Congress of Obstetricians and Gynecologists, New York State Chapter;
- American Lung Association of NYS and NYC;
- Association of New York State Youth Bureaus;

- Association of Perinatal Networks;
- Boards of Cooperative Education Services (BOCES);
- Children for Children
- Columbia University School of Public Health;
- Community Health Centers Association of NY;
- Cornell University
- Cornell University Cooperative Extension, Human Development Center and 4-H;
- Families Together in NYS
- Family Support New York;
- Family Voices;
- Greater New York Hospital Association (representing hospitals in the Greater Metropolitan area);
- Healthcare Association of New York State (representing hospitals across the state);
- Healthy Start;
- Leadership Education in Adolescent Health at University of Rochester;
- March of Dimes;
- Medical Society of the State of New York;
- Mount Sinai Adolescent Center;
- New York Academy of Medicine;
- New York Chapter American College of Physicians;
- New York Counseling Association
- New York State Academy of Family Physicians;
- New York State Alliance for Family Literacy;
- New York State Association of Counties;
- New York State Association of County Health Officials;
- New York State Association of Perinatal Programs;
- New York State Association of School Nurses;
- New York State Child Care Coordinating Council;
- New York State Coalition of Prepaid Health Services Plan;
- New York State Community Health Partnership;
- New York State Health Plan Association;
- New York State Nurses Association;
- New York State Partners for Children;
- New York State Perinatal Association;
- New York State Public Health Association;
- New York State School Boards Association;
- New York State Thoracic Society;
- New York State United Teachers;
- NYS Conference of Local Mental Hygiene Directors
- Parent-to-Parent, New York State;
- Pharmacy Society of the State of New York;
- School Nurses statewide;
- Schuyler Center for Analysis and Advocacy;
- SIDS Alliance;

- The Association of Community Health Nursing Educators;
- The Association of State and Territorial Dental Directors;
- The Association of State and Territorial Directors of Nursing;
- The Community Health Center Association of New York State;
- The Head Start Association and the Head Start Collaboration Office;
- The New York – New Jersey Public Health Training Center;
- The New York State Council on Sexual Assault;
- The New York State Dental Hygiene Society;
- The New York State Dental Society;
- United Way of New York State;
- University Affiliated Programs at Westchester, Rochester and Jacobi/Albert Einstein;
- University at Albany School of Public Health;
- University at Buffalo School of Social Work;
- University of Rochester
- YMCA of New York State;

and many others who enhance the capacity of Title V programs to operate effectively.

The pyramid depicted below presents the framework for New York’s services to the maternal and child health population. Through the provision of funding and services at four tiers including, direct health care services, enabling services, population-based services, and, infrastructure-building services, New York demonstrates a commitment to ensuring all New York’s mothers and children, as well as children with special health care needs, have the necessary supports and services to improve health outcomes.

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

**DIRECT
HEALTH
SERVICES**

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

Examples:

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

ENABLING SERVICES

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

Examples:

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

POPULATION-BASED SERVICES

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

Examples:

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

INFRASTRUCTURE-BUILDING SERVICES

Develops, maintains and supports access to high-quality maternal and child health services

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

5. Selection of State Priorities

Methodology for Ranking Selecting/Ranking Priorities

As described above in the Needs Assessment Methodology section, the needs assessment process was developed based upon three main information components:

- stakeholder input from a variety of sources, including stakeholder input related to specific MCH populations and program areas;
- analysis of MCH data from a number of sources, including MCH program data and national and state performance, outcome and capacity measures; and,
- information obtained from needs assessment cycles for specific MCH programs.

The inclusion of all of these qualitative and quantitative inputs, in conjunction with the assessment of capacity, provided a comprehensive body of information to develop state priorities.

The MCH director and core members of the MCH Leadership Group, including the Department's Public Health Information Group, met several times to develop the priorities and performance measures for New York State. Prior to finalizing the priorities and performance measures, staff in the MCH Leadership Group reviewed and integrated information from the three information sources identified above. Major factors that were considered in developing priorities and how those priorities should be ranked included the following:

- the magnitude of the need or issue confronted by the priority, in terms of the populations and geographic areas affected, and the consequences of failure to address the need or issue, in terms of mortality, morbidity and/or social and economic costs;
- the priority addresses a significant issue related to eliminating a health disparity(ies);
- stakeholder input identifying an issue as a priority;
- alignment with already-established priorities of the governor, legislature or Department which can be based upon many of the factors above; and,
- the degree to which the problem effects downstream issues.

Other practical factors in considering priorities and developing performance measures, included:

- whether the identified priority is actually a strategy related to improving performance to achieve an outcome;
- whether the priority is too broadly or narrowly focused;
- whether the priority was measurable;
- the amenability of the need or issue to action;
- whether there are feasible and affordable evidence-based approaches or best practices that will have impact upon the problem;
- current capacity to meet identified needs;
- whether, in light of resource constraints, there is currently an opportunity to address the priority through reallocating existing resources or identifying new resources.

List of Priorities for New York State

The following is the list of priorities for New York State. The list reflects current priorities and how they were modified or eliminated in the new five year needs assessment cycle, as well as new priorities with the description of the rationale for selection of the priority. These priorities address all three MCH population groups. Most of these priorities relate to direct health care and population-based services. However, the strategies undertaken to monitor and address these priorities and associated outcomes are likely to span the entire MCH pyramid of direct, enabling, population-based, and infrastructure-building services. Program capacity related to the identified priorities was described in detail in Section 3 of the Needs Assessment. State MCHBG performance measures have been identified for priorities, and, in some cases, previous State performance measures have been revised or changed to better align with these updated State priorities. The Department will continue to monitor a number of additional measures to track performance related to those priorities. In some instances, there are other MCHB National Health System Capacity Indicators (HSCI), Health Status Indicators (HSI), National Performance Measures (NPM), and National Outcome Measures (NOM) that directly relate to each of the priorities below; these have been noted where relevant to provide the broadest possible picture of how each priority will be assessed and monitored.

New York State has a current priority as follows:

“To improve access to high quality health services for all New Yorkers, with a special emphasis on prenatal care and primary and preventative care, which includes attention to mental health issues and which serves those with special health care needs.”

In the MCH needs assessment survey, this issue was ranked the most important issue for the MCH populations. Ensuring access to high quality primary care and preventive care, including prenatal care, is a high priority of the Department, however, this MCHBG priority as currently described is too broad to be meaningful as a single priority. Instead, for this grant cycle, two priorities will be identified as Priority 1 and 2 as follows:

1. State Priority (revised): To improve access to early, adequate and high quality prenatal care, with a specific focus on eliminating health disparities.

Access to prenatal care was identified as the highest priority issue in the MCH needs assessment survey response related to priorities for pregnant women, mothers and infants; a majority of the respondents to this question picked it as among the top five issues impacting the health of this population. The ECCS plan also identified the provision of comprehensive prenatal care services that support the needs of at risk vulnerable women and families as a key strategy in achieving the goal of healthy children; this priority has subsequently been adopted by the Early Childhood Advisory Council (ECAC) as a priority item to be monitored.

Improving access to prenatal care was identified as a priority issue by several counties responding to the Prevention Agenda. Perinatal networks identified access to early, comprehensive, continuous prenatal care as a high priority, with the need for more targeted approaches to reach high-risk women. Improving prenatal care access is a high priority for the Department.

Prenatal care provides a critical opportunity for health care providers to assess and address maternal and familiar risk factors related to domestic violence, compromised nutrition, chronic medical conditions, mental health problems, economic needs and substance abuse. It is essential that women, especially high risk women, receive early prenatal care where their needs can be assessed, and they can be provided with necessary health and psychosocial supports. Home visiting is an important strategy for ensuring that high risk women are appropriately assessed and receive needed services. The statewide rate of early (first trimester) prenatal care has been stagnant for the past decade, currently at 72.2%, far short of the Healthy People 2010 goal of 90% first trimester entry into prenatal care. While health disparities related to early entry prenatal care have improved somewhat in the last decade, they still remain significant, highlighting the specific importance of monitoring prenatal care for minority populations.

State MCHBG Performance Measure (new) 1: The percentage of infants born to Black and Hispanic women receiving prenatal care beginning in the first trimester

Related Federal Health Systems Capacity Indicators (HSCI), Performance Measures (NPM), National Outcome Measures (NOM) and Health Status Indicators (HSI)

HSCI 04: Percent of women (15-44) with a live birth during the reporting year whose observed to expected prenatal care visits are greater than or equal to 80% of the Kotelchuck index

HSCI 05C: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester, by health insurance type

HSCI 05D: Percent of pregnant women with adequate prenatal care (observed to expected prenatal care visits greater than or equal to 80% Kotelchuck Index), by health insurance type

NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

2. State Priority (revised): To improve access to comprehensive, high quality primary and preventive health care for children and adolescents, consistent with the medical home model, including children with special health care needs.

This priority was ranked as the highest priority in the section of the MCHBG needs assessment survey related to issues impacting the health of children and adolescents and was also a key strategy in the ECCS plan related to improving children's health. This is also a high priority of the Department. The MCH Program coordinates closely with the Office of Health Insurance Programs related to improving primary and preventive services, including within the medical home.

Unmet needs for health care services among children and youth in New York State were reviewed based on several relevant sources of data specific to New York State, including the National Survey of Children's Health (2007) the National Survey of CSHCN (2006) and the NYSDOH Quality Assurance Reporting Requirements (QARR) report of managed care plan performance (2008). Overall, these data demonstrate several important findings:

- a significant proportion of NYS children and youth do not receive recommended basic primary and preventive health care services;

- having health insurance alone does not assure access to or utilization of necessary health care services;
- there are notable disparities in many measures of health care access and utilization based on race, ethnicity, income, insurance type and other factors.

Specific key findings include:

- Over 94% of NYS children (aged 0-17 years) reported having health insurance at the time of survey. However, over 13% of children had inconsistent insurance coverage, defined as one or more periods without insurance within the past year. Inconsistent insurance coverage was more common among children with lower income and those with black or Hispanic race/ethnicity.
- Of those children with current health insurance, nearly 23% reported it was not adequate to meet their child's needs. This rate appears comparable between children with public vs. private insurance. Families of CSHCN were more likely to report that insurance was not adequate to meet their child's needs in the 2007 National Survey of Children's Health, which is consistent with previous data exclusively for CSHCN in the 2005-06 national CSHCN survey.
- Overall, based on parent report through the 2007 national survey, the vast majority of children (over 96%) had at least one preventive medical visit in the previous year. However, data from NYS managed care plans demonstrate less consistent performance in this area. Among children enrolled in NYS Medicaid Managed Care plans: 79% of children received five or more well child visits in the first 15 months of life; 81% of children age 3-6 years received a well child and preventive care visit in the last year; and 58% of adolescents age 12-21 years had a well child or preventive care visit in the past year. Rates were slightly higher among children enrolled in commercial managed care plans.
- Based on parent report, only about 57% of children age 0-17 years receive care that meets all the criteria of a "medical home" as defined by AAP. Children and youth who are uninsured or have public insurance, who have black or Hispanic race/ethnicity, and children who have special health care needs, are less likely to receive care that meets these criteria.
- Approximately 6.4% of children age 0-17 years had one or more self-reported unmet needs for health care during the previous year. Children who were uninsured or had lower family income appear to be more likely to report unmet needs for health care, though the number of respondents in this category was small overall and thus may not be reliable for drawing conclusions among sub-groups.
- Among children who had a need for specialty care, approximately 21% reported difficulty in accessing such care. This was consistent for children generally and CSHCN. Children with public health insurance and those residing in urban areas reported more difficulty in accessing needed specialty care.

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

Related Federal Health Systems Capacity Indicators (HSCI), Performance Measures (NPM), National Outcome Measures (NOM) and Health Status Indicators (HSI)

HSCI02:Percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

HSCI03: Percent SCHIP enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

HSCI07A: Percent of potentially Medicaid eligible children receiving services paid by the Medicaid program.

NPM01: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for conditions mandated by their State-sponsored newborn screening programs

NPM 03:The percent of children with special health care needs ages 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical homes.

NPM05: The percent of children with special health care needs ages 0 to 18 whose families report the community-based services systems are organized so they can use them easily.

NPM07:Percent of 19 to 35 months olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diptheria, Tetanus, Pertussis, Haemophilis Influenza, Hepatitis B

NPM12: Percentage of newborns who have been screened for hearing before hospital discharge

3. State priority (current): To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality.

This is a current state priority measure and will be continued. The elimination of health disparities was ranked the second highest priority by all respondents in the MCH needs assessment survey. In addition, “health disparities in mothers and infants” was ranked the third highest priority in the section of the survey pertaining to issues impacting the health of pregnant women, mothers and infants. Elimination of health disparities is a high priority for the Department and the Governor and permeates the work of the department.

State Performance Measure (new): The ratio of the Black infant low birth weight rate to the White infant low birth weight rate.

Related Federal Health Systems Capacity Indicators (HSCI), Performance Measures (NPM), National Outcome Measures (NOM) and Health Status Indicators (HSI)

HSCA05A: Percent of Low Birth Weight under 2500 grams

NPM17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

NOM2 (Previous state measure adopted at the federal level) The ratio of black infant mortality rate to the white infant mortality rate

HSI01A: The percent of live births weighing less than 2,500 grams

HSI01B: The percent of live singleton births weighing less than 2,500 grants

HSI02A: The percent of live births weighing less than 1,500 grams

HSI02B:The percent of live singleton births weighing less than 1,500 grams

4. State Priority (revised): To prevent and reduce the incidence of overweight and obesity for infants, children and adolescents, with a focus upon reducing health disparities.

This priority was ranked as the number three priority by all respondents in the MCH needs assessment survey. It ranked second in the section of the survey ranking issues impacting the health of children and adolescents. Obesity and nutrition and physical activity were significant priorities of counties and their partners responding to the Prevention Agenda priorities. Prevention and reducing the incidence of overweight for children is a high priority for the State DOH and NYCDOHMH. Research indicates that adult morbidity and mortality are increased by childhood obesity, even if the condition does not persist into adulthood. However, in general, overweight and obesity tend to track or persist from childhood into adolescence and adulthood. The older the child/adolescent and the greater the obesity, the more likely that child/adolescent obesity will persist.

The prevalence of obesity (based on age- and sex-specific body mass index (BMI) percentiles calculated from measured height and weight) among elementary school children in New York State has increased dramatically between 1988 and 2004. However, data from 2007-2009 (from slightly different grades and a broader sampling frame) suggest that prevalence of child obesity may be decreasing. Among New York City elementary school children, in 2003, 24% of children in grades K-5 were obese, while in 2007-2008, 21% of children in grades K-8 were obese.

In 2004, 21% of third grade school children in Upstate New York were obese. In 2008-2009, in school districts outside New York City, 17% of school-age children (in grades pre-Kindergarten, K, 2, 4, 7, and 10), were obese, with a range of prevalence. These prevalences continue to exceed the prevalence reported for the U.S. (15.8%) in NHANES 1999-2002, and the Healthy People 2010 target of 5%. In both New York City and upstate NY, prevalence rates differed across racial/ethnic categories; Hispanics have the highest rates (29.3% and 31.1%), with rates for non-Hispanic Whites the lowest (18.7% and 15.9%), and rates for non-Hispanic Blacks in between (22.5% and 22.8%, respectively).

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

Related Federal Health Systems Capacity Indicators (HSCI), Performance Measures (NPM) and National Outcome Measures (NOM)

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

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

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.

This is a current State priority which has been modified to provide additional focus on improving adolescent sexual health and reducing health disparities. Preventing unintended and adolescent

pregnancy was ranked as the fourth highest priority for all respondents to the MCH Survey. Teen pregnancy and teen births was ranked as the fifth highest issue in the section of the survey related to health of children and adolescents. This is also a high priority of the SDOH and NYC DOHMH.

An increasing percentage of women giving birth in New York State over the past decade have indicated their pregnancies were intended (70% in 2008). However, the Guttmacher Institute indicates that while New York State is second in the country in funding for publicly supported family planning services from all sources, including Medicaid, New York State is reaching only 41 percent of women in the state needing public support for family planning services. Of New York women with unintended pregnancies who delivered live born infants, 55% reported that they were not using contraceptive methods when they became pregnant.

Despite this significant commitment to supporting family planning, consistent with national data, significant health disparities exist among women giving births in NYS with 54.3% of women under the age of 20; 53.1% of unmarried women; 55.6% of Black women; 46.5% of women receiving Medicaid benefits, and 54.3% of women with less than high school educations reporting that their pregnancies were unintended.

Adolescent pregnancy is an area where considerable health disparities exist. Among Black and Hispanic teens in the 15-19 age groups, pregnancy rates are more than double that of White teens. In 2008, the White teen pregnancy rate was 40.7 per 1,000 white adolescents, less than half the rate for Black (97.6) and Hispanic (103.3) adolescents.

Unprotected, high-risk sexual behavior places adolescents at risk for sexually transmitted diseases and HIV. If undiagnosed and untreated, there can be lifelong consequences, including infertility and death. In 2008, 88,460 cases of Chlamydia were reported in New York State, making it the most commonly reported communicable disease. Chlamydia morbidity has continued to increase since reporting began in 2000. Women are disproportionately affected by Chlamydia. The case rate per 100,000 for females in 2008 was more than twice the rate for males (623.3 vs. 296.6). Young women had the highest rates of infection. Among females 15-19 in New York State, the infection rate was 3,749.6 per 100,000, and among females aged 20-24, the rate was 3290.3 per 100,000.

In addition, according to the U.S. Department of Justice, one of every six American women has been the victim of an attempted or completed rape in her lifetime. About 44 percent of rape victims are women under age 18. Girls 15-19 are four times more likely than the general population to be victims of rape, attempted rape or sexual assault. The 2009 Youth Risk Behavior Survey also asked students about physical abuse. About eleven percent of New York high school students reported they were physically hurt (hit, slapped or physically hurt on purpose) by a girlfriend or boyfriend in the past 12 months. Rates were highest among Black and Hispanic males and females. Adolescent are subject to significant levels of violence and bullying, as well as suicides and unintentional injuries.

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

Related Federal Health Systems Capacity Indicators (HSCI), Performance Measures (NPM), National Outcome Measures (NOM) and Health Status Indicators (HSI)

NPM08: The birth rate (per 1,000) for teenagers aged 15 through 17.

HSI05A: The rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia

NPM16: The rate (per 100,000) of suicide deaths among youths aged 15-19

HSI03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years

HSI04C: The rate of non-fatal injuries due to motor vehicle car crashes among youth aged 15 through 24 years

6. State Priority (current): To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women

Reducing tobacco, alcohol and substance abuse was the fifth highest priority for all respondents to the Department's MCH survey. PRAMS data indicate a decline in women who report smoking during pregnancy, although levels of alcohol use during pregnancy remain stagnant.

Of respondents to the 2009 YRBS, 41.4% of all students reported having had at least one drink of alcohol in the past 30 days; 20.9% had their first drink before age 13. In 2007, these data were at 43.7% and 22.9%, respectively. Binge drinking (five or more drinks of alcohol in a row on one or more days in the last 30 days) in 2009 was reported by 26.6% of males and 20.7% of females. In 2005, 25.7% of males and 23.8% of females reported binge drinking.

The 2009 survey findings regarding drug use were as follows:

- 34.7% of students reported they had tried marijuana, compared to 35.2% in 2007;
- 20.9% used marijuana one or more times in the last 30 days, compared to 18.6% in 2007;
- 7.2% of students reported using cocaine, compared to 7.0% in 2007;
- 10.8% of students reported they had sniffed glue or breathed the contents of aerosol cans to get high, compared to 11.9% in 2007;
- 3.9% used heroin one or more times during their life, compared to 3.4% in 2007.
- 4.8% reported using methamphetamines, compared to 4.4% in 2007.

Tobacco use is a major risk factor in adolescents and is a high priority of the Department.

According to the 2006 New York State Youth Tobacco Survey, the current use of cigarettes among middle school and high school students is approximately 4.1% and 16.3% respectively.

Among high school students, the current use of cigarettes for white, black and Hispanic students was 20.1%, 7.9% and 13.4%, respectively.

State MCHBG Performance Measure (current): The percentage of high school students who smoked cigarettes in the last month.

Related Federal Health Systems Capacity Indicators (HSCI), Performance Measures (NPM), National Outcome Measures (NOM) and Health Status Indicators (HSI)

HSCI09B: The ability of states to determine the percent of adolescents in grades 9-12 who reported using tobacco products in the past month.

NPM15: The percentage of women who smoke in the last three months of pregnancy

7. State Priority (current): To improve oral health, particularly for pregnant women, mothers and children, and among those with low income.

Improving oral health was the sixth highest priority for all respondents to the Needs Assessment Survey and a priority of the Department of Health. Tooth decay, the most common chronic childhood disease impacts children's functioning, including eating, growth and speaking and learning. In the US, children are estimated to lose over 51 million school hours annually because of dental problems and dental visits. In a report titled Oral Health in America, the Surgeon General concluded that a "silent epidemic" of oral and dental diseases is affecting some population groups. The report noted profound disparities in oral health among poor children.

According to a survey of 3rd grade children conducted during 2002-2004 by the New York State Health Department in collaboration with many partners, the prevalence of dental caries was 54.1%. The estimated percent of children with untreated caries was 33.1%. The *Healthy People 2010* target for caries experience and untreated caries for 6-8 year old is 42% and 20% respectively. Consistently, both caries experience and untreated caries were more prevalent in the low-income group. The percentage of EPSDT-eligible children 6 through 9 years of age receiving dental services has increased each year since 2003. However, despite improvements in the provision of dental services to low income children, NYS remains below the Healthy People 2010 target of 56%. New York State is committed to achieving optimum oral health for all New Yorkers.

Even though dental sealants are effective in preventing dental decay, their rate of utilization among children and adolescents is below the Healthy People 2010 objective and Maternal and Child Health Block Grant Performance Measure of 50%. Nationally, the prevalence of dental sealants among 6-19 year old children is about 32%. A survey of third grade children in New York State showed that the prevalence of dental sealant was 27%, which is below the Maternal and Child Health Block Grant Performance Measure of at least 50% of children with a dental sealant on a molar tooth.

Significant disparities were found by geographic area and socioeconomic status in the prevalence of dental caries, untreated decay, and sealants. Low income children and children in inner cities and rural areas are more likely to have caries and untreated decay and are least likely to receive dental sealants. The use of dental sealants was also found to be significantly higher among children in schools with a dental sealant program (68%) compared to those in schools without a program (33%).

State MCHBG Performance Measure (new): The percentage of Medicaid enrolled children and adolescents between the ages of two and twenty-one years who had a least one dental visit within the last year.

Related Federal Health Systems Capacity Indicators (HSCI), Performance Measures (NPM), National Outcome Measures (NOM) and Health Status Indicators (HSI)

NPM09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

8. State Priority (new): To eliminate childhood lead poisoning.

Despite dramatic declines in the incidence and severity of elevated blood lead levels among young children, childhood lead poisoning remains a significant public health issue in New York State. New York State has the highest number and proportion of old housing stock, and has more new cases of lead poisoning among young children annually, than any other state in the nation. At the same time, significant geographic, economic and racial/ethnic disparities persist, as the problem of childhood lead poisoning is increasingly concentrated within specific communities that are challenged by a combination of poverty and old housing. Childhood lead poisoning is a serious health problem that can have devastating permanent effects on children's physical, social, behavioral and cognitive development, with serious social and economic repercussions for society as a whole. And while the results of lead poisoning are thought to be irreversible, exposure to lead is completely preventable. As a result of these collective factors, the prevention and elimination of childhood lead poisoning has been identified by both the Department of Health and the Governor as one of the state's highest child health priorities.

Early identification of elevated blood lead levels through routine blood lead testing of at-risk children is a critical component of overall strategies to eliminate childhood lead poisoning. Blood lead testing assures that children exposed to lead receive timely educational, medical and environmental interventions to mitigate the effects of lead poisoning and prevent continued exposure. In addition, blood lead test data form the basis of surveillance activities that support targeting and monitoring prevention and intervention strategies. New York State Public Health Law and implementing regulations require health care providers to test all children for lead at or around ages one year and two years. Lead testing rates continue to increase in NYS. Approximately 66 percent of children born in 2005 were tested for lead at or around age one year, compared to 45 percent of children born in 1998. Similarly, lead testing rates for children at or around two years are improving. Sixty-two percent of children born in 2005 were tested for lead at or around age two, compared to 48 percent of children born in 1998. Although lead testing rates for two-year old children remain below the rates for one-year-old children, that gap appears to be narrowing. More work is needed to further improve lead testing rates among both one and two year olds.

State MCHBG Performance Measure (Revised): The Percentage of children who were tested for lead two or more times by age three years.

9. State Priority (current): To improve diagnosis and treatment of asthma in the maternal and child health population.

Improving diagnosis and treatment of asthma in the maternal and child health population is a high priority of the department. Asthma has emerged as a significant chronic disease over the

past 25 years and continues to be a major public health problem in the United States (U.S.). In 2007, approximately 18.6 million Americans, including 6.7 million children, indicated that they currently had asthma. In 2004, asthma accounted for an estimated 14 million lost school days in children 5-17 years and 14.5 million lost work days in adults 18 years of age and older. The annual economic cost of asthma is \$18 billion, including direct health care costs of \$10 billion and indirect costs of \$8 billion.

In 2008, asthma affected over 1.3 million New York State (NYS) adults and 475,000 children. The Behavioral Risk Factor Surveillance System asks about asthma in the annual survey of adults in New York State. Beginning in 2006, NYS added questions to this survey about asthma prevalence and demographic characteristics for children. Based on responses to these questions, asthma prevalence estimates for current asthma in children have been calculated for the 2006-2008 time period. During 2006-2008, current asthma prevalence among children in NYS was 11.0%, well over the national prevalence rate. Children aged 5-9 years had the highest current asthma prevalence (14.3%).

New York State Children missed more than 1.9 million days of daycare, pre-school, or school due to asthma each year.

The prevalence of current asthma was lower in both Non-Hispanic White (8.7%) and Hispanic (11.1%) children in 2006-2008 compared to Non-Hispanic Black children (17.3%).

State MCHBG Performance Measure (revised): The rate of hospitalizations for asthma among children and adolescents ages 0 – 17 years per 10,000 children and adolescents ages 0-17

Related Federal Health Systems Capacity Indicators (HSCI), Performance Measures (NPM), National Outcome Measures (NOM) and Health Status Indicators (HIS)

HSCI01: Rate of children hospitalized for asthma per 10,000 children less than 5 years of age.

10. State Priority (new): To increase the percentage of infants who are breastfed for at least six months.

The U.S. Surgeon General recommends that babies be fed **only** breast milk for the first six months of their lives. The public health benefits of breastfeeding have long been recognized. Human milk is uniquely adapted to the nutritional needs of infants and provides for optimal growth and development. Breast milk is easy to digest and contains antibodies that help reduce the infant's risk of infection, from diarrhea and colds to meningitis and other life-threatening infections. Infants who are breastfed for three months or more make fewer medical office visits, receive fewer procedures, take fewer medications, and experience fewer hospitalizations. Breastfed infants are at reduced risk for asthma, respiratory infections, childhood and adult obesity, diabetes and other chronic illnesses, including cardiovascular disease and cancer, throughout their lifetimes. Breastfeeding also benefits the mother, reducing postpartum bleeding, promoting an earlier return to pre-pregnancy weight, and reducing the risks of breast and ovarian cancers. Breastfeeding yields both health and economic benefits to the family and society. Given

the well-documented benefits of breastfeeding, to both mothers and infants, breastfeeding is now regarded as a health imperative.

In the MCH Survey, breastfeeding initiation and duration was selected as the second highest priority for the MCH population pregnant women, mothers and infants. Increasing protection, promotion and support for continued breastfeeding, including when mothers return to the workplace was a key strategy in the ECCS plan related to healthy children. Improving rates of breastfeeding, especially exclusive breastfeeding, is a high priority of both the SDOH and NYCDOHMH who have been collaborating related to this effort.

Of children born in 2006 in New York State, 76.4 percent were ever-breastfed. Children born to women in New York City were more likely to have been breastfed (82.4%) as compared to infants statewide. Nationally, 73.9% of infants born in 2006 were ever breastfed. However, about 43% of children born nationally and in New York State in 2006 were being breastfed when they were 6 months of age. Rates were higher among New York City children (53.6%). The American Academy (AAP) of Pediatrics recommends that infants be breast-fed exclusively for the first 6 months of life; 9.6 children in New York State and 13.6% of children nationally met this recommendation. In New York City 10.7% of children were exclusively breast-fed at 6 months of age.

State MCHBG Performance Measure (new): The percentage of infants who were exclusively fed breast milk in the delivery hospital.

Related Federal Health Systems Capacity Indicators (HSCI), Performance Measures (NPM), National Outcome Measures (NOM) and Health Status Indicators (HSI)

NPM 11: The percent of mothers who breastfeed their infants as 6 months of age.

The following previous priorities were not included in this grant cycle because they were subsumed under one of the ten priorities listed above.

- The availability of comprehensive genetics services statewide, including follow up on positive newborn screening tests, specialty services and genetic counseling for affected families. The priority related to newborn screening and follow up is a high priority for the Department and is subsumed under Priority 2.
- To reduce the rate of violence across all age groups, including inflicted and self inflicted injuries and suicides in 15 to 19 year olds. This priority is a high priority of the Department and is subsumed under Priority 5.
- To improve partner and consumer participating in the Children with Special Health Care Needs Programs as evidenced by parent score. This priority did not reflect the significant concerns expressed by families with CSHCNs related to access to services and a medical home which are now addressed under Priority 2.

The following is a list of other issues that were identified as priorities by external stakeholders and/or Department staff that were considered but not selected as state priorities at this time. These priority issues were not selected due to three main concerns: the identified issue was

considered to be a broad based strategy that impacted upon several priorities; another State agency has primary responsibility for addressing the priority; or, there is currently inadequate funding for the Department to address the priority, Although the Department did not identify the issues below as priorities for the MCHBG, the Department is significantly invested in the work related to these priorities within the constraints of existing resources and organizational responsibility:

- **Home visiting** was identified as a high priority in the MCH needs assessment survey. The Department has made a significant investment in home visiting services as described in Section 3 of the needs assessment, and the State is very interested in pursuing home visiting funding available through federal Health Reform legislation. However, the Department views home visiting as a broad-based strategy for addressing multiple health outcomes and priorities. The Department is currently working with several other state agencies to develop the needs assessment required for the federal Maternal, Infant and Early Childhood Home Visiting Program. A goal of our efforts to coordinate home visiting activities will be to improve our data collection related to access to home visiting services, however, there would be significant challenges in developing a performance measure related to this priority at this time.
- **Mental health issues:** Infant developmental, social and emotional screening and follow up was identified by approximately a fifth of the respondents to the MCH needs assessment survey as an issue impacting upon the health of pregnant women and infants. Mental health screening, assessment and treatment was identified by a fifth of the respondents to the MCH needs assessment survey as an issue impacting upon children and adolescents. In addition, addressing postpartum depression has been identified as a need by both the State DOH and NYCDOHMH.

Through the leadership of the State Office of Mental Health and multiple state agencies and stakeholder perspectives, the Children's Plan has been developed. This plan provides concrete steps for raising the awareness of social emotional/mental health needs of young children and their families. Ideally, the Department's role in providing access to mental health services would be to integrate mental health into health care by training health providers to screen and refer for mental health services as part of routine health care. However, with the exception of funding provided through Project LAUNCH which is targeted to a limited catchment area in the state (as described in Section 3 of the needs assessment), there is currently no available funding to support a statewide training effort. Title V staff will continue to actively participate in the Governor's Early Childhood Advisory Council, including efforts to broadly support children's social-emotional health and to integrate physical and mental health strategies across child-serving settings.

The Department has made a significant effort to address postpartum depression, initially with limited federal grant funding which is no longer available, and on a continued basis through use of other programs and resources. However, these efforts have been hampered by the absence of a dedicated funding stream. Although the Department will continue to address this issue, it was not selected as a priority due to funding constraints.

The Department is awaiting federal guidance related to the new section in Title V providing \$3 million to support services to individuals with a postpartum condition and their families.

- **Child abuse and neglect** was ranked as the fourth highest issue impacting upon the health of children and adolescents in the MCH needs assessment survey. While the Department fully recognizes the importance of this issue related to child health outcomes, it was not selected as a priority, since the State's Office of Children and Family Services has primary responsibility for addressing this issue. Although it was not selected as a priority, the Department will continue efforts to address this issue, especially through its home visiting programs.
- **Parent Education** was ranked as a priority issue for pregnant women, mothers and infants by 22% of respondents to the MCH needs assessment survey. Like home visiting, the Department views parent education as a broad-based strategy for addressing multiple health outcomes and priorities, rather than a priority in and of itself. The Department will continue to directly support a variety of parent education activities and resources across a number of public health programs, including materials and supports specifically for families of CSHCN. In addition, Title V staff will continue to actively participate in the New York State Parenting Education Partnership and the Governor's Early Childhood Advisory Council, including efforts to expand cross-agency activities and resources to educate and support families.

6. State Outcome Measures

In addition to the priorities and performance measures selected above, the Department is including the following outcome measures for this MCHBG grant cycle.

Maternal Mortality: The Department is continuing to select maternal mortality as an outcome measure for this new grant cycle for the MCHBG. Maternal mortality continues to be a significant issue in New York State. The 2008 NYS rate is substantially higher than the 2007 NYS rate of 15.8 per 100,000, and the 2008 U.S. maternal mortality rate of 13.0 per 100,000, and is more than 6 times the Healthy People 2010 goal of 4.3 per 100,000. The racial disparity in maternal mortality in New York is dramatic and exceeds the differences seen in infant mortality and low birth weight. The 2008 Black maternal mortality rate of 70.2 per 100,000 births and the White rate of 18.8 per 100,000 births, result in a Black-to-White ratio of 3.7 to 1. These rates are based on 32 deaths among Black women and 31 deaths among White women. The rate for Hispanic women in 2008 was 21.7 per 100,000 live births based on 13 deaths.

To address this issue, the Department is revising its protocol for maternal mortality reviews with a focus upon prevention of future deaths as described in Section 3 of the Needs Assessment. It is critical that we continue to track this outcome to determine whether this effort will have a positive effect on reducing maternal deaths.

State Outcome Measure (current): The maternal mortality rate per 100,000 live births

Late Preterm Birth: Babies delivered prior to 39 weeks, and in particular those delivered between 34 and (up to but not including) 37 weeks (34-36+) have emerged as an increasing concern, particularly when delivery prior to term is not medically indicated.

The preterm birth (less than 37 weeks gestation) rate in New York State increased between 1999 and 2007, although it has decreased slightly between 2007 and 2008 from 12.4% to 12.1%. The preterm birth rate in New York City has been consistently higher than rates in Rest of State during the past 10 years. The percentage of black women delivering at less than 37 weeks gestation was 16.3% in 2008, 47% higher than the 11.1% rate among white women. Hispanic women giving birth had a prematurity rate of 12.6% in 2008. This was 14% higher than the rate among white women but 23% lower than the rate for black women. Disparities between black, white and Hispanic births have persisted over the past ten years.

In response to this concern, in 2009, the NYSDOH launched the New York State Obstetric and Neonatal Quality Collaborative (NYSONQC) to improve maternal and neonatal outcomes and eliminate disparities. Through NYSONQC, Regional Perinatal Centers will implement quality improvement interventions designed to improve maternal and newborn patient safety. The obstetrical workgroup of the collaborative will initially focus on reducing late preterm birth. The new outcome measure is being added to determine whether this new effort is having a positive effect on reducing elective deliveries prior to term without appropriate risks.

State Outcome Measure (new): The percentage of elective deliveries, both cesarean sections and inductions, performed without appropriate indication between 36 and 38 6/7 weeks gestation.

Attachment A

Public Summary

Background

The New York State Department of Health is applying for funds through the federal Title V Maternal and Child Health Services Block Grant (MCHBG). The MCHSBG provides over \$41 million in annual funding that currently supports a wide range of programming designed to improve the health and well-being of pregnant women, mothers and infants, children and adolescents and children and youth with special health care needs. Title V legislation requires that the State prepare a statewide needs assessment every five (5) years that shall identify (consistent with health status goals and national health objectives), the need for:

- Preventive and primary care services for pregnant women, mothers and infants up to age one;
- Preventive and primary care services for children; and,
- Services for children with special health care needs.

To help identify need in the MCH populations and to identify priorities for the next MCHBG cycle, the Department has engaged in an extensive effort to obtain public input which is described below. The methodology and information sources used to determine priorities for New York State for the 2011-2016 MCHBG cycle is also described.

Goals and Vision for the Needs Assessment

The Department's goal in the need assessment process is to comprehensively review the needs of the MCH populations; to examine existing program priorities and realign those priorities to address new identified needs to the extent that resource permit; and, to clearly assess performance related to program priorities to ensure MCH programming results in real improvement in the health and well being of the MCH populations in New York State. This review includes not only MCH programming supported by federal MCH funding, but also the substantially greater MCH programming that is supported by state funding. In addition, the Needs Assessment is an important resource for information for stakeholders and consumers interested in MCH services in the state, providing comprehensive quantitative and qualitative information regarding the state's MCH programs and performance. As a result, in the past, New York State has produced and updated some components of the needs assessment on an annual basis, particularly quantitative data, in support of the informational needs of the MCH community.

Methodology

Needs assessment of the maternal and child health population is a continuous and ongoing process, and is one that is critical to developing and updating priorities and monitoring progress on programs. Stakeholder input, related to the five year needs assessment, as well to specific MCH populations and program areas, provides an additional and often uniquely compelling perspective on the needs of the MCH population. Analysis of data from a wide variety of sources, including MCH Program data, provides a substantial window on needs of the MCH population, both for the state overall, and for specific populations or geographic areas. Finally, programs providing services to MCH populations have undergone their own strategic needs

assessment cycles, from assessment of need and capacity, to identification of priorities, developing program plans and performance measures to address those priorities and identifying or reallocating resources to implement the plans. All of these methods of assessment were incorporated in the Department's needs assessment process and were synthesized to develop the State's priority needs. This summary provides information related to the process for obtaining stakeholder input and the selection of priorities. The full needs assessment is included in the MCHBG application and includes all information sources as described above.

Stakeholder 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, NYSDOH 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 Title V Block Grant Application include the following:

- The Department's Prevention Agenda development process
- A survey of stakeholders related to MCH needs and priorities
- Regional forums for youth/young adults with special health care needs and families of children with special health care needs
- A survey of families of children with special health care needs and youth representatives
- Focus groups with adolescents and their families
- MCHBG Advisory Council discussions related to MCH needs and priorities
- Incorporation of local level stakeholder input to inform the state level assessment, including structured listening sessions with:
 - the MCH committee of the New York State County Health Association
 - the New York City Department of Health and Mental Health MCH Bureau
 - Comprehensive Prenatal-Perinatal Services Networks (CPPSNs).

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

In addition, to the specific efforts described that provided public input related to MCH needs and priorities, the Department has a significant number of regular mechanisms to obtain public input related to MCH program 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 below.

New York State Prevention Agenda

In April, 2008, Commissioner Daines launched the Prevention Agenda for the Healthiest State, establishing 10 statewide public health priorities with an emphasis on prevention strategies. The Prevention agenda was a call to action, asking hospitals, local health departments, and other health care and community partners to collaborate in planning to bring about measurable progress toward mutually-established goals related to two to three of the priorities. Across all the

priority areas, the Prevention Agenda focuses on eliminating the profound health disparities that impact racial and ethnic minorities. The public health priorities include:

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

Local Health Departments (LHDs) recorded their efforts in Community Health Assessments (CHA) and Municipal Public Health Service Plans (MHSP), which were submitted to the Department in July of 2009 as part of requirements for receipt of state funding through Article 6 of the NY Public Health Law. Hospitals submitted their Community Service Plans (CSP) in mid-September, 2009. With input from community members and stakeholders, two or three Prevention Agenda priorities were selected for community action, and a plan was developed. By coordinating their needs assessment and program planning activities, all participants will be better able to meet the needs of their communities while avoiding duplicative efforts and achieving economies of scale. The goal is for local health departments and hospitals to develop shared visions of what must be addressed.

A special section of the Department's public Web site has been designated to support the Agenda and the needs of partners in their effort. Key indicators with measurable five year objectives were established to track progress. Visitors can access recent statistics, information about evidenced based programs and best practices in each area, as well as information related to cost effectiveness. A new data source called the Prevention Quality Indicators was used in many of the assessments. These are a set of measures developed by the federal Agency for Health Care Research and Quality (AHRQ) to assess the quality of and access to outpatient care for ambulatory care sensitive conditions. The PQI provided invaluable zip code level information that enhances collaborative efforts. Detailed information about the Prevention Agenda can be found at: http://www.health.state.ny.us/prevention/prevention_agenda/index.htm. A highly successful follow up meeting was held with counties to provide them with additional information related to evidence based approaches and best practices to move forward with Prevention Agenda implementation.

While all the above public health priorities are important to the health and well-being of the MCH population targeted by the Title V program, the "Healthy Mothers, Healthy Babies, Healthy Children" priority is most immediately relevant, and the needs assessments produced by local health units and hospitals that selected this priority will provide a central focus for our efforts to understand the nature and extent of locally-determined needs. To measure progress toward improvements in this priority area, the Department has identified a range of important

health status measures that will be employed by communities as a starting point for the development of locally-appropriate performance targets:

Indicator	Prevention Agenda 2013 Objective	US	NYS	White non-Hispanic	Black non-Hispanic	Asian non-Hispanic	Hispanic
HEALTHY MOTHERS/ HEALTHY BABIES/HEALTHY CHILDREN							
% early prenatal care (1 st trimester) ⁵	90%†	83.9% (2005)	75.4% (2005)	77.0% (2004)	60.9% (2004)	66.9% (2004)	64.4% (2004)
% low birthweight ⁵ births (<2500 grams)	5%†	8.2% (2005)	8.3% (2005)	6.7% (2004)	12.9% (2004)	7.6% (2004)	7.4% (2004)
Infant mortality (per 1,000 live births) ⁶	4.5†	6.9 (2005)	5.8 (2005)	4.6 (2004)	11.1 (2004)	3.4 (2004)	4.5 (2004)
Increase % of 2 year old children who receive recommended vaccines (4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 HepB) ⁷	90%	80.5% (2006)	82.4% (2006)	84.3% (2006)	NA	NA	80.3% (2006)
% of children with at least one lead screening by age 36 months ⁸	96%	-	77% (NYS excl. NYC) (2002 birth cohort)	NA	NA	NA	NA
Prevalence of tooth decay in 3 rd grade children ⁹	42%†	53.0% (2004)	54.1% (2004)	NA	NA	NA	NA
Pregnancy rate among females aged 15-17 years ¹⁰ (per 1,000)	28.0	44.4 (2002)	36.5 (2005)	14.5 (2004)	71.0 (2004)	11.6 (2004)	70.4 (2004)

Because they planned together, hospitals and local health departments tended to pick the same four key priorities: Access to Quality Health Care, Chronic Disease, Physical Activity and Nutrition and Tobacco Use. Response to the Healthy Mothers, Healthy Babies, Healthy Children Priority was more limited with 35 counties or collaborating counties and 19 hospitals collaborating around this priority. County response to the Prevention Agenda was discussed with the members of the New York State Association of Counties MCH Committee. The members of that committee indicated that the MCH arena was a major priority for counties, and that MCH issues, in some cases, were subsumed into larger categories, for example, obesity prevention. MCH committee members indicated that while MCH issues were a major priority

for them, entities with whom they collaborated might have had other priority concerns. However, taken together, the responses for the above major priority areas provided substantial input related to local MCH needs.

Maternal and Child Health Service Block Grant Needs Assessment Survey

One of the many elements for the needs assessment strategy for the 2011-2016 program period was to develop a better understanding of key informants' views on current MCHSBG priorities and the issues and problems that confront the three MCHSBG target populations: pregnant women, mothers and infants; children and adolescents ages 1-21; and, children and youth with special health care needs. It was determined that a tightly-framed internet survey could obtain useful and cost-effective feedback to help inform decisions regarding the priorities and issues that should be addressed over the next five years. Survey methods and results are discussed below.

Identifying Stakeholders to Participate in the Survey

The first step in the survey development process was to identify a pool of potential respondents with in-depth knowledge of MCHSBG target populations and experience in meeting their needs. In September, 2009, all Bureau Directors within the Division of Family Health, the Directors of other Divisions within the Center for Community Health, and program contacts within the Wadsworth Laboratories and elsewhere in the Department were requested to provide a list of stakeholders who should be involved in our needs assessment process and subsequent planning. From an exhaustive list of potential stakeholders obtained from these sources, a workgroup composed of the DFH Director, Associate Director and DFH Bureau and Office Directors selected 183 whose input was viewed as essential.

The stakeholders selected for the survey included the Commissioners and Directors of all 58 county and city health departments, the 10 members of the MCHSBG Advisory Council, the state's 15 regional perinatal centers and 12 perinatal networks, 23 advocacy groups such as the March of Dimes, and the Health Care Association of New York, 16 professional organizations like the American Academy of Obstetricians and Gynecologists (ACOG), American Academy of Pediatrics and the NYS Dental Association, 4 health foundations, 12 American Indian Nations, 10 universities and 6 consumer groups. In addition, the survey was sent to 16 Department staff and 5 other state agencies.

Developing the Survey Instrument

A prime consideration in the design of the survey instrument was to ensure ease of completion to maximize return rates from the busy professionals to whom the survey was addressed. We reviewed a large number of surveys employed by other state MCH agencies and consulted several to obtain the benefit of their experiences. After further review and discussion, the Department workgroup determined that the best survey approach would be to ask stakeholders to rank the Department's current ten state MCHSBG priorities, and then to select five particular issues or problems they felt impacted heavily on each of the three MCHSBG populations. The survey instrument provides a lengthy list of issues for each population group. A wrap-up question at the end of the survey asked respondents to identify emerging issues not addressed elsewhere in the survey. The instrument was tested by NYSDOH staff for ease and speed of completion prior to release.

Conducting the Survey

An e-mail was sent to each survey participant with background information on current federal and state MCHSBG priorities, links to DOH information resources, including our 2010 MCHSBG Application, and a request to click on a link to the Department's Survey Monkey web site, <https://www.surveymonkey.com/s/BNYLBG5>, to begin the survey. After a reminder e-mail was sent to improve response rates, the survey was closed. When results were first tabulated, it was recognized that additional follow-up would be needed to improve response rates among certain stakeholder classes; the survey was reopened with another e-mail request to the stakeholder list.

Results of the Survey

All told, 234 survey responses were received, 207 of which were determined to be complete and subject to analysis. Responses exceeded participant invitations because a number of consumer group contacts shared the survey solicitation with other individuals, mainly parents of CSHCN, and a few county health departments shared the invitation within their agencies, so that multiple staff participated in the survey. When the responses were sorted, it was possible to estimate response rates for two key stakeholder groups to assess representativeness. Fully 89% (52/58) of county health departments, including the NYCDOH, responded, with 56 individual respondents representing them. Of the ten members of the MCHSBG Advisory Council, seven returned complete surveys. Below we compare and contrast the responses of these stakeholder groups with those of the total survey population to determine if there are significant response differences that need to be accounted for in our analysis of results.

Ranking of NYS MCHSBG Priorities

Survey participants were provided a list of the current MCHSBG priorities as they are stated in this year's application:

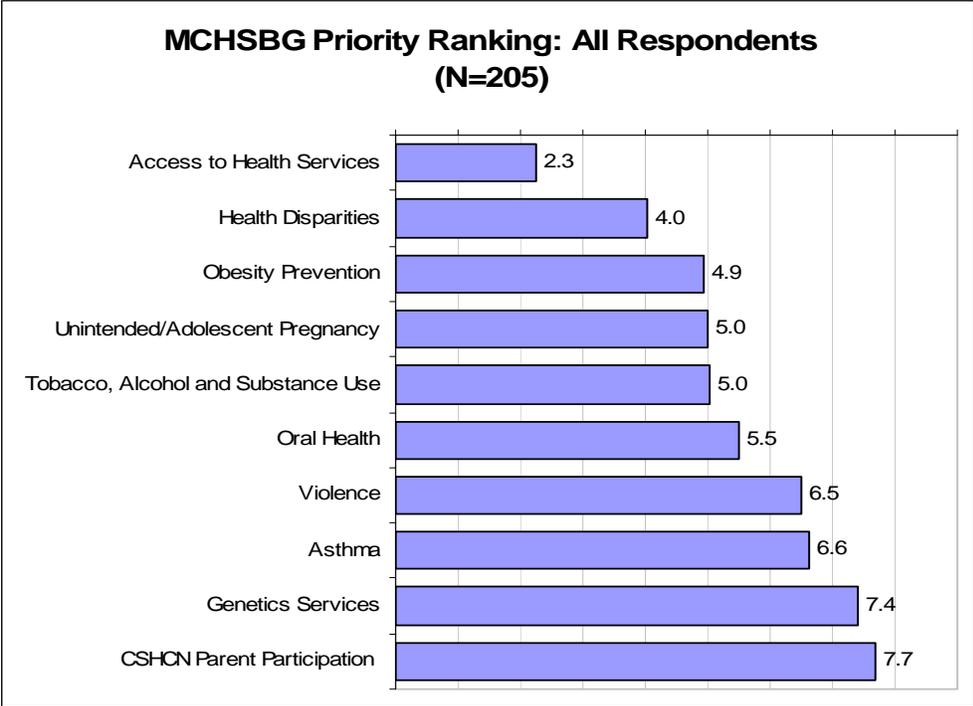
Current New York State MCHSBG Priorities

1. To improve access to high-quality health services for all New Yorkers, with a special emphasis on prenatal care and primary and preventative care, which includes attention to mental health issues and which serves those with special health care needs;
2. To improve oral health, particularly for pregnant women, mothers and children, and among those with low income;
3. To prevent and reduce the incidence of overweight for infants, children and adolescents;
4. To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality;
5. To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;
6. To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women;
7. To reduce unintended and adolescent pregnancies;
8. To ensure the availability of comprehensive genetics services statewide, including follow-up on positive newborn screening tests, specialty services and genetic counseling for affected families;
9. To reduce the rate of violence across all age groups, including inflicted and self inflicted injuries and suicides in 15- to 19-year-olds;

10. To improve parent and consumer participation in the Children with Special Health Care Needs Program, as evidenced by parent scores.

Participants were asked to rank these priorities from one to ten, with one signifying most important and ten, least important. A lower rating average therefore signifies higher ranking of a priority. The chart below, which condenses the wording of priorities for presentation purposes, indicates that the 205 respondents who completed this question selected “Access to Health Services” as the most important priority, with” CSHCN Parent Participation” considered of least importance.

Chart 1

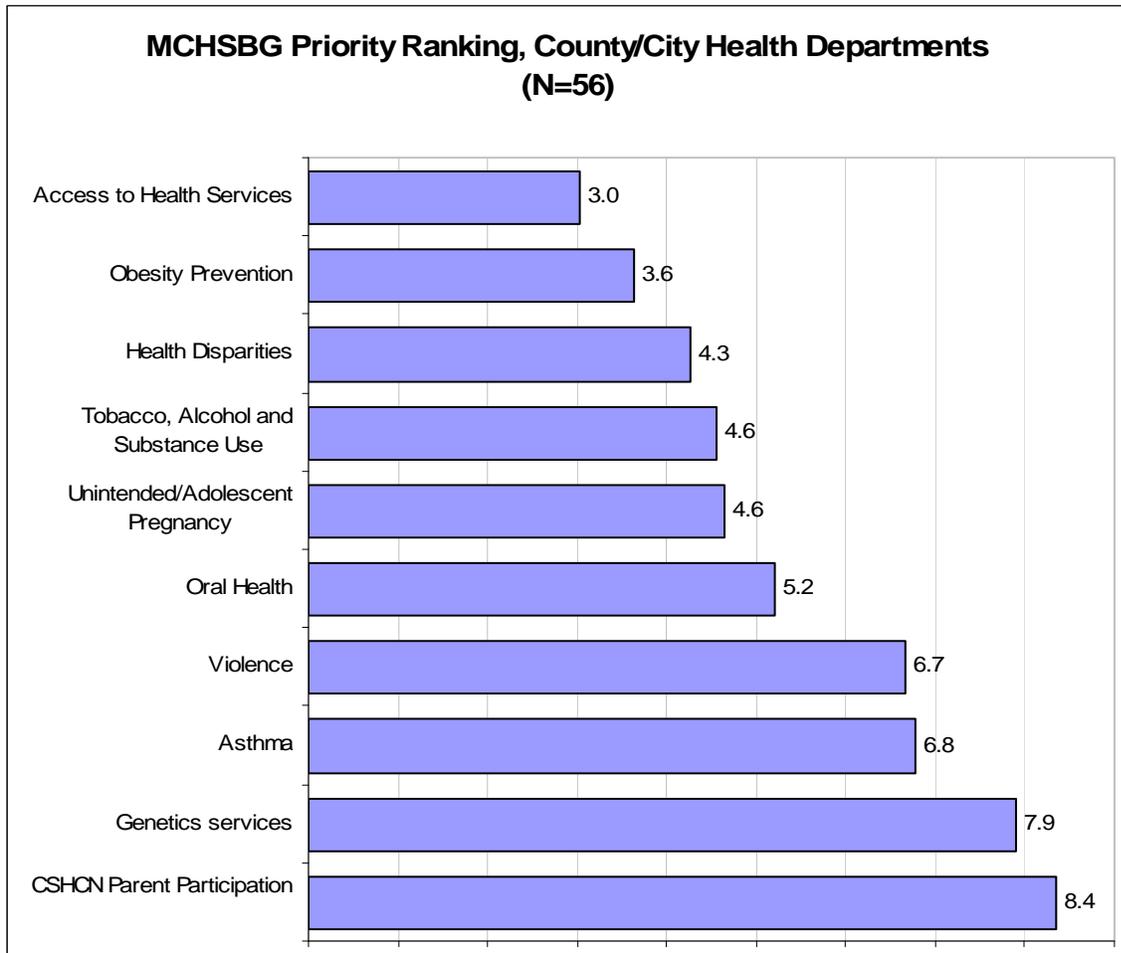


Given the tremendously different dimensions of these two priorities, this ranking comes as no surprise. What is positive about this chart is the importance respondents gave to the need for the Department to address health disparities, in addition to our need attend to obesity prevention, an important factor in development of chronic diseases among our young people, particularly those in minority or economically disadvantaged populations. Acknowledgement of the need to confront the problem of unintended and adolescent pregnancies is longstanding in New York State, and it is obvious that our tobacco, alcohol and substance use informational activities have kept the public health and health provider communities aware of the issue’s importance to the health of the MCH population. Given the general inattention given to oral health concerns across the country, it is heartening to see that respondents considered oral health to be among the highest priority issues that should be addressed.

Priority rankings in the main were constant across key stakeholder groups; consonance of results is far more apparent than differences. Chart 2 shows that when we restrict responses to those

from County and the NYC Health Departments, a very similar ranking emerges, with obesity prevention and tobacco, alcohol and substance use issues moving up slightly in importance, while the bottom four priorities remain in the same positions. County and city health department have been very busy in recent years with initiatives promoting good nutrition and greater physical activity, so their obesity prevention ranking is fully expected.

Chart 2



A slightly different pattern of priorities is noted in the responses of the members of the MCHSBG Advisory Council, as Chart 3 demonstrates below. Oral health increases in prominence, but overall, very little distinguishes the Council's ratings from those of the entire survey population, except for the fact that obesity prevention drops to sixth place among priorities. Of course, the small number of responses here means that one respondent can swing ratings dramatically, a fact that makes the similarity of these results with those of larger survey population that much more remarkable.

Chart 3

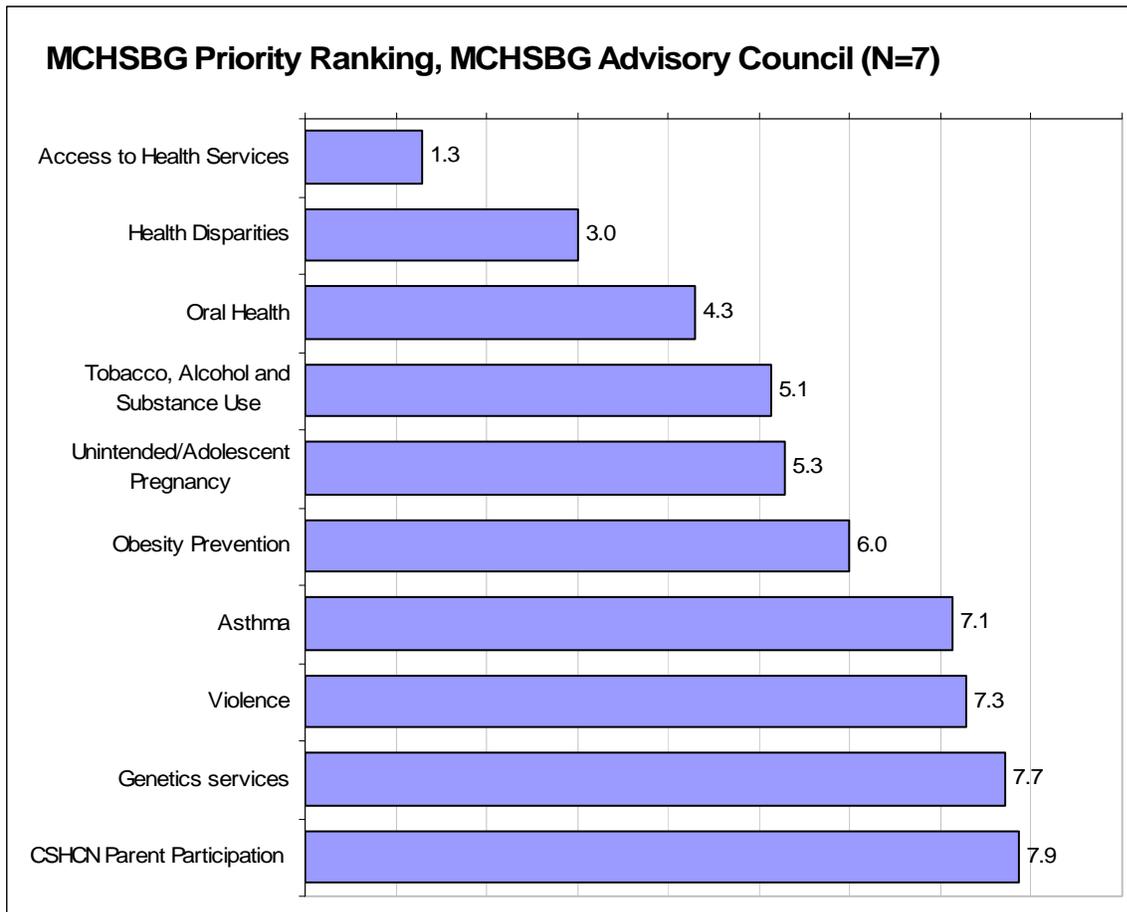
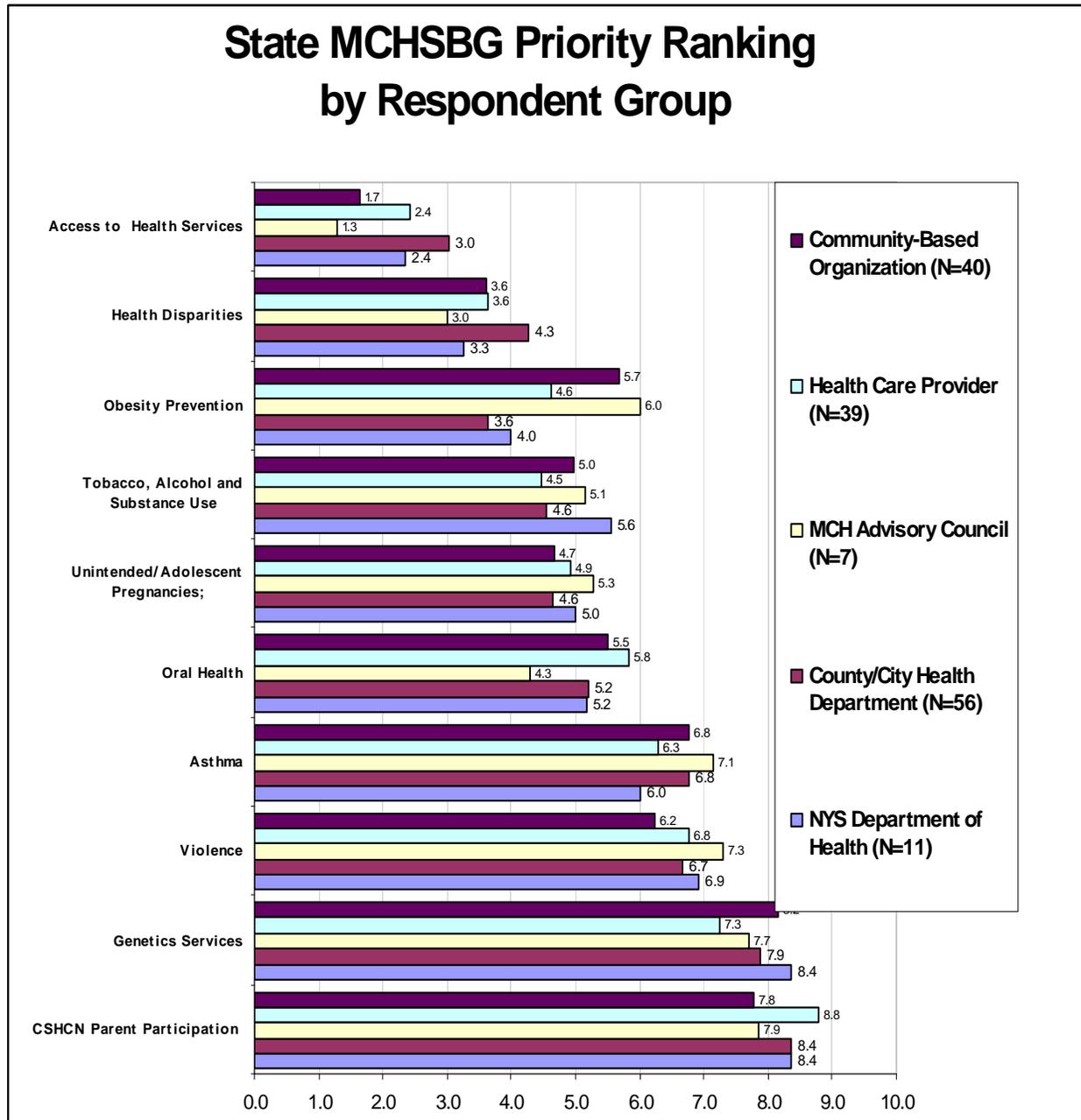


Chart 4, on the following page, reveals the priority rankings of five respondent groups that accounted for 152 of the 205 responses to this question: community-based organizations (CBOs), health care providers, MCHSBG Advisory Council members, county/city health departments and NYSDOH staff. Again, the overall pattern of rankings remains intact, with the obesity prevention priority showing the largest preference discordance among the groups. The MCHSBG Advisory Council and CBOs afforded the priority a lower ranking than did county/city health departments, health providers and NYSDOH staff, but otherwise ranking within groups reflects that of the entire survey population.

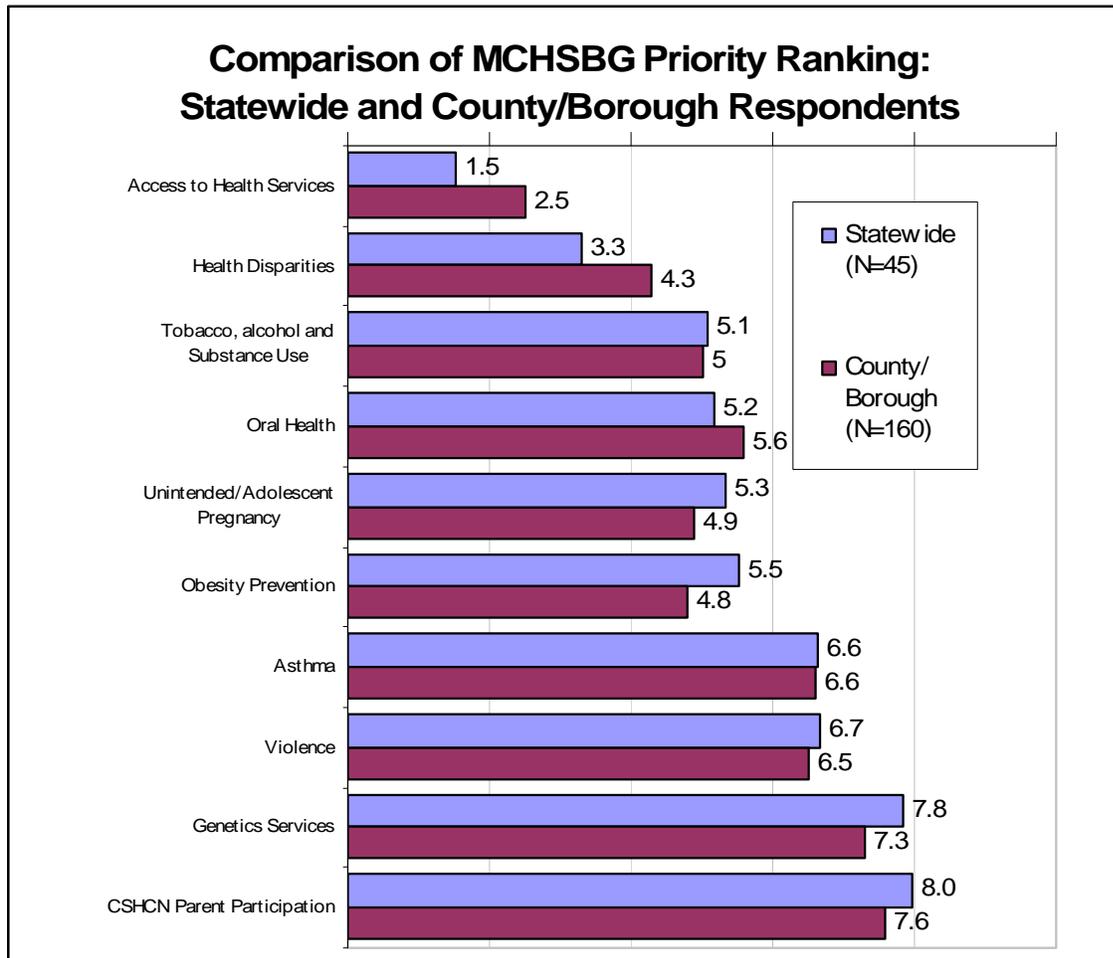
Chart 4



To gauge whether respondents' geographic orientation impacted results, we looked at how those representing themselves as reflecting statewide or county/borough concerns responded to the priority question. Those with a county/borough orientation were further divided into urban and rural to see if important differences arose among them. We could discern no essential differences between those with different geographic orientations. Chart 5 shows that respondents with a statewide orientation ranked access to health services very high, with an average rating of 1.5, and demonstrated elevated attention to health disparities and oral health relative to

respondents who selected county/borough as their area of focus. For their part, county/borough respondents were more concerned about unintended/adolescent pregnancy and obesity prevention than their counterparts with statewide perspective. For both groups, the bottom four priorities were identical to those of the total survey population.

Chart 5



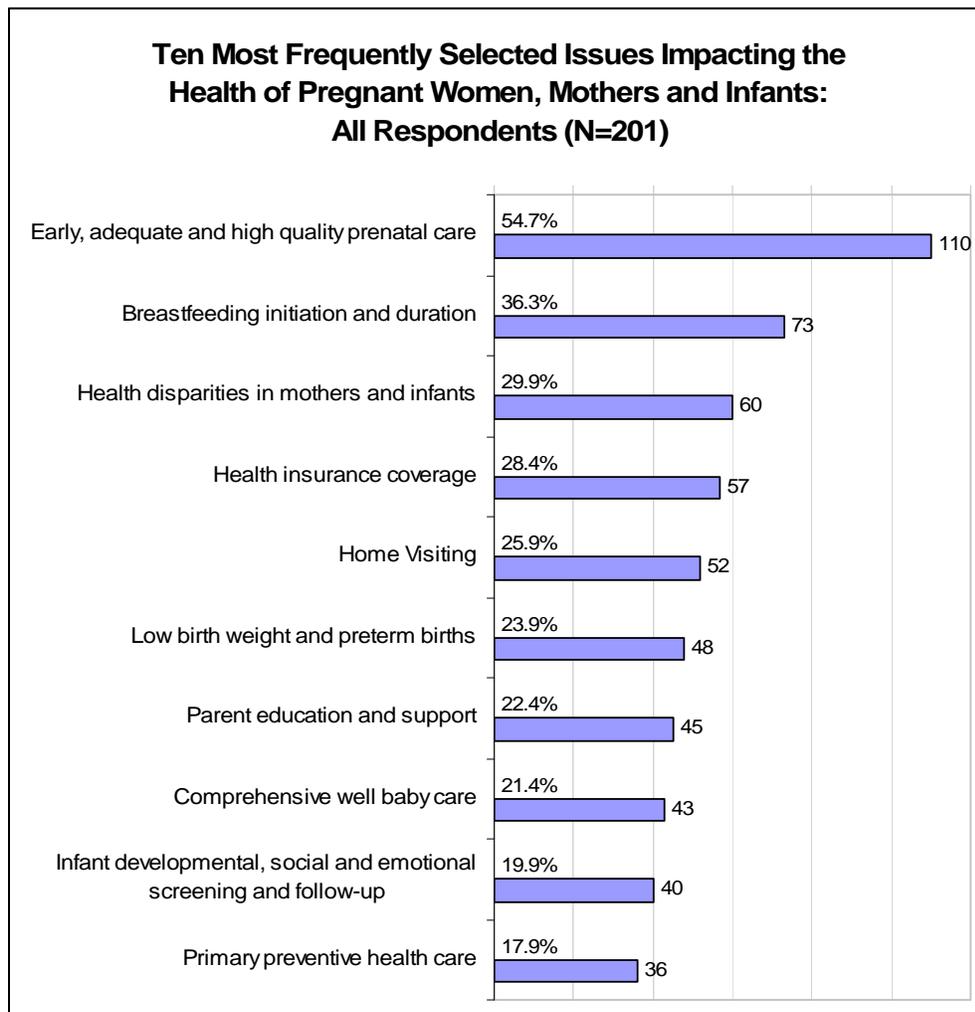
Issues Impacting the Health of MCHSBG Populations

Because of the congruity of results between stakeholder groups in their responses to the MCHSBG priority ranking question, we feel confident that that the results accurately reflect the opinions of the broad survey population as well as those of the specific stakeholder groups to whom the survey was targeted. A principal aim with this section of the survey was to move respondents beyond the confines of the MCHSBG priority list to determine if there were important matters not addressed there, and, therefore, to help move us toward new priorities. A secondary concern was to understand whether respondents would affirm the validity of one or more of the current MCHSBG priorities. Recipients were presented a lengthy list of issues and problems and were asked to select the top five affecting each of the three target populations. If recipients could not find a suitable issue on the list, they were provided the opportunity to enter one for each population group. Results for the three population groups follow below.

1) Pregnant Women, Mothers and Infants

As Chart 6 demonstrates, *prenatal care* was the most frequently selected issue, with 110, or 54.7% of the 201 respondents to this question picking it among the top five issues impacting the health of this population group. Other important issues selected included *breastfeeding* and *disparities*, lending support to current MCHSBG priorities. *Health insurance coverage* was the fourth most-often cited issue, and if taken together with *health insurance adequacy*, which garnered another 31 selections (but was not among the top ten), health insurance was noted by more than 43% of respondents. Interestingly, *home visiting* was selected as one of the top five issues by nearly 26% of respondents; if combined with related *parent education and support* and *infant developmental screening*, this result lends strong support for the Department’s focus on parenting support activities of all kinds, including expansion of prenatal-perinatal home visiting services. The remainder of issues selected by respondents appears to support current MCHSBG priorities, most particularly access to health services. Seven respondents entered *Other*, but their entries either repeated issues listed or were unresponsive, addressing children with special health care needs.

Chart 6

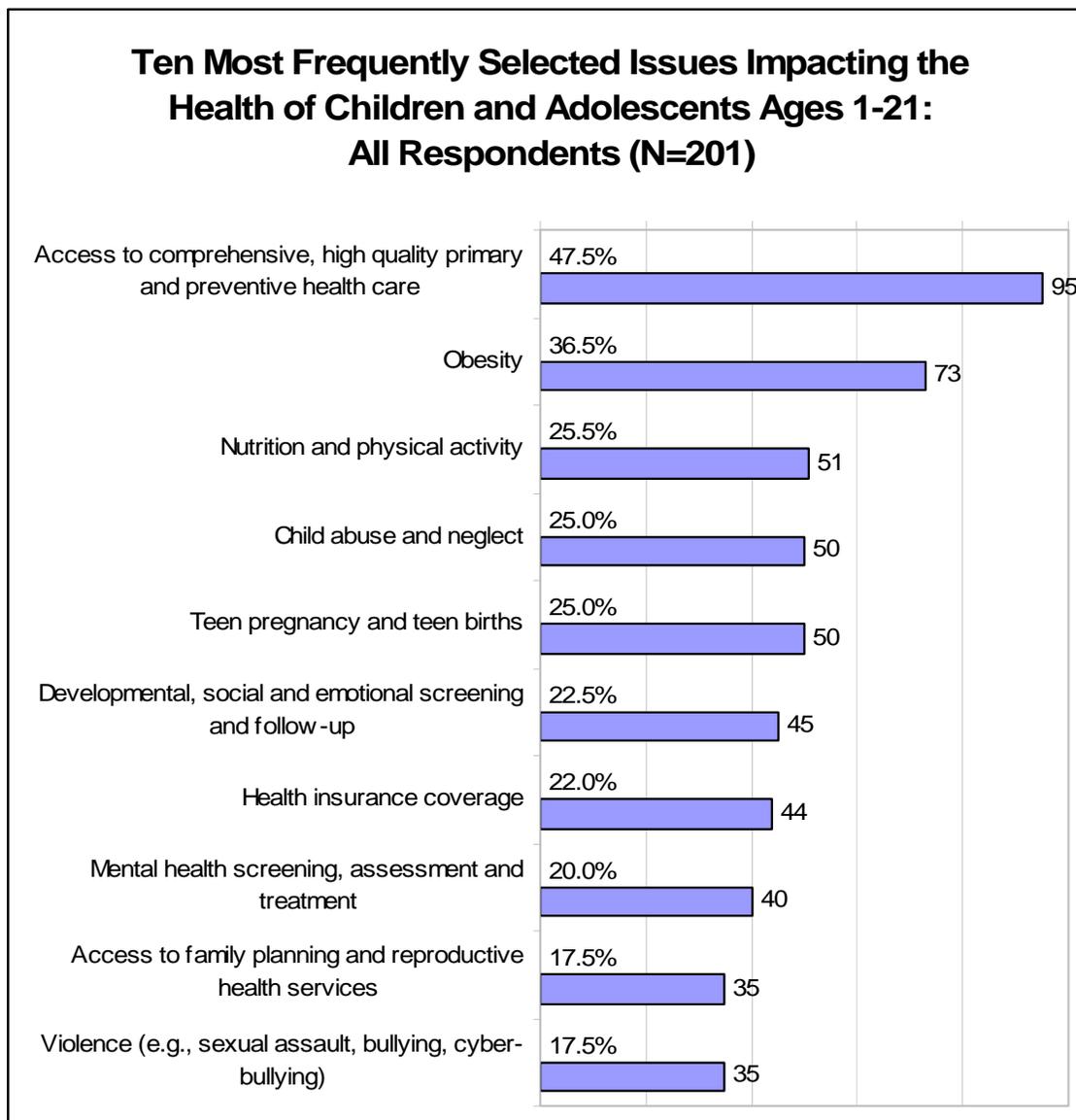


2) Children and Adolescents 1-21

For issues impacting the health of children and adolescents, *access to primary and preventive care* was the predominant issue for respondents, as shown in Chart 7. *Obesity* and the related *nutrition/physical activity* issues combined as top five choices of 62% of respondents. One-quarter of respondents selected *child abuse/neglect* and *teen pregnancy* as among the five most important issues, followed closely by *developmental screening* and *health insurance*.

The remainder of the ten most frequently selected issues is in accord with our current MCHSBG priorities, especially those regarding *access to care* and *violence prevention*. Only seven respondents chose to offer open-ended issues, but most were unresponsive to this question, as they either restated issues listed or related to children with special health care needs, the subject of the next issues identification exercise.

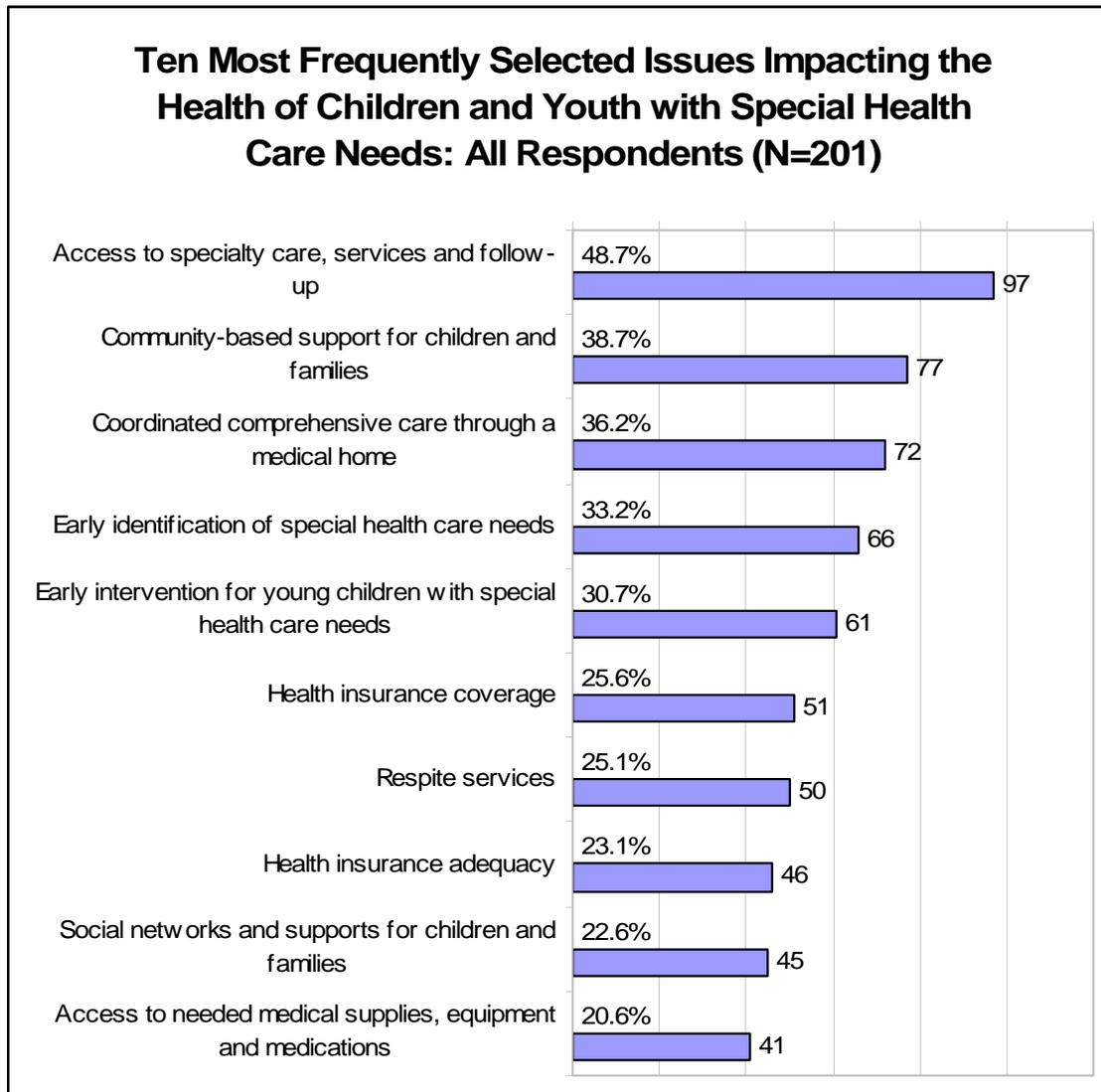
Chart 7



3) Children and Youth with Special Health Care Needs.

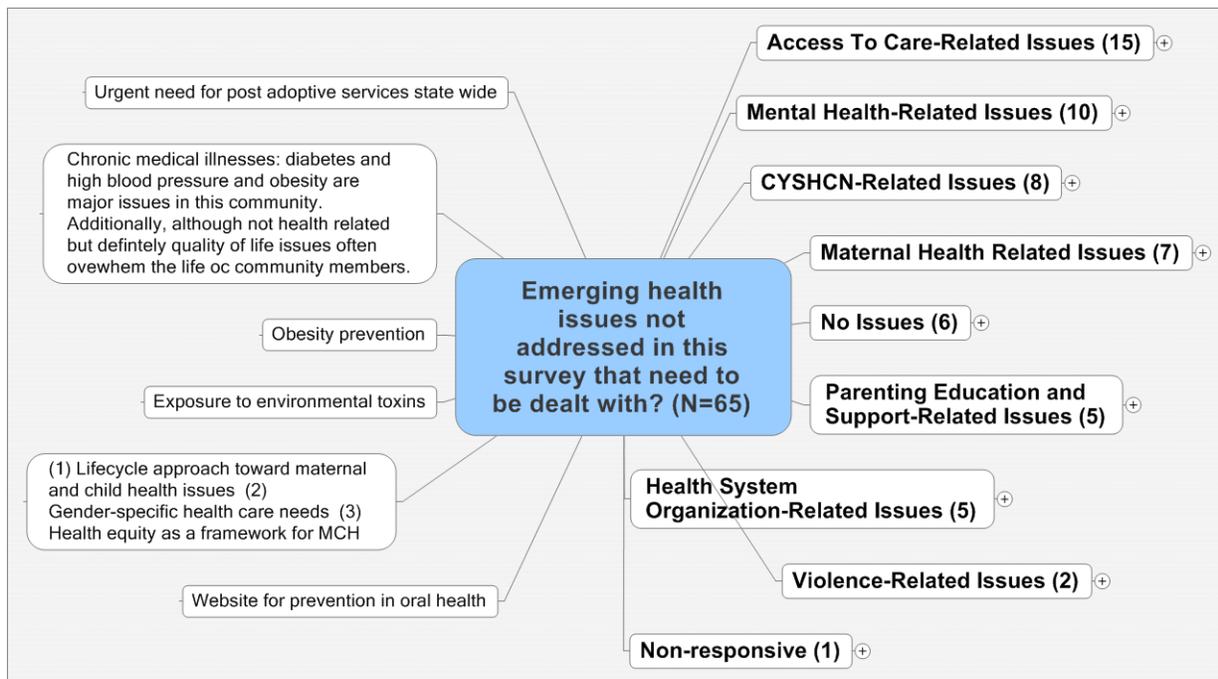
Access to specialty care was the most frequently-cited issue among those responding to this question, followed by *community-based support* and *coordinated comprehensive care*, issues that affirm the results of the detailed feedback obtained from parents of clients of our CSHCN, PHCP and Early Intervention programs, and provide support to our intensive efforts to ensure that all CSHCN and their families benefit from high-quality services. The remaining issues selected further reinforce the validity of the service strategies employed by our programs aimed at CSHCN and their families.

Chart 8



Emerging Health Issues

The last question of the survey asked respondents to identify emerging health issues that had not been addressed in the survey. A total of 65 responses were received and arranged into affinity groups using concept-mapping software (Mindmanager). The results are illustrated below, and a detailed review of all responses received is appended to this document. Issues related to the many dimensions of *access to care* were foremost among those identified by respondents: concern for immigrant families was apparent, and concerns about access to primary and specialty medical providers were frequent. Lack of childbirth alternatives, including midwifery services, was cited by a number of respondents, and health insurance-related access issues were also identified.



Mental health matters figured importantly for respondents, with perinatal depression, shortages of child psychiatrists and other mental health professionals among the more common concerns. One respondent expressed concern about eligibility requirements hindering access to MH services, while another emphasized the relationship between stress and a host of adverse outcomes. Among the *CYSHCN* issues noted were problems related to the aging of children with disabilities, the lack of OB/GYN care for adolescent and young adult CYSHCN, and problems accessing quality services in rural counties. *Maternal health* concerns included maternal mortality, cesarean section rates, and environmental exposure to teratogens. *Parenting education and support* issues covered safe infant sleep practices and health literacy training needs. *Health system* concerns centered on the need for better coordination and continuity of care, i.e. horizontal and vertical integration, as well as avoidance of service duplication. *Violence* concerns covered child abuse and inter-teen violence, both addressed by the issues lists. Six responses were unique and are highlighted above. These responses lend nuance to our priority ranking and issues identification efforts.

Regional forums for youth/young adults with special health care needs and families of children with special health care needs

In February and March 2010, the CSHCN Program held regional forums for youth/young adults with special health care needs and families of children with special health care needs 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 (consumer partnership in decision making and satisfaction with services, medical home, adequate insurance, organization of systems for ease of use, and transition) that are identified in the Block Grant application. Public forums for families were held in four regions of the state (Capital, Central, Western and Metropolitan). Seventeen families attended the public forums. A youth forum, in which five youth/young adults participated, was held in the Metropolitan region. A youth forum was planned in three other regions of the state; however, three of the four forums were cancelled due to lack of any youth respondents in the region. Qualitative data from the family forums was coupled with quantitative data specified in the performance indicators of the 2005-2006 National Survey of CSHCN to reflect a statewide needs assessment for children with special health care needs.

Consumer concerns raised during the forums include difficulty in obtaining Medicaid-funded transportation to doctor's appointments; access to Medicaid enrolled providers and specialists, including primary care, dental, and mental health; health care provider and Medicaid Service Coordinators' lack of knowledge about community resources related to special health care needs services; and, the need for additional training of these providers about the needs of these children and families. The consumers in the Central Region explained that some children are not able to utilize public transportation because of their special needs. Some consumers indicated the number of allowable services/visits under Medicaid for PT, OT and mental health were inadequate and others stated the need to bear out-of-pocket expenses for services and equipment not covered by Medicaid. Consumers also mentioned issues associated with the Medicaid prior approval process. Many consumers felt the coordination of their child's care rested primarily with the parents rather than the provider. Consumers also pointed out the lack of transition resources to find adult health care, get a job, find housing and learn life skills as challenges. Peer mentoring was suggested as a possible strategy to overcome these challenges.

Parents of CSHN also responded to the general survey related to MCH priorities as described above.

Survey of families of children with special health care needs and youth representatives

In addition, annually, a survey of family representatives is distributed to elicit feedback for the Maternal Child Health Block Grant application item (Form 13), "Characteristics Documenting Family Participation in the CSHCN Program". The surveys were distributed to 17 Family Champions as well as the 17 consumer participants in the forums. Five individuals have responded (response rate of 14.7%). The raw individual scores were compiled and averaged for each of the six items of Form 13. Scores are rounded to the nearest whole number. A score of 2 represents the characteristic is "Mostly Met" and 3 indicates the item is "Completely Met". The total score of 14 is lower than last year's total score of 18. However, a small sample size should

be viewed with caution when assessing trends in data over time. A copy of the survey is included in Appendix

The results for family participation in the CSHCN Program are as follows:

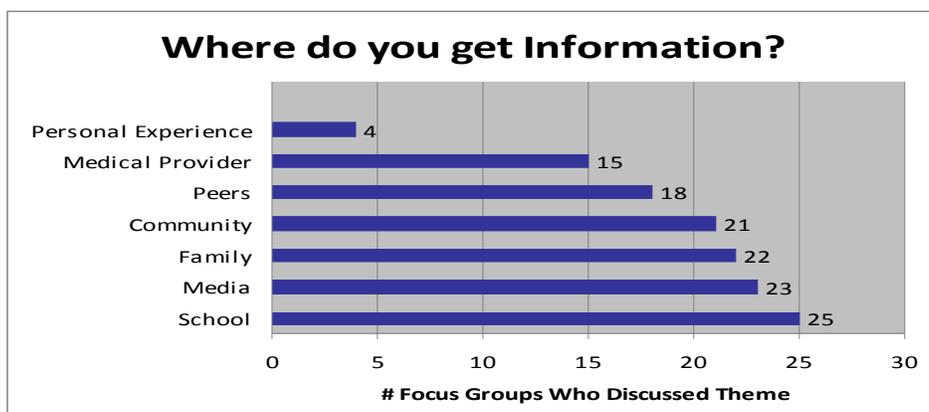
	Score
1. Family members participate on advisory committee or task forces and are offered training, mentoring, and reimbursement, when appropriate.	<u>2.2</u>
2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.	<u>2.0</u>
3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.	<u>2.2</u>
4. Family members are involved in service training of CSHCN staff and providers.	<u>2.5</u>
5. Family members hired as paid staff or consultants to the State CSHCN Program (a family member is hired for his or her expertise as a family member).	<u>2.3</u>
6. Family members of diverse cultures are involved in all of the above activities.	<u>2.5</u>
Total	13.7

Focus Groups of Adolescents and Families

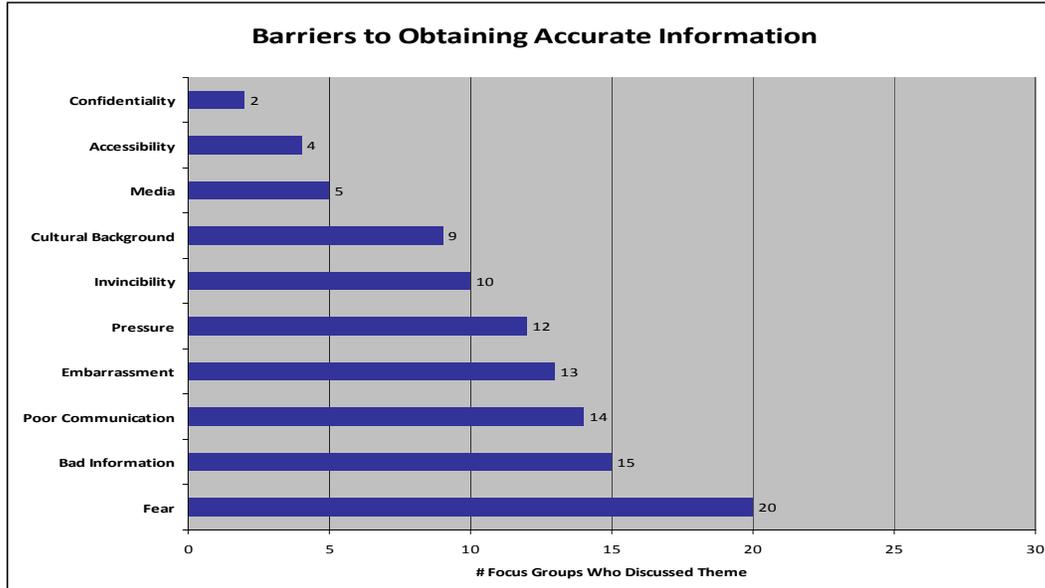
In the fall of 2008 with the analysis completed and presented in early 2009, an Adolescent Sexual Health Focus Group study was conducted by the DOH-funded adolescence Center of Excellence (COE) at Cornell University (and their partners at University of Rochester School of Medicine, NYS Center for School Safety and New York City Cornell Cooperative Extension). This study was designed 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. Twenty-seven focus groups with 291 participants (age 13-21) were held statewide with consideration given to geographic and participant characteristics, including gender/gender identity and race/ethnicity.

Demographic breakdown of non-pilot group participants were 50.4% male, 48.3% female, and 1.3% transgender. Five percent of youth reported they were not currently in school, while the remaining participants were in the following grades: 8th - 3.4%, 9th - 17.6%, 10th - 18.0%, 11th - 26.2%, and 12th - 29.6%. Racial/ethnic breakdown was 25% Hispanic, 56.8% - Black or African American, 23.5% - White, 18% - Other (includes multiracial and specific ethnic affiliations), 5.1% - American Indian or Alaska Native, and 3.4% - Asian.

Participants were asked where they most commonly got their information:



They were also asked to identify the barriers to receiving accurate information.



Recommendations included:

- Offer more extensive sexual health education, with schools identified as the most logical vehicle for this;
- Increase access to sexual health information and services, including into already existing community centers and organizations;
- Make resources more visible in the community;
- Improve communication between parents and their children by providing information to parents;
- Focus on media, such as launching a media campaign, instituting greater media controls, or developing a reliable and accessible Internet website “*that teaches everything*”; and
- Develop a mechanism for information to be transmitted by clearly reliable sources, such as from medical professionals, speakers who easily connect with youth, and/or the Department of Health.

Many of these recommendations are being implemented through our current media campaign, the launch of [nysyouth.net](http://www.nysyouth.net), the enhanced focus on sexuality education in schools within the pregnancy prevention programming and our upcoming health care provider education. A copy of the report from the symposium is available on the ACT for Youth Center of Excellence (COE) website at <http://www.actforyouth.net/>.

The COE also conducted focus groups with parents, guardians, grandparents and other adults in NYS to assess parent needs for talking with their adolescents about sexual health and as a follow up to the ASH focus group project with adolescents. Fifteen statewide parent focus groups were held during June 2009. Preliminary results of the groups have been released. Five groups (with 42% of participants) were conducted in Spanish. The analysis of these focus groups will

determine whether the adults in the group endorsed, elaborated, and/or contradicted the youth focus group recommendations regarding what they want to ask/discuss with their parents.

Major findings from these focus groups include the need to:

- Inform parents about the normative changes in physical development that occur as their children mature through adolescence to empower them as sex educators;
- Improve parental knowledge of youth psychosocial development to assist them to support youth health sexual and reproductive development;
- Increase general information about STIs and HIV related to how infections/diseases are transmitted and prevented and how to prevent pregnancy, as well as use of contraceptives including practical guidance in demonstrating how to put on a condom;
- Normalize the process in which youth develop their sexual identity, including how to “talk to children if they are confused about their sexuality”; and,
- Emphasize the importance of teaching youth about sex in the context of healthy romantic relationships. This includes helping youth understand "the emotional elements of sex" including love, marriage, “that sex isn't just the physical act,” “is serious and powerful,” and can include caring, trust, and responsibility.

Input from the Maternal and Child Health Services Block Grant Advisory Council

The New York State Department of Health established the Maternal and Child Health Services Block Grant Advisory Council in 1983, following the enactment of Chapter 884 of the New York State Laws of 1982. The Council serves in an advisory role to the Department regarding the administration of funds under Title V of the Social Security Act. The Council assists the department in determining the program priorities and in soliciting public input for the preparation of annual applications.

By statute, the Council is composed of twelve individuals, six of whom are appointed by the Governor, three of whom are appointed by the Temporary President of the Senate and three of whom are appointed by the Assembly Speaker. Also by law, members are to include representatives of local government, the not-for-profit sector, and the community.

The Council members, in their advisory capacity, bring a wealth of experience, information and concern to the table. Advisory Council members carefully consider the testimony offered by individuals presenting at the meetings, and often bring new information encountered in their daily professional lives in formulating their recommendations to the Commissioner and the Governor.

Development of the Maternal and Child Health Block Grant needs assessment and application was an agenda item for several of Council meetings. In addition, a 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. The Council provided valuable recommendations related to the establishment of priorities. Members of the MCHBG Advisory Council were also asked to respond to the Maternal and Child Health Service Block Grant Needs Assessment Survey. The results are described above.

Incorporation of local level stakeholder input to inform the state level assessment

New York State Association of County Health Officials (NYSACHO)

NYSACHO is the organization linking together the 58 local health departments that comprises New York's municipal public health system. Membership consists of health commissioners, public health directors, deputy commissioners, and directors of patient services from county and city health departments. Through its members and staff, NYSACHO seeks to build upon its strong collaborative partnerships with the Department and other academic and health related organizations in designing and implementing effective public health policies. As the operational arm of the public health system, local health departments understand the unique needs of their communities. As such, they are essential voices at the planning table in developing policies that are realistic, effective, and appropriate in scale. NYSACHO work is conducted through a number of standing and ad hoc committees related to different public health subject areas, one of which one is related to Maternal and Child Health.

County health department response to the MCH needs assessment survey was previously described. MCH staff in the Division of Family Health conducted a telephone meeting with members of the MCH Committee to obtain additional insight related to the survey results. The meeting generally confirmed the results of the survey, including the high ranking related to access to care, and the need to develop additional strategies to address access issues.

Comprehensive Prenatal-Perinatal Services Networks (CPPSNs)

The Department funds 16 CPPSNs that engage consortia of local health and human service providers and consumers to identify and address gaps in local and regional perinatal health and child health care and service delivery systems. In addition to perinatal networks completion of the survey, Division of Family Health and Bureau of Maternal and Child Health staff met with staff from the 16 Comprehensive Prenatal-Perinatal Services Networks (CPPSN) on April 10, 2010 and engaged in an active dialogue discussing current and future priorities related to perinatal health. Strengths, capacity, gaps and priorities were discussed in the context of current perinatal, reproductive and other MCH-related programs and initiatives, as well as the broader MCHBG needs assessment. The requirements of the MCHBG Needs Assessment and the MCHBG structure and service levels pyramid were reviewed as a framework for the discussion.

Through these discussions, the following themes and priorities were identified:

- The underlying importance of maintaining and strengthening community and regional infrastructure and partnerships
 - Comprehensive Prenatal-Perinatal Services Networks (CPPSNs) are positioned to support and further develop local infrastructure. Networks can support infrastructure and partnerships to: identify and respond to needs, both known and emerging; connect needs to resources and coordinate services; mobilize stakeholders for local action; and establish strong communication networks and promote consistent messaging.
 - Networks voiced support for an increased focus on outcome driven work and evidence-based strategies. Additional community level data, including race and ethnicity data, could support further targeting of activities. More feedback on what works will help drive ongoing improvement.

- At the same time, flexibility is important in order to identify and be responsive to emerging issues. Need to balance innovation and flexibility and a “big picture” focus with attention to specific priorities.
- Access to early, comprehensive, continuous prenatal care
 - This remains a high priority, but more targeted approaches are needed to reach high-risk women and increase rates of early entry into prenatal care.
 - The number of women utilizing Medicaid prenatal care programs must also be increased, and we need to ensure high-risk women are engaged in appropriate services.
 - Early scheduled deliveries (inductions and C-sections) was noted as an issue of concern. Patient (consumer) education is one important component of addressing this problem.
- Attention to issues of cultural competency, including urban and rural cultural differences
 - The culture in New York City and even across different boroughs within NYC may be different from upstate, especially from rural areas.
 - Addressing health disparities is a priority, but reaching hard-to-reach populations requires true cultural competency. Programs need to know the city, neighborhood, language barriers, and literacy levels of the populations being targeted for services. They also need to understand what target populations see as their needs and issues, and to “drill down” to qualitative information from people to understand if there is a “problem”, how it is perceived, and why it exists.
- Further attention for adolescent pregnancy prevention and support for teen parents and their babies, including
 - How to meet the developmental needs of both the teen parents and their babies;
 - Understanding of what is going on in communities that affects life choices related to early parenting. In some communities and cultural groups, this is not necessarily perceived as a problem. To address this effectively may require a shift in focus from pregnancy prevention to preconception/interconception care to meet people where they are;
 - Programs need to address understanding relationships- what to expect from a partner, both as a dating partner and as parents. A life course approach is needed.
- Further attention to child well being and special needs
 - Child abuse and neglect was identified as a critical issue that may be a gap in current MCHBG programming. Child abuse and neglect can’t be unlinked from infant mortality and morbidity. Non-punitive supportive services, preparedness for parenthood and parenting education are needed. Family violence and work to engage fathers also needs to be addressed. The Importance of considering these as health issues was addressed.

The New York City Department of Health and Mental Health, Bureau of Maternal, Infant and Reproductive Health (BMIRH)

The NYCDOHMH, BMIRH submitted their responses to the on-line survey. The Division of Family Health conducted a telephone meeting with the NYCDOHMH Assistant Commissioner BMIRH. The purpose of the call was to obtain additional insight related to NYCDOHMH concerns related to State MCHBG priorities.

NYCDOHMH priorities were discussed that overlapped the current State priorities. The integration of reproductive health services into the primary care setting is imperative. This integration promotes a lifespan approach to reproductive health care by not only better ensuring improved access to reproductive health services, but in developing the linkage between primary health care and an individual's reproductive health, including management of chronic diseases that may impact later pregnancies and birth such as obesity, diabetes and other chronic diseases. Adolescent health services, including the prevention of teen pregnancy and access to quality adolescent and reproductive health services continues to be a priority. Pregnant adolescents who go on to deliver their babies have higher rates of complications and suffer economic and psychosocial impacts as a result of the pregnancy. Teenage pregnancies are associated with increased rates of alcohol and substance abuse, lower educational level, and reduced earning potential in teen fathers.

NYCDOHMH also indicated that ensuring access to mental health services, especially for pregnant and parenting women is essential as well. Mental health services are not always readily available for this population and can have significant impact on both maternal and infant well being.

The promotion of exclusive breastfeeding is also a priority of the NYCDOHMH, as breastfeeding has been demonstrated to have significant health benefits for the mother as well as the infant. Through ongoing public awareness and promoting exclusive breastfeeding in the hospital setting, the goal is to encourage all women to breastfeed their infants exclusively for at least the first six months of age. Significant challenges still exist for breastfeeding support for women following discharge from the hospital. Obesity is of course a significant public health issue requiring attention on many levels as it is a complex issue requiring behavioral change as well as access to healthy foods and increase physical activity.

Finally, the maternal mortality review process by the NYCDOHMH continues to raise the significant of public health issues, such as obesity and chronic disease, and its impact on birth outcomes.

The Assistant Commissioner indicated that she believes that the partnership between the NYCDOHMH and the State Department of Health has never been stronger and is encouraged with our ongoing work on issues such as adolescent health, breastfeeding and maternal mortality.

Other Efforts to Obtain Input into MCH Service Delivery

The Department, as the Title V agency, has been very successful in coordinating with other state agencies that serve the MCH population such as the State Education Department, the Office of Children and Family Services, the Office of Temporary Assistance to Needy Families, the Office

of Mental Health, the Office of Mentally Retarded and Developmental Disabled, the Office of Alcohol and Substance Abuse Services, among others. In addition, the Title V program has been particularly effective in working with the Department's Office of Health Insurance Programs and Office of Health Systems Management to ensure access to comprehensive, high quality services that are appropriately reimbursed. The following are examples of the Department's ongoing efforts to obtain input into MCH service delivery.

Early Childhood Comprehensive Systems (ECCS)

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

This emphasis on a broad range of stakeholder input and involvement has continued and expanded through the state's Early Childhood Advisory Council (ECAC). A subgroup of the Governor's Children's Cabinet, the ECAC includes over 40 individuals with early childhood expertise who represent early care and education, health care and public health, child welfare, and mental health programs, as well as state agencies, advocacy organizations, foundations, higher education, unions, and others involved in the provision of services to young children and their families. Through its organizational structure, which includes a steering committee, general membership and several workgroups, there are many opportunities for members to engage and provide meaningful, ongoing input. Specific projects linked to the ECAC, including the current Project LAUNCH initiative, have further expanded stakeholder networks. Project LAUNCH, which involved substantial coordination with the State's Office of Mental Health, specifically brings the perspective of a rich and growing network of local stakeholders in Westchester County, including local health and mental health agencies, community health centers and other health care providers, early care and education providers, family support specialists and families. The ECAC is currently considering additional ways to seek and incorporate family and consumer input in its work.

Perinatal Health

The Title V staff in the Division of Family Health worked collaboratively with the Department's Office of Health Insurance Program (OHIP) to craft the new legislation related to the delivery of Medicaid reimbursed prenatal care, and, during 2008-2009, worked with OHIP and internal and

external stakeholders to develop updated prenatal standards of care for all pregnant women enrolled in Medicaid. The Title V program also continues to work closely with OHIP to implement and monitor the new law. This effort is further described in Section 3 of the needs assessment.

In 2009, the Division of Family Health, in collaboration with the National Initiative for Children's Health Care Quality and the RPCs, launched the New York State Obstetric and Neonatal Quality Collaborative (NYSONQC) to improve maternal and neonatal outcomes and eliminate disparities. Through NYSONQC, Regional Perinatal Centers, the highest level hospitals in NYS related to the provision of perinatal care, will implement quality improvement interventions designed to improve maternal and newborn patient safety. The goal of NYSONQC is to bring together leaders in perinatal health to partner to explore opportunities to use evidence based information to improve patient outcomes.

The Association of Perinatal Networks of New York, Inc. (APN) is an organization of the 18 Perinatal Networks serving New York State. Its mission is to improve perinatal, maternal and child health throughout New York State, and to support the work of the individual Perinatal Networks. CPPSNs engage consortia of local health and human service providers and consumers to identify and address gaps in local and regional perinatal health care and service delivery systems. The APN meets quarterly, with the Department staff attending and providing informational updates with dialogue related to specific issues. At a recent meeting, the APN provided input for both the MCHBG application and the home visiting needs assessments the Department is completing.

Childhood Obesity Prevention

A number of opportunities for stakeholder input on strategies for childhood obesity prevention have been utilized. Both the Division of Nutrition and the Division of Chronic Disease and Injury Prevention within the Department of Health solicit input related to childhood obesity prevention from such stakeholders as program contractors, statewide associations, child care providers, schools, the health care community, public health agencies and the community-at-large. The New York State Council on Food Policy, of which the NYSDOH is a lead member, held listening sessions throughout the state to gather feedback on what nutrition and food related issues should be addressed by the Council, and how best to address them. The Division of Nutrition Obesity Prevention Council, with representatives from several USDA funded child nutrition programs, provides guidance and feedback on division-wide policies, practices and positions relating to childhood obesity. In the Fall of 2009, the Division of Chronic Disease and Injury Prevention held a statewide strategic planning meeting with over 100 stakeholders. This forum provided an opportunity to review and respond to a comprehensive plan that will guide the state in preventing chronic disease and obesity. Specific program efforts, such as the Eat Well Play Hard in Child Care Settings intervention, Fit WIC Project, the Hunger Prevention and Nutrition Assistance Program and the Just Say Yes To Fruits and Vegetables Project have utilized focus groups and participant surveys to obtain consumer input.

Lead Poisoning Prevention

The Department engages multiple stakeholders to update and implement the action plan. NYS's Advisory Council on Lead Poisoning Prevention meets several times each year to discuss issues

relevant to the development and implementation of the statewide plan and make recommendations. The council reports annually to the Governor and the Legislature about the progress in eliminating lead poisoning in NYS. The program also meets with external stakeholders, including the Statewide Coalition to End Lead Poisoning. In 2009, DOH participated in a series of stakeholder meetings convened by the Governor's Office to obtain input on primary and secondary prevention priorities and strategies. In June 2009, Governor David Paterson issued Executive Order No. 21, which established a new Governor's Task Force on the Prevention of Lead Poisoning. The Task Force, comprised of Governor's office staff and state agencies, is charged with developing and implementing specific coordinated strategies to reduce childhood exposure to lead.

The program also obtains input from local health departments (LHDs) and Regional Lead Resource Centers, which are the frontline providers of lead prevention and follow up services. Quarterly conference calls obtain input and feedback and identify any emerging issues or needs.

Asthma

The NYS Asthma Plan was collaboratively developed with key state and national partners. NYSDOH convened statewide partners and national experts in asthma and chronic care improvement to participate in re-visioning the State Asthma Plan, and the *Framework for Improving Asthma Outcomes in NYS* was developed. A critical element of this framework is an enduring public/private collaboration to include people with asthma, providers, plans, purchasers, and public health partners. Guided by common vision and shared goals, the Asthma Partnership of NY is responsible for overseeing the implementation of the State Asthma Plan, to include continuous review and modification of the goals, objectives, and activities through analysis of data, evaluation findings and progress towards meeting process and outcomes measures.

School Based Health Centers

New York State has one of the largest school based health center programs in the country. The program has a long standing practice of soliciting SBHC stakeholder input and collaboration. The NYSDOH has established a relationship with the NYS Coalition of SBHCs which represents primary program stakeholders, and is comprised of virtually every SBHC sponsor organization in the State. A stakeholders workgroup was convened to strengthen communication between the NYSDOH and key staff of the facilities that sponsor SBHCs. This workgroup allowed our stakeholders to identify needs, challenges and barriers faced in operating the clinics, as well as to collaborate on innovative ideas to address these issues. As a result of the original workgroup a quality improvement sub-workgroup was formed in 2007 and participated in a SBHC quality improvement initiative led by NYSDOH. Another important group of SBHC stakeholders is the community members that benefit from the SBHC. To obtain their input, SBHCs are required to establish advisory councils comprised of SBHC staff, school administration and faculty, parents and students. The purpose of this requirement is to assure that there is an established line of communication and involvement at every level.

Adolescent Sexual Health

In 2009, the Department convened a symposium on adolescent sexual health through its contract with the COE. The symposium included youth, national and state experts on adolescent sexual

health and key stakeholders to review research and best practices, and make recommendations for future programming. Dr. Jonathan Klein, Associate Executive Director of the American Academy of Pediatrics, provided the professional leadership for this event through his role with the COE. The attendance of several adolescents was supported in this event, providing a venue for direct feedback from adolescents related to effective strategies.

The COE formed a youth network that develops materials for the Department and advises on issues important to and relevant to youth in New York State. Communication strategies are also diverse, using social networking sites (e.g., Face book), monthly meetings (with a NYC group) and interaction with groups who have invited COE staff to attend meetings. The COE provided input to all areas of the website (www.nysyouth.net) development. During the initial preparation for the Adolescent Sexual Health Media Campaign, the COE spoke with youth from across the state about the content of the website addressing sexual health.

The Sexual Violence Primary Prevention Committee meets quarterly to provide input to the DOH on the development of a comprehensive primary prevention and evaluation plan. The Committee is comprised of key state and community partners in the prevention of sexual violence.

Children with Special Health Needs

The CSHCN Program supports a cadre of family and youth representatives (a.k.a. Family Champions and Youth Advisors) that provide input on resources and tools being developed and the system of care for children and youth with special health care needs. The **Family Champions Project** engages parents of children with special health care needs in training on planning, policy and advocacy. In 2007, the Department added a **Youth Advisory Committee** (YAC) which was formed to advise the NYSDOH Children with Special Health Care Needs (CSHCN) Program on what youth need to transition successfully to adulthood in terms of employment, medical care and independent living. YAC members also provided information regarding their experiences with having a medical home and suggested methods for distributing materials and information to assist with the transition process. The YAC will give the youth an opportunity to develop their leadership skills and to be heard on issues that affect them directly. These consumers, who submit an application to become a family or youth representative, are racially and ethnically diverse and represent all regions of the state. They receive orientation and training about the mission of the CSHCN Program and its activities and the MCHBG process of needs assessment, program planning, implementation and evaluation. In 2010, four family forums and one youth forum were held this to provide input into the MCHBG needs assessment.

Dental Health

The Bureau of Dental works closely with the New York State Oral Health Coalition (NYSOHC), a statewide coalition of oral health providers, advocates, individuals, institutions, agencies and organizations sharing a common interest in oral health and access to care. Standing committees address access to care, workforce, public policy, communications, research and surveillance, and fluoridation. Presentations on current Bureau activities, initiatives and plans are routinely provided to the Steering Committee, Standing Committees and full membership and feedback and input from all Coalition members is regularly sought.

Standing Committee members provide input to: improve access to high quality, comprehensive and continuous oral health services; promote best practices; assess workforce capacity issues and identify strategies to address workforce needs; identify oral health indicators and gaps in oral health surveillance and methods for the dissemination of data, potential data partners, and strategies for addressing data and evaluation needs; development of policies that have the greatest potential to reduce the burden of oral disease, improve access and enhance the quality and efficiency of oral health care; and promote fluoridation and counteract misinformation about fluoridation.

Under the HRSA Targeted Oral Health Service System (TOHSS) grant, meetings are held with key representatives of maternal and child health and social service programs, such as the WIC Programs, Healthy Families NY, Head Start and Early Head Start, Council on Children and Families and Perinatal Networks, to obtain input into the oral health education needs of staff and the families they serve. These meetings have resulted in specific training programs, resources, and materials being developed, as well as mechanisms established for obtaining periodic feedback and input from program staff and parents on the usefulness of trainings and resources provided to date and the need for any additional resources, education materials and trainings.