

**Maternal and Child  
Health Services Title V  
Block Grant**

**New York**

**FY 2022 Application/  
FY 2020 Annual Report**

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## I. General Requirements

### I.A. Letter of Transmittal



KATHY HOCHUL  
Governor

## Department of Health

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

LISA PINO, M.A., J.D.  
Executive Deputy Commissioner

August 27, 2021

Christopher Dykton, Acting Director  
Division of State and Community Health  
Maternal and Child Health Bureau  
Health Resources and Services Administration  
5600 Fishers Lane  
Room 18N33  
Rockville, Maryland 20857

Dear Mr. Dykton:

With this letter, I transmit New York's FFY 2022 Maternal and Child Health Services Block Grant Application and FFY 2020 Annual Report.

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

Sincerely,

Kirsten Siegenthaler, Ph.D.  
Director, NYS Title V Program and  
Associate Director, Division of Family Health

## **I.B. Face Sheet**

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

## **I.C. Assurances and Certifications**

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

## **I.D. Table of Contents**

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

## **II. Logic Model**

*Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.*

### **III. Components of the Application/Annual Report**

#### **III.A. Executive Summary**

##### **III.A.1. Program Overview**

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

States submit an annual application and report in accordance with MCHB guidance. This year's NY application reflects our continued leadership and commitment to protect and promote the health of women, infants, children and families, within the context of a changing health care landscape, the continued adoption of a life course perspective and a focus on data-driven, evidence-based public health interventions. Additionally, this application reflects the ways in which NY continued this commitment throughout its response to the COVID-19 pandemic. When NY was the epicenter of the COVID-19 pandemic, NYS Department of Health (DOH) staff including many Title V MCHSBG funded staff, were deployed in support and have overseen a range of COVID-19 response efforts. In allowing the NYSDOH and its Title V staff the flexibility to respond to this ongoing public health emergency as needed, the NY Title MCHSBG program became an important asset in the state's fight against COVID-19. This year's application reflects the many ways in which COVID-19 impacted the NY MCH workforce and MCH population. Our upcoming action plan represents our ongoing commitment to address the objectives, strategies and performance measures to address our 2021-25 Action Plan priorities across five MCH population health domains: maternal and women's health, perinatal and infant health, child and adolescent health, and children and youth with special health care needs. In spite of the challenges presented by COVID-19, NY's application continues to reflect significant input from families, providers and other key stakeholders across the state, and remains centered on the issues that have been voiced by communities that impact family and community health and wellbeing. It emphasizes understanding and addressing social determinants of health to address health disparities and reflects a concerted effort to build a more comprehensive system of supports for CYSHCN and their families.

Within NYSDOH, Title V MCHSBG activities are led by the Division of Family Health (DFH). As the Title V program, DFH provides NYSDOH-wide leadership on MCH, directly oversees many MCH programs and initiatives, and collaborates with other key MCH-serving programs outside the DFH. A critical role of NY's Title V program is to ensure the needs of the MCH population are addressed through key policy initiatives as reflected throughout the application.

In keeping with a commitment to ensure NY's supports and services align with the needs of communities, the Title V MCHSBG program continues to obtain community input to inform activities. Input was obtained from the Title V MCHSBG Advisory Council, Parent to Parent of NY, Schuyler Center for Advocacy and Analysis, American Academy of Pediatrics, Association of Regional Perinatal Programs and Networks, MCH Committee of the New York State Association of County Health Officials, New York State Perinatal Association, community listening forums, providers and key stakeholders.

Under Title V MCHSBG leadership, NY continued to build on its previous work to supplement and further refine its 2021-25 Needs Assessment and State Action Plan. This included continued engagement of stakeholders to provide input and feedback on MCH outcomes in the state, ongoing collection and analysis of relevant MCH health data, and opportunities for community member input. Feedback and insight gained through this process was used to refine activities during the previous year and further develop our upcoming State Action Plan.

While the past year presented a series of unique and transformative challenges for the NY Title V MCHSBG program, it also required an innovative approach that allowed the NY program to restructure the way in which it approaches completing and reporting on Title V work. In order to ensure that Title V and MCHSBG work during the COVID-19 pandemic and the large-scale transition of the workforce to remote access, DFH developed a new structure to oversee this work that promoted

cross-division teams to work collaboratively on objectives throughout the year.

Title V staff from across DFH were assigned to work on cross-disciplinary teams centered around each of the MCH population domains. Leaders for each team were identified based on their primary area of focus in their daily work, and from there they were tasked with ensuring that work and activities for their subsequent domain, as outlined in the most recent Title V application were completed. Domain teams met virtually throughout 2020 and 2021 to discuss ongoing work, plan for necessary adaptations related to COVID-19, and capture the scope of work in annual reports.

With all DOH working remotely for the past year, Title V staff were able to successfully use online platform, including Microsoft Teams, to share information, work on shared documents, and regularly meet virtually while working from home. The new platform and structure helped to foster increased collaboration between team members.

Below are the NY National Performance Measures (NPM) and State Performance Measures (SPM) with the cross-cutting, community and data-informed Title V MCHSBG priorities.

**Title V State MCH Priorities and Performance Measures, 2021-2025**

Population Domains and NPMs/SPMs		Community-Informed Priorities
<p><u>Women's/Maternal Health</u></p> <ul style="list-style-type: none"> <li>NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year</li> </ul>		<p>Health Care: Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities</p>
<p><u>Perinatal/Infant Health</u></p> <ul style="list-style-type: none"> <li>NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a</li> </ul>		<p>Community Services: Promote awareness of and enhance the availability, accessibility, and coordination of community services for families and youth, including children and youth with special health care needs and</p>



<p>Level III+ NICU</p> <ul style="list-style-type: none"> <li>SPM1: Percent of samples received at the lab within 48 hours of collection</li> </ul> <p><u>Child Health</u></p> <ul style="list-style-type: none"> <li>NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day</li> </ul> <p><u>Adolescent Health</u></p> <ul style="list-style-type: none"> <li>NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year</li> </ul> <p><u>Children and Youth with Special Health Care Needs (CYSHCN)</u></p> <ul style="list-style-type: none"> <li>NPM 12: Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care</li> <li>SPM 2: Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months</li> </ul>	<p><b>CROSS-CUTTING PRIORITIES ACROSS ALL DOMAINS</b></p>	<p>their families, with a focus on communities most impacted by systemic barriers including racism.</p> <p>Parenting and Family Support: Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers</p> <p>Social Support and Cohesion: Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course</p> <p>Healthy Food: Increase access to affordable fresh and healthy foods in communities.</p> <p>Community &amp; Environmental Safety: Address community and environmental safety for children, youth, and families.</p> <p>Poverty: Acknowledge and address the fundamental challenges faces by families in poverty and near-poverty, including the “working poor” as a result of systemic barriers, including racism.</p> <p>Awareness of Resources: Increase awareness of resources and services in the community among families and the providers who serve them.</p> <p>Housing: Increase the availability and quality of affordable housing.</p> <p>Transportation: Address transportation barriers for individuals and families.</p>
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The FFY 21 MCH Needs Assessment Summary and the five year State Action Plan were developed as a result of community input and analysis of MCH performance measures and investments. Below is a summary by domain of key findings and priorities identified as a result.

**Domain 1 – Maternal/Women’s Health**

The preventive medical visit measure was selected for this domain because it is foundational to women’s health throughout the life course, population health data demonstrate a need for its continued improvement, and it relates directly to several priorities voiced by women and families through community listening forums, including awareness of community resources, transportation, social support, and health care access and quality. In addition to well-woman visits, strategies will address a

continuum of primary and preventive care and support that includes preconception, reproductive and sexual health, family planning, prenatal and postpartum care, and a full spectrum of medical, mental and behavioral health, oral health, and other supports and services. NY's Action Plan reflects continued efforts to address access to comprehensive, high quality and equitable health care services to people of childbearing age and a continued commitment to reduce maternal mortality and morbidity.

*"We used to have a village and today it's gone."*

*"Doctors don't respect us because they don't value us."*

## **Domain 2 – Perinatal/Infant's Health**

Measuring appropriateness of perinatal care was selected for this domain because of its relevance to quality and systems of care for high-risk and vulnerable infants. While site of delivery for very low birth weight infants is one critical indicator of care, NY's Title V MCHSBG program views this indicator as part of a continuum of supports, services, and systems of care for infants, mothers, families, and service providers. This broader approach aligns with several priorities voiced by families in NY's Needs Assessment, including awareness of community resources and services, enhancing supports for families, improving people's health care experiences, and fostering community engagement and empowerment. Strategies include promoting early prenatal care and increasing awareness of community resources, supports, and services through Title V MCHSBG funded programs.

*"I encourage people to enroll into whatever program is offered because through that you can be connected to other services that might be available in the community."*

## **Domain 3 – Child Health**

The physical activity measure was selected for this domain because it is responsive to concerns voiced directly by families in NY and reinforced by state-specific population health data. NY families identified the availability and accessibility of amenities that support children's safe, active play and access to healthy foods as top priority needs, alongside priorities for community and environmental safety for children and community transportation. Supporting healthy, active play and recreation for children and youth of all ages is critical to promoting healthy weight as well as general physical and mental health during childhood and throughout the life course. Strategies under the Child Health domain focus on promoting environments that support physical activity among children of all ages and abilities and support overall well-being.

*"I had concerns with my daughter gaining weight and the doctor said it was fine. Then when her 4-year check-up came she said it was a concern. She didn't listen to me."*

*"I want a community where they can grow up and know that they're safe and can go anywhere they want to go and trust the adults in their community. Right now, I am scared for my kids..."*

## **Domain 4 – Adolescent Health**

Measuring adolescent well visits was selected for this domain because it aligns with both population health data indicators and concerns voiced directly by adolescents in NY. Preventive medical visits are one part of overall wellness, based on community input and population data, need to include social-emotional wellbeing and preparation for taking on the responsibilities of adulthood. Adolescence is often a very challenging stage in a person's life, during which there is immense physical, cognitive, social-emotional, and sexual development. Supporting adolescents' health and development and helping them prepare for their futures can have a lasting impact throughout the life course. Adolescent Health strategies focus on

promoting routine care related to reproductive, oral, and behavioral health, and resources needed to successfully transition to adulthood.

*"Everybody needs to talk even for one second or ten minutes. Even boys."*

*"I feel like we should have more African American counselors. Because the counselors that are there, I feel like the students don't feel comfortable talking to them."*

#### **Domain 4 – Children and Youth with Special Health Care Needs (CYSHCN)**

Measuring transitions to adult health care was selected because it was voiced as a key priority by youth with special health care needs and their families, reinforced by state-specific population health data. Families reported that only 15% of CYSHCN receive care in a well-functioning system, and less than 18% of youth age 12-17 with special health care needs received services necessary to make transitions to adult health care. This is consistent with experiences described by YSCHN and their families throughout the state. CYSHCN strategies include engaging youth with special health care needs and their families in our efforts to improve systems and practices supporting this population, including care coordination and transition support.

*"[There should be] easier access to those resources so I do not have to be on a computer for 6 hours doing research."*

### **III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts**

NYS is committed to ensuring the health and wellbeing of the MCH population. Due to generous Medicaid benefits, insurance availability through the NYS of Health, and significant state appropriations for MCH, Title V MCHSBG funds support an infrastructure within the DOH that ensures the work of the Title V program and provides additional funding to support public health infrastructure for priority efforts to augment state investments. For example, Title V MCHSBG funds augment State investments to support family planning and adolescent health services. In addition, Title V MCHSBG funds support quality improvement efforts through grants to the Regional Perinatal Centers (RPC) for quality improvement activities to NY's 120 obstetrical hospitals to improve maternal and infant mortality and morbidity. Grants are provided to local health departments to support information and referral services for CYSHCN. NY's Title V application illustrates the extensive resources offered to NY's MCH population. NY's MCH programs and initiatives are complex. NY's Title V application provides an overview that demonstrates NY's ongoing commitment to ensure the health and wellness of all NY's women, children and families.

### III.A.3. MCH Success Story

Despite the many challenges of the past year, the NYS Title V MCHSBG program experienced a range of successes that helped to demonstrate the vital role this program plays in meeting the unique needs of the MCH population in NY. One of the most important successes, and the one on which the other positive results were built, was the flexibility the Title V MCHSBG offered in supporting the redeployment of staff to COVID-19 response activities. In allowing a significant proportion of NYS Title V staff to engage in COVID-19 response activities in general (e.g. working at drive-through testing sites, overseeing contact tracing programs, developing testing/vaccination guidance, working at vaccination sites, etc.) and COVID-19 perinatal health response activities in particular, Title V MCHSBG played a significant role in supporting NYS's overall response to the COVID-19 pandemic.

Among the specific COVID-19 response activities focused on Title V MCHSBG-funded programs and/or MCH populations, several unanticipated successes were observed. First was the successful COVID-19 Maternity Task Force which was led by staff from the NYS Governor's Office and supported by Title V staff this group of perinatal health professionals and clinicians met in early 2020 to develop recommendations to prioritize the MCH population in COVID-19 response. These recommendations centered birth equity, birthing site choice, COVID-19 testing for pregnant people, and promoting increased understanding of the impact of COVID-19 on pregnancy and childbirth in the NYS response to COVID-19 throughout the past year. Title V staff worked on a comprehensive literature review of COVID-19 and pregnancy, regularly shared information and updates with community and clinical health care providers, and provided weekly forums for obstetric and neonatal providers to share best practices in managing COVID-19 through regular calls of the NYS Perinatal Quality Collaborative.

In addition, specific MCH programs were able to successfully pivot to implement telehealth visits and integrate other supports and services to support MCH populations during the pandemic. The NYS Sickle Cell program was able to support the increased utilization of telehealth services for young adults during transitional periods to great success. Following the transition to telehealth, this program saw an overall increase in visit utilization and retention, as well as higher levels of reported satisfaction reported by both program enrollees and providers. The Maternal Infant Community Health Collaborative (MICHC) programs provided early feedback to NYSDOH about the many immediate and emergency needs of their clients and families during the pandemic. Based on this feedback, the NYSDOH was able to authorize the one time use of program funds to support the purchase of emergency items including: diapers, wipes, PPE, and other items not readily available in food pantries.

By allowing the NYS Title V MCHSBG program and its staff the flexibility to meet the evolving needs of the MCH population and the NYSDOH during this time period, Title V was a fundamental element in the success of the NYS response to the COVID-19 pandemic. This level of support and collaboration should serve as a model for future collaboration should a similar emergent need arise.

### III.B. Overview of the State

According to population estimates from the 2019 American Community Survey, New York State is the fourth most populous state in the country, housing more than 19 million people (19,453,561). Within the state, approximately 43% of the population, or 8 million people (8,419,316), reside in New York City.

#### Density

Estimates from the 2019 Census indicate that there are 414.70 people per square mile in New York State. The most densely populated counties include New York County (71,886 persons per square mile), Kings County (37,232 persons per square mile), and Bronx County (34,058 persons per square mile). In addition to counties in NYC, Long Island, and the Hudson Valley region, other densely populated counties include Erie County, Monroe County, Onondaga County, Schenectady County, and Albany County.

According to Census estimates, New York State's population as a whole has grown between 2010 and 2018 at a rate of 0.8%. This statistic, however, masks significant variation observed at the county level. While many counties surrounding NYC and the Hudson Valley experienced population gains between 2010 and 2016, most counties in the state (41 of 62 counties) experienced population losses between 0 and 4%.

#### Diversity

New York State is home to a highly diverse population. Across all states, New York ranks second in terms of having the highest percentage of foreign-born people. According to data from the 2019 American Community Survey, 22.4% of New York State's population is foreign born.

Of New York State's 19,453,561 residents, approximately 63% of individuals identify as White alone, 19% identify as Hispanic or Latino, 16% identify as Black or African American, 9% identify as Asian alone, 0.5% identify as American Indian or Alaska Native, and 0.1% identify as Native Hawaiian or Other Pacific Islander. Compared to national estimates, New York State has a higher percentage of non-Hispanic Black, Asian residents, and Hispanic residents.

Counties in NYC and the Hudson Valley have the highest percentage of Black or African American residents. According to the 2017 American Community Survey, 30 to 40% of residents living in both Kings County and Bronx County identify as Black or African American. Larger population centers including Buffalo (Erie County), Rochester (Monroe County), Syracuse (Onondaga County), and Albany (Albany County) also have higher percentages of Black or African residents compared to the rest of the state.

Similar geographic patterns can be observed for New York State's Hispanic and Latino population. Bronx County, in particular, ranks highest across the state with approximately 55% of the total county population identifying as Hispanic or Latino.

#### Immigration

2019 Census estimates indicate that 22.4% of New York State's population (4,360,291) is foreign born. Among this group, 12.6% (2,596,160) are naturalized citizens while 10.1% (1,764,131) are non-citizens. The largest percentage of foreign-born individuals migrated from the Americas (49.5%), Asia (30.4%), and Europe (15.2%). In addition to counties surrounding NYC, Long Island, and the Hudson Valley, counties with larger population centers, including Buffalo, Rochester, and Albany, have higher percentages of foreign-born residents.

#### Households and Families

According to five-year estimates from the 2019 American Community Survey, there are 7,446,812 households in New York State, with an average of 2.54 people per household. Of these households, 43.3% (3,222,615) are married couple families, and 56.7% (4,224,197) are non-family households. Approximately 28% (2,080,208) of all households have at least one child under the age of 18.

#### Income and Poverty

Five-year estimates from 2019 American Community Survey reveal that the median household income in New York State is \$62,765. Counties with the highest income levels are heavily concentrated in NYC, Long Island, and the Hudson Valley. Nassau County, in particular, ranks highest in the state with a median household income level above \$100,000.

Median household income has increased steadily since 2010 (\$54,047). However, income levels vary significantly by race. The average median household income is \$70,712 for Whites, \$68,567 for Asians, \$43,997 for Blacks or African Americans, \$43,889 for Hispanics or Latinos, and \$40,043 for American Indians and Alaska Natives.

Income inequality has also increased over time in the state. The Gini coefficient has risen from 0.499 in 2010 to 0.516 in 2017. According to 2017 Census Bureau estimates, New York State ranks highest among all states in terms of income inequality.

According to 2019 estimates from the American Community Survey, 15.1% of New York State's population is living below the federal poverty line. Counties with the highest percentage of families falling below the threshold are concentrated in the NYC region, particularly in Bronx County (26.76%) and Kings County (17.87%).

### Age Distribution

The median age in New York State is 39.2. Approximately 21% (4,022,096) of the population is under 18 years of age, and roughly 17% (3,295,968) of the population is 65 years or older. The median age has increased over the past decade, rising from 37.7 in 2007 to 39.2 in 2019.

### Women of Childbearing Age

Estimates from the 2019 American Community Survey indicate that there are 4,027,930 women of childbearing age (15-44 years), representing 39% of the total female population. The percentage of women of childbearing age has steadily decreased over the years. For reference, in 2010, 40.9% of all females were between the ages of 15 and 55.

### Children

Of New York State's 19,453,561 residents, 5.8% of the population is under the age of 5 and 20.7% of the population is under the age of 18. According to 2017 estimates from the Kids Count Data Center, approximately 20% of all children in the state are living with families below the federal poverty line. Further, 30% of children are living with families where no parent has regular, full-time employment.

### Education

According to 2018 data published by the New York State Department of Education, 2,598,921 children are enrolled in K-12 public schools. Approximately 43% of public school students (1,133,631) are White, 27% (708,319) are Hispanic, and 17% (448,499) are Black or African American.

The high school graduation rate for all public school students is 85%. However, graduation rates vary significantly by ethnicity. While 91% of white students graduate, only 78% of Black or African American students graduate from high school. Additionally, graduation rates differ based on immigration status. The graduation rate for immigrants is 54%, compared to 85% for non-immigrants.

In terms of educational attainment of adults (ages 25 to 34), approximately 25.8% of the population has a high school diploma or GED, 21.2% of the population has a bachelor's degree, and 16.6% of the population has a graduate degree. The percentage of individuals with a bachelor's or graduate degree has increased over the past decade while the percentage of individuals with a high school diploma or less has decreased.

### Language

According to five-year estimates from the 2019 American Community Survey, approximately 69% of the population over the age of 5 (12,709,931) speaks only English. Of the 5,623,805 residents that speak a language other than English, 14.9% speak Spanish, 8.8% speak other Indo-European languages, and 5.2% speak Asian and Pacific Island languages. Approximately 26.2% of the population who speaks a language other than English report that they speak English less than "very well."

### Health Care

Approximately 7% of the non-elderly population (ages 0-64) in New York State has no health insurance. Estimates from the 2017 American Community Survey reveal that uninsured rates vary significantly by ethnicity. While only 4% of Whites are uninsured, 12% of Hispanics, 11% of American Indians or Alaska Natives, 8% of Asians or Native Hawaiian and Pacific Islanders, and 7% of Blacks have no health insurance coverage.

Ensuring access to health care by making affordable health insurance available is one of the critical accomplishments of the Governor's health care agenda. As part of this agenda NY expanded access to Medicaid and created The NY State of Health (NYSOH), the state's official health plan marketplace, was created to assist New Yorkers to gain access to quality affordable health care coverage.

### Public Health Prevention Agenda

Further commitment to improving the health of all New Yorkers is evident in the NYS Prevention Agenda (PA) that was developed in conjunction with the Public Health Committee of the NYS Public Health and Health Planning Council (PHHPC), and in partnership with more than 140 organizations across the state. The PA focuses on eliminating the profound health disparities across all priority areas including preventing chronic diseases; promoting a healthy and safe environment; promoting healthy women, infants and children; promoting wellbeing and preventing mental and substance use disorders; and, preventing communicable diseases. Title V MCHSBG staff directed the update in the PA 2019 – 2024 related to Promoting Healthy Women, Infants and Children and worked to ensure the alignment with NYS's Title V MCHSBG State Action Plan. The vision for the 2019-2024 PA highlights a Health in All Policies approach and a focus on healthy aging.





### III.C. Needs Assessment

#### FY 2022 Application/FY 2020 Annual Report Update

New York's 2021 application presented a comprehensive five-year Needs Assessment (NA) summary describing the state's MCH needs, strengths, capacity, and partnerships. The NA identified ten themes voiced by families and community members across the state through listening forums and surveys. These crosscutting themes relate to social determinants of health including poverty, transportation, housing, biases in health care, environmental and neighborhood safety, family support, social cohesion, and more. As noted, the five-year NA was conducted prior to the onset of the COVID-19 public health emergency. Thus, the primary focus of this year's NA update is the impact of COVID-19 as the dominant emerging public health issue for 2020-21 on NYS' MCH population and programs. Please refer to the five-year NA summary for descriptions of MCH programs referenced in this update.

#### Ongoing NA Activities:

Over the past year, Title V staff remained in close communication with local programs and partners who work directly with individuals and families. Partners shared emerging needs of MCH populations and programs on an ongoing basis through email and phone communication, program meetings and webinars, and quarterly grant reports.

In addition, several programs incorporated structured assessment activities related to COVID-19. For example, Regional Support Centers for CYSHCN included questions about COVID-19 in listening forums with families, and our Title V program held a webinar with local health departments in July 2020 to discuss concerns and gather feedback from families of CYSHCN about their pandemic experiences. As another example, Adolescent Health programs (CAPP and PREP) added questions about COVID-19 impact to biannual reports from grantees, following up directly with local program staff to elaborate on reports. In addition, the Title V MCHSBG program tracked nearly 14,000 calls to the state's Growing Up Healthy Hotline in 2020. Title V MCHSBG staff also continued to monitor program and population surveillance data, along with relevant scientific literature and media.

This combination of structured assessments and more flexible ad hoc communication channels has been essential during this extended public health emergency.

#### Health Status & Needs of MCH Population:

At the family and community level, the COVID-19 pandemic has laid bare and exacerbated previous health and socioeconomic disparities, while also creating new needs. The crosscutting themes voiced by community members in our five-year NA summary remain salient and have only been magnified by COVID-19. Among those ten themes, only transportation diminished in prominence this year because of the lockdown and expansion of virtual/remote services. At the same time, access to high-speed internet and technology/ hardware for remote work, school, and other services emerged as a new need, with familiar racial, ethnic, economic, and geographic disparities.

Specific emerging needs related to COVID-19 identified for MCH populations<sup>[1]</sup> this year include:

- **Basic needs.** Early in the pandemic, local MICHC programs reported an overwhelming need among client families for necessities, including food, diapers, toiletries, masks, and other PPE, as these items quickly became scarce or increasingly expensive based on supply. MICHC data for this period confirm an overall increase in referrals per client from 3.4 to 4.6, including notable increases in referrals for food pantry and clothing/baby care items, housing, family planning, and primary health care services for adults. To meet these immediate needs, NYSDOH allowed MICHC programs to use some unobligated funds to purchase emergency supplies for their clients in need (*MWH, PIH*). Data from the Growing up Healthy Hotline illustrate a wide variety of needs including referrals for prenatal care, Medicaid and other health insurance options (*MWH, PIH, CH*).

- **Access to reliable internet.** While not a new issue, disparities in technology were amplified urgently because of COVID-19, with the shift to remote programming for schools, community-based programs, and many health and other services. Lack of broadband internet access remains a concern in some rural communities, and adequate hardware and data are concerns for many, especially families with multiple adults and children needing to work and learn from home simultaneously. In addition, parents of CYSHCN expressed special concerns about having adequate equipment and support for virtual learning, combined with frustration about limited guidance related to special education and the loss of supportive therapeutic services and respite (*All domains*).
- **Fear and distrust of hospital safety for birthing people.** Many partners shared this concern, especially in the early waves of the pandemic. In response, a COVID-19 maternity task force convened by the Governor's office in spring 2020 issued recommendations to diversify and ensure equity in birthing options. As an outgrowth of this work, the Title V MCHSBG program developed and launched an educational campaign aimed at increasing awareness of safety practices and rebuilding confidence in maternity care at birthing centers and hospitals and supporting mental health of pregnant and birthing people in New York. This campaign will continue through spring 2021, and resulting data available later in 2021 will inform ongoing efforts to address these needs. While there were initially many questions from providers and patients about the safety and guidelines for COVID-19 vaccines for pregnant and breastfeeding people, to date this has not persisted as a major ongoing concern within our Title V MCHSBG programs (*MWH, PIH*).
- **Mental health & stress of pregnant and postpartum people.** This was another common theme voiced by many providers, with accompanying needs to support providers in responding appropriately to support their patients and clients. Data from the Growing up Healthy Hotline confirm a large number of calls related to perinatal depression. As part of the rapid response to this need, the Title V MCHSBG program expedited the release of a previously-developed educational campaign (August-November 2020) on perinatal mood and anxiety disorders (PMAD), directing pregnant people and families to statewide resources, and directing primary care providers to Project TEACH ([projectteachny.org](http://projectteachny.org)) for additional clinical management supports. In addition, the NYS Perinatal Quality Collaborative (NYSPQC) conducted webinars on maternal mental health in conjunction with Project TEACH for OB-GYN providers. In response to additional concerns heard from parents of infants about heightened stress around returning to work due to concerns about the safety and availability of affordable childcare, Title V MCHSBG programs helped connect families with childcare community resources (*MWH, PIH, CH*).
- **Social-emotional health and well-being of children and adolescents, including CYSHCN.** Concerns about increased anxiety and social isolation were widely voiced by parents and youth, consistent with emerging national research literature on this issue. Partners cited loss of social contact and relationships, community support systems and resources, established routines, healthy meals and snacks from schools and afterschool programs, and privacy for confidential and sensitive conversations (e.g., sexual health). Partners also described "Zoom fatigue" as a challenge for young people staying engaged and focused in programs, especially after long days of remote schoolwork. Mental health, anxiety, and social isolation concerns were the most prominent themes voiced by families of CYSHCN in the regional forums, with parents expressing special concern about the children's potential "regression" resulting from loss of socialization in combination with decreased access to special education and therapy services (*CH, AH, CYSHCN*).
- **Loss of key health care access points for children and youth.** Closure of schools across the state caused serious barriers to continuation of School Based Health Center (SBHC) services, as schools would not allow operation in closed buildings. Most SBHC sites and all school-based dental sites were closed in 2020, and many local SBHC staff were redeployed to other assignments within their health systems to assist with the pandemic relief efforts. Many Family Planning clinics closed temporarily, and other reduced days/hours, apparent in an initial 60% reduction in client volume by April 2020. While many SBHCs and family planning clinics rapidly moved to offer telehealth visits, important

limitations remained due to clinical staff availability and families not having the technology and time to participate. In addition, family planning providers noted that many patients - especially adolescents - expressed difficulty maintaining privacy and confidentiality during telehealth visits from home, with a preference for in-person visits even during lockdown. As of spring 2021, most SBHC and Family Planning sites have fully or partially re-opened (*CH, AH, CYSHCN*).

- **Lapses in preventive health care.** Even when health care sites were open, local programs reported that many families were not obtaining routine health care visits because of lockdown and safety concerns about going into public health care settings, with implications for all MCH populations. MICH data for this period show increases in referrals for family planning, and primary health care services for adults (*MWH*). Family Planning Providers described an increased need for outreach, education and testing for sexually transmitted infections (STIs), especially in minority populations, with more difficulty reaching clients and concerns about increase in STIs across the state (*MWH, AH*). Adolescent programs reported diminished access and use of clinical reproductive health and family planning services, along with some schools removing sexual health activities from health classes because of privacy concerns in the remote learning environment (*AH*). Lead Poisoning Prevention Programs noted a decrease in routine blood lead testing of young children (*CH, CYSHCN*). Providers across many programs reported significant concerns about babies and children of all ages not receiving necessary screenings, vaccines, and other routine preventive care. MCH home visiting staff worked locally with families of infants and young children to help prepare them for what to expect and help them navigate pediatric visits in the context of the public health emergency, and engaged in a multi-agency statewide effort to disseminate *Learn the Signs, Act Early* materials to enhance parent monitoring of their children's development (*CH, CYSHCN*).

**Population health data** are another key source of information for our ongoing MCH needs assessment. Analysis of the most recently available key data measures shows **improvements** in: maternal mortality (including measures of racial disparity), preconception health counseling, postpartum depression screening, and referrals for dental care and completion of birthing plans among pregnant women enrolled in MICH services (*MWH*); provision of dental sealants through school-based clinics (*CH*); enrollment of children and adolescents with serious emotional disturbances or complex trauma in Medicaid Health Homes for children, and provision of transition supports for adolescents with special health care needs generally and with sickle cell disease (*CYSHCN*).

Unfortunately, measures related to timeliness of newborn bloodspot screening analysis and follow-up care for newborns with abnormal initial hearing screening results (*PIH*); preventive health care visits for adolescents (*AH*), and provision of financial or technical support to local water systems for community water fluoridation (*CH*) **worsened** for the most recent periods available. Data measures related to delivery of VLBW infants in Level III and IV birthing hospitals (*PIH*), well woman visits (*MWH*), and physical activity among children (*CH*) were relatively **stable** in the most recent period.

While these data are important and informative, it is important to recognize that because of standard lags in reporting and analysis of population health data, most reflect trends prior to 2020 and thus do not reflect any impact of COVID-19.

#### Title V Program & MCH Systems Capacity and Partnerships:

The pandemic and associated public health response have significantly challenged and stressed the capacity of programs and agencies at all levels.

**At the state level**, many staff were deployed full time or part time to support COVID-19 response efforts. For example, five staff who support the NYS Maternal Mortality Review and NYSPQC initiatives, two staff who oversee Regional Perinatal Centers, two Rape Prevention Education staff, most Family Planning staff, all SBHC staff, and all Adolescent Health staff were fully or partially deployed for part of this year. Title V MCHSBG staff have been deployed to a wide array of pandemic response duties including coordinating regional testing sites, serving as NYSDOH duty officers, fielding medical questions from vaccine PODs, providing epidemiologic and data analysis support, and more. While this has been a major stress to

program staffing, it has also been essential to the state's pandemic response capacity, and MCHB's flexibility in allowing Title V MCHSBG staff to participate in these efforts has been invaluable. (*All domains*)

At the same time, other state staff have needed to absorb the work of these re-deployed staff, while rapidly shifting to handle extensive new activities to develop and implement COVID-19 responses within our MCH programs. Selected examples of the wide array of response activities embedded within Title V MCHSBG programs include:

- providing informational support to NYS birthing hospital teams (*MWH, PIH*);
- assisting in the development of MCH-related state COVID-19 guidance and protocols for pregnant people, infants, and children, including CYSHCN (*All domains*);
- developing guidelines for infection prevention in dental settings, teledentistry, and safe provision of dental care for CYSHCN (*CH, AH, CYSHCN*);
- triaging questions from health care providers (*All domains*);
- creating and maintaining up to date COVID-19 trainings and informational resources for providers (*All domains*); hosting and participating in national and state COVID-19 related webinars (*All domains*);
- staffing the new COVID-19 Maternity Taskforce (*MWH, PIH*);
- collaborating with the Special Supplemental Nutrition Program for Women, Infant, and Children (WIC) and the NYC Department of Health and Mental Hygiene on a statewide effort to distribute emergency supplies to high-need food pantry sites (*MWH, PIH, CH*).

Staff accomplished this extensive new workload while rapidly adjusting to new remote work environments, caring for family members and parenting during remote schooling, and otherwise managing the impact of the pandemic on their own family and personal lives. This collective upheaval has resulted in significant personal and professional stress for our MCH workforce.

These workforce challenges and the larger context of the pandemic challenged the Title V MCHSBG program's ability to manage competing priorities and implement previously planned program and policy activities within original timelines. For example:

- A two-day state conference on trauma, Adverse Childhood Experiences (ACEs), and resiliency for over 200 community-based organizations planned for May 2020 was cancelled and ultimately rescheduled as a virtual event for May 2021 (*CH, AH, CYSHCN*);
- The development of new program guidelines, policy manual, and funding procurement for family planning were delayed (*MWH, AH*);
- Joint site visits with staff from the NYSDOH Office of Health Insurance Programs to designated Health Homes for Children, planned for 2020, had to be postponed and rescheduled as virtual visits (*CYSHCN*);
- COVID-19-related industry shipping delays, in combination with a major winter snowstorm, affected the timeliness of the state laboratory receiving newborn screening samples (*PIH, CYSHCN*).

**At the local level**, staff redeployments were also common, especially for programs based in local health departments (e.g., LPPP, some MICH and MIECHV) and health care systems (e.g., SBHCs). This was evident in an increase in referrals to other programs from local health departments. Similar to the state level, local staff had to rapidly adjust to remote working environments and virtual service delivery, while absorbing new and expanded workloads associated with the deployment of colleagues and emerging needs of families and communities served. Because many local programs intentionally recruit staff representative of underserved populations, local staff were themselves disproportionately impacted by COVID-19. Some agencies experienced staff resigning due to personal impacts of COVID-19 on their health, the health of family members, and the stress of managing remote schooling of their own children (*All domains*).

Highlights of additional specific local MCH program capacity challenges identified through our ongoing NA activities this year include:

- **Need for timely COVID-19 information & guidance.** As the pandemic rapidly unfolded, partners increased requests

for timely guidance. For example, early in the pandemic, many clinical providers requested guidance on how to manage prenatal care, birthing care, breastfeeding, and mental health challenges for pregnant and postpartum people (*MWH*). In response, our Title V MCHSBG program, through NYSPQC, organized a series of provider-led webinars. The gradual decline in participation, from over 2000 participants in early spring 2020 sessions to under 300 for more recent spring 2021 sessions may reflect increasing confidence in this area. As noted above, similar informational and guidance needs were identified across all MCH populations, and Title V MCHSBG staff led or were engaged in developing guidance in a wide range of areas related to COVID-19.

- **Increasing needs among clients and communities.** By design, most Title V MCHSBG programs prioritize serving underserved, higher need areas and people. These same communities have been disproportionately impacted by COVID-19. The racial diversity of MICHHC clients during this period increased, with the percentage of Hispanic and non-Hispanic black clients rising from 52% to 59% (*MWH, PIH*). CAPP and PREP programs reported significant concerns about the disproportionate impact of COVID on the well-being of adolescents already facing numerous challenges (*AH*).
- **Loss of access to homes, schools, and other community settings.** Programs centered on face-to-face home-based interactions – including MCH home visiting programs (MICHHC, MIECHV), Lead Poisoning Prevention Program services, Early Intervention services, and others - faced fundamental challenges to ongoing family engagement and service provision (*MWH, PIH, CH, CYSHCN*). Similarly, youth-serving programs typically based in school buildings, community centers, libraries, or other community settings – such as CAPP, PREP, SRAE, and school-based health and dental clinics – were challenged to consistently engage with youth, to implement certain community-based program elements (such as volunteer and recreational youth development activities), and to connect youth with other needed community resources (*CH, AH, CYSHCN*). While the transition to remote services and other program adaptations partially mitigated these challenges (see below), they clearly resulted in some loss of engagement and quality. As of spring 2021, some programs have begun to resume in-person activities, but this is uneven based on geography and other factors.
- **Need to transition to virtual service delivery.** Many local programs rapidly transitioned to virtual services. This shift clearly reduced in-person community outreach activities and the scope and quality of some services. For example, adolescent programs noted the loss of “organic” networking and “drop-in” relationships and communication with youth and other colleagues. Even with new virtual formats, not all programs, youth, and families had technology (hardware and internet service) to participate (*AH*).

At the same time, this shift created some innovation and opportunities, with many programs finding creative ways to ‘pivot’. For example, more frequent telephone and email communication nearly doubled the overall number of contacts between MICHHC Community Health Workers and clients in this period (*MWH, PIH*). Rape Prevention Education regional centers were able to leverage supplemental CDC funding for COVID-19 response support partners in adapting, implementing, and evaluating prevention strategies through virtual platforms and other innovative techniques (*MWH, AH*). The ACT CCA worked with program model developers to ensure that evidence-based programs could be adapted with fidelity in virtual environments (*AH*). Family Planning clinics expanded social media outreach and implemented curbside pick-up of contraceptives and modified workflows for in-person clinic services (*MWH, AH*). Sickle Cell program grantees reported that during this period, youth with sickle cell disease had more stable days with fewer symptoms, and that they attended telehealth appointments more regularly and consistently than traditional clinic visits, with more participation and consistent engagement and dialogue with the transition navigators and with peer groups for both youth and their parents (*CYSHCN*). As services start to re-open, local programs now need to assess which aspects of telehealth, remote and virtual services to continue and how to balance these with return to traditional in-person services post-COVID.

- **Delays in planned program activities & expansion.** Many programs experienced delays in various activities due to the pandemic. For example:

- local MICHC agencies were challenged to hire new Community Health Workers (CHWs) under their expansion grant awards (*MWH, PIH*);
  - some local MIECHV programs were unable to fully support Continuous Quality Improvement (CQI) projects that required parent-child observation and experienced delays in rolling out a new streamlined referral tool in collaboration with WIC programs (*MWH, PIH, CH*);
  - the launch of a new rural perinatal telehealth was delayed due to shortages of (Information Technology) IT staff until fall 2020 (*MWH, PIH*);
  - a planned statewide expansion of NYSPQC's opioid use/neonatal abstinence syndrome project was delayed from spring to fall of 2020 (*MWH, PIH*);
  - previous momentum in transitioning SBHCs into the Medicaid Managed Care model was slowed (*CH, AH, CYSHCN*);
  - implementation of Sexual Risk Avoidance Education (SRAE) programming was challenged to retain participants and maintain program fidelity with the shift to online learning modules (*AH*);
  - new Regional Support Centers for CYSHCN, which launched in fall 2019 shortly before the arrival of COVID, had to rapidly adjust and carefully balance plans for establishing new working relationships and communication channels with LHD-based CYSHCN programs, most of whom were redeployed to other local COVID-19 response work, and faced challenges spending additional legislative awards (*CYSHCN*).
- **Delays in data collection & reporting.** Several programs experienced delays in data submissions due to staff and resource diversions related to COVID-19 response. For example:
    - birthing hospitals were delayed in submitting NYSPQC QI project data related to obstetrical hemorrhage improvement practices (*MWH*);
    - final months of data collection for the Infant Mortality CoIIN were impacted by local agencies' inability to meet with clients and collect surveys (*PIH*);
    - shipping delays impacted newborn bloodspot screening early in the pandemic (*PIH*);
    - local CYSHCN programs were delayed in submitting 2020 program data (*CYSCHN*).

#### Operationalizing Needs Assessment Activities & Findings:

Despite the dominant challenges of COVID-19, NY's Title V MCHSBG program continued to pursue key efforts to operationalize NA activities and responses. One important element of this work is increasing the routine use of community listening forums as an ongoing community engagement and needs assessment strategy across all Title V MCHSBG programs. To operationalize this, the Division intends to incorporate this as a key step in the concept development for all new grant procurements. Initial performance data demonstrate great success, with the percentage of DFH procurement processes that completed community listening forums as part of the concept development rising from 0% at baseline in 2018-19 to 50% in 2019-20. While this work has necessarily slowed in 2020 due to the public health emergency, it will remain a key aspect of our work going forward.

A second key strategy to operationalize needs assessment activities is continued investment in collection, analysis, and dissemination of information from an array of population health surveillance and data systems, which are foundational to ongoing MCH needs assessment as a core public health function. Specific examples of this approach underway in NY's Title V program include:

- **Maternal Mortality.** NY's Title V program continues to lead this work, in conjunction with the NYS Maternal Mortality Review Board (MMRB). The statewide Maternal Mortality Review (MMR) Initiative seeks to identify and address factors affecting maternal mortality and morbidity through comprehensive surveillance activities, data analysis, and review of deaths. Authorizing legislation for the NYS MMRB was enacted in August 2019, providing explicit powers and protections

for the NYSDOH in its role supporting the MMRB. In August 2020 the report of [maternal deaths for 2012- 2014](#) was published; a report for 2016-17 is under development and analysis of the 2018 cohort is underway. Several key public health initiatives, including a media campaign and NYSPQC quality improvement projects, have been launched to respond systematically to findings in this area (*MWH*).

- **Infant Mortality & Morbidity.** This year, NY's Title V program carried out an expanded plan for analysis of infant mortality and morbidity data, completing a draft *New York State Infant Mortality Report*, highlighting collaborations and describing trends in NYS's infant mortality for 2002-2016. Additional analysis of geographic, racial, and ethnic disparities and determinants is currently underway and will be incorporated in the final report to align with a Feb 2021 amendment to state public health law (*PIH*).
- **Adverse Childhood Experiences (ACEs).** In 2016, the NYSDOH began collecting regional and state-level ACEs data from over 9,000 adults through the Behavioral Risk Factor Surveillance System (BRFSS). The NYSDOH Division of Chronic Disease Prevention leads this work, and Title V MCHSBG staff are engaged in planning and use of data. A second round of data was collected in 2019, and analysis is currently underway. Going forward, NYSDOH plans to implement the ACEs module every three years, providing an important ongoing snapshot of ACEs prevalence and impact at the population level (*All domains*).
- **Social-Emotional Assets for Children and Youth.** Title V MCHSBG staff developed and implemented a validated tool for measuring positive developmental social-emotional assets among children and youth. The tool measures self-efficacy, healthy decision-making and youth/adult connectedness as key constructs identified by the Search Institute as part of their nationally recognized 40 [Developmental Assets framework](#). The three constructs will be used together incorporating pre-post surveys and measuring specific aspects related to social-emotional assets in children and adolescents. <https://www.search-institute.org/our-research/development-assets/developmental-assets-framework>. Initial implementation is being trialed through the Prevention (CAPP) initiative, with the intention to expand to other programs based on that experience (*CH, AH*).
- **Children and Youth with Special Health Care Needs.** In 2020 NY's Title V/CYSHCN program completed and published an updated [New York State Profile of Children and Youth with Special Health Care Needs](#) for 2017-2018, compiling key measures for CYSHCN from the National Survey of Children's Health (NSHC). The program is currently reviewing 2018-2019 NSCH data, along with data reported by NY's Title VMCHSBG funded local health department-based (LHD) CYSHCN Program and the NYS Early Intervention Program under Part C of the federal Individuals with Disabilities Act. We will continue to produce annual updates as key sources of information to support work in this area. In addition, we are continuing to pursue plans to collaborate with the U.S. Census Bureau to conduct an enhanced oversampling of Black/African-American, Hispanic, and CYSHCN for the 2021 NYS NSCH sample (*CYSHCN*).

#### Organizational and leadership changes:

Kirsten Siegenthaler, PhD assumed the role of NYS Title V Director in April 2021, following the Lauren Tobias' departure from NYSDOH. Dr. Siegenthaler provides leadership across the diverse portfolio of the Division of Family Health, including supporting the Title V Maternal and Child Health Services Block Grant and the DFH's programs that serve women, infants, and children, and adolescents, including children and youth with special health care needs (CYSHCN). Dr. Siegenthaler has over 18 years of experience at the NYSDOH and has served as the Assistant Director of the Bureau of Early Intervention in the Division of Family Health, the NYS HIV Surveillance Coordinator, and the Lead Evaluator for the NYS Cancer Services Program before becoming the Associate Director for the Division of Family Health in 2018.

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<sup>[1]</sup> Key for specific relevant MCH population domains: *MWH*=maternal and women's health; *PIH*= perinatal and infant health; *CH*=child health; *AH*=adolescent health; *CYSHCN*=children and youth with special health care needs.

## **Five-Year Needs Assessment Summary (as submitted with the FY 2021 Application/FY 2019 Annual Report)**

### **III.C.2.a. Process Description**

The New York State Department of Health (NYSDOH) facilitated an extensive multi-pronged process to identify and assess the Maternal Child Health (MCH) needs, strengths, capacity, and partnerships that will inform its Title V work for the next five years and beyond. This Needs Assessment (NA) serves as the basis for the state's MCH priorities and State Action Plan that follow.

The NA was led by a Title V Leadership Team, chaired by the Title V Director and comprised of key organizational leaders from the Division of Family Health (DFH), with coordination and technical assistance from the University at Albany's HRSA-funded MCH Catalyst Program. A logic model (Appendix 1) was developed to guide the process. Guiding principles for the NA included family and community engagement, equity and inclusion, data-driven evidence-based decisions, alignment with the NYS Prevention Agenda and other key frameworks and investments, and a commitment to maintaining and building on key MCH infrastructure and capacity. The Title V NA was done in close coordination with the NYS Maternal, Infant, and Early Childhood Home Visiting (MIECHV) NA, which was also led by DFH.

A rich array of quantitative and qualitative information was gathered to support the NA, and stakeholders were engaged throughout the process. Key information sources and methods for the NA include:

**Population Health Data**—In collaboration with the Bronfenbrenner Center for Translational Research at Cornell University, quantitative data encompassing more than 100 key indicators spanning population domains were compiled and analyzed for current status, trends, and disparities. Measures reflect Title V National Performance Measures (NPMs) and National Outcome Measures (NOMs) and input from MCH partners on other topics of importance for NYS. Data were from Vital Statistics, hospital discharge data, population surveys (e.g., Pregnancy Risk Assessment Monitoring System, National Survey of Children's Health, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System), and other population health data sources.

**Community Listening Forums (forums)**—In collaboration with the NYS MIECHV program and a broad network of community-based partner organizations, forums were hosted across the state with families and community members to facilitate open discussion about individual, family, and community health and services. A total of 37 forums were held in 18 NYS counties and in the Akwesasne Territory of the St. Regis Mohawk Tribe, with over 700 community members. Individual forums focused on specific populations including expectant parents and parents of young children, done in partnership with the MIECHV program (n=10 forums and 230 parent participants); other adult men and women (n=15 forums and 292 participants, primarily parents and grandparents); adolescents (n=9 forums and 154 teen and young adult participants); and families of Children and Youth with Special Health Care Needs (CYSHCNs) (n=3 forums and 37 family participants). Forums were conducted and notes of the discussions were recorded by community partners. Participants were racially diverse: 32% identified as Black or African American, 28% as White, 19% as Asian or other race(s), and 3% as American Indian. Approximately 25% of participants identified as Hispanic, and participants reported primary languages of English, Spanish, Chinese, and Haitian/Creole. DFH staff analyzed forum documentation using qualitative analysis methods.

**Public and Provider Surveys**—Web-based surveys designed for the public and service providers, respectively, were posted on the NYSDOH website and social media and distributed widely through a broad network of over 20 organizational partner groups. Through a mix of closed- and open-ended questions, providers were asked the following: what's working and what can be strengthened in their communities; social determinants, root causes, disparities, and health outcomes; community partnerships; population engagement strategies; and a range of potential MCH priorities. Consumer respondents were asked about factors that affect health in their communities, available and needed services, and barriers to and satisfaction with existing services. Over 770 providers and over 320 individual consumers responded, representing all regions of the state. While the provider respondents reflected the diverse array of MCH-serving organizations in NYS, family/consumer respondents were less diverse, with 80% of respondents identifying as female, 73% as white, and over 60% with private health insurance, suggesting the survey did not reach or engage a sufficiently diverse demographic. Thus, a sub-analysis limited to respondents with Medicaid or no insurance coverage (n=45) was conducted.



**Stakeholder Meetings**—Information on the Title V program and NA was included in meetings with stakeholder groups on an ongoing basis, with partner input routinely shared and integrated in assessment of key issues and recommendations. DFH convened a special meeting in June 2019 with representatives of community-based programs and their community member partners, which directly informed the content and process for the community listening forums. The state’s Title V Advisory Council provided key input and feedback throughout the NA process, with meetings convened in September 2019 and February and June 2020.

**MCH Program Inventory**—In order to assess current MCH public health infrastructure and capacity, a comprehensive inventory tool was developed to gather key information about MCH-serving programs across NYSDOH. Similar information was gathered directly from MCH-serving programs in other state agencies. A total of 28 programs completed the inventory.

Additional detail about these sources is provided in Appendix 2.

In addition, companion NYS NAs were reviewed to inform the Title V NA, including Head Start, Child Abuse Prevention Treatment Act (CAPTA), Birth to 5 Preschool Development, and the NYS Prevention Agenda, alongside recent DFH statewide maternal health listening forums, a care mapping exercise with parents of CYSHCN, and adolescent focus groups conducted by partners at Cornell University through the ACT for Youth initiative.

Of note, most information to support the NA was collected prior to the arrival of the COVID-19 public health emergency in NYS. Updates to reflect needs related to COVID-19 will be included in the NA update in next year’s application.

All NA data were analyzed and summarized in several formats. The initial plan included a series of stakeholder meetings to present and discuss findings and resulting priorities for the state action plan. Unfortunately, this plan was significantly disrupted by COVID-19. A virtual meeting with the NYS Title V Advisory Council was held on June 17; Council members voiced support for the NA and resulting priorities and performance measures. Additional virtual and/or in-person meetings with stakeholders will resume when feasible to continue collaborative processes for refining and acting on priorities.

### III.C.2.b. Findings

#### III.C.2.b.i. MCH Population Health Status

From the Needs Assessment (NA) sources and methods outlined above, **ten key cross-cutting themes** emerged. These themes reflect the voices of community listening forum (forum) participants across all population groups and geographic areas, reinforced by survey responses from providers and community members. The themes cut across the five Title V domains and provide context for relevant findings reported in the domain-specific summaries below. These themes emerged organically from open-ended group discussions and survey questions in community members’ own voices and were not prompted by topic-specific questions.

**Theme 1: Lack of awareness of resources and services in the community.** This was the most frequently reported need, raised in three-quarters of the community forums. Participants noted that they rely on “word of mouth” to know about services in their communities or that you must encounter a problem (e.g., have a preterm infant or enter a domestic violence shelter) to enter the system and be connected to needed services. Their recommendations include enhanced community outreach at locations such as churches, supermarkets, and groups; printed and virtual materials and resources; and increased referrals, coordination, and navigation support from service providers. Specific services frequently mentioned for which increased awareness is needed include mental health, substance use, and family planning services.

*“Just tonight, everyone is talking about different programs that a lot of us didn’t know about. Education, knowing more about what’s out there and the people who are providing these services, getting the info out there.”*

*“If it was not for finding myself in a shelter due to a domestic violence situation, I would have not known about resources in my community and I do not feel like that is a good thing.”*

**Theme 2: Transportation barriers.** This was the second most commonly cited issue, voiced by participants in two-thirds of forums. Participants cited lack of public transportation options, cost, reliability, long wait times, and accessibility as key barriers. They described the impact of transportation barriers on keeping and arriving on time for appointments, reliably getting to jobs, running errands, and participating in community activities. They voiced recommendations for low/ no cost transportation to non-medical services (such as Supplemental Nutrition Programs for Women, Infants, and Children (WIC), Departments of Social Services (DSS), and support groups like Alcoholics Anonymous), more short-notice and emergency transportation options, more informational resources about available transportation, and more family-friendly transportation accessible to strollers, wheelchairs, and families with multiple children. Families described concerns about pedestrian safety especially for children and called for improvements to make communities more walkable.

*"I had to walk through town with my groceries in a cart and walk the cart back. It was embarrassing."*

*"We have the [...] county bus that goes around, but there's not a lot of them. There are big gaps in the day when you either have to... go early and spend your whole day waiting for your appointment. So you waste a lot of your day that you [could] have worked or done something else."*

**Theme 3: Availability and accessibility of services and amenities in the community.** Within this common theme, participants identified many different specific resources needed in their communities. Most notably, each of the following were identified by two-thirds of the community forums as needs:

- resources for affordable, fresh, and healthy foods, especially farmer's markets and food pantries;
- local health care providers and specialists, particularly specialists for children and youth with special health care needs (CYSHCN), mental health, and substance use treatment services. Some communities also voiced a need for more dental providers, local urgent care clinics, and full-service hospitals;
- activities or centers with age-appropriate activities for children and families, including young children, teens, and differently-abled children and adults.

Participants in many forums also voiced the need for more accessible and safe places for physical activity and exercise, such as fitness centers and more walkable areas.

Respondents cited barriers to using community services including the cost of programs; distance/ travel time; inconvenient locations and hours; challenges with eligibility, available "slots" or long waiting lists; and fears of seeking services due to stigma about undocumented status or mental health issues. They described bad experiences and bad reputations of some programs and staff as factors that discouraged use of available services. These challenges were exacerbated by transportation issues, forcing residents to travel outside the community for services or go without.

*"There needs to be more after school programs for children and things for them to do so they can use their time. Rather than becoming invested in drugs because they have all this time."*

*"If we had more mental health programs/options that would help our community to not be so depressed."*

**Theme 4: Poverty and issues of the working poor.** In one-third of the community forums, participants described challenges specific to earning too much to qualify for benefits but not enough to get by voicing a sentiment that "the system holds you down" with no opportunity to save and get ahead. Individuals described challenges qualifying for and obtaining services, citing the burdensome nature of documentation and application processes, inconsistent information, and experiences of feeling judged and disrespected by social service systems and staff. Some noted that benefits they did receive were insufficient to meet their family's needs. They described being "suddenly dropped" from services if their income increases or if two adults are working, with gaps in coverage. They suggested providing access to copiers and fax machines to assist people with applications, and instituting processes to "wean off" of benefits when eligibility changes.

Within this theme, respondents also described the desire for financial stability and opportunities to grow financially for their family and children. They cited the need for more stable, quality job opportunities, with livable wages and benefits. Participants asked for more assistance to find jobs, develop career skills, continue education, and obtain free or affordable higher education. Both youth and adults called for more education in schools on financial literacy skills related to budgeting,

taxes, and credit. The high cost of basic needs including food, health insurance and health care, housing, childcare, clothing, diapers, and others was frequently noted as a barrier to saving and getting ahead financially, and organizations that assist with meeting those basic needs were often discussed as an important asset.

*"If you are in poverty, you are more likely to spend more money because there is this whole thing of like you pay for something to get it immediately rather than saving up to get something that lasts, so you end up buying something that will break really quick. So you end up spending more money. So really, being poor is expensive."*

*"If you are making a 'livable wage' you can't qualify for certain services. The system is made for us to fail. If you do improve, you lose services, you fall back."*

**Theme 5: Supports for parents and families.** Families voiced the need for additional supports at different stages, from pregnancy and postpartum through early childhood and school-age years. They described needs for more support related to health promotion and health care, parenting education including relationship support for both mothers and fathers, benefits such as paid family leave and sick leave, affordable high-quality childcare, and safe, positive after school activities for children and youth. While additional details related to this theme are presented in the domain-specific summaries below, the core focus on family support across all stages stood out in the NA.

*"I felt welcome at prenatal visits when they introduced themselves and included me [dad] in the conversation. The doctor let me know as a father how much I can help. Included both of us."*

*"I have no family support in this country."*

**Theme 6: Social support and social cohesion.** Beyond the needs for tangible parent supports described in Theme 5, participants across all demographic groups frequently described feelings of isolation due to geographic, social, and language-based barriers. Participants identified family and friend support as an important asset, while lack of those supports was identified as a factor that negatively impacts health and well-being, including mental health. They offered recommendations including:

- more support groups, both peer and face-to-face support
- opportunities and resources to support mentoring, encouragement, and positive relationships for children, teens, and adults
- more community events for socializing and to connect with each other
- more opportunities for community engagement, empowerment, and organization.

More fundamentally, participants called for the need to cultivate a better sense of community, in which community members help or care for each other and children. They described the need for more courtesy, kindness, empathy, and trust among community members—this was raised in more than half the forums across all populations and demographic groups.

*"I feel isolated because not everyone is experiencing what I am experiencing."*

*"If they had these types of sessions in the community to talk about success stories there might be more success."*

*"I feel like I need someone to listen like my friend."*

**Theme 7: Health care access and quality.** Participants across many local forums (approximately one-third of sessions) described that they do not “feel heard” by their health care providers. They described feeling that their concerns and treatment preferences are not taken seriously, and that providers do not care about them or understand what they are going through, resulting in people avoiding seeking care and services because they feel judged or anticipate being treated poorly. Participants expressed a desire for providers to show more compassion and respect and to have more providers who are like themselves—from their own community and who speak their language.

Participants describe numerous barriers to care including long wait times for appointments, inconvenient hours (paired with

inability to take time off from work), long travel time/distance, lack of medical and dental providers accepting Medicaid or uninsured patients, high insurance costs and co-pays (especially for prescriptions), inadequate insurance coverage, high provider turnover or lack of continuity, and insufficient numbers of providers in some communities. They recommended bias and cultural competence training for providers and staff, help to improve their own advocacy skills and health literacy, extended service hours, and more assistance with insurance and care navigation.

**Theme 8: Community and environmental safety.** Concerns about community violence and safety were another common theme. In many forums, participants reported feeling unsafe in their communities, specifically describing guns, gangs, and public drug use, with special concern for children's safety in schools and neighborhoods. Parents and teens described a sense of isolation related to crime and safety concerns. Participants called for safer communities, better community and police relationships, adult supervision for children, more community centers and after-school programs, safer parks and playground equipment, and more greenspace where families can go safely. Additionally, many groups raised concerns about visible trash in streets and public spaces and air, water, and noise pollution that negatively impact their communities.

*"I have to cover my kids' eyes as they walk through the park."*

*"I see syringes in the stairs, in the elevators, this is a big need in my building."  
"This a prison yard or a community?"*

**Theme 9: Housing.** More than half the forums discussed the need for affordable housing. The high cost of rent and utilities, the prohibitive expense of security deposits, long waits and cumbersome processes for housing subsidies, a lack of safe quality housing appropriate for families, and lack of accountability from landlords were frequently cited as barriers. Homelessness and the need for more shelters for families were also mentioned frequently.

*"Affordable housing is not affordable for people trying to get out of the project."*

*"Kids are sleeping on top of each other because there's no room in the houses. It's crazy."*

*"I don't feel there's a system in place to make sure landlords treat you like human beings."*

**Theme 10: Healthy eating.** Most groups described a need for sources for affordable fresh and healthy foods in their communities. Participants indicated that healthy foods are too expensive, while unhealthy foods are more affordable and have more coupons. Some stores and food pantries provide food that is rotten or expired. Community members recommended removing advertising for unhealthy and fast foods, more farmer's markets (emphasizing food rather than crafts), more food pantries with healthy options, more affordable healthy food in schools, community gardens, and education for students and community members on healthy food choices, cooking, and budgeting.

*"There is never enough to go around. We go to soup kitchen, pantries but there needs to be more."*

*"We need more healthy food in the hood all hoods have crappy food."*

Domain-specific findings are summarized below. A bibliography of data sources used for these summaries is in Appendix 3. All data cited are for the most recent year available.

## **Summary**

The NA themes summarized above cut across the Title V domains and provided important context for relevant findings reported in the domain-specific summaries that follow.

### **Domain 1: Maternal & Women's Health**

Women's health throughout the life course is fundamentally important to their own well-being and the health and well-being of children, families, and communities. Key indicators of women's health in NYS show that while some measures are improving, others have been flat or are getting worse. Moreover, there are significant and persistent racial, ethnic, and

economic disparities across virtually all measures of maternal and women's health.

While nearly 80% of reproductive age women received a well-woman visit in the past year, only 35% of women report ever talking with a health care provider about how to prepare for a healthy pregnancy, and only 25% of reproductive age women enrolled in Medicaid are using a moderately or highly effective method of contraception. For pregnant women, early entry into prenatal care has continued to improve to 80.9%, although preventive dental care during pregnancy is much lower at 43.3% and continues to trend downward. Cesarean deliveries among low-risk first births declined slightly to 28.9%, and the percent of elective early deliveries without medical indication declined to 1%. Women's use of alcohol (7.3%) and tobacco (4.3%) during pregnancy have been declining, but maternal opioid use, as measured by the rate of Neonatal Abstinence Syndrome (NAS) (5.0 per 1,000 births), is increasing. Maternal mortality rates, after a period of increase, have improved the past two years, but unacceptable disparities persist with Black or African American women three to four times more likely to die from causes related to their pregnancy than White women. Severe maternal morbidity, after a period of increasing, has recently improved to 80 per 10,000 deliveries (of note, this measure was redefined this year). The percentage of women reporting postpartum depression symptoms (15.5%) has continued to increase for several years.

Through the statewide forums and public surveys, over 800 NYS women and girls voiced many needs and challenges, as well as current strengths and recommendations for improvement—encompassing and echoing all 10 cross-cutting themes described above. Specific to maternal and women's health, participants emphasized the need for better supports and services related to family planning, pregnancy, birth, and postpartum care, especially resources and coping supports for maternal depression. Women and their families want more continuous support in the postpartum period beyond a single medical visit, and they called for increased and more extended access to doulas, midwives, home visiting, and breastfeeding support services, along with longer paid leave for both mothers and fathers. They called for more programs specifically for fathers, more peer support groups for women and families, and supports for co-parenting, conflict resolution, and healthy partner relationships. This input builds on themes previously voiced by Black or African American women during a series of statewide listening forums conducted in 2018 on racial disparities and maternal mortality. Through those seven forums, the New York State Department of Health (NYSDOH) heard from nearly 250 women who shared their experiences accessing care and giving birth in NYS. Across the state, women frequently identified themes impacting maternal health outcomes for Black or African American women, including disparate levels of care between public and private hospitals and insurance payers; lack of connection to and trust in health care providers; desire to have more time with providers; the need for better information and education, especially within lower income communities; and the pervasive impact of racism and bias on the care received and subsequent birth outcomes.

*"A lot of people are afraid to get services, if they use drugs, they think their baby will get taken away."*

*"I have to wait for my husband to get home to go shopping or do anything."*

*"I had a C-section was alone at home. I did not have help."*

*"Even with...family around it is still needed to have a support specific to the mother."*

*"We used to have a village and today it's gone."*

*"Doctors don't respect us because they don't value us."*

*"[Coming into the hospital with Medicaid] you are already labeled. You are already treated a certain way."*

## **Domain 2: Perinatal & Infant Health**

Infant mortality is a fundamental indicator of the health of a nation, state, or community. Infant mortality rates have continued to improve in NYS, declining to 4.6 infant deaths per 1,000 births. This is better than the U.S. infant mortality rate. The neonatal mortality rate (within the first month of life), which accounts for two-thirds of infant deaths, has also declined. This mirrors declines in preterm-related mortality and demonstrates continued success in ensuring that the majority (91.2%) of the highest risk very low birth weight infants are delivered in hospitals with Level III+ neonatal intensive care units. However,

previous improvements in the overall preterm birth rate may be reversing, with an increase from the prior low of 8.7% back to 9% of births over the past two years and a parallel increase in the percentage of early term births (defined as 37-38 week) to 23.7%. Post-neonatal mortality (defined as age one month to one year) has remained fairly steady (1.5 deaths per 1,000 births), but the sudden unexpected infant death (SUID) mortality rate has increased to 58.3 per 100,000 births after fluctuating the past several years, and safe sleep practices including sleep position and sleep environment likewise have not improved. Significant racial disparities persist for all these measures. As an important cause of infant morbidity, the rate of NAS has continued to increase, with higher rates among infants who are White, low income, and residing in non-metropolitan areas. Breastfeeding has been fluctuating, with 82.9% of infants ever breastfed. Only 23.2% were exclusively breastfed through age six months, with lower rates among Black or African American and Hispanic infants.

The 37 forums included seven forums conducted in collaboration with the NYS Maternal, Infant, and Early Child Home Visiting (MIECHV) program to hear specifically from expectant parents and parents of young children who are either currently enrolled in, or potentially eligible for, home visiting programs (230 individuals, including 203 mothers, 25 fathers, and 2 unspecified participants). Their comments encompassed all ten cross-cutting themes described above, with issues specific to perinatal and infant periods. Many families expressed the need to raise awareness about available community resources and services, in particular for postpartum depression, and to increase the availability and scope of services to support families in the postpartum period, including postpartum doulas, home visitors, community health workers, and breastfeeding support. Transportation barriers described across groups were especially challenging for parents with young children, and homelessness is a special challenge for families seeking family-friendly shelters. Parents described a desire for more parenting education classes and resources on a range of specific topics (e.g., infant care, infant development, childproofing and safety, behavior and discipline, bonding). They called for more classes and programs specifically for fathers, including single fathers, more parenting support groups, and more community activities and programs to help new parents get out of the house. Returning to work after birth is a special challenge for lower income families, and the need for longer paid parental leave and sick leave for both mothers and fathers was emphasized. Childcare was a topic of frequent concern, with parents describing challenges to find affordable, reliable, safe, and trusted child-care providers—both to work and to be able to participate in community programs and services—especially for parents working second and third shifts and variable schedules.

*"I don't think people value spaces to vent and talk. That's why I really enjoy the fatherhood program."*

*"[I] can't even roll a stroller in some neighborhoods."*

*"By the time you go to work, pay for daycare, you were better off on services and not working- more poor than when you got help."*

*"I encourage people to enroll into whatever program is offered because through that you can be connected to other services that might be available in the community."*

### **Domain 3: Child Health**

Families report that 91.2% of NYS children age 0-5 and 91.6% of age 6-11 are in excellent or very good health, but this percentage is lower for children who are Black or African American, Hispanic, are poor, or who have parents born outside the U.S. or with lower education levels. Nearly 20% of NYS children are living in poverty, 23% receive supplemental nutrition assistance program benefits, and 4.3% of children enrolled in public schools are homeless, although all of these have improved over the last decade. Approximately 17 per 1,000 NYS children were reported as victims of maltreatment, and over 23,000 children and youth are in foster care. Mortality rates among children ages 1-9 years have decreased by 10% over the past five years to 13.7 deaths per 100,000 children, with conditions originating in the perinatal period and injuries as the leading causes of death and 171 injury-related hospitalizations per 100,000 children ages 0-9. Over 11.1% of children age 1-17 have decayed teeth or cavities and 13.7% of children age 2-4 are obese. Families report that 27% of children age 6-11 years are physically active for at least 60 minutes daily, and 72% ate a family meal with everyone living in the household four or more days weekly. Approximately 10.7% of NYS children live in a house where someone smokes inside the house.

The vast majority (over 97%) of NYS children have health insurance, but fewer (74.6%) have insurance that is adequate and continuous, and only 47.2% of children without special health care needs receive coordinated, ongoing, comprehensive care that meets the criteria for medical home. While 72.2% of children reported having preventive medical and 79.3% reported a preventive dental visit in the past year, rates of both are lower for Black or African American children (66% and 70.4%, respectively). Specific preventive care services vary: 68.8% of children age 19-35 months had a complete the full vaccine series; 27.1% of children age 9-35 months reported a developmental screening using a parent-completed screening tool; 60.8% of children were tested for blood lead levels two times by the age of 36 month years in accordance with NYS requirements; and 69.6% of children age 6-17 were vaccinated against influenza.

Forum participants, including many parents and grandparents, voiced concerns and strengths related to children's health and well-being, reiterating the cross-cutting themes summarized above. Families describe transportation with children as especially challenging and called for more family-friendly transportation and placing transportation near family activities and services. They asked for health care and other service providers that are more respectful, compassionate, and reflective of their languages and cultures, where they do not feel judged or stigmatized.

Improving community and neighborhood environments was a major theme among families. They emphasized the need for improved pedestrian safety and better sidewalks, with concerns about children walking along unsafe roads, and lack of access to fresh, affordable, healthy foods in the community and schools. Community violence, gangs, and drug use—in both neighborhoods and schools—were major concerns, leading to increased fear and social isolation. Pollution and trash in the streets were also raised as concerns that impact children's health. Families voiced the desire for more activities, programs, open greenspace and safe places for their children after school, summers, and on weekends, along with more family activities and facilities outside of work hours to support quality time with their children. They called for more mentoring and positive relationships for children, and a better sense of community connection, trust, engagement, and support.

*"Have to drive 10 minutes down the mountain to reach bus stop for child."*

*"I had concerns with my daughter gaining weight and the doctor said it was fine. Then when her 4-year check-up came she said it was a concern. She didn't listen to me."*

*"Back in the old days, neighbors watched out for others' children."*

*"I want a community where they can grow up and know that they're safe and can go anywhere they want to go and trust the adults in their community. Right now I am scared for my kids."*

#### **Domain 4: Children & Youth with Special Health Care Needs (CYSHCN)**

An estimated 15.8% (approximately 656,000 children) of children and youth age birth to 17 years in NYS have one or more special health care needs. The most commonly reported chronic conditions among NYS children are allergies (18.3%), oral health problems (11.1%), Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) (5.3%), asthma (7.5%), anxiety (6.9%), developmental delays (5.7%), autism spectrum disorders (3.1%), and depression (2.9%). Lead poisoning remains a special concern among NYS children because of the high percentage of older housing and other risk factors, with elevated blood lead levels (defined as greater than or equal to 10 mcg/dL) identified in 3.7 out of 1000 children tested for lead. NYS has recently changed the definition to great than or equal to 5 mcg/dL.

Almost half of CYSHCN live in households with income below 200% of the federal poverty level. CYSHCN are more likely to have their daily activities greatly affected by their health condition(s), to miss 11 or more school days a year, and to have trouble making or keeping friends. Families of CYSHCN report higher out-of-pocket medical expenses, have trouble paying medical bills, spend more time coordinating their child's health care, and report reducing or stopping work due to their child's health. Families of CYSHCN report that only 15.2% receive care in a well-functioning system, and 41.7% received care meeting all criteria for medical home, although these may be improving. Nearly all (99.98%) of resident births were screened for 50 disorders by the newborn bloodspot screening program. Nearly 1.3% of newborn hearing screenings had abnormal results; of these, only 29.5% had a documented follow-up screening. NYSDOH is actively working to improve completion and documentation of follow-up hearing testing. About 53.5% of children age 3-17 with a mental or behavioral

condition received treatment or counseling. Among families of infants and toddlers participating in the State's Early Intervention Program for federal Fiscal Year 2018-19, 63.7% met the State's standard for positive impact on families using the Rasch methodology. The Department has positive anecdotal evidence from parents directly impacted by the EIP's Improving Family Centeredness Together (IFaCT) quality improvement initiative. Only 17.8% of youth age 12-17 with special health care needs received services necessary to make transitions to adult health care, and this appears to be getting worse.

To better understand the gaps, barriers, and needs of families with CYSHCN, the NYSDOH Division of Family Health (DFH) implemented a care mapping process in partnership with several programs, including NY's Parent to Parent and Leadership Education in Neurodevelopmental Disabilities (LEND) programs, to collect feedback from parents and caregivers of CYSHCN and professionals who serve them. Recruitment was conducted from March 2017-June 2018, and feedback collected from 138 caregivers and 40 providers through a combination of online and paper mapping tools. Common challenges reported by caregivers included accessing and coordinating medical care and related services, identifying and coordinating child care, providing emotional and social supports for children and families, providing financial support including health insurance, navigating and obtaining assistance from the school system, integrating their children and their families into the community, providing and coordinating transportation, and transitioning to adult services. In addition, providers of CYSHCN report challenges connecting with families, staying up to date with knowledge of available community resources, and providing continuity of care. These findings resonate with the input received through the forums, in which 39 parents or caregivers of CYSHCN shared concerns and ideas related to both the cross-cutting themes described above and concerns more specific to families of CYSHCN.

*"[There should be] easier access to those resources so I do not have to be on a computer for 6 hours doing research."*

*"I am a mother of three special needs kids. I have to travel to Buffalo 8-15 times a month because there are no pediatrician offices for my son."*

*"I feel isolated because not everyone is experiencing what I am experiencing."*

*"My son cries because he does not have any friends."*

*"A child with special needs does not live in a vacuum. They are part of a family and have to address their needs and other family needs."*

*"I have to choose between paying mortgage and putting food on the table and the medical needs of my child."*

#### **Domain 5: Adolescent Health**

Families report that nearly 90.9% of NYS youth age 12-17 are in excellent or very good health. All-cause mortality for teens (21.9 per 100,000 age 10-19) has been declining. Injuries remain the leading cause of adolescent mortality, and for every injury death there are more than ten youth hospitalized for non-fatal injuries (221 per 100,000 age 10-19). While mortality related to motor vehicle injuries (5 per 100,000 age 15-19) has declined, suicide (6.0 per 100,000 age 15-19) has increased.

Depression among teens is increasing, with 11.5% of NYS teens age 12-17 experiencing a major depressive episode in the past year, over 30% of high school (HS) students reporting feeling sad or hopeless for more than two weeks in the past year, and over 10% of HS students reporting that they attempted suicide. Parents report that 33.1% of teens age 12-17 have been bullied and 12.6% of teens have bullied others. These rates are consistent with reports directly from HS students, 27.7% of whom reported that they were bullied electronically or at school, which has been steadily increasing. Nearly one in ten HS students report that they did not go to school because they felt unsafe at or on their way to/from school. About 10% of HS students report experiencing sexual dating violence and 10% physical dating violence. Youth arrests (age 10-17) ranged from 33 per 100,000 for weapons, 62 per 100,000 for assault, and nearly 300 per 100,000 for drug abuse.



About 7% of HS students report no fruit consumption in the past week, nearly 14% report drinking soda daily, and over 15% report never eating breakfast in the past week. Parents report that only 19.9% of teens age 12-17 were physically active at least 60 minutes every day, and 14.8% of HS students report no days with physical activity of 60 minutes or more in the past week. Over 40% of HS students report spending more than three hours daily using electronic devices (video games, social media, etc.), and 21% report three or more hours watching television. Nearly 30% of HS students are obese or overweight. Almost 80% of students report getting less than eight hours of sleep on an average school night.

Alcohol and combustible cigarette use among teens both have been declining, but use of electronic vaping products has increased dramatically, with over 27% of HS students reporting past or current use. Nearly 4% of students report ever using heroin. About 22% of HS students are currently sexually active, and among this group nearly 16% reported using no method to prevent pregnancy and over 41% reported not using condoms at last intercourse. The teen birth rate (11.7 per 1,000 girls 15-19) continued to decline, but case rates of sexually transmitted infections (STI), such as gonorrhea and chlamydia, among teens have not declined.

From October 2018 to April 2019, the ACT for Youth Center for Community Action based at Cornell University gathered input from youth around the state to explore why teen pregnancy rates have improved while STI rates have not. Over 200 young people completed surveys and over 75 participated in focus groups to discuss where they seek reproductive health care, their attitudes about sexual relationships, and their perceptions of sexual risk reduction behaviors. Participants indicated that teen pregnancy rates are down because of better education and awareness about sexual health, better access to and less stigma about contraception and condoms, teens engaging in other activities (both recreational, such as video games or social media, and other types of sexual activity, such as sending pictures), teens having other priorities and goals, and teens engaging in more oral or anal sex. To explain why STI rates are not improving, participants suggested teens are not using condoms for oral and anal sex; are more focused on pregnancy prevention than STI prevention; have misconceptions about personal STI risk, how they are transmitted, and the purpose of contraception; and have issues with navigating relationships, whether partners lying to each other about STI status or other partners, coercion, or open relationships.

Disparities vary across these behaviors and outcomes. White students report higher rates of bullying, but both Black or African American and Hispanic students are more likely to miss school because of safety fears. Hispanic students are more likely to report depression symptoms and suicide attempts. Cigarette smoking and alcohol use are higher among White teens, while Black or African American and Hispanic teens are more likely to use other illegal drugs, including heroin. Black or African American and Hispanic teens also report lower fruit and higher soda consumption, less physical activity, and higher rates of obesity and inadequate sleep. There are dramatic disparities across virtually all measures based on sexual identity; for example, among HS students identifying as gay, lesbian, or bisexual, 60% report depression symptoms, 26% report a suicide attempt, and 10% have used heroin.

In addition to the surveys and focus groups with young people, ACT for Youth interviewed 19 gender and sexually fluid young people to learn more about their experiences and perceptions about sexual health. Common themes discussed included that unprotected sex is common among this population and that sex work and survival sex happen. They discussed how sex education does not meet their needs: "Even in schools the sex education is very binary, doesn't really talk about gay sex or lesbian sex, it is always just mostly on reproductive sex...It is mostly about just about how to prevent pregnancy." Similarly, participants discussed not feeling affirmed by providers when accessing sexual health care as a barrier.

Most teens ages 12-17 had a preventive medical (81.3%) and preventive dental (79.3%) visits in the past year, and rates have been increasing. Teen vaccination rates for tetanus, diphtheria, and pertussis (i.e., whooping cough) (Tdap) (91.7%) and meningococcus (94.9%) are also relatively high, but the percentage vaccinated for human papilloma virus (HPV) (71.2% of girls and 67.1% of boys) is lower. Only 16.4% of adolescents without special health care needs received services necessary to transition to adult health care.

Over 150 adolescents participated in forums across the state. They called for more positive mentors and social support and increased access to teen-friendly community activities, including fitness centers and areas for exercise. Teens spoke

frequently of the need for better housing, healthy foods, and economic supports for their families. Teens expressed the desire for more compassion and respect from healthcare providers, and more providers who reflect their cultures and speak their language. Along similar lines, confidentiality was raised during the adolescent surveys and focus groups as a concern when seeking sexual and reproductive health care. They indicated they are less concerned about the confidentiality of electronic medical records and more concerned about interpersonal confidentiality.

*"Everybody needs to talk even for one second or ten minutes. Even boys."*

*"My mom waited 3 years for them to put on a door."*

*"Must have hope that you trust your provider and make sure someone is not trying to hurt you."*

*"I feel like we should have more African American counselors. Because the counselors that are there, I feel like the students don't feel comfortable talking to them."*

*"If I admit to needing care, then I admit to doing certain things. By seeking care, there might be guilt."*

### **III.C.2.b.ii. Title V Program Capacity**

#### **III.C.2.b.ii.a. Organizational Structure**

NY's Title V and CYSHCN Programs are based in the NYSDOH, an executive branch state agency under the direction of Commissioner Howard Zucker MD, JD, who was appointed by the Governor. Within NYSDOH, they are in the Office of Public Health, Center for Community Health, Division of Family Health (DFH). The DFH Director, Lauren J. Tobias, is the Title V Director (see organizational charts).

NYSDOH is responsible for the administration of all programs carried out with allotments under Title V, most of which are organizationally within DFH. Title V-funded programs and staff are integrated across DFH, its Office of Medical Directors, and its four bureaus: Women, Infant and Adolescent Health; Child Health; Early Intervention; and Administration.

Several key Title V-funded programs and initiatives are based in other parts of NYSDOH, including: American Indian Health Program (Office of Minority Health & Health Disparities), Asthma Prevention & Control (Division of Chronic Disease Prevention), Lead Poisoning Prevention (Center for Environmental Health), Migrant & Seasonal Farmworker Program (Center for Community Health), and Newborn Bloodspot Screening (Wadsworth Center). A list of Title V-funded programs is in Appendix 4.

#### **III.C.2.b.ii.b. Agency Capacity**

NY's commitment to protecting and promoting the health and well-being of the priority population is manifest in a comprehensive array of programs and services. Most services are carried out at the community level by local partners. NYSDOH and Title V program provide, administer, and oversee funding, training, technical assistance, data support, quality improvement, and other policy and program efforts to guide and support local and regional systems and programs. Within NYSDOH, staff, who are in Albany, coordinate with NYSDOH colleagues in regional offices to support and oversee Title V funded programs. See Appendix 4 for a description of programs and services funded directly through the Title V grant.

In addition to administering specific programs and initiatives, Title V staff routinely collaborate with a wide array of partners, both within and outside NYSDOH, to help inform, strengthen, and coordinate statewide systems of services and supports for women, children, and families. See Section III.C.2.b.iii. below for more information on partnerships.

Of note, NY's Title V Program works extensively with the state's Medicaid program and other partners to support Children and Youth with Special Health Care Needs (CYSHCN) and their families as a priority population, and to ensure statewide and local systems are in place to meet their needs. In NYS, all (Social Security Income) SSI beneficiaries, including blind and

disabled children receiving benefits under SSI, are categorically eligible for Medicaid; thus, Title V funds are not used for these direct care services.

This year, NY's Title V Program capacity was significantly challenged by COVID-19, with NYS as an epicenter for the pandemic in the U.S. As staff rapidly adjusted to working remotely, all Title V and other DFH programs mobilized to support the state's response. Staff led and contributed to wide-ranging response efforts including development and dissemination of guidance documents, webinars for local providers, and facilitation of telehealth and other virtual programming. Some staff were deployed to serve on intra- and inter-agency workgroups and support teams to coordinate regional epidemiology support and to directly assist with testing and contact tracing activities. The Title V program staffed the Governor's COVID-19 Maternity Task Force, convened to rapidly respond and develop recommendations related to birthing facilities and to review the literature on the impact of COVID-19 on pregnancy. Local MCH-serving programs have made significant adjustments to provide continued support for vulnerable MCH populations (see Appendix 5 for details).

The impact of the pandemic on families, communities, and MCH programs is expected to be a continuously evolving challenge for the foreseeable future. Further assessment of how Title V programs have responded, how the capacity of programs may be leveraged, assess how they have been impacted by continued response needs will be addressed in next year's application.

### **III.C.2.b.ii.c. MCH Workforce Capacity**

A strong and diverse workforce is needed to lead and implement core Maternal and Child Health (MCH) public health functions, effectively administer program resources, and collaborate with families and organizational partners at all levels. The size and complexity of NYS populations and service systems require significant leadership and capacity for program and policy development, program operations and implementation, data analysis and evaluation, and intra- and inter-agency communication and collaboration.

There are 128 filled Title V-funded positions within NYSDOH central, regional, and district offices, supplemented with additional non-Title V-funded positions supporting Title V programs and activities. Staff cover the full range of MCH populations and essential public health services.

Key Title V staff in the NYSDOH Division of Family Health (DFH) include:

- Lauren J. Tobias, MPP, DFH Director and NYS Title V Director
- Kirsten Siegenthaler, PhD, MSPH, Associate Director, DFH
- Marilyn Kacica, MD, MPH, Medical Director, DFH
- Megan Tyrrell, Title V Coordinator, DFH
- Christopher Kus, MD, MPH, Associate Medical Director, DFH
- Dionne Richardson, DDS, MPH, Public Health Dental Director, DFH
- Michael Acosta, MPP, Bureau of Women, Infant and Adolescent Health (BWIAH) Associate Director
- Eric Zasada, MPA, BWIAH Assistant Director and NYS Title V Adolescent Health Coordinator
- Suzanne Swan, MPH, Bureau of Child Health Director and NYS Title V Child and Youth Special Health Care Needs (CYSHCN) Director
- Constance Donohue, AuD, CCC-A, Bureau of Early Intervention Director
- Deborah Rock, Bureau of Administration Director

The BWIAH Director position is vacant following Kristine Mesler's retirement in late 2019. See Appendix 6 for brief descriptions of key qualifications for these staff.

NYS has experienced the same workforce trends described in national reports and surveys, including attrition and shrinking public workforce, with a large percentage of the current workforce poised to retire within the next five years, and needs for additional knowledge and skill development related to both emerging and persistent MCH challenges. Of critical importance, the diversity of the MCH workforce nationally and in NYS does not yet reflect the diverse populations the MCH workforce needs to serve and support.

The Title V program's internal capacity is enhanced and supplemented through formal and informal partnerships with external organizations. For example, the statewide and regional centers described above provide additional subject matter expertise, training, and technical assistance capacity for specific program areas. The Title V program also partners extensively with the HRSA-funded MCH Public Health Catalyst program based at University at Albany School of Public Health. The Catalyst program is engaged in recruiting and training the next generation of MCH professionals, with a special focus on individuals from disadvantaged and underrepresented populations. Specific partnerships between the Catalyst and Title V programs have supported numerous student projects and internships, an award-winning national webcast on maternal mortality, a literature review on COVID-19 and pregnancy for the COVID-19 Maternity Task Force, and extensive technical assistance to coordinate this five-year Title V NA and application, among others.

Parent and family members are critical partners in the Title V program's work at all levels.

At the state level:

- Michelle Juda, the Executive Director NYS Parent to Parent and the state's Family2Family Information Center, serves on the Title V Advisory Council.
- ACT for Youth Center for Community Action has a youth advisory board.
- Community members will serve on the Maternal Mortality and Morbidity Advisory Council (currently being established).

At the regional level:

- CYSHCN Regional Support Centers are required to hire a parent of a CYSHCN and convene family forums to provide direct input on program development.
- NYS Perinatal Quality Collaborative (NYSPQC) teams include patients, families, and those with lived experience in their educational curricula.

At the community level:

- School Based Health Centers (SBHCs) and Comprehensive Adolescent Pregnancy Prevention (CAPP) programs routinely engage parents and youth in their program activities
- Maternal and Infant Community Health Collaborative (MICHC) programs are engaged in developing work with community advisory boards.

### **III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination**

Partnerships and collaborations with other programs, organizations, and community groups are a fundamental way in which NY's Title V Program strives to meet the needs of MCH populations. These span partnerships with other state MCH-serving public health programs, within the NYS Department of Health (NYSDOH) Division of Family Health (DFH) and with other NYSDOH programs, other state and local agencies, community-based and private sector partners, families, and consumers. An overview of key partners and collaborations is in Appendix 7.

### **III.C.2.c. Identifying Priority Needs and Linking to Performance Measures**

Findings from the statewide Needs Assessment (NA) drove the 10 MCH priorities identified for the NYS Title V program for the next five years. To identify and choose priorities, the following factors were considered:

- Areas identified by families and community members as their most important needs and priorities;
- Areas for which Title V infrastructure, capacity, partnerships, and investments can be leveraged; and
- Areas that the state Title V program can impact over the next five years in a lead or key supporting role.

While all factors are important, **listening and responding to community voices** was given the most weight. The Title V leadership team asked the question: *How can we be responsive to the themes voiced by families and communities, within*

*the context of the program infrastructure and resources we have, and with a focus on making measurable progress in specific areas encompassed by the HRSA national performance measures?*

Given this approach, the starting point for choosing priorities was to review and discuss the top themes emerging from the forums, public survey, and other companion efforts described in the methodology and findings above. Ten priorities were identified, corresponding directly to the ten cross-cutting themes described in Findings (Section b.1).

1. **Health Care:** Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities
2. **Community Services:** Promote awareness of and enhance the availability, accessibility, and coordination of community services for families and youth, including children and youth with special health care needs and their families, with a focus on communities most impacted by systemic barriers including racism.
3. **Parenting and Family Support:** Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers
4. **Social Support and Cohesion:** Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course
5. **Healthy Food:** Increase access to affordable fresh and healthy foods in communities.
6. **Community & Environmental Safety:** Address community and environmental safety for children, youth, and families.
7. **Poverty:** Acknowledge and address the fundamental challenges faces by families in poverty and near-poverty, including the “working poor” as a result of systemic barriers, including racism.
8. **Awareness of Resources:** Increase awareness of resources and services in the community among families and the providers who serve them.
9. **Housing:** Increase the availability and quality of affordable housing.
10. **Transportation:** Address transportation barriers for individuals and families.

This approach to priority-setting is different from the prior cycle, in which priorities were domain-specific and directly linked to specific objectives and performance measures. For this five-year cycle, NY has chosen instead to adopt a set of priorities that serve as a broad vision that is directly responsive to the cross-cutting needs, challenges, and positive ideas shared by community members. Thus, all priorities are “new” from the previous cycle, as reflected in Form 9. The priorities will serve as a compass to guide the work of all Title V programs in considering how existing infrastructure, capacity, services, partnerships, and other resources can be leveraged to more effectively address these critical priorities.

Guided by these priorities, the leadership team selected five national performance measures (NPMs) and two state performance measures (SPMs) as the basis for the NYS Title V State Action Plan for the next five years. Because the priorities are cross-cutting, there is not one-to-one alignment between priorities and performance measures. Rather, the NPMs and SPMs were selected to collectively drive work in areas that align with these cross-cutting priorities and for which the leadership team determined our Title V program can make meaningful progress over the next five years. See the State Action Plan Table for a more detailed crosswalk of the priorities and selected performance measures.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$38,909,810	\$38,241,544	\$37,671,810	\$25,616,759
<b>State Funds</b>	\$29,226,355	\$29,285,355	\$29,285,356	\$29,285,356
<b>Local Funds</b>	\$64,591,358	\$122,724,134	\$122,324,435	\$57,532,053
<b>Other Funds</b>	\$0	\$0	\$0	\$0
<b>Program Funds</b>	\$26,851,106	\$28,299,351	\$30,303,017	\$22,258,095
<b>SubTotal</b>	\$159,578,629	\$218,550,384	\$219,584,618	\$134,692,263
<b>Other Federal Funds</b>	\$68,845,166	\$67,884,924	\$47,470,052	\$53,655,287
<b>Total</b>	\$228,423,795	\$286,435,308	\$267,054,670	\$188,347,550
	2020		2021	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$38,909,810	\$32,378,022	\$38,909,810	
<b>State Funds</b>	\$29,285,355	\$29,285,355	\$29,285,355	
<b>Local Funds</b>	\$55,483,224	\$35,333,319	\$55,602,278	
<b>Other Funds</b>	\$0	\$0	\$0	
<b>Program Funds</b>	\$22,224,404	\$25,288,886	\$16,735,967	
<b>SubTotal</b>	\$145,902,793	\$122,285,582	\$140,533,410	
<b>Other Federal Funds</b>	\$65,608,665	\$48,210,047	\$49,308,573	
<b>Total</b>	\$211,511,458	\$170,495,629	\$189,841,983	

	2022	
	Budgeted	Expended
<b>Federal Allocation</b>	\$38,909,810	
<b>State Funds</b>	\$29,285,355	
<b>Local Funds</b>	\$35,897,127	
<b>Other Funds</b>	\$0	
<b>Program Funds</b>	\$21,713,525	
<b>SubTotal</b>	\$125,805,817	
<b>Other Federal Funds</b>	\$61,858,217	
<b>Total</b>	\$187,664,034	

### III.D.1. Expenditures

FY 20 Expenditures, including Title V MCHSBG, State appropriations, and other grant funding, demonstrate NY's commitment to providing supports and services to NY's women, children, and families. The State Allocation Plan is described in Section 504, Use of Allotment of Funds, and Section 505, Application for Block Grant Funds.

Expenditures, reflected in Form 2, confirm that NY has continued to comply with the 30%-30%-10% requirements, as specified in Section 504(d) and Section 505(a)(3). The scope and comprehensiveness of services for NY's MCH population are fully outlined and described in the FY 2020 report and FY 2022 application.

Title V MCHSBG funds supported primary and preventive health care services and infrastructure to continue to achieve the objectives for each State Priority in NY's Title V State Action Plan. Initiatives. Programs such as the Comprehensive Adolescent Pregnancy Prevention (CAPP), Center for Community Action on Adolescent Health, and Family Planning and Reproductive Health Care Program promote primary and preventive health care, preconception and interconception health, and physical, social and emotional health and wellness for all individuals served. Programs such as the School-Based Health Center Program (SBHC) ensure access to health care for children and adolescents, also focusing on reproductive and behavioral health. The Lead Poisoning Prevention Program provides identification and follow-up for children at risk for or with high blood lead levels. Title V MCHSBG funding is provided to NY's Regional Perinatal Centers to ensure all pregnant women and newborns have access to high quality, appropriate level of perinatal care to improve birth outcomes. The School-Based Dental Sealant Program promotes improved oral health for NY's highest risk population. Programs targeting specific populations, such as the American Indian Health, Maternal and Infant Community Health Collaboratives (MICHHC), and Migrant and Seasonal Farmworker Health, engage populations in health care across the life course. Title V MCHSBG funds supported monitoring of family planning, SBHC and school-based dental sealant programs to ensure services are provided in accordance with State and Federal requirements where applicable. Title V MCHSBG funds also support efforts to update NY's standards for perinatal regionalization and efforts to identify and address those factors that result in maternal mortality and morbidity.

Title V MCHSBG funds, in conjunction with state and other federal funds, supports a rich tapestry of programs and initiatives developed to support NY's Title V State Action Plan, and assist NY to address the needs of women, children and families, including the overarching priority to promote health equity. NY's Part C of the Individuals with Disabilities Education Action funding supports the administration of the largest Early Intervention Program in the nation. Grants such as MIECHV support evidence-based home visiting and efforts to engage women and families into health insurance, interconception health, breastfeeding, parenting support, and a range of other supports and services. Funding provided through PREP and Pregnancy Assistance Fund allows an expansion of adolescent programming to support the growth and development of children and adolescents. The HRSA Universal Newborn Hearing Screening and the CDC Early Hearing Detection and Intervention (EHDI) Surveillance grant augments the statewide newborn hearing screening program and supports enhanced efforts to track newborns lost to follow-up services. NY leverages the Perinatal Quality Collaborative grant to support efforts to improve the quality of care provided to women and newborns in NY's perinatal hospitals. Efforts supported in NY's Rape Prevention and Education (RPE) program are targeted at decreasing sexual violence and promoting healthy relationships among NY's adolescents and young adults.

Supports and services to NY's Children and Youth with Special Health Care Needs (CYSHCN) and their families are an essential component of NY's Title V services. Through the Physically Handicapped Children's Program - Diagnosis & Evaluation (PHCP-D&E), funding is provided for medical assessment of children with suspected health issues where there is no other source of financial support. Although all primary and preventive health care programs provide services to CYSHCN, NY's Title V program also oversees services specifically designed to serve CYSHCN. For example, Title V MCHSBG funds support forty-nine Local Health Departments (LHDs) to provide information and referral services to families of CYSHCN. This funding supports staff in LHDs to respond to inquiries by families related to issues such as insurance coverage, assistance with services, family support and needed items for their CYSHCN. Support is provided to NY's Wadsworth Center Laboratory that administers the statewide Newborn Metabolic Screening Program as well as specialty



centers for individuals with genetic diseases and disabilities. NY's Lead Poisoning Prevention Program focuses on environmental changes as well as identifying and supporting potentially lead poisoned children and their families. Programs such as NY's SBHC provide services to children, including CYSHCN that can result in decreased absenteeism, improved school performance, and better health outcomes. As stated in NY's application, NY's Title V MCHSBG program continues to focus improving supports and services for CYSHCN and their families. Information obtained from CYSHCN and their families will assist NY's Title V Program to improve and enhance supports and services for CYSHCN in the coming years.

The total Federal funds includes funds to support an oversample of the National Survey of Children's Health (NSCH) which reflects the State's commitment to invest in strengthened data capacity.

To calculate data on priority populations served by group (pregnant women, infants under 1 year of age, children ages 1-22 years, CYSHCNs and others) and by level of the MCH pyramid (direct health care services, enabling services, and population and infrastructure services), program managers provide information based on actual data collected from each program or provide an estimate for each of these categories. These data are compiled for Forms 3a and 3b. Expenditure reports are generated for the appropriate period and distributions by population and pyramid level are then calculated. NY does not provide direct health care services using Title V funding except for limited funding through the Physically Handicapped Children's Program Diagnosis and Evaluation (PHCP D&E) services. A rich health care coverage and service system in NY results in very limited expenditures through PHCP D&E as NY's direct care expenses remain less than 1%.

NY's commitment to the MCH population is evidenced by the substantial State appropriation that is devoted to supports and services for NY's women, children, including CYSHCN and families. Differences in state and local contributions from prior years are evident as NY continues to promote enrollment into health insurance coverage for all New Yorkers, as well as to maximize the use of other state and federal fund sources to enhance services for the MCH population.

Overall, the actual expenditures for FY 20 appear less than originally projected. The FY 20 award value remains fully obligated and will be fully dispersed by the liquidation deadline at the end of this year.

NY's FY 20 application reflected a budget of over \$55 million in Local funds, but actual expenditures were less than anticipated. This is likely related to the timing of the reporting by LHDs rather than an actual decrease in expenditures.

NY has decided to remove many of the federal grants listed as Other Federal Funds in the FY 20 application as they were not awarded to the NY State Department of Health, but to Health Research Incorporated (HRI). The DOH works very closely with HRI to manage these grants but is not the awardee.

NY continues to be committed to identifying additional resources to serve NY's MCH population. NY's Title V program has been very successful in accessing additional funding to develop the comprehensive system that currently exists in NY and a myriad of other grants support NY's efforts to improve outcomes of all women, infants, and children, including CYSHCN and families across NY.

### III.D.2. Budget

This FY 2022 budget reflects NY's commitment to Title V MCHSBG programs and services. NY will continue to use FY 2022 Title V funds to support the implementation of NY's Title V State Action Plan. Title V MCHSBG funds, in addition to State appropriation, Federal Medical Assistance Program (FMAP), and federal grant funds will continue to support programs and initiatives across all domains as described in the application section. This includes the development of substantial data analyses and reports to guide NY's services for the MCH population. Support for efforts such as maternal and infant mortality and morbidity surveillance and quality improvement efforts to avoid these devastating outcomes is a priority. Enhancing NY's efforts to identify those factors that result in maternal mortality and morbidity and addressing those factors will continue to be of importance in NY's Title V MCHSBG program. NY's Title V MCHSBG will continue interagency efforts to address maternal depression.

Efforts will continue to update and improve NY's system of perinatal regionalization. NY will continue to move towards a greater understanding of comprehensive health, development, morbidity, and health disparities, social-emotional development in children and adolescents, and will promote and support efforts to ensure all NY's children have the opportunity for healthy development. Information obtained through systems/care mapping has been used to develop enhanced systems for CYSHCN and their families. The Title V program is increasing its investment in the LHD CYSHCN program to provide more support to local staff who can connect with and support CYSHCN and their families. The Title V program will also continue to invest in three regional technical assistance centers at the state's University Centers of Excellence in Developmental Disabilities (UCEDD). In NYS, the UCEDDs are the Westchester Institute for Human Development in Valhalla, Montefiore Medical Center in New York City, and the Strong Center for Developmental Disabilities at the University of Rochester. These entities are federally designated by HRSA and established through a competitive application process to work with people with disabilities, family members, state and local government agencies, and community providers in projects that provide training, technical assistance, service, research, and information sharing. This will assist NY's Title V MCHSBG program to improve and enhance supports and services for CYSHCN and their families.

Overall efforts will continue to provide supports and services for children and adolescents, with a significant focus on physical activity and nutrition, social-emotional development, SBHCs and school-based dental programs, evidence-based home visiting services, oral health services, services for CYSHCN, and many other supports and services discussed throughout NY's application. Paramount to the plan is the promotion of health equity for all across the life course.

Financially, the Title V Administrative budget of \$3.3 million increased slightly from prior years and remains below the 10% limit for these costs. As in prior years, the NY share for MCH services will continue to be considerable and will more than meet the requirements for state match. Expenditures for FY22 are expected to utilize the full allocation of \$38,909,810. NY continues to be fully committed to the health and wellness of all New Yorkers and will move forward in the comprehensive work as outlined in the Title V State Action Plan.

### **III.E. Five-Year State Action Plan**

#### **III.E.1. Five-Year State Action Plan Table**

**State: New York**

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

### III.E.2. State Action Plan Narrative Overview

#### III.E.2.a. State Title V Program Purpose and Design

NY's Title V MCHSBG program builds on years of MCH leadership and public health investments. As a large state with well-developed health care, public health insurance, and public health systems, New York addresses the needs of the MCH population through a robust mix of public health programs, policy initiatives, and partnerships. Partnerships encompass collaboration with other public health programs, other state agencies, and a broad array of external organizations ranging from large, sophisticated hospital and health care systems to small, grassroots community-based organizations.

Like other large states, NY does not provide direct services. Rather, our Title V MCHSBG program works to improve supports and services and to deliver public health strategies and programs through contracts and community partnerships to address the state's large and extremely diverse MCH population. Title V MCHSBG funding supports internal state public health infrastructure and systems, and, in combination with other state and federal funding sources, supports gaps in services and programs to maximize outcomes for MCH populations. Key programs and partnerships are described in the *Title V Program Capacity* and *Title V Program Partnerships, Collaboration, and Coordination* sections of the five-year Needs Assessment (NA) Summary.

NY's State Action Plan (SAP) is driven by data, evidence, and input from stakeholders including families and youth. The life course model, including MCHB's seminal 2010 concept paper *Rethinking MCH: The Life Course Model as an Organizing Framework*, informed both the NA and SAP. NY's SAP aims to translate life course concepts into an integrated portfolio of actionable, effective, and measurable strategies to improve MCH outcomes and equity across the state. The SAP flows directly from the state's five-year NA and subsequent NA updates, and from the State Priorities and the National and State Performance Measures selected in response to the NA.

NY's SAP established quantitative five-year targets for objectives, based on analysis of data trends and projected impact of strategies; these targets are revisited annually. Initial five-year strategies and associated Evidence-Based/Informed Strategy Measures (ESM) are updated and refined annually to reflect evolving and emerging needs, progress, and lessons learned. In selecting and refining strategies, key considerations include evidence base, feasibility, and alignment with stakeholder priorities, with attention to advancing a balanced portfolio of population health surveillance and data analysis, policy and systems, workforce development, community-based prevention, and clinical quality improvement strategies. Across all of these, we continue to deepen our commitment to centering the voices and experiences of affected populations, and to advancing health equity.

Organizationally, much of this work continues to be led by cross-programmatic Title V MCHSBG Staff Teams. These teams are especially effective for driving progress in domains and strategies that do not have a single 'home' within the Division of Family Health or NYSDOH, such as perinatal health, child health and CYSHCN. As evidenced in the Annual Report and Application section, NY's Title V program continues to make substantial progress in carrying out defined strategies, despite the significant challenges of the past year at all levels. This is accomplished through direct oversight and administration of key MCH public health programs, as well as Title V MCHSBG roles as a convener and collaborator. We seek to engage external partners at all levels to enrich the MCH programs administered through Title V MCHSBG, while simultaneously seeking to bring an MCH perspective and voice to initiatives led outside the Title V MCHSBG program.

### **III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems**

#### **III.E.2.b.i. MCH Workforce Development**

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

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

MCH providers also use funds provided by the Title V MCHSBG program to access qualified and competent staff, participate in training and conferences and other activities to improve the quality of the workforce providing services. Title V MCHSBG supports staff participation to attend national conferences (virtually on 2020-21) to continue to build expertise in the MCH arena and make connections on the federal level as well as develop partnerships between states to continue to improve NY's approach to improving the health and wellness of the MCH population. A biannual newsletter created by the DFH social and emotional wellness team, provides staff and partners with information and learning opportunities to improve knowledge on the tenets of social and emotional wellness as it relates to MCH populations.

As previously discussed, NY's Title V MCHSBG program also leads various efforts with health care providers, hospitals and other professionals throughout NY to enhance practice. These include, but are not limited to, the improvement initiatives through New York State Perinatal Quality Collaborative (NYSPQC) and training and information provided to and through professional organizations (topics include the identification of children with Autism Spectrum Disorder (ASD), developmental screening, the identification and treatment of hypertension during pregnancy, and screening and referral of children for oral health services). Staff are integrated into the regional perinatal center re-designation process, offering professional staff development opportunities, as high-level medical professionals work together to modernize the state's system of care in birthing hospitals throughout NY.

Title V MCHSBG staff within NYSDOH are the core of the Title V MCHSBG program and responsible to ensure the scope and mission of Title V MCHSBG is carried out in NY. To ensure a strong focus on the needs of the Title V MCHSBG programs, strong connections and linkages are maintained with relevant stakeholders. For example, staff is participating in an 18-month, three state (NY, NJ and PA) learning collaborative, managed by the Center for Law and Social Policy (CLASP), with NYS Office of Mental Health, NYS Office of Medicaid, the Schuyler Center for Analysis and Advocacy (SCAA) and other stakeholders. The Moving on Maternal Depression (MOMD) will work to achieve five goals:

(1) Leverage and coordinate the significant interest and activity at state and local levels for maternal health and early childhood health and development and cultivate a strong community of diverse voices working to ensure that all women receive screening and treatment for maternal mental health that is accessible, affordable and culturally appropriate.

(2) Meaningfully engage in the policy-making process with diverse voices of women who have experienced maternal depression, with an emphasis on the inclusion of people from communities that have been historically marginalized.

(3) Establish key metrics that will be utilized for implementing continuous improvement activities on maternal depression across state agencies and through health care providers and community-based organizations. This will include steps to develop prevalence data differentiated by race and ethnicity and key performance indicators to drive improvement in process e.g., connecting women to treatment, reducing provider stigma, reducing disparities).

(4) Better understand the capacity in each region of the State for screening and treating women with maternal depression and have a plan focused on workforce capacity for screening and treatment options. The landscape assessment will aim to understand the needs of geographic areas and populations that have been historically underserved

(5) Develop a plan to integrate policies and information on maternal depression across State agencies and with partnerships at the community level that are working in the areas of maternal health, child health, early childhood development and family economic security with an emphasis on strategic alliances to advance health equity.

Title V MCHSBG Program staff partnered with Parent to Parent of NYS on a HRSA sponsored learning collaborative with the NY State Parent Advocacy Network (SPAN) to prepare and support emerging family leaders for identified roles on community, state, and national teams and advisory groups focused on CYSHCN systems and to increase the racial and ethnic diversity of these representatives. The HRSA-funded Strengthen the Evidence site continues to serve as a resource for information related to evidence-based practice in MCH.

Title V MCHSBG continues to foster the growth of the MCH workforce by encouraging staff to access the Association of

Maternal and Child Health Programs' (AMCHP) educational opportunities to network and grow in the field of MCH. An AMCHP representative regularly presents at the NY MCHSBG Advisory Council meetings to ensure NY has the most current information from the federal level.

The Division of Family Health (DFH), in which the Title V MCHSBG Program and other MCH programs are located organizationally, is committed to improving health equity for all New Yorkers. In order to further this agenda, DFH staff have been engaging in educational opportunities and integrating this knowledge into policies and practices. DFH established a Health Equity team, which identified four courses focused on different aspects of health equity. These have been packaged into a comprehensive health equity curriculum with pre- and post-evaluation modules. All existing and incoming staff from entry level and support staff through top management are required to complete the series, and success is monitored and reported to leadership. Through this workforce development initiative, leadership aims to sensitize and educate staff on the issues of health equity, which impacts all aspects of Title V work. Involvement in work related to health equity including Racial Justice Workgroup within the Center for Community Health (CCH), which includes DFH as well as the Divisions of Nutrition, Chronic Disease Control and Prevention, and Epidemiology. The CCH Racial Justice Workgroup began a year long process in 2018 to focus their work on turning commitment to racial justice into action. A Racial Justice Work Group was formed, comprised of diverse representatives focused on achieving racial justice principles. In addition, a range of innovative training interventions are being implementing to build the capacity of health and human services providers, health care facilities, community-based organizations (CBOs) and larger communities to employ a health equity framework to improve health outcomes. NYS Department of Health staff participated in a Government Alliance on Race and Equity (GARE) training and became a GARE member in 2019.

As an outgrowth of the partnership between the State University of New York at Albany School of Public Health (SPH) and NYSDOH, and with initial grant funding from the federal HRSA MCH Catalyst initiative, SPH established an MCH program starting in 2015. Consistent with the federal MCH Catalyst Program goals, the program at SPH seeks to develop an increased focus on MCH within the school and university and to prepare students for MCH careers. Rachel de Long, M.D., M.P.H., the former NY Title V MCHSBG Director, and Christine Bozlak, PhD, MPH, a full-time SPH faculty, serve as co-directors for the SPH MCH Program. The program offers both graduate and undergraduate level academic coursework in MCH, funds MCH-related internships for SPH students, supports student and faculty travel to MCH conferences, and facilitates a wide array of professional development opportunities for both students and MCH practitioners. A new graduate certificate in MCH launched in the 2019-20 academic year. The partnership with the state's Title V MCHSBG program is a distinguishing strength of the school's MCH Program.

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

### **III.E.2.b.ii. Family Partnership**

The NYS Title V MCHSBG Program has a long history of partnering with consumers, including families and family organizations to ensure family voice across the state's MCH initiatives.

The NYS Title V MCHSBG Program ensures there is a 'family voice' represented in the state's MCH services and programs, through our local partners including local health departments (LHDs), universities and academic medical centers, hospitals and clinics, and community-based organizations. When procuring services, the Division of Family Health (DFH) requires local partners that receive contracts to ensure ongoing involvement and feedback is received from consumers who represent the diverse MCH population served in their community. Community involvement may take the form of membership on a board to guide services, workgroups to provide input regarding education materials or outreach strategies, or direct input from families served either from a survey or in-person listening forums. In a state the size of NY, obtaining input through provider organizations or other organizations representative of the population is the most practical, meaningful way to obtain input from the state's large, diverse population.

NYS' Children and Youth with Special Health Care Needs (CYSHSN) Program requires the three University Centers of Excellence in Developmental Disabilities (UCEDDs), which are the state's Resource Support Centers that provide technical support and assistance to counties, employ a parent/family member/caregiver of a child or youth with a special health care need to ensure that families can talk to a trusted messenger and that the programs' supports and services meet family's needs. The LHD CYSHCN Program work plan requires that they provide program outreach and awareness regarding the local CYSHCN Program, gap-filling programs and community resources. The goal of these activities is to empower families of CYSHCN and youth/young adults with special health care needs to navigate the systems of care. All 49 local contractors are required to report quarterly on their activities in this area.

NYS's Early Intervention Program's (EIP) ensures there is a family voice through the State Systemic Improvement Program (SSIP) quality improvement teams. This quality improvement initiative aims to improve family outcomes in the EIP service delivery system. The SSIP work is highlighted in the Children with Special Health Care Needs section. In addition to the SSIP, the EIP supports the Family Initiatives Coordination Services Project that coordinates the development and implementation of a variety of family initiatives including training and support for parents involved in the EIP to become advocates for special needs children at local, state and national levels continues.

The NYS Advisory Councils often include a family voice. Parents are members of the Early Intervention Coordinating Council as well as the MCHSBG Advisory Council and provide valuable input to guide policy and practice. Michelle Juda, executive director of Parent to Parent of NY has been designated as a member of NY's MCHSBG Advisory Council and NY's family representation to AMCHP. The Early Childhood Advisory Council, oversee by the NYS Council on Children and Families (CCF), has recruited and is supporting parents/caregivers as members of the Council and to provide guidance and review of state-led MCH programs.

### III.E.2.b.iii. MCH Data Capacity

#### III.E.2.b.iii.a. MCH Epidemiology Workforce

MCH data are critical to the effective, efficient, and equitable implementation and improvement of MCH programs, services, and policies. Descriptions of the data systems and sources that inform NYS's Title V MCHSBG work are provided in Section 2b.iii.c. DFH relies on a strong workforce comprised of data analysts, epidemiologists, evaluation specialists, program research specialists, programmers, and research scientists to develop, maintain, and utilize our various MCH data systems, to evaluate and improve our programs and to monitor ongoing and emerging priorities. This workforce includes both staff within DFH and partners in other NYSDOH organizational units. While staff are funded by different funding sources, including Title V MCHSBG, State Systems Development Initiative (SSDI), other federal grants, and state funds, data staff collaborate with other data staff as well as program staff to meet the needs of our Title V MCHSBG Program and NYSDOH's MCH initiatives overall.

As of May 2021, NYS's MCH epidemiology workforce within DFH included 24 staff with the titles and funding sources outlined in the table below. Currently there are two FTE research scientists under recruitment and one FTE research scientist has been submitted for a waiver to hire. There are no vacancies in MCH epidemiology-related positions within DFH at the time of this report.

Division of Family Health Staff with MCH Epidemiology-related Titles by Funding Source

MCH Epidemiology-related Titles	Funding Source				Total
	Title V	SSDI	Other Federal Funding	Contractor	
Data Analyst				4	4
Evaluation Specialist				1	1
Program Research Specialist	2	1	5	1	9
Programmer				1	1
Project Manager				1	1
Research Scientist	4		3	1	8
Total	6	1	8	9	24

In addition to informal information sharing and collaboration that happen among DFH data staff, the division hosts a DFH Data Team that meets monthly and serves as a forum for professional development through presentations given by members or other NYSDOH staff and for information sharing and feedback through discussions about issues staff encounter in their work.

Beyond DFH, there are staff with similar titles throughout NYSDOH that support programs receiving Title V MCHSBG funds, such as Newborn Bloodspot Screening in the Wadsworth Laboratory, Lead Poisoning Prevention Program in the Center for Environmental Health, and Comprehensive Services and Health Systems Approaches to Improve Asthma Control in Division of Community Chronic Disease Prevention. Examples of NYSDOH staff outside of DFH that support MCH efforts but are not Title V MCHSBG funded include data staff who are located organizationally in the Office of Quality and Patient Safety (OQPS) and who manage critical data sources, such as vital statistics, Medicaid claims, and hospital discharge data.

Other state agency partners outside of NYSDOH support MCH epidemiological efforts. The NYS Council on Children and Families developed the Kids' Well-being Indicators Clearinghouse (KWIC; [www.nyskwic.org](http://www.nyskwic.org)), which aims to advance the use of children's health, education and well-being indicators as a tool for policy development, planning, and accountability. NYSDOH is a member agency of KWIC and provides data to the clearinghouse. Programmers contracting with NYS Office of Information Technology update, fix, and test NYS's Vital Records data systems.

The COVID-19 pandemic presented a period of both immense challenges as well as opportunities for the MCH epidemiology workforce in DFH. Nearly all staff were reassigned to COVID-19 response tasks, sometimes for short-term discrete projects or at times for months-long deployments. Some assignments were done in addition to usual duties while others required 100% effort, removing staff completely from their usual duties and leaving other staff to cover. Response efforts strained all data staff, both those who were reassigned and those who continued all usual duties. But this was also an opportunity to forge new relationships with staff throughout NYSDOH that can be fostered and leveraged into the future and to gain new skills and experiences that can be applied to MCH and Title V MCHSBG work specifically.



### **III.E.2.b.iii.b. State Systems Development Initiative (SSDI)**

One of the main objectives of the State Systems Development Initiative (SSDI) is to build and expand NY MCH data capacity to support Title V MCHSBG program activities and contribute to data-supported decision making in MCH programs, including assessment, planning, implementation and evaluation. The importance of NYSDOH data capacity is recognized as critical to identifying needs of the MCH population, including the impact of structural racism. Improving data integration and utilization allows for greater ability to assess trends in outcomes, including health disparities. With the changing landscape of NY's population, services and resources, coupled with health reform changes that seek to improve outcomes and reduce disparities while not increasing costs, there is an increased demand for quality data that is available to MCH decision makers, program administrators and staff who are monitoring and evaluating programs and their impact.

#### **i. Contributions of the SSDI grant in building and supporting accessible, timely & linked MCH data systems, as documented on Form 12**

NY has a strong commitment to data systems development and invests in infrastructure to promote data linkages and timely reporting. The following data sources are provided by partners to allow SSDI and other Title V staff to assess, monitor, and evaluate Title V programming in NY: Newborn Screening Program data; Vital Records (births, deaths); New York City Vital Records; Statewide Perinatal Data System; Children with Special Health Care Needs Database; Early Intervention Program Data; Behavioral Risk Factor Surveillance System; Centers of Disease Control and Prevention (CDC) Pregnancy Risk Assessment Monitoring System; Immunization Information System; Medicaid; Quality Assurance Reporting; Statewide Planning and Research Cooperative System; National Survey of Children's Health; Early Hearing Detection Intervention; CDC Breastfeeding Report Card; National Immunization Survey; Sexually Transmitted Disease Surveillance; United States Current Population Survey; National Pediatric Nutrition Surveillance System; National Survey of Children with Special Healthcare Needs, Statewide Health Information Network in New York; Psychiatric Services and Clinical Knowledge Enhancement System; and United States Census data.

The SSDI Principal Investigator (PI), who is the DFH Medical Director, the SSDI Program Research Specialist (PRS), and other DFH research scientists have initiated several efforts to increase data capacity and advance the development and utilization of linked information systems between key MCH datasets in NY to improve access to electronic MCH health data. Updates on these various data linkage projects are as follows:

**NY and NYC Linked Birth and Infant Death Data:** Linked birth and infant death data sets for infant deaths occurring between the years 2002 and first quarter of 2020 (provisional data) are currently available for use by the Title V MCHSBG program. In this statewide linked data set, information from the death certificate is linked to information from the birth certificate for each infant under one year of age who was born and died as a NY resident. Title V MCHSBG staff uses linked birth and infant death data to identify mortality patterns during the neonatal and post neonatal time periods and risk factors present at birth needed for prevention planning to lower the burden of and decrease disparities in infant mortality (IM) rates.

**Statewide Perinatal Data System (SPDS):** SPDS is an electronic maternal and newborn data collection system established and maintained by NYSDOH with the purpose of improving prenatal, obstetric, and newborn care for NYS mothers and infants. The SPDS was developed to make data available to NYSDOH and hospitals for monitoring and quality improvement. Web-based and modular in design, the Core module comprises the electronic birth certificate (EBC) that captures birth data in hospitals outside of NYC, and an additional Neonatal Intensive Care Unit (NICU) module that captures data on high risk newborns admitted to neonatal intensive care units across NY. EBC data for births in NYC hospitals are captured in a separate coordinated system. The SPDS links individual-level data elements related to clinical measures and interventions, participation in public programs, demographics, and psychosocial and socioeconomic characteristics from various data sources including the NY/ NYC live birth certificate and other sources specific to maternal and newborn health and care in hospitals and birthing centers. The SPDS has been used to conduct public health surveillance of birth outcomes, to develop and implement an expanded plan for analysis and reporting of IM and selected morbidity data, and issue initial data reports.

**NYS and NYC Linked Birth, Death and Hospital Discharge Data for Maternal Mortality and Morbidity:** The Maternal Mortality Review (MMR) initiative identifies maternal deaths through complex linkages between NYS death records of women ages 10-65 years old, birth records, and Statewide Planning and Research Cooperative System (SPARCS) hospital discharge records. A statewide file which contains comprehensive information from each data source is provided to DFH staff to prepare cases for the Maternal Mortality Review Board (MMRB). The MMRB completes a comprehensive review of factors leading to maternal deaths and provides recommendations to prevent these deaths. DFH staff works closely with the OQPS to improve data quality and completeness of administrative state databases for this initiative. DFH obtained access to preliminary statewide death records for 2019 deaths and the first quarter of 2020 death records. Quarterly linkages between statewide vital records (VR) (death and birth file) and SPARCS hospital discharge data provide additional sources of data for our maternal and IM and morbidity efforts. Title V staff have not received the linked VR to SPARCS data from OQPS during this reporting period due to data issues with SPARCS and COVID priorities. Title V MCHSBG staff gained direct access to the Office of Mental Health's Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) which provides behavioral health information related maternal death cases. The newly hired SSDI-funded PRS is learning the early death identification process in support of MMR activities and will be assisting with this process during the upcoming year.

**All Payor Database (APD):** is a comprehensive health claims and clinical database aimed at improving quality of care, efficiency, cost of care and patient satisfaction available in a self-sustainable, non-duplicative, interactive and interoperable manner that ensures safeguards for privacy, confidentiality and security. The APD includes hospital discharge (i.e., SPARCS), VR death data, Medicaid claims and encounter data, and will ultimately integrate VR birth and commercial claims data, other public health registries and electronic health records. The APD is an invaluable source of comprehensive and longitudinal MCH data for the Title V MCHSBG program and will allow for more direct access to vital statistics, hospital discharge and Medicaid data. This platform will be the basis on which Title V MCHSBG builds a Perinatal Data Module which will allow NYS birthing facilities access to timely data for monitoring their outcomes, including maternal mortality, and support quality improvement. This module will be modeled after California Maternal Quality Care Collaborative.

**Linked NY Early Intervention Program (EIP) and Children and Youth with Special Health Care Needs (CYSHCN):** The comprehensive statewide EIP, part of a national EIP, serves over 65,000 infants and toddlers with developmental delays, with a focus on both child and family outcomes and strong commitments to better addressing children's social-emotional developmental needs as well as family-centered practices and outcomes. To strengthen coordination and collaboration between EIP and CYSHCN programs on the local level, Title V staff have facilitated ongoing discussions between staff of both programs to ensure coordination of services for families of CYSHCN, including supports and services after the child has aged out of EIP. As part of program efforts, staff can see how many referrals EIP makes to CYSHCN Program. CYSHCN staff worked with EIP about referring to the CYSHCN Program. Our data is showing that this is working.

**Early Hearing Detection and Intervention-Information System (EHDI-IS):** This platform allows healthcare professionals to document results and details of newborn hearing screening, follow-up screening, audiological diagnosis, and referral to EIP. EHDI-IS' connection to the NYS Immunization Information System allows NYC and Rest of State VR systems to initiate a child profile so healthcare professionals (e.g., audiologists, EHDI staff at birth hospitals and pediatricians) can review prior results, document new results, and determine the best care for children with hearing loss in a timely manner. Updating code that produces the screening, diagnosis, and referral information allowed the data analyst to produce results more efficiently. Time for monthly data downloads have decreased from 150 to approximately 20 minutes. Over the past year, the EHDI Team came across two system-related challenges – one related to updates sent to the system from NYC VR and the other when merging multiple profiles for the same infant in NYSIIS – that affect the accuracy of EHDI-IS. Both challenges are under discussion with leadership to address and resolve.

**Pregnancy Risk Assessment Monitoring System (PRAMS) Data Linked to NYS Birth Data:** New York State PRAMS (excluding NYC) is combined with NYC PRAMS data each year to create a statewide PRAMS dataset that is used to update the PRAMS Dashboard. The dashboard includes data from 2004-2017 that is presented as single year indicators in charts

and tables as well as ten-year trend charts. Total prevalence as well as demographic breakdowns are available for 64 maternal and child health indicators. The PRAMS dashboard is used by Title V MCHSBG staff for the tracking of various programmatic activities, including oral health care during pregnancy, infant sleep positioning, and breastfeeding practices.

**ii. The role SSDI plays in enabling ongoing Title V program assessment, monitoring and reporting.**

The SSDI PI, the SSDI PRS, and other program research scientists guide the collection and analysis of the data that forms the basis for the Five-Year Needs Assessment and the State Action Plan. Collectively these describe NY's priority needs, key strategies and activities and National Health Status/Outcome Measures (NHS/OMS), National Performance Measures (NPMs), and State Performance Measures (SPMs) and structural and process measures. Staff partners with stakeholders to review and discuss relevant MCH data and recommend structural and process measures used to monitor progress in all MCH population domains.

In 2020, Title V staff guided the development, selection, refinement and/or tracking of data and performance measures that are associated with the MCHSBG priorities for the purpose of ascertaining progress towards achieving reported goals. SSDI and other Title V analytic staff assisted with the coordination of data collection for reporting minimum and core data set elements (M/CDS), NPMs, and SPMs both within and outside the DFH; contributed to ad hoc data analyses; and wrote summaries of data analyses relevant to the MCH population for the MCHSBG Application/Annual Report. These activities support Title V MCHSBG analysis of the NPMs and related structural/process objectives as part of the MCHSBG Application/Annual Report.

Staff are assisting with a plan to improve data linkages across the five-year SSDI funding cycle, particularly focusing on indicators from the Minimum/Core Dataset for Title V MCHSBG programs. In FFY 2018-2022, SSDI staff will implement the plan for overcoming identified barriers. New York State is currently reporting seven of the Core/National Dataset elements and six of the Core/State Dataset (CDS) elements as part of the MCHSBG. In 2021, staff will continue to perform a gap analysis based on amended or added CS elements. Staff will review the CDS gap analysis with Title V and Public Health Information Group (PHIG) and discuss strategies to improve NY's capacity to report additional CDS elements.

**iii. Key SSDI program activities, including any products or resource materials that were developed, which served to support State Title V program efforts**

**NYS Perinatal Quality Collaborative (NYSPQC)**

The SSDI Program Research Scientist is assisting with data collection and analysis for the NYSPQC's Opioid Use Disorder and Neonatal Abstinence Syndrome project with 47 birthing hospitals. This collaborative aims to reduce maternal and neonatal morbidity and mortality through screening, referral, and management of pregnant women and affected newborns.

The NYSPQC conducted the Obstetric Hemorrhage project in collaboration with the American College of Obstetricians and Gynecologists (ACOG) District II, Healthcare Association of New York State, and Greater New York Hospital Association, with support from the National Institute for Children's Health Quality (NICHQ). Eighty-three NYS birthing hospitals from all levels of perinatal regionalization have participated. The project aligns with the national Alliance for Innovation on Maternal Health led by ACOG.

**NYS Safe Sleep IM Collaborative Improvement and Innovation Network (CoIIN)**

Title V MCHSBG staff and 7 community-based organizations (CBOs), i.e. Healthy Start and Maternal and Infant Community Health Collaboratives, participated in the second national Safe Sleep IM CoIIN. Under the leadership of NICHQ, NYS and several other states worked to reduce disparities in infant mortality due to unsafe sleep. Between July 2018 and May 2020, the CBOs provided safe sleep information to caregivers and administered a survey 30-60 days postpartum. Completed surveys were submitted to NYSDOH monthly for quality improvement purposes. Run charts were provided to the organizations to identify areas to focus their tests of change and assess whether the changes they made resulted in improvement.

**Products or Resource Materials:**

- New York State Maternal Mortality Review Report: A Comprehensive Review of the 2014 Cohort
- New York State Department of Health Infant Safe Sleep Toolkit
- Opioids and Neonatal Abstinence Syndrome: Language Matters (pamphlet)
- How to Care for a Baby with Neonatal Abstinence Syndrome (pamphlet)
- Perinatal Substance Use – 5 Ways You Can Improve Care During Pregnancy and Beyond (pamphlet)
- Your Pregnancy and Substance Use – 4 Ways to Get and Stay Healthier (pamphlet)
- ABCs of Safe Sleep Coloring Sheet
- Promoting Safe Sleep Practices in NYS – Information for Action

### III.E.2.b.iii.c. Other MCH Data Capacity Efforts

NY's Title V MCHSBG program relies on a number of robust data and information systems to inform priority setting, monitor health outcomes and disparities, and assess programs and policies. These systems include population-level data (e.g., vital statistics), representative surveys (e.g., Behavioral Risk Factor Surveillance System, Pregnancy Risk Assessment Monitoring System), and program data systems. The various data sources augmented the data provided in the Federally Available Dataset during the Five-Year Needs Assessment to help set priorities and since then have been used monitor progress on improving the objectives and measures in the State Action Plan.

Data and information systems that inform Title V MCHSBG and MCH efforts overall are administered within DFH or are administered by other NYSDOH organizational units and DFH staff maintain strong partnerships and formal data use agreements to access needed data. Within DFH are the following systems:

- Early Hearing Detection and Intervention System (EHDI-IS 2.0) is a front-end web application integrated with the New York State Immunization Information System (NYSIIS) in 2018. It allows hospitals, audiologists and primary care practitioners to document all hearing screening, diagnoses, and referrals to early intervention.
- New York Early Intervention System (NYEIS) is a centralized, web-based system that electronically manages Early Intervention Program (EIP) administrative tasks and provides for the exchange of information among municipalities, EIP providers and State administrators. The system is designed to support the EIP's service delivery, provider approval, financial, administration, and management activities at both the local and state levels by recording all EIP activities, including initial intake, evaluation, eligibility determination, Individualized Family Service Plan development, service provision, collection of third party insurance information (Medicaid and Commercial Insurers) and entry of claims from providers requesting reimbursement for EIP services provided.
- Individual program data systems (e.g., Family Planning Program; Maternal, Infant, and Early Childhood Home Visiting program; School-Based Health Centers; Adolescent Pregnancy Prevention Programs; NYS Perinatal Quality Collaborative) where data particular to each program are collected for program monitoring and evaluation.

The systems outside of DFH that DFH staff access via partnership or formal agreements are:

- Vital Records (VR), two separate systems for NYC and Rest of State (ROS)
  - Core Electronic Birth Certificate (EBC): The Statewide Perinatal Data System (SPDS) is an electronic maternal and newborn data collection system which was established and is currently maintained by NYSDOH with the purpose of improving prenatal, obstetric and newborn care for mothers and infants in NYS. The SPDS was developed to make data available for NYSDOH and hospitals for monitoring and quality improvement. Web-based and modular in design, SPDS includes the Core EBC that captures birth data in hospitals outside of NYC, and the NICU module (see below). The EBC provides near-real-time data for use in vital records birth registration, rapid enrollment of eligible newborns in Medicaid, and maternal/child public health surveillance of hospitals and communities. In addition to meeting National Center for Health Statistics (NCHS) standards for collection of electronic birth data, the Core EBC Module also includes quality improvement (QI) variables.
  - NYS Electronic Death Registration System (EDRS) is a secure web-based system for electronically registering deaths for NYS hospitals, excluding NYC. EDRS simplifies the data collection process and enhances communication between health care providers and medical certifiers, medical examiners/coroners, funeral directors, and local registrars as they work together to register deaths.
  - eVital allows all NYC hospitals to electronically submit birth and death registrations using mobile devices and facial recognition security. The eVital birth module captures the same birth data as the SPDS, using NCHS standards supplemented by the set of QI variables, but does not as yet provide NYC hospitals with access to the same statistical summary reports and data extraction capabilities as are available for upstate hospitals.
- Neonatal Intensive Care Unit (NICU) Module is a module of the SPDS that captures detailed clinical information from all hospitals, including NYC, certified to provide specialty or intensive care to high risk neonates, i.e., those designated as Level II, III or Regional Perinatal Center. The NICU Module captures data for all neonates admitted to

special and intensive care nurseries for longer than four hours, and also includes information on newborns who die in the delivery room, or in transit to or within the neonatal special or intensive care units. Data include demographics for the infant and birthing person and diagnoses and treatments for the infant.

- Statewide Planning and Research Cooperative System (SPARCS) is a comprehensive all payer data reporting system established in 1979. It currently collects patient level detail on patient characteristics, diagnoses and treatments, services, and charges for each hospital inpatient stay and outpatient (ambulatory surgery, emergency department, and outpatient services) visit; and each ambulatory surgery and outpatient services visit to a hospital extension clinic and diagnostic and treatment center licensed to provide ambulatory surgery services.
- All Payor Database (APD) is a comprehensive health claims and clinical database aimed at improving quality of care, efficiency, cost of care and patient satisfaction available in a self-sustainable, non-duplicative, interactive and interoperable manner that ensures safeguards for privacy, confidentiality and security. Currently the APD includes hospital discharge (i.e., SPARCS), VR death data, and Medicaid claims and encounter data. Going forward, VR birth data, commercial claims data, and other public health registries and electronic health records will be integrated.
- Newborn Screening laboratory information management system (LIMS) is maintained by the Wadsworth Laboratory to record bloodspot samples received, demographics, results for the 50 different disorders tested, and follow-up.
- New York State Immunization Information System (NYSIIS) is the system where health care providers report all immunizations administered to persons less than 19 years of age and their immunization histories. It aims 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.
- Statewide Health Information Network for New York (SHIN-NY) facilitates the electronic exchange of clinical information and connects healthcare professionals statewide to improve patient outcomes, reduce unnecessary and avoidable tests and procedures, and lower costs. It ensures access to a patient's electronic medical records wherever and whenever they need it. Health records are not publicly accessible. Only a patient decides who can see their records and may opt out at any time.
- Electronic Clinical Laboratory Reporting System (ECLRS) provides laboratories that serve NYS with a single electronic system for secure and rapid transmission of reportable disease information to NYSDOH, local health departments (LHD), and the New York City Department of Health and Mental Hygiene. It enhances public health surveillance by providing timely reporting; improving completeness and accuracy of reports; and generally facilitating the identification of emergent public health problems by monitoring communicable diseases, lead poisoning, HIV/AIDS, and cancer. ECLRS was particularly critical during the COVID-19 pandemic to record test results; public health law was changed to mandate reporting of SARS-CoV-2.
- LeadWeb is a NYSDOH-maintained system used by LHDs to carry out the required case management and follow-up activities for children with elevated blood lead levels (BLL). All BLL test results for children younger than 18 are reported to LeadWeb by laboratories, and LHDs are notified of new cases identified in their county. LeadWeb also collects information on housing-related hazards and environmental follow-up for each child. LHD staff are required to document when follow-up services are provided for each case, which they input directly into LeadWeb. As such, the system provides a real-time database of blood lead tests and follow-up activities.
- Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing mail/telephone survey of mothers who have recently given birth to a live born infant, designed by the CDC. It collects information from mothers about behaviors and experiences before, during, and after pregnancy that are not available from other data sources. The goal of the PRAMS project is to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity. PRAMS provides state-specific data for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant health.
- Behavioral Risk Factor Surveillance System (BRFSS) is an annual statewide random telephone and cellular surveillance survey designed by the CDC. The survey monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in the population. Data from the BRFSS are useful for planning, initiating, and supporting health promotion and disease prevention programs at the state and federal level,

and monitoring progress toward achieving health objectives for the state and nation. NYS's BRFSS sample is representative of the non-institutionalized civilian adult population, aged 18 years and older.

- The Youth Risk Behavior Survey (YRBS), coordinated by the CDC, monitors students' health risks and behaviors in several categories, including weight and diet, physical activity, injury and violence, tobacco use, alcohol, and other drug use, and sexual behaviors. The YRBS is conducted every two years among a representative group of NY students in grades 9–12. The NYS Center for School Health conducts the YRBS in NYS on behalf of the NYS Education Department.

DFH partnered with NYSDOH's Public Health Information Group to build a MCH Dashboard (<https://www.health.ny.gov/MCHdashboard>), which is comprised of select national and state performance measures related to the NYS's Title V MCHSBG application. It was built to support the assessment of needs, monitor progress towards improving the health of NYS MCH populations, and reducing health disparities. It provides an interactive visual presentation of state and county data and for select measures, socio-demographic data. Where available, the most current data are compared to previous year data to monitor performance at both state and county levels. Trend graphs, tables, maps, and bar charts are available from the state and county homepage dashboard views.

DFH partnered with OQPS to begin building a Perinatal Data Warehouse, which will house linked VR birth and death data and hospital discharge data (i.e., SPARCS) and provide summary reports of priority birthing outcomes to birthing facilities and DFH. The warehouse and its reports will aid the quality improvement efforts of the NYSPQC, with the broader aim of addressing health disparities in birth outcomes, particularly maternal mortality and morbidity. This project is ongoing after being delayed March 2020-February 2021 due to staff reassignment for COVID-19 pandemic response.

### **III.E.2.b.iv. MCH Emergency Planning and Preparedness**

The NYS written Emergency Operations Plan (EOP) is called the Comprehensive Emergency Management Plan (CEMP) and is coordinated by the Office of Emergency Management (OEM) and involves participation from other state agencies, including the NYSDOH and the Office of Children and Family Services (OCFS). The CEMP is reviewed annually.

The NYSDOH written EOP is called the Health Emergency Preparedness and Response Plan (HEPRP) and is coordinated through the NYSDOH Office of Health Emergency Preparedness (OHEP). It includes input from major NYSDOH Programs, including the Center for Community Health and Division of Family Health's Title V MCHSBG Program. The HEPRP is reviewed every three years or as needed after major events or identified changes.

Both the NYS CEMP and the NYSDOH HEPRP includes annexes which specifically look at the needs of the MCH populations. Under the NYS CEMP, NYSDOH participates in the Emergency Support Function (ESF) 6 with OCFS and other human service agencies, and in other ESFs, to identify methods of serving various populations, including the MCH population, when responding to an emergency impacting NYS.

Under the NYSDOH HEPRP, MCH populations are considered as part of overall access and functional needs populations, as well as specifically planned for under the Pediatric Surge annex. This annex focuses on large scale events and the impacts to the healthcare system with large number of pediatric patients.

NYSDOH OHEP staff participate in the ESF meetings where NYSDOH is a member agency and other NYS CEMP meetings, and coordinate with NYSDOH program subject matter experts, including Title V MCHSBG program staff, as needed for specific questions about program area activities or populations which are served to inform State level and Department level emergency response plans, including the CEMP and HEPRP.

Title V MCHSBG program staff, specifically Dr. Marilyn Kacica, who is the Medical Director, was a key expert in providing information and identifying pediatric resources for the HEPRP Pediatric Surge annex.

NYSDOH staff at the state Emergency Operation Center (EOC) or within NYSDOH will review current state or department level plans and current situational assessments at the time of a disaster to modify and develop plans specific to an incident. This includes engagement and coordination with identified program subject matter experts, including Title V MCHSBG program staff, as needed for any MCH planning before or during a disaster.

The NYSDOH Incident Management System (IMS) is a flexible and scalable structure based on the needs of the incident. In an incident where MCH concerns are identified, Title V MCHSBG leadership would be activated within the IMS as a key response group. This activation would include participation on key leadership coordination calls, as well as focused groups dealing with specific aspects of response operations. Title V MCHSBG leadership will also be included for situational awareness on any department wide IMS activations to share information with appropriate program areas and NYSDOH leadership as identified.

Title V program staff helped identify key resources for training as part of the HEPRP Pediatric Surge plan. Additionally, Title V MCHSBG program staff were part of the development group that created the NYSDOH Pediatric and Obstetric Emergency Preparedness Toolkit, a guide for emergency preparedness planning, training and practice, including clinical and operational information for emergencies.



### **III.E.2.b.v. Health Care Delivery System**

#### **III.E.2.b.v.a. Public and Private Partnerships**

Working collaboratively to improve health outcomes for the MCH population in NYS is an essential part of the NYS Title V MCHSBG program. Title V MCHSBG programs and staff engage with a wide range of partners, both internal and external, to collaborate on a range of projects and activities aimed at ensuring the MCH population in NYS has access to high quality health care services. These collaborations are highlighted throughout the Needs Assessment, Title V MCHSBG application and report, and include partnerships with other public health programs, state and local agencies, private sector partnerships, families and consumers. A summary of major partnerships is included in Supporting Document 1.

### **III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)**

As required by HRSA, the NYS Title V MCHSBG program has an active intra-agency agreement with the NYS Title XIX Medicaid program. The NYS Title V program has and continues to be housed within the NYSDOH, as is the NYS Medicaid Program. Operated by the NYS Office of Health Insurance Programs (OHIP) the NYS Medicaid program is part of the larger organizational structure of the NYSDOH along with the NYS Title V MCHSBG program.

Among the many advantages of being part of the same agency, the Title V MCHSBG and OHIP programs have been able to establish a strong relationship designed to enhance the services for the MCH population within NYS. This further enables Title V staff to support the use of OHIP programs and funding whenever possible, ensuring that the Title V MCHSBG program is the payer of last resort. The strong collaborative relationship between these programs is outlined in detail in the attached Intra-Agency Agreement (IAA). In addition to the formal outlined scope of services, OHIP and Title V MCHSBG staff regularly work together on various MCH initiatives, readily share data on MCH populations and outcomes, and collaborate to improve systems of care for NYS residents.

### III.E.2.c State Action Plan Narrative by Domain

#### State Action Plan Introduction

As described in the five-year Needs Assessment summary, New York's state priorities for the current five-year grant cycle were driven by this fundamental question: *how can we be responsive to the themes voiced by families and communities, within the context of the program infrastructure and resources we have, and with consideration for the national priorities and specific performance measures established by HRSA?*

From this question, we endorsed ten crosscutting priorities for NY's Title V State Action Plan. These priorities align directly with the ten crosscutting themes identified from family and community members through the NA process described in our NA summary. In turn, we selected five NPMs and developed two additional SPMs as focal points for action. These NPMs and SPMs align with both the priorities voiced by families and community members, and the capacity and mission of our Title V MCHSBG programs.

This approach continued to develop New York's five-year State Action Plan. The plan is anchored by the 10 broad crosscutting priorities and the seven specific performance measures. The action plan responds to this question: *what strategic public health approaches and specific program activities can New York's Title V program lead or meaningfully support over the next five years to make measurable progress in the specific areas encompassed by these seven performance measures, in ways that are responsive to the crosscutting priorities voiced by families and community members?*

The resulting State Action Plan serves to link the broad, crosscutting priorities identified by families and community members with the specific outcomes encompassed in the selected national and state performance measures. The State Action Plan table presents the strategic public health approaches identified to address each of the national or state performance measures, highlights selected activities and action steps to carry out that strategic approach, and shows how each strategic approach aligns with the crosscutting priorities.

Evidence-based strategy measures (ESMs) were developed for each domain to capture the reach and effectiveness of these strategies for the relevant populations directly served through the Title V MCHSBG program. Specific objectives with measurable improvement targets were developed for each domain to further operationalize the strategies and measures. Wherever possible, these objectives and measures were aligned with the NYS Prevention Agenda to reinforce consistency and synergy with the Title V State Action Plan.

Further detail on specific program and policy activities associated with each of these strategic approaches is described in the narrative by domain below.

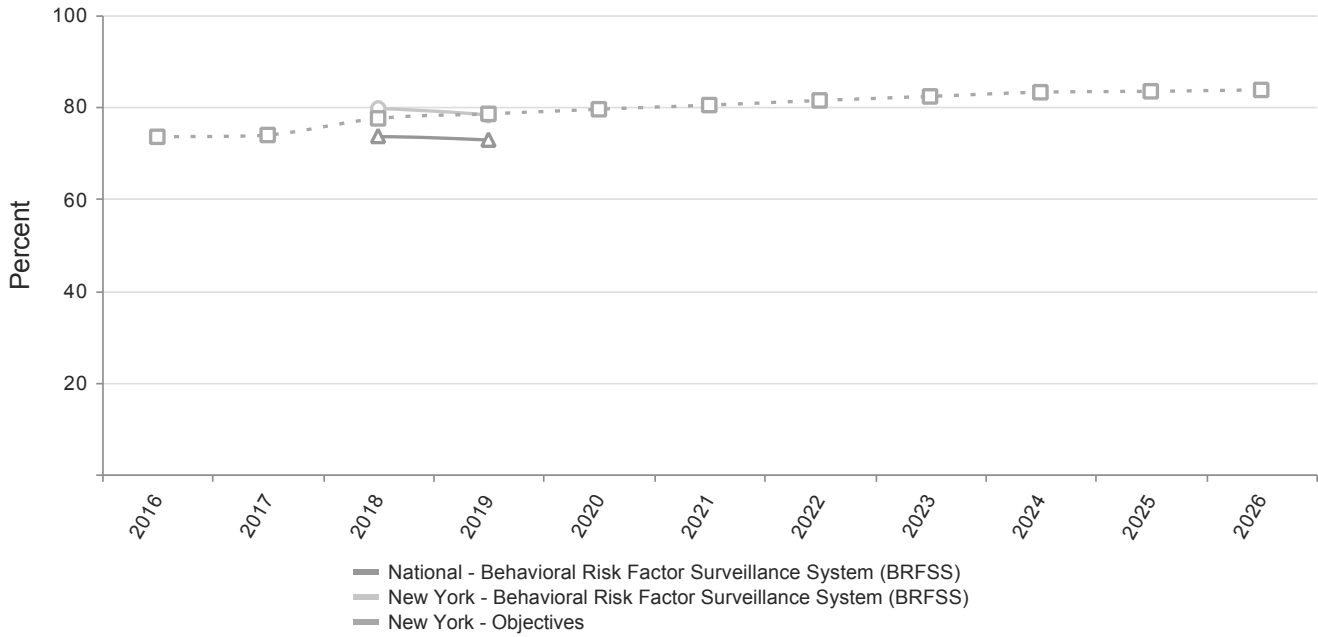
#### Women/Maternal Health

##### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	89.5	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	18.4	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	8.1 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	9.2 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	24.7 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	5.4	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	4.3	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	2.9	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.4	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	141.0	NPM 1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2019	7.8 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	4.4	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	11.2 %	NPM 13.1
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	11.0 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.4 %	NPM 13.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	11.4	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	12.9 %	NPM 1

**National Performance Measures**

**NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year  
Indicators and Annual Objectives**



**Federally Available Data**

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

	2016	2017	2018	2019	2020
Annual Objective					79.4
Annual Indicator				79.6	78.3
Numerator				2,826,660	2,737,695
Denominator				3,550,054	3,498,639
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

**Annual Objectives**

	2021	2022	2023	2024	2025	2026
Annual Objective	80.3	81.3	82.2	83.1	83.3	83.6

**Evidence-Based or –Informed Strategy Measures**

**ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)**

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	52.7	63.4
Numerator		2,068
Denominator		3,260
Data Source	MICHC Program Data	MICHC Program Data
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	55.3	58.1	61.0	64.1	67.3	70.7

**ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year**

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	37.3	39.7
Numerator		
Denominator		
Data Source	Family Planning Program Client Visit Record data	Family Planning Program Client Visit Record data
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	37.5	37.7	37.9	38.2	38.2	38.2

## State Action Plan Table

### State Action Plan Table (New York) - Women/Maternal Health - Entry 1

#### Priority Need

Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities

#### NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

#### Objectives

Objective WMH-1: Increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year by 5%, from 79.6% in 2018 to 84.6% in 2022. (BRFSS)

Objective WMH-2: Reduce the maternal mortality rate by 10%, from 17.8 deaths per 100,000 live births in 2014-2018 to 16 deaths per 100,000 live births in 2018-2022. (NVSS)

Objective WMH-3: Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 5%, from 83.5 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2017 to 79.3 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2021. (HCUP-SID)

Objective WMH-4: Reduce the percent of women who have depressive symptoms after birth by 5%, from 13% in 2017 to 12.4% in 2021. (PRAMS)

#### Strategies

Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care through coordination and linkages across systems of care (hospital to community). Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy WMH-2: Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy WMH-3: Apply public health surveillance and data analysis findings to improve services and systems related to maternal and women’s health care. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women’s health and use of health care across the life course. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.



ESMs	Status
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ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)	Active
--	--------

ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year	Active
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NOMs
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NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

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

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

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

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

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

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

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

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

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

## State Action Plan Table (New York) - Women/Maternal Health - Entry 2

### Priority Need

Acknowledge and address the fundamental challenges faced by families in poverty and near-poverty, including the “working poor” as a result of systemic barriers, including racism.

### NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

### Objectives

Objective WMH-1: Increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year by 5%, from 79.6% in 2018 to 84.6% in 2022. (BRFSS)

Objective WMH-2: Reduce the maternal mortality rate by 10%, from 17.8 deaths per 100,000 live births in 2014-2018 to 16 deaths per 100,000 live births in 2018-2022. (NVSS)

Objective WMH-3: Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 5%, from 83.5 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2017 to 79.3 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2021. (HCUP-SID)

Objective WMH-4: Reduce the percent of women who have depressive symptoms after birth by 5%, from 13% in 2017 to 12.4% in 2021. (PRAMS)

### Strategies

Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care through coordination and linkages across systems of care (hospitals to community). Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy WMH-2: Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy WMH-3: Apply public health surveillance and data analysis findings to improve services and systems related to maternal and women’s health care. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

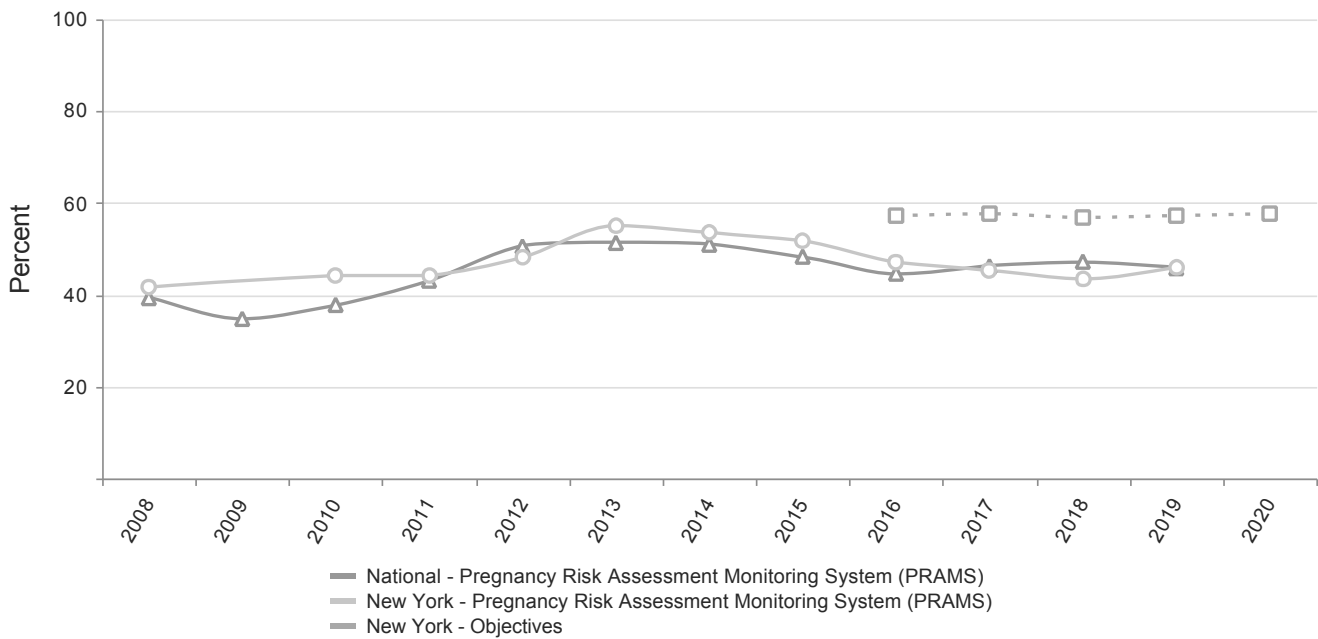
Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women’s health and use of health care across the life course. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

ESMs	Status
ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)	Active
ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year	Active

NOMs
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
NOM 3 - Maternal mortality rate per 100,000 live births
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
NOM 5 - Percent of preterm births (<37 weeks)
NOM 6 - Percent of early term births (37, 38 weeks)
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.2 - Neonatal mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.4 - Preterm-related mortality rate per 100,000 live births
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

**2016-2020: National Performance Measures**

**2016-2020: NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy  
Indicators and Annual Objectives**



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	2017	2018	2019	2020
Annual Objective	57.2	57.6	56.8	57.2	57.6
Annual Indicator	54.9	51.7	45.4	43.3	45.8
Numerator	117,570	110,325	95,006	42,679	90,543
Denominator	214,301	213,585	209,242	98,649	197,781
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2017	2018	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	57.2	57.6	56.8	57.2	57.6
Annual Indicator	53.5	51.7			
Numerator					
Denominator					
Data Source	PRAMS NYS	PRAMS NYS			
Data Source Year	2014	2015			
Provisional or Final ?	Final	Final			

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: ESM 13.1.1 - Percentage of pregnant women served by Title V community health workers that have a documented screening or referral for dental services.**

<b>Measure Status:</b>		<b>Active</b>			
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		10	50	50	50
Annual Indicator	36.7	45.3	56.6	60.5	67.5
Numerator					2,133
Denominator					3,160
Data Source	MICHHC reports	MICHHC reports	MICHHC reports	MICHHC reports	MICHHC reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

**2016-2020: State Performance Measures**

**2016-2020: SPM 1 - The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy**

Measure Status:		Active				
State Provided Data						
	2016	2017	2018	2019	2020	
Annual Objective		45	36.4	37.6	38.2	
Annual Indicator	34.6	35.3	35.3	35.3	43.1	
Numerator						
Denominator						
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS	
Data Source Year	2014	2016	2016	2016	2019	
Provisional or Final ?	Final	Final	Final	Final	Final	

**2016-2020: SPM 2 - The percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception.**

Measure Status:		Active				
State Provided Data						
	2016	2017	2018	2019	2020	
Annual Objective		8	25	25	26.3	
Annual Indicator	27	24.5	55.2	56	49.5	
Numerator						
Denominator						
Data Source	Medicaid Claims	Medicaid Claims	BRFSS	BRFSS	BRFSS	
Data Source Year	2016	2017	2017	2018	2019	
Provisional or Final ?	Final	Final	Final	Final	Final	

**2016-2020: SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water**

<b>Measure Status:</b>		<b>Active</b>				
<b>State Provided Data</b>						
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	
Annual Objective		72	73	75	77	
Annual Indicator	71.7	71.6	70.8	70.8	70.8	
Numerator						
Denominator						
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	
Data Source Year	2017	2018	2017	2017	2017	
Provisional or Final ?	Final	Final	Final	Final	Final	



## **Women/Maternal Health - Annual Report**

### **DOMAIN: WOMEN'S/ MATERNAL HEALTH**

Annual Report for FY19-20 (October 19-September 20)

Women's/Maternal Health – State Priority #1: Reduce maternal mortality and morbidity

The factors impacting women's health are complex and varied, ranging from social-emotional, environmental, health insurance status, access to health care, and any number of other factors including the social determinants of health in which individuals are born, grow, live, play, work, and age. Improving women's health throughout the life course is essential to improving the health and wellness of women. The NYS Title V MCHSBG program promotes and supports a myriad of efforts to improve the health of all women.

Over the past year pursuant to the State Action Plan (SAP), the NYS Title V MCHSBG program continued to focus on improving access to health care, increasing access to the most effective forms of contraceptives, supporting preconception health, promoting whole women's health through the life course, and improving screening and treatment for maternal depression and substance use. Of importance to these efforts is the goal to promote health equity for all New Yorkers, which is emphasized throughout all domains and reflected in the Life Course section of this application.

Maternal mortality and morbidity are critical indicators for maternal and women's health in NYS and therefore a priority in NY's Title V SAP. Understanding factors associated with maternal mortality and morbidity is essential for improving maternal health outcomes. Therefore, a strategy for this domain continues to be a more complete analysis of factors impacting maternal mortality and morbidity. As stated in previous Title V MCHSBG applications, NYS has a history of more than a decade in assessing factors leading to maternal deaths and developing strategies to reduce the risk of maternal mortalities. NY's Title V program led the effort to establish the MMR Initiative in 2010, which is a comprehensive review of all maternal deaths. In the MMR Initiative, the NYSDOH conducts comprehensive surveillance activities based on linked birth and death record data, hospital in-patient and emergency department data and a hospital-based adverse event reporting system to identify maternal deaths.

Recently, the report of maternal deaths for 2012-2014 was published. The findings from this cohort indicated the top six leading causes of pregnancy-related deaths (N=96) was: embolism (not cerebral) (23%), hemorrhage (17%), infection (17%), cardiomyopathy (11%), cardiovascular problems (7%) and hypertensive disorders (6%). This is consistent with the results from 2012-2013 cohort. The expansion of the cohort to include 2014 revealed that Non-Hispanic Black mothers accounted for 45% of pregnancy-related deaths versus 30% for Non-Hispanic White mothers. The majority of pregnancy-related deaths were covered by Medicaid.

Racial disparities in maternal deaths are persistent; the statewide 3-year-rolling Black to White mortality ratio ranged from a high of 4.3 to 1 in 2005-2007 to a low of 3.2 to 1 in 2011-2013, with the most current ratio (2015-2017) falling at 3.3. The most recent data showed small geographic differences. In New York City, the Black to White ratio decreased from 3.4 in 2013-2015 to 3.0 in 2015-2017. This decrease in Black to White ratios was due to a slight increase in the maternal mortality rate among White women and the decrease in the maternal mortality rate among Black women. Outside New York City, the Black to White ratio decreased slightly from 3.9 in 2013-2015 to 3.4 in 2015-2017. This decrease in Black to White ratios was due to a slight but bigger decrease in the maternal mortality rate among Black women than the decrease in the maternal mortality rate among White women.

Recent data from NYS Vital Statistics showed that maternal deaths decreased from 20.2 per 100,000 live births in 2014-2016 to 18.9 per 100,000 live births in 2015-2017, and remained lower than the Prevention Agenda (PA) 2013-2018: New York State's Health Improvement Plan goal to reduce maternal mortality (MM) to fewer than 21 maternal deaths for every 100,000 live births by 2018. By continuing the comprehensive review of factors leading to maternal deaths through the MMR Initiative and designing strategies to address those factors, Title V MCHSBG aims to continue to improve outcomes for birthing people and babies and is expected to meet the Prevention Agenda (PA) 2019-2024: New York State's Health

Improvement Plan goal to decrease maternal mortality (MM) to 16 maternal deaths for every 100,000 live births by 2024. [https://health.ny.gov/prevention/prevention\\_agenda/2019-2024/background.htm](https://health.ny.gov/prevention/prevention_agenda/2019-2024/background.htm)

The reviews of the recent-year cohorts of maternal deaths are underway. The review of all 216 cases in the 2016 cohort and all 214 cases in the 2017 cohort have been completed, and the program is currently working on the MMR report for 2016-2017 cohort. For the 2018 cohort, New York State Department of Health (NYSDOH) and NYC Department of Health and Mental Hygiene (NYCDOHMH) each convened a committee for the review of all maternal deaths of NYS residents aged 10-60 years old who died during pregnancy or within one year from the end of pregnancy. The NYSDOH committee, called the MMRB, reviews all deaths of mothers occurring outside of NYC (i.e. Rest-of-State [ROS] and out-of-State), While the NYCDOHMH committee, called the Maternal Mortality and Morbidity Review Committee (M3RC), reviews all deaths of mothers occurring within NYC.

As of 9/30/2020, NYSDOH identified 121 potentially pregnancy-associated deaths that occurred in ROS in 2018 and reviewed 68 cases; NYCDOHMH identified 48 deaths that occurred in NYC in 2018 and reviewed 22 cases. 2018 cases continued to be reviewed. During the report period, NYSDOH held two MMRB meetings to review the 2018 ROS deaths and NYCDOHMH held five M3RC meetings to review the 2018 NYC deaths.

The reviews of the recent-year cohorts of maternal deaths are underway. All 216 cases in the 2016 cohort and all 214 cases in the 2017 cohort have been completed. For 2018, 45% of the 173 identified cases are complete using the CDC hosted Maternal Mortality Review Information Application (MMRIA) System.

One of the initiatives underway is a Medicaid Doula Pilot. In launching the Doula Pilot, OHIP gathered information for doula programs currently operating in NYS as well as Medicaid doula programs in other states. OHIP considered several data metrics to determine the eligibility areas for the Medicaid pilot including the availability of doulas and volume of Medicaid births and data that showed high maternal and infant mortality. Based on these metrics, OHIP decided to launch the doula pilot in Erie and Kings Counties. Under the pilot, doula services are available for any Medicaid-eligible pregnant woman in fee-for-service or Medicaid Managed Care in these geographic locations. Prior to the launch OHIP hosted several webinars on the pilot including billing coding. Phase 1 of the pilot project began March 1, 2019 in Erie County. Phase 2 of the project will include selected zip codes in Kings County once provider capacity has been achieved. This two-year pilot includes an analysis of data including breastfeeding rates and adherence to postpartum visits. It will also assess doulas' and mothers' experiences and feedback on participation in the program. OHIP has ongoing engagement with stakeholders and has made several adjustments in order to increase participation in the pilot by both pregnant women and doulas.

Another ongoing project included in both the Governor's Maternal Mortality efforts and as a priority in the First 1000 Days on Medicaid initiative is a pilot project to assess feasibility of making the CenteringPregnancy prenatal care model a Medicaid covered benefit. Led by the NYSDOH OHIP, this project focused on studying the impact of CenteringPregnancy on infant health outcomes. NYSDOH engaged the Centering Healthcare Institute (CHI), the agency that developed the Centering Pregnancy model, to help develop tools and project materials to assess the impact of their model in areas of NYS with the poorest birth outcomes. Webinars and ongoing TA have been held for both Managed Care Plans and providers/clinics who will be participating in the project. The pilot's target areas include the five NYC boroughs and ten counties that have been known to have relatively higher rates of poor birth outcomes in NYS. Several Medicaid Managed Care health plans and prenatal care clinics expressed interest and have been engaged in the pilot project. Enrolled sites are working to engage women in the pilot study, both as part of the control and experimental groups. Phase 1 of the project, with those clinics already operating an established Centering Program, began in June 2019. Clinics will continue to serve women, collect data on their participation in CenteringPregnancy, and report information on their birth outcome upon delivery. Phase 2, will expand to include sites just beginning to implement CenteringPregnancy.

To build on NYSDOH's work related to maternal death reviews, the Title V MCHSBG staff is currently implementing an enhanced process for maternal death reviews that was developed in collaboration with ACOG-NY. The goal of these efforts is to address this significant public health issue with not only the population health approach, which includes surveillance and planning on a statewide level, but also provide health care providers and others with information needed to improve and enhance health care standards and practices. Substantial progress was made towards achieving these objectives during

the reporting period. Two staff (one analytical and one programmatic) who support the Maternal Death Review initiative have been deployed full-time to respond to COVID-19 and a third staff (analytical) has been deployed part-time to COVID-19 efforts.

NYS was awarded a five-year CDC Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) grant in August 2019. The purpose of this grant is to support Maternal Mortality Review Committees to prevent maternal deaths. Currently, NYS has two active, multidisciplinary maternal mortality review committees: The NYSDOH MMRB and the NYCDOHMH M3RC. Under this grant, NYSDOH is collaborating with NYCDOHMH to identify and review all pregnancy-associated deaths in NYS. The MMRB reviews all deaths occurring outside of NYC, while the M3RC reviews all deaths occurring within NYC. Both committees are conducting a complete assessment of the causes of death, factors leading to death, preventability, and opportunities for intervention. The data and determinations for both committees will be entered into the statewide CDC central-hosted MMRIA, and the NYSDOH will compile and analyze the statewide data to inform opportunities for intervention and provide recommendations for statewide initiatives.

NYCDOHMH, a NYS subcontractor of the ERASE MM grant, is required to submit the quarterly reports to fulfill the sub-contract requirement. During the reporting period, NYCDOHMH submitted three quarterly reports to NYSDOH. NYCDOHMH reported that they held five M3RC meetings to review 2018 cases, delivered three presentations, and submitted two reports. In March 2020, NYS has successfully submitted the NYS ERASE MM grant Evaluation and Performance Measurement Plan to CDC. In April 2020, NYSDOH submitted the annual performance report for both NYSDOH's MMRB activities and NYCDOHMH's M3RC activities, per ERASE MM grant report requirements. The program also submitted the grant reapplication for Year 2 and received CDC approval.

Legislation to create and empower the NYS MMRB was signed into law on August 1, 2019. In addition to creating, empowering, and protecting the MMRB itself, the legislation included explicit powers and protections for the NYSDOH in its role supporting the MMRB. Title V MCHSBG staff have used this authority to gather case information from more sources than were previously available, which will enable the MMRB to examine the details of these women's lives in order to identify and understand the non-clinical factors that may have contributed to the deaths. A small number of Title V MCHSBG staff have access to the NYS Department of Corrections database that provides information on individuals with incarceration histories. Additionally, a small number of Title V MCHSBG staff have access to the NYS Office of Mental Health Psychiatric Services and Clinical Knowledge Enhancement System that shares HIPAA compliant information about behavioral health services provided in outpatient settings and in state operated psychiatric centers. The MMRB held its second full meeting on September 15, 2020. The MMRB meetings are now being held virtually due to COVID-19. While some Board members have not been able to attend the meetings due to their COVID-19 responsibilities, the attendance has regularly been high overall.

The MMRB's findings on recent trends and issues will be translated into action through collaboration with ACOG-NY and other key stakeholders to develop Issue Briefs, Grand Rounds, and quality improvement projects through the NYSPQC and its partners (e.g., hospital associations, professional associations, regional perinatal centers and affiliate obstetrical hospitals, among others). A statewide maternal mortality report will also be issued to provide data and information that can be broadly used to improve maternal outcomes. The 2014 maternal mortality report is complete and posted on the Department's website: [https://health.ny.gov/community/adults/women/docs/maternal\\_mortality\\_review\\_2014.pdf](https://health.ny.gov/community/adults/women/docs/maternal_mortality_review_2014.pdf)

Due to the prevalence of maternal mortality and morbidity in NYS resulting from maternal hemorrhage, the Title V staff through the NYSPQC is leading the NYS Obstetric Hemorrhage Project, which seeks to reduce mortality and morbidity by improving the assessment, identification and management of obstetric hemorrhage. Title V is collaborating on this project with ACOG-NY, Healthcare Association of NYS (HANYS), and Greater New York Hospital Association (GNYHA), with support from NICHQ. This project began in November 2017, and 67% (80/120) of NYS birthing hospitals are participating. Hospitals document completion of a hemorrhage risk assessment to improve recognition and care based on risk level. The percent of maternity patients with a documented risk assessment for obstetric hemorrhage completed on admission increased by 26.1% during the project period, from 75.5% in March 2018 to 95.2% in September 2020. Documentation of risk assessment for obstetric hemorrhage completed post-partum (between birth and discharge) increased by 88.6% during the

project period, from 41.3% in March 2018 to 77.9% in September 2020. We experienced delays in data submissions from hospitals due to their staff and resources diverted to COVID-19 activities. In some cases, obstetrical services were closed or moved to a different location and no data could be collected by the hospital during that time period.

During the reporting period, NYSPQC staff have spent time responding to the COVID-19 pandemic and specifically providing support to NYS birthing hospital teams. Several staff from the NYSPQC team have been deployed to COVID-19 response activities. Two staff (one analytical and one programmatic) who support the NYSPQC have been deployed full-time to respond to COVID-19 and two additional NYSPQC staff have served part-time as duty officers. Remaining staff have taken on their roles, in addition to their own. Further, NYSPQC staff have assisted in the development of COVID-19 guidance from the NYSDOH related to the MCH population. In December 2020, the Department updated its protocol for COVID-19 testing for Pregnant People and Support Persons. The updated guidance is in the approval process.

In response to the COVID-19 pandemic, in April 2020, the NYS COVID-19 Maternity Taskforce was created. NYS birthing hospital staff who actively participate in the NYSPQC are represented on the Taskforce. Additionally, NYSPQC Executive Director, Marilyn Kacica, MD, MPH, has had an active role as a staff member of the group. The Taskforce issued recommendations to Governor Cuomo related to COVID-19 and maternity care, which Governor Cuomo fully endorsed. One of the six recommendations of the group was for the NYSDOH NYSPQC to host webinars addressing the management of maternity care during the pandemic and one specifically on obstetrical care and implicit bias within the context of the COVID-19.

Six Educational Webinars related to the management of pregnant people during the COVID-19 pandemic were held on March 30, April 20, May 7, May 28, July 13, and December 15, 2020. These events were hosted by the NYSPQC in collaboration with the ACOG District II Safe Motherhood Initiative and featured NYS obstetric leaders sharing their experiences, success and challenges related to treating pregnant and postpartum people during the COVID-19 pandemic. Additionally, NYSPQC staff, in collaboration with colleagues in the NYSDOH Division of Family Health, hosted a webinar focused on Maternal Equity & COVID-19 in June 2020. The webinar featured a panel discussion facilitated by Dr. Joia Crear-Perry, MD, FACOG, Founder and President of the Birth Equity Collaborative and seven panel members from various NYS hospitals, midwifery/doula programs, and community organizations. In addition to the COVID specific webinars, discussions around COVID-19 were integrated into two NYSPQC project Coaching Call webinars.

Staff from the NYSPQC have participated on several national webinars related to COVID-19, and its relation to obstetric and neonatal outcomes. On these webinars, NYSPQC staff and affiliated birthing hospital providers had several opportunities to share their experiences in relation to COVID-19.

During the reporting period, a COVID-19 Resources section was added to the NYSPQC website. The page contains both CDC and NYS specific materials. It also includes links to recordings of all COVID-19 related webinars hosted by the NYSPQC. These materials can be accessed by NYSPQC participating birthing hospitals and the general public. Additionally, NYSPQC team members have been triaging questions from NYS perinatal providers directed to the project's listserv since March.

Title V MCHSBG funding supports the work of the New York State Family Planning Program (FPP), a statewide network of providers that deliver high-quality comprehensive reproductive health services to low-income individuals. The FPP's contracted training and technical assistance center, the New York State Family Planning Training Center (NYFPTC), has provided training to family planning providers to emphasize equity and reinforce reproductive justice principles in the delivery of family planning services. In 2019, the annual NYS Family Planning Program provider meeting featured a keynote address related to exploring unintended pregnancies through a reproductive justice lens. In addition, the NYFPTC conducted a series of in-person regional trainings for family planning providers across the state that focused on developing individual and organizational strategies to mitigate unconscious bias in family planning settings.

NY's Title V MCHSBG also continued to support and promote direct outreach to engage women into health care and promote health insurance enrollment and entry into prenatal care. Through the Maternal and Infant Community Health Collaborative (MICHC) program, Community Health Workers (CHWs) focused on educating women on improved birth

spacing, adherence to the postpartum visit, and use of an effective contraceptive method. In 2019, the MICHC program connected 207 women to health insurance, 79.7% of clients engaged in prenatal care in the first trimester, and 55.2% of postpartum clients attended a postpartum visit and an additional 35.4% had a visit scheduled at the time of reporting. As per the recommendations of the Task Force on Maternal Mortality and Disparate Racial Outcomes, the scope and breadth of work of the MICHC program were enhanced via the CHW Expansion grant. In August 2019, CHW Expansion contracts were awarded to the 23 established MICHC agencies throughout NYS to address key disparities, including providing more childbirth education and support, assisting in the development of collaborative child care and social support networks, assisting with the development of a birth plan and supporting increased health literacy among communities around the state. With these funds, 30 new CHWs were hired statewide to provide services for prenatal and postpartum women.

In response to the COVID-19 pandemic, MICHC agencies were able to maintain CHW services by working remotely. In-person home visits rapidly transitioned to virtual visits, and CHWs continued regular communication with their clients via phone and web-based apps/services (e.g., FaceTime, Zoom, etc), supporting clients in accessing needed services and support networks. Though MICHC staff were able to make this transition to remote services with little delay, the COVID-19 pandemic has had an impact on the scope and volume of virtual visits conducted.

With the transition to remote working, and social distancing practices in place in all communities served by MICHC, community outreach efforts were greatly diminished, resulting in a decrease in the number of overall clients served by MICHC programs. Due to the relative convenience of conducting remote visits, CHWs were able to stay in more frequent contact with existing clients, resulting in almost double the number of contacts with MICHC clients. However, maintaining CHW staffing levels during a pandemic were challenging.

By design and definition, the MICHC program is centered on improving perinatal and infant health outcomes and reducing health disparities in communities that are disproportionately impacted by disparities and is staffed with CHWs that are “indigenous to the communities they serve.” Meaning, oftentimes, CHWs are also disproportionately impacted by these disparities. The COVID-19 pandemic proved no exception, with many MICHC CHWs having to resign from the program due to illness or death in their family, or contracting the virus themselves, or from the stress and exhaustion of balancing the remote schooling of their children and lack of childcare options while maintaining a full client caseload. Given these challenges, MICHC agencies were limited in the number of new CHWs they were able to hire in the CHW Expansion awards. In addition, as response efforts to the pandemic increased, more CHWs and MICHC supervisory staff across the state were diverted to COVID-19 efforts; particularly for those MICHC projects based in local health departments. With staff deployed to activities, such as contact tracing, testing coordination, and call centers, the scope of MICHC services decreased in these areas. Staff working on call centers were able to refer eligible prenatal and postpartum community members for home visiting services. MICHC programs also received increased referrals from public health nursing, as their nursing staff were 100% deployed to the pandemic response.

At the onset of the pandemic, MICHC programs reported an overwhelming need among clients for basic necessities such as food, diapers, toiletries, masks and other PPE, as these items quickly became scarce or increasingly expensive based on supply. To meet these immediate needs, NYSDOH allowed MICHC programs to use a small amount of unobligated funds to purchase emergency supplies for their clients in need. Title V MCHSBG staff also worked with partners in WIC and NYCDOHMH on a statewide effort to distribute emergency supplies to food pantry sites in high-need communities.

Data observations for MICHC in this reporting period include:

- More diverse clients sought MICHC services, with an increase in the percentage of Hispanic and non-Hispanic black clients from 52.4% to 59.2%
- Referrals issued per client increased from 3.4 to 4.6
- Referrals issued for Food Pantry and Clothing/Baby Care Items increased noticeably, largely due to the changing needs of communities impacted by the pandemic
- For prenatal clients, transportation no longer ranked in the top five for needs, presumably due to access to telemedicine and virtual home visiting services. Instead, Family Planning, Family Resource Center and Food Pantry moved up in rank to fall within the top five health care and family and social referrals made
- For postpartum clients, Adult Primary Care and Housing ranked in the top five health care and family and social referrals, replacing Child Primary Care and Home Visiting Services.

To support MICHC program efforts during the pandemic, Title V MCHSBG staff provided MICHC agencies with COVID Maternity guidance documents they developed in support of the NYS COVID Maternity Task Force. (Guidance materials may be found here: <https://coronavirus.health.ny.gov/protecting-public-health-all-new-yorkers#pregnancy-guidelines>)

Evidence-based home visiting programs (Nurse-Family Partnership and Healthy Families New York) also emphasized birth spacing, importance of the postpartum visit, and effective contraceptive usage. In FY2020 (October 1, 2019 – September

30, 2020), 51.8% of clients enrolled in the Maternal, Infant, and Early Child Home Visiting (MIECHV) programs attended a postpartum visit within eight weeks of their delivery.

Another strategy used to engage more women in health care is the promotion of telehealth. In January 2019, Governor Cuomo launched efforts to promote access to rural telehealth services for perinatal care. This initiative includes four components: 1) providing up to \$5 million in capital funds to increase regional perinatal center, rural birthing hospital and private provider access and capacity for perinatal telehealth services; 2) establishing a Perinatal Telehealth Workgroup with national experts including the founders of the successful Arkansas Antenatal and Neonatal Guidelines, Education and Learning System (ANGELS); 3) engaging hospitals participating in the Rural Health Care Access Development Program (RHCADP) to encourage expansion of perinatal telehealth initiatives; and 4) establishing a Project ECHO™ (Extension for Community Healthcare Outcomes) telementoring initiative to engage and enhance obstetric provider skills.

In order to meet the goals of this initiative, Title V MCHSBG staff collaborated with the Office of Primary Care and Health Systems Management (OPCHSM) to integrate the telehealth capital funds into a Statewide Healthcare Transformation Grant.. Additionally, Title V MCHSBG staff have collaborated with the NYSDOH Charles D. Cook Office of Rural Health to provide information and updates for RHCADP participating hospitals.

In May 2019, NYSDOH launched the Rural Perinatal Telehealth Workgroup, which includes representatives from rural birthing hospitals, regional perinatal centers that serve rural communities, rural private practitioners, and representatives from the ACOG-NY, New York State Association of Licensed Midwives, HANYS, Arkansas ANGELS project, and other stakeholders. The first meeting included a presentation from Dr. Curtis Lowery, founder of Arkansas ANGELS, Tina Benton (ANGELS Project Manager), Dr. Thao Doan (Westchester Medical Center Perinatal ECHO Project), and Drs. Heather Brumberg and Edmund LaGamma (Westchester Medical Center RPC).

Finally, in collaboration with OPCHSM, Westchester Medical Center (WMC) launched a pilot Project ECHO™ on perinatal health in June 2019. This pilot project represented only the second perinatal-focused ECHO program in the country since its inception in 2003 by the University of New Mexico Health Sciences Center. The WMC Perinatal ECHO Pilot continued into January 2020 with the following presentations:

- Late Preterm Infants – NOT Just “Small” Babies (October 24, 2019) by Dr. Jordan Kase, MD, FAAP (14 attendees from seven affiliate hospitals and private practices)
- Prevention of Preterm Birth (November 7, 2019) by Dr. Desmond White, MD, MFM, FACOG (12 attendees from nine affiliate hospitals and private practices)
- Perinatal HIV (December 12, 2019) by Dr. Nina Arlievsky, MD (seven attendees from seven affiliate hospitals and private practices); and
- Cell Free DNA Prenatal Testing (January 23, 2020) by Dr. Geetha Rajendran, MD (10 attendees from seven affiliate hospitals and private practices).

In addition to addressing women’s physical and reproductive health, NY’s Title V MCHSBG program is addressing women’s social-emotional health. Perinatal Mood and Anxiety Disorders (PMAD) have a significant impact on mothers and the social-emotional stability of their children and families. NY’s Title V MCHSBG program is committed to addressing the comprehensive needs of women. In 2014, legislation was enacted requiring hospitals to educate patients about PMADs, maternal depression screening, and referrals. The Title V program, in collaboration with the Department’s OPCHSM, notified all obstetric hospitals of this requirement. Staff also researched and updated resources on the NYSDOH web site and continue to regularly review this information to ensure resources are current and applicable. In addition, the Title V MCHSBG program participated in the MOMD project, convened by the CLASP, with tOMH and other key stakeholders to address strategies to improve maternal depression screening and enhance resources for those women experiencing depression. New York’s goal for the MOMD project is to improve the health and well-being of mothers and children by strengthening state and local policies that identify, screen, prevent, refer, and treat maternal depression and other maternal mental disorders. Finally, legislation was passed mandating that, to the extent depression screening is already a covered benefit, insurers must pay regardless of which health care provider performs the screening.

Building upon NYSDOH participation in the MOMD workgroup, Title V MCHSBG and MIECHV staff developed and coordinated a media campaign to improve public awareness and treatment of PMAD and to direct primary care physicians and OB/GYNs to the OMH Project TEACH. NYSDOH worked with OMH staff to create digital and print messages for both the public and provider arms of the campaign. NYSDOH also partnered with the Postpartum Resource Center of New York (PPRCNY), as well as home visiting clients served by the MICHHC, to obtain feedback on draft public messages from those with lived experience with PMAD. The digital public messages directed the public to the NYSDOH PMAD website ([www.health.ny.gov/pmad](http://www.health.ny.gov/pmad)), which was updated to feature gender inclusive language and the phone number for the PPRCNY helpline prominently displayed. Provider messages directed users to the Project TEACH website, where resources on maternal depression, including office hours for consultations with psychiatrists, are posted. The campaign ran from August-November 2020. The public arm of the campaign delivered more than 102 million impressions and delivered approximately 182,000 clicks to the NYSDOH website, with nearly 147,000 new users. The provider arm of the campaign delivered more than 1.7 million impressions which drove over 2,100 clicks to the Project TEACH website. This strategy is measured by ESM MWH-5: Percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care. The Title V MCHSBG program is monitoring this strategy using PRAMS data effective this past grant year. The collaborative project with OHIP originally reported has concluded. According to PRAMS data from 2016, which is the most recent data available for NYS, 81.6% of women on Medicaid report that a doctor, nurse, or other healthcare worker asked at the postpartum check-up if they were feeling down or depressed. This improved slightly to 83.1% in 2018. While a significant percentage of women are being screened, evidence is lacking regarding use of standardized screening tools, and there is room for improvement in percentage of women screened. Additionally, practitioners often identify lack of treatment services as an issue for women who screen positive.

NY's Title V MCHSBG program is committed to continued work to address this significant health issue for mothers and children. Through the Report on the Status of New York Women and Girls, 2018 Outlook, NYS Governor Andrew Cuomo launched efforts to address maternal depression and reduce maternal mortality. The components of the maternal depression efforts include the NYS Department of Financial Services requiring all health insurance policies to include coverage for maternal depression screening; expediting referrals and treatment, including expansion of Project TEACH (NY's model for pediatric psychiatry consultation) to connect primary care providers and obstetricians and gynecologists with mental health specialists; enhanced screening and referrals at WIC clinics; increased access to telepsychiatry for those in rural communities; and a media campaign to increase awareness of and decrease stigma about maternal depression.

Title V MCHSBG staff work with OMH staff in increasing awareness of the expansion of Project TEACH for maternal mental health. WIC has added the Patient Health Questionnaire-2 to the screening questions on enrollment into the program. They have also increased training for WIC staff on maternal depression. The NYSDOH promoted awareness through social media and revised the NYSDOH consumer web pages on maternal depression. Social media kits were sent to local MCH providers for use in their social media efforts.

In addition to the above, NYS initiatives addressing PMADs include First 1000 Days on Medicaid (Dyadic therapy and home visiting proposals), HealthySteps grants, the Early Childhood Comprehensive Systems (ECCS) Impact Grant, and participation in the Moving on Maternal Depression learning collaborative with the Center for Law and Social Policy. The NYS Early Childhood Advisory Council (ECAC) identified early identification, prevention, and intervention for maternal depression as a current priority and convened a workgroup to develop and help advance relevant strategies. ECAC members were active in NYS's First 1000 Days on Medicaid initiative (described elsewhere in this application), advocating for efforts to improve screening and treatment for maternal depression and dyadic therapy. They also are participating in the MOMD learning collaborative discussed below. Title V MCHSBG staff participate in this ongoing workgroup.

Two of the initiatives in the 10-point plan selected under the First 1000 Days on Medicaid initiative (described elsewhere in this application) could positively affect maternal depression. One is for Medicaid to allow providers to bill for the provision of evidence-based parent/caregiver-child therapy (also called dyadic therapy) based solely on the parent/caregiver being

diagnosed with a mood, anxiety, or substance use disorder. The second is statewide home visiting, which would include a pilot in three communities and an identification of common programmatic elements that could be reimbursed through Medicaid funding. The first would allow for treatment of mothers identified as depressed and the second would help identify women through maternal depression screening conducted by home visitors. OHIP worked with OMH and Office of Addiction Services and Support (OASAS) to catalogue existing statewide efforts related to dyadic therapy and researching the provision and payment of the benefit. Currently, OHIP is drafting a Medicaid Update article to clarify this benefit that is planned to be released by Spring 2020. The SCAA Home Visiting Workgroup has been convened and parameters for the work established. Title V MCHSBG staff participate on the leadership team for the workgroup and pilot. To develop the pilot, Title V MCHSBG staff have been involved in the Aligning Early Childhood and Medicaid (AECM) initiative, which provides technical assistance to help design the pilot. The AECM initiative has linked OHIP and Title V MCHSBG staff to other states who have aligned Medicaid and home visiting. The pilot was anticipated to begin in Spring of 2020 but, due to the COVID-19 pandemic, has been delayed until Spring 2021.

In August 2018, NYS was selected to participate in the CLASP 18-month MOMD learning collaborative that aims to advance policies around maternal depression prevention, screening, and treatment. The NYS Team is co-led by OMH and the SCAA and includes members from OMH, NYSDOH, OASAS, American Academy of Pediatrics (AAP), ACOG-NY, Postpartum Resource Center, and the Children's Agenda. Title V MCHSBG staff participate on the core team and on several subcommittees. NYS has five broad goals: 1) leverage and coordinate existing activity around maternal health and mortality and early childhood health and development, to generate action on maternal mental health; 2) meaningfully engage women with lived-experience into policy/advocacy for maternal depression; 3) develop key metrics/data relating to maternal depression; 4) develop an understanding of the scope, options and location of existing services to treat maternal depression; and 5) integrate policies and information across state agencies and partnerships at the community level.

To build on the work that began in June 2018 at the CLASP learning collaborative, Title V MCHSBG staff have participated on regular calls with the core team, as well as the workforce, equity, and data subcommittees. The data subcommittee is committed to developing a matrix that includes data measures on programs throughout NYS. The equity subcommittee worked to set up two equity webinars to gather input on equity that will help inform the in-person workforce meeting as well as other aspects of our work. The workforce subcommittee has worked to develop a continuum of care that highlights preconception, pregnancy, high-risk, and postpartum activities to address maternal depression. This document will help to inform the core group's work on addressing maternal depression in NYS.

Addressing the complex needs of NY's women requires interagency partnerships and collaboration among key stakeholders. The NYS OMH supports 17 HealthySteps programs in pediatric medical practices across the state. The HealthySteps model is an evidence-based pediatric primary care program focused on early child development and effective parenting. A child development professional (HealthySteps Specialist) connects with families during pediatric well child visits as part of the primary care team. The NYS initiative provides full-time HealthySteps Specialists in medical practices to provide screening, including maternal depression, parental protective and risk factors, and social determinants of health. The 17 HealthySteps providers are fully operational, engaging new parents to enroll their infants in the HealthySteps program by 4 months of age. Over 5,000 children and their families were served as of September 30, 2019.

HealthySteps Specialists provide screening to include maternal depression, parental protective and risk factors, and social determinants of health. OMH is conducting an independent evaluation. Sites are tracking the maternal depression screening tools utilized, referrals made and/or approaches to care and report challenges to accessing services when making linkages/referrals to supports and services. The 17 sites have administered over 9,000 maternal depression screens for families enrolled in the program and provided over 3,000 maternal depression related referrals and/or services. Data are being analyzed to determine the positive screen rate and disposition of the positive screens.

Other program components include:

- Team-based well-child visits
- Positive parenting guidance and information



- Screening following a periodicity.
- Adverse Childhood Experiences (ACE)
- Parent Education Groups
- Home Visiting at key developmental times
- Access to support between visits
- Connections to resources
- Care coordination/systems navigation
- Early Literacy Reach Out and Read.

In January of 2018, the OMH HealthySteps sites completed a 12-month Learning Collaborative on Building a Trauma-Informed Practice and Integrating the ACE survey into practices in collaboration with technical assistance and training from Montefiore Medical Group's nationally recognized experts in Trauma Informed Care and Healthy Steps. The sites have completed over 2,300 ACEs surveys.

To further enhance supports and services, the Title V MCHSBG program successfully collaborated on the development of an ECCS Impact grant with the Council on Children and Families (CCF). The grant supports collaborative quality improvement projects in three high need counties (Erie, Niagara and Nassau) to improve maternal depression screening and follow-up as well as developmental screening and follow-up for young children. CCF is working closely with NYSDOH on this grant which was initiated in 2016. With leadership from Dr. Kuo, Associate Professor and Division Chief for General Pediatrics at the University at Buffalo, the Erie/Niagara team organized a learning collaborative and designed a universal referral algorithm and form for families with young children to use in six local pediatric practices to make referrals to Erie County and Niagara County Early Intervention and local community supports. At the other end of the state, under the leadership of Dr. Elizabeth Isakson, the Nassau team has used ECCS activities to support the implementation of Help Me Grow Long Island. Help Me Grow Long Island offers free developmental and social emotional screens and provides free, virtual, ongoing support to families with young children on Long Island who have concerns such as their child's development or behavior, navigating service systems, or locating baby items. In addition, at the state level the ECCS initiative is connected to various technical assistance initiatives and statewide workgroups and committees such as the OHIP's First 1000 Days on Medicaid initiative, the New York Strengthening Infant/Toddler Policies and Practices, the NYS Parenting Education Partnership, and workgroups on the NYS Governor's Early Childhood Advisory Council and the Governor's Child Care Availability Task Force.

In an effort to improve coordination and bi-directional referrals between home visiting programs and local WIC sites, the Title V MCHSBG program collaborated with NYS WIC and OCFS. Title V staff met with OCFS and NYS WIC to determine how best to improve coordination between home visiting programs and local WIC sites and how to improve referrals from local WIC sites to home visiting programs. State WIC indicated that the home visiting referral forms were lengthy and asked for more information about the WIC participant than the WIC staff were willing to share. State-level collaboration led to the creation of a universal referral form for the local WIC sites to use to refer to MICHHC, Nurse-Family Partnership, and Healthy Families New York home visiting programs. In July 2020, Title V MCHSBG and MIECHV staff presented at a quarterly WIC call on home visiting programs and the new universal referral form. Referral data is being reviewed quarterly to determine if the universal referral form is having an impact on referrals to home visiting programs and to assist in determining next steps in efforts to improve collaboration and bi-directional referrals between home visiting programs and local WIC sites.

The Title V MCHSBG program also collaborated with CCF on the Preschool Development Birth through Five (NYSB5) project (\$13.4 million in federal funding for the next three years) to strengthen and build new partnerships, coordinate the NYS early childhood care and education system, improve transitions, expand parent choice and knowledge and promote equity with a focus on vulnerable populations. The grant also seeks to institutionalize parent voice, align and strengthen interdisciplinary professional development, expand access to high quality early care and education programs and identify strategies to maximize and coordinate funding. Title V MCHSBG staff have been collaborating with the CCF on several NYSB5 project activities. To complete the NYSB5 Needs Assessment, OHIP provided data about Medicaid usage for young children and regularly attended the NYSB5 bi-monthly partner meetings. Title V MCHSBG staff participated in the

NYSB5/NYS ECAC Strategic Plan Development over the course of several months. Collaboration with CCF is further strengthened through work with the First 1000 Days on Medicaid Infant Mental Health and Home Visiting Work Groups. The NYSDOH is also included as a partner on the NYSB5 Parent Portal ([www.nysparenting.org](http://www.nysparenting.org)) with links to NYSDOH resources and a searchable chart for NYS home visiting programs. NYSB5 launched a statewide Talking Is Teaching Media Campaign in collaboration with the NYSDOH, OpAD, and the NYS Office of Child and Family Services (OCFS), which translated posters in six languages (Spanish, Russian, Chinese, Haitian-Creole, Korean, Bangladeshi). NYSDOH and CCF also worked closely in the development of a Family Resource Guide to Early Childhood Services – Prenatal through Age Five. The resource includes programs and supports available to families with children 0-5 like home visiting, childcare, early intervention, Head Start, prekindergarten and preschool special education. Title V MCHSBG staff presented at the first annual NYSB5 Technical Assistance Alignment Summit and worked with NYSB5 partners to establish an understanding of the technical assistance resources in NYS and begin discussion around ways to maximize resources, reduce redundancies, address technical assistance gaps and improve effectiveness.

Addressing the opioid epidemic is a public health priority in NYS, mirroring the national experience. In 2014, Governor Cuomo established the Heroin and Opioid Task Force and signed the Combat Heroin Legislation which established a multi-faceted response to the opioid epidemic, with a focus on prevention, harm reduction, treatment, recovery, and law enforcement. In response to the Task Force and legislation, NYSDOH developed an interagency opioid surveillance workgroup that consists of various state agencies and stakeholders with an interest in addressing this public health priority. The workgroup developed a comprehensive [website for opioid-related data in NYS](#) to improve the timeliness of reporting opioid-related data to key stakeholders. This site provides the most recent data (NYS Opioid Annual Report 2019) and trends over time on opioid prevalence, healthcare utilization (emergency department visits, hospitalizations) and mortality at state, regional and county (County Opioid Quarterly Report for NYS) level, where available. The NYSDOH created an interactive Opioid Data Dashboard that is a visual presentation of opioid related indicators tracking fatal and nonfatal opioid overdoses, opioid prescribing, opioid use disorder treatment and the overall opioid overdose burden. Title V MCHSBG staff share the reports and dashboard links, as well as other resources such as webinars and educational materials, with NYSDOH-funded perinatal programs, hospitals involved in perinatal quality improvement efforts for maternal Opioid Use Disorder/Neonatal Abstinence Syndrome and other stakeholders across the state. Access to these data and other resources allows agencies and stakeholders to more easily identify priority areas to target to address the opioid epidemic, help tailor interventions, and show improvements in NYS.

NY's Title V MCHSBG Program is also working collaboratively with state agencies and stakeholders to increase understanding of and develop strategies to address NY's opioid epidemic. Since Spring 2016, Title V MCHSBG staff participated on an interagency work group, led by OASAS, to address pregnant and parenting women with opioid use disorders. OASAS received an in-depth technical assistance grant from the National Center for Substance Abuse and Child Welfare, focused on women with substance use disorders and their substance exposed infants in Onondaga, Warren and Washington counties. This was a two and a half-year pilot (6/2016 – 2/2019) and the core team, which includes Title V MCHSBG staff and agencies in the three pilot counties, aimed to establish universal screening, increase treatment access, develop peer services, and address the Comprehensive Addiction and Recovery Act (CARA) amendment to the Child Abuse Prevention and Treatment Act (CAPTA). As part of the initiative, participating counties assessed how pregnant women who use opioids would negotiate the health care and support systems in their respective counties. They identified areas of disconnect that they are working to improve, e.g., lack of communication between health care providers. NYS OASAS has issued a Local Services Bulletin to its providers with instructions on how to work with pregnant women in relation to Plans of Safe Care. NYS OCFS and NYSDOH Title V MCHSBG staff are collaborating to identify how best to work with hospitals on reporting.

Title V MCHSBG staff in collaboration with other NYSDOH offices, including the OHIP and OQPS staff have been co-leading an analytic project to conduct two studies of maternal opioid use and neonatal abstinence syndrome (NAS). The workgroup met four times during this reporting period to develop consistent methodology on study inclusion and exclusion criteria, exposure definition and categorization, morphine milligram equivalent (MME) calculation and other analytic points. The data analysis planning team, comprised of Title V MCHSBG staff and other state agency representatives, has been addressing

questions and concerns that arise throughout the study period. The studies are on hold indefinitely due to competing needs for analytic resources.

Further, the NYSPQC, in partnership with ACOG-NY, HANYS and GNYHA, and with support from NICHQ, is leading the NYS Opioid Use Disorder (OUD) in Pregnancy & Neonatal Abstinence Syndrome Project. This learning collaborative, which kicked-off in September 2018, was piloted in 17 birthing hospitals, and seeks to identify and manage the care of pregnant people with OUD, and improve the identification, standardization of therapy, and coordination of aftercare of infants with NAS. To date, topic areas of focus have included: verbal screening related to substance use for all pregnant people during the prenatal period and on admission to the birth hospitalization; trauma informed care; improved communication between obstetrics and pediatrics; reducing stigma; training clinical staff on the signs and severity of NAS; improving both pharmacologic and non-pharmacologic care for infants with NAS; Eat Sleep Console as a method of treatment for infants with NAS; considerations for breastfeeding for women who use substances; and linkages to care. The statewide project expansion, originally planned for Spring 2020, was delayed to September 2020 due to COVID-19. The NYSPQC is participating in the national Alliance for Innovation in Maternal Health (AIM) through this initiative.

During the reporting period, the NYSPQC continued participating in the Association of State and Territorial Health Officials (ASTHO) Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) Learning Community. The purpose of the learning community is to provide technical assistance, build capacity, and disseminate strategies and best practices to support program and policy implementation on substance use disorder (SUD) among pregnant and postpartum women and infants prenatally exposed to opioids, including NAS. Agencies and organizations convened as part of this effort include ACOG-NY; HANYS; GNYHA; Northwell Health; NYSDOH OHIP, AIDS Institute, and Office of Drug User Health; OASAS; NICHQ; and Community Health Care Association of New York State (CHCANYS). The overarching goal of the NYS OMNI team, in alignment with the NYS OUD in Pregnancy & NAS Project's goal of increasing the percent of pregnant women screened for SUD with a verbal screening tool, is to train prenatal care hospital staff on standardized screening, develop provider resources for screening and referral, and connect diverse work happening across the state.

In addition, NYSDOH's Growing Up Healthy Hotline (GUHH), NY's Title V 24/7 phone line provides information and referral in English, Spanish and other languages via the AT&T language line. Any New Yorker can call the GUHH for information on a wide range of programs and services and is used in public health media campaigns. From October 1, 2019 to September 30, 2020, GUHH responded to 13,692 calls, which included calls requesting referral and information related to prenatal care, health insurance and Medicaid, and perinatal depression, among other priority MCH needs.

This NYS priority is tracked through NPM #1: Percentage of women with a past year preventive medical visit; data are obtained through Behavioral Risk Factor Surveillance System (BRFSS). In 2018, 79.6% of women interviewed had a past year preventative visit as compared to 78.3% in 2019. This is steady in NYS and exceeds the national measure of 72.8% in 2019. SPM 1: The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy which is also calculated from BRFSS data showed an improvement from 35.3% in 2016 to 43.1% in 2019. This priority is also monitored through SPM 2: The percentage of women age 15-44 years and enrolled in Medicaid using the most effective, or moderately effective methods of contraception, which is calculated using Medicaid claims data, declined from 27% in 2015 to 24.5% in 2016. Due to data access issues, this measure was calculated using more recent BRFSS data similarly finding that values have been declining from 55.2% in 2017 to 49.5% in 2019.

The National Outcome Measures (NOM) that align with this priority are as follows: NOM #2 Percent of delivery or postpartum hospitalizations with an indication of Severe Maternal Morbidity (SMM). NYS exceeds the national measure of 77.5 incidents of SMM per 10,000 delivery hospitalizations as reported in Healthcare Cost and Utilization Project (HCUP) data in 2018. For the same time period, NYS is reported to have 89.5 per 10,000 delivery hospitalizations. For NOM #3 Maternal mortality rate per 100,000 live births, NYS increased from 17.8 deaths per 100,000 live births in 2014-2018 to 18.4 in 2015-2019, which is higher than the national average of 17.8 in 2015-2019. NYS also demonstrates significant success in NOM #7 Percent of non-medically indicated deliveries at 37, 38 weeks gestation among singleton deliveries without pre-

existing condition continued to decline, decreasing from 2.0% in 2015-2016 to 1.0% in 2016-2017, which is lower than the national average of 2.0%. Finally, for NOM #11 The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births, NYS continued to fall below the national average with the NYS rate 4.2 vs the national average 6.4 in 2015.

The application for activities in FY22 (October 1, 2021- September 30, 2022) continues to reflect ongoing efforts to address these priority public health issues to achieve selected targets.

## Women/Maternal Health - Application Year

Application for FY21-22 (October 21-September 22)

For Women's and Maternal Health (WMH), New York's Title V program selected **National Performance Measure (NPM) 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year**. This NPM was selected because it is foundational to women's health throughout the life course, is supported by population health data demonstrating a need for continued improvement, and relates directly to several priorities voiced by women and families through community listening forums, including awareness of community resources, transportation, social support, and health care access and quality. This NPM also aligns directly with the NYS Prevention Agenda goal to increase use of primary and preventive health care services among women of all ages, especially women of reproductive age.

While NPM 1 directly measures annual preventive medical visits, it should be viewed as part of a continuum of primary and preventive care that also includes preconception, reproductive and sexual health, family planning, prenatal, and postpartum care, and that includes a full spectrum of medical, mental and behavioral health, oral health, and other supports and services.

Increasing access to comprehensive, high quality, and equitable health care services has been identified as a key element of efforts to eliminate the striking racial and ethnic disparities in mortality and morbidity outcomes. A recent report ranked New York State (NYS) 23<sup>rd</sup> in the nation for the rate of maternal mortality. While NYS's maternal mortality rate has been declining, racial disparities in maternal deaths are persistent, with maternal deaths 3-4 times more common among Black women compared to White women. Severe maternal morbidity also fundamentally affects the lives of birth persons, newborns, families, and health care provider teams. It can result in prolonged hospital stays, substantial medical costs, higher life-long burden of health problems, physical and emotional stress, and interference with maternal-newborn bonding, and is associated with an increased risk for maternal death. Perinatal depression is among the most common morbidities during pregnancy and postpartum periods, with significant implications for the health and well-being of the entire family. NYS women and families consistently highlighted maternal depression as a challenge requiring more attention and supports.

The following specific objectives were established to align with this performance measure:

**Objective WMH-1:** Increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year by 5%, from 79.6% in 2018 to 83.6% in 2022. (BRFSS)

**Objective WMH-2:** Reduce the maternal mortality rate by 10%, from 17.8 deaths per 100,000 live births in 2014-2018 to 16 deaths per 100,000 live births in 2018-2022. (NVSS)

**Objective WMH-3:** Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 5%, from 83.5 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2017 to 79.3 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2021. (HCUP-SID)

**Objective WMH-4:** Reduce the percent of women who have depressive symptoms after birth by 5%, from 13% in 2017 to 12.4% in 2021 (PRAMS)

Four strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the State Action Plan Table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

**Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care.**

Improving the health of people of child-bearing age requires a life course approach to be most effective. Preventive medical visits are a key opportunity for delivering health education and reinforcing health-promoting behaviors. Preventive visits help to identify chronic conditions, such as hypertension and diabetes, in child-bearing people that could contribute to maternal morbidity and mortality. Family planning and reproductive health visits ensure that people of child-bearing age have access to contraception for prevention of pregnancy, and counseling on reproductive life planning, appropriate birth spacing, and preconception health. Title V programs also provide enabling services, such as social support and referrals/linkages to a wide range of community services, to holistically address health and wellness, including mental health and social determinants of health, for people of child-bearing age. Incorporating specific activities across programs leverages the public health infrastructure and capacity supported through previous and ongoing Title V investments.

Through the Maternal & Infant Community Health Collaboratives (MICHC) program, community health workers (CHWs) conduct basic health and well-being assessments in the prenatal and postpartum periods, using standardized evidence-based and/or validated screening tools, to identify and prioritize needs of the individuals and families served. Assessments are completed at enrollment and updated throughout clients' service periods and individualized care plans are developed based on the needs identified. CHWs receive annual training on how to talk with families about difficult topics like mental health and depression, using a trauma informed care approach, and including how to manage emergency situations. CHWs also connect clients and families to needed services and provide enhanced social support. CHWs help ensure early and consistent participation in preventive and primary health care services, including early prenatal care, particularly for those individuals not engaged in care and other supportive services. CHWs provide health information to increase clients' knowledge and ability to self-advocate and make informed health care decisions, with the goal of helping families achieve optimal health, self-sufficiency, and overall well-being.

MICHC programs coordinate outreach and engagement activities with other home visiting programs serving the same communities including programs supported by New York's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative. MICHC and MIECHV programs coordinate outreach, referral, assessment, and intake processes to find and engage pregnant and parenting families and ensure they are connected with home visiting programs and supportive services responsive to their needs.

The NYS Family Planning Program (FPP) supports 43 Article 28 health facilities (e.g., hospitals and clinics) that operate 156 family planning service sites across the state. Through these service sites, the FPP delivers comprehensive, confidential reproductive health services for low-income, uninsured and underinsured people of reproductive age. Services provided include contraceptive services; preconception planning and counseling services; pregnancy testing and related counseling; preventive services such as basic health screening, screening for sexually transmitted diseases, HIV counseling and testing, breast and cervical cancer screening; and appropriate referrals and health education. Ensuring continued access to these core primary and preventive services is essential.

As reinforced by the community forums, increasing awareness of available resources among both consumers and providers is critical. The use of social media messages can enhance awareness of the state's Growing Up Healthy Hotline service, which in turn provides callers with linkages to local community resources, supports, and services including Supplemental Nutrition Program for Women, Infants and Children (WIC), Medicaid, Family Planning, and prenatal care. Social media and other emerging communication forums online have the potential to reach large and diverse populations. When messages are developed using science-based health messaging, social media can be a communication medium that can educate and influence health decision making.

The NYS Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- **Activity WMH 1.1:** Across all Title V programs, enhance promotion of the NYS Growing Up Healthy Hotline (GUHH) to increase awareness of available community resources, supports, and services including WIC, Medicaid, family

planning, and prenatal care. Title V and MIECHV staff will continue to promote the GUHH through presentations to Title V programs and partners, as well as broadly share the GUHH flyer.

- **Activity WMH 1.2:** As an extension of the Title V-funded Rural Perinatal Telehealth Initiative (1/1/20 – 9/30/21), which supported establishment and expansion of telehealth capacity in five Upstate regions, Title V staff will continue to engage with these providers and other perinatal/neonatal telehealth initiative providers, and support relevant collaborations across the Department to support telehealth initiatives, including the Office of Health Insurance Program's maternity telehealth workgroup.
- **Activity WMH 1.3:** Through the Maternal and Infant Community Health Collaboratives (MICHC) and Maternal Infant and Early Childhood Home Visiting (MIECHV) programs, integrate use of virtual home visiting services to increase acceptance and support of services for hard to reach families. Recent experience suggests that virtual home visits conducted in the context of the response to COVID-19 have helped to maintain communication and allow for essential CHW and home visiting services to continue including providing health information, support and referral and follow-up for preventive and prenatal care visits. As COVID-19 vaccinations become more widely available and accepted in some marginalized communities, we anticipate home visiting programs to slowly transition to modified in-person visits, and continue to use the virtual option as needed to ensure at risk individuals and families continue to receive supportive services.
- **Activity WMH 1.4:** Through the MICHC program, support community health workers (CHWs) to conduct outreach to find and engage high-risk pregnant and postpartum families in consistent, comprehensive preventive and primary care services, including preconception, prenatal, and postpartum care. CHWs will continue to routinely screen clients for health insurance enrollment and health care engagement, assist them in obtaining care if needed, provide ongoing social support and reinforcement for health care utilization, and provide clients with health information and social support to increase knowledge and ability to self-advocate and make informed health care decisions, including assistance to develop birthing and postpartum plans. CHWs will initiate development of a birth plan with all prenatal clients and monitor the number of birth plans initiated through the MICHC data management information system (DMIS). It is anticipated that in fall of 2021, a new five-year competitive request for applications (RFA) will be released. This RFA will include the development of postpartum plans, beginning 10/1/22, that will also be monitored and tracked via the DMIS.
- **Activity WMH 1.5:** Through the FPP, continue to support the delivery of comprehensive, confidential reproductive health services for low-income, uninsured and underinsured women and men of reproductive age. Barriers to accessing reproductive health care will be addressed through implementation of alternatives to traditional in-person visits (such as telehealth) as appropriate and dispensing a 12-month supply of contraceptives. Family Planning Providers will assist uninsured clients in enrolling in the most appropriate health insurance plans including Medicaid, Family Planning Benefit Program (FPBP), and Family Planning Extension Program (FPEP).

**Strategy WMH-2: Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous.**

Coordination between birthing hospitals, community providers, and community-based organizations that provide essential support to birthing persons and their families is critical to maintaining optimal health and well-being and ensuring continuity of care during a key life course period. MICHC programs routinely coordinate with a wide variety of community-based organizations that provide health and social support services to address needs related to both physical and mental health, and social determinants of health, including safe housing, transportation, poverty, nutrition, and other supports. Birthing hospitals in New York State are required to provide similar referral services through support and social services. As noted above, telehealth services have emerged as a promising approach to delivery of clinical care that can be tailored to the needs of each region and community, both urban and rural. Strengthening the connection between the MICHC providers and individual birthing hospitals will ensure that pregnant New Yorkers, including those with high-risk pregnancies and chronic conditions, are connected to the highest quality of birthing services and support services, including timely postpartum care.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- **Activity WMH 2.1:** Coordinate NYSDOH's response to public comments and adopt regulations related to perinatal services in hospitals, as well as the state's regional perinatal network, including midwifery and physician-led birth centers as the first level of care. Following adoption of these regulations, Work with Island Peer Review Organization (IPRO), which has a contract with NYSDOH to support this work, to develop and implement a redesignation survey based on the new regulations. Each birthing hospital will complete the survey of their intended level of care (which may mean hospitals requesting to move up or down a level of care). These surveys will be reviewed, and a portion of the applicants (20% of birth centers, Level 1 and Level 2 birthing hospitals, and all Level 3 and Regional Perinatal Center applicants) will have an on-site visit with IPRO staff and contracted neonatologists and/or maternal-fetal medicine specialists, to verify that the applicant meets the regulatory requirements and can provide appropriate care. Title V staff will also coordinate and support Regional Perinatal Centers (RPC) as they work with their affiliate birthing facilities to meet the new regulatory requirements related to providing referral and support for ancillary services, including mental health, alcohol and substance use treatment, and other services which are not requirements under current regulations.
- **Activity WMH 2.2:** Collaborate with MICHC, MIECHV, WIC, local health and social service programs, midwives, doulas, as well as state and national organizations, such as the American College of Obstetricians and Gynecologists (ACOG), AAP, Society for Maternal-Fetal Medicine, hospital associations and the NYS Association of Licensed Midwives, on messaging and strategies to promote birthing options appropriate for anticipated level of care, and safety of birthing hospitals, especially during health emergencies. Title V staff will:
  - present to MICHC and MIECHV home visiting programs on the Perinatal Regionalization system and on guiding clients to the birthing hospital with the appropriate level of care for their clients.
  - collaborate with state and local stakeholders to distribute COVID-19 messaging as part of the Department's COVID-19 Maternity Care Media Campaign. Messaging will be assessed throughout the current year and funding cycle and will be adapted as necessary to reflect changes in COVID-19 circumstances (vaccine safety for pregnancy, addressing vaccine hesitancy, etc.), which were not part of the 2020-21 campaign.
- **Activity WMH 2.3:** To improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs, Title V staff will assist in connecting MICHCs with their local birthing hospitals and support formal meetings. The NYS Council on Children and Families has created a statewide parent portal (<https://www.nysparenting.org/>) that includes a home visiting program directory by county along with an informational one page flyer ([https://www.ccf.ny.gov/files/7416/1669/0489/HV\\_flier\\_2021v2.pdf](https://www.ccf.ny.gov/files/7416/1669/0489/HV_flier_2021v2.pdf)). These resources will be shared by email via internal list serves with RPC hospitals and their affiliates, with a goal of reaching Obstetricians, Neonatologists and other hospital staff serving high-risk women. To determine the utility of the resources provided, recipients will receive a short follow up survey. MICHC program data will also be monitored to track incoming client referrals from birthing hospitals. Additionally, Title V staff will share promising and best practices from established home visiting-birthing hospital partnerships across the state to encourage collaboration. Title V staff will also collaborate with MICHC, MIECHV, WIC, and OCFS on the WIC Referral Project, the State MIECHV CQI project, to improve bi-directional referrals between local WIC sites and local MICHC and MIECHV home visiting programs.

### **Strategy WMH-3: Apply public health surveillance and data analysis findings to improve services and systems related to maternal and women's health care.**

Data-driven, evidence-based practice is essential to achieving public health goals for the Title V program. Across all Title V programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of Title V-funded programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts



at all levels.

The Title V staff has implemented and will continue a comprehensive review process with the multidisciplinary NYS Maternal Mortality Review Board (MMRB) for the purpose of reviewing maternal deaths and maternal morbidity. During the COVID-19 pandemic, the MMRB has continued to meet virtually about four times per year to enable timely maternal death reviews. NY has an established public health surveillance process in place to identify and review cases of maternal death through multiple sources of public health data and chart reviews. The MMRB will assess the causes of deaths, factors leading to the deaths, and preventability for each maternal death reviewed, and will develop and disseminate strategies to reduce the risk of maternal mortality and morbidity, including risk resulting from racial, economic, or other disparities. Recommendations based on the review of the 2018 maternal death cohort have been scored and ranked by MMRB members and the themes of these recommendations have been presented to the Maternal Mortality and Morbidity Advisory Council (MMMAC). The MMRB recommendations for preventability will be translated into action through collaboration with the MMMAC, ACOG District II of NY (ACOG-NY) and other key stakeholders, including the development of issue briefs, webinars, and quality improvement projects through the New York State Perinatal Quality Collaborative (NYSPQC).

Analysis of NYSPQC project data provided by participating birthing hospitals helps to improve services and systems related to maternal health care. The NYSPQC, in collaboration with ACOG-NY, Healthcare Association of New York State (HANYS), and Greater New York Healthcare Association (GNYHA), and with support from the National Institute for Children's Health Quality (NICHQ), will continue to lead an improvement project focused on opioid use disorder in pregnancy as an important cause of maternal mortality and morbidity.

Based on analysis of qualitative data obtained from 2018 listening sessions that engaged over 200 women statewide, NYSDOH has developed a comprehensive interdisciplinary hospital quality improvement project focused on birth equity and anti-racism. This learning collaborative, which launched in January 2021, has engaged birthing hospital staff from clinical, administrative, and executive levels to analyze hospital policy and procedures that may contribute to bias and develop strategies to improve outcomes. As with all NYSPQC projects, Title V staff will collect and analyze project data.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- **Activity WMH 3.1:** Summarize, share, and discuss findings of the Maternal Mortality Review Board (MMRB) with key partners, including the MMMAC, to inform statewide prevention strategies as described above.
- **Activity WMH 3.2:** Issue a maternal mortality report to provide data and information that can be used to improve maternal outcomes.
- **Activity WMH 3.3:** Identify cases of Severe Maternal Morbidity (SMM) through hospital discharge data, and conduct an analysis using linked birth data and hospital discharge data to define the major causes of maternal morbidity.
- **Activity WMH 3.4:** Through the NYSPQC, continue work with birthing hospital teams participating in the NYS Opioid Use Disorder (OUD) in Pregnancy & NAS Project. This learning collaborative, which kicked-off in September 2018 with 17 pilot site birthing hospitals was expanded in 2020 to include an additional 30 birthing hospitals. The project seeks to identify and manage the care of people with OUD during pregnancy, and improve the identification, standardization of therapy, and coordination of aftercare of infants with NAS. NYS participates in the national Alliance for Innovation on Maternal Health (AIM) through this project.
- **Activity WMH 3.5:** Through the NYSPQC, continue to engage partners to implement a new comprehensive interdisciplinary hospital quality improvement project focused on implicit bias and birth equity (see Strategy WMH-4 below for further detail).

**Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women's health and use of health care across the life course.**

Women's and Maternal Health outcomes are impacted by the social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability, and quality of SDOH. All ten priorities that emerged from community members' input during the needs' assessment revolve around SDOH and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

The NYS Title V program strives to contribute to broad-based efforts to address inequality and social determinants of health. Strategies focus on improving outreach to find and engage high-need women and their families in health insurance and health care; increasing knowledge of available community resources and supports; working with community stakeholders to improve delivery of care and services; the development of supports, opportunities and social norms that promote and facilitate healthy behaviors across the lifespan; involving community members in program implementation and policy; and promoting community engagement and mobilization to proactively address bias and racism and other community and systems-level factors impacting racial and ethnic disparities.

In April 2020, Governor Andrew Cuomo signed into law the Child-Parent Security Act (CSPA), which allowed gestational surrogacy in New York, and outlined the requirements of gestational surrogacy programs (GSP; also known as 'matching programs'), assisted reproductive technology service providers, and ova donation programs (a subset of tissue banks). Regulations were enacted February 5, 2020, and gestational surrogacy programs continue to apply for licensure. The CSPA and GSPs provide opportunities for New Yorkers to start or expand their families when pregnancy and childbirth are not feasible options. The NYSDOH anticipates approximately 30 GSP applications; Title V staff have been and continue to be directly involved in the program, now coordinated through the Office of Primary Care and Health Systems Management (OPCHSM).

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- **Activity WMH 4.1:** Through the MICHC programs, continue to work with diverse community stakeholders including community residents to identify and collaboratively address issues and barriers impacting maternal and infant health outcomes at the community level, including activities to:
  - Actively participate in community advisory boards, consortiums, or coalitions to address issues impacting perinatal and infant health and identify effective strategies for addressing the social determinants impacting those outcomes.
  - Engage and partner with diverse stakeholders from a wide array of community sectors including community residents, grassroots organizations, community-based service organizations, health care providers, local government, local foundations, and local businesses.
  - Work collaboratively to address relevant community issues such as safe housing, availability and accessibility of resources and services (e.g., health care, mental health, substance abuse services, home visiting, family support resources), social norms (e.g. related to use of preventive care services, breastfeeding, or personal health behaviors), and community mobilization to effectively identify and address community problems.
- **Activity WMH 4.2:** Through the MICHC program, continue to provide supports to individual clients and their families to address behavioral social determinants of health outcomes, including specific program activities to:
  - Provide information on available community resources for needs related to housing, food, employment and job training, transportation, and other basic needs.
  - Routinely screen for health insurance enrollment, and assist clients with enrollment as needed, including referral to enrollment Navigators and Community Health Advocates.
  - Conduct screenings using standardized, evidence-based or validated tools for domestic violence, substance

use, smoking, and depression, and make referrals for follow-up as needed. In April 2021, a new data management information system was launched. In the fall of 2021, the Department anticipates releasing a five-year competitive request for proposals for a qualified data vendor to continue and enhance systematic tracking and monitoring of MICHC program data.

- Help families connect and use or enroll in enhanced social support resources and programs including parenting classes, peer support groups, childbirth education and resources to develop birth and postpartum care plans, and breastfeeding education, and directly support clients to develop birth plans.
- Provide professional development support for CHWs to delivery these services, including annual training on how to talk with families about difficult topics like mental health and depression, using a trauma informed care approach, and how to manage emergency situations.
- In fall of 2021, the NYSDOH anticipates releasing a five-year competitive RFA for a MICHC program training and technical assistance provider. Training and technical assistance (TA) will include assessing training needs of funded grantees and providing appropriate TA, developing/conducting web-based and in-person trainings, ensuring competencies of CHWs and supervisors, standardization of best practice strategies, promoting/conduct continuous quality improvement activities, and conducting an annual learning collaborative.
- **Activity WMH 4.3:** Collaborate with partners, including but not limited to:
  - The NYS Office of Children and Family Services (OCFS), Prevent Child Abuse New York, and the SCAA Home Visiting Workgroup to integrate parent engagement and leadership into state level home visiting efforts. Use current and former home visiting program clients who are presently caregivers of young children to provide input on matters of interest to state agency partners and develop professional skills as a result of their participation parent engagement and leadership. Title V and MIECHV staff will share lessons learned with MICHC programs to enhance their community member participation on Community Advisory Boards.
  - Office of Mental Health's Project Teach, ACOG-NY, home visiting programs and other community-based organizations, to address mental health in pregnant and postpartum people by increasing screening and follow-up support.
- **Activity WMH 4.4:** The Title V Program, in collaboration with its NYSPQC, began a comprehensive learning collaborative project, the NYS Birth Equity Improvement Project in 2021 which will continue through 2022. New York State birthing hospitals and centers were invited to join this project, which seeks to assist birthing facilities in identifying how individual and systemic racism impacts birth outcomes at their organizations and taking action to improve both the experience of care and perinatal outcomes for Black birthing people in the communities they serve. Projects will receive training on anti-racism and the impact of bias in perinatal health care, develop a plan to ensure that staff at their respective facilities are fully trained in those same topics, develop new and/or improve existing policies on racism to better meet the needs of their community, and finally ensure they are centering the experience of Black birthing people through the implementation of a Patient Reported Experience Measure (PREM).
- **Activity WMH 4.5:** Support newly enacted gestational surrogacy regulations, including licensure of gestational surrogacy programs and collaborations with the GSPs.
  - The CPSA and associated regulations and guidance support gestational surrogacy for surrogates living in New York State; this includes establishment of a Surrogates' Bill of Rights, clinical screening guidelines for prospective surrogates and intended parent(s), informed consent requirements, voluntary surrogacy and ova donor registries, and conflict of interest requirements for gestational surrogacy providers and assistive reproductive therapy service providers.
  - Applicant GSPs submit required documentation ([https://health.ny.gov/community/pregnancy/surrogacy/program\\_license.htm](https://health.ny.gov/community/pregnancy/surrogacy/program_license.htm)) through the secure NYS Health Commerce System.
  - Completed applications are then reviewed by the Department's Gestational Surrogacy Program (housed within OPCHSM), the Division of Legal Affairs, and Title V Division of Family Health staff to ensure that the legal and regulatory requirements are met, background checks are conducted and appropriate, and there are no

contraindicators that would deny an applicant licensure. DOH-GSP staff communicate with applicants to address any identified deficiencies.

- Approved GSPs receive a certificate of operations and are then legally allowed to serve as a GSP to match and coordinate services for prospective surrogates and intended parents.

The NYS Title V Program established two Evidence-Based Strategy Measures (ESMs) to track the programmatic investments and inputs designed to impact NPM1:

**ESM WMH-1: Percent of MICHC program participants engaged prenatally who have created a birth plan during a visit with a CHW.**

Data for this measure come from monthly reports submitted by local MICHC contractors in the new DMIS. The baseline value for this measure, taken from 6-month program period of 10/1/19-3/31/20, is 52.7%. The program has set an improvement target of 5% annually, to 67.3% of participants by 2024 . (MICHC)

**ESM WMH-2: Percent of Family Planning Program clients with a documented comprehensive medical exam in the past year.**

Data for this measure come from FPP clinic visit record (CVR) data. Current FPP data for program year 2018 shows 37.3% of female FPP clients had a documented comprehensive medical exam. The FPP program has set a five-year improvement target of 2.5%, to 38.2% of clients in 2023.

## Perinatal/Infant Health

### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	5.4	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	4.3	NPM 3 NPM 5
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	2.9	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.4	NPM 5
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	141.0	NPM 3
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	58.3	NPM 5

**National Performance Measures**

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	91	91	93.4	93.7	93
Annual Indicator	92.3	92.7	92.5	91.2	92.2
Numerator				2,782	2,626
Denominator				3,052	2,849
Data Source	NYS VS	NYS VS	NYS VS	NYS VS	NYS VS
Data Source Year	2014	2015	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	92.4	92.6	92.8	93.1	93.4	93.4

**Evidence-Based or –Informed Strategy Measures**

**ESM 3.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards**

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	NYS Data	NYS Data
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	50.0	75.0	100.0	100.0

**State Performance Measures**

**SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection**

Measure Status:		Active	
State Provided Data			
	2019	2020	
Annual Objective			
Annual Indicator	70	68	
Numerator			
Denominator			
Data Source	Newborn Blood Spot data	Newborn Blood Spot data	
Data Source Year	2019	2020	
Provisional or Final ?	Final	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	75.0	77.0	79.0	81.0	85.0	85.0



## State Action Plan Table

### State Action Plan Table (New York) - Perinatal/Infant Health - Entry 1

#### Priority Need

Address transportation barriers for individuals and families.

#### NPM

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

#### Objectives

Objective PIH-1: Increase or maintain the percent of very low birth weight infants born in a hospital with a Level III+ NICU by 2.4%, from the 2017 level of 91.2% to 93.4% by 2021. (NYS Vital Statistics Birth Data)

Objective PIH-2: Decrease the infant mortality rate by 2.6%, from 4.6 deaths per 1,000 live births in 2017 to 4.49 deaths per 1,000 live births in 2021 (NVSS)

#### Strategies

Strategy PIH-1: Integrate specific activities across all relevant Title V programs to promote access to early prenatal care, access to birthing facilities appropriate to one's needs, postpartum care, and infant care. Please see Supporting Document 2 "State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy PIH-2: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals and centers. Please see Supporting Document 2 "State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy PIH-3: Apply public health surveillance and data analysis findings to improve services and systems related to perinatal and infant health care. Please see Supporting Document 2 "State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy PIH-4: Address social determinants identified by community members that impact infant health and use of perinatal and infant health care and support services. Please see Supporting Document 2 "State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

#### ESMs

#### Status

ESM 3.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards

Active

NOMs

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

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

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

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

State Action Plan Table (New York) - Perinatal/Infant Health - Entry 2

Priority Need

Increase awareness of resources and services in the community among families and the providers who serve them.

SPM

SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection

Objectives

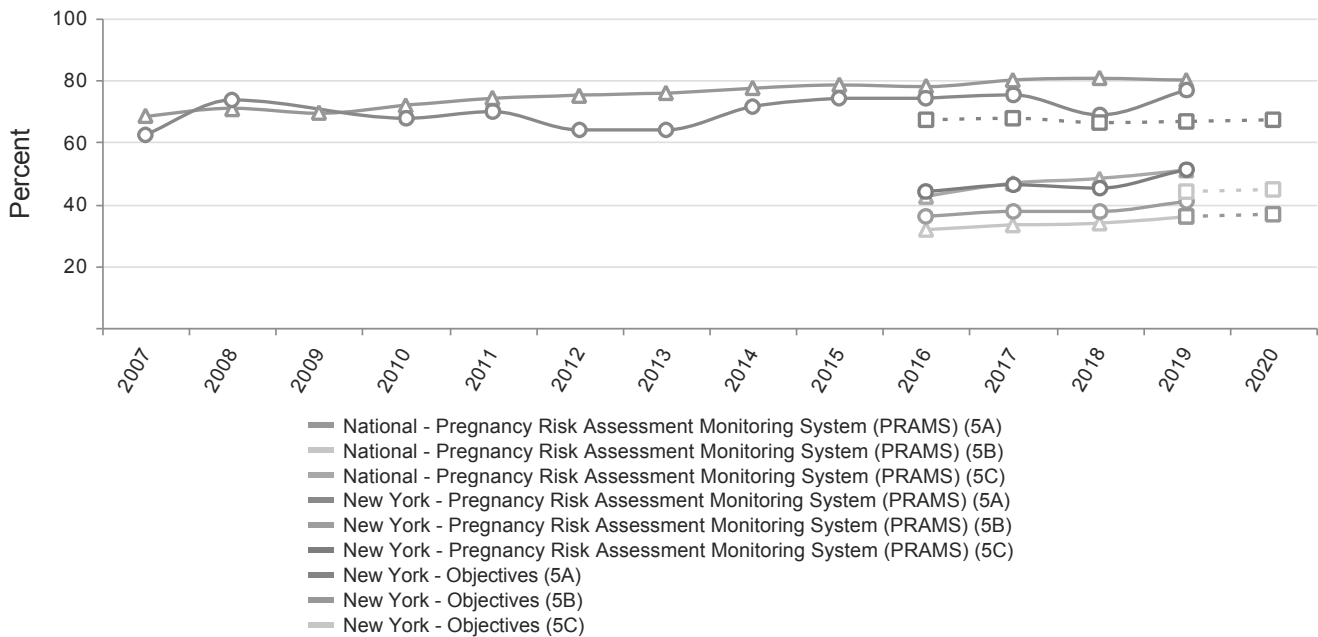
Objective PIH-3: Improve the timeliness of Newborn Blood Spot samples received at the NYSDOH Wadsworth Laboratory from 74.34% to greater than 85% of samples received within 48 hours of collection by September 2023. (Newborn Blood Spot data)

Strategies

Strategy PIH-5: Maintain and strengthen a robust statewide population-based Newborn Screening Program. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

2016-2020: National Performance Measures

2016-2020: NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding  
Indicators and Annual Objectives



2016-2020: NPM 5A - Percent of infants placed to sleep on their backs

**Federally Available Data****Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

	2016	2017	2018	2019	2020
Annual Objective	67.1	67.6	66.2	66.6	67.1
Annual Indicator	63.9	73.9	75.3	68.6	76.5
Numerator	135,686	155,836	152,784	65,253	145,881
Denominator	212,507	210,880	202,843	95,190	190,739
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2017	2018	2019

**State Provided Data**

	2016	2017	2018	2019	2020
Annual Objective	67.1	67.6	66.2	66.6	67.1
Annual Indicator	71.3	73.9			
Numerator					
Denominator					
Data Source	PRAMS NYS	PRAMS NYS			
Data Source Year	2014	2015			
Provisional or Final ?	Provisional	Final			

**2016-2020: NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface**

<b>Federally Available Data</b>			
<b>Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)</b>			
	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		36	36.7
Annual Indicator	37.6	37.4	40.9
Numerator	71,966	32,530	74,016
Denominator	191,278	87,007	181,144
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

<b>State Provided Data</b>				
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective			36	36.7
Annual Indicator	0			
Numerator	0			
Denominator	100			
Data Source	NYS PRAMS			
Data Source Year	2016			
Provisional or Final ?	Provisional			

**2016-2020: NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding**

<b>Federally Available Data</b>			
<b>Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)</b>			
	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		44	44.7
Annual Indicator	46.3	45.2	51.2
Numerator	89,933	39,272	91,951
Denominator	194,052	86,816	179,619
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

<b>State Provided Data</b>				
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective			44	44.7
Annual Indicator	0			
Numerator	0			
Denominator	100			
Data Source	2016			
Data Source Year	2016			
Provisional or Final ?	Provisional			

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: ESM 5.5 - Percent of infants, sleeping or awake-and-unattended in crib, in a safe sleep environment**

Measure Status:	Active			
State Provided Data				
	2017	2018	2019	2020
Annual Objective	90	90	90	90
Annual Indicator	91.7	91.6	91.6	91.6
Numerator		831		
Denominator		907		
Data Source	NYS sampled Birthing Hospitals	NYS sampled Birthing Hospitals	NYS sampled Birthing Hospitals	NYS sampled Birthing Hospitals
Data Source Year	2017	2018	2018	2018
Provisional or Final ?	Final	Final	Final	Final

**2016-2020: State Performance Measures**

**2016-2020: SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water**

<b>Measure Status:</b>		<b>Active</b>			
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		72	73	75	77
Annual Indicator	71.7	71.6	70.8	70.8	70.8
Numerator					
Denominator					
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System
Data Source Year	2017	2018	2017	2017	2017
Provisional or Final ?	Final	Final	Final	Final	Final



## Perinatal/Infant Health - Annual Report

### DOMAIN: PERINATAL/INFANT HEALTH

Annual Report for FY19-20 (October 19-September 20)

Perinatal and Infant Health – State Priority #2: Reduce infant mortality and morbidity.

Addressing factors that lead to infant mortality continues to be at the forefront of all NYS's maternal and child health initiatives. Overall, infant and neonatal mortality rates are declining in NYS and are below the Healthy People (HP) 2020 thresholds. NYS's infant mortality rate was 4.5 per 1,000 live births in 2016, compared with 4.6 per 1,000 births in 2015. The number of infant deaths was 1,045 in 2016, 314 fewer than in 2008. From 2008 to 2016, the infant mortality rate declined 9% for non-Hispanic Whites to 3.45 per 1,000 live births; 28% for non-Hispanic Blacks to 7.85 per 1,000 live births; and 3% for Hispanics to 3.6 per 1,000 live births. Non-Hispanic Asian and Pacific Islanders had the lowest rate in 2016 at 2.87 per 1,000 live births, representing a 13% decrease since 2002 for this group. From 2008 to 2016, the neonatal mortality rate declined by 19% to 3.0 per 1,000 live births, while the post-neonatal mortality rate declined 17% to 1.5 per 1,000 live births.

Despite improvements, striking disparities exist. The ratio of non-Hispanic Black-to-White low birth weight rates was 1.9 in 2016, unchanged from 2015. In 2016, the mortality rate for early term infants (37-38 weeks gestation) was nearly twice the rate of full-term infants (39-40 weeks gestation): 2.32 and 1.31 per 1,000 live births, respectively. The three leading causes of infant death in 2016 were prematurity, congenital malformation, and sudden unexpected infant death (SUID). The NYS Title V program is leading statewide efforts with key stakeholders, agencies, partners, and providers to reduce infant deaths and decrease economic and racial/ethnic disparities in infant mortality rates across NY. Through a variety of focused and collective evidence-based interventions, the NYS Title V program is improving the ability of parents/caregivers to raise healthy infants through several strategies. This State Priority is measured through **NOM #8 Perinatal mortality rate per 1,000 live births plus fetal deaths**. NYS is below the national average at 5.2 per 1,000 live births vs. 6.0 nationally in 2015. NYS is better than the national average based on National Vital Statistics Data for **NOM #9.1 Infant mortality rate per 1,000 live births** at 4.5 vs. 5.9 in 2015. NYS is also lower than the national average for **NOM #9.2 Neonatal mortality rate per 1,000 live births** (3.20 vs. 3.88) and **NOM #9.3 Post-neonatal mortality rate per 1,000 live births** (1.7 vs. 2) and **NOM #9.4 Preterm-related mortality rate per 100,000 live births** (175.9 vs. 200).

In order to address priorities, such as infant mortality, on a state, regional, or local level, it is imperative to access comprehensive data for identification, implementation and evaluation of public health initiatives. The NYS Title V program developed and implemented an expanded plan for analysis and reporting of infant mortality and selected morbidity data. The *New York State Infant Mortality Report*, highlighting collaborations and describing trends in NYS's infant mortality rates between 2002 and 2016, the NYSDOH's plan to reduce infant mortality was developed and placed in the review and approval process. Additional multivariate analysis was requested prior to final approval and release of the report; this additional analysis is underway.

To monitor progress of improving the health of women, infants, and children and reducing health disparities, Title V staff previously collaborated with the NYSDOH Office of Public Health Practice to develop the Maternal and Child Health (MCH) dashboard that is comprised of National Performance and Outcome Measures as well as State Performance Measures and Objectives. The MCH Dashboard, which was described in the previous annual report, includes 50 unique measures related to NYS Title V application. This dashboard was released in September 2018 and continues to be maintained. The dashboard serves as an interactive visual presentation of available national, state and county data (where available) that can be used by a wide group of public and private partners to identify trends and issues and develop strategies for improvement. The most current data are compared to previous year data to monitor performance. The dashboard integrates data from multiple sources, includes State and county-level, socio-economic, race/ethnicity and historic data. The measures are presented visually as trend graphs, bar charts, maps, and tables, and compare change over time and as related to 2020 MCH objectives.

An important factor in improving birth outcomes and reducing infant morbidity and mortality is ensuring access to comprehensive prenatal care. NYS has long supported access to comprehensive prenatal care for all women. Title V staff continued its collaborative efforts with the NYSDOH Office of Health Insurance Programs (OHIP) to ensure quality prenatal care services are available to NY's Medicaid (MA) population. Services are available to women up to 223% of the Federal poverty level (FPL) and undocumented women, using State only funding. Supports are also provided to women to promote healthy behaviors and foster infant development.

The NYS Title V program is home to the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative that strives to improve the health and well-being of high-risk families and reduce racial/ethnic disparities through 19 evidence-based home visiting programs including eight Nurse-Family Partnership (NFP) and 11 Healthy Families New York (HFNY) in ten high-risk counties. NY MIECHV grantees provided services to 3,023 families in the FY20 (10/1/2019 to 9/30/2020) reporting period. The NYS Office of Child and Family Services (OCFS) receives MIECHV funding through a Memorandum of Understanding (MOU) with the NYSDOH to fund Healthy Families programs.

The following items are data on the four constructs within the Maternal and Newborn Health Benchmark related to newborn health.

- 11.5% of infants, born during the reporting period, were born preterm
- 42% of infants, with mothers enrolled prenatally, were breastfeeding at six months of age
- 65% of infants received the last recommended well-child visit during the reporting period
- 38.5% of primary caregivers who reported using tobacco or cigarettes at enrollment were referred to tobacco cessation counseling or services within three months of enrollment.

HRSA requires an 85% filled capacity rate for MIECHV programs. To increase awareness of home visiting in NYS, the MIECHV team worked with NYS Council on Children and Families to develop a new searchable chart that assists families to locate evidence-based home visiting programs in their community. The searchable chart can be found on the NYS CCF Parent Portal at <https://www.nysparenting.org/>.

The NYS MIECHV Program was required to update the statewide needs assessment to determine priority counties, gaps and barriers, and strengths in home visiting services in NYS. To gather community input for both the Title V and MIECHV needs assessments, NYSDOH held a workgroup meeting with representatives of community-based programs and their community member partners to engage them in conducting and reporting on community listening sessions. Community-based partner organizations across NYS facilitated open discussions with families and community members about individual, family, and community health and services. A total of 37 forums were held in 18 NYS counties and in the Akwesasne Territory of the St. Regis Mohawk Tribe, with over 700 community members.

Recognizing the need to promote systems change on the local level to improve communitywide MCH outcomes, the Title V program has continued to fund 23 Maternal and Infant Community Health Collaboratives (MICHC) projects in 32 NY counties, extending their service contracts through September 2021. The MICHC initiative seeks to improve maternal and infant health outcomes for high need, low income or Medicaid-eligible women and their families by supporting the development of multi-dimensional community systems of integrated and coordinated community health programs and services. MICHCs work to improve preconception, prenatal, postpartum, and interconception health of Medicaid-eligible women by working collaboratively with community partners to implement strategies to find and engage Medicaid-eligible women and their families in health insurance, health care and other community services; assess a woman's needs and risk factors and make referrals to appropriate services; coordinate services across community programs; and promote opportunities and supports for women to engage in healthy behaviors. MICHCs utilize Community Health Workers (CHWs) to assist Medicaid-eligible women of reproductive age to effectively access continuous and coordinated health care and other needed community services responsive to their needs and risk factors. On a systems level, MICHC providers work with community partners in the health and social services arena to assess resources, prioritize community needs and strengths, and implement community-level strategies to address the needs identified. In project year 2019-2020, the MICHC program served 3,160 prenatal and postpartum women and their families.

The following outcomes were achieved:

- 79.7% of postpartum clients engaged prenatal care during the 1<sup>st</sup> trimester.
- 55.2% of clients attended a postpartum visit, with an additional 35.4% having a scheduled appointment.
- 1,936 babies were born to MICHC clients in 2019, of which 13.6% were born preterm.
- 65% of postpartum clients initiated breastfeeding.
- 70.6% of clients referred for smoking cessation programs completed the referral.
- 64.5% of clients referred to family planning were completed.
- 67.7% of referrals for child primary care were completed.

Expanding access to CHW services was a top recommendation made by Governor Cuomo's Taskforce on Maternal Mortality and Disparate Racial Outcomes and was a common suggestion for addressing maternal mortality made by

individuals participating in the NYSDOH Maternal Mortality Listening Sessions conducted in Summer, 2018. CHW expansion has been implemented through the MICHC program with funding from the Governor's maternal mortality initiative and has supported 30 new full time CHW positions to provide services to high-need pregnant and postpartum individuals and families. In addition to outreach, referral and home visiting services, CHW expansion allows for providing childbirth education and support, promoting collaborative childcare and social support networks, assisting with the development of birth plans and supporting increased health literacy.

In response to the COVID-19 pandemic, MICHC agencies were able to maintain CHW services by working remotely. In-person home visits rapidly transitioned to virtual visits, and CHWs continued regular communication with their clients via phone and web-based apps/services (e.g., FaceTime, Zoom, etc.), supporting clients in accessing needed services and support networks. Though MICHC staff were able to make this transition to remote services with little delay, the COVID-19 pandemic has had an impact on the scope and volume of virtual visits conducted.

With the transition to remote working and social distancing practices in place in all communities served by MICHC, community outreach efforts were greatly diminished, resulting in a decrease in the number of overall clients served by MICHC programs. Due to the relative convenience of conducting remote visits, CHWs were able to stay in more frequent contact with existing clients, resulting in almost double the number of contacts with MICHC clients. However, maintaining CHW staffing levels during a pandemic were challenging.

By design and definition, the MICHC program is centered on improving perinatal and infant health outcomes and reducing health disparities in communities that are disproportionately impacted by disparities and is staffed with CHWs that are "indigenous to the communities they serve." Meaning, oftentimes, CHWs are also disproportionately impacted by these disparities. The COVID-19 pandemic proved no exception, with many MICHC CHWs having to resign from the program due to illness or death in their family, contracting the virus themselves, or from the stress and exhaustion of balancing the remote schooling of their children and lack of childcare options while maintaining a full client caseload. Given these challenges, MICHC agencies were limited in the number of new CHWs they were able to hire in the aforementioned CHW Expansion awards. In addition, as the need for response efforts to the pandemic increased, more CHWs and MICHC supervisory staff across the state were diverted to COVID-19 efforts, particularly for those MICHC projects based in local health departments. With staff deployed to activities, such as contact tracing, testing coordination, and call centers, the scope of MICHC services decreased in these areas. Staff working on call centers were able to refer eligible prenatal and postpartum community members for home visiting services. MICHC programs also received increased referrals from public health nursing, as their nursing staff were fully deployed to the pandemic response.

At the onset of the pandemic, MICHC programs reported an overwhelming need among clients for basic necessities, such as food, diapers, toiletries, masks, and other PPE, as these items quickly became scarce or increasingly expensive based on supply. To meet these immediate needs, NYSDOH allowed MICHC programs to use a small amount of unobligated funds to purchase emergency supplies for their clients in need. Title V staff also worked with partners in WIC and NYCDOHMH on a statewide effort to distribute emergency supplies to food pantry sites in high-need communities.

Data observations for MICHC in this reporting period include:

- More diverse clients sought MICHC services, with an increase in the percentage of Hispanic and non-Hispanic black clients from 52.4% to 59.2%.
- Referrals issued per client increased from 3.4 to 4.6.
- Referrals issued for food pantry and clothing/baby care items increased noticeably, largely due to the changing needs of communities impacted by the pandemic.
- For prenatal clients, transportation no longer ranked in the top five for needs, presumably due to access to telemedicine and virtual home visiting services. Instead, Family Planning, Family Resource Center and food pantry were the most common needs among the top five reasons for referrals made.
- For postpartum clients, adult primary care and housing were the most common needs among the top five reasons for referrals, which had previously been child primary care and home visiting services referrals.

To support MICHC program efforts during the pandemic, Title V staff provided MICHC agencies with COVID Maternity guidance documents they developed in support of the NYS COVID Maternity Task Force. (Guidance materials may be found here: <https://coronavirus.health.ny.gov/protecting-public-health-all-new-yorkers#pregnancy-guidelines>)

Improving birth outcomes requires greater coordination of referrals and services on the local level. Stakeholders, including pediatricians and home visiting grantees, expressed concerns and confusion about where to enroll women into home visiting, when multiple home visiting programs are operating in close proximity. In addition, the length of enrollment as well as the number of home visits otherwise known as "dosage" has an impact on outcomes. It is important to match families to

home visiting programs that can best meet their needs to maximize the family's ability to stay to dosage and so communities can use all the home visiting programs available.

The Coordinated Intake and Referral System Pilot project ran from 2017 to 2019 with formal technical assistance and training to community teams. In 2019, the community teams had been provided with the tools and training needed to plan and implement a coordinated system in their community. Title V and MIECHV staff remain available for one-on-one training and technical assistance for any community team.

Addressing a public health issue, such as infant mortality, requires coordination of all available resources to address the complex factors leading to infant deaths. MICHC initiatives are located in areas of NYS also served by federal Healthy Start (HS) grantees, namely in Queens, Brooklyn, Staten Island, Harlem, Bronx, and Syracuse; four of the six NY HS grantees are also MICHC grantees. Title V staff meet quarterly with the HS grantees to discuss communication, collaboration, and coordination between the HS, MIECHV, and MICHC programs to maximize existing resources and improve community infrastructure. The calls also served as a means to ensure collaboration with the HS grantees in NYSDOH initiatives, including Medicaid's First 1000 Days and the Infant Mortality CollN. The calls also help Title V staff connect local grantees to local HS efforts, such as the coordinated intake project that the Brooklyn HS program is developing.

The NYS Title V program continues to enhance local systems building efforts through training, technical assistance, data collection and analysis, and quality improvement for NYS Title V funded community-based perinatal and infant programs. Quarterly calls continued and included topics, such as maternal depression, annual data reports, collaborative outreach, and improving referrals.

For the MIECHV continuous quality improvement (CQI) cycle from October 1, 2019 to September 30, 2020, all nineteen MIECHV-funded programs selected CQI projects based on measures for which the agency underperformed relative to state MIECHV benchmarks. To help reduce burden, the programs selected data collection tools and their preferred CQI tools. The most commonly selected measures were behavioral concerns and parent child interaction. NYS MIECHV staff offered technical assistance to programs in the form of webinar presentations and one-on-one calls. The calls are used to check in with local implementation agencies (LIAs) on their progress and problem solve any challenges they may be facing in running their Plan-Do-Study-Act (PDSA) cycles. A few programs indicated that they were unable to provide support for their projects due to COVID-19 related disruptions in service, such as difficulties conducting parent child interaction observations remotely.

NYS MIECHV selected increasing referrals to home visiting programs as the state level CQI project for 2020 and continues to seek and obtain technical assistance for this work from the MIECHV TA provider. Building upon years of work, by our partner OCFS, to increase referrals to HFNY programs by WIC local agencies, NYSDOH MIECHV, OCFS and Title V staff created a simplified, educational referral tool for use by WIC local agencies for each county of the state in which an NFP, HFNY, or MICHC is in operation. The tool was approved for use by NYS WIC, which supported its use over the multitude of referral documents in circulation, in early 2020, with implementation of the tool planned for the Spring. However, due to the COVID-19 public health emergency, implementation was deferred until late July 2020, when it was presented to both state and local WIC staff, and each county's form made available in the NY WIC online library for use. Both quantitative (number of referrals from WIC, number of enrolled clients from WIC) and qualitative (anecdotal reports and survey data from home visiting agencies) from each home visiting program are being collected to drive future changes to the form and its use. Communication and coordination with NYS WIC on this work is ongoing. Data collection and the CQI process will continue into 2021, with technical assistance being supplied by the MIECHV TA provider.

The goals of the Pathways to Success initiative, funded by the federal Office of Population Affairs beginning July 1, 2017 through June 30, 2020, are to strengthen community systems serving pregnant and parenting teens and young adults; improve the health, development, and well-being of young parents and their children; improve young parents' self-sufficiency through educational attainment; and increase awareness of resources available to expectant and parenting teens and young adults. The initiative is focused in New York City based on 2015 NYS Vital Statistics data showing Kings, Bronx and Queens counties with the highest birth rates among females who were between the ages of 15 and 24.

The Pathways to Success grant supports three community colleges (Hostos, LaGuardia and Borough of Manhattan) and a community-based organization (Public Health Solutions) to develop, expand, and sustain supportive communities to help expectant and parenting teens/young adults maintain their health and meet educational or vocational goals. The funded projects collaborate with Title V programs, such as MICHC and MIECHV for home visiting supports and other programs, to strengthen support networks and referral systems for pregnant and parenting teens and young adults in these communities.

Pathways to Success utilizes an Asset and Risk Assessment Tool that assesses the student's financial, social, and educational support, as well as mental health, employment status, housing, food, clothing, health care, transportation, parenting skills, and touches upon developmental assets in all eight categories. All students and community members enrolled in the initiative receive healthcare referrals for prenatal, interconception, and postpartum care, social service referrals to the Special Supplemental Nutrition Program for Women, Infants and Children's program (WIC); local Department of Social Services (DSS); and educational or vocational supports to better ensure academic/career success. The goals of this program align with the Title V priorities including support and enhance adolescent social-emotional development and relationships, increase use of primary and preventive health care services, early identification and support for children's special health care needs, and promote supports and opportunities that foster healthy and safe home and community environment.

The Pathways to Success program ended June 30, 2020 due to a lack of federal funding. From July 1, 2019 to June 30, 2020, the program served 532 expectant and parenting students or community members, developed 29 new partnerships, and made 844 referrals. The most frequently cited needs of the program participants were help obtaining information, resources, or services for child needs; food insecurity; child café resources, referrals and supports; parenting education; and resources; housing assistance; self-sufficiency and other supports; academic/educational supports; and home visitation.

In addition to strong community supports and services, improving birth outcomes necessitates a strong system of perinatal hospital services, ensuring pregnant and postpartum women and newborns receive a comprehensive level of care to meet their needs. Perinatal regionalization is essential to improving the health of pregnant and postpartum women and infants. NYS has achieved long-standing leadership in the field of perinatal regionalization by ensuring pregnant and postpartum women and their newborns receive care from, and deliver at, a perinatal hospital with the appropriate level of expertise. In 2018, 92.2% of very low birth weight (VLBW) infants were delivered at facilities for high-risk deliveries and neonates, well above the Healthy People (HP) 2020 target of 82.5%. NYS's system of regionalized perinatal services includes a hierarchy of four levels of perinatal care provided by the hospitals within a region and led by the Regional Perinatal Center (RPC). The regional systems are led by RPCs capable of providing all services and expertise required by the most acutely sick or at-risk pregnant women and newborns. RPCs provide or coordinate maternal-fetal and newborn transfers of high-risk patients to and from their affiliate hospitals, and are responsible for support, education, consultation, and improvements in the quality of care in the affiliate hospitals within their regions.

Due to the changing landscape of the health care system as well as standards of perinatal care, the NYSDOH is fully supporting efforts to update perinatal hospital standards in NYS. The NYS Title V program has developed a process to update standards for perinatal regionalization in NYS, re-designate all obstetrical hospitals and birthing centers, and develop standard metrics to assess maternal and neonatal outcomes to identify opportunities for quality improvement. This work began in 2017 and is jointly led by the NYSDOH Office of Primary Care and Health Systems Management (OPCHSM), which is responsible for regulatory oversight of hospitals, and is being accomplished in close partnership with key partners, including birthing hospitals, clinicians, hospital associations, professional organizations and other key stakeholders. To ensure standards for the NYS system of regionalized care aligned with current standard of practice, Title V staff began this initiative by researching standards of care for perinatal levels of regionalized care as well as conducting an extensive review of research and literature for evidence-based and promising practice. An expert panel, co-chaired by the Executive Director of American College of Obstetricians and Gynecologists District II of New York (ACOG-NY) and the Associate Commissioner of NYSDOH at the Western Region Office, was then established that consisted of maternal fetal medicine

specialists, obstetricians, and nurses for RPCs, Level III and Level II perinatal hospitals across NYS. In addition, the panel consisted of representatives from the NYSDOH OHIP, NYS Association of Licensed Midwives, Healthcare Association of NYS, Greater NY Hospital Association, Community Healthcare Association of NYS, March of Dimes, NYS Academy of Family Physicians, NYS Nurses Association, and representatives from health plans and the NYS Department of Financial Services. To gain a national perspective, the panel also included a representative from the Association of Women's Health, Obstetric and Neonatal Nurses, and a representative from the ACOG Maternal Care Consensus Panel from the University of North Carolina.

Three meetings of the expert panel were held at which the panel reviewed standards of care and made recommendations to the NYSDOH regarding standards of care for birthing centers, Level I, II, III perinatal hospitals and RPCs. The standards included recommendations for requirements and qualifications of clinical and ancillary staffing, facility requirements and equipment, and laboratory requirements among others. Subcommittees were formed to address several topics, including the role of the RPC, neonatal and maternal subspecialists requirements, behavioral health, patient transfers, volume and acuity standards, and finance. Recommendations have been finalized with subcommittee discussions to address final recommendations regarding subspecialists, volume and acuity standards, and finance. In addition to receiving input from the expert panel, Title V staff held conference calls with lower level birthing hospitals from around the state to ensure their perspective is captured in the recommendations to the standards and in relation to the perinatal system.

The final meeting of the expert panel on May 10, 2018 was an opportunity to review and discuss the proposed recommendations made by the expert panel through the first two in-person meetings and the multiple subcommittees. In 2016, legislation was passed allowing midwifery-led birthing centers in NYS. Regulations related to midwifery-led birthing centers were adopted November 13, 2019. The new standards will include physician-led and midwifery-led birthing centers as the first level of care, followed by Level I through III hospitals, while RPCs represent the highest level of perinatal care. **ESM PIH-2: Percentage of birthing hospitals re-designated with updated standards** was established to evaluate this work. The goal of this important initiative is to strengthen the perinatal regionalized system in NYS to ensure all birthing centers and obstetrical hospitals in NY meet current standards of care, and are affiliated with a strong RPC, so that all pregnant and postpartum patients and newborns receive the best care possible at an appropriate level perinatal hospital.

In response to the COVID-19 pandemic, Governor Andrew Cuomo issued a series of executive orders, including EO 202.25, issued on April 29, 2020. This order suspended sections of Title 10, New York Codes, Rules and Regulations, and allowed the Commissioner to approve and certify temporary birthing sites operated by currently licensed birthing hospitals and birthing centers. This led to the approval of two temporary birthing centers – Jazz Birthing Center (Manhattan), an expansion the existing Brooklyn Birthing Center, and Refuah Health Center, a Federally Qualified Health Center. These two birthing centers expanded access to non-hospital based birthing options during a time when pregnant people in New York State were concerned about exposure to COVID-19. Title V staff are involved in review and approval of all birthing center and birthing hospital applications, along with staff from OPCHSM.

Additionally, the executive order expedited NYSDOH's need to establish an application process for midwifery-led birth centers. These entities had been allowed by public health law, and regulations had been adopted in November 2019. In June 2020, the NYSDOH issued guidance on the certificate of need licensure process for midwifery-led birth centers. While there have not been any approved midwifery birth centers at the time of reporting (there is one application under review), this provides New Yorkers another option for appropriate birthing care.

Title V staff continued efforts to enhance and expand the use of telehealth services for prenatal and postpartum birthing people. This includes ongoing efforts related to a series of efforts announced by Governor Cuomo in January 2019, including providing funding to regional perinatal centers that serve rural communities, and completion of the Westchester Medical Center's Perinatal ECHO pilot program. The COVID-19 pandemic, and its' impact on state resources did negatively impact the NYSDOH's effort to provide up to \$5 million in capital funds to increase regional perinatal center, rural birthing hospital, and private provider access and capacity for perinatal telehealth services. Discussions of how to continue to support healthcare providers in these efforts are ongoing.

The five funded RPCs in the Rural Perinatal Telehealth Initiative (with one-time Title V funding) were also affected by COVID-19. While the increased interest and use of telehealth to provide virtual visits increased exponentially, it also challenged hospital's information technology (IT) departments. These staff were integral to the rural telehealth initiative, and deliverables had to be delayed in order to enhance hospital-wide capacity. All five contractors were in various stages of their plans when COVID-19 impacted the health care system but have been able to restart and continue efforts by late Fall 2020. The Department has issued no-cost time extensions for all projects, acknowledging the need for additional time lost to COVID-19.

Finally, in collaboration with OPCHSM, Westchester Medical Center (WMC) launched a pilot Project ECHO™ (Extension for Community Health Outcomes) on perinatal health in June 2019. This pilot project represented only the second perinatal-focused ECHO program in the country since its' inception in 2003 by the University of New Mexico Health Sciences Center. The WMC Perinatal ECHO Pilot continued into January 2020 with the following presentations:

- Late Preterm Infants – NOT Just “Small” Babies (October 24, 2019) by Dr. Jordan Kase, MD, FAAP (14 attendees from 7 affiliate hospitals and private practices);
- Prevention of Preterm Birth (November 7, 2019) by Dr. Desmond White, MD, MFM, FACOG (12 attendees from 9 affiliate hospitals and private practices);
- Perinatal HIV (December 12, 2019) by Dr. Nina Arlievsky, MD (7 attendees from 7 affiliate hospitals and private practices); and
- Cell Free DNA Prenatal Testing (January 23, 2020) by Dr. Geetha Rakendran, MD (10 attendees from 7 affiliate hospitals and private practices).

To build on NYS's rich system of perinatal care and aim to provide the best and safest care for pregnant and postpartum people and infants, Title V staff leads the New York State Perinatal Quality Collaborative (NYSPQC) initiative through collaboration with RPCs, RPC-affiliate birthing hospitals, perinatal care providers, community-based organizations, NYS hospital associations, the National Institute for Children's Health Quality (NICHQ), and other key stakeholders. The initiative aims to prevent and minimize harm through the translation of evidence-based guidelines to clinical practice. During the reporting period, several initiatives under the scope of the NYSPQC have focused on reducing infant mortality and morbidity including the: New York State Infant Mortality CollIN Community-based Safe Sleep Project, National Action Partnership to Promote Safe Sleep – Innovation and Improvement Network (NAPPSS-IIN), NYSPQC Enteral Nutrition Improvement Project, and NYS Opioid Use Disorder (OUD) in Pregnancy & Neonatal Abstinence Syndrome (NAS) Project.

The NYSPQC has supported birthing hospitals during the COVID-19 pandemic by hosting two webinars on neonatal best practices at which experts shared experiences and answered questions submitted by hospitals. In addition to the COVID-19 specific webinars, discussions around COVID-19 were integrated into two NYSPQC project Coaching Call webinars. Staff from the NYSPQC have participated on several national webinars related to COVID-19, and its relation to obstetric and neonatal outcomes. On these webinars, NYSPQC staff and affiliated birthing hospital providers had several opportunities to share their experiences in relation to COVID-19.

A COVID-19 Resources section was added to the NYSPQC website. The page contains both CDC and NYS specific materials. It also includes links to recordings of all COVID-19 related webinars hosted by the NYSPQC. These materials can be accessed by NYSPQC participating birthing hospitals and the general public. Additionally, NYSPQC team members have been triaging questions from NYS perinatal providers directed to the project's listserv since March.

The NYSDOH developed guidance on the care of the newborn whose birthing parent was suspected or confirmed COVID-19 positive. Additionally, a consumer education FAQ document on breastfeeding and COVID-19 was developed and distributed in April 2020. Additional guidance documentation and consumer education materials were developed and are described in the Women and Maternal Health domain report. These guidance and education materials for birthing hospitals is posted on the Department's website.

NYS also administers a comprehensive Newborn Bloodspot Screening program that collects, analyzes, and reports on newborn specimens for 50 diseases and condition recommended by the American College of Medical Genetics and the March of Dimes. Follow-up is provided through condition specific Specialty Care Centers located throughout NYS with systems in place to better ensure early identification and proper treatment of these infants.

Under the HRSA-led national Infant Mortality CoIIN, the Title V program led a second phase of the NYS Safe Sleep Infant Mortality CoIIN from July 2018 to July 2020, with a focus on community-based organizations (CBOs), to continue to reduce disparities in infant mortality through the promotion of infant safe sleep. Seven pilot sites, including MICHG grantees, participated in the project. The pilot sites administered surveys to caregivers during the postpartum period, 30-60 days after their organization provided the caregiver with safe sleep education. During the reporting period, the project held eight Coaching Call webinars. The webinar topics included breastfeeding and safe sleep, screening and referrals to tobacco cessation services, hazards associated with sitting and carrying devices for infants, recent safe sleep literature, bereavement, and team learning and sharing regarding improvement activities.

To support the pilot sites' efforts, the Title V program provided Sleeping Safely Starter Kits and safe infant sleep clothing (sleep sacks) to each participating pilot site during the reporting period. One program staff person who supported the CoIIN has been deployed full time to support COVID-19 activities. The last months of data collection were impacted by CBOs' inability to meet with clients and collect surveys due to COVID-19.

Additionally, Title V continued to increase awareness and collaboration for stakeholders on one of the leading causes of infant mortality in NY, Sudden Unexpected Infant Death (SUID). The NY Infant Mortality CoIIN develops key projects in partnership with the child welfare system including the NYS OCFS, NYS Office of Addiction Services and Supports (OASAS), and the NYSDOH Division of Nutrition's (DON), and Special Supplemental Nutritional Program for Women, Infants and Children (WIC) clinics. During the reporting period, the Title V program worked to implement the Governor's directive that the NYSDOH and the NY OCFS continue their work on an infant safe sleep public awareness media campaign, expand outreach to medical providers, engage community-based organizations (CBOs) by promoting staff education tools, and distributing Safe Sleep Kits to 10,000 caregivers. The kits include sleep sacks, safe sleep literature, and NYSDOH educational materials. In August 2019, NY passed legislation expanding infant safety measures, including a ban on the sale of crib bumper pads.

In 2019, the NYSDOH updated and expanded translations of the patient education materials highlighting the ABCs (Alone, Back, Crib) of safe sleep available at no cost to the public. These safe sleep materials include a brochure available in the thirteen most commonly spoken languages in NYS (six translations were added in 2019), mirror clings, magnets, posters in English and Spanish, crib cards, and a one-minute video in English and Spanish made available on the NYSDOH YouTube channel. The NYSDOH also adapted an anatomical diagram originally created by National Institutes of Health (NIH) to provide patient education on the importance of putting a baby to sleep on his/her back while addressing the concern parents have regarding the potential for babies choking while they are on their backs. The anatomical diagram was translated into six additional languages in 2019 for a total of thirteen languages available; these were laminated and made available to all NYS birthing hospitals and stakeholder organizations.

During the reporting period, the NYSDOH, in collaboration with Title V staff, developed a safe sleep campaign to promote the ABCs of safe sleep and a new message: Baby should sleep in a smoke-free home. NYSDOH created three 10-15 second videos for the campaign and a new safe sleep poster in English and Spanish, all of which featured the new message. The videos were created to run on Facebook and Instagram, reaching women ages 16+, grandparents and caregivers. The out-of-home and social media campaigns were launched on November 4, 2019 and ran through January 2020. For the out-of-home print campaign, NYSDOH targeted NYS counties with the highest infant mortality burden with bus shelter ads and posters in convenience stores and bodegas. Additionally, Title V staff updated the Department's safe sleep website ([www.health.ny.gov/safesleep](http://www.health.ny.gov/safesleep)) to include information about tobacco cessation and the updated patient education materials.

The Title V team, in collaboration with NICHQ, released the electronic NYSDOH Safe Sleep Toolkit in September 2020 (<https://www.health.ny.gov/diseases/conditions/safesleep/docs/toolkit.pdf>), which features change ideas, presentations, materials, tools, references and key insights from hospitals and community-based organizations that are working to improve infant safe sleep practices. The target audience is public health and health care professionals.



Title V staff are collaborating with the National Action Partnership to Promote Safe Sleep – Innovation and Improvement Network (NAPPSS-IIN). NAPPSS is an initiative to make infant safe sleep and breastfeeding the national norm by aligning stakeholders to test safety bundles in multiple care settings to improve the likelihood that infant caregivers and families receive consistent, evidence-based instruction about safe sleep and breastfeeding. In 2019, the project, which is funded by HRSA's Maternal and Child Health Bureau (MCHB), expanded from five pilot site hospitals in five states, including NYS, to twenty hospitals in ten states. NYS's representative hospitals during the reporting year included New York Presbyterian (NYP) Lawrence (Westchester), Montefiore Medical Center – Wakefield Division (Bronx) and Crouse Hospital (Onondaga). The Title V team will continue to participate in and hold conference calls with statewide and national safe sleep and breastfeeding stakeholders to disseminate, spread and scale best practices to improve safe sleep practices, breastfeeding rates, and reduce disparities in both areas.

NYS's efforts related to safe sleep are measured by **NOM #9.5 Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births**. NY is far below the national average at 58.3 vs. 91.2 nationally as reported in 2017, which demonstrates the efforts NY has made to reduce the incidence of SUID.

The NYSPQC initiative also focused on an Enteral Nutrition Improvement Project that aimed to reduce the percentage of newborns born prior to 31 weeks' gestational age discharged from a Neonatal Intensive Care Unit (NICU) below the 10<sup>th</sup> percentile on the Fenton Growth Scales. Outcome, process, and balancing measures were calculated for infants born prior to 31 weeks' gestation, admitted within 48 hours of birth to a NICU, and discharged alive. Key measures were the percentage below the 10<sup>th</sup> percentile for discharge weight, difference in Z-scores for birth and discharge weights, incidences of comorbidities nosocomial sepsis and necrotizing enterocolitis, post-menstrual age at discharge (days), and median initial length of stay (days).

With efforts and results shared through monthly Coaching Calls, quarterly performance measure data reports, and yearly Learning Sessions, all NYS RPCs began participation in 2010 and an additional 20 Level III facilities joined the project in 2016. Throughout the project, RPCs exhibited longer lengths of stay, higher percentages of breastmilk feeding, and higher rates of growth restriction at discharge, which may reflect greater clinical severity of their patients as well as the breastmilk paradox, where breastmilk fed babies grow more slowly. The initiative appears to have significantly improved growth, as measured by a sustained decrease in the percentage of infants weighing below the 10th percentile at discharge, with the rate among RPCs dipping significantly below the baseline and nearing the lower rate reached by the Level IIIs. There were no significant changes in the incidences of comorbidities or in discharges above the 75<sup>th</sup> percentile for weight, further substantiating that the interventions were safe. The goal of reducing baseline percentages by 10% was exceeded; for RPCs change was from 32.6% to 29.3%, and for Level IIIs change was from 30.8% to 27.7%. This project has ended. An in-person closing Learning Session was planned for March 2020, but due to COVID-19 was delayed to a virtual event in June 2020. We estimate that over 370 additional babies were discharged above the 10th percentile for weight, and more than 750 babies received exclusive breast milk at their first full feedings because of the initiative's efforts, and therefore conclude that our project was highly successful overall.

The NYSPQC Project Team has conferred with the Vermont Oxford Network (VON) and California Perinatal Quality Care Collaborative (CPQCC) and hosted an onsite meeting with the NYSPQC's Neonatal Clinical Expert Work Group, NICHQ, and Joseph Shulman, MD, from California's DOH for an in-depth review of an additional QI project relevant to high-risk neonatal populations. This meeting took place in January 2020. Topics under consideration include the "Golden Hour," i.e., appropriate fetal and newborn interventions at the time of and immediately after delivery; antibiotic stewardship in the NICU; transition in care, including from NICU to home; and health equity/family-centered care.

Further, the NYSPQC, in partnership with ACOG-NY, Healthcare Association of NYS (HANYS) and the Greater New York Healthcare Association (GNYHA), and with support from NICHQ, is leading the NYS OUD in Pregnancy & NAS Project. This learning collaborative, which kicked-off in September 2018 at 17 pilot site birthing hospitals, seeks to identify and manage the care of pregnant people with OUD, and improve the identification, standardization of therapy, and

coordination of aftercare of infants with NAS. To date, topic areas of focus have included verbal screening related to substance use for all pregnant people during the prenatal period and on admission to the birth hospitalization, trauma informed care, improved communication between obstetrics and pediatrics, reducing stigma, training clinical staff on the signs and severity of NAS, improving both pharmacologic and non-pharmacologic care for infants with NAS, Eat Sleep Console as a method of treatment for infants with NAS, considerations for breastfeeding for women who use substances, and linkages to care. A statewide project expansion was planned for Spring 2020 and due to COVID-19 was delayed to September 2020. The NYSPQC is participating in the National Alliance for Innovation in Maternal Health (AIM) through this initiative.

During the reporting period, the NYSPQC continued participating in the Association of State and Territorial Health Officials (ASTHO) Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) Learning Community. The purpose of the learning community is to provide technical assistance, build capacity, and disseminate strategies and best practices to support program and policy implementation on substance use disorder (SUD) among pregnant and postpartum women and infants prenatally exposed to opioids, including NAS. Agencies and organizations convened as part of this effort include ACOG-NY; HANYS; GNYHA; Northwell Health; NYSDOH OHIP, Office of Drug User Health, and AIDS Institute; NYS OASAS; NICHQ; and Community Health Care Association of New York State (CHCANYS). The overarching goal of the NYS OMNI team, in alignment with the NYS OUD in Pregnancy & NAS Project's goal of increasing the percent of pregnant women screened for SUD with a verbal screening tool, is to train prenatal care hospital staff on standardized screening, develop provider resources for screening and referral, and connect diverse work happening across the state.

NYSDOH is reinvesting federal savings generated by the Medicaid Redesign Team (MRT) reforms into the Delivery System Reform Incentive Payment Program (DSRIP) to promote community-level collaborations on system reform with a goal of 25% reduction in avoidable hospital use over five years. Safety net providers (Preferred Provider Systems, PPS) are program leads and are required to collaborate to implement innovative community projects in three domains: 1) system transformation, 2) clinical improvement, and 3) population health improvement.

One DSRIP project involved a state funded MICHC program Mothers and Babies Perinatal Network in Binghamton, NY, who implemented the Care Transitions Model for newly delivered Moms and Babies by aiming to improve pregnancy and birth outcomes for every woman, infant, and family. Mothers and Babies Perinatal Network and UHS Hospitals collaborated to improve post-discharge results for mothers and newborns with Medicaid coverage. Participating in the Care Transitions project, Mothers and Babies Perinatal Network partnered with two local hospitals to deploy Health Coach services to over 500 new mothers, providing face-to-face visits and follow-up phone calls during the 30-day post maternity discharge. Mothers and Babies and UHS presented the results from their collaborative approach at a Care Compass Network Stakeholders Meeting. The presentation can be seen on YouTube by following this link: <https://www.youtube.com/watch?v=c4fTXeb1p6I>. The outcome goals were parental/family practice of safe sleep strategies for infants, identify and refer post-partum women for perinatal mood disorders/post-partum depression.

The project found:

- Safe Sleep for Babies Education: 100% all moms receiving a home visiting and 30-day follow-up (including safe sleep)
  - Identification of families with no crib – provision of pack n play
- Depression/mental health screen: provision of PHQ-9 survey. 559 completed (10/1/18 – 9/12/19)
  - 24 (4%) scored 10 or more/100% referred
- 90-day phone follow up
  - 1/1/19 – 6/30/19: 134 calls made; 58 completed (43%)
  - 100% following the safe sleep guidelines
  - 0 re-hospitalizations of moms
  - 3 re-hospitalizations for babies (all medically necessary)

Another DSRIP project involves two NFPs – one in Chautauqua county and the other in Erie county. The Erie county NFP receives MIECHV funding. Catholic Medical Partners in western NY selected establishing or expanding home visiting as one of their strategies. Catholic Medical Partners began implementing an NFP in Chautauqua County in 2016 and began implementing an NFP program in Erie County in October 2018.

Through Medicaid Redesign, Health Information Technology (HIT) projects were established in four high need areas (Monroe, Onondaga, Westchester, and Kings counties) to demonstrate the effectiveness of HIT to coordinate perinatal services, reduce costs by streamlining fragmented and redundant systems, increase on-time patient access to medical records, and improve quality of care. In 2017, one of the HIT projects (Westchester County) stopped, as they were not able to meet the planned objectives. The HIT systems are designed to identify the medical, pregnancy, and psycho-social risks of pregnant women and make and track referrals to needed services. During development of the HIT systems, national guidance and state legal counsel addressed system issues related to confidentiality. In 2018, HIT systems went live for all three projects with full data collection in September 2018. Data extract templates were developed for the pilot projects to submit de-identified aggregate data on a quarterly basis to the Department. To date only two of the three projects have reported final data. Final data were due December 31, 2020. During the reporting period, contractors screened 263 clients, identifying 90 at risk health conditions and made over 930 referrals. Final data analysis will be conducted and reported to the state and Medicaid Redesign Team in the first quarter of 2021, presenting the efficacy of the HIT projects in the targeted communities. During 2020, HIT projects continued to expand their provider enrollment within their network and have implemented sustainability plans.

The NYS Title V program remains ready to address any public health issue impacting the maternal and child health population including new and emerging public health priorities such as the opioid epidemic and maternal depression. The Maternal and Women's Health annual report and application sections include information related to NYS Title V program's role in the opioid epidemic and maternal depression.

## Perinatal/Infant Health - Application Year

Application for FY21-22 (October 21-September 22)

For Perinatal and Infant Health (PIH), New York's Title V program selected **NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)**. This National Performance Measure (NPM) was selected because of its relevance to quality and systems of care for high-risk and vulnerable infants. While NPM 3 specifically measures site of delivery for very low birth weight infants as one critical indicator of care, the NYS Title V program views this indicator more broadly as part of a continuum of supports, services, and systems of care for infants, pregnant, birthing and parenting people, families, and service providers. This broader approach aligns with several priorities voiced by families in NY's needs assessment, including awareness of community resources and services, enhancing supports for families, improving people's health care experiences, and fostering community engagement and empowerment.

In addition, New York's Title V program established one **State Performance Measure (SPM) for this domain, state-wide improvement from 74.34% to greater than 85% of newborn bloodspot samples received at the lab within 48 hours of collection**. This SPM was developed to reflect the state's continued commitment to ensure that every newborn in the state receives newborn bloodspot screening as a public health service to identify and support infants with a wide range of medical conditions. As a population-based program, the Newborn Bloodspot Screening program is an integral part of the state's public health system for supporting the health and lifelong well-being of newborns and their families.

A focus on improving services and outcomes for infants is supported by other measures assessing the perinatal period. The proportions of low birth weight (8.1%) and preterm (9%) births in NYS have not changed for years; racial and ethnic disparities continue. Non-Hispanic Black infants represent significantly more low birth weight births (12.9%) and preterm births (12.7%) than non-Hispanic white infants (6.3% and 7.6%, respectively). NYS has improved the proportion of pregnant people entering prenatal care during the first trimester to 80.9%, but disparities persist with only 70% of non-Hispanic Black and 76.1% of Hispanic pregnant people beginning early prenatal care compared to 86.1% of non-Hispanic white pregnant people. In Title V led community forums, community members expressed that they do not "feel heard" by their health care providers, that their concerns and treatment preferences are not taken seriously, and that providers do not care about them or understand of what they are going through. They indicated people avoid seeking care and services because they feel judged or anticipate being treated poorly. Participants indicated that people would be more likely to visit a provider who shows compassion, has been trained about bias and cultural competence, and who is relatable (i.e., from the community and speaks their language).

During the forums, many families expressed the need to raise awareness about available community resources and services, in particular for postpartum depression, and to increase the availability and scope of services to support families in the postpartum period, including postpartum doulas, home visitors, community health workers, and breastfeeding support. Indeed, data available about the postpartum experience show that not only is the proportion of mothers who experience postpartum depressive symptoms increasing (15.5%), but non-Hispanic Black mothers more frequently have this experience (20.7%) compared to non-Hispanic white mothers (13.3%).

NYS historically has been a leader in establishing systems of perinatal regionalization, with consistently high performance in this measure. Building on that success, the NYS Title V program is currently engaged in a multi-year effort to expand and update perinatal regionalization standards and designations for the state's birthing hospitals and centers. As this work progresses, it is essential to closely monitor NPM-3 and other related measures to ensure that quality of care and key health outcomes are maintained or improved.

Both NPM-3 and SPM-1 align with the NYS Prevention Agenda goal to reduce infant mortality and morbidity.

Three specific objectives were established to align with this performance measure:

**Objective PIH-1:** Increase or maintain the percent of very low birth weight infants born in a hospital with a Level III+ NICU by 2.4%, from the 2017 level of 91.2% to 93.4% by 2022. (NYS Vital Statistics Birth Data)

**Objective PIH-2:** Decrease the infant mortality rate by 2.6%, from 4.6 deaths per 1,000 live births in 2017 to 4.49 deaths per 1,000 live births in 2022 (NVSS).

**Objective PIH-3:** Improve the timeliness of Newborn Blood Spot samples received at the NYSDOH Wadsworth Laboratory from 74.3% to greater than 85% of samples received within 48 hours of collection by September 2023. (Newborn Bloodspot Screening program data)

Five strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the State Action Plan Table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

**Strategy PIH-1: Integrate specific activities across all relevant Title V funded programs to promote access to early prenatal care, birthing facilities appropriate to one's needs, postpartum care, and infant care.**

Consistent with a life course perspective, improving birth outcomes for infants requires attention to health and health care services for both babies, parents, and people of child-bearing age (see MWH above for additional discussion). NYS has made significant strides to reduce infant mortality and morbidity yet work remains. Timely and comprehensive prenatal and postpartum medical visits are essential to providing prevention education and anticipatory guidance, screening for risk factors that may negatively affect the health of the neonate, managing chronic conditions and pregnancy complications, and connecting families with a wide array of community services and social supports to holistically address the health and wellness needs of pregnant people, neonates, and new families. Several Title V funded programs, including Maternal & Infant Community Health Collaboratives (MICHC), Newborn Bloodspot Screening (NBS), NYS Perinatal Quality Collaborative (NYSPQC), and Regional Perinatal Centers (RPCs), play a direct role in promoting comprehensive health and wellness of neonates through population-based systems, public health interventions, and delivering or linking people to health care services.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- **Activity PIH-1.1:** Across all Title V funded programs, enhance promotion of the NYS Growing Up Healthy Hotline to increase awareness of available community resources, supports, and services including Supplemental Nutritional Programs for Women, Infants and Children (WIC), Medicaid, family planning, home visiting, and prenatal care.
- **Activity PIH-1.2:** Through the MICHC and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs, integrate use of a birth plan including a discussion of appropriate Level of care (LoC) (high risk = higher LoC) for childbirth.
- **Activity PIH-1.3:** In collaboration with OPCHSM, review and approve applications to establish midwifery-led and physician-led birth centers across New York State (see *Domain 1 Women and Maternal Health (WMH) for details*)
- **Activity PIH-1.4:** Support ongoing messaging and educational campaign to promote the safety of birthing hospitals, maternity care options (levels of care and types of care providers), and infection control, to strengthen community awareness and advocacy for obtaining prenatal and postpartum care at the appropriate level of care. This includes the ongoing COVID-19 Maternity Care media campaign (see *Domain 1 WMH for details*).
- **Activity PIH-1.5:** Through the Regional Perinatal Centers (RPCs) and networks of affiliate birthing hospitals, support and enhance capacity to provide high quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and communities with disproportionate access to such services. (See *Domain 1 WMH for details*).
- **Activity PIH-1.6:** Through the MICHC and MIECHV programs, integrate use of virtual home visiting services to

increase acceptance and support of services for hard-to-reach families (See *Domain 1 WMH for details*).

- **Activity PIH-1.7:** Through the MICHC and MIECHV programs, support community health workers (CHWs) to engage high-risk pregnant and postpartum families in consistent, comprehensive preventive and primary care services, including newborn care, screening and assisting families in enrolling in health insurance, and providing families with social support to enhance health literacy and use of health care (See *Domain 1 WMH for details*).
- **Activity PIH-1.8:** Through the NYSPQC, provide educational opportunities and implement structured quality improvement projects with birthing hospitals (See *Strategy PIH-2 below for detail*)

**Strategy PIH-2: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals and centers.**

NYS has been a longstanding national leader in implementing statewide systems of regionalized perinatal care. NYS's regulations for perinatal regionalization and designation, as well as perinatal care services, were last updated in 2000 and 2005, respectively. It is imperative for NYS to ensure all perinatal hospitals are functioning in accordance with current standards of care for both obstetrical and neonatal outcomes. Since 2017, the Title V program has worked to update these regulations to reflect current national standards of obstetrical and neonatal care and perinatal levels of care; changes in health care systems and reimbursements, as well as hospital restructuring and other corporate structural changes. As part of the regulation development process, Title V program staff conducted an extensive review of current standards, in consultation with a 49-member multi-disciplinary Expert Panel and other topical expert consultants. Additionally, the proposed regulations further integrate recently established midwifery birth centers, along with physician-led birth centers, into the perinatal regional system, and place a greater emphasis on quality care and patient safety, particularly for obstetrical patients. Current efforts to strengthen this public health system includes increased efforts to address maternal morbidity and mortality, integration of physician- and midwifery-led birth centers into the regional systems, and increased access to ancillary services such as alcohol and substance use and mental health services, directly and/or through referral and commensurate with the birthing facility's level of care. The NYSDOH submitted the regulatory package for approval and publication in the State Register (anticipated Summer 2021) and anticipates adoption of regulations by December 2021.

Working within this statewide system of perinatal regionalization, NY's Title V program implements the NYSPQC, which aims to provide the best, safest, and most equitable care for women and infants in NYS by collaborating with birthing hospitals, perinatal care providers, and other key stakeholders to prevent and minimize harm through the translation of evidence-based guidelines to clinical practice. The NYSPQC has adapted the Institute for Healthcare Improvement (IHI) model for Idealized Perinatal Care and Breakthrough Series Methodology as a framework to guide improvement. Key NYSPQC activities include:

- embedding evidence-based guidelines into practice
- strengthening collaboration and communication within and among neonatal and obstetric providers, administrators, and organizations
- fostering prepared and proactive care teams
- assessing, conducting, and sharing surveillance and performance data on maternal and neonatal health indicators
- evaluating and measuring performance continuously
- setting priorities and implementing a comprehensive strategy for benchmarking and data driven quality improvement (QI) activities
- providing topic-specific, intensive QI supportive activities, trainings and toolkits that are all-inclusive packages to facilitate improved clinical outcomes, excellent patient care and efficient resource allocation
- researching best practices
- reassessing outcomes of performance improvement interventions continually.

Specific priorities set by the NYSPQC are implemented by all participating NYS birthing hospitals and partners to improve outcomes for perinatal care. Analysis of NYSPQC project data provided by participating birthing hospitals helps to improve services and systems related to perinatal health care.

The NYS Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- **Activity PIH-2.1:** Finalize and adopt revised regulations for perinatal services and perinatal regionalization, according to the NYS regulatory reforms process (*see Domain 1 WMH for additional details*).
- **Activity PIH-2.2:** Develop and implement surveys and conduct site visits to select birthing hospitals, to assess the appropriate level of perinatal designation (*see Domain 1 WMH for additional details*).
- **Activity PIH-2.3:** To improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs, Title V staff will assist in connecting MICHCs with their local birthing hospitals and support formal meetings. Additionally, Title V staff will share promising and best practices from established home visiting-birthing hospital partnerships across the state to encourage collaboration (*see Domain 1 WMH for additional details*).
- **Activity PIH-2.4:** Collaborate with other NYSDOH units to support the programmatic review to establish midwifery-led birthing centers, and support integration of these facilities into the regional perinatal system as a critical foundation for low-risk obstetrical and neonatal patients.
- **Activity PIH-2.5:** Collaborate with stakeholders to educate OB/GYN and family practice providers about changes to local birthing hospitals' level of perinatal care designation.
- **Activity PIH-2.6:** Lead quality improvement projects through the NYSPQC, with birthing hospital teams and community-based organizations, to improve obstetric and neonatal outcomes in specific areas including:
  - Reducing maternal morbidity and mortality by improving the assessment, identification and management of care for pregnant and postpartum people with OUD
  - Improving the identification, standardization of therapy and coordination of aftercare for infants with NAS
  - Improving infant outcomes, with a focus on those in the NICU, by improving equity and increasing the practice of family-centered care
  - Improving outcomes for all NYS birthing people by focusing on racial justice and birth equity
  - Increasing provider knowledge and birthing hospital protocols related to the COVID-19 vaccination for the perinatal population and their families.

**Strategy PIH-3: Apply public health surveillance and data analysis findings to improve services and systems related to perinatal and infant health care.**

Data-driven, evidence-based, or informed practice is essential to achieving public health goals for Maternal and Child Health (MCH). Across all Title V funded programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of MCH programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

The NYS Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- **Activity PIH-3.1:** Collaborate with the Office of Children and Family Services to implement a PDSA-style quality improvement initiative with the goal of increasing referrals from WIC to Home Visiting programs (including MIECHV and MICHC).
- Lead quality improvement projects through the NYSPQC, with birthing hospital teams and community-based organizations, with a focus on:
  - **Activity PIH-3.2a:** Reducing maternal morbidity and mortality by improving the assessment, identification, and management of care for pregnant and postpartum people with OUD
  - **Activity PIH-3.2b:** Improving the identification, standardization of therapy, and coordination of aftercare for infants with NAS
  - **Activity PIH-3.2c:** Improving infant outcomes, with a focus on those in the NICU, by improving equity and increasing the practice of family-centered care

- **Activity PIH-3.2d:** Improving outcomes for all NYS birthing people by focusing on racial justice and birth equity
- **Activity PIH-3.2e:** Increasing provider knowledge and birthing hospital protocols related to the COVID-19 vaccination for the perinatal population and their families.
- **Activity PIH-3.3:** Summarize, share, and discuss findings and recommendations of the Maternal Mortality Review Board (MMRB) with key stakeholders, including the Maternal Mortality and Morbidity Advisory Council (MMMAC) and American College of Obstetricians and Gynecologists District II of New York (ACOG-NY), to inform statewide prevention strategies to improve maternal outcomes. This will include the development of issue briefs, case reports, webinars, quality improvement projects through the NYSPQC, and a maternal mortality report.
- **Activity PIH-3.4:** Establish a comprehensive perinatal data warehouse of perinatal outcomes to make data available in a timely way to birthing hospitals and support quality improvement activities.

**Strategy PIH-4: Address social determinants identified by community members that impact infant health and use of perinatal and infant health care and support services.**

As noted in other domains, perinatal and infant health outcomes are impacted by the social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability, and quality of SDOH. All ten priorities that emerged from community members' input during the Title V Needs Assessment revolve around SDOH and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

Efforts to improve infant health outcomes must focus directly on addressing longstanding and persistent racial and ethnic disparities in infant health. This persistence of disparities in most of our major health indicators clearly shows that while evidence-based interventions can affect positive change, they alone are not enough to address the larger issues contributing to health inequities. NY's Title V program thus seeks to combine the strength of data-driven, evidence-based or informed programs and interventions with authentic community engagement opportunities across all Title V funded programs that address perinatal and infant health, including discussions and actions related to racial justice, as well as strengthening community-based and clinical/provider relationships, to increase equity in access to health care and social support services. Title V funded programs seek to engage and empower individuals, families, and communities by increasing awareness of available community resources and supports; working with community stakeholders to improve delivery of care and services; and enhancing social support, health literacy, and self-care and advocacy skills for pregnant and parenting families.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- **Activity PIH-4.1:** Title V staff will distribute a Parent Portal resources flyer, developed by the NYS Council on Children and Families to birthing hospital/center obstetrical, neonatal, and social work/patient discharge planning teams. Evaluation will include development of follow-up to assess usage of the resource by institutions, as well as monitoring referrals from birthing hospitals to MICHC as reported via the DMIS.
- **Activity PIH-4.2:** Through the MICHC programs, work with diverse community stakeholders including community residents to identify and collaboratively address issues and barriers impacting maternal and infant health outcomes at the community level (*see Domain 1 WMH for further detail*).
- **Activity PIH-4.3:** Through the MICHC and MIECHV programs, provide supports to individual clients and their families to address social determinants of health outcomes. Provide information on community resources, screen and assist families in enrolling in health insurance and health care, work directly with families to strengthen health literacy, self-care, and advocacy skills, and provide and enroll families in enhanced social supports and educational opportunities (*see Domain 1 WMH for further detail*).



- **Activity PIH-4.4:** Through the NYSPQC, lead a new quality improvement project with birthing hospital teams and community-based organizations, to improve outcomes for all NYS birthing people and infants by focusing on racial justice and birth equity.

**Strategy PIH-5: Maintain and strengthen a robust statewide population-based Newborn Bloodspot Screening Program (NBSP).**

The NYS NBSP is a population-based program and public health system that identifies infants who may have a rare, but treatable disease through bloodspot screening shortly after birth. Within NYSDOH, the NBSP is housed and administered by the Wadsworth Center, NYS's public health laboratory, with direct support from Title V and several other state and federal funding sources. The NBSP currently performs laboratory testing for 50 diseases, following national recommendations for NBS programs. The program ensures that every newborn in the state receives newborn bloodspot screening as a public health service, with no fee for testing. The program also performs follow-up case management to ensure newborns with a positive screening result receive appropriate diagnostic testing and treatment. Specialty Care Centers are certified and monitored to ensure newborns have access to specialty care for disease-specific testing and management. In addition, the NBSP contracts with each of the state's 10 Inherited Metabolic Disease (IMD) Specialty Care Centers to enroll patients with an IMD diagnosis identified by newborn screening in the NYS Newborn Screening Patient Registry. These IMD Specialty Care Centers are responsible for entering and tracking for consented patients annually and for attending an annual meeting to discuss long-term follow-up data. Patients are monitored until age 18, when the individual must consent to continue participation until age 21. In 2020, the program screened 208,707 infants, 99.98% of all NYS resident infants born that year (See Form 4 for further details).

NBSP practices continuous quality improvement using LEAN principles, with a focus on improving overall efficiencies, reducing false positives, and improving timeliness in newborn screening for time-critical conditions. The program also strives to promote the growth of the field of NBS by promoting the development of its staff, participating in national committees, conducting pilot studies, and training other state newborn screening programs. The NBSP collaborates with other public health programs to support mutual goals. For example, the NBSP collaborated with the state's Early Hearing Detection and Intervention (EHDI) program on a project to send letters to primary care providers regarding newborns requiring follow-up for failed newborn hearing screening. The NBSP has identified a need for continued education for primary care providers on newborn screening and genetics.

COVID-19 presented unique challenges and barriers to the NBSP, including challenges related to site visits at hospitals during this public health emergency, as well as system-wide delays in shipping that affected the ability to meet the state performance measures of samples being received within 48 hours of collection. To address and reduce the impact of these barriers, the NBS program established protocols for conducting virtual site visits and conducted virtual visits at five birthing hospitals (Nathan Littauer Hospital, Bellevue Woman's Care Center – Ellis; St. Barnabas Hospital; NYP-Brooklyn Methodist Hospital, and Cohen Children's Medical Center at NYP-Koch (formerly NYP-Weill Cornell), and one physician-led birthing center (Brooklyn Birthing Center). Despite these challenges, the NBSP anticipates that these issues will not affect the 2021-22 program year and has identified several activities to continue to support efforts to meet the SPM.

The Title V program will collaborate with the NBS program on the following activities to advance this strategy over the upcoming 2021-22 year:

- **Activity PIH-5.1:** NBSP staff will continue to conduct virtual site visits with birthing facilities and hospitals to provide education to the hospital staff about Part 69-1, newborn screening regulation and compliance. The site visits are part of a birth hospital Continuous Quality Improvement (CQI) initiative supported by the Association of Public Health Laboratories to improve pre-analytic turnaround times (from collection of newborn dried blood specimens to receipt of specimens by the Program).
- **Activity PIH-5.2:** To ensure the newborn blood specimens are collected between 24-36 hours of age, a root cause analysis was conducted to help the NBSP understand the reasons for late collection. A hospital late collection

(>120hr) follow-up process with birth hospitals is in development to ensure timely collection and mitigate any risks of hospital staff oversight.

- **Activity PIH-5.3:** An ongoing CQI initiative will be rolled out to the 10 Inherited Metabolic Disease (IMD) Centers for Short-term Follow-up compliance in 2021-2022. The baseline data in 2018 and 2019 will be established by extracting and cleaning data and conducting case reviews to ensure accuracy. Individual quality reports with the following outcome measures will be provided to each of the 10 IMD Center Directors: total number of referrals for center, percentage/number of referrals closed more than 90 days, percentage/number of referrals lost-to follow-up, and the NYS overall averages in each category. Standard operating procedures for follow-up practices at the Centers will be requested and reviewed. A similar project was completed with the Endocrine Specialty Care Centers in the past (2019-2020).

The NYS Title V program established one Evidence-Based Strategy Measure (ESM) to track the programmatic investments and inputs designed to impact NPM-3:

**ESM PIH-1: Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards.**

Data for this measure will come from hospital surveys and site visit reports from the NYSDOH subrecipient (IPRO) and NYSDOH staff. The baseline value for this measure will be determined after regulations are adopted (anticipated in December 2021). The program has set a target to update designations for 50% of hospitals within one year post-adoption and 100% within three years of adoption.

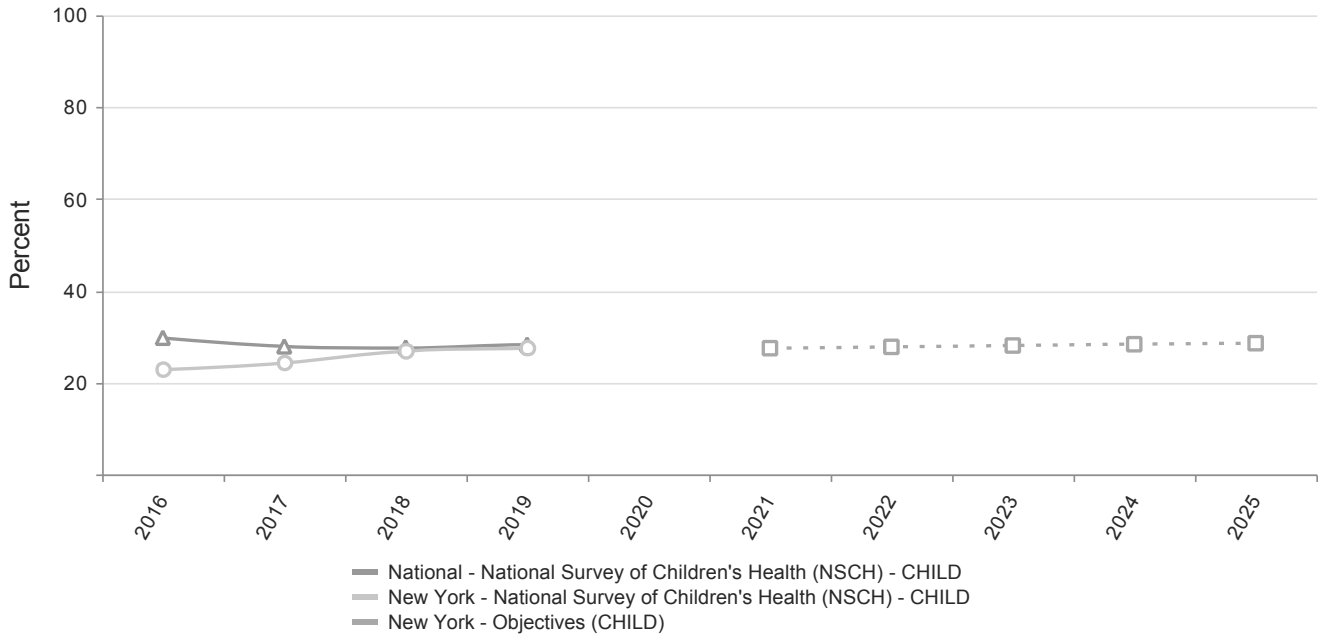
## Child Health

### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	11.2 %	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	11.0 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.4 %	NPM 6 NPM 8.1 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	10.7 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	14.0 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	13.4 %	NPM 8.1

**National Performance Measures**

**NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day  
Indicators and Annual Objectives**



**Federally Available Data**

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

	2016	2019	2020
Annual Objective			
Annual Indicator		27.0	27.4
Numerator		369,498	316,874
Denominator		1,370,994	1,158,167
Data Source		NSCH-CHILD	NSCH-CHILD
Data Source Year		2017_2018	2018_2019

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**Annual Objectives**

	2021	2022	2023	2024	2025	2026
Annual Objective	27.5	27.8	28.1	28.4	28.6	28.9

**Evidence-Based or –Informed Strategy Measures**

**ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year.**

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		51.6
Numerator		98,941
Denominator		191,920
Data Source		SBHC quarterly report
Data Source Year		2018-2019
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	51.6	51.6	52.6	53.6	54.7	55.8

## State Action Plan Table

### State Action Plan Table (New York) - Child Health - Entry 1

#### Priority Need

Increase access to affordable fresh and healthy foods in communities.

#### NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

#### Objectives

Objective CH-1: Increase the percent of NYS children age 6-11 who are physically active at least 60 minutes per day by 3.7%, from 27% in 2017-2018 to 28% in 2021-2022 (NSCH).

Objective CH-2: Decrease the percent of NYS children age 10-17 who are obese (BMI at or above the 95th percentile) by 2.8%, and from 14.4% of children age 10-17 in 2017-2018 to 14% in 2021-2022 (NSCH).

#### Strategies

Strategy CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children's health and well-being. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

#### ESMs

#### Status

ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year. Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

## State Action Plan Table (New York) - Child Health - Entry 2

### Priority Need

Address community and environmental safety for children, youth, and families.

### NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

### Objectives

Objective CH-1: Increase the percent of NYS children age 6-11 who are physically active at least 60 minutes per day by 3.7%, from 27% in 2017-2018 to 28% in 2021-2022 (NSCH).

Objective CH-2: Decrease the percent of NYS children age 10-17 who are obese (BMI at or above the 95th percentile) by 2.8%, and from 14.4% of children age 10-17 in 2017-2018 to 14% in 2021-2022 (NSCH).

### Strategies

Strategy CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active. Please see Supporting Document 2 "State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities. Please see Supporting Document 2 "State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care. Please see Supporting Document 2 "State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children's health and well-being. Please see Supporting Document 2 "State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

### ESMs

### Status

ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year. Active

### NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

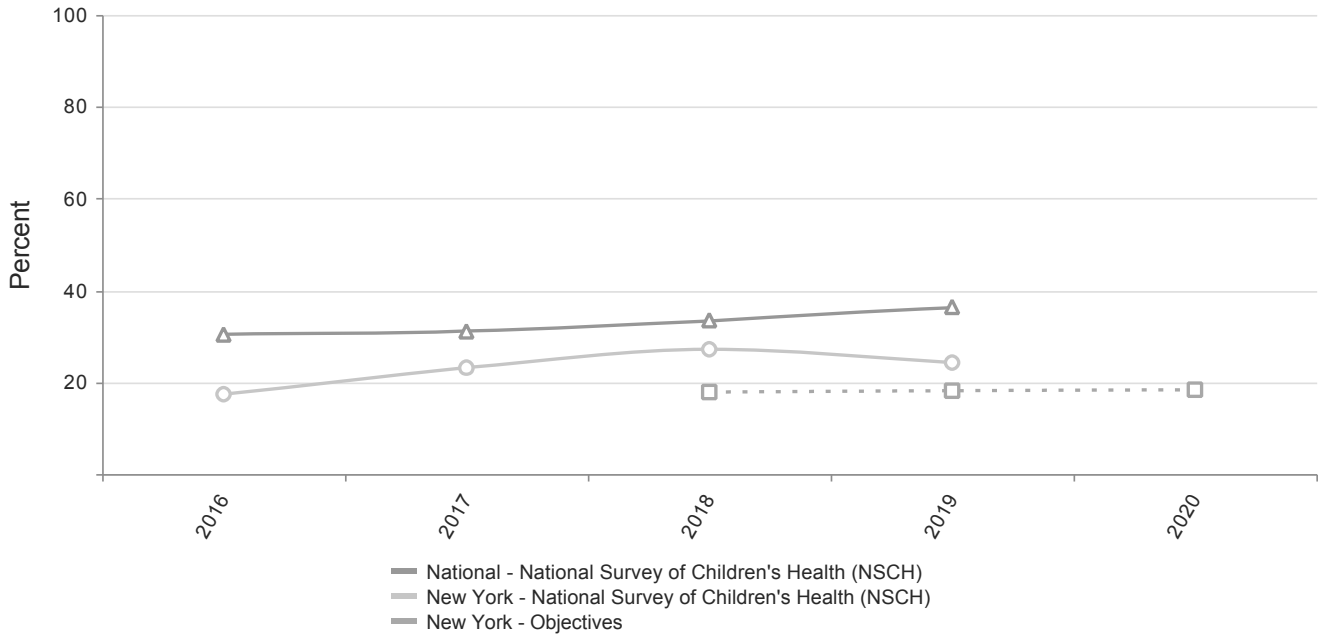
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)



**2016-2020: National Performance Measures**

**2016-2020: NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**

**Indicators and Annual Objectives**



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			17.9	18.2	18.4
Annual Indicator		17.5	23.1	27.1	24.4
Numerator		101,178	117,256	140,531	133,123
Denominator		578,216	506,773	519,134	546,228
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

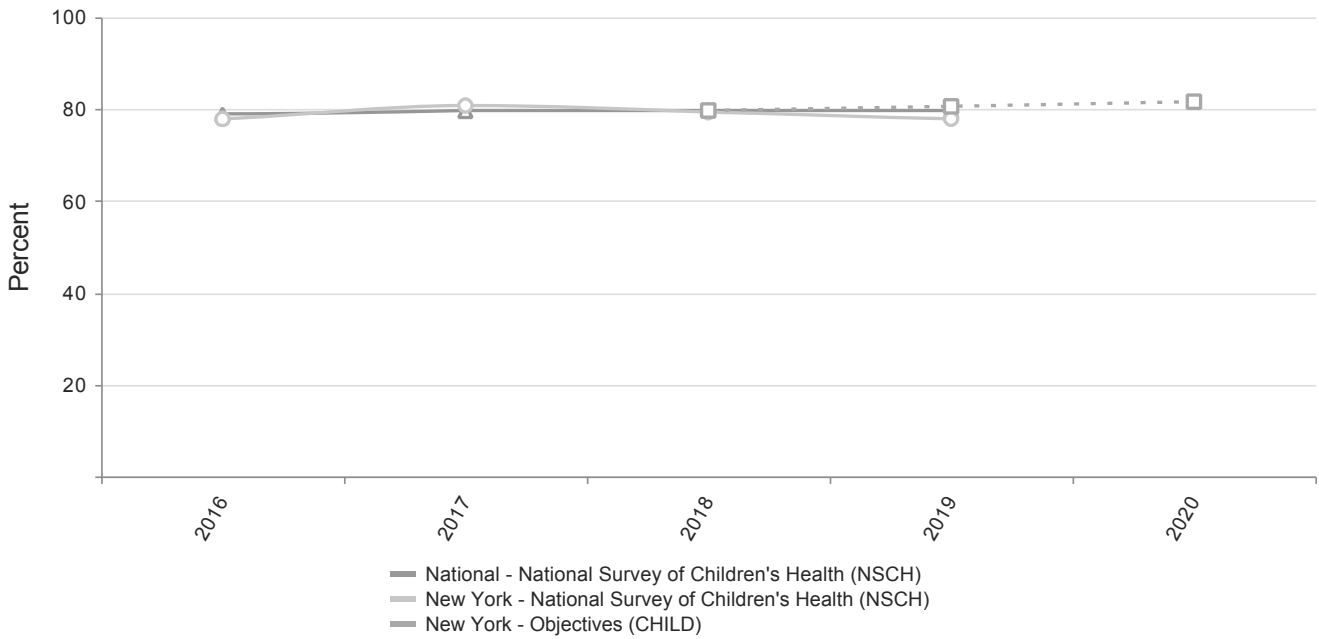
**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: ESM 6.5 - Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.**

<b>Measure Status:</b>		<b>Active</b>			
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		0	1,600	1,680	1,764
Annual Indicator	0	1,694	2,488	5,468	7,079
Numerator					
Denominator					
Data Source	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data
Data Source Year	2016-17	12/16-17	12/16-18	2018-19	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

**2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year  
Indicators and Annual Objectives**



**2016-2020: NPM 13.2 - Child Health**

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			79.6	80.5	81.5
Annual Indicator		77.6	80.6	79.3	77.7
Numerator		2,955,156	3,137,003	3,084,314	2,940,662
Denominator		3,810,186	3,890,746	3,887,411	3,785,630
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: ESM 13.2.1 - Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.**

Measure Status:		Active				
State Provided Data						
	2016	2017	2018	2019	2020	
Annual Objective		20	60	61	61	
Annual Indicator	58	60	48	29	25	
Numerator						
Denominator						
Data Source	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records	
Data Source Year	2017	2018	2019	2020	2019-2020	
Provisional or Final ?	Final	Final	Final	Final	Final	

**2016-2020: ESM 13.2.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.**

Measure Status:		Active				
State Provided Data						
	2016	2017	2018	2019	2020	
Annual Objective		40	41	44	47	
Annual Indicator	61.2	50.5	39.1	21	24	
Numerator						
Denominator						
Data Source	SEALS (CDC Data)	SEALS (CDC Data)	SEALS (CDC Data)	SBSP quarterly reports	SBSP quarterly reports	
Data Source Year	2016	2017	2018	2019	2019-2020	
Provisional or Final ?	Final	Final	Final	Final	Final	

**2016-2020: State Performance Measures**

**2016-2020: SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets**

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		50	50	50	50
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Data Source	To Be Developed	Developmental Assessment Tool	Developmental Assessment Tool	Developmental Assessment Tool	To Be Developed
Data Source Year	2017-2018	2017-2018	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

**2016-2020: SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water**

<b>Measure Status:</b>		<b>Active</b>				
<b>State Provided Data</b>						
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	
Annual Objective		72	73	75	77	
Annual Indicator	71.7	71.6	70.8	70.8	70.8	
Numerator						
Denominator						
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	
Data Source Year	2017	2018	2017	2017	2017	
Provisional or Final ?	Final	Final	Final	Final	Final	

## **Child Health - Annual Report**

### **DOMAIN: CHILD HEALTH**

Annual Report for FY19-20 (October 19-September 20)

Child Health – State Priority #3: Support and enhance children’s social-emotional development and relationships.

The NYS Title V program prioritized supporting children’s social-emotional development and relationships based on the established importance of the impact of high-quality relationships and environment on brain architecture, health, and school readiness. The Title V program has selected this area for children and adolescents.

One key challenge to this priority is the complexity of quantifying the construct of social-emotional development and relationships (e.g., developing or selecting one or more measurement instruments, implementing broadly especially in a state as large as NY, and continually reassessing).

For the Title V program, NYS selected the National Outcome Measure for children’s overall health. Results from the 2018-2019 National Survey of Children’s Health (NSCH) indicate that 91.4% of children ages 0-17 are in excellent or very good health, which compares closely with the national estimate of 90.3%. The Title V program also recognizes that systematic developmental screening is critical to identify children who may need supports and services. Based on results of the NSCH, only 24.4% of parents reported completing a developmental screening.

Title V staff collaborates with the Council on Children and Families (CCF) on the Early Childhood Comprehensive Systems (ECCS) Impact grant, which supports collaborative quality improvement projects in three high-need counties (Erie, Niagara and Nassau) to improve developmental screening and follow-up for young children.

With leadership from Dr. Kuo, Associate Professor and Division Chief for General Pediatrics at the University at Buffalo, the Erie/Niagara team organized a learning collaborative focused on improving developmental screening at six pediatrics practices, including Niagara Street Pediatrics, Towne Gardens Pediatrics, Main Street Pediatrics, Neighborhood Health Center, Jericho Road Community Health Center, and Tonawanda Pediatrics. The team credits the changes and improvements they have made to the importance of creating run charts of ASQ data. In the upcoming year the team will be designing a referral algorithm for families with young children.

In Nassau County, under the leadership of Dr. Elizabeth Isakson, the Nassau team has used ECCS activities to support the implementation of Help Me Grow Long Island. Help Me Grow Long Island offers free developmental and social emotional screens and provides free, virtual, ongoing support to families with young children on Long Island who have concerns such as their child’s development or behavior, navigating service systems, or locating baby items. Nearly 800 screens have been completed in the last year alone. The Nassau team is working with partners on creative ways to spread information about developmental health among families and increase the number of sites providing developmental screens. In the upcoming year, Nassau County ECCS will continue to build their Help Me Grow Long Island infrastructure.

Ensuring improved developmental screening is important. However, assessing social-emotional development and relationships requires more than screening. Title V staff have implemented a cross-cutting approach to this domain.

The first strategy of the State Action Plan (SAP) is to develop and implement a plan for analysis and reporting of available data on children’s social-emotional well-being and adverse childhood experiences (ACEs). In 2016, for the first time, the NYSDOH collected regional and state-level ACEs data from over 9,000 adults through the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is an annual statewide telephone survey of adults developed by the Centers for Disease Control and Prevention (CDC) and administered by NYSDOH. The BRFSS is designed to provide information on behaviors, risk factors, and utilization of preventive services related to chronic and infectious diseases, disability, injury, and death among the non-institutionalized, civilian population aged 18 years and older. ACEs were examined both individually and scored as a sum of total ACEs. New York State’s BRFSS sample is representative of the non-institutionalized civilian

adult population, aged 18 years and older. While respondents are over 18 years old, the information provides valuable insight to the experience of the population. One of the key findings is that ACEs are common in NYS. Six out of 10 adults (59.3%) reported having experienced at least one ACE, and 13.1% reported four or more ACEs. The most frequently reported ACEs are emotional abuse (24.6%), parental separation (23%) and substance abuse in the home (22.2%). Adults in households with children are more likely to have reported ACEs than households that had no children. ACEs are higher among women, Hispanics, and multiracial groups, though not statistically significant due to small sample size in the survey. The detailed findings about ACEs from the BRSS can be accessed online at [https://www.health.ny.gov/statistics/brfss/reports/docs/adverse\\_childhood\\_experiences.pdf](https://www.health.ny.gov/statistics/brfss/reports/docs/adverse_childhood_experiences.pdf) (Data will be updated for 2019.)

In addition to the collection of ACEs information, the Title V program has worked closely with CCF to support their cross-system approach, including a clearinghouse of data on children's well-being, which is located online in the Kids' Well-Being Indicators Clearinghouse (KWIC) at <https://www.nyskwic.org> and in the New York Kids Count Data Book (2017) at <https://www.ccf.ny.gov/council-initiatives/kids-well-being-indicators-clearinghouse-kwic>. The clearinghouse includes data from child welfare, abuse and maltreatment, economic security, physical and emotional health, and education.

Furthermore, within NYSDOH and aligned with the Title V Program, the state's Part C of the Individuals with Disabilities Education Act (IDEA) Early Intervention program (EIP) evaluates the program's impact on social-emotional development, including the establishment of relationships, among young children served by the EIP. The US Department of Education Office of Special Education Programs requires all state EIPs measure the impact of the program on young children's social emotional development using a validated tool. In NYS, the Child Outcome Summary (COS) Process has been implemented. The COS Process is completed by the parents/caregivers of the child and the service providers who have been working with the child. For the sample of children who were assessed (6,377) who exited the EIP or turned three between July 1, 2019 and June 30, 2020 and were served by the EIP for at least six months, 93% made improvement in their social-emotional skills and, of those, 67% made substantial improvement.

The second strategy in the SAP is to identify, pilot test and implement a validated tool for measuring positive developmental social-emotional assets among children and adolescents that can be used across MCH child-serving programs.

Foundational work was conducted to develop a framework within which to address social-emotional development in the children and families that Title V programs serve. The focus for some of the formative work in this area includes research and data for positive youth development strategies, impact of ACEs, trauma informed care, well-child definitions and early intervention strategies as well as reviewing state and national-level data on specific measures that are considered to be within the scope of social-emotional development and relationships for the child health domain, including from the YRBS and the NSCH.

Title V staff implemented a validated tool for measuring positive developmental social-emotional assets among children. The tool measures self-efficacy, healthy decision making, and youth/adult connectedness. The three constructs will be used together incorporating pre-post surveys and measuring specific aspects related to social-emotional assets in children and adolescents. The three constructs encompass youth developmental assets as identified by the Search Institute, which is a public health research and policy organization that specializes in tools concentrating on social-emotional wellness and positive development for youth. The Search Institute developed the 40 developmental assets for specific age-ranges from newborns through adolescence. More information about the Developmental Assets Framework developed by the Search Institute can be found online at <https://www.search-institute.org/our-research/development-assets/developmental-assets-framework>.

The first program that implemented the tool is the Comprehensive Adolescent Pregnancy Prevention (CAPP) initiative. Eighteen of the CAPP providers are implementing an optional component of their program that strives to support and enhance adolescents' social emotional development and relationships, as well as promote home and community environments that support their health and safety.



The validated surveys are used within priority populations focusing on children and adolescents currently enrolled in Title V programs that use positive youth development approaches.

While the Title V program continues to implement tools to measure social-emotional development, a concerted effort has been concentrated in the third strategy of the SAP to provide training for Title V staff and external partners, including local child-serving grantees, to increase: 1) awareness, knowledge, and skills to support children's social emotional development; and 2) trauma-informed care practices.

Recognizing the need for professional development and that content knowledge exists across the Title V programs in the Division of Family Health, staff formed a Social Emotional Workgroup, consisting of representatives from different programs and including a team member with access to and understanding of data. The workgroup was formed in the first year of the grant and has continued to advance the priorities of the Title V program to support social-emotional development among children and adolescents. The workgroup meets regularly to identify training opportunities and new data or research on evidence-based practices, and to monitor progress within these domains.

During the Summer of 2019, Title V staff participated in a cross-agency collaborative which included a four-month long training on Trauma Informed Care (TIC), to establish TIC Champions. The training was led by the University of Buffalo Center for Social Research, Institute on Trauma and Trauma Informed Care, and sponsored by the NYS Department of Criminal Justice Services (DCJS). The 28 Champions, from over 11 agencies, will work together to promote, train, and advance the integration of a trauma informed approach within their organizations and throughout the State. Since the training has concluded, the TIC Champions continue to meet regularly to further work on how to promote TIC across the State and incorporate it into State Agency work. The Champions are focused on first creating definitions to increase consistency, determining baseline data, and identifying targeted areas in need.

Supporting children and adolescents' social-emotional development is an emerging area for NY's Title V program and work on this priority for NY's Title V program continues to evolve. Over the past year, Title V staff have worked to increase their understanding of the complexities within this topic and to identify and embrace the evidence-based strategies associated with this work.

The Title V Social Emotional Workgroup members were critical in identifying existing data sources, relevant research findings, and evidence-based program resources, and created an internal website to make them accessible to all Title V staff. The workgroup has continued to share this information through the publication and distribution of an electronic newsletter, titled "Social Emotional Wellness Update." This publication was created to help highlight and disseminate information with internal partners regarding social emotional development and relationships in children and adolescents by exploring relevant data, discussing available resources and addressing the importance of using these strategies while allowing for an opportunity to take an in-depth view on specific aspects related to the priority. In total, six editions of this publication have been developed and shared with Title V staff. Starting with the July 2018 update, the distribution was expanded to include contractors and other interested stakeholders beyond Title V staff. Topics highlighted in the Winter 2018 and Spring/Summer 2019 updates included Trauma-Informed Care (TIC), and TIC Initiatives, ACEs, the NYS Trauma Informed Network, cyberbullying, and youth suicide. In 2020 the newsletters were put on hold due to the Department's prioritizing COVID-19 efforts, however topics identified for 2021 newsletters include a focus on the LGBTQIA+ community, effects of COVID-19 on social-emotional wellness, and the impact of the Black Lives Matter movement.

The Title V Social Emotional Workgroup members hosted a Division of Family Health Meeting on December 5, 2019. At this meeting the members presented the Division staff with information regarding ACEs data in NYS and an overview of TIC. The documentary *Resilience* was shown to provide additional information on TIC and provide a more personal look at the topic. Following the film, the members lead a discussion with Division staff to look internally on how they interact with other people, as well as how this information can be incorporated into all aspects of Division work.

As discussed previously, promoting positive social-emotional development, including nurturing relationships, is fundamental to the Part C Early Intervention Program. The EIP provided just over 8 million service interactions to more than 66,000 children in 2019-2020. In addition to collecting and reporting on children's progress in this area, the EIP has developed guidance and training to support professionals who serve children through the EIP. It was previously reported that a guidance document on social-emotional development, Meeting the Social-Emotional Development Needs of Infants and Toddlers: Guidance for Early Intervention and Other Early Childhood Professionals, was developed and is available on the DOH website at <https://www.health.ny.gov/publications/4226.pdf>. This document contains guidance for early childhood professionals who deliver services to infants and toddlers and their families across a broad array of early childhood programs and services including the EIP, early education, child welfare, health and mental health care, home visiting, and supportive services. There are four objectives for the guidance document: 1) ensure that the general population of young children receive routine and ongoing screening of children's development, including social emotional development; 2) identify children at risk of experiencing social emotional development delay or disability and ensure their families receive assistance from a wide array of early childhood programs and services; 3) improve the early identification of children who may already be experiencing developmental delays in social-emotional development; and 4) ensure that evaluations, and assessments for all children in the EIP adequately address the area of social emotional development. The guidance document was published in June 2017.

Since its publication in June 2017, the EIP has been working with the Early Intervention Coordinating Council (EICC) to support the training and dissemination of the guidance document. In December 2018, the workgroup and the Division of Family Health's Bureau of Early Intervention (BEI) created a webpage on the NYSDOH website dedicated to social-emotional development, and families are the intended audience. In August 2020, a five-module e-learning series based on the guidance document was released to the public. The series is self-paced and accessed through the BEI's training vendor, Measurement Inc.'s platform. The vendor also hosted a live webinar version of all five modules which reached max registration capacity within hours of release. As of September 14, 2020, 171 people have completed the course. The workgroup is also creating six desk aids to assist those connected to the EIP to incorporate social-emotional development at key points in the program from referral through transition. The goal is to complete these desk aids by end of 2021.

Title V staff built on previous work completed that assessed the capacity of existing Title V programs with a social-emotional component, by assessing the effectiveness of the strategies used. Programs using evidence-based strategies or evidence informed strategies were considered to be the most effective by Title V staff since these practices use the best available research and practice knowledge to guide program design and implementation.

A chart was developed identifying the practices used and how the programs focused on aspects of social-emotional wellness. Of the 21 previously identified Title V programs, Title V staff identified ten programs that utilize evidence-based or evidence informed strategies, and five programs that use best practices. Staff will continue to review existing and new programs to continue to ensure that these programs directly impact the developmental assets as defined by the Search Institute.

In a state as large and diverse as NYS, it is imperative to develop community partnerships to connect with families on the local level. The Maternal and Infant Community Health Collaboratives (MICHHC) initiative aims to improve health outcomes for high need women and infants, by working with community partners and utilizing Community Health Workers (CHW) to assess women and their families and connect them with needed resources. There are currently 23 MICHHC projects in priority communities across NYS. CHWs served 5,987 families and provided 15,789 home visits in 2019. The MICHHC initiative touches upon developmental assets in the following areas: support, empowerment, positive values, social competencies, and positive identity.

NYS supports and promotes evidence-based home visiting services. Evidence-based home visiting programs have demonstrated improvements in pregnancy and maternal health, child health and development, home and child safety, school readiness, family safety, family self-sufficiency, and coordination and referrals to community resources and supports. Home visiting also helps to improve birth outcomes and increases pregnancy spacing.

The Division of Family Health oversees the Title V and MIECHV programs. The MIECHV funding supports the Nurse Family Partnership (NFP) and the Healthy Family New York (HFNY) programs to achieve home visiting goals to improve pregnancy outcomes for high-risk women and babies, improve children's health and development, and strengthen family functioning and life course. These goals support several objectives in Title V, including decreasing maternal and infant morbidity and mortality; supporting and enhancing social-emotional development and relationships for children and adolescents; and reducing racial, ethnic, economic and geographic disparities and promoting health equity for the maternal and child populations. Pregnant women can enroll in NFP until their 28th week of pregnancy and can enroll in HFNY either prenatally or up to three months post-partum. Home visits can be provided until the children are two to five years of age, respectively. Currently, 19 home visiting programs (eight NFP, 11 HFNY) are located in the following counties: Bronx, Dutchess, Erie, Kings, Monroe, Nassau, Onondaga, Queens, and Schenectady. Three NFP programs are funded through state appropriations. Through MIECHV funding, 3,060 families were served, receiving 34,526 home visits in 2019. The NYS Office of Children and Family Services administers the HFNY program, and they serve 38 counties across the state.

The Family Initiative Coordination Services Project (FICSP) facilitates, supports, and develops parent involvement in all levels of the Part C Early Intervention Program (EIP). The FICSP develops and implements a training program, referred to as Partners, that provides parents with the opportunity to enhance their leadership skills, network with each other, and learn how to become better advocates for the care of their child with special needs on the local, state, and national levels. The Family Initiative Coordination Services Project was developed in collaboration with Early Intervention contractor, Just Kids Early Childhood Learning Center.

- The FICSP facilitates, supports, and develops parent involvement at all levels of the EIP.
- The FICSP facilitates and supports parent attendance at national conferences on early childhood development and facilitates parent involvement on the EICC. The EICC is a 30-member Governor appointed council that advises and assists the Department in the administration of the EIP. There are six parent members on this Council.
- The FICSP has a dedicated website for families which includes information on the EIP, local and national resources on child development and disabilities, and the parent training that is offered in collaboration with NYSDOH. The FIC also has a closed Facebook page to better connect the families participating in the training.
- The FIC develops short vignettes on EIP topics to enhance families' understanding of the EIP.
- The FICSP provides an opportunity for NYSDOH to communicate directly with and obtain feedback from parents of children in the EIP, to ensure its policies and procedures are family centered.

NY's innovative Sexual Risk Avoidance Education Program (SRAE), which launched July 1, 2019, supports 12 community-based organizations across the state to implement strategies to build protective factors for young people ages 9-12 living in high risk communities, including youth in foster care, youth with physical disabilities, and homeless and disconnected youth, to promote a transition to a healthy, productive, connected adolescence. SRAE projects provide youth with support and information on a wide range of topics framed in a youth development philosophy, focusing on the needs of youth and building on and nurturing the youth's individual strengths and needs. They also provide adult-supervised activities to stimulate cognitive, social, physical, and emotional growth. Caring adults are available for more in-depth support and discussions. These programs also provide parent education to parents, guardians, and adult caregivers to create a more nurturing environment for these youth. During FF20, SRAE reached more than 900 youth. As a result of the COVID-19 pandemic, the SRAE program had to switch to an online learning module while retaining as many participants as possible and maintaining program fidelity. This provided an initial setback to the program's major components. However, it is anticipated that the program will continue to expand during FFY21.

Title V programs serving school-age children also include core strategies that address positive development and behavioral health. School-Based Health Centers (SBHCs) are required to provide behavioral health screening for all patients (elementary, middle, and high school age) as part of ongoing primary care, and most provide additional mental health services on-site within SBHC clinics. Mental health services are also provided by referral in sites that do not have in-clinic resources. NYS has more than 264 SBHC-sites which provide services including mental health assessments, crisis

intervention, counseling, and referrals to a continuum of services including emergency psychiatric care, community support programs, and inpatient care and outpatient programs. Research has shown SBHCs improve attendance in school and decrease emergency room visits. In the past year NYS SBHCs enrolled nearly 200,000 students and provided more than 730,000 visits for health and supportive services. Of the more than 730,000 visits approximately 94,000 included a mental health visit. Seventy-five percent of NYS SBHCs provide mental health services on site, the remainder of sites refer children to mental health providers within their community. These critical services have been largely diminished since March 2020, the start of NYS's state of emergency due to the COVID19 pandemic. Closure of schools across the state caused serious barriers to SBHC services being delivered as they were not allowed to operate on closed school grounds. Additionally, many SBHC staff were redeployed to other assignments within the Article 28 operator's system to assist with the pandemic relief efforts. Many SBHCs ramped up their telehealth efforts, especially for the provision of mental health services, but there remained limitations to this effort, both with the clinical staff availability and with families having the technology and time to participate. The effects of the public health emergency were not limited to the SBHC clinics, but in fact had a strong impact on NYSDOH's infrastructure meant to support this important program. Every staff member has been deployed to serve in other capacities to assist with the NYSDOH response to the COVID-19 pandemic. The percent of effort has ranged from 50% to full time, dependent on the need at the time. For example, one person hired to support an important data project for the program, was deployed full time for nearly six months. This caused a shift in the timeline for deliverables and have posed a challenge to timely completion of projects. Managing priorities has also been impacted by the availability of staff outside of the work unit as most all NYSDOH employees are working to balance pandemic related efforts with normal responsibilities. For example, shifting SBHCs into the Medicaid Managed Care model has been a priority that was gaining momentum before the pandemic. Once staff deployed and priorities shifted to the public health emergency, momentum was lost. Internally, people had pandemic related conflicts preventing regular meetings, and externally SBHC clinicians were not always able to complete the required work of a pilot project due to being re-deployed to other clinical efforts.

Declaration of the state's public health emergency also lead to addressing the potential risk of transmission of coronavirus in dental settings and specifically in school-based dental health care programs. Therefore, developing infection prevention guidelines in dental settings became a primary focus. Collaboration with the NYSDOH Healthcare Associated Infections and Epidemiology units lead to the Division of Family Health (DFH) spearheading development of the first set of guidelines for New York's oral health workforce. Subsequently the DFH developed Covid-19 guidance specifically for school-based dental clinics. Response to the COVID-19 pandemic increased and led to continuous communication with providers and community members through updated guidance documents and response to email inquiries, phone, and conference calls. Covid-19 response efforts also led to work with the OHIP to provide input on expanding tele-dentistry services and addressing issues regarding access to PPE for dental providers and regarding patients' access to care given the restrictions placed on the oral health service delivery system. The DFH continues to play an integral role in updating communications that provide guidance and recommendations for the safe provision of dental care in oral health care settings including settings that provide dental care for children and individuals with special health care needs.

Title V staff is also involved in an interagency workgroup focused on identifying the prevalence of ACEs in New Yorkers as well as best practices for preventing, reducing, and addressing ACEs. Partners include representatives from NYSDOH as well as the Offices of Mental Health (OMH) and NYS Office of Addiction Services and Supports (OASAS). The workgroup submitted a proposal to Robert Wood Johnson Foundation called Facilitating Resilient Communities, Integrating ACEs Science Initiative that focuses on community revitalization efforts as a strategy to promote resilience and wellbeing using a trauma-informed lens in at least five communities in NYS. Interventions will include leveraging the potential of anchor institutions, worker cooperatives, and processes such as procurement policies as drivers of community revitalization, using a trauma-informed lens. There are ongoing efforts in the state to integrate a trauma-informed lens in health care and school-based settings.

The fifth strategy of the SAP is to continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for eligible children with serious emotional disturbance and complex trauma.

As described in the CYSHCN domain, the enrollment of children in Children's Health Homes (CHH) began in December 2016. To be eligible for CHH, a child must be Medicaid eligible and have two or more chronic conditions including alcohol or substance abuse, mental health condition, cardiovascular disease, metabolic disease, respiratory disease, BMI at or above 85% or other chronic conditions, or one single qualifying condition such as HIV/AIDS or serious mental illness, serious emotional disturbance, or complex trauma, and at risk for another chronic condition. Enrollment and outreach data are being reported as a point-in time reference as of October 5, 2019. The number of children enrolled in CHH for the third quarter of year three, is reported to be 27,071. Compared to the number of children enrolled in CHH for the last quarter in 2018 was 17,524. In December 2018, 1,605 children had received outreach from a CHH compared to 1,687 in third quarter of 2019. In April 2019, the six 1915 (c) Home and Community Based Services consolidated into a single 1915 (c) Children's Waiver.

In addition to supporting the CHH, Title V program staff have collaborated within NYSDOH to support the "First 1,000 Days on Medicaid" initiative. This initiative recognized that a child's first three years are the most crucial years of their development, including social-emotional development. The initiative is designed to ensure that NY's Medicaid program works with health, education, and other system stakeholders to maximize outcomes and deliver results for the children served through a collaborative effort. This initiative identified a ten-point agenda to focus on enhancing access to services and improving outcomes for children on Medicaid in their first 1,000 days of life. Title V staff worked on several specific proposals for this initiative which include social-emotional development related subject matter.

One proposal of the ten-point First 1,000 Days on Medicaid agenda was to require managed care plans to have a Kids Quality Agenda. The BEI participates in the Medicaid Managed Care 2019-20 Kids Quality Agency Performance Improvement Project (PIP), which includes three measures: newborn hearing screening and follow-up, blood lead testing and follow-up, and developmental screening. Specifically, the DFH's BEI Early Hearing Detection and Intervention (EHDI) team is collaborating with the Office of Health Insurance Programs (OHIP) and the Office of Quality and Patient Safety (OQPS) to ensure that infants who do not pass newborn hearing screening receive timely diagnostic testing (by three months of age) and that those infants confirmed as deaf or hard of hearing are receiving Early Intervention (EI) services by six months of age. The goal of this project is to ensure infants and toddlers who are deaf or hard of hearing receive intervention services as early as possible to achieve age-appropriate language development and learning. Using EHDI data, Medicaid Managed Care Organizations will enhance tracking and follow-up of infants with suspected or confirmed hearing loss and will facilitate connecting infants who are deaf or hard of hearing and their families to timely services.

Title V program and Part C Early Intervention Program staff have provided subject matter expertise and technical support to a Medicaid Redesign 2 (MRT2) project on Early Childhood Transitions. The goals include streamlining transitions from early childhood programs and services and ensuring that children's medical homes are engaged as well.

Taken together these actions and strategies are critical assets that can be effectively leveraged to further support social-emotional development and relationships for children and their families through the integration of additional evidence-based/-informed practices and strategies.

## Child Health - Application Year

### Application for FY21-22 (October 21-September 22)

For Child Health (CH) domain, NY's Title V program selected **National Performance Measure (NPM) 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day**. This NPM was selected because it is responsive to concerns voiced directly by families in NYS and reinforced by state-specific population health data.

Over 14% of NYS children age 10-17 are obese, and only 27% of NYS children age 6-11 years are physically active for at least 60 minutes daily. NYS families identified the availability and accessibility of amenities that support children's safe, active play and access to healthy foods as top priority needs, alongside priorities for community and environmental safety for children and community transportation. Supporting healthy, active play, and recreation for children and youth of all ages is critical to promoting healthy weight as well as general physical and mental health during childhood and throughout the life course. In addition, this measure provides opportunities to be responsive to the Title V priorities for health care access and quality, social support, and social cohesion. This NPM aligns directly with NYS Prevention Agenda goals for physical activity and chronic disease prevention.

The NYS Title V program has important capacity to address these priorities through its School Based Health Center (SBHC) program and through collaboration with the NYSDOH Creating Healthy Schools and Communities program to enhance environmental infrastructure and supports, both in schools and in the community, to support physical activity. SBHCs serve NYS's highest need communities and provide critical access to quality primary care for school-aged children.

Two specific objectives were established to align with this performance measure:

**Objective CH-1:** Increase the percent of NYS children age 6-11 who are physically active at least 60 minutes per day by 5%, from 27% in 2017-2018 to 28.1% in 2021-2022 (National Survey of Children's Health, NSCH).

**Objective CH-2:** Decrease the percent of NYS children age 10-17 who are obese (BMI at or above the 95<sup>th</sup> percentile) by 2.8%, and from 14.4% of children age 10-17 in 2017-2018 to 14% in 2021-2022 (NSCH).

Four strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the State Action Plan (SAP) Table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

**Strategy CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active.**

To be physically active, children's basic health needs for growth, development, and good nutrition must be met. Health care providers play an important role in promoting physical activity and other healthy behaviors, and in managing children's health needs including mental health, obesity, asthma, and other special health care needs and challenges that may impinge on children's ability to participate in active play and recreation. Health care providers should follow current evidence-based guidelines for anticipatory guidance, screening, counseling, and disease management, including guidelines specific to physical activity and healthy weight, and help guide children and their families in finding and using available community resources for active play and recreation.

School Based Health Centers (SBHCs) are an important source of primary and preventive care services for thousands of NYS children and have the opportunity and capacity to holistically address children's needs. Title V staff will work with SBHCs statewide to ensure anticipatory guidance to promote proper nutrition and daily physical activity, weight status assessment, and attention to overall health promotion and chronic disease management, as part of routine primary and preventive care for children. In addition, the Title V program will continue to support an array of core public health programs

that address children's health and wellness and access to and primary and preventive health care services.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- Activity CH-1.1: Provide guidance and add quarterly reporting requirements for all funded School-Based Health Centers (SBHCs) to increase provision of 1) age-appropriate anticipatory guidance regarding physical activity and nutrition and 2) routine assessment for indicators of overall health, one of which will be weight status but it will not be the sole factor. Data from quarterly reports will be reviewed and reports will be generated for feedback to SBHCs to assess progress and drive improvements in these practices.
- Activity CH-1.2: Promote the use of the American Academy of Pediatrics' (AAP) Bright Futures model for anticipatory guidance in SBHCs and seek opportunities to engage AAP for assistance to promote this resource.
- Activity CH-1.3: Incorporate guidance, reporting, and tracking to support SBHCs to engage their dental patients in conversations about physical activity and nutrition through the delivery of anticipatory guidance on nutrition including water and sugar-sweetened beverage consumption, and work with SBHCs to ensure that enrolled students have an established dental home to promote optimal oral and overall health.
- Activity CH-1.4: Explore opportunities to collaborate with New York School-Based Health Alliance (NYSBHA) to support SBHCs' increased effort towards promoting physical activity such as hosting webinars with subject matter experts.
- Activity CH-1.5: Within the Title V program, strengthen collaboration between child- and adolescent- serving programs to enhance promotion of physical activity through established programs that focus on adult-led activities and social-emotional wellness.
- Activity CH-1.6: Collaborate with the NYSDOH Division of Nutrition to incorporate public health nutrition messaging with physical activity guidance across child health programs, including SBHC and CYSHCN programs.
- Activity CH-1.7: Continue to directly support a portfolio of Title V-funded programs and services that promote children's wellness and enhance access to comprehensive primary and preventive care services for children, including:
  - School-based dental sealant and community water fluoridation programs to promote children's oral health and reduce dental caries as key contributors to children's overall health and well-being.
  - Comprehensive Services and Health Systems Approaches to Improve Asthma Control in New York State to improve the quality and availability of guidelines-based asthma care.

**Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities.**

To achieve state goals related to increasing children's physical activity, children and their families need safe, appealing, and accessible places to play and be active – at home, in school, and in their neighborhoods and communities. Across the community listening forums, families and children voiced a desire for amenities in their neighborhoods that provide opportunities for active play and daily physical activity, such as playgrounds, athletic facilities, greenspace, and community centers. They want streets, sidewalks, and trails that are accessible and safe for walking and biking, both for transportation and recreation. They want these areas to be clean, appealing, and safe for children and families. They want to know what is available, have a way to get there, and feel welcome and included. These concepts are central to the mission of the NYSDOH Creating Healthy Schools and Communities program. Title V staff will develop strong relationships with this program and integrate SBHC staff into the program's local efforts to enhance outcomes for the communities served.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- Activity CH-2.1: Collaborate with the NYSDOH Division of Chronic Disease Prevention (DCDP) to implement multi-

pronged strategies to enhance the work of Creating Healthy Schools and Communities grantees, and other initiatives aimed at increasing children's physical activity.

- Activity CH-2.2: Facilitate partnerships between local Creating Healthy Schools and Communities grantees (as available) and SBHCs to engage and educate community partners, families, and community residents on the benefits of physical activity through Complete Streets implementation, including Safe Routes to School programs.
- Activity CH-2.3: Actively participate in DCDP's Pediatric Obesity Prevention Work Group, contribute to the direction of the group, and establish mutually beneficial priorities.

**Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care.**

Data-driven, evidence-based practice is essential to achieving public health goals for the Title V program. Across all Title V programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of Title V-funded programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- Activity CH-3.1: Collaborate with the U.S. Census Bureau to conduct an over-sample of NYS 2022 National Survey of Children's Health for NYS to allow for enhanced sampling of Black/African-American, Hispanic, and CYSHCN.
- Activity CH-3.2: Design and implement a SBHC data collection system that allows SBHCs to identify, track, and address disparities within the SBHC.
- Activity CH-3.3: Engage and survey stakeholders to identify, track, and address disparities within the SBHC.
- Activity CH-3.4: Explore collaborative opportunities with DCDP's Bureau of Chronic Disease Evaluation and Research to review and share information on student weight status assessments to inform SBHC work in this area.

**Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children's health and well-being.**

Child health outcomes are impacted by social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability, and quality of SDOH. All ten priorities that emerged from community members' input during the Title V Needs Assessment revolve around SDOH and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

SBHCs are located in areas of NYS with the highest needs. The school communities served are disadvantaged economically and disproportionately impacted by key social determinants of health such as housing, transportation, employment, access to health care, and sources of healthy food. Families facing day-to-day challenges of poverty and racism may be less able to prioritize or take advantage of opportunities for recreational physical activity.

Development of community resources, public health programs, and other opportunities to promote physical activity need to be viewed through an equity lens. SBHC staff can have a direct effect on their school communities by assessing the physical activity needs and weight status of the students, helping to identify barriers to exercise and healthy food, and partnering with key stakeholders to take action to create a more equitable distribution of resources. These steps can contribute to environmental improvements that lead to increased physical activity and reduce health disparities attributed to lack of exercise and unhealthy lifestyle.



The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- Activity CH-4.1: Design the new SBHC data collection system with a racial justice and health equity lens, building a reporting tool that allows SBHCs to identify, track, and address disparities within the SBHC (site or provider level).
- Activity CH-4.2: Partner with key stakeholders such as the Community Health Care Association of New York State (CHCANYS) and NYSBHA to identify and share best practices for SBHCs to address racial justice and health equity.

The NYS Title V program established one Evidence-Based Strategy Measure (ESM) to track the programmatic investments and inputs designed to impact NPM 8.1:

**ESM CH-1: Percent of children and youth enrolled in SBHCs who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year.**

Data for this measure come from the SBHC quarterly reporting system. The baseline for 2021 (51.6%) has been established using program year 2018-2019 data. Targets have been established to achieve a 2% increase each year, except for 2022 as the first year is primarily a planning year and an increase in anticipatory guidance delivery is not expected.

Targets are as follows:

Baseline/2021	51.6%
2022 Target	51.6%
2023 Target	52.6%
2024 Target	53.6%
2025 Target	54.7%

## Adolescent Health

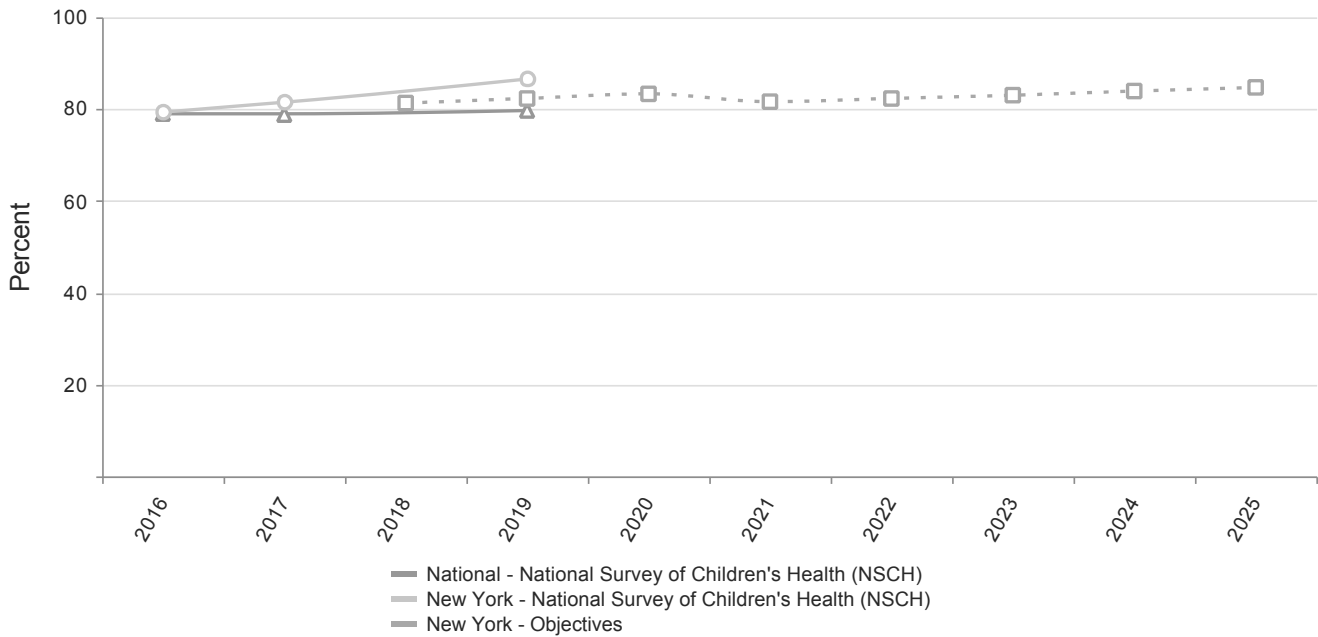
### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	11.2 %	NPM 13.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	20.4	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	4.4	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	6.2	NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	11.0 %	NPM 10 NPM 12 NPM 13.2
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	58.1 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.4 %	NPM 8.2 NPM 10 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	10.7 %	NPM 8.2 NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	14.0 %	NPM 8.2 NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	13.4 %	NPM 8.2 NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	69.6 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	70.8 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	93.4 %	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	95.0 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	11.4	NPM 10

**National Performance Measures**

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



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			81.2	82.2	83.2
Annual Indicator		79.2	81.3	81.3	86.3
Numerator		1,103,856	1,081,532	1,081,532	1,367,654
Denominator		1,393,274	1,331,106	1,331,106	1,583,876
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	81.5	82.2	82.9	83.8	84.6	85.4

**Evidence-Based or –Informed Strategy Measures**

**ESM 10.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, etc.**

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		96.3
Numerator		52
Denominator		54
Data Source		Survey of CAPP and PREP Programs
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	96.3	96.3	98.2	100.0	100.0	100.0

**ESM 10.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation**

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		68.7
Numerator		46
Denominator		67
Data Source		Survey of CAPP, PREP, and SRAE Programs
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	68.7	70.1	71.6	73.1	74.0	75.0

## State Action Plan Table

### State Action Plan Table (New York) - Adolescent Health - Entry 1

#### Priority Need

Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course

#### NPM

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

#### Objectives

Objective AH-1: Increase the percent of adolescents, ages 12-17, with a preventive medical visit in the past year by 5%, from 81.3% in 2016-2017 to 85.4% in 2021-2022. (NSCH)

Objective AH-2: Increase the percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling by 5%, from 53.5% in 2017-2018 to 56.2% in 2021-2022. (NSCH)

Objective AH-3: Increase the percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine by 8%, from 67.3% in 2018 to 72.7% in 2022. (NIS)

Objective AH-4: Increase the percent of NYS adolescents without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 16.4% in 2017-2018 to 17.2% in 2021-2022. (NSCH)

#### Strategies

Strategy AH-1: Incorporate specific activities to promote the wellness of adolescents across all Title V programs, including promoting and facilitating routine well visits, reproductive health care, oral health, and behavioral health. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy AH-2: Promote supports for adolescents to gain the knowledge, self- efficacy, and resources they need to prepare for and transition to adulthood. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy AH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy AH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact adolescents' health and well-being. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

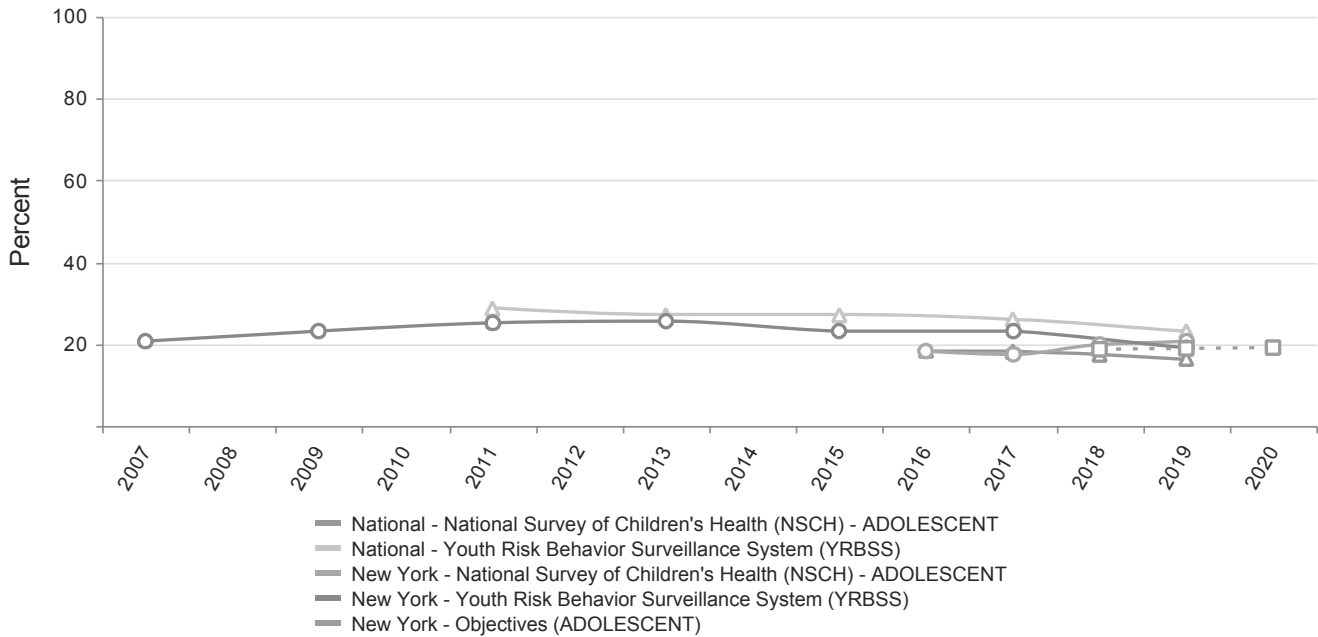
ESMs	Status
ESM 10.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, etc.	Active
ESM 10.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

**2016-2020: National Performance Measures**



**2016-2020: NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day**  
**Indicators and Annual Objectives**



Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	2017	2018	2019	2020
Annual Objective	27.1	27.5	18.8	19	19.2
Annual Indicator	23.3	23.3	23.2	23.2	19.2
Numerator	161,704	161,704	159,614	159,614	132,694
Denominator	694,960	694,960	689,106	689,106	691,623
Data Source	YRBSS- ADOLESCENT	YRBSS- ADOLESCENT	YRBSS- ADOLESCENT	YRBSS- ADOLESCENT	YRBSS- ADOLESCENT
Data Source Year	2015	2015	2017	2017	2019

**Federally Available Data****Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT**

	2016	2017	2018	2019	2020
Annual Objective			18.8	19	19.2
Annual Indicator		18.3	17.7	19.9	20.6
Numerator		246,053	232,223	284,451	318,977
Denominator		1,346,787	1,313,811	1,426,960	1,551,971
Data Source		NSCH- ADOLESCENT	NSCH- ADOLESCENT	NSCH- ADOLESCENT	NSCH- ADOLESCENT
Data Source Year		2016	2016_2017	2017_2018	2018_2019

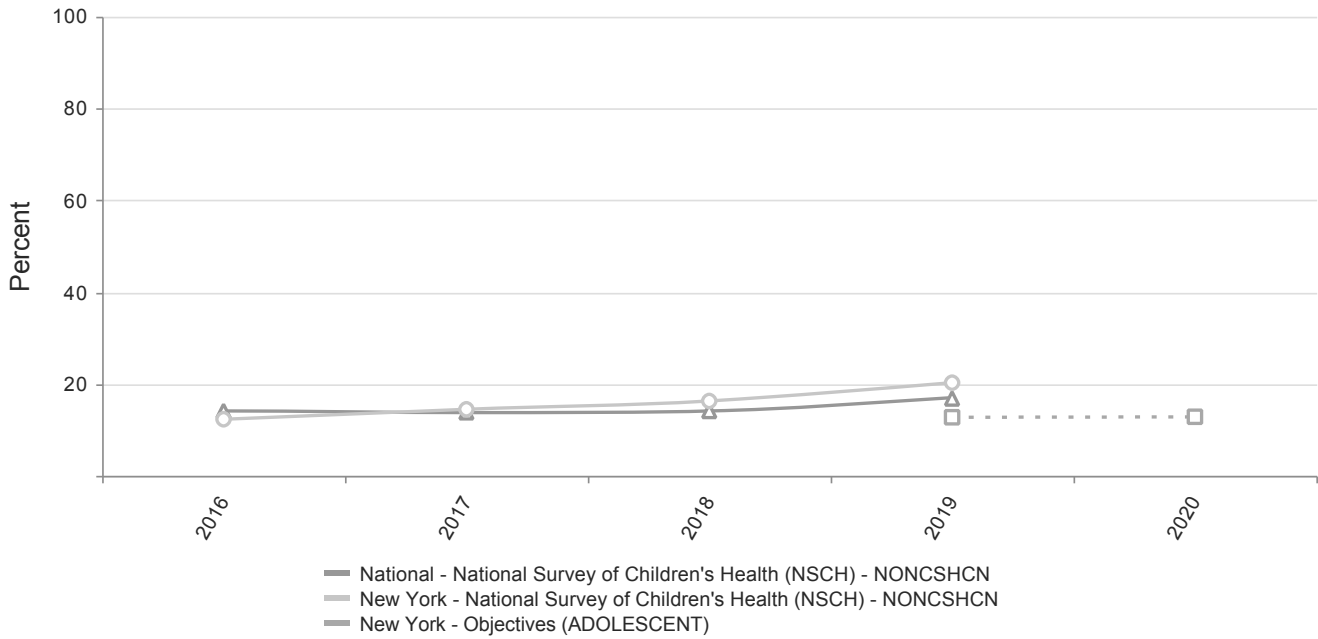
**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: ESM 8.2.1 - Number of community environmental changes demonstrated as a result of enhanced collaborations.**

<b>Measure Status:</b>		<b>Active</b>			
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective			6	7	8
Annual Indicator	1	6	6	8	6
Numerator					
Denominator					
Data Source	Title V Program data	Title V Program data	Title V Program data	Title V Program data	Title V Program data
Data Source Year	7/16-6/17	2016-2018	2017-2019	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

**2016-2020: NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care**  
**Indicators and Annual Objectives**



**2016-2020: NPM 12 - Adolescent Health - NONCSHCN**

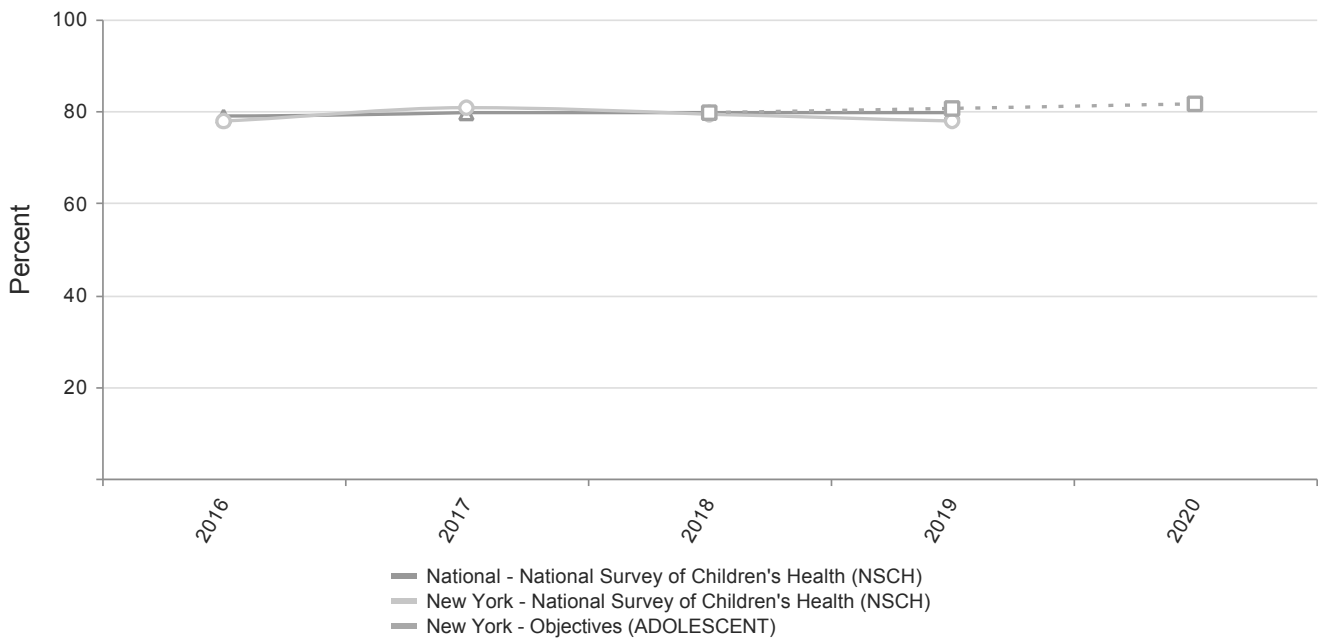
Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN				
	2017	2018	2019	2020
Annual Objective			12.8	12.9
Annual Indicator	12.3	14.5	16.4	20.3
Numerator	130,919	156,317	189,724	244,654
Denominator	1,062,218	1,079,417	1,158,201	1,208,051
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: ESM 12.7 - Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.**

<b>Measure Status:</b>		<b>Active</b>			
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		45	60	32.8	33.2
Annual Indicator	63.9	66.9	32.5	75.2	68.6
Numerator	4,275	5,244	902	5,038	4,168
Denominator	6,688	7,843	2,777	6,702	6,072
Data Source	NYEHDI	NYEHDI	NYEHDI	NYEHDI	NYEHDI
Data Source Year	CY2016	CY2017	CY2018	CY2018	CY2019
Provisional or Final ?	Final	Final	Provisional	Final	Final

**2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year  
Indicators and Annual Objectives**



**2016-2020: NPM 13.2 - Adolescent Health**

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			79.6	80.5	81.5
Annual Indicator		77.6	80.6	79.3	77.7
Numerator		2,955,156	3,137,003	3,084,314	2,940,662
Denominator		3,810,186	3,890,746	3,887,411	3,785,630
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: ESM 13.2.1 - Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.**

Measure Status:		Active				
State Provided Data						
	2016	2017	2018	2019	2020	
Annual Objective		20	60	61	61	
Annual Indicator	58	60	48	29	25	
Numerator						
Denominator						
Data Source	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records	
Data Source Year	2017	2018	2019	2020	2019-2020	
Provisional or Final ?	Final	Final	Final	Final	Final	

**2016-2020: ESM 13.2.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.**

Measure Status:		Active				
State Provided Data						
	2016	2017	2018	2019	2020	
Annual Objective		40	41	44	47	
Annual Indicator	61.2	50.5	39.1	21	24	
Numerator						
Denominator						
Data Source	SEALS (CDC Data)	SEALS (CDC Data)	SEALS (CDC Data)	SBSP quarterly reports	SBSP quarterly reports	
Data Source Year	2016	2017	2018	2019	2019-2020	
Provisional or Final ?	Final	Final	Final	Final	Final	

**2016-2020: State Performance Measures**

**2016-2020: SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets**

<b>Measure Status:</b>		<b>Active</b>			
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		50	50	50	50
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Data Source	To Be Developed	Developmental Assessment Tool	Developmental Assessment Tool	Developmental Assessment Tool	To Be Developed
Data Source Year	2017-2018	2017-2018	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final



**2016-2020: SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water**

<b>Measure Status:</b>		<b>Active</b>			
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		72	73	75	77
Annual Indicator	71.7	71.6	70.8	70.8	70.8
Numerator					
Denominator					
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System
Data Source Year	2017	2018	2017	2017	2017
Provisional or Final ?	Final	Final	Final	Final	Final

## Adolescent Health - Annual Report

### DOMAIN: ADOLESCENT HEALTH

#### Annual Report for FY19-20 (October 19-September 20)

Adolescent Health – State Priority #3: Support and enhance adolescent’s social-emotional development and relationships.

As stated in the Child Health Domain of this report, a priority for the NYS Title V State Action Plan (SAP) is *Social-Emotional Development and Relationships for Children and Adolescents*. Work on this priority is focused in both the Child Health and Adolescent Health domains and there is a tremendous overlap of the strategies and activities.

In 2020, Title V staff recommended dissemination of previously identified existing data sources, relevant research findings, and evidence-based program resources, for DFH staff and adolescent serving programs. These resources are available and accessible to all Title V staff via the Title V program internally shared website. This includes current research, national and state-level statistics and indicators, registries of programs effective in reducing youth risk behaviors and resources for evidence-based programs.

On a periodic basis, Title V staff reviews materials and discusses information during team and Division-wide meetings. In 2017, staff created a preliminary information publication distributed throughout the Title V program, titled “Social Emotional Wellness (SEW) Update.” This publication was created to help highlight and disseminate information regarding social emotional development and relationships in children and adolescents by exploring relevant data, discussing available resources and addressing the importance of using these strategies while allowing for an opportunity to take an in-depth view on specific aspects related to the priority. DFH-wide staff involvement for the COVID-19 pandemic response efforts limited the team’s ability to produce an update in 2020; several e-newsletter concepts have been developed, including an issue focusing on individuals who identify as LGBTQIA+, as well as one on social and racial justice. These issues will be further developed for release in FY21.

As with the Child Health domain, in order to provide a meaningful contribution, a priority of the past year was to increase Title V staff’s understanding of the complexities within this topic and to learn about the evidence-based strategies associated with this work. In 2020, foundational work was conducted to develop a framework within which to address social-emotional development. The focus for some of the formative work in this area includes research and data for positive youth development strategies, Adverse Childhood Experiences (ACEs), trauma-informed care, well-child definitions as well as reviewing state and national-level data on specific measures that are within the scope of social-emotional development and relationships for the adolescent health domain.

In 2017, New York State data from nationally recognized surveys that included questions on ACEs and trauma were reviewed by Title V staff. The survey data were gleaned from the 2016 NSCH, the 2015 Youth Risk Behavior Survey (YRBS) and the 2016 Behavioral Risk Factor Surveillance System (BRFSS). Key findings include six out of 10 adults (59.3 %) reported having experienced at least one ACE and 13.1% reported 4 or more ACEs. The most frequently reported ACEs are emotional abuse (24.6%), parental separation (23%) and substance abuse in the home (22.2%). The surveys all indicated that there is a significant presence of trauma being faced by today’s youth. Therefore, it is advisable to proceed with a trauma-informed approach with vulnerable maternal, child and adolescent populations.

Title V staff have worked on collaborative efforts on social-emotional wellness subject-matter. In addition to the Early Childhood Advisory Council (ECAC) and Early Intervention Coordinating Council (EICC), the ACEs workgroup partnered with several NYSDOH areas as well as the NYS Office of Addiction Services and Supports (OASAS). Objectives included discussing the prevalence of ACEs in NYS and demographics of those affected and best practices to prevent, reduce and address ACEs. NYS has the Youth Development Team, which includes NYSDOH Title V staff, OASAS, Office of Mental Health (OMH), the Office of Temporary Disability Assistance (OTDA), and Office for Children and Family Services (OCFS)

and meets on a quarterly basis to address many topics facing today's teenagers.

In 2020, Title V staff continued to participate in the Trauma-Informed Care Champion Collaborative sponsored by the New York State Department of Criminal Justice Services (DCJS). Staff participated in ongoing meetings that address trauma-informed organizational change and how it can be implemented at the state level. The group includes 28 Champions from agencies such as Office of Victim Services (OVS), Office for the Prevention of Domestic Violence (OPDV), State Education Department (SED), Office for People with Developmental Disabilities (OPWDD), the Justice Center, OCFs, OMH and OASAS. The group has spearheaded this movement and continues to meet regularly to further work on how to promote trauma-informed care across the State and incorporate it into each State Agency's work. The Champions have been focused on first creating trauma-informed care definitions to increase consistency and understandability, determining baseline data, and identifying targeted areas in need. Creating these foundations will help the group to eventually implement the trauma-informed care lens at the state level.

The NYS Title V program has a long history of addressing social and emotional wellness in many programs that serve youth and adolescents, in fact, social and emotional wellness is at the heart of these programs. Programs focusing on both children and adolescents have been included in the Child Health Domain of the Annual Report. An additional Title V program focusing on adolescents and adults is the Rape Prevention and Education program, which has a central focus on social-emotional development and relationships. Programs are supported with Rape Prevention and Education (RPE) funds from the Centers for Disease Control and Prevention (CDC). The six Regional Centers for Sexual Violence Prevention implement interventions that focus on adolescents aged 10 to 24 years old and include community mobilization, coalition building, development or improvement of sexual violence prevention organizational policies, changing social norms, policy education, building social capital and additional educational sessions. The Bureau of Women, Infant and Adolescent Health (BWIAH) prepared to host a two-day provider conference in May of 2020 for over 200 community-based organizations, focusing on the impact of trauma, and headlining some of the national subject experts on ACES, trauma, and resiliency. Unfortunately, due to the rise of the COVID19 pandemic, the Provider Day seminar was cancelled. The conference was held in May 2021, and all of the keynote speakers originally booked, agreed to participated during the rescheduled conference.

The Rape Crisis and Sexual Violence Prevention Program (RCSVPP), overseen by DFH's Bureau of Women, Infant and Adolescent Health (BWIAH), provides 24-hour crisis hotlines and intervention services, short-term counseling, medical, forensic, and support services (e.g. accompaniment, advocacy, information, and referrals) to rape and sexual assault victims and survivors. BWIAH is responsible for approving rape crisis programs throughout the state for rape crisis counselor certification. These programs also build community support systems to improve prevention and response, provide community education and trainings for professionals who respond to victims/survivors and, provide direct services and outreach. Rape crisis programs touch upon the developmental assets in the following areas: support, empowerment, boundaries and expectations, positive values, social competencies, and positive identity.

The RPE program consists of six Regional Centers for Sexual Violence Prevention and the Statewide Center for Sexual Violence Prevention Training and Technical Assistance. These centers are funded by the CDC to implement evidence-based/evidence-informed primary prevention strategies and community change strategies in 17 counties throughout the state that have the highest reported forcible rapes in NYS. In 2020, the six Regional Centers for Sexual Violence Prevention implemented 49 total prevention strategies targeting all levels of the social ecological model. Of the 49 strategies, 12 were aimed at the individual/relationship level and 37 at the community/societal level. There was a total of 92 unique cycles of individuals/relationship level curricula completed, reaching 2,081 individuals.

The RPE program has spearheaded a Safer Bars Initiative, currently funded through a CDC cooperative agreement. As part of this initiative, NYSDOH funds six Regional Centers for Sexual Violence Prevention, which implement innovative sexual violence prevention community-level strategies, including Safer Bars curriculum training in 17 high-need counties. Studies have shown a significant link between increased sexual violence and alcohol consumption for both perpetrators and victims. As a result, training bar proprietors and their staff on what is sexual violence, how to observe and assess situations for signs of sexual violence, bystander intervention skills building, policy change assistance and environmental assessments

are all components of a comprehensive approach addressing all levels of the social-ecological model of violence prevention, which is the prevention framework the RPE grant program. CDC use a four-level social-ecological model to better understand violence and the effect of potential prevention strategies. This model considers the complex interplay between individual, relationship, community, and societal factors and allows for the conceptualization of the range of factors that put people at risk for violence or protect them from experiencing or perpetrating violence.

Currently, five out of six Regional Centers are utilizing the Safer Bars Curriculum created by the Arizona Safer Bars Alliance and Arizona's State Department of Health. The Regional Centers implement all components of the Safer Bars training (i.e., an individual/relationship level curriculum) including the environmental assessment and policy change assistance components (i.e., community/societal level approaches). One Regional Center is utilizing the OutSmart NYC bar bystander curriculum.

Across NYS, there are currently 45 Alcohol Serving Establishments (ASE) that have been trained in the Safer Bars curriculum and 16 trained in OutSmart with 669 bar staff/managers/owners trained. To teach the curriculum there are currently 50 trainers across the state qualified to train on the Safer Bars curriculum.

During this reporting period, the COVID-19 pandemic presented many challenges and barriers for the RPE program. To address many of the concerns with implementing and evaluating the RPE work, the NYSDOH RPE program issued a document titled "New York State Department of Health Guidance to Rape Prevention and Education Programs During COVID-19 Emergency" to the Regional Centers and their community partners. This document included information such as background information, the purpose for the guidance document, and suggestions for virtual program activity ideas. COVID-19 also required RPE staff to deploy on COVID-19 assignments. Several RPE staff (RPE Director and RPE Coordinator) were deployed on COVID-19 assignments for the NYS contract tracing efforts from 5/1/20 – 9/30/20.

In this reporting period, due to the COVID-19 pandemic, the Regional Centers were awarded COVID-19 Supplemental Funds from CDC. NYSDOH proposed four core activities to CDC in the state workplan that would be completed utilizing the supplemental funding. These activities included data use for the prevention efforts to support response, support partners to adapt prevention strategies, adaptations of the outer layer strategies, and track and evaluate risk and protective factors. At the Regional level, the six Regional Centers have been continuously working towards implementing innovative sexual violence practices both at the individual/relationship and community/societal levels of the social ecological model. The Regional Center contracts were amended for the implementation of current activities but adapted to be implemented through virtual platforms and innovate strategies. The Regional Centers have worked to implement current activities utilizing virtual platforms such as Zoom and other innovative techniques to be able to implement activities in a COVID-19 environment. This includes activities such as the adaptation of evidence-based/evidence-informed curriculum for virtual implementation, policy review and recommendations, media/marketing campaigns, and environmental scan and recommendations. In addition to implementing activities, the Regional Centers have been evaluating the adapted activities to determine reach, effectiveness, and feasibility.

The Enough is Enough (EIE) law was signed by Governor Cuomo in July 2015 to address sexual assault, dating violence, stalking, and domestic violence on college and university campuses. This program is overseen by the NYSDOH Campus Sexual Assault Prevention Unit within DFH's BWIAH. In the 2019-2020 contract year, funding was distributed to 52 rape crisis and sexual violence programs throughout the state to partner with colleges and universities to assist them in implementing uniform prevention and response policies and procedures to prevent and respond to sexual assault, dating violence, domestic violence and stalking on their campuses. Some activities offered through this initiative are faculty, staff, and student training and awareness activities to prevent sexual violence and domestic violence, provision of victim services, referrals, and medical services. The social-emotional components of this program include the provision of crisis counseling and victim services provided to campus sexual assault survivors, in addition to education and training on the prevention of sexual and domestic violence in campus communities. Trainings included the following webinars: a two-part webinar series titled *Serving Students with Intellectual and Developmental Disabilities, How Do We Engage Male Students in Prevention Sexual and Domestic Violence?* and *Addressing Alcohol's Role in Campus Sexual Assault: A Toolkit for and by Prevention*

*Specialists*. In addition, there were two in-person full-day trainings for all three of the Alliance TA regions titled; *Engaging Students and Reframing Workshop Titles: Complicating the Victim-Perpetrator Binary*, and *Beyond the Letters- Unpacking Queer Identities*. To date, through 252 partnerships with local colleges/universities, EIE rape crisis programs have provided information and/or direct services to 44,063 campus sexual assault victims and have reached 520,454 individuals through awareness events or educational campaigns, and 158,407 through training. These numbers include college/university students, faculty, staff, and parents/caregivers and are expected to continue to increase.

School-Based Health Centers (SBHCs), which receive Title V funding, serve elementary, middle, and high school age children, and are required to provide behavioral health screening for all patients as part of ongoing primary care. Most SBHCs provide additional mental health services on-site within the clinics located within the school buildings; mental health services are provided by referral at sites that do not have in-clinic resources. Currently, in NYS there are over 260 SBHCs which provide services including mental health assessments, crisis intervention, counseling, and referrals to a treatment continuum of services including emergency psychiatric care, community support programs, and inpatient care and outpatient programs. Research has shown SBHCs improve attendance in school and decrease emergency room visits. In the past year SBHCs enrolled 197,346 students and provided 702,865 visits for health and supportive services.

The goals of the Pathways to Success initiative, funded by the federal Office of Population Affairs beginning July 1, 2017 through June 30, 2020, were to strengthen community systems serving pregnant and parenting teens and young adults; improve the health, development, and well-being of young parents and their children; improve young parents' self-sufficiency through educational attainment; and increase awareness of resources available to expectant and parenting teens and young adults. The initiative is focused in New York City based on 2015 NYS Vital Statistics data showing Kings, Bronx, and Queens counties with the highest birth rates among females ages 15 to 24. This program ended on 6/30/2020 and a final report was submitted.

The Pathways to Success grant supports three community colleges (Hostos, LaGuardia and Borough of Manhattan) and a community-based organization (Public Health Solutions) to develop, expand, and sustain supportive communities to help expectant and parenting teens and young adults maintain their health and meet educational or vocational goals. The funded projects collaborate with Title V programs such as Maternal and Infant Community Health Collaboratives (MICHHC) and Maternal, Infant and Early Childhood Home Visiting (MIECHV) for home visiting supports, and other programs to strengthen support networks and referral systems for pregnant and parenting teens/young adults in these communities.

Pathways to Success utilizes an Asset and Risk Assessment Tool that assesses the student's financial, social, and educational support, as well as mental health, employment status, housing, food, clothing, health care, transportation, parenting skills, and touches upon developmental assets in all eight categories. All students and community members enrolled in the initiative receive healthcare referrals for prenatal, interconception, and postpartum care, social service referrals to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program; local Department of Social Services (DSS); and educational or vocational supports to better ensure academic and career success. The goals of this program align with the Title V program priorities including support and enhance adolescent social-emotional development and relationships, increase use of primary and preventive health care services, early identification and support for children's special health care needs, and promote supports and opportunities that foster healthy and safe home and community environment.

From July 1, 2019 to June 30, 2020, the program served 498 expectant and parenting students/community members, developed 29 new partnerships, and made 844 referrals. The most frequently cited needs of the program participants were help obtaining information, resources, or services for child needs; food; childcare resources, referrals, and supports; parenting education and resources; housing assistance; self-sufficiency and other supports; academic and educational supports; and home visitation.

Adolescent Health initiatives, including the Comprehensive Adolescent Pregnancy Prevention (CAPP), Personal Responsibility Education Program (PREP) and Sexual Risk Avoidance Education (SRAE) programs, aim to promote

healthy development, parent-child communication, relationship skills and healthy life skills through youth-focused activities. The CAPP and PREP programs continue to support providers specifically focusing on a multi-dimensional approach to adolescent health to support social-emotional well-being and strengthen community relationships to increase positive youth development and build developmental assets in youth. The CAPP and PREP programs reach approximately 31,000 adolescents aged 9-21 on an annual basis. The NYS Title V began the SRAE program in July 2019 to support implementation of education on sexual risk avoidance that teaches youth 10-13 years of age to voluntarily refrain from sexual activity and provide opportunities to build developmental assets through adult-supervised activities. The first year of SRAE had 879 participants. The Title V program continues to be committed to exploring additional funding opportunities that provide positive social-emotional development and relationship initiatives to pre-adolescents in underserved populations and communities.

Due to the COVID19 pandemic, between March and September of 2020, Kindergarten through 12<sup>th</sup> grade schools and youth-serving locations throughout the state experienced closures, transportation options were limited, and social distancing protocols were introduced. This reduced the ability for programs to meet the youth in a consistent manner. The ACT CCA worked with program model developers to ensure that evidence-based programs could be adapted with fidelity to a new virtual environment. Unfortunately, significantly less youth were served across the state compared to similar time periods. Additionally, Title V staff working on adolescent health initiatives were assigned to work on COVID19 related response efforts. This caused a temporary suspension of focused work on the Social-Emotional Wellness team and limited the ability for staff to interact with their program providers.

## Adolescent Health - Application Year

### Application for FY21-22 (October 21-September 22)

For Adolescent Health, New York's Title V program selected **the National Performance Measure (NPM) 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year**. This NPM was selected because it aligns with both population health data indicators and concerns voiced directly by adolescents in NYS. Most teens ages 12-17 had a preventive medical (86.3%) and preventive dental (89.1%) visits in 2019, but there is room for improvement and disparities persist – only 86.0% of Hispanic adolescents had a preventive medical visit compared to 89.3% of non-Hispanic White adolescents and only 78.2% of adolescents on Medicaid had their annual visit compared to 91.5% with private insurance. Adolescents across the state discussed that their medical providers lack compassion and respect for their young patients and that youth would prefer visiting providers who are more affirming and reflective of the youth themselves.

Preventive medical visits are one part of overall wellness, but data and community input point to other areas that could help adolescents thrive, such as social-emotional wellbeing and preparation for taking on the responsibilities of adulthood. Over 30% of high school students reported feeling sad or hopeless for more than two weeks in the past year and over 10% reported that they attempted suicide. Hispanic students are more likely to report depression symptoms and suicide attempts, and there are dramatic disparities based on sexual identity as well, with 60% of students identifying as gay, lesbian, or bisexual reporting depression symptoms and 26% reporting a suicide attempt. The importance of social support and the need for more people to talk to positive mentors were frequently mentioned by adolescents. They discussed feeling socially isolated and wanting opportunities for community engagement or building a sense of belonging. Only 16.4% of adolescents without special health care needs received services necessary to transition to adult health care. And beyond assuming responsibility for their own health care, adolescents voiced a desire for education about financial literacy, healthy cooking, navigating relationships, and other aspects of adulthood.

Adolescence is often a very challenging stage in a person's life. During this time, adolescents experience growth through physical development, cognitive development, social-emotional development, identity, and sexual development. Supporting adolescents' health and development and helping them prepare for their futures can have a lasting impact throughout the life course. The multifaceted nature of adolescent development and wellness means the selected NPM and its associated strategies are responsive to most of the priority areas, particularly health care, social support and cohesion, community services and amenities, and awareness of resources. This NPM also aligns directly with established priorities encompassed in the NYS Prevention Agenda goals to support and enhance children and adolescents' social-emotional development and relationships, strengthen opportunities to build well-being and resilience across the lifespan, facilitate supportive environments that promote respect and dignity for people of all ages, and other Prevention Agenda goals related to mental health and substance use.

Four specific objectives were established to align with this performance measure:

**Objective AH-1:** Increase the percent of adolescents, ages 12-17, with a preventive medical visit in the past year by 5%, from 81.3% in 2016-2017 to 85.4% in 2021-2022. (National Survey of Children's Health, NSCH)

**Objective AH-2:** Increase the percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling by 5%, from 53.5% in 2017-2018 to 56.2% in 2021-2022. (NSCH)

**Objective AH-3:** Increase the percent of adolescents, ages 13 through 17, who have received at least one dose of the Human Papilloma Virus (HPV) vaccine by 8%, from 67.3% in 2018 to 72.7% in 2022 (NIS).

**Objective AH-4:** Increase the percent of NYS adolescents without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 16.4% in 2017-2018 to 17.2% in 2021-2022. (NSCH)

Four strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the State Action Plan (SAP) table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

**Strategy AH-1: Incorporate specific activities to promote the wellness of adolescents across all Title V programs, including promoting and facilitating routine well visits, reproductive health care, oral health, and behavioral health.**

Adolescence is a critical stage of development when children grow physically, cognitively, emotionally, and socially to become adults. The lifestyle choices, behaviors, and relationships established during this time can affect an adolescent's current and future health. Routine well visits during adolescence are recommended by the American Academy of Pediatrics' Bright Futures as one way to foster health in the present and build a foundation for wellness into the future. They are an opportunity to promote healthy behaviors, discuss risky behaviors, provide important vaccinations, and address conditions that can interfere with healthy development. Comprehensive and inclusive reproductive health care and education are opportunities to help adolescents avoid or mitigate risky sexual behaviors. Title V funded programs also provide enabling services to adolescents, such as referrals to and linkages with community services and social supports to holistically address health and wellness, including mental health and social determinants of health.

The key programs that work to support adolescent wellness and help connect adolescents to needed services include Comprehensive Adolescent Pregnancy Prevention (CAPP) Program, Sexual Reproduction Avoidance Education (SRAE), Children and Youth with Special Health Care Needs (CYSHCN), School-Based Health Centers (SBHC), Family Planning Program, and Sexual Violence Prevention programs.

The NYS Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- Activity AH1.1: Through CAPP, provide information to adolescents and parents on the offering and arranging of adolescent sexual health reproductive services. The federally funded Personal Responsibility and Education Program (PREP) also provides this information, in partnership with the Title V program.
- Activity AH1.2: Through SRAE, provide medically accurate and complete sexuality health education services to youth.
- Activity AH1.3: Through CAPP, PREP and SRAE, increase access to health care services for adolescents through a referral process that includes confirmation as permitted while ensuring confidentiality.
- Activity AH1.4: NYSDOH staff, including Title V funded staff, and community youth-serving organizations provide trauma-informed education and training on social emotional wellness and positive youth development for children and adolescents
- Activity AH1.5: Within the Title V program, enhance collaboration between adolescent serving programs, including CAPP, SRAE, SBHC, and CYSHCN, to promote holistic adolescent health through provision of comprehensive physical exams and anticipatory guidance, including body mass index (BMI), behavioral health, oral health and reproductive health, for adolescents with and without special health care needs.
- Activity AH1.6: Collaborate with internal, including NYSDOH AIDS Institute and Bureau of Immunization, and external, NYS HPV Coalition, stakeholders to promote HPV vaccination with clinical providers.
- Activity AH1.7: Refer adolescent parents to family planning providers for contraception and birth planning, including SBHCs, where available.
- Activity AH1.8: Promote access to confidential reproductive health care services and preventive medical visits for adolescents, including through SBHCs, where available. Family planning providers deliver counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/interconception health.
- Activity AH1.9: Promote healthy relationships and sexual violence prevention using policy change, protective



environment strengthening, healthy social norms reinforcement, and skill-building to address individual, relationship, community, and societal risk and protective factors. Focus on groups experiencing disproportionate burden of sexual violence, including communities of color, adolescents and young adults, domestic violence victims, those experiencing low income, people affected by alcohol and drug abuse, and LGBTQIA+ persons.

- Activity AH1.10: Promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs.

**Strategy AH-2: Promote supports for adolescents to gain the knowledge, self-efficacy, and resources they need to prepare for and transition to adulthood.**

For young adults, with or without special health care needs, the transition to adulthood is a crucial time in their development. Young adults may move away from their parents, transition to adult health care, become increasingly sexually active, continue their education, and/or start a career. Navigating these transitions can be difficult for youth as their independence continues to grow. Often, an increased sense of independence can lead to an increase of unhealthy risky behaviors. Title V programs will provide youth with support to help prepare for and navigate this transition.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- Activity AH-2.1: Ensure adolescent providers have a mechanism in place to provide adolescent-related health care service referrals to other providers of health care services, including substance abuse (e.g., alcohol, tobacco cessation), mental health issues, and intimate partner violence.
- Activity AH-2.2: Refer adolescent parents to family planning providers or SBHC for contraception and birth planning.
- Activity AH-2.3: Support pregnant and birthing adolescent parents in attending prenatal, postpartum and well-baby appointments.
- Activity AH-2.4: Promote access to confidential reproductive health care services and preventive medical visits for adolescents. Family planning providers provide counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/interconception health.
- Activity AH-2.5: Ensure adolescent-serving programs provide training on adulthood preparation subjects, such as, healthy relationships, effective communication, career and education opportunities, health care transition, and financial literacy for adolescents with and without special health care needs to prepare them for a transition into adulthood.

**Strategy AH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care.**

Data-driven, evidence-based practice is essential to achieving public health goals for NYSDOH and the NYS Title V program. Across all Title V funded programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of programs and policies. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

The combination of public survey data gleaned from sources like NSCH and the Youth Risk Behavior Survey (YRBS) with data from NY's Adolescent Sexual Health Needs Index (ASHNI), Vital Statistics and other data systems provide information to identify areas throughout the state with the most pressing health needs for youth.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- Activity AH-3.1: Collaborate with the US Census Bureau and HRSA to conduct an over-sample of NYS National Survey of Children's Health, for NYS to allow for enhanced sampling of Black/African-American, Hispanic, and

CYSHCN during the 2022 data collection period.

- Activity AH-3.2: Title V staff will continue to use publicly available and internal surveillance data to identify adolescent needs and/or health behavior trends to support optimum adolescent health and development and determine funding areas for NYSDOH adolescent health procurements.
- Activity AH-3.3: Through ACT CCA trainings, webinars, and web posts, provide information and education to youth-serving organizations.
- Activity AH-3.4: Explore collaborative opportunities with the NYSDOH Division of Chronic Disease Prevention's (DCDP) Bureau of Chronic Disease Evaluation and Research (BCDER), which works with the NYS Education Department, to review and share information gathered through the YRBS.

**Strategy AH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact adolescents' health and well-being.**

Adolescent health outcomes are impacted by the social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability, and quality of SDOH. All ten priorities that emerged from community members' input during the Title V Needs Assessment revolve around SDOH and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities. Adolescents who participated in the listening sessions and focus groups were aware of how things like quality housing, safe communities, employment, and community services affect their health and well-being and that of their families and were well aware of the inequities in the access and quality for their communities. They discussed seeing their parents struggle and wanting change for their parents and for themselves as they near adulthood. Strategies focus on involving stakeholders who are representative of populations impacted by health inequities, particularly engaging and collaborating with youth, to inform program planning and implementation and policy development.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- Activity AH-4.1: Collaborate with other state agencies and youth-serving organizations on adolescent-centered priorities through the Youth Development Team (YDT). The YDT includes representation from NYSDOH, Office of Children and Family Services (OCFS), Council on Children and Families (CCF) and the Developmental Disabilities Planning Council (DDPC) in coordination with youth-led organizations.
- Activity AH-4.2: Ensure that NYSDOH health equity teams review materials before being widely disseminated to youth and youth-serving organizations.
- Activity AH-4.3: Collaborate with youth through focus groups and community forums for direct input with state initiatives and special projects.
- Activity AH-4.4: Involve stakeholders that are representative of the populations most impacted by racism and health inequities in programmatic decisions.
- Activity AH-4.5: Through NYSDOH adolescent providers, issue information on locally available resources and provide referrals specific to addressing the SDOH with adolescents from populations impacted by disparities.

The NYS Title V Program established two Evidence-Based Strategy Measures (ESMs) to track the programmatic investments and inputs designed to impact NPM 10:

**ESM AH-1: Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, and adult health care for adolescents with and without special health care needs to prepare them for a transition into adulthood.**

Data for this measure will come from annual surveys of adolescent health providers. The baseline value for this measure, taken from a 6-month program period of 7/1/2020 – 12/31/20, is 96.3%. The program has set an improvement target of 100% by 2025.

**ESM AH-2: Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation.**

Data for this measure will come from annual surveys of adolescent health providers. The baseline value for this measure, taken from a 6-month program period of 7/1/2020 – 12/31/20, is 68.7%. The program has set an improvement target of 75% by 2025.

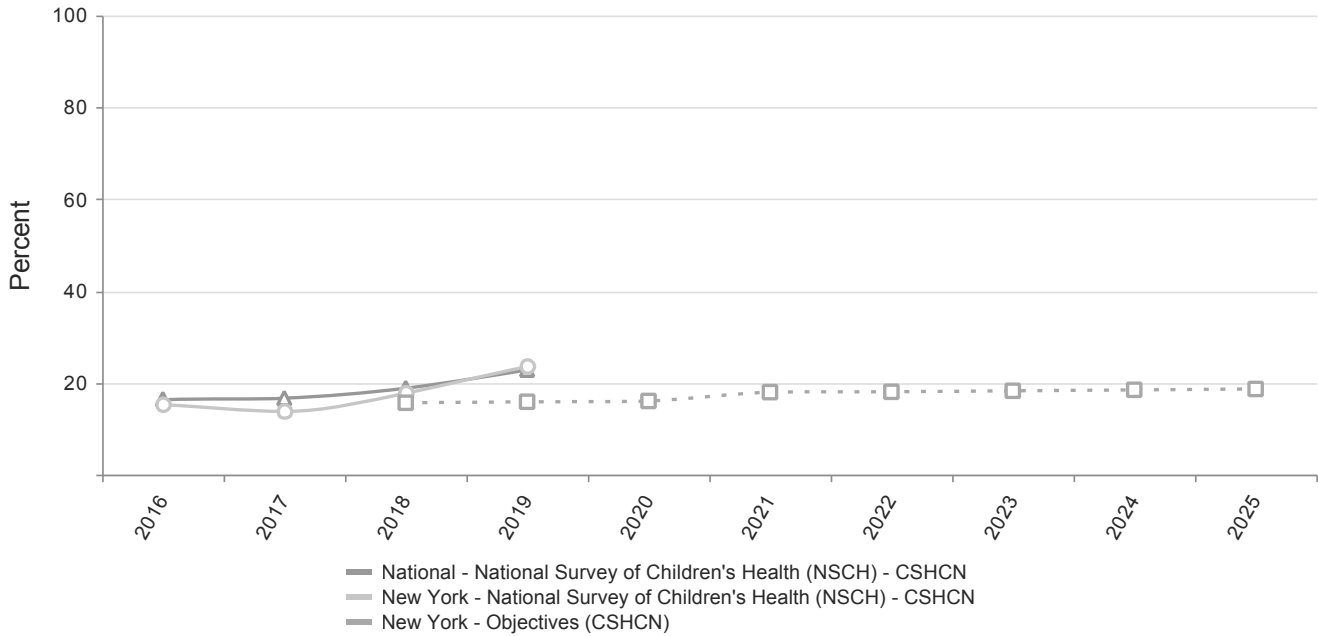
## Children with Special Health Care Needs

### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	11.0 %	NPM 12

**National Performance Measures**

**NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care**  
**Indicators and Annual Objectives**



**NPM 12 - Children with Special Health Care Needs**

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	2017	2018	2019	2020
Annual Objective			15.7	15.9	16.1
Annual Indicator		15.3	13.7	17.8	23.6
Numerator		48,081	34,736	48,580	87,040
Denominator		314,730	253,092	273,067	369,539
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	18.0	18.1	18.3	18.5	18.7	18.9

**Evidence-Based or –Informed Strategy Measures**

**ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.**

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	40.3	62.4
Numerator		295
Denominator		473
Data Source	Contractor Reports	Contractor Reports
Data Source Year	2018-2019	2019-2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.3	40.8	41.3	41.8	42.3	42.7

**State Performance Measures**

**SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months**

<b>Measure Status:</b>	<b>Active</b>	
<b>State Provided Data</b>		
	<b>2019</b>	<b>2020</b>
Annual Objective		
Annual Indicator		3.6
Numerator		1,772
Denominator		498,946
Data Source		NYS Child Health Lead Poisoning Prevention Program
Data Source Year		2018
Provisional or Final ?		Final

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	3.6	3.4	3.2	3.0	2.9	2.8



## State Action Plan Table

### State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 1

#### Priority Need

Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers

#### NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

#### Objectives

Objective CYSCHN-1: Increase the percent of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (NSCH)

Objective CYSCHN-2: Increase the percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (NSCH)

#### Strategies

Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy CYSHCN-3: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy CYSHCN-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well- being of children and youth with special health care needs. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

#### ESMs

#### Status

ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment. Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 2

Priority Need

Promote awareness and enhance availability, accessibility and coordination of services for families and youth, including CYSHCN, with a focus on areas impacted by systemic barriers, including racism

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Objectives

Objective CYSCHN-1: Increase the percent of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (NSCH)

Objective CYSCHN-2: Increase the percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (NSCH)

Strategies

Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy CYSHCN-3: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy CYSHCN-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well- being of children and youth with special health care needs. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

ESMs

Status

ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment. Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 3

Priority Need

Increase the availability and quality of affordable housing.

SPM

SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months

Objectives

Objective CYSHCN-3: Reduce the incidence of confirmed high blood lead levels at 5 micrograms per deciliter or greater per 1,000 tested children aged less than 72 months, with baseline incidence and benchmarks established in 2020-21 program year. The current incidence of confirmed blood lead levels at 10 micrograms per deciliter or greater is 3.7 per 1,000 children tested in 2016. (NYS Child Health Lead Poisoning Prevention Program Data)

Strategies

Strategy CSHCN-5: Support comprehensive public health efforts to prevent, identify, and manage childhood lead poisoning. Please see Supporting Document 2 "State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

## Children with Special Health Care Needs - Annual Report

### DOMAIN: CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN)

Annual Report for FY19-20 (October 19-September 20)

Children and Youth with Special Health Care Needs (CYSHCN) – State Priority #4: Increase supports to address the special health care needs of children and youth.

Children and youth with special health care needs (CYSHCN) and their families have needs for care and support beyond those experienced by other children generally. As stated previously in the overview and needs assessment, according to the 2018-2019 National Survey of Children's Health (NSCH), more than 751,000 (18.4%) of New York's children age 0-17 have a special health care need. NY's Title V program strives to support a coordinated system of supports and services for CYSHCN and their families.

While most of NY's children are insured, families continue to experience financial challenges meeting the needs of their CYSHCN. The Title V program provides funding for direct services through the Children and Youth with Special Health Care Needs Support Services Program (CYSHCNSS). In 2020, twenty (20) children received an evaluation and 61 received treatment services funded through CYSHCNSS. Data for 2020 has been delayed due to the COVID-19 public health emergency as local health departments continue to be heavily involved in response efforts. Services included orthodontia (26%), enteral formula and specialty foods (21%), medications (21%), medical equipment or supplies (7%), custom made/fitted equipment (5%), and ambulatory surgery (5%).

As outlined in the State Action Plan (SAP), the Title V program implemented the seven strategies for CYSHCN, and progress is described below.

The **first strategy** in the SAP involved the in-depth review and analysis of available data for CYSHCN and issuance of a data report. Title V staff reviewed data from the 2018-2019 National Survey of Children's Health and data reported by NY's Title V local health department-based (LHD) CYSHCN Program and the NYS Early Intervention Program under Part C of the federal Individuals with Disabilities Education Act (IDEA). Title V staff implemented a data analysis plan that included NSCH data for CYSHCN and children not identified as having special healthcare needs (non-CYSHCN). Weighted frequencies were performed to identify gaps in services and experiences among CYSHCN and non-CYSHCN. Title V staff sought to better understand the impact of having a child with special health care needs on both the child and the family and the associated factors.

Key findings included that 41% of CYSHCN live in households with income below 200% of the federal poverty level. About 9.3% of CYSHCN have their daily activities greatly affected by their health condition(s), 16.4% of CYSHCN miss 11 or more school days in a year, compared to 3.5% of NYS children without SHCN, and nearly half (49%) had trouble making or keeping friends. Families of CYSHCN report higher out-of-pocket medical expenses, have trouble paying medical bills, spend more time coordinating their child's health care, and report reducing or stopping work due to their child's health. In 2018–2019 the five key components indicating a child meets medical home criteria showed 64.5% of CYSHCN met the criteria, compared to 51.2% of children without SHCN. Less than one in four SHCN age 12-17 (23.6%) received services needed for transition to adult health care. Most of SHCN adolescents (70%) had a chance to speak to their health care provider alone at their last preventive check-up. Most providers (78.7%) actively worked with adolescents with SHCN to gain the skills to manage their health, while 33% of health care providers worked with adolescents with SHCN to understand changes in health care happening at age 18, and only 16.2% of providers discussed the shift to a provider who treats adults. The results are available on the NSCH website: <https://www.childhealthdata.org/browse/survey/results?q=7782&r=34&q=807>

To augment this national data, Title V CYSHCN program collects data from the 49 CYSHCN programs administered by

Local Health Departments (LHDs). Data elements added in 2019 to the system for LHD CYSHCN programs include whether the child has dental insurance and is enrolled in Medicaid's Health Home (HH). These elements were added to reflect the importance of understanding issues related to improving oral health and providing coordinated care management. An analysis of the LHD CYSHCN data for 2019-2020 program demonstrated that of the 1,033 CYSHCN children served, 52% had Medicaid, 28% had commercial insurance, 7% had Child Health Plus (CHP), 13% had other insurance, and 1.7% had no insurance reported. Additionally, 5.6% of children had Social Security Income (SSI). Sixty-six (66%) percent of CYSHCN served were White, 12% African American, 1.9% Asian or Pacific Islander, 1.2% American Indian or Alaska Native, 5% more than one race, 0.6% other race, and 12% had unknown race (i.e., did not respond); 12% of children were Hispanic. The percent of children reported to have a primary care provider was 99%. Among those served, 8.7% of CYSHCN needed assistance for a service not covered by insurance, 34% for a service exceeding the limit of the benefit package, 11% needed help with co-pays, 12% for deductible costs, and 17% for premium costs. In addition, information about referrals from the state's IDEA Part C Early Intervention Program was included. Approximately 25% of CYSHCN were referred by Early Intervention Program, up from 23% last year. There were 19 children referred to HH in 2019-2020, compared to 28 children the year before.

As previously reported, quantitative data alone cannot illustrate the complexities of navigating the many systems of care available to families of CYSHCN and statewide data cannot be used to understand local or regional differences. The **second strategy** in the SAP included engaging parents, families, and providers in a system mapping exercise (later renamed Care Mapping at caregiver's request) to identify the gaps and barriers in the system of public health programs and services for CYSHCN and their families. To get a comprehensive understanding of the complex needs of families with CYSHCN in NY, the Title V program engaged in a multi-year effort to conduct a comprehensive system mapping initiative. The results of the Care Mapping project were reported in the 2018 annual report. The work has continued and expanded as part of the comprehensive Title V Needs Assessment to continue to hear from families with CYSHCN.

NYSDOH has continued to share this feedback with stakeholders and partners, e.g., Parent to Parent of New York State, the NYS Association of County Health Officials (NYSACHO), the Office of Mental Health (OMH), the Office for People with Developmental Disabilities (OPWDD), and the Office for Child and Family Services (OCFS).

Beyond sharing the information back to the communities, NYSDOH has integrated the findings from the Care Mapping sessions into the current five-year procurement cycle (2020 – 2025) for funding of CYSHCN programs at LHDs that began October 2020. Elements added to the new work plan include reaching out to school systems, health care providers and childcare providers in order to help find CYSHCN and their families and connect them to services. In addition, NYSDOH allocated Title V funding to establish contracts with three Regional Support Centers for CYSHCN through existing relationships with three HRSA-designated University Centers of Excellence in Developmental Disabilities (UCEDDs). From October 1, 2019 to September 30, 2021 the Regional Support Centers (RSCs) will improve services to CYSHCN through the following initiatives:

1. Completing a needs assessment with each local health department and providing technical assistance to improve information and referral services to families of CYSHCN. RSCs will work with LHDs to build capacity to serve families through improved outreach and program promotion. As of September 30, 2020, RSCs conducted seven (7) needs assessments with LHDs. Additional assessments will be conducted in Fall 2020.
2. Developing an online searchable regional resource guide for both families and providers. Resource guides will include a comprehensive catalog of available resources, enabling LHDs to make more timely and effective referrals to services. Resource Guides are currently available on the Westchester Institute for Human Development RSC's website at: <https://www.wihd.org/research/cyshcn/>. Ultimately, Resource Guides will be housed on the NYSDOH website once they are properly formatted.
3. Gathering family feedback through listening sessions and telephone interviews with families of CYSHCN. The care mapping feedback sessions conducted in 2017-2018 provided NYSDOH valuable information on the challenges families and providers encountered in caring for CYSHCN. Continuous feedback is vital to ensuring challenges are addressed and to evaluate how the information received is aligned with local program and NSCH data. Feedback was collected by the RSCs from CYSHCN families via listening sessions to gauge their experiences with systems of

care, barriers, and challenges to caring for CYSHCN as well as including a focus on racial, ethnic, and language diversity. The three RSCs conducted 79 family listening sessions with a total of 205 participants, 31 who were Spanish speaking. In year two of RSC funding, Mandarin language capability will be added to listening sessions.

4. Developing educational materials. RSCs are developing training and educational materials for families and providers, including print materials and webinars on the importance of a medical home, transition of adolescents with SHCN to adult health care, and other topics determined from family feedback gathered. In September 2020, RSCs provided two (2) webinars for LHDs: a reintroduction to the RSC project with INCLUDEnyc as a guest speaker and an overview of Parent to Parent as a resource available for CYSHCN families. Thirty-two and 14 LHDs participated, respectively.

In reviewing participation in the Care Mapping initiative, Title V staff recognized that more work was needed to engage more diverse families. NYS has taken advantage of an opportunity to join a HRSA-sponsored learning collaborative led by the NJ State Parent Advocacy Network (SPAN) in partnership with Parent to Parent of NYS to support emerging family leaders for identified roles on community, state, and national teams and advisory groups focused on CYSHCN systems with a goal of increasing the racial and ethnic diversity of family representatives. Parent to Parent of NYS and Title V staff have developed a work plan and objectives to increase the number and diversity of families who provide input into the development of the state's priorities and initiatives and includes providing training for family leaders from underrepresented or underserved communities.

To provide additional support to LHD CYSHCN programs, Title V staff resumed quarterly calls with contractors and offered educational webinars. On January 13, 2020, the CYSHCN Program held a webinar with the LHDs to describe the new and exciting changes to the program for the upcoming 2020-2025 grant year. The CYSHCN program also introduced LHDs to our new partners, the three University Centers for Excellence in Developmental Disabilities (UCEDD), were introduced to the LHDs. Program details were provided as well. On March 6, 2020, CYSHCN staff traveled to one of the LHDs (Hamilton County) to discuss the program details with the new staff and their Director. On July 9, 2020, NYSDOH held a webinar with the LHDs to discuss the concerns and gather the feedback from the families of what they were experiencing during the pandemic. The concerns caregivers/parents were expressing the inability to provide the technical equipment and support for virtual learning. Caregivers/parents having difficulty expressing the "new normal" to their children with special needs. Families experiencing frustration on the limited guidance from the Committee on Preschool Education (CPSE) and other specialty areas. Another webinar with the LHDs was held on October 5 about the new five-year procurement, including reintroduction of the RSCs, especially to the new LHDs that had joined. In addition, Title V staff gave a presentation on the future of the CYSHCN program on January 27, 2020 to the New York State Association of Counties (NYSAC).

The **third strategy** of the SAP was to provide subject matter and technical support to the NYS Medicaid Program to implement and enhance care coordination and transition support services for CYSHCN through the Children's Health Homes (CHH).

As described in the CYSHCN domain, the enrollment of children in CHH began in December 2016. To be eligible for CHH, a child must be Medicaid eligible and have two or more chronic conditions including alcohol or substance abuse, mental health condition, cardiovascular disease, metabolic disease, respiratory disease, BMI at or above 85% or other chronic conditions; or one single qualifying condition such as sickle cell disease, HIV/AIDS, serious mental illness, serious emotional disturbance or complex trauma and at risk for another chronic condition.

In 2020, the Title V program participated with OHIP staff on site visits to twelve designated CHH agencies. On January 24, 2019 staff participated in a site visit with St. Mary's Healthcare (Amsterdam) and on February 6, 2019 staff attended Institute for Family Health (New Paltz). Title V and OHIP staff participated in site visits with the 10 remaining designated Children's Health Homes through 2019. On February 27, 2019, staff participated in a site visit with Northwell Health Homes; March 6, 2019 with Adirondack Health Institute; April 10, 2019 with Niagara Falls Memorial Medical Center; May 1, 2019 with Coordinated Behavioral Care (aka. Institute for Community Living); June 26, 2019 with Community Care Management Partners; July 17, 2019 with Greater Rochester Health Home; August 21, 2019 with Bronx Accountable Healthcare Network



Health Home; October 2, 2019 with Mount Sinai Health Home; October 10, 2019 with Central New York Health Home Network; and November 14, 2019 with Hudson River HealthCare, Inc. There were five anticipated visits remaining that were to take place in the Summer 2020 before the pandemic struck: on May 7, Collaborative for Children and Families (CCF), Children's Health Home of Upstate New York (Oshei) tentatively on May 27, Children's Health Home of Upstate New York (CHHUNY) in June 2020 and Niagara Falls Memorial Medical Center HH (NFMMC) and Greater Rochester Health Home Network LLC (GRHHN) were to be visited in the Fall. The following CHH have been rescheduled: Collaborative for Children and Families (CCF) for 2/23-2/26/21, Children's Health Home of Upstate New York (CHHUNY) for 2/9-2/12/21, and Niagara Falls Memorial Medical Center (NFMMC) for 1/26-1/29/21. Title V continues to provide subject expertise matter and provide technical assistance to NYS Medicaid Program to implement enhanced care coordination and transition support services for the CYSHCN through CHH. Title V will continue to provide subject matter to NYS Medicaid Program by participating in weekly conference calls for the CHHs. Title V will continue to participate in site visit to CHH, which might be different this year due to the pandemic, with OHIP and other state agency staff. Staff will continue to review policy and procedures for the Health Home site visits. Title V will review the HH correction action plan and provide feedback.

The purpose of the site visits is to assess each of the agency's organizational structure, governance model, readiness criteria, relations and connection to adult HH, planning for transitional youth, provider connection and training/knowledge of special populations (Medically Fragile, Early Intervention, specific geographical needs, among others) and their role in behavioral health. Title V staff are involved with the development of the site visit auditing process, as well the onsite case/chart review, and how providers can add expertise and build capacity to expand the populations they can serve. OHIP has developed several reports concerning the number of children in the outreach and enrollment phases of CHH. Title V staff has requested consideration of additional reports, such as the number of children enrolled by specific condition type, such as sickle cell disease, asthma, diabetes, and autism.

In addition, between January 1, 2019 and March 31, 2019, six 1915 (c) Home and Community Based Services (HCBS) waiver case management providers transitioned to HH care managers. They are also transitioning their enrolled waiver children in to HH care management if they chose to be in HH. On April 1, 2019, the Children's Waiver consolidated all six HCBS waivers into a single waiver. A single 1915 (c) Children's Waiver will streamline HCBS administration to have more consistent eligibility processes and benefits across all populations of children meeting the institutional level of care functional criteria. Also, Medicaid authorized Family Peer, Youth Peer and Crisis Intervention services to HCBS eligible children in July 2019 for Family Peer and 2020 for Youth Peer and Crisis Intervention.

Title V staff continue to promote HH in their public health work. The state CYSHCN Program will be monitoring the number of children referred to HH by the local CYSHCN programs.

Local CYSHCN programs are encouraged to reach out to the HH in their area and accept referrals made by the Care Management Agencies. In February 2019 Title V and OHIP staff hosted a one-hour webinar on HH to the Sickle Cell Disease contractors to inform them about CHH and to strengthen the collaboration and referral process between the two agencies. The work from this strategy has strengthened the collaboration and referral activities between CHH and the CYSHCN Program. Title V staff, as part of the CHH team, also helped to define policy related to comprehensive assessment of children enrolled in CHH. Title V staff contributed to the development of CHH indicators designed to assess process and outcomes related to children receiving care management. Title V staff co-presented at three webinars for CHH and Early Intervention Program provider agencies to gain input on supports and barriers to the CHH referral process for EI eligible children.

Enrollment data is being reported for the time period of 10/1/2019-9/30/2020. The number of children enrolled in CHH for this time period is reported to be 39,045 unique members an increase from the 27,071 children enrolled in CHH for the last quarter in 2019.

The **fourth strategy** in the SAP is to provide grant funding and technical assistance to support successful transition to adult services for young adults with Sickle Cell Disease (SCD) and evaluate projects to identify best practices for enhancing

support to other key CYSHCN population.

The Title V program has funded three contracts for “Coordinating Care and Supporting Transition for Children, Adolescents and Young Adults with Sickle Cell Disease (AYA/SCD)” beginning in July 2018.

Ensuring proper care and transition from pediatric care to adult self-directed care is the goal of the program. Transition is facilitated through provision of care management services, linkages with CHH and HH for adults for eligible individuals, and consistent implementation of transition services. Each grantee employs a Transition Navigator who builds a relationship with the individuals, their schools, their families, their doctors, and the interdisciplinary team to ensure a successful transition to adult medical care providers. The contractors have adapted the promising practices of the *Got Transition Health Care Transition Process Measurement Tool for Transitioning Youth to Adult Health Care Providers and Six Core Elements of Health Care Transition* as a tool to improve the outcomes for individuals with SCD. On January 30, 2020, the National Alliance to Advance Adolescent Health presented to the three contractors, “Evidence-informed Approach to Transitioning Youth to Adult Health Care”. In the Fall 2020, another webinar was held with the three contractors for the topic: Data Summary 2018-2020. The quarterly statistical tool that the contractors use to collect the quarterly data was updated for gathering consistent and concise quarterly statistical data. Transition Navigators were recruited and trained. Contractors employ tracking systems for patient reminders of scheduled appointments, missed appointments, and follow-up via text messaging and phone calls. Health specialty services are being provided to individuals when required.

Quarterly calls with the contractors were held to provide technical assistance. Work in strengthening the bond between the contractors and the Health Home agencies continue to be a priority to increase the number of individuals enrolled that meet eligibility. In April 2020, through Legislative Add On, the three contractors were awarded an additional \$66,666 each.

Title V staff review grantee’s progress towards meeting workplan deliverables. Data have been collected to monitor that 1) appointments are kept and, if needed, follow-up is received; 2) education on self-management and preventive care is provided; 3) support and linkages for peers/health/social supports and services needed by the children, AYA/SCD, and their families are received; and 4) enrollment in the appropriate HH care management occurs for AYA/SCD insured by Medicaid. In addition, Title V staff participated on a work group with the NYSDOH Office of Health Insurance Programs to identify initiatives to reduce hospitalizations among the sickle cell patient population.

From July 2018 to June 2020, performance measures and narratives have been submitted by the grantees’ quarterly using data reporting tool. The performance measures include the percentage of individuals ages 14-21 who 1) had an initial transition readiness assessment completed, 2) a subsequent transition assessment completed, 3) a refusal of assessment, and 4) no assessment. Additional performance measures include percentage of individuals ages 12-21 who reported the use of self-management strategies for pain management and percentage of eligible Medicaid-insured AYA/SCD ages 12-21 enrolled in HH care management. From July 2019 to June 2020, 62% individuals ages 14-21 completed transition readiness assessment which is more than 50% improvement compared to 39% for July 2018 to June 2019.

The **fifth strategy** in the SAP is to support the statewide IDEA Part C Early Intervention Program’s State Systemic Improvement Plan (SSIP), which is overseen within the Division of Family Health’s Bureau of Early Intervention (BEI). The SSIP is required by the U.S. Department of Education, Office of Special Education Programs. Each State’s Early Intervention Program (EIP) was charged with developing an SSIP focused on either improving child outcomes or improving family outcomes. The NYS EICC, which is the state’s governor-appointed advisory council, unanimously supported the selection of Family Outcomes for the New York State SSIP. The SSIP project in NYS is called Improving Family Centeredness Together (IFaCT).

NYSDOH completed a study of both family and child outcomes data in EIP. In response to a state survey, only 65% of families reported receiving enough help on family outcomes. For this reason, the focus of the SSIP is on family outcomes, as increased family centeredness can lead to improved child outcomes.

BEI worked from July 2017 to September 2020 with each county and borough to improve the experience for families and children receiving services through the EIP. Over the course of three years, BEI partnered with three HRSA-designated University Centers for Excellence in Developmental Disabilities (UCEDDs) to use an evidenced-based learning collaborative model to improve family outcomes by ensuring EIP services provided are family centered. UCEDD staff, municipal administrators, EIP providers, and parents shared experiences, planned strategies, and developed innovative ideas to further support children and families within EIP. The goal was to improve the quality of EIP services, increase parent satisfaction, and improve health and developmental outcomes for young children with caregivers taking a leading role in the effort.

IFaCT is a three-part project. First, in the planning phase, teams used data and evidence-based strategies to identify quality improvement goals. Next, in the collaboration phase, teams connected at an in-person learning collaborative meeting and through monthly coaching calls supported by the UCEDDs on how to implement their local plans. Caregivers, parents, and family members were on every local team and provided important insight and direction on ideas to improve family-centeredness in the EIP. After the in-person meetings, teams collected data to study the impact their change has made, and then acted on it over the course of one year (Plan-Do-Study-Act cycles). If the change improved family outcomes the team increased its use, and if the change did not help, the team reevaluated and adjusted their plan. Once local projects were completed, UCEDDs analyzed the data and used the information to develop web-based training and resource materials on best practices for family-centeredness.

NYSDOH had worked with the UCEDDs to identify best practices from the local projects and develop a Resource Guide. Based on feedback, the Resource Guide was transformed into two standalone publications, one for parents and one for providers. BEI staff are working with the Department's Bureau of Media and Creative Marketing and the Public Website Group to ensure the publications meet Department of Health standards for posting to the Department's website. The Department is also working with the UCEDD to ensure the publications are revised for readability at a sixth-grade reading level. The Resource Guides will also be included on the [www.eifamilies.com](http://www.eifamilies.com) website. This website is dedicated to parents of young children with disabilities, through a separate NYSDOH contract, which provides parent leadership and advocacy skills training for parents of children receiving EIP services.

BEI is integrating these best practices into State-sponsored professional development and training to reinforce family-centeredness, and update policies and procedures to support family centered practices in the EIP. Each of the three UCEDD spent Year 3 of their contract developing 10 trainings based on the best practices and successful projects from IFaCT. These 30 trainings vary in formats and include webinars, self-paced modules, and videos. All trainings will be available through the NYSDOH website once finalized and approved.

Examples of projects to increase family connections to each other and to their community include Facebook pages, family activity calendars, community resource websites and resource lists, parent support groups, increasing the number of family outcomes included in Individualized Family Service Plans (IFSP), and increasing the number of EIP services provided in the family's community (e.g., park, grocery store, church or synagogue, family gatherings). Based on several of the successful projects, NYSDOH is working on creating an electronic family listserv to connect directly with families, as well as a Facebook Group. The goal of both will be to better connect families directly with the NYSDOH, as well as provide resources and trainings to families.

Performance as measured by a parent-completed survey has demonstrated an improvement, as demonstrated by both higher percentages of families with positive responses than in the previous year (FFY 2018) and a higher percentage than the FFY 2019 Targets for all three indicators. In FFY 2019, 94% of families had a positive response on Indicator 4A (exceeding the Target of 93%), 96% of families had a positive response to Indicator 4B (exceeding the Target of 91%) and 95% of families had a positive response on Indicator 4C (exceeding the Target of 93%). There has been fluctuation from year-to-year, but the overall trend is improving.

The **sixth strategy** in the SAP is to use the IDEA Part C Early Intervention Programs Family Outcomes Survey data to

inform CYSHCN program initiatives. The EIP Family Outcomes Survey was developed to collect information about the ways in which EIP helps families of children receiving EI services. This survey is for families who are ending (exiting) or have recently ended (exited) EI services. The Family Outcomes Survey is part of an ongoing federally required initiative to improve outcomes for children and families who receive EI services. This national quality improvement effort is to learn about family views on the ways EI services help children and families in EIP, including family-centered practices that connect parents of children with similar needs and helping families take part in typical activities for children and families in their community. The results of this survey help guide efforts to improve services and results for children and families receiving EI services. In Federal Fiscal Year (FFY) 2017, NYSDOH decreased the number of questions on the family survey from 95 questions to 36 questions. These 36 questions comprise the Impact of EI Services on Your Family Scale (IFS).

The survey was also translated into six additional languages (Arabic, Bengali, Chinese, Russian, Spanish, and Yiddish). In FFY 2018, NYSDOH provided the survey in all seven languages in an online format, with the option to request a paper survey. This change however still did not see an increase in response. For FFY 2019, NYSDOH decreased the survey questions from 36 to 22, with two additional questions regarding telehealth. This survey was mailed on the back of the letter that was sent, with an online option to complete as well. In FFY 2019, NYSDOH saw the largest number of responses received ever, with 2,644 surveys received.

With the initiation of the CYSHCN Regional Support Centers this task will become part of the educational webinars and outreach they provide to counties. Subject matter and presentations will be identified and developed by the RSCs and approved by NYSDOH. Webinars will be recorded for continued use by Title V staff throughout the state.

The **seventh strategy** in the SAP is to provide technical assistance and facilitate a structured quality improvement project to engage health care providers, hospital staff, parent representatives, and audiologists to improve reporting of initial hearing screening and follow up results into the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS).

The Early Hearing Detection and Intervention (EHDI) Program works to ensure infants receive hearing screening by one month of age, diagnostic testing by three months of age for those who fail the screening, and are enrolled in appropriate EIP services by six months of age for those with diagnosed hearing loss. The EHDI Program collects data initially through the birth certificate from the state's two vital records system, Statewide Perinatal Data System (SPDS) outside of NYC and the E-Vitals system in NYC. These records are then integrated into the NYEHDI-IS, an application located within the state's online health portal, the Health Commerce System. If an infant does not pass the newborn hearing screening, follow-up and/or diagnostic audiologic evaluation results must be manually entered into the NYEHDI-IS by providers of these services.

Grant funding from the CDC was received for the period of July 1, 2020 through June 30, 2024 to support NYEHDI-IS. Funding from this grant was used to develop enhancements to the NYEHDI-IS.

Grant funding from HRSA was received for the period, April 1, 2020 through March 31, 2024 to support work to improve documentation of screening and follow-up test results and referrals to the EIP. The main objectives of this grant are: to maintain at least a 95 percent screening rate each year the number of number of infants that completed a newborn hearing screening no later than 1 month of age; to increase by 10% from baseline the number of infants that completed a diagnostic audiologic evaluation no later than 3 months of age; to increase by 15% from baseline the number of infants identified to be deaf or hard of hearing that are enrolled in EI services no later than 6 months of age; and to contract with a program or organization, that provides support to families of infants who are deaf or hard of hearing.

The EHDI program has recently released a Request for Proposal to contract with a program or organization, to develop content for a training curriculum including parent advocacy and leadership, along with specific content to support families of newly identified children who are deaf or hard of hearing. This contract was anticipated to start April 1, 2021 but has been delayed due to COVID-19.

The COVID-19 public health emergency significantly impacted CYSHCN programs, services, and staff. Title V staff COVID-19 deployments and assignments throughout the pandemic greatly limited and delayed traditional program work, including work with LHDs and RSCs. However, Department CYSHCN staff checked in with LHDs regularly to gauge what services they were able to continue providing CYSHCN and their families, what they were hearing from those families, and how we could help them. During those calls, emails, and webinars, their readiness and willingness to engage with the RSCs was evaluated.

In the spring of 2020, Title V staff prepared a document providing information and resources for CYSHCN and their families during COVID-19. Once approved, that document will be shared widely with LHDs, RSCs, and advocacy organizations. This will also be a resource for LHDs to use with families.

Since March 2020, many LHD staff have been focused almost exclusively on COVID-19 response, testing, and vaccination. Therefore, many traditional LHD programs and services were delayed or paused, including CYSHCN. Where possible, LHDs served the community remotely through virtual calls and meetings with families instead of in-person meetings as well as emailing information and resources to families.

COVID-19 greatly affected how the RSCs would need to work with the LHDs. The RSCs were flexible about how they could best support LHDs. RSCs established an email distribution list to share information and resources with LHDs. In addition, RSCs added three questions to the family session questions about COVID-19's impact on their children, families, and communities, especially regarding the disruption of services during the pandemic. The feedback from these questions allowed the RSCs and the NYSDOH a unique opportunity to gauge the CYSHCN community voice in the midst of the pandemic. This information will help inform the NYSDOH approach to technical assistance from the LHDs and RSCs going forward. RSCs were able to establish work plans and goals with some LHDs, while others have not yet had the time or ability to engage with the RSCs on that level.

## Children with Special Health Care Needs - Application Year

Application for FY21-22 (October 21-September 22)

For Children and Youth with Special Health Care Needs (CYSHCN), the NYS Title V program selected **National Performance Measure (NPM) 12: Percent of adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care.** This NPM was selected because it was voiced as a key priority by youth with special health care needs and their families and reinforced by state-specific population health data. Families reported that only 15% of CYSHCN receive care in a well-functioning system, and less than 18% of youth age 12-17 with special health care needs received services necessary to make transitions to adult health care. This is consistent with findings from New York's care mapping process conducted in 2017-2018, and with findings from the community listening forums conducted for this application, as detailed in the Needs Assessment summary, and discussed further below. Similar feedback was heard through family sessions conducted by Regional Support Centers in 2020. This NPM also aligns directly with NYS Prevention Agenda goals and interventions related to support for CYSHCN.

In addition, New York's Title V program established one State Performance Measure (SPM) for this domain, **SPM 2: Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months.** This SPM was developed to reflect the state's longstanding commitment to eliminating childhood lead poisoning as a key public health problem in NYS. It is responsive to cross-cutting priorities voiced by families related to safe and healthy environments to support children's development, and access to comprehensive, high quality health care services. It is also responsive to specific concerns shared by families regarding challenges in accessing and coordinating medical care and related services for children with special health care needs. It builds on critical public health investments and capacity to prevent, identify, and address lead poisoning in NYS, including recent amendments to state public health law, as discussed further below.

Three specific objectives were established to align with this performance measure:

**Objective CYSHCN-1:** Increase the percentage of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (National Survey of Children's Health, NSCH).

**Objective CYSHCN-2:** Increase the percentage of children and youth with special health care needs (CYSHCN), ages 0 through 17, who receive care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (NSCH).

**Objective CYSHCN-3:** Reduce the incidence of confirmed high blood lead levels at 5 micrograms per deciliter or greater per 1,000 tested children aged less than 72 months. The current incidence of confirmed blood lead levels at 10 micrograms per deciliter or greater is 3.55 per 1,000 children tested in 2019. (NYS Child Health Lead Poisoning Prevention Program Data)

Five strategic public health approaches were identified to accomplish these objectives over the five-year grant period. These are presented in the State Action Plan (SAP) table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

**Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN.**

Families and youth need to be directly involved in program and policy planning and implementation in meaningful roles at all levels. This is consistent with the Title V program's longstanding commitments to family-centered care/family-professional partnerships and positive youth development. As described in the Needs Assessment summary, families expressed a lack of awareness of resources and services in the community, barriers accessing transportation, challenges in finding and

accessing services and amenities in their communities, and needs for better social supports, social cohesion, and specific supports for parents and families. Directly involving family members, including youth, in the design, implementation, and evaluation of programs and services is critical to ensuring that those programs and services meet their needs and are delivered in ways that are empowering, respectful, accessible, culturally competent, and effective. Families of CYSHCN face unique challenges and bring knowledge, experience, and strengths that are a tremendous asset; they are the experts about their needs and care. This is a theme woven into all CYSHCN-serving Title V programs.

For example, the Title V Program contracts with three HRSA-designated University Centers for Excellence in Developmental Disabilities (UCEDDs), known as Regional Support Centers (RSCs), to provide training and technical assistance to local health department (LHD)-based CYSHCN programs and to conduct family engagement. The RSCs each have a family liaison who is a parent/caregiver of a CYSHCN; the family liaison role is seen as a critical component of the RSC work with families, CYSHCN, and LHDs. Family liaisons bring firsthand experience, perspective, and knowledge of barriers and gaps in care to all aspects of RSC activities, including meeting with families and resource gathering. Family liaisons are responsible for conducting family engagement sessions with a prescribed set of questions to gauge the needs of CYSHCN families. Meetings are all virtual, and not in-person as intended, due to the COVID-19 public health emergency. In addition, RSCs continue to conduct needs assessment surveys with each county, as available, to gather feedback and determine gaps and barriers, type of technical assistance needed, and what resources are available in each community. Some counties have established work plans regarding engaging their CYSHCN communities that the RSCs will continue to provide support on.

In addition, the NYSDOH has established contract with LHDs to administer the CYSHCN program locally, with the current contract timeframe from October 2020 to September 2025 and deliverables which include addressing family and community engagement at many levels. LHDs will involve families of CYSHCN in work groups, committees, task forces or advisory committees to improve the system of care for CYSHCN, involve families and CYSHCN in local planning activities, such as the Community Health Assessment (CHA), and use feedback from families of CYSHCN to develop training for CYSHCN staff and providers.

Sickle cell disease (SCD) grantees at three Hemoglobinopathy Centers (HC) work directly and exclusively with youth in support services. HCs conduct peer support groups to gauge barriers to care and transition for youth and young adults with SCD. Transition navigators at HCs engage youth with SCD to ensure compliance with care regimens and to understand that barriers youth experience in caring for themselves.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- Activity CYSHCN 1.1: Maintain at least one dedicated family representative on the state's Title V Advisory Council and engage all Council members in updates and discussion related to CYSHCN program activities.
- Activity CYSHCN 1.2: Collaborate with advocacy groups like Parent to Parent of NYS to understand the needs of CYSHCN and their families, facilitate information sharing, and promote LHD CYSHCN programs.
- Activity CYSHCN 1.3: Support RSCs to employ parents of CYSHCN as parent liaisons. Work with the RSCs and their parent liaisons to conduct surveys, family engagement sessions and family forums to assess and share family needs and apply results to inform family resources and TA for LHD programs.
- Activity CYSHCN 1.4: Support RSCs to develop a CYSHCN Resource Directory that will be made available online to provide families and health care providers with current information about services and supports.
- Activity CYSHCN 1.5: Support LHD CYSHCN programs to involve CYSHCN and their families in work groups, committees, task forces or advisory committees, local health assessment and planning activities, and other systems development work. Use feedback from families of CYSHCN to develop training for CYSHCN staff and providers.
- Activity CYSHCN 1.6: Engage the New York State Association of County Health Officials (NYSACHO) to promote and

bolster LHD CYSHCN programs to raise awareness of LHD CYSHCN services and reach and serve more families. NYSACHO will provide opportunities for Title V staff to speak directly to their members, participate in calls with LHDs, and help disseminate information and opportunities for CYSHCN and families.

- Activity CYSHCN 1.7: Support SCD programs in three Hemoglobinopathy Centers to provide supports by and for youth with SCD, including peer support groups, system navigation supports, and self-care services.
- Activity CYSHCN 1.8: Collaborate with other Title V and Division of Family Health adolescent-serving programs, including School-Based Health Centers, Comprehensive Adolescent Pregnancy Prevention, and ACT for Youth Center for Community Action to identify additional opportunities to meaningfully engage adolescents in program and policy development that impacts CYSHCN.
- Activity CYSHCN 1.9: Serve on the New York State Developmental Disabilities Planning Council (DDPC) and the Individuals and Families Committee, to promote inclusion of CYSHCN-specific focus to the DDPC's agenda and policy portfolio. DDPC membership includes parents of CYSHCN from around New York State who are directly involved in decision making regarding funding opportunities and policy development.

### **Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs.**

The Institute of Medicine identified care coordination as a key strategy to improve the effectiveness, safety, and efficiency of the U.S. health care system, improving outcomes for patients, providers, and payers. The most recent NSCH data for NYS show that about 73% of all children, and 64% of CYSHCN, age birth to 17 years who needed care coordination services received effective services. Preparing for and supporting the transition from youth to adulthood is especially important for CYSHCN and their families. Only 17.8% of youth age 12-17 with special health care needs received services necessary to make transitions to adult health care, highlighting the need for more specific attention to program and systems improvements in this area. Within this overall measure, there is variation in individual components of transition services. About 60% of adolescents with special health care needs had a chance to speak to their health care provider alone at their last preventive check-up. While 73% of adolescents with SHCN reported that their health care provider actively worked with them to gain skills to manage their health, health care, and understand changes in health care happening around age 18, only 12% reported that their doctors discussed the shift to a provider who treats adults, if needed.

Title V staff will identify supports to help youth and families coordinate care, including a specific focus on transition services, to improve efficiency, quality, health outcomes and patient satisfaction. CYSHCN often require specialty medical services across multiple providers and service settings and may experience multiple transitions as they develop and "age out" of specific programs or services, move across service and community settings, and become more independent growing from children to youth to adults. Care coordination services and more informal transition supports can be critical for CYSHCN and their families to manage their health and family needs during key periods of change and over time.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- Activity CYSHCN 2.1: Provide funding and program guidance to LHD-based CYSHCN programs to work with medical providers, childcare providers, and local school systems to improve communications between service providers to assist families with the referral process and support the transition of CYSHCN from pediatric to adult health care. LHDs will provide timely and appropriate information and referrals to insurance, health services, transportation, and community resources to support transition and other services for CYSHCN.
- Activity CYSHCN 2.2: Continue to support three HRSA-designated UCEDDs, which are known as the RSCs, to support youth, families, and LHD CYSHCN programs. RSCs will identify resources and develop a comprehensive Resource Directory for LHDs and families; provide technical assistance to LHDs; conduct family engagement opportunities; identify webinars or professional development for LHDs; develop training and education materials; facilitate communication among LHDs; and identify barriers, unmet needs and opportunities for CYSHCN and their



families. As described in the previous strategy, families and youth are deeply involved in guiding this work.

- Activity CYSHCN 2.3: In collaboration with the RSCs, facilitate professional development and information sharing between LHD programs related to transition, including a webinar on Got Transition's Six Core Elements.
- Activity CYSHCN 2.4: Administer CYSHCN Support Services (CYSHCNSS), a gap-filling supplemental program that provides reimbursement for specialty health care services for severe chronic illness or physically handicapping conditions in children who meet county financial and medical eligibility criteria.
- Activity CYSHCN 2.5: Provide grant funding, evidence-based strategies (NYS uses Got Transition) and technical assistance to Hemoglobinopathy Centers to support successful transition to adult services for young adults with SCD, including but not limited to transition policy, tracking and monitoring, transition readiness and planning, transfer of care, and transition feedback and completion.
- Activity CYSHCN 2.6: Support care coordinators at Hemoglobinopathy Centers to help SCD patients with appointments, scheduling, education, peer support and other health care transition services. These providers serve as "transition navigators," to assist the adolescent make a successful transition to an adult hematologist or other adult medical care provider. They also focus on providing these adolescents with the skills they need to successfully transition to adult care as evidenced by evaluation of readiness and follow-up post transition for satisfaction with care.
- Activity CYSHCN 2.7: Facilitate collaboration between Title V programs serving youth, including SBHC and CAPP programs, to inclusively address broader health needs of CYSHCN including social emotional health, oral health, healthy relationships, and sexual reproductive health.
- Activity CYSHCN 2.8: Provide subject matter and technical support to NYS Medicaid Program to implement enhanced care coordination and transition support services for CYSHCN through Medicaid Children's Health Home, including integration of eligible children also receiving services through the Early Intervention Program, referral of CYSHCN to Health Homes, and transition from Children's to Adult Health Homes.

**Strategy CYSHCN-3: Support comprehensive public health efforts to prevent, identify, and manage activities for children who have confirmed elevated blood lead levels.**

Studies show that no amount of lead exposure is safe for children. Even low levels of lead in blood have been shown to affect a variety of adverse health effects including reduced growth indicators, delayed puberty, and lowered Intelligence Quotient (IQ), as well as hyperactivity, attention, behavior, and learning problems. Children under six years old are more likely to be exposed to lead than any other age group, as their normal behaviors result in them breathing in or swallowing dust from old lead paint that gets on floors, window sills, and hands, and can be found in soil, toys, and other consumer products. New York has more pre-1950 housing containing lead paint than any other state in the nation, with approximately 43 percent of all of New York's dwellings containing lead-based paint.

Effective October 2019, NYS Public Health Law (§ 1370) and regulations (Part 67 of Title 10 of the New York Codes, Rules, and Regulations) were amended to lower the definition of an elevated blood lead level in a child to 5 micrograms per deciliter ( $\mu\text{g}/\text{dL}$ ), from the previous level of 10  $\mu\text{g}/\text{dL}$ . Health care providers in NYS are required to assess or test all young children in accordance with public health regulations, to confirm and report test results, and to ensure appropriate follow-up evaluation and management as needed. Local Health Departments are required to ensure follow up including environmental management based on the child's blood lead level. The Title V program supports supplemental grants for lead poisoning prevention programs in local health departments, as well as Regional Lead Resource Centers (RLRCs) based in academic medical centers to provide outreach and education to health care provider and families, technical assistance, individual case consultation and treatment of childhood lead poisoning. These programs are administered by the NYSDOH Center for Environmental Health. These Title V-funded program elements complement other components of the state's comprehensive public health approach that also includes laboratory testing and reporting, surveillance, outreach and education, and neighborhood-based primary prevention and healthy housing initiatives.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming

202122 year:

- Activity CYSHCN 3.1: Provide continued grant funding to local health department Lead Poisoning Prevention Programs (LPPP) and a statewide network of Regional Lead Resource Centers (RLRCs) to support enhanced regional and local efforts to reduce the prevalence of elevated blood lead levels in children birth to 18 years.
- Activity CYSHCN 3.2: Work with LPPPs, RLRCs, and other partners to ensure that all blood lead test results, including testing done in permitted/registered laboratories and point of service testing conducted in health care provider offices, are reported to the NYSDOH within the timeframes required.
- Activity CYSHCN 3.3: Through the RLRCs, support the provision of outreach and education to health care provider and families, technical assistance to providers and LHD programs, individual case consultation, and treatment of lead poisoning among children, pregnant women, and newborns, including chelation treatment where indicated.
- Activity CYSHCN 3.4: Through the LHD LPPPs and RLRCs, promote clinical prevention and screening practices in accordance with state requirements, including:
  - Routine blood lead testing for all children at age one year and again at age two years
  - Assessment of all children ages six months to six years at every well visit for risk of lead exposure, with blood lead testing as indicated by risk assessment
  - Provision of anticipatory guidance for all families about lead poisoning prevention as part of routine care.
- Activity CYSHCN 3.5: Through the LHD LPPPs, ensure that all children with elevated blood lead levels receive appropriate evaluation and management, including:
  - Confirmatory venous blood lead testing for capillary screening results  $\geq 5$   $\mu\text{g}/\text{dL}$
  - A complete diagnostic evaluation that includes a detailed lead exposure assessment, nutritional assessment, and developmental screening
  - medical treatment, as needed
  - referral to the appropriate local health department for environmental management.
- Activity CYSHCN 3.6: Through the RLRCs, increase capacity and sustainability in local health care and public health systems by engaging health care providers and professional medical groups in leadership roles within regional or community coalitions focused on the prevention and elimination of lead poisoning.

**Strategy CYSHCN-4: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs.**

As noted in other domains, data-driven, evidence-based practice is essential to achieving public health goals for CYSHCN. Continuous efforts are needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of CYSHCN programs and policy work. Sharing data with stakeholders, including providers, families, youth, and other community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels. Title V staff will continue to assess all available data sources to inform public health improvement strategies related to CYSHCN. A recently drafted summary document titled "New York State Profile of Children and Youth with Special Health Care Needs, 2017-2018", which updates the program's current 2016-2017 summary, may serve as one starting point for additional work in this area. This report explores the demographic, health, and functional difficulty profile of the NYS CYSHCN population, determines the impact that having special health care needs has on children and families, and identifies areas in most need of improvement to ensure NYS CYSHCN receive care in a well-functioning system. The NSCH 2018-19 is available now as well so the Profile will be updated again and posted to the NYSDOH website and shared with partners. As additional data become available (about annually), Title V staff will update this report, make it available through the NYSDOH public website, and share it with CYSHCN grantees, partner organizations like Parent to Parent and NYSACHO.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- Activity CYSHCN 4.1: Complete a careful analysis of the revised NSCH when available to assess available measures, trends, and other updates related to CYSHCN in NYS.
- Activity CYSHCN 4.2: Collaborate with the U.S. Census Bureau to conduct an over-sample of NYS 2022 National Survey of Children's Health for NYS to allow for enhanced sampling of Black/African-American, Hispanic, including CYSHCN.
- Activity CYSHCN 4.3: Analyze and report on available CYSHCN data for NYS, including data from the National Survey of Children's Health, share reports with LHDs and other stakeholders, and post on the Department's public website.
- Activity CYSHCN 4.4: Develop and implement plans for updating the current data reporting methods (quarterly and annual reports) of LHD CYSHCN programs and SCD care transition programs to NYSDOH Title V program. Analyze and share relevant data collected from programs to improve services and inform larger program and policy work related to CYSHCN.
- Activity CYSHCN 4.5: Use the data gathered from the CYSHCN programs to identify specific areas for further improvement and to inform improvement activities.

**Strategy CYSHCN-5: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well-being of children and youth with special health care needs.**

As noted in other domains, MCH outcomes are impacted by the social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability, and quality of SDOH. All ten priorities that emerged from community members' input during the Title V Needs Assessment revolve around SDOH and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

Many NYS families of CYSHCN are struggling with poverty, transportation, access to care (including availability of specialists), and sometimes employment, as many caregivers reported having to decrease hours worked or leaving jobs altogether in order to care for their children and coordinate care. Families facing day-to-day challenges like these may be less able to seek and use programs, or to take advantage of opportunities to provide feedback to LHDs or RSCs. NYSDOH, RSCs and LHDs need to meet people where they are, provide multiple methods and means for CYSHCN and their families to engage, and ensure that a diverse population is being recruited and retained by LHDs.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2021-22 year:

- Activity CYSHCN 5.1: Support 50 local CYSHCN programs based in LHDs, including encouraging inclusion and health equity measures in outreach and referrals.
- Activity CYSHCN 5.2: Work with the RSCs and LHD CYSHCN programs to integrate health equity into written materials, communication, outreach, and referrals for CYSHCN and families, all of which will reflect the ethnicity and diversity of the community, including engagement strategies. Health literacy will be supported by providing information in multiple languages, at appropriate reading levels and abilities, as available.
- Activity CYSHCN 5.3: Develop and implement data collection systems that allows LHD CYSHCN programs and Sickle Cell Disease care transition grantees to identify, track, and address disparities.
- Activity CYSHCN 5.4: Partner with key stakeholders such as Parent to Parent, LHDs and RSCs to identify and share best practices to address racial justice and health equity.

The NYS Title V Program established one Evidence-Based Strategy Measure (ESM) to track the programmatic investments

and inputs designed to impact NPM 12:

**ESM CYSHCN-1: Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.**

Data for this measure is from SCD Care Transition contractor reports. The initial baseline value for this measure, from the 2018-19 program grant cycle, is 40.3%. The 2019-2020 data reflects a percentage of 62.4%. However, the program improvement target of 5% for 2022 (to 42.3%) will be retained due to unknown factors during COVID-19 that may have contributed to an unusual data year.

## Cross-Cutting/Systems Building

### Cross-Cutting/Systems Building - Annual Report

#### DOMAIN: CROSS CUTTING AND LIFE COURSE

Annual Report for FY19-20 (October 19-September 20)

#### **Preventive Health – State Priority #5: Increase use of primary and preventive health care services across the life course.**

A life course approach to preventive health care is essential to ensuring healthy families and healthy communities. Increases in chronic disease such as heart disease, diabetes and obesity impact longevity and health outcomes. Racial and ethnic minority communities experience higher rates of obesity, cancer, diabetes, and HIV/AIDS, and maternal mortality and morbidity disproportionately impact women of color. Children are becoming increasingly vulnerable as an increase in overweight or obesity predisposes them to chronic disease and the numbers are even higher in African American and Hispanic communities. NY's Title V program selected this as a state priority to focus on preventing disease and illness before they occur with an emphasis on how social determinants impact health to work towards supporting healthier homes, workplaces, schools and communities.

An essential component of any effort to improve birth outcomes must be a specific focus on improving access and utilization of preventive health care services. With 50% of all pregnancies in NY unplanned, impacting the overall health of all women in NY is a key step in improving pregnancy and birth outcomes. To that end, improving access to health insurance and preventive health care is a major priority across the life course. By improving the overall health of NY women before pregnancy and concurrently working to improve the intendedness of pregnancies, Title V can be assured that this work will improve the health status and birth outcomes for all women.

Preventive health care services encompass well-woman, preconception, prenatal, postpartum, interconception, well-baby, well-child, and well-teen care. Based on analysis of available data and stakeholder input, Title V staff identified access to health insurance as a necessary element to the increased use of preventive services. NY's Title V program continued to rely on key external resources to further develop this scope of work that included the U.S. Preventive Services Task Force (USPSTF) recommendation for preventive care, the AAP *Bright Futures* Guidelines for Health Supervision of Infants, Children and Adolescents, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines for state Medicaid programs.

Building on an initial assessment conducted during the last reporting period, the NYS Title V program worked to identify and evaluate various program requirements and measures currently used by Title V-funded programs to promote preventive care. Currently, 58% of all Title V programs include a requirement to promote well woman care and 65% of programs include a focus on increasing health insurance enrollment. To better understand the types of measures being used, Title V staff worked with colleagues to obtain examples of how requirements and measures promoting preventive health care were being used across all Title V programs. Staff spoke with colleagues across DFH and identified several key programs with a major emphasis on promoting access to preventive care. Broadly speaking, this emphasis was most often seen in program requirements that promote health insurance enrollment, annual well woman visits, as well as assistance accessing preventive services for children and adolescents.

One such program emphasizing the role of preventive care is the Maternal and Infant Community Health Collaboratives (MICHC) program. The MICHC program seeks to improve maternal and infant health outcomes for high need, low income or Medicaid-eligible women and their families by supporting the development of multi-dimensional systems of integrated and coordinated community health programs and services. Using a life course approach, MICHCs work to improve preconception, prenatal, postpartum, and interconception health of Medicaid-eligible women by working collaboratively with community partners to implement strategies to find and engage Medicaid-eligible women and their families in health insurance, health care and other community services; assess a woman's needs and risk factors and make referrals to

appropriate services; coordinate services across community programs; and promote opportunities and supports for women to engage in healthy behaviors.

Another Title V program, which promotes access to preventive health care and provides those services, is the NYS Family Planning Program (FPP). Comprised of a network of 48 subrecipient agencies operating 166 separate clinic sites, the NYSFPP aims to make sexual and reproductive health accessible and affordable to low-income women and men across NYS. This program includes several comprehensive strategies used to promote access to preventive care for residents across NYS. These include, but are not limited to, the provision of required preventive health visits and screenings (including annual well woman visits, routine breast and cervical cancer screenings, vaccinations, etc.), as well as community education and outreach activities aimed at increasing community awareness of the necessity of timely access of preventive care services. NYSFPP clinics are also able to screen and enroll clients in a range of public health insurance options including Medicaid, Family Planning Benefit Program (FPBP), and the Family Planning Extension Program (FPEP).

NYSDOH Title V staff also work to improve preventive care access through the continued promotion of developmental screening for all children in NYS. Currently Title V staff from across the DFH are participating in or leading several major initiatives aimed at improving developmental screenings in NYS. These initiatives include the following collaborations/projects supporting the inclusion of developmental screening in Title V's maternal and infant health initiatives, ongoing steps to promote early identification of potential developmental delays and referrals to the NYS Early Intervention Program (EIP), participation in the Early Childhood Advisory Council (ECAC), ongoing work with the Early Childhood Comprehensive Systems (ECCS) grant with the Council on Children and Families (CCF), and collaborating on several statewide First 1000 Days in Medicaid Initiative workgroups.

NY's Title V program remains committed to ongoing efforts to support the integration of improved developmental screenings in both Title V work and within the EIP; Title V, EIP, MICHC, and MIECHV are overseen by the Division of Family Health. Title V staff working in MICHC and MIECHV programs have continued to make the inclusion of developmental screenings, either directly by program staff or via referrals to appropriate providers, a priority of their work. Current MIECHV activities include facilitation of a parent-completed developmental screening which is reviewed by home visitors and used to determine whether a referral to the state's EIP is necessary. MICHC activities include screening children with the Ages and Stages Questionnaire (ASQ) and providing referrals to the state's EIP when appropriate. EIP staff continue to focus on increasing developmental screening for all children they serve. The Child Find component of the EIP, which coordinates efforts made by other agencies and community programs that serve infants and toddlers to identify, locate, and track at-risk children using available resources, will also increase emphasis on developmental screening.

An important element of these strategies has been Title V's long-standing commitment to the NYS ECAC workgroup. Convened by the NYS Governor's Office, this council is comprised of partners from all sectors of the early childhood community. ECAC has a priority interest in promoting children's development, and a specific focus on increasing rates of developmental screening. To further that goal, ECAC convened a workgroup to advance developmental screening and follow-up, with a focus on policy-oriented interventions. Members of the workgroup have been involved in Medicaid's First 1000 Days initiative and the ECCS Impact grant. The Title V Director is the NYSDOH designated member of the ECAC and DFH staff are members of this group and will remain in this capacity throughout the upcoming program year.

NYS Title V program also works to support improved developmental screening across NYS through the work of the ECCS Impact grant. The grant supports efforts in three communities, Nassau County (Docs for Tots) and Erie and Niagara counties (Help Me Grow Western NY & CCRN of Western NY). Through a place-based approach focused on an "intentional effort to build, sustain and operationalize community capacity in improving systems around children's developmental health and family well-being," the project specifically aims to demonstrate a 25% increase from baseline in age appropriate developmental skills among 3-year-old children in selected NYS communities.

The grant supports collaborative quality improvement projects in the three high need counties (Erie, Niagara, and Nassau) to improve maternal depression screening and follow-up as well as developmental screening and follow-up for

young children. CCF is working closely with NYSDOH on this grant which was initiated in 2016. Progress is discussed in the Women's/Maternal Health Domain annual report.

Another unique collaborative opportunity to promote developmental screenings can be seen through the NYSDOH support of the Connections Project (formerly referred to as the Albany Promise Project) which is a regional cross sector partnership where community leaders in Albany, NY come together to support a shared cradle to career education vision. Focused on increasing school readiness among young children in the city of Albany, the Connections Project targets children under the age of five with a range of cross-sector multi-dimensional interventions. The NYSDOH is partnering with Connections, Medicaid managed care plans, and pediatricians to create a pilot program in Albany County that incentivizes pediatricians and health plans to help ensure all children enter school ready to learn. Title V staff participate on the Early Childhood Success Team that has focused on increasing enrollment in quality early childcare programs and increasing the proportion of Albany children performing at or above benchmark when they enter pre-kindergarten. Concurrently, the NYS Medicaid Redesign Team is conducting a pilot program that is assessing a wide range of benchmarks associated with access and quality of developmental screenings available. This included number of well child visits, number of children screened above, close to, or below cut-off, the number of children who screened in need that were referred to either the NYS EIP or the Committee on Preschool Special Education (CPSE), as well as longer-term outcomes including the number of children screened and number referred who then received services and did or did not show improvement.

Early in the process, partners identified a key area of concern – the late identification of developmental delays in many school-aged children. Finding that many children were beginning school with delays that could have been identified earlier, partners began an intensive process to better understand the system of child health care and how improved developmental screenings could improve subsequent outcomes for youth. Screening children at ages birth to four and addressing any needs that are present at that point in the child's life can significantly improve a child's outcomes as they grow.

Beginning with a process map of the current screening, referral, and treatment systems with the community, the Connections Project worked through a collective impact framework. This work included development of mutually reinforcing activities to improve the identification of developmental delays, referral, and service provision systems. While this kind of collaboration is not without its challenges, this dynamic opportunity is working to better inform the NYS Title V program support for developmental screenings in ways that could be applicable in other communities across NYS.

The NYS Title V program is continuing work to support the First 1,000 Days initiative a multi-disciplinary effort to maximize access to services for children and families within the first 1,000 days of life. NY's Title V program has been selected to partner on several activities as part of this initiative, chief among them working to expand access to Centering Pregnancy and evidence-based home visiting programs. Progress in these areas is discussed in the Maternal/Women's Health Priority section.

Recognizing the unique barriers impacting the ability of adolescents to obtain preventive health care services and the need to identify strategies that address barriers, staff have been collaborating with adolescent health experts from Cornell University ACT for Youth Center of Excellence (ACT for Youth) to identify the most effective way to obtain adolescent feedback on this topic. Building on the literature review conducted by ACT for Youth, Title V staff collaborated with experts from ACT for Youth on the development and facilitation of a survey focused on obtaining feedback from adolescents on barriers to accessing preventive services. Title V staff met several times during the project period to review potential questions, brainstorm which topics should be included, and contribute to the development of a plan to distribute surveys to CAPP/PREP providers. The electronic survey was deployed to CAPP/PREP providers early in 2019. Full analysis of this information is expected in Summer 2019 and will be used to inform program development.

To compliment this work and generate a broader understanding of the state-wide health status of adolescents in NYS, a student intern was hired to compile a report of overall adolescent health across NYS. The student reviewed data and resources from the Division of Chronic Disease Prevention on adolescent health, cancer prevention, tobacco control, healthy schools, and obesity prevention. Final data sources included Youth Risk Behavior Survey System, National Survey

of Children's Health, National Youth Tobacco Survey, and others. A comprehensive report on the current state of adolescent health in New York State based on race, ethnicity, and socio-economic status was completed. Special health care needs populations, geographical location, gender, and sexual orientation were considered when analyzing data. The information gathered provides a comprehensive snap-shot view with the most available information (as of 2018) on a variety of health information that can be used by public health administrators in making informed decisions, assessing the needs of communities, developing adolescent health-related grant programs, and responding to providers and funders

Beyond ensuring preventive care is emphasized in Title V programs, staff also recognized the importance of assessing whether women of reproductive age receive preconception health care. To measure the actual implementation of preconception health during routine visits, Title V staff have been working to support the inclusion of a "preconception health" module in the NYS BRFSS sampling. This survey, which broadly represents the non-institutionalized civilian 18 years and older population of NYS, will be used to help Title V staff understand if women are getting these important health care services. The BRFSS contains seven questions on pre-conception health as part of the family planning module, and these data have been analyzed and reports issued.

### **Oral Health: State Priority #6: Promote oral health and reduce tooth decay across the life course**

Oral health remains a key health indicator for women, infants, children, and families throughout their lives due to the impact it has on learning, social-emotional wellness, and overall health. The prevention of tooth decay remains a high priority for the Title V program, not only because of the effects of this disease and the associated social and financial impacts, but also because it is largely preventable and entirely treatable. According to 2016 NYS hospital discharge data (SPARCS), the rate of caries-related outpatient visit for children aged 3-5 years was 90 for every 10,000 children. NY's Title V Program is committed to promoting oral health through education, community-based interventions and programming that benefits all NYS residents.

One strategy to promote oral health is to provide financial and technical support for maintenance and expansion of community water fluoridation (CWF).

NYSDOH continues to provide both technical and financial assistance to communities to maintain and expand CWF. To ensure adequate technical assistance support, NYSDOH awarded a contract to the NY Rural Water Association (NYRWA) for the period of August 2018-July 2023. The contract is intended to provide technical assistance and guidance, increase water operators' knowledge about CWF, and help ensure fluoridated public water systems (PWS) are maintained and operated in compliance with all laws, rules and regulations and optimal fluoridation levels are maintained. NYRWA conducts onsite visits at water treatment plants to provide guidance on operating issues, provides technical support to water operators to ensure PWS are fluoridating at the optimal level, and delivers continuing education trainings (CE) for water operators on the topic of CWF. During the recent reporting period, NYRWA completed 21 onsite technical assistance visits to 13 unique PWS and held four CWF trainings for 125 water operators.

Financial assistance was also provided to 13 PWS through the Drinking Water Fluoridation (DWF) Grant program. As reported in previous annual reports, the grants have been awarded in four separate rounds. The most recent funding (fourth round) was released in August 2017 and a total of \$5.2 million was encumbered to support 14 executed contracts. The grant program can support either Planning and Feasibility Projects (i.e., development of an engineering report to assess the equipment and financial impact of CWF in a community) or Implementation and Maintenance Projects (i.e., upgrade of equipment to maintain CWF).

This strategy is measured by **ESM LC-6: Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.** Over the course of the reporting period, 25 different PWS received technical and/or financial support for CWF from the DOH DWF Grant program.

The State Priority is measured by **SPM #5: percentage of NYS residents served by community water systems that**



**have optimally fluoridated water.** Approximately 70.8% of NYS residents are served by community water systems with optimally fluoridated water. This data is captured by the Safe Drinking Water Information System (SDWIS), which is an Environmental Protection Agency (EPA) database managed by the DOH Center for Environmental Health (CEH). The most recent data are from 2017.

A second strategy to promote oral health is to increase the delivery of evidence-based preventive dental services across key settings, including school-based clinics, primary care practices and public health nutrition programs.

The Title V program has prioritized access to preventive dental care through promoting the delivery of care through schools. NYS has the largest School-Based Health Center (SBHC) program in the US. SBHCs can provide both medical and dental services, medical only or dental only. There are 48 hospital or FQHC sponsors (regulated by NYSDOH under Article 28 of NYS Public Health Law) providing dental services in 2,206 schools serving areas with low-income children (as determined by the percentage of students who qualify for the free lunch program) and may have limited access to dental services. The Title V Program has allocated funding to establish the School-Based Sealant Program (SBSP), with the goal of expanding the application of sealants on first-year molars of 2<sup>nd</sup> and 3<sup>rd</sup> graders, which is an evidence-based approach to combatting tooth decay. Twenty-five SBHC providers of dental services were awarded \$50,000 per year for five years. Columbia Memorial Hospital (CMH), a SBHC provider of dental services and SBSP contractor, closed its school-based dental program in December 2018 due to their inability to hire a dentist despite a year-long search. As such, 24 SBHC providers currently provide SBSP services. SBSP grantees are required to report data to NYSDOH to support the evaluation this strategy.

This strategy is measured by **ESM LC-7: Percentage of 2<sup>nd</sup> and 3<sup>rd</sup> graders served by School Based Sealant Programs (SBSP) who receive sealants.** For the current reporting period, 24% of 2<sup>nd</sup> and 3<sup>rd</sup> graders enrolled in the SBSP received sealants compared to 21% the previous year. It must be noted, due to the COVID-19 public health emergency, NYSDOH directed SBHC providers to suspend all non-urgent dental services until further notice, as per the "Interim Guidance for School-Based Health Centers Regarding COVID-19" released by NYSDOH on April 2, 2020. As such, these results reflect services that were provided from October 1, 2019 to March 31, 2020.

The Title V program continued to partner with the Madison County and Jefferson County local health departments (LHD), through funding from the HRSA Oral Health Workforce Grant, to address dental workforce needs and access to oral care in underserved areas of the state. DFH Oral Health staff and Title V Dental Director are supporting these LHDs, which have prioritized oral health initiatives in their counties, to promote evidence-based oral health strategies including community water fluoridation and fluoride varnish in the medical setting. Title V staff have supported the LHDs' efforts by participating in community meetings, securing experts to provide consultation and technical assistance, and making connections to other agencies and support systems, such as Title V funded SBHCs, in their area. Staff also worked to identify additional LHDs to partner with for the 2020-2021 grant year. They presented on the HRSA grant, alongside Madison and Jefferson County, at the New York State Association of County Health Officials (NYSACHO) monthly membership meeting in December 2019. Staff also reviewed the community health assessments for the 7 counties that selected oral health as a priority and selected two counties (Cayuga and Essex) to engage in discussion. Calls were held in February 2020, and both agreed to partner with NYSDOH, but COVID-19 impacted progress. The grant is supporting the development of a public health detailing curriculum to promote and increase primary care providers' application of fluoride varnish as part of a routine well-child visit. Two live webinar trainings on applying fluoride varnish in the medical setting were held in August 2020, one for LHDs and the other for medical providers. Thirty-nine people requested continuing education credits for the live events. The trainings were recorded and posted on SUNY Albany's website as enduring continuing education credit activities through August 2023. All training participants received a copy of NYSDOH's Children's Oral Health kit, a folder of patient and provider resources. LHDs participating in the detailing pilot were also sent copies of the kit in preparation for detailing in 2021. This public health detailing curriculum builds off the work conducted by NYSACHO, as reported in previous annual reports.

Title V staff continued to collaborate with the worked with NYSDOH Division of Chronic Disease Prevention (DCDP) on the closeout of the on addressing sugar-sweetened beverage (SSB) project which aimed to address SSBH consumption

among adolescent males of color. The project ended in July 2019 and the final progress and evaluation reports were submitted to and accepted by CDC in November 2019. The posters developed under the SSB project continued to be promoted across Title V programming even after the conclusion of the grant.

A third strategy to promote oral health is to integrate oral health messages and strategies within existing community-based maternal and infant health programs.

From 2015-2018, BWIAH received funding from Health Resource and Services Administration (HRSA) for the Perinatal and Infant Oral Health Quality Improvement (PIOHQI) to integrate oral health strategies into community-based maternal and infant health programs through care coordination and public health detailing.

The PIOHQI Project was integrated into BWIAH's Maternal and Infant Community Health Collaboratives (MICHC) Program. Title V staff worked with a MICHC program in Western New York - the Healthy Baby Network (HBN)- and their subcontractor, Eastman Institute for Oral Health (EIOH), to engage providers and community partners in finalizing the Oral Health Manual Toolkit and refining individual and systems-level strategies to improve maternal and infant access to oral health care and increase provider capacity. EIOH, in collaboration with HBN, trained 126 participants, ranging from dental care providers, perinatal care providers, and community health workers virtually and in-person on the use of the Toolkit and how providers can address oral health needs among high-need pregnant or parenting women and their families.

An Oral Health Manual and Toolkit was developed for providers and community health workers to provide a best practice resource and increase knowledge and capacity. The Toolkit was shared with the state's MICHC programs. MICHCs also received training on use of the Toolkit and in turn trained their staff (Community Health Workers) and prenatal care and dental providers on best practices.

During the reporting period, MICHC programs continued to train new community health workers, and worked to identify oral health champions in their communities, share information with and/or train healthcare professionals through public health detailing, and/or educate partners at community network meetings.

The Pathways to Success initiative (which ended June 30, 2020) continued its work integrating oral health strategies into community-based maternal and infant health programs. Pathways to Success works to develop and implement programs to improve educational, health and social outcomes for expectant and parenting teens, women, fathers, and their families. The project was based in NYC with three community colleges and a community-based organization. These projects focused on building collaborations both internally within their organizations and externally with community providers and with other NYSDOH maternal and child health programs to strengthen support networks and referral systems to core services, including personal health, child health, education, employment, concrete supports (e.g. housing, transportation) and parenting supports (e.g. parenting education, healthy relationships). The goal was to establish solid and sustainable collaborations to ensure that young parents and their families are identified early on and receive referrals to needed resources and supports. The Pathways to Success program shared the Toolkit developed by the PIOHQI Project with these organizations to ensure that staff working with expectant and parenting teens were knowledgeable about oral health needs and made appropriate recommendations for this population.

This strategy is measured by **ESM LC-8 Percentage of pregnant women served by Title V community health workers that have a documented screening or referral for dental services**. NYSDOH tracks aggregate data reported quarterly by all 23 MICHCs to monitor the number of clients who are screened for oral health needs, received appropriate oral health information, and are referred for needed dental services. These data are reviewed quarterly, assessed for accuracy, and presented back to the MICHC programs for quality improvement purposes. In 2020, a reported 67.7% (12% increase from 60.5% in 2019) of prenatal and postpartum women who were served by CHWs had a documented screening for dental issues, and 15.3% of women screened were referred for dental services. Data collected allows tracking of completed referral rates and shows 27.6% of prenatal and postpartum clients referred for dental services completed the referral. This is a decrease from 2019, most likely due to the COVID-19 pandemic.

A final strategy in the SAP to promote oral health is to strengthen the NYS Title V program's internal capacity, dental public health core competencies and workforce development for oral health surveillance and evidence-based interventions through continued support for NYS Dental Public Health Residency.

The NYS Dental Public Health Residency Program (NYSDPHRP) was designed to support and build capacity for all MCH oral health programs through the utilization of dental residents' subject matter expertise in clinical dentistry and public health. The curriculum, based upon the core competencies as recognized by the American Association of Public Health Dentistry, focuses on MCH goals and objectives. Through collaboration and engagement with Title V staff on various MCH programs, the dental residents have a unique opportunity to apply concepts and tools in real public health settings, preparing them to assume critical roles in the practice of dental public health for improving health outcomes. Specifically, NY's strategy is to strengthen Title V internal capacity by developing core dental public health competencies in residents. During their residency, the residents contribute to oral health program activities and analysis of evidence-based interventions implemented by the Title V program. Between 1998 and 2018, NYSDPHRP had 43 graduates, the majority of whom are working as public health dentists in state government, community-based clinics, and academic and hospital settings.

NYSDOH continues to partner with the Eastman Institute for Oral Health (Eastman). CODA granted the request to transfer the program to Eastman. As a result of the transfer, Eastman has become the accredited program to sustain operation of the dental public health residency program for current and future residents. NYSDOH and Eastman are currently finalizing an affiliate agreement that outlines NYSDOH's roles and responsibilities as an affiliate site. These changes support the long-term objectives of the residency program to maintain a fully accredited training program for dentists interested in careers in dental public health.

During the COVID-19 response the residency program curriculum is being assessed in recognition of emerging dental public health issues related to workforce and access to care, health equity and current resources available to support the program. The Dental Director is also seeking out evidence-based and evidence-informed training resources to enhance residency program experiences that address updates to CODA standards focused on social determinants of health; and identifying specific activities for residents to support oral health interventions including preventive services in school-based dental clinics and the Community Water Fluoridation Program.

This State Priority is measured by NPM #13.1 Percent of women who had a dental visit during pregnancy and NPM #13.2 Children age 1-17 who had a preventive dental visit in the past year. For 2017 as reported in PRAMs, 45.4% of women surveyed had a dental visit during pregnancy as compared to the 47.2% in 2016, which was a slight decrease. For children with a preventive dental visit, the NSCH 2018-19 combined data reports NY at 77.7, slightly lower than the national average of 79.6. For NOM #14 Percent of children ages 1-17 who had decayed teeth or cavities in the past 12 months, the NSCH 2018-19 combined data reports NYS at 11.2% similar to 11.1 on the level for 2017-18, although slightly lower than the national average 11.6. The NSCH 2018-19 combined data show a decrease in the decay rate yet showing a slight decrease in preventive visits.

**Healthy Communities – State Priority #7: Promote supports and opportunities that foster healthy homes and community environments.**

The objectives and measures in this priority area address a variety of subjects, reflecting the broad scope of factors impacting MCH. This priority area aims to impact physical activity, obesity, wellness, safety, and community social cohesion. Title V programs cannot impact these areas alone, making collaboration a critical focus of this priority area's strategies. The sources of these metrics are national surveys including the NSCH, using the most recent data available. Measured by **NPM #8 Percent of children ages 6-11 and adolescents age 12-17 who are physically active at least 60 minutes per day.** For adolescents ages 12 to 17 years, daily physical activity increased slightly between 2016 (18.3%) and 2017-2018 (19.9%) and was better than the national percentage of 17.5%. For children aged 6 to 11 years, those participating in daily physical activity increased from 22.9% in 2016 to 27.0% in 2017-2018.

In the 2017-2018 NSCH surveys, 53.0% of NY parents reported that their child lives in a supportive neighborhood, which is slightly lower than the national level (56.3%), but higher than those reporting in 2016 (50.1%). This includes parents' responses about whether people in the neighborhood help each other out and watch out for each other's children, and whether they know where to go for help in their community. Fewer NYS parents reported they agree their child is safe in their neighborhood compared to all parents nationally (58.1% compared to 65.3%, respectively) and the perception of safety increased slightly from 2016 (57.2%).

Stakeholder input obtained in the preparation for this application identified factors, including access to healthy, affordable food, safe places, to engage in physical activity and social support as important elements of a desirable community and are believed to have significant impact on families' health and wellbeing. These perceptions are consistent with broader and longstanding public health approaches aimed at supporting healthy communities, including strong commitments to community-driven change, fostering policy, systems, and environmental change strategies, and addressing social determinants of health. These broad, policy-level issues require a collaborative approach; the health sector must work with social services, planners, transportation, and other partners to begin to create change in NY's communities.

Title V staff also kept abreast of NYSDOH partners' efforts to change community environments to improve health outcomes for women, children, and families. The broad scope of environmental-level issues impacting communities' health—physical activity, obesity, wellness, safety, and community social cohesion—require cross-sector involvement. Staff had varying levels of engagement with the following partner programs: Creating Healthy Schools and Communities, Healthy Neighborhoods Program, Regional Centers for Sexual Violence Prevention and NY Rural Water Association.

Staff monitor the accomplishments of Title V partnerships by tracking programs with activities focused on collaboration or partnerships and outcomes at the community, environmental, or policy levels. Measured by **ESM LC-11: Number of community environmental changes demonstrated as a result of enhanced collaborations**. During the past reporting period, of nine programs meeting those criteria, six met their community, environmental, or policy level changes as a result of their enhanced collaborative efforts.

Environmental change continues through enhanced collaboration with partnerships from activities of the six Regional Centers for Sexual Violence Prevention (Regional Centers). Since 2014, these Regional Centers have been implementing innovative primary prevention community-level (coalition-building, community mobilization, social norms and policy change) and individual-level sexual violence prevention strategies (Bringing in the Bystander, Shifting Boundaries) with youth and young adults, ages 8-24, from seventeen high-risk counties across NYS. In past years, the Centers for Disease Control and Prevention (CDC) State Profile of NYS indicated that at least 60% of the Regional Center program strategies were currently being implemented at the community/societal level of the social ecological model, exceeding the CDC requirement of at least 50% of strategies implemented at the community/societal-level. During the current reporting period (2/1/19 – 1/31/20), the Regional Centers worked to maintain this level of community/societal-level strategies. This unique comprehensive approach will increase NYSDOH Rape Prevention Education program's (RPE) capacity to access and use data, leverage support, and align state goals and proposed outcomes with implemented strategies at the local level. To ensure RPE continues to increase the capacity for implementation of community/societal level strategies, RPE will utilize guidance, evaluation, and continuous quality improvement efforts to direct activities to the outer layer of the social-ecological model and create multi-layer approaches to sexual violence prevention.

In addition to the CDC's four focus areas, the RPE has created four initiatives through which the Regional Centers will focus primary prevention efforts. Each Regional Center is required to work within two, but no more than three, of the following RPE initiatives:

- Healthy School Communities
- Healthy Nightlife Communities
- Healthy Sport Communities
- Healthy Neighborhoods.

Within each chosen RPE initiative, Regional Centers must incorporate the following components:

- Implement individual/relationship level curriculum from either CDC's STOP Sexual Violence Technical Package or that meets CDC requirements
- Media/marketing campaign
- Policy scan and recommendations
- Environmental scan and recommendations.

A monthly tracking tool will estimate the proportion of each Regional Centers' effort towards community and societal level strategies per month. Effort may be measured in the form of meetings with partners, description of changes to documents such as posters, letters, or strategic plans, delivery of curriculum, targeted recruitment efforts, and other steps along the path to producing outcomes.

The Regional Centers and community partners continue to invest considerable time and effort in the development and/or implementation of healthy community-level strategies including healthy nightlife (an initiative aimed to promote a healthy community by engaging bar owners, bar staff, and community patrons to create and build safe nightlife establishments) and healthy school initiatives (an initiative aimed to promote a healthy school community by providing sexual violence prevention education and establishing policies). Studies have shown a significant link between increased sexual violence and alcohol consumption for both perpetrators and victims. As a result, training bar proprietors and their staff on what is sexual violence, how to observe and assess situations for signs of sexual violence, bystander intervention skills building, policy change assistance and environmental assessments are all components of a comprehensive approach addressing all levels of the social-ecological model. The Regional Centers have been implementing the Healthy School and Healthy Nightlife initiatives since the previous five-year (2/1/14 – 1/31/19) RPE project period. The Healthy Sports and Healthy Neighborhood initiatives are new as of February 1, 2019 and are in the preliminary stages of development with assistance from the Regional Centers as well as the Statewide Center for Sexual Violence Prevention Training and Technical Assistance (Statewide Center). Between February 1 to July 31, 2019, Regional Centers conducted 30 nightlife trainings in bars/restaurants to 378 participants and 19 trainings within school communities to 1,846 students.

The settings of sports and neighborhoods are important settings to address for sexual violence prevention. For example, the Statewide Center has been in contact with Kansas RPE Director to discuss their work with Crime Prevention Through Environmental Design (CPTED) and how Kansas is utilizing this approach to address the environmental safety. While CPTED is a possibility for use in this initiative, it is important to ensure that NYSDOH RPE assesses potential challenges this model may present for the SV framework, such as reinforcing ideas about bystander intervention and the effects of gentrification. Unfortunately, environmental safety design is an area where there is a significant lack of individual-level curricula and overall research specifically regarding SV. For the sports initiative, the NYSDOH RPE evaluation team contacted the Coaching Boys Into Men (CBIM) and Athletes as Leaders (AAL) developers to assess the effectiveness of the programs and how we may be able to utilize the curricula within the NYSDOH RPE sports initiative to address this community. Additionally, the Statewide Center has communicated with the Director of Prevention at the New York State Coalition Against Domestic Violence (NYSCADV) about partnering to offer CBIM and AAL trainings to NYS.

Studies also indicate there is a higher incidence of sexual violence, and accompanying behaviors and attitudes, within schools among youth and young adult populations. The Regional Centers and community partners prioritize ages 8-24 years old as studies have shown this is where the problem persists most. School-based interventions for adolescents have shown emerging evidence of effectiveness in "improving gender-equitable attitudes and increasing self-reported likelihood to intervene in situations of bullying and partner violence" (Lundgren & Amin, 2015). Currently, the Regional Centers have been implementing bystander intervention curricula, such as Bringing in the Bystander; other programs for implementation include Shifting Boundaries, Girl's Circle and Council for Boys and Young Men, and Mentors in Violence Prevention. Currently there are 12 schools, 818 individuals trained, and 53 trained trainers throughout the six Regional Centers. From February 1, 2018 – January 31, 2019, the Regional Centers have trained 12 schools in various sexual violence

prevention/healthy relationship curriculum. Currently, there are 53 trainers across the state qualified to train in various healthy relationship, sexual violence prevention, and bystander intervention curricula such as Shifting Boundaries, Mentors in Violence Prevention, and Bringing in the Bystander.

Further community-level collaborative efforts are supported through the MICHCs. The MICHC initiative seeks to improve maternal and infant health outcomes for high need, low income or Medicaid-eligible women and their families by supporting the development of multi-dimensional community systems of integrated and coordinated community health programs and services. MICHCs work to improve preconception, prenatal, postpartum, and interconception health of Medicaid-eligible women by working collaboratively with community partners to implement strategies to find and engage Medicaid-eligible women and their families in health insurance, health care and other community services; assess a woman's needs and risk factors and make referrals to appropriate services; coordinate services across community programs; and promote opportunities and supports for women to engage in healthy behaviors. MICHCs utilize Community Health Workers (CHWs) to assist Medicaid-eligible women of reproductive age to effectively access continuous and coordinated health care and other needed community services responsive to their needs and risk factors. On a systems level, MICHC programs work with community partners in the health and social services arena to assess resources, prioritize community needs and strengths; and implement community-level strategies to address the needs identified. For example, Many of the MICHC programs have established formal and informal agreements with their local Regional Perinatal Centers and birthing hospitals to allow CHWs access to NICU and maternity wards to engage with new parents, offering support with breastfeeding and other psychosocial needs and connecting parents to home visiting services as appropriate.

Efforts such as Pathways to Success also demonstrate a strong community partnership to enhance the lives of young parents. The Pathways to Success initiative funds three community colleges and one community-based organization to create and sustain supportive systems that help expectant and parenting teens and young adults succeed through health, education, self-sufficiency and building strong families. The initiative utilizes an Asset and Risk Assessment (ARA) tool that helps Pathways staff to assess the needs and existing resources for young parents and their families. This structured interview tool enables funded projects to identify and prioritize assets and needs and develop a tailored list of referrals for each program participant. The ARA tool is also conducted over multiple client contacts, helping build a relationship between program staff and student participants, as well as providing opportunities to reassess needs and outcomes of referrals previously made. From July 1, 2018 to June 30, 2019, the program served 737 expectant and parenting students/community members, developed 190 new partnerships, and made 817 referrals. The most frequently cited needs of the program participants were: childcare resources, referrals and placement; parenting education and resources; child needs; transportation services; housing assistance; food; academic or educational supports; workforce development; other self-sufficiency, education, or employment services; and benefits eligibility screening or application services.

This State Priority is also measured by **NOM #15 Rate of death in children aged 1 through 9 per 100,000**. In 2017, NY's rate was far below the national rate (13.1 compared to 17.2 per 100,000). **NOM #16.1 Rate of deaths in adolescents age 10-19 per 100,000**. In 2017, NY was again below the national rate at 22.1 vs. 33.7. Finally, **NOM #20 Percent of children and adolescents who are obese (BMI at or above the 95<sup>th</sup> percentile)**. NY again is below the national percentage of 15.5% at 13.4% as reported in 2019 YRBS for high school students.

**Health Equity - State Priority #8: Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population.**

While numerous interventions have positively impacted MCH health outcomes over the years, persistent health inequities, especially racial, ethnic, and geographic, have continued to manifest. As stated in NY's FY 2019 application, NY's Title V program includes health equity as a life course priority to ensure a stronger concentration on improving access to quality, comprehensive health, and supportive services across all domains.

To fully meet the needs of all New Yorkers, NY's Title V program has made a concerted effort to incorporate a Health Equity framework into all aspects of NY's Title V program. Since Fall 2016, Title V initiated the development and implementation of a

series of strategies aimed at improving health equity in NYS as it relates to MCH.

As with all State Priorities (SP) across Domains, Title V staff focused on improving data collection and measurement of Title V initiatives to identify health disparities. Coordination expanded among the Title V staff and research groups within the NYSDOH Bureau of Chronic Disease Research and Evaluation, Bureau of Injury and Occupational Health, Office of Minority Health and Health Disparities Prevention (OMH-HDP), OHIP, and PHIG, to provide performance and outcome measures for each SP area.

For several years, NYSDOH has had a Prevention Agenda (PA) dashboard which tracks many public health elements at the county level. The PA dashboard enables partners to use these data to tailor their efforts and track impact. Title V program decided to pattern the MCH dashboard on the NYSDOH PA dashboard. Plans for the MCH dashboard were developed and Title V staff worked with OPHP to identify pertinent data elements that could be tracked at the county level. The ability to view county-level data that mirror national and state metrics in NY's SAP that include race and ethnicity will allow partners to address Title V priorities on the local level and strengthen NY's efforts to promote health equity and improve the health and wellness of the MCH population. Targets were established by the Title V data committee for each of the measures and the dashboard is now live and regular updates are planned.

Social determinants impact health equity, and therefore it is imperative that staff develop an understanding of the complex interconnection of various social, environmental, and systemic issues that often manifest in health inequity. Additionally, NY's Title V program recognizes that all staff members bring with them their own experiences, history, and bias which can make proactively addressing health equity even more challenging. To improve Title V staff's understanding of health equity, additional training and support beyond the typical onboarding process and education is being planned.

Title V staff worked to improve the internal capacity of Title V staff to promote and support health equity in all aspects of work. Promotion of health equity requires a unique, often tailored, approach. As noted in earlier applications, DFH established a cross functional health equity team for this purpose. Team members are drawn from all areas of DFH broadly representing the various population domains and programs funded by Title V. By engaging a diverse range of staff on the Health Equity, Title V staff is working to ensure that a Health Equity framework is incorporated all work within DFH at various levels. Title V staff investigated the disparities that exist, strategies and mechanisms that Title V programs are currently using to address disparities and/or health equity, possible additional areas for intervention and committed to at least one health equity area on which to focus for each SP. Increasingly, health equity team members are called upon by Title V to lend their expertise in program discussions and new initiatives to ensure that they include ways to improve equity.

Continuing to emphasize the importance of increasing staff capacity to proactively address health equity issues, Title V staff worked to finalize implementation plans for a comprehensive health equity curriculum. Required of all Title V staff, including administrative and support staff as well as interns, this multi-session curriculum was selected and compiled by the Title V Health Equity team with a goal of building a solid foundation of health equity understanding. Using the DOH Learning Management System (LMS) ensures that participation in training modules are effectively tracked across all Title V Staff. Using resources from a variety of partner organizations including; HRSA-funded Region 2 Public Health Training Center (PHTC), a partnership of three Council on Education for Public Health accredited schools of public health, including Columbia University Mailman School of Public Health, Rutgers School of Public Health, and the University of Puerto Rico Graduate School of Public Health, along with the University of the Virgin Islands Community Engagement and Lifelong Learning Center, and NYSACHO, this training series is meant to ensure all Title V understand the ways in which they can work to directly improve health equity through their day-to-day work.

Based on a comprehensive review of available modules, the four courses selected were: 1) From Concept to Practice: Health Equity, Health Inequities, Health Disparities & Social Determinants of Health, 2) Health Literacy for Public Health Professionals, Center for Community Health Lecture Series: 3) Bridges out of Poverty and 4) Health Equity Data to Action. All staff working in the Title V program will be required to complete the training over a four-month period. Objectives from the four courses were collected to form the basis for an evaluation plan for the curriculum.

Building on last year's work Title V staff continued to support the completion of this training across DFH. This work included a large-scale training roll out for all existing staff, followed by a comprehensive audit to ensure completion. Any staff identified as failing to complete the training were re-issued instructions and required to complete the training within a specific timeframe. In addition, new staff were directed to the LMS system and given instructions on completing the required training within their first six months as a new hire. As part of ongoing performance management initiatives, Title V staff continues to track quarterly completion of each training to ensure all staff have completed the required health equity trainings.

Title V staff also continued to ongoing in person training opportunities related to health equity for any interested Title V staff. This continues to include regular meetings of a health equity-focused book club held during hours outside of the normal workday, for any staff who choose to participate. The purpose of the book club is to offer a non-threatening venue in which issues related to health disparities can be discussed by a diverse group of interested members to increase awareness and understanding. Since its inception the book club has continued to generate positive employee feedback and participation. To date the book club has read and discussed several different books including: The Immortal Life of Henrietta Lacks by Rebecca Skloot The Hillbilly Elegy: A memoir of a Family and Culture in Crisis by J.D Vance, My Beloved World by Sonia Sotomayor, and "How to Be Antiracist" by Ibram X. Kendi.

Much of the health equity work accomplished in DFH and done by Title V staff continues to emphasize new and innovative ways to center community and participant voice in program planning. DFH employs several different mechanisms to capture community voice and incorporate that feedback into the development and improvement of programs. The most consistent way in which this is achieved is through a series of community listening sessions. Allowing participants to direct conversation and collectively identify what they perceive to be the barriers and assets of their respective communities, listening sessions have been an invaluable tool in aiding Title V staff to better understand priority populations and individuals receiving services.

Following the facilitation of seven listening sessions centered around maternal mortality in 2018, DFH staff spent much of 2019 completing a comprehensive analysis of the data collected in order to develop a report outlining barriers, challenges, and suggestions for improvement from those women most impacted by poor maternal health outcomes While participants at each session brought up regionally or locally specific issues, DOH analysis revealed that the majority of feedback shared revealed common themes across the state. Based on the data collected from each forum, DFH staff identified six recurring areas of concern for women across the state. This included health systems, providers, racism, information and education, disrespect, and social supports.

Common barriers expressed across all seven listening sessions included:

- Access to health care (limited facility choice, quality of provider and facility care).
- Poor communication with health care providers (especially feeling providers were not listening to them, that they were not given enough time with providers, and that few providers reflected their lived experience).
- Lack of information and education from providers.
- Racism and its impact on the quality of care received.
- Disrespect from health care providers, including support and administrative staff.
- Lack of social supports.

And common suggestions for addressing the racial disparities in maternal mortality included:

- More black and Hispanic health care professionals, reflective of the community.
- Increase health care professionals' awareness of racial disparities in health outcomes.
- Train health care professionals on the impact of implicit bias on health care outcomes.
- Increase provider support during the postpartum period.
- Increase availability of social support for example, birthing classes, group prenatal care, doulas, midwives, community health workers and parenting classes.



- Increase availability of community services and resources, for example, community health worker services and home visiting services.

The final report created based on this feedback was completed in early 2019 and approved for publication in summer 2019. This report was shared with those organizations that hosted sessions as well as other maternal child health providers across the state.

The Department's commitment to promoting health equity continues to extend well beyond NY's Title V program. Title V staff have continued to play a major role in the NYSDOH's Center for Community Health (CCH)'s Racial Justice (RJ) Workgroup. The workgroup is charged with proactively promoting a racial justice framework throughout the work of CCH, including Title V activities, epidemiology, WIC, SNAP, tobacco control, and cancer prevention services. Activities of the RJ workgroup take place within the context of a performance management infrastructure leading to the development of a series of RJ focused performance measures to guide the work of CCH.

Each division was charged with creating two measures, one internally focused (e.g., staff development, training, and capacity building) and one externally focused (e.g., community collaboration, coalition building, engagement of priority populations). The Title V program continues to play a major leadership role in the development of these performance measures. Building on several years of successful health equity focus, RJ workgroup members elected to develop a single internal performance measure to be used across CCH, based largely on Title V MCHSBG activities led by DFH for the past several years. This performance measure mirrors the format and evaluation of Title V MCHSBG work and dramatically expanded the staff who are required to complete a comprehensive online training on health equity. Title V staff further impacted the development of several external performance measures (PMs) by modeling a community listening session protocol that was adopted by several other divisions to increase community input and participation in program development.

The Title V program recognizes the value and importance of understanding and addressing health equity to improve the health and wellness of all New Yorkers and will continue efforts to ensure all families have access to quality primary and preventive health services. The priority placed on addressing health disparities is integrated throughout NY's work and in this report. It is clear through efforts spearheaded by Governor Cuomo related to maternal mortality and efforts through NYSDOH and Title V, there is a strong commitment to addressing this significant public health priority.

**Cross-Cutting/Systems Building - Application Year**

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

### III.F. Public Input

The mission of the NYS Title V program is to improve the health and wellness of women, children, and families. Engaging the community to gain a more comprehensive understanding of those factors impacting the health of the community and practical strategies to impact those factors is critical. When the community is engaged, new insights emerge, and ideas staff thought to be true were challenged or refined based on input from those who are directly impacted by the work. Developing approaches to improve health outcomes for all NY's families requires commitment and partnerships with families, health and human service providers and professionals, organizations, and advocacy groups as well as other key stakeholders.

The NYS Title V Program has always sought public input to ensure the state's Title V strategies and efforts reflected the needs, thoughts, and priorities of all Maternal and Child Health (MCH) stakeholders. During the reporting period, in addition to the stakeholder group conversations that staff conduct on an on-going basis, a more formal and systematic approach was used to intentionally prioritize specific groups to delve deeply into communities from whom greater understanding of life experience might shed light on disparate health outcomes.

In collaboration with the NYS Maternal, Infant, and Early Child Home Visiting (MIECHV) program and a broad network of community-based organizations, forums were hosted across the state with families and community members to facilitate open discussion about individual, family, and community health and services. A total of 37 forums were held in 18 NYS counties and in the Akwesasne Territory of the St. Regis Mohawk Tribe, with over 700 community members. Each forum focused on specific populations including expectant parents and parents of young children, done in partnership with the MIECHV program; other adult men and women; adolescents; and families of Children and Youth with Special Health Care Needs (CYSHCNs). Notes of the discussions were recorded by community partners. Participants were racially diverse and reported primary languages of English, Spanish, Chinese, and Haitian/Creole.

Ten common themes emerged reflecting the voices of forum participants across all population groups and geographic areas. Specific quotes from community members are invaluable in understanding the issues they face. Some powerful examples are included below for each theme.

1. Lack of awareness of resources and services in the community
  - *If it was not for finding myself in a shelter due to a domestic violence situation, I would have not known about resources in my community and I do not feel like that is a good thing. (Expectant or new parent)*
  - *You hear about services too late; you're already struggling. (Expectant or new parent)*
2. Transportation barriers
  - *...here are big gaps in the day when you either have to spend your whole day... go early and spend your whole day waiting for your appointment. So you waste a lot of your day, that you [could] have worked or done something else. (Adolescent)*
  - *I have to let one bill go if I have to go to Buffalo [for medical care]. (Family of CYSHCN)*
3. Availability and accessibility of services and amenities in the community
  - *There needs to be more after school programs for children and things for them to do so they can use their time. Rather than becoming invested in drugs because they have all this time. (Adolescent)*
  - *Not all providers are a good fit for your child. Due to the limited providers, you have to deal with it not being a good fit if you want your child to receive services because there are no other options. (Family of CYSHCN)*
4. Poverty and issues of the working poor
  - *If you are in poverty, you are more likely to spend more money because there is this like whole thing of like you pay for something to get it immediately rather than saving up to get something that lasts, so you end up buying something that will break really quick. So you end up spending more money. So really, being poor is expensive. (Adolescent)*
  - *Teach children about finances and budgets so they can better manage their futures. (Adult)*

- *If you are making a 'livable wage' you can't qualify for certain services. The system is made for us to fail. If you do improve, you lose services, you fall back. (Expectant or new parent)*
5. Supports for parents and families
    - *I had a c-section and was alone at home. I did not have help. (Expectant or new parent)*
    - *I felt welcome at prenatal visits when they introduced themselves and included me [dad] in the conversation. The doctor let me know as a father how much I can help. Included both of us. (Father)*
    - *I have no family support in this country. (Expectant or new parent)*
  6. Social support and social cohesion
    - *Everybody needs to talk even for one second or ten minutes. Even boys. (Adolescent)*
    - *I feel isolated because not everyone is experiencing what I am experiencing. (Family of CYSHCN)*
    - *Having a village, not doing it alone. (Expectant or new parent)*
  7. Health care access, quality, and bias
    - *I've skipped appointments for myself because I can't afford the co-pay. (Adult)*
    - *...you go into the clinic and you see someone different every time. So there's not that relationship with doctors. (Adult)*
    - *If you have a lifestyle, they [providers] don't agree with, they won't respect you. (Adolescent)*
  8. Community and environmental safety
    - *I want a community where they can grow up and know that they're safe and can go anywhere they want to go and trust the adults in their community. Right now I am scared for my kids... (Adult)*
    - *I see syringes in the stairs, in the elevators, this is a big need in my building. (Family of CYSHCN)*
  9. Housing
    - *I don't feel there's a system in place to make sure landlords treat you like human beings. (Expectant or new parent)*
    - *My mom waited 3 years for them to put on a door. (Adolescent)*
  10. Healthy food
    - *There is never enough to go around. We go to soup kitchen, pantries but there needs to be more. (Adolescent)*
    - *We need more healthy food in the hood all hoods have crappy food. (Expectant or new parent)*

The most common suggestions raised by community members (each mentioned in a quarter of the forums) to help foster healthy, thriving communities included:

- More education for both adolescents and adults about financial literacy and life skills, such as budgeting, taxes, credit, parenting, etc.
- More access to healthy foods through community gardens or farmers markets
- Removing sources of and advertising for unhealthy foods, fast food, bars and alcohol in communities
- Clean up programs to tidy parks and public spaces.

Community members found it empowering to talk about their experiences, desires, and suggestions and in several forums discussed how more opportunities for community members to come together to connect are needed. It is important to close the loop of this feedback process by sharing back and discussing forum results with participants and other community members. Due to the COVID-19 pandemic, plans to re-engage community members and other stakeholders were delayed. In-person meetings to share results and the action items they informed and discuss actionable ways to collaborate and collectively further the Title V agenda were planned with state agency partners and local community stakeholders in April 2020—those were postponed to October and November 2020 as virtual events.

In addition to the forums, web-based surveys designed for the public and service providers were posted on the NYSDOH website and social media and distributed widely through a broad network of over 20 organizational partner groups. Through a mix of closed- and open-ended questions, providers were asked about what's working and what can be strengthened in their communities; social determinants, root causes, disparities, and health outcomes; community partnerships; population engagement strategies; and to rate a range of potential MCH priorities. Consumer respondents were asked about factors

that affect health in their communities, available and needed services, and barriers to and satisfaction with existing services. Over 770 providers and over 320 individual consumers responded, representing all regions of the state.

The impact of COVID-19 on MCH work and health outcomes throughout the past year cannot be overstated. This included a significant impact on our ability to obtain information directly from members from the MCH population across NYS. In early 2020, MCH staff worked to convene and support the work of a COVID-19 Maternity Task Force. Charged with assessing the impact of the COVID-19 pandemic on pregnant and parenting individuals, this Task Force was comprised of medical and perinatal health professionals from across the state. Beginning in March 2020, the Task Force met several times to assess the impact of COVID-19 on maternal health, develop a series of recommendations to support pregnant and parenting individuals during the pandemic, and advance the general understanding of the physiological impact of COVID-19 on pregnant people and their newborns.

By April 2020 the Task Force issued a series of recommendations, which Governor Cuomo promptly accepted and directed NYSDOH to complete. Whether the audience was pregnant/parenting community members or medical providers specializing in obstetrics and/or neonatology, working to center their interest or feedback in COVID-19 was a key part of all recommendations. Beginning early in the pandemic, Title V staff supported weekly virtual meetings of the NYS Perinatal Quality Collaborative (NYSPQC) which helped obstetric providers from across the state share questions, experience, and emerging research on COVID-19 and its impact on pregnancy and birth. Through this dialog providers shared topics on which they needed additional support/information and suggested ways in which the state could develop and direct resources to better support MCH populations. Based on this feedback, the NYSPQC and Title V staff worked to develop resources to meet the needs of providers including a June webinar on COVID-19 and Maternal Health Equity.

In August and September 2020, Title V staff convened a small focus group of MCH professionals and community members to aid in the development of a public information campaign on COVID-19 and pregnancy. Community members included several women who had given birth during the COVID-19 pandemic, including a group of five Spanish speaking women. These community members discussed their fears and concerns giving birth during a pandemic, the uncertainty and confusion around existing messaging and changing requirements, and finally, the trauma experienced by those individuals forced to give birth alone during the early days of the pandemic. Focus group members also helped to develop messaging and content designed to address the concerns of pregnant people, help build confidence and trust in health care facilities, and empower birthing people to advocate for their rights during labor and delivery. Based on this feedback, NYSDOH launched a multi-media campaign via social media, radio, and television in December 2020.

In addition to listening sessions, health care provider calls, and focus groups, MCH providers themselves proved invaluable in helping NYSDOH to better understand the impact of COVID-19 on some of the most vulnerable NYS residents. Beginning in early March 2020, MCH providers including Community Health Worker, Home Visiting, and other MCH outreach programs began to provide regular information to Title V staff via monthly phone calls. Calls focused on community needs, gaps in services and supports, common concerns and misinformation about COVID-19, and specific suggestions at how DOH could help support MCH populations. Based on the feedback shared from providers, NYSDOH allowed the NYS Title V program to redirect both staff resources and funding to these MCH programs to allow greater flexibility to meet the unique community needs. This included allowing MICHC and MIECHV programs to use unallocated program funding to support the purchase of high need items including diapers, wipes, formula, PPE for staff, and other items not available at the time via SNAP/WIC or local food pantries.

The CYSHCN Program sought family feedback by hosting discussion groups and interviews with parents of CYSHCN, ages 0-21, and individuals with SHCN, ages 18-21 throughout the reporting period. They sought to learn about issues families face, how to improve family experiences, and create resource guides and training materials that NYS Local Health Departments (LHD) can use to help children and youth and their families in the future. There were nearly 200 participants. Highlights from what was shared include parents feel that their children's physicians were dismissive, and they had to make extra effort to get the proper diagnosis to begin services. Most community programs are not inclusive. Adequate childcare is

extremely hard to find. Parents are not satisfied with the Department of Education placement process. Most families have been met with financial hardships while trying to get their child(ren) adequate care.

Throughout the reporting period, seven LHDs conducted needs assessments to identify gaps and barriers in supporting CYSHCN and their families and identify the LHDs' technical assistance needs. Among identified issues were understaffing, referral programs for YSHCN transitioning to adulthood, and updated resource guides to direct families to proper care. Learning communities for local CYSHCN programs could help address these issues.

DFH was able to engage the MCH Advisory Council, which includes the Executive Director of Parent to Parent of NYS and a member from the Schuyler Center for Analysis and Advocacy. The Title V Director and staff reviewed the Needs Assessment and the MCH priorities with the MCH Advisory Council on June 17, 2020. The current annual report and application was presented to the MCH Advisory Council on June 30, 2021.

DFH is engaging state agencies that serve the MCH population, including the Office for Children and Family Services (OCFS), the NYS Education Department (NYSED), Office for Temporary and Disability Assistance (OTDA), Council on Children and Families (CCF), Office for People with Developmental Disabilities (OPWDD), Office of Mental Health (OMH), Office for Addiction Services and Supports (OASAS), Office of Victim Services (OVS), NYS Parks Department, Department of Agriculture and Markets, Department of Transportation (DOT), NYS Division of Criminal Justice Services (DCJS), Department of State, and the Department of Labor.

DFH will continue to seek public input on the MCH Priorities and State Action Plan in the coming year and will further reflect this input in subsequent applications/annual reports.

### **III.G. Technical Assistance**

NY's Title V program welcomes opportunities to have periodic teleconferences with HRSA and other large states focused on specific topics, programs and initiatives to support Title V outcomes. Several states are focusing on the same of similar priority areas. For example, conversations with the "Big 5" States have been very informative in the development of a more comprehensive approach to supports and services for CYSHCN and their families as well in planning for the comprehensive needs assessment for next year's full five-year application.

NY would benefit from focused discussions on efforts related to perinatal regionalization including the development of metrics and processes for ongoing quality improvement, strategies to best engage birthing hospitals to participate in quality improvement work with limited funding, telehealth models to improve access to health care supports and services, state efforts to identify and address maternal mortality and morbidity, specifically related to efforts to address the impact of racism on perinatal health outcomes. Other topics of importance are supporting pregnant and parenting individuals experiencing substance use disorders in the development and implementation of Plans of Safe Care (POSC) while mitigating the impact of racism and bias in child welfare reporting. Discussions with colleagues in other large states on establishing policy to promote systems change, identifying evidence-based or evidence-informed practices on an ongoing basis, modifying evidence-based programs to better fit the needs of certain populations, and addressing public health issues in more rural areas where the burden is not as great and resources are limited are just a few additional examples of areas that may be of benefit to discuss in a forum with large states.

In addition, significant travel restrictions continue for staff in the NYSDOH. This may continue to impact the ability of NY's Title V staff to participate in State or National Conferences and in-person meetings. It would greatly benefit states such as NY for HRSA to utilize technology to share and learn rather than in-person meetings or conferences. In particular, it would be helpful if this were the primary mode of transmitting essential information. In addition, the inability to travel to national meetings can impact NYS sharing valuable experiences and showcasing accomplishments with federal and state representatives.

As described in the MCH Workforce Development section, New York's Title V program has a strong established collaborative relationship with the University at Albany School of Public Health's HRSA-funded MCH Catalyst program. Our programs have worked closely together for over five years to support mutual goals related to MCH workforce development, including efforts to engage and train students and to support the professional development of current Title V staff. The U Albany MCH Catalyst Program has provided technical assistance to the Title V Program for several major projects, including extensive support to plan, implement, and document the comprehensive five-year Needs Assessment and state action plan for this application. The Catalyst Program Co-Directors' strong working knowledge of New York's Title V Program and larger state systems, as well as the geographic proximity of the programs (especially in light of current and anticipated travel restrictions), make this a uniquely strong approach to technical assistance for our program. In the upcoming year and beyond, NY's Title V program is interested in working with HRSA MCHB to explore how the Bureau may support this relationship to facilitate future technical assistance support from the U Albany Catalyst Program.

#### **IV. Title V-Medicaid IAA/MOU**

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



## **V. Supporting Documents**

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

Supporting Document #01 - Public and Private Partnerships.pdf

Supporting Document #02 - State Action Plan Table.pdf

## **VI. Organizational Chart**

The Organizational Chart is uploaded as a PDF file to this section - DOH OPH CCH DFH Org Charts 2021.pdf

## VII. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

**State: New York**

	FY 22 Application Budgeted	
<b>1. FEDERAL ALLOCATION</b> (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 38,909,810	
A. Preventive and Primary Care for Children	\$ 17,773,716	(45.6%)
B. Children with Special Health Care Needs	\$ 14,393,781	(36.9%)
C. Title V Administrative Costs	\$ 3,366,617	(8.7%)
<b>2. Subtotal of Lines 1A-C</b> (This subtotal does not include Pregnant Women and All Others)	\$ 35,534,114	
<b>3. STATE MCH FUNDS</b> (Item 18c of SF-424)	\$ 29,285,355	
<b>4. LOCAL MCH FUNDS</b> (Item 18d of SF-424)	\$ 35,897,127	
<b>5. OTHER FUNDS</b> (Item 18e of SF-424)	\$ 0	
<b>6. PROGRAM INCOME</b> (Item 18f of SF-424)	\$ 21,713,525	
<b>7. TOTAL STATE MATCH</b> (Lines 3 through 6)	\$ 86,896,007	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 58,268,752		
<b>8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL</b> (Total lines 1 and 7)	\$ 125,805,817	
<b>9. OTHER FEDERAL FUNDS</b> Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
<b>10. OTHER FEDERAL FUNDS</b> (Subtotal of all funds under item 9)	\$ 61,858,217	
<b>11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL</b> (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 187,664,034	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 2,841,081
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 8,407,073
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 26,271,804
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Sexual Risk Avoidance Education	\$ 2,906,486
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match	\$ 8,550,489
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > American Rescue Plan Act Funding for Home Visiting	\$ 1,398,700
US Department of Education > Office of Special Education Programs > Individuals with Disabilities Act-Special Education/American Rescue Plan Act of 2021	\$ 11,482,584

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 38,909,810		\$ 32,378,022	
A. Preventive and Primary Care for Children	\$ 12,241,697	(31.5%)	\$ 15,823,085	(48.8%)
B. Children with Special Health Care Needs	\$ 15,148,899	(38.9%)	\$ 11,023,960	(34%)
C. Title V Administrative Costs	\$ 2,783,594	(7.2%)	\$ 1,823,431	(5.7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 30,174,190		\$ 28,670,476	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 29,285,355		\$ 29,285,355	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 55,483,224		\$ 35,333,319	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 22,224,404		\$ 25,288,886	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 106,992,983		\$ 89,907,560	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 58,268,752				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 145,902,793		\$ 122,285,582	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 65,608,665		\$ 48,210,047	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 211,511,458		\$ 170,495,629	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	\$ 0	\$ 0
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	\$ 0	\$ 0
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 2,956,063	\$ 2,956,063
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 150,000	\$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 1,801,265	\$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	\$ 0	\$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement	\$ 200,000	\$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	\$ 400,000	\$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 9,212,347	\$ 9,135,718
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Children's Oral Care Access Program	\$ 0	\$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,000	\$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 248,000	\$ 0

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 8,500,000	\$ 0
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 25,867,377	\$ 25,867,377
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Oral Health and Chronic Disease Collaboration	\$ 0	\$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Strength Based Curriculum	\$ 450,000	\$ 0
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Sexual Risk Avoidance Education	\$ 3,491,120	\$ 3,660,326
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match	\$ 12,232,493	\$ 6,590,563



**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

1.	<b>Field Name:</b>	<b>1.FEDERAL ALLOCATION</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Overall, the actual expenditures for FY 20 appear less than originally projected. The FY 20 award value remains fully obligated and will be fully dispersed by the liquidation deadline at the end of this year.
2.	<b>Field Name:</b>	<b>Federal Allocation, A. Preventive and Primary Care for Children:</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Overall, the actual expenditures for FY 20 appear less than originally projected. The FY 20 award value remains fully obligated and will be fully dispersed by the liquidation deadline at the end of this year.
3.	<b>Field Name:</b>	<b>Federal Allocation, B. Children with Special Health Care Needs:</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Overall, the actual expenditures for FY 20 appear less than originally projected. The FY 20 award value remains fully obligated and will be fully dispersed by the liquidation deadline at the end of this year.
4.	<b>Field Name:</b>	<b>Federal Allocation, C. Title V Administrative Costs:</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Overall, the actual expenditures for FY 20 appear less than originally projected. The FY 20 award value remains fully obligated and will be fully dispersed by the liquidation deadline at the end of this year.
5.	<b>Field Name:</b>	<b>4. LOCAL MCH FUNDS</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>

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**Field Note:**

NY's FY 20 application reflected a budget of over \$55 million in Local funds, but actual expenditures were less than anticipated. This is likely related to the timing of the reporting by LHDs rather than an actual decrease in expenditures.

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6. **Field Name:** **6. PROGRAM INCOME**

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**Fiscal Year:** **2020**

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**Column Name:** **Annual Report Expended**

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**Field Note:**

NY's FY 20 application reflected a budget of over \$22 million in Program Income, but actual expenditures were more than anticipated. This is likely related to the timing of the reporting by LHDs rather than an actual increase in expenditures.

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7. **Field Name:** **Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs**

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**Fiscal Year:** **2020**

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**Column Name:** **Annual Report Expended**

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**Field Note:**

NY has decided to remove many of the federal grants listed as Other Federal Funds in the FY 20 application as they were not awarded to the NY State Department of Health, but to Health Research Incorporated (HRI). The DOH works very closely with HRI to manage these grants but is not the awardee.

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8. **Field Name:** **Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program**

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**Fiscal Year:** **2020**

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**Column Name:** **Annual Report Expended**

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**Field Note:**

NY has decided to remove many of the federal grants listed as Other Federal Funds in the FY 20 application as they were not awarded to the NY State Department of Health, but to Health Research Incorporated (HRI). The DOH works very closely with HRI to manage these grants but is not the awardee.

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9. **Field Name:** **Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement**

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**Fiscal Year:** **2020**

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**Column Name:** **Annual Report Expended**

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**Field Note:**

NY has decided to remove many of the federal grants listed as Other Federal Funds in the FY 20 application as they were not awarded to the NY State Department of Health, but to Health Research Incorporated (HRI). The DOH works very closely with HRI to manage these grants but is not the awardee.

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10.	<b>Field Name:</b>	<b>Other Federal Funds, Department of Health and Human Services (DHHS) &gt; Health Resources and Services Administration (HRSA) &gt; Oral Health</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	NY has decided to remove many of the federal grants listed as Other Federal Funds in the FY 20 application as they were not awarded to the NY State Department of Health, but to Health Research Incorporated (HRI). The DOH works very closely with HRI to manage these grants but is not the awardee.
11.	<b>Field Name:</b>	<b>Other Federal Funds, Department of Health and Human Services (DHHS) &gt; Health Resources and Services Administration (HRSA) &gt; State Systems Development Initiative (SSDI)</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	NY has decided to remove many of the federal grants listed as Other Federal Funds in the FY 20 application as they were not awarded to the NY State Department of Health, but to Health Research Incorporated (HRI). The DOH works very closely with HRI to manage these grants but is not the awardee.
12.	<b>Field Name:</b>	<b>Other Federal Funds, Department of Health and Human Services (DHHS) &gt; Health Resources and Services Administration (HRSA) &gt; Universal Newborn Hearing Screening and Intervention</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	NY has decided to remove many of the federal grants listed as Other Federal Funds in the FY 20 application as they were not awarded to the NY State Department of Health, but to Health Research Incorporated (HRI). The DOH works very closely with HRI to manage these grants but is not the awardee.
13.	<b>Field Name:</b>	<b>Other Federal Funds, Department of Health and Human Services (DHHS) &gt; Office of Population Affairs (OPA) &gt; Title X Family Planning</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	NY withdrew from this federal program.
14.	<b>Field Name:</b>	<b>Other Federal Funds, Department of Health and Human Services (DHHS) &gt; Centers for Disease Control and Prevention (CDC) &gt; Strength Based Curriculum</b>
	<b>Fiscal Year:</b>	<b>2020</b>

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**Column Name:**

**Annual Report Expended**

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**Field Note:**

NY has decided to remove many of the federal grants listed as Other Federal Funds in the FY 20 application as they were not awarded to the NY State Department of Health, but to Health Research Incorporated (HRI). The DOH works very closely with HRI to manage these grants but is not the awardee.

**Data Alerts: None**

**Form 3a**  
**Budget and Expenditure Details by Types of Individuals Served**  
**State: New York**

**I. TYPES OF INDIVIDUALS SERVED**

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	\$ 2,901,447	\$ 3,436,664
2. Infants < 1 year	\$ 3,125,677	\$ 3,015,966
3. Children 1 through 21 Years	\$ 14,648,038	\$ 12,807,119
4. CSHCN	\$ 14,393,781	\$ 11,023,960
5. All Others	\$ 474,250	\$ 270,882
Federal Total of Individuals Served	\$ 35,543,193	\$ 30,554,591

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	\$ 12,460,684	\$ 11,943,570
2. Infants < 1 year	\$ 5,565,651	\$ 5,860,617
3. Children 1 through 21 Years	\$ 35,754,058	\$ 23,245,926
4. CSHCN	\$ 8,665,898	\$ 23,017,579
5. All Others	\$ 24,449,716	\$ 25,839,868
Non-Federal Total of Individuals Served	\$ 86,896,007	\$ 89,907,560
Federal State MCH Block Grant Partnership Total	\$ 122,439,200	\$ 120,462,151

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

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1.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 3. Children 1 through 21 years</b>
	<b>Fiscal Year:</b>	<b>2022</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>
	<b>Field Note:</b>	Form 2, Line 1A, Preventive and Primary Care for Children includes Infants < 1 year and Children 1 though 21 years.

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2.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 3. Children 1 through 21 years</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Form 2, Line 1A, Preventive and Primary Care for Children includes Infants < 1 year and Children 1 though 21 years.

---

**Data Alerts:**

- 
- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
  - Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.

**Form 3b**  
**Budget and Expenditure Details by Types of Services**

State: New York

**II. TYPES OF SERVICES**

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	\$ 2,301,586	\$ 1,524,076
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 0	\$ 0
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 2,301,586	\$ 1,524,076
2. Enabling Services	\$ 21,179,546	\$ 19,858,536
3. Public Health Services and Systems	\$ 15,428,678	\$ 10,995,410
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 1,524,076
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Direct Services Line 4 Expended Total		\$ 1,524,076
<b>Federal Total</b>	<b>\$ 38,909,810</b>	<b>\$ 32,378,022</b>

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	\$ 16,161,096	\$ 11,024,969
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 5,416,943	\$ 4,781,731
B. Preventive and Primary Care Services for Children	\$ 10,744,153	\$ 6,243,238
C. Services for CSHCN	\$ 0	\$ 0
2. Enabling Services	\$ 46,420,121	\$ 48,551,253
3. Public Health Services and Systems	\$ 14,363,495	\$ 17,209,527
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Other		
Other		\$ 11,024,969
Direct Services Line 4 Expended Total		\$ 11,024,969
<b>Non-Federal Total</b>	\$ 76,944,712	\$ 76,785,749



**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

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1.	<b>Field Name:</b>	<b>IIB. - Other - Other</b>
	<b>Fiscal Year:</b>	<b>2022</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>

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**Field Note:**

This level of detail is not available

**Form 4**  
**Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated**

**State: New York**

**Total Births by Occurrence: 208,707**

**Data Source Year: 2021**

**1. Core RUSP Conditions**

<b>Program Name</b>	<b>(A) Aggregate Total Number Receiving at Least One Valid Screen</b>	<b>(B) Aggregate Total Number of Out-of-Range Results</b>	<b>(C) Aggregate Total Number Confirmed Cases</b>	<b>(D) Aggregate Total Number Referred for Treatment</b>
Core RUSP Conditions	208,630 (100.0%)	1,383	315	315 (100.0%)

<b>Program Name(s)</b>				
3-Hydroxy-3-Methylglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, βeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiencies	β-Ketothiolase Deficiency
Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy	

## 2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
HIV	208,630 (100.0%)	334	0	0 (0%)
Tyrosinemia, type 2, 3	208,630 (100.0%)	2	0	0 (0%)
Spinal Muscular Atrophy	208,630 (100.0%)	15	15	15 (100.0%)
GAMT deficiency	208,630 (100.0%)	4	0	0 (0%)
Krabbe disease	208,630 (100.0%)	16	2	2 (100.0%)

## 3. Screening Programs for Older Children & Women

None

## 4. Long-Term Follow-Up

Infants in NY are followed until we receive a confirmatory diagnosis. We have begun a long term follow-up program for some of the inherited metabolic diseases with limited funding from NYS to pay the Centers to enter data. Uptake has been slow. We have worked with Centers on progress reports & getting Institutional Review Board approvals at all 10 sites. The plan is to enroll children until age 18 & re-consent enrollees at that age until age 21. We have worked with the Newborn Screening Translational Research Network & their Longitudinal Pediatric Data Resource to create a series of common data elements to be collected. We are in the process of applying for additional funding to move this work forward as there are limited staff within the newborn screening program at present to conduct this work & the necessary follow-up with providers. We are expecting a new module to be added to our Laboratory Information Management System that will allow Centers to enter data more easily & include updates.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

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1.	<b>Field Name:</b>	<b>Data Source Year</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Data Source Year Notes</b>
	<b>Field Note:</b>	
	2021	

---

**Data Alerts: None**

**Form 5**  
**Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V**

State: New York

Annual Report Year 2020

**Form 5a – Count of Individuals Served by Title V**  
**(Direct & Enabling Services Only)**

Types Of Individuals Served	(A) Title V Total Served	Primary Source of Coverage				
		(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	157,497	47.0	0.0	52.0	0.0	1.0
2. Infants < 1 Year of Age	222,414	47.0	0.0	52.0	0.0	1.0
3. Children 1 through 21 Years of Age	282,997	39.0	0.0	58.0	0.0	3.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	124,084	45.0	0.0	53.0	0.0	2.0
4. Others	236,297	22.0	0.0	72.0	0.0	6.0
Total	899,205					

**Form 5b – Total Percentage of Populations Served by Title V**  
**(Direct, Enabling, and Public Health Services and Systems)**

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	221,539	No	218,777	100.0	218,777	157,497
2. Infants < 1 Year of Age	222,347	No	222,414	100.0	222,414	222,414
3. Children 1 through 21 Years of Age	4,793,214	Yes	4,793,214	59.9	2,871,135	282,997
3a. Children with Special Health Care Needs 0 through 21 years of age^	923,154	Yes	923,154	41.9	386,802	124,084
4. Others	14,436,417	Yes	14,436,417	4.3	620,766	236,297

^Represents a subset of all infants and children.

**Form Notes for Form 5:**

None

**Field Level Notes for Form 5a:**

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1.	<b>Field Name:</b>	<b>Pregnant Women Total Served</b>
	<b>Fiscal Year:</b>	<b>2020</b>

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**Field Note:**

Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5a for Pregnant Women:

- Comprehensive Adolescent Pregnancy Prevention and ACT for Youth Center of Excellence
- Family Planning Program
- Regional Perinatal Centers
- Community Water Fluoridation
- Maternal and Infant Community Health Collaborative (MICHC) Programs
- Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs – Nurse Family Partnership and Healthy Families.

Estimates for the Primary Source of Coverage were provided by HRSA.

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2.	<b>Field Name:</b>	<b>Infants Less Than One YearTotal Served</b>
	<b>Fiscal Year:</b>	<b>2020</b>

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**Field Note:**

All NYS infants receive Title V funded or supported services as a result of investments in the state's Newborn Metabolic Screening Program for the screening, as well as Newborn Hearing Screening, services through the perinatal system, and home visiting.

Estimates for the Primary Source of Coverage were provided by HRSA.

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3.	<b>Field Name:</b>	<b>Children 1 through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2020</b>

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**Field Note:**

Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5a for Children 1-21 years old:

- Asthma Program
- Child Lead Poisoning Prevention Program
- Local Health Department Children with Special Healthcare Needs Programs
- Comprehensive Adolescent Pregnancy Prevention Program and ACT for Youth Center of Excellence
- School Based Health Center Program
- Family Planning Program
- Enough is Enough Program
- Maternal, Infant and Early Child Home Visiting (MIECHV) Programs – Nurse Family Partnership and Healthy Families
- Sickle Cell Disease Transition Grants to Hemoglobinopathy Centers
- Physically Handicapped Children Program (PHCP)

Estimates for the Primary Source of Coverage were provided by HRSA.

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4. **Field Name:** **Children with Special Health Care Needs 0 through 21 Years of Age**

**Fiscal Year:** **2020**

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**Field Note:**

Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise. Children and Youth with Special Healthcare Needs (CYSHCN) counts are a subset of the counts for Infants under 1 and Children ages 1-21 years old.

The following MCH serving programs were included in Form 5a for CYSHCN:

- Asthma Program
- Child Lead Poisoning Prevention Program
- Local Health Department Children with Special Healthcare Needs Programs
- School Based Health Center Program
- Maternal, Infant and Early Child Home Visiting (MIECHV) Programs – Nurse Family Partnership and Healthy Families
- Migrant Health
- Family Planning Program
- Sickle Cell Disease Transition Grants to Hemoglobinopathy Centers
- Physically Handicapped Children Program (PHCP)

Estimates for the Primary Source of Coverage were provided by HRSA.

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5. **Field Name:** **Others**

**Fiscal Year:** **2020**

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**Field Note:**

Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5a for Other Populations:

- Asthma Program
- Family Planning Program
- Enough is Enough Program
- Migrant Health Program
- Maternal and Infant Community Health Collaborative (MICHC) Program
- Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs – Nurse Family Partnership and Healthy Families

Estimates for the Primary Source of Coverage were provided by HRSA.

**Field Level Notes for Form 5b:**

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1. **Field Name:** **Pregnant Women**

**Fiscal Year:** **2020**

**Field Note:**

All pregnant women in NYS benefit from Title V funding as a result of investments in training and quality improvement initiatives with the Regional Perinatal Centers and birthing hospitals as well as work with other medical and healthcare providers.

Data for Form 5b for pregnant women served are reported based on NYS Vital Statistics data reported in Form 6 of the Title V application.

---

2. **Field Name:** **InfantsLess Than One Year**

**Fiscal Year:** **2020**

**Field Note:**

All NYS infants benefit from Title V funding as a result of investments in the state's Newborn Metabolic Screening Program for the screening, as well as Newborn Hearing Screening, services through the perinatal system, and home visiting.

Data for Form 5b for pregnant women served are reported based on NYS Vital Statistics data reported in Form 6 of the Title V application.

---

3. **Field Name:** **Children 1 Through 21 Years of Age**

**Fiscal Year:** **2020**



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**Field Note:**

Data for Form 5b were aggregated from reports provided by MCH programs directly funded by Title V or funded by state/ other funds but with Title V funded staff support for subject matter expertise. The following MCH serving programs were included in 5b for Children 1-21 years old: Asthma Program, Child Lead Poisoning Prevention Program, LHD CYSHCN Programs, CAPP & ACT for Youth Center of Excellence, SBHC Program, Family Planning Program, Enough is Enough Program, MIECHV Programs – Nurse Family Partnership and Healthy Families, Sickle Cell Disease Transition Grants to Hemoglobinopathy Centers, PHCP, Community Water Fluoridation, and the Medicaid Performance Improvement Project (PIP)\*\*.

\*\*Footnote: Since approximately 50% of NYS children have Medicaid coverage and would be counted in the Medicaid PIP, the other MCH serving programs were reduced by 50% to reduce the potential for overcounting or double counting of children served by Title V.

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4. **Field Name:** **Children with Special Health Care Needs 0 through 21 Years of Age**

**Fiscal Year:** **2020**

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**Field Note:**

Data for Form 5b were aggregated from reports provided by MCH programs directly funded by Title V or funded by state/ other funds but with Title V funded staff support for subject matter expertise. The following MCH serving programs were included in 5b for CYSHCN: Asthma Program, Child Lead Poisoning Prevention Program, Local Health Department Children with Special Healthcare Needs Programs, School Based Health Center Program, Maternal, Infant and Early Child Home Visiting (MIECHV) Programs – Nurse Family Partnership and Healthy Families, Migrant Health, Family Planning Program, Sickle Cell Disease Transition Grants to Hemoglobinopathy Centers, Physically Handicapped Children Program (PHCP), and the Medicaid Performance Improvement Project (PIP)\*\*.

\*\*Footnote: Since approximately 50% of NYS children have Medicaid coverage and would be counted in the Medicaid PIP, the other MCH serving programs were reduced by 50% to reduce the potential for overcounting or double counting of children served by Title V.

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5. **Field Name:** **Others**

**Fiscal Year:** **2020**

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**Field Note:**

Data for 5b were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in 5b for Other Populations:

- Asthma Program
- Family Planning Program
- Enough is Enough Program
- Maternal and Infant Community Health Collaborative (MICHC) Program
- Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs – Nurse Family Partnership and Healthy Families
- Community Water Fluoridation

**Data Alerts:**

1.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
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**Form 6**  
**Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX**

State: New York

Annual Report Year 2020

**I. Unduplicated Count by Race/Ethnicity**

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	218,776	107,079	31,339	50,024	359	23,248	1,263	3,403	2,061
Title V Served	218,776	107,079	31,339	50,024	359	23,248	1,263	3,403	2,061
Eligible for Title XIX	110,751	37,833	20,772	36,507	244	11,995	319	1,827	1,254
2. Total Infants in State	222,412	108,947	31,970	50,717	363	23,578	1,280	3,465	2,092
Title V Served	222,412	108,947	31,970	50,717	363	23,578	1,280	3,465	2,092
Eligible for Title XIX	112,383	38,365	21,184	36,975	247	12,159	322	1,861	1,270

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

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1.	<b>Field Name:</b>	<b>1. Total Deliveries in State</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Total</b>

---

**Field Note:**  
222975

**Form 7**  
**State MCH Toll-Free Telephone Line and Other Appropriate Methods Data**

**State: New York**

<b>A. State MCH Toll-Free Telephone Lines</b>	<b>2022 Application Year</b>	<b>2020 Annual Report Year</b>
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 522-5006	(800) 522-5006
2. State MCH Toll-Free "Hotline" Name	Growing Up Healthy Hotline	Growing Up Healthy Hotline
3. Name of Contact Person for State MCH "Hotline"	Cindi Dubner	Cindi Dubner
4. Contact Person's Telephone Number	(518) 474-6968	(518) 474-6968
5. Number of Calls Received on the State MCH "Hotline"		13,692

<b>B. Other Appropriate Methods</b>	<b>2022 Application Year</b>	<b>2020 Annual Report Year</b>
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

**Form Notes for Form 7:**

None

**Form 8**  
**State MCH and CSHCN Directors Contact Information**

**State: New York**

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

Name	Kirsten Siegenthaler, PhD
Title	Associate Director, Division of Family Health
Address 1	New York State Department of Health
Address 2	Corning Tower Rm 890
City/State/Zip	Albany / NY / 12237
Telephone	(518) 474-6968
Extension	
Email	Kirsten.Siegenthaler@health.ny.gov

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

Name	Suzanne Swan, MPH
Title	Director, Bureau of Child Health
Address 1	New York State Department of Health
Address 2	Corning Tower Rm 878
City/State/Zip	Albany / NY / 12237
Telephone	(518) 474-1961
Extension	
Email	Suzanne.Swan@health.ny.gov

### 3. State Family or Youth Leader (Optional)

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



**Form Notes for Form 8:**

None

**Form 9**  
**List of MCH Priority Needs**

**State: New York**

**Application Year 2022**

<b>No.</b>	<b>Priority Need</b>	<b>Priority Need Type (New, Revised or Continued Priority Need for this five- year reporting period)</b>
1.	Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities	Continued
2.	Promote awareness and enhance availability, accessibility and coordination of services for families and youth, including CYSHCN, with a focus on areas impacted by systemic barriers, including racism	Continued
3.	Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers	Continued
4.	Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course	Continued
5.	Increase access to affordable fresh and healthy foods in communities.	Continued
6.	Address community and environmental safety for children, youth, and families.	Continued
7.	Acknowledge and address the fundamental challenges faced by families in poverty and near-poverty, including the “working poor” as a result of systemic barriers, including racism.	Continued
8.	Increase awareness of resources and services in the community among families and the providers who serve them.	Continued
9.	Increase the availability and quality of affordable housing.	Continued
10.	Address transportation barriers for individuals and families.	Continued

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

None

**Form 9 State Priorities – Needs Assessment Year – Application Year 2021**

<b>No.</b>	<b>Priority Need</b>	<b>Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)</b>
1.	Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities	New
2.	Promote awareness and enhance availability, accessibility and coordination of services for families and youth, including CYSHCN, with a focus on areas impacted by systemic barriers, including racism	New
3.	Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers	New
4.	Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course	New
5.	Increase access to affordable fresh and healthy foods in communities.	New
6.	Address community and environmental safety for children, youth, and families.	New
7.	Acknowledge and address the fundamental challenges faces by families in poverty and near-poverty, including the “working poor” as a result of systemic barriers, including racism.	New
8.	Increase awareness of resources and services in the community among families and the providers who serve them.	New
9.	Increase the availability and quality of affordable housing.	New
10.	Address transportation barriers for individuals and families.	New

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

None

**Form 10  
National Outcome Measures (NOMs)**

**State: New York**

**Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	81.3 %	0.1 %	175,882	216,241
2018	80.9 %	0.1 %	177,826	219,882
2017	80.6 %	0.1 %	180,884	224,372
2016	80.7 %	0.1 %	185,073	229,239
2015	80.3 %	0.1 %	184,418	229,561
2014	79.1 %	0.1 %	182,737	231,024
2013	75.4 %	0.1 %	173,442	230,047
2012	74.5 %	0.1 %	173,825	233,372
2011	73.7 %	0.1 %	172,588	234,324
2010	73.9 %	0.1 %	174,690	236,300
2009	74.1 %	0.1 %	174,327	235,200

**Legends:**

■ Indicator has a numerator <10 and is not reportable

⚠ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 1 - Notes:**

None

**Data Alerts: None**

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

Data Source: HCUP - State Inpatient Databases (SID)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	89.5	2.0	1,937	216,424
2017	83.5	2.0	1,849	221,444
2016	80.0	1.9	1,788	223,595
2015	93.2	2.4	1,581	169,707
2014	94.9	2.1	2,153	226,888
2013	88.3	2.0	1,982	224,369
2012	86.3	2.0	1,983	229,658
2011	86.2	2.0	1,930	223,901
2010	87.5	2.0	1,962	224,289
2009	75.5	1.8	1,718	227,545
2008	70.4	1.8	1,622	230,494

**Legends:**

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

**NOM 2 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2019	18.4	1.3	211	1,149,071
2014_2018	17.8	1.2	208	1,166,305

**Legends:**

🚫 Indicator has a numerator <10 and is not reportable

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

**NOM 3 - Notes:**

None

**Data Alerts: None**



**NOM 4 - Percent of low birth weight deliveries (<2,500 grams)**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	8.1 %	0.1 %	17,821	221,153
2018	8.1 %	0.1 %	18,208	225,864
2017	8.1 %	0.1 %	18,543	229,334
2016	7.9 %	0.1 %	18,573	233,979
2015	7.8 %	0.1 %	18,507	236,941
2014	7.9 %	0.1 %	18,722	238,423
2013	8.0 %	0.1 %	18,847	236,671
2012	7.9 %	0.1 %	19,074	240,654
2011	8.1 %	0.1 %	19,557	241,031
2010	8.2 %	0.1 %	20,049	244,116
2009	8.2 %	0.1 %	20,341	247,850

**Legends:**

■ Indicator has a numerator <10 and is not reportable

⚠ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 4 - Notes:**

None

**Data Alerts: None**

**NOM 5 - Percent of preterm births (<37 weeks)**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	9.2 %	0.1 %	20,312	221,211
2018	9.0 %	0.1 %	20,281	225,904
2017	9.0 %	0.1 %	20,607	229,382
2016	9.0 %	0.1 %	20,956	233,991
2015	8.7 %	0.1 %	20,531	236,998
2014	8.9 %	0.1 %	21,114	238,475
2013	8.9 %	0.1 %	21,052	236,558
2012	9.1 %	0.1 %	21,884	240,504
2011	9.2 %	0.1 %	22,117	240,932
2010	9.4 %	0.1 %	22,904	244,016
2009	9.5 %	0.1 %	23,527	247,770

**Legends:**

■ Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 5 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	24.7 %	0.1 %	54,745	221,211
2018	23.7 %	0.1 %	53,647	225,904
2017	23.5 %	0.1 %	53,936	229,382
2016	23.4 %	0.1 %	54,862	233,991
2015	22.8 %	0.1 %	54,082	236,998
2014	22.7 %	0.1 %	54,104	238,475
2013	22.9 %	0.1 %	54,190	236,558
2012	23.4 %	0.1 %	56,356	240,504
2011	23.5 %	0.1 %	56,643	240,932
2010	24.2 %	0.1 %	59,001	244,016
2009	24.9 %	0.1 %	61,620	247,770

**Legends:**

■ Indicator has a numerator <10 and is not reportable

⚠ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 6 - Notes:**

None

**Data Alerts: None**

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

**Data Source: CMS Hospital Compare**

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019/Q1-2019/Q4	1.0 %			
2018/Q4-2019/Q3	1.0 %			
2018/Q3-2019/Q2	1.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	4.0 %			
2013/Q2-2014/Q1	5.0 %			

**Legends:**

**NOM 7 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	5.4	0.2	1,230	226,927
2017	5.3	0.2	1,218	230,389
2016	5.4	0.2	1,267	234,975
2015	5.2	0.2	1,234	237,919
2014	5.5	0.2	1,315	239,457
2013	5.8	0.2	1,386	237,712
2012	5.8	0.2	1,398	241,663
2011	6.1	0.2	1,483	242,097
2010	6.2	0.2	1,521	245,195
2009	6.3	0.2	1,561	248,922

**Legends:**

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

**NOM 8 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	4.3	0.1	979	226,238
2017	4.6	0.1	1,053	229,737
2016	4.5	0.1	1,056	234,283
2015	4.6	0.1	1,098	237,274
2014	4.6	0.1	1,102	238,773
2013	4.9	0.1	1,169	236,980
2012	5.0	0.1	1,207	240,916
2011	5.1	0.2	1,236	241,312
2010	5.1	0.1	1,242	244,375
2009	5.4	0.2	1,331	248,110

**Legends:**

■ Indicator has a numerator <10 and is not reportable

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

**NOM 9.1 - Notes:**

None

**Data Alerts: None**



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

Data Source: National Vital Statistics System (NVSS)

### Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	2.9	0.1	656	226,238
2017	3.1	0.1	710	229,737
2016	3.0	0.1	713	234,283
2015	3.1	0.1	747	237,274
2014	3.2	0.1	767	238,773
2013	3.5	0.1	829	236,980
2012	3.4	0.1	808	240,916
2011	3.5	0.1	855	241,312
2010	3.5	0.1	863	244,375
2009	3.7	0.1	918	248,110

#### Legends:

■ Indicator has a numerator <10 and is not reportable

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

#### NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

#### Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	1.4	0.1	323	226,238
2017	1.5	0.1	343	229,737
2016	1.5	0.1	343	234,283
2015	1.5	0.1	351	237,274
2014	1.4	0.1	335	238,773
2013	1.4	0.1	340	236,980
2012	1.7	0.1	399	240,916
2011	1.6	0.1	381	241,312
2010	1.6	0.1	379	244,375
2009	1.7	0.1	413	248,110

#### Legends:

■ Indicator has a numerator <10 and is not reportable

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

#### NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	141.0	7.9	319	226,238
2017	172.8	8.7	397	229,737
2016	152.0	8.1	356	234,283
2015	168.2	8.4	399	237,274
2014	175.9	8.6	420	238,773
2013	184.0	8.8	436	236,980
2012	188.4	8.9	454	240,916
2011	182.3	8.7	440	241,312
2010	191.9	8.9	469	244,375
2009	197.9	8.9	491	248,110

**Legends:**

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

**NOM 9.4 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	58.3	5.1	132	226,238
2017	58.3	5.0	134	229,737
2016	47.4	4.5	111	234,283
2015	56.5	4.9	134	237,274
2014	48.6	4.5	116	238,773
2013	55.7	4.9	132	236,980
2012	54.8	4.8	132	240,916
2011	51.4	4.6	124	241,312
2010	50.3	4.5	123	244,375
2009	60.9	5.0	151	248,110

**Legends:**

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

**NOM 9.5 - Notes:**

None

**Data Alerts: None**

**NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy**

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	7.8 %	1.4 %	8,029	102,532
2017	7.3 %	1.3 %	7,606	103,903
2016	6.0 %	0.9 %	6,230	104,133
2015	8.3 %	0.7 %	17,596	213,268
2014	9.5 %	0.7 %	20,794	218,296
2013	9.5 %	0.8 %	20,516	216,615
2012	9.9 %	1.0 %	10,943	110,416
2011	8.4 %	0.7 %	18,417	218,407
2010	8.1 %	0.7 %	18,042	222,166
2008	7.3 %	1.0 %	8,464	115,245
2007	8.4 %	0.7 %	19,845	235,020

**Legends:**

■ Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM 10 - Notes:**

None

**Data Alerts: None**

**NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations**

Data Source: HCUP - State Inpatient Databases (SID)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	4.4	0.2	768	173,133
2017	5.0	0.2	1,091	218,652
2016	4.7	0.2	1,058	224,123
2015	4.2	0.2	709	170,164
2014	3.7	0.1	858	229,739
2013	3.7	0.1	839	228,951
2012	2.8	0.1	646	231,715
2011	2.6	0.1	619	234,599
2010	1.9	0.1	443	237,744
2009	1.8	0.1	436	240,486
2008	1.5	0.1	353	240,674

**Legends:**

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

**NOM 11 - Notes:**

None

**Data Alerts: None**

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

Federally available Data (FAD) for this measure is not available/reportable.

**NOM 12 - Notes:**

None

**Data Alerts: None**

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

Federally available Data (FAD) for this measure is not available/reportable.

**NOM 13 - Notes:**

None

**Data Alerts: None**



**NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year**

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

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	11.2 %	1.6 %	422,964	3,792,855
2017_2018	11.1 %	1.6 %	428,582	3,870,687
2016_2017	10.3 %	1.4 %	396,968	3,835,834
2016	8.4 %	1.4 %	317,135	3,758,559

**Legends:**

■ Indicator has an unweighted denominator <30 and is not reportable

⚠ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 14 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	14.1	0.8	284	2,020,962
2018	13.7	0.8	278	2,031,885
2017	13.1	0.8	270	2,064,799
2016	13.1	0.8	272	2,071,007
2015	13.3	0.8	278	2,084,298
2014	14.7	0.8	306	2,084,950
2013	15.1	0.9	314	2,083,766
2012	14.5	0.8	303	2,084,583
2011	15.0	0.9	311	2,076,119
2010	13.9	0.8	291	2,087,905
2009	15.8	0.9	330	2,082,079

**Legends:**

■ Indicator has a numerator <10 and is not reportable

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

**NOM 15 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	20.4	1.0	465	2,276,104
2018	21.9	1.0	506	2,306,162
2017	22.1	1.0	523	2,363,270
2016	22.8	1.0	544	2,389,012
2015	21.5	0.9	517	2,409,802
2014	21.1	0.9	513	2,436,467
2013	22.7	1.0	557	2,458,767
2012	23.2	1.0	578	2,494,939
2011	25.8	1.0	651	2,520,885
2010	25.9	1.0	668	2,577,734
2009	27.0	1.0	702	2,603,195

**Legends:**

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

**NOM 16.1 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	4.4	0.4	159	3,585,673
2016_2018	4.6	0.4	169	3,647,654
2015_2017	5.0	0.4	186	3,709,210
2014_2016	5.0	0.4	187	3,750,090
2013_2015	5.7	0.4	215	3,792,482
2012_2014	6.1	0.4	233	3,850,581
2011_2013	6.6	0.4	257	3,911,971
2010_2012	6.7	0.4	269	3,998,477
2009_2011	7.5	0.4	305	4,071,307
2008_2010	7.2	0.4	296	4,137,652
2007_2009	8.2	0.4	339	4,159,162

**Legends:**

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

**NOM 16.2 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	6.2	0.4	221	3,585,673
2016_2018	6.0	0.4	218	3,647,654
2015_2017	5.4	0.4	201	3,709,210
2014_2016	5.0	0.4	189	3,750,090
2013_2015	4.6	0.4	175	3,792,482
2012_2014	5.2	0.4	201	3,850,581
2011_2013	5.6	0.4	218	3,911,971
2010_2012	5.7	0.4	227	3,998,477
2009_2011	5.2	0.4	212	4,071,307
2008_2010	4.2	0.3	175	4,137,652
2007_2009	3.9	0.3	163	4,159,162

**Legends:**

■ Indicator has a numerator <10 and is not reportable

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

**NOM 16.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17**

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

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	18.4 %	1.6 %	751,706	4,084,608
2017_2018	15.8 %	1.6 %	656,207	4,140,731
2016_2017	16.5 %	1.4 %	689,627	4,169,385
2016	18.3 %	1.7 %	765,082	4,185,517

**Legends:**

■ Indicator has an unweighted denominator <30 and is not reportable

⚠ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.1 - Notes:**

None

**Data Alerts: None**

**NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system**

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

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	11.0 %	2.3 %	82,499	751,706
2017_2018	15.2 %	3.5 %	99,924	656,207
2016_2017	15.0 %	3.1 %	103,462	689,627
2016	11.0 %	2.7 %	83,973	765,082

**Legends:**

■ Indicator has an unweighted denominator <30 and is not reportable

⚠ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.2 - Notes:**

None

**Data Alerts: None**

**NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder**

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

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	2.6 %	0.7 %	88,286	3,332,666
2017_2018	3.1 %	0.8 %	107,077	3,441,661
2016_2017	2.5 %	0.5 %	85,905	3,457,869
2016	2.5 %	0.6 %	83,469	3,349,664

**Legends:**

■ Indicator has an unweighted denominator <30 and is not reportable

⚠ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.3 - Notes:**

None

**Data Alerts: None**



**NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

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

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	6.0 %	1.0 %	199,467	3,330,834
2017_2018	5.3 %	0.9 %	181,410	3,441,139
2016_2017	6.1 %	0.9 %	209,010	3,435,443
2016	7.5 %	1.3 %	246,377	3,292,586

**Legends:**

■ Indicator has an unweighted denominator <30 and is not reportable

⚠ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.4 - Notes:**

None

**Data Alerts: None**

**NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling**

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

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	58.1 % †	6.6 % †	225,173 †	387,496 †
2017_2018	53.5 % †	7.3 % †	149,733 †	279,615 †
2016_2017	45.5 % †	5.6 % †	131,277 †	288,794 †
2016	45.2 % †	6.7 % †	169,907 †	375,487 †

**Legends:**

■ Indicator has an unweighted denominator <30 and is not reportable

† Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 18 - Notes:**

None

**Data Alerts: None**

**NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health**

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

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	91.4 %	1.3 %	3,721,719	4,071,957
2017_2018	91.2 %	1.3 %	3,768,420	4,131,497
2016_2017	90.0 %	1.3 %	3,731,359	4,144,180
2016	89.3 %	1.6 %	3,694,889	4,139,390

**Legends:**

■ Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 19 - Notes:**

None

**Data Alerts: None**

**NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)**

Data Source: WIC

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	14.0 %	0.1 %	23,080	164,822
2016	13.7 %	0.1 %	25,048	182,401
2014	14.3 %	0.1 %	27,888	195,413
2012	15.1 %	0.1 %	28,760	189,928
2010	16.1 %	0.1 %	30,128	186,760
2008	16.4 %	0.1 %	27,601	168,629

**Legends:**

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	13.4 %	0.9 %	93,266	696,658
2017	12.4 %	0.9 %	86,909	699,950
2015	13.1 %	0.8 %	93,740	713,323
2013	10.6 %	0.5 %	75,265	711,539
2011	11.0 %	0.6 %	85,634	777,042
2009	10.8 %	0.9 %	69,040	639,137
2007	10.8 %	0.6 %	80,363	745,792
2005	10.3 %	0.7 %	78,925	765,158

**Legends:**

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	10.7 %	2.0 %	200,961	1,873,439
2017_2018	14.4 %	2.3 %	267,724	1,853,746
2016_2017	15.3 %	2.2 %	271,153	1,767,904
2016	14.8 %	2.5 %	247,537	1,673,430

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

**NOM 21 - Percent of children, ages 0 through 17, without health insurance**

Data Source: American Community Survey (ACS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	2.3 %	0.1 %	92,621	4,017,665
2018	2.2 %	0.1 %	91,033	4,060,665
2017	2.7 %	0.2 %	112,728	4,146,346
2016	2.5 %	0.2 %	103,337	4,173,030
2015	2.5 %	0.1 %	105,108	4,203,284
2014	3.4 %	0.2 %	142,448	4,218,611
2013	4.1 %	0.2 %	172,518	4,229,729
2012	4.0 %	0.2 %	170,847	4,255,688
2011	4.4 %	0.2 %	188,067	4,276,363
2010	4.8 %	0.2 %	205,478	4,310,594
2009	4.8 %	0.2 %	211,576	4,422,300

**Legends:**

■ Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 21 - Notes:**

None

**Data Alerts: None**

**NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3\*:3:1:4) by age 24 months**

Data Source: National Immunization Survey (NIS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	63.8 %	3.1 %	154,000	241,000
2015	66.9 %	2.8 %	157,000	234,000
2014	68.3 %	2.5 %	161,000	236,000
2013	69.7 %	2.5 %	165,000	236,000
2012	66.3 %	2.7 %	158,000	238,000
2011	66.2 %	2.9 %	159,000	241,000

**Legends:**

- Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2
- ⚡ Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

**NOM 22.1 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Immunization Survey (NIS) – Flu

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	69.6 %	1.1 %	2,645,284	3,800,695
2018_2019	69.6 %	1.3 %	2,682,388	3,852,898
2017_2018	64.9 %	1.4 %	2,540,516	3,914,345
2016_2017	65.9 %	1.2 %	2,577,837	3,909,960
2015_2016	65.6 %	1.3 %	2,586,217	3,943,606
2014_2015	67.0 %	1.4 %	2,665,415	3,975,858
2013_2014	64.5 %	1.3 %	2,569,841	3,983,768
2012_2013	60.9 %	1.4 %	2,443,270	4,014,396
2011_2012	54.8 %	1.8 %	2,235,474	4,081,388
2010_2011	54.3 %	1.8 %	2,196,305	4,044,760
2009_2010	47.8 %	2.4 %	1,749,743	3,660,551

**Legends:**

■ Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.2 - Notes:**

None

**Data Alerts: None**



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

Data Source: National Immunization Survey (NIS) - Teen

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	70.8 %	2.8 %	796,876	1,125,173
2018	67.3 %	2.7 %	774,548	1,151,627
2017	68.5 %	2.2 %	802,423	1,170,574
2016	71.5 %	2.1 %	843,600	1,179,474
2015	61.3 %	2.3 %	730,501	1,192,326

**Legends:**

■ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

⚡ Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM 22.3 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Immunization Survey (NIS) - Teen

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	93.4 %	1.2 %	1,050,427	1,125,173
2018	91.7 %	1.3 %	1,056,227	1,151,627
2017	92.9 %	1.1 %	1,087,093	1,170,574
2016	91.2 %	1.3 %	1,075,050	1,179,474
2015	89.0 %	1.5 %	1,061,525	1,192,326
2014	91.5 %	1.5 %	1,101,490	1,204,315
2013	89.5 %	1.5 %	1,079,545	1,206,859
2012	90.3 %	1.5 %	1,098,346	1,216,701
2011	88.5 %	1.3 %	1,096,560	1,238,598
2010	82.9 %	1.8 %	1,041,143	1,255,446
2009	69.2 %	2.4 %	901,124	1,302,154

**Legends:**

- Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2
- ⚡ Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM 22.4 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Immunization Survey (NIS) - Teen

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	95.0 %	1.1 %	1,068,518	1,125,173
2018	94.9 %	1.2 %	1,092,813	1,151,627
2017	89.3 %	1.5 %	1,045,009	1,170,574
2016	89.2 %	1.5 %	1,052,380	1,179,474
2015	86.2 %	1.6 %	1,028,154	1,192,326
2014	79.6 %	2.1 %	958,880	1,204,315
2013	83.4 %	1.7 %	1,005,909	1,206,859
2012	78.5 %	2.1 %	954,645	1,216,701
2011	74.9 %	1.9 %	927,636	1,238,598
2010	71.2 %	2.3 %	893,640	1,255,446
2009	62.9 %	2.6 %	818,840	1,302,154

**Legends:**

■ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

⚡ Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM 22.5 - Notes:**

None

**Data Alerts: None**

**NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	11.4	0.1	6,606	577,660
2018	11.7	0.1	6,847	584,413
2017	12.5	0.1	7,480	600,098
2016	13.2	0.2	8,003	607,309
2015	14.6	0.2	8,961	612,905
2014	16.1	0.2	9,954	619,857
2013	17.6	0.2	11,128	630,896
2012	19.6	0.2	12,592	642,269
2011	21.0	0.2	13,718	652,723
2010	22.8	0.2	15,126	663,928
2009	24.2	0.2	16,306	673,401

**Legends:**

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

**NOM 23 - Notes:**

None

**Data Alerts: None**

**NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth**

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	12.9 %	1.1 %	25,052	194,416
2018	15.5 %	1.1 %	14,715	95,176
2017	13.0 %	0.9 %	26,713	204,888
2016	13.6 %	0.9 %	28,516	209,969
2015	12.2 %	0.9 %	25,899	212,047
2014	11.4 %	0.8 %	24,427	214,506
2013	11.0 %	0.8 %	23,561	213,692
2012	12.0 %	1.1 %	13,109	109,303

**Legends:**

■ Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM 24 - Notes:**

None

**Data Alerts: None**

**NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year**

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

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	1.8 % †	0.6 % †	71,665 †	4,007,278 †
2017_2018	2.2 % †	0.8 % †	87,291 †	4,015,472 †
2016_2017	2.1 % †	0.7 % †	84,929 †	4,099,217 †
2016	2.0 % †	0.6 % †	81,336 †	4,165,523 †

**Legends:**

■ Indicator has an unweighted denominator <30 and is not reportable

† Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 25 - Notes:**

None

**Data Alerts: None**

**Form 10**  
**National Performance Measures (NPMs)**  
**State: New York**

**NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	2017	2018	2019	2020
Annual Objective					79.4
Annual Indicator				79.6	78.3
Numerator				2,826,660	2,737,695
Denominator				3,550,054	3,498,639
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.3	81.3	82.2	83.1	83.3	83.6

**Field Level Notes for Form 10 NPMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	annual objectives adjusted following review of data

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	91	91	93.4	93.7	93
Annual Indicator	92.3	92.7	92.5	91.2	92.2
Numerator				2,782	2,626
Denominator				3,052	2,849
Data Source	NYS VS	NYS VS	NYS VS	NYS VS	NYS VS
Data Source Year	2014	2015	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	92.4	92.6	92.8	93.1	93.4	93.4

**Field Level Notes for Form 10 NPMs:**

1.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

2016 data provided by NYS Vital Statistics as of May 2019



**NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day**

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CHILD			
	2016	2019	2020
Annual Objective			
Annual Indicator		27.0	27.4
Numerator		369,498	316,874
Denominator		1,370,994	1,158,167
Data Source		NSCH-CHILD	NSCH-CHILD
Data Source Year		2017_2018	2018_2019

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	27.5	27.8	28.1	28.4	28.6	28.9

**Field Level Notes for Form 10 NPMs:**

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			81.2	82.2	83.2
Annual Indicator		79.2	81.3	81.3	86.3
Numerator		1,103,856	1,081,532	1,081,532	1,367,654
Denominator		1,393,274	1,331,106	1,331,106	1,583,876
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	81.5	82.2	82.9	83.8	84.6	85.4

**Field Level Notes for Form 10 NPMs:**

None

**NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs**

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	2017	2018	2019	2020
Annual Objective			15.7	15.9	16.1
Annual Indicator		15.3	13.7	17.8	23.6
Numerator		48,081	34,736	48,580	87,040
Denominator		314,730	253,092	273,067	369,539
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	18.0	18.1	18.3	18.5	18.7	18.9

**Field Level Notes for Form 10 NPMs:**

None

**Form 10**  
**National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)**

**State: New York**

**2016-2020: NPM 5A - Percent of infants placed to sleep on their backs**

<b>Federally Available Data</b>					
<b>Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective	67.1	67.6	66.2	66.6	67.1
Annual Indicator	63.9	73.9	75.3	68.6	76.5
Numerator	135,686	155,836	152,784	65,253	145,881
Denominator	212,507	210,880	202,843	95,190	190,739
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2017	2018	2019

<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective	67.1	67.6	66.2	66.6	67.1
Annual Indicator	71.3	73.9			
Numerator					
Denominator					
Data Source	PRAMS NYS	PRAMS NYS			
Data Source Year	2014	2015			
Provisional or Final ?	Provisional	Final			

**Field Level Notes for Form 10 NPMs:**

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1.	<b>Field Name:</b>	<b>2016</b>
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	<b>Column Name:</b>	<b>State Provided Data</b>
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**Field Note:**  
NYS PRAMS 2014 preliminary data as of 5/22/2017  
Annual Objectives based on statewide data:  
2017 67.1  
2018 67.8  
2019 68.4  
2020 69.1  
2021 69.8

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2.	<b>Field Name:</b>	<b>2017</b>
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	<b>Column Name:</b>	<b>State Provided Data</b>
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**Field Note:**  
2018 - 2023 Annual objectives have been updated to reflect 2013 as the baseline year.

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3.	<b>Field Name:</b>	<b>2018</b>
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	<b>Column Name:</b>	<b>State Provided Data</b>
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**Field Note:**  
Percentage of infants placed to sleep on their backs  
Annual Indicator: 74.2  
PRAMS NYS  
2016

**2016-2020: NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface**

<b>Federally Available Data</b>			
<b>Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)</b>			
	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		36	36.7
Annual Indicator	37.6	37.4	40.9
Numerator	71,966	32,530	74,016
Denominator	191,278	87,007	181,144
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

<b>State Provided Data</b>				
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective			36	36.7
Annual Indicator	0			
Numerator	0			
Denominator	100			
Data Source	NYS PRAMS			
Data Source Year	2016			
Provisional or Final ?	Provisional			

**Field Level Notes for Form 10 NPMs:**

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1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2016 NYS Data

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2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Percent of infants placed to sleep on a separate approved sleep surface Annual Indicator: 36.0 NYS Prams 2016

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**2016-2020: NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding**

<b>Federally Available Data</b>			
<b>Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)</b>			
	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		44	44.7
Annual Indicator	46.3	45.2	51.2
Numerator	89,933	39,272	91,951
Denominator	194,052	86,816	179,619
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

<b>State Provided Data</b>				
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective			44	44.7
Annual Indicator	0			
Numerator	0			
Denominator	100			
Data Source	2016			
Data Source Year	2016			
Provisional or Final ?	Provisional			



**Field Level Notes for Form 10 NPMs:**

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1.      **Field Name:**                      **2017**

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**Column Name:**                    **State Provided Data**

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**Field Note:**  
2016 NYS Data not available yet

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2.      **Field Name:**                      **2018**

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**Column Name:**                    **State Provided Data**

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**Field Note:**  
Percent of infants placed to sleep without soft objects or loose bedding  
Annual Indicator: 43.8  
NYS PRAMS 2016

**2016-2020: NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			17.9	18.2	18.4
Annual Indicator		17.5	23.1	27.1	24.4
Numerator		101,178	117,256	140,531	133,123
Denominator		578,216	506,773	519,134	546,228
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**Field Level Notes for Form 10 NPMs:**

None

**2016-2020: NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day**

<b>Federally Available Data</b>					
<b>Data Source: Youth Risk Behavior Surveillance System (YRBSS)</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective	27.1	27.5	18.8	19	19.2
Annual Indicator	23.3	23.3	23.2	23.2	19.2
Numerator	161,704	161,704	159,614	159,614	132,694
Denominator	694,960	694,960	689,106	689,106	691,623
Data Source	YRBSS- ADOLESCENT	YRBSS- ADOLESCENT	YRBSS- ADOLESCENT	YRBSS- ADOLESCENT	YRBSS- ADOLESCENT
Data Source Year	2015	2015	2017	2017	2019
<b>Federally Available Data</b>					
<b>Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective			18.8	19	19.2
Annual Indicator		18.3	17.7	19.9	20.6
Numerator		246,053	232,223	284,451	318,977
Denominator		1,346,787	1,313,811	1,426,960	1,551,971
Data Source		NSCH- ADOLESCENT	NSCH- ADOLESCENT	NSCH- ADOLESCENT	NSCH- ADOLESCENT
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**Field Level Notes for Form 10 NPMs:**

None

**2016-2020: NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Adolescent Health - NONCSHCN**

<b>Federally Available Data</b>				
<b>Data Source: National Survey of Children's Health (NSCH) - NONCSHCN</b>				
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective			12.8	12.9
Annual Indicator	12.3	14.5	16.4	20.3
Numerator	130,919	156,317	189,724	244,654
Denominator	1,062,218	1,079,417	1,158,201	1,208,051
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019

**Field Level Notes for Form 10 NPMs:**

None

**2016-2020: NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy**

<b>Federally Available Data</b>					
<b>Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective	57.2	57.6	56.8	57.2	57.6
Annual Indicator	54.9	51.7	45.4	43.3	45.8
Numerator	117,570	110,325	95,006	42,679	90,543
Denominator	214,301	213,585	209,242	98,649	197,781
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2017	2018	2019

<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective	57.2	57.6	56.8	57.2	57.6
Annual Indicator	53.5	51.7			
Numerator					
Denominator					
Data Source	PRAMS NYS	PRAMS NYS			
Data Source Year	2014	2015			
Provisional or Final ?	Final	Final			

**Field Level Notes for Form 10 NPMs:**

None

**2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health**

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			79.6	80.5	81.5
Annual Indicator		77.6	80.6	79.3	77.7
Numerator		2,955,156	3,137,003	3,084,314	2,940,662
Denominator		3,810,186	3,890,746	3,887,411	3,785,630
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**Field Level Notes for Form 10 NPMs:**

None

**NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Adolescent Health**

**Field Level Notes for Form 10 NPMs:**

None

**Form 10  
State Performance Measures (SPMs)**

State: New York

**SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection**

<b>Measure Status:</b>	<b>Active</b>	
<b>State Provided Data</b>		
	<b>2019</b>	<b>2020</b>
Annual Objective		
Annual Indicator	70	68
Numerator		
Denominator		
Data Source	Newborn Blood Spot data	Newborn Blood Spot data
Data Source Year	2019	2020
Provisional or Final ?	Final	Provisional

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	75.0	77.0	79.0	81.0	85.0	85.0

**Field Level Notes for Form 10 SPMs:**

- Field Name:** 2019

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**Column Name:** State Provided Data

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**Field Note:**  
QI project did not begin until December 2019, snow storm after Thanksgiving caused shipping delays that impact timeliness of the lab receiving samples.
- Field Name:** 2020

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**Column Name:** State Provided Data

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**Field Note:**  
2020 data was significantly impacted by the 2019 snow storm and subsequent holiday shipping delays early in the year and then by the COVID-19 pandemic for the remainder of the year. 2020 data considered preliminary, will be finalized for 2023 application next year.



**SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months**

<b>Measure Status:</b>	<b>Active</b>	
<b>State Provided Data</b>		
	<b>2019</b>	<b>2020</b>
Annual Objective		
Annual Indicator		3.6
Numerator		1,772
Denominator		498,946
Data Source		NYS Child Health Lead Poisoning Prevention Program
Data Source Year		2018
Provisional or Final ?		Final

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	3.6	3.4	3.2	3.0	2.9	2.8

**Field Level Notes for Form 10 SPMs:**

- Field Name:** 2020

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**Column Name:** State Provided Data

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**Field Note:**  
2021 is the baseline year. Incidence of confirmed ( $\geq 10$  ug/dL) high blood lead levels per 1,000 tested children aged less than 72 months' is 3.55 for test year 2018.
- Field Name:** 2021

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**Column Name:** Annual Objective

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**Field Note:**  
2021 is the baseline year. Incidence of confirmed ( $\geq 10$  ug/dL) high blood lead levels per 1,000 tested children aged less than 72 months' is 3.55 for test year 2018.  
2015-2018 NYS Child Health Lead Poisoning Prevention Program Data as of November, 2020. Community Health Indicator Reports (CHIRS)

**Form 10**  
**State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)**

**2016-2020: SPM 1 - The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy**

<b>Measure Status:</b>	<b>Active</b>				
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		45	36.4	37.6	38.2
Annual Indicator	34.6	35.3	35.3	35.3	43.1
Numerator					
Denominator					
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2014	2016	2016	2016	2019
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2014 estimate revised to closer align with the performance measure.
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	The BRFSS is a survey, and therefore the weighted proportion of reproductively capable women who reported talking with a health care worker about ways to prepare for a healthy pregnancy before pregnancy is reported. The BRFSS sample size was larger to provide regional estimates for 2016 causing a delay in final calculation of the measure. Annual objectives have been modified to reflect 5% increase from baseline to 38.2 by 2020. With a projection of 5% increase every 2 years.
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2018 NYS BRFSS data is not available yet
4.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2017 BRFSS data were not available in time to calculate the updated indicator, and staff were deployed to support the state's response to the COVID pandemic.
5.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Question about speaking with a provider about a healthy pregnancy not included in 2017 and 2018 BRFSS surveys

**2016-2020: SPM 2 - The percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception.**

Measure Status:	Active				
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		8	25	25	26.3
Annual Indicator	27	24.5	55.2	56	49.5
Numerator					
Denominator					
Data Source	Medicaid Claims	Medicaid Claims	BRFSS	BRFSS	BRFSS
Data Source Year	2016	2017	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	NYSDOH OQPS created a CMS Developmental Measure of most and moderately effective contraception use in females 15-44 years of age.
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Since 2017, Medicaid Claims data were not available for this measure. This year, BRFSS data were used instead and the past three years (Data Source year 2017-2019) were entered for the years when Medicaid Claims data were not available. 2016 values from BRFSS are not comparable, different age range for skip pattern, so were not included. Numerator: Included female sterilization, male sterilization, contraceptive implant, IUD, Shots, birth control pills, contraceptive patch, contraceptive ring. Denominator: Excludes respondents who were male, currently pregnant, those who did not know or refused to answer what type of contraception was used, those who did not do anything because self or partner sterilized, had a hysterectomy, or have a same sex partner.
3.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Since 2017, Medicaid Claims data were not available for this measure. This year, BRFSS data were used instead and the past three years (Data Source year 2017-2019) were entered for the years when Medicaid Claims data were not available. 2016 values from BRFSS are not comparable, different age range for skip pattern, so were not included. Numerator: Included female sterilization, male sterilization, contraceptive implant, IUD, Shots, birth control pills, contraceptive patch, contraceptive ring. Denominator: Excludes respondents who were male, currently pregnant, those who did not know or refused to answer what type of contraception was used, those who did not do anything because self or partner sterilized, had a hysterectomy, or have a same sex partner.
4.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Since 2017, Medicaid Claims data were not available for this measure. This year, BRFSS data were used instead and the past three years (Data Source year 2017-2019) were entered for the years when Medicaid Claims data were not available. 2016 values from BRFSS are not comparable, different age range for skip pattern, so were not included. Numerator: Included female sterilization, male sterilization, contraceptive implant, IUD, Shots, birth control pills, contraceptive patch, contraceptive ring. Denominator: Excludes respondents who were male, currently pregnant, those who did not know or refused to answer what type of contraception was used, those who did not do anything because self or partner sterilized, had a hysterectomy, or have a same sex partner.

**2016-2020: SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets**

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		50	50	50	50
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Data Source	To Be Developed	Developmental Assessment Tool	Developmental Assessment Tool	Developmental Assessment Tool	To Be Developed
Data Source Year	2017-2018	2017-2018	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Three validated tool constructs developed with 23 developmental assets. Comprehensive Adolescent Pregnancy Prevention (CAPP) programs began piloting surveys in January 2018. Data not yet available.
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Three validated tool constructs developed with 23 developmental assets. Comprehensive Adolescent Pregnancy Prevention (CAPP) programs began piloting surveys in January 2018. Data not yet available.
3.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	No data available

**2016-2020: SPM 4 - The percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale**

Measure Status:	Active				
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		65	65.5	71	71.5
Annual Indicator	61.6	70.1	67	63.7	93.9
Numerator	673	1,021	1,238	1,034	59,596
Denominator	1,092	1,456	1,848	1,624	63,460
Data Source	New York Family Survey	New York Family Survey	New York Family Survey	New York Family Survey	New York Family Survey
Data Source Year	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data collection: 7/1/2015-6/30/2016
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data collection: 7/1/2016-6/30/2017. The annual objectives were set in conjunction and through consensus with the state's Early Intervention Coordinating Council. The quality improvement initiative to improve this measure has resulted in exceeding the target originally set, but this is only the second year of data. These objectives have been updated as requested. They will differ from the state's Early Intervention Program State Performance Plan/Annual Performance Report (SPP/APR) reported to the US Department of Education.
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data collection: 7/1/2017-6/30/2018. The annual objectives were set in conjunction and through consensus with the state's Early Intervention Coordinating Council. The quality improvement initiative to improve this measure has resulted in exceeding the target originally set, but this is only the second year of data. These objectives have been updated as requested. They will differ from the state's Early Intervention Program State Performance Plan/Annual Performance Report (SPP/APR) reported to the US Department of Education.
4.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data time period is 7/1/19-6/30/20. In 2019, the Early Intervention Coordinating Council voted for a change in methodology for this measure. This new methodology was previously submitted in the 2019 SSIP Report which was accepted by OSEP (numerator=48,549, denominator=55,885, rate=86.87%). The new method identifies the percentage of positive response which is calculated by dividing the number of positive responses by the total number of positive and negative responses across all items in the Family Outcomes Survey. The quality improvement initiative to improve this measure has resulted in exceeding the target originally set.



**2016-2020: SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water**

<b>Measure Status:</b>		<b>Active</b>			
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		72	73	75	77
Annual Indicator	71.7	71.6	70.8	70.8	70.8
Numerator					
Denominator					
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System
Data Source Year	2017	2018	2017	2017	2017
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	The slight decrease in fluoridation percentage is associated with the identification and correction of discrepancies between the New York State section of the Environmental Protection Agency's Safe Drinking Water Information System and the Centers for Disease Control and Prevention's Water Fluoridation Reporting System databases (systems added/deleted, population change, New York City (NYC) System moved their fluoridation injection point - 6 systems now purchasing non-fluoridated water from NYC).
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	No new data available. Prevention Agenda, 2017.
3.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	No new data available. Prevention Agenda, 2017.
4.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	No new data available. Prevention Agenda, 2017.

**Form 10  
Evidence-Based or –Informed Strategy Measures (ESMs)**

State: New York

**ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)**

<b>Measure Status:</b>	<b>Active</b>	
<b>State Provided Data</b>		
	<b>2019</b>	<b>2020</b>
Annual Objective		
Annual Indicator	52.7	63.4
Numerator		2,068
Denominator		3,260
Data Source	MICHC Program Data	MICHC Program Data
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	55.3	58.1	61.0	64.1	67.3	70.7

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Baseline data period for 10/1/19-3/31/20
2.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data collection period was 10/1/19-9/30/20, note the first half of this period is inclusive of the baseline data period.

**ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year**

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	37.3	39.7
Numerator		
Denominator		
Data Source	Family Planning Program Client Visit Record data	Family Planning Program Client Visit Record data
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	37.5	37.7	37.9	38.2	38.2	38.2

**Field Level Notes for Form 10 ESMs:**

None

**ESM 3.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards**

<b>Measure Status:</b>	<b>Active</b>	
<b>State Provided Data</b>		
	<b>2019</b>	<b>2020</b>
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	NYS Data	NYS Data
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	0.0	0.0	50.0	75.0	100.0	100.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Re-designation process still underway, no data to report. Anticipate completion in December 2021.

**ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year.**

<b>Measure Status:</b>	<b>Active</b>	
<b>State Provided Data</b>		
	<b>2019</b>	<b>2020</b>
Annual Objective		
Annual Indicator		51.6
Numerator		98,941
Denominator		191,920
Data Source		SBHC quarterly report
Data Source Year		2018-2019
Provisional or Final ?		Final

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	51.6	51.6	52.6	53.6	54.7	55.8

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Measure wording changes:

ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year"

**ESM 10.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, etc.**

<b>Measure Status:</b>	<b>Active</b>	
<b>State Provided Data</b>		
	<b>2019</b>	<b>2020</b>
Annual Objective		
Annual Indicator		96.3
Numerator		52
Denominator		54
Data Source		Survey of CAPP and PREP Programs
Data Source Year		2020
Provisional or Final ?		Final

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	96.3	96.3	98.2	100.0	100.0	100.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Baseline data period 7/1/20-12/31/20. Surveyed CAPP &/or PREP providers, those who checked that they did training or education with youth/adolescent participants in the following topics included in numerator: Accessing health insurance, Healthy relationships, Educational and career success, Financial literacy, Healthy life skills, Maintaining routine preventive medical visits, Transitioning to adult health care, and relevant "Other" topics. 100% response rate

**ESM 10.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation**

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		68.7
Numerator		46
Denominator		67
Data Source		Survey of CAPP, PREP, and SRAE Programs
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	68.7	70.1	71.6	73.1	74.0	75.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Baseline data period is 7/1/20-12/31/20. Surveyed CAPP, PREP, & SRAE providers, those who responded yes to engaging youth in program planning and implementation included in numerator, 100% response rate



**ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.**

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	40.3	62.4
Numerator		295
Denominator		473
Data Source	Contractor Reports	Contractor Reports
Data Source Year	2018-2019	2019-2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.3	40.8	41.3	41.8	42.3	42.7

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Baseline based on 2018-2019 data
2.	<b>Field Name:</b>	<b>2021</b>
	<b>Column Name:</b>	<b>Annual Objective</b>
	<b>Field Note:</b>	Used 2018-2019 as a reference.
3.	<b>Field Name:</b>	<b>2025</b>
	<b>Column Name:</b>	<b>Annual Objective</b>
	<b>Field Note:</b>	Used 2018-2019 (40.3) as a reference to improve 5% in 2025.

**Form 10**  
**Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)**

**2016-2020: ESM 1.3 - Percentage of DFH procurements that complete community listening forums as part of concept development process.**

<b>Measure Status:</b>		<b>Active</b>			
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		40	5	5	11
Annual Indicator	5	5.3	5.3	0	50
Numerator		1	1	0	2
Denominator		19	19	1	4
Data Source	Title V Program Records	Title V Program Records	Title V Program Records	Title V Program Records	Title V Program Records
Data Source Year	2017	2018	2019	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

- 
1. **Field Name:** 2017
- 
- Column Name:** State Provided Data
- 
- Field Note:**  
Annual Objectives have been adjusted to reflect programs initiating community listening forums in the third year.
- 
2. **Field Name:** 2020
- 
- Column Name:** State Provided Data
- 
- Field Note:**  
Data period 10/1/19-9/30/20

**2016-2020: ESM 1.7 - The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services.**

Measure Status:	Active				
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			7	7	7
Annual Indicator	11	7	7	7	6
Numerator					
Denominator					
Data Source	NYS Title V Program Records	NYS Title V Program Records	NYS Title V Program Records	NYS Title V Program Records	NYS Title V Program Records
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	11 of 17 relevant Title V programs incorporated strategies to reinforce well-woman and preconception health care services
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	7 of 16 Title V programs reported the incorporation of strategies to reinforce well-woman and preconception health care services
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	7 of 16 Title V programs reported the incorporation of strategies to reinforce well-woman and preconception health care services

**2016-2020: ESM 1.15 - Percentage of women with Medicaid insurance who report that a doctor, nurse, or other healthcare worker asked at the postpartum checkup if they were feeling down or depressed**

Measure Status:	Active		
State Provided Data			
	2018	2019	2020
Annual Objective			81
Annual Indicator	81.6	79.7	83.1
Numerator			
Denominator			
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

This measure was originally planned to be reported from MA Claims data but was retired. PRAMS data has been used in it's place, based on the measure "Percentage of women on Medicaid who report that they were asked if they were feeling down or depressed at the postpartum checkup"

**2016-2020: ESM 3.1 - Percentage of birthing hospitals re-designated with updated standards.**

Measure Status:	Active				
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		0	0	0	100
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Data Source	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	New York is continuing efforts to update standards for perinatal level of care. Due to the complexity of the initiative, it is anticipated that birthing center and hospital re-designations will not occur until 2020.
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	New York is continuing efforts to update standards for perinatal level of care. Due to the complexity of the initiative, it is anticipated that birthing center and hospital re-designations will not occur until 2020.
3.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Re-designation still in process; no data to report

**2016-2020: ESM 5.5 - Percent of infants, sleeping or awake-and-unattended in crib, in a safe sleep environment**

Measure Status:	Active			
State Provided Data				
	2017	2018	2019	2020
Annual Objective	90	90	90	90
Annual Indicator	91.7	91.6	91.6	91.6
Numerator		831		
Denominator		907		
Data Source	NYS sampled Birthing Hospitals	NYS sampled Birthing Hospitals	NYS sampled Birthing Hospitals	NYS sampled Birthing Hospitals
Data Source Year	2017	2018	2018	2018
Provisional or Final ?	Final	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	The NYSPQC initiative has ended. The last data collection for this measure was in October 2018 (one month in the current 2018-19 time period). 91.6% was the last complete year of data. There will be no additional data to report.
2.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	No new data to report, project ended October 2018

**2016-2020: ESM 6.5 - Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.**

<b>Measure Status:</b>		<b>Active</b>			
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		0	1,600	1,680	1,764
Annual Indicator	0	1,694	2,488	5,468	7,079
Numerator					
Denominator					
Data Source	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data
Data Source Year	2016-17	12/16-17	12/16-18	2018-19	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Not Available Yet
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Children age 0-12 with documented serious emotional disturbance and/or complex trauma enrolled in Health Home Serving Children December 2016-February 2018. Health Homes for children did not begin until Dec. 2016. Estimated 5% increase 2020 and 2021 and a 2% increase 2022 and 2023.
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data Source Year: 12/1/2016-5/2018. Children age 0-12 with documented serious emotional disturbance and/or complex trauma enrolled in Health Home Serving Children December 2016-May 2018. Medicaid provided data for all children (unduplicated) since the inception of CHH. Health Homes for children did not begin until Dec. 2016.
4.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data were reported by the NYS Medicaid Program for the time period from 10/1/18-9/30/19 for children under the age of 13 years old. Member counts include members that met the following criteria in the month/year based on Billing Support information submitted by Health Homes into the MAPP HHTS: 1) enrolled in a children's Health Home program, 2) received a billable Health Home service, and 3) reported SED or complex trauma as a reason that the member was Health Home eligible.
5.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data were reported by the NYS Medicaid Program for the time period from 10/1/19-9/30/20 for children under the age of 13 years old. Member counts include members that met the following criteria in the month/year based on Billing Support information submitted by Health Homes into the MAPP HHTS: 1) enrolled in a children's Health Home program, 2) received a billable Health Home service, and 3) reported SED or complex trauma as a reason that the member was Health Home eligible.



**2016-2020: ESM 8.2.1 - Number of community environmental changes demonstrated as a result of enhanced collaborations.**

<b>Measure Status:</b>		<b>Active</b>			
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective			6	7	8
Annual Indicator	1	6	6	8	6
Numerator					
Denominator					
Data Source	Title V Program data	Title V Program data	Title V Program data	Title V Program data	Title V Program data
Data Source Year	7/16-6/17	2016-2018	2017-2019	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data Source Year: 10/1/16-3/31/18 10 programs/initaitives were identified as having collaborative activities working towards community-, environmental, or policy/systems-level goals this reporting period. 6 met their goals (or had some local contractors meet their goals), for 60% success.
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data Source Year: 10/1/17-3/31/19 10 programs/initaitives were identified as having collaborative activities working towards community-, environmental, or policy/systems-level goals this reporting period. 6 met their goals (or had some local contractors meet their goals), for 60% success.
3.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	During the past reporting period, of 8 programs meeting those criteria, 4 met their community, environmental, or policy level changes as a result of their enhanced collaborative efforts.
4.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data Source Year: 10/1/19-9/30/20 9 programs/initiatives were identified as having collaborative activities working towards community-, environmental-, or policy/systems-level goals this reporting period. 6 met their goals (or had some local contractors meet their goals), for 66.7% success.

**2016-2020: ESM 10.3 - Number of adolescents with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.**

Measure Status:	Active			
State Provided Data				
	2017	2018	2019	2020
Annual Objective	1,000	1,000	1,050	1,103
Annual Indicator	1,060	1,605	4,088	5,913
Numerator				
Denominator				
Data Source	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data
Data Source Year	12/16-18	12/16-18	2018-19	2019-2020
Provisional or Final ?	Final	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Adolescent age 13-21 with serious emotional disturbance and/or complex trauma enrolled in a Health Home Serving Children December 2016-Feb. 2018.
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Adolescent age 13-21 with serious emotional disturbance and/or complex trauma enrolled in a Health Home Serving Children December 2016-May 2018.  Medicaid provided data for all children (unduplicated) since the inception of CHH.
3.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data were reported by the NYS Medicaid Program for the time period from 10/1/18-9/30/19 for youth 13-21. Member counts include members that met the following criteria in the month/year based on Billing Support information submitted by Health Homes into the MAPP HHTS: 1) enrolled in a children's Health Home program, 2) received a billable Health Home service, and 3) reported SED or complex trauma as a reason that the member was Health Home eligible.
4.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data were reported by the NYS Medicaid Program for the time period from 10/1/19-9/30/20 for youth 13-21. Member counts include members that met the following criteria in the month/year based on Billing Support information submitted by Health Homes into the MAPP HHTS: 1) enrolled in a children's Health Home program, 2) received a billable Health Home service, and 3) reported SED or complex trauma as a reason that the member was Health Home eligible.

**2016-2020: ESM 10.4 - Number of strategies implemented to improve adolescent use of preventive health care services.**

Measure Status:	Active			
State Provided Data				
	2017	2018	2019	2020
Annual Objective	1	1	1	1
Annual Indicator	1	1	1	1
Numerator				
Denominator				
Data Source	NYS Title V Program Records	NYS Title V Program Records	NYS Title V Program Records	NYS Title V Program Records
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

- 
1. **Field Name:** 2017
- 
- Column Name:** State Provided Data
- 
- Field Note:**  
 The numerator for last year was the number of actions taken to develop strategies. This measure and the work on adolescent health has progressed, and will continue to evolve as more work is accomplished. Instead of a discreet number of actions, we now have a comprehensive strategy to improve adolescent health. There is 1 comprehensive strategy to improve adolescent use of preventive health care services.
- 
2. **Field Name:** 2018
- 
- Column Name:** State Provided Data
- 
- Field Note:**  
 There is 1 comprehensive strategy to improve adolescent use of preventive health care services.

**2016-2020: ESM 12.7 - Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.**

Measure Status:	Active				
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		45	60	32.8	33.2
Annual Indicator	63.9	66.9	32.5	75.2	68.6
Numerator	4,275	5,244	902	5,038	4,168
Denominator	6,688	7,843	2,777	6,702	6,072
Data Source	NYEHDI	NYEHDI	NYEHDI	NYEHDI	NYEHDI
Data Source Year	CY2016	CY2017	CY2018	CY2018	CY2019
Provisional or Final ?	Final	Final	Provisional	Final	Final

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	The annual objectives were decreased because, while the state is improving, the improvement is slower than originally projected.
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Preliminary 2018 data shows a 32.5% drop in the number of infants receiving follow-up due to a lag in reporting by EHDl providers. The New York Early Hearing Detection and Intervention Information System (NYEHDI-IS) receives a one-time feed of initial newborn hearing screening results from vital statistics, all other results documented are user entered. To address this issue, the NYEHDI program has initiated a number of activities including: implementation of a lost to follow-up child list function into the NYEHDI-IS; targeted technical assistance to providers; letters to physicians of infants lost to follow-up; and hosting regional meetings and webinars.
3.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data issues were addressed and updated. Data are for calendar year 2018, reported by the NYS Early Hearing Detection and Intervention (EHDl) program. Uses CDC HSFS data from NYEHDI-IS.



**2016-2020: ESM 13.1.1 - Percentage of pregnant women served by Title V community health workers that have a documented screening or referral for dental services.**

<b>Measure Status:</b>		<b>Active</b>			
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		10	50	50	50
Annual Indicator	36.7	45.3	56.6	60.5	67.5
Numerator					2,133
Denominator					3,160
Data Source	MICHHC reports	MICHHC reports	MICHHC reports	MICHHC reports	MICHHC reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

In 2019, a reported 60.5% of prenatal and postpartum women who were served by CHWs had a documented screening for dental issues, and 19.6% of women screened were referred for dental services. New this year, the data collected allows tracking of completed referral rates and shows 41.4% of prenatal and postpartum clients referred for dental services completed the referral.



**2016-2020: ESM 13.2.1 - Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.**

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		20	60	61	61
Annual Indicator	58	60	48	29	25
Numerator					
Denominator					
Data Source	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records
Data Source Year	2017	2018	2019	2020	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Over the course of the reporting period, 29 different public water systems (PWS) received technical and/or financial support for community water fluoridation (CWF) from the NYSDOH DWF Grant program.
2.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Over the course of the reporting period, 25 different public water systems (PWS) received technical and/or financial support for community water fluoridation (CWF) from the NYSDOH DWF Grant program.

**2016-2020: ESM 13.2.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.**

<b>Measure Status:</b>		<b>Active</b>			
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		40	41	44	47
Annual Indicator	61.2	50.5	39.1	21	24
Numerator					
Denominator					
Data Source	SEALS (CDC Data)	SEALS (CDC Data)	SEALS (CDC Data)	SBSP quarterly reports	SBSP quarterly reports
Data Source Year	2016	2017	2018	2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	The discrepancies in the numbers from report years. 2016 to 2017 can be attributed to DOH staff were data entering handwritten documents that had errors. Those errors would prevent forms from being data entered. Starting 2017, providers data enter their own forms.
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	These data are reported in the CDC SEALS system for school years from September-June. The decrease from 2017 to 2018 is due to inability of three SBSP-funded dental programs to provide services in the 2017-2018 school year due to lack of dental staff and difficulties with the data submission.
3.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Previously, this information was gathered from Sealant Efficiency Assessment for Locals and States (SEALS) data calculated by the Centers for Disease Control and Prevention (CDC). However, as of 2018, NYSDOH no longer receives funding from CDC for this program, so this ESM is now calculated using data submitted by SBSP grantees to NYSDOH on quarterly reports.

**Form 10**  
**State Performance Measure (SPM) Detail Sheets**

**State: New York**

**SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection**  
**Population Domain(s) – Perinatal/Infant Health**

<b>Measure Status:</b>	Active									
<b>Goal:</b>	The goal is to achieve state-wide improvement from 74.34% to greater than 85% of samples received at the lab within 48 hours of collection by September 2023									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #cccccc;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #cccccc;"><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td style="background-color: #cccccc;"><b>Numerator:</b></td> <td>Number of samples received within 48 hours of collection</td> </tr> <tr> <td style="background-color: #cccccc;"><b>Denominator:</b></td> <td>Number of births</td> </tr> </table>		<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of samples received within 48 hours of collection	<b>Denominator:</b>	Number of births
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Numerator:</b>	Number of samples received within 48 hours of collection									
<b>Denominator:</b>	Number of births									
<b>Data Sources and Data Issues:</b>	NYS Newborn Blood Spot Data									
<b>Significance:</b>	<p>This SPM was developed to reflect the state’s continued commitment to ensure that every newborn in the state receives newborn bloodspot screening as a public health service, to identify and support infants with a wide range of medical conditions. As a population-based program, the NBS program is an integral part of NY’s public health system for supporting the health and lifelong well-being of newborns and their families. In 2018, the program screened 222,049 infants, 99.98% of all NYS resident infants born that year, and timely receipt of the sample is critical to ensure appropriate care can be provided. The Title V Program will collaborate with the Newborn Blood Spot Program to support the quality improvement initiative to improve timely receipt of newborn blood spot samples.</p>									

**SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months**

**Population Domain(s) – Children with Special Health Care Needs**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Reduce the incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months by at least 5% each year.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Rate</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of children ages less than 72 months old with blood lead levels 5.0 micrograms per deciliter or greater</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of children ages less than 72 months old with blood lead tests</td> </tr> </table>	<b>Unit Type:</b>	Rate	<b>Unit Number:</b>	1,000	<b>Numerator:</b>	Number of children ages less than 72 months old with blood lead levels 5.0 micrograms per deciliter or greater	<b>Denominator:</b>	Number of children ages less than 72 months old with blood lead tests
<b>Unit Type:</b>	Rate								
<b>Unit Number:</b>	1,000								
<b>Numerator:</b>	Number of children ages less than 72 months old with blood lead levels 5.0 micrograms per deciliter or greater								
<b>Denominator:</b>	Number of children ages less than 72 months old with blood lead tests								
<b>Data Sources and Data Issues:</b>	Baseline data is based on the confirmed high blood lead levels ( $\geq 10$ ug/dL) from 2015-2018 NYS Child Health Lead Poisoning Prevention Program Data as of November, 2020.								
<b>Significance:</b>	This SPM was developed to reflect the state’s longstanding commitment to eliminating childhood lead poisoning as a key public health problem in NYS. It is responsive to cross-cutting priorities voiced by families related to safe and healthy environments to support children’s development, and access to comprehensive, high quality health care services. It is also responsive to specific concerns shared by families regarding challenges in accessing and coordinating medical care and related services for children with special health care needs. It builds on critical public health investments and capacity to prevent, identify, and address lead poisoning in NYS, including recent amendments to state public health law								

**Form 10**  
**State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)**

**2016-2020: SPM 1 - The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy**  
**Population Domain(s) – Women/Maternal Health**

<b>Measure Status:</b>	Active									
<b>Goal:</b>	Increase from baseline the percent of women aged 18 to 44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy.									
<b>Definition:</b>	<table border="1" style="width: 100%;"> <tr> <td style="background-color: #cccccc;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #cccccc;"><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td style="background-color: #cccccc;"><b>Numerator:</b></td> <td>Female BRFSS respondents 18 – 44 years old who are reproductively capable and who report ever talking with their health care provider about ways to prepare for a healthy pregnancy</td> </tr> <tr> <td style="background-color: #cccccc;"><b>Denominator:</b></td> <td>All female BRFSS respondents 18-44 years old who are reproductively capable</td> </tr> </table>		<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Female BRFSS respondents 18 – 44 years old who are reproductively capable and who report ever talking with their health care provider about ways to prepare for a healthy pregnancy	<b>Denominator:</b>	All female BRFSS respondents 18-44 years old who are reproductively capable
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Numerator:</b>	Female BRFSS respondents 18 – 44 years old who are reproductively capable and who report ever talking with their health care provider about ways to prepare for a healthy pregnancy									
<b>Denominator:</b>	All female BRFSS respondents 18-44 years old who are reproductively capable									
<b>Healthy People 2020 Objective:</b>	N/A									
<b>Data Sources and Data Issues:</b>	NYS BRFSS survey data In some survey years, number of respondents meeting criteria for this measure may be small.									
<b>Significance:</b>	Incorporating preconception health care in routine health care for all women of reproductive age is critical to several NYS Title V priorities and strategies.									

**2016-2020: SPM 2 - The percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception.**

**Population Domain(s) – Women/Maternal Health**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase from baseline the percent of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Continuously enrolled female Medicaid recipients, 15-44 years of age, at risk for unintended pregnancy, initiating or continuing use of most or moderately effective contraception in the assessment period (year).</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Continuously enrolled female Medicaid recipients, 15-44 years of age at risk for unintended pregnancy</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Continuously enrolled female Medicaid recipients, 15-44 years of age, at risk for unintended pregnancy, initiating or continuing use of most or moderately effective contraception in the assessment period (year).	<b>Denominator:</b>	Continuously enrolled female Medicaid recipients, 15-44 years of age at risk for unintended pregnancy
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Continuously enrolled female Medicaid recipients, 15-44 years of age, at risk for unintended pregnancy, initiating or continuing use of most or moderately effective contraception in the assessment period (year).								
<b>Denominator:</b>	Continuously enrolled female Medicaid recipients, 15-44 years of age at risk for unintended pregnancy								
<b>Healthy People 2020 Objective:</b>	FP – 16: Increase the percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception. HP2020 uses the National Survey of Family Health to measure.								
<b>Data Sources and Data Issues:</b>	<p>NYS proposes to use Medicaid claims data to measure. NYSDOH OQPS is creating a CMS Developmental Measure of most and moderately effective contraception use in females 15-44 years of age.</p> <p>Baseline to be established and targets for improvement to be determined as part of implementation</p>								
<b>Significance:</b>	Unplanned and closely spaced pregnancies have less healthy maternal and infant outcomes. Increased rate of use of most/moderately effective contraception will help improve birth spacing and pregnancy planning. This is a shared priority for Title V and Medicaid in NYS.								

**2016-2020: SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets**

**Population Domain(s) – Child Health, Adolescent Health, Children with Special Health Care Needs**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the percentage of children surveyed who demonstrate 20 or more developmental assets by 10% from baseline								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of children and adolescents surveyed who demonstrate 20+ developmental assets</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of children and adolescents surveyed</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of children and adolescents surveyed who demonstrate 20+ developmental assets	<b>Denominator:</b>	Number of children and adolescents surveyed
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of children and adolescents surveyed who demonstrate 20+ developmental assets								
<b>Denominator:</b>	Number of children and adolescents surveyed								
<b>Healthy People 2020 Objective:</b>	N/A								
<b>Data Sources and Data Issues:</b>	Developmental assessment tool to be adopted/ established (tentative consideration for Search Institute tool). Validated constructs on self-efficacy, healthy decision-making, and youth-adult connectedness identified by CAPP programs.								
<b>Significance:</b>	Positive social-emotional development and the presence of assets has been associated with positive health and wellbeing outcomes. Measurement of positive developmental assets among young people served by Title V Programs will provide a strong basis for informed youth development activities and interventions.								



**2016-2020: SPM 4 - The percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale**  
**Population Domain(s) – Children with Special Health Care Needs**

<b>Measure Status:</b>	Active									
<b>Goal:</b>	Increase the percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of respondent families participating in Early Intervention who meet the State's standard (person mean <math>\geq 576</math>) on the New York Impact on Family Scale</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of respondent families</td> </tr> </table>		<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of respondent families participating in Early Intervention who meet the State's standard (person mean $\geq 576$ ) on the New York Impact on Family Scale	<b>Denominator:</b>	Number of respondent families
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Numerator:</b>	Number of respondent families participating in Early Intervention who meet the State's standard (person mean $\geq 576$ ) on the New York Impact on Family Scale									
<b>Denominator:</b>	Number of respondent families									
<b>Healthy People 2020 Objective:</b>	N/A									
<b>Data Sources and Data Issues:</b>	Data will be collected using the New York Family Survey, which includes the NYS Impact on Family Scale and is conducted annually with a representative sample of families whose children exited the Part C Early Intervention Program in the year.									
<b>Significance:</b>	Positive impact on families, including families of CSHCN, is central to the mission of our Title V Program. This measure is associated with New York's State Systemic Improvement Plan approved by the U.S. Department of Education, Office of Special Education Programs and thus aligns Title V and Early Intervention goals. New York is one of five states focusing on improved family outcomes as part of results-driven accountability for Part C early intervention program for infants and toddlers with disabilities and their families.									

**2016-2020: SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water**

**Population Domain(s) – Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the percentage of NYS residents served by community water systems that have optimally fluoridated water								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of residents served by community water systems with optimal fluoride levels</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of NYS residents served by community water systems</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of residents served by community water systems with optimal fluoride levels	<b>Denominator:</b>	Number of NYS residents served by community water systems
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of residents served by community water systems with optimal fluoride levels								
<b>Denominator:</b>	Number of NYS residents served by community water systems								
<b>Healthy People 2020 Objective:</b>	OH13- Increase the proportion of the US population served by community water systems with optimally fluoridated water								
<b>Data Sources and Data Issues:</b>	CDC Water Fluoridated Reporting System								
<b>Significance:</b>	Community water fluoridation reduces the prevalence and severity of tooth decay								

**Form 10**  
**State Outcome Measure (SOM) Detail Sheets**  
**State: New York**

No State Outcome Measures were created by the State.

**Form 10**  
**Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets**

**State: New York**

**ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)**  
**NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

<b>Measure Status:</b>	Active									
<b>Goal:</b>	The baseline value for this measure, taken from 6-month program period of 10/1/19-3/31/20, is 52.7%. The program has set an improvement target of 5% annually, to 67.3% of participants by 2024.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of MICHC participants engaged prenatally who have created a birth plan during a visit with a CHW</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of MICHC participants engaged prenatally with a CHW</td> </tr> </table>		<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of MICHC participants engaged prenatally who have created a birth plan during a visit with a CHW	<b>Denominator:</b>	Number of MICHC participants engaged prenatally with a CHW
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Numerator:</b>	Number of MICHC participants engaged prenatally who have created a birth plan during a visit with a CHW									
<b>Denominator:</b>	Number of MICHC participants engaged prenatally with a CHW									
<b>Data Sources and Data Issues:</b>	Data for this measure will come from quarterly and annual reports submitted by local MICHC contractors.									
<b>Significance:</b>	<p>Through the Maternal &amp; Infant Community Health Collaboratives (MICHC) program, community health workers (CHWs) conduct basic health and well-being assessments in the prenatal and postpartum periods, using standardized evidence-based and/or validated screening tools, to identify and prioritize needs of the individuals and families served. Assessments are completed at enrollment and updated throughout clients' service periods and individualized care plans are developed based on the needs identified. CHWs receive annual training on how to talk with families about difficult topics like mental health and depression, using a trauma informed care approach, and including how to manage emergency situations. CHWs also connect clients and families to needed services and provide enhanced social support. CHWs help ensure early and consistent participation in preventive and primary health care services, including early prenatal care, particularly for those individuals not engaged in care and other supportive services. CHWs provide health information to increase clients' knowledge and ability to self-advocate and make informed health care decisions, with the goal of helping families achieve optimal health, self-sufficiency, and overall well-being.</p>									

**ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year**

**NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Current FPP data for program year 2018 shows 37.3% of female FPP clients had a documented comprehensive medical exam. The FPP program has set a five-year improvement target of 2.5%, to 38.2% of clients in 2023.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of Family Planning Program clients with a documented comprehensive medical exam in the past year</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of FPP clients</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of Family Planning Program clients with a documented comprehensive medical exam in the past year	<b>Denominator:</b>	Number of FPP clients
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of Family Planning Program clients with a documented comprehensive medical exam in the past year								
<b>Denominator:</b>	Number of FPP clients								
<b>Data Sources and Data Issues:</b>	Data for this measure will come from FPP clinic visit record (CVR) data.								
<b>Significance:</b>	The NYS Family Planning Program (FPP) supports 43 Article 28 health facilities (i.e., hospitals and clinics) that operate 156 family planning service sites across the state. Through these service sites, the FPP delivers comprehensive, confidential reproductive health services for low-income, uninsured and underinsured women and men of reproductive age. Services provided include: contraceptive services; preconception planning and counseling services; pregnancy testing and related counseling; preventive services such as basic health screening, screening for sexually transmitted diseases, HIV counseling and testing, breast and cervical cancer screening; and appropriate referrals and health education.								

**ESM 3.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards**

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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	The baseline value for this measure will be determined after regulations are adopted (anticipated in December 2021). The program has set a target to update designations for 50% of hospitals within one year post-adoption and 100% within three years of								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of birthing hospitals with final level of perinatal care designation</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of birthing hospitals</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of birthing hospitals with final level of perinatal care designation	<b>Denominator:</b>	Number of birthing hospitals
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of birthing hospitals with final level of perinatal care designation								
<b>Denominator:</b>	Number of birthing hospitals								
<b>Data Sources and Data Issues:</b>	Data for this measure will come from hospital surveys and site visit reports from IPRO/NYSDOH staff								
<b>Significance:</b>	NYS historically has been a leader in establishing systems of perinatal regionalization, with consistently high performance in this measure. Building on that success, the Title V program is currently engaged in a multi-year effort to expand and update perinatal regionalization standards and designations for the state’s birthing hospitals and centers. As this work progresses, it is essential to closely monitor the success of designating birthing hospitals in accordance with updated regulations as well as performance and outcome measures to ensure that quality of care and key health outcomes are maintained or improved.								

**ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year.**

**NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	The baseline for 2021 (51.6%) has been established using program year 2018-2019 data. Targets have been established to achieve a 2% increase each year.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Children and youth enrolled in SBHCs who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Children with a visit to a SBHC within the past year</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Children and youth enrolled in SBHCs who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year	<b>Denominator:</b>	Children with a visit to a SBHC within the past year
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Children and youth enrolled in SBHCs who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year								
<b>Denominator:</b>	Children with a visit to a SBHC within the past year								
<b>Data Sources and Data Issues:</b>	Data for this measure comes from the SBHC quarterly reports. Targets have been established to achieve a 2% increase each year, except for 2022 as the first year is primarily a planning year and an increase in anticipatory guidance delivery is not expected.								
<b>Significance:</b>	NY's Title V program has important capacity to address these priorities through its School Based Health Center (SBHC) program. SBHCs serve NYS's highest need communities and provide critical access to quality primary care for school-aged children. SBHCs are an important source of primary and preventive care services for thousands of NYS children, and have the opportunity and capacity to holistically address children's needs. Title V staff will work with SBHCs statewide to ensure anticipatory guidance to promote proper nutrition and daily physical activity, weight status assessment, and attention to overall health promotion and chronic disease management, as part of routine primary and preventive care for children.								

**ESM 10.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, etc.**

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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	The baseline value for this measure, taken from a 6-month program period of 7/1/2020 – 12/31/20, is 96.3%. The program has set an improvement target of 100% by 2025.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of youth-serving programs that provide training on adult preparation subjects for adolescents with and without special health care needs to prepare them for a transition into adulthood</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of youth-serving programs that provide training on adult preparation subjects for adolescents with and without special health</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of youth-serving programs that provide training on adult preparation subjects for adolescents with and without special health care needs to prepare them for a transition into adulthood	<b>Denominator:</b>	Number of youth-serving programs that provide training on adult preparation subjects for adolescents with and without special health
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of youth-serving programs that provide training on adult preparation subjects for adolescents with and without special health care needs to prepare them for a transition into adulthood								
<b>Denominator:</b>	Number of youth-serving programs that provide training on adult preparation subjects for adolescents with and without special health								
<b>Data Sources and Data Issues:</b>	Data for this measure will come from biannual reports and annual data requests submitted by local adolescent health providers.								
<b>Significance:</b>	Adolescence is a critical stage of development when children grow physically, cognitively, emotionally, and socially to become adults. The lifestyle choices, behaviors, and relationships established during this time can affect an adolescent's current and future health. Comprehensive and inclusive reproductive health care and education are opportunities to help adolescents avoid or mitigate risky sexual behaviors. Title V Programs also provide enabling services to adolescents, such as referrals to and linkages with community services and social supports to holistically address health and wellness, including mental health and social determinants of health.								



**ESM 10.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation**

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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	The baseline value for this measure, taken from a 6-month program period of 7/1/2020 – 12/31/20, is 68.7%. The program has set an improvement target of 75% by 2025.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of youth-serving programs</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation	<b>Denominator:</b>	Number of youth-serving programs
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation								
<b>Denominator:</b>	Number of youth-serving programs								
<b>Data Sources and Data Issues:</b>	Data for this measure will come from biannual reports and annual data requests submitted by adolescent health providers.								
<b>Significance:</b>	Significance needed								

**ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.**

**NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	The baseline value for this measure, from the 2018-19 program grant cycle, is 40.3%. The program has set an improvement target of 5% for 2022, to 42.3%.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Individuals ages 14-21 with sickle cell disease who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed	<b>Denominator:</b>	Individuals ages 14-21 with sickle cell disease who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed								
<b>Denominator:</b>	Individuals ages 14-21 with sickle cell disease who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment								
<b>Data Sources and Data Issues:</b>	Sickle Cell Disease Care Transition contractor reports								
<b>Significance:</b>	Sickle cell disease (SCD) grantees at three (3) Hemoglobinopathy Centers (HC) work directly and exclusively with youth in support services. HCs conduct peer support groups to gauge barriers to care and transition for youth and young adults with SCD. Transition navigators at HCs engage youth with SCD to ensure compliance with care regimens and to understand that barriers youth experience in caring for themselves. In studies by Treadwell et al. (2011) and Telfair (2004) participants with SCD voiced a fear of leaving their pediatric health care providers, expressing concern that adult care providers might not understand their needs and might not believe their complaints of pain. The youth also expressed concerns about having limited information about transition and about adult health care programs. There is increased risk for individuals with SCD during this transition period.								

**Form 10**

**Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)**

**2016-2020: ESM 1.3 - Percentage of DFH procurements that complete community listening forums as part of concept development process.**

**NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Integrate an equity framework into the development of all DFH/Title V procurements through community listening forums conducted as part of the concept development process.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of DFH procurements that include community listening forums as part of concept development process</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of procurements released by DFH</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of DFH procurements that include community listening forums as part of concept development process	<b>Denominator:</b>	Number of procurements released by DFH
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of DFH procurements that include community listening forums as part of concept development process								
<b>Denominator:</b>	Number of procurements released by DFH								
<b>Data Sources and Data Issues:</b>	Title V Program records								
<b>Significance:</b>	Understanding the myriad of social, political, and environmental factors that contribute to issues and factors that drive health disparities is a complex and ongoing task. By providing opportunities for that input in the earliest stages of program development, we will allow for the opportunity to refine the approach and scope of programs to better meet the needs of our priority populations while engaging and empowering affected populations								

**2016-2020: ESM 1.7 - The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services.**

**NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Incorporate performance measures and strategies to reinforce use of well-woman care including pregnancy planning and prevention across core Title V programs serving women of reproductive age.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>20</td> </tr> <tr> <td><b>Numerator:</b></td> <td>The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services.</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	20	<b>Numerator:</b>	The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services.	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	20								
<b>Numerator:</b>	The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services.								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	NYS Title V Program records								
<b>Significance:</b>	Incorporation of performance measures and strategies can reinforce use of well-woman care including pregnancy planning and prevention across core Title V programs serving women of reproductive age.								

**2016-2020: ESM 1.15 - Percentage of women with Medicaid insurance who report that a doctor, nurse, or other healthcare worker asked at the postpartum checkup if they were feeling down or depressed**  
**NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Collaborate with partners to increase screening and follow-up support for maternal depression.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of postpartum women who are screened for depression during postpartum checkup with Medicaid as insurance</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of women with a live birth</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of postpartum women who are screened for depression during postpartum checkup with Medicaid as insurance	<b>Denominator:</b>	Number of women with a live birth
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of postpartum women who are screened for depression during postpartum checkup with Medicaid as insurance								
<b>Denominator:</b>	Number of women with a live birth								
<b>Data Sources and Data Issues:</b>	Pregnancy Risk Assessment Monitoring System (PRAMS)								
<b>Significance:</b>	Increase in screening for postpartum depression is recommended by American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the U.S. Preventive Services Task Force. The result will be an increased referral and treatment rates for depression.								

**2016-2020: ESM 3.1 - Percentage of birthing hospitals re-designated with updated standards.  
 NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Update NYS perinatal regionalization standards and designations and implement updated performance measures for Regional Perinatal Centers and affiliate birthing hospitals.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number Birthing Facilities Re-designated</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Total Number Birthing Facilities in the state</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number Birthing Facilities Re-designated	<b>Denominator:</b>	Total Number Birthing Facilities in the state
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number Birthing Facilities Re-designated								
<b>Denominator:</b>	Total Number Birthing Facilities in the state								
<b>Data Sources and Data Issues:</b>	NYS Title V Program records - current list of birthing facilities and updated list as birthing hospitals are re-designated.								
<b>Significance:</b>	It is imperative for NYS to ensure all perinatal hospitals are functioning in accordance with current standards of care for both maternal and infant outcomes. The last comprehensive review of NY’s regionalized system was in the early 2000s.								

**2016-2020: ESM 5.5 - Percent of infants, sleeping or awake-and-unattended in crib, in a safe sleep environment**  
**2016-2020: NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	At least 90% of infants, sleeping or awake-and-unattended, will be in a safe sleep environment during their hospital stay.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of infants, sleeping or awake and unattended in crib, positioned supine, in safe clothing, with head of crib flat and crib free of objects</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of cribs audited</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of infants, sleeping or awake and unattended in crib, positioned supine, in safe clothing, with head of crib flat and crib free of objects	<b>Denominator:</b>	Number of cribs audited
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of infants, sleeping or awake and unattended in crib, positioned supine, in safe clothing, with head of crib flat and crib free of objects								
<b>Denominator:</b>	Number of cribs audited								
<b>Data Sources and Data Issues:</b>	NYS sampled Birthing Hospitals Data are collected by 56% (69/123) of NYS birthing hospitals, with hospital staff performing crib audits on a sample of at least 20 infant cribs per month. Data are submitted via the NYSDOH Health Commerce System on a monthly basis. These data represent ~40% of births in NYS.								
<b>Significance:</b>	It is important that hospitals are modeling safe sleep practices and educating parents/caregivers so that the parents/caregivers will have the knowledge and self-efficacy to practice safe sleep at home.								

**2016-2020: ESM 6.5 - Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.**

**2016-2020: NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for eligible children and adolescents with serious emotional disturbance and complex trauma.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>10,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10,000	<b>Numerator:</b>	Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	10,000								
<b>Numerator:</b>	Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	NYS Medicaid Health Home Data								
<b>Significance:</b>	Children enrolled in a Medicaid Health Home are more likely to access key health care services and receive coordinated care across multiple systems, which may lead to better health outcomes and reduction of unnecessary emergency room visits and hospital stays.								



2016-2020: ESM 8.2.1 - Number of community environmental changes demonstrated as a result of enhanced collaborations.

2016-2020: NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Enhance collaboration with key partners at the state or local levels to advance changes at the community-, environmental- or policy/systems-levels that promote maternal and child health								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of DFH programs/initiatives in the Denominator reporting meeting their community-, environmental- or policy/systems-level goals during the reporting period.</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of DFH programs/initiatives in the Denominator reporting meeting their community-, environmental- or policy/systems-level goals during the reporting period.	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of DFH programs/initiatives in the Denominator reporting meeting their community-, environmental- or policy/systems-level goals during the reporting period.								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	Title V Program data DFH staff were surveyed once to identify those belonging in the denominator, then were surveyed again after the reporting period to report on progress towards meeting goals.								
<b>Significance:</b>	As highlighted in the needs assessment, both families and providers identified the critical role that home and community environments play in health outcomes and health behaviors. Factors including access to healthy affordable food and places to engage safely in physical activity have significant impact on families' health and well-being. These perceptions are consistent with broader and longstanding public health approaches aimed at supporting "healthycommunities", including strong commitments to community-driven change, policy and environmental change strategies (vs. individual-level strategies), and a focus on addressing social determinants of health rather than treating disease. Title V programs cannot impact in isolation all of areas of social determinants of health, making collaboration a critical focus of DFH.								

**2016-2020: ESM 10.3 - Number of adolescents with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.**

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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for young adults with serious emotional disturbance and complex trauma.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>20,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	20,000	<b>Numerator:</b>	Number with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	20,000								
<b>Numerator:</b>	Number with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	NYS Medicaid Health Home Data								
<b>Significance:</b>	Adolescents enrolled in a Medicaid Health Home are more likely to access key health care services and receive coordinated care across multiple systems, which may lead to better health outcomes and reduction of unnecessary emergency room visits and hospital stays.								

**2016-2020: ESM 10.4 - Number of strategies implemented to improve adolescent use of preventive health care services.**

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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Improve adolescent access to/utilization of preventive health care by implementing strategies to support adolescent access to preventive care through BWIAH programs serving adolescents.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of actions taken to develop strategies (i.e. literature review, surveys, focus groups)</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of actions taken to develop strategies (i.e. literature review, surveys, focus groups)	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of actions taken to develop strategies (i.e. literature review, surveys, focus groups)								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	NYS Title V staff reporting activities completed. (Eventually, number of BWIAH programs serving adolescents which have implemented strategies)								
<b>Significance:</b>	Adolescents having access to preventive care services will aid in healthy lifestyle and healthy behavior choices, knowledge for those with existing chronic conditions, and encourages the adolescent to manage care for themselves.								

2016-2020: ESM 12.7 - Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.

NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Provide technical assistance and facilitate a structured quality improvement project to engage health care providers, parent representatives, & audiologists to improve reporting of initial hearing screening and follow up results into the NYEHDI-IS.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of infants with a failed hearing screening who had a documented diagnostic evaluation in the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS).</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of infants who receive an abnormal newborn hearing screening.</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of infants with a failed hearing screening who had a documented diagnostic evaluation in the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS).	<b>Denominator:</b>	Number of infants who receive an abnormal newborn hearing screening.
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of infants with a failed hearing screening who had a documented diagnostic evaluation in the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS).								
<b>Denominator:</b>	Number of infants who receive an abnormal newborn hearing screening.								
<b>Data Sources and Data Issues:</b>	NYEHDI System Data								
<b>Significance:</b>	Infants with abnormal hearing screening will have follow-up.								

**2016-2020: ESM 13.1.1 - Percentage of pregnant women served by Title V community health workers that have a documented screening or referral for dental services.**

**2016-2020: NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Integrate oral health messages and strategies within existing community-based maternal and infant health programs.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of pregnant women served by the Title V community health workers that have a documented screening or referral for dental services</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of pregnant women served by Title V community health workers</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of pregnant women served by the Title V community health workers that have a documented screening or referral for dental services	<b>Denominator:</b>	Number of pregnant women served by Title V community health workers
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of pregnant women served by the Title V community health workers that have a documented screening or referral for dental services								
<b>Denominator:</b>	Number of pregnant women served by Title V community health workers								
<b>Data Sources and Data Issues:</b>	Reports from MICHHC grant (Bureau of Women, Infant and Adolescent Health)								
<b>Significance:</b>	Our current pilot project promotes community-level systems changes to integrate oral hygiene practices and information about services within MICHHC and link families with dental services. Successful strategies gleaned from this initiative will be disseminated to other MICHHC, and potentially other home visiting projects.								

**2016-2020: ESM 13.2.1 - Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.**

**2016-2020: NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Provide financial and technical support for maintenance and expansion of community water fluoridation.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of public water systems that receive financial and/or technical support from NYSDOH</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of public water systems that receive financial and/or technical support from NYSDOH	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of public water systems that receive financial and/or technical support from NYSDOH								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	NYS Title V Program records								
<b>Significance:</b>	CWF improves oral health by reducing the prevalence and severity of tooth decay. DOH provides financial and other technical assistance directly and via contractor to support local water systems.								

2016-2020: ESM 13.2.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.

2016-2020: NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the delivery of evidence-based preventive dental services across key settings: <ul style="list-style-type: none"> <li>• school-based clinics</li> <li>• primary care practices</li> <li>• public health nutrition programs.</li> </ul>								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of 2nd and 3rd grade children who received sealants in School-Based Health Center – Dental (SBHC-D)</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of children in 2nd and 3rd grade who are enrolled in SBHC-D programs</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of 2nd and 3rd grade children who received sealants in School-Based Health Center – Dental (SBHC-D)	<b>Denominator:</b>	Number of children in 2nd and 3rd grade who are enrolled in SBHC-D programs
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of 2nd and 3rd grade children who received sealants in School-Based Health Center – Dental (SBHC-D)								
<b>Denominator:</b>	Number of children in 2nd and 3rd grade who are enrolled in SBHC-D programs								
<b>Data Sources and Data Issues:</b>	SEALS/ CDC Data								
<b>Significance:</b>	Evidence based programs such as school-based or linked dental sealant programs have the potential to reduce the burden of oral diseases.								

**Form 11**  
**Other State Data**  
**State: New York**

The Form 11 data are available for review via the link below.

Form 11 Data



**Form 12  
MCH Data Access and Linkages**

**State: New York**

**Annual Report Year 2020**

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Quarterly	3		<ul style="list-style-type: none"> <li>• Hospital Discharge</li> </ul>
2) Vital Records Death	Yes	Yes	Quarterly	3	Yes	<ul style="list-style-type: none"> <li>• Infant birth and death</li> <li>• Mother death linked to Infant birth</li> <li>• Hospital Discharge</li> </ul>
3) Medicaid	Yes	No	Quarterly	3	Yes	
4) WIC	No	No	Never	NA	No	
5) Newborn Bloodspot Screening	Yes	No	Annually	12	No	
6) Newborn Hearing Screening	Yes	Yes	Annually	12	Yes	New York State <ul style="list-style-type: none"> <li>• Immunization Information System</li> </ul>
7) Hospital Discharge	Yes	Yes	Quarterly	3	Yes	<ul style="list-style-type: none"> <li>• Birth and Death</li> </ul>
8) PRAMS or PRAMS-like	Yes	No	Monthly	12	Yes	

**Form Notes for Form 12:**

None

**Field Level Notes for Form 12:**