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

2007 APPLICATION / 2005 ANNUAL REPORT

Submitted to:

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

By:

New York State Department of Health
Center for Community Health
Division of Family Health
Barbara L. McTague, Director
Room 890, Corning Tower
Albany, New York 12237 - 0657
Telephone (518) 473 - 7922; Facsimile (518) 473 - 2015

Note to the Reader:

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

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

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

I. A. LETTER OF TRANSMITTAL

July 15, 2006

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

Dear Ms. Lauver:

With this letter, I transmit New York's FFY 2007 Maternal and Child Health Services Block Grant Application, Needs Assessment and Annual Report.

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

Sincerely,

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

OMB Approval No. 0348-0043

APPLICATION FOR FEDERAL ASSISTANCE	2. DATE SUBMITTED 6/30/2006	APPLICANT IDENTIFIER
1. TYPE OF SUBMISSION: Application ☐ Construction ☑ Non-Construction; Pre-application ☐ Construction ☑ Non-Construction	3. DATE RECEIVED BY STATE	STATE APPLICATION IDENTIFIER
	4. DATE RECEIVED BY FEDERAL AGENCY	FEDERAL IDENTIFIER

5. APPLICANT INFORMATION

Legal Name: **New York State Department of Health** Organizational DUNS: **806781340**	Organizational Unit: **Division of Family Health**
Address (give city, county, state and zip code) **Room 890 Corning Tower** **Empire State Plaza** **Albany, NY 12237** County: **Albany**	Name and telephone number of the person to be contacted on matters involving this application (give area code) Name: **Barbara L. McTague** Email: **blm01@health.state.ny.us** Tel Number: **518-473-7922** Fax Number: **518-473-2015**

6. EMPLOYER IDENTIFICATION NUMBER (EIN): 1 4 6 0 1 3 2 0 0

7. TYPE OF APPLICANT: (Enter appropriate letter in box) A

A. State
B. County
C. Municiple
D. Township
E. Interstate
F. Intermunicipie
G. Special District
H. Independent School District
I. State Controlled Institution of Higher Learning
J. Private University
K. Indian Tribe
L. Individual
M. Profit Organization
N. Other (Specify)

8. TYPE OF APPLICATION:
☐ New ☑ Continuation ☐ Revision
Revision, enter appropriate letter(s) in box(es)
☐ ☐
A. Increase Award B. Decrease Award C. Increase Duration
Decrease Duration Other (specify):

9 NAME OF FEDERAL AGENCY:
Health Resources and Services Administration, Maternal and Child Health Bureau

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 9 3 9 9 4
TITLE: **Maternal and Child Health Services Block Grant**

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Maternal and Child Health Services Block Grant

12. AREAS AFFECTED BY PROJECT (cities, communities, states, etc.):
Statewide- NYS

13. PROPOSED PROJECT:

Start Date:	Ending Date:
10/01/2006	**09/30/2007**

14. CONGRESSIONAL DISTRICTS OF:

a. Applicant	b. Project

15. ESTIMATED FUNDING:

a. Federal	$ 41,621,706.00
b. Applicant	$ 0.00
c. State	$ 351,809,825.00
d. Local	$ 242,471,037.00
e. Other	$ 0.00
Program Income	$ 268,918,266.00
g. TOTAL	$ 904,820,834.00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. YES, THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:
b. NO ☑ PROGRAM IS NOT COVERED BY E.O. 12372
☑ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT
☐ Yes. If "Yes", attach an explanation ☑ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE

TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY BY THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Typed Name of Authorized Representative	b. Title	c. Telephone Number
Barbara L. McTague	**Director, Division of Family Health**	**518-473-7922**
d. Signature of Authorized Representative		e. Date Signed
		7/14/06

Previous Editions Not Usable

Standard Form 424 (REV. 4-88)
Prescribed by OMB A-102

I. C. ASSURANCES AND CERTIFICATIONS

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: *Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.*

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis

of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sects. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18 Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a

public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about:
   - (1) The dangers of drug abuse in the workplace;
   - (2) The grantee's policy of maintaining a drug-free workplace,
   - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
   - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will:
   - (1) Abide by the terms of the statement; and

(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions, generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, Disclosure of Lobbying Activities, in accordance with its instructions. (If needed, Standard Form-LLL, Disclosure of Lobbying Activities,its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

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

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I. E. PUBLIC INPUT

The New York State Department of Health, as New York's Title V agency, has several methods for making this application public and for soliciting, accepting and incorporating public input during its development and after its transmittal. These include:

1. using a variety of public interaction processes as first modeled in **Communities Working Together for a Healthier New York,** the document that served as the basis for forming New York's public health priorities for the last decade;
2. placing the document on our public website and making hardcopies available through the Division of Family Health;
3. an active and involved Maternal and Child Health Services Advisory Council, statutorily-established as a method of public input;
4. annually establishing public hearings, rotating locations across the State;
5. surveying parents of Children with Special Health Care needs for parent involvement and other relevant issues;
6. conducting a series of focus groups with Title V consumers and Title V-eligible groups across the State;
7. soliciting advice from the Healthy Start-Title V Collaboration Consumer Group;
8. meeting annually with LEND scholars and others providing services to Children with Special Health Care Needs; and
9. accepting phone calls, letters, faxes and e-mails regarding the content of the document and the needs of the population.

Each of these methods is described in more detail under **Section II. Needs Assessment.**

/2007/ In the FFY 2006 year, in preparation for the FFY 2007 application, public hearings were held in New York City (November 5, 2005), Buffalo (April 7, 2006) and Albany (June 23, 2006). Topics brought to the hearing included continued support for the NYS Center for Sudden Infant Death and their services, school-based health centers, genetics services, childhood nutrition; and oral health. //2007//

Focus groups were also held in various parts of the state with various target populations. New York has been conducting focus groups on Maternal and Child Health since 1999. The purpose of conducting focus groups is to gather information directly from consumers about health issues and what most concerns them. New York considers these focus groups as a very useful addition to other forms of public input. Confidentiality is of the utmost importance. Participants in focus groups received travel reimbursement, culturally-appropriate nutritious snacks and stipends for their participation.

Early in this program year, six focus groups were conducted as follows: at Akwasasne (Franklin County) with Native American women; Rochester (Monroe County) with Hispanic women; Syracuse (Onondaga County) with mothers of children with special health care needs; Westfield (Chautauqua County) with rural residents; Schenectady (Schenectady County) with Guyanese women; and in the Capital District area with Family Champions who are all parents of children with special health care needs from around the state. The feedback from these consumers included identifying transportation/distance to reach care, limited hours of operation, lack of insurance coverage and long waits for services as the largest barriers to obtaining needed care for themselves and their children. The changes they would most like to see in the health system include quicker service and more respect for the time, effort and energy that is made by the parents or the patients.

Later in the program year, five additional focus groups were added, with the purpose of getting adolescents' input on the performance measures that most related to them. These groups, which included one group of institutionalized males and one group of institutionalized females, responded to questions about risk behavior associated with binge use of alcohol, motor vehicle crashes, depression and suicide, and smoking.

The Family Champions group was asked to focus their discussion on the National Performance Measures relating to children with special health care needs and how New York could improve its performance on these measures. Of 17 Family Champions, 15 chose to participate in the focus group. For each measure, the Champions identified factors that hindered New York's ability to improve (listed as "Challenges") and factors that they believed would help New York improve its performance on each measure (listed as "Potential Solutions"). The process involved group brainstorming, combining like ideas in a common strategy or category, and then having individuals vote for the items they believed to be of greatest importance, thereby establishing priorities for the group. Each parent had five votes. The opinions of the Family Champions regarding New York's greatest challenges and potential solutions are summarized in the discussion of the performance measures in Section IV.

Results of all public input processes are shared with program staff and agency administration for incorporation into program policies and procedures.

Each year, New York updates the Block Grant Application Glossary, which is included herein. State-specific abbreviations and information are added to the Federal boilerplate in order to make the block grant application more understandable and readable to its multiple audiences.//2007//

II. NEEDS ASSESSMENT

A. Needs Assessment Process

Needs assessment of the maternal and child health population is a continuous and ongoing process, and critical to program development, to accurate program planning and targeting of services, and to monitoring the effectiveness of interventions. Comprehensive needs assessment requires ongoing sources of information about:

- *Maternal and child risk factors* (age, socioeconomic status, education, previous pregnancy history, physical and emotional stressors, wantedness of pregnancy, and maternal knowledge and behaviors);
- *Access to appropriate health care and capacity of the health care system* (entry into prenatal care, adequacy of prenatal care, access to specialty/tertiary level of care, availability of ancillary or enabling services); and
- *Pregnancy and health outcomes* (fetal deaths, infant morbidity and mortality, maternal morbidity and mortality, low birthweight, prematurity, causes of death);

New York's Title V program employs several methods to identify need for various levels and types of care for pregnant women, mothers, infants and children, including children with special health care needs. Data are available on statewide, countywide and local levels, with ability to do comparisons. Program managers are responsible for incorporating data on changing demographics, and on risk factors and health outcomes for the MCH population into their program plans.

Step 1. Assessing Needs

In this assessment cycle, the needs of the maternal and child health population have been ascertained through:

- Routine surveillance of vital statistics/vital records;
- Census data;
- Registries;
- Provider-generated or program data;
- Hospital discharge data;
- Special studies;
- Community-based assessment data available through the Article 6 process;
- The input of families and consumers;
- The input of those who spoke at focus groups, the public hearings or sent testimony; and
- The input of the Maternal and Child Health Services Block Grant Advisory Council.

Many of the data displayed herein are available on the Department's intra-net Health Information Network or HIN, on the HPN or Health Provider Network, and most are on our public website www.health.state.ny.us as a part of the Community Health Data Set. Most data are available on the county level, and many on the sub-county or zip code level.

Vital Statistics Data: Historically, birth, death and fetal death certificates have been the main source of information for maternal and child health surveillance. They offer information on birth outcomes, maternal socio-demographic characteristics, prenatal and intrapartal care on an annual basis on the state, county and sub-county level. From these sources, information is generated on different mortality rates, the percentages at various

birth weights, the percentages of prenatal care in each trimester, the adolescent pregnancy rates, fetal losses, live birth-to-pregnancy ratios and maternal mortality.

Census Data: The US Census is a classic and elegant source of data down to the sub-county level. The Department is making full use of data from the 2000 Census and subsequent projections.

Registries: De-identified aggregated information is also available from the Department's various registries, including the HIV/AIDS, Congenital Malformations, Newborn Screening, Communicable Disease, Tuberculosis, Sexually Transmitted Disease, Cancer, Heavy Metals (lead), Trauma and Immunization Registries.

The State Education Department maintains a registry for each of the licensed professions, and this is a good source of data on age, specialty and practice location. This information is useful in assessing access to care in the various areas of the State and predicting or verifying health personnel shortages.

Provider-Generated or Program-Generated Data: Considerable data are generated by programs such as WIC, Medicaid, the Immunization Program, the Family Planning Program, the Childhood Lead Poisoning Prevention Program, the Early Intervention Program, the Newborn Screening Program, the Preventive Dentistry Program, the Children with Special Health Care Needs Program, the Dental Rehabilitation Program, and the Community Health Worker Program. These data are often useful in profiling various segments of the community that are using services, but have the limitation that not all are population-based. Caution must be used in interpreting these data, since they reflect only the characteristics of those who are program-eligible and have actually sought and enrolled in services.

Medicaid Utilization Data has been very useful in the past. As less of Medicaid is fee-for-service and more Medicaid-financed care is delivered under a managed care model, newer systems have been developed and are being refined. These systems provide data to serve as a basis for inference regarding the adequacy and quality of care.

Provider performance reports have been released annually since 1994 for commercial, Medicaid and Child Health Plus providers through New York's **Quality Assurance Reporting Requirements (QARR)** system. QARR measures many maternal and child health indicators, such as risk-adjusted low birth weight rates, initial access to prenatal care, vaginal birth after cesarean section (VBAC) rates, risk-adjusted primary cesarean section rates, rates for HIV testing of pregnant women, completion of postpartum check-ups, access to facilities for high-risk deliveries, completion of health preventive screenings, childhood immunization rates, and well child visits both in the first 15 months of life and at ages 3, 4, 5, and 6. Adolescent well care visit rates are also calculated, as are screening rates for alcohol, tobacco and substance use. The system also monitors appropriate use of medications for people with asthma, ages 5 through 20.

The **Statewide Perinatal Data System (SPDS)** is able to provide information on the course of prenatal, perinatal and newborn care. SPDS presently consists of 2 modules, the Neonatal Intensive Care Unit (NICU) module that collects data on all admissions to NICUs throughout the state, inclusive of New York City, and the Core module, consisting of birth certificate data and additional quality of care indicators. All obstetrical hospitals outside of New York City have been using the Core module since January 1, 2004. The secure, internet-based system allows real-time access to important perinatal information on an individual, institutional, regional and statewide basis.

The **Integrated Child Health Information System (ICHIS)** is a data warehouse of children's health-related information, linked anonymously and longitudinally across multiple data sources. The primary goal of ICHIS is to serve as a single, primary source of child health data and information that identifies and monitors different child populations, allows identification and follow-up of specific child health areas of need, and enables improved targeting and effective planning of children's health programs and services. Currently, ICHIS is populated with data from birth certificates, death certificates, SPARCS, congenital malformations registry and vaccine-preventable disease occurrences. ICHIS de-duplicated Immunization Registry information for potential addition. PRAMS, WIC Pediatric Nutrition Surveillance, MA managed care encounters, child blood lead screening tests, lead poisoning case management, newborn metabolic screening and dental surveillance data are under discussion for addition to ICHIS.

Hospital Discharge Data: Hospital discharge data offer detailed medical information and information about the socio-demographic characteristics of mothers, infants and children who enter and are discharged from New York's hospitals. The **SPARCS** data system, which collects information on every hospital discharge in the State, yields information on length of stay, level of care required (i.e. NICU vs. regular nursery), costs and rates of hospitalization for various morbidities (such as asthma, gastroenteritis, otitis media, head injuries and other conditions). Information is available on how many hospitalizations are drug-related or occur as the result of a motor vehicle crash. As more care is handled on an outpatient basis, information in this system becomes less reflective of the health of the community. Systems are now in place for collecting Emergency Room encounter data.

Special Studies: The **Pregnancy Risk Assessment Monitoring System** or **PRAMS** collects population-based information on maternal knowledge, attitudes and behaviors, on service access and utilization, and on possible physical and emotional stressors during pregnancy from a sample of women who have recently given birth. Examples of data that are available through PRAMS include: percentage of moms who drank alcohol or smoked during their pregnancies, who experienced physical violence in the year prior to delivery, who were satisfied with the number of prenatal visits, and who breastfed beyond their baby's first week of life. Data from PRAMS also includes the number of pregnancies that were unintended, that is, not wanted or wanted later. New York initiated PRAMS in 1993 with assistance from the Centers for Disease Control and Prevention. The State's PRAMS grant covers those parts of the state outside New York City.

New York City Department of Health initiated PRAMS in 2001 and began collecting data in August of that year. The first years of data collection, response rates from the City, were less than 70%, the optimal response rates required by CDC for data analysis. In 2004, response rates reach of 70% where achieved for half of the batches. As a result, CDC has agreed to develop a statewide PRAMS dataset. As long as NYC continues to achieve 70% response rates with their PRAMS data, statewide datasets will be available. The State PRAMS staff continue to collaborate with New York City Department of Health on a regular basis.

Each year, the Office of Medicaid Management creates a **prenatal study file**. This is an annual match of birth certificates with Medicaid prenatal care records that supports evaluation of prenatal care and birth outcomes for Medicaid-enrolled women.

The **Youth Risk Behavior Study (YRBS)** collects information on the knowledge, attitudes and behaviors of high school students in the State. This study excluded New

York City until 1996, but New York City data is now available. YRBS is conducted every two years by the State Education Department.

On a wider adult population, the **Behavioral Risk Factor Surveillance System (BRFSS)** collects valuable information on behaviors associated with the development of chronic diseases and the use of health resources. Information on these risks is collected nationally by telephone survey using a standardized questionnaire.

BRFSS information is made available at the county and regional level. Population-based telephone surveys are conducted in 38 localities comprising the entire state using methods comparable to the Center for Disease Control and Prevention (CDC) methods. A number of the localities are single counties; other counties are grouped together. A total of 630 interviews with adults, aged 18 years and older, is conducted in each of the 38 localities. The questionnaire includes an 8-minute CORE module that is the same in each locality. In addition, each locality is able to select modules they would like added to the basic survey. A standard 4-minute questionnaire is also available for counties who do not opt for selecting an individualized set of additional questions. The advantage to selecting the standard module is that those counties will be able to compare responses to other counties that selected the standard questionnaire.

The Census Bureau's **Current Population Survey (CPS)** reflects demographics such as age, sex, race and socioeconomic status. These data are available on the state level only. The last available year is 2003.

The Federal Maternal and Child Health Bureau has recently completed a National **State and Local Area Integrated Telephone Survey of Children with Special Health Care Needs (SLAITS CSHCN Survey)** and the SLAITS-based **National Survey of Child Health**. The Division of Family Health uses the New York State data from both these surveys.

Local Community Health Assessment Data: Each of the State's 58 local health departments in New York are required to submit a Community Health Assessment to the State Health Department every six years, with updates required every two years. This assessment interprets vital statistics information, local trends, disease rates and special access issues, which the local health departments are then expected to address. Community health assessments are a particularly rich source of data describing unmet needs for direct medical services or for enabling services on a local level.

The Public Health Information Group and the Office of Local Health Services coordinated an intensive review of each county's assessment and provided feedback to local departments. They helped local staff to identify their training needs, further advance their local assessment skills, select priorities that provide the greatest opportunities to impact public health in their jurisdiction, and define their plans as a community. Many local departments are developing more comprehensive assessments and plans as a result.

The satellite version of the CDC training program, "Public Health Data: Our silent partner" was televised as a collaboration with the Public Health Information Group, the Office of Local Health Services, the University at Albany School of Public Health, and the New York State Association of County Health Officials. Public Health Information Group staff also provide live training sessions to improve data analysis capacity at the local level. Most recently, an educational offering has been added that addresses disparities in birth outcomes. Courses were made available on the New York – New Jersey Public Health Training Center's website: www.nynjphtc.org

The *Communities Working Together* Public Participation Process to Evidence-Based Public Health: Communities Working Together served as great model for including communities in the process of setting public health priorities. The Department continues to assist localities in identifying and address local priorities through a collaborative, open, community-based process through several training initiatives in **Assessment** and **Evidence-Based Public Health** that continue the themes of community-involvement and data use. Hospitals and local health departments are now collaborating in formulating Community Services Plans required of all hospitals by the State Hospital Code.

Input of Families and Consumers: The Department continues to work to improve parent and consumer input into the design and implementation of maternal and child health and Children with Special Health Care Needs programs. Two years ago, family and consumer forums were conducted in twelve locations with the goal of having families and consumer identify, through their own experiences, parts of the health care system that are not welcoming, supportive or working for them. This year, that process was again repeated, and additional focus groups were conducted. The idea is to improve maternal and child health programs through the expressed needs of consumers.

These focus groups came about because the Family Specialist, the SSDI Coordinator and the Title V Coordinator met with parents and graduates of the "Making the Pieces Fit" training to write a strategic plan for enhanced parent involvement. Parent planners then assisted in formulating the agenda for the groups. The plan was then implemented with assistance from parents, local agency partners and the NYSDOH regional staff. Parents of children with special health care needs are surveyed annually for their input on implementation of the parent involvement plan.

Through a contractual arrangement with the Association of Prenatal/Perinatal Networks, more focus groups were conducted. Downstate, in 2005, the Northern Manhattan Perinatal Partnership conducted focus groups with Native Americans in Suffolk County, African-American women from Nassau County and Far Rockaway (Queens), Asian women from Lower Manhattan, Middle Eastern families from Brooklyn, Puerto Rican and Mexican women from Nassau County, homeless moms at an American Red Cross shelter, and Caribbean/Dominican women from Northern Manhattan. Upstate, the Mothers and Babies Perinatal Network conducted focus groups with refugees from Bosnia and other Eastern European countries settled in the Mohawk Valley, and with rural, low-income mothers and migrant and seasonal farmworker families from Western New York, as well as pregnant and parenting teens and a group of grandparents raising young children in the Southern Tier area.

This year, groups were conducted at Akwasasne (Franklin County) with Native American women; Rochester (Monroe County) with Hispanic women; Syracuse (Onondaga County) with mothers of children with special health care needs; Westfield (Chautauqua County) with rural residents; Schenectady (Schenectady County) with Guyanese women; and in the Capital District area with Family Champions who are all parents of children with special health care needs from around the state. Later in the program year, five additional focus groups were added, with the purpose of getting adolescents' input on the performance measures that most related to them. These groups, which included one group of institutionalized males and one group of institutionalized females, responded to questions about risk behavior associated with binge use of alcohol, motor vehicle crashes, depression and suicide, and smoking.

Parents also have a major role in the policy and program development in the Early Intervention Program. Early Intervention conducts parent policy development training and the Early Intervention Parent Workgroup addresses a variety of service delivery issues.

Each year, New York updates the Block Grant Application Glossary, which is included herein. State-specific abbreviations and information are added to the Federal boilerplate in order to make the block grant application more understandable and readable to its multiple audiences.

Testimony at Public Hearings: Each year, the Maternal and Child Health Services Block Grant Advisory Council and the Department of Health sponsor a series of public hearings across the State. This year's locations were New York City, Buffalo and Albany. In addition to those who testified in person, written testimony in the form of letters and e-mail notes were also accepted. Requests for copies of the block grant application increase each time a pubic hearing notice is posted.

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

By mandate of statute, the Council is composed of twelve individuals, six of whom are appointed by the Governor, three of whom are appointed by the Temporary President of the Senate and three of whom are appointed by the Assembly Speaker. Also by law, members are to include representatives of local government, the not-for-profit sector, and the community. The Council was fully constituted at twelve active members until November 2005. At this time, there is a Senate-appointed seat on the council that is vacant. Title V staff are working with the Office of Governmental Affairs to secure a replacement for Mr. Skinner.

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

Current members are:

- **Dr. William Grattan, M.D., Council Chairperson**
  Pediatrician and former Health Commissioner of Albany County
  (Governor's appointment)

- **Richard Aubry, M.D., M.P.H.**
  SUNY Health Science Center, Syracuse, New York
  (Senate appointment)

- **Mecca S. Cranley, Ph.D., R.N.**
  SUNY at Buffalo College of Nursing, Buffalo, New York
  (Governor's appointment)

- **Thomas R. Curran, D.D.S.**
  Maxillofacial surgeon and member of Chemung County Board of Health
  (Governor's Appointment)

- **Joan Ellison, M.P.H., R.N.**
  Director of the Livingston County Department of Health, Mt. Morris, New York
  (Governor's appointment)

- **Shirley Gordon**
  Gordon & Gordon Associates, Inc., Albany, New York
  (Senate appointment)

- **Neil Heyman**
  Southern New York Health Association, New York, New York
  (Governor's appointment)

- **Sarah Liebschutz, Ph.D.**
  University of Rochester, Rochester, New York
  (Governor's appointment)

- **Donna O'Hare, M.D.**
  New York, New York
  (Assembly appointment)

- **Christine Saltzberg, Ph.D., R.N.**
  Pittsford, New York
  (Assembly appointment)

- **Joseph S. Sanfilippo**
  Binghamton, New York
  (Assembly appointment)

- **Stanley Skinner**
  Schenectady Municipal Housing Authority, Schenectady, New York
  (Senate appointment- Resigned November 2006)

Step 2. <u>Examining Capacity</u>

To assess system capacity, New York's Title V program, consistent with the Ten Essential Services of Public Health and the CAST-V framework, continually re-evaluates New York's ability to:

a. Assess and monitor maternal and child health status to identify and address problems;
b. Diagnose and investigate problems and hazards affecting women, children and youth;
c. Inform and educate the public and families about maternal and child health issues;
d. Mobilize statewide and community partnerships between policy makers, health care providers, families, the general public and others to identify and solve maternal and child health problems;
e. Provide leadership for priority-setting, planning and policy development to support community efforts to assure the health of women, children, youth and families;

f. Promote and enforce legal requirements that protect the health and safety of women, children and youth and ensure public accountability for their well-being;
g. Link women, children and youth to health and other community and family services, and assure access to comprehensive, quality systems of care;
h. Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs;
i. Evaluate the effectiveness, accessibility and quality of personal health and population-based maternal and child health services; and
j. Support research and demonstration to gain new insights and innovative solutions to maternal and child health-related problems.

Each bureau and program in the Division of Family Health has a Logic Model that illustrates the resources and partners needed to ensure capacity to carry out vital program elements, key objectives of each program, program activities and evaluation measures.

Assessing Capacity with regard to Direct Medical Services: Comprehensive assessment of the maternal and child health population's ability to access high quality health care and to determine any gaps in the health care delivery system takes place at both the state and local level. DOH program staff monitor for access issues at the provider level, also.

Statewide, assessment activities utilize vital records to assess access to prenatal care and births by level of facility. SPARCS data, which are data on hospital discharges, are used to assess hospitalizations for ambulatory care sensitive conditions and source of payment at time of delivery. Program data and registries are used to monitor immunization and lead screening rates statewide, access to WIC and family planning services, and linkages to Early Intervention, specialty care and care coordination. QARR outlines access and quality of health care from Medicaid Managed Care, Child Health Plus and commercial Health Maintenance Organization enrollees. The Behavioral Risk Factor Surveillance Survey questions respondents about whether they were unable to consult a physician because of cost. Enrollment in public or private insurance and insurance status can relate directly to access to care, but should be interpreted with caution; enrollment in insurance, including public insurance, does not guarantee access to care.

Information about high-risk populations, health needs and service delivery is best obtained through local county health department, health care providers and the consumers themselves. These are rich sources of information on gaps in local service delivery and the treatment experience of people in need. Key information is also obtained from contractor workplans and consumer focus groups. The new Children with Special Health Care Needs data system and the national SLAITS survey will fill a gap in our knowledge of this population, augmenting what was learned through the Family Voices/Brandeis study. Focus groups can provide additional insight into barriers to care and needed supports.

New York employs multiple strategies to ensure access and availability of primary and preventive maternal and child health services to its population. Strategies include:

- providing low income and disabled New Yorkers with a generous Medicaid, Child Health Plus, Family Health Plus and Family Planning Benefit Program insurance packages;
- providing incentives for small businesses to purchase health insurance for employees;
- ensuring availability of adequate numbers of health care professionals through participation in programs such as the National Health Services Corps, the State Health

Services Corps, providing practitioner incentives to practice in underserved areas, and recruitment of under-represented minorities to health professions;
- ensuring cultural competence training of staff through training and such venues as the New York- New Jersey Public Health Training Center (www.nynj-phtc.org)
- providing "public goods" such as bad debt and charity allowances and provision for graduate medical education through pools established under the New York Health Care Reform Act;
- providing sufficient regulatory authority to ensure necessary programs are of high quality;
- ensuring adequate infrastructure at the level of the State Health Department;
- ensuring, by law, linkages between levels of care, such as between Level One birthing hospitals and Level Two and Three hospitals and with Regional Perinatal Centers;
- raising awareness of health services in vulnerable populations through extensive health outreach and health education campaigns;
- providing the Growing Up Healthy Hotline and extensive NYSDOH and other web pages to direct consumers to services;
- providing enabling services such as Medicaid transportation, translation and community health worker assistance;
- assisting providers to become more culturally competent;
- encouraging cross-system collaborations to better meet the human services needs of New Yorkers;
- contracting for the provision of gap-filling direct health services when none are available otherwise;
- providing state local assistance funds to ensure public health capacity at local county health departments; and
- actively monitoring gaps in services and access issues at the community level through local community health assessment.

The shift from a rate-setting to a free-market environment, and the expansions in Medicaid, managed care, Child Health Plus and Family Health Plus, have enabled some local health departments to concentrate less on providing direct medical services and more on providing population-based services. More and more of the population is receiving care in a managed care environment, and New York has moved to mandatory Medicaid managed care where adequate coverage choices are available.

Welfare reform has had a noticeable effect on Title V populations. Welfare to work programs are moving mothers into the workplace. The State is working to ensure that they have adequate benefits and safe and healthy child care. New York is working to assist mothers entering into the work place with job training, extended supportive benefits, and expanding capacity and quality in the child care system.

Welfare reform is also changing the way MCH services must be delivered. Providers have had to adapt to the fact that there can no longer be a reliance on daytime clinic visits or home visits. Fewer mothers and infants are at home during the day, and low-income workers may not be able to take days off without losing pay. Services must be delivered during weekend and evening hours, or in convenient settings, like school-based health centers or workplace programs.

The passage of the Family Health Plus Program, modeled on Child Health Plus, provided benefits similar to those under Child Health Plus to low income, working adults who are not eligible for regular Medicaid.

Even 100% enrollment in expanded Medicaid or insurance initiatives does not assure that all children and pregnant or parenting women will get access to the care they need. Other factors, such as the maldistribution of providers, shortages in providers that will accept Medicaid clients, large distances to specialty centers, and shortages of culturally-competent, bilingual staff may have a negative effect on access to appropriate direct medical services. When these trends and issues in utilization are noted, Title V programs are expected to then assess appropriate interventions, whether enabling services, population-based approaches or infrastructure-building activities.

Assessing Capacity with regard for Enabling Services: Disease and disability do not affect all segments of society equally. The need for enabling services often becomes apparent when health outcome data are analyzed. Consumers and local providers have taught us that disparities are often the result of the complex interplay between financial, structural and personal issues like socioeconomic conditions, culture, language and education, and are not necessarily due to lack of health care resources. Often, the need for enabling services (transportation, translation, referral and care coordination) become more apparent when communities look for reasons for underutilization of resources and poor health outcomes.

The need for additional enabling services is often gleaned from information from the direct services systems, from disparities in health status, and from consumers themselves. All Title V programs are required to examine barriers to health care in the populations they serve, whether financial, cultural, geographic, institutional or personal, and to institute measures to minimize or eliminate those barriers in collaboration with other stakeholders.

All Title V and Title V-related programs are also required to have extensive linkages and referral networks, thus assuring that care is delivered at the appropriate level of specialty and in the appropriate community or regional setting. Compliance with program linkage requirements are monitored by DOH program managers. The new statewide Perinatal Data System will allow an in-depth examination of referral patterns between community-based providers and differing levels of perinatal care.

Certain populations present unique access issues that make them particularly vulnerable to poor health outcomes. Migrant and seasonal farmworkers and their families are one example. Each year, between 15,000 and 70,000 migrant and seasonal farmworkers come to New York to perform the skilled, manual tasks needed to get New York's crops planted, tended, harvested, processed and prepared for market, or to care for agricultural animals. These workers include men, women and children who have unique difficulties accessing and sustaining contact with the health care system. Health problems often reach very serious levels before care is sought, and the migrant family must often move on before care is completed. Because there is little continuity in their care, and because the work itself can be dangerous and stressful, complications from poorly controlled acute and chronic conditions are very common in this group. In-camp, culturally- and language-appropriate services and assistance with linking to health services, both in their present location and future locations, is imperative to improving their health status. The Migrant Health Program provides just such care, and continually evaluates their capacity to assist the population in sustaining contact with the health care system.

Program data from the Community Health Worker Program, which is targeted to and staffed by people from the same high-risk zip codes, show that enhanced outreach, the modeling of care-seeking behavior, and providing a supportive, helping relationship can help low-income, oftentimes overstressed mothers and families to engage and remain

engaged with the health care system and to gain better health outcomes for their families.

The Bureau of Dental Health has tested new, community-based models for enabling services under the Innovative Oral Health Services Initiative. Tompkins, Onondaga and Broome Counties are testing innovative dental case management models, which are proving to be very effective in enabling access to care, sustaining contact with dental providers and reducing no-show rates among rural and urban populations at high-risk for oral disease.

Assessing Capacity with regard for Population-Based Services: The need for population-based services may surface on a statewide or community level, based on a health need that can be prevented, controlled, or ameliorated, through a public health intervention that is safe, accepted, economical and effective. Examples of factors assessed to determine the need for population-based services are immunization levels, blood lead screening levels, incidence of anemia and overweight, rates of hearing loss, oral health status, injury rates, rates of neural tube defects, or the recognition of a widespread need for certain knowledge. These needs may become known through the analysis of vital statistics, use of registry data, analysis of queries for health information, the administration of population-based knowledge, attitude and behavior (KAB) studies, focus groups or other types of special studies.

Assessing Capacity with regard for Infrastructure-Building Services: The protection and promotion of the public's health is not possible without adequate public health infrastructure. Public health agencies must have the ability to perform adequate needs assessment, to appropriately evaluate public health issues and programs, to develop meaningful policies and standards, to engage their communities, to coordinate existing resources, to ensure quality, and to adequately train the public health workforce.

In late 2001, the New York State Public Health Council appointed a public health infrastructure workgroup and charged it with the task of assessing the public health system infrastructure in New York State. Members of this workgroup included individuals in academics, medicine, public policy, government, private foundations, the business community, and the voluntary sector. In December 2003, the Public Health Council presented a report to the Commissioner titled, ***Strengthening New York's Public Health System for the 21st Century.*** The report reviewed the strengths and needs, as well as made recommendations for improvement around the public health infrastructure around: the public health workforce, public health organizational systems and relationships, public health data and information systems. The Department is working toward implementing the recommendations during the coming years.

The Department is able to assess the adequacy of the infrastructure for maternal and child health services through:

- Establishing and maintaining regular multi-directional communication with local health departments, local contractors, our regional offices, other units within the State Health Department and other State and Federal agencies;

- Regularly and frequently monitoring the quality and the content of local health assessments, public health service plans and contractor workplans;

- Monitoring the ability of our programs, our contractors and county health departments to effectively achieve the desired results;

- Monitoring and auditing the use of available resources, including available technical assistance;

- Monitoring the mainstream health care systems for their ability to respond to cultural and language differences, changing trends and demographics and public health emergencies;

- Annually reassessing our internal controls system for areas of vulnerability; and

- Performing special assessments relative to the ability of local agencies to perform essential public health services.

Step 3. Selecting Priorities

Utilizing annual Needs Assessment, priority setting is conducted as a melding process, combining:

1. the results of the open, public input processes;
2. the use of the many and various data sets available to the Department;
3. the use of program data and provider input to identify trends and issues;
4. infrastructure evaluation;
5. the input of the public and the Maternal and Child Health Services Advisory Council and consumers to assist in interpreting these data and identifying important trends, gaps in services or barriers to care; and
6. the input of key staff within the Department.

Needs are ranked according to the severity of the problem, the number of people affected, the human and monetary cost to individuals and society, and the years of productive life lost.

Step 4. Setting targets

New York's State initially developed its state performance measures and performance targets under the pilot of the new application process seven years ago. Measures were picked that best depicted our State's goals for maternal and child health; that is, those that were not already in the core set of Federal Performance Measures. In the 2001 application, new measures were drafted based on the inclusion of some of our measures as Health Status Indicators, based on the new needs assessment, and based on enhanced consumer and Advisory Council input.

Following the five-year assessment cycle required by Title V, and in consideration of past progress, several performance targets were re-adjusted in 2002. For the Fiscal Year 2003 application, performance targets were updated based on this improvement cycle, based on parent and consumer input, and based on the more detailed needs assessment process required for that application.

The table that follows summarizes the relationship between New York's priority needs and Federal and State Performance and Outcome Measures.

Priority Area	Applicable National Performance Measures	Applicable State Performance Measures	Applicable Outcome Measure
Access to Care, incorporating Mental Health issues	1 – 18	1, 2, 4, 5, 10	1 – 6, NY
Oral Health	9,15,18	3,9	1
Overweight/Obesity	14	3	NY
Disparities	1-18	1-10	1 - 6, NY
Asthma	HSCI 1	2	6
Tobacco, alcohol, drugs	8,10,15	8,9	1 - 6, NY
Unintended/Adolescent Pregnancies	8	1	---
Genetics-Screening/Follow-up	1,12	---	1 - 6
Violence	16	7	6
Parent Partnership	2 - 6	---	---

Please refer to Form 11 for New York's Performance Targets. Performance targets were set in consideration of present status on the measures, Healthy People 2010 goals and, to ensure that the target set was realistic, trends in achievement over the past few years. In places where New York State had a perfect score, the goal is to remain at that level. The method varied somewhat with the measure.

National Performance Measure (NPM) #1: New York has consistently achieved 100% on newborn metabolic screening, and aspires to continue our success in this area.

National Performance Measure 2 through 6 are new as of two years ago, taken directly from the SLAITS survey. The first year's data was used as a baseline.

The goals for the following measures were set based on Healthy People 2010 Objectives for the Nation:

- National Performance Measure #8, the rate of births to teens ages 15 to 17;
- National Performance Measure #16, the rate of suicide deaths among 15 to 19 year olds;
- National Performance Measure #18, relative to first trimester prenatal care;
- State Performance Measure #1, relative to unintended pregnancies;
- State Performance Measure #6, infants placed on their backs to sleep;
- State Performance Measure #8, high school students who drank five or more drinks of alcohol in the last 30 days;
- Outcome Measure #1, infant mortality;
- Outcome Measure #3, neonatal mortality;
- Outcome Measure #5, perinatal mortality; and
- State Outcome Measure, maternal mortality.

National Performance Measure #9, percent of third-grade children who have received protective sealants, was previously NPM #7. Goals were set at a level below the Healthy People Objective, but at a level that is believed to be a realistic endpoint.

The following targets were set based on trends or linear projection of current progress and by what was believed to be a realistic endpoint:

- National Performance Measure #7, immunization levels;

- National Performance Measure #10, deaths due to motor vehicle crashes in children under age 14;
- National Performance Measure #11, percentage of mothers who breastfeed their infants at hospital discharge;
- National Performance Measure #12, percentage of children screened for hearing loss before hospital discharge;
- National Performance Measure #13, percent of children without health insurance;
- National Performance Measure #14, percent of children receiving WIC with a Body Mass Index (BMI) at or above the 85th percentile;
- National Performance Measure #15, percent of women who smoke in the last three months of pregnancy;
- National Performance Measure #17, percent of very low birthweight infants who were delivered at a facility for high risk deliveries and neonates;
- State Performance Measure #2, hospitalization rates for asthma for children age 1 to 14;
- State Performance Measure #4, teen pregnancy rate for girls 15 to 17 years of age;
- State Performance Measure #5, percent of women who, after giving birth, feel down, depressed or hopeless;
- State Performance Measure #7, hospitalizations for self-inflicted injuries in 15-19 year olds;
- State Performance Measure #9, high school students who reported that they smoked cigarettes in the last month;
- State Performance Measure#10, children screened for high blood lead before their second birthday;
- Outcome Measure #2, ratio Black Infant Mortality to White Infant Mortality;
- Outcome Measure #4, postneonatal mortality rate; and
- Outcome Measure #6, child death rate.

Endpoints may be above or below the Healthy People 2010 Objectives, if a comparable Healthy People 2010 Objective is available. Program staff and Division of Family Health and Center for Community Health administration review accomplishments on Core and State Negotiated Performance Measures, along with other strategic measures, in each application cycle. This information is then used to inform program managers of areas where improvement is or is not occurring at the expected rate and identify strategies for improvement. Some goals are difficult to realistically set, given lack of longevity in the data (National Performance Measures #2-6).

Step 5. Identifying Activities

Activities planned for FFY 2007 are included in section IV. New York's annual plan flows from the identification of priority needs, progress on the National and State 5-year performance and outcome measures, consumer and advisory input and the capacity and resources of this agency and its partners. Anticipated program activities are grouped by level of the pyramid and by segment of the Title V population--meaning whether the service relates to services for pregnant women, for mothers and infants, for children or specifically for children with special health care needs. Most, if not all, of the Title V and Title V-related programs have activities in more than one level of the MCH Pyramid. For example, direct services may have an enabling component, population-based services may have an infrastructure-building component, and so forth.

Step 6. Allocating Resources

In each of the last program years, the Maternal and Child Health Service Block Grant Advisory Council has re-affirmed its "Principles and Guidelines for the Use of Block Grant Funds." This document has continued relevance to allocation decisions to ensure maximum benefit from New York's allocation.

These guidelines, coupled with the structure for the MCHSBG reflected by the MCH Pyramid, guide recommendations for reductions/increases in program allocations, and/or redirection of program focus or elimination.

Principles of Allocation of the Maternal and Child Health Block Grant Funds
I. Programs must support functions and be consistent with the purposes of Title V, The Maternal and Child Health Services Block Grant.
II. In general, MCHSBG funds must support needed functions for which adequate funds are not available through other sources. However, availability of these funds should be determined on a case-by-case basis considering criteria established below.
III. MCHSBG funds should be targeted so as to render the greatest public health benefits while maximizing limited resources. Criteria for targeting include: - identification of populations at greatest risk or need based on geographic, demographic, social, cultural and economic factors; - mortality and morbidity; - availability of effective and cost-effective interventions; - ability to measure program outcomes; and - inadequate funding from other sources to meet the need.
IV. These funds should be used to augment, not supplant, other funding sources, and when possible, should support demonstration projects and coordination activities that can later be maintained by other funding sources.
V. Block Grant funds should not be used to support basic research.
VI. Block grant funds should be directed toward preventive services as much as possible. When funds must be allocated for personal health care services because of demonstrated need and lack of any other funding sources, preventive services must be incorporated into these services.
VII. Block Grant funds should be allocated in a manner consistent with Federal and State requirements and be consistent with the Public Health Priorities of New York State.
VIII. Block Grant funds should not be used to support established public health services.

Step 7. Monitoring Progress

The Department and the MCHSBG Advisory Council have been monitoring and will continue to carefully monitor MCHSBG-funded programs to assure that block grant resources complement rather than duplicate the direct provision of personal health care services under Medicaid and expanded insurance or eligibility initiatives such as PCAP, Child Health Plus and Family Health Plus. Careful attention has been given to ongoing need, effectiveness and availability of alternative resources, enabling the redirection of resources to bolster core public health functions, improve systems development and support community-based prevention initiatives and safety net services. Program managers and administrators are responsible for monitoring progress on health and process outcomes related to their programs. Each bureau and program has a Logic Model describing key objectives and evaluation measures used to ascertain progress toward those objectives.

B. Five Year Needs Assessment

1. Conducting the Needs Assessment

The needs assessment cycle was described in Section II A. Stated simply, New York's Title V program determines need through assessment of delivery systems, agency capacity and the health care environment; health status and health outcome data; and information supplied by key informants, namely parents, consumers, program staff, providers and other interested parties. Needs are ranked according to the severity of the problem, the number of people affected, the human and monetary cost to individuals and society, and the years of productive life lost. Our framework for examining need and for designing effective solutions to public health issues was provided in the ***Communities Working Together*** process. New York State Department of Health also incorporates Healthy People 2010 Objectives for the Nation into virtually all goal setting and programming.

New York's Planning Framework—From *Communities Working Together* to Evidence-Based Public Health: In the summer of 1996, a committee of the **New York State Public Health Council** undertook an inclusive priority-setting process. In doing so, the Council enabled input from multiple partners and citizens, and established a framework for focusing community action in those areas that lead to the most significant improvement in the functional lifespan of all New Yorkers, as well as for reducing health disparities among New York residents. The Committee was guided by five key principles:

1.) Local communities can have the greatest impact on health by intervening in the **causes of poor health,** rather than focusing on the health problems themselves.
2.) The greatest improvements in health can be achieved in areas where there are **effective interventions that involve the entire community and the individual.**
3.) The priority health areas must address those conditions that result in the **greatest morbidity, mortality, disability and years of productive life lost.**
4.) The priorities should reflect **problems of greatest concern to local communities.**
5.) Progress should be measurable through **specific, quantifiable, and practical objectives.**

The Committee, in their final report ***Communities Working Together for a Healthier New York,*** identified 12 priority areas, most of which had a maternal and child health component, and addressed these priorities as "opportunities for action":

(Readers will note the similarity of the Committee's choice of "opportunities" with the ***Healthy People 2010*** "Leading Health Indicators," which came out later.)

- Access to and Delivery of Health Care
- Education
- Healthy Births
- Mental Health
- Nutrition
- Physical Activity
- Safe and Healthy Work Environment
- Responsible Sexual Activity

- Substance Abuse: Alcohol and other Drugs
- Tobacco Use
- Unintentional Injuries
- Violent and Abusive Behavior

The report asked communities to collaborate in addressing the underlying causes of poor health, stressing the need for a commitment from all New Yorkers and from all sectors of our society. While the regulatory role of government, for instance in ensuring safe water or surveillance and control of infectious diseases, was not listed as a priority area, the report cautioned that government must continue to meet its responsibilities for essential public health infrastructure. The report underscored the need for assessment, policy development and assurance functions to be maintained to meet the objectives of the report.

As a state health agency, we continue to use these principles and goals as a guiding framework to approach health issues.

More specifically, the charts that follow summarize important data used to establish the need for services by population group and level of the MCH Pyramid.

Data Indicating Need for Direct Medical Care – Preventive and Primary Care for Pregnant Women, Mothers and Infants	
Need Identified	**Supporting Data/Documentation**
Improved access to comprehensive, continuous, family-focused, community-based, age- and sex-appropriate primary and preventive care, including access to: • family planning information and services; • medical homes; • dental services; • prenatal care; • mental health services; • health insurance; • statewide availability of services; • referral to appropriate levels of care; and • prevention of secondary disability.	Unwanted, mistimed pregnancy rates Adolescent pregnancy rates/birth rates Low birth weight rates Perinatal and infant mortality rates Early entry into prenatal care rates/late and no entry rates Kotelchuk Index Disparities in birth outcomes between population groups Maternal mortality rates/study Behavior Risk Factor Survey results on access to care Percentages of uninsured children and families Immunization data Rates of hospitalization for asthma and otitis media Rates for perinatal transmission of HIV and Hepatitis B Family and consumer input MCHSBG Advisory Council input Local community health assessments Program data, including data from Medicaid, Child Health Plus, CSHCN, the Community-Based Adolescent Pregnancy Prevention Program, the Children with Special Health Care Needs program, the Family Planning Program, the Preventive Dentistry Program, the Dental Rehabilitation Program, the Migrant Health Program, the American Indian Health Program, and School-Based Health Centers

Data Indicating Need for Direct Medical Care – Preventive and Primary Care for Pregnant Women, Mothers and Infants (Continued)	
Need Identified	**Supporting Data/Documentation**
Healthy births	Low birth weight rates and very low birth weight rates Adolescent pregnancy and birth rates Perinatal and infant mortality rates Rates for early entry into prenatal care Disparities in birth outcomes between population groups PRAMS data Family and consumer input MCHSBG Advisory Council input Local community health assessments Early intervention program and CSHCN program data Use of appropriate level of birth facility Cost of hospitalization for NICU in human suffering and dollars Medicaid and Managed Care data Maternal morbidity and mortality data Congenital anomaly registry data Genetics services utilization data

Data Indicating Need for Direct Medical Care – Preventive and Primary Care Services for Children, Ages 1 through 21	
Need Identified	**Supporting Data/Documentation**
Improved access to comprehensive, continuous, family-focused, community-based, age- and sex-appropriate primary and preventive care, including access to: • family planning information and services; • medical homes; • dental services; • mental health services; • health insurance; • counseling on risk-taking behaviors; • statewide availability of services; • referral to appropriate levels of care; and • prevention of secondary disability.	Immunization Rates – by age, location, payment source, insurance status, etc Rates of dental caries – by age and economic level Rates for placement of dental sealants Lead screening data Adolescent pregnancy rates High rates of use for tobacco, alcohol and other drugs Rates for suicide attempts and suicides Family/suicide survivors' input Family and consumer focus groups MCHSBG Advisory Council input Local community health assessments Rates of hospitalization for self-inflicted injuries Rates of unintentional injuries STD and HIV rates Health disparities information Rates of hospitalizations for ambulatory care sensitive conditions Rates of risk-taking behaviors MA data/EPSDT Child Health Plus coverage rates

Data Indicating Need for Direct Medical Care – Children with Special Health Care Needs	
Need Identified	**Supporting Data/Documentation**
Improved access to comprehensive, continuous, age- and sex-appropriate primary and preventive care and specialty level care, including access to: • medical homes; • referrals to appropriate specialty services and higher levels of care; • needed durable medical equipment and supplies; • supportive services, like respite; and • family involvement.	Use all of data sources mentioned above under "Children," plus: Parent and consumer input Public hearings MCHSBG Advisory Council input Family Voices/Brandeis study Children with Special Health Care Needs Program data Dental Rehabilitation Program data Early Intervention Program data Local community health assessments MA data/Child Health Plus data SLAITS

Data Indicating Need for Enabling Services – Preventive and Primary Services for Pregnant Women, Mothers and Infants	
Need Identified	**Supporting Data/Documentation**
Early and improved access to prenatal care and other primary and preventive care through: • enhanced and sustained outreach; • transportation; • translation services; • role modeling appropriate care seeking behaviors; • parenting support; • health guidance; • insurance programs; • assistance with locating and accessing services; and • referral and support services.	Medicaid utilization and QARR data Rates of early and late/no entry into prenatal care Kotelchuk Index PRAMS data Program reports (migrant health, adolescent programs, school health) Rates of uninsured Data on source of payment for obstetrical deliveries Family and consumer input MCHSBG Advisory Council input "Growing Up Healthy" Hotline and other MCH-related hotline calls The number of hotline callers who inquire about eligibility based on immigration status Local community health assessments MA/PCAP data

Data Indicating Need for Enabling Services – Preventive and Primary Care Services for Children, Ages 1 through 21	
Need Identified	**Supporting Data/Documentation**
Same as above.	Same as above. Substitute Hospitalizations for Ambulatory Care Sensitive Conditions for prenatal care measures.

Data Indicating Need for Enabling Services – Children with Special Health Care Needs	
Need Identified	**Supporting Data/Documentation**
Same as above. Additional need identified: Assistance with care coordination and with vendors for home care/medical equipment.	Use all of data sources mentioned above under "Children," plus: SLAITS Family Voices/Brandeis study Parent and consumer input MCHSBG Advisory Council input Early Intervention Program data Children with Special Health Care Needs data

Data Indicating Need for Population-Based Services – Primary and Preventive Care for Pregnant Women, Mothers and Infants	
Need Identified	**Supporting Data/Documentation**
Healthy births	Rates of early entry into prenatal care Rates of late and no prenatal care Kotelchuk Index Perinatal Hepatitis B and HIV transmission rates Rates of prenatal HIV counseling and testing Rates of low and very low birth weight Mortality rates: infants, perinatal, postneonatal Breast feeding data Maternal mortality rates PRAMS data PCAP/MOMS data Advisory Council and Public Hearings/consumer input

Data Indicating Need for Population-Based Services – Primary and Preventive Care for Children, Ages 1 - 21	
Need Identified	**Supporting Data/Documentation**
Improved oral health and better access to preventive oral health services	NYS Oral Health Survey Percentages of water supplies that are fluoridated Rates of dental caries Data on dental underserved areas Rate of Medicaid children who receive a dental preventive service (includes sealants and dental exams) Data on lack of dental insurance and high out-of-pocket expense Family and Consumer Input Public Hearings/consumer input Advisory Council input

Data Indicating Need for Population-Based Services – Primary and Preventive Care for Children, Ages 1 – 21 (Continued)	
Need Identified	**Supporting Data/Documentation**
Improved access, on a population-wide basis, to comprehensive, continuous, family-focused, community-based, age- and sex-appropriate primary and preventive care, including access to: • family planning information and services; • medical homes; • mental health services; • health insurance; • counseling on risk-taking behaviors; • statewide availability of services; • referral to appropriate levels of care; and • prevention of secondary disability.	Rates of uninsured Youth Risk Behavior Survey data on use of alcohol, drugs and tobacco. Rates of intentional injuries/suicides/suicide attempts Rates of teen pregnancies and births SPARCS data on hospitalizations for ambulatory sensitive conditions including data on asthma Immunization levels and occurrences of vaccine-preventable diseases STD and HIV morbidity data Local community health assessment data Program data (lead poisoning, family planning, school health, etc.) Family and consumer input Public Hearings/consumer input MCHSBG Advisory Council input
Completion of high school and compulsory health education	Data on drop out rates and associated socio-economic consequences, Level of maternal education, Rates of high school non-completion among teen moms and others
Mental health	Rates for teen suicides, attempted suicides, intentional injuries Youth Behavioral Risk Survey data on use of substances, mental health Program data (School-Based Health Centers, ACT for Youth)
Responsible sexual behavior	Youth Behavioral Risk Survey data on use of contraception, students forced to have sex when it wasn't wanted, age at initiation Unplanned and adolescent pregnancies and births Rates of induced terminations of pregnancies Morbidity data: STD, HIV Program data (Family Planning, Community-Based Adolescent Pregnancy, Abstinence Education, School Health)
Nutrition and physical activity	Nutrition surveillance studies, WIC program data YRBS
Reduced use of tobacco, alcohol and other drugs	Youth Behavioral Risk Survey, PRAMS Rates of injuries where drugs and alcohol are involved
Reduction of violence/intentional injuries	Youth Behavioral Risk Survey, Hotline Calls SPARCS data on hospitalizations, ER use for injuries

Data Indicating Need for Population-Based Services – Children with Special Health Care Needs	
Need Identified	**Supporting Data/Documentation**
Need for comprehensive, continuous, family-centered, community-based system of care for the full population of children with special health care needs, including: • readily accessible information about the location and availability of services; and • access to and insurance for accessing appropriate levels of care and appropriate specialty services.	Use all of data sources mentioned above under "Children," plus: SLAITS Family Voices/Brandeis study Parent and Consumer input Public Hearings input MCHSBG Advisory Council input

Data Indicating Need for Infrastructure Services – All Populations	
Need Identified	**Supporting Data/Documentation**
Continued need for a strong and vibrant public health infrastructure that supports maternal and child health services in New York State	There is a continued need for the infrastructure to support: • Assessment of problems and conditions that affect the MCH population; • Ability to identify and bring resources to bear on priority health issues; • Coalition-building and collaboration skills; • Availability and access to necessary technical assistance; • Appropriate numbers, types and distribution of MCH/public health personnel; • Statewide accessibility, availability and acceptability of MCH services at all levels of care; • Form effective linkages between/across systems of care; and • Assurance of quality through assessment and monitoring of local health departments, providers and contractors, law and regulations.
The need for infrastructure that supports access an array of affordable, high-quality, comprehensive, continuous, culturally-competent, linguistically-appropriate services for all MCH populations	Uninsured data and program utilization data GIS locators for facilities and practitioners/underserved areas Health personnel data and registries Locations of providers, comprehensiveness of provider networks Linkages between primary, secondary and tertiary levels of care Appropriate monitoring and regulation Special populations data Special studies

Data Indicating Need for Infrastructure Services – Primary and Preventive Services for Pregnant Women, Mothers and Infants	
Need Identified	**Supporting Data/Documentation**
An infrastructure that promotes healthier births: • affordability and access to insurance for prenatal and intrapartal care; • appropriate array of services/ locations; • regionalized system of perinatal care; • family planning education to promote appropriate spacing; • content of care that includes risk assessment and patient education; and • links to nutrition/other supports.	Data on uninsured Vital Statistics and SPARCS data on payment for source deliveries Locations of providers and facilities Linkage agreements between levels of care Rates of unintended and teen pregnancies and births QARR and MA data Percentages of high-risk infants born at Level 3 facilities PRAMS data Program data (Family Planning, Community Health Worker, PCAP and MOMS Programs) Rates of low and very low birth weight/Mortality rates Infant Mortality Community Review Panel recommendations Public Hearing, Consumer and MCHSBG Advisory Council input Monitoring and regulatory data

Infrastructure Services – Primary and Preventive Services for Children, Ages 1- 21	
Need Identified	**Supporting Data/Documentation**
Need for infrastructure to support comprehensive child health and school health and wellness in order to promote: • access to insurance; • access to a full array of screening and treatment services for medical, dental and mental health issues; • responsible sexual behavior; • reduced use of tobacco, alcohol and other drugs; • reduction in unintentional injuries; and • reduction of violent behaviors.	Appropriate assessment capacity Ability to design and implement effective strategies Ability to form statewide and community-level coalitions Insurance/uninsured data Free and reduced price lunch data Teen pregnancy and birth rates Morbidity and mortality data Utilization data Program data ATUPA enforcement activities Presence or absence of health education services SPARCS data on injuries Youth Behavioral Risk Survey data

Infrastructure Services – Children with Special Health Care Needs	
Need Identified	**Supporting Data/Documentation**
Need for infrastructure that supports: • better assessment of need; • family-centered care/enhanced family participation in care; • easy access to necessary services; • compassionate, coordinated care.	Use all of data sources mentioned above under "Children," plus: SLAITS and Family Voices/Brandeis survey data Family and consumer input MCHSBG Advisory Council input Public hearing testimony Children with Special Health Care Needs and Early Intervention Program data Medicaid and managed care data Monitoring data

2. Needs Assessment Partnership Building and Collaboration

There are multiple collaborations and partnerships formed around needs assessment, planning and policy development. Here are just a few examples of the collaboratives that work with NYSDOH:

The **State Education Department (NYSED)** is a key partner in needs assessment and priority setting for services relating to the school-aged population. NYSED and DOH have formal planning structures related to youth risk behavior surveillance, comprehensive school health, school-based primary care and dental services, and workforce and scope of practice issues. NYSED also collaborates with NYSDOH on the Supplemental Fluoride Distribution Program. The Children with Special Health Care Needs Program and the Early Intervention Program regularly interact with SED's Vocational and Educational Services for Individuals with Disabilities (VESID) Program.

Other regular state-level collaborators include the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Office of Temporary and Disability Assistance, the Office of Children and Family Services, the Office of Substance Abuse and Alcohol Services, Developmental Disabilities Planning Council, the Commission on Quality of Care and Advocacy for Persons with Disabilities. There are also numerous private and not-for-profit groups who are consulted and enlisted in planning for maternal and child health services. Some examples follow:

Bureau of Dental Health recently held a series of **regional oral health stakeholder meetings** involving school dental health and Head Start/Early Head Start stakeholders for the purpose of needs assessment and discussing implementation of the statewide Oral Health Plan. Attendees received meeting summaries, membership in the Oral Health listserv, information about additional potential regional and statewide partnerships, and an invitation to participate in the newly formed statewide Oral Health Coalition. The Dental Bureau has also engaged an expert panel to consider the scientific evidence related to oral care during pregnancy and in early childhood and to formulate practice guidelines for New York State dentists and obstetrical care providers. The guidelines are presently ready for distribution.

NYS Touchstones, with the Council on Children and Families in the lead, began as a collaborative of 13 NYS agencies that fund programs and services for children and

families. Touchstones is a set of measurable goals and objectives as well as health, education and well-being indicators that reflect the status of children and families in relation to those goals and objectives. The Council produces the Touchstones/KIDS COUNT Data Book annually. The KWIC, Kids Well-being Indicators Clearinghouse, makes vital youth statistical information more timely, accessible and usable to communities in a user-friendly format. The Clearinghouse is available on the website http://www.nyskwic.org/ .

The **New York State Youth Development Team** is a partnership established in 1998 by more than two dozen public and private organizations. The partnership has lead efforts to develop and promote youth development strategies across health and human services systems in New York State. Agency team members include all major state agencies serving youth (health, mental health, education, public assistance, juvenile justice, substance abuse), as well as the New York State Nurses Association, Cornell University, the YMCA, the NYS Association of Youth Bureaus, the Mount Sinai Adolescent Health Center the Association of Family Services Agencies, the NYS Center for School Safety, University of Buffalo, Families Together of NYS, University of Rochester, the Schuyler Center for Analysis and Advocacy, the Conference of Local Mental Hygiene Directors, and the NYS Counseling Association. The team is currently developing a compendium of outcome indicators for state and local use in measuring youth development efforts.

The **Coordinated Children's Services Initiative (CCSI)** is a cross-systems process for serving children with special emotional and behavioral services needs that builds upon legislation enacted in 2002. The process utilizes strength-based approaches, consistent and meaningful family involvement, individualizing planning, and encourages creative, flexible decision-making and funding strategies. CCSI Statewide Partners are: Family Representatives, Office of Mental Health, State Education Department, Office of Children and Family Services, Council on Children and Families, Division of Probation and Correctional Alternatives, Office of Mental Retardation and Development Disabilities, Department of Health, NYS the Commission on Quality of Care and Advocacy for Persons with Disabilities, and the Developmental Disabilities Planning Council. Priority areas for CCSI include the development and delivery of training and technical assistance related to building and sustaining local systems of care, including a family advocacy training curriculum. CCSI continues to work to implement the comprehensive set of recommendations for improving services for children who have cross-systems needs (developed in 2004).

It is to be noted that on August 2, 2005 Governor Pataki signed Chapter 392 of the Laws of 2005, establishing the Out-of-State Placement Committee within the Council on Children and Families. The Out-of-State Placement Committee is responsible for improving the monitoring of out-of-state residential placements, promoting coordination across all levels of government, and establishing a process for identifying and considering in-state resources prior to making an out-of-state placement.

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

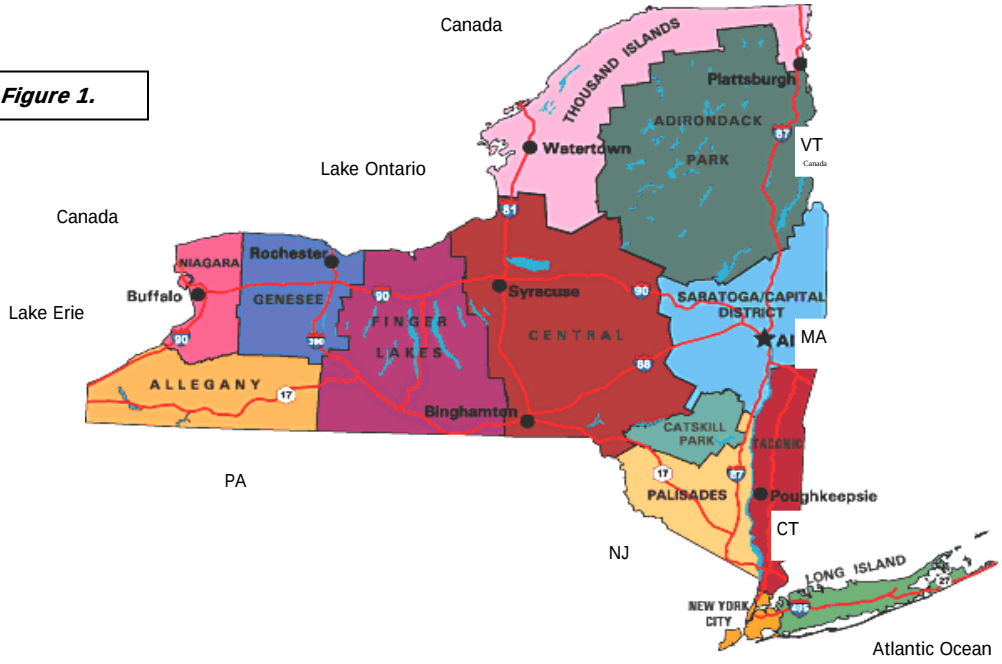
Overall, needs assessment and health planning are the shared responsibility of every program within DOH and their local counterparts, which is successful because:

- *As a State Health Department, we have entered into a partnership with consumers and families, with local health agencies and local communities, and with other State agencies.* These partnerships help Title V to identify the need for additional information and act on those needs.
- *We are united in a common vision for New York and the health of New Yorkers*. Thanks to an inclusive planning process, to multiple collaborations and partnerships and to the Department's administrative, legislative and educational initiatives, localities are playing a larger role in identifying local needs, designing programs to effectively address local need, and evaluating local results.
- *Title V and the New York State Department of Health are supporting this process through the dedication of needed resources*. Support and training are provided to local agencies and partners in their needs/capacity assessment and planning efforts.

Assessment of Needs of the Maternal and Child Health Population

Geography: New York State has a total area of 54,471 miles. That includes a landmass of 47,832 square miles and inland water covering 7,247 miles. Bordered to the north and west by Canada and the Great Lakes of Ontario and Erie, to the south and west by Pennsylvania and New Jersey, to the east by Vermont, Massachusetts and Connecticut, and to the southwest by the Atlantic Ocean, the geography of New York is both vast and diverse. Our borders hold 8,000 lakes, nine major rivers, four mountain ranges (the Adirondacks, the Catskills, the Taconics and the Shawangunks), hundreds of small, rolling valleys, fertile glacial plains, awe-inspiring gorges and waterfalls, quaint rural villages, and one of the most vibrant metropolitan areas in the world. (See *Figure 1*.)

Figure 1.



New York's diverse geography can also present interesting public health challenges. While the Finger Lakes and our mountain ranges are among our most beautiful natural resources, these attributes can also impede transportation and delay access to health care. Its location southeast of the Great Lakes ensures temperate upstate summers, but it can also, especially for the Tug Hill plateau region, mean sudden and heavy "lake effect" snowstorms in the winter. And because New York's natural resources attract tourists year-round with recreational activities like boating and skiing, some areas experience a striking seasonal demand on health services, especially in the areas of emergency medical services and public health. Ellis Island, our various ports of entry, and the Statue of Liberty have historically been beacons to newcomers and are well-known entry points for many new New Yorkers and new Americans from around the world.

Population: New York State is notable for the great diversity of both its geography and its people. According to the 2000 US Census, New York State is home to almost 19 million people (18,976,457). New York is now the third most populous state, behind California and Texas. Seven percent of the US population lives in New York. New York City contains 42% of the State's population with over 8 million people (8,008,276).

New York's population is aging. The median age in the State has increased from 10.3 years in 1970, to 32.0 years in 1980, to 33.8 years in 1990, to 35.9 years in 2000. This represents an aging of the "Baby Boomers" born between 1946 and 1964, as well as a longer survival rate for the elderly. The expectations for length of life for New York State residents has increased, from 75.2 years for those born in 1991 to 78.1 years for those born in 2000.

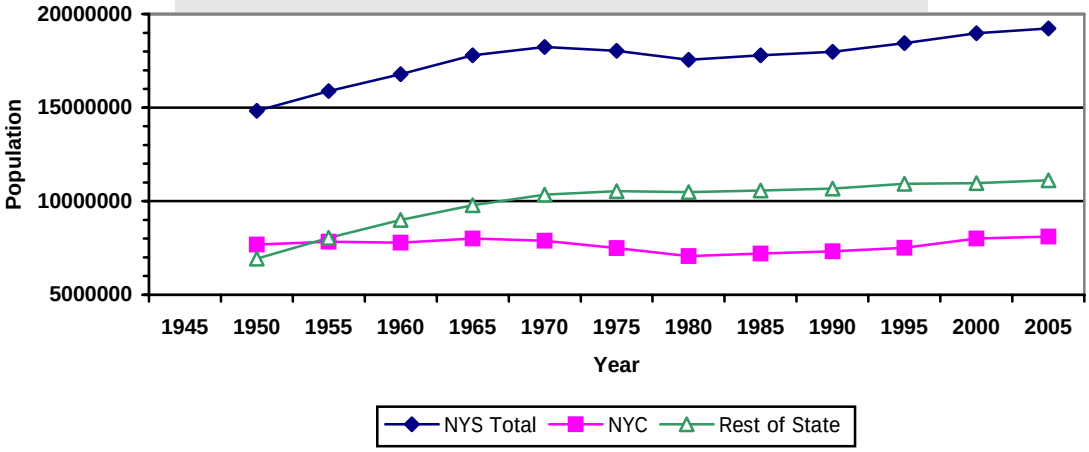
Population Growth: According to the 2004 Census estimates, 19,227,088 people live in New York State. Population trends indicate that, after a slight downward trend in the late 70's and early 80's, New York's population rose, and then leveled off. (See *Table 1* and *Figure 2*.) New York was the second most populous state until the late 1990's, when its population growth slowed to less than 1%. Early estimates indicate that NYS may have lost population (about 26,000 people or 0.1% of its population) from 2004 to 2005. The trend was said to be related to higher housing costs, a level job market and fewer immigrants entering the state.

***Table 1.* Population of New York State, 1950-2004**
Source: US Census Bureau

Year	New York State	New York City	Rest of State
1950	14,830,192	7,891,957	6,938,235
1960	16,782,304	7,781,984	9,000,320
1970	18,241,584	7,895,563	10,346,021
1980	17,558,165	7,071,639	10,486,526
1985	17,795,916	7,232,980	10,562,936
1990	17,990,455	7,322,564	10,667,891
1995	18,439,500	7,510,600	10,928,900
1996	18,506,400	7,542,500	10,963,900
1997	18,571,800	7,575,000	10,996,800
1998	18,637,800	7,609,200	11,028,600
1999	18,705,695	7,643,800	11,061,900
2000	18,976,457	8,008,278	10,968,179
2001	19,074,843	8,055,166	11,019,677
2002	19,157,532	8,084,316	11,073,216
2003	19,190,115	8,085,742	11,104,373
2004	19,227,088	8,104,079	11,123,009

According to the Census Bureau, New York City remained the nation's largest city. With an estimated 8.1 million people, the City added an estimated 135,000 people and lost an estimated 21,500 from 2004 to 2005.

Figure 2. *Population of New York State 1950-2004*
Source: *US Census Bureau*



Population Density: Population density often determines the number and types of health services that an area can support. The US Census shows that in 2000 there were 401.9 persons per square mile in New York State, compared to 79.6 persons per square mile in the US, but population density within New York varies widely. New York City is 104 times more densely populated than the rest of the state, and New Yorkers are more likely to live in urban areas than residents of other states.

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

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

Households and Families: In 2000, there were 7,056,860 households in New York State. The average household size was 2.61 people. A family household, by Census definition, has at least two family members related by blood, marriage or adoption, one of which is the householder. The average family size in New York State was 3.22 in 2000. Families made up 65.7% of the households in New York in 2000. This figure includes married couple families (46.6%), female householders (14.7%), and male householders (4.4%). Non-family households made up 34.3% of all the households in New York State. The majority of the non-family households were people living alone. Households containing children under the age of 18 numbered 2,466,483 or 35.0%, and households with adults 65 and older numbered 1,767,452 or 25.0%.

Women of Childbearing Age: The population of women of childbearing age has been decreasing since 1990. In 2004, it is estimated there were 4,119,291 females between the ages of 15 and 44 in New York State. A total of 633,458 females were between the ages of 15 and 19. An additional 649,774 females were between the ages of 10 and 14.

Children: Of New York's 2004 population, 4.5 million (23.8%) were under age 18. The number of children under the age of 20 in 2004 was just over 5 million (5.088,698), broken down by age groups as shown in *Table 2.* Approximately 42% of these children (2,119,501) live in New York City.

Table 2. **Child Population in NYS 1998-2004**
Source: US Census Bureau (*estimated from 1990 Census/**estimated from 2000 Census)

Age in Years	Number in 1990	Number in 1999*	Number in 2000	Number in 2002**	Number in 2003**	Number in 2004**
<1	1,255,764	241,692	1,239,417	256,954	250,062	254,293
1-4		996,028		971,190	964,990	991,752
5-9	1,178,006	1,367,101	1,351,857	1,269,659	1,224,847	1,213,572
10-14	1,140,177	1,339,242	1,332,433	1,349,522	1,327,017	1,331,263
15-19	1,230,127	1,218,320	1,287,544	1,279,332	1,279,454	1,297,818
Total Birth-20	4,804,074	5,162,383	5,211,251	5,125,657	5,046,370	5,088,698
Total in NYC	1,888,075	2,073,827	2,153,450	2,122,939	2,111,183	2,119,501

The U.S. Census Bureau estimated that the number of children ages 4 and under grew in New York City by an estimated 8% from 2000 to 2004. In the rest of State, however, there was a 5% decline in population in this age group. Demographers attribute the growth in the youngest age groups to the influx of immigrant families in New York City, many of whom are of childbearing age. The Census Bureau estimated that Manhattan had a 20% gain in this age group, the Bronx had a 4.8% increase, Brooklyn a 2.3% increase, and Queens showed a 1.1% increase. Upstate rural counties lost the greatest number of infants and toddlers under age 5: Greene and Schoharie Counties lost 14% each, while Orleans County lost 13%.

Race and Ethnicity: New York's population reflects diverse race and ethnicity; we are more diverse than the nation as a whole. New York has higher percentages of non-Hispanic Black residents, Hispanic residents and non-citizen immigrant residents than the U.S. average. New York ranks second of all states in non-citizen immigrants, with 2.2 million non-citizen residents in 1996. Almost 90% of New York's non-citizen immigrants live in New York City.

Between 1990 and 1998, there had been small shifts in the ethnic composition of New York's population, with the population of New York City being more racially and ethnically diverse than the rest of the State. The 1999 New York State population under age 24 was 72% white, 22% African American, and 18% Latino. Approximately 6% were identified as Asian/Pacific Islander.

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

According to the 2000 U.S. Census, the largest group (67.9%) reported White alone, while Black or African American alone represented 15.9 percent of New Yorkers. 7.1% reported being Some Other Race. 5.5% stated they were Asian alone, and 0.4% reported they were American Indian or Alaska Native. Native Hawaiian or Other Pacific Islander accounted for only 0.05% of those reporting.

Hispanics accounted for the majority of the Some Other Race category. Of New York State residents who selected Some Other Race, 94.4 percent identified themselves as Hispanic. Hispanics represent 15.1% of New York State's total population. In New York City, 27% indicated they were Hispanic. Four out of 10 Hispanics did not identify themselves with one of the five specific race alone categories or two or more races category. Of those New Yorkers identifying themselves as Hispanic, 44.2 said they were Some Other Race.

About 70% of African Americans and 75% of Hispanics/Latinos in the State reside in New York City. Among New York City residents, 44.7% reported their race as White alone, 26.6% reported Black or African American alone, 9.8 percent reported Asian alone, and 14.4 percent reported being Some Other Race. About 27% of New York City's population identifies themselves as Hispanic/Latino.

Several counties outside of New York City have significant Hispanic/Latino population, as well. In Rockland, Nassau, Orange, Suffolk, Sullivan and Westchester Counties, Hispanics/Latinos make up at least 9% of the population.

Population growth as a percentage of total population grew between 1990 and 2000 by 29.5% for Hispanics and 9.5% for non-Hispanic Blacks. The Asian population surged by 56.1% to over one million (1,035,926).

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

Form 12 in the Appendix of this document contains a racial and ethnic breakdown for all births.

Table 3.
New York State Population Breakdowns by Race
Source: 2000 US Census

Race Categories	New York Population		New York Hispanic Population			
	Number	% of Total Population	Number	% of Total Population	% of Total Hispanics	% of Race Category
One Race	18,386,275	96.9	2,643,517	13.9	92.2	14.4
▪ White	12,893,689	67.9	1,132,708	6.0	39.5	8.8
▪ Black or African American	3,014,385	15.9	201,762	1.1	7.0	6.7
▪ American Indian/ Alaska Native	82,461	0.4	29,962	0.2	1.0	36.3
▪ Asian	1,044,976	5.5	9,050	0.0	0.3	0.9
▪ Native Hawaiian/ Other Pacific Islander	8,818	0.0	3,588	0.0	0.1	40.7
▪ Some Other Race	1,341,946	7.1	1,266,447	6.7	44.2	94.4
Two or More Races	590,182	3.1	224,066	1.2	7.8	38.0
TOTAL	18,976,457	100.0	2,867,583	15.1	100.0	15.1

A great number of New Yorkers (3,747,874, according to the Census) are foreign born. The largest group of the foreign born are from Latin America (1,818,773). Asians are the second largest group of immigrants (929,297), and Europeans the third (823,899). African immigrants (102,772), other North Americans (67,249) and Oceanians (5,884) follow in descending order.

Languages: In addition to our great cultural diversity, there is also great diversity in languages spoken in New York. Of the estimated 17,144,924 New Yorkers over age 5, an estimated 12,440,299 speak only English at home, while 4,704,625 speak a language other than English. 2,092,875 speak English less than "very well." About 2,360,792 New Yorkers speak Spanish at home. The New York State Education Department found that, of the 3.34 million students attending school in New York, 7.6% were identified as having limited proficiency in English.

Immigration: New York has always served as a major gateway for immigration, and as an entry point for many new New Yorkers and new Americans. Unfortunately, data on immigrants, especially undocumented immigrants, is very scant, and does not break down immigrant populations by maternal and child health categories. The reliability of the data is uncertain, at best.

In April 1998, the Urban Institute published a report with the support of multiple private foundations entitled, "Immigrants in New York: Their Legal Status, Incomes and Taxes." To date, this remains the best estimate of demographic and economic information on legal immigrants living in New York State, but the report also addressed multiple, significant shortcomings in existing data for immigrants and the fiscal impact of immigration.

The report focused on four areas: the size of the legal immigrant population; the characteristics of legal and undocumented populations; the incomes and taxes paid by immigrant populations; and the economic adaptation of immigrants and their descendants. The report gives separate population estimates for naturalized citizens, legal non-immigrants (such as diplomats and foreign students), and undocumented aliens residing in New York State. Estimates are derived from the Immigration and Naturalization Service (INS), the Office of Refugee Resettlement (ORR), and the Bureau of Census.

The study estimated:

- New York had a foreign-born population of 3.4 million in 1995, just prior to the initiation of welfare reform. This number represents 17.7% of the State's population, or about one in six people. Only California has a higher percentage (25.1%) of foreign-born residents. The national average for the foreign-born is approximately 9.3%.

- The majority of the foreign-born in New York are here legally (84%).

- About 16% or 540,000 of the State's immigrants are undocumented. Undocumented people represent a smaller percentage of the State's immigrant population than any other major immigrant state, except New Jersey. Nevertheless, New York (with 540,000) is estimated to have the third highest number of illegal immigrants living in the state, behind California (2 million) and Texas (700,000).

- There are approximately one million legal permanent resident aliens and over a million naturalized citizens in New York. These two groups compose about 77% of New York's immigrants and about 15% of the State's total population.

- New York has more naturalized citizens than the country as a whole, probably because more of New York's immigrants come from countries that tend to naturalize and more are long-term immigrants, who are also more likely to naturalize.

- New York has approximately 200,000 refugees, representing 5.9% of the foreign-born population. Most refugees in New York are from the former Soviet Union, while refugees from Southeast Asia dominate in the rest of the country.

- New York's immigrant population is very diverse, with no particular region or country having clear dominance.

- Of the estimated 3.4 million immigrants in New York:
    - About 915,000 or ~27% come from the Caribbean;
    - About 864,000 or ~25% come from Europe;
    - About 665,000 or ~20% come from South or East Asia;
    - About 411,00 or ~12% are from South America;
    - About 171,000 or ~5% are from Central America;
    - About 105,000 or ~3% were from the Middle East;
    - About 45,000 (~1.3%) are from Mexico;
    - About 31,000 (~0.9%) are from Canada;
    - About 26,000 (~0.8%) are from Africa; and
    - About 121,000 (~3.5%) are from other or unknown jurisdictions.
    - The largest single country of birth is the Dominican Republic, with about 395,000 or ~12%;
    - About 229,000 or~7% are from China;
    - About 195,000 or ~6% are from Jamaica; and
    - About 182,000 or ~5% are from the former Soviet Union.

- There is thought to be greater diversity among the undocumented foreign-born than among those here legally. Only New Jersey is thought to have similar diversity in the foreign-born population.

- About half (46.5%) of households headed by legal immigrants and over a third (37.3%) of the households headed by undocumented immigrants contain one or more US natives. Babies born in this country are defined as natives and citizens.

- The incomes of natives and immigrants differ substantially by their status. Based on 1995 income and tax data, the study found:
    - The average native's annual income was $18,100.
    - The average income of the legally present foreign-born was very comparable at $18,000.
    - The average household income for legally present foreign-born individuals ($38,000) is lower than that for households headed by natives ($49,300).
    - Of those that are here in New York legally, naturalized citizens have the highest per capital income ($23,900), surpassing that of natives ($18,100), and far surpassing that of refugees ($8,300).
    - Among New York State residents outside of New York City, legal foreign-born residents were found to have higher incomes than natives, regardless of the measure used. For example, legal immigrants had per capital income of $23,900, compared to $19,100 for natives.
    - The average income for undocumented aliens was found to be substantially lower than for those foreign-born who were legally present, $12,100 vs. $18,000.

The Unauthorized Population: The most current estimates available indicate that, in the U.S. as a whole, there are an estimated 10.3 million unauthorized immigrants based on an average over 3 years of March Current Population Survey data (2002-2004). About 7 percent or 650,000 of the unauthorized population are living in New York State. New York ranks fourth among the states with the largest unauthorized immigrant populations. In 1990, New York State ranked third and was home to 15 percent of unauthorized immigrants. (***Unauthorized Migrants: Number and Characteristics***, Passel, June 14, 2005).

Education: According to the NYS Education Department, in Fall 2003, 3.32 million students were enrolled in New York State's public and non-public schools. Over 14 percent of the State's school children attend non-public schools. In Fall of 2003, 6.8 percent of students in public schools were identified as limited English proficient and 12.1 percent were identified as students with disabilities. In 2002-2003, funding for education in New York was from several sources. Specifically, 46 percent was from the State, 48.3 percent from local school districts and 5.7 percent from the federal government.

During the 2002-2003 school year, the per-pupil expenditures in New York State were $13,085. This represents a 6.7 percent increase over the 2001-2002 school year. The average for the US as a whole was $8,255 (2001-2002 – National Center for Education Statistics). With a rank of 1 being the best and 51 the worst, New York ranked 3rd in the US for per pupil expenditure, reflecting the high priority of education in New York State (1999-2000).

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

Table 4. **Statistics for Public and Nonpublic Schools Enrollment by Race by Type of School, Fall 2003**
Source: NYS Education Department

Category	Enrollment					
	Total	% White	% Black	% Hispanic	% Amer. Indian/ Alaskan Native	% Asian/ Pacific Islander
Public						
New York City	1,028,546	14.6	33.8	38.6	0.4	12.6
Large City Districts	118,932	22.7	52.8	21.0	0.8	2.6
Districts Excluding the Big 5	1,681,039	80.3	8.7	7.5	0.5	3.1
BOCES	19,680	76.7	14.2	6.8	0.7	1.5
Total Public	2,840,735	53.8	19.9	19.3	0.5	6.5
Total Nonpublic	476,782	68.2	15.2	11.9	0.2	4.5
Total State	3,317,517	55.9	19.2	18.2	0.4	6.2

In the 2004-2005 school year, there were 13.1 pupils per teacher in New York State's public schools (New York State Total Public Report Card, May 2006). This compares to the US average of 14.1 pupils per teacher (2003-2004 National Center for Education Statistics). Class sizes in NYS public schools for the school year 2004-2005 ranged from an average of 20 students in each kindergarten class to about 22 students in high school regents classes. Class sizes in NYC public high schools were larger than in other parts of the state. An average NYC Regents History and Government class had 29 students while NYC kindergartens averaged 22 students (NYS Report Card, May 2006).

In New York, 77 percent of the students in the 2000 graduation cohort (students expected to graduate by August 2004) actually graduated. Seventy-two percent of these graduates received Regent's diplomas. Graduation rates varied among students. Fifty-five percent of black students, 59 percent of Hispanic students and 86 percent of white students graduated as expected. Of students considered economically disadvantaged, 58 percent graduated on time while the rate among students with limited English proficiency was 45 percent (NYS Report Card, May 2006).

Despite the heavy emphasis put on secondary and post-secondary education in our State, there is still concern for the small percentage of students that don't complete high school.

According to the 2004 American Community survey, 25 percent of persons in New York State with less than a high school education live below poverty. Among females without a high school education, the percent below poverty is 30 percent. The chart below presents Education attainment by Poverty level and sex.

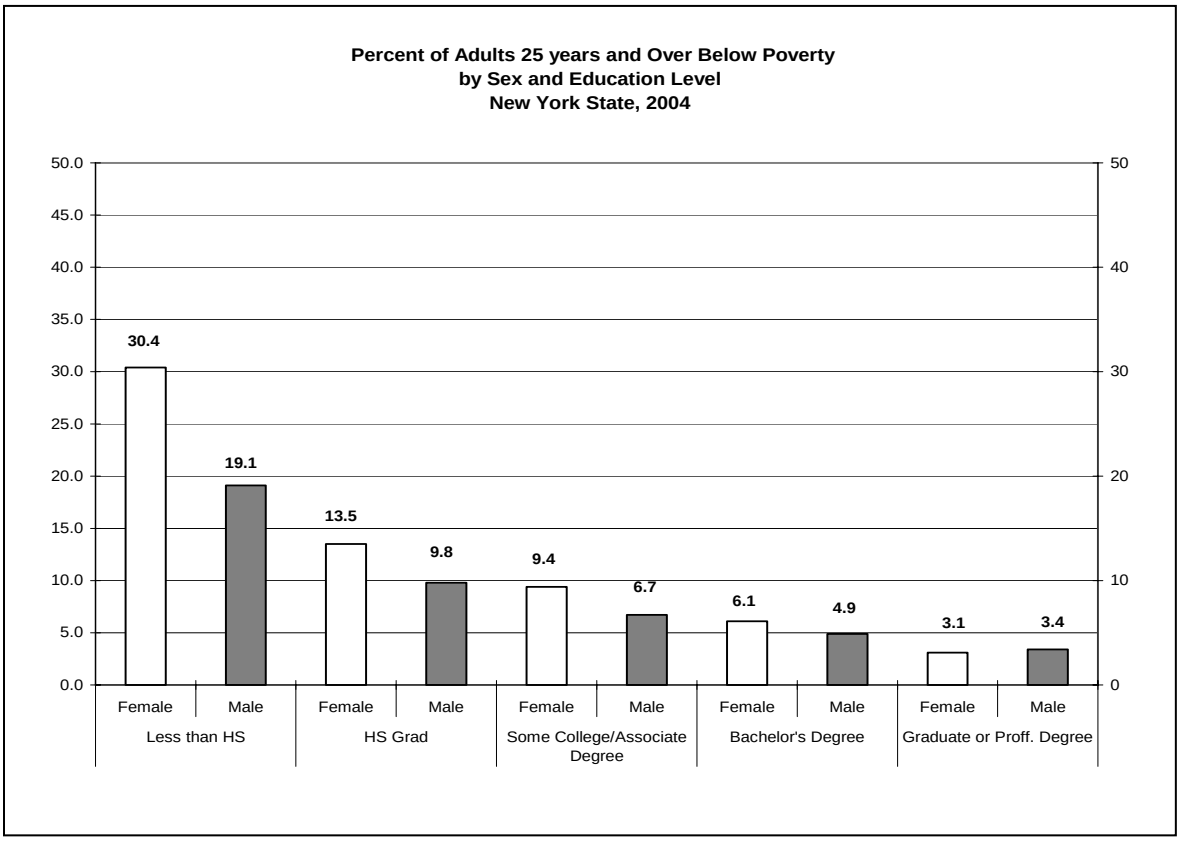


Figure 3. Source: US Census Bureau, American Community Survey 2004 - (S1501) Educational Attainment

In New York State during the 2003-2004 school year, 4.3 percent of students dropped out of high school. New York City had a higher drop out rate than the rest of State. The New York City rate was 7.5 percent and the rate for districts outside the city was 2.5 percent. Minority students were more likely than white students to drop out. Drop out rates by race and ethnicity were black (7.1%), Hispanic (7.8%), American Indian/ Alaskan Native (6.7%), Asian/PI (3.9%) and white (2.2%).

Among the 2004-2005 graduates in NYS, 52 percent planned to attend a four-year college, and 28 percent a two-year college. Only 6% planned to seek full-time employment after graduation. According to the 2004 American Fact Finder Survey, among New York State adults 25 and older, 84 percent have completed high school and 54 percent have at least some college. The chart below presents the percent of the population that has at least a bachelor degree. Interestingly, in the younger age groups, females (41%) are more likely to have a bachelor's degree as compared to males (35%). Nationally, females account for about 57 percent of college campus populations even though, according to the US Census population figures, males out number females in the 18-24 age group. In New York, 24.1 percent of males, compared to 17.4 percent of females in the 18-24 age group have less than a high school education (American Fact

Finder Survey). Among New York students that graduate, females were more likely than males to earn a Regents-endorsed diploma.

In fact, gender differences are appearing early on in the educational process. According to the NYS Department of Education, there are substantial differences in performance between males and females on the elementary and middle-level English language Arts assessments in favor of females.

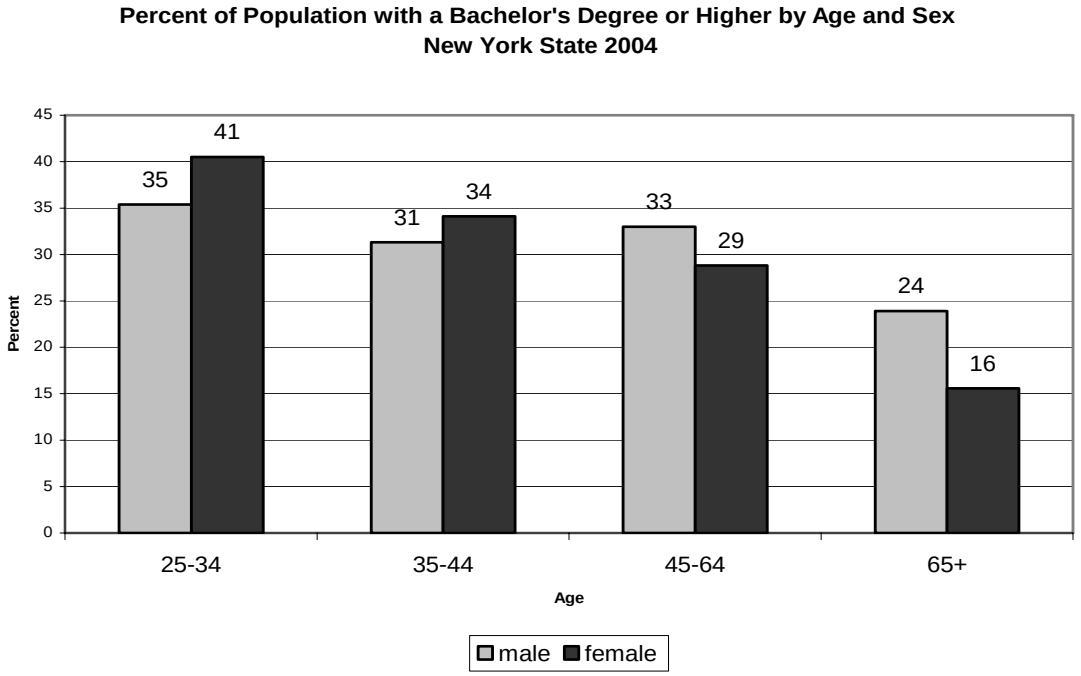


Figure 4. Source: US Census Bureau, American Community Survey 2004 - (S1501) Educational Attainment

High School Disenrollment: Census data indicate that of the 910,676 youth ages 16 to 19 in the State, 77,241 or 8.5% are not enrolled in school and not a high school graduate. Of those, 48,449, or 5.3% of the youth in that age group, are not in the labor force. New York is actively pursuing a Youth Development focus that emphasizes workforce development through the Partners for Children Youth Development/Workforce Development Workgroup and the National Governors' Association (NGA) Youth Policy Network Grant.

Internet Access: Internet access is becoming increasingly more important in education and in accessing information that people can use in their everyday lives. As the use of the Internet becomes more widespread, those without access are at a growing disadvantage. In New York State, between 55 and 58% of the population over three years of age had access to the internet according to an October 2003 Current Population Survey.

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

In New York State, 19.1% of women giving birth in 2004 had less than a high school education. Among African American and Hispanic women, the percentage is even higher (24.9% and 40.5%, respectively).

Mothers in New York City were nearly twice as likely as mothers in the rest of the state (23.0% vs. 15.5%) not to have completed high school. The number of mothers without a high school diploma in the Bronx and Brooklyn alone was nearly equal to the number of mothers in the rest of the state outside New York City. Women giving birth in the Bronx in New York City and in Yates County in Upstate New York were least likely to have graduated from high school, with graduation rates of 65% and 68%, respectively. On the other hand, mothers from Putnam and Hamilton Counties had the highest high school completion rates, at 94% and 95% completion, respectively. In New York City, Richmond and New York County had the highest completion rates (84% and 83% respectively).

Per Capita Income/Median Income: New York is ranked 5th in the nation for per capita income. The US Bureau of Economic Analysis reports that residents of New York have a higher-than-average per capita income, $40,507 compared to $34,586 nationwide in 2005. This is a 5.9 percent increase over last year. The per capital income figure is derived by dividing total personal income by the mid-year population of the state.

Median family income in New York State was $56,556 in 2004. Again, New York's median family income ranks higher than the $53,692 average median family income for the nation as a whole (2004 American Community Survey). Median family income is the midpoint of the distribution of incomes for all families including those with no income.

Employment/Unemployment: According to the New York State Department of Labor Publication, Workforce New York, New York State's private sector job count in March 2006 was 7,087,500 (seasonally adjusted). Since the beginning of New York's economic recovery in August 2003, the state has added 181,000 private sector jobs.

In New York City, between March 2005 and March 2006, the number of jobs has increased by 58,200, or 1.6 percent, and the number of private sector jobs has increased by 56,700, or 1.9 percent.

New York State's unemployment rate, after seasonal adjustment, was 4.7 percent in March 2006, matching the national March rate. For the same time period, New York City's seasonally adjusted unemployment rate was 5.4 percent. This marked the lowest March unemployment rates in both New York State and New York City since 2001.

Since March 2005, the number of non-farm jobs in New York State increased by 86,200, or 1.0 percent, and the number of private sector jobs increased by 80,600, or 1.2 percent. Nationally, the number of non-farm jobs increased by 1.6 percent and the number of private sector jobs increased by 1.8 percent between March 2005 and March 2006.

Educational and health services added the most jobs (+27,800) over the March 2005-March 2006 period, with most of the increase in health care and social assistance (+21,500). Employment also increased in professional and business services; financial activities; trade, transportation and utilities; construction; leisure and hospitality; government; other services; information; and natural resources and mining. Employment declined in manufacturing (-17,300).

The service sector is the largest employer in the State; employing approximately 45.7% of the employed New Yorkers ages 16 and over, according to Census figures. Retail is the second largest group of employers, employing approximately 10.6%. Manufacturing is a close third, employing about 10.2% of employed New Yorkers ages 16 and above.

Agriculture is important to New York as a major seasonal and year-round employer in New York. According to the NYS Department of Agriculture and Markets, there are 35,600 farms in New York, covering 7.55 million acres (about 25% of the state's land mass), which produce and sell about $3.6 billion in agricultural products annually. Livestock, dairy and poultry farming account for about 63% of agricultural sales or $2.3 billion, while vegetable, fruit, greenhouse and nursery crops are also major contributors to the agricultural economy. Milk is New York's leading agricultural product, accounting for over one-half of the total agricultural receipts, and placing New York as third in the nation for dairy production. The USDA lists New York as the second leading state in the nation for apples, which are mostly produced along the southern Lake Ontario shore, along the Hudson Valley, and along the upper Lake Champlain Valley. New York is third leading state for grapes behind California and Washington, and for strawberries. New York rates second in value of maple sugar produced, third for production of cauliflower; fourth for production of pears, cucumbers, sweet corn and green pea production; fifth for squash and snap beans; and sixth for onions. We lead the nation in cabbage and pumpkin production, and we are seventh among all states for vegetable production.

Poverty: During the 1990s poverty in New York State was trending downward. The percent of New Yorkers living below poverty went from 18.4% in 1993 to 14.1% in 1999. Since 2000 however, the percent of New York State's population that lives below poverty has been slowly increasing. In 2004, 15 percent of the population lived below the federal poverty level. This is higher than the national average of 12.7 percent. About 18.6 percent of New Yorkers had incomes below 125% of poverty.

Table 5. **Population Below Poverty and 125 Percent of Poverty New York State, 2000-2004**

	2000		2001		2002		2003		2004	
Population Grouping	**Below Poverty**	**Below 125% Poverty**	**Below Poverty**	**Below 125% Poverty**	**Below Poverty**	**Below 125% Poverty**	**Below Poverty**	**Below 125% Poverty**	**Below Poverty**	**Below 125% Poverty**
Total Population	13.4%	17.4%	14.2%	18.8%	14.0%	17.9%	14.3%	18.8%	15.0%	18.6%
Children Ages <18	19.0%	24.0%	20.0%	25.8%	20.5%	25.8%	19.9%	25.0%	21.3%	25.3%
Families	10.8%	14.0%	12.0%	16.4%	10.7%	14.2%	11.9%	15.7%	12.6%	15.7%
Female-headed families with children	38.9%	47.8%	39.1%	50.1%	39.6%	47.7%	38.1%	46.1%	40.0%	47.0%

Poverty is highly associated with poor health outcomes, especially for women and children. About 12.6 percent of New York State families, versus 10.2 percent in the US as a whole, lived at or below the Federal Poverty level in 2004. Poverty is most common in families headed by single females, and single-female headed households with children are more likely than other families to be living below poverty. This is true regardless of race or ethnicity. Given this, New York continues it's commitment to reduce rates of teen pregnancy and out-of-wedlock births and to provide poor heads of households with jobs.

According to the 2005 Current Population Survey, during 2004, 40 percent of the people in female-headed households with children lived below poverty in NY State. For a female headed household with two children that would be an income of $15,067 or less per year. Even at 200% of poverty, which includes 66 percent of female – headed families, the income level is no more than $30,134.

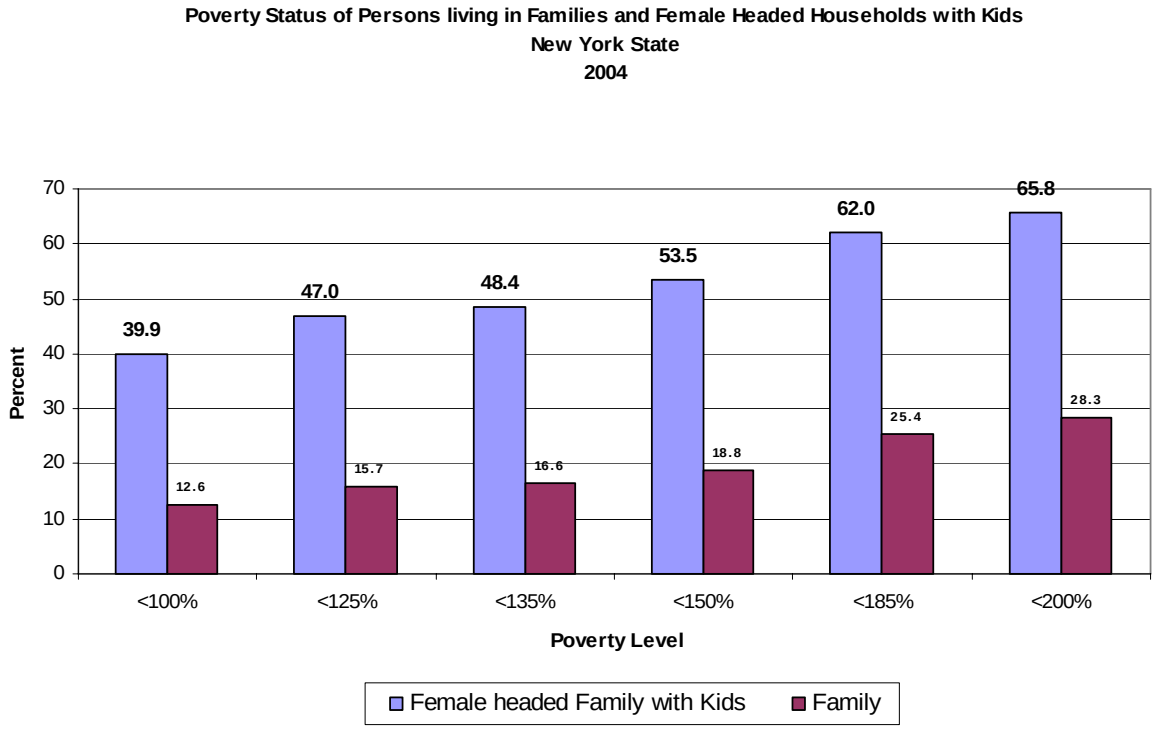


Figure 5. *Source: Current Population Survey, Annual Social and Economic Supplement 2005*

Poverty rates among children in New York State have also been increasing since 2000. In 2004, 969,000 of NY State's children (21.3 percent) were living below poverty. This is higher than the 17.8 percent in the nation as a whole. Even more New York State children lived in households with incomes below 125 % of poverty (1,155,000 or 25.3%).

Prior to the recent upturn in poverty rates among children, New York State had made much progress in reducing child poverty. In 2000, New York's child poverty rate was at its lowest level in 21 years, largely because the State had increased employment among its most economically needy families. According to the US Bureau of the Census, employment for the State's most vulnerable families rose sharply after implementation of welfare reform in 1995. There was a concurrent 28% decline in the rate of child poverty, from 26.4% in 1994 to 20% in 2001. According to the NYS Office of Temporary and Disability Assistance, reductions in the number of families on Public Assistance were accompanied by a rise in employment among the disadvantaged and a reduction in both teen pregnancies and out-of-wedlock births. In addition, Census data indicates that the upward trend in single mother families and the downward trend in married couple families have abated. With the improvement in the New York economy, the percent of persons living below poverty is expected to again start to decline.

Small area poverty estimates provided by the Census bureau indicate that, in 2003, more than 30 percent of children living in the Bronx, Brooklyn and Manhattan were in households with incomes below the federal poverty level. The Bronx rate of 37 percent

was the highest in the state. These data underscore New York's continued commitment to employment for parents, and to supportive programs such as the Prenatal Care Assistance Program, Child Health Plus, Children's Medicaid, Family Health Plus, WIC and the Child and Adult Care Feeding Program. In 2004, 44.7 of all obstetrical deliveries were paid for by Medicaid or self-pay. In 2003 the percent was 41.3 and in 2002, 43.6.

In comparing poverty levels among age groups, there is a general decrease in poverty, as individuals grow older. In 2000, the percent of those living in households earning less than 100% of the poverty level were: 19.2% for children birth to age 9, 18.2% for 10 to 19 year-olds, 14.1% for 20 to 29 year olds, 11.6% for 30-39 year olds, and 10.7% for those over 50.

Income Disparities: The Center for Budget and Policy reported that despite a tight labor market, and strong economic growth in recent years, income disparities in New York and most other states grew significantly during the 1990s, and the trend continued into this decade. This is thought to be due primarily to wage disparities. Factors contributing to wage inequity include the decline of manufacturing jobs, the expansion of low-wage service jobs, globalization and the lowered real value of the minimum wage. Families at the lower end of the wage scale are less likely to afford health or dental insurance, and have less flexibility for out-of-pocket medical or dental expenses. Specifically, according to the Bureau of the Census small area estimates for 2003, median family income varied considerably from county to county. While for the state as a whole the median household income was $44, 139, in the Bronx it was $27,550. On the other end of the scale was Putnam County where the median household income was $72,614.

The table below presents wages by occupational group and sex of worker in 2003.

Table 6. **Median Income by Occupational Group and Sex**	**Males**		**Females**		**Female Earnings as a % of Male Earnings**
Occupations	**%**	**Median Earnings**	**%**	**Median Earnings**	
Civilian employed pop ages 16+	57.7	44,369	42.3	35,195	79.3
Management Professionals & related	54.2	55,975	45.8	49,344	88.2
Education, training, library	35.0	51,654	65.0	45,784	88.6
Legal	57.9	100,000	42.1	57,388	57.4
Health diagnosing, treating practitioners and technical	32.9	89,976	67.1	60,879	67.7
Health technologists	33.0	45,395	67.0	35,710	78.7
Community & social service	41.3	37,720	58.7	35,969	95.4
Service	54.5	30,455	45.5	23,011	75.6
Healthcare support	14.1	30,174	85.9	24,339	80.7
Sales and office	41.7	41,400	58.3	31,633	76.4
Office support	28.5	39,799	71.5	31,678	79.6
Farming, fishing and forestry	80.6	24,059	19.4	18,441	76.6
Construction and extraction	96.4	40,127	3.6	34,959	87.1
Production, transportation & material moving	79.8	35,795	20.2	21,846	61.0

Wages varied by occupation, educational attainment level and gender in New York State. According the US Census Bureau's American Community Survey males earn more than females in every occupational category, even occupations that have been traditionally female dominated. On average, females in NY State earn 79 cents for every dollar earned by their male counterparts. Within legal occupations females earn 57.4 percent of what

males earn. The most equitable occupational group was the community and social service occupations. Generally, earnings for both males and females varied widely, depending on the occupational group.

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

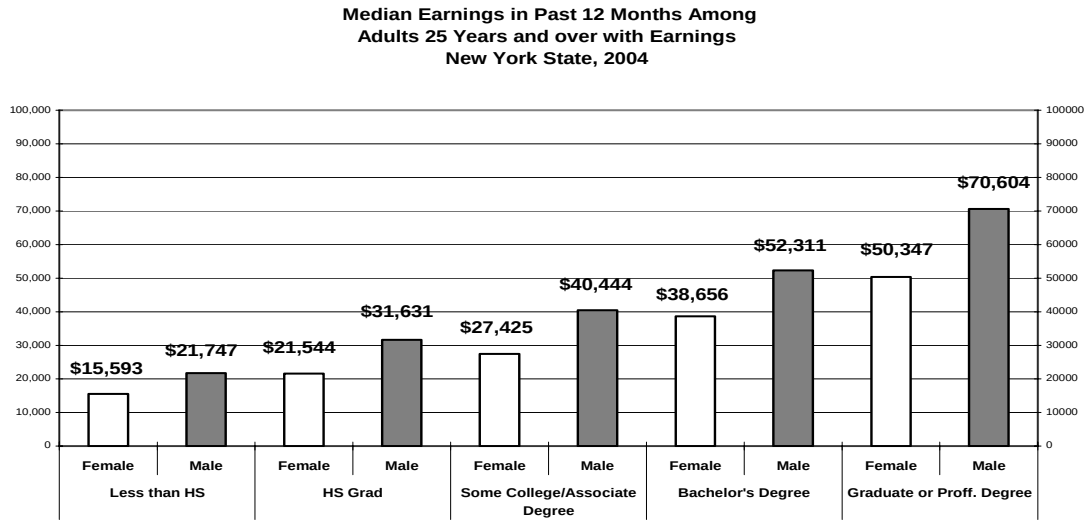


Figure 6. *Source: American Community Survey, 2004 (S1501 Educational Attainment)*

Access to Primary Care: : According to the New York State Behavioral Risk Surveillance Survey, 11.9% of those surveyed in 2005 did not see a doctor when they needed to because of cost. This figure was an improvement over 2004 when 13.7 percent of individuals put off a doctor's visit due to cost. Among African Americans and Hispanics, 14.6% and 22.2%, respectively, indicated cost prevented them from seeing a doctor. These figures were an improvement for African Americans (down from 18.6%) but an increase for Hispanics (up from 19.0%) compared to 2004. Of New Yorkers surveyed in 2005, 17.2 percent said they did not have a personal doctor or health care provider. Hispanics were most likely to not have a medical care provider (34.1%) as compared to Blacks (16.3%) and Whites (12.6%). Males were much more likely not to have a health care provider as compared to females (23.8% vs. 17.2%).

According to the National Survey of Children's Health 2003, 57 percent of New York's children had a personal doctor or nurse and received care that was accessible, comprehensive, culturally sensitive, and coordinated. Eighty-eight percent had a preventive medical visit in the past year and about 69 percent had a preventive medical visit and a preventive dental visit in the past year. All of these percentages were higher than the national averages for these indicators.

More New Yorkers are establishing a medical home under a managed care plan. In 1998, 29.1% of New Yorkers enrolled in the Medicaid program received their care through enrollment in managed care. In the March of 2005, about 63% or 2,496,346 of the 3,934,453 Medicaid-eligible people in the State received their care through a managed

care plan. Percentages are higher for New York City when compared to rates for the State outside New York City.

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

New York State, with 83.6 dentists per 100,000 population, was well above the national rate of 63.6 and ranked 4th in the nation in dentists per capita. The per capita ratio of dental hygienists was slightly higher than the national rate. However, the distribution of dentists and dental hygienists is geographically uneven. There are many rural and inner city areas in the State where shortages of dentists and dental hygienists exist, where specialty services may not be available, and where the number of dental professionals treating underserved populations is inadequate. The demand for dentists, based on current employment levels, is projected to increase by 3.1% from 10,220 jobs in 2002 to 10,530 in 2012. During the same time period, the demand for both dental hygienists and dental assistants are both projected to increase by nearly 30%. In 2004, of the 14,932 dentists licensed to practice in New York State, 46% were enrolled in Medicaid and 20% were enrolled in Child Health Plus B. During the same time period, however, only 3,845 dentists statewide (26%) had at least one claim paid by Medicaid. Of the 3,845 dentists submitting at least one claim, 90% (3,454) had $1,000 or more in Medicaid claims during 2004.

Half of all New Yorkers have an insurance plan to cover oral health services. Even with dental insurance, there tend to be higher out-of-pocket expenses associated with dental care. Dental insurance plans tend to be difficult to purchase and, even when available, cover a limited number of procedures. Fortunately, New York provides a comprehensive package of coverage for those enrolled in Medicaid, Child Health Plus and Family Health Plus.

Even the comprehensive coverage New York offers under public and private dental insurance is not enough to guarantee access. Other factors, such as the geographic location, transportation, the availability and distribution of dentists and pediatric dental specialists, and parent and patient knowledge and attitudes play a significant role in access to dental care, especially for the poor. According to the Behavioral Risk Factor Surveillance Study, in 2004, 71.8% of New York State respondents indicated that they had seen a dentist in the last year. Among Blacks and Hispanics, 68.8% and 65.6% had visited a dentist during 2004.

Access to Primary and Preventive Medical and Dental Care for Children: The National Survey of Children's Health, 2003, reported that New York is above the national average for children, ages birth through seventeen, who had both a preventive medical and dental visit in the past year. The results for New York were 68.6%, while the national average was 58.8%.

Health Insurance: The proportion of children between birth and 17 years of age that were uninsured declined for the second year in a row between 2003 and 2004 to 8.6 percent. Although the rate of uninsured increased in 2002, it had declined each of the four years prior to 2002. Historically, the percentage had been steadily increasing since 1990, with the exception of 1995, when it dropped to 9.4%. The rate of uninsured in the general population (14.2%) was down from the 2002 rate of 15.9%, and the 2003 rate of 15.1%. The percentage of children insured by public insurance increased slightly from 31.2% in 2003 to 32.4% in 2004. In the table below, public insurance includes Medicaid

and Medicare. Persons with both public and private are included under public insurance. Private insurance includes those with military-related insurance.

Table 7. **Percentages of Children Insured by Type of Insurance and Uninsured**
Source: Current Population Survey, 1990, 1994-2004

Type of Insurance>	Public		Private*		Uninsured	
Year	Birth - 17	Total Population	Birth - 17	Total Population	Birth - 17	Total Population
1990	23.4%	24.4%	68.1%	63.5%	8.5%	12.1%
1994	25.4%	26.2%	60.5%	57.8%	14.1%	16.0%
1995	28.0%	26.4%	60.1%	58.2%	11.9%	15.2%
1996	28.9%	26.7%	56.0%	56.3%	15.1%	17.0%
1997	26.3%	26.4%	58.2%	56.1%	15.5%	17.5%
1998	27.2%	26.1%	59.0%	56.6%	13.8%	17.3%
1999	28.8%	26.1%	60.7%	57.5%	10.5%	16.4%
2000	28.1%	25.4%	61.1%	59.4%	10.8%	15.2%.
2001	29.5%	26.3%	61.2%	58.3%	9.3%	15.5%
2002	29.9%	26.1%	60.2%	58.1%	9.9%	15.8%
2003	31.2%	27.8%	58.4%	57.1%	9.4%	15.1%
2004	32.4%	28.6%	59.0%	54.2%	8.6%	14.2%

Up until recently, it has been difficult to estimate the number of uninsured within each county in the state. In 2005, however, the US Census Bureau released experimental, model based health insurance coverage estimates for counties and states for the year 2000. According to this methodology, 9.5% of New York State's children were uninsured in 2000. The percent of children uninsured varied widely throughout New York State. Several counties in NYC had the highest percentages of uninsured children (Bronx County - 14.8%, Kings County - 14.3%, and Queens County - 13.3%). The lowest rates of uninsured were among children residing in the Upstate counties of Hamilton (7.3%), Ontario (8.0%) and Genesee (8.6%).

Based on the latest two years of data from the Census Bureau's Current Population Survey (CPS), the Division of Planning, Policy and Resource Development estimates the numbers of people are "income eligible" for Medicaid, Family Health Plus and Child Health Plus. "Income eligible" takes into account that the CPS does not provide estimates of other factors that affect eligibility for these programs (immigration status, availability of public-employee coverage). Estimates were derived by forming 'applying units' from the CPS households, to reflect the countable income of people who would apply together for coverage, using the Medicaid eligibility levels in place in 2005. The latest CPS data covers calendar years 2003 and 2004, although the data are used to estimate current conditions. The CPS counts people as "uninsured" if they report they were without coverage for all of the previous year.

Based on these data, DPPRD estimates that there are 217,000 uninsured children and 285,000 children with private coverage in the Medicaid income range, 439,000 uninsured single/childless adults and in Medicaid Income Range, 124,000 uninsured single/childless adults in Family Health Plus Income Range, 164,000 uninsured adults with children in Medicaid Income Range, and 164,000 uninsured adults with children in Family Health Plus Income Range. To address concerns for New York's children who are uninsured, the Department and local partners are working diligently to find and enroll the uninsured children who are Medicaid- and Child Health Plus-eligible and their families who may be Family Health Plus-eligible.

The Urban Health Institute reported in June 2004 on the National Survey of America's Families. They reported, based on 2002 figures, that among the uninsured, 27.5% had incomes below the Federal Poverty Level (FPL), 21.2% had incomes between 100 and 200% of the FPL, 11.1% had incomes between 200 and 399% of the FPL, and 5.3% of the uninsured had incomes 300% or higher than the FPL. People living in metropolitan areas were slightly more likely to be uninsured than those in non-metropolitan areas (2.1% as opposed to 10.5%). Being uninsured was more common among foreign-born individuals (26.1%) as compared to U.S. born (8.4%). The uninsured were more likely to rate their current health status as fair or poor (23.6%) than excellent, very good, or good (10.3%). 12.8% of the uninsured reported having a limiting disability.

According to the Current Population Survey, the number of uninsured children under the age of 18 in New York State declined from 551,000 in 1999 to 486,000 in 2000, and 425,000 in 2001. In 2004, it was 396,000.

New York has made a huge commitment to public support of health and social welfare services for state residents under Medicaid and other public insurance programs. Additionally, New York has had a Bad Debt and Charity Care Pool for a number of years to cross-subsidize hospitals that bear higher rates of uncompensated care from those with fewer non-paying users. People in need are not turned away from New York's hospitals for inability to pay for services.

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

Expanded Medicaid Eligibility for People Who Have Disabilities: The Medicaid Buy-In Program for People Who Have Disabilities and Work (MDI-WPD) Program is a Medical Assistance option for people who 1.) meet SSI guidelines for a disability; 2.) have a job; and 3.) meet financial requirements of the program. Not all income and assets are counted in the calculations for eligibility, allowing people with disabilities to earn more income and keep more resources without losing their Medicaid coverage.

Access to Emergency Care: A national report card issued by the American College of Emergency Physicians gave New York State high marks in public health and injury prevention, ranking it first in the nation for low incidence of fatal job-related injuries, second for low incidence of fatalities in alcohol-related crashes, and third in per capital expenditure on hospital care. The nation as a whole ranked a C-; New York received a C+. Of greatest concern was capacity to handle an epidemic.

Overall Health: According to the United Health Foundation, the American Public Health Association and the Partnership for Prevention, which regularly assess the overall healthiness of the nation, New York ranked 26th in 2005, which is an improvement over 2003 and 2004 when the ranking was 31st. The improved rating between 2004 and 2005 was due to increased per capita health care spending ($216 to $316), a decrease in the prevalence of smoking (21.6 to 19.9) and a decrease in violent crime (496/100,000 to 430/100,000).

A. Pregnant Women, Mothers and Infants/Women of Childbearing Age

Births: There were 248,876 births in New York State in 2004. Of these, 118,650 (48%) were to residents of NYC and the remaining 130,226 were to Upstate NY residents. This is about 4,000 fewer births than occurred in 2003. The numbers of births were lower as compared to 2003 in both NYC and Upstate.

Table 7. **Resident Live Birth Summary by Mother's Age**
New York State -- 2004

		Mother's Age									
Groups	**Total**	**< 15**	**15-17**	**18-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45 +**	**N. S.**
All Births	248,876	271	5,415	11,612	49,561	63,617	68,532	39,607	9,582	644	35
Race (1)											
White	167,413	128	3,011	6,987	31,228	41,553	48,685	28,509	6,820	477	15
Black	47,028	111	1,888	3,512	11,813	11,810	9,827	6,207	1,756	94	10
Other	34,102	31	508	1,105	6,449	10,178	9,933	4,830	992	72	4
Ethnicity (2)											
Hispanic	56,940	123	2,337	4,206	15,519	15,378	11,757	6,115	1,434	66	5
Marital Status											
Out of Wedlock	93,699	265	5,084	9,902	31,029	22,900	14,263	7,843	2,266	142	5
Married	151,969	6	310	1,624	18,066	40,057	53,218	31,058	7,146	484	0

(1) Race coding based on 2000 Census categories: White Alone, Black Alone, Other, Not Stated.

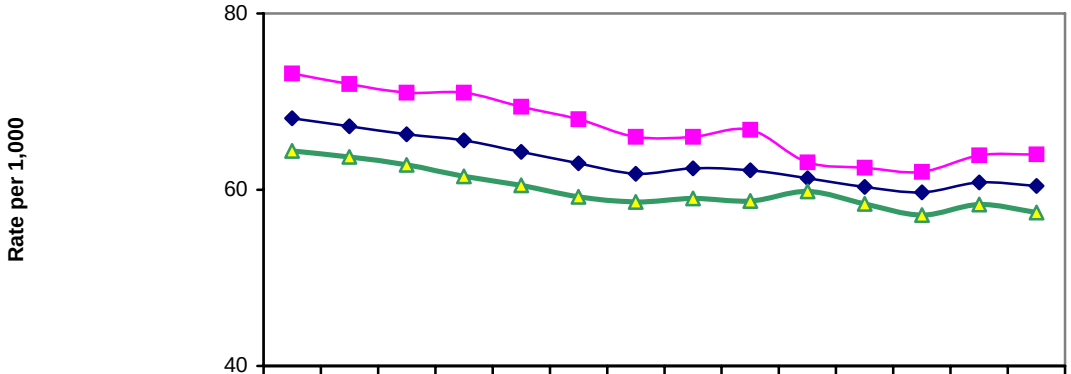
(2) Hispanic is a separate count equal to Hispanic White Alone + Hispanic Black Alone + Hispanic Other + Hispanic Race Not Stated

In 2004, white births accounted for 67 percent of all births while black births represented 19 percent of the total. Fourteen percent of births were in the "other" category. This includes births to persons of multiple race as well as all other races. The majority of births occurred to women between the ages of 20 and 39 (89%). Women aged 45 plus had 644 births and women under fifteen had 271.

Out of wedlock births accounted for 37.6 percent of total births. This is similar to 2003 when 36.8 percent of births were out of wedlock. Mothers 17 years of age and younger were more likely (94%) to be unmarried compared to mothers aged 25 or older (26%). Out of wedlock births were also more common among black (68.1%) and Hispanic (61.6%) mothers.

Birth Rates: After declining from 2000-2001, the birth rates increased slightly again from 2002 to 2003 to 60.8% per 1000 females aged 15 to 44 years. In 2004 the rate was about the same as 2003 (60.4/1,000). New York City rates (at 64.0 per 1,000) were higher than rates for the rest of the State (57.4 per 1,000). The New York City rate was virtually unchanged, while the rate for the rest of the State was slightly lower.

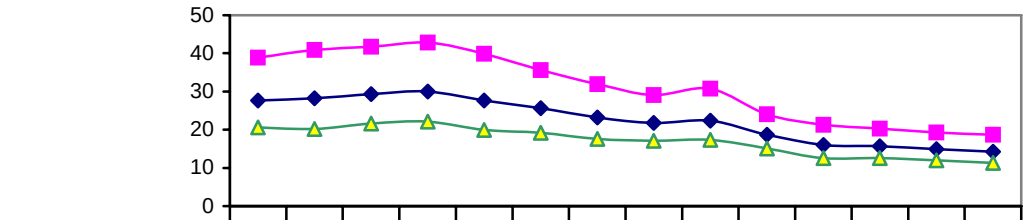
Figure 8: **Births to Females Ages 15 to 44**
New York State by Region, 1991-2004



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
New York State	68.1	67.2	66.3	65.6	64.3	63	61.8	62.4	62.2	61.3	60.3	59.7	60.8	60.4
New York City	73.2	72	71	71	69.4	68	66	66	66.8	63.1	62.5	62	63.9	64
Rest of State	64.4	63.7	62.8	61.5	60.5	59.2	58.6	59	58.7	59.8	58.4	57.1	58.3	57.4

Adolescent Birth Rates: Birth rates decreased for the 5th year in a row in the 15- to 17-year old group; the 2004 rate was 14.2. The rate has decreased about 24% from 2000 to 2004. Both New York City and Rest of State rates have been declining. The New York City rate, at 18.7 per 1,000, is higher than the Rest of State rate, which was 11.3 per 1,000 young women between the ages of 15 and 17. Birth rates among Black and Hispanic teens were significantly higher than among White teens. During 2004 there were 34.4 births for every 1,000 Hispanic teen girls aged 15-17 in New York State. This is more than 3 times the rate for White teens (11.1 per 1,000) in this age group. Among Black 15-17 year olds the birth rate, at 22.2 per 1,000, was exactly double the rate for white teens.

Figure 9. **Births per 1,000 Females Ages 15 - 17**
New York State by Region 1991 - 2004

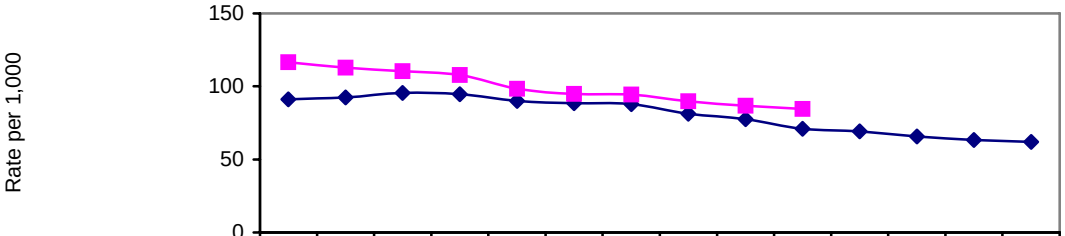


	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
New York State	27.6	28.2	29.3	30	27.6	25.6	23.2	21.8	22.4	18.7	16	15.7	14.9	14.2
New York City	38.9	40.9	41.7	42.8	39.9	35.6	31.9	29.1	30.7	24	21.3	20.3	19.3	18.7
Rest of State	20.6	20.2	21.6	22.1	19.9	19.2	17.6	17.1	17.3	15.1	12.6	12.6	12	11.3

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

Although New York's adolescent pregnancy rate is lower than the national average, New York is still working hard to decrease pregnancies in this age group. Since 1993 the pregnancy rate for girls aged 15-19 has been decreasing; the 2004 rate of 61.9 per 1,000 is 35% lower than the 1993 high of 95.4/1000.

Figure 10. **Teen Pregnancy Rates per 1,000 Women Ages 15 - 19**
New York and United States 1991 - 2004

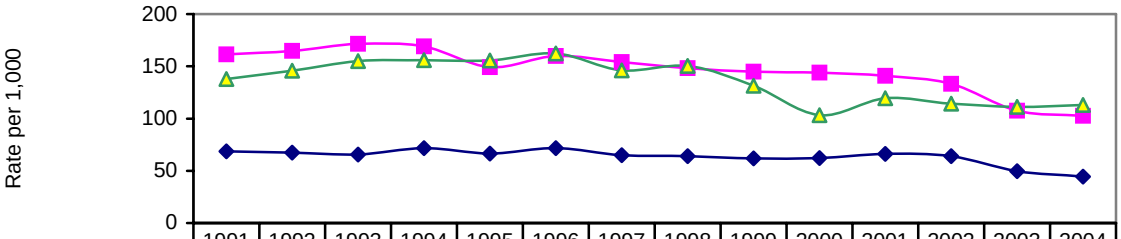


	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
New York State	91	92.3	95.4	94.7	90.1	88.5	87.8	81.3	77.5	71	69.1	65.8	63.3	61.9
United States	117	113	110	108	98.3	94.8	94.3	89.8	86.7	84.5	DNA	DNA	DNA	DNA

DNA = Data not available.

Among African Americans and Hispanics in this age group, the pregnancy rates are double the rate of White teens. Teen pregnancy rates declined between 2001 and 2002 among African American, White and Hispanic teens. In 2003, due to a change in reporting of population data by race/ethnicity, the rates are not comparable to past years. (Reporting of Numerator data was unchanged). Between 2003 and 2004 small declines were seen for white and black teens while the rate for Hispanic teens increased slightly.

Figure 11. **Pregnancy Rate per 1,000 Women Ages 15 - 19**
New York State Residents by Race 1991 - 2004



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White	68.7	67.3	65.5	71.7	66.5	71.6	64.9	64	61.8	62.2	66.1	64.1	49.7	44.3
Black	161.3	164.8	171.5	169.2	149.1	160	154	148.3	145	143.8	141	133.1	107.4	102.6
Hispanic	137.9	145.7	155.1	155.9	155.6	162.2	146.2	150.3	131.5	103.3	119.4	114.1	111.3	112.9

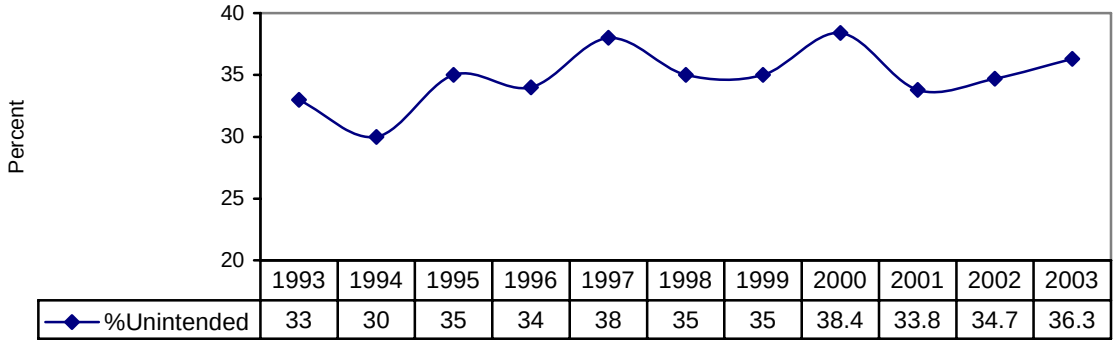
Unintended Pregnancy: In 2003, over one third of new mothers responding to the PRAMS survey indicated that their pregnancy was unwanted or mistimed (36.3%). This rate is an improvement over the 2000 rate of 37.8% but is higher than the 2001 rate of 33.8% and the 2002 rate of 34.7%.

Groups at highest risk for unintended pregnancy in 2003 were women under the age of 20 (66.1%); women who were not married (63.2%); African American women (71.1%); women on Medicaid (57.6%); and women with less than a high school education (53.2%). Almost 65% of women reported that they wanted their pregnancy either when it occurred (45.0%), or earlier (18.7%).

Table 9. **Responses to Question on Intendedness of Pregnancy PRAMS Survey 1998 to 2004 (Does not include NYC)***

Response:	**1999**	**2000**	**2001**	**2002**	**2003**
Total reporting pregnancy was unwanted or mistimed	35.1%	38.4%	33.8%	34.7%	36.3%
Of those that were:					
Under age 20	82.3%	76.4%	77.5%	81.7%	66.1%
Unmarried	68.0%	67.9%	60.1%	63.2%	63.2%
African American	55.3%	64.8%	56.6%	62.3%	71.1%
On Medicaid	61.7%	57.9%	56.6%	57.2%	57.6%
Less than high school education	57.2%	51.2%	57.1%	51.9%	53.2%
Total reporting pregnancy was wanted when it occurred	42.9%	44.5%	44.6%	44.1%	45.0%
Total reporting pregnancy was wanted earlier	22.0%	17.2%	21.6%	21.2%	18.7%

Figure 12. **Women Whose Pregnancy Was Unintended**
New York State Excluding New York City 1993 - 2003
Source: PRAMS Survey

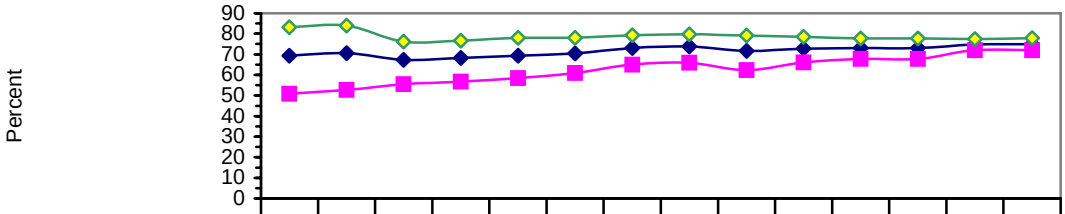


*NYC PRAMS data is not included due to low response rate in NYC.

Prenatal Care: In 2004, the percent of women giving birth in New York State who received early prenatal care was 74.9, relatively unchanged from the 2003 percentage of 74.7. These rates were, however, an improvement over the 2001 and 2002 rates of 73.0 percent; and the 2000 rate of 72.8 percent. Between 1998 and 1999 the percent actually declined slightly. This was partially due to New York City Department of Health changing their method of accounting for "unknowns" recorded for "entry to prenatal care." Prior to this decline, there had been improvement in rates of women receiving prenatal care in the first trimester of pregnancy.

From 1994 to 1998, the percent of New York women accessing early prenatal care had increased 8.2% to 73.8%. Much of that improvement occurred among New York City residents where the percent increased from 56.8% in 1994 to 65.9% in 1998. Although the New York City rate slipped to 62.4% in 1999, the 2000 rate was up to 66%. In 2001 and 2002, the City rate reached 67.7%. The City rate improved to 71.9% in 2003 and 72 percent in 2004. In the rest of the State, the rate went from 76.7% in 1994 to 79.7% in 1998. Rest of State rates dropped slightly in 1999 and 2000 to 78.5%. Between 2001 and 2003, the rate declined further to 77.4 percent. The 2004 rate was 77.8%. These rates are still below the Healthy People 2010 goal of 90%.

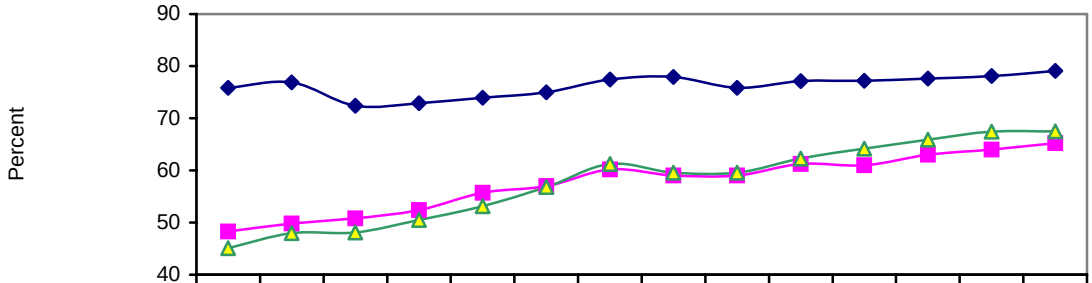
Figure 13. **Early (First Trimester) Prenatal Care**
New York State, New York City and Rest of State, 1991 - 2004



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
New York State	69.3	70.5	67.3	68.2	69.4	70.4	73.1	73.8	71.7	72.8	73	73	74.7	74.9
New York City	50.9	52.7	55.5	56.8	58.5	61	64.9	65.9	62.4	66	67.7	67.7	71.9	72
Rest of State	83.2	84	76.2	76.7	78.1	78	79.2	79.7	79.1	78.5	77.7	77.7	77.4	77.8

Early prenatal care rates in 2004 were slightly improved for African American and white moms and was relatively unchanged for Hispanic/Latina moms. The Black-to-White ratio for early entry into prenatal care was 0.82, based on rates of 65.2% and 79.1%.

Figure 14. **Early (First Trimester) Prenatal Care**
By Race, NY State 1991 - 2004



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White	75.8	76.9	72.4	72.9	73.9	75	77.4	77.9	75.8	77.1	77.2	77.6	78.1	79.1
Black	48.3	49.8	50.8	52.4	55.7	57	60.2	59	59	61.2	61	63	64	65.2
Hispanic	45.1	48	48.1	50.5	53.1	56.8	61.2	59.6	59.6	62.3	64.2	65.9	67.4	67.5

Adequacy of Prenatal Care: The Kotelchuk Index is a calculation based on the number of women ages 15 to 44 who had a live birth during the reporting year whose observed-to-expected number of prenatal visits is greater than 80%. In other words, this index tracks the percentage of women who have completed at least 80% of the prenatal visits that they would be expected to have completed. The Kotelchuk percentages for New York women ages 15 to 44 in New York improved from 2003 in both New York City and the rest of the state and for all racial groups.

Table 10. **Adequacy of Prenatal Care (Kotelchuk Index)**
Women Ages 15 – 44 years Who Gave Birth in that Year
By Region and By Race, 1992 – 2004

	Year →	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04
Region	New York City	43.9	44.4	45.8	48.7	52.5	55.4	56.1	57.6	57.6	56.6	56.5	57.8	59.9
	Rest of State	77.1	70.5	71.9	72.3	71.5	73.2	73.9	73.8	72.3	69.7	69.9	67.6	72.7
	Total NYS	62.7	59.2	60.3	61.8	63.1	65.6	66.4	66.9	65.6	63.5	63.6	63.1	66.4
Race	White	69.5	65.4	65.9	66.9	67.9	70.5	71.2	71.5	70.1	68.0	68.6	66.6	70.2
	Black	40.3	39.7	42.0	38.6	41.5	51.0	51.7	52.9	53.4	50.6	51.8	49.8	53.0
	Hispanic	40.8	39.5	42.0	46.0	50.1	54.0	55.5	56.2	56.1	55.0	57.1	55.8	57.8

Location of Prenatal Care: PRAMS responses indicate that 75% or more of women reported in 2003 that they received their prenatal care in physicians' offices (private MDs or health maintenance organizations). Other sources of care were hospital clinics (12%), and community health centers (5%). In the past few years, health department clinics provided less prenatal care: 5.7% in 1998, 4.6% in 2000, and 3.5% in 2001 and 2002. In 2003, 4 percent of women surveyed received care in health department clinics.

Content of Care: PRAMS questions on prenatal care elicited responses to indicate that most women received educational information during their pregnancy on nutrition, drinking, smoking, and HIV testing. According to the 2003 survey, of the 94% of women that recall education on HIV testing being given by their provider, 97% went on to be tested during their pregnancy. In 1998, 76.6% went on to be tested and in 2000, 81% went on to be tested. The percentage is steadily increasing.

The proportion on women who reported via PRAMS having read or heard about the importance of folic acid intake in prevention of birth defects increased from 67.9% in 1996 to 77.3% in 1998 to 85.1% in 1999. In 2002 and 2003, women were asked if they could identify the reason folic acid is important in a multiple choice question. 91 percent of the women answered this question correctly.

Use of Alcohol and Tobacco during Pregnancy: Smoking during pregnancy can cause stillbirth, low birthweight, SIDS and other serious pregnancy complications. About 26% of women who responded to the PRAMS survey in 2003 reported that they had smoked in the three months prior to pregnancy (up from 23.3% in 2002), and though most reported that they reduced their smoking during pregnancy (15% in 2003 reported that they smoked in the last three months), many reported in 2003 that they returned to smoking more frequently after pregnancy than during pregnancy. In doing so, they are exposing their infants to second-hand smoke. The percentage of those that smoked after pregnancy, however, was consistently lower than the percentage that smoked before pregnancy.

Drinking alcohol during pregnancy is associated with fetal alcohol syndrome, a birth defect that is 100 percent preventable by not drinking alcohol during pregnancy. Women sampled in the PRAMS survey reported that they reduced the use of alcohol during pregnancy. In 2003, 54% reported drinking alcohol in the three months prior to pregnancy, but only 6% drank alcohol during the last three months of pregnancy. This percentage is down from 8% of the women sampled who reported drinking alcohol during pregnancy in 2002 and 7% in 2001 and 2000.

Adult Smoking: The American Cancer Society estimates cigarette smoking alone is directly responsible for approximately 30% of all cancer deaths and about 87% of all lung cancer deaths. In addition, smoking by pregnant women is linked to poor birth outcomes and SIDS.

According to studies commissioned by the New York City Department of Health and Mental Hygiene, the number of adult smokers in New York City declined by 11% from 2002 to 2003. This was believed to be one of the steepest short-term declines experienced in recent years. Researchers from Baruch College, who conducted the telephone survey, found that the number of regular smokers decreased by more than 100,000 between 2002 and 2003. The study also found that the number of cigarettes smoked by those surveyed declined by about 13%, indicating that people are smoking less. City health officials attribute this decline to tough anti-smoking laws and high cigarette taxes. These findings also coincide with a new state law that bans smoking in bars and restaurants and a city-wide anti-smoking campaign. (A later section of the Needs Assessment details youth smoking rates.)

In 1990, according to the Behavioral Risk Factor Surveillance Survey (BRFSS) 22.5 percent of the population considered themselves a current smoker; in 2000, 21.6%; and in 2005, 20.5% (BRFSS). This is similar to the nationwide usage of 20.6%. Tobacco use was highest among the 18 to 24 age group at 26.6% and least in the 65 + age group at 8.8%. BRFSS also shows evidence that New Yorkers are trying to quit smoking: in 2005, 40% of current smokers surveyed indicated they had tried to quit smoking at least once during the past year.

The first annual independent evaluation of New York's Tobacco Control Program, conducted by the Research Triangle Institute (RTI) of North Carolina showed that smoking among adults declined to an all-time low of 18.1 percent in 2004. 2003 New York rates

were at 20.5%. Comparable US rates were 21.6 percent in 2003 and 20.0 percent in 1004. In addition, the study showed marked reductions in New Yorkers' exposure to second hand in-home smoke, a decline in per capita cigarette consumption that outpaced the national average, and very high compliance with the Clean Indoor Air Act, which lead to reductions in workplace secondhand smoke exposure.

Also according to the RTI study, tobacco companies are estimated to spend $830 million in New York on advertising and tobacco promotion. New York has spent $165 million over the last four years to prevent and reduce tobacco use.

Oral Health of Adults: The Behavioral Risk Factor Surveillance System (BRFSS) is the main source of data on the prevalence of dental diseases and risk factors in adults. It is an ongoing statewide telephone-based surveillance system designed by the Centers for Disease Control and Prevention (CDC). BRFSS monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in the population. New York State's BRFSS sample represents the non-institutionalized adult household population, aged 18 years and older. The oral health module includes questions on tooth loss and use of dental services. The data on oral cancer are available through the Cancer Registry. In addition, the Pregnancy Risk Assessment and Monitoring System (PRAMS) provides data on risk factors in pregnant women.

Tooth Loss in Adults - Dental caries (tooth decay) and advanced periodontal (gum) diseases ultimately lead to loss of some or all teeth, if not treated in a timely manner. Tooth loss is indicative of the importance given to oral health, availability and accessibility of dental care and the prevailing standard of care. Loss of all natural permanent teeth not only considerably reduces daily functioning in terms of chewing and speaking, but also reduces self-esteem and quality of life. According to the 2005 Behavioral Risk Factor Surveillance System, the percent of adults 65 years and older that had lost all their natural teeth was 16.9%. The percentage was lower at each successive educational and income level.

Oral and Pharyngeal Cancers - These cancers are not usually an issue for the MCH population, but have implications for later in life. Some of the same risk factors for pregnant women and youth are risk factors for oral cancers.

Data from the New York State Cancer Registry show an annual average of 1,916 new cases and 476 deaths of oral and pharyngeal cancer for the period 1999-2003. An average of 1,267 new cases occurred in males and 649 in females. These oral and pharyngeal cancers account for approximately 2.7% of all malignancies in men and 1.4% in women. The age adjusted incidence rates per 100,000 for males and females are 14.6 and 3.7, respectively, with corresponding age adjusted mortality rates of 3.7 and 1.4 in the same period. Trends in incidence and mortality for oral and pharyngeal cancer in New York State show that both the incidence and mortality have declined in the last 2 decades, particularly among black males. However, black males still have the highest incidence and mortality rates. Despite advances in surgery, radiation and chemotherapy, the five-year survival rate for oral cancer has not improved significantly over the past several decades. The percentages of cases diagnosed at an early stage in 2003 were 30.1% and 45.1% among males and females, respectively. African American's higher mortality can be partly attributed to the fact that their cancers are more often discovered at an advanced stage. Among black males, only 21.9% were diagnosed in an early stage.

Risk factors and protective factors for adult oral health include tobacco and alcohol use and annual dental visits. Tobacco use is one of the most common risk factors for oral

cancer and other conditions in the mouth such as oral mucosal lesions, periodontal disease, gingival recession, and caries. The magnitude of the effect of tobacco on the occurrence of oral diseases is high, with users having many times the risk of non-users. Alcohol and tobacco use are the major risk factors for oral cancer, accounting for 75% of all oral cancers. According to the 2005 BRFSS, the statewide current use of tobacco is about 20.5%; heavy alcohol use (female having more than one drink per day or male having at least 2 drinks per day) in New York State is about 5%.

An annual dental visit presents an opportunity for providing preventive services as well as early detection of oral lesions. According to the 2004 BRFSS data an estimated 70.0% of New Yorkers reported visiting a dentist or a dental clinic within the past year. This compares favorably with the Healthy People 2010 Objective of increasing the proportion who uses the oral health care system each year to 56%. The lower income population visited a dentist less frequently compared to those with higher incomes (54% vs. 82%).

Oral Health and Pregnancy - Evidence is emerging to show that poor oral health may be associated with adverse pregnancy outcomes. Several studies have shown the associations between periodontal disease and increased risk for preterm labor and low birth weight babies. Visits to a dentist during pregnancy are recommended to avoid the consequences of poor oral health. In NYS in 2003, 47 percent of pregnant women, as estimated from the Pregnancy Risk Assessment and Monitoring System (PRAMS) used dental services during their pregnancies. The percentages were 51.4% and 22.7% among white and black women, respectively.

Because New York is concerned about the potential effect of poor oral health prior to and during pregnancy, because of potential effects of maternal oral health on early childhood caries, and because there are no national standards for the oral health care of women during pregnancy, New York convened an expert panel of obstetricians, dentists and pediatricians to formulate guidelines for the oral care of women during pregnancy and for the prevention of early childhood caries. The guidelines are completed and are now ready for distribution.

Maternal Stress and Violence: Stress during pregnancy is linked to a number of social and reproductive risks. Not surprisingly, the greater the number of stressors that the women reported, the less likely the woman was to report, "Pregnancy was one of the happiest times of [her] life." In 2003, those describing pregnancy as "one of the happiest times of [their] life" reported an average of 1.9 stressors, while those that described pregnancy as "one of the worst times of [their] life" reported an average of 4.6 stressors.

In 2003, 27% of those surveyed reported that it was "one of the happiest times of [their] life." 3% reported that it was "one of the worst times of [their] life." Most reported that it was somewhere in between:

- 53% reported that it was "a happy time with a few problems;"
- 12% responded that it was a "moderately hard time;"
- 5% reported that it was a "very hard time."

In 2003, the same percent of PRAMS respondents reported they experienced physical abuse during pregnancy as reported abuse during the 12 months before they were pregnant (3%). This is lower than what was reported in 2002 when 5% reported abuse prior to pregnancy and 4% reported abuse during their pregnancy.

Table 11. Tracking of Selected PRAMS Responses, 1996 – 2003								
Percent of mothers who reported that…	**'96**	**'97**	**'98**	**'99**	**'00**	**'01**	**'02**	**'03**
…they drank alcohol during pregnancy	9.0	8.3	7.4	7.2	6.5	6.7	8.2	6.2
…they smoked prior to pregnancy	29.1	32.1	28.0	28.0	27.1	24.8	23.3	25.6
…they smoked during pregnancy	15.6	18.6	13.8	15.7	17.0	14.4	14.6	14.6
…they smoked after pregnancy	22.5	26.0	21.7	22.8	22.4	20.6	19.3	19.2
…they were physically abused in pregnancy	4.4	4.9	5.0	5.0	3.7	4.2	4.4	3.4
…their pregnancy was unwanted/ wanted later	34.1	38.4	35.3	35.1	38.4	33.8	34.7	36.3
…they initiated breastfeeding	63.4	64.7	66.9	67.0	69.1	68.6	72.1	71.6
…they put their babies to sleep on their side	41.5	34.9	29.5	25.1	20.2	15.3	15.0	14.3
…back	34.5	45.2	53.0	56.7	66.3	68.5	69.4	70.9
…stomach	24.0	19.9	17.4	18.2	13.3	15.9	15.1	14.4
…their babies were exposed to 2nd hand smoke	11.3	9.4	6.9	6.8	9.9	9.4	7.7	5.3
…knew that folic acid can prevent birth defects	67.9	78.2	77.3	81.3	92.0	90.5	90.7	90.7

Prenatal HIV Counseling and Testing: Since 1990, there has been a 66% decline in HIV infected women giving birth in New York State. Specifically, the number of HIV infected women giving birth in the state went from 18,981 in 1990 to 642 in 2004. As of December 2004, women represented 25.3% of total AIDS cases in the State.

The percent of women who were aware of their HIV status prior to delivery in New York State has increase significantly. In 1997, only 64% of women knew their HIV status prior to delivery. In 2004, 95% were aware of their status. This information allows providers to administer drugs in time to reduce perinatal transmission.

Prenatal care enrollment among HIV-positive women is increasing. If women are enrolled in care, they can more easily obtain prenatal counseling and testing. The percent of HIV-infected women who received prenatal care increased to 92.4% in 2001, up from 88.5% in 1997.

An increasing percentage of prenatal women are receiving HIV counseling and testing. The percent of all women presenting for delivery who were tested during pregnancy increased in 2004 to 95% from 89% in 2000 and 46.7% in 1999.

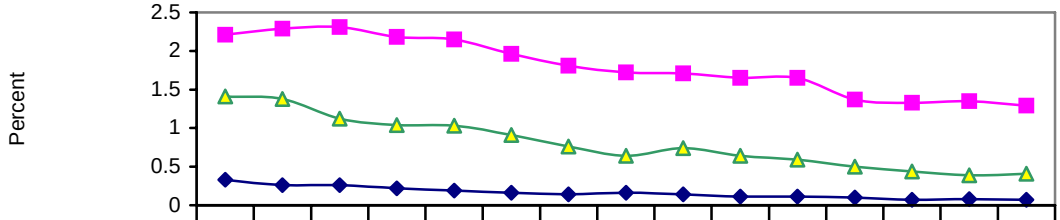
Currently in New York, perinatal HIV counseling and testing are a standard of prenatal care. In 1996, the Department promulgated regulations requiring HIV counseling with testing recommended for all women in prenatal care in regulated facilities (licensed clinics, hospitals, and managed care plans).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

Perinatal HIV Transmission Rates: As a result of various State initiatives, perinatal HIV transmission rates declined dramatically from 1997 through 2004. In 1997, the perinatal HIV transmission rate was 10.9 percent with 97 HIV-positive infants born. In 2000, it was 3.6 percent (28 HIV- positive infants) and in 2003, 1.2 percent (8 HIV-positive infants). In 2004, the rate was up slightly to 2.8 percent resulting in 16 HIV-positive infants.

The percent of HIV-infected mothers and/or HIV-exposed infants who received prenatal, intrapartum or neonatal ARV to reduce HIV transmission increased from 63.8% in 1997 to 98.1% in 2002.

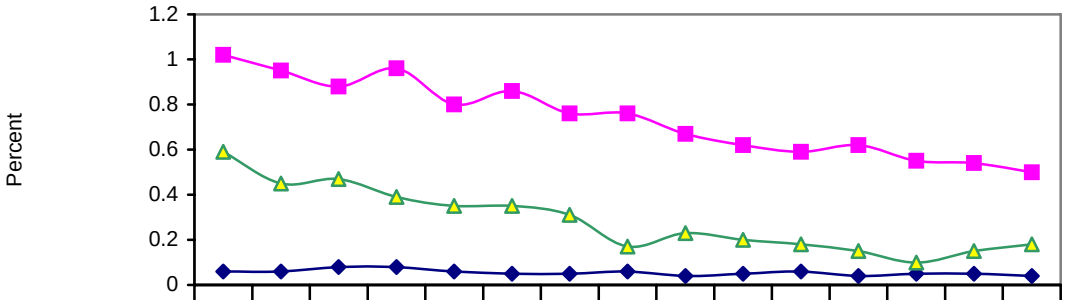
Perinatal HIV Seroprevalence Rates: Perinatal prevalence rates are significantly higher in African American and Hispanic/Latina women and significantly higher in New York City residents.

Figure 15. **HIV Prevalence in Childbearing Women**
New York City Residents by Race 1989 - 2003



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	0.33	0.26	0.26	0.22	0.19	0.16	0.14	0.16	0.14	0.11	0.11	0.1	0.07	0.08	0.07
Black	2.21	2.29	2.31	2.18	2.15	1.96	1.81	1.72	1.71	1.65	1.65	1.37	1.33	1.35	1.29
Hispanic	1.41	1.38	1.12	1.04	1.03	0.91	0.76	0.64	0.74	0.64	0.59	0.5	0.44	0.39	0.41

Figure 16. **HIV Prevalence in Childbearing Women**
New York State, Excluding NYC Residents, by Race 1989 - 2003

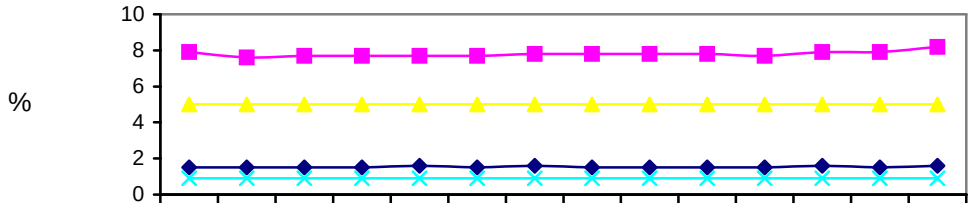


	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	0.06	0.06	0.08	0.08	0.06	0.05	0.05	0.06	0.04	0.05	0.06	0.04	0.05	0.05	0.04
Black	1.02	0.95	0.88	0.96	0.8	0.86	0.76	0.76	0.67	0.62	0.59	0.62	0.55	0.54	0.5
Hispanic	0.59	0.45	0.47	0.39	0.35	0.35	0.31	0.17	0.23	0.2	0.18	0.15	0.1	0.15	0.18

New York's partner/spousal notification law is in effect. The Department tracks the effects on HIV transmission rates. It is important to note that the law contains a mandate that providers screen for risk of domestic violence.

Low and Very Low Birth Weight: Changes in low birth weight rates for the last decade have not paralleled the decrease in infant mortality. Rates of births with infants weighing less than 1500 grams and less than 2500 grams have been relatively unchanged over the past ten years and have actually increased slightly between 2003 and 2004. The 2004 low birth weight rate of 8.2% is 64% greater than the Healthy People 2010 goal of 5.0%, and the rate of 1.6% for very low birth weight is 78% greater than the Healthy People 2010 goal of 0.9%.

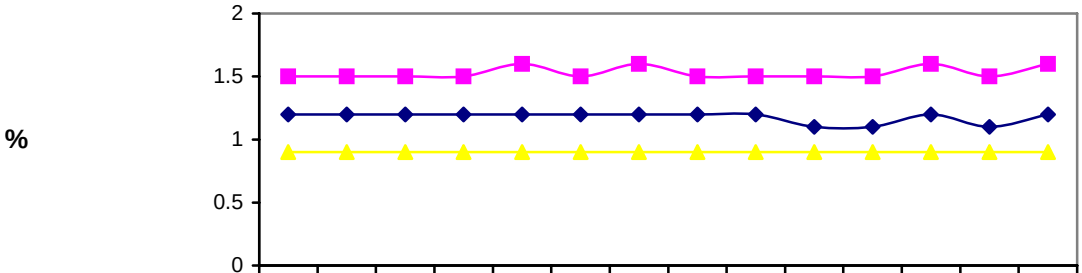
Figure 17. **Percent Low (<2.5 kg) and Very Low (<1.5 kg) Birth Weight**
New York Total Births 1991 - 2004



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Very Low Birthweight	1.5	1.5	1.5	1.5	1.6	1.5	1.6	1.5	1.5	1.5	1.5	1.6	1.5	1.6
Low Birthweight	7.9	7.6	7.7	7.7	7.7	7.7	7.8	7.8	7.8	7.8	7.7	7.9	7.9	8.2
HP Goal/LBW	5	5	5	5	5	5	5	5	5	5	5	5	5	5
HP Goal/VLBW	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9

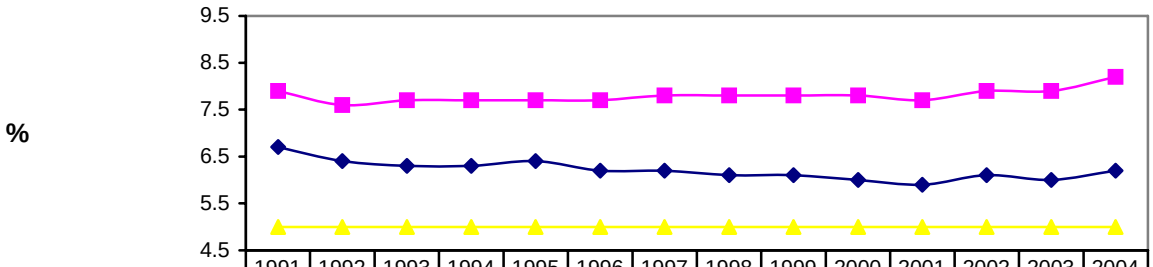
When low birth weight rates for total births are compared to those for singleton births, the latter shows a slight decreasing trend. Multiple births seem to be responsible for a portion of the lack of change in these rates over the last ten years. Multiple births are more common due to advances in the technology of assisted reproduction.

Figure 18. **Percent Very Low Birth Weight (<1500 gm)**
New York Singleton and Total Births 1991 - 2004



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Singleton	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.1	1.1	1.2	1.1	1.2
Total Births	1.5	1.5	1.5	1.5	1.6	1.5	1.6	1.5	1.5	1.5	1.5	1.6	1.5	1.6
HP Goal/VLBW	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9

Figure 19. **Percent Low Birth Weight (<2500 gms)**
New York Singleton and Total Birth 1991 - 2004

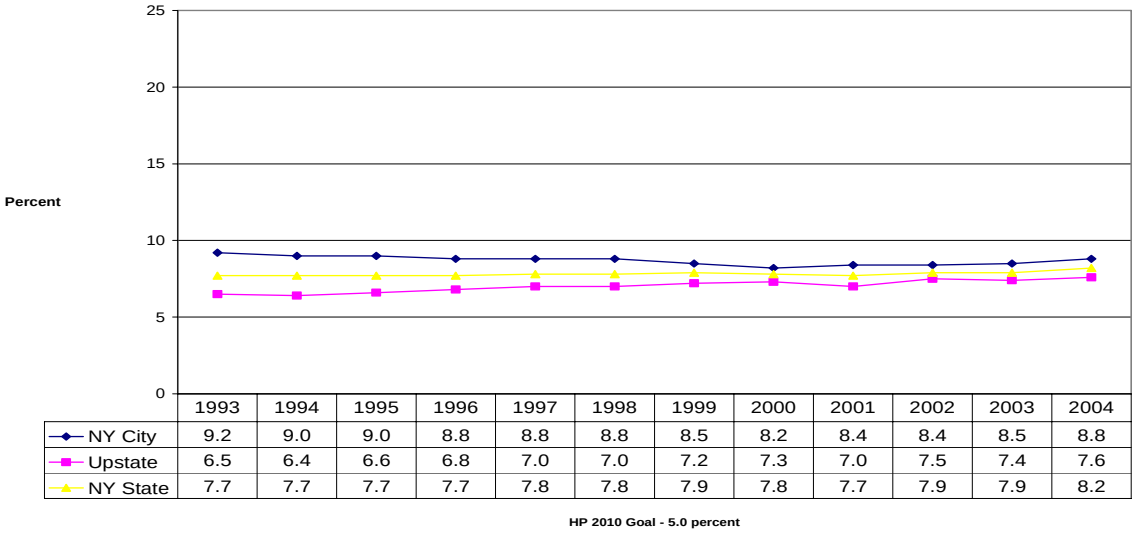


	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Singletons	6.7	6.4	6.3	6.3	6.4	6.2	6.2	6.1	6.1	6	5.9	6.1	6	6.2
Total	7.9	7.6	7.7	7.7	7.7	7.7	7.8	7.8	7.8	7.8	7.7	7.9	7.9	8.2
HP Goal/LBW	5	5	5	5	5	5	5	5	5	5	5	5	5	5

WIC participants in New York State fare better than WIC participants nationwide as well as non-WIC participants in relation to low birth weight. In 2002, the percentage of low birth weight was 7.4% among NYS WIC participants, compared to 9.0% of WIC participants nationwide, and compared to a statewide total low birth weight rate of 7.9%. In 2004, the NYS WIC low birth weight rate was 7.7%, compared with 9.1% for WIC nationwide.

Low Birth Weight by Region: Low birth weight rates have been consistently higher in NYC as compared to rest of State. In New York City the low birth weight rate declined from 9.2% in 1993 to 8.2% in 2000. Since 2001, however, the rate either stayed the same or increased slightly and was up to 8.8% in 2004. In Rest of State the rate increased from 6.5% in 1995 to 7.3% in 2000. The rate declined in 2001 to 7.0% but increased again between 2002 and 2004 to 7.6 percent.

Figure 20. **Low Birthweight (<2.5kg) Rate**
New York State, Upstate and NYC
1993 - 2004

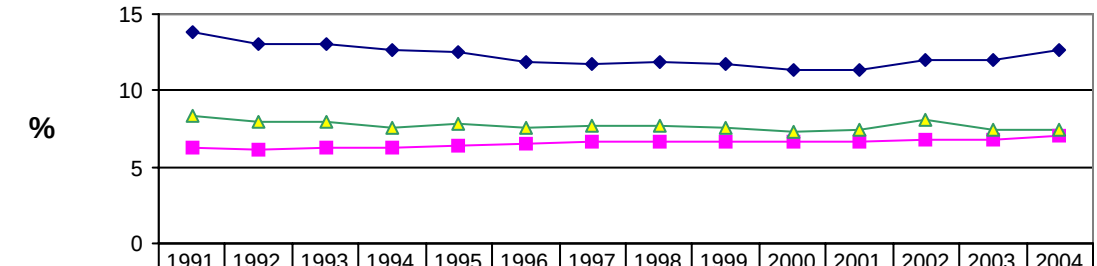


	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
NY City	9.2	9.0	9.0	8.8	8.8	8.8	8.5	8.2	8.4	8.4	8.5	8.8
Upstate	6.5	6.4	6.6	6.8	7.0	7.0	7.2	7.3	7.0	7.5	7.4	7.6
NY State	7.7	7.7	7.7	7.7	7.8	7.8	7.9	7.8	7.7	7.9	7.9	8.2

<u>Low Birth Weight Trends by Race and Ethnicity</u>: Between 1991 and 2001 the Black low birth weight rate declined steadily from 13.8% to 11.3%. In 2002 and 2003, however, it increased to 12 percent and in 2004 to 12.6 percent. Among Hispanics the low birth weight rate went from 8.3% in 1991 to its lowest point of 7.3% in 2000. Since 2000 it has fluctuated between 7.4 and 7.5 percent. Among whites, unlike the other groups, the low birth weight rate in 2004 was higher than it was in 1991. The rate has increased from about 6.2% in the early 1990s to 6.7% between 1997 and 2001. In 2002 and 2003 it was 6.8% and in 2004 it was 7.0 percent.

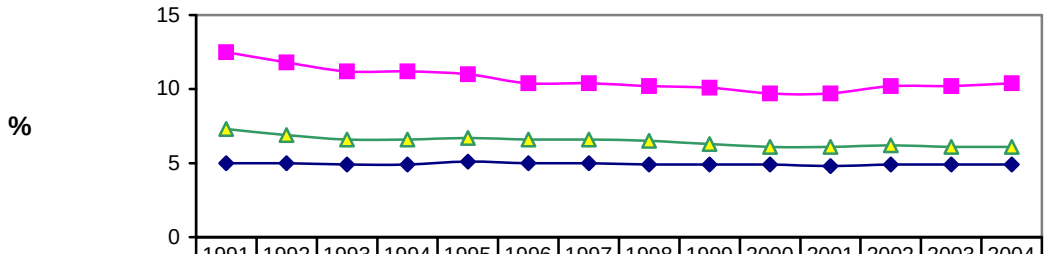
Trends in singleton low birth weight rates were similar to what was seen for total births among blacks and Hispanics. Among whites, however, the increase that occurred in total births was not seen in singleton births. The white singleton low birth weight rate was virtually unchanged between 1991 (5.0%) and 2004 (4.9%).

Figure 21. **Percent Low Birth Weight (<2.5 Kg.)**
NYS by Race 1991- 2004



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Black	13.8	13.1	13.1	12.7	12.5	11.9	11.8	11.9	11.7	11.4	11.3	12	12	12.6
White	6.2	6.1	6.2	6.2	6.4	6.5	6.7	6.7	6.7	6.7	6.7	6.8	6.8	7
Hispanic	8.3	7.9	8	7.6	7.8	7.6	7.7	7.7	7.6	7.3	7.4	8.1	7.4	7.5

Figure 22. **Percent Low Birth Weight (<2.5 Kg.)**
NYS Singleton Births by Race 1991-2004



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White	5	5	4.9	4.9	5.1	5	5	4.9	4.9	4.9	4.8	4.9	4.9	4.9
Black	12.5	11.8	11.2	11.2	11	10.4	10.4	10.2	10.1	9.7	9.7	10.2	10.2	10.4
Hispanic	7.3	6.9	6.6	6.6	6.7	6.6	6.6	6.5	6.3	6.1	6.1	6.2	6.1	6.1

Ratio of Black to White Low Birth Weight rates: Disparities in low birth weight rates have shown improvement over time, but still persist. These disparities may be measured in the ratio of the Black low birth weight rate to the White low birth weight rate. The ratio has improved from 1991, when it was 2.2. The 1998 Black-to-White ratio for low birth weight based on the total number of births for each race was 1.8 based on rates of 11.9 and 6.7. From 1999 to 2001, the ratio was 1.7. From 2002 through 2004, it was 1.8. The trend is also seen in Black-to-White low birth weight rates for singleton births, a reduction from 2.5 in 1991 to 2.0 in 2000 and 2001. In 2002 through 2004, it was 2.1.

Table 12. **Ratio of Black Low Birth Weight Rate to White Low Birth Weight Rate Total Births, 1998-2004**

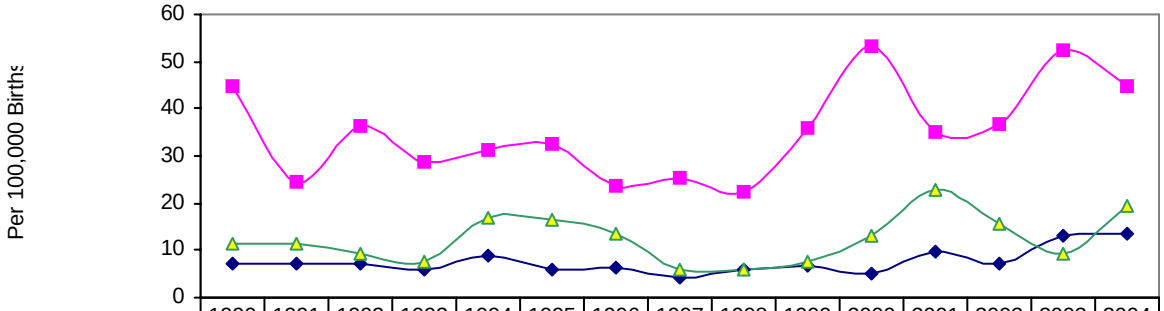
Year	1998	1999	2000	2001	2002	2003	2004
Ratio	1.8	1.7	1.7	1.7	1.8	1.8	1.8

Maternal Mortality: Maternal Mortality was down slightly to 20.5 per 100,000 live births in 2004 from 20.9 in 2003. The decline was due to a reduction in the Rest of State rate from 18.7 in 2003 to 16.9 per 100,000 live births in 2004. During this same time period, the New York City rate increased slightly from 23.9 to 24.4. Before this slight improvement, between 2002 and 2003, the statewide maternal mortality rate had increased from 13.2 to 20.9 per 100,000 live births. This was primarily due to an increase in maternal mortality in the areas of the state outside New York City where the rate went from 4.5 in 2002 to 17.7 in 2003. Prior to 1998, the rate had been declining. Between 1990 and 1997, the rate dropped 47% to an all-time low of 9.3 per 100,000 births. Between 1998 and 2001, however, the rate doubled to 20.1. The 2002 decline was the first since that time, but the decline did not continue in 2003.

The rate in 1997, when the rate was the lowest, is based on 24 maternal deaths. In 2003, there were 53 maternal deaths with a rate of 20.9 per 100,000 live births and in 2004 there were 51 deaths with a rate of 20.5.

The maternal mortality rate in 2004 of 20.5 per 100,000 births is 6.2 times the Healthy People 2010 goal of 3.3 per 100,000.

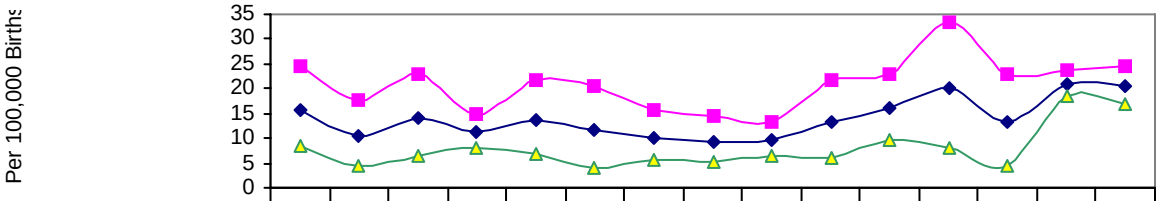
Figure 23: **Maternal Mortality Rate**
1990-1998 ICD9 Codes 630 to 676
1999-2002 ICD10 Codes 000-099
New York State Residents by Race 1990 - 2004



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White	7.3	7	7.1	5.9	8.9	6.1	6.3	4.4	6	6.6	4.9	9.9	7.2	13.2	13.7
Black	44.6	24.4	36.4	28.8	31.1	32.4	23.7	25.5	22.2	35.8	53.2	34.9	36.6	52.4	44.7
Hispanic	11.3	11.2	9.4	7.7	16.9	16.6	13.4	5.9	5.8	7.5	13	22.9	15.7	9.1	19.3

The racial disparity in maternal mortality in New York is dramatic and exceeds the differences seen in infant mortality and low birth weight. The 2004 Black maternal mortality rate of 44.7 per 100,000 births compared to the White rate of 13.7 per 100,000 births, results in a Black-to-White ratio of 3.3. These rates are based on 21 deaths among African American women and 23 deaths among Caucasians. The rate for Hispanics in 2004 was 19.3 per 100,000 live births based on 11 deaths.

Figure 24: **Maternal Mortality Rate**
1990-1998 ICD9 Codes 630 to 676
1999 - 2003 ICD10 Codes 000 to 099
New York State, New York City and Rest of State 1990 - 2004



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
New York State	15.8	10.6	13.9	11.1	13.7	11.8	10.2	9.3	9.7	13.3	15.9	20.1	13.2	20.9	20.5
New York City	24.4	17.9	22.8	14.7	21.7	20.6	15.5	14.3	13.3	21.8	23.1	33.5	22.9	23.9	24.4
Rest of State	8.6	4.4	6.4	8	6.7	4.1	5.7	5.1	6.5	5.9	9.5	8.2	4.5	18.7	16.9

In part, wide fluctuations in the rate are related to the rarity of the occurrence. The small numbers of deaths that occur each year create great swings in rates.

There are many reporting issues related to maternal mortality that contribute to inconsistent rates. For example, if investigators rely solely on the death certificates to identify maternal deaths, the relationship of certain conditions to a previous pregnancy may not be clear, and the death may never be classified as a maternal death. The greater the efforts made toward ascertainment of a previous pregnancy, the more likely investigators are to identify a true maternal death.

If the health care provider completing the death certificate does not connect the death to a recent pregnancy, the death is frequently reported under a non-maternal cause. Working with the NYS Chapter of ACOG through the Safe Motherhood Initiative, the NYSDOH have been working to increase awareness of maternal mortality which may have improved the completeness of maternal death reporting through death certificates.

B. Children

Childhood Nutrition: New York participates in a variety of United States Department of Agriculture (USDA) programs, including the Supplemental Food Program for Women, Infants and Children (WIC), Food Stamps, the School Breakfast and School Lunch Program, and the Child and Adult Care Food Program (CACFP). The table below summarizes recent participation data:

Table 13. **New York USDA Program Participation October 1, 2002-September 30, 2003**

Program	Average Participation
Food Stamps	1,435,986 monthly
WIC	458,177 monthly
Farmers Market Nutrition Program	383,177 monthly
Child Nutrition	
School Lunch	1,789,181 daily
School Breakfast	459,924 daily
Child and Adult Care Feeding Program (CACFP)	22,584 daily
Food Distribution Program (FDP)	
Commodity Supplemental Food Program (CSFP)	36,284 monthly
Food Distribution Program on Indian Reservations (FDPIR)	418 monthly

Descriptions of the various USDA Program can be found on the USDA website: www.usda.gov.

According to the 2005 Youth Risk Behavior Survey, twenty-one percent of adolescents (comparable to 26% of adults) in New York State consumed at least five fruits or vegetables per day. While 38% of New York adolescents eat between one and three fruits per day, only 12% ate green salad 4-6 times per week. Twenty-one percent reported eating vegetables other than carrots and potatoes 4 – 6 times per week. Consumption of fruits and vegetables diminishes with grade. Differences by gender and race were insignificant.

Among high school girls in 2005, only 10 percent reported drinking 3 or more glasses of milk per day as compared to 20 percent of the boys. Among girls in 12th grade, only 6 percent drank 3 glasses of milk daily.

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

Breastfeeding: New York uses PRAMS, WIC and National Immunization Survey (NIS) data to track breastfeeding trends.

Through 1999, the PRAMS breastfeeding question was asked as follows: "For how many weeks did you breastfeed your baby?" Possible responses were: "I didn't breastfeed my baby." "I breastfed less that one week." "I am still breastfeeding." Also, through 1999, there was a New York State-specific question on why the mother didn't breastfeed. In 2000, additional breastfeeding questions were added to the PRAMS survey. The question is now asked: "Did you ever breastfeed or pump your breast milk to feed your new baby?" "What were your reasons for not breastfeeding your baby?" "How many weeks did you breastfeed or pump milk to feed your baby?" "What were your reasons for stopping breastfeeding?" "How old was your baby the first time you fed him or her anything besides breast milk?"

PRAMS data show that rates of breastfeeding initiation improved. There was a 5% improvement between 1999 and 2000, but there is not certainty as to whether this is due to the change in the way the questions were asked in 2000.

Highlights from the PRAMS 2003 (New York State – excluding NYC) data are as follows:

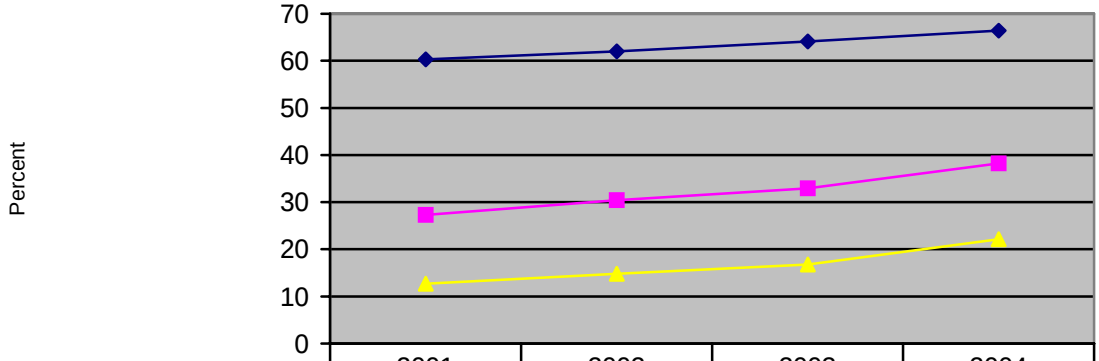
- Breastfeeding rates have shown slight, but steady improvement over the last few years.
- Breastfeeding rates drop dramatically one month postpartum.
- Mothers with more than 12 years of education were more likely to breastfeed.
- Marriage increases the likelihood that mothers will initiate breastfeeding and continue to breastfeed past the immediate postpartum period. Among married women responding in 2003, 76.5% initiated breastfeeding, compared to 59.9% for unmarried women.
- Of the 28.4% that chose not to breastfeed in 2003, 46% stated that they did not do so because they did not like breastfeeding, and 28% indicated that they didn't because they had other children to care for. 26% said they had to return to work or school.

Table 14. **Breastfeeding Initiation and Duration for PRAMS Respondents, 1996 – 2003**
Source: PRAMS data

Year>	1997	1998	1999	2000	2001	2002	2003
PRAMS – Initiation	63.0%	65.4%	65.4%	69.1%	68.6%	72.1%	71.6%
PRAMS – 1 Mo. Postpartum	52%	52%	50%	57.1%	55.3%	57.6%	57.4%

WIC breastfeeding data is showing slight improvement. In 2004, 66.4% of WIC moms reported ever breastfeeding. This is a 10% increase over 2001. At 12 months, 22% of WIC participants reported in 2004 that they were still breastfeeding. This is 32% more than in 2003 and almost double the rate reported in 2001.

Figure 19.
Trends in Breastfeeding 1999-2003
Source: Pediatric Nutrition Surveillance - WIC



	2001	2002	2003	2004
% ever	60.3	62	64.1	66.4
% at least 6 mo.	27.3	30.4	32.9	38.2
% at least 12 mo.	12.7	14.8	16.8	22.1

A recent study, which utilized National Maternal and Infant Health Survey data, found that breastfed children have a decreased risk of post-neonatal death, compared to those who are never breastfed. The study, published in **Pediatrics,** found that:

- Overall, children who were ever breastfed had 0.79 times the risk of post-neonatal death, compared to those who were never breastfed.
- Most of the infants who died were less than age four months.
- Longer breastfeeding was associated with lower risk of post-neonatal death.
- The mothers of children who died were younger, less educated and smoked more often during pregnancy.
- The infants who died tended to be of higher birth order, and were more often male, African American and low birth weight.

National Immunization Survey Data on Breastfeeding: Each year since 1994, the CDC National Immunization Program, in partnership with CDC's National Center for Health Statistics, has conducted the National Immunization Survey (NIS) within all 50 states, District of Columbia, and selected geographic areas within the states. Since January 2003, breastfeeding questions have been asked of all survey respondents selected to participate in the National Immunization Survey (NIS). All data collected on breastfeeding in this survey relates to the child about which immunization data is being collected. As a result, the 2004 NIS results provide geographically-specific breastfeeding rates for the initiation, duration, and exclusivity of breastfeeding:

- In 2003, 70 percent of women in New York State reported ever-breastfeeding. Women in New York City were more likely (72.7%) to report ever breastfeeding as compared to women in Upstate (67.6%). New York State Women were similar to women nationwide in the percent ever breastfeeding.
- About one-half of the NY state women reporting ever breastfeeding were still breastfeeding when their babies were 6 months of age (37.2%). Rates were similar for Upstate, NYC, and the nation. If only looking at women exclusively breastfeeding at 6 months of age, which is recommended by the American Academy (AAP) of

Pediatrics, 14.8 percent of women in New York State were in this category. Slightly more NYC moms reported excusive breast feeding at 6 months of age (15.5%), as compared to Upstate (14.8%) and the nation (14.1%).

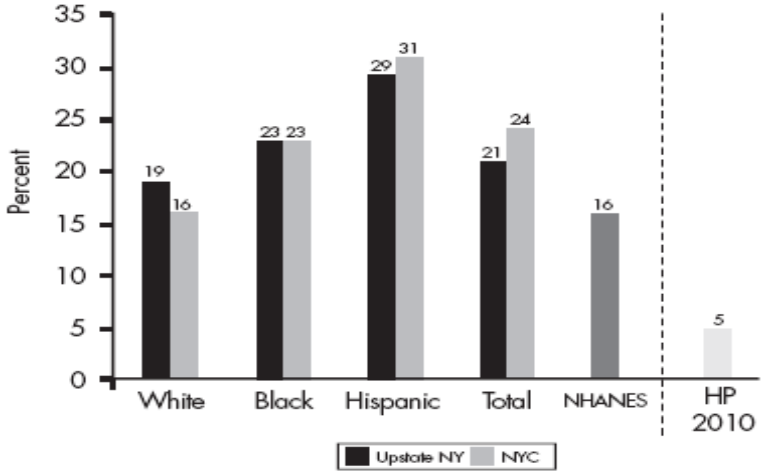
- New York State has not yet achieved the national *Healthy People 2010* objective of 75% of mothers initiating breastfeeding. According to the CDC, only 14 states have achieved this goal.

Table 15. **Breastfeeding Patterns Of Participants In The National Immunization Survey**
New York State By Region And US , 2004

Region	Ever Breastfeeding	Breastfeeding at 6 months	Breastfeeding at 12 months	Exclusive at 3 months	Exclusive at 6 months
Upstate	67.6+/-6.1	36.6+/-5.9	19.6+/-4.6	36.0+/-6.0	14.8+/-4.4
New York City	72.7+/5.2	38.0+/-5.5	19.8+/-4.2	41.6+/-5.8	15.5+/-4.2
New York State	70.0+/-1.0	37.2+/-4.0	19.7+/-3.2	38.6+/-4.2	15.1+/-3.1
US	70.3+/-0.9	36.2+/-0.9	17.8+/-0.7	38.5+/-1.0	14.1+/-0.7

Childhood Overweight: There is growing concern about the national epidemic in childhood overweight and adult obesity. Research indicates that adult morbidity and mortality are increased by childhood obesity, even if the condition does not persist into adulthood. A recent study by the University College of London found that children who are overweight at age 11 continue to be overweight at age 16.

Figure 25*:* **Proportion of elementary school children in upstate NY and New York City who are obese**

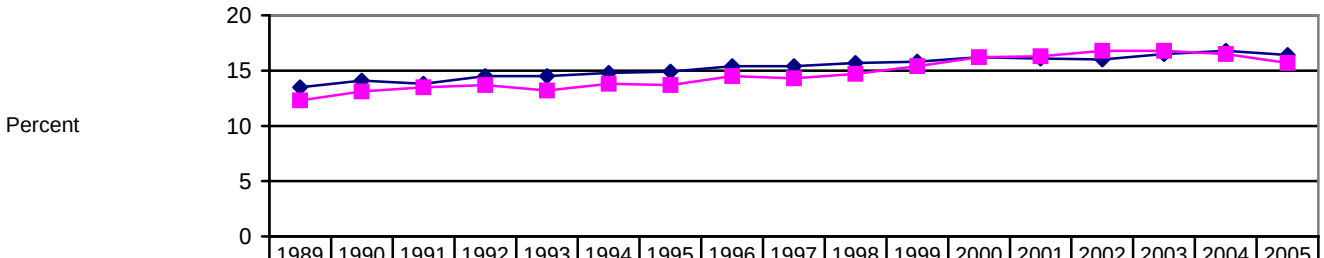


Sources: Upstate New York: Grade 3 Oral Health, Physical Activity, and Nutrition Survey, 2004. New York City: Am J Public Health, 2004; 94: 1498. U.S. NHANES, 1999-2002, J Am Med Assn 2004;291: 2847-2850.

The prevalence of obesity among elementary school children in NYS has increased dramatically between 1988 and 2003-2004. Based on measured height and weight in 2003, 24% of elementary school children (grades K-5) in New York City were obese. In 2004, 21% of third grade school children in Upstate New York were obese. These prevalence rates greatly exceed the prevalence reported for the U.S. (15.8%) in NHANES 1999-2002, and the Healthy People 2010 target of 5%. In both New York City and upstate NY, prevalence rates differed across racial/ethnic categories; Hispanics have the highest

rates (29.3% and 31.1%), with rates for non-Hispanic Whites the lowest (18.7% and 15.9%), and rates for non-Hispanic Blacks in between (22.5% and 22.8%, respectively).

Figure 26. **Trends in Overweight and At-Risk for Overweight Among WIC Program Children Ages 2 to 4 Years 1989 - 2005 Source: WIC Program**



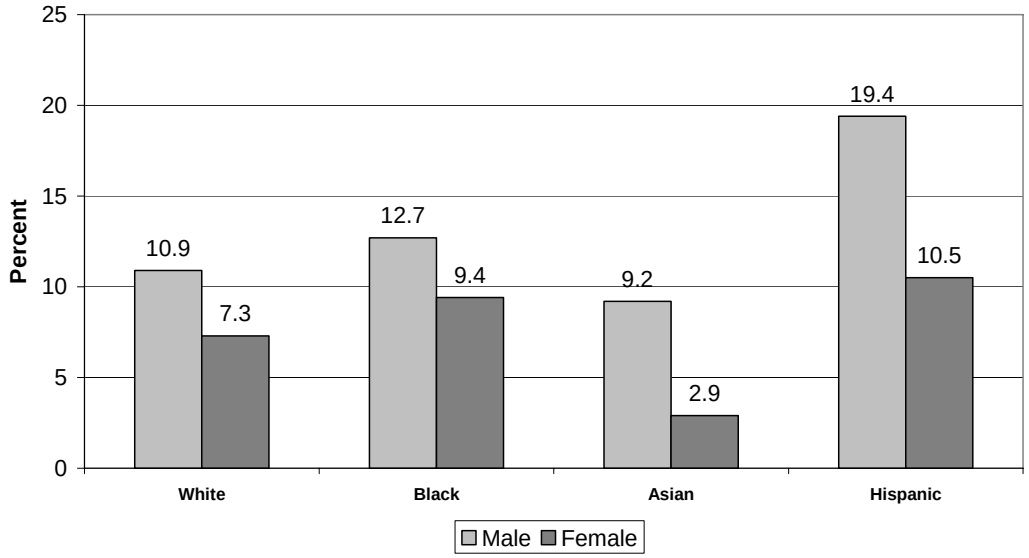
	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
At Risk	13.5	14.1	13.8	14.5	14.5	14.8	14.9	15.4	15.4	15.7	15.8	16.2	16.1	16	16.5	16.8	16.4
Overweight	12.3	13.1	13.5	13.7	13.2	13.8	13.7	14.5	14.3	14.7	15.4	16.2	16.3	16.8	16.8	16.5	15.7

At risk of overweight= BMI greater than 85th percentile, less than the 95th percentile
Overweight= BMI greater than or equal to the 95th percentile
Both measured by age- and sex-specific 2000 CDC growth charts

For preschool-age children in NYS, data are only available for children from low-income families enrolled in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). In 2005, 15.7% of the two- to four-year-olds participating in New York's WIC Program were overweight. This is down 5% from 2004 but still a 28% increase since 1989. The percent of overweight children varies considerably by race and ethnicity. Hispanic children are almost twice as likely to be obese than Black or White children.

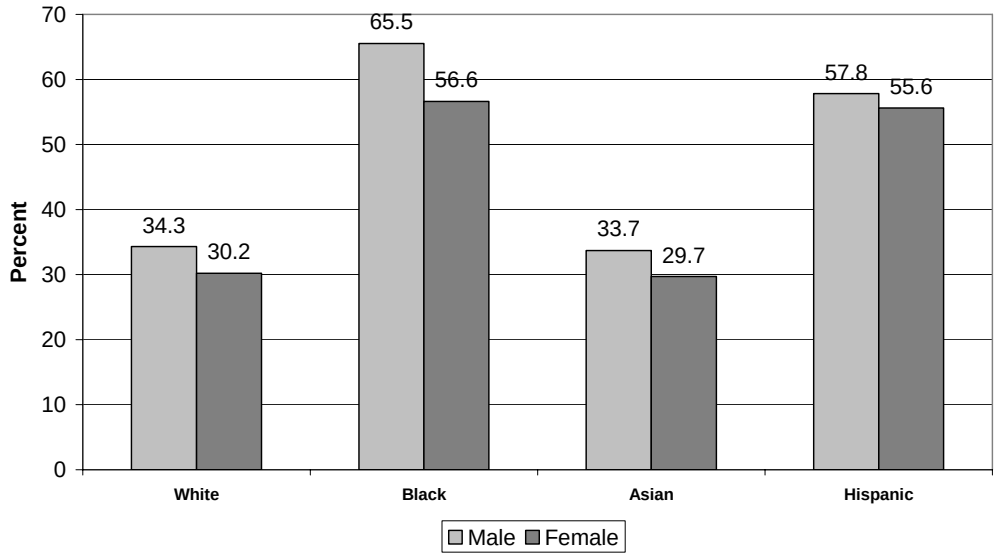
Television Viewing: Current research suggests there is a relationship between TV watching and obesity. Specifically, one study found that, in 26 year olds, 17 percent of overweight can be attributed to watching television for more than 2 hours per day (www.thelancet.com Vol. 264 July 2004). Another study found that for each hour increase of television viewing, fruit and vegetable intake decreases by 0.14 servings per day. (Pediatrics, 2003 Dec: 112 (6 Pt 1):1321-6) The 2001 *Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* recommended that children watch no more than two hours of television per day (The Surgeon General's Call, 2001). The American Academy of Pediatrics (AAP) recommends that children younger than two years of age be discouraged from viewing television, and that viewing for children two years and older be limited to no more than one to two hours per day of high quality educational shows (American Academy of Pediatrics, 2001).

Figure 27. **Percent of High School Students Who Were Overweight (At or above the 95th Percentile) by Sex and Race New York State, 2005**



Data from the 2005 YRBS found that 10.5% of adolescents are overweight (BMI ≥ 95th percentile based on reference data). Adolescent males were more likely to be overweight than females and African American adolescents were more likely to be overweight than white adolescents. Among Hispanic males almost 20% were overweight in 2005.

Figure 28. **Percent of High School Students Who Watched Three of More Hours of TV on an Average School Day by Sex and Race New York State, 2005**

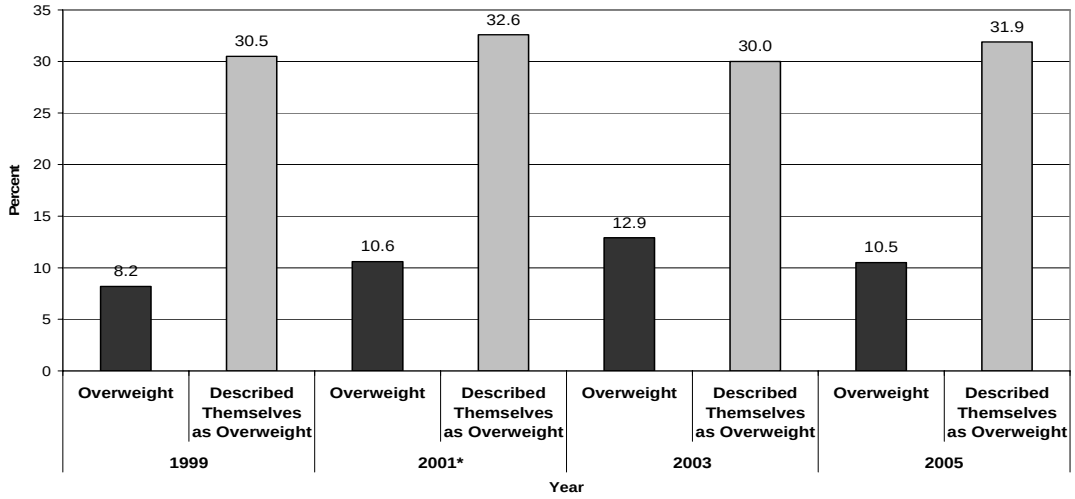


Interestingly, TV watching habits followed a similar pattern to the overweight percentages. Males were more likely to watch more than three hours of TV per weekday as compared to females. Whites and Asians had the lowest rates of TV watching.

Younger children are also at risk in NYS for watching too much TV. A random sample of third grade children surveyed in upstate NYS in 2004 revealed that 18.4% watched more than 2 hours per day. A survey of TV viewing habits was collected from a sample of WIC participants in 2000. Children from ages 2 up to 5 years watched an average of 2.3 hours per day of TV. Twenty percent (23%) of children and 20% of adults usually or always snacked while watching TV and 38% had a TV in their bedroom (Dennison et al., 2002).

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

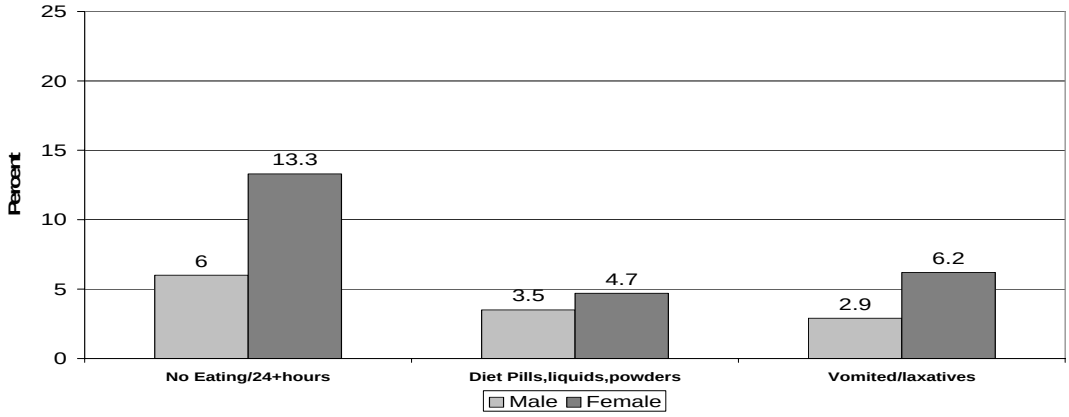
Figure 29. **Overweight and Overweight Perception Among Female High School Students New York State, 1999-2005**



According to the 2005 YRBS, 31.9 percent of female high school students described themselves as overweight when only 10 percent were actually overweight. This discrepancy between perception and actual weight was relatively unchanged between 1999 and 2005. Among males in 2005, 26 percent thought they were overweight while 12.8 percent actually were.

Inappropriate Weight Loss Methods/Male and Female Adolescents: Among female NYS high school students in 2005, 60.5 percent reported they were trying to lose weight. While most used methods such as exercise (69.7%) or eating fewer calories (53.3%), 13.3 percent fasted for 24 hours in order to lose weight, 6 percent vomited or took laxatives and almost 5 percent took diet pills or powders (not prescribed).

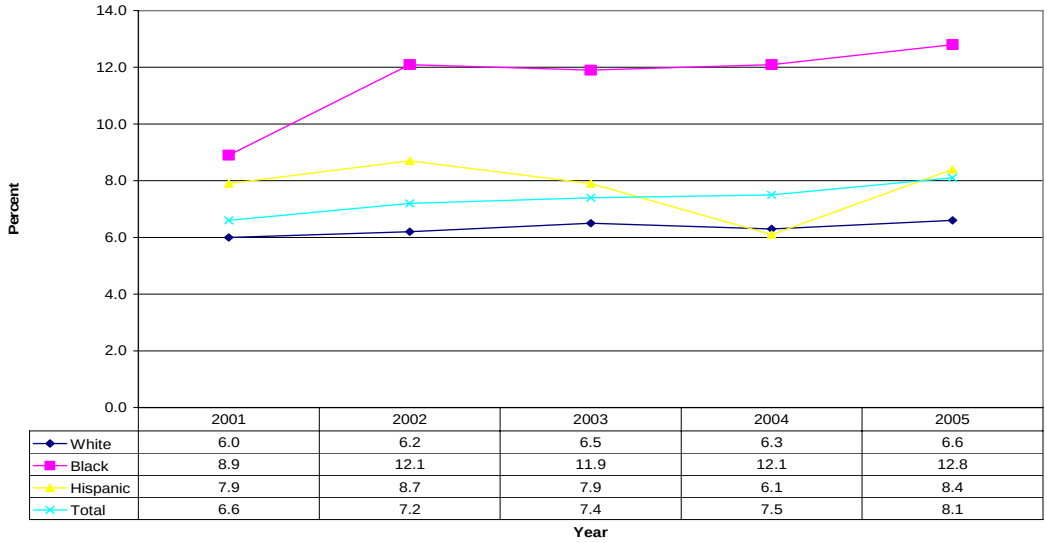
Figure 30. **Inappropriate Weight Loss Methods Practiced by High School Students New York State 2005**



<u>Adult Overweight</u>: The 2005 BRFSS found 59.7% of New York adults were overweight or obese, up from 57.3 in 2003. The rate has been climbing upward during the past several decades. In 1990, 42.3 percent and in 2000, 56.9 percent of New York's population was overweight or obese. Increasing overweight and obesity rates have implications for women of childbearing age. The overweight/obesity rate increases with age, from 41.0% among 18 to 24 year-olds to 68.7% among 55 to 64 year olds. Rates are higher among men than women (66.0% vs. 53.8%) and higher among African Americans (71.2%) and Hispanics (60.7%) than whites (58.3%). Rates are also significantly higher among those with less education.

<u>Diabetes Prevalence</u>: Overweight and obesity are major risk factors for diabetes. Diabetes prevalence has been increasing in New York State as well as in the nation, over the past several decades. In 1990, 4.3 percent of New Yorkers indicated they had been told by a doctor that they had diabetes. In 2000, 6.6 percent had been diagnosed with diabetes and in 2005, 8.1 percent.

Figure 31. **Diabetes Prevalence by Race New York State 2001-2005**



	2001	2002	2003	2004	2005
White	6.0	6.2	6.5	6.3	6.6
Black	8.9	12.1	11.9	12.1	12.8
Hispanic	7.9	8.7	7.9	6.1	8.4
Total	6.6	7.2	7.4	7.5	8.1

There are also race and ethnic differences in diabetes prevalence. In 2005, the prevalence of diabetes among blacks was 12.8 percent; almost double the white rate and 50 percent higher than the Hispanic rate.

The vision is for all New Yorkers to achieve and maintain and healthy weight. NYSDOH's mission includes decreasing the prevalence of overweight and obesity and to reduce the burden of obesity-related diseases by improving healthy eating and increasing physical activity. Over the past two years, the department and many partners and stakeholders have been involved in developing the *New York State Strategic Plan for Overweight and Obesity Prevention.* This plan includes a role for individual behavioral change, but also focuses on population-focused preventions efforts for policy, environmental and systems change. These large-scale strategies are designed to decrease barriers to healthy food choices and exercise opportunities, and to increase the ease of making healthy food and physical activity choices by making them accessible in childcare, schools, worksites, healthcare setting and in the community, making changes more sustainable than individual or group education strategies.

The following ten goals were identified to guide New York's efforts:

- Increase awareness of overweight and obesity as a major public health threat;
- Increase early recognition of overweight and/or excessive weight gain;
- Improve management, both medical and non-medical, of people who are overweight or obese and those with obesity-related diseases;
- Increase initiation, exclusivity and duration of breastfeeding during infancy;
- Improve lifelong healthy eating;
- Improve lifelong physical activity;
- Decrease exposure to television and other recreational screen time;
- Increase policy and environmental supports for physical activity and healthy eating, including breastfeeding;
- Increase and maintain effective public health responses to the obesity epidemic in New York State; and
- Expand surveillance and program evaluation to prevent overweight and obesity.

Title V will continue to work with colleagues in the Division of Chronic Disease Prevention and Adult Health and the Division of Nutrition to meet the challenges of this epidemic.

Nutrition Assistance: According to the US Department of Agriculture, food insecurity in New York State is thought to be in the range of 10% ($\pm$0.74) and food insecurity with hunger is thought to be in the range of 3.9% ($\pm$0.31%). Approximately 56% of all licensed childcare entities participate in the Child and Adult Care Feeding Program.

Physical Activity: According to the 2005 YRBS, 23.8% of adolescents were estimated to participate in moderate physical activity (activity that did not make them sweat or breathe hard) for at least 30 minutes on at least five or more of the past seven days. There were no substantial differences noted by race, grade or gender.

Of students reporting they were enrolled in a physical education class, 76.5 percent said they actually exercised or played sports for at least 20 minutes during an average PE class. While 94.2 percent of students said they attended physical education class at least once per week, only 17.4 percent reported having a daily PE class. More than half of both male and female students (57.5%) reported that they played on a sports team. Males were somewhat more likely (62%) to play on a sports team as compared to females (53%).

Oral Health Status of Children: Oral health is vital to the overall health and well-being of children. Left untreated, pain and infection caused by tooth decay can lead to problems in eating, speaking and learning. According to the US Surgeon General, tooth decay or dental caries, the most common chronic childhood disease, is five times more common than asthma and seven times more common than hay fever in U.S. children.

HRSA recently published, ***The Oral Health of Children: A Portrait of States and the Nation 2005***. This report is the second in a series of overviews that examines national and state-level data and includes breakdowns by ethnic and racial group. Parents of 102,353 children ages 0-17 participated in the 2003-04 survey, which was supported by HRSA's Maternal and Child Health Bureau and conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics.

The report indicates that most children up to age 17 receive annual preventive dental care and have excellent or very good oral health, and that few go without needed care. However, the report noted that young children (ages 1 to 5) and children of families with lower incomes are much less likely to access preventive oral health care.

Seventy-two percent (72%) of children, according to surveyed parents, had a preventive dental visit in the past year. Ninety-three percent (93%) of the children of the parents surveyed received all necessary dental care in the past year, 90.5 percent of children have teeth in excellent, very good or good condition –- 68.5 percent with teeth in excellent or very good condition and 21.9 percent in good condition. Seventy-seven percent (77%) of young children (ages 1 to 5 years) have teeth reported to be in excellent or very good condition compared to only 61.8 percent of 6- to 11-year-olds and 67.5 percent of 12- to 17-year-olds.

Access to dental care rises steadily with increased income. Only 58.1 percent of children with family incomes below 100 percent of the federal poverty level (FPL) received care in the past year, compared to 82.4 percent of children in families with incomes of 400 percent FPL and above. Younger children are less likely to receive preventive dental care than school-aged children. Only 10.1% of 1-year-olds and less than a quarter (23.8%) of 2-year-olds received a preventive dental visit in the past year, despite the recommendation that all children see a dentist by age 1. Parents of 88.9 percent of children who did not see a dentist in the past year did not believe that their children needed a preventive dental visit, which could indicate a need for oral health education among parents.

Dental care rises steadily with income. Only 58.1 percent of US children with family incomes below 100 percent of the federal poverty level (FPL) received care in the past year, compared to 82.4 percent of children in families with incomes of 400 percent FPL and above.

In the United States and in New York, dental caries in children is the most common chronic disease. Nationally, a progress review toward Healthy People 2010 observed that the prevalence of dental caries in 2-4 year old children was approximately 23% (HP 2010 Target 11%). Of children aged 1-5 years enrolled in the Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT), only 16% received any preventive service. A survey of a disadvantaged group of children in northern Manhattan found a high level of unmet need. Because management of children of this age group in a dental office is difficult, many children require treatment in an operating room. In New York,

approximately 2900 children younger than 6 years of age annually undergo hospital stays for dental caries.

Cleft lip and cleft palate are one of the most common congenital anomalies. These conditions affecting the oral cavity may occur as isolated defects or as part of other syndromes. In the United States, the prevalence rates in the general population have been reported to be approximately 1.2 per 1000 births for cleft lip with or without cleft palate and 0.56 per 1000 births for cleft palate alone. In Year 2000, according to New York's Congenital Malformations Registry, there were 183 cases of cleft lip with or without cleft palate (0.71 per 1000 births) and 143 cases of cleft palate (0.55/1000 births) in New York State. The rate of oral clefts has been reported to be higher among whites compared to that for blacks. In New York State, the rate varied from 0.8 to 1.5/1000 births in different racial and ethnic groups. In 2002 and 2003, there were a total of 713 children with clefts (over 350 per year), or a rate of 14.2 per 10,000 live births

According to a survey of 3rd grade children conducted during 2002-2004 by the New York State Health Department in collaboration with many partners, the prevalence of dental caries was 54.1%. The estimated percent of children with untreated caries was 33.1%. The Healthy People 2010 (HP 2010) target for caries experience and untreated caries for 6-8 year old is 42% and 20% respectively. Consistently, both caries experience and untreated caries were more prevalent in the low-income group.

Protective factors for oral health include:

- Water Fluoridation
  More than 12 million New Yorkers receive fluoridated water. The percent of the population on community water supplies receiving fluoridated water is approximately 70%, compared to the Healthy People 2010 Objective of 75%. The percent of the population on fluoridation was 100% in New York City and 46% in upstate New York. Counties with large proportions of the population not covered by fluoridation are Nassau, Suffolk, Rockland, Ulster, Albany, Oneida and Tompkins.

- Fluoride Use

  Fluoride tablets are prescribed to children living in areas where water is not fluoridated in upstate New York State communities. (New York City children receive fluoride from water.) About 30.5% and 17.7% of high income and low income children respectively in upstate New York reported the use of fluoride tablets on a regular basis.

- Dental Sealants
  The estimated percent of children with a dental sealant on a permanent molar in New York State was 17.8% and 41.1% in the low and high-income groups respectively. Again, a lower proportion of low-income children had dental sealants compared to that of high income children.

- Insurance Coverage
  Approximately, 80.1% of children reportedly had some type of dental insurance coverage. There was no noticeable difference in the insurance coverage between high and low-income groups.

- Dental Visit in the Past Year
  The percent of children with a dental visit in the past year was 73.4%. While there was no noticeable difference in the insurance coverage between high and low income

groups, a lower proportion of low income children had visited a dentist in the last one-year (60.9% vs. 86.9%).

- Use of Dental Services in Medicaid and Child Health Plus Programs
  For those New York State children aged 4 to 21, who are continuously enrolled for a year in 2003, 45% in Medicaid and 40% in Child Health Plus program visited a dentist.

A major risk factor is tobacco use in children. According to the 2002 New York State Youth Tobacco Survey (3), the current use of cigarettes among middle school and high school students is approximately 6.7% and 21% respectively. Among high school students, the current use of cigarettes for white, black and Hispanic students was 23.3%, 11.9% and 18.3% respectively.

Childcare: In New York, more than half of mothers with children younger than age 13 are employed. Childcare is a major issue for working families. Each family needs to decide who will care for their children while they work and, for their peace of mind, needs to feel comfortable that their child is safely cared for in a supportive, nurturing environment.

In June 2004, the Urban Institute released a report entitled, "State Profile of New York: Data from the 2002 National Survey of America's Families". According to the report, among NYS full-time employed mothers with children under 5, 35.8 percent of the children spend about 35 hours per week in nonparental care. Nationwide the figure is 38 percent. In NYS, center-based care accounts for 24.5 percent of the arrangements for kids under 5 years of age. Other arrangements are Family Childcare (12.6%), Relative (24.7), babysitter/nanny (7.4%) and parent/other (31.0%). On the average, working families who pay for childcare spend one out of every ten dollars they earn on childcare.

The 2000 US Census provided further information. According to the Census, 55.8% of children under age 6 have both parents working; 65.5% of children 6 to 17 years of age have both parents working. An estimated 139,135 of 496,212 grandparents with their own grandchildren under age 18 in the home are responsible for their grandchildren. About 83,802 of those children are under age 5; about 55,333 are over age 5.

The growing use of self-care for children is of great concern. Self-care means that an adult does not directly supervise children. The uses of self-case increases as children grow older. Almost 20% of 6- to 9-year olds whose moms are employed are in before- and/or after-school care, but less than 10% of 10- to 12-year olds are in such programs. Fewer than 10% of 6- to 9-year olds spend any time in self-care on a regular basis, compared to more than 25% of the 10- to 12-year olds.

The Office of Children and Family Services (OCFS), who licenses and regulates these facilities in this State, reports in 1999 there are a total of 28,208 licensed facilities in the State, providing day care to 556,783 children, when they are at capacity. Of these facilities, 15,970 (56.6% of the total facilities) are located in New York City, serving 299,120 children (53.7% of all children served). It is important to keep in mind that these data reflect only licensed facilities, and not more informal arrangements.

Figure 32. **NYS Capacity by Types of Child Care**

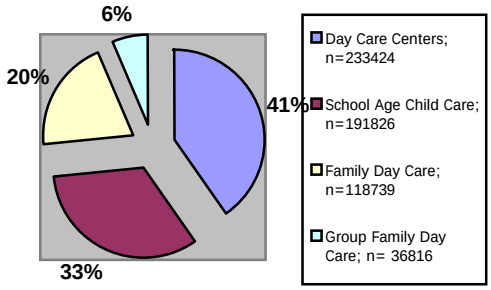
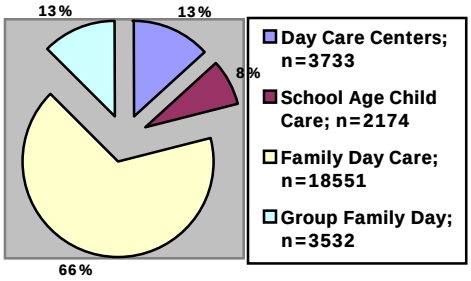


Figure 33.
NYS Child Care
% Children Enrolled by Types of Care



There are currently over 100 trained Childcare Health Consultants across the State. These consultants are mostly public health nurses or public health educators who work for local health departments. Training will take place in the western portion of the state within the next few months, which is projected to increase the number of Childcare Health Consultants in that area.

A total of 49,473 New York children participated in the Federal Head Start program in FFY 2003, up from 45,608 in FFY 1998, 45,040 in FFY 1999, and 46,805 in 2000.

According to the NYS Department of Labor, salaries for child care workers in New York State in 2004 ranged from an average annual income of $15,110 for entry level workers to $24,920 per year for experienced workers. The average earnings were $21,650 annually. This is an improvement in wages from 1998, when the average annual income of a childcare worker in New York was $16,890.

Young Children of Migrant and Seasonal Farmworkers - The Agri-Business Child Development in 2004 released a Needs Assessment of the children and families enrolled in their migrant and seasonal Head Start Program. Family needs included:

- Child care for school-aged children who are over the age for services of Head Start;
- Assistance with transition to public school;
- English as a Second Language (ESL) and high school equivalency diploma (GED) classes;
- Help with overcoming barriers to enrolling and utilizing insurance;
- Help with successfully completing follow-up services for children referred to dental care and to specialists, given the short timeframe during which the family remains in any given area;
- Access to bi-lingual, bi-cultural mental health providers and removing the stigma of using mental health services; and
- Assistance with enabling services, such as transportation and translation.

Many parents felt it was critical that children speak English prior to entering kindergarten. Parents also link their success with English to greater economic success for themselves and their families. Less than 2 percent of the parents of the Head Start children have a high school diploma or its equivalent. They state that onsite childcare is a significant factor in whether they are able to take part in ESL or GED classes.

With regard to health and dental services, parents reported that sometimes their coverage lapses. They point out sometimes, due to the nature of their employment and

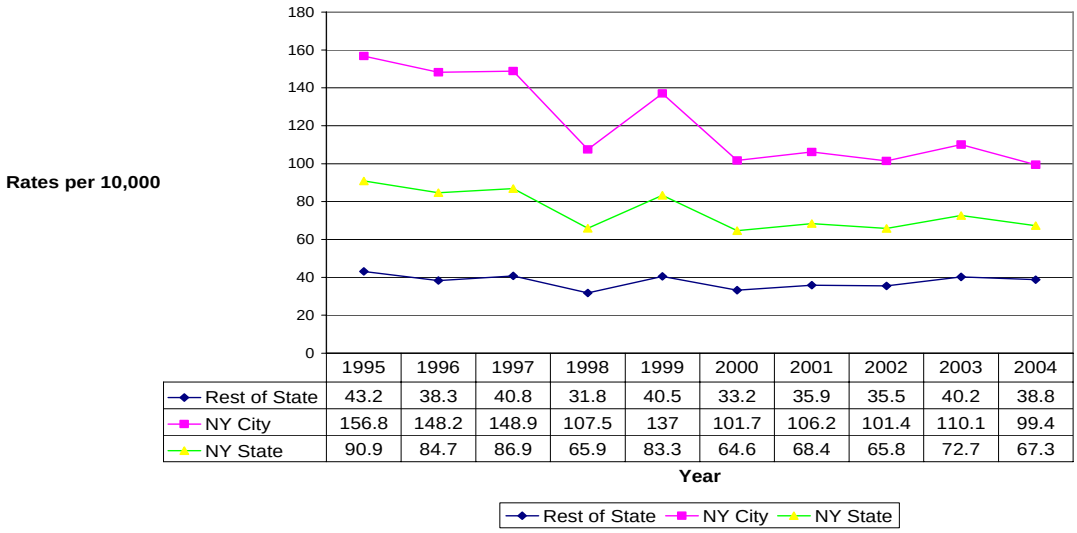
the time it takes to process applications, their applications or re-applications are pending in one areas when they move on to other areas of the state. Families also reported being confused by HIPPA paperwork. The Head Start Program is working diligently with their community partners and state agencies (such as the Migrant Health Program) to overcome the lack of Spanish language materials and translators, and to improve access throughout the state for migrant children and their families.

Ambulatory Care Sensitive Conditions: Conditions are considered "ambulatory care sensitive" if early care and treatment make hospitalization avoidable. Two conditions often tracked as ambulatory care sensitive are asthma and otitis media (middle ear infection).

Asthma Hospitalizations: Since 1995, asthma hospitalization rates for children aged birth to four years have declined 26 percent to 67.3 per 100,000 in 2004. Most of the reduction, however, occurred by the year 2000 when asthma hospitalizations for this age group were at their lowest level (68.4/100,000). Between 2001 and 2004, the rate fluctuated slightly in both directions and is now just above the 2000 rate.

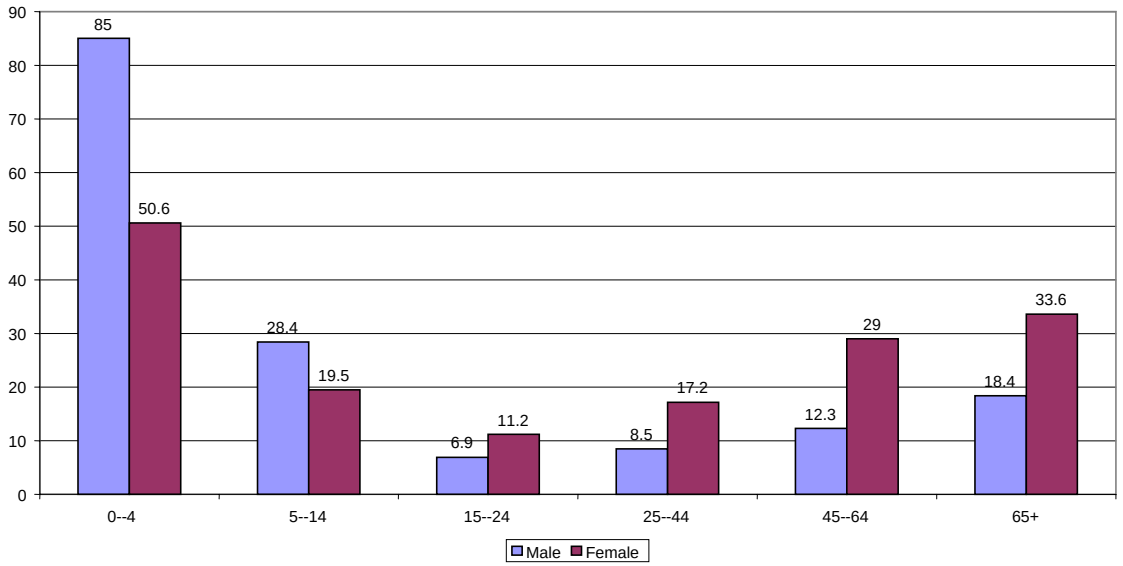
Asthma hospitalizations continue to be almost 3 times more frequent in New York City than in the rest of the State. Both areas experienced a decline in hospitalizations between 2003 and 2004.

Figure 34. **Asthma Hospital Discharge Rates (Ages 0-4) per 10,000**
New York State, New York City and Rest of State
1995-2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Rest of State	43.2	38.3	40.8	31.8	40.5	33.2	35.9	35.5	40.2	38.8
NY City	156.8	148.2	148.9	107.5	137	101.7	106.2	101.4	110.1	99.4
NY State	90.9	84.7	86.9	65.9	83.3	64.6	68.4	65.8	72.7	67.3

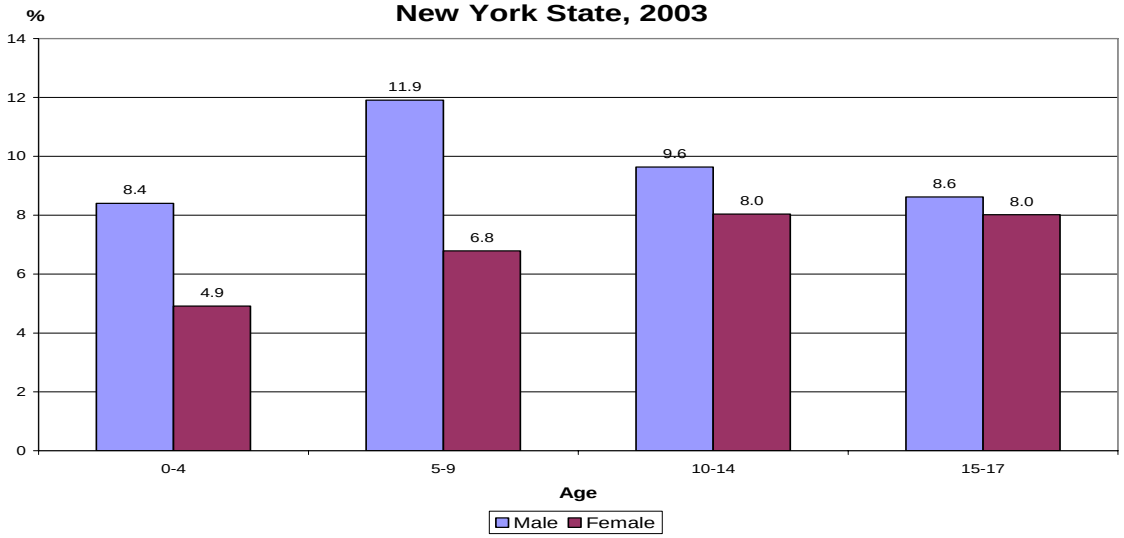
Table 35. **Average Annual Asthma Hospitalization Rate Per 10,000 Residents by Age and Gender, New York State, 2002-2004**



When looking at asthma hospitalizations by age and gender an interesting pattern exists. At ages under 15 males have a higher rate of hospitalization. However, after age 15 females account for a higher percentage of asthma hospitalizations. This is especially significant for women during child bearing years because asthma can cause complications during pregnancy and must be monitored closely.

Table 36.

Current Asthma Prevalence by Gender and Age
New York State, 2003



Recently, 2003 data from the National Asthma Survey for New York State became available. At ages 0-4, 8.4 percent males and 4.9 percent of females reported they had been diagnosed with asthma. Among males ages 5-9, 11.9 percent reported being diagnosed with asthma compared to 6.8 percent of the females. Interestingly, at ages 15-17 the percent of males with asthma dropped to 8.6 percent while the females increased to 8.0 percent.

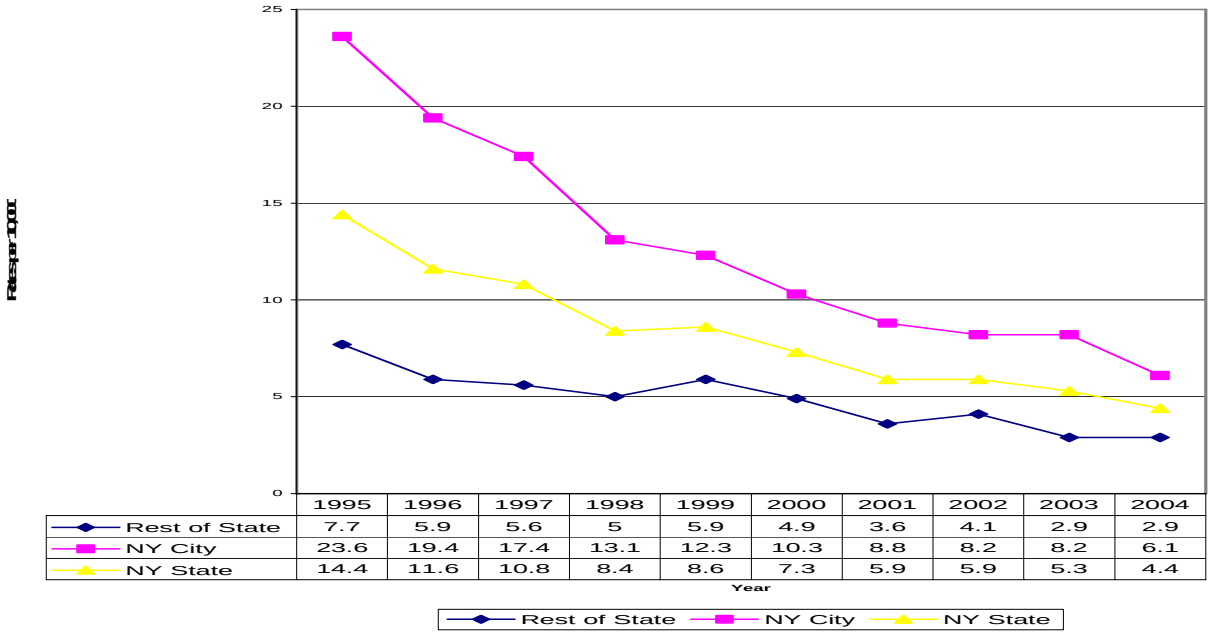
Table 16. **National Asthma Survey Children ages Birth through 17 New York State - 2003**	
Children <18 years	**Percent with Asthma**
Total	8.4%
Gender	
Male	9.8%
Female	6.9%
Race / Ethnicity	
White	7.3%
Black	10.0%
Hispanic	10.9%
Household Income	
<$10,000	11.5%
$10,000-$14,999	12.2%
$15,000-$19,999	7.5%
$20,000-$29,999	8.7%
$30,000-$39,999	10.6%
$40,000-$49,999	9.2%
$50,000-$74,999	9.4%
$75,000-$99,999	8.1%
$100,000+	6.1%

In 2003, asthma in New York State among children less than 18 was more prevalent among blacks and Hispanics and children living in homes with incomes below $15,000 per year.

Otitis Media Hospitalizations: Otitis media hospitalizations have declined over the past ten years. In 2004, 4.4 per 10,000 children aged birth to four were hospitalized for otitis media. This is down 69% from 1995 when the rate was 14.4 per 10,000. A significant difference in rates exists between New York City and the rest of the State. Rates in New York City declined 74% from a high of 23.6 per 10,000 in 1995 to 6.1 per 10,000 in 2004. The rest of the State also experienced significant declines, although the rates are much lower.

Figure 37.

Otitis Media Hospital Discharge Rates (Ages 0-4) per 10,000
New York State, New York City and Rest of State
1995-2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Rest of State	7.7	5.9	5.6	5	5.9	4.9	3.6	4.1	2.9	2.9
NY City	23.6	19.4	17.4	13.1	12.3	10.3	8.8	8.2	8.2	6.1
NY State	14.4	11.6	10.8	8.4	8.6	7.3	5.9	5.9	5.3	4.4

Childhood Lead Poisoning: Progress continues to be made in protecting New York's children from lead poisoning. Childhood lead poisoning is a serious health problem that can have a devastating effect on the child, and that has serious repercussions for society as a whole. Human interaction with lead in the environment is most dangerous for children under the age of six. Exposure to even small amounts of lead can contribute to behavior problems, learning disabilities and lowered intelligence. Screening and prompt and effective intervention have been shown to prevent some of the more advanced effects of lead poisoning, such as seizures and severe kidney and nervous system damage.

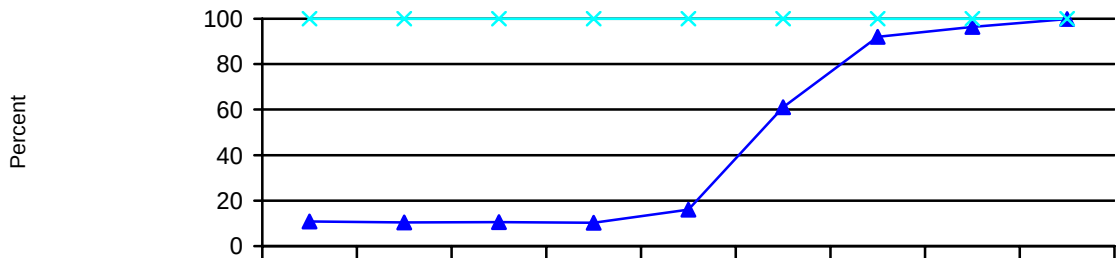
Provisional data not yet released from the New York State Department of Health Childhood Lead Poisoning Prevention Program, exclusive of New York City for the years 2002-2003 showed that:

- The incidence and prevalence of lead poisoning in the period 2002-2003 declined across all categories and all blood lead levels, and screening rates continued to improve.
- The number of children newly identified with lead poisoning, defined as children with blood lead levels of 10 micrograms per deciliter or higher, declined.
- In 2003, the incidence rate declined to 1.57 from a 2002 incidence rate of 1.67. In 2002, the prevalence rate of children with levels of 10 micrograms per deciliter or greater was 2.6%. In 2003, the prevalence rate decreased to 2.5%.
- The number of children with higher blood lead levels requiring environmental intervention, defined as 20 micrograms per deciliter or higher, was stable over this period as expected, leveling off of the dramatic declines experienced in previous years. While total number of children declined an additional 4% over the two years studied from 440 in 2002 to 422 in 2003, incidence rates remained stable at 0.23 per 100 children screened.

- New York's lead screening rate remained at a high level. Analysis of screening rates for the 2000-2001 birth cohorts of children under age two shows New York's screening rates have increased from 66.6% in children born in 2000 to 67.6% for children born in 2001.
- The screening rate for those children enrolled in Medicaid managed care was higher than for the rate for the state as a whole. Seventy-six percent of children enrolled in Medicaid managed care programs were screened for blood lead in New York State.
- New York City reported a similar decline in new childhood lead poisoning cases. The New York City Department of Health recently released 2003 annual report showed stable incidence of childhood lead poisoning over the period from 2002 to 2003. The number of new cases of children from birth through seventeen years of age with elevated blood leads of ten micrograms per deciliter or higher declined. In 2003 the incidence rate declined to 1.10 from a 2002 incidence rate of 1.29. The number of children with higher blood lead levels requiring environmental intervention, defined as 20 micrograms per deciliter or higher, remained stable from 520 cases in 2002 to 519 cases in 2003. Due to differences in methodology, these data cannot be directly compared to those figures for the rest of the State.

Universal Newborn Hearing Screening: Since the passage of legislation mandating the screening of all newborns for hearing deficits, the percentage of newborns screened before hospital discharge has steadily risen. New York conducted a pilot program from 1996 to 1999 that included all regional perinatal centers and high-risk nurseries in the State, which provided a strong foundation for launching universal screening.

Figure 38. **Infants Screened for Hearing Loss Prior to Hospital Discharge 1996 - 2004**



	1996	1997	1998	1999	2000	2001	2002	2003	2004
% Screened	10.9	10.4	10.5	10.2	16	61	92	96.4	99.9
Goal	100	100	100	100	100	100	100	100	100

Table 17. **Infants Screened for Hearing Loss Prior to Hospital Discharge As a Percentage of Total Births**
Source: NYS Early Intervention Program

Year>	1996	1997	1998	1999	2000	2001	2002	2003	2004
Infants screened	28,215	26,697	27,063	26,578	41,355	156,000	231,123	227,848	240,577
Total Births	258,897	257,567	257,748	260,571	258,449	255,529	250,434	236,259	240,921
Percent screened	10.9%	10.4%	10.5%	10.2%	16%	61%	92%	96.4%	99.9%

It is also significant to note that the age at referral of children with hearing loss to the statewide Early Intervention Program decreased from 12.65 months in 2000-01 (prior to implementation of newborn hearing screening regulations) to 4.14 months in the 2002-03 and 4.04 months in 2004.

Tuberculosis: New York State reported a decrease in the number of tuberculosis cases in 2004 as compared to 2003. Statewide in 2004, 1,363 cases were reported, with 1,039 cases in New York City and 363 cases in the rest of the State.

In New York City, there were 101 fewer cases reported in 2004 as compared to 2003. In New York State outside of New York City, there were 24 fewer cases. Approximately half of all the cases outside New York City are from three counties: Nassau, Suffolk, and Westchester, while the remainder of the cases is distributed throughout the State, especially in areas with large foreign-born populations. In a recent report issued by CDC, New York State led the nation in reducing the number of cases reported in 2002 compared to 1992. Over the 11-year period, the number of cases in New York State declined 68.6 percent, a rate of decline over 22 percent better than the next ranking state, among states reporting 500 or more cases annually.

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

There has been very little change in incidence of vaccine-preventable illness between 1999 and 2001, with the exception of Hepatitis B. The increase in Hepatitis B cases was primarily among New York City residents. Between 1999 and 2000, the number of cases in NYC increased by 254 to a total of 529. In 2001 and 2002 NYC reported 673 and 727 cases of Hepatitis B. In 2003, however, this trend was reversed when 204 cases of hepatitis B were reported in NYC. In 2004 there were 255 cases of Hepatitis B statewide and 163 in New York City. The statewide rate has declined form the 2001 high of 4.4/100,000 to the 2004 rate of 1.3 per 100,000 population.

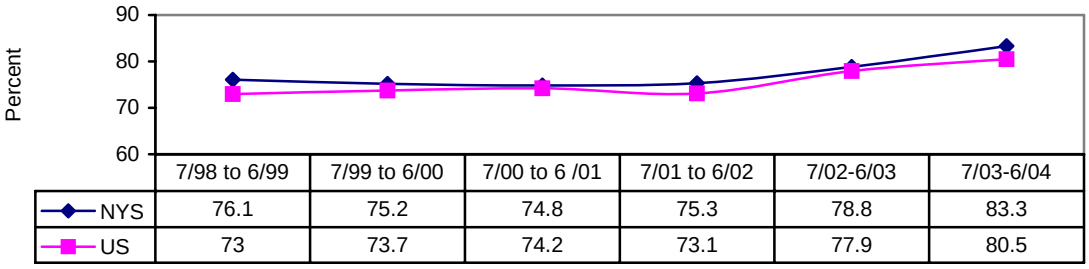
Similar to the nation, in 2003 and 2004 there was a significant increase in the number of pertussis cases reported in New York State. The case rate went from 2.4/100,000 in 2002 to 6.4/100,000 in 2003 and 11.3/100,000 in 2004. Several factors are probably responsible for this. First, the vaccine is 80-90% effective which leaves quite a few susceptible people. In addition, the immunity from both disease and vaccine seems to wane over time, creating a susceptible cohort among adolescents and adults. They get less sick than infants but provide a reservoir of infection. There has also been an increased awareness among physicians that has lead to increased testing using new more sensitive tests. It is likely that a the combination of these factors were responsible for the increased case rate with waning immunity being the most important. It is now recommended that adolescents aged 11-18 receive further immunization against pertussis. The US Food and Drug administration has approved two new vaccines for a booster immunization.

Table 18. Cases of Vaccine-Preventable Disease 1996-2003														
Year	1998		1999		2000		2001		2002		2003		2004	
Disease	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*	Case	Rate
Hep B	651	3.5	496	2.7	710	3.9	827	4.4	867	4.6	314	1.6	255	1.3
HiB**	131	0.7	18	0.1	174	1.0	157	0.8	205	1.1	222	1.2	226	1.2
Measles	4	---	2	---	10	0.1	4	0.0	91	---	7	.04	5	0.0
Mumps	157	0.8	0	---	12	0.1	4	0.0	7	---	15	0.1	26	0.1
Pertussis	364	2.0	1020	5.5	385	2.1	175	1.6	447	2.4	1217	6.4	2165	11.3

***Rate is per 100,000**
*****Hemophilus influenza* B**

Childhood Immunization: New York has surpassed the healthy People 2010 goal of 80% for childhood immunization. After declining from July 1998 – June of 2001 rates have improved for the past three years to a high of 83.3 percent of kids ages 19-35 that are fully immunized. New York State's rates have been consistently higher than the immunization rates nationally.

Figure 39. **Vaccination Coverage with 4:3:1:3:3* Among Children**
Ages 19-35 Months, New York State
Source: National Immunization Survey



*4:3:1:3:3 -Four or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of any MCV, three or more doses of Hib, and three or more doses of HepB.

Onset of Sexual Activity: There is a relationship between age of sexual initiation, number of partners, frequency of sexual activity, history of sexual abuse, and a myriad of other risk factors particular to adolescents.

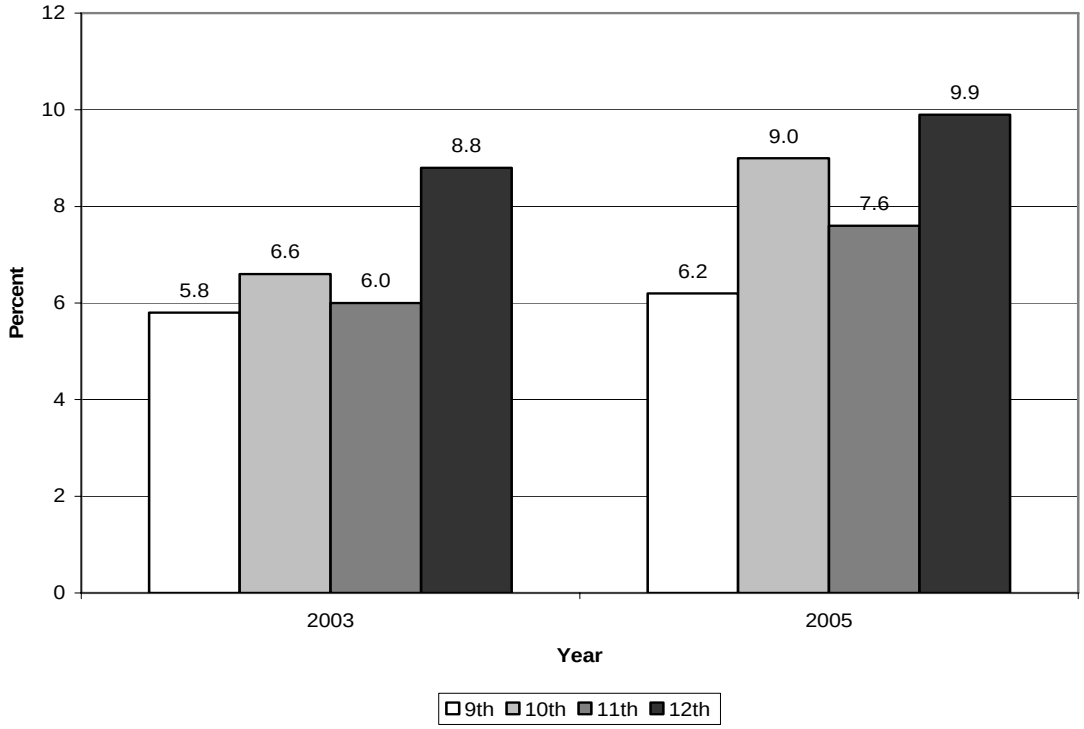
In New York State, the 2005 Youth Risk Behavior Survey (YRBS) found the percentage of teens that have experienced sexual intercourse increases with age, from 31.7% of ninth graders to 62.2% of 12th graders. Although these numbers are cause for great concern, they are comparable to the national average of 30.2% of ninth graders and 56.4% of 12th graders. Of New York students responding, 5.8% reported having had sexual intercourse for the first time before the age of 13, compared to seven percent nationally; 29.2% of New York State high school students describe themselves as currently sexually active, compared to 33% nationally.

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

According to the 2005 New York State Youth Risk Behavior Survey, one out of every 10 female 12th grade high school students reported that they have been forced to have sex when they didn't want to in their lifetime.

Figure 40.

Percent of Female High School Students who were Physically Force to Have Sexual Intercourse When They Did Not Want To New York State, 2003-2005

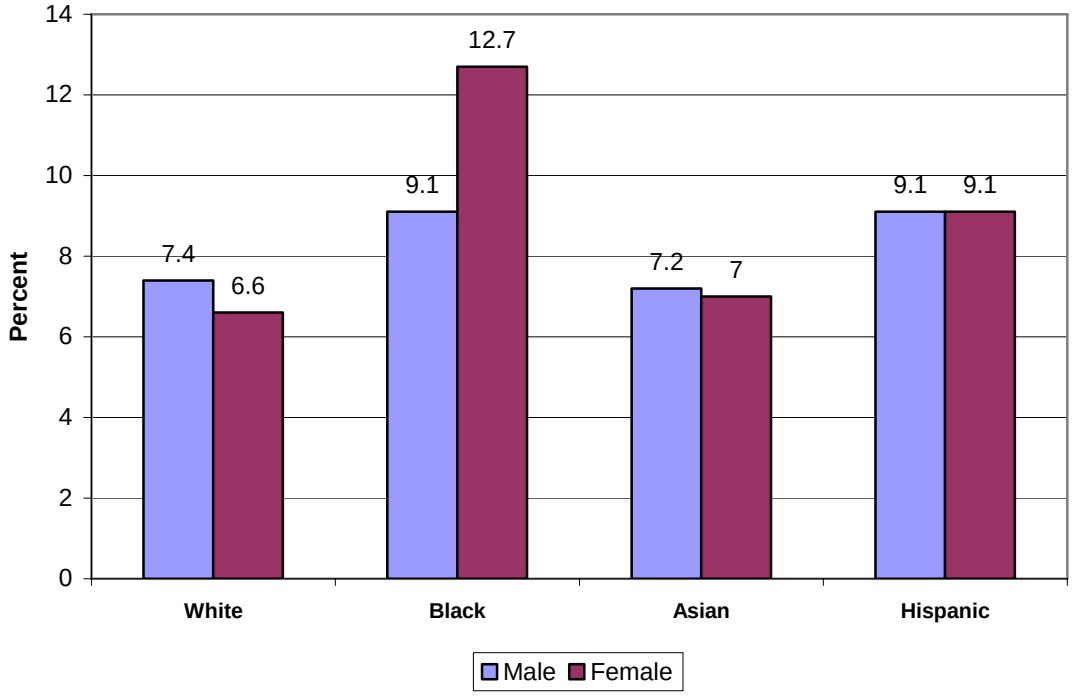


Source: Youth Risk Behavior Survey – 2003, 2004

The Youth Risk Behavior Survey also asked students about physical abuse. Eight percent of New York high school students reported they were physically hurt by a girlfriend or boyfriend in the past 12 months. Rates were highest among Black females and both male and female Hispanics. White and Asian males were more likely to report physical abuse by a girlfriend or boyfriend as compared to their female counterparts.

Figure 41.

Percent of High School Students Who, During the Past 12 Months, Were Physically Hurt by a Girlfriend or Boyfriend by Sex and Race New York State, 2005



Source: Youth Risk Behavior Survey – 2005

Self-Injurious Behavior: Self injury is a behavior among adolescents and young adults that some believe is increasing. Self injurious behavior includes activities such as cutting, scratching, burning or using any method of harming oneself with the purpose of causing injury without intending to commit suicide. Recently, a study on this topic was published in **Pediatrics**, Volume 117, Number 5, June 2006.

The study was conducted at two northeastern colleges as an on-line mental health survey. According to this study, 17 percent of the college students surveyed indicated they engaged in self harming behavior at some time during their lifetime. Among those, 75% indicated they had done it more than once. The researchers compared the repeat-abusers to the non-abusers and found that the repeat self injurers were more likely to be female, bisexual or questioning their sexual orientation. They were also more likely to have a history of sexual or emotional abuse and to have ever considered or attempted suicide. Of the students reporting abuse, 37 percent said no one else knew of their behavior and only 3.3 percent reported that a physician knew about the behavior. This is of concern because it makes it difficult to provide treatment for these young people. Some researchers suggest that this behavior is used as coping method for stress.

Contraceptive Use: There is often a significant period of time between initiation of sexual intercourse and the choice and utilization of an effective method of contraception. According to the 2005 YRBS:

- The percentage of New York teens reporting condom use during their last sexual intercourse was 70.7% in 2005, up from 62% on the 1999 survey and 70.4% in the 2003 survey. Nationally, the rate was 58%.
- New York State adolescent males reported higher use of condoms during their last sexual intercourse than do adolescent females – 75.9% of adolescent males (compared to 67.9% in 1999 and 77.1 in 2003) and 66.3% of adolescent females (compared to 56.3% in the 1999 survey and 64% in the 2003 survey) reported using condoms during their last intercourse. Nationally, 65.5% of adolescent males and 51.3% of adolescent females reported condom use on last intercourse.
- In New York State, 13.8% of high school students (compared to 18.2% nationally) reported using birth control pills during their last sexual intercourse.
- 23.4% of the adolescent males responding to the survey and 14.6% of adolescent females who responded reported alcohol or drug use at last sexual intercourse. Nationally the figures were 27.6% and 19.0%, respectively. Use of alcohol is generally associated with reduced inhibitions and has a negative statistical correlation with effective use of contraceptives.

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

In 2004, there were 1475 cases of early stage syphilis in New York State, down from 1596 cases in 2003. The bulk of the cases were in New York City and among males. Between 2003 and 2004, among both males and females in New York City, case rates went down. In Upstate, there was a small increase in the number of cases and the rates per 10,000 among both males and females. Still, the bulk of the cases are among residents of New York City (89%).

There were 18,549 reported cases of gonorrhea in New York State in 2004. This was down from 21,895 cases in 2003. Both New York City and Upstate, NY reported a reduced number of cases as compared to 2003. The Gonorrhea case rate for New York City residents (168.2) was more than double the rate for Upstate residents (77.4). Females accounted for 52% of all cases.

Among women aged 15-19 the case rate was 509.5 per 100,000. Among males in this age group the case rate was less than half the female rate (208.1 per 100,000). Among 20-44 year olds, males experienced the higher case rate (196.0 vs. 166.1).

Chlamydia cases in New York State have been increasing since data collection began in 2000. Chlamydia is the most frequently reported bacterial sexually transmitted disease in the United States. In New York State in 2004, there were 58,820 cases reported, 2,396 more than were reported in 2003. Slightly more than half of these cases were among New York City Residents. Persons at highest risk for Chlamydia are teenage girls.

Because the cervix of teenage girls and young women is not fully matured, they are at particularly high risk for infection if sexually active. Twenty-eight percent of reported Chlamydia cases were among young girls aged 15-19. The case rate for 15- to 19-year-old girls in New York City was 3,454.5 per 100,000 and in Upstate, 2,085.2 per 100,000. Males in this age group had much lower case rates, 547.1/100,000 in New York City and 389.3/100,000 in Upstate, NY.

Table 19.
Early Syphilis by Age and Sex
New York State, New York City And Rest of State
2003 - 2004

2003	**NY City**		**Upstate**		**Total State**	
	No. Cases	**Rate**	**No. Cases**	**Rate**	**No. Cases**	**Rate**
Female						
15-19	22	8.8	3	0.8	25	4.0
20-44	145	8.7	19	1.0	164	4.6
Total	199	4.7	23	0.4	222	2.3
Male						
15-19	32	12.3	2	0.5	34	5.1
20-44	1047	67.1	73	3.7	1120	32.1
Total	1283	33.9	91	1.7	1374	15.0
2004	**NY City**		**Upstate**		**Total State**	
	No. Cases	**Rate**	**No. Cases**	**Rate**	**No. Cases**	**Rate**
Female						
15-19	6	2.4	1	0.3	7	1.1
20-44	105	6.3	16	0.8	121	3.4
Total	128	3.0	25	0.4	153	1.6
Male						
15-19	23	8.8	5	1.3	28	4.2
20-44	989	63.4	113	5.9	1102	31.6
Total	1,174	31.0	148	2.8	1,322	14.5

Table 20.
Gonorrhea
New York State, New York City And Rest of State
2003-2004

2003	**New York City**		**Upstate**		**Total State**	
	No. Cases	**Rate**	**No. Cases**	**Rate**	**No. Cases**	**Rate**
Female						
15-19	2032	811.1	1702	465.5	3734	596.6
20-44	4302	258.9	2602	135.1	6904	192.4
Total	6691	158.4	4522	80.5	11213	114.1
Male						
15-19	842	322.6	712	182.5	1554	234.9
20-44	5377	344.7	2978	154.4	8355	239.5
Total						
2004	**NY City**		**Upstate**		**Total State**	
	No. Cases	**Rate**	**No. Cases**	**Rate**	**No. Cases**	**Rate**
Female						
15-19	1,723	687.8	1,466	400.9	3,189	509.5
20-44	3,523	212.1	2,437	126.5	5,960	166.1
Total	5,544	131.2	4,097	72.9	9,641	98.1
Male						
15-19	739	283.1	638	163.5	1377	208.1
20-44	4,167	267.2	2,670	138.5	6,837	196.0
Total	5286	139.7	3622	67.7	8908	97.4

Table 21.
Chlamydia
New York State, New York City And Rest of State
2003-2004

2003	**NY City**		**Upstate**		**Total State**	
	No. Cases	**Rate**	**No. Cases**	**Rate**	**No. Cases**	**Rate**
Female						
15-19	8917	3559.5	6893	1885.1	15810	2525.9
20-44	17129	1031.0	9013	467.8	26142	728.6
Total	27173	643.3	16418	292.2	43591	443.5
Male						
15-19	1280	490.4	1277	327.3	2557	386.5
20-44	5754	368.9	4003	207.6	9757	279.7
Total	7397	195.5	5436	101.6	12833	140.3
2004	**NY City**		**Upstate**		**Total State**	
	No. Cases	**Rate**	**No. Cases**	**Rate**	**No. Cases**	**Rate**
Female						
15-19	8,654	3,454.5	7,625	2085.2	16,279	2600.8
20-44	16,645	1001.9	10,179	528.3	26,824	747.6
Total	26,398	624.9	18,404	327.6	44,802	455.8
Male						
15-19	1,428	547.1	1,519	389.3	2,947	445.4
20-44	5,895	377.9	4,587	237.9	10,482	300.5
Total	7,703	203.6	6,315	118.0	14,018	153.3

HIV/AIDS case rates appear on page 91.

Other Youth Risk Behavior: The 2005 Youth Risk Behavior Survey offers a great deal of information about high school students across the State. A summary of these data follows:

Risk for Unintentional Injuries - According to the survey, more than four out of five (81%) students who rode bicycles in the past 12 months reported they never or rarely wore a bike helmet. Students at highest risk were older (85% of seniors vs. 81.5% for ninth graders), and New York City students were less likely to wear helmets (90%) than those in the rest of the State (76.2%).

10.6% reported on the survey that they never or rarely wore seatbelts when in a car driven by someone else. 23% reported this behavior in 1997.

20% of the high school students responding reported they rode in a car with someone who had been drinking alcohol. 5.8% reported they had driven a car or other vehicle when drinking alcohol; males were more likely to report doing so than females (7.0% vs. 4.6%).

Motor Vehicle Crashes - Statistics compiled by the New York State Department of Motor Vehicles and the Governor's Traffic Safety Commission showed a continued decline in the rate of fatal crashes. The data, compiled by the Traffic Safety Management and Research, which showed a rate of 1.1 deaths per 100 million vehicle miles traveled is the safest year since 1920, when records began. In 2002, there were 1,390 fatal crashes and 1,509 deaths on New York's roads. In 2003, there were 1,351 fatal crashes and 1,477 people

killed on New York's roadways. Raymond P. Martinez, Commissioner for the New York State Department of Motor Vehicles, attributes the low rates to public education and enforcement of the state's stringent traffic laws.

The study also found:

- The 2003 rate of 13 deaths per 100,000 licensed drivers to mark the safest year on record.
- The rate of deaths per 100,000 population was 7.7.
- Vehicle occupant fatalities were down more than 4.2% from 2002.
- The number of fatal crashes in New York State has declined by over 50% in the past three decades.

Risk for Intentional Injuries - Males in New York were more than three times as likely to carry a weapon to school than females (22.2% vs. 6.2%).

5.3% of students responding to the YRBS reported that they had missed school because they felt unsafe at school or on the way to school, females at the rate of 5% and males at the rate of 5.7%.

7.2% of students reported being threatened or injured with a weapon while on school property. More males were threatened than females (9.9% vs.4.5%). Ninth graders were more likely to be threatened or injured than seniors (10.3% vs. 9.8%).

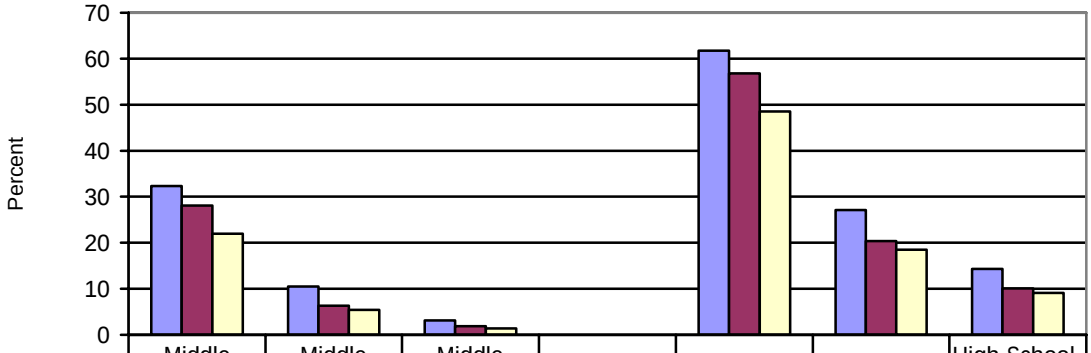
About a third of the students (32.1%) reported participating in a physical fight. Ninth graders were again more likely to report this behavior than seniors (39.6% vs. 21.3%). 8.2% of students reported being slapped or being physically hurt by a boyfriend or girlfriend. 8% of females and 4.1% of males reported being forced to have sexual intercourse when it was not wanted. By 12th grade, one out of ten female high school students report being forced to have sex.

27.3% (almost a third) of students reported feeling sad or hopeless almost every day for two weeks or more. The rate for females (35.3%) was higher than for males (19.3%). 14.4% of students seriously considered attempting suicide. Females were more likely to have considered this than males (18.9% vs. 9.8%). 10.2% of students actually made a plan for how they would attempt suicide. 7.1% reported attempting suicide one or more times. Females attempted at a higher rate than males (8.7% vs. 5.3%). 1.8% needed medical care.

Youth Tobacco Use - The Youth Tobacco Survey (YTS) is administered in New York State on a biannual basis to students in sixth through twelfth grades. The YTS estimates tobacco use, exposure to environmental tobacco smoke, knowledge and attitudes about tobacco, access to tobacco products by minors, counter-marketing and tobacco cessation in middle and high school students. The results of the 2000, 2002 and 2004 YTS show important declines in youth tobacco use. Among New York State middle school students, current use of tobacco declined from 10.5% in 2000 to 5.4% in 2004. High school students had a decline in current use (from 27.1% to 18.6%), frequent use (from 14.3% to 9.1%) and ever use (61.7% to 48.5%).

Table 42. **Middle & High School Ever, Current, & Frequent Use of Cigarettes**

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



	Middle School - Ever Use	Middle School - Current Use	Middle School - Frequent		High School Ever Use	High School Current Use	High School Frequent Use
2000	32.3	10.5	3.1		61.7	27.1	14.3
2002	28.1	6.3	1.9		56.8	20.4	10.1
2004	22	5.4	1.4		48.5	18.5	9.1

The Youth Behavioral Risk Survey (YRBS) also queries students about smoking. 47.3 percent of students participating in the Youth Risk Behavior Survey in New York in 2005 reported they had tried smoking, compared to 51.2 percent in 2003. 11.2 percent reported smoking a whole cigarette before the age of 13. 16.2 percent reported smoking one or more cigarettes in the last 30 days. 6.3 percent smoke cigarettes on 20 of the last 30 days. Twenty percent of students under age 18 reported they were able to purchase cigarettes. 14.7 percent of males and 4.5 percent of females reported smoking cigars, cigarillos, or little cigars. 54.2 percent of students who were current smokers tried to quit during the past 12 months.

Youth Alcohol and Substance Use - Of respondents to the 2005 YRBS, 75.9 percent of all students had at least one drink of alcohol on one or more days of their lives; 25.1 percent had their first drink before age 13. In 2003, those data were at 74.2 percent and 27.0 percent, respectively. 43.4 percent of 2005 respondents had at least one drink of alcohol in the last 30 days, compared to 44.2 percent on the 2003 survey. 26.2 percent of males and 21.4 percent of females reported in 2005 that they had five or more drinks of alcohol in a row on one or more days in the last 30 days. This compares to 27.5 and 23.0 for males and females, respectively, in 2003.

The use of drugs other than alcohol was consistently higher for males than for females. The 2005 survey found:

- 34.7% of students reported they had tried marijuana, compared to 37.1% in 2003;
- 18.3% used marijuana one or more times in the last 30 days, compared to 20.7% in 2003;
- 5.1% of students reported using cocaine, compared to 6.1% in 2003;
- 8.6% of students reported they had sniffed glue or breathed the contents of aerosol cans to get high, compared to 10.1% in 2003; and
- 3.3% reported using methamphetamines, compared to 4.7% in 2003.

A recent study published in the American Journal of Public Health found that high school students who were exposed to the World Trade Center attacks in New York City on September 11th, 2001, were more likely to be drinking alcohol six months later. Researchers found that, of the 2,731 students surveyed, almost 11 percent reported that their drinking increased after the event. White students in the study were more likely to report an increase in drinking than African American or Hispanic students. Findings suggest that youth may need to be targeted for large-scale substance-use interventions after disasters.

Sudden Infant Death Syndrome: The table below illustrates the relationship between occurrence of SIDS deaths as a subset of total infant and post-neonatal deaths. The table also contains PRAMS Survey responses indicating mothers who reported putting their infants to sleep on their backs. It is widely believed that changing infant sleep position to backs only has greatly reduced the SIDS rate from 0.8 per 100,000 population in 1995 to 0.1 per 100,000 in 2004. Total SIDS deaths in New York State declined from 50 in 2003 to 22 in 2004. They now account for only about 5 percent of post-neonatal deaths. In 1996, SIDS was the cause of death for 25 percent of these deaths.

***Table 22.* Proportion of Post-Neonatal Deaths that Are SIDS, % Moms Reporting Back-to-Sleep 1995 - 2002**

Year	1996	1997	1998	1999	2000	2001	2002	2003	2004
All deaths < 1 Year	1829	1728	1607	1571	1436	1450	1489	1450	1503
Post-neonatal deaths	570	520	467	478	443	447	436	458	445
SIDS deaths	146	118	100	74	74	74	57	50	22
% SIDS of Post-Neonatal Deaths	25.6%	22.6%	21.4%	15.5%	16.7%	16.6%	13.1%	10.9	4.9%
% PRAMS Moms responding that they put their infants on their back to sleep	34.5%	45.2%	53.0%	56.7%	63.4%	68.0%	65.8%	69.0	DNA*

*DNA = Data Not Available.

Shaken Baby Syndrome: In the United States there are approximately 1,000 to 3,000 cases of Shaken Baby Syndrome annually and that one in four shaken babies dies of their injuries. In New York alone, there are approximately 30 shaken baby cases per year. Shaken Baby Syndrome accounts for 10 to 12 percent of all deaths due to neglect. Close to 70 percent of victims are male; over 80% of the perpetrators are males in their twenties. Female perpetrators tend to be caregivers other than the baby's mother. The average age of victims is between 3 and 8 months. One third of all victims lived in New York City.

***Table 23.* Shaken Baby Syndrome Hospitalizations**

Period	Hospitalizations
October 1996-December 1997	42 - 83% with Traumatic Brain Injury/ 17% died while in the hospital.
2002	32
2003	32
2004	25
2001-2004	89 Total/Averages 30 cases per year

Homicide and Major Crime / New York City: The New York City Police Department reported that the 2005 homicide rate in New York City showed a decline of 76.1% since 1990. Overall, major crime in New York City, including robbery and assault, was down approximately 67% in the same time period. Subway crime was down 5%.

Overall Crime Rates: Crime in New York is at its lowest level since standardized crime reporting was started nearly 40 years ago. Data from the FBI's 2004 crime statistics places New York sixth safest in the nation among all states and first safest in the nation amid large states. Data from 2004 shows crime dropping for the eleventh consecutive year. Rates per 100,000 for violent crimes (murder, rape, robbery and aggravated assault) dropped 5.2 percent in New York, compared to a 2.0 percent drop nationwide.

Leading Causes of Death: The leading causes of death for children, birth-to-19-years in 2004 for New York State, New York City, and the rest of the state are reflected on the table that follows.

The table shows:

- More than half of the infant deaths in the state are caused by conditions arising in the perinatal period.

- Among children aged one through nine, unintentional injury is the most likely cause of death in both New York City (17.4%) and New York State-excluding NYC (30.2%). In New York State-excluding NYC, homicide and legal intervention remains in the top five causes of death for this age group.

- Among children aged one through nine, cancer, congenital anomalies and heart disease are important contributors to the child death rate.

- Unintentional injuries are the leading cause of death among children ages 10 to 19 years of age in New York State – excluding New York City (45.5%), but in New York City, the category of homicide and legal intervention is the leading cause of death (22.5%).

- Suicide is the third leading cause of death among New York State 10- to 19-year-olds. Suicide accounts for 9.9% of deaths in this age group, and when New York City is excluded, it represents 10.2% of deaths in the rest of the state. The lower death rate in New York City may be reflective of better access to mental health services and emergency care.

Table 24. LEADING CAUSES OF DEATH, 2004 FOR CHILDREN BIRTH TO AGE 19 YEARS					
New York State Children					
All Ages			**Under Age 1**		
Cause	**Number**	**Percent**	**Cause**	**Number**	**Percent**
All Causes	151,343	100	All Causes	1,500	100
Diseases of the heart	52,079	34.4	Cond Orig in Perinatal Period	853	56.9
Malignant Neoplasms	35,829	23.7	Congenital Anomalies	263	17.5
Cerebrovascular disease	6,852	4.5	Diseases of the Heart	24	1.6
CLRD	6,735	4.5	SIDS	20	1.3
Pneumonia	5,610	3.7	Unintentional Injuries	16	1.1
Ages 1 – 9 Years			**Ages 10 – 19 Years**		
Cause	**Number**	**Percent**	**Cause**	**Number**	**Percent**
All Causes	360	100	All Causes	790	100
Unintentional Injuries	88	24.4	Unintentional Injuries	284	35.9
Malignant Neoplasms	58	16.1	Homicide & Legal Intervention	104	13.2
Congenital Anomolies	48	13.3	Suicide	78	9.9
Homicide and legal intervention	17	4.7	Malignant Neoplasms	69	8.7
Diseases of the Heart	11	3.1	Congenital Anomalies	24	3.0
New York State – Exclusive of New York City					
All Ages			**Under Age 1**		
Cause	**Number**	**Percent**	**Cause**	**Number**	**Percent**
All Causes	95,306	100	All Causes	780	100
Diseases of the Heart	29,657	31.1	Cond Orig in Perinatal Period	434	55.6
Malignant Neoplasms	23,188	24.3	Congenital Anomalies	135	17.3
CLRD	5,037	5.3	Diseases of the Heart	13	1.7
Cerebrovascular disease	5,031	5.3	SIDS	9	1.2
Unintentional Injuries	2,823	3.0	Unintentional Injuries	8	1.0
Ages 1 – 9 Years			**Ages 10 – 19 Years**		
Cause	**Number**	**Percent**	**Cause**	**Number**	**Percent**
All Causes	199	100	All Causes	479	100
Unintentional Injuries	60	30.2	Unintentional Injuries	218	45.5
Malignant Neoplasms	32	16.1	Suicide	49	10.2
Congenital Anomalies	24	12.1	Malignant Neoplasms	37	7.7
Homicide and legal intervention	11	5.5	Homicide & Legal Intervention	34	7.1
Diseases of the Heart	5	2.5	Diseases of the Heart	13	2.7
New York City					
All Ages			**Under Age 1**		
Cause	**Number**	**Percent**	**Cause**	**Number**	**Percent**
All Causes	56,037	100	All Causes	720	100
Diseases of the Heart	22,422	40.0	Cond Orig in Perinatal Period	419	58.2
Malignant Neoplasms	12,641	22.6	Congenital Anomalies	128	17.8
Pneumonia	2,944	5.3	SIDS	11	1.5
Cerebrovascular disease	1,812	3.2	Diseases of the Heart	11	1.5
Diabetes Mellitus	1,714	3.1	Pneumonia	10	1.4
Ages 1 – 9 Years			**Ages 10 – 19 Years**		
Cause	**Number**	**Percent**	**Cause**	**Number**	**Percent**
All Causes	161	100	All Causes	311	100
Unintentional Injuries	28	17.4	Homicide & Legal Intervention	70	22.5
Malignant Neoplasms	26	16.1	Unintentional Injuries	66	21.2
Congenital Anomalies	24	14.9	Malignant Neoplasms	32	10.3
Diseases of the Heart	6	3.7	Suicide	29	9.3
Pneumonia	6	3.7	Diseases of the Heart	11	3.5

AIDS Deaths: Though the number of Annual AIDS deaths has declined dramatically over the period of the last 5 years, New York remains an epi-center for AIDS with more than 18% of the total U.S. AIDS cases. As of December 31, 2004, the rate of AIDS deaths per 100,000 was 9.0, compared to 5.4* nationally. The number of persons who are HIV-infected in the State is estimated at 150,000. As of December 2004, there were 37,558 presumed living, HIV-only (not AIDS) cases confirmed and reported in New York State since the beginning of HIV reporting in June 2000.

AIDS Cases: As of December 2004, children under the age of 13 made up 1.4% of New York's AIDS cases, while adolescents ages 13 – 19 made up 0.5%. Approximately 51% of these cases were males and 49% were female. Of those diagnosed in the young adult age group, a significant portion likely contracted the disease in adolescence. In 1993, 88% of the students responding to the Youth Risk Behavior Survey stated that they had ever been taught about HIV or AIDS. On the 2001 YRBS, that percentage had increased to 91%, but on the 2003 YRBS was again at 88%. In 2005, 89% reported being taught about HIV or AIDS.

The breakdown of cumulative reported CDC-defined AIDS cases in the State compared to the US was as follows:

Table 25. **Cumulative AIDS Cases Reported Through December 31, 2004**
New York State Data - Includes State Prison Inmates
Source: NYS Data From Data Set As Of 2/2/06

AIDS Cases	Total	Male	Female	White	Black	Hispanic	Asian/Pacific Islander	Native American	Other/ Unknown
US*	918,286	80.8%	19.2%	40.2%	39.8%	18.6%	0.8%	0.3%	0.3%
NYS**	164,005	74.7%	25.3%	25.9%	43.8%	29.2%	0.7%	0.1%	0.3%

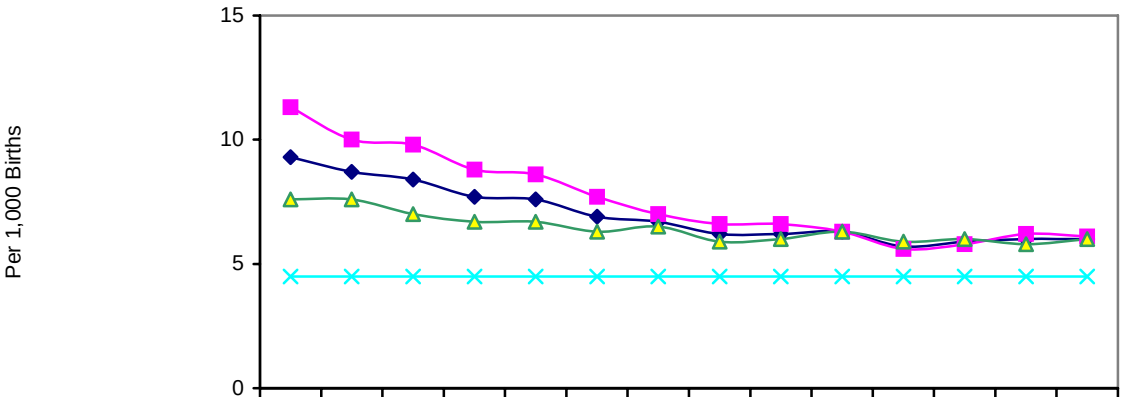
*The race/ethnicity data for national pediatric AIDS cases are based on CDC estimates rather than an actual case count.

**In 2004 the Center for Disease Control and Prevention (CDC) completed the Interstate Duplication Evaluation Project (IDEP) in which all states were required to participate. The purpose of the project was to identify duplicate cases of HIV/AIDS that have been reported to the National HIV/AIDS Surveillance System by two or more states and to assure that the cases are only counted once. If a case was reported by two or more states, the earliest data of diagnosis was used to determine to which state the case was assigned. CDC estimates that 30,000 of the AIDS cases in the national surveillance system were duplicates, representing less than 5% of the almost 1 million cases that have been reported to CDC over the history of the epidemic through 2002. It is anticipated that this process will be conducted on an ongoing basis. The percent of AIDS cases that were lost in NYS due to this process was approximately 3%. Please note that this loss of AIDS cases will most likely not affect New York's Ryan White funding or other funding based on AIDS count. This is because New York's estimated 3% loss in AIDS cases compares favorably with the average loss of cases for the nation, which was a little less than 5%.

Infant Mortality: The infant mortality rate has declined by approximately 35% since 1991. For the first time in 1996, New York's infant mortality rate was below the Healthy People 2000 goal of 7.0 per 1000 births. In 1997 and 1998, the decline continued and infant mortality reached a low of 6.2 per 1000. Between 1998 and 2000, however, the rate leveled off. In 2000, the rate was at 6.3 per 1000. In 2001, the rate again started to decline. The 2001 rate of 5.7 was the lowest NYS rate ever recorded. The rate increased slightly in both 2002 and 2003 to 6.0 per 1,000.

The rate remained at 6.0 per 1,000 in 2004. The New York City rate was 6.1 and the Rest of State rate was 6.0 per 1,000 live births. The Healthy People 2010 goal is 4.5 per 1000 live births. Efforts to reduce infant mortality must continue and be reinforced in order to meet the Healthy People 2010 goal for the nation.

Figure 43. **Infant Mortality Rate**
New York State, New York City and Rest of State 1989 - 2004



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
New York State	9.3	8.7	8.4	7.7	7.6	6.9	6.7	6.2	6.2	6.3	5.7	5.9	6.0	6.0
New York City	11.3	10	9.8	8.8	8.6	7.7	7	6.6	6.6	6.3	5.6	5.8	6.2	6.1
Rest of State	7.6	7.6	7	6.7	6.7	6.3	6.5	5.9	6	6.3	5.9	6.0	5.8	6.0
HP 2010 Goal	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5

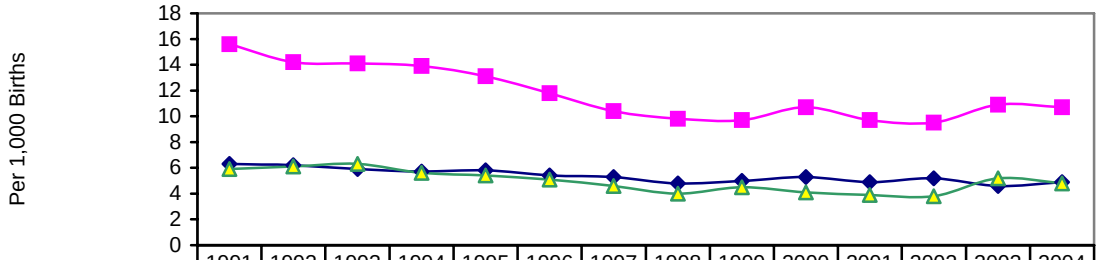
New York City Department of Health Office of Vital Records tracks infant mortality on a neighborhood basis (Health Center Districts), but since the rates are based on relatively small numbers of infant deaths, they are subject to year-to-year fluctuations, which may represent random variations, and not significant trends. From these data in 2004, infants born in the neighborhood with the highest infant mortality rate, namely Brownsville (Brooklyn) with a rate of 12.2 infant deaths per 1,000 live births, are six times as likely to die in their first year than infants from the neighborhood with the lowest rate, Kips Bay-Yorkville (Manhattan) with a rate of 1.9 deaths per 1,000 live births. The New York City infant mortality rate of 6.1 was based on a total of 760 deaths out of 124,099 live births.

In a statewide analysis of infant deaths over the three years from 2000 to 2003, the counties with the lowest infant mortality rates were Putnam (1.1), Genesee (2.0) and Cortland (3.0). Rates were highest in Hamilton (14.7), Lewis (10.3) and Onondaga and Yates (10.2).

Infant mortality rates have declined for all racial and ethic groups over the past decade. Specifically, since 1991, Black infant mortality rates have declined 31% (15.6 to 10.7), White infant mortality declined 22% (6.3 to 4.9) and Hispanic infant mortality declined 18.6% (5.9 to 4.8). Between 2003 and 2004, infant mortality was down slightly in the Black (10.9 to 10.7) and Hispanic (5.1 to 4.8) populations and increased slightly among whites (4.6 to 4.9).

Hispanics have continued to experience lower rates than blacks, and in 2004, have lower rates of infant mortality than the white population. At 4.8 per 1,000, the rate for the Hispanic population is getting close to the Healthy People 2010 goal of 4.5 per 1,000 live births.

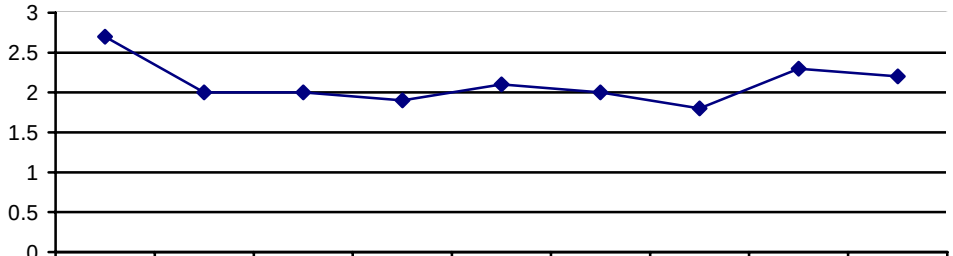
Figure 44. **Infant Mortality Rate**
New York State Residents by Race 1989 - 2004



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White	6.3	6.2	5.9	5.7	5.8	5.4	5.3	4.8	5	5.3	4.9	5.2	4.6	4.9
Black	15.6	14.2	14.1	13.9	13.1	11.8	10.4	9.8	9.7	10.7	9.7	9.5	10.9	10.7
Hispanic	5.9	6.1	6.3	5.6	5.4	5.1	4.6	4	4.5	4.1	3.9	3.8	5.2	4.8

Disparities: Even though rates have been declining for all groups, Black infant mortality rates are still significantly higher than rates for both whites and Hispanics. In 1990, the disparity between black and white rates peaked when the Black/White ratio for infant mortality reached 2.7, meaning there were 2.7 black infant deaths for every one white infant death. The ratio was based on rates of 16.0 and 6.0, respectively. Between 1991 and 1997, the black/white ratio was reduced to 2.0. It fluctuated slightly in both directions between 1998 and 2002. In 2003, the ratio was up to 2.3 based on rates of 10.9 and 4.6. In 2004, however, the rate was reduced slightly to 2.2.

Figure 45. **Ratio of Black to White Infant Mortality**
1990, 1997 - 2004
Source: Based on Vital Records Data

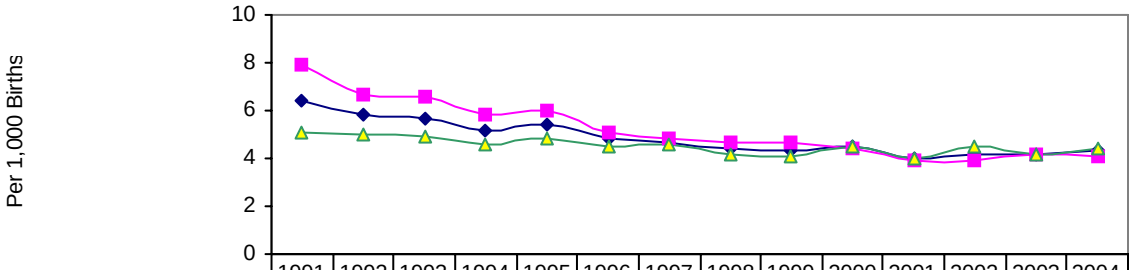


	1990	1997	1998	1999	2000	2001	2002	2003	2004
B:W Ratio	2.7	2	2	1.9	2.1	2	1.8	2.3	2.2

Neonatal Mortality: Trends in neonatal mortality mimic those of infant mortality. Between 1991 and 2001 neonatal mortality declined 37% to 4.0 per 1000 births. Similar to infant mortality, the declines have leveled off in recent years and the rate increased slightly between 2003 and 2004 to 4.3 per 1,000 live births. The New York City neonatal mortality rate at 4.1 in 2004 has been reduced by almost 50 percent since 1991, when it was 7.9 per 1,000 live births. Rates have not declined as sharply in the Rest of State. Since 1991 the rate has declined by 14 percent to 4.4 per 1,000 live births in 2004. In 2000, New York City's rate dropped below the rate for the Rest of State and has been either equal to or lower than the rate for the Rest of State since that time.

While neonatal mortality rates among Black births have experienced the largest percent decline since 1991 (29%), as compared to Whites (14%) and Hispanics (11%), their rates remain the highest. In 2004, the Black neonatal death rate was 7.1 per 1,000 births, almost double the rate for Whites (3.6) and slightly more than double the rate for Hispanics (3.4). The Black/White ratio was 2.0. While still significant, it is an improvement over what existed in 1991 when the Black/White ratio was 2.3. The lowest black/white ratio to date was 1.7 in 2002 when black neonatal mortality was at its lowest point (3.9/1,000).

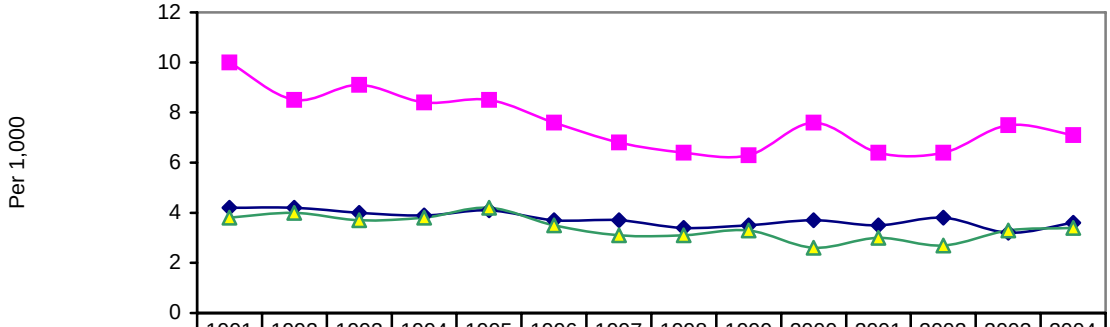
Figure 46. **Neonatal Mortality Rate**
New York State Residents by Region 1991 - 2004



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
New York State	6.4	5.8	5.7	5.2	5.4	4.8	4.7	4.4	4.3	4.5	4	4.2	4.2	4.3
New York City	7.9	6.7	6.6	5.8	6	5.1	4.8	4.7	4.7	4.4	3.9	3.9	4.2	4.1
Rest of State	5.1	5	4.9	4.6	4.8	4.5	4.6	4.2	4.1	4.5	4	4.5	4.2	4.4

Hispanics continued to experience the lowest neonatal death rates. The rate was at its lowest point in 2000 when it was 2.6 per 1,000 live births. Between 2000 and 2004, however, the rate increased slightly all but one year. The 2004 rate of 3.4 per 1,000 live births is still lower than the rates for whites and blacks.

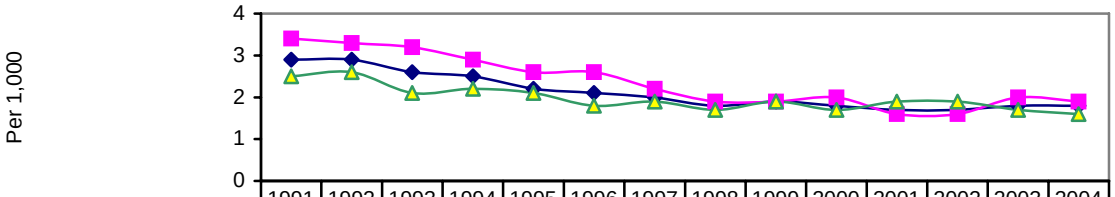
Figure 47. **Neonatal Mortality Rate**
NYS Residents by Race 1991 - 2004



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White	4.2	4.2	4	3.9	4.1	3.7	3.7	3.4	3.5	3.7	3.5	3.8	3.2	3.6
Black	10	8.5	9.1	8.4	8.5	7.6	6.8	6.4	6.3	7.6	6.4	6.4	7.5	7.1
Hispanic	3.8	4	3.7	3.8	4.2	3.5	3.1	3.1	3.3	2.6	3	2.7	3.3	3.4

<u>Post-Neonatal Mortality Rate</u>: The post-neonatal mortality rate in New York State has also declined significantly. Between 1991 and 2004, it declined 37.9% to 1.8 per 1000 live births. Declines have been seen in both New York City and the rest of the State. In 1999, there was no difference in the rates for the two areas. Between 1999 and 2000 the rest of State rate dropped slightly to 1.7 while the New York City rose at 2.0 per 1000. In 2001 the statewide rate dropped to 1.7. The entire decline was seen in NYC where the rate went to 1.6 in 2001 and from 2.0 in 2000. The rest of the state rate rose slightly to 1.9 per 1000. In 2002 the rates remained at 2001 levels for all areas. In 2003, there was a slight increase in the rate from 1.7 to 1.8 per 1,000 live births. The rate remained at 1.8 per 1,000 live births in 2004 even though there was a slight decrease in both New York City (2.0 to 1.9) and the Rest of State (1.7 to 1.6).

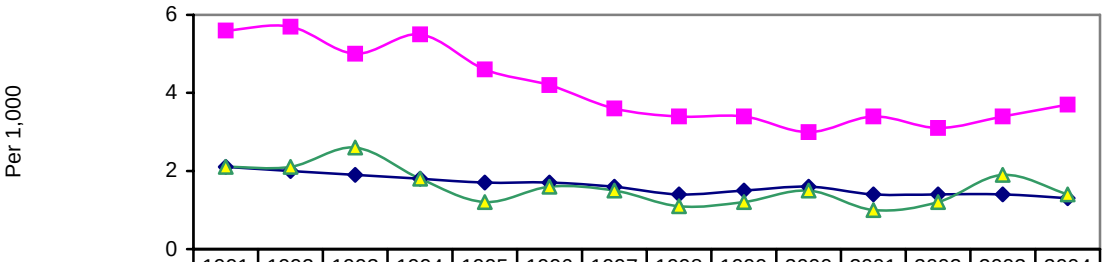
Figure 48. **Post-Neonatal Mortality**
New York State Residents by Region 1991 - 2004



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
New York State	2.9	2.9	2.6	2.5	2.2	2.1	2	1.8	1.9	1.8	1.7	1.7	1.8	1.8
New York City	3.4	3.3	3.2	2.9	2.6	2.6	2.2	1.9	1.9	2	1.6	1.6	2	1.9
Rest of State	2.5	2.6	2.1	2.2	2.1	1.8	1.9	1.7	1.9	1.7	1.9	1.9	1.7	1.6

The disparities in rates between Blacks and Whites that were seen in both infant and neonatal mortality rates are also seen here in post-neonatal mortality. Between 2002 and 2004, the disparity has grown even wider. Post-neonatal mortality rates have increase among black births from 3.1 per 1,000 in 2002 to 3.7 in 2004. Rates among white births have declined slightly from 1.4 in 2002 to 1.3 in 2004. Based on post-neonatal death rates of 1.3 per 1000 among whites and 3.7 per 1000 among blacks, the Black/White ratio in 2004 was 2.8. This was the highest black/white ratio since 1992 when it was also 2.8.

Figure 49. **Post-Neonatal Mortality Rate**
New York State Resident by Race 1991 - 2004



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White	2.1	2	1.9	1.8	1.7	1.7	1.6	1.4	1.5	1.6	1.4	1.4	1.4	1.3
Black	5.6	5.7	5	5.5	4.6	4.2	3.6	3.4	3.4	3	3.4	3.1	3.4	3.7
Hispanic	2.1	2.1	2.6	1.8	1.2	1.6	1.5	1.1	1.2	1.5	1	1.2	1.9	1.4

C. Children with Special Health Care Needs

New York applauds national efforts to establish data for numbers of children with special health care needs. As a State Health Department, we are working to improve what is known about special needs children in our State in order to better serve them and better serve their families. We also continue to work closely with families, advocates and other agencies to assess need and assure availability of high-quality, comprehensive, culturally-sensitive, community-based, family-centered services.

According to HRSA estimates, the number of self-reported Children with Special Health Care Needs is estimated to be 558,173, or 11.8 percent of the child population. Prevalence increases with age: 7.7 percent from birth to five, 13.2 percent from ages six through eleven, and 14.4 percent at ages 12 through 17. The prevalence is reported higher in males (14.2%) than in females (9.4%). Prevalence is also higher in lower income groups: 14% percent at or below the Federal Poverty Level (FPL), 14.3 percent in those between 100 and 199 percent of FPL, 12.1% at 200 to 399 percent of FPL, and 9.4% for families 400% and higher of the FPL. The highest rates are reported in non-Hispanic Whites at 12.7 percent, compared to African Americans (11.8%) and Hispanics (11.1%). The same survey found that 29.9% of the families of children with special health care needs reported that the child's condition affected their employment, and 20.9% reported that their child's condition created financial problems for the family.

The Children with Special Health Care Needs (CSHCN) Program provides information and referral services for health and related areas for families of CSHCN. All 58 contractors, with the exception of one, are utilizing an electronic application to record the number and types of services provided to CSHCN and their families. This CSHCN Program data system has been in operation since 1999. The CSHCN Program is working with Center for Community Health Information Technology staff to perform a system upgrade to improve the accuracy and completeness of data reported by local CSHCN Programs.

In 2005, the local CSHCN Programs reported serving 5011 CSHCN. The age breakdown of these children are as follows: birth to four years, 27%; five to nine years, 17%; ten to fourteen years, 28%; fifteen to nineteen years, 24%; and twenty up to 21 years, 3%. This breakdown indicates that a significant number of CSHCN are identified and referred early (27%) by four years of age. The largest percentage of CSHCN are in the ten to fourteen age range (28%), representing those who require medically necessary orthodontia. There is a focus on connecting young adults, ages 18 to 21 years, who have lost their family's insurance, to other insurance or a gap-filling program, such as the Physically Handicapped Children's Program.

Data are collected on medical homes at time of admission to the CSHCN Program. The data from the local health departments indicate that, of the children who enter the CSHCN Programs, 75.5% in 1999, 74.2 % in 2000, 61.0 in 2001, 51% in 2003, 54% in 2004 and 66% in 2005, have primary care providers. A focus of the CSHCN Program is connecting CSHCN to primary care providers who are the child's medical home.

The major sources of referrals for the CSHCN Program are: hospitals/specialty health care providers, 36%; parent/family, 24%; Early Intervention Program, 5%; Physically Handicapped Children's Program 5%; and other, 13%.

The racial background of the children referred was reported as white (56%), African-American (6%), Other (12%), Asian (1%), American Indian or Alaskan Native (0.2%), and no responses from (24%). Nine percent of CSHCN were reported to be Hispanic.

Orthodontia represents the most common diagnosis (36%). Ear disorders are the second most common diagnosis (17%); followed by developmental delay (9%), musculoskeletal (8%), nervous system disorders (4%); respiratory disorders (4%); perinatal disorders (prematurity/apnea)(3%) and other categories of diagnoses (such as cleft lip and palate, cardiac, neoplasms), each representing less that 2% of all diagnoses reported.

SLAITS Study: The Maternal and Child Health Bureau at HRSA identified six core outcomes for measuring States' progress toward implementing family-centered, community-based, comprehensive, coordinated, easily accessible system for Children with Special Health Care Needs. MCHB also developed a monitoring strategy utilizing a national telephone survey conducted by the National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC) called SLAITS – State and Local Area Integrated Telephone Survey.

From the SLAITS, New York learned that:

- An estimated 60.3% ± 4.5% of New York families of children with special health care needs were partners in decision-making and were satisfied with the services they are receiving.

- An estimated 51.7% ± 2.4% of New York families of children with special health care needs were obtaining care within a medical home.
  - About 92% reported a usual source of care.
  - About 90% had a personal doctor or nurse.
  - About 76% said they had no problem receiving needed referrals.
  - About 46% reported receiving effective care coordination when needed.
  - About 67% said their care was usually family centered.

- An estimated 59.1% ± 2.3% of New York families of children with special health care needs had adequate insurance coverage to pay for the services they need.
  - About 96% had public or private insurance at the time of the interview.
  - About 89% had no gaps in coverage in the year prior to the interview.
  - About 83% had insurance that always or usually met the child's needs.
  - About 72% found costs not covered by insurance was usually or always reasonable.
  - About 85% said insurance usually or always permitted the child to see needed providers.

- Approximately 75.3% ± 3.8% of families said systems were organized in a way that families can use them easily.

- Relative to transition of children with special health care needs to adulthood, an estimated 61.5% ± 7.1% said their doctors had spoken to them about their changing needs as they become an adult. Approximately 48.4% ± 11.5% have a plan for transition to adult services and 32.6% ± 9.5% said their doctor had discussed shifting to an adult provider. Approximately 35.7% ± 7.8% received vocational or career training.

The results of the SLAITS study for New York are documented on **Form 11. National Performance Measures 2 through 6.**

Fetal Alcohol Syndrome Surveillance: Fetal Alcohol Syndrome or FAS is a preventable birth defect caused by maternal alcohol drinking during pregnancy. The syndrome is diagnosed by using a combination of findings, which may include poor growth, central nervous system disorders, certain FAS-related facial features, and a history of maternal alcohol use during pregnancy. The syndrome may be more difficult to recognize in newborns, but easier to diagnose in older children. New York has two systems to ascertain Fetal Alcohol Syndrome cases: the statewide birth defects registry and FASSNet, or the Fetal Alcohol Syndrome Surveillance Network. FASSNet is a population-based, multi-source system where records of children with FAS or known or suspected prenatal exposure to alcohol are actively enrolled and their records abstracted. In a recent study comparing the accuracy of FAS reports to the registry with the FASSNet system, FASSNet was shown to identify more children than the registry alone.

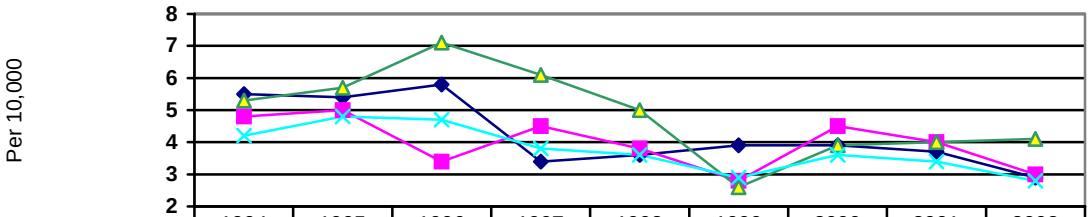
From 1996 through 2003, New York was a part of the National Birth Defects Prevention Study, a CDC-funded collaborative. For this study, a random sample of women who gave birth from 1997 to 2003, whose children did not have a major structural malformation were controls. The study area was an 8-county region in Western New York. Women were interviewed within two years of childbirth. The study questionnaire asked about alcohol intake before and during pregnancy. In the three months before conceiving, 50% of the women reported any drinking (95% CI 41-59%), and 15.2% reported at least one episode of binge drinking (95% CI 9.4 to 22.7%). In the first three months of pregnancy, 8% reported at least one episode of binge drinking (95% CI 4.0 to 14.1%). Past studies have shown that drinking during pregnancy tends to be under-reported. Also, while most women reduce or stop drinking once they know they are pregnant, pre-pregnant levels of alcohol consumption may continue in the earliest stages of pregnancy until the woman realizes or is told she is pregnant.

In the project area, the 1995-1999 birth cohort had an incidence of FAS of 0.72 per 1,000. Rates were higher in urban Buffalo, where there was an overall rate of 1.92 per 1,000. The non-Hispanic white rate was 0.83 /1,000; the rate for African Americans was 3.4/1,000.

Neural Tube Defects: The figure that follows shows the trend in incidence of neural tube defects has declined since 1994 when the rate was 4.2 per 10,000 to 2.8 per 10,000 in 2002. Rates are highest among Hispanics. Interestingly, according to the NYS PRAMS survey data, Hispanics are less likely than non-Hispanics to be knowledgeable about the relationship between folic acid and neural tube defects (70% of Hispanics versus 93% of non-Hispanics are knowledgeable.)

The source of these data is the New York State Congenital Malformations Registry. Please note: The Black and White categories do not include Hispanics in the calculation. Information is reportable to this registry for up to two years from the date of birth. Therefore, later figures are not available. This rate is affected by rates of pregnancy termination based on the information provided by prenatal testing.

Figure 50. **Rate of Neural Tube Defects per 10,000 Live Births**
New York State 1991 - 2002*



	1994	1995	1996	1997	1998	1999	2000	2001	2002
White	5.5	5.4	5.8	3.4	3.6	3.9	3.9	3.7	2.9
Black	4.8	5	3.4	4.5	3.8	2.8	4.5	4.0	3.0
Hispanic	5.3	5.7	7.1	6.1	5.0	2.6	3.9	4.0	4.1
Total*	4.2	4.8	4.7	3.8	3.6	2.9	3.6	3.4	2.8

*Including unknown race

Please refer to ***Table 11*** for information from the NYS PRAMS on mothers' knowledge of folic acid to prevent neural tube defects.

Cleft Lip and Palate: During 1998-2001, 1061 children in this state, at a rate of 10.4 per 10,000 live births, were born with cleft lip, palate or both. New York has an effective mechanism for identifying, recording, and referring these infants for treatment. Cleft lip and palate are eligible conditions under the Physically Handicapped Children's Program (PHCP) and the Dental Rehabilitation component of PHCP.

Transitioning CSHCN to Adult Services: Our work with families of children with special health care needs (CSHCN) shows that families and caregivers need guidance and support as they assist their loved one with the transition to the adult health care system and with shifting their role from providing primary medical coordination to one of promoting self-determination and independence for their loved one with disabilities. Medical providers also play a pivotal role in this transition process; however, many medical providers have stated that they do not have the tools and skills necessary to assist individuals and caregivers with this transition.

4. MCH Capacity by Pyramid Level

Overall Capacity: The State Title V Agency in New York State remains the **New York State Department of Health (NYSDOH)**. Responsibility for the administration of Title V is vested with the Division of Family Health. To understand capacity relative to direct medical, enabling, population-based and infrastructure services, it is first helpful to understand NYSDOH's capacity as a state agency.

The New York State Department of Health has as its mission: *"Working together and committed to excellence, we protect and promote the health of New Yorkers through prevention, science and the assurance of quality health care delivery."* Our organizational vision is that of "*a community of professionals who, through commitment to education, innovation, leadership, customer respect and research solutions for health problems, make New Yorkers the healthiest people in the nation."* We seek to carry out our mission through a core set of values, which includes: *dedication to public good, innovation, excellence, integrity, teamwork,* and *efficiency.*

NYSDOH is an executive agency, with Commissioner Antonia C. Novello, M.D., M.P.H., Dr.P.H., reporting directly to Governor George E. Pataki. As a former U.S. Surgeon General, and as a pediatrician and former Special Representative to UNICEF, Dr. Novello has a solid record of leadership and commitment to maternal and child health. She has many times over demonstrated her capacity to promote and protect the health of all mothers, infants and children, including those with special health care needs. Early in her tenure, she met with the MCHSBG Advisory Council and discussed her plans for the Department and her appreciation for the advice of the Council. She continues on a daily basis to provide the leadership needed to effectively address New York's multiple and complicated health issues.

Maternal and child health programs are located throughout the New York State Department of Health, but are mostly located in the **Center for Community Health** and the **Division of Family Health**, where administrative oversight for the Block Grant is vested.

In addition to its responsibility for Title V, the **Division of Family Health** is responsible for family planning (Title X), early intervention (Part C) services, the Prenatal Care Assistance Program, perinatal networks, designation of perinatal centers and CSHCN specialty centers, dental health, lead poisoning prevention, adolescent health, youth development, adolescent pregnancy prevention, universal newborn hearing screening and programs for children with special health care needs. This division is located within the **Center for Community Health**. The State Health Department's organizational chart is included with this submission under **Appendix C.** (*Figures 3 and 4)*. Organizational structure and staffing support our mission, vision and values.

There are currently 218 filled Title V-funded positions within the NYSDOH and an additional 630 non-Title V-funded positions performing Title V-related activities. Positions are located within the Department's central, regional and district offices. Staff cover the full range of MCH activities, including child and adolescent health, women's health, perinatal health, dental health, local health services, nutrition, child safety, injury control, laboratory operations, human genetics, congenital malformations, data and information systems infrastructure, health communications, managed care and facility surveillance.

The Center for Community Health

Guthrie Birkhead, M.D., M.P.H., is the Director of the **Center for Community Health.** Dr. Birkhead was appointed Director of the Center for Community Health in January 2001 and has been Director of the AIDS Institute since December 1995. Prior to that Dr. Birkhead worked in the field of communicable disease epidemiology and control for 11 years. He is a graduate of the CDC Epidemic Intelligence Service program and the CDC Preventive Medicine Residency Program. He joined the New York State Health Department in 1988 and became the Director of the Bureau of Communicable Disease Control in 1993. He is board certified in internal medicine and preventive medicine, and holds a Masters of Public Health Degree. He is Associate Professor of Epidemiology at the School of Public Health at the University at Albany, founding Director of the Department's Preventive Medicine Residency Program, and Past President of the Council of State and Territorial Epidemiologists.

Executive Deputy Director of the Center for Community Health is Ms. Ellen Anderson. Ms. Anderson comes to the Center after having served as co-director of the Office of Managed Care. She has an extensive administrative background. Ms. Phyllis Silver is Special Assistant. Ms. Silver also came to the Center from the Office of Managed Care. Prior to that time, she was the Department's Advocate for Children, and in that title had responsibility for Title V activities. She has an extensive background in early childhood issues and maternal and child health.

The **Office of Local Health Services** is located within the Center for Community Health and directed by Ms. Sylvia Pirani. This unit is the touch point for communication and coordination with the 58 local health units. This unit ensures that the State is working in partnership with local health departments and other health care providers to strengthen core public health functions as changes are occurring in health care financing and delivery systems. Working closely with local health units, the Department is able to promote and ensure essential maternal and child health services that complement those provided by managed care and the private sector. Ms. Marie Miller is deputy director and oversees State Aid to local health units, the completion of community health assessments and municipal public health services plans.

Information and data needs related to Title V activities are met through the Center for Community Health's **Public Health Information Group (PHIG)**. Directed by Mr. Michael Medvesky, PHIG provides data access and technical assistance to central office, regional offices and local county health departments. The Public Health Information Group provides services such as preparing data for the Title V needs assessment and developing MCH data sets. This unit also has responsibility for the **Pregnancy Risk Assessment Monitoring Survey (PRAMS)**. Partially supported by a grant from the Centers for Disease Control and Prevention, they seek to improve capacity for data management and for targeting and designing successful public health interventions at a state and local level. Ms. Anne Radigan is the PRAMS Project Director.

Mr. Medvesky has over 25 years of experience in public health, epidemiology, research methods and evaluation. He advises on public health indicators for many health initiatives in addition to the Block Grant, and is very knowledgeable about community and local assessment methods, sources of data, and improvement of data capacity. He currently serves as the project manager of New York's CDC-funded Cooperative Agreement to Support State Assessment Initiatives.

PHIG is also responsible for the New York State **Community Health Data Set**, which consists of a series of tables, maps and graphs containing health statistics organized by

county of residence. Because it resides on the Health Information Network, it is readily available for use by counties in compiling their community health assessment. The Community Health Data Set includes information from natality and mortality data from the birth, death and fetal death files; from SPARCS (a data set containing information on all hospital discharges in the state); from the Department of Health's disease registries, and from program-based systems. The Community Health Data Set is organized in nineteen sections, and offers mortality data as both crude rates and age-adjusted rates.

The **Office of Minority Health,** directed by Ms. Wilma Waithe, promotes the health of the State's minority populations by leading, coordinating, supporting and assessing the Department's efforts to reduce and, ultimately, eliminate health disparities. This Office works with Title V in facilitating community awareness of MCH services, and helping to assure access, appropriateness and acceptability of services. Central to the Office's activities are: the Minority Health Community Partnerships, grant program, which mobilizes communities to eliminate health disparities through coalition-driven, asset-based, neighborhood-specific interventions; and the Minority Health Mini-Grants Program, which supports short-term, small-scale projects which build capacity of community-based organizations to provide culturally- and linguistically- appropriate services, and improve outreach to minority populations.

Fiscal expertise for preparation of the MCHSBG application is provided by the **Division of Family Health Fiscal Unit**, directed by Ms. Deborah Nance. Ms. Nance and her unit now provide fiscal analyses of block grant spending and contract management. It is important to note that New York externally appropriates half of its block grant dollars to support MCH services at the local and statewide level. In the Division of Family Health alone, approximately 600 contracts are administered annually.

The Division of Family Health

The **Division of Family Health** continues to be responsible for coordinating MCH-related programs and directly managing many MCHSBG-funded initiatives. This Division contains four bureaus: the **Bureau of Child and Adolescent Health**, the **Bureau of Women's Health**, the **Bureau of Dental Health** and the **Bureau of Early Intervention Services**.

The mission statement of the Division states that, *"[a] s members of the public health community, the Division promotes the health of New Yorkers and supports family empowerment to create healthy communities. With a primary focus on the health needs of women and children, our efforts involve the promotion of healthy behaviors, assurance of quality and accessible health care and adherence to state of the art knowledge and best practices. In partnership with other Departmental units, state agencies and county health departments, we work collaboratively with provider organizations, professional associations, advocacy groups and community coalitions to achieve these goals."*

The values of the Division of Family Health are outlined in this statement: *"Division staff work with integrity, efficiency and professionalism. Vigilantly anticipating future challenges, we remain dedicated to the public good and committed to family-centered care. Innovation is encouraged and teamwork is rewarded. The tasks of accomplishing the Division goals are conducted with compassion and tempered with good humor."*

Ms. Barbara McTague was appointed Director of the Division of Family Health in June 2005. Since 1987, Ms. McTague has implemented and managed a variety of programs with in the Department of Health, and in 1991, she was appointed Director of the Bureau of Women's Health. More recently, she served as Director of the Bureau of Early

Intervention Services. Ms. McTague's experience in the AIDS Institute and with various programs and bureaus within the Division of Family Health has given her a very broad understanding of health and development issues impacting women, children and families. Ms. McTague has overall responsibility for policy, direction and oversight for the Division of Family Health and its bureaus and programs.

Dennis Murphy, M.A., is Associate Director of the Division of Family Health. Mr. Murphy received a BA in Education and a Masters degree in Political Science/Public Administration from the University of New York at Buffalo. He has extensive experience in public health and epidemiology, particularly in working with local health departments and health provider agencies. He directed New York State's STD Control Program of a number of years. Mr. Murphy provides administrative oversight for each of the Divisions bureaus.

The Division of Family Health has created a new Office of the Medical Director and has appointed a director and staff. The Office of the Medical Director will ensure that clinical expertise is available to address the needs of the Division's broad array of programs and will work with the Division's Bureaus and programs to identify areas where medical expertise can facilitate the achievement of program goals.

Marilyn Kacica, M.D., M.P.H., has joined the Office as the new Medical Director of the Division of Family Health. She is formerly the Director of the Healthcare Epidemiology Program in the Division of Epidemiology's Bureau of Communicable Disease Control. Dr. Kacica has been with the Department for six years. She holds a BA from St. Louis University and an MD from the St. Louis University School of Medicine. She completed pediatric specialty training at Cardinal Glennon Children's Hospital and pediatric sub-specialty training in pediatric infectious diseases at the Children's Hospital of Cincinnati. She earned her MPH and completed the New York State Preventive Medicine Residency Program through the University at Albany School of Public Health. Prior to joining the department, Dr. Kacica was a practicing physician and Associate Professor of Pediatrics at Albany Medical College. She is currently a Clinical Associate Professor of Epidemiology at the University at Albany School of Public Health and is board certified in Pediatrics and Pediatric Infectious Diseases.

In addition, Dr. Christopher Kus continues in his role as pediatric consultant for the Division within the Office of the Medical Director. Christopher Kus, M.D., M.P.H., is a developmental pediatrician who has worked with the New Hampshire and Vermont Departments of Health prior to coming to New York. He has been with the New York State Department of Health for the past eleven years. He serves as a liaison with the State Medicaid Program and the Office of Managed Care. Dr. Kus is Past President of the Association of Maternal Child Health Programs (AMCHP). He has chaired their committee on Service Delivery and Financing Systems and co-chaired the MCH-Medicaid Technical Advisory Group.

Effective in January 2006, Renee Samelson, M.D., M.P.H., joined the new office. Her focus is primarily on women's health issues. She received her baccalaureate degree from the University of Cincinnati, her M.D. from the University of Cincinnati Medical School and her M.P.H. in 2004 from the University at Albany, School of Public Health. She has completed residencies in Family Practice (Deaconess Hospital, Buffalo), Obstetrics and Gynecology (Southern Illinois University School of Medicine, Springfield, Illinois) and Preventive Medicine (U at Albany) and completed a fellowship in Maternal-Fetal Medicine (Southern Illinois University School of Medicine). Dr. Samelson is Associate Clinical Professor of Maternal Fetal Medicine at the Department of Obstetrics and Gynecology,

Albany Medical College. She has previously served as an attending physician at Brigham and Women's Hospital and at Albany Medical Center. She was director of Maternal-Fetal Medicine at Albany Medical Center from 1997 to 1999.

Donna Noyes, Ph.D., has been appointed as the Director of the Office of Policy and Planning for the Division of Family Health. She previously served the Department in the Early Intervention Program. She is joined in that office by Mr. Todd Gerber, whose responsibilities include assisting Division of Family Health programs manage existing public health data systems and develop improved business process models. Mr. Gerber received a Master of Science degree in biostatistics/epidemiology from the University of Massachusetts, School of Public Health. He has many years of experience in the field of epidemiology, biostatistics and program evaluation.

Within the Division Director's office, Michelle Cravetz, M.S., R.N.-B.C., coordinates MCHSBG-related activities, grant submission, grant management activities and special projects. Ms. Cravetz has over 30 years of maternal and child health experience at the local, regional and State level. She served as MCH Consultant Nurse, Regional Director of Preventive Health Services, Clinical Consultant to the Migrant and Indian Health Programs, Director of the School Health Program, and Director of the Office of Rural Health and Primary Care. Ms. Cravetz is Principal Investigator (PI) to the State Systems Development Initiative and family and consumer forums. She is a member of the Department's Institutional Review Board for the Protection of Human Subjects and serves on the University at Albany's Continuing Education in Public Health Advisory Panel. Ms. Cravetz was appointed Assistant Director of the Bureau of Dental Health in January 2003.

Thomas Carter, Ph.D., continues to coordinate the cross-systems, cross-agency partnerships for the Department. Dr. Carter also coordinates the MCH Graduate Assistant Program, which matches priority MCH projects with graduate assistants from the School of Public Health at the University at Albany, and directs the Migrant and Seasonal Farmworker Health Program.

Patricia Waniewski, M.S., R.N. is the Asthma Coordinator as part of a five-year grant with the Centers for Disease Control. As such, Ms. Waniewski coordinates the various asthma initiatives across the Department and is instrumental in implementing our New York State Asthma Plan. Ms. Waniewski came to the Department with extensive experience in ambulatory care systems and is a retired officer of the US Navy.

Wendy Stoddart, R.N., B.S.N., is a former Director of Patient Services for St. Lawrence County Public Health Department. She has 28 years of experience planning and implementing preventive health programs. She is working within the Division as Clinical Coordinator of the American Indian Health Program. Ms. Stoddart works with Primary Care Contractors through out the state and the Nations' clinic staff to ensure that the Native American nations across the state have access to preventive health education as well as primary health care services.

The Division of Family Health is also administrative home to New York's **State Systems Development Initiative (SSDI)** grant, coordinated by Ms. Cathy Tucci-Catalfamo. The goal of SSDI grant is to ensure meaningful measurement of attainment of Block Grant Performance Measures. To this end, Ms. Tucci-Catalfamo has been working the Title V Coordinator and program staff to develop the Children with Special Health Care Needs Data System and in gathering parent and consumer input to this grant's needs assessment. SSDI worked with the Integrated Child Health Information System (ICHIS) and assist Title V with data matching and data infrastructure issues.

The Division of Family Health has four bureaus: the Bureau of Child and Adolescent Health, the Bureau of Dental Health, the Bureau of Women's Health, and the Bureau of Early Intervention Services.

The Bureau of Child and Adolescent Health

The mission of the **Bureau of Child and Adolescent Health** (BCAH) is to promote and protect the health and well being of New York's infants, children and youth through:

- Defining the parameters of optimal health for children, birth through 21 years of age, throughout New York State;
- Assessing current status of children's health in New York State;
- Conducting Needs Assessments to obtain and maintain optimal health and to identify resources and gaps in resources;
- Identifying/developing/implementing strategies to address the disparity between existing health status and optimal health status and to maintain optimal health; and
- Providing ongoing monitoring and evaluation of efficiency and effectiveness of strategies employed.

Title V and Title V-related programs within the Bureau of Child and Adolescent Health include: Childhood Lead Poisoning Prevention, Pediatric Asthma, Healthy Children New York, Children with Special Health Care Needs, the Physically Handicapped Children's Program, Youth Development, the School Health Program, Comprehensive Coordinated School Health Program, ACT for Youth, Abstinence Education, the Community-Based Adolescent Pregnancy Prevention Program, Enhanced Services, Infant and Child Mortality Review, Interim Lead-Safe Housing Program, the Regional Lead Poisoning Technical Assistance Centers, and the Lesbian, Gay, Bisexual and Transgender Health Initiative. BCAH also has responsibility for the Early Childhood Comprehensive Systems Initiative.

The Bureau Director for the **Bureau of Child and Adolescent Health** (BCAH) is Rachel de Long, M.D., M.P.H. She was appointed in May 2005. Dr. de Long is a graduate of the Preventive Medicine Residency Program at the University at Albany. She had served as Acting Director of the Bureau and Coordinator of the Early Childhood Comprehensive Systems Planning Initiative. Ms. Marta Riser, Associate Director of this Bureau, continues her active leadership role in activities related to adolescent services, assets building and risk reduction activities. She has also been very involved in putting together the State's **Adolescent Health Agenda** and the **ACT for Youth** initiative.

The Bureau has five units and one initiative: the School Health Unit; the Medical Home Unit; the Adolescent Health Unit, the Childhood Lead Poisoning Prevention Unit; the Child Morbidity and Mortality Prevention Unit and the Statewide Early Childhood Comprehensive Systems Planning Initiative.

The **School Health Unit** is headed by Annette Johnson and contains the following programs: School Based Health Centers and Comprehensive Coordinated School Health.

The **School Health Program** is the largest school-based primary care program in the US, with over 180 school-based health center sites. Sites offer comprehensive, accessible services to children from preschool age through high school in high-risk urban, suburban and rural communities. The **Coordinated School Health** representative is Laurie Ann Wagner at the State Health Department and Owen Donovan at the State Education Department. This is a collaborative initiative promotes comprehensive health and wellness in the school setting.

The **Childhood Lead Poisoning Prevention Unit** is headed by Barbara Leo, M.S., R.N., and provides prevention, early detection and effective treatment of childhood lead poisoning. A collaborative relationship exists between this program, the Center for Environmental Health's housing and community efforts, and Wadsworth Laboratories' efforts in lead testing and tracking. The unit funds **Regional Lead Resource Centers,** where county health departments and providers may receive technical assistance; **Lead Poisoning Prevention Coalitions;** and **Interim Lead-Safe Housing.** They are also responsible for the **Statewide Lead Elimination Plan**.

The **Medical Home Unit** is directed by Susan Slade, M.S., R.N. This unit has responsibility for the **Children with Special Health Care Needs Program**, the **Physically Handicapped Children's Program**, **Asthma Coalitions,** and the **Medical Home Resource Centers**. The **Childhood Asthma Program** supports seven regional asthma coalitions and public and provider education. The coordinator works closely with the Division's Asthma Coordinator. The **Champions for Progress** grant is also housed in this unit.

Healthy Children New York, originally funded as a **Community Integrated Service Systems (CISS)** grant, is coordinated by Ms. Mary Huber, working closely with the Office of Children and Family Services (childcare licensors) to improve the health and safety of children in childcare. The program has educated over 100 individuals in the Northeast, Central, Western, Lower Hudson Valley, Long Island, and Capital Regions of the State.

The **Children with Special Health Care Needs (CSHCN) Program** provides services to children, ages birth to 21, that are not provided through Medicaid or SSI Medicaid. The CSHCN Program also certifies specialty centers to promote access to comprehensive evaluation and treatment services for those children in whom a serious, chronic illness or physical disability is suspected. Recently, the program strengthened their ability to identify, report and act on identified needs for the CSHCN population and their families by launching a new data system for the use of the 58 local health department-based Children with Special Health Care Needs Programs. Additional changes are underway to bring the CSHCN data system into compatibility with the Early Intervention Program data system.

The Title V program employs **five parents of children with special health care needs**, one of whom, Ruth Walden, is officially employed as **Family Specialist** and a parent advocate. (The others are employed as public health program nurses, health program administrator and SSDI Coordinator.) The parents help link our agency to parent groups like Family Voices, Parent-to-Parent, Mothers United for Moral Support (MUMS) and other statewide parent advocacy agencies. Employing parents and using parent input has improved our focus on comprehensive, family-centered, community-based, culturally competent, coordinated care. Title V parents and Title V coordinator worked with the various stakeholders statewide to formulate the parent recruitment and training under the Champions for Progress initiative.

The role of the Family Specialist, our official "Title V Parent", is to maintain communication and linkages with families of Children with Special Health Care Needs. She provides support, exchanges information between parents and the Department, gets input on program actions, reviews and evaluates information from families and professionals, and determines possible course of action that may improve service delivery systems. Typically, her activities include organizing training programs, advising intra- and inter-agency groups on policies related to children with special health care needs, public speaking and assisting in the development of grant proposals that reflect the parent perspectives. As New York's Title V parent, Ms. Walden has taught several

parents, both within and outside our State, to be Block Grant reviewers and is frequently called upon by others to provide training in parent involvement or to review other States' grants. Ms. Walden is often called upon by the Maternal Child Health Bureau to provide family feedback regarding Children with Special Health Care Needs. Ms. Walden has also served as the Family Voices Coordinator for New York State and on the Emergency Medical Services for Children advisory panel. With the Title V Coordinator, she has presented a number of workshops and panels at AMCHP and HRSA meetings on parent involvement. She was recently elected to the Board of Directors of AMCHP.

The **Adolescent Health Unit** is directed by Ms. Stephanie Sheehan. The programs in this unit include ACT for Youth, the Community-Based Adolescent Pregnancy Prevention Program, Abstinence Education and the Lesbian, Gay, Bisexual, Transgender Health Project. Ms. Kristine Mesler serves as New York's **Adolescent Health Coordinator.**

The **Abstinence Education Program** seeks to reduce the teen pregnancy and birth rates, as well as to reduce the proportion of adolescents who have engaged in sexual intercourse in target communities and the incidence of sexually transmitted diseases in teens in the targeted communities.

The **Community-Based Adolescent Pregnancy Prevention** also uses a targeted community approach to reduce adolescent pregnancy rates. The program provides community information and education to sensitize the public about the local need to address the prevention of unintended pregnancy. The program also promotes use of peer educators to reach adolescents at risk of unintended pregnancy. Peer educators provide factual information, identify social pressures and responses to these pressures and teach assertiveness skills. They also work with peers parents, schools, community health and human service organizations, local governments, businesses and the media. Youth development activities, including educational, recreational and vocational opportunities designed to improve self-esteem, are also provided.

The **Childhood Morbidity and Mortality Unit** is directed by James Raucci. This unit is responsible for Childhood Death Review, morbidity and mortality surveillance, SIDS prevention and response, and the Enhanced Services Initiative.

The **New York State Early Childhood Comprehensive Systems Initiative** is co-chaired by Dr. Rachel de Long and Mr. Robert Frawley, Director of Policy and Planning, at the New York State Council on Children and Families with assistance from Tammy Nazarko, as project coordinator. Activities in the current year will focus on the transition from planning to implementation.

The Bureau of Women's Health

Barbara Brustman, Ed.D., is the Director of the Bureau of Women's Health, and Ms. Wendy Shaw, R.N., M.S., is Assistant Director. The Bureau of Women's Health has responsibility for the Department's perinatal, family planning, maternal mortality review, breastfeeding and rape crisis programs, and works with other units throughout the Department to coordinate initiatives related to women's health. The Bureau of Women's Health also has responsibility for the **"Growing Up Healthy Hotline"**. The Bureau is the liaison with **Healthy Start.**

The mission of the Bureau of Women's Health is to promote the health of women across their reproductive life span through the development, implementation and coordination of women's health programs. The Bureau endeavors to promote the health of women of reproductive age, to promote the birth of healthier babies, to ensure the availability of

reproductive choices to prevent unintended pregnancies, to reduce adolescent pregnancy, and to reduce violence against women as well as its impact on women, their families and their communities. The Bureau values teamwork, integrity, professionalism, commitment and communication.

The **Family Planning/Reproductive Health Services Unit** is directed by Ms. Joan Linton, RN. The **Family Planning Programs** provide low-income, uninsured and underinsured women with comprehensive reproductive and preventive health services, including routine gynecological exams and laboratory testing; screening for high blood pressure, anemia and diabetes; health education; screening and treatment of sexually transmitted infections; HIV counseling and testing; contraceptive services; preconception planning and counseling; pregnancy testing, and referral to prenatal care. **Infertility services** are also housed within this unit.

Ms. Deborah Joralemon, R.N., M.S., directs the **Rape Crisis Program**, which includes the development of programs and provision of services to improve the response to rape and sexual assault.

Ms. Linda Thornton, R.N., M.S., directs the **Perinatal Services Unit** within the Bureau. This unit is responsible for an array of services to improve perinatal, maternal and infant outcomes throughout New York State, including **PCAP** and **MOMS Programs**, the **Community Health Worker Program**, the **Comprehensive Prenatal/Perinatal Services Networks**, **perinatal regionalization**, and the **Statewide Perinatal Data System**.

Ms. Tammy Nazarko has served as the **Comprehensive Women's Health Coordinator**. The Comprehensive Women's Health Initiative served to coordinate across agency programs and across agencies all those efforts related to improving women's health across the lifespan. Under this initiative, a women's heath program profile describing all programs providing services to women administered by the Department has been published and a Women's Health Summit was held. A woman's health data profile is currently under development.

The Bureau of Dental Health

The Bureau of Dental Health is directed by Elmer Green, D.D.S., M.P.H., and Michelle Cravetz, M.S., R.N.-B.C. is Assistant Director. Jayanth Kumar, D.D.S., M.P.H., serves as Director of Dental Public Health Research. The mission of the Bureau is to improve the oral health of all New Yorkers. The Bureau implements and monitors statewide dental public health initiatives to assess, prevent, control or reduce oral diseases and other health conditions, and promote healthy behaviors, dental sealants, school-based supplemental fluoride and dental rehabilitation programs. The Bureau conducts oral health surveillance projects, including projects in Head Starts and third-grade students.

The Dental Bureau provides oversight to 26 **Dental Preventive Services for High-Risk Populations** grantees. Under this program, community-based providers collaborate to provide access to needed dental preventive services, especially for low-income children and pregnant women. More recently, the Bureau funded seven **Innovative Dental Services** grantees, charged with testing new solutions to dental health access issues within their communities. Under this initiative, a statewide **Technical Assistance Center** was also funded at the Rochester Primary Care Network. Both initiatives encourage efficient use of dental resources, community partnerships and collaborations and the establishment of community-based or school-based dental services that will assist individuals to access and obtain needed preventive and primary dental services.

The **Dental Rehabilitation Program** provides medically-necessary orthodontic services to children with physically handicapping malocclusions. In October 2004, the Bureau, in collaboration with the Medicaid Dental Program, extended the pilot of a new method for prior approval to all counties in the state outside of New York City and Long Island. The pilot eliminates the need for regional screening clinics and allows children to be screened for clinical eligibility through clinical documentation of their orthodontic conditions. Treatment services are authorized and approved under the Physically Handicapped Children's Program in participating counties.

Other responsibilities of the Bureau of Dental Health include administration of an accredited **Dental Public Health Residency Program,** implementing a grant from the Centers for Disease Control and Prevention to improve surveillance and infrastructure for oral health services in the state and implementation of the **Statewide Oral Health Plan** implementation of the **Perinatal Oral Health Guidelines**.

The Bureau of Early Intervention

The **Bureau of Early Intervention (BEI)** administers the **Part C/IDEA Program** and the **Universal Newborn Hearing Screening Program.** The Bureau is also responsible for the publication of ***"Welcome to Parenthood,"*** which is available in English and Spanish and received by all new mothers delivering their babies in any of New York State's hospitals. Ms. Barbara McTague will continue to direct this Bureau until recruitment of a new director is completed.

The **Early Intervention Program** provides therapeutic and supportive services for children, from birth to age 3, who have developmental disabilities and their families. The program ensures children at risk for disabilities have a "medical home" and receive developmental surveillance and screening from their primary health care provider. Children referred to the Early Intervention Program receive a comprehensive multidisciplinary evaluation to assess the child's cognitive, physical, communication, social/emotional, and adaptive development. Eligible children and their families receive ongoing service coordination services, Individualized Family Services Plans (IFSPs), and Early Intervention services included in their IFSP.

The **Universal Newborn Hearing Screening Program** is within the BEI. Newborn hearing screening program components include: conducting inpatient infant hearing screening prior to discharge from the birth facility; conducting follow-up infant screening or providing referrals to obtain follow-up screening on an outpatient basis for infants who fail or do not receive infant hearing screening prior to discharge; and, referring infants in whom a hearing loss is suspected to the Early Intervention Program for appropriate evaluation and early intervention services.

Other Divisions within the Center for Community Health

Division of Family Health/Title V staff work especially closely with the other Divisions within our Center on MCH-related issues.

Mark Baptiste, Ph.D., directs the **Division of Chronic Disease Prevention and Adult Health.** Assistant Director is Mr. Thomas Blake. Mr. Blake was for many years the Assistant Director in the Bureau of Child and Adolescent Health and is well acquainted with MCH issues. This division has as its mission increasing the years of healthy and independent life for New Yorkers. The division promotes healthy lifestyles; recommends policies for chronic disease prevention in health care, educational, social and other community-based systems; and promotes health and continued independence for those

with chronic diseases and disabilities. This division administers several programs that affect the maternal and child population.

Within the Division of Chronic Disease Prevention and Adult Health, their **Bureau of Health Risk Reduction** oversees prevention efforts to reduce tobacco use and change diet and physical activity patterns. In addition, this bureau works closely with the Bureau of Child and Adolescent Health on youth tobacco programs. The Bureau is working with the Bureau of Dental Health on a surveillance project. When third graders were screened under the Oral Health Surveillance Project, trained staff also completed height and weight measurements.

The Bureau of Health Risk Reduction is the organizational home for **Activ8 KIDS!**, a program for the prevention of childhood overweight and obesity. The components of the program include: centers for best practices, school and community partnerships, and initiatives in the child care setting. The **Activ8 KIDS!** Booklet can be downloaded at http://www.health.state.ny.us/prevention/obestity/activ8kids/toolkits.docs/toolkit.pdf.

The **Bureau of Injury Prevention,** directed by Ms. Susan Hardman, addresses injuries associated with motor vehicles, bicycles, recreation, poisoning, assaults, and suicide. This unit has very strong ties to the Title V program. The primary prevention of violence, particularly intimate violence, is a priority with the Department for the coming years.

The **Division of Nutrition (DON)**, which is directed by Ms. Patricia Hess, administers the **WIC Program**, nutrition services for the homeless and destitute, nutrition training and technical assistance, and the **Child and Adult Care Food Program**. Division of Nutrition collaborates with the Title V programs on issues relating to nutrition assessment and services, nutritional consultation for children with special health care needs and services for hard-to-reach, hard-to-serve individuals. Examples of past DON/Title V collaborations include the Monroe County contract consolidation project, childcare health consultation, and joint WIC/Food Stamps/Medicaid/Child Health Plus application. Title V has also collaborated with DON in initiating ***Eat Well, Play Hard***, an intervention to prevent childhood overweight and long-term risks for chronic disease by promoting healthy eating habits and increased physical activity. The ***Eat Well, Play Hard*** strategies targeted to children ages 2 and older are: increase the amount of developmentally-appropriate physical activity; increase consumption of fruits and vegetables; and increase consumption of 1% or less milk and low fat dairy products.

The **Division of Epidemiology (DOE)**, directed by Perry Smith, M.D., State Epidemiologist, is responsible for disease control and disease prevention efforts within the Department. The **Bureau of Sexually Transmitted Disease Control** within DOE collaborates in the Title V funded *chlamydia* screening and treatment program with the Bureau of Women's Health. The **Immunization Program** is located within their **Bureau of Communicable Disease Control**. The Division continues to work with the Title V workgroup on birth outcomes. This Division is also charged with responsibility for new initiatives in HIV reporting and partner notification.

Assistance from Outside the Center for Community Health

The **Bureau of Health Media and Marketing** is responsible for coordinating the efforts of state and local governmental units, voluntary agencies, schools, health care facilities and other community resources to address the state's priority health issues. In this role, the bureau provides consultative and technical support services to department program units in designing, implementing and evaluating community-based health communications programs and social marketing strategies to reach target populations. The bureau has

expertise in print production and distribution; mass media production and placement; market research and program evaluation; community development; direct marketing; satellite teleconferencing and other distance learning techniques; health education advocacy and training; conference and event planning; and interactive, computer-assisted instruction.

The **Office of Medicaid Management (OMM)** is also within the Department of Health. This has resulted in a close organizational relationship that benefits maternal and child health programs for the Medicaid population. OMM administers the Child/Teen Health Program, New York's EPSDT program. All health plans participating in the Medicaid Managed Care Partnership Plan and Child Health Plus must adhere to Child/Teen Health Program standards. The Department works to ensure the quality of that care through formulation of Medicaid policy, through requirements for statewide certification and through surveillance of facilities and health plans. In addition, the Family Health Plus Program is located within the Office of Medicaid Management.

Since the Office of Medicaid Management is within the same agency as the Title V program, the **Memorandum of Understanding** is no longer thought necessary. Title V and Medicaid staff drafted a **"Title V/EPSDT Action Plan"** to outline our mutual support for each program. The Action Plan serves as a plan for coordination between the two programs; and states our shared goals for access, availability and quality of health services; and actions each program will take in collaboration with the other. Title V staff worked with the Office of Medicaid Management on an EPSDT provider manual and on improving access to oral health services.

The **Office of Managed Care (OMC)** oversees both commercial and publicly-funded managed care plans throughout the state. OMC works very closely with a variety of maternal and child health programs, including those for children with special health care needs, and with our MCHSBG Advisory Council. OMC was instrumental in assisting the Bureau of Women's Health and Division of Family Health with the incorporation of Prenatal Care and Assistance Program standards into Medicaid Managed Care. OMC staff has also worked with the Bureau of Dental Health on issues related to provider capacity.

The Office of Managed Care has required health plans to coordinate their public health-related activities with the local health units in each of New York's 57 counties and the City of New York. Guidelines were issued that describe required coordination activities for such areas as communicable disease control including tuberculosis, STD, rabies and HIV counseling and testing, and for maternal and child health programs including childhood lead poisoning prevention. The guidelines encouraged managed care organizations to participate with local health departments in joint community health assessment processes that would identify and address local health problems and gaps in services and to assist in the mobilization of needed services as appropriate.

The **Child Health Plus Program** is administered by the Division of Planning, Policy and Resource Development, which is located outside the Center for Community Health. Title V staff and the MCH Advisory Council have offered policy input. Child Health Plus also actively collaborates with the Title V-funded School Health Program, which is located within the Bureau of Child and Adolescent Health.

The **New York State Charles D. Cook Office of Rural Health (ORH),** operates within the Division of Planning, Policy and Resource Development, under the direct guidance of the Deputy Commissioner for Policy. The ORH provides the Department with guidance on the unique issues faced by rural communities in New York State. ORH coordinates and

administers statewide rural health programs, disseminates information and technical assistance to rural providers, and participates in federal and state partnerships to influence rural policy development. ORH implements state-funded programs including the Rural Health Network Development Program and the Rural Health Care Access Development Program, enacted under the New York State Health Care Reform Act. The Office also administers the federally-funded Rural Hospital Flexibility Program, the Small Hospital Improvement Program and the Rural Access to Emergency Devices Program. The office is directed by Ms. Karen Madden.

The **AIDS Institute (AI)**, directed by Dr. Guthrie Birkhead, is responsible for coordinating the State's response to the AIDS epidemic. The AI works with community organizations and governmental agencies to assess need and to ensure a coordinated, coherent, statewide approach to the HIV/AIDS epidemic. Among its responsibilities, the AI monitors and analyzes epidemiological and clinical developments in HIV/AIDS health care and prevention services; plans immediate and long-term objectives for HIV/AIDS health care and prevention services; provides policy advice on HIV/AIDS issues at the local, state and federal levels; develops funding strategies and priorities; administers state and federal funding for HIV/AIDS health care and prevention services; and produces educational materials to reduce the risk of HIV transmission and promote optimal use of health care services.

New York was the first state to develop a comprehensive program of newborn HIV testing in which all mothers and their physicians will be notified if the infant's test result is positive. Under statute, HIV antibody testing was added to the statewide Newborn Screening Program. Expedited testing is also available at time of delivery for those women who are not aware of the HIV status.

AI also administers New York's Partner Notification Law, passed in 1998. The law enhanced existing AIDS case reporting and added reporting of newly-diagnosed HIV infection and HIV-related illnesses by physicians and laboratories to the State Health Commissioner. The law mandates reporting of known contacts for the provision of partner notification assistance and conducting domestic violence screening prior to notification.

The AIDS Institute works with Title V in New York State, and has established coordination and collaboration with Title V staff. AI also participated in a consolidated MCH monitoring pilot with Title V and CCH programs serving the prenatal, postpartum, and birth-to-five population. AI administers monies under Title II of the Ryan White Care Act.

An important collaboration between Title V and the AIDS Institute is the **Community Action for Prenatal Care (CAPC) Program**. This initiative seeks to engage high-risk, pregnant, HIV-positive women in early prenatal care. CAPC is closely coordinated with the Community Health Worker Programs in overlapping regions of New York City and Buffalo.

Title V programs also work in collaboration with programs within our **Center for Environmental Health (CEH)**. CEH provides overall direction for environmental health. CEH also provides direct environmental services through ten district offices to counties whose local health departments do not provide environmental services.

Within the Center for Environmental Health, the **Bureau of Environmental and Occupational Epidemiology** has responsibility for monitoring adverse reproductive outcomes through the **Congenital Malformations and Chromosome Registries**. The

bureau conducts studies evaluating possible causes of these outcomes, and studies related to abatement of leaded housing and environmental exposure to lead.

The **Bureau of Community Sanitation and Food Protection** works closely with MCH migrant health staff for issues related to migrant housing and is the liaison with the Department of Labor for issues related to migrant employment. They also are charged with the responsibility of licensing children's camps and investigating injuries and illnesses associated with camp attendance.

The **Office of Health Systems Management (OHSM)** is the arm of the Department that licenses, monitors and regulates health facilities and agencies. OHSM staff performs facility and home care agency surveys, review and approve plans for new services, and work to improve quality in regulated facilities and agencies. Title V staff interact with OHSM staff on issues relating to standards and quality of care in facilities and agencies that serve the maternal and child population.

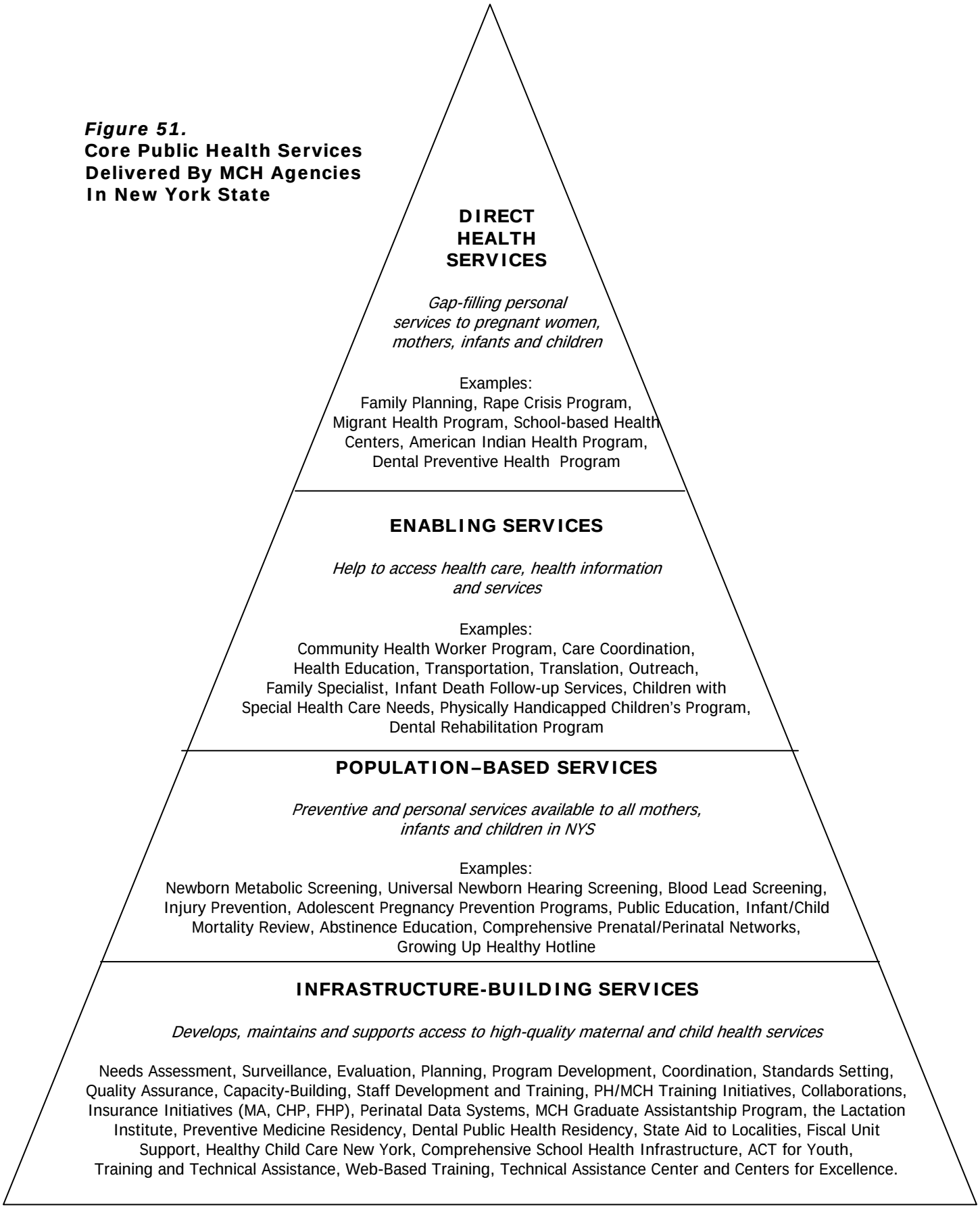
The **Emergency Medical Services for Children (EMSC) Program** was administered by the Bureau of Emergency Medical Services in the Office of Health Systems Management. The EMSC Program enhanced emergency medical care for children. Title V representatives regularly attended the EMSC Advisory Committee meetings and provide needed input on the development of EMSC resources benefiting MCH stakeholders. Last year, MCH and EMSC staff worked collaboratively to develop a brochure for families on how to be prepared for emergencies involving their child. It contained a special section for families of children with special health care needs. In addition, a reference card was developed on medical assessment and emergency treatment of technology-assisted children and was distributed to a variety of appropriate partners.

The **Wadsworth Center for Laboratories and Research** is one of the most comprehensive laboratories devoted to public health in existence, providing analytical and diagnostic services, regulation and licensing, investigation, research, and education.

The majority of the Wadsworth Center's MCHSBG activities are based in the **Division of Genetic Disorders**, **Laboratory of Newborn Screening** and **Genetic Services**. Wadsworth performs specialized diagnostic and reference laboratory services; manages comprehensive statewide newborn metabolic screening programs; conducts a quality assurance program in cytogenetics, oncofetal antigens and DNA genetic testing; and undertakes research in genetics. This laboratory also administers a registry of infants identified by newborn metabolic screening and tracks their referral to treatment centers. They provide oversight and fiscal administration for genetic screening and counseling and have supported the Federally-designated Region II genetic network, GENES. Wadsworth Laboratories works closely with Division of Family Health to ensure those testing positive to genetic tests are linked to CSHCN Specialty Centers.

Regional Offices are a cornerstone of our assessment, monitoring and technical assistance capacity. Out-stationed in the regions are approximately 278 public health staff, including **Regional Public Health Program Nurses, Public Health Nutritionists, Epidemiologists, Public Health Representatives**, **Sanitarians** and **support staff,** that are in contact with MCHSBG-funded and other MCH-related programs on a daily basis. Through a strong regional presence, the Department is able to quickly recognize emerging local trends, effectively mobilize resources, coordinate and link program efforts, and provide a stable, long-term relationship with contractors and other key players in maternal and child health.

Figure 51.
Core Public Health Services Delivered By MCH Agencies In New York State



a. State Capacity to Provide Direct Health Services

Please see previous explanations of the Family Planning, Rape Crisis Program, the Migrant Health Program, School-based Health Centers, American Indian Health Program, and the Dental Preventive Health Programs under ***Overall Capacity***.

Health Workforce: According to HRSA State Health Workforce Profiles for New York, released in December 2000, New York had a total of 48,113 active patient care physicians in 1998. At 265 physicians per 100,000 populations, New York is well above the national average of 198 per 100,000. New York ranked second among the 50 states for physicians per capita. New York had 73 active primary care physicians per 100,000 populations in 1998, compared to 59 per 100,000 in the US. Minorities are under-represented. Only five percent of active physicians in New York are African American and four percent are Hispanic/Latino, compared to a general population of about 15% of each.

New York is also fourth in the country for the number of dentists in the State, and fourth in the US for number of psychologists. New York ranks 15 out of 50 for number of registered professional nurses, tenth for number of nurse practitioners, and first for number of home health aides. New York ranks 48 out of 50 states for number of emergency medical technicians.

These rates do not tell the full story, however. While New York has plenty of personnel in terms of numbers, the distribution of health professions is uneven. There are 1173 Health Professional Shortage Areas (HPSAs) in New York. The Federal government has helped support workforce development and to ease maldistribution through several Health Resources and Services Administration (HRSA) programs.

According to HRSA's State Profile for New York, in addition to the Block Grant and Ryan White Act funds, HRSA helps fund:

- 36 Community/Migrant Health Centers;
- 14 Health Care for the Homeless grantees;
- one Health Services in Public Housing grantee;
- 93 State loan re-payers;
- 30 National Health Service Corps (NHSC) scholars;
- 117 participants in the NHSC Loan Repayment Program;
- 240 NHSC providers, including 133 primary care physicians, 8 non-primary care physicians, 32 physician assistants, 27 nurse practitioners, 27 dentists, and 13 certified nurse midwives;
- the State Office of Rural Health, two rural health outreach grants, one state rural hospital flexibility grant and three rural health network development grants;
- nine training grants to improve workforce diversity;
- 56 scholarship and loan programs for disadvantaged and/or financially needy students in health professions;
- 101 training grants to improve access to health care for the underserved;
- 12 training grants to improve public health;
- five projects training maternal and child health professionals;
- a Workforce Information and Analysis State Center for Excellence;
- two emergency medical services for children grants;
- five Healthy Start communities;
- three Emergency Relief Assistance (Title 1) programs in the City of New York, Dutchess and Nassau Counties;

- a grant for HIV/AIDS care, including the AIDS Drug Assistance Program;
- nine HIV/AIDS programs for children, youth and families;
- one AIDS Educational Training Center;
- seven new models of AIDS care;
- 31 organizations providing oral health services to people living with HIV/AIDS; and
- one traumatic brain injury grant.

All of these programs share these common goals: to increase access to comprehensive, high-quality, primary and preventive care, to improve access for vulnerable and underserved populations, and to strengthen the safety net within communities to address the needs of the vulnerable populations at risk for poor health outcomes. This assistance is helping New York and HRSA to meet mutual goals for "100% access, zero disparities."

The Governor's budget set aside $58.4 M for health workforce recruitment and retention to help facilities continue delivering high quality health care to community residents during one of these challenging times for recruitment in health care.

Public Insurance/Public Goods: In the summer of 1996, the **New York State Health Care Reform Act (HCRA)** was adopted, fundamentally changing our State's reimbursement system and providing new and innovative ways to pay for "public goods." Under HCRA, beginning in January 1997, hospitals began to negotiate their own rates of reimbursement with all payers except Medicaid fee-for-service, no-fault automobile insurance, workers' compensation, and Medicare. Graduate medical education reform, charity care, rural health, primary care development, and insurance initiatives were all addressed by "HCRA '96." At the same time, Governor Pataki signed a Medicaid managed care bill making available to consumers more detailed information concerning health coverage options; establishing grievance procedures, due process protections, and standards for utilization review; and establishing requirements for adequate provider capacity and access to specialty care. Integrated health networks began replacing more traditional delivery structures, producing a variety of new partnerships and enterprises. More and more New Yorkers began receiving their health care from managed care organizations.

In December 1999, the Health Care Reform Act was renewed. **"HCRA 2000"**, as it is called, continued the State's ability to provide for the public good and significantly expanded care for the uninsured and underinsured. It enabled Family Health Plus, modeled on New York's successful Child Health Plus Program, to make comprehensive health insurance available at no cost to lower-income, uninsured adults, ages 19 through 64, who do not have employer-sponsored coverage and who are not eligible for Medicaid or Medicare. Like the arrangement for Child Health Plus, Family Health Plus enrollees can access services through participating managed care plans, and parents may join the same plans as their Child Health Plus- or Medicaid-enrolled children. Income eligibility varies depending on the applicant's family size and whether or not he/she lives with a child. New York's waiver to implement Family Health Plus was approved by the Center for Medicare and Medicaid Services (CMS) and is now implemented.

Health Insurance Initiatives: Improving and sustaining access to high-quality, continuous primary health care and treatment services are critical to improving health outcomes for all New Yorkers and achieving our public health and maternal and child health priorities. The hallmarks of success will be prevention, early intervention, and continuity of care through establishing and maintaining a "medical home" for every New Yorker. Success will also depend on the actual delivery of appropriate, high-quality,

comprehensive health services to people in need, and requires practitioners to be knowledgeable about and practice good preventive and therapeutic medicine.

New York is committed to removing the most significant barrier to health care: lack of health insurance. The reasons for being uninsured or underinsured were many. Urban Institute data show that a smaller percentage of New York's employers offer health insurance than in the US as a whole (64.0% in 1999 compared to 66.7% for the US). Many employers offer insurance for the employee only, and offer family coverage only at unaffordable high rates. Families have testified that the rates offered are too high for the families to "buy in" to family coverage. As a result, they told us, fathers are covered by their employers, young children were covered by Child Health Plus, but many mothers and older children were not covered at all. New York's insurance programs for the uninsured and underinsured are helping. In addition to offering these families Child Health Plus, families like these were targeted for Family Health Plus, a State insurance program. The Healthy New York Insurance Program is also helping.

Another very significant reason for the high rate of un-insurance was thought to be that the public did not always understand the difference between cash assistance and Medicaid. Fewer people were applying for cash assistance and are waiting until they had an acute medical need before applying for Medicaid-only benefits. The Office of Medicaid Management then worked with Local Departments of Social Services to help remedy this situation.

The high number of immigrants in New York State must certainly be another factor in the number of remaining uninsured. There has been misunderstanding among the documented immigrant communities regarding use of Medicaid and Child Health Plus being used to "count against" immigrants as having used public services (a "public charge"). The Immigration and Naturalization Service (INS) has issued statements to try to correct this misinformation about public charge, and Office of Medicaid Management has also provided guidance to local districts on this ruling.

There have been three situations in which undocumented immigrants in New York have been entitled to government coverage: 1.) uninsured children are eligible for Child Health Plus under the state-financed portion of the program; 2.) anyone accessing care at an emergency room has been eligible for emergency Medicaid; and 3.)poor, undocumented immigrant women were eligible for prenatal care.

In May 2000, the United States Court of Appeals for the Second Circuit, in Manhattan, ruled that undocumented immigrant women are not entitled to federally financed prenatal care. This ruling overturned a 1991 Federal District Court Lewis v. Grinker ruling that ordered the federal government to provide prenatal care (care of the unborn) for undocumented immigrants. The children born of those pregnancies, who are US citizens, are still automatically eligible for one full year of Medicaid benefits after their birth. The Court of Appeals sent the ruling back to a lower court for a decision as to how to carry out this ruling, which would affect approximately 13,000 women. It was decided that undocumented immigrant women would continue to receive prenatal care until the lower court provided guidelines.

Then, Governor Pataki signed Chapter 16 of the Laws of 2002, which amends the Social Services Law to continue to provide Prenatal Care Assistance Program (PCAP) coverage to undocumented aliens as a State-only funded program. This became effective February 1, 2002. Now, no matter what the court ruling on Lewis v. Grinker, undocumented women in our State will be able to receive comprehensive services under PCAP.

Ensuring access to health care coverage for the uninsured and underinsured remains a very high priority in New York State. New York State's Title V Program will continue to work with **Medicaid, Medicaid Managed Care, Healthy New York, Child Health Plus** and **Family Health Plus** to address access to care through these major public insurance programs.

Medicaid and Child Health Plus A (Children's Medicaid): There have been major expansions in New York's Medicaid Program over the last few years relative to the maternal and child health population. Medicaid also administers or provides access to several special programs and federal waivers designed to improve the health of Medicaid-eligible women and children. County governments play a major role in administration of Medicaid and TANF in New York; counties contribute 25% of the costs for these programs.

Most children under age 19 who have been determined eligible for Medicaid now receive **12 months of continuous coverage**, even if their family's income exceeds eligibility levels during that year. Infants up to one year of age through five may be eligible with incomes up to 200% FPL. Children ages one through five may be eligible with incomes up to 133% of the Federal Poverty Level, and children from age 6 through 18 years of age may be eligible with incomes up to 100% of the Federal Poverty Level. There is no resource test for Medicaid eligibility for children under age 19.

Pregnant women may be eligible with incomes up to 200% of the FPL and have no resource test. Coverage continues through 60 days postpartum. An infant born to a woman eligible for and receiving Medicaid is eligible for Child Health Plus A until the end of the month in which the child turns age 1.

The **Family Planning Extension Program:** Women and adolescents residing in New York State and insured by Medicaid during their pregnancy who lose Medicaid eligibility for any reason are eligible for up to 26 months of family planning benefits immediately following their pregnancy. These women are eligible whether their pregnancy ended in miscarriage, live birth, stillbirth or induced termination. At present the program is only available from our contracted Family Planning Providers. Undocumented women are eligible for this program. The federal Medicaid Program supports 90% of the cost of family planning services for eligible women. The benefit package includes all services normally provided by family planning programs for their patients.

There is also a **Family Planning Benefit Program,** the waiver for which was approved by the Centers for Medicare and Medicaid Services (CMS). One of the major limitations of the Family Planning Extension Program is that a woman needs to first become pregnant to be eligible for its services. Governor Pataki and the Legislature addressed this issue by expanding family planning eligibility based solely on the countable income being below 200% of the Federal Poverty Level, regardless of previous Medicaid eligibility or pregnancy. Both men and women are eligible. New York is one of a limited number of states that have pursued this approach. Under the waiver, Federal Medicaid will support 90% of the cost of contraceptive services for eligible women and men and the State pays the other 10%. No local share is required of the counties.

Pregnant women and infants under age one who have countable income at or below 200% of the Federal Poverty Level (up from 185%), are eligible for Medicaid. With this Medicaid expansion, more pregnant women can now choose to enroll in the clinic-based **Prenatal Care Assistance Program (PCAP),** or **MOMS**, the private physician model, for a special package of prenatal care services: nutrition screening and referral,

psychosocial screening and referral for needed services, health education on a wide variety of topics, laboratory services, prescriptions, inpatient care, antepartum and postpartum services, and related services such as dental services and home visiting, as needed. PCAP and MOMS also offer presumptive Medicaid eligibility for women seeking coverage, a streamlined way to obtain care immediately where eligibility is verified after the fact. As previously stated, PCAP will continue to be available to low-income undocumented pregnant women as a State-only funded initiative.

Timely, risk-appropriate, coordinated, comprehensive prenatal care is provided to all **Prenatal Care Assistance Program (PCAP)** and **MOMS Program** enrollees. PCAP and MOMS require adherence to Part 85.40 standards of prenatal care, and all managed care plans serving Medicaid women are required to adhere to these comprehensive standards, as well. The provision of high quality prenatal care and appropriate level of care mandated by the standards was shown to reduce low birth weight rates among Medicaid women, particularly minority women, when compared to non-participants. In studies comparing Medicaid women receiving care under these programs with Medicaid women receiving other types of prenatal care, PCAP and MOMS clients had consistently better birth outcomes, and these outcomes were better even at the lower birth weights. Presumptive eligibility helps ensure timely entry into care.

The **Newborn Project** has taken steps to enroll all newborn children born of women on Medicaid within fifteen business days of birth. In this way, Medicaid coverage is assured for babies during the first year of life, a critical time for many babies born to low-income families. Enrollment is now facilitated via the Statewide Perinatal Data System (SPDS), or, in New York City, the electronic birth certificate.

Medicaid provides comprehensive health care to both medically needy and categorically eligible children in the State under the aegis of **EPSDT**, known in New York as the **Child/Teen Health Program (C/THP)**. Using a broad definition of medical necessity, Medicaid covers medical, mental health and substance abuse in a rich service package. New York is currently reviewing their EPSDT standards, and recently developed a new provider manual describing the EPSDT benefit, and adopting the American Academy of Pediatrics Guidelines as their standard of care, except in cases where State law contravenes. Title V staff were involved in the process.

Medicaid has also undertaken many **special initiatives** to promote access to quality care for children:

- **Teenage Services Act (TASA) Case Management:** More than half of our county departments of social services choose to meet their state obligation to provide TASA case management to pregnant, parenting and at-risk teenagers through Medicaid targeted case management.

- **Early Intervention (EI):** Medicaid provides targeted case management and the full complement of EI services to developmentally delayed, Medicaid-eligible children ages birth to three participating in New York's Early Intervention Program.

- **Preschool and School Supportive Health Program:** For Medicaid-eligible children ages three through twenty, Medicaid also reimburses counties and school districts for the provision of a wide array of medically-related services in the students' individualized educational programs.

- Medicaid reimburses **school-based health centers** located in designated high-need areas of the State that meet children's health, mental health and dental needs in the school setting.

- Several federal **Home- and Community-Based Services Medicaid Waivers** allow the State to provide non-traditional services in the community to populations of special needs children who qualify for institutional placement. There are waivers specifically for physically disabled children and for developmentally disabled children who would not otherwise qualify for Medicaid coverage. Developmentally disabled children may participate in a waiver program that includes the family home, as well as small-scale residential alternatives to Intermediate Care Facilities and a wide array of habilitative services to developmentally disabled adults and children. There is also a waiver operating in many counties in the State to cover children who have serious emotional disturbances. This waiver provides innovative treatment to children who would ordinarily be in in-patient psychiatric settings. Recently the age of eligibility for the Traumatic Brain Injury Waiver was lowered from age 22 to age 18 and the requirement that the age at which the injury occurred be after the individual turned 18 has been removed.

- Medicaid has also utilized fee enhancement as an approach to promoting access to quality care. The **Preferred Physicians and Children's Program (PPAC)** has been in operation for over ten years and has brought and retained thousands of highly qualified pediatricians, family practitioners and nurse practitioners into Medicaid.

- In marketing the Medicaid program for children statewide, the State has adopted the name **Child Health Plus A** for children's Medicaid. It was hoped that this might remove any perception parents might have of a stigma attached to Medicaid. The name change also underscores efforts to make the two programs as seamless as possible.

- Medicaid has collaborated extensively for several years with the State Office of Children and Family Services to improve access to health care services for children in Foster Care by upgrading the eligibility process, revamping policies and procedures, sharing Foster Care Medicaid data with counties, and troubleshooting the child care agency rate-setting process. Title V staff have been involved, as well. Many major improvements to care have resulted for this special needs population.

Medicaid Managed Care: More New Yorkers than ever before are receiving care through managed care providers. According to the Medicaid Managed Care Monthly Enrollment Report, enrollment as of May 2003 and April 2004, is as reflected in the chart below.

Table 26. **Medicaid Managed Care Enrollment by Location**
Source: NYSDOH Office of Managed Care

	Total # Eligibles	Total # Enrollees	% Eligibles Enrolled	% Of Target Enrolled
Enrollment As of May 2003				
New York City	1,653,412	1,116,564	68%	n/a
Rest of State	799,031	452,130	57%	n/a
Total NYS	2,452,443	1,568,694	64%	n/a
Enrollment as of April 2004				
	Total # Eligibles	Total # Enrollees	% Eligibles Enrolled	% Of Target Enrolled
New York City	1,868,310	1,341,965	71%	89%
Rest of State	898,740	515,087	56%	70%
Total NYS	2,766,870	1,857,870	67%	83%

Mandatory Medicaid managed care represents the single greatest effort the State has made to ensure that every New Yorker with Medicaid has access to high-quality primary care in a "medical home" model. This ensures that more care takes place within the context of the primary and preventive care setting, with less reliance on more expensive and less continuous forms of care, including the emergency rooms.

Health Plans participating in Child Health Plus A (Medicaid) and B are required to submit New York's **Quality Assurance Reporting Requirements (QARR)** reports annually. Among other measures, the QARR contains measures of preventive care and health outcomes related to maternal, infant, child and adolescent health.

According to the Quality Assurance Reporting Requirements (QARR) Report, there have been significant advances in the quality of care for individuals in Medicaid managed care. With eight years of QARR data, we have seen a trend in which the difference between the historically under-served Medicaid population and those individuals with private insurance has narrowed or disappeared with respect to primary care access and receipt of preventive services. There has been continuous improvement in usage of screening mammograms, cervical cancer testing, and immunizations. In addition, with respect to care of people with chronic diseases like asthma, heart disease and diabetes, there has been an improvement in the delivery of recommended interventions that will positively impact health outcomes. The Department, providers and plans are engaged in prioritizing areas for further quality improvement, which is further advancing the health status of New Yorkers.

The Child Health Plus B Program: Child Health Plus B provides free or low-cost private health insurance to children from age one month to age 19 in low-income working families who are not eligible for Medicaid. The program is paid for through a combination of state funding and federal funding under Title XXI, the State Child Health Insurance Program (SCHIP). The program encourages parents to seek routine primary and preventative care, resulting in healthier children.

The Child Health Plus B Program holds the potential for near universal coverage of New York's children. Currently, families with incomes at or below 250% of the FPL, or $47,125 for a family of 4, are eligible for subsidized health insurance coverage under Child Health Plus. Coverage for those under 160% FPL is free. Premium contribution for families between 160 and 222% is $9 per child per month, with a maximum of $27 per family per month. For families with incomes between 222 and 250% FPL, the contribution is $15 per child per month, with a maximum of $45 per family. For families with incomes over 250% of the FPL, Child Health Plus B is available at full premium. There are no co-payments for services. *Table 27* below indicates current eligibility levels.

Table 27. **2006 Income Eligibility Levels for Child Health Plus A and B**
(Based on Initial 2006 Federal Poverty Levels)

Child Health Plus A – Children's Medicaid									
Age Categories for Children	**Monthly Income for Family Size****								**Each Additional Person, Add**
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	
Children under 1 year; Pregnant women**	$1634	2200	2767	3334	3900	4467	5034	5600	$567
Children 1 – 5 years	$1087	1463	1840	2217	2594	2971	3348	3724	377
Children 6 - 18 years	$817	1100	1384	1667	1950	2234	2517	2800	284
*****Pregnant women count as two when determining family size.***									

Child Health Plus B									
Premium Category	**Monthly Income for Family Size****								**Each Additional Person, Add**
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	
Free Insurance	$1306	1759	2213	2666	3119	3573	4026	4479	$454
$9 per Child per Month ($27/family max.)	$1813	2442	3071	3700	4329	4958	5587	6216	629
$15 per Child per Month ($45/family max.)	$2042	2750	3459	4167	4875	5584	6292	7000	709
Full Premium per Child per Month	Over $2040	Over 2750	Over 3459	Over 4167	Over 4875	Over 5584	Over 6292	Over 7000	
*****Pregnant women count as two when determining family size.***									

These eligibility levels are updates on the NYSDOH public website at: http://www.health.state.ny.us/nysdoh/chplus/who_is_eligible.htm

As of April 2005, a total of 321,569 children were enrolled in Child Health Plus B and an additional 75,000 were enrolled in Child Health Plus A. See *Table 28* for the number of children enrolled in each age group. Approximately 14.9% of the children ever enrolled in the national child health insurance program in 2004 were New York State-enrolled Child Health Plus children.

According to a recent report by the Urban Institute, the extent to which Medicaid and Child Health Plus reach uninsured children varies with the characteristics of the child. Younger children participate at higher rates than older children. Also, children with health issues were more likely to participate than other children. This is not surprising, given that younger, sicker children tend to have more contact with the health care system.

Table 28. **Number of Child Health Plus Enrollees by Age, by Point in Time December 1997, May 1998 and 1999, March 2000, April 2001, -02, -03, -04, -05**

Ages	**May '98**		**May '99**		**March '00**		**April '01**		**April '02**		**April '03**		**April '04**		**April '05**		**April '06**	
	#	**%**	**#**	**%**	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**		
Birth - 1 Yr.	5,013	3	9,086	3	13,122	2.7	10,339	2	10,471	2	7,916	2	6,073	1.7	3,846	1.2	3804	1.0
1 – 9	110,845	57	180,528	55	260,018	53.5	254,419	51	250,880	47	192,648	46	167,441	46	142,532	44.3	156933	41.7
10 – 14	52,019	27	87,851	27	133,168	27.4	146,073	29	164,223	31	126,325	30	109,444	30.1	98,394	30.6	120788	32.1
15-19.1	24,354	13	49,716	15	79,707	16.4	90,107	18	111,588	21	89,059	21	81,020	22.3	76,797	23.9	94506	25.1
Total	**191,385**		**327,181**		**486,015**		**500,993**		**537,162**		**486,015**		**359,910**		**321,569**		**376,031**	

The Family Health Plus Program: With the enactment of the Health Care Reform Act of 2000, the Governor and the Legislature authorized the Department of Health to apply to CMS for an amendment to the Partnership 1115 Waiver, which when approved, enabled New York to establish the **Family Health Plus Program.** Like the **Child Health Plus B Program**, this program offers comprehensive health insurance at no cost to low-income, uninsured individuals who are not income-eligible for Medicaid due to income or resources. However, unlike the Child Health Plus B Program, Family Health Plus is a Medicaid funded program and it is for adults only. As of April 2004, enrollment in Family Health Plus exceeded 390,000. To qualify, the individuals must be between the ages of 19 and 65 and not meet the criteria for Medicaid but meet the following income criteria:

- In the case of an adult with children under the age of 21, gross family annual income is up to 150% of the Federal Poverty Level or $30,000 for a family of four.
- In the case of a single adult, gross family income is up to 100% of the Federal Poverty Level or $9,800 per individual.

Current eligibility is as follows in *Table 29.*

Table 29. **Maximum Gross Annual Income for Family Health Plus**
Effective January 1, 2006

Maximum Income	Family Size								Each Add'l Person, Add:
	Single Adult	Couple, No children	2	3	4	5	6	7	
Yearly Income	$9800	$13200	$19800	$24900	$30000	$35100	$40200	$45300	+$5100
Monthly Income	$817	1100	1650	2075	2500	2925	3350	3775	+$425
Weekly Income	$188	253	380	478	576	675	773	871	+$98
Resource Level	$12450	16200	16200	18300	18450	18600	20400	22950	+$2550

Family Health Plus does not consider assets and other resources in determining eligibility. The Family Health Plus managed care benefit package is similar to that of Child Health Plus, covering:

- physician services;
- inpatient and outpatient health care;
- prescription drugs and smoking cessation products;
- laboratory tests and x-rays;
- vision, speech and hearing services;
- rehabilitative services (some limits may apply);
- durable medical equipment;
- radiation, chemotherapy, and hemodialysis;
- emergency room visits and emergency ambulance services;
- behavioral health and chemical dependence treatment services (some limits may apply);
- hospice services;
- diabetic supplies and equipment; and
- dental services (if offered by the plan).

A toll-free help-line is currently available at 1-877-934-7587 or 1-877-9FHPLUS.

Coordination: Under these initiatives and expansions, the Department is striving to make the transitions between these systems seamless to the consumer in every way possible. Facilitated enrollers provide outreach and application assistance to Medicaid, Child Health Plus and Family Health Plus programs and a joint Medicaid-Child Health Plus-Family Health Plus-WIC application has been implemented. To facilitate children's retention of their primary care provider, most Child Health Plus providers are also Medicaid managed care providers. Many of the Family Health Plus providers participate in Medicaid managed care, as well. Quality is also being monitored in a coordinated fashion, with plans participating in New York's public insurance program required to submit reports annually.

The Title V programs continue to have a role in outreach, enrollment, standards development, quality assurance and evaluation.

The Physically Handicapped Children's Program: Within the Children with Special Health Care Needs Program, there is a state-reimbursed program for financially-eligible, non-Medicaid-enrolled children afflicted with certain handicapping medical and dental conditions. The program also has a component that will pay for a number of visits in order to reach a diagnosis on a physically handicapping medical or dental condition, called the **Diagnosis and Evaluation Program (D & E Program).**

Dental Rehabilitative Services: Dental rehabilitative services are available both under the Medicaid Program and the Physically Handicapped Children's Program. Screening clinics are provided in Article 28 facilities in New York City and Nassau and Suffolk Counties. The Department piloted a new process for the Dental Rehabilitation Program in Upstate counties that bypasses screening clinics and allows initial evaluations to be done by the child's orthodontist. In all Upstate counties, children who are financially eligible for services have direct access to orthodontists who perform screening exams and request authorization for the services through NYSDOH. Additional Diagnostic and Evaluation funds are used for non-Medicaid recipients who sought services under the Physically Handicapped Children's Program.

School-Based Health Centers: School-based health centers were established in New York under Chapter 198 of the Laws of 1978. Under this statute, school-based health centers are jointly established by the Commissioner of Education and the Health Commissioner. New York establishes these centers only in areas of high need for services and under the auspices of an Article 28 facility (hospital or diagnostic and treatment center). New York currently has over 180 of these centers, serving approximately 120,000 children. In 2005, the Department began authorizing freestanding school-based dental services under this same provision of law.

Federally Qualified Health Centers/Community Health Centers: As the state primary care agency, the Department of Health is a partner to a three-way **Cooperative Agreement** with the US Public Health Service and the Community Health Care Association of New York State (CHCANYS), the organization representing the bulk of the Federal 330 contractors in New York. This cooperative agreement provides the basis for mutual support of primary care development. Community Health Centers are often contractors for DOH initiatives under MCH, Family Planning, School-based Health Center and the Primary Care Initiatives. CHCANYS and Department staff will assist localities with obtaining designation as a medically underserved are or a health professional shortage designation.

Other Primary Care and Insurance Initiatives: Under the Health Care Reform Act (HCRA), funding is designated to **encourage education of minorities in health professions**, and monies are available for **loan repayment**.

The **Healthy New York Insurance Program** is available to pay health insurance premiums for employers with 50 or fewer employees who have not offered health insurance to their employees for at least one year. In addition, individuals whose employers do not offer health insurance coverage or who lost their coverage may purchase comprehensive health insurance directly through the Healthy New York Program. All of the State's Health Maintenance Organizations (HMOs) are required to offer the Healthy New York standardized, steam-lined, low-cost managed care benefits package. The cost of the coverage is split between the employer and the employee. There is a mandated 90% reimbursement rate for claims between $30,000 and $100,000 per member per year. Governor Pataki recently announced that premiums under the

Healthy New York Program were cut by an average of 17%, making the program even more affordable.

Eligibility requirements for working, uninsured individuals are as follows:

- The individual's employer does not provide health insurance;
- The individual's gross family income meets the guidelines in the chart below;
- The individual did not have health insurance in effect for the 123-month period preceding application or lost insurance due to a qualifying event (loss of employment, death of a family member, change to a new employer, change in residence, discontinuation of a group health plan, termination or cancellation of COBRA coverage, legal separation or divorce, annulment, loss of eligibility for group insurance coverage, reaching the maximum age for dependent coverage);
- The individual is ineligible for Medicare;
- The individual resides in New York; and
- The individual or the individual's spouse is currently employed or has worked some time in the past year.

Table 30. **Healthy New York Income Guidelines***
As of January 1, 2006
*Family size is not related to whether you are purchasing individual, spousal or family coverage.
Pregnant women count as two people for the purpose of calculating family size.

Family Size	Annual Household Income	Monthly Household Income
1	Up to $25,125	Up to $2,094
2*	Up to $33,375	Up to $2,782
3	Up to $47,625	Up to $3,469
4	Up to $49,875	Up to $4,157
5	Up to $58,125	Up to $4,844
Each extra person	Add $8,250	Add $688

New York in 1992 passed a landmark **community ratings** law that established subsidies for insurance companies serving the individual and small groups market. This law allows insurers that serve these markets to draw down donations to a pool to cover costs of serving a disproportionate number of sick enrollees due to adverse selection.

The **Catastrophic Insurance Program** assists low-income, uninsured New Yorkers facing devastating medical bills. HCRA also created a new **Individual Health Insurance Program** to defray the cost of premiums for people with incomes below 200% FPL, and a **Cancer and Children Initiative** provided grant funds to health care providers to expand access and quality of cancer services and for specialty cancer and children's hospitals. The **AIDS Drug Assistance Program** helps employed persons with HIV or AIDS purchase expensive medications that they need to control their illness.

The **Community Health Care Conversion Demonstration Project (DHCCDP)** is a federally funded initiative targeted to those hospitals that historically have served a substantial number of Medicaid recipients and the uninsured. The project's aim is to assist hospitals in transitioning to a Medicaid managed care environment and to continue to meet the health care needs of low income New Yorkers. During the five years of this program, $1.25 billion was awarded to hospitals on a non-competitive formula basis. Funded hospitals were asked to focus their activities within three broad areas: worker retraining; primary care expansion and managed care readiness.

In 2000, New York State ranked third nationally for number of physicians per 100,000 civilian population, and third in per capita health care expenditures. However, New York has 315 **federally-designated medically-underserved areas/medically-underserved populations** and **1173 designated health professional shortage areas**, mostly rural and inner-city areas. Access to care in rural areas is especially variable. Providers are usually clustered in small cities and towns, but are caring for residents whose homes are scattered over larger geographic areas. Access problems can be exacerbated by a shortage of health personnel and by fiscal constraints of rural health care facilities. HCRA 2000 continued numerous provisions designed to assist rural areas and rural hospitals. Local communities are assisted in completing their applications for shortage designation by staff from the Department of Health.

The **New York State Council on Graduate Medical Education** has been involved in developing policies that support the education of primary care physicians, expanding opportunities for training of physicians who are under-represented minorities, and expanding use of community-based ambulatory care sites as training sites for physicians. In addition, New York's **Area Health Education Centers** are expanding opportunities for training students in primary care and for engaging students in health careers.

As the designated **Primary Care Organization**, the State Health Department sponsors or collaborates with several programs designed to increase the health workforce in underserved areas of New York State. These include the federally-funded **National Health Service Corps** loan repayment and scholarship programs and a state-funded scholarship program, the **New York State Regents Scholarship Program in Medicine and Dentistry.**

The **National Health Service Corps,** with two program components, is highly competitive. The **National Health Services Corps Loan Repayment Program** pays up to $25,000 annually for two years and $35,000 annually for two renewal years. There is one year of obligated service for each year of assistance. The **National Health Services Corps Scholarship Program** pays tuition, fees, books, supplies, equipment and a monthly stipend. The program will pay for up to four years of assistance, with one year of obligated service for every year of assistance. The **Regents Scholarships in Medicine and Dentistry Program** gives disadvantaged minority candidates priority in accessing up to $5,000 annually in tuition, fees, books, supplies and equipment for up to four years, with one year of obligated service for each year of assistance.

Private Sector Resources: New York remains a world center for commerce, learning, finance and the arts. In a time of increasing government fiscal restraint and increasingly complex social and health issues, private sector resources are increasingly called upon to help improve the health of communities. Businesses hold great purchasing power as suppliers of employee benefits and purchasers of health insurance coverage. Business and unions have helped to set the health care agenda and to assist New York in meeting goals for health insurance enrollment, as well. To enhance its competitiveness in national and international markets, and to retain its international stature in business, education, the arts, research and development, continued collaboration from all sectors, including business and private concerns, is expected, enlisted and enjoyed. The New York State Department of Health regularly partner with the private sector to address issues related to health, education and public health and safety. Business is a major force in ensuring access to health care and insurance coverage for all New Yorkers.

According to the National Survey of America's Families (NSAF), private employer-sponsored health insurance in 1999 covered about 70.8% overall of adult New Yorkers

ages 19 to 64 and about 64% of those under age 19. Not surprisingly, the percentages are higher in those with incomes over 200% of the Federal Poverty Level, where employer-sponsored insurance covers 84.6% of adult New Yorkers ages 19 to 64, and 86.5% of those under age 19. (US averages are 83.7% and 85.3%, respectively.)

Overall, New York is also doing better than the US average for insuring the poor uninsured. NSAF data shows 16.1% of New Yorkers under age 19 and under 200% of the Federal Poverty Level to have been uninsured in 1999, compared to 22.4% as the US average. For adults ages 19-64 under 200% of poverty, 32.1% of New Yorkers are uninsured, compared to 34.9% as the US average.

b. Capacity to Deliver Enabling Services

Please see descriptions of Community Health Worker Program, Care Coordination Waivers, Health Education, Transportation, Translation, Outreach, Family Specialist, Sudden Infant Death Follow-up Services, the Dental Rehabilitation Program, Children with Special Health Care Needs, Physically Handicapped Children's Program.

Healthy Start: Many of the federal Healthy Start grantees are also grantees of New York State Department of Health under the **Comprehensive Prenatal/Perinatal Services Network** initiative. The Networks were initially funded under Title V, but have now moved onto a different source of funding. However, the need for close association with Title V programs continues in order to maximize our mutual effectiveness. During the past year, Healthy Start grantees met with the Department on a number of occasions to explore opportunities for collaboration. The Department holds periodic meetings (at least two per year) with Healthy Start grantees in order to foster better communication, explore areas for potential collaboration and share late-breaking developments. Regional staff meet with the Networks on a routine basis.

Family Support New York: The goal of this collaborative is to advance an agenda that transforms public/private systems and services to support and foster empowerment of families in New York State. The Council on Children and Families is the lead agency. Other members include the Department of State, the Department of Health, the Office of Children and Family Services, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Family Development Association of New York State, Family Support NYS, and various community and parent representatives.

Adolescent Pregnancy Prevention and Services (APPS) Program: The **Office of Children and Family Services** also administers the **Adolescent Pregnancy Prevention and Services (APPS) Program**, providing prenatal support and parenting education to high-risk teens in high need communities.

Family Planning/TANF Outreach: In 2006, the State Legislature allocated $10 M in funding from the federal **Temporary Assistance to Needy Families (TANF) Block Grant** to the Department of Health for outreach and education activities to prevent unintended pregnancies. Family Planning Program providers provide outreach and education activities in community settings, including schools, to educate children and adults regarding reproductive health and to provide programs to prevent adolescent pregnancy. TANF funding expanded the program consistent with state and federal priorities, including:

- increased community education, public information and counseling to prevent adolescent pregnancy and increase access to clinic service for sexually active teens;
- increased outreach to women not likely to seek services, especially underserved minorities, homeless and substance-abusing women;
- improved access in underserved areas to women and adolescents at risk for unintended pregnancy.

Coordinated Children's Services Initiative (CCSI): The Coordinated Children's Services Initiative (CCSI) is a cross-systems process for serving children with special emotional and behavioral services needs that builds upon legislation enacted in 2002. The process utilizes strength-based approaches, consistent and meaningful family involvement, individualizing planning, and encourages creative, flexible decision-making and funding strategies. CCSI Statewide Partners are: Family Representatives, Office of Mental Health, State Education Department, Office of Children and Family Services, Council on Children and Families, Division of Probation and Correctional Alternatives, Office of Mental Retardation and Development Disabilities, Department of Health, NYS Commission on Quality of Care and Advocate for Persons with Disabilities, and the Developmental Disabilities Planning Council.

Priority areas for CCSI include the development and delivery of training and technical assistance related to building and sustaining local systems of care, including a family advocacy training curriculum. CCSI continues to work to implement the comprehensive set of recommendations for improving services for children who have cross-systems needs (developed in 2004).

c. Capacity to Deliver Population-Based Services

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

In 2005, the Growing Up Healthy Hotline provided information to 60,953 callers (up from 59,191 callers in 2004) on a variety of maternal and child health issues, including information on eligibility for programs and the location of the nearest services. This total does not include 6,425 calls that were nuisance, hang-ups or otherwise erroneous. Over six percent (6.1%) of calls are handled in languages other than English. Of these calls, 3,584 or 5.9% (up from 3,131 or 5.7% last year) of the total calls were from Spanish-speaking callers and 162 or 0.2% of the calls were in languages other than English or Spanish, compared to 119 calls last year.

In 2005, callers requested assistance in the following areas: adult insurance 0.2%, breast and cervical screening 0.1%, Child Health Plus 4.2%, child/adult care food program

0.2%, dental/orthodontia 0.8%, early intervention 2.2%, educational materials 0.6%, Family Health Plus 1.9%, family planning 2.1%, farmer's market 6.2%, food and nutrition programs 0.4%, health department programs 1.2%, immunizations 0.3%, Medicaid for adults 4.0%, Medicaid for children 1.0%, newborn screening 0.5%, pregnancy care 11.2%, social services 0.6%, summer food program 4.6%, WIC 54.1%, WIC complaints 1.2%, and other 2.3%.

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

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

The declining percentage of calls about prenatal care has been a concern, even knowing that New York City Department of Health and Mental Hygiene operates a **toll-free hotline for the five boroughs of New York** that handles a substantial number of calls. New York State Department of Health implemented a statewide, multimedia prenatal care promotion campaign in 2005 using television, radio, and print media, including posters; bus sides, shelters and interiors; and subway interiors. The materials advertised the toll-free and TTY hotline numbers. The benefits of prenatal care and access to services under the Prenatal Care Assistance Program (PCAP) was broadly promoted and women were given the toll-free Growing Up Healthy hotline number to call for a link to local services. Our experience has been that the more media coverage there is, the greater the use of the hotline. As a result of the campaign, a 75% increase in the number of calls (2,869 versus 1,638) requesting information on prenatal care was noted for the February to May 2005 compared to the same period in 2004.

New York also has a toll-free hotline for **Child Health Plus** calls, which is linked to take rollover calls from the National Governor's Association hotline. However, the volume of Child Health Plus-related calls remains very heavy on the Title V hotline. In 2003, the Growing Up Healthy Hotline received 11,267 calls for information about Child Health Plus. The Child Health Plus hotline offers certain advantages, in that they can provide the public with more in-depth information about eligibility for Medicaid and Child Health Plus. The number for the Child Health Plus hotline is 1-800-698-4KIDS or 1-800-698-4543.

The list below is a partial listing of statewide hotlines and info-lines serving mothers and children:

Toll-Free Hotlines Serving the Maternal and Child Health Population in New York State	
Title V Growing Up Healthy Hotline: Immunization Child Health Plus Insurance Early Intervention Food and Nutrition, including WIC Infant Health Assessment Prenatal Care Sudden Infant Death Syndrome(SIDS) Teen Pregnancy Dental Health/Orthodontia	1-800-522-5006

Child Health Plus Hotline	1-800-698-4KIDS
Family Health Plus Hotline	1-877-9FH-PLUS
Child Abuse and Maltreatment Hotline	1-800-342-3720 (TDD 1-800-638-5163)
Domestic Violence Hotline	1-800-942-6906 (English) -6908 (Spanish) 1-800-621-HOPE (NYC English and Spanish)
Missing Children Hotline	1-800-FINDKID -- or –- 1-800-346-3543
Child Care Complaint Hotline	1-800-732-5207
Child and Adult Care Food Program	1-800-942-3858
Disabilities Information Line	1-800-522-4369
HIV/AIDS Information Service	1-800-541-AIDS; Spanish: 1-800-233-7432
HIV/AIDS Drug Assistance Program	1-800-542-2437
HIV Counseling and Testing Hotline After hours Albany Area Buffalo Area Nassau County New Rochelle Rochester Area Syracuse Area Suffolk County	 1-800-872-2777 1-800-962-5065 1-800-962-5064 1-800-462-6785 1-800-828-0064 1-800-962-5063 1-800-562-9423 1-800-462-6786
HIV Perinatal Counseling and Testing Complaints	1-877-249-5115
SIDS – NYS Center for Sudden Infant Death	1-800-336-7437
Cancer Information Service	1-800-462-1884 or in Erie Co.: 716-845-3380
Cancer Maps	1-800-458-1158
Roswell Park Cancer Referral Services	1-800-767-9355
Ovarian Cancer Information	1-800-682-7426
Smokers Quit Line	1-866-697-8487
Medicaid Helpline	1-800-541-2831
Medicaid Managed Care	1-800-505-5678 – NYC only
Medicaid Billing Assistance for Instate Providers	1-800-522-5518 – Practitioner Assistance 1-800-522-1892 – Institutional Assistance 1-800-522-5535 – Professional Services
Medicaid Fraud Reporting Line	1-877-87FRAUD
Child Support Info Line	1-800-846-0773
New York State Parent Connection Hotline	1-800-345-5437
Environmental Health Info Line	1-800-458-1158
Drug Abuse Information Hotline	1-800-522-5353
Consumer Fraud Hotline	1-800-771-7755 (TTY 1-800-788-9898)
Crime Victims Board	1-800-247-8035
Mental Hygiene Complaint Line (MH facilities)	1-800-624-4143 (TTY 1-800-624-4143)
Mental Hygiene Customer Relations	1-800-597-8481 (TTY 1-800-597-9810)
Organ and Tissue Donation Hotline	1-877-752-3175
Managed Care Complaint Line	1-800-206-8125
Home Health Care	1-800-628-5972
Environmental Health	1-800-458-1158
Health Care Fraud Hotline	1-800-771-7755

Talking Book/Braille Library	1-800-342-3688
Office of Professional Discipline – for health care professions other than medicine	1-800-442-8106
Medical Conduct Complaint Line – physicians	1-800-663-6114
Vocational and Educational Services for Individuals with Disabilities (VESID)	1-800-222-JOBS
VESID Disabilities Benefits Counselors/ Statewide Technical Assistance	1-888-224-3272 (TDD 716-847-1322)
NYC Department of Health and Mental Health Hotline for Prenatal Care	NYC Residents Only – Dial 311
Community Action for Prenatal Care (CAPC)	1-800-220-7606

Local health departments and local departments of social services often get phone calls directly from the residents of their municipality. Local departments of health and social services are generally very active in providing information and referral services on a county level, as are the Comprehensive Prenatal/Perinatal Services Networks. Local agencies also have access to hotline numbers and directories in order to handle calls for residents outside of their districts.

Newborn Metabolic Screening: Under mandate of **New York State Public Health Law §2500(a)**, all newborns must be screened for a number of amino acid, endocrine, fatty acid oxidation, hemoglobin, organic acid, urea cycle and other disorders and conditions including, but not limited to: phenylketonuria (PKU), congenital hypothyroidism, homozygous sickle cell disease, branched-chain ketonuria (Maple Syrup Urine Disease), galactosemia, homocystinuria, biotinidase deficiency and HIV. The **Newborn Screening Program** tests these samples, tracks findings, provides education and follows up on infants needing additional evaluation or treatment.

The purpose of testing newborns is to permit early detection and treatment of these conditions that, if untreated, lead to mental retardation or other disability. In 2005, 246,243 newborns were tested. (A complete listing of numbers served by newborn screening appears on Form 6. New York's panel of tests exceeds the guidelines of the American College of Medical Genetics and the March of Dimes.) The Newborn Screening Program consistently achieves 100% follow-up on confirmed cases. In 2001, three new tests were added: congenital adrenal hyperplasia, medium chain Acyl-Co-A dehydrogenase (MCAD), and cystic fibrosis. Local health units can and do use Article 6 State Aid reimbursement to pay for follow-up visits by public health nurses or bill insurance companies for these services. Children identified through the genetics screening process are referred to Children with Special Health Care Needs Specialty Centers. NYSDOH recently recertified various specialty centers.

Clinical genetics services, including follow-up genetics counseling for families of children with inborn metabolic errors are available through the **Genetics Program**. As a member of NYMAC (the New York-Mid-Atlantic Conference, the Genetics Program ensures that there are comprehensive services available throughout the state in order to provide counseling, testing, diagnosis and treatment to those in need. The Wadsworth Center for Laboratories and Research administers programs that cover services to over 24, 000 people annually through 25 NYSDOH and 12 NYMAC contracts.

Universal Newborn Hearing Screening: In 1999, the New York State Legislature passed and Governor Pataki signed a **bill requiring Universal Newborn Hearing Screening** in birthing hospitals in New York State. In 2000, the Department convened an Ad Hoc Work Group on Newborn Hearing Screening. This group advised the Department on the development of policies and procedures for newborn hearing screening, tracking, and follow-up as necessary to ensure successful expansion of the program to statewide. Final regulations were published for implementation in August 2001. New York used a four-year grant from the Health Resources and Services Administration to ensure that babies are appropriately screened, diagnosed and tracked for the timely receipt of needed services.

In the latter part of 2001, the program's focus shifted from development of regulations to provision of technical assistance and training to hospitals on the implementation of universal newborn hearing screening. In addition, public/parent education materials were developed and provided to facilities to coincide with the effective date of regulations. In 2001, the Department developed clinical practice guidelines and established quality assurance and review protocols with hospitals. State level review of protocols was initiated in 2001.

Health Information Materials: In 2005-2006, as in past years, the **Bureau of Health Media and Marketing,** planned, developed, produced, distributed and/or evaluated MCHSBG-related materials and campaigns. The following is a partial listing of recent projects:

- Activ8Kids (Frisbee, beach balls, stress balls in fruit and vegetable shapes, pedometers, t-shirts)
- Antibiotic Resistance (professional brochure, viral prescription order forms and prescription pads)
- Anti-Smoking Transit (Posters)
- Applications for Child Health Plus, Access NY, other programs
- As I Grow (new parent developmental guide and video)
- Ask Me! Campaign (canvas totes, aprons, buttons, brochures, clings, cards)
- Asthma: Don't Let Asthma Knock the Wind Out of Your Child (statewide campaign, brochures in English, Spanish, French, Chinese, Russian and low-literacy versions; posters in English and Spanish; TV and radio spots; prescription form)
- Aware/Prepare (first aid kits, folders, pens, flashlights)
- Berenstain Bears Tobacco Use Prevention Initiative (booklets in English and Spanish for all second graders)
- Booster Seat Demonstration Project (activity book, jungle, CD-ROM, tambourine, sunglasses)
- Breastfeeding Your Baby Is Special (Poster)
- Breastfeeding – Why Not Give It a Try? (booklet)
- Child and Adult Care Food Program (brochures and posters in English and Spanish)
- Child Health Plus (dental floss, band-aids, medicine spoon, coloring books, crayons, plastic bag)
- Community Action for Prenatal Care Campaign (palm card, posters)
- Cut the Fat (stickers, aprons, table covers)
- Dental Sealants Work Hard (stickers)
- Diseases that Can Spread during Sex (folder)
- The Diabetes Tool Kit and Manage Your Diabetes
- Ear Infections in Children (brochure)
- The Early Intervention Program (booklet)
- Eat at Mom's

- Eat Well, Play Hard (nutrition and activity campaign for children)
- Emergency Medical Services (booklet, stress ball in shape of ambulance)
- Fall Prevention for Children Birth to Three (brochure)
- Female Circumcision (brochure)
- Fight the Bite campaign (flyswatters, spray bottles, brochures on West Nile Virus)
- Fire Prevention (stickers)
- Fit for Life (gym bag, booklet)
- Fit WIC (nylon bag)
- Folic Acid Awareness Week (informational campaign, emery boards, hair brush/mirror)
- Having A Baby (booklet in English and Spanish)
- Hepatitis C (brochures, posters, lanyards, totes)
- Hike Water Bottle with Strap
- It's Never Too Late to Protect Your Family from Flu
- Lead Program…If You Have Children, Get Ahead of Lead (folder)
- Leo the Lion on Lead (coloring booklet, stuffed animal, washcloths, spray bottles)
- A Mammogram Can Find (poster, flyer)
- Maternity Information Law (brochure given to each mother upon registering for hospital maternity services)
- Medical Home: How Can I Get the Best Care for My Child? (folder, brief folder)
- Men's Health (cards, placards, telephone kiosk)
- Molly and Michael Molar (about dental sealants)
- A Mother's Right to Breastfeed (card)
- Newborn Hearing Screening Education (4 brochures and 7 posters in English, Spanish, Chinese, Creole, Russian, Urdu and Bengali)
- Parents Resource Directory for Families of Children with Special Health Care Needs (English, Spanish, French, Russian, Mandarin Chinese and Urdu)
- Pedestrian Safety (formative research/focus groups)
- Physician and Parent Guidelines for the Treatment of Otitis Media (brochure)
- Pregnancy Care calendar
- Pregnant? Protect Yourself and Your Baby in Transit
- Protect Your Baby from Smoke (brochure)
- Reality Check (t-shirts, banners, self-inking stamps, bracelets)
- Reducing Lead Hazards when Remodeling Your Home
- Save the Skin Your Child Is In (folder)
- Scooter Safety (brochure)
- Shaken Baby Syndrome (brochure, information kit, poster- see our website)
- Skin Cancer Prevention campaign (posters, placards)
- Smokefree N Y (stickers, cards)
- Suds Up! (on lead clean-up, stickers, brochures)
- Survive an Emergency (kit)
- Take Folic Acid Every Day (emery boards with countertop display holder)
- Tobacco Quit Kits and Quitline (kits, laminated cards)
- Wait! You May Not Need an Antibiotic!
- We All Chase the Same Dream (disabilities awareness poster, folder)
- Welcome to Parenthood (packet given to every new mother after delivery, English and Spanish)
- WellNYS Weekend (health screening fact sheets)
- A Whale of a Smile (stickers)
- What Providers Said: Doctors and Patients Working Together
- WIC Breastfeeding Promotion (fans)
- WIC Coloring Books
- WIC Saves You Money (posters)

- WIC Works Wonders campaign
- Your Guide to a Healthy Birth (booklet, English and Spanish)

Each season, the Bureau produces Media Advisory Packets of seasonal interest. The packets also contain ready-go-use press releases on a variety of seasonal topics and note health celebrations of interest. Local health departments use the packet to help with seasonal press releases. MCH topics, such as heat safety and sun avoidance, are often a component of these packets.

The Bureau of Dental Health is currently working with the Bureau on revamping Oral Health information, based on a recent needs assessment.

Immunization Services: The **Immunization Program** provided vaccines through the **NYS Vaccines for Children Program**, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted local health departments with disease surveillance and outbreak control activities, and continued to develop a statewide immunization registry. CDC categorical grants and State funds were used to provide staffing in both central and regional offices. Both CDC and State dollars were used to purchase vaccines and support local immunization activities at county health departments. Laboratory reports of Hepatitis B surface antigen-positive mothers are follow-up to ensure that their infants received appropriate vaccinations and treatment.

Over 90% of two year-old children in New York State (outside New York City) are vaccinated in private doctor's offices, not public clinics. Under the **Provider-Based Immunization Initiative**, county staff visit pediatricians and assess the medical records of their patients. The information is then keyed into a computer using CDC-developed software, the Clinical Assessment Software Application, (CASA). CASA calculates the providers' immunization rate and enables them to improve their vaccination protocols, when necessary.

Childhood Lead Poisoning Prevention: The **Childhood Lead Poisoning Prevention Program** coordinates efforts to prevent, detect and treat childhood lead poisoning; educates the public and health professionals about prevention, early detection and appropriate medical management of childhood lead poisoning; ensures that families of children with lead poisoning are given appropriate advice and assistance in locating and eliminating sources of lead within the child's environment; provides lead-safe interim housing while lead hazards are being removed; and collects and analyzes statewide data on the extent and severity of childhood lead poisoning.

In New York, blood lead testing is done primarily by the child's medical provider. The Childhood Lead Poisoning Prevention Program has contracts with 58 local health departments to provide prevention programs and care coordination. Seven teaching hospitals serve as Regional Lead Resource Centers. Local health departments and State Health Department District Offices provide environmental assessments and assure lead hazards are corrected. The Program has recently completed a comprehensive New York State Lead Elimination Plan in conjunction with the Center for Environmental Health.

Childhood Overweight Prevention: Eat Well, Play Hard was initiated in 1997 as a comprehensive response to the childhood overweight epidemic. The program's three-part strategy has been incorporated into all New York State Department of Health nutrition programs. To reduce the prevalence of overweight among New York State children, Eat Well, Play Hard promotes:

- Increasing developmentally-appropriate physical activity;
- Increasing the consumption of 1% or lower fat milk and low-fat dairy products; and
- Increasing the consumption of fruits and vegetables.

The Bureau of Child and Adolescent Health, in collaboration with New York State chapters of the American Academy of Pediatrics and the American Academy of Family Physicians will be distributing BMI growth charts and BMI wheels (to determine BMI) along with resource information on childhood obesity and interventions.

New interventions focus on improving the health and fitness of young children and preventing the development of overweight among preschool children by targeting the environment where children spend an increasing amount of time: preschools, child care and Head Start centers. The Division of Chronic Disease Prevention and Adult Health will be testing community-wide interventions that will collaboratively develop food and physical activities guidelines and policies, increase physical activity, decrease television and video watching, and address behaviors that encourage overeating or discourage physical activity.

The Department this year launched the Activ8Kids! Program, which is described elsewhere in this document.

The Department of Health's **Maternal Mortality Program** was funded by the CDC via cooperative agreement with the **Association of Schools of Public Health**. A new collaboration on maternal mortality review has developed with the **American College of Obstetricians and Gynecologists** with funding from the New York State Health Commissioner's Priority Pool. The goal of this initiative is to institutionalize maternal mortality review as one of the responsibilities of the Regional Perinatal Centers. A protocol and data collection tool are complete and in use, and reviews of maternal deaths initiated. Educational programs targeted towards obstetricians and gynecologists are now being developed based on findings from these reviews.

Welcome to Parenthood, a packet given to the family of each newborn born in New York, contains information about normal growth and development, parenting, child safety, calming a crying baby, early intervention and childhood immunizations.

d. Capacity to Deliver Infrastructure-Building Services

The protection and promotion of the public's health is not possible without adequate public health infrastructure. Public health agencies must have the ability to perform adequate needs assessment, to appropriately evaluate public health issues and programs, to develop meaningful policies and standards, to engage their communities, to coordinate existing resources, to ensure quality, and to adequately train the public health workforce.

The Department is able to assess the adequacy of the infrastructure for maternal and child health services through:

- Establishing and maintaining regular multi-directional communication with local health departments, local contractors, our regional offices, other units within the State Health Department and other State and Federal agencies;

- Regularly and frequently monitoring the quality and the content of local health assessments, public health service plans and contractor workplans;

- Monitoring the ability of our programs, our contractors and county health departments to effectively achieve the desired results;

- Monitoring and auditing the use of available resources, including available technical assistance;

- Periodically reassessing our internal controls system for areas of vulnerability; and

- Performing special assessments relative to the ability of local agencies to perform essential public health services.

Health Insurance Infrastructure
New York has developed adequate infrastructure for health insurance (previously described under Overall Capacity and Capacity to Deliver Direct Medical Services), essential public health services, information, education and collaboration among agencies.

Health Services Infrastructure
Since most of the maternal and child health services delivered in this State are not delivered directly by the New York State Department of Health, not only is State infrastructure important, but the local infrastructure is also critical to the delivery of high-quality services. The Department employs various mechanisms to ensure that services are coordinated and resources are maximized. The Department's ability to keep apprised of local conditions and to ensure the stability of the MCH infrastructure is supported the Public Health Law, strong regulations, its data collection and data analysis capacity, technical assistance capacity, and through oversight of contracts and letters of agreements with local providers of service.

Local Health Departments: County health departments continue to play an essential role in the assurance of high-quality, accessible maternal and child health services. They assessed the needs of their local communities, worked with their communities to design and implement programs that meet those needs, and evaluated the effects on their communities.

Under New York State Public Health Law, the **58 local health departments** extend the powers of the state health commissioner. Each of the non-New York City counties have a county health department, while all five counties in New York City are covered by the New York City Department of Health. The county health departments provide community health assessment, family health services, health education and disease control services. Most also provide environmental services. Counties that do not provide their own environmental services rely on the State Health Department's District Office in their area. Most counties in New York also operate certified home health agencies or licensed home health care agencies, through which they provide a variety of home-based services, including skilled nursing, home health aide, therapies, early intervention, maternal and child health and disease control visits. Some county health departments also operate diagnostic and treatment centers operated under Article 28 of the New York State Public Health Law. The trend is for counties to either divest personal care services or ensure that they are competitive in the market environment. There is also an emerging trend toward streamlining the administrative structures of local agencies. As a result, a handful of New York's local health agencies have combined with other county agencies, such as mental health or social services.

Under **Article 6** of the Public Health Law, local health departments perform comprehensive community health assessment on a two-year updating cycle, and subsequently produce a county-wide (or in the case of New York City, a city-wide) Municipal Public Health Service Plan (MPHSP). These local plans explicitly address the needs of the maternal and child health population in sections on health education, infant mortality prevention, child health, family planning, chronic disease prevention, injury control, disease control and nutrition. The Title V program staff provide technical assistance to local health units in plan development and participated in the review and approval process, as well as in monitoring of the implementation of the plans. Because local health departments know their local systems and community needs, the Plans address coordination across public and private resources, and across the continuum of primary, secondary and tertiary care. Local health departments play a critical role in fostering local collaborations.

Relationships with local health departments are coordinated through the **Office of Local Health Services,** the unit that also administers the local assistance/state aid program. Collaboration between the counties and the State and between agencies on the local level is yielding better use of data, better local plans, and more attention to outcomes of public health activities.

Perinatal Regionalization / Tertiary Care Centers / Regional Perinatal Centers: New York State has a long-established system of regionalized perinatal care with highly specialized **Regional Perinatal Centers (RPCs)** in each region of the state. These Centers provide tertiary level clinical care to high-risk mothers and newborns, and also serve as important contact points for the Department of Health in our interactions with the health care community. They help ensure that high-risk mothers and newborns receive appropriate levels of care by working with their affiliate hospitals to monitor perinatal morbidity and mortality and to provide education and technical assistance to physicians and others. The RPCs have helped the Department address important public health issues such as perinatal HIV, breast-feeding promotion, cesarean prevention, and collection and use of perinatal data.

The Department of Health worked collaboratively with hospitals of all levels and stakeholders statewide in perinatal care to re-examine the **perinatal designation levels** of all hospitals that provide obstetrical and newborn care. Factors like managed care, hospital downsizing and hospital mergers have altered the relationships between individual facilities and the Regional Perinatal Centers. Recently, new designations were prepared for all obstetrical hospitals based on the level of care available to both high-risk mothers and infants.

The Regional Perinatal Centers not only serve as the hub for consultation and transport within a network, but lead quality improvement activities within their network. The implementation of the Statewide Perinatal Data System (described under Information Infrastructure) has been closely tied to Perinatal Regionalization**.** The Regional Perinatal Centers are key to the development of a system for quality improvement within an affiliate network. SPDS is an important source for data for those activities. The Centers have responsibility for data quality within the network, including responsibility for training and technical assistance to affiliate hospitals. During 2002, Regional Perinatal Centers received their final designations as to level of perinatal care. Workplan guidance was developed and disseminated to all Regional Perinatal Centers in order that they gain a clearer understanding of their roles as leaders in regionalization. Throughout 2003, the Department worked with the Regional Perinatal Centers to enhance their understanding of

the provision of quality improvement activities among their affiliate network and promoted their leadership in the Regional Perinatal Forums to work with community collaborators in promoting improved perinatal outcomes within their regions.

Information Infrastructure

The Department of Health continued to improve accessibility of local data, both on the internet-based public website and on our intra-net, the **Health Information Network (HIN).** More and better data became available via electronic means in 1999 and 2000. This application has been posted on our public website since 1997.

Statewide Perinatal Data System: A **Statewide Perinatal Data System** is now implemented. This system involves the regional centers in coordinating data analysis for their regions and in helping their affiliated hospitals and others in the community (such as perinatal networks) use data for needs assessment, planning and quality improvement activities.

The Statewide Perinatal Data System (SPDS) provides a wealth of information on our achievement of our goals. The system is an internet-based, secure network consisting of all data from the Electronic Birth Certificate and data collected from hospitals and free-standing birth centers within the State as well as additional data elements. The system is used to assess birth outcomes at three levels: within hospitals, in integrated health care systems and in the community. It enables the Department to identify, in real-time, health care delivery and public health problems. It provides a powerful tool for quality assurance and quality improvement. At the same time that electronic birth certificate information is being collected, the system also collects the content of prenatal care, breastfeeding status on discharge from the hospital, maternal depression during pregnancy and periodontal disease during pregnancy. The development of the Statewide Perinatal Data System required regulatory amendments, which were processed through the Department for adoption.

Indicators of maternal and child health are built into the **Quality Assurance Reporting Requirement (QARR) System** for monitoring managed care and Child Health Plus providers. Title V works closely with the Office of Managed Care to make health plan performance data available to county health departments so that they may monitor the delivery of care to the population within their county.

The **SSDI Project** continued to support the **Children with Special Health Care Needs (CSHCN) Program** by assisting with the development of the data system. The CSHCN data will be capable of being linked with other child health data sets. The Project also revised and reprinted the Resource Directory for CSHCN. Over 50,000 directories were distributed to local health departments, hospitals, community-based organizations, schools, libraries, families and other providers. The directory is available in English, Spanish, Russian, Chinese and French.

MCH and Public Health Education Infrastructure

The **New York State Preventive Medicine Residency Program** trains five physicians annually, preparing them for leadership careers in state and local health departments. The program seeks to reduce health disparities among New Yorkers by increasing the number of well-trained public health physicians to address the needs of high-risk populations. This two-year residency program for physicians consists of an academic year, leading to a Masters in Public Health degree, and a practicum year, during which public health residents complete projects throughout the New York State Department of Health and affiliated sites.

Many of the residents go on to employment at the New York State Department of Health and other public health agencies in important maternal and child health positions. They include the former director and current medical director of the Division of Family Health, the director of the Bureau of Child and Adolescent Health, and the medical directors of the Bureau of Women's Health, the Immunization Program and the Hospital Epidemiology Program. The Program is implementing a three-year grant from the American Cancer Society, supplementing the support provided by the Maternal and Child Health Services Block Grant.

The **Dental Public Health Residency Program** continues to graduate residents from its statewide program. The Program continued its accreditation status and continued to collaborate with four dental residency sites in New York State. The Bureau of Dental Health currently employs one Resident, one Senior Resident and one graduate of the residency program.

GENES, the Genetic Network of New York, Puerto Rico and the Virgin Islands, has been replaced by **New York/Mid-Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC)**. The purpose of NYMAC is to improve access to genetics and newborn screening service through the development and implementation of local solutions to barriers to accessing specialty care by children with congenital conditions, through enhanced funding, and improved community and professional understanding of genetics services.

Area Health Education Centers (AHECs): Area Health Education Centers (AHECs) work to recruit, retain, and support health professionals to practice in communities with health provider shortages. They do so by developing opportunities and arranging placements for future health professionals to receive their clinical training in underserved areas, by providing continuing education and professional support for professionals in these communities and by encouraging local youth to pursue careers in health care. Plans currently call for the establishment of 9 AHEC offices across the State by the year 2010. Sites are currently operational in: Buffalo, Batavia, Potsdam, Glens Falls, Cortland, and the Bronx. Two additional sites will be located in the Erie-Niagara and Catskill area.

Title V has established a relationship with the AHECs. Dr. Thomas Rosenthal, AHEC Project Director, met with the Maternal and Child Health Services Advisory Council to exchange information and investigate collaboration opportunities. The Advisory Council and the AHECs are mutually concerned about the aging of the health care workforce, the aging of nursing faculty, current shortages in certain key health professions, and in interesting young people in health careers early in their student careers. The Bureau of Dental Health is working with AHECs to improve access to primary dental care, especially in rural areas.

Universities and Schools of Public Health: The **University at Albany School of Public Health** is unique in that it is jointly sponsored by a university and a state health department. The New York State Department of Health serves as the laboratory for the University at Albany School of Public Health, with graduate students working shoulder-to-shoulder with practicing professionals in the state health department or in local departments. A number of DOH and Title V staff serve as faculty and advisors to the school. Title V staff also serve on the School's **Continuing Education Advisory Board**, providing approvals for continuing medical and nursing education. Title V has utilized the School of Public Health as the continuing medical education provider for its annual Breastfeeding Grand Rounds, and for forums on public health genetics, HIV/AIDS, the

dental public health residency, home visiting, women's health and female circumcision. Among the other offerings through continuing education are: social marketing, environmental health, Hepatitis C, substance abuse, and occupational health and safety.

Title V staff in the Division of Family Health coordinate the **MCH Graduate Assistant Program**, under which fifteen University at Albany School of Public Health graduate students per semester (fall, spring and summer) are supported by block grant funds to work on priority MCH research and planning projects. This arrangement supports the Department of Health's mission through attracting bright and motivated individuals who are interested in gaining both theoretical and practical knowledge of public health and maternal and child health. The use of students also enhances the Department's research capacity, and improves the availability of pertinent and timely educational offerings for practicing public health professionals in the region.

The University at Albany's School of Public Health sponsors the **Northeast Public Health Leadership Institute**, now serving the northeast corner of the US. Several Title V staff have attended the Institute. Several graduates of the Institute also serve Title V in other states and at the New York City Department of Health.

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

The **New York – New Jersey Public Health Training Center (NYNJPHTC)** is a joint project between Columbia University's Mailman School of Public Health, the University at Albany School of Public Health, and the New Jersey School of Medicine and Dentistry/School of Public Health, in partnership with state, county and local health departments in the two states. NYNJPHTC is funded by HRSA's Public Health Training Center Project. They offer free, web-based training in public health topics, including Orientation to Public Health, Exploring Cross-Cultural Communication, and Overcoming Disparities in Birth Outcomes. Continuing education units are offered for nurses, physicians and health educators.

University Affiliated Programs: New York is fortunate to be home to three **University-Affiliated Programs** who offer **Leadership Education in Neurodevelopmental Disabilities (LEND)**. The three are located at the **University of Rochester**, the **Westchester Institute at Valhalla**, and **Jacobi/Albert Einstein Medical Center**. LEND Programs provide for leadership training in the provision of health and related care for children with developmental disabilities and other special health care needs and their families. The Department works with the LENDs on a variety of issues related to children with special health care needs and to meet training needs, and the University Affiliated Programs are a great source for physician consultants on a variety of issues. For example, the Bureau of Child and Adolescent Health worked with staff at Jacobi/Albert Einstein to improve identification of children with special health care needs.

The Department has participated in joint planning with the Westchester Institute, and we routinely meet with LEND faculty and students. Title V staff have traveled to Westchester Institute to present information on the Title V program and to answer questions.

Title V and the Adolescent Coordinator maintain linkages to the **Leadership Education in Adolescent Health (LEAH) Program** at the **University of Rochester.** The purpose

of LEAH is to prepare trainees in a variety of professional disciplines for leadership roles in the public and academic sectors and to ensure high levels of clinical competence in the area of adolescent health. Training is given in the biological, developmental, emotional, social, economic and environmental sciences, within a population-based public health framework. Prevention, coordination and communication are stressed.

Pediatric Pulmonary Center: New York's **Pediatric Pulmonary Center** is located at **Mount Sinai Medical Center** in Manhattan. The Pediatric Pulmonary Center takes an interdisciplinary approach to developing health professionals for leadership roles in the development, enhancement or improvement of community-based care for children with chronic respiratory diseases and their families. In addition serving as a model of excellence in interdisciplinary training, Mount Sinai also engages in active partnership with state and local health agencies and provides model services and research related to chronic respiratory conditions in infants and children. The Department is working with a pediatric pulmologist from Mount Sinai on a school-based asthma management initiative. Mount Sinai is a CDC National Cooperative Inner-City Asthma Study grantee, as are Albert Einstein College of Medicine and Bronx-Lebanon Hospital in the Bronx and University of Buffalo.

Behavioral Pediatric Training Center: Montefiore Medical Center sponsors the **Behavioral Pediatrics Training Program**. Training grants from the Federal Maternal and Child Health Bureau support faculty who demonstrate leadership and expertise in the teaching of behavioral pediatrics, scholarship and community service. Fellows who have completed training are board-eligible in pediatrics. The three-year fellowship program includes course work and clinical practice in growth and development, adaptation, injury prevention, disease prevention and health promotion. The program is also available to provide continuing education and technical assistance.

Statewide Satellite Broadcasts: The Department of Health, with the School of Public Health at the University at Albany, the New York State Community Health Partnership and the New York State Association of County Health Officials, sponsors monthly **Third Thursday Breakfast Broadcasts (T2B2).** T2B2 provides continuing education opportunities covering a variety of public health issues. Local site coordinators in each county health department coordinate local logistics. Out-of-state attendees can locate sites by visiting the University at Albany's website: www.albany.edu/sph/coned/t2b2site.html. Continuing medical and nursing education credits are available. Series have focused on Children's Health, Quality of Life, Emergency Preparedness, Promoting Healthy Behavior, and Model Programs.

The Office of Children and Family Services also sponsors with partners such as DOH, the SUNY Distance Learning Project, and the New York State Child and Family Trust Fund, monthly satellite broadcasts on child health and safety topics such as SIDS and Risk Reduction.

Infrastructure for Collaboration

The Department of Health continued to support a variety of **regional and local collaboratives** to improve needs assessment, identify and build local capacity, outreach to hard-to-reach segments of the population, and assure quality. The common thread among these efforts is community engagement and commitment to collaboration and coordination in the use of resources. Examples of such efforts include: Comprehensive Prenatal Perinatal Services Networks, Rural Health Networks, community assessment and joint planning initiatives, Comprehensive Planning for Youth Services, Partners for Children, Early Intervention Coordinating Councils, the affiliation networks of the regional

perinatal centers, regional EMS councils, Infant Mortality Review Community Councils, Comprehensive School Health and Wellness, the Women's Health Project, the Coordinated Asthma Program, HIV/AIDS Prevention Planning Groups, and many more.

Voluntary and Professional Organizations: DOH strives to maintain positive and collaborative relationships with several not-for-profit, voluntary groups who share concerns for the health and well-being of mothers, infants, children and women of childbearing age. The Department's Title V program has active relationships/collaborations with:

- Family Voices;
- Family Support New York;
- New York State Alliance for Family Literacy;
- Parent-to-Parent, New York State;
- New York State Public Health Association;
- Healthy Start;
- New York State Perinatal Association;
- New York State Association of County Health Officials;
- New York State Association of Counties;
- New York State Association for Rural Health;
- New York State Nurses Association;
- March of Dimes;
- New York State United Teachers;
- Boards of Cooperative Education Services (BOCES);
- New York State School Boards Association;
- New York State Child Care Coordinating Council;
- New York State Partners for Children;
- The New York State Council on Sexual Assault;
- New York State Community Health Partnership;
- University Affiliated Programs at Westchester, Rochester and Jacobi/Albert Einstein;
- American Academy of Pediatrics, District 2;
- New York Academy of Medicine;
- American College of Obstetricians and Gynecologists, New York State Chapter;
- American Academy of Family Practice, New York State Chapter;
- American College of Nurse Midwives, New York State Chapter;
- New York State Association of Perinatal Programs;
- Medical Society of the State of New York;
- Healthcare Association of New York State (representing hospitals across the state);
- Greater New York Hospital Association (representing hospitals in the Greater Metropolitan area);
- Schuyler Center for Analysis and Advocacy, and its Children's Policy Agenda;
- Cornell University Cooperative Extension, Human Development Center and 4-H;
- YMCA of New York State
- United Way of New York State;
- Association of New York State Youth Bureaus;
- New York State School Boards Association;
- School Nurses statewide;
- University at Albany School of Public Health;
- Columbia University School of Public Health;
- University at Buffalo School of Social Work;
- Leadership Education in Adolescent Health at University of Rochester;
- Mount Sinai Adolescent Center;
- SIDS Alliance;

and many others who enhance the capacity of Title V programs to operate effectively.

Infrastructure for Collaboration on Child Health Care Quality Improvement: In October 2005, New York kicked off the Empire State Child Health Improvement Partnership (ES-CHIP) with a partnership dinner. Working with the Vermont Child Health Improvement Project (V-CHIP) and the National Initiative for Children's Healthcare Quality (NICHQ), and built on our success with the Medical Home Learning Collaborative, New York has committed to developing a durable regional collaboration with an initial focus on quality improvement in developmental services for children under age five. The Plan-Do-Study-Act cycle is testing changes in real work settings (pediatric practices). Partners include the New York State Department of Health, the American Academy of Pediatrics Chapter 1, the New York Academy of Family Physicians and Family Voices. The collaboration began in March 2006.

Collaborations in Women's Health: The results of Comprehensive Women's Health Summit were released in 2005. The summit was entitled, "Pathways to Women's Health: Integrating health services for women." The summit brought together key stakeholders for the development of a more comprehensive, integrated approach to coordinating women's health services in New York State and to explore opportunities to improve care statewide.

5. Selection of State Priority Needs

The overall goals for health care delivery in New York are:

- to continue insurance coverage and enrollment of the uninsured and underinsured;
- to assure that the health care delivered in New York State is of high quality;
- to emphasize prevention and education by involving communities in addressing and improving health; and
- to create a seamless health care system whereby our residents may retain continuous health care delivery at a "medical home" irrespective of insurance status.

In addition, Governor Pataki has set these more specific goals for health in New York:

- to reduce potentially deadly asthma attacks in children;
- to ensure that every child in New York receives all their vaccinations by their second birthday;
- to ensure that every newborn is screened for hearing impairment;
- to significantly reduce smoking among youth in New York State; and
- to protect infants born to HIV-infected mothers to ensure that virtually none develop AIDS.

Improving and sustaining access to high-quality, continuous primary health care and treatment services are critical to improving health outcomes for all New Yorkers and achieving our public health and maternal and child health priorities. The hallmarks of success will be prevention, early intervention, and continuity of care through establishing and maintaining a "medical home" for every New Yorker. Success will also depend on the actual delivery of appropriate, high-quality, comprehensive health services to people in need, and requires practitioners to be knowledgeable about and practice good preventive and therapeutic medicine.

As previously described, New York has undergone extensive priority-setting processes. Throughout, participants decline to rank priorities, preferring that each of these "opportunities for improvement" be considered of equal importance. The ten priorities that follow, and the specific performance measures related to each, stem specifically from areas of unmet need in the State.

Most often, programs that address maternal and child health issues initiate services and interventions on a variety of levels. For example, in addressing access to care, we are improving the insurance and charity care infrastructure, targeting population-based messages, enabling clients to access and sustain their relationship to a medical home, and work to remove barriers to accessing high-quality direct medical services. Thus, each of the four levels of the MCH pyramid may be relevant to a particular need.

The following are New York's maternal and child health services priority needs:

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

The Maternal and Child Health Services Block Grant Advisory Council elaborated on these needs:

- Relative to access to care, the Advisory Council reinforced that all children and adolescents need access to comprehensive primary and preventive services that is consistent with the Child-Teen Health Plan (EPSDT) and includes a specific source for ongoing primary care or a "medical home" and a specific source for ongoing dental care.
- Dental services for children should include fluoridation or fluoride treatment and dental sealants.
- Children with special health care needs should also have access to a source on care that prevents secondary disability and improves or maintains their quality of life. This includes access to evaluation and treatment sources for CSHCN, access to early developmental and hearing screening, access to early intervention services, early coordination of their care and family support services, and access to clinical and laboratory genetics services.

- Relative to pregnant women, the MCHSBG Advisory Council stressed the need for comprehensive and effective prenatal care. This should include health education on pregnancy and child care, outreach and home visitation, nutritional counseling, prevention of tobacco, drug, alcohol and substance abuse, HIV prevention services, prevention of congenital infection, and detection or prevention of genetic disorders.
- On the subject of education, the MCHSBG Advisory Council stressed the need for comprehensive health education, beginning at an early age, and including HIV prevention, substance abuse, family life, sexuality, conflict resolution skill building, and healthy lifestyles.
- Mental health issues and issues related to violence clearly have an impact on the health status of the maternal and child population. The Advisory Council sees the need for suicide prevention and post-partum depression services in each community.

- Further, violence related to homicide, child abuse and neglect, other domestic violence and assault are clearly issues. The Advisory Council stressed the need for families to provide nurturing care to their children.
- The Advisory Council continually re-affirms the value of parent and consumer input in their decision-making process.

Priority needs relate to all MCH population groups and all levels of the MCH Pyramid.

C. Needs Assessment Summary

As a result of New York Title V needs assessment process, the following ten priorities have been identified:

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

The justification for their selection as priorities may be found in Section II. B.1. and a description of our planning/targeting framework may be found in Section II.A.

Priority setting was conducted as a melding process, combining:

- The results community-participative processes;

- The use of the many and various data sets available to the Department, such as:
    - Routine surveillance of vital statistics/vital records;
    - Census data;
    - Registries;
    - Hospital discharge data;
    - Special studies;
    - Community-based assessment data;

- The use of program data and provider input to identify trends and issues;
- Infrastructure evaluation;

- The input of the public and the Maternal and Child Health Services Advisory Council, including the input of those who spoke at focus groups, the public hearings or sent testimony, to assist in interpreting data and identifying important trends, gaps in services or barriers to care; and

- The input of key staff within the Department.

The process remains unchanged since the last application. Collaborations and partnerships that contribute to the needs assessment process have also remained unchanged. NYSDOH will continue to strive to meet these needs.

D. Health Status Indicators

Please see Form 20 and 21 for multi-year reports on required Health Status Indicators. Below, please see brief explanations of program efforts designed to address the indicators.

#01A Health Status Indicator
The percent of live births weighing less than 2,500 grams.
#01B Health Status Indicator
The percent of live singleton births weighing less than 2,500 grams.
#02A Health Status Indicator
The percent of live births weighing less than 1,500 grams.
#02B Health Status Indicator
The percent of live singleton births weighing less than 1,500 grams.

Please see graphs and discussion of low birthweight and very low birthweight data on pages 56 through 59, figures 17 through 22, and table 12.

The Statewide Perinatal Data System is providing real-time internet-based data to providers, networks and local health departments on the occurrence of high-risk births.

These data are affected by multiple births and the growth of assistive reproductive technology. Assisted reproduction and infertility treatments are associated with an increase in multiple and pre-term births.

Poor spacing of pregnancies contributes to poor birth outcomes. Through funding from Title X and Title V, 57 Family Planning Programs provided services including comprehensive reproductive health service to 341,532 women and adolescents. In addition, community education and outreach was conducted across the state.

Timely, risk-appropriate, coordinated, comprehensive prenatal care is provided to all Prenatal Care Assistance Program (PCAP) and MOMS Program enrollees. PCAP and MOMS require adherence to Part 85.40 standards of prenatal care, and all managed care plans serving Medicaid women are required to adhere to these comprehensive standards, as well. The provision of high quality prenatal care and appropriate level of care mandated by the standards was shown to reduce low birth weight rates among Medicaid women, particularly minority women, when compared to non-participants. In studies comparing Medicaid women receiving care under these programs with Medicaid women receiving other types of prenatal care, PCAP and MOMS clients had consistently better birth outcomes, and these outcomes were better even at the lower birth weights. Presumptive eligibility helps ensure timely entry into care. The availability of comprehensive prenatal care to all women through the PCAP and MOMS Programs will result in healthier births. Hard-to-reach women are often found through the Community Health Worker Program or through local Public Health Nurse home visits.

WIC has directly promoted the birth of healthy infants by preventing low birth weight. In 2003, the percentage of low birthweight was 7.9% among NYS WIC participants, compared to 8.9% of WIC participants nationwide, and compared to a statewide total low birthweight rate which was also 7.9%.

The Growing Up Healthy Hotline linked women with prenatal, nutrition, psychosocial and supportive services that contribute to healthy pregnancy and improved birth weights.

The Infant Mortality Review process contributed epidemiologic information to promote healthy birth outcomes, to assure adequate prenatal risk assessment, and to encourage follow-up for all high-risk pregnancies.

The Comprehensive Prenatal/Perinatal Services Networks and Healthy Start grantees addressed low birth weight through collaboration with a variety of health and human services providers, focusing on low birth weight as a serious issue in their communities and monitoring and disseminating actual data on incidence in their communities. Networks also stress the need for appropriate sites of delivery for high-risk pregnant women.

In 2004, 89.1% of infants born to women in the Community Health Worker Program were of normal birthweight, 8.8% were low birthweight, and 1.9% were very low birthweight. There were no data on 0.2% of births. Fully 5.0% of the low birthweight births were the result of multiple births. Of the pregnant women entering CHWP, 49% were already engaged in prenatal care. Of those women who were not, 87% were assisted to receive prenatal care within 1 month of entry to the program, and the remainder entered prenatal care more than one month after entry into the CHWP. Of the total number of pregnant women in CHWP, 75.7% entered prenatal care in the first trimester, 14.9% in second, 2.7% in third; 1.5% did not receive prenatal care and there are no data for 5.2% of the pregnant women in CHWP.

Prenatal genetics counseling and screening services were provided to approximately 24,000 women and families. Through preconception and prenatal genetic counseling and screening, babies who may be at risk for genetic, infectious or other congenital conditions

can be identified before birth. The mother is offered appropriate options, including close monitoring of fetal development throughout the pregnancy, fetal surgery or other medical interventions, deliver in tertiary medical facilities with neonatal intensive care units, early developmental assessments and interventions, and termination of pregnancy.

The Department completed a re-designation process for all birthing hospitals in the State. Under this process, hospitals were required to be able to provide maternal/obstetrical, as well as neonatal, care for high-risk women and their pregnancies.

For discussion and trend information on these indicators, please refer to pages 47 through 49 of this Needs Assessment and program efforts briefly described above.

#03A Health Status Indicator
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.
#03B Health Status Indicator
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.
#03C Health Status Indicator
The death rate per 100,000 due to unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years. – and –
#04A Health Status Indicator
The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.
#04B Health Status Indicator
The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.
#04C Health Status Indicator
The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Bureau of Injury Control sponsors multiple programs in pedestrian and passenger safety, head injury prevention, burn prevention, and child safety. They promote passenger restraint, including the use of car seats. Bureau of Injury Control is represented at meetings of the Governor's Traffic Safety Committee.

Camper and staff injuries are collected and entered into the injury surveillance database. Local health departments are audited for permit issuance, inspections, written safety plan, and injury reporting and investigation requirements. As a result of these analyses, the State Sanitary Code was amended to require bunk bed guardrail installation. Statewide inspector training programs are conducted to train inspectors in camp safety and regulations. Allegations of abuse must be reported, investigated and entered into the incident surveillance system. Prevention strategies and findings from these incidents are shared in trainings and through mailings.

In 2004, 484 incidents of illness, 140 bat exposures and 12 epinephrine administrations were reported by camps and entered into the illness surveillance system. 27 outbreaks were also reported and investigated. Data from analysis of illness due to potable water supplies was used to justify amendment of the State Sanitary Code to require additional disinfection, start-up procedures and sampling requirements. No campers drowned in the 2004 season. In 2005, there were 928 camper and 26 staff injuries. 6 campers died; one from a fall from a tree, five in a car crash. No campers drowned.

Children's Camp regulations were amended relative to on-site, off-site and wilderness swimming and incidental water immersion to better protect against drowning.

Written information regarding injury prevention was sent to all local health departments seasonally in media packets containing ready-to-use media releases.

All new parents are given instruction in prevention of Shaken Baby Syndrome prior to taking their newborns home from the hospital.

Bushwick families enrolled in the Healthy Families New York Program (Bushwick Bright Start) received home safety assessments, education and remediation plans and services. All families received fire extinguishers, carbon monoxide detectors, and first aid kits. All family services workers in the program were trained in home safety and scored 95% or higher on post-training assessment.

Comprehensive Prenatal/Perinatal Service Networks sponsor educational offerings, some of which focus on domestic violence and child safety.

Smoke alarms were distributed to communities who responded to an FRA and documented a need. The alarms were provided to families with young children who are at risk for injury due to fire.

New York has mandated reporter laws for reporting child abuse.

New York's rate of motor vehicle crashes are at an all-time low. This phenomenon was recently studied at the direction of HRSA by the University of North Carolina at Chapel Hill's School of Public Health. The low rates are attributed to:

- a long history of stakeholder collaboration around traffic safety and the positioning of the Traffic Safety Commission, which reports directly to the Governor;
- highway engineering that provides wide shoulders on roads, good visibility, rumble strips, easily accessible and sensibly spaced rest areas, and clear, well-placed directional signs;
- New York State has graduated licensing of young drivers;
- DWI laws are well known and there are several designated driver programs;
- STOP DWI efforts, and efforts of private groups such as Mothers Against Drunk Driving and RID, which advocates for removing intoxicated drivers from the roadways;
- excellent law enforcement; and
- stringent driving and passenger restraint regulations.

The lead within NYSDOH for traffic related public health issues is the director of the Injury Control Program. See information above on program efforts of the Bureau of Injury Control.

#05A Health Status Indicator

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

#05B Health Status Indicator

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

Please see discussion and data display on pages 83 and 85 and Tables 19 through 21 of this Needs Assessment. Chlamydia rates are rising, but it is impossible to assess how much of the increase in cases is due to increased awareness, testing and case ascertainment.

Family Planning providers educate women and their partners in disease prevention and reducing risk of transmission of sexually transmitted diseases.

Each county health department is responsible for control of sexually-transmitted diseases within their jurisdiction. This includes prevention strategies, as well as case finding, diagnosis, treatment and follow-up.

#06A and B, 07 A and B, 08 A and B, 09 A and B, 10, 11 and 12 Health Status Indicators

Demographics - Please see Form 21.

Each county health department and health care provider has access to useful data through the Community Health Data Set on the HIN and HPN intranet sponsored by the New York State Department of Health. There are multiple sources of data available through the Public Health Information Group, the Office of Managed Care, the Office of Medicaid Management and the State Insurance Department.

E. Outcome Measures – Federal and State

Outcome measures denote the final desired result of Title V program activities and interventions. Progress on outcome measures can be attributed to any number of program activities and influences from the health care and social environments. Effectively reducing adverse events requires programmatic investment across the various levels of the MCH Pyramid and the various MCH populations.

Please refer to Form 12, which tracks New York's progress on the six required outcome measures. Outcome measures are indicative of the collective efforts of New York's public and private health care systems to obtain optimum health for all New Yorkers. Local health departments, who monitor health outcomes through statutorily required community health assessments, may use local funds and State Aid to Localities to pay for tracking of outcomes in their municipality. However, Title V funding supports training and technical assistance, data production and posting of information on Department of Health websites on the Internet and the intranets.

Relative to our State Outcome Measure, maternal mortality, all of the Department's maternal and child health programs, but especially the Prenatal Care Assistance Program (PCAP), MOMS, Medicaid and Managed Care, promoted early entry into prenatal care, provision of related services, coordination of care through the intrapartum and postpartum periods, risk assessment and provision of risk-appropriate care. PCAP Part 85.40 standards apply to all pregnancy-related care under Medicaid and Managed Care.

The table below indicates how New York State MCH priorities relate to Federal and State Outcome Measures.

Priority Area	Applicable Outcome Measure
Access to Care	1 – 6, NY
Oral Health	1
Overweight	---
Disparities, especially LBW and IM	1 – 6, NY
Asthma	6
Reducing Use of Alcohol and Tobacco Use among Children and Pregnant Women	1, 2, 3, 5
Responsible Sexual Activity	6
Genetics Services	1-6
Violence and Self-Inflicted Injury	6
Parent Partnership	---

The matrix on the next page gives examples of how the various programs relate to the various Federal and State Performance and Outcome measures. On the page after that appears the model for NYS Title V performance evaluation.

Relationship of Measures to Program Activities: In New York State, multiple programs contribute to multiple outcomes. The following matrix cross-references programs with the National Performance Measures, National Outcome Measures and State-Selected Performance Outcome Measures. Each performance measure or outcome is only counted once below, though the measure or outcome may be related to more than one level of the pyramid.

NYS MCH Programs	*National Performance Measures*																		*National Outcome Measures*						*State Selected Performance Measures*										*State Outcome Measure*
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*	*1*	*2*	*3*	*4*	*5*	*6*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	
Abstinence Education						★		★								★			★	★	★	★	★	★	★			★							★
ACT for Youth/ Youth Development		★	★			★		★								★								★	★		★			★	★	★	★		
American Indian Health Program	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Asthma/ Asthma Coalitions		★	★	★	★	★																				★									
Childhood Injury Prevention										★						★			★	★	★	★	★	★								★	★		
CSHCN Program Physically Handicap'd	★	★	★	★	★	★							★						★	★	★	★	★	★		★	★								
Chlamydia/STD								★																											
Columbia Collaborative		★																								★									
Comm-based Adoles. Preg. Prev.						★		★							★				★	★	★	★	★	★	★			★							★
Community Health Worker		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Comp. Pre/Perinatal Services Networks	★							★			★	★	★		★		★	★	★	★	★	★	★		★			★	★	★					★
Congenital Anomalies Registry																			★	★	★	★	★	★											
Dental Public Health Residency									★				★	★																					
Dental Preventive Programs		★		★	★				★				★	★																					
Early Intervention	★	★	★	★	★					★		★	★						★					★										★	
Eat Well, Play Hard Activ8Kids/others										★				★													★								
Family Planning				★	★	★		★					★		★	★	★	★	★	★	★	★	★	★	★			★	★		★	★	★		★
Genetics Services/ Newborn Screening	★	★	★	★	★	★						★	★	★				★	★	★	★	★	★	★											★
HIV-Related Services	★	★	★	★	★	★		★					★			★	★	★	★	★	★	★	★	★											
Hotlines	★	★	★	★	★	★	★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★		★	★		★			★	★
Immunization & Hep B Follow-up		★	★	★	★	★	★						★					★																	
Infant /Child Mortal Review/ SIDS															★	★		★	★	★	★	★	★	★	★	★		★		★	★	★			
Lactation Institute/ Breastfeeding Prom		★								★	★																		★						
Lead Poisoning Prevention & Fllwup		★	★	★	★								★	★										★										★	
Medicaid/Uninsured Projects/CHP	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Migrant Health	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Pediatric Enhanced Services		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★			★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
Pren. Care Assist. Prog. (PCAP)		★	★	★	★	★	★	★		★		★	★	★	★	★	★	★	★	★	★	★	★		★		★	★	★	★		★	★		★
School Health		★	★	★	★	★	★	★	★	★			★		★	★	★	★						★	★	★	★	★	★	★	★	★	★	★	★
Tobacco Control Activities															★											★	★						★		

NYS - TITLE V PERFORMANCE MEASUREMENT SYSTEM

Needs Assessment → *Select Priority Needs* → *Program Implementation* → *Performance Measurement National and State Perf. Meas.* → *Improved Health Outcomes* → Start Again

Tracking Data/Trends Analysis:

- Vital Records
- Census Data
- Registries
- Hospital Discharges
- Program Data/Payer Information
- Special Studies
- Community Assmnt.
- Health Status Indicators
- Health System Capacity Indicators
- Infrastructure Evaluation

Input from Parents and Consumers

Input from Advisory Council

Input of Key Staff

1. Improve Access to Care
2. Improve Oral Health
3. Overweight Prevention
4. Eliminate Disparities in LBW and IM
5. Reduce Asthma
6. Reduce /Eliminate Tobacco and Alcohol Use
7. Reduce Unintended Pregnancies
8. Genetics Services
9. Reduce Violence
10. Enhance Parent Consumer Participation

Direct Services

Gap-filling personal services to pregnant women, mothers, infants & children, including CSHCN

Enabling Services

Help to access health care/ information
Ex: Community Health Worker Program, Family Specialist, Care Coordination, CSHCN Program, Translation, Transportation

Population-Based Services

Preventive or personal health services available to all pregnant women, mothers, infants or children
Ex: Newborn Metabolic and Hearing Screening Immunization, Growing Up Healthy Hotline

Infrastructure Services

Develops, maintains and supports access to MCH services
Ex: Needs Assessment, Evaluation, Planning, Program Development, Collaborations, Surveillance, PH Residencies, MCH Grad Assistantship

NPM 1 - % infants screened for metabolic disease
NPM 2 -CSHCN whose families partner in decision-making
NPM 3- CSHCN with Medical Home
NPM 4 - % CSHCN with adequate insurance
NPM 5 - % CSHCN reporting community systems are easy to use

NPM 6 – Transition services
NPM 7 - Immunization
NPM 8 – Teen Birth Rate
NPM 9 – Dental Sealants for 3rd graders
NPM 10 – MV Deaths 0-14
NPM 11- Breastfeeding

NPM 12 – Newborn Hearing Screened
NPM 13- % Children without health insurance
NPM 14 - % 2-5 in WIC who are Overweight
NPM 15 - % Pregnant Women Smoked Last 3Mo

NPM 16 –Suicide deaths 15-19
NPM 17- VLBW at facilities for hi risk
NPM 18- First trimester prenatal care

NY 1- Unintended pregnancies
NY 2 – Asthma hospitalizations 1-14
NY 3 - % >3 hrs. TV per day
NY 4 – Teen pregnancies
NY 5 – % depressed/down moms

NY 6 - % back to sleep
NY 7 – Self-inflicted injuries
NY 8 – Students binge drinking

NY 9 – Students/tobacco in 30 days

NY 10 - % screened for lead

Outcome Measure 1 –
Infant Mortality

Outcome Measure 2 –
Ratio BIM to WIM

Outcome Measure 3 –
Neonatal Mortality

Outcome Measure 4 –
Post-Neonatal Mortality

Outcome Measure 5 –
Perinatal Mortality Rate

Outcome Measure 6 –
Child Death Rate

New York Outcome Measure –
Maternal Mortality

III. STATE OVERVIEW

A. Overview

The overall goals for health care delivery in New York are:

- To continue to expand insurance coverage to the uninsured and underinsured;
- To assure that the health care delivered in New York State is of high quality;
- To emphasize prevention and education by involving communities in addressing and improving health; and
- To create a seamless health care system whereby our residents may retain continuous health care delivery at a "medical home" irrespective of insurance status.

As previously described, New York has undergone extensive priority-setting processes. The ten priorities that follow, and the specific performance measures related to each, stem specifically from areas of unmet need in the State.

The following are New York's maternal and child health services priority needs:

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

Improving and sustaining access to high-quality, continuous primary health care and treatment services are critical to improving health outcomes for all New Yorkers and achieving our public health and maternal and child health priorities. The hallmarks of success will be prevention, early intervention, and continuity of care through establishing and maintaining a "medical home" and a "dental home" for every New Yorker. Success will also depend on the actual delivery of appropriate, high-quality, comprehensive health services to people in need, and requires practitioners to be knowledgeable about and the practice good preventative and therapeutic care. Title V works closely with the Office of Medicaid Management an/d the Office of Managed Care to ensure that any gaps in care are recognized and acted upon.

*Please see **Section II. Needs Assessment** for a more complete description of New York State's geography, population, resources and health care delivery environment.*

Measuring Success will rely on accurate assessment of progress. Factors that play a role are:

Diversity: Recapping the Needs Assessment, New York's diverse geography can also present interesting public health challenges. The state has both urban centers and sparsely populated rural areas. New York's beautiful natural resources attract tourists year-round to our historic and recreational attractions, which can produce variable seasonal demand on health services, especially in the areas of emergency medical services and public health. Seasonal variations in weather can also affect how and when New Yorkers seek services. Heavy "lake effect" snowstorms can delay access to care and make travel dangerous, especially in the northern and eastern areas of the State.

Our population is even more diverse than our geography, more diverse than the nation as a whole, with New York City being the most diverse area. On the 2000 Census, 67.9% of New York residents reported they were White alone, 15.9% reported they are Black or African American alone, 5.5% reported they were Asian alone, 0.4% reported they were American Indian or Alaskan Native, and 7.1% reported being some other race. 15.1% of the State's total respondents reported they were Hispanic. Over 3.1% of New Yorkers identified themselves as being of more than one race. Native Americans were severely undercounted.

New York is also home to many new New Yorkers and new Americans. New York ranks higher than the country as a whole for non-Hispanic Black residents, Hispanic residents, and non-citizen residents. We are third among states for non-citizen immigrants, with an estimated 2.2 million resident non-citizen immigrants. 90% of non-citizen immigrants in the State live in New York City. Our foreign-born population was estimated at 3.4 million in 1995, representing 17.7% of the State's or one in about six people. The vast majority of the foreign-born in New York are here legally (84%). 4,704,625 New Yorkers speak a language other than English as their primary language. 2,092,875 reported speaking English less than "very well."

Poverty and Health Care: Although New York is fifth in the US for per capita income, poverty is a major factor for affordability and access to health care services. According to the US Census Bureau, about 15% of New Yorkers lived below the Federal Poverty Level (FPL) in 2004, and 18.6% were below 125% of the FPL. 12.6% of New Yorker families live in households with incomes at or below 100% of the FPL. More New York adults with children than adults without children are poor. 11.9% of those participating in the Behavioral Risk Factor Surveillance Study in 2005 reported not seeking care when they needed it due to cost. Figures are higher among African Americans and Hispanics. Uninsurance rate among children ages birth through age 17 is 8.6%. To address the health care needs of the poor, New York has a generous Medicaid package, Child Health Plus and Family Health Plus.

Pregnancy and Birth Rates: The overall number of births has shown a decline in both New York City and the rest of the state. The birth rate was 60.2 per 1,000 in 2004, the same as in 2003. Adolescent birth and pregnancy rates declined for the fifth straight year and remain below national averages. Birth rates among Black and Hispanic teens were significantly higher than among White teens. During 2004 there were 34.4 births for every 1,000 Hispanic teen girls aged 15-17 in New York State. This is more than 3 times the rate for White teens (11.1 per 1,000) in this age group. Among Black 15-17 year olds the birth rate, at 22.2 per 1,000, was exactly double the rate for white teens. The rate of unintended pregnancy among PRAMS respondents remains mostly stable, but with a slight upswing in 2003 to 36.3%. Those most at risk for unintended pregnancy in 2003 were African American women (71.1%), those under age 20 (66.1%), women who were not married (63.2%), women on Medicaid (57.6%), and women with less than a high school education (53.2%).

Prenatal Care: The percentage of women entering prenatal care in the first trimester has shown slight improvement each year since 1993. After the percentage leveled off in 2002 there were improvements in 2003 and leveling off in 2004. The percentage of New York City residents entering prenatal care in the first trimester leveled off in 2003 and 2004 (72%), but rates among Hispanic and African American women improved slightly. During that same time period, adequacy and content of prenatal care improved among all regions and among all racial and ethnic groups.

Other positive trends in the PRAMS data were noted from 1995 to 2003:

- Fewer mothers reported drinking alcohol while pregnant.
- Mothers reported smoking less after pregnancy than prior to pregnancy.
- Fewer mothers exposed their babies to second-hand smoke.
- Fewer mothers experienced physical abuse during pregnancy.
- More mothers initiated breastfeeding.
- More mothers place their babies on their backs to sleep.
- More mothers had knowledge of the positive effect of folic acid on birth defects.

Prenatal care enrollment increased among HIV+ women and more women presenting for delivery had received counseling and testing during pregnancy. The percent of HIV-exposed infants who received prenatal intrapartal, or neonatal ARV to reduce transmission also increased. As a result of these efforts, neonatal HIV infection rates have declined dramatically.

Low and Very Low Birth Weight: Overall rates of low birth weight and very low birth weight have been relatively unchanged over ten or more years. The rate for singleton births had declined, indicating that the increase in multiple births seems to be responsible for the unchanged overall rates. Though disparities in low birth weight rates have shown some improvement over time, they still persist. Rate among African American singleton births increased slightly, as have rates among Latina and White births.

Maternal Mortality: Wide fluctuations in rates of maternal mortality appear to be a result of the rarity of the occurrence and the zealousness of ascertainment. Rates are highest in New York City and among African American women. The overall 2004 rate of 20.5 per 100,000 live births is 6.2 times the Healthy People 2010 goal of 3.3 per 100,000. The overall rate includes rates among White mothers at 13.7, for Hispanic mothers at 19.3, and for African American women at 44.7. The ratio of Black-to-White maternal mortality is about 3.3.

Children: There were some very encouraging and some not-so-encouraging trends.

A survey of WIC participants showed more children are drinking low-fat skim milk and more fruits and that group is consuming vegetables. However, consumption of low-fat milk and fruits and vegetables are still well below recommended level and overweight in children is still increasing. The 2005 YRBS found 10.5% of adolescents were overweight. Adolescent males and African American students were more likely to be overweight. In 2005, 15.7% of all children ages two to four enrolled in WIC were overweight. Hispanic children in WIC were found to be almost twice as likely to be overweight than Black or White children. The 2005 YRBS found that male adolescents surveyed were more likely to have watched three or more hours of television per day. Of those participating in the YRBS survey in 2005, there were a number of adolescents who reported using inappropriate methods of weight loss. 13.3% fasted for over 24 hours, 6% reported vomiting or taking laxatives, and 5% took diet pills or powders not prescribed by their health care provider.

Asthma hospitalization rates are down from a high in 1999, as are hospitalizations for otitis media. The incidence and prevalence of childhood lead poisoning are declining and

childhood immunization rates are rising. The early syphilis rate among teens declined. SIDS deaths and infant mortality rates continued to decline, with Hispanics having the lowest rate at 3.8 per 1,000, compared to 5.2 per 1,000 for the White population and 9.5 per 1,000 for the Black population. Neonatal and post-neonatal rates also continue to show an overall decline. With regard to risk taking behavior, the 2003 YRBS showed seat belt and bike helmet use increasing, fewer students using violence, and fewer students feeling sad or hopeless everyday. New York has a lower percentage of sexually active teens than the country as a whole. More New York teens reported using condoms at last intercourse than teens in the rest of the country. However, more children reported being afraid for their safety at school.

Children with Special Health Care Needs and their Families: New York is in receipt of SLAITS data on Children with Special Health Care Needs, and has done further analysis. These data are helpful in development of further policy affecting this population and their families. At this time, SLAITS data serves as a baseline against which New York measures progress. However, parents have testified as to what makes medical care a "medical home" and what types of support they need from the system, so New York is already at work on some of these issues. (See program plan.) The Family Champions initiative has helped increase parent involvement.

Health Insurance: New York's public insurance programs include the Medicaid program, Child Health Plus and Family Health Plus. There are additional health insurance programs that assist small businesses and people who have lost health insurance with access to insurance products. Data from the National Survey of American Families shows New York to do better than the US average for insuring the poor.

Health Care Access: Health care access is the most difficult for the uninsured, those with less education and those whose primary language is not English. Other barriers to access include high out-of-pocket-expenses, lack of public transportation and a misdistribution of health care professionals, especially dentists and specialists that are willing to accept Medicaid as payment.

A. Agency Capacity

The New York State Department of Health, as the Title V agency in New York State, plays a major role in assuring quality and access to essential maternal and child health services. Title V, the Maternal and Child Health Services Block Grant, provides the basic framework for provision of all maternal and child health services by the New York State Department of Health. *Please see a full description of agency capacity as it appears in the Needs Assessment.*

Title V Roles and Responsibilities: The Title V role of the New York State Department of Health includes:

- Assessing and monitoring maternal and child health status to identify and address problems;
- Diagnosing and investigating health problems and health hazards affecting women, infants, children and youth in New York State;
- Informing and educating the public and families in New York State about maternal and child health issues (and we encourage the public to educate and inform us, as well);
- Mobilizing partnerships between policy makers, providers, families, and the public to identify and solve maternal and child health issues in New York State;

- Providing leadership in priority-setting, planning and policy development to support county and community efforts to assure the health of women, infants, children, youth and their families;
- Promoting and enforcing legal requirements that protect the health and safety of women, infants, children and youth in New York State and to ensure public accountability for their well being;
- Linking women, their infants, children and youth to health and other human services and to assure access to comprehensive, high quality systems of care;
- Assuring the capacity and competency of the public health/maternal and child health workforce to effectively address maternal and child health needs within the State;
- Evaluating the effectiveness, accessibility and quality of personal health and population-based maternal and child health services; and
- Supporting research and demonstrations to gain insights and innovative solutions to maternal and child health-related problems.

Assessing and monitoring maternal and child health status to identify and address problems: Please refer to the Needs Assessment portion of this document, which reflects our structures and capacity to gather, analyze and report data across a variety of areas and providers.

NYSDOH is able to track problems and hazards specific to the maternal and child health population, including but not limited to:

- Vital events (births, deaths, fetal losses, causes of death);
- Self-reported (through surveys and special studies) health conditions;
- Vaccine-preventable and other diseases and conditions affecting the maternal and child health population (STDs, lead poisoning, dental caries, unintended pregnancies, injuries);
- Perinatal conditions of the newborn and mother (low birth weight, very low birth weight);
- Sentinel events;
- Service usage;
- Knowledge, attitudes and behaviors of mothers and youth; and
- Treatment experience of at0risk infants and toddlers.

Like wise, NYSDOH and the Title V program are able to prepare, analyze, and report information about the maternal and child health population to inform needs assessment, planning and policy development, including, but not limited to:

- Population demographics (age, race, ethnicity);
- Populations/areas at risk;
- Socioeconomic conditions (poverty, employment, insurance coverage);
- Behavioral and other health risks (teen drinking, smoking, seat belt use, drug use); and
- Health status (morbidity and mortality rates);
- Health services utilization (early trimester prenatal care, immunization coverage); and
- Public perception of health problems and needs (block grant public hearings, focus groups).

NYSDOH maintains and active public website at www.health.state.ny.us and has additional intranet sites for the state and local health department use and for the use of health providers. Our public website gets about 32,000,000 hit annually. The Community Health Data Set is more fully described in the Needs Assessment.

Diagnosing and investigating health problems and health hazards affecting women, infants, children and youth in New York State: In addition to its normal

surveillance activities, Title V and the NYSDOH maintains the capacity for conducting and have a conducted a number of special studies involving such areas as communicable diseases, childhood lead poisoning, oral health, height/weight/BMI, maternal and infant morality, substance abuse, and smoking.

Each municipal health department in New York is required to provide local community health assessments, which are available to Title V staff and which serve as a basis for the municipalities' public health service plans and can serve as a needs assessment for counties seeking additional funds to address MCH issues.

Informing and educating the public health and families in New York State about maternal and child health issues: Title V provides the Growing up Healthy Hotline, provides expertise and fiscal support for development of printed and promotional materials, media campaigns and educational experiences. A more thorough discussion of some of DOH's recent maternal and child health related public education topics is included elsewhere in this application. The NYSDOH website is a major source of information on health topics and provides numerous linkages to other, related sites.

Though public hearings, focus groups, libraries and web postings, we encourage the public to educate and inform the Department, as well. In this grant year, under the auspices of the Maternal and Child Health Services Block Grant Advisory Council, public hearings were again held in various locations across the State. An additional ten focus groups were held. We strive to make all materials and events culturally-, linguistically-, and age- appropriate. Consumers are paid for their time, childcare and travel expenses to participate in the focus groups. We required our contractors to provide translations services, as appropriate, and to provide nutritious, culturally appropriate snacks.

Mobilizing partnerships between policy makers, providers, families and the public to identify and solve maternal and child health issues in New York State: The Title V agency develops and provides materials and mechanisms for dissemination of information on maternal and child health status and services, needs, and gaps in addressing needs to policy makers, health delivery systems, consumer organizations and the general public. Please refer to the Needs Assessment for a listing of partners and examples of collaborative efforts for the betterment of the child and health population.

Providing leadership in priority-setting, planning, and policy development to support county and community efforts to assure the health of women, infants, children, youth and their families: The Title V agency has developed and promoted an MCH agenda using **Healthy People 2010** and **Communities Working Together for a Healthier New York** as our framework. The NYSDOH also provides the infrastructure/communication structures for collaborative partnerships in the development of MCH needs assessments, policies, services and programs through:

- Providing routine communications (newsletters, website postings and links, technical assistance workshops, conferences, "Dear Administrator" letters, mass mailings, and, if the need arises, through a provision of in the Public Health Law called a "Commissioner's Call," which allows the State Commissioner of Health to summon the commissioner or public health director of each county to a meeting);
- Convening and staffing commissions and advisory councils for the oversight of maternal and child health services planning and recommending resource allocation; and
- Providing funding and support for parent networks and coalitions.

It is the information gathered in performance of its essential roles and responsibilities that, taken together with knowledge of the existing trends and systems of care, form the strategic process that determines the priorities for Title V effort.

Promoting and enforcing legal requirements that protect the health and safety of women, infants, children and youth in New York State and to ensure public accountability for their well being: The Department works with our Office of Governmental Affairs and Division of Legal Affairs to help ensure consistency in legislative mandates, to resolve inconsistencies, to write regulations and ensure consistent policy across family and child-serving programs. Title V provides expertise in development of legislation and regulations. Title V requires contractors to adhere to all required regulations and ensures compliance through program monitoring and audits. Contractors and health plans are required to regularly report on health services process and outcome measures.

To help protect the health and well being of our MCH population, New York State has a strong legislative base for:

- MCH-related governance and the organization and function of advisory bodies;
- MCH practice and facilities standards, including standards for all hospitals and freestanding diagnostic and treatment facilities, for levels of high-risk Perinatal care and for educational and practical preparation of health care providers;
- Uniform data collection through vital records and statewide registries;
- Public health reporting of communicable diseases, births and deaths, child abuse and other adverse events;
- Environmental protections, such as indoor smoking laws, firearms control, traffic safety, and regulations covering children's camps, temporary (farmworker) housing, use of pesticides and toxic chemicals in schools, swimming pools and bathing beaches; and
- Access and quality assurance monitoring required by public insurance programs.

The Title V program in New York takes a role in development, promulgation, and regular review of statutes, regulations, standards, and guidelines related to health services delivered and funded though the public and private sectors. For example, Title V worked with Medicaid to review and update a provider manual containing standards for health supervision under New York's EPSDT Program, the Child-Teen Health Program. Title V staff regularly interact in such matters with WIC, Title X, Title XIX, and Part C (IDEA). Title V staff have participated in certification, monitoring, onsite reviews and quality improvement activities of health plans and public health providers with respect to MCH services, standards, and regulations. Title V staff have also been involved in review of foster care and detention services. A listing of some of New York's statutes related to maternal and child health are listed in Section D.

Linking women, their infants, children and youth to health and other human services and to assure access to comprehensive, quality systems of care: Title V and the NYSDOH provide a range of outreach interventions including street-level outreach and home visiting in targeted efforts to reach MCH populations that can be hard to find, hard to keep engaged, and/or hard to keep in services because of their unique life circumstances (homeless women who move frequently, geographically isolated women and families, drug abusing women, and those of different languages and cultures).

DOH provides culturally- and linguistically-appropriate staff, resources, materials and communications, either directly or through our contractors. The availability and use of toll-free telephone information and referral lines, resource directories, public advertising and enrollment assistance greatly assists in this effort. Please see the description of the Growing Up Healthy Hotline and other health hotlines and the use of the AT&T Language Line in the Needs Assessment.

Title V monitors public response to health plans, facilities and public provider enrollment practices with respect to consumer understanding of required forms and procedures,

orientation of new enrollers, and ease of access to care, and has provided assistance with identifying at-risk, or hard-to-reach individuals and in using effective methods to reach them.

Title V also provides, arranges or administers women's children's and adolescent health services, and specialty services for children with special health care needs. We provide, generally through contractual services, those gap-filling services not generally available through health plans or mainstream benefits packages, such as school-based primary care and dental services, school-based mental health services, care coordination, public health nursing or social work, community health worker services and dental rehabilitation services. We have universal screening programs for genetic/metabolic disorders, hearing impairment and Perinatal HIV. Statute requires health care providers to screen children for childhood lead poisoning at ages one and two. Immunization is also required by statute for daycare, school and college entry.

Assuring the capacity and competency of the public health/maternal and child health workforce to effectively address maternal and child health needs within the State: NYSDOH provides the infrastructure and technical capacity for efforts to ensure the competency of the public health/maternal and child health workforce training efforts.

- Title V staff serve as faculty and preceptors to the University at Albany's School of Public Health (SPH) students, in a unique arrangement where NYSDOH, an active State Health Department, provides the learning laboratory for SPH students.
- Title V provides paid internships and graduate assistantships to graduate students in public health to work on various research and planning projects related to Maternal and Child Health.
- Title V sponsors Healthy Children New York, an effort that educates public health nurses and public health educators to provide consultation to child-serving agencies, such as child care providers. Staff also participate in efforts with the Office of Children and Family Services to educate child care providers in health and safety issues through their satellite broadcast system
- Title V and NYSDOH staff work with their community partners to educate the public and providers in their area on important issues, in areas such as asthma and women's health.
- Title V staff provide workshops on community health assessment, use of data, and best practices to improve services to the maternal and child health population.
- NYSDOH recently sponsored a one-day seminar for local public health directors and county attorneys on Public Health Emergency Law, utilizing a curriculum developed by the Centers for Disease Control and Prevention.
- NYSDOH commissions studies of health workforce issues.

Evaluating the effectiveness, accessibility and quality of personal health and population-based maternal and child health services: The Department regularly reviews program effectiveness and uses information to formulate responsive policies, standards and programs. DOH has the capacity to develop surveys and profiles of health status, health care access, and health care availability (types of service, provider distribution, hours of service, etc.), as well as profiles of consumer and provider knowledge, attitudes and behaviors. Programs regularly identify and report on barriers to care and collect and analyze information on community and constituent perceptions of needs within their communities.

Title V supports a number of gap-filling direct services programs, such as the School Health Program, Family Planning, Preventive Dentistry and the Migrant Health Program. All funded programs are regularly reviewed for qualify by DOH stag.

Supporting research and demonstrations to gain insights and innovative solutions to maternal and child health-related problems: Current examples of the research to gain insights and innovative solutions are the oral health surveillance initiative, SSDI consumer focus groups, and a joint CDC project to further analyze New York State-specific information from the SLAITS survey of Children with Special Health Care Needs. Title V also funds 15 graduate assistantships per semester, allowing graduate students in public health to complete investigations into current research issues in maternal and child health.

NYSDOH also has an active Institutional Review Board that sponsors researcher training and reviews all requests for vital records data, health department-related research, and registry data. Title V staff serve on this important agency review board.

The Title V agency continues to play a major role in assuring the quality and access to essential maternal and child health services in New York State. The Title V programs help ensure women, infants and children receive high-quality, comprehensive, appropriate services, and that the public health safety net effectively and appropriately protects vulnerable populations. We do so in the context of careful, coordinated department-wide and statewide strategic planning, collaboration with other State agencies and private organizations, and State support for local communities.

C. Organizational Structure

As previously stated in the Needs Assessment, the responsibility for New York's Title V Program is located within the New York State Department of Health, Center for Community Health, Division of Family Health, which is "responsible for the administration (or supervision of the administration) of programs carried out by Title V." [Section 509(b)].

The New York State Department of Health is an executive agency, with Commissioner Antonia C. Novella, M.D., M.P.H., Dr. P.H., reporting directly to Governor George E. Pataki. Maternal and child health programs are located throughout the Department, but are mostly located in the **Center for Community Health** and the **Division of Family Health**, where administrative oversight for the Block Grant is vested. In addition to its responsibility for Title V, the Division of Family Health is responsible for family planning (Title X), early intervention (Part C/IDEA) services, the Prenatal Care Assistance Program, Perinatal networks, designation of Perinatal centers and CSHCN specialty centers, dental health, lead poisoning prevention, adolescent health, youth development, adolescent pregnancy prevention, universal newborn heating screening and programs for children with special health care needs.

The State Health Department's organizational chart is included with this submission in the Appendix. Organizational structure and staffing support our mission, vision and values.

Division of Family Health has four Bureaus:

- The Bureau of Child and Adolescent Health;

  Title V and Title V-related programs within the Bureau of Child and Adolescent Health include: Childhood Lead Poisoning Prevention, Pediatric Asthma, Healthy Children New York, Children with Special Health Care Needs (including the Family Specialist), the Physically Handicapped Children's Program, Youth Development, the School Health Program, the School Health Infrastructure Initiative, ACT for Youth, Abstinence Education, the Community-Based Adolescent Pregnancy Prevention Program, Enhanced Pediatric Services, Infant Mortality Review, Interim Housing for the Lead Poisoned Children and their Families, the Regional Lead Poisoning Technical Assistance Centers,

and the Gay, Lesbian, Bisexual and Transgendered Initiative. BCAH also has responsibility for the Early Childhood Comprehensive Services Initiative.

- The Bureau of Dental Health;

  Title V and Title V-related programs within the Bureau of Dental Health include Dental Public Health Education, the Preventive Dentistry for High-Risk Underserved Children's Program/Dental Sealant Program, the Fluoride Supplementation Program, the Dental Public Health Residency Program, Oral Health Surveillance and Dental Research, the Dental Rehabilitation (Orthodontia) Program, Innovative Dental Services, and School-Based Dental Services.

- The Bureau of Early Intervention Services; and

  The Bureau of Early Intervention Services administers the Part C/IDEA programs and the Universal Newborn Hearing Screening Program. This Bureau is also responsible for publication of "Welcome to Parenthood," a publication received by all new mothers delivering in any of New York State's hospitals.

- The Bureau of Women's Health.

  Title V and Title V-related programs within the Bureau of Women's Health include the Family Planning Program/Title X, the Growing Up Healthy Hotline, the Community Health Worker Program, Comprehensive Prenatal/Perinatal Services Networks, the Prenatal Care Assistance Program (PCAP) and the Medicaid Obstetrical Maternity Services (MOMS) Program, the Lactation Institute, the Preventive Medicine Residency Program, the Osteoporosis Program and Advisory Committee, Maternal Mortality Review, and the Statewide Perinatal Data System, and designation of all birthing hospitals for Perinatal services level. BWH also works with the AIDS Institute on the Community Action for Prenatal Care (CAP-C) Program.

The Division of Family Health directly administers SSDI, the American Indian Health Program, the Columbia Collaborative Public Health Education Project, the Asthma Collaborative, and Migrant and Seasonal Farmworker Health Services. Genetics Services and the Newborn Metabolic Screening Program are administered by NYSDOH's Wadsworth Laboratories. The Congenital Malformations Registry is located within the Center for Environmental Health.

D. Other MCH Capacity

The Division of Family Health continues responsibility for coordinating MCH-related programs and directly managing many MCHSBG-funded initiatives.

Statutory Authority: The New York State Public Health Law provides statutory authority for various maternal and child health programs, including establishment of health departments and health care facilities and agencies, qualifications of public health officials, newborn screening, lead poisoning prevention, immunization, and health care financing.

Article 6 of the Public Health Law (PHL) authorizes payment of State Aid to Localities for certain public health services, including maternal and child health services.

The New York Code, Rules and Regulations (NYCRR) interpret how Public Health Laws are to be implemented.

State Budget Bills delineate the use of State funds, including for public health and maternal and child health programs.

State Finance Law provides the requirements for management of State funds and federal funds coming through the state, and Article 7 of the Public Health Law relates to Grants in Aid.

State Education Law regulates the professions, including physicians, nurses, nurse practitioners, medical social workers, pharmacists, therapists and midwives.

Chapter 884 of the Laws of 1982 outlines the composition and responsibilities of the Maternal and Child Health Block Grant Advisory Council.

Statutory Authority for childhood lead poisoning prevention and intervention is found in Section 206 of the Public Health Law and Title X of Article 13, the Lead Poisoning Prevention Act. Regulations are contained in Sub-Part 67-1.

Article 25 of the Public Health Law covers Maternal and Child Health, with Title I- General Provisions, Title II – Prenatal Care, Title III 0 Midwifery, Title IV – Institutions for Children, Title V – Children with Physical Disabilities, Title VI is expired, Title VII – Nutrition Outreach and Public Education.

The Children with Special Health Care Needs Program is authorized by Title V of the federal Social Security Act and New York State Public Health Law 2580.

The Healthy Heart Program is authorized by Article 27-B of the NYS Public Health Law. Article 27-C relates to the Birth Defects Institute, 27-D relates to Burn Care, and 27-E and F relate to HIV and AIDS.

Children's camps in New York are regulated under PHL Article 13-B.

Section 2500(1) of the PHL authorizes the Commissioner to oversee care in hospitals, while section 2800 give these Department responsibility for development of state policy relative to hospitals. Both statutes authorize the Commissioner to establish standards and promote quality of maternal, child and infant health and for prevention of maternal, perinatal and infant mortality and low birth weight.

The Prenatal Care Assistance Program (PCAP) is authorized under PHL 2522. Section 85-40 in the NYCRR sets forth the regulatory parameters of the program. Comprehensive Prenatal/Perinatal Services Networks are authorized under the legislation authorizing the Prenatal Care Assistance Program, Public Health Law 2522, which includes a provision for outreach, public education and promotion of community awareness of the benefits of preconception health care and early and continued prenatal care.

Abstinence Education is authorized by Public Health Law 104-193 and the federal Personal Responsibility and Work Opportunity Act (Welfare Reform).

Final regulations on universal newborn hearing screening appear in Subpart 69-8 of 10 NYCRR.

The American Indian Health Program is administered pursuant to Public Health Law § 201(1)(s), under which the Department is required to "administer to the medical and health needs of the ambulant sick and needy Indians on reservations."

The statewide Early Intervention Program was established in Public Health Law Title II-A, Article 25 in 1992.

PHL 2500-B directs the Commissioner to provide professional and public education on Sudden Infant Death Syndrome, as well as counseling to the families affected by SIDS.

Family Planning is authorized under federal Title X and 10 NYCRR 42CFR, 43CFR, 45CFR, BCHS Guidelines.

New York has laws requiring:

- Helmets while riding bikes, scooters and motorcycles;
- Seatbelt use and passenger restraint;
- 3-tiered graduated drivers license;
- Child death review by a panel that includes citizen reviewers;
- Provision of safe havens for abandoned infants;
- School district nutrition advisory committees;
- Universal newborn genetic, HIV and heating screening and follow-up;
- Restriction of use of vaccines containing thimersol;
- Insurance coverage of child immunizations and food for special dietary usage;
- Free or reduced price lunch programs to provide food for special diets;
- Mandated reporters to report suspected methamphetamine labs; and
- A ban on purchase or use of elemental mercury in primary and secondary schools. In addition, NYSDOH recommends school inventories include location of any mercury containing products and, if found, that they be given highest priority for removal.

Pending legislation will give the Commissioner authority to train civilians in health care in the case of emergency. Also pending is a law to require all registered professional nurses practicing in New York who are educated at the diploma or associates degree level to obtain a baccalaureate in nursing within ten years of initial licensure.

Laws relating to public health are described on the Department's public website, www.health.state.ny.us/nysdoh/phforum/phforum.htm and all New York State laws and regulations are available on the World Wide Web at this address: Http://unix2.nysed.gov/ils/topics/laws.htm. All necessary assurances and certifications are kept on file in the office of the Title V director and can also be found on the Department's website;
www.health.state.ny.us/nysdoh/grants/main.htm

E. State Agency Coordination

The New York State Department of Health has formalized relationships with other state agencies, local public health agencies, federally-qualified health centers, tertiary care facilities, academic institutions and the non-profit voluntary sector, which all enhance the capacity of the Title V program.

Agreements with Other State Agencies

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

- In New York, the **State Education Department** (**SED**) is not an executive agency, but a constitutional body, not under the Governor or Legislature. SED is responsible for general supervision of all educational institutions in the State, for operating certain

educational and cultural institutions, for certifying teachers, and for certifying or licensing practitioners of thirty-eight professions. The department's supervisory activities include chartering all schools, libraries and historical societies; developing and approving school curricula; accrediting colleges and university programs; allocating state and federal financial aid to schools; and providing coordinating vocational rehabilitation services.

The State Education Department administers the Youth Risk Behavior Surveillance System with NYSDOH collaboration. NYSDOH also collaborates with the Education Department on issues such as placement of automated external defibrillators in schools, administration of fluoride rinse programs, issues related to the healthcare/public health workforce, scope of practice issues, transition from early intervention to preschool programs, and approval of school-based primary care and dental care centers.

- The Department has a Memorandum of Understanding with the State Education Department regarding **school health infrastructure and coordination**. This memorandum supports the statewide implementation of comprehensive school health and wellness. Comprehensive School Health and Wellness Centers help school districts across the State create positive learning environments for their students. Schools that model and encourage students to engage in healthy behaviors create an atmosphere for academic success and individual growth.

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

- The **Office of Children and Family Services** (**OCFS**) administers the **Adolescent Pregnancy Prevention and Services** (**APPS**) **Program**, providing prenatal support and parenting education to high-risk teens in high need communities.

- DOH Title V staff work with the **Office of Children and Family Services** on health care of children in **foster care** and on issues related to the health and safety of infants and children in **child care**. The Bureau of Early Intervention collaborated with OCFS in the development of a guidance document entitled, *Protocols for Children in Foster Care Who Participate in the Early Intervention Program*.

- The State Legislature allocated funding from the federal **Temporary Assistance to Needy Families** (**TANF**) **Block Grant** to the Department of Health for outreach and education activities to prevent unintended pregnancies and for School Health. The Department has entered into a Memorandum of Understanding with the **Office of Temporary and Disability Assistance** to provide for the transfer of these funds to the Department. This office is also the lead agency for the **Teenage Services Act** (**TASA**) Program, providing services to pregnant and parenting teens on Public Assistance.

Other State Agency Collaborations

- The **Touchstones Initiative**, with the Council on Children and Families as the lead agency, began as a collaborative of 13 New York State agencies that fund programs for children and families. State agencies were challenged to agree on the benefits of funded services in clear, consistent, measurable terms. The Team established a **Kids Wellbeing Indicator Clearinghouse** (**KWIC**) on the Internet, the purpose of which is to make vital youth statistical information more timely, accessible and usable to communities.

- The **New York State Youth Development Team** is a partnership established in 1998 by more than two dozen public and private organizations. The partnership has lead efforts to develop and promote youth development strategies across health and human services systems in New York State. Agency team members include all major state agencies serving youth (health, mental health, education, public assistance, juvenile justice, substance abuse), as well as the New York State Nurses Association, Cornell University, the YMCA, the NYS Association of Youth Bureaus, the Mount Sinai Adolescent Health Center the Association of Family Services Agencies, the NYS Center for School Safety, University of Buffalo, Families Together of NYS, University of Rochester, the Schuyler Center for Analysis and Advocacy, the Conference of Local Mental Hygiene Directors, and the NYS Counseling Association. The Team's vision is for families, schools and communities partnering to support the development of healthy, capable and caring youth.

  The Youth Development team, c-chaired by DOH and OCFS, has guided the creation of several cutting edge products, events and initiatives. These include: *The Governor's Blueprint for Youth*; local youth development partnerships and centers for excellence under the *Assets Coming Together (ACT) for Youth* initiative; a briefing paper on youth development, a cross-system initiative to prevent childhood overweight called *Eat Well, Play Hard*; a youth development resource notebook for communities; and a symposium on outcome indicators for youth development. The team is currently developing a compendium of outcome indicators for state and local use in measuring youth development efforts.

- The Coordinated Children's Services Initiative (CCSI) is a cross-systems process for serving children with special emotional and behavioral services needs that builds upon legislation enacted in 2002. The process utilizes strength-based approaches, consistent and meaningful family involvement, individualizing planning, and encourages creative, flexible decision-making and funding strategies. CCSI Statewide Partners are: Family Representatives, Office of Mental Health, State Education Department, Office of Children and Family Services, Council on Children and Families, Division of Probation and Correctional Alternatives, Office of Mental Retardation and Development Disabilities, Department of Health, NYS Commission on Quality of Care and Advocate for Persons with Disabilities, and the Developmental Disabilities Planning Council.

  Priority areas for CCSI include the development and delivery of training and technical assistance related to building and sustaining local systems of care, including a family advocacy training curriculum. CCSI continues to work to implement the comprehensive set of recommendations for improving services for children who have cross-systems needs (developed in 2004).

  It is to be noted that on August 2, 2005 Governor Pataki signed Chapter 392 of the Laws of 2005, establishing the Out-of-State Placement Committee within the Council on Children and Families. The Out-of-State Placement Committee is responsible for improving the monitoring of out-of-state residential placements, promoting coordination across all levels of government, and establishing a process for identifying and considering in-state resources prior to making an out-of-state placement.

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

- The **NYS Developmental Disabilities Planning Council (DDPC)** is seeking to develop more non-segregated socialization opportunities (beyond one-time events) for youth with and without disabilities, through a statewide technical assistance and capacity building model. DDPC will issue a competitive Request for Proposals targeting a statewide entity such as the YWCA, Boy Scouts, Girl Scouts, etc. to serve as an umbrella organization that will provide information, skill-building, and technical assistance to build capacity within schools and "chapter" organizations of the chosen statewide entity to facilitate the development of friendship and socialization between youth with and without disabilities.

- In effort to address the issue of successful health care transitioning, the NYS Developmental Disabilities Planning Council (DDPC) issued a Request for Proposals to establish an **Institute for Training on Health Care Transitioning**. The Institute will focus on developing statewide expertise on youth with developmental disabilities, age 14-25, as they transition from pediatric to adult health care, caregivers who support the transition and primary care physicians who are integral to making a successful transition.

  The Institute will be required to develop three interrelated curricula on health care transitioning including:

  a) Curricula for primary care medical providers, covering information such as: understanding and recognizing disabilities, understanding developmental aspects of disabilities, providing accommodations including physical, sensory and other disability related issues.

  b) Curricula for individuals with developmental disabilities covering information such as: developing a relationship with adult medical providers, asking questions and sharing relevant information with adult health care providers, keeping track of and sharing medical history.

  c) Curricula for caregivers covering information such as: planning for transition to adult health care providers, locating and interviewing adult health care providers, decision making issues after the child turns 18.

Other Collaborations

- **Healthy Start**: Many of the federal healthy Start grantees are also grantees of New York State Department of Health under the **Comprehensive Prenatal/Perinatal Services Network** initiative. The Networks were initially funded under Title V, but have now moved onto a different source of funding. However, the need for close association with Title V programs continues in order to maximize mutual effectiveness. The Department holds periodic meetings (at least two per year) with Healthy Start grantees in order to foster better communication, explore areas for potential collaboration and share late-breaking developments. The Healthy Start consumer group assisted Title V in evaluating focus group methods and provided feedback that was incorporated in planning for the next wave of consumer focus groups. Regional staff meets with the Networks on a routine basis.

- **Local Health Departments: County health departments** continued to play an essential role in the assurance of high quality, accessible maternal and child health services. They assessed the needs of their local communities, worked with their communities to design and implement programs that meet those needs, and evaluated the effects on their communities.

Under **Article 6 of the New York State Public Health Law**, local health departments perform comprehensive community health assessments, and subsequently produce a Municipal Public Health Service Plan. Plans address the needs of the maternal and child health population in health education, infant mortality prevention, child health, family planning, chronic disease prevention, injury control, disease control and nutrition. Title V provides technical assistance to local health units in plan development, participates in the review process and monitors implementation. Because local health departments know local systems and community needs, Plans address coordination across public and private resources, and across the continuum of primary, secondary and tertiary care. Local health units play a critical role in fostering local collaborations.

- New York State has a long-established system of highly specialized **Regional Perinatal Centers (RPCs)**. These Centers provide tertiary level clinical care to high-risk mothers and newborns, and also serve as important contact points for the Department of health in our interactions with the health care community. They help ensure that high-risk mothers and newborns receive appropriate levels of care by working with their affiliate hospitals to monitor perintal morbidity and mortality and to provide education and technical assistance to physicians and others. The Regional Perinatal Centers not only serve as the hub for consultation and transport within a network, but lead quality improvement activities within their network. All birthing hospitals in the state, including Regional Perinatal Centers, were reassessed and redesignated in 2001.

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

- The **University at Albany School of Public Health** is unique in that it is jointly sponsored by a university and a state health department. The New York State Department of Health serves as the laboratory for the University at Albany School of Public Health, with graduate students working shoulder-to-shoulder with practicing professionals in the state health department or in local departments. A number of DOH and Title V staff serve as faculty and advisors to the school. Title V staff also serve on the School's **Continuing Education Advisory Board** and on the advisory council for the **Northeast Public Health Leadership Institute**.

- Title V staff coordinate the **MCH Graduate Assistant Program**, under which fifteen University at Albany graduate students per semester (fall, spring and summer) are supported by block grant funds to work on priority MCH research and planning projects. This arrangement supports the Department of Health's mission through attracting bright, motivated individuals who are interested in gaining theoretical and practical knowledge of public health and maternal and child health. The relationship with the University enhances the Departments research capacity, and improve the availability of pertinent and timely educational offerings for practicing public health professionals in the region. The arrangement also enhances NYSDOH's ability to hire stellar students from diverse backgrounds whose performance on public health projects has already been evaluated during their internships.

- The University at Albany's School of Public Health sponsors the **Northeast Public Health Leadership Institute (NEPHLI)** serving the northeast corner of the U.S. Several Title V staff have attended the Institute. Several graduates of the Institute also serve Title V in other states and at the New York City Department of Health. Title V staff and Dr. Birkhead serve on their advisory council.

- The Department also maintains a relationship with the **Columbia University School of Public Health** through a **Collaborative Studies Initiative**. Metropolitan Area Regional Office staff serve as advisors and contract managers to the program. Columbia students and public health faculty identify current issues in maternal and child health, and apply public health theory and practice in designing and implementing solutions to those issues. As a result, several projects in very high need areas of New York City have been planned, implemented and evaluated. Students are required to submit their projects to peer-reviewed journals and to present at national meetings.

- New York has three **University-Affiliated Programs** who offer **Leadership Education in Neurodevelopmental Disabilities (LEND)**. They are the **University of Rochester**, the **Westchester Institute at Valhalla**, and **Jacobi/Albert Einstein Medical Center**. LEND Programs provide for leadership training in the provision of health and related care for children with developmental disabilities and other special health care needs and their families. The Department works with the LENDs on a variety of issues related to children with special health care needs and to meet training needs, and the University Affiliated Programs are a great source for physician consultants on a variety of issues. LEND fellows travel to Albany to meet with Title V staff in the Division of Family Health to discuss their recent research. Several LEND fellows attended an orientation to Title V sponsored by the New York Medical College, School of Public Health.

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

- **Healthy Tomorrows Partnership for Children** is a collaboration between **HRSA** and the **American Academy of Pediatrics (AAP)** formed to stimulate innovative programs in areas of limited health care access and high need. In May 2006, Title V staff from the Bureau of Dental Health accompanied AAP on a Technical Assistance visit to the project at the **University of Rochester Medical Center, the Dental Home for Children Project**. This project targets children with significant dental needs to address barriers to service and other related issues. The project also seeks to improve communication between primary care providers and dentists.

- New York's **Pediatric Pulmonary Center** is located at **Mount Sinai Medical Center** in Manhattan. The Pediatric Pulmonary Center takes an interdisciplinary approach to developing health professionals for leadership roles in the development, enhancement or improvement of community-based care for children with chronic respiratory diseases and their families. In addition serving as a model of excellence in interdisciplinary training. Mount Sinai also engages in active partnership with state and local health agencies and provides model services and research related to chronic respiratory conditions in infants and children.

- **Montefiore Medical Center** sponsors the **Behavioral Pediatrics Training Programs.** Training grants from the Federal Maternal and Child Health Bureau support faculty who demonstrate leadership and expertise in the teaching of behavioral pediatrics, scholarship and community service. Fellows who have completed training are board-eligible in pediatrics. The three-year fellowship program includes course work and clinical practice in growth and development, adaptation, injury prevention, disease prevention and health promotion. The program is also available to provide continuing and technical assistance.

- The Department of Health, with the School of Public Health at the University at Albany, the New York State Community Health Partnership and the New York State Association of County Health Officials, sponsors monthly **Third Thursday Breakfast Broadcasts (T2B2)**. T2B2 provides statewide continuing education opportunities covering a variety of public health issues. Local site coordinators in each county health department coordinate local logistics. Out-of-state attendees can locate sites by visiting the University of Albany's website: www.albany.edu/sph/coned/t2b2site.html. Continuing medical and nursing education credits are available.

- The Office of Children and Family Services also sponsors with partners such as DOH, the SUNY Distance Learning Project, and the New York State Child and Family Trust Fund, monthly satellite broadcasts on child health and safety topics.

- DOH strives to maintain positive and collaborative relationships with several **not-for-profit, voluntary groups** who share concerns for the health and well-being of mothers, infants, children and women of childbearing age. The Department's Title V program has many active relationships/collaborations. *Please see pages 143-144 in the Needs Assessment section for a list of active collaborations.*

F. Health "Systems Capacity" Indicators

#01 Health Systems Capacity Indicator: *The rate of children hospitalized for asthma (per 10,000 children less than 5 years of age*

Rates went from 65.8 in 1998, to 81.5 in 1999, to 62.9 in 2000, to 66.6 in 2001, 65.4 in 2002, 72.7 in 2003 and 67.3 in 2004. It appears that 1999 was a "blip" in a downward trend, as rates have been decreasing over the last ten years. Rates continued to be higher in New York City, compared to the rest of the State. We are continuing to monitor these rates as we continue implementing the Statewide Asthma Plan.

#02 Health Systems Capacity Indicator: *The percentage of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen*

Idiosyncrasies in data sources and analysis make those data hard to interpret. It appears we are one an upward trend, but have just three years of data consistency. Percentages were 74.9% in 2002, 74.9% in 2003, and 76.5% in 2004. Title V staff continue to monitor access to programs and services on a local level and work with the Office of Medicaid Management to identify and solve access issues.

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

New York uses QARR data from the Office of Managed Care to generate these data, and as a result, have slightly different categories of data. What is available is "Five or More Well Child and Preventive Care Visits in the First Fifteen Months of Life." These data remain about stable or increasing: 62.0% in 2001, 67.0% in 2002, and 79% in 2003 and 2004.

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

These data have been trending toward improvement. There was a one-year of decrease from 2000 to 2001, then rates were relatively unchanged from 2001 to 2002, at 63.5% and 63.6%, respectively.

The rates showed improvement from 63.1% in 2003 to 66.4 % in 2004. There are racial and geographic disparities in these rates. In New York City in 2004, the Kotelchuk Index was 59.9, while the rest of the state achieved 72.2 on the index. For White New Yorkers, the index was 70.2. for African Americans it was 53.0, and for Hispanic women it was 57.8.

The Prenatal Care Assistance Program sets clinical standards for content of prenatal care, which are codified in Part 85.40 of New York State Public Health Law. Programs are reviewed for their compliance with these standards.

#05 Health Systems Capacity Indicator: ***Comparison of health systems capacity indicators for Medicaid, non-Medicaid and SCHIP programs for infants (birth to age 1), children and pregnant women***

In general, health outcomes are less favorable for those of lower socioeconomic status than those that enjoy higher standards of living. Medicaid populations generally fair less favorably than privately insured populations with regard to low birth weight rates, infant mortality, rates of early prenatal care and adequacy of prenatal care. This is not totally related to the source of payment for their care, but more likely attributable to a confluence of life factors.

#06 Health Systems Capacity Indicator: ***The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (birth to age 1), children and pregnant women***

Medicaid: Pregnant women and infants under one year of age, at or below 200% of the Federal Poverty Level (up from 185%), are eligible for Medicaid. Women are eligible for family planning based solely on the woman's income being below 200% of the Federal Poverty Level, planning based solely on the woman's income being below 200% of the Federal Poverty Level, regardless of previous Medicaid eligibility or pregnancy. If women are on New York State Medicaid at the time of pregnancy, then lose their eligibility, they are eligible for 24 months of continuous family planning coverage following their pregnancy.

Children one through five are eligible at 200% of FPL. Children ages six to nineteen are eligible at 133% of the FPL without resource testing.

Children, ages one month to age 19 years, with family incomes at or below 250% of the FPL. are eligible for subsidized health insurance coverage under Child Health Plus. Coverage for those under 160% FPL is free. Premium contribution for families between 160 and 222% is $9 per child per month, with a maximum of $27 per family per month. For families with incomes between 222 and 250% FPL, the contribution is $15 per child per month, with a maximum of $45 per family. For families with incomes over 250% of the FPL, Child Health Plus is available at full premium. There are no co-payments for services. Table 27 indicates current eligibility levels.

Family Health Plus is available at two levels. Adults with children under the age of 21, whose gross family annual income is up to 150% of the Federal Poverty Level, or $30,000 for a family of four, are eligible. Single adults, with gross family income is up to 100% of the Federal Poverty level or $9,800 per individual, are also eligible. Table 28 indicates current eligibility levels.

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

Local CSHCN Program staff inquire as to the insurance status of each child who is referred to the CSHCN Program. Staff link families to public insurance programs such as Medicaid, Child Health Plus and Family Health Plus and gap-filling programs such as the Physically Handicapped Children's Program. In 2005, 6% of CSHCN were reported as without health insurance. There were 82 CSHCN referred and enrolled in Medicaid, 33 CSHCN referred and enrolled in CHP-B, and 13 CSHCN referred and enrolled in SSI. There are 145 referrals to insurance pending results at this point of data collection.

All Title V programs have a component that assures that potentially-eligible families are referred to public insurance programs.

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

It appears that percentages are stable. We believe this is due to the limited number of dentists willing to take Medicaid. (The number of clients across all age groups who receive MA-financed dental services is low, despite fees having been raised.) These issues are addressed in our statewide Oral Health Plan.

In 2002, the percentage was 35.8%; in 2003 the percentage was 35.1%: in 2004 the percentage was 36.3%.

#08 Health Systems Capacity Indicator: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program*

This indicator is not particularly applicable to New York, since all SSI recipients automatically have Medicaid, which is more generous than our Physically Handicapped Children's Program.

#09A Health Systems Capacity Indicator: *The ability of States to assure that the Maternal and Child Health Program and the Title V agency has access to policy- and program-relevant information and data*

MCH data is placed on the HIN (NYSDOH's public website) and on the HPN (NYSDOH's provider health network). Regional Perinatal Centers and Local Health Departments also have access. The Title V application is available on the public website, as well.

#09B Health Systems Capacity Indicator: *The ability of States to monitor tobacco use by children and youth*

This is an item on the YRBS, in which New York participates through the State Education Department. Adolescent smoking rates are also available through the Youth Tobacco Survey. The Division of Chronic Disease Prevention and Adult Health employs an epidemiologist for the tobacco program who works with both adult and child smoking data.

#09C Health Systems Capacity Indicator: ***The ability of States to determine the percent of children who are obese or overweight***

Obesity data is available both from the WIC program and from the Youth Risk Behavior Survey. Recently, nutrition/obesity surveillance was incorporated into the ongoing dental surveillance initiative, doing height and weight measurements at the same time as dental assessments. There are also data collection efforts associated with individual community-level interventions. Under the PAN (Physical Activity and Nutrition) Initiative, there will be further discussion on gaps in data gathering.

IV. PRIORITIES, PERFORMANCE, AND PROGRAM ACTIVITIES

A. Background and Overview

This section profiles New York's maternal and child health priorities, selected performance measures, and program activities and discusses the extent to which National and State objectives were met in this program year.

As previously described, New York has undergone extensive priority-setting processes. Throughout, participants decline to rank priorities, preferring that each of these "opportunities for improvement" be considered of equal importance. Following the last five-year assessment cycle required by Title V, and in consideration of past progress, several performance targets were re-adjusted. The ten priorities that follow, and the specific performance measures related to each, stem specifically from areas of unmet need in the State.

New York Title V is using an Oracle-based system for gathering and managing program information that delineates goals, objectives, sources of funds, staffing and performance measures for the maternal and child health-related programs. These data are gathered from program managers in all of the MCH-related programs, whether or not the programs are block grant funded.

Most often, program that address maternal and child health issues initiate services and interventions on a variety of levels. For example, in addressing access to care, we are improving the insurance and charity care infrastructure, targeting population-based messages, enabling clients to access and sustain their relationship to a medical home, and work to remove barriers to accessing high-quality direct medical services. Thus, each of the four levels of the MCH pyramid may be relevant to a particular need.

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

B. State Priorities

After the last full Needs Assessment, priority setting was conducted as a melding process, combining:

- The use of the many and various data sets available to the Department;
- The use of program data and provider input to identify trends and issues;
- Infrastructure evaluation;
- The results of the participative processes;
- The input of the public and the Maternal and Child Health Services Advisory Council to assist in interpreting these data and identifying important trends, gaps in services or barriers to care; and
- The input of key staff within the Department.

The process remains unchanged since the last application. Collaborations and partnerships that contribute to the needs assessment process have also remained unchanged.

As a result of the needs assessment process, the following ten priorities were identified:

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

The justification for their selection as priorities may be found in Section II. B. 1. and a description of our planning/targeting framework may be found in Section II. A. This same section also contains a table that summarizes the relationship between New York's priority needs and the measurement of their progress through Federal and State Performance and Outcome Measures.

C. National Performance Measures

Each chart that follows contains a discussion of the National Performance Measures, including sections for:

- Performance Measure;
- Last Year's Accomplishments;
- Current Activities; and
- Plans for the Coming Year.

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

Last Year's Accomplishments

- 246,243 infants were screened for genetic disorders in 2005 by NYSDOH's Wadsworth Laboratories Newborn Screening Program.
- 100% of newborns in NYS are tested for over 30 congenital conditions, including:
    - PKU
    - congenital hypothyroidism
    - galactosemia
    - sickle cell disease
    - biotinidase deficiency
    - cystic fibrosis
    - homocystinuria
    - congenital adrenal hyperplasia
    - maple syrup urine disease
    - medium-chain acyl-Co-A dehydrogenase deficiency
    - citrullinemia/arginosuccinic academia
    - tyrosinemia
    - carnitine uptake deficit
    - short-chain acyl-CoA dehydrogenase deficiency
    - very long-chain acyl-CoA dehydrogenase deficiency
    - carnitine palmitoyltranferase II deficiency/cariniten/acylcarnitine translocase deficiency
    - long-chain hydroxyacylacyl-CoA dehdrogenase deficiency
    - propionic academia/melhyl malonic academia/multiple carboxylase deficiency
    - beta-ketothiolase deficiency
    - isovaleric academia
    - 3-hydroxy-3-methylgluteryl-CoA lyase deficiency/3-methylcrotonyl-CoA carboxylase deficiency
    - glutaric academia type 1
    - multiple amino acid disorders
    - multiple acylcarnitiens
    - multiple amino acids and aclycarnitines and
    - exposure to HIV-1.
- Of children screened, there were 4 confirmed cases of PKU, 174 confirmed cases of Congenital Hypothyroidism, 5 cases of Glactosemia, 117 of Sickle Cell Disease, 1 of Biotinidase Deficiency, 60 cases of Cystic Fibrosis, 10 cases of CAH, 1 of MSUD, 2 of homocystinuria, and 10 cases of MCADD/MADD/MCKAT. (See Form 6.) Expanded testing began in November 2004.
- The Newborn Screening Program and the Children with Special Health Care Needs Program approved standards for new types of Specialty Centers.
- Prenatal Genetics Services were provided to 27,650 pregnant women in 2005.
- Another 4955 infants, 9864 children and 8829 other individuals received Clinical Genetics Services through genetics services grantees.
- Wadsworth Laboratories continued to provide certification of clinical and environmental laboratories serving NYS residents.

Current Activities

- Wadworth Laboratories continues to screen 100% of the state's newborns for the conditions listed above. 100% of presumptive positive screens are followed for confirmation; 100% of confirmed cases are followed to ensure treatment.
- Title V continues to monitor follow-up on active cases to ensure that infants with positive results receive appropriate follow-up.
- Local health units continue to use Article 6 State Aid reimbursement to pay for follow-up visits by public health nurses or bill insurance companies for these services.
- Clinical genetics services, including follow-up genetics counseling for families of children with inborn metabolic errors are available through the Genetics Program. The Wadsworth Center for Laboratories and Research administers 23 contracts that cover services.
- Comprehensive Prenatal/Perinatal Services Networks promote newborn screening and appropriate follow-up through newsletters and provider meetings.
- NYMAC has formed two workgroups specifically charged to educate the professional and lay public about genetics and newborn screening. They are identifying existing curricula and educational materials and developing new resources that can be used through the region and nationally to improve the use of genetics and specialty care services.
- NYMAC maintains an extensive mailing list of all persons involved in or interested in genetics, newborn screening and specialty care.
- Both through the NYS Newborn Screening website and the soon-to-be-released NYMAC website, individuals concerned with genetics or specialty care will be able to access educational resources or identify clinical services providers, support groups and other public health resources.

Plan for the Coming Year

- The Newborn Screening Program will continue.
- The CSHCN and the Genetics Screening Programs with continue to monitor implementation and ensure appropriate follow-up services.
- The CSHCN and Newborn Screening Program will continue joint monitoring visits to Cystic Fibrosis, Endocrine and Inherited Metabolic Diseases Specialty Centers.
- NYSDOH Title V staff will remain involved in NYMAC activities.
- NYMAC and the Genetics Services Programs will investigate ways to maximize resources/reimbursement for genetics services providers.
- Wadsworth laboratories will continue to assure that clinical public health laboratories are available to the residents of New York State, including but not limited to:
    - An anatomic pathology laboratory;
    - A cytogenetic laboratory for diagnosis of prenatal and clinical abnormalities; and
    - A laboratory for identification of reproductive and metabolic disorders.
- Wadsworth Laboratories will continue to operate a state-of-the-art clinical and environmental laboratory evaluation program to ensure that laboratories offering tests to NYS residents meet appropriate quality requirements and can pass proficiency tests.
- Endocrine specialty centers will be visited in 2006 by the CSHCN and Newborn Screening Program staff.
- There are no plans for further changes at this time.

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

Last Year's Accomplishments

- The CSHCN Program continued to employ a Family Specialist, the parent of a child with special health care needs, and several other employees
- The Bureau of Child and Adolescent Health has engaged a diverse stakeholder group to advise the Department on the identification, recruitment, and training of family advisors (a.k.a. Family Champions) to the Title V Program. The stakeholders group includes representatives from the Department of Health and other state agencies (Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, Developmental Disabilities Planning Council), family organizations (Parent to Parent, Family Voices, Families Together, and Parent Training and Information Centers). After feedback from the stakeholders group about the application and recruitment process, an announcement and application were distributed through the stakeholders to prospective Champions partners and local health units. Family Champions will be selected, provided with additional training, and engaged in CSHCN Program activities.
- The CSHCN Program continues to broaden parent input in policy development, improving access to health and related services for CSHCN, identifying and referring CSHCN to appropriate services, and collecting information to identify gaps and barriers in order to improve the system of care for CSHCN.
- Parents were invited and participated in consumer focus groups held around the State. Parents participating were reimbursed for their time, travel and child care expenses. Focus groups were held to engage groups most at risk for poor health outcomes and obtain information on their health care needs. The information from the focus groups will help to improve the systems of care for all women, infants, children and youth in New York State, including those with special needs. These groups were funded by SSDI and initiated by the SSDI Coordinator and the Title V Coordinator.
- Parents of CSHCN spoke at public hearings sponsored by the MCHSBG Advisory Council.
- Healthy Start consumers met with Title V staff to discuss consumer involvement and focus groups.
- The NYS Medical Home Project began training local CSHCN programs in medical home concepts and began to require that programs include in their annual workplans enhanced parent involvement.
- Family Specialist participated as a member of the state team at the national EMSC conference. The Family Specialist presented to family and EMS providers about how to be prepared for an emergency that involves a child with special needs. As a Family Voices representative, the Family Specialist represents families of CSHCN at meetings and conferences of regional significance.
- NYSDOH won a Champions of Progress grant.

Current Activities – National Performance Measure 02 Continued.

- CSHCN Program staff continues to work with the parent involvement strategic plan formulated in 1999 to improve consumer input into MCH programs and policy development.
- CSHCN Program staff are working with other MCH programs and stakeholders to plan training for Parent Champions.
- CSHCN Program staff and the Title V Coordinator worked with the SSDI Coordinator to implement parent/consumer focus groups.
- The CSHCN Program has begun provider training in medical home concepts.
- CSHCN Program staff and the Title V Coordinator worked with the SSDI Coordinator to facilitate a meeting of Healthy Start consumer representatives who were invited to critique our focus groups methodology.
- The Early Intervention Program offered leadership training programs, informational bulletins, and parent membership on all clinical practice consensus panels. There is an active Parent Involvement Committee.
- The Early Intervention Program employs a Family Initiatives Coordinator, who is the parent of a child with a disability, to coordinate a range of parent initiatives.
- Parent involvement scores improved in 2005.
- The SSDI project continues to provide support for the development of CSHCN data systems that will provide valuable program information to program staff and families and that can be used for data improvement.
- The CSHCN Program collects information about the needs expressed by the family. Forty-three (43%) of the CYSHCN who presented to the CSHCN Program needed gap filling assistance as their insurance was not adequate for treatment services. Sixteen percent (16%) of families needed financial assistance with reimbursement for a diagnostic evaluation. In 2005, the families reported one or more of the following: 3% needed assistance with paying the deductible; 12% needed assistance with paying the co-payment; 39% needed assistance because item not covered by benefit package; and 7% needed assistance because the item exceed the benefit package.

Plan for the Coming Year

- The Medical Home Unit will:
  - Continue to enhance the function of our cadre of Family Champions by seeking their perspectives on the development, implementation and evaluation of resources and tools for use by families and MCH Programs that serve families.
  - Continue implementation of the NYS Medical Home Project and improving parent involvement.
  - Continue funding local health departments to assist CSHCN and their families.
  - Continue to engage a diverse stakeholder group to advise the Department on the identification, recruitment, and training of family advisors (a.k.a. Family Champions) to the Title V Program. The stakeholders group includes representatives from the Department of Health and other state agencies (Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, Developmental Disabilities Planning Council), family organizations (Parent to Parent, Family Voices, Families Together, and Parent Training and Information Centers). Family Champions will be provided with additional training, and engaged in CSHCN Program activities.
- The SSDI project will repeat consumer and parent focus groups.

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

Last Year's Accomplishments

- In FFY 2005, 3329 (66%) of the CYSHCN served by the CSHCN Program reported having a primary care provider. The presence of a primary care provider is only one of the five core components of a medical home. However, this component is the only one which the CSHCN Program collects and is therefore utilized as a proxy measure for medical home.
- The Children with Special Health Care Needs (CSHCN) Program implemented Year 3 of NYS Medical Home Project funded by HRSA. The grant is a collaborative activity of families of CSHCN, NYSDOH, District II of the American Academy of Pediatrics, the American Academy of Family Physicians and other key stakeholders. The goal is to develop and implement a statewide medical home plan for New York State and to ensure all NYS CSHCN have access to medical homes.
- To improve the percentage of CYSHCN who receive coordinated, ongoing comprehensive care within a medical home, the Medical Home Unit staff provided fifteen medical home presentations to a wide group of audiences. The participants at these sessions included child care providers, families (Exceptional Family Resources), physician and allied health professional groups (Westchester and Cobleskill Hospitals) and state agency staff (Developmental Disabilities Planning Council).
- The CSHCN Program funds local county health departments to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service needs.
- The CSHCN Program worked with the New York State Technology Enterprise Corporation (NYSTEC) to finalize business requirements for the CSHCN Information System. This system will provide relevant program data and make it easier for local programs to track the CSHCN treatment experience.
- In 2005, there were 716 children who received a diagnostic evaluation under the Physically Handicapped Children's Program (PHCP). This program assists families who are underinsured to obtain a diagnostic evaluation for their child by reimbursing specialty providers for their services. Additionally, 2,828 children were served through the PHCP Treatment Program. This data is based upon 57/58 local PHCPs reporting.
- The CSHCN Program collects information about the needs expressed by the family. Forty-three (43%) of the CYSHCN who presented to the CSHCN Program needed gap filling assistance as their insurance was not adequate for treatment services. Sixteen percent (16%) of families needed financial assistance with reimbursement for a diagnostic evaluation. In 2005, the families reported one or more of the following: 3% needed assistance with paying the deductible; 12% needed assistance with paying the co-payment; 39% needed assistance because item not covered by benefit package; and 7% needed assistance because the item exceed the benefit package.
- The Early Intervention Program has an active Medical Home Workgroup to ensure children in their program have access to medical homes.

Last Year's Accomplishments - National Performance Measure 03 continued.

- The American Indian Health Program and the Migrant Health Program both work to improve access to comprehensive care and to establish a medical home for children. Because of the unique circumstances of migrant children, providers concentrate on connectivity with upstream and downstream providers.
- The Growing Up Healthy Hotline continued to provide information to callers about access to medical homes for children.
- The School Health Program located 192 school-based health centers in areas where morbidity and mortality from preventable and mental health conditions are disproportionately high. School-based health centers in NY are required to provide access to care 24 hours per day, seven days per week.
- All New York State Department of Health Programs dealing with prenatal care (PCAP, MOMS, Community Health Worker) work with expectant parents to help find a provider for their baby.
- Increased the number of Healthy Children New York Child Health Promotion Specialists who can assist families in child care and other child-serving agencies to locate and enroll in a medical home.

Current Activities –

- NYS Title V staff have examined SLAITS data from NYS and include these data in all presentations for the Medical Home Project. Staff query the Data Resource Center for Child and Adolescent Health/Child and Adolescent Health Measurement Initiative data base.
- Medical Home outreach activities continue. The concept is included in Champions training.
- The Early Intervention Program has an active Medical Home Workgroup to ensure children in their program have access to medical homes.
- CSHCN Program staff continue to assist families without medical homes to find medical homes for their children.
- Title V staff participate in NICHQ Medical Home Learning Collaborative (MHLC) including attendance at all three learning sessions and site visits to all NYS MHLC participating practices.
- Hotline activities continue.
- Local health department programs actively link lead poisoned children with special health care needs to the appropriate services, if available in the communities. In most cases, a lead poisoned case is automatically given a developmental screening and/or referred to local Early Intervention (EI) program to ensure care coordination.
- Discussions and informational sessions have been held with the Early Intervention Program and the Developmental Disabilities Planning Council.
- No major changes were made.

Plan for the Coming Year

- Local CSHCN Programs will continue to increase the percentage of CYSHCN through increasing the number of children who have a primary care provider and medical home. Upon a child's intake into the local CSHCN Program, program staff inquire whether a child has a primary care provider. If a child does not, local CSHCN Program staff will assist families in locating a primary care provider who participates in their insurance plan.
- Continue Medical Home outreach and implementation by integrating the medical home concept into other Department initiatives, such as the child development learning collaborative, the school-based health center learning collaborative and regional asthma coalitions.

Plan for the Coming Year – National Performance Measure 03 Continued.

- Continue implementation of the NYS Medical Home Improvement Project. Community medical home informational sessions for providers and families are being planned with one team who attended the National Initiative for Child Health Quality Learning Collaborative sessions.
- Continue to provide through the Physically Handicapped Children's Program reimbursement for diagnostic and treatment services for eligible children who are underinsured. Participation by localities in the treatment program is voluntary in the form of state aid reimbursement for 50% of the county's expenditures. The state's capacity to assist families is limited by the degree that localities participate in the program.
- Continue to engage key stakeholders in development and implementation of a statewide medical home plan for NYS. More regional trainings will be offered.
- Continue funding local health departments to provide CSHCN Program services.
- The CSHCN Program will continue to work with contractors who serve CSHCN to refer children without a primary care provider to health care providers and sources of insurance to access health care providers.
- The CSHCN Program will encourage local CSHCN Programs to become aware of the medical home concepts. Medical home and parent involvement are now required workplan elements.
- The Physically Handicapped Children's Program will continue to provide reimbursement for diagnostic and treatment services for those eligible children who are underinsured.
- Continue analysis of SLAITS. Use as benchmarking.
- Continue Medical Home Workgroup under the Early Intervention Program.
- Continue to increase number of child health consultants who can assist children to obtain a medical home.

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

Last Year's Accomplishments

- The Physically Handicapped Children's Program under the NYS Children with Special Health Care Needs Program continued to provide gap-filling coverage for children with special health care needs birth to age 21 for services that insurances will not cover or for children in special financial circumstances who are ineligible for Medicaid or Child Health Plus.
- In 2005, there were 716 children who received a diagnostic evaluation under the Physically Handicapped Children's Program (PHCP). This program assists families who are underinsured to obtain a diagnostic evaluation for their child by reimbursing specialty providers for their services. Additionally, 2,828 children were served through the PHCP Treatment Program. This data is based upon 57/58 local PHCPs reporting.
- The CSHCN Program collects information about the needs expressed by the family. Forty-three (43%) of the CYSHCN who presented to the CSHCN Program needed gap filling assistance as their insurance was not adequate for treatment services. Sixteen percent (16%) of families needed financial assistance with reimbursement for a diagnostic evaluation. In 2005, the families reported one or more of the following: 3% needed assistance with paying the deductible; 12%

Last Year's Accomplishments –National Performance Measure 04 Continued.

needed assistance with paying the co-payment; 39% needed assistance because item not covered by benefit package; and 7% needed assistance because the item exceed the benefit package.

- The CSHCN Program continued to fund local county health departments to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service needs.
- Each county within NYS has enrollment sites where families can be assisted to gain access to public insurance and fill out enrollment forms. Each local health department CSHCN Program is required to have a referral linkage to the facilitated enrollment agency in their area. In some cases, the facilitated enrollment program is within the same agency.
- NY uses a combined Medicaid, Food Stamps, Child Health Plus, Family Health Plus and WIC enrollment application.
- All children identified as uninsured and underinsured by the Childhood Lead Poisoning Prevention Program are referred to appropriate local public insurance enrollment source. Lead poisoned children and their families, without health insurance are directed to and assisted with enrollment in MA and/or Child Health Plus to expedite access to care. Systems are in place to help uninsured needing immediate medical attention.
- Updates and revisions were to the Resource Directory for CSHCN were made, including the addition of two programs descriptions that were not included in the previous version (Home and Community Based Waiver for Long Term Care and Traumatic Brain Injury). The Program assessed the needs for materials in different languages, assessing the populations served by the local CSHCN Programs. Several local programs reported the need for print materials in Spanish due to various reasons, i.e. large migrant population, and current or increasing Hispanic population. This need was addressed through the plan to continue translation of the Resource Directory into Spanish along with French, Chinese and Russian.

Current Activities

- Same as above. There is discussion about changing the performance goals for this measure, but it is difficult to determine based on a single data point. There are no new SLAITS data this year. Program data differs significantly from SLAITS results. Performance targets will be modified when there is a second data point that indicates in what direction trends are moving.

Plan for the Coming Year

- The Physically Handicapped Children's Program will continue to provide reimbursement for diagnostic and treatment services for those eligible children who are underinsured. Participation by localities in the Treatment Program is voluntary in the form of state aid reimbursement for 50% of expenditures. The state's capacity to assist families is limited by the degree that localities participate in the program.
- The CSHCN Program will continue to fund local health departments to work with CSHCN and their families to ensure access to health insurance and medical homes.
- No major changes are planned with regard to Medicaid or Child Health Plus coverage.
- Local programs will continue to link with facilitated enrollers.

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

Last Year's Accomplishments

- The CSHCN Program continued to fund local county health departments to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service needs.
- The CSHCN Program, under authority of the Physically Handicapped Children's Program legislation, is authorized to approve Specialty Centers. Specialty Centers are expected to provide family-centered, comprehensive, culturally- and language-appropriate care. They are also expected to work in a coordinated fashion with the child's community-based medical home.
- The Early Intervention Program is funded by State and other Federal appropriations, but it has strong ties to the MCHSBG programs and services, providing direct services to infants and young children who are identified as having or being at risk for disabilities. The child find mechanism under EI locates and tracks developmental surveillance of at-risk infants and their families and links families with appropriate services. EI is a major source of MCH referrals. In FFY 2006, the Early Intervention Program will continue to work with the Children with Special Health Care Needs Program on cross-program issues, such as parent involvement and sharing of data.
- The Early Intervention Program employed two types of service coordination. The first type assists families through the initial phase of entry into the Early Intervention Program, helping them to deal with the multi-disciplinary evaluation and development of the first Individualized Family Services Plan. The second type of service coordination is ongoing, designed to ensure that families are supported through all aspects of the Early Intervention Program and that EI services are coordinated with other services and supports offered to families for sources outside of the program.
- The Community Health Worker Program assists families to connect to health care services and sustain that connection.
- Consumer focus groups were asked about their experiences with accessing services. This information is shared with program managers and policy makers to ensure incorporation into program planning.
- The Resource Directory for Children with Special Health Care Needs was reprinted and has been distributed to local health departments, hospitals, community agencies, schools, libraries, families and other providers. The directory is available in English, Spanish, Russian, Chinese and French.
- The Congenital Malformations Registry staff sent informational mailings to notify families of children born with malformations of the Early Intervention Program and support groups available statewide.
- Local health department programs actively link lead poisoned children with special health care needs to the appropriate services, if available in the communities. In most cases, a lead poisoned child is automatically given a developmental screening and/or referred to local Early Intervention (EI) program to ensure care coordination.

Current Activities- National Performance Measure 05 Continued.

- The Medical Home and ES-CHIP Projects are organized to have an impact on the "family friendliness" of local systems of care.
- Local health department CSHCN Coordinators work with families and providers to enable smooth referrals to specialty providers and other needed services.
- The Early Intervention Program continued to provide initial and ongoing service coordination.
- SLAITS data was received and is undergoing more analysis with the aid of the CDC.
- Results of consumer focus groups are being shared with all MCH and public insurance programs.
- Training of Family Champions is currently taking place.

Plan for the Coming Year

- The CSHCN Program will continue to fund local health departments to work with CSHCN and their families to ensure access to health insurance and medical homes.
- The CSHCN Program will continue to work with the providers of specialty care to ensure ease of referral and family-centered care.
- EI service coordination will continue.
- Continue implementation of the Medical Home and Family Champions Projects.
- Continue Medical Home Training for providers.
- Continue to monitor Specialty Centers for adherence to program standards.
- Continue to make this a topic for the MCH consumer focus groups.

PERFORMANCE MEASURE #06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

Last Year's Accomplishments

- The CSHCN Program sends out materials to children enrolled in the program who have reached transitional ages. Materials explain the need for transition planning and give key points to consider.
- Transition activities were required for inclusion in the local CSHCN workplans.
- Family Champions were queried about transition issues during needs assessment focus groups.
- Transition was included in a brochure on how to get good quality health care for their child, which focuses on family-professional partnerships.

Current Activities

- CSHCN Program staff continues to work with the State Education Department and the State Department of Labor on transition issues.
- CSHCN Program staff monitor and provide technical assistance to local programs around transition issues.
- Title V staff continue to utilize SLAITS data in understanding the status of this issue for NYS.
- Staff provide sessions for parents regarding transition of youth and importance to families.
- BCAH is planning to convene a youth and young adult advisory group that will deal with transition from parental responsibility to self-responsibility. The group

Current Activities- National Performance Measure 06 Continued.

will help identify what transition resources are needed and help formulate a plan for how to better address transition issues.

- The CSHCN Program is working with other Youth Development groups for help and advice with inclusion of youth in policy development.
- A hand-held record/health diary is being formulated that can ease in the transition. The document will be carried with the youth and will be a tool to comprehensive and coordinated services.

Plan for the Coming Year

- DOH will continue to work with the State Education Department and the State Department of Labor on transition issues.
- CSHCN staff will continue to monitor the performance of local programs on issues related to transition.
- CSHCN staff will continue to work on information systems development that will assist the program to track these activities.
- Implement the Youth Advisory Committee.
- Implement the handheld record/health diary.

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

Last Year's Accomplishments

- The Immunization Program provided vaccines through the NYS Vaccines for Children Program, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted local health departments with disease surveillance and outbreak control activities, and continued to develop a statewide immunization registry. CDC categorical grants and State and Local Assistance dollars were used to provide staffing in both central and regional offices and to purchase vaccines. County health department s assist in recruiting VFC providers.
- Over 90% of two year-old children in New York State (outside New York City) are vaccinated in private doctor's offices, not pubic clinics. Under the Provider-Based Immunization Initiative (PBII), county staff visit pediatricians and assess the medical records of their patients for compliance with immunization and lead screening schedules. The information is then keyed into a computer using CDC-developed software, the Clinical Assessment Software Application, (CASA). CASA calculates the providers' immunization rate and enables them to improve their vaccination protocols, when necessary.
- Comprehensive Prenatal/Perinatal Services Networks provide education and outreach to engage children into the health care system. Some networks conducted outreach for Child Health Plus and to ensure that parents are aware of the need for comprehensive immunization.

Last Year's Accomplishments –National Performance Measure 07 Continued.

- Lead Program has strong programmatic links to the Immunization program via VFC and PBII. Immunization and lead screening records are reviewed, in many instances by SDOH and/or local health department staff. This helps ensure promote provider awareness and compliance.
- *Welcome to Parenthood*, a packet given to the family of each newborn born in New York, contains information about childhood immunizations.
- Article 6 State Aid to Localities reimbursed local health departments for the infrastructure that supports immunization surveillance, tracking, parent and provider education and special studies.
- Up-to-date immunizations were provided to over 1800 children in migrant day care settings in NYS.
- The Community Health Worker Program educated parents about immunization, assessed the immunization status of all children in the program, referred and assisted families to obtain immunization, and followed-up with families to assure they actually received the service. Assistance is given with insurance enrollment. In 2005, 89% of children entering the program were up-to-date, and of those who were not, 80% received immunizations while in the program, 88% were pending at the time of the data collection and 97% were fully immunized.
- PCAP and MOMS also educated parents in the need for preventive services, including immunization. Assistance is given with health insurance enrollment.
- Immunization records are reviewed and children are referred or provided with immunizations and for lead screening during clinic visits for WIC, and on risk-reduction home visits to the homes of lead affected children. Early Intervention Program service coordinators also checked that children received appropriate primary care and immunizations.
- Healthy Children New York training included discussion of immunization requirements Child Health Consultants. Child health consultants assist child care providers and other youth-serving agencies to document immunizations and thereby increase verified rates of immunization and lead testing.
- Child care providers are required to check immunizations and refer children lacking immunizations to their provider.

Current Activities – Same as above

Plan for the Coming Year – Same as above

PERFORMANCE MEASURE #08: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Last Year's Accomplishments

- The Family Planning Programs provide community education, comprehensive reproductive health care, a full range of contraceptive methods, counseling and testing for HIV, and screening and treatment for sexually transmitted diseases. Fifty-seven family planning programs provided services to 338,166 individuals in 2004, and 27.8% were under the age of 20.
- NYSDOH funded 37 Abstinence Education and Promotion contractors to provide with abstinence education, mentoring, counseling, and adult supervision to promote abstinence from sexual activity in 15 to 19 year olds. They focus on junior high/middle school aged students. The ***Not Me, Not Now* campaign** continued as a statewide, large-scale media campaign to support the community-based initiatives.
- The Comprehensive Prenatal/Perinatal Services Networks promoted reduction of adolescent pregnancy rates through provider and community conferences, outreach and education efforts. The Networks conduct education and outreach activities to improve the reproductive health of all women, including teens.
- Article 6 reimbursed local health departments with State Aid for health education and other population-based efforts, and support infrastructure needed to provide data collection, data evaluation, community-based planning and implementing collaborative intervention strategies.
- The Rape Crisis Program developed and implemented policies designed to provide effective and compassionate care to victims of sexual assault and supported professional and community-based prevention education programs.
- Risk assessment for sexual activity is a part of the initial assessment and anticipatory guidance offered in School-Based Health Centers. Pregnancy testing is done when indicated. Students have access to family planning services, either onsite or by referral. Students are also referred early for prenatal services; practitioners co-manage the students' prenatal care. School-based health centers provided services to approximately 35,000 female students ages 15 to 19 years.
- ACT for Youth continued its youth development focus, building assets for resiliency and resourcefulness among youth.
- ACT for Youth Centers for Excellence provided information statewide and in various conferences on Youth Development concepts and best practices.
- The Department met with Healthy Start grantees in order to enhance communication and coordination among grantees and Title V.

Current Activities – No major changes during this program year.

Plan for the Coming Year – No major changes planned.

PERFORMANCE MEASURE #09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Last Year's Accomplishments

- The Bureau of Dental Health completed dental surveillance in each county. The surveillance grant was active across the State, enrolling children for oral health screening and referring children to dental care.
- Twenty-four of the twenty-six School-Based Preventive Dentistry Programs continued to place sealants in 2004, serving 30,769 children and providing 9,929 referrals. This program targeted school children in grades 2, 3, 7, and 8 in low socioeconomic areas and provided children with a point of entry into the dental care system. Students were screened for adverse dental conditions and for the need for application of sealants. Sealant sites increased participation in their program each year. Children who need restorative oral health services are referred. All families in targeted school districts receive promotional and educational information, which appears to contribute to the program's success.
- Programs entered into community partnerships involving parents, consumers, providers and public agencies for identifying and addressing community problems related to oral health. This community-based problem solving approach has help to identify effective interventions to suit community needs.
- Funding for school-based sealant programs was increased by $1M in 2003-2005.
- Other dental programs also promote the use of sealants, including the Preventive Dentistry Fluoride Supplement Program, which provided over 125,000 children with fluoride supplementation in non-fluoridated areas through schools, day care and Head Start programs.
- The Bureau of Dental Health continued to fund seven projects for Innovative Dental Services to Underserved Areas. Under this initiative, a Technical Assistance Center was funded at the Rochester Primary Care Network. The TAC Director, Dr. Buddhi Shrestha, who has demonstrated success with building community-based organizations responsive to children's dental needs, will provide consultation to developing projects.
- The Bureau of Dental Health, with the assistance of multiple stakeholders, formulated the state's Oral Health Plan. Dr. Thomas Curran, an oral-maxillary surgeon who is also a member of the Maternal and Child Health Services Block Grant Advisory Council was appointed to that committee. The plan recognizes school-based dental sealant programs as an effective population-based strategy to improve the oral health of children.
- The Bureau of Dental Health implemented a listserv and an Oral Health Coalition.
- Article 6 State Aid provided funding for dental health education to each county in New York.
- The American Indian Health Program offered dental services to approximately 2000 children under age 20 either onsite or via off-reservation referrals. The children's fluoride program is on-going for Pre-K through Grade 6 with monitoring of the number of dental caries found.
- Dental services were offered to approximately 3500 children through our Migrant Health Program. Sealants are also promoted in this setting.

Current Activities- National Performance Measure 09 Continued.

- The Preventive Dentistry Program providers have continued to establish community partnerships involving parents, consumers, providers and other organizations for identifying and addressing problems within their communities. This focus has helped to identify effective interventions to suite community needs.
- The Bureau of Dental Health continues to work with stakeholders on the statewide Oral Health Plan.
- Ongoing oral health screening and referral was available to all School Based Health Center (SBHC) enrollees. The School Health Program provides funding for school-based health centers to establish and enhance dental services for children and youth served by SBHCs, exhibiting substantial risk for dental health problems. Eight providers with thirty-one school-based health center sites serving 34,000 students will provide a range of services including education and outreach, screening, referral and follow-up, and treatment for students in these schools. Sites will be staffed with a combination of dental assistants, dental hygienists and dentists. Dental students and residents may also be part of the programs to provide them with professional development opportunities and to help expand these services.
- The Department. Based on an agreement with the State Education Department, established 35 new School-Based Dental Center sites.

Plan for the Coming Year

- Re-bid Preventive Dentistry Programs via Request for Applications.
- Expansion of Innovative Dental Services grants to new grantees.
- Continue surveillance activities that were started in the past fiscal year.
- Promote use of Dental Surveillance data.
- Implementation of a Statewide Oral Health Plan.
- Monitor provider billing efforts and their efforts to obtain other sources of funding such as grants, donations from local businesses, etc.
- Continue to promote the use of effective preventive services such as community-based fluoride, dental sealants, education and other innovative programs.
- Ongoing oral health screening and referral will be available to all SBHC enrollees.

PERFORMANCE MEASURE #10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

Last Year's Accomplishments

- Childhood Injury Prevention Projects have built successful coalitions for injury control at the local level, reaching out to diverse segments of the community to ensure that the populace is well informed on issues related to childhood injury prevention.
- The Injury Prevention Program performs traffic related research and conducts surveillance of passenger safety and traumatic brain injury in NYS. The Bureau of Injury Control also represents the Department on the Governor's Traffic Safety Committee.

Last Year's Accomplishments – National Performance Measure 10 Continued

- The Emergency Medical Services for Children Project continued to compile data to assist providers in prevention activities and in further enhancing the pediatric trauma care system. Motor vehicle crashes annually account for about 20% of all pediatric trauma cases and are the largest percentage, of all pediatric Dead On Arrivals (about 35%).
- The Community Health Worker, PCAP and MOMS Programs all have extensive child safety components, which stress car seat use and other infant safety measures.
- Parents who are enrolled with Community Health Workers are given extensive information about childhood safety. Homes are assessed for hazards and workers role model positive parenting skills.
- American Indian Nations with Community Health Worker Programs all have formalized car seat education components. Other reservation clinics promote vehicle safety during individual health education/risk reduction encounters. Last year, a vehicular accident helped rally the tribal members to address alcohol/substance abuse, vehicle safety and risk reduction.
- PCAP and MOMS have an extensive health education agenda, including infant and child safety, use of safety seats, and burn prevention and other causes of infant injuries.
- All school-based health centers provide psychosocial and health risk assessment beginning with the initial visit. Student and family education about safety issues and abuse are included.

Current Activities - No major changes occurred.

Plan for the Coming Year - No major changes are planned.

PERFORMANCE MEASURE #11: Percentage of mothers who breastfeed their infants at six months of age.

Last Year's Accomplishments

- State regulation requires each hospital to have a lactation consultant. Regulations specifically forbid the administration of anti-lactation drugs by standing order and the issuance of sample packs of formula without prescription.
- The Department of Health continued to support the New York State Institute for Human Lactation to increase the breastfeeding initiation and continuation rate and to provide continuing education on breastfeeding to physicians, midwives, nurses and other health care providers, helping them to promote and manage breastfeeding effectively. The Institute produces an annual videoconference called the Breastfeeding Grand Rounds that addresses both clinical and public health issues related to breastfeeding and lactation. The conference, which is broadcast statewide to an audience of approximately 500 professionals annually, includes a clinical lecture, a public health lecture, discussion of case studies, and extensive opportunity for audience participation and questions.
- For over 25 years, the WIC Program has been effective in reducing the incidence and prevalence of nutrition-related disorders of pregnancy, infancy and early childhood, specifically low birth weight, infant mortality and iron deficiency

anemia. New York's WIC Program supports a service delivery system of 100 local agencies, 570 delivery sites, 4300 retail food vendors and 475,000 participants. Breastfeeding promotion and support activities were expanded into all local WIC agencies.

- In 2004, 66.4% of WIC moms reported ever breastfeeding. This is a 10% increase over 2001. At 12 months, 22% of WIC participants reported in 2004 that they were still breastfeeding. This is 32% more than in 2003 and almost double the rate reported in 2001.
- The Lactation Institute sponsored a satellite broadcast on the link between breastfeeding and obesity. Over 100 downlink sites participated, and post-production DVD and video materials were distributed.
- According to the National Immunization Survey on Breastfeeding, About one-half of the NY state women reporting ever breastfeeding were still breastfeeding when their babies were 6 months of age (37.2%). Rates were similar for Upstate, NYC, and the nation. If only looking at women exclusively breastfeeding at 6 months of age, which is recommended by the American Academy (AAP) of Pediatrics, 14.8 percent of women in New York State were in this category. Slightly more NYC moms reported excusive breast feeding at 6 months of age (15.5%), as compared to Upstate (14.8%) and the nation (14.1%).
- It is important to initiate discussion about infant feeding choices prior to the antenatal hospital admission. PCAP and MOMS encourage breastfeeding through education during prenatal care and at the postpartum visit.
- The Community Health Worker Program (CHWP) recognizes the benefits of breastfeeding for the infant and mother. To promote breastfeeding, the CHWs provide support and referrals for services. Home visits are conducted shortly after birth with ongoing visits, as necessary. In 2005, 66.2% (up from 64.4%) of the women in CHWP were breastfeeding at discharge from the hospital and 52.1% (up from 47.1%in 2004) of them continued to breastfeed for at least six weeks postpartum. 33.1% continued to breastfeed for at least six months postpartum.
- The Comprehensive Prenatal/Perinatal Services Networks developed and implemented workshops on the importance of breastfeeding. Part of this strategy in several areas of the State is to work with obstetrical nurses and hospital staff to encourage and support breastfeeding. Some hospitals later developed breastfeeding support groups.
- The Bureau of Women's Health also responds to inquiries about the Department's K through 12 breastfeeding education materials. There were developed a few years ago and posted on the DOH website (http://www.health.state.ny.us/nysdoh/b_feed/index.htm).
- The Bureau also conducts periodic hospital surveys to monitor breastfeeding rates, and is currently implementing a Statewide Perinatal Data System that will allow, among other things, more detailed assessments of breastfeeding rates and trends. Positive breastfeeding policies and practices in hospitals and managed care settings are promoted through periodic provider surveys and feedback about how practices compare to regional and state averages. BWH will continue to distribute materials on best practices to support breastfeeding.

Current Activities/Plan for the Coming Year – No major changes are planned.

- The topic of this year's satellite conference will be the relationship between breastfeeding and mental health and illness in the mother and infant.

PERFORMANCE MEASURE #12: Percentage of newborns who have been screened for hearing before hospital discharge.

Last Year's Accomplishments

- New York continued improvement in newborn hearing screening rates through the Universal Newborn Hearing Screening Program.
- New York now screens 99.9% of infants discharged from hospitals for hearing loss. It is also significant to note that the age at referral of children with hearing loss to the statewide Early Intervention Program decreased from 12.65 months in 2000-01 (prior to implementation of newborn hearing screening regulations) to 4.14 months in the 2002-03, and 4.04 months in 2004.
- The Department continued to support hospital-based newborn hearing screening programs through technical assistance and data maintenance. Program and Data Unit staff maintain data reporting requirements and continue to refine data collection and management protocols.
- Early Intervention Guidance Memorandum 2003-03 on Newborn Hearing Screening was disseminated on an ongoing basis. The document contains guidance on newborn hearing screening, the program requirements for maternity hospitals and birthing centers, and the role of the Early Intervention Program in facilitating follow-up for infants referred.
- Program staff provided ongoing training and technical assistance to local Newborn Hearing Screening Program managers and to local Early Intervention Programs. Quality Improvement efforts targeted data collection from the state's 161 maternity hospitals/birthing centers.
- Although the Community Health Worker Program does not screen for hearing loss, the program uses the Ages and States Questionnaire (ASQ), a parent-completed developmental screening tool. Through this process, the Community Health Worker program can potentially identify issues related to the child's development that could include hearing loss. The program refers to the Early Intervention Program, as appropriate.

Current Activities

- Currently, all hospitals have systems for testing, tracking and reporting newborn hearing screening. DOH continues to provide technical assistance to hospitals and other constituents on newborn hearing screening program implementation.
- DOH continues to reinforce links between newborn hearing screening and the Early Intervention Program and continues to target data improvement.
- Award winning public education/parent education materials on newborn hearing screening are available in six languages.

Plan for the Coming Year

- Continue efforts to establish data-driven quality assurance and review protocols, and to continue provision of technical assistance on newborn hearing screening for hospitals and other constituents, with an emphasis on follow-up for infants who do not pass their initial hearing screening and/or who are suspected of having a hearing loss.
- Full implementation of clinical practice guidelines on assessment and intervention is also planned, which will facilitate expansion of training on issues related to hearing loss in young infants to other groups, such as early intervention service providers, physicians and primary health care providers.

PERFORMANCE MEASURE #13: Percent of children without health insurance.

Last Year's Accomplishments

- Children ages one through five years are eligible for Medicaid at 133% of the Federal Poverty Level (FPL) for twelve months of continuous coverage, even if their family's income exceeds eligibility levels during that year. Children ages six through 18 years of age are eligible for Medicaid at 100% of the FPL.
- Since November 2000, pregnant women and infants are eligible at or below 200% of poverty. All infants born to mothers enrolled in PCAP are MA-eligible for at least the first year of life. PCAPs also refer to programs such as Child Health Plus and/or Family Health Plus as appropriate. The Department has developed an application for all programs to help simplify the application process.
- Eligibility for Family Planning coverage is available up to 200% of poverty, regardless of previous pregnancy or eligibility. Under this waiver, the Federal government pays 90%, the State 10%, and there is no local share. FPBP screens every enrolled family for eligibility for public insurance.
- Facilitated enrollers are available statewide to assist families with public insurance enrollment processes.
- Children's Medicaid is called Child Health Plus A to avoid the stigma associated with Medicaid.
- Families at or below 250% of the Federal Poverty Level are eligible for Child Health Plus B (New York's State Child Health Insurance Program). Families over 250% of FPL are eligible for participation at full premium.
- Comprehensive Prenatal/Perinatal Services Networks facilitate the implementation of Medicaid Managed Care within their catchments area. Many Networks are facilitated enrollers for health insurance programs. Networks provide outreach, information and education regarding Managed Care and have the ability to identify new and emerging issues related to managed care.
- All MCHSBG funded programs are required to facilitate enrollment in insurance.
- Children with Traumatic Brain Injury injured before the age of 18 are eligible for Medicaid under a special waiver.
- CSHCN who did not have a source of insurance were assisted by the CSHCN Program to enroll in an insurance program, if eligible.
- The Community Health Worker Program (CHWP) assists any child or member of an enrolled family to access health insurance. Success rates are tracked.
- All children identified as uninsured and underinsured by the Childhood Lead Poisoning Prevention Program continue to be referred to appropriate local public insurance enrollment source. Lead poisoned children and their families, without health insurance are directed to and assisted with enrollment in MA and/or Child Health Plus to expedite access to care.
- Systems are in place to help uninsured needing immediate medical attention.
- Healthy Children New York increased the number of child health consultants who assist children in child care to obtain insurance.

Current Activities – No major changes.

Plan for the Coming Year – No major changes are planned.

PERFORMANCE MEASURE #14: Percent of children, ages 2 to 5, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Last Year's Accomplishments

- The Division of Chronic Disease Prevention and Adult Health and the Bureau of Dental Health in the Division of Family Health collaborated to complete surveillance of third-graders across the state. Height, weight and BMI measurements were added to an existing dental surveillance project. Dental hygienists were trained to accurately gather and record anthropometric data while completing oral screening.
- Obesity data is available both from the **WIC** program and from the **Youth Risk Behavior Survey.** There are also data collection efforts associated with individual community-level interventions.
- Under the **PAN (Physical Activity and Nutrition)** initiatives, there was also further discussion on gaps in data gathering.
- The Department continued to support the **Eat Well, Play Hard** program. The program is an intervention to prevent childhood overweight and long-term risks for chronic disease by promoting healthy eating habits and increased physical activity. The ***Eat Well, Play Hard*** strategies targeted to children ages 2 and older are: increase the amount of developmentally-appropriate physical activity; increase consumption of fruits and vegetables; and increase consumption of 1% or less milk and low fat dairy products.
- The Bureau of Health Risk Reduction implemented **Activ8 KIDS!**, a program for the prevention of childhood overweight and obesity. The components of the program include: centers for best practices, school and community partnerships, and initiatives in the child care setting.
- **Centers for Excellence in the Treatment of Eating Disorders** were conceived and established.
- A project to impress physicians with the importance of tracking Body Mass Index (BMI) was completed under the Preventive Medicine Residency and the Bureau of Child and Adolescent Health. The study provided a baseline for physician practice related to BMI-for-age, an educational intervention, and follow-up evaluation.
- The WIC Program provides nutrition information to all participants. FitWIC was initiated.
- Healthy Children New York is working with child care providers on an obesity prevention program that aims to improve nutrition and physical activity in child care settings.
- Division of Chronic Disease Prevention and Adult Health tested new interventions that utilize concepts of social marketing and diffusion of innovation on a community-wide level in fourteen Head Start centers, ten of which will serve as controls. Interventions include assessment of food and activities policies, environmental assessment, collaborative policy development, and development of training sessions/materials for staff and families. Environmental and policy changes promote an increase in physical activity, a decrease in TV/video viewing and a decrease in language and policies that promote overeating and inactivity. A community-wide intervention component will support program changes.

Current Activities - Continued to implement initiatives outlined above.

Plan for the Coming Year - No major changes are planned.

PERFORMANCE MEASURE #15: The percent of women who smoke in the last three months of pregnancy.

Last Year's Accomplishments

- These data are tracked and reported via PRAMS.
- Efforts to reduce smoking in pregnant women are a part of the multi-pronged efforts to reduce smoking in the general public. These efforts include: Reality Check campaigns, Community Tobacco Control Coalitions, Tobacco Cessation Centers, NY Smokefree Workplace, and website (see www.nysmokefree.com) and hotlines (1-866-NYQUITS) that support smokers to quit.
- PCAP promotes healthy behaviors during pregnancy. PCAPs provide information regarding the impact of smoking on the woman and the fetus and have developed various programs to deal with smoking, including individual counseling and referrals to group or other programs that support smoking cessation.
- The School Health Program continued to screen for tobacco use and make appropriate referrals, including to obstetrical services and smoking cessation programs, and to counsel students accordingly.
- The Comprehensive Prenatal/Perinatal Services Network's priorities included developing and implementing programs to reduce the number of women who smoke or use other substances during pregnancy. Networks provide education and training to health and human services providers on ways to assist women to enhance healthy behaviors, including smoking cessation.
- Although the Community Health Worker Program keeps not specific data on smoking, an important role of the Community Health Worker is to provide education for women to increase their understanding of behaviors that pose a risk to health. This includes the use of tobacco. The Community Health Worker will not only provide this information, but will provide appropriate referrals for those women seeking assistance in this area, including accompanying them to care, if necessary.
- Family Planning Programs refer for smoking cessation.
- All Migrant Health and American Indian Health Program providers screen for tobacco use and make appropriate referrals.
- School-based health center staff continue to screen all enrollees, including pregnant adolescents, for tobacco-use, provide counseling and make appropriate referrals.
- New York State continued to enforce a tough, new Clean Indoor Air Act.
- NYS Medicaid covers smoking cessation products and programs.

Current Activities

- New York continued to invest in anti-smoking messages. Funding increased.
- The Tobacco Control Program monitors implementation of the new Clean Indoor Air Act and other factors related to the evaluation of New York's anti-smoking efforts.
- The Tobacco Control Program funds the American Cancer Society for "Make Yours a Fresh Start, a program working with pregnant women.
- A WIC Program in New York City is funded to do a smoking cessation encounters with pregnant and parenting women.
- No major changes.

Plan for the Coming Year – No major changes are planned.

PERFORMANCE MEASURE #16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Last Year's Accomplishments

- Bureau of Injury Control and the Public Health Information Group make suicide data available and are able to perform additional analyses for use in planning.
- The Office of Mental Health (OMH) was given the lead in all suicide prevention activities in the state. OMH continued to make available their prevention campaign. Title V programs have access to the campaign and associated materials.
- Teen alcohol use is correlated with suicide attempts. The New York State Office of Alcohol and Substance Abuse Services (OASAS) continued to make available their campaign entitled, "Underage drinking: Not a minor problem." The package includes fact sheets and resource directories. MCHSBG Advisory Council members were also presented with this package. Title V programs have access to the campaign and associated materials.
- The School Health Program includes an evaluation for suicide risk as a part of the initial health assessment. Mental health services, including crisis intervention, were available through the school-based health center or by referral. Referrals may also have been made for more intensive consultation or treatment. School staff, family members and other students are also offered consultation and education. Approximately 16% of SBHC visits indicated emotional issues as a primary reason for the visit.
- The School Health Program, in conjunction with SED and OMH, continued to operate an expanded school-based mental health initiative in seven schools. This initiative co-located a comprehensive mental health services clinic in seven schools with a school-based health center to provide a range of psychological support, education, consultation and treatment for students and families. School staff education and support were also an integral component of the model.
- Assets Coming Together (ACT) for Youth focuses community attention on asset-building activities for youth as a way of reducing risk-taking behaviors. Through these community collaborations, ACT for Youth has developed youth forums on violence abuse and risky sexual behaviors, as well as peer education materials, conflict resolution training to train peer mediators, and mentoring programs.
- NYS continued implementation of the Lesbian, Gay, Bisexual and Trans-gendered Health Initiative. Over half of the grantees under this initiative are focused on issues related to gay and lesbian youth and issues with alcohol, substance abuse and self-inflicted injuries. Data from other states indicate that gay, lesbian and bisexual youth are approximately 4 times more likely to attempt suicide than their heterosexual counterparts.

Current Activities

- There have been no major changes in programming. Title V will continue to collaborate with partners in suicide prevention.

Plan for the Coming Year - Continued collaboration with the Bureau of Chronic Disease Prevention and Adult Health, Bureau of Injury Prevention, Office of Mental Health and Office of Children and Family Services.

PERFORMANCE MEASURE #17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Last Year's Accomplishments

- In 2004, NYSDOH completed a perinatal re-designation process of all 157 obstetrical hospitals in the State to ensure that all pregnant women and newborns have timely access to the appropriate level of perinatal care. Levels are based on each hospital's capacity to provide care for pregnant/postpartum women as well as newborns. Bureau of Women's Health continued to work with designated hospitals over the past year. Revised perinatal regulations were adopted in September 2005.
- All hospitals with Level I, II or III designations are required to by State Hospital Code to have perinatal affiliation agreements with a Regional Perinatal Center that is easily accessible within two hours. There must also be patient transfer agreements, which include transfer criteria, policies and procedures for maternal-fetal, postpartum and newborn transfers and back transfers. Facilities are also required to cooperate in outreach, education and training activities and in onsite quality of care reviews by the Regional Perinatal Center.
- NYSDOH has 11 Regional Perinatal Forums that join the expertise of the hospital provider community with the expertise of the non-hospital community to bring a public health perspective to the regionalization process. Regional Perinatal Centers and Comprehensive Prenatal/Perinatal Networks collaborate in the development and the governance of the Forums. Forum membership includes a range of community-based agencies that provide prenatal care, local March of Dimes, Community Health Worker Programs and others. There is one Forum in each borough of New York City, one on Long Island, and five in Upstate.
- Bureau of Women's Health worked with New York City Department of Health and Mental Hygiene to implement a City-wide Forum that brought together the issues across New York City.
- All Prenatal Care Assistance Programs (PCAPs) conduct risk assessment on all patients to identify any high risk factors that warrant appropriate follow-up. They have agreements with tertiary care centers for referral of high risk women for appropriate level of care. In that way, women can receive an appropriate level of service prior to admission to the hospital (perinatologist, maternal-fetal medicine specialist, etc.) and also receive inpatient services at a hospital that is capable of providing the level of care required for the pregnant woman and/or her infant.
- The cytogenetics laboratory provides prenatal and postnatal cytogenetic analysis, identifying congenital abnormalities and enabling treatment.

Current Activities

- DOH is continuing to implement Regionalization and Perinatal Regional Forums.
- Perinatal Forums identified a number of public health concerns that on which they plan to work, including: smoking cessation, improving prenatal care and using vital statistics data to identify areas where services are needed.
- No major changes are planned.

Plan for the Coming Year

- No major changes are planned.

PERFORMANCE MEASURE #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Last Year's Accomplishments

- An important finding of the Department's CDC-funded Maternal Mortality Study was that lack of access to prenatal care in the first trimester was associated with higher risk for maternal mortality; additional data was gathered about barriers to care.
- The Comprehensive Prenatal/Perinatal Services Networks (CPPSNs) have as their objective to increase the percentage of women entering prenatal care in their first trimester. In addition to the statewide Growing Up Healthy Hotline, Networks have local toll-free numbers, web sites, resource directories or other mechanisms to provide pregnant women with information and referral to prenatal care. Networks also identify gaps and barriers to the service system, and in collaboration with the Consortium, work to increase accessibility and the quality of the local perinatal service system.
- PCAP and MOMS encouraged early enrollment in prenatal care, offered presumptive eligibility, and ensured timely initiation of services.
- Public awareness campaigns and the Healthy Baby Hotline helped raise awareness of the need for early prenatal care.
- An important collaboration between Title V and the AIDS Institute is the Community Action for Prenatal Care (CAPC) Program. This initiative seeks to engage pregnant, HIV positive women in early prenatal care. CAPC is closely coordinated with the Community Health Worker Programs in overlapping regions of New York City and Buffalo.
- The Community Health Worker Program is a premier enabling service. Specially trained individuals from the target communities and populations educate pregnant women and parents about health needs and instruct/role model the appropriate use of the health care system. They provide enhanced outreach services to engage families and individuals into the health care system and assist them to sustain relationships with appropriate providers.
- Of the pregnant women entering CHWP, 49% were already engaged in prenatal care. Of those women who were not, 87% were assisted to receive prenatal care within 1 month of entry to the program, and the remainder entered prenatal care more than one month after entry into the CHWP. Of the total number of pregnant women in CHWP, 75.7% entered prenatal care in the first trimester, 14.9% in second, 2.7% in third; 1.5% did not receive prenatal care and there are no data for 5.2% of the pregnant women in CHWP.
- The School Health Program provided pregnancy testing and reinforced the need for early prenatal care. Access is provided either on-site or through referral to back-up facilities. Nearly 2% of visits indicated pregnancy or contraception as a primary diagnosis.
- The Family Planning Programs make early referrals for women testing positive for pregnancy, thereby improving rates for early access to prenatal care in the populations served. Early entry into prenatal care continues to be a high priority. The Bureau of Women's Health conducted a statewide media campaign to increase awareness of the importance of early entry into prenatal care and increase awareness of where low-income women can go to obtain prenatal care. The number of calls for prenatal care to the statewide MCH hotline (Growing Up Healthy Hotline) increased during the campaign.

- The Safe Motherhood Initiative, collaboration between the American College of Obstetricians and Gynecologists (ACOG) and NYSDOH, recommended early entry into high-quality care to deter maternal mortality.

Current Activities – No major changes

Plan for the Coming Year – No major changes are planned.

- We will continue efforts through PCAP/MOMS, Outreach and Education projects, Community Action for Prenatal Care (CAPC) Project, school-based health center, and Comprehensive Prenatal/Perinatal Services Networks.
- Educational materials and media messages will continue to be available through the Bureau of Community Relations.

D. State Performance Measures

Please refer to Section X/Appendix B/ Form Number 107/ 11 for a master list of State Performance Measures. Form 4b. contains State Performance Measures from the Annual Report Year Summary Sheet and up to 10 major activities, by level of the pyramid.

Discussion of State Performance Measures will be in the format of: Last Year's Accomplishments, Current Activities and Plan for the Coming Year.

STATE PERFORMANCE MEASURE #01: The percent of live births that were unintended.

Last Year's Accomplishments

- The Family Planning Program implemented outreach for the Family Planning Benefits Program. This program provides family planning services to individuals under 200% of poverty who meet eligibility requirements. Eligibility does not depend on previous pregnancy or previous Medicaid status, and provides a full range of contraceptive services and reproductive health care. The outreach initiative includes a statewide satellite teleconference and training, a brochure, and production of a training video or DVD to allow providers to train new staff. In 2005, over 30,000 clients enrolled in the Family Planning Benefits Program.
- The Family Planning Program continued to provide access to reproductive health care through the Family Planning Extension Program. This program provides family planning benefits to eligible women for 24 months after a pregnancy ends. In 2005, 14,437 women received family planning services through the family Planning Extension Program.
- Family Planning Programs provided over 11,080 community education sessions, reaching approximately 105,462 individuals. In addition, to education, the program provided comprehensive reproductive health care, including screening for breast and cervical cancer, STD screening and treatment, and HIV counseling and testing.
- The Community Health Worker Program provided family planning information to all women of childbearing age and referred clients to family planning services.

They then follow-up to see that services were received.

- The Community-Based Adolescent Pregnancy Prevention Program's worked to reduce teen pregnancies in the highest risk zip codes across New York State. C-BAPPP promoted abstinence and the delay of sexual activity among teens; encouraged educational, recreational and vocational opportunities as alternatives to sexual activity; taught assertiveness skills; and promoted access to family planning and comprehensive reproductive health services.
- The School Health Program provided risk assessment for sexual activity as part of the initial assessment and anticipatory guidance is offered. Pregnancy testing is done, where indicated. Students have access to family planning services, either onsite or by referral. Students are also referred early for prenatal services; practitioners co-manage the student's prenatal care. School-based health centers provided services to approximately 34,000 female students ages 15-19.
- The Comprehensive Prenatal/Perinatal Services Networks implemented several activities related to decreasing pregnancies through provision of family planning information and education on the importance of inter-conceptional care. Some Networks have access schools to provide structured educational programs addressing reproductive health and pregnancy care. One Network developed a peer-mentoring program to encourage and model healthy behaviors in adolescents. Others have developed groups such as teen pregnancy coalitions to address local issues related to adolescent pregnancies. Some Networks are also the lead agencies for Community-Based Adolescent Pregnancy Prevention Programs.
- NYSDOH continued to fund 37 Abstinence Education and Promotion contractors to provide abstinence education, mentoring, counseling, and adult supervision to promote abstinence from sexual activity in 15- to 19-year-olds. Funding included a statewide, large-scale media campaign to support the community-based initiatives. BWH also participated in the Governor's Task Force on Unintended Pregnancy.
- Though PCAP will likely see people for the first time when already pregnant, an important component of PCAP is to provide family planning education and services, ensuring all enrolled postpartum women have identified a method of family planning the will utilize. The concept of spacing of pregnancies and provide family planning services and referrals may impact future pregnancies of teens in PCAP.
- A law requiring all hospitals to promptly provide information on emergency contraception (EC) to survivors of sexual assault, and provide EC if necessary, was implemented. An EC brochure was drafted and made available in seven languages. It is also available on the NYSDOH website. Hospitals and other sites are directly compensated for forensic exams.

Current Activities

- No major changes took place.

Plan for the Coming Year –

- No major changes are planned.

STATE PERFORMANCE MEASURE #02: The hospitalization rate for asthma for children ages one to 14.

Last Year's Accomplishments

- The Asthma Coordinator continued to play a pivotal role in coordinating asthma prevention and control efforts across the agency. Title V and the Asthma Coordinator are working with the Office of Medicaid Management, the Office of Managed Care, The Center for Environmental Health, the Division of Chronic Disease Prevention and Adult Health, the State Education Department, the New York City Department of Health (which has its own major asthma initiative), the Pediatric Pulmonary Center, the Public Health Information Group and Child Health Plus.
- Asthma hospitalization rates were updated. Rates have been generated by age, sex, race/ethnicity, and on the state, regional, county and zip code levels. This information is available on the HIN, the HPN and the public website.
- The public website includes information on asthma interventions, asthma care and asthma-related patient materials.
- The Occupational Lung Disease Registry now obtains information about work-related asthma.
- Medicaid fee-for-service and managed care data have been used to generate age- and county-specific rates. These data were also used to generate asthma-related costs.
- User-friendly asthma treatment guidelines were updated and distributed across the state with the help of an expert panel. The New York State Consensus Asthma Guideline Expert Panel finalized the Clinical Guideline for the Diagnosis, Evaluation, and Management of Adults and Children with Asthma 2005, which builds on the NAEPP/NIH guidelines. Endorsements were obtained from several groups across the spectrum of government, insurance plans, and professional societies.
- NYSDOH has been measuring asthma care through HEDIS since 1997. Rates of performance increased across all payers (commercial, Medicaid and Child Health Plus) and all age groups. Plans with sub-standard performance in this area are required to develop action plans for improvement.
- NYSDOH, with support from the Center for Health Care Strategies, engaged in a Learning Collaborative with thirteen Medicaid health plans over the past two years. The aim is to improve compliance with the asthma guidelines statewide.
- The NYSDOH continued to award funds to nine regional asthma coalitions across the State to improve the diagnosis, treatment and prevention of childhood asthma, and provide care coordination services to asthmatic children in an effort to reduce asthma-related morbidity and mortality.
- The School Asthma Management Pilot Program represents a school-based program to improve asthma care and management in the school setting. The program is a replication of the evidence-based program developed by St. John's Riverside Hospital in Yonkers. The three components of the program are: asthma education, clinical intervention and care coordination. This program has been shown to reduce asthma ER visits and days lost from school. The program has been translated and spread to over 365 schools by regional coalitions in collaboration with school districts.
- The National Association of School Nurses and the School Nurse Asthma Management Program in collaboration with NYSDOH and the regional coalitions were able to reach over 100 school nurses with this project to improve the health and learning potential of students with asthma.

- School-Based Health Centers developed for each affected student in coordination with primary care physician that includes all clinical and educational interventions. The state-funded school-based health centers have enhanced their asthma services with the Asthma Resource Kit (a kit that includes asthma supplies and resources such as spacers, nebulizers, peak flow meters, and asthma educational materials).
- Three New York City school-based health centers initiated Asthma Peer Leader Programs, which identifies and supports peer leaders in mentoring children with persistent asthma.
- The Healthy Neighborhoods Program provided in-home asthma, lead and safety assessment interventions programs in eight counties. Interventions included education on asthma triggers, dust and pest control measures, installing pillow and mattress covers, mold remediation and eliminating or restricting smoking from the housing units. An evaluation of the program from 1997 to 2000 suggests that these interventions reduced asthma hospitalizations and was cost-effective.
- An Occupational Lung Disease Toolkit was developed and distributed to 16,000 physicians and partners. It is also available on the public website.
- A statewide needs assessment was conducted to determine key messages and best practice materials on environmental and occupational asthma. The project identified that lack of communication disconnecting providers and patients is a major barrier to effectively treating asthma.
- The School Environment Assessment Project began in all public elementary schools.
- Child health promotion specialists provide technical assistance to child care providers and other child-serving organizations in the prevention and treatment of asthma.

Current Activities

- Continued to implement as above.

Plan for the Coming Year

- Continue to distribute Best Practice Manuals and provide training.
- Continue to provide asthma education, training and case management activities through Asthma Coalitions.
- Continue asthma as a topic for Child Health Promotion Specialist Training.
- Continue School-Based Health Center activities.
- No major changes are planned.

STATE PERFORMANCE MEASURE #03: The percent of students who reported they watched three or more hours of television per day on an average school day. (YRBS)

Last Year's Accomplishments -

- This is a new measure as of this year. The measure replaces a State Performance Measure on overweight WIC children which became a National Performance Measure. This measure was selected due to the relationship between television watching and overweight in teens.

Current Activities –

- This measure will be tracked through the Youth Risk Behavior Survey.
- See National Performance Measure 16.

- Currently, the Department has a number of initiatives that address improving physical activity.
  - The Coordinated School Health Team worked to support School Health Index Incentive Program. After completing the index schools formulate plans to address their deficiencies. Over 300 schools participated. $1M was distributed.
  - Active 8 Kids RFA has been released and communities are writing their applications for funding.
  - "Steps to a Healthier New York" is in four counties in NYS. This is an approach to working with entire communities. Each site must have a school coordinator to pull the community activities into the school.
  - The School Nutrition and Physical Activity Tool kit was distributed to all schools. The electronic version is on the public website.
  - Twenty-four (24) school districts are participating in the Healthy Schools Leadership Institute, which promotes and supports good nutrition and physical activity in schools.
  - FitWIC trainers (about 20 NYSDOH staff, mainly from the WIC Program) conducted and coordinated FitWIC sessions at the 2005 and 2006 annual WIC Association conferences.
  - Healthy Children New York is working with child care providers to identify space for physical activity and to improve nutrition.
  - Pre- and Post-surveys were completed for the BMI-for-age project.
- New York has laws mandating physical education in schools and that all students complete a mandated, semester-long course in health.

Plan for the Coming Year –
- No major changes are planned.
- The Provider/BMI-for-age activities will broaden to include additional obesity prevention and treatment strategies for primary care providers.

STATE PERFORMANCE MEASURE #04: The teenage pregnancy rate for girls ages 15 - 17

Last Year's Accomplishments
- MCHSBG funds support 59 local Family Planning Programs. These programs serve low-income, uninsured women, or approximately one third of those estimated in need, and approximately one third of which were under the age of 20. The program strives to ensure that each pregnancy is intended. Family Planning Programs provided community education and public information services, comprehensive medical exams, a full range of contraceptive services, and special counseling to teens.
- Community-Based Adolescent Pregnancy Prevention Program maintain a roster of about 300 peer counselors in 54 high risk zip codes to effectively counsel their peers, dispel common myths about sexuality, encourage discussions about abstinence and responsible sexual behavior, and provide accurate information about how and where to obtain primary and preventive health services. C-BAPPP worked with schools and parents to increase communication skills and sexual literacy.
- 37 Abstinence Education and Promotion contractors provide abstinence education,

mentoring, counseling, and adult supervision to promote abstinence from sexual activity in 15- to 19-year-olds. In this first year, programs were established and services begun. The initiatives initially focused on junior high/middle school aged students and those groups at highest risk for bearing children out-of-wedlock. Funding includes a statewide, large-scale media campaign to support the community-based initiatives. The "Not Me, Not Now" campaign was purchased from Monroe County and viewed an average of 23 times by 86.28% of all teens in the State in ten major markets.

- The Networks implement several activities related to decreasing adolescent pregnancies through provision of family planning information and education on the importance of intra-conceptional care. Some Networks have accessed schools to provide structured educational programs addressing reproductive health and pregnancy care. One Network has a peer mentoring program to encourage and model healthy behaviors in adolescents. Others have developed groups such as teen pregnancy coalitions to address local issues related to adolescent pregnancies. Some are lead agencies for the Adolescent Pregnancy Prevention Program.
- The Comprehensive Prenatal/Perinatal Services Networks provided conferences on adolescent pregnancy prevention for their communities. Each Network takes a localized approach to the issue.
- The School Health Program provided risk assessment on enrollment, consultation, anticipatory guidance, family planning services (either directly or by referral), pregnancy testing, prenatal care (either directly, by co-managing care, or by referral, and follow-up consultation and education).
- The Community Health Worker Program educated women of childbearing age regarding family planning, referred to family planning services and followed up to determine whether appointments are kept and services are received.
- The "Growing Up Healthy" Hotline links women (including adolescents) with prenatal, nutrition, family planning, psychosocial and supportive services, which contributed to healthy pregnancies and improved birth weights.
- Teens may be eligible for PCAP/MOMS.
- ACT for Youth utilizes an assets-based approach to reduce risk-taking behavior among youth.
- The Department continued to work with other agencies, including the Office of Children and Family Services and the State Education Department.
- The 76 Rape Crisis Centers work to reduce the incidence of rape and sexual assault, as well as to ensure effective, compassionate treatment of victims to reduce debilitating consequences once an assault has occurred.
- Please refer to materials presented under State Performance Measure 01 on unintended pregnancy.
- The ***"Not Me, Not Now"*** Campaign aired statewide in all larger media markets and at times when teenagers are likely to see the ads. Promotional materials are available free of charge through out communications outlet.

Current Activities – No major changes

Plan for the Coming Year – No major changes are planned

STATE PERFORMANCE MEASURE #05: The percent of women who, who after giving birth, felt down, depressed or hopeless always or often.

Last Year's Accomplishments – This is a new performance measure. This measure replaces a State Performance Measure on smoking during pregnancy, which became a National Performance Measure this year. This measure has been tracked using PRAMS. This measure was selected based on the implications of maternal depression on health of the mother, parenting styles, family functioning and child outcome.

Current Activities –

- NYSDOH worked closely with the NYS Office of Mental Health and Postpartum Support International of New York to develop a successful media campaign on post-partum depression. The campaign included television and radio spots, bus sides and bus/subway posters, and provider fact sheets. This was originally piloted in one region and later materials were made available statewide.
- Media Kits, complete with fill-in-the-blanks press releases, were made available to all Networks and local health departments.
- Materials were made available to all Comprehensive Prenatal/Perinatal Services Networks, Healthy Starts, Prenatal Care Assistance Programs/MOMS and other providers.
- The Bureau of Women's Health receives multiple requests for materials from other states. Staff recently spoke at a meeting of Postpartum Support International in New Jersey.
- Materials are being prepared for posting on the website. Providers will be able to add local contact information for services in their area.
- The Growing Up Healthy Hotline was prepared to take calls on postpartum depression and refer callers to services as a section on postpartum depression was added to their resource directory. In 2005, 0.1% or 61 calls were related to postpartum depression.
- Comprehensive Prenatal/Perinatal Networks conducted professional education sessions, including co-hosting conferences and grand rounds, and provided in-services to Prenatal Care Assistance Program providers, the Community Health Worker and the Health Family New York programs. They have also conducted consumer education, developed support groups for women with post partum depression, and developed materials that promote awareness of and provide information on dealing with perinatal depression.
- NYSDOH staff continue to work with the Office of Mental Health and various stakeholders to plan future activities. Office of Mental Health is preparing a consumer education piece and are in the process of formulating medication guidelines.

Plan for the Coming Year –

- Funding for the media campaign has been renewed through August 2006. Additional funding will be sought.
- Office of Mental Health will release consumer education materials and medication guidelines.
- **Networks** will use materials developed to increase recognition of perinatal depression and ensure women affected by this condition are identified and referred for the appropriate level of services.

STATE PERFORMANCE MEASURE #06: The percent of infants who are put down on their backs to sleep

Last Year's Accomplishments

- Again, there was a decline in the number of SIDS deaths through a comprehensive statewide education about risk factors associated with SIDS through the Back to Sleep Campaign.
- The Department continued to implement the "Back to Sleep" first kicked off by First Lady Libby Pataki in 1999. The Department produced T-shirts imprinted on the front and back with, *"Put me on my back to sleep."* These T-shirts and a flyer on SIDS prevention were distributed thorough all hospitals in the State. SIDS Prevention Information Cards (the same cards that were made available with the T-shirt) are available through our health publications catalog and on the public website.
- SIDS Prevention Posters were developed after staff learned of the lack of awareness of the "Back to Sleep" message in the child care community. We continue to distribute posters to childcare providers in the state as a reminder to place babies on their backs to sleep. Other SIDS prevention messages were included, too.
- Statewide training efforts continue. Police, fire fighters, emergency medical personnel and public health nurses are educated on appropriate responses to SIDS. The Department oversees notification of infant deaths by funeral directors, coroners and medical examiners. The Center for Sudden Infant Death at SUNY Stony Brook and its satellites provide training and family support services. For families that have experienced any infant death in the last year, they provide a 1-800 "warm line" for support, information and referral to self-help groups and other mental health services. The Center also arranges a home visit by a public health nurse. Newsletters are sent on a regular basis, and are a very popular item. The Center also released health education materials about the dangers of placing infants to sleep in adult beds.
- A special SIDS prevention project was initiated among the St. Regis Mohawks.
- In May 2002, a new State law was passed amending the autopsy provisions of the Public Health Law and requiring standardized protocols for the performance of autopsies in cases of sudden, unanticipated death in infants under the age of one year. Protocols were developed. This law is now fully implemented.
- BCAH and DFH staff worked with Office of Children and Family Services Staff on new materials for inclusion in ***Welcome to Parenthood*** concerning back-to-sleep and overlaying dangers.

Current Activities

- No major changes were made.

Plan for the Coming Year – No major changes are planned.

STATE PERFORMANCE MEASURE #07: The rate of hospitalizations for self-inflicted injuries for 15- to 19-year olds.

Last Year's Accomplishments

- *See National Performance Measure 16.* This measure was selected because rates of suicide attempts are higher than rates of completion would indicate.
- All School-Based Health Centers provided psychosocial assessment beginning with the initial visit. Students and families were offered individualized education regarding safety issues and abuse, and mental health services were made available, where indicated. Potential abuse and neglect cases were reported. Staff follow-up on all referrals and behavioral issues.
- Out of 125 school-based health center sites in New York City, 90 (72%) provide onsite mental health services and 35 provide mental health services through referral. In the rest of the state, there are 60 additional school-based health centers, 53 (88%) of which provide onsite mental health services and 7 of which provide services through referral. Over 202,000 students have access to mental health services through school-based health centers.
- Through community collaborations, the ACT for Youth Initiative has developed:
    - Youth forums on violence, abuse and risky sexual behaviors;
    - Peer education for violence prevention;
    - Conflict resolution training to train peer mediators; and
    - Mentoring programs.
- The Community-Based Adolescent Pregnancy Prevention Program employs a youth development/youth empowerment approach.
- Emergency Medical Services for Children improved pre-hospital care for children and youth.
- The Maternal and Child Health Services Advisory Council have arranged for a variety of speakers on the issue of inclusion of mental health concepts in primary care. The result is that several promising practices have been explored.

Current Activities

- Bureau of Child and Adolescent Health is currently working with the Office of Mental Health and other partners to identify key elements of a statewide suicide prevention plan.
- School-Based Health Centers continue to assess students for suicide risk, and are implementing enhanced mental health services.
- Youth development continues to be a focus of all youth-focused activities.
- The Advisory Council continued to explore promising practices for the incorporation of mental health concepts in primary care. Most recent, the Council hosted speakers from Mary Imogene Bassett Hospital and Johns Hopkins University who presented their project on improving communication skills for primary care providers. This model appears to improve patient outcomes while making effective use of limited practitioner time.

Plan for the Coming Year

- No major changes planned.

STATE PERFORMANCE MEASURE #08: The percent of high school students who had at least five or more drinks of alcohol in a row at least once in the last month

Please Note: In previous years, the indicator tracked those that reported drinking alcohol at least once in the last month.

Last Year's Accomplishments

- DOH/Title V staff continued to collaborate with our state Office of Alcoholism and Substance Abuse Services (OASAS) on substance abuse and alcohol-related prevention policy. Beginning in 1999, OASAS involved multiple human service agencies at the county level in identifying alcohol and substance abuse risk and protective factors, and in strengthening and expanding local partnerships for alcohol and substance abuse prevention. Fifteen (15) counties were funded for three years to develop and implement countywide, prevention- and results-focused work plans. These work plans identify, re-direct, and leverage state and local resources for a comprehensive, multi-system approach to alcohol and substance abuse prevention at the local level.
- OASAS implemented a new statewide prevention campaign entitled, "Underage Drinking: Not a Minor Problem." Title V programs promoted the campaign to health care providers.
- The focus of ACT for Youth, (Assets Coming Together for Youth) is to empower youth and to prevent abuse, violence and risky sexual activities, all of which are associated with low self-esteem; poor decision making related to sexual behavior, alcohol and substance use and abuse; poor nutrition and eating disorders. Community Development Partnerships target the most vulnerable populations (substance abusing/using, those in foster care and group homes, homeless and runaway, orphaned, out-of-school, incarcerated, HIV affected/ infected, migrant, parenting, with disabilities, with different sexual preferences, in special education programs, and Black/African American, Hispanic/Latino, Asian/Pacific Islander and Native American).
- Over half of the Lesbian, Gay, Bi-Sexual, Trans-gendered Health Initiative contractors targeted issues related to alcohol, substance abuse and self-inflicted injury.
- PCAP/MOMS clients are assessed for alcohol and substance abuse issues; referrals are made accordingly.
- The initial assessment in school-based health centers includes questions about tobacco and alcohol use. Students are counseled and educated accordingly. Referral is available.

Current Activities

- No major changes.
- All Title V related programs continue focus on youth empowerment/ youth development.

Plan for the Coming Year

- All Title V related programs will continue to employ a youth empowerment/ youth development focus.

STATE PERFORMANCE MEASURE #09: The percent of high school students who smoked cigarettes in the last month

Last Year's Accomplishments

- These data are tracked via the Youth Risk Behavior Survey (YRBS).
- New York has one of the highest tobacco excise taxes in the nation. Raising the price of cigarettes discourages smoking.
- Enforcement of a tough indoor air law continued, banning smoking in public places, including restaurants and bars.
- The Tobacco Control Program continued to identify youth to become active in unannounced compliance checks on retail sales of tobacco to minors. (New York State provided funds to this enforcement effort so that every retail outlet would receive an unannounced compliance check.) New York state law requires that all tobacco products be kept behind the counter.
- The Tobacco Control Program continued to fund Youth Partnerships for Health (YPH) to help youth resist peer pressure and become involved in social and community anti-tobacco activities. These partnerships "de-normalize" the use of tobacco and counteract the heavy advertising to youth by tobacco companies.
- The State also funds local Tobacco Control Coalitions in every county of the state to mobilize communities in counter-advertising activities such as banning billboards that promote tobacco near schools and playgrounds.
- The Tobacco Control Program has also assisted communities to pass local ordinances on smoking in public places, to remove tobacco products from the reach of youth, and to reduce tobacco advertising in areas frequented by youth.
- The Tobacco Control Program began in 2001 planning for inclusion of tobacco education in School-Based Health Centers. Several centers are now funded to provide tobacco education and cessation.
- The initial assessment in school-based health centers includes questions about tobacco and alcohol use. Students are counseled and educated accordingly. Referral for smoking cessation is available. The Program also funded 19 Tobacco Cessation Centers.
- PCAP, MOMS and the Community Health Worker Program assess prenatal clients for tobacco use and refer to or provide smoking cessation and other counseling/health teaching.
- Comprehensive Prenatal/Perinatal Services Networks create awareness of the dangers of smoking, particularly in pregnancy.
- The Tobacco Control Program maintained youth empowerment "Reality Check" contracts
- The Tobacco Program participated in the Oral Health Coalition and formulation of the Oral Health Plan.
- New York makes smoking cessation assistance available through a toll-free hotline and purchase of smoking cessation products is available through Medicaid.

Current Activities - No major changes.

Plan for the Coming Year

- Title V will continue to collaborate with Division of Chronic Disease Prevention and Adult Health, who is the DOH lead for smoking related public health programming. More funding was obtained for tobacco use prevention.

STATE PERFORMANCE MEASURE #10: The percent of children in the birth year cohort who were screened for high blood lead before the age of two

Last Year's Accomplishments

- The Childhood Lead Poisoning Prevention Program coordinates efforts to prevent, detect and treat childhood lead poisoning; educates the public and health professionals about prevention, early detection and appropriate medical management of childhood lead poisoning; ensures that families of children with lead poisoning are given appropriate advice and assistance in locating and eliminating sources of lead within the child's environment; provides lead-safe interim housing while lead hazards are being removed; and collects and analyzes statewide data on the extent and severity of childhood lead poisoning.
- In New York, lead testing is done primarily by the child's medical provider. State and local health department employees conducting PBII (Physician Based Immunization Initiative) visits monitor for lead screening when they check records for immunization compliance. Providers are given feedback on missed opportunities for both lead testing and immunization administration.
- The Childhood Lead Poisoning Prevention Program has contracts with 57 local health departments and New York City to provide prevention programs and provide care coordination.
- Additional funding to the Childhood Lead Poisoning Prevention Program was used to assist local health departments with targeting high incidence areas, improve laboratory reporting, perform a Medicaid match of cases, produce an annual report, increase primary prevention efforts, perform community outreach and working through the Division of Housing and Community Renewal to improve information sharing between local health departments and housing agencies.
- Seven teaching hospitals serve as Regional Lead Resource Centers.
- Local health departments and State Health Department District Offices provide environmental assessments and lead hazard control services.
- Because NYS has more pre-1950's housing than any other state, New York has a universal screening policy. Health care providers are required to screen children for high blood lead at ages 1 and 2.
- Wadsworth Center operates a public health lead screening laboratory where blood from children throughout the state is tested for lead levels.
- New York has regulations concerning prenatal screening for lead.
- Examination of the percentage of children born between 1994 and 1999 who received a blood lead screening test by 24 months of age shows New York's screening rates have remained steady at approximately 63%. An additional 25% of children are screened beyond age two for an overall total screening rate of 88%. In 2000, 76% percent of children enrolled in Medicaid Managed Care plans were screened for blood lead levels by 24 months of age. These reflect improvements. Strong media campaigns endeavor to raise rates of lead screening.
- Promoting an understanding of the need for lead screening and the importance of primary health care is a priority of the Community Health Worker Program. The CHWP will continue to strive to improve the percent of children who receive lead screening.
- WIC and PCAP continue to stress the need for preventive services for infants, including lead screening.
- Lead screening was provided to the 1800 children attending migrant day care.
- Healthy Children New York, provided the infrastructure for reaching the day care

centers and family day care providers statewide. Mailings and teleconferences educate providers as to the need for a lead screening certificate to attend child care. Children without the required certificate are referred to an appropriate provider. Child health consultants assist child care providers to document & thereby increase verified rates of immunization and lead testing.

- The Healthy Children New York increased the number of child health consultants who assist child care providers in tracking lead screening.
- Local health department programs actively link lead poisoned children with special health care needs to the appropriate services, if available in the communities. In most cases, a lead poisoned case is automatically given a developmental screening and/or referred to local Early Intervention (EI) program to ensure care coordination
- The Childhood Lead Poisoning Prevention Program was recently re-funded by the CDC at reduced funding.

Current Activities

- NYS continued to implement a plan to Eliminate Childhood Lead Poisoning by 2010, consistent with federal requirements. Improving screening rates is one focus of the Plan. Examination of the percentage of children born between 1994 and 1999 who received a blood lead screening test by 24 months of age shows New York's screening rates have remained steady at approximately 63%. An additional 25% of children are screened beyond age two for an overall total screening rate of 88%. In the year 2003, 79% percent of children enrolled in Medicaid Managed Care plans were screened for blood lead levels by 24 months of age. These reflect improvements. Program and partners try to increase screening using strong media campaign.
- In March 2006, a roundtable discussion was held with local health departments focusing on improving screening rates, expanding primary prevention, and increased use of local Commissioner authority to designate areas at high risk. A goal of the meeting was to align local lead plans with the statewide plan for lead elimination.
- In June 2006, a two-day meeting with local health departments discussed current clinical information, prenatal lead exposure, non-lead paint hazards, EPA child health enforcement initiative, EPA lead paint regulations, an overview of HUD, coalition-building, strategies for outreach to medical providers, effective presentation skills, and program evaluation strategies.
- The five existing lead coalitions met in Syracuse in June 2006 to discuss their grant projects and lessons learned.
- Commissioner Novello wrote to all local health departments to reinforce the need for universal screening and increased screening compliance at the local level.
- The program transitioned from a PC-based data system to LeadWeb, an electronic, relational database to collect, compile and share blood lead and case management data, including environmental inspections, remediation and clearance data.
- Child health consultants provide technical assistance to child care providers.
- Community Health Workers and Healthy Neighborhoods Workers continue to educate parents in high-risk areas about the need for lead screening and follow-through on high lead results.
- Wadsworth Center operates a public health lead-screening laboratory where blood

- lead specimens are tested.

Plan for the Coming Year

- Full development of the LeadWeb data system is expected to be completed.
- Development and release of expanded data.
- Continue with implementation of statewide Lead Elimination Plan.
- Release of an RFA to announce the availability of funds to qualified organizations to establish and/or maintain a network of regional childhood lead poisoning prevention services.
- Development and dissemination of additional educational materials and clinical tools for health care providers.
- No major changes.

E. Health Status Indicators

New York updates its full needs assessment, including Health Status Indicators, annually. Annual updates are needed to track trends in resident health status and to assist in program planning, monitoring and evaluation. Please see **Section II Needs Assessment** for trend graphs and health status indicators for various Maternal and Child Health Population Groups. Please refer to forms 20 and 21 for annual reporting of Health Status Indicators.

F. Other Program Activities

ACCOMPLISHMENTS RELATED TO STRENGTHENING HEALTH SYSTEMS CAPACITY – UNRELATED TO SPECIFIC PERFORMANCE MEASURES
Last Year's Accomplishments

- **Vital Records** processed over 90,000 birth records; 50,000 death records; 35,000 marriage records; 15,000 divorces; 15,000 research records; and 22,000 genealogy-related requests.
- Wadsworth Center provides public health laboratory facilities to the residents of New York State including, but not limited to, laboratories for testing water purity, for identifying lead levels and strains of microorganism (anthrax, botulism, rabies, E. coli, and other bacterial and viral organisms), for diagnosis of sexually transmitted diseases, for review of cytologic specimens, including pap smear review, for an anatomic pathology analysis, for cytogenetic identification of prenatal and clinical abnormalities, and for identification of reproductive and metabolic disorders. Wadsworth Center operates state-of-the-art clinical laboratory and environmental laboratory evaluation programs to ensure that laboratories offering tests to NYS residents meet appropriate quality requirements and can pass proficiency tests. Wadsworth Center performs basic scientific research to ensure that technologic advances and scientific knowledge have application in public health. Wadsworth Center maintains appropriate laboratory capacity in the event of an epidemic or terrorist attack.
- **SSDI** provides support to the CSHCN program and assisted in the development of the CSHCN data system. The CSHCN data system will be online in Fall of 2007.
- **SSDI** issued and made an award under an RFA for Title V Consumer Focus Groups. A total of 11 groups were completed in this program year.
- The **Genetics Centers** provided educational opportunities to medical students

- (approximately 200 programs), practicing health professionals (about 300 programs), people with a diagnosed genetic condition (about 80) and the general public (about 175).
- The **Genetics Program** works closely with March of Dimes to produce educational materials for populations with an interest in genetics or with a genetic condition.
- Because the **Growing Up Healthy Hotline** operates 24/7 and utilizes various languages, anyone throughout the state is able to connect to the Hotline for information at any time.
- In 2005, the **hotline** responded to 60,953 calls, in the following areas: adult insurance 0.2%, Child Health Plus 4.2%, child/adult care food program 0.2%, early intervention 2.2%, educational materials 0.6%, Family Health Plus 1.9%, family planning 2.1%, farmer's market 6.2%, food and nutrition program 0.4%, health department 1.2%, immunizations 0.3%, Medicaid for adults 4.0%, Medicaid for children 1.0%, newborn screening 0.5%, pregnancy care 11.2%,postpartum depression 0.1%, social services 0.6%, summer food program 4.6%, WIC 54.1%, WIC complaints 1.2%, other 2.3%. More WIC information was added in 2005. Information about perinatal depression was added to the resource directory during the year. Although there is no way to connect the calls with an increase of services and better outcomes, it is anticipated that having a 24-hour service to provide this information will ultimately result in better outcomes. The Association for the Blind and Visually Impaired has been identified for a role in emergency preparedness and bioterrorism. Part of the national crisis network, ABVI has a built-in capacity to "staff up" very quickly in the event of emergency.
- The **New York State Preventive Medicine Residency Program** provided academic and/or practicum training to seven physicians, including three with strong interests in MCH. Residents contributed to a wide variety of initiatives in maternal and child projects.
- The **Fluoride Supplementation Program** provided educational training on early childhood oral health issues to day care centers, Head Start centers and professional educators. Supplemental fluoride is distributed across the state to school and Head Start centers in non-fluoridated area. Children participate with the consent of their parents.
- The **Dental Public Health Residency Program** graduated three residents from its statewide program. The Program continued its accreditation status and proceeds to collaborate with the other four dental residency programs in New York State.
- The **Rape Crisis Program** continued to implement the DOH Hospital-Based Sexual Assault Forensic Examiner Program. Nineteen hospitals were approved by DOH as designated centers in 2005. Thirty-four SAFE examiners were approved in 2005. Mini-grants were made available to hospitals applying for SAFE designation in 2005. As a result, 17 additional hospitals applied for designation.
- Two pieces of legislation were implemented to assist survivors of sexual assault and those who provide services for them. The **Forensic Payment Act** allows hospitals to bill the Crime Victims Board directly for forensic examinations and other services provided to survivors. In addition, all hospitals are now required to provide information and access to EC, emergency contraception, to victims of sexual assault.
- In 2005, fifteen **Migrant and Seasonal Farmworker Health Program** contractors provided primary healthcare to more than 8,000 adults and 5,000 children, ages 18 and under. About 2,500 children and adults received dental care. The program completed over 13,800 screenings for blood pressure, vision, hearing, blood lead, HIV/AIDS, STDs and tuberculosis. They provided more than

- 9,900 educational encounters, over 16,400 translation encounters, 6,000 transportation encounters and 19,000 home visits.
- All of the state's obstetrical hospitals have received their final **perinatal designation**. Revised perinatal regionalization regulations were adopted September 2005. Bureau of Women's Health is working to assess the quality of care at the Regional Perinatal Centers (RPCs) and their affiliate hospitals.
- **Regional Perinatal Forums** are operational in all regions of the state. The Perinatal Networks have become co-leaders with Regional Perinatal Centers in the development and implementation of the Forums in their regional areas. The purpose of the Forums is to engage medical providers, community based organizations and other key stakeholders in identifying perinatal health problems and developing solutions, from a public health perspective, in a regional action plan. This process and these activities impact many of the measures identified above.
- The provision of **early intervention services** to eligible infants and toddlers took into account the specific needs of the family and the types of services required that would enhance the child's development. Services are based on the results of multidisciplinary evaluations, with the number of different types of services and frequency of services increasing as the number and severity of developmental delays increased. Services needed by the child and family that were outside of the Early Intervention Program were also identified and appropriate referrals made. All municipalities conducted outreach activities during the year to ensure that infants and toddlers suspected of having a developmental delay were referred to the **Early Intervention Program** in a timely manner from a variety of sources.
- **Congenital Malformations Registry** continues to employ a Health Provider Network (HPN) electronic reporting option. The Internet reporting option eases the burden on hospital staff and has improved the timeliness and accuracy of reporting to the registry.

ACTIVITIES RELATED TO STRENGTHENING HEALTH SYSTEMS CAPACITY – UNRELATED TO SPECIFIC PERFORMANCE MEASURES –
Current Activities

- The Department continues to work with New York City Vital Records to implement the Statewide Perinatal Data System (SPDS). It is imperative to develop a collaborative relationship, as New York City is a separate Vital Records district. Frequent conference calls and meetings have been initiated to identify issues and resolutions in order that SPDS can be used in NYC as well as the rest of the state.
- The Fluoride Supplement Program continued to expand in non-fluoridated areas across New York State serving children who are at high risk for oral health diseases. Program changes were initiated in order to comply with new day care licensing requirements for medication administration. The Program worked in collaboration with the Office of Children and Family Services, the agency that licenses child care, and the State Education Department, the agency that regulates schools and licensed professions in New York State.
- There are currently three dental public health residents in training.
- The Congenital Malformations Registry continues to promote and expand HPN Internet reporting to the CMR through conference calls and regional meetings

with hospital medical records and information technology staff, continue collaboration in the National Birth Defects Prevention Study to determine the etiologies of birth defects, continue population-based surveillance of Fetal Alcohol Syndrome (FAS) in a 9 county region of Western New York State, continue to send informational mailings to families of children reported to the Registry with special health care needs to inform them of the early intervention programs and support groups available statewide.

- The Preventive Medicine Residency Program (PMRP) successfully increased recruitment of minorities into the program. The PMRP is providing academic and practicum training to physicians, 3 of which have strong interests in maternal and child health (MCH). MCH-related projects include: analysis of the child health aspects of bioterrorism, development of guidelines for oral health care during pregnancy, study of prevention failures in mother-to-child HIV transmission, interventions to increase use of BMI measurements in pediatric practice, and participation in the Lactation Institute.
- Professional education programs on osteoporosis are provided throughout the state in an effort to communicate current, evidence-based information about osteoporosis prevention, diagnosis and treatment.
- Two (2) educational brochures were developed for **lead hazards and lead-safe work practices**. Educational materials that can be utilized to provide contactors with information on lead-safe work practices were also identified/developed.

Plans for Next Year

- Continuation of activities listed above.
- **SSDI** will work with programs within the Division of Family Health and NYSDOH to integrate results of recent focus groups.

ACTIVITIES RELATED TO OUTCOME MEASURE 01 to 05 – Infant Mortality Rate, Ratio Black Low Birth Weight to White Low Birth Weight, Neonatal Mortality Rate, Post-Neonatal Mortality Rate, Perinatal Mortality Rate

- The **Networks** increase awareness of the importance of **early and continuous prenatal care** through local outreach and education of professionals as well as consumers. Over the past year, the Networks have sponsored educational programs for providers as well as women of child bearing age and pregnant women to address areas such as pregnancy and substance abuse, smoking cessation, domestic violence, HIV/AIDS, cultural sensitivity, infant mortality and low birth weight. The Networks provide information and referral services to assist women to engage in prenatal care. All these efforts work to decrease infant mortality among high risk, hard to serve women. A number of the networks are also Healthy Start contractors.
- An important priority of the Networks is to identify issues with the **local perinatal service system**. All Networks work with a Consortium of perinatal health and human service providers and consumers to identify gaps and barriers to services and work collaboratively to improve the local perinatal service system. Although the Networks cover large geographic catchments areas, they target the highest risk areas, meaning areas with high rates of infant mortality, low birth weight infants, Medicaid-enrolled women or women and families potentially eligible for Medicaid, out-of-wedlock births, teen pregnancies and births, and those areas with high rates of late or no prenatal care. These women tend to be minorities, including Black

- women. Programs conducted by the Networks, such as education for providers in cultural awareness, as well as consumer education and outreach activities, are aimed at decreasing racial disparities in health care and health outcomes.
- All CHWP services are targeted to the **highest risk pregnant and parenting families** in the state.

  Family planning programs help to prevent unplanned pregnancies and births. As birth outcomes are significantly better for planned pregnancies, the reduction of unwanted or mistimed pregnancies leads to improved health of newborns and a reduction in infant mortality.
- The **Cytogenetics Laboratory** provides prenatal and postnatal cytogenetic analysis, identifying congenital abnormalities and enabling treatment.
- **Prenatal genetics counseling** and screening services can identify congenital defects in the fetus before birth, and enables the parents, physician, and birth facility better plan.
- While conditions in the **newborn screening panel** are not chosen for their incidence in any specific racial or ethnic population, some conditions are more common in one or another population. Sickle cell disease tends to be found more often in African, African-American, Mediterranean, Middle Eastern, South Asian or Southeast Asian populations. Cystic fibrosis is more prevalent in Caucasian populations. By identifying those children with sickle cell disease or cystic fibrosis and enrolling them into specialized care soon after birth, the ratio of Black IMR to White IMR may be altered. Identifying infants with inborn errors of metabolism in their first weeks of life enable them to receive vital medical services before their congenital condition causes mortality, irreversible disability or death.

  The presence of the **Prenatal Care and Assistance Program (PCAP)** throughout the state increases access to comprehensive prenatal care for high risk, hard to reach women. PCAPs also implement outreach strategies to engage these women into care. All PCAPs use a risk assessment tool and process to identify women at risk for poor outcomes and provide appropriate services to address any needs. For example, women can be referred for specialty services such as maternal fetal medicine or perinatal care if needed. All these should result in decreased infant mortality.
- The implementation of **perinatal regionalization** enhances perinatal outcomes in all areas. Having access to appropriate levels of care will improve maternal as well as neonatal outcomes. One of the outcomes likely to be affected will be the infant mortality rate, as a higher percentage of babies are born in hospitals with the appropriate level of services.
- Regional perinatal forums assess poor birth outcomes to determine quality improvement activities that may be necessary.

ACTIVITIES RELATED TO OUTCOME MEASURE 06 – Child Death Rate

- As stated previously, no data is collected on this specific variable, but an important role of the **Community Health Worker Program** is to ensure families are engaged in continuous health care and have appropriate supports and services to meet their needs.
- **Prenatal genetics** counseling and screening services can identify a genetic or other congenital defect in the fetus before birth. This enables the parents, physician, and birth facility to make available any necessary interventions before birth. Early intervention by clinical geneticists, dysmporphologists and genetic counselors once a child is born with a congenital condition, whether diagnosed before or after birth, can significantly improve the child's chances of living a healthy life.
- **Child care health consultants** and **Child Health Promotion Specialists** assist child care providers and other child-serving agencies in injury prevention, prevention of SIDS, and other issues that contribute to child morbidity & mortality. The goal of Healthy Child Care New York is to increase number of child care health consultants who will assist child care providers in preventing injuries and identifying child abuse & neglect.
- Plans for the **Injury Control Program** include: 1. Conduct ongoing surveillance of injuries, develop reports and disseminate statewide and nationally. 2. Continue development of pedestrian safety program for children. 3. Develop teen driving guide for parents. 4. Conduct statewide conference for child passenger safety. 5. Conduct regional training workshops focusing on the problem of injuries to adolescents 15-24 years and prevention strategies. 6. Conduct one-day training for Local Health Departments and their partners to identify problems and distribution of safety devices provided from MCHB funds.

ACTIVITIES RELATED TO NEWYORK'S STATE-SELECTED OUTCOME MEASURE - Maternal Mortality

- Onsite death reviews by ACOG have been concluded.
- Emphasis will be on providing education to clinicians on prevention of maternal mortality and protocols for management of major causes of maternal death.
- ACOG will work with Regional Perinatal Centers to institute the SMI Maternal Death Review Protocol within the Regional Perinatal Center and with their affiliate hospitals.

G. Technical Assistance Needs

New York participated in technical assistance workshops related to maternal and child health priority setting in Kansas City, Missouri, in June 2006.

This year, New York is requesting TA in the areas of genetics services and adolescent health.

Comprehensive Genetics providers are requesting assistance with financial sustainability issues. In addition, the specialty centers are requesting technical assistance to enable them to incorporate the medical home concept into their practices.

The state adolescent coordinators are requesting technical assistance regarding adolescent health, implementation of the National Initiative, capacity building, and updates on current adolescent health topics.

V. BUDGET NARRATIVE

A. Expenditures

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

Principles for Allocation: Also, please refer to the Principles for Allocation of Maternal and Child Health Services Block Grant Funds, page 15 of the Needs Assessment.

Due to ongoing allocation reviews and expenditure disbursement analyses, reallocations have resulted with efforts made to reduce the unobligated balance. Until the FFY 2005 application, carryover was noted in the "Unobligated Balance" column. *In reality, all funds were obligated, though not all spent at the time of submission.* NYSDOH was given guidance from HRSA that these funded should not be shown as unobligated. Therefore, starting with the FFY 2006 application, budgeted and expended amounts are shown on Form 3 within Line 1 only and are not displayed as unobligated balance. The total Federal allocation is committed to program services and will no longer be viewed as unobligated.

Concerted efforts are made to reduce the carryover balance by addressing areas of need as indicated in emerging public health issues for mothers and children. Program areas receiving increased fund allocations include: nutrition and physical activities in schools, oral health and pediatric overweight initiatives.

B. Budget

Maintenance of Effort: New York meets and exceeds the maintenance of effort requirements of Section 505 (a) (4). The New York State Department of Health plans continued Title V funding for the following efforts in FFY 2006:

- The Adolescent Health Initiative, including ACT for Youth and Youth Risk Behavior Surveillance;
- An Adolescent Health Coordinator;
- American Indian Health Program Community Health Workers;
- Asthma Coalitions;
- Children with Special Health Care Needs Program, including the Physically Handicapped Children's Program Diagnostic and Evaluation Program;
- Columbia Collaborative Projects;
- Community-Based Adolescent Pregnancy Prevention;
- Congenital Malformations Registry;
- Family Planning;
- The Genetics Program and Newborn Metabolic Screening;
- SUNY School of Public Health MCH Graduate Assistantship Program;
- Health Communications;
- Immunization activities;
- Infant and Child Mortality Review;
- Injury Prevention;
- The Lactation Institute;

- Lead Poisoning Prevention;
- Migrant and Seasonal Farmworker Health;
- Newborn Hearing and Metabolic Screening;
- Innovative Oral Health Initiatives;
- Osteoporosis Prevention;
- Parent and Consumer Focus Groups;
- Public Health Information/Community Assessment infrastructure;
- The Statewide Perinatal Data System;
- Preventive Dentistry Initiatives and the Dental Residency Program, including an expanded dental sealant program and a Task Force on Oral Health in Pregnancy;
- School-Based Health Centers and School Health Infrastructure;
- STD Screening and Education;
- Universal Newborn Hearing Screening;
- Vital Records; and
- Women and Disabilities.

The Monroe Consolidated Child and Family Health Grant will continue in FFY 2007. Under this initiative, seven grants are given to the county with an integrated work plan.

Methodology: Effort is made to match funding to the level of unmet need, and to address the four layers of the MCH pyramid and the three target populations. Because funded programs often take more than one structural approach to targeted needs and populations, program appropriations are proportioned out to reflect percentage of effort in infrastructure-building, population-based services, enabling services and direct health care services. Program appropriations also take into account the "30-30-10" requirements of Title V.

New York State uses a fair method to allocate Title V funds among individuals and areas identified as having unmet needs for maternal and child health services. The State uses its MCH funds for the purposes outlined in Title V, Section 505 of the Social Security Act. The MCHSBG Advisory Council assists the Department in determining program priorities and has been instrumental in seeking public input into the application process. The Council developed in 1984 a document entitled "Principles and Guidelines for the Use of Block Grant Funds," which was updated and affirmed each year. New York is using an Oracle-based system of gathering program information which more finely delineates sources of funds for the programs for only the second year.

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

- Appropriate cost centers, representing specific areas of activity related to MCH, are identified.
- Data for the appropriate fiscal periods are obtained from the Office of the State Comptroller (OSC).
- Data for selected cost centers are extracted on a quarterly basis.
- Quarterly data is compiled from relevant cost centers to reflect expenditures made during the federal fiscal year.
- All expenditure data represent payments made on a cash (vs. accrual) basis.
- Transactions associated with specific grants are identified and tracked through appropriation, segregation, encumbrance and reporting processes to permit proper and complete recording of the utilization of available funds.

- Identifying codes are assigned to record these transactions by object of expense within each cost center.

Any amount payable to the State under this title from allotments for this fiscal year which remain unobligated at the end of that year are carried forward and obligated in the following fiscal year. The Department and the Office of the State Comptroller (OSC) maintain budget documentation for Block Grant funding and expenditures consistent with Section 505(a) and Section 506(a)(1) for the purpose of maintaining an audit trail. The grant expenditures are recorded through standard OSC documents.

Reporting requirements and procedures for each particular grant are instituted to comply with conditions specified within each notice of grant award.

The state share in MCH services is considerable, more than meeting the requirements for state match. State appropriations dedicated to MCH include:

- AIDS Adolescent Research Network, Adolescent HIV Prevention, Pediatric and Maternal Initiative, Maternal and Child HIV, Ob/Gyn, Homeless and Run-Away Women and Children, HIV Services to Homeless and Run-Away Adolescents;
- Child Care;
- Early Intervention;
- Family Planning;
- Genetic Screening and Human Genetics;
- Health Care Reform Act Allocations;
- Immunization, Vaccine Distribution and State Aid for Immunization;
- Lead Control and Prevention, Lead Poisoning Prevention Local Assistance and Lead Interim Housing;
- Physically Handicapped Children's Treatment Program/Children with Special Health Care Needs Program;
- School-Based Health Centers;
- State Aid to Local Health Departments;
- SIDS and Infant Death; and
- Tobacco Settlement Dollars.

Federal sources of MCHSBG dollars other than the block grant included:

- Abstinence Education;
- Centers for Disease Control and Prevention (Lead, Immunization, Public Health Information Infrastructure; Oral Health Surveillance, Oral Health Systems);
- CISS grants;
- Early Intervention, Part C;
- Family Planning;
- Rape Crisis;
- STD/fertility;
- SPRANS Grants;
- SSDI Funds;
- TANF Funds;
- Early Childhood Comprehensive Systems planning grant; and
- Integrated Women's Health Initiative.

A regional analysis of Title V external contracts shows that about 65% of funds are contracted for the metropolitan New York City area, where most of the State's

population is located; about 16% goes to the Western New York area, our second most populous region; about 11 % goes to Central New York; and about 8% goes to the Northeastern and Capital District areas of the state. These breakdowns are fairly consistent with the proportion of New York's population residing in each of these areas.

The State more than meets **"30-30-10 Requirements"** for 30% allocation to primary and preventive care to children ($17,672,805 or 42.46%), for 30% for children with special health care needs ($14,357,933 or 34.5%) and under 10% for administration ($2,144,196 or 5.15%).

VI. REPORTING FORMS--GENERAL INFORMATION

Title V Block Grant Application
Forms (1-21)
State: NY
Application Year: 2007

- Form 1 - SF424
- Form 2 - MCH Budget Details
- Form 3 - State MCH Funding Profile
- Form 4 - Budget Details By Types of Individuals Served and Sources of Federal Funds
- Form 5 - State Title V Program Budget and Expenditures by Types of Services
- Form 6 - Number and Percentage of Newborn and Others Screened, Case Confirmed, and Treated
- Form 7 - Number of Individuals Served (Unduplicated) Under Title V
- Form 8 - Deliveries and Infants Served by Title V and Entitled to Benefits under Title XIX
- Form 9 - State MCH Toll-Free Telephone Line Data
- Form 10 - Title V Maternal and Child Health Services Block Grant State Profile for FY 2004
- Form 11 - National and State Performance Measures
- Form 12 - National and State Outcome Measures
- Form 13 - Characteristics Documenting Family Participation in Children with Special Health Care Needs
- Form 14 - List of MCH Priority Needs
- Form 15 - Technical Assistance (TA) Request and tracking
- Form 16 - State Performance/Outcome Measure Detail Sheets
- Form 17 - Health System Capacity Indicators (01 through 04,07,08) - Multi-year Data
- Form 18
  - Medicaid and Non-Medicaid comparison
  - Medicaid Eligibility Level (HSCI 06)
  - SCHIP Eligibility Level (HSCI 06)
- Form 19
  - General MCH Data Capacity (HSCI 09A)
  - Adolescent Tobacco Use Data Capacity (HSCI 09B)
- Form 20 - Health Status Indicators 01-05 - Multi-year Data
- Form 21
  - Population Demographics Data (HSI 06)
  - Live Birth Demographics Data (HSI 07)
  - Infant and Children Mortality Data (HSI 08)
  - Miscellaneous Demographics Data (HSI 09)
  - Geographic Living Area Demographic Data (HSI 10)
  - Poverty Level Demographic Data (HSI 11)
  - Poverty Level for Children Demographics Data (HSI 12)

OMB Approval No. 0348-0043

APPLICATION FOR FEDERAL ASSISTANCE

2. DATE SUBMITTED: 6/30/2006

APPLICANT IDENTIFIER

1. TYPE OF SUBMISSION:

Application: ☐ Construction ☑ Non-Construction

Pre-application: ☐ Construction ☑ Non-Construction

3. DATE RECEIVED BY STATE

STATE APPLICATION IDENTIFIER

4. DATE RECEIVED BY FEDERAL AGENCY

FEDERAL IDENTIFIER

5. APPLICANT INFORMATION

Legal Name:
New York State Department of Health

Organizational DUNS:
806781340

Organizational Unit:
Division of Family Health

Address (give city, county, state and zip code)
Room 890 Corning Tower
Empire State Plaza
Albany, NY 12237
County: **Albany**

Name and telephone number of the person to be contacted on matters involving this application (give area code)
Name: **Barbara L. McTague**
Email: **blm01@health.state.ny.us**
Tel Number: **518-473-7922**
Fax Number: **518-473-2015**

6. EMPLOYER IDENTIFICATION NUMBER (EIN):
1 4 6 0 1 3 2 0 0

7. TYPE OF APPLICANT: (Enter appropriate letter in box) A

A. State
B. County
C. Municiple
D. Township
E. Interstate
F. Intermuniciple
G. Special District
H. Independent School District
I. State Controlled Institution of Higher Learning
J. Private University
K. Indian Tribe
L. Individual
M. Profit Organization
N. Other (Specify)

8. TYPE OF APPLICATION:
☐ New ☑ Continuation ☐ Revision

If Revision, enter appropriate letter(s) in box(es) ☐ ☐
A. Increase Award B. Decrease Award C. Increase Duration
Decrease Duration Other (specify):

9 NAME OF FEDERAL AGENCY:
Health Resources and Services Administration, Maternal and Child Health Bureau

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:
9 3 9 9 4

TITLE: **Maternal and Child Health Services Block Grant**

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Maternal and Child Health Services Block Grant

AREAS AFFECTED BY PROJECT (cities, communities, ...es, etc.):
Statewide- NYS

13. PROPOSED PROJECT:

Start Date: **10/01/2006**

Ending Date: **09/30/2007**

14. CONGRESSIONAL DISTRICTS OF:

a. Applicant

b. Project

15. ESTIMATED FUNDING:

a. Federal	$ 41,621,706.00
b. Applicant	$ 0.00
c. State	$ 351,809,825.00
d. Local	$ 242,471,037.00
e. Other	$ 0.00
f. Program Income	$ 268,918,266.00
g. TOTAL	$ 904,820,834.00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. YES, THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON
DATE:

b. NO ☑ PROGRAM IS NOT COVERED BY E.O. 12372

☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT

☐ Yes. If "Yes", attach an explanation ☑ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY BY THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Typed Name of Authorized Representative
Barbara L. McTague

b. Title
Director, Division of Family Health

c. Telephone Number
518-473-7922

d. Signature of Authorized Representative

e. Date Signed

Previous Editions Not Usable

Standard Form 424 (REV. 4-88)
Prescribed by OMB A-102

FORM 2

MCH BUDGET DETAILS FOR FY 2007

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

STATE: NY

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

$ 41,621,706

A.Preventive and primary care for children:

$ 17,672,805 (42.46%)

B.Children with special health care needs:

$ 14,357,933 (34.5%)

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

C.Title V admininstrative costs:

$ 2,144,196 (5.15%)

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

2. UNOBLIGATED BALANCE (Item 15b of SF 424) $ 0

3. STATE MCH FUNDS (Item 15c of the SF 424) $ 351,809,825

4. LOCAL MCH FUNDS (Item 15d of SF 424) $ 242,471,037

5. OTHER FUNDS (Item 15e of SF 424) $ 0

6. PROGRAM INCOME (Item 15f of SF 424) $ 268,918,266

7. TOTAL STATE MATCH (Lines 3 through 6) $ 863,199,128
(Below is your State's FY 1989 Maintainence of Effort Amount)
$ 58,268,752

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL) $ 904,820,834
(Total lines 1 through 6. Same as line 15g of SF 424)

9. OTHER FEDERAL FUNDS
(Funds under the control of the person responsible for the administration of the Title V program)

a. SPRANS:	$ 0
b. SSDI:	$ 100,000
c. CISS:	$ 0
d. Abstinence Education:	$ 3,675,827
e. Healthy Start:	$ 0
f. EMSC:	$ 0
g. WIC:	$ 0
h. AIDS:	$ 0
i. CDC:	$ 2,380,573
j. Education:	$ 25,623,183
k. Other:	
Title X (Family Plan	$ 10,296,956
	$

10. OTHER FEDERAL FUNDS (SUBTOTAL of all Funds under item 9) $ 42,076,539

11. STATE MCH BUDGET TOTAL $ 946,897,373
(Partnership subtotal + Other Federal MCH Funds subtotal)

Form Notes for Form 2

None

Field Level Notes

None

FORM 3

STATE MCH FUNDING PROFILE

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

STATE: NY

	FY 2005		FY 2006		FY 2007	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
1. Federal Allocation *(Line1, Form 2)*	$ 44,048,128	$ 40,665,186	$ 43,450,702	$ 0	$ 41,621,706	$ 0
2. Unobligated Balance *(Line2, Form 2)*	$ 7,500,000	$ 3,043,124	$ 0	$ 0	$ 0	$ 0
3. State Funds *(Line3, Form 2)*	$ 378,564,700	$ 365,856,081	$ 388,295,930	$ 0	$ 351,809,825	$ 0
4. Local MCH Funds *(Line4, Form 2)*	$ 242,527,827	$ 261,412,884	$ 266,309,718	$ 0	$ 242,471,037	$ 0
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
6. Program Income *(Line6, Form 2)*	$ 274,010,452	$ 299,360,489	$ 299,431,541	$ 0	$ 268,918,266	$ 0
7. Subtotal *(Line8, Form 2)*	$ 946,651,107	$ 970,337,764	$ 997,487,891	$ 0	$ 904,820,834	$ 0
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 50,506,443	$ 41,885,193	$ 44,307,745	$ 0	$ 42,076,539	$ 0
9. Total *(Line11, Form 2)*	$ 997,157,550	$ 1,012,222,957	$ 1,041,795,636	$ 0	$ 946,897,373	$ 0
	(STATE MCH BUDGET TOTAL)					

FORM 3

STATE MCH FUNDING PROFILE

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

STATE: NY

	FY 2002		FY 2003		FY 2004	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
1. Federal Allocation *(Line1, Form 2)*	$ 41,936,322	$ 29,330,257	$ 42,848,561	$ 39,554,850	$ 42,726,728	$ 46,657,529
2. Unobligated Balance *(Line2, Form 2)*	$ 8,000,000	$ 6,040,000	$ 8,000,000	$ 5,000,000	$ 7,258,731	$ 0
3. State Funds *(Line3, Form 2)*	$ 266,321,880	$ 235,618,531	$ 319,537,400	$ 287,597,150	$ 329,643,258	$ 347,014,521
4. Local MCH Funds *(Line4, Form 2)*	$ 289,481,333	$ 289,928,776	$ 305,292,778	$ 257,108,298	$ 264,011,444	$ 266,309,718
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
6. Program Income *(Line6, Form 2)*	$ 288,738,900	$ 295,026,892	$ 285,739,300	$ 302,825,713	$ 330,962,153	$ 299,805,166
7. Subtotal *(Line8, Form 2)*	$ 894,478,435	$ 855,944,456	$ 961,418,039	$ 892,086,011	$ 974,602,314	$ 959,786,934
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 45,802,500	$ 0	$ 50,702,646	$ 45,632,381	$ 49,459,819	$ 46,438,687
9. Total *(Line11, Form 2)*	$ 940,280,935	$ 855,944,456	$ 1,012,120,685	$ 937,718,392	$ 1,024,062,133	$ 1,006,225,621
	(STATE MCH BUDGET TOTAL)					

Form Notes for Form 3

None

Field Level Notes

1. **Section Number:** Main
   Field Name: FedAllocExpended
   Row Name: Federal Allocation
   Column Name: Expended
   Year: 2005
   Field Note:
   Federal Title X grant award less than budgeted.

2. **Section Number:** Main
   Field Name: FedAllocExpended
   Row Name: Federal Allocation
   Column Name: Expended
   Year: 2004
   Field Note:
   Federal allocation expended exceeds amount budgeted due to use of rollover funds from previous grant year. Previously, obligated, unspent funds appeared in Unobligated. NYSDOH has been advised by HRSA that this amount should appear as Federal allocation expended.

3. **Section Number:** Main
   Field Name: UnobligatedBalanceExpended
   Row Name: Unobligated Balance
   Column Name: Expended
   Year: 2005
   Field Note:
   Previously, New York had included obligated, unspent funds under the category of Unobligated. NYSDOH was advised by HRSA that obligated funds were to appear as expended.

4. **Section Number:** Main
   Field Name: UnobligatedBalanceExpended
   Row Name: Unobligated Balance
   Column Name: Expended
   Year: 2004
   Field Note:
   Previously, obligated, unspent funds appeared in the Unobligated category. NYSDOH was advised by HRSA that obligated funds are to appear in the Federal allocation expended category, and not in the Unobligated line.

5. **Section Number:** Main
   Field Name: OtherFedFundsExpended
   Row Name: Other Federal Funds
   Column Name: Expended
   Year: 2005
   Field Note:
   Title X (Family Planning) grant award was $10,296,956

FORM 4

BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: NY

	FY 2005		FY 2006		FY 2007	
I. Federal-State MCH Block Grant Partnership	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
a. Pregnant Women	$ 51,497,820	$ 52,883,408	$ 53,904,738	$ 0	$ 48,860,325	$ 0
b. Infants < 1 year old	$ 198,607,402	$ 208,622,619	$ 173,879,542	$ 0	$ 185,488,271	$ 0
c. Children 1 to 22 years old	$ 52,633,802	$ 49,002,057	$ 139,787,098	$ 0	$ 54,289,250	$ 0
d. Children with Special Healthcare Needs	$ 556,441,521	$ 572,014,112	$ 547,371,892	$ 0	$ 531,129,829	$ 0
e. Others	$ 40,138,007	$ 39,298,680	$ 30,594,283	$ 0	$ 39,812,117	$ 0
f. Administration	$ 47,332,555	$ 48,516,888	$ 51,950,338	$ 0	$ 45,241,042	$ 0
g. SUBTOTAL	$ 946,651,107	$ 970,337,764	$ 997,487,891	$ 0	$ 904,820,834	$ 0

II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).			
a. SPRANS	$ 0	$ 0	$ 0
b. SSDI	$ 100,000	$ 100,000	$ 100,000
c. CISS	$ 0	$ 0	$ 0
d. Abstinence Education	$ 3,755,454	$ 3,614,500	$ 3,675,827
e. Healthy Start	$ 0	$ 0	$ 0
f. EMSC	$ 0	$ 0	$ 0
g. WIC	$ 0	$ 0	$ 0
IDS	$ 0	$ 0	$ 0
i. CDC	$ 1,150,161	$ 3,854,137	$ 2,380,573
j. Education	$ 26,175,777	$ 26,210,607	$ 25,623,183
k.Other			
Title X (Family Plan	$ 0	$ 0	$ 10,296,956
Family Planning	$ 19,325,051	$ 10,528,501	$ 0
III. SUBTOTAL	$ 50,506,443	$ 44,307,745	$ 42,076,539

FORM 4

BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: NY

	FY 2002		FY 2003		FY 2004	
I. Federal-State MCH Block Grant Partnership	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
a. Pregnant Women	$ 49,948,691	$ 46,600,749	$ 49,245,494	$ 48,172,645	$ 53,018,366	$ 53,487,003
b. Infants < 1 year old	$ 182,914,430	$ 186,185,438	$ 202,180,624	$ 187,338,062	$ 204,471,565	$ 181,024,586
c. Children 1 to 22 years old	$ 56,407,520	$ 41,777,061	$ 52,122,747	$ 49,956,817	$ 54,187,889	$ 75,873,541
d. Children with Special Healthcare Needs	$ 519,277,775	$ 503,847,857	$ 572,818,913	$ 524,546,574	$ 572,871,240	$ 560,329,600
e. Others	$ 41,206,097	$ 34,736,128	$ 36,979,359	$ 37,467,612	$ 41,323,138	$ 37,700,384
f. Administration	$ 44,723,922	$ 42,797,223	$ 48,070,902	$ 44,604,301	$ 48,730,116	$ 51,371,820
g. SUBTOTAL	$ 894,478,435	$ 855,944,456	$ 961,418,039	$ 892,086,011	$ 974,602,314	$ 959,786,934
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 141,851		$ 241,412		$ 0	
b. SSDI	$ 100,000		$ 81,601		$ 100,000	
c. CISS	$ 100,000		$ 100,000		$ 50,000	
d. Abstinence Education	$ 3,377,584		$ 3,377,584		$ 3,377,584	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 0		$ 0		$ 0	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 1,053,297		$ 800,000		$ 900,000	
j. Education	$ 22,320,520		$ 25,063,710		$ 25,063,710	
k.Other						
Family Planning	$ 18,709,248		$ 21,038,339		$ 19,793,525	
HRSA-Medical Home	$ 0		$ 0		$ 175,000	
III. SUBTOTAL	$ 45,802,500		$ 50,702,646		$ 49,459,819	

Form Notes for Form 4

None

Field Level Notes

1. **Section Number:** I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Expended
   Row Name: Infants <1 year old
   Column Name: Expended
   Year: 2004
   Field Note:
   Expenditures attributed to serving infants under the age of one were less in FFY 2004 than budgeted. Decreasing expenditures in this category are believed due to increases in Medicaid eligibility in this age group. The decreasing expenditures may also be due to Medicaid initiatives that extend coverage and that enroll newborns at birth through the electronic birth certificate process.

2. **Section Number:** I. Federal-State MCH Block Grant Partnership
   Field Name: Children_1_22Expended
   Row Name: Children 1 to 22 years old
   Column Name: Expended
   Year: 2004
   Field Note:
   Expenditures attributed to serving infants under the age of one were less in FFY 2004 than budgeted. Decreasing expenditures in this category are believed due to increases in Medicaid eligibility in this age group. The decreasing expenditures may also be due to Medicaid initiatives that extend coverage and that enroll newborns at birth through the electronic birth certificate process. Expenditures for the older age group may have increased because NYSDOH undertook a number of school- and preschool-based services. In addition, children 6 to 19 are eligible for MA at the 100% of poverty level, not at 133% as they previously had been.

FORM 5

STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: NY

TYPE OF SERVICE	FY 2005		FY 2006		FY 2007	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 628,765,665	$ 655,463,160	$ 635,696,049	$ 0	$ 587,681,132	$ 0
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 174,562,464	$ 176,116,304	$ 187,621,486	$ 0	$ 171,011,137	$ 0
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 67,590,889	$ 64,527,461	$ 102,671,574	$ 0	$ 70,123,615	$ 0
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 75,732,089	$ 74,230,839	$ 71,498,782	$ 0	$ 76,004,950	$ 0
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 946,651,107	$ 970,337,764	$ 997,487,891	$ 0	$ 904,820,834	$ 0

FORM 5

STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: NY

TYPE OF SERVICE	FY 2002		FY 2003		FY 2004	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 588,818,021	$ 578,648,754	$ 630,677,494	$ 592,345,111	$ 647,330,857	$ 604,784,768
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 164,732,405	$ 154,629,333	$ 180,032,990	$ 164,143,826	$ 179,716,667	$ 195,495,265
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 68,391,129	$ 57,170,684	$ 73,306,539	$ 63,338,106	$ 69,586,605	$ 87,802,134
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 72,536,880	$ 65,495,685	$ 77,401,016	$ 72,258,968	$ 77,968,185	$ 71,704,767
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 894,478,435	$ 855,944,456	$ 961,418,039	$ 892,086,011	$ 974,602,314	$ 959,786,934

Form Notes for Form 5

None

Field Level Notes

1. **Section Number:** Main
   Field Name: PopBasedExpended
   Row Name: Population-Based Services
   Column Name: Expended
   Year: 2004
   Field Note:
   NYSDOH has undertaken to shift services from the top of the MCH Pyramid to the base. Expenditures for direct medical services were reduced in FFY 2004 and shifted toward population-based services. Within given MCH programs, more attention is focused on program elements that are infrastructure-building, population-based, and enabling in nature. Data are taken from NYSDOH MCH Program Managers Survey reports.

FORM 6

NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED, AND TREATED

Sect. 506(a)(2)(B)(iii)

STATE: NY

al Births by Occurrence: 246,243

Reporting Year: 2005

Type of Screening Tests	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	%
Phenylketonuria	246,243	100	250	4	4	100
Congenital Hypothyroidism	246,243	100	4,539	219	219	100
Galactosemia	246,243	100	11	5	5	100
Sickle Cell Disease	246,243	100	231	234	234	100

Other Screening (Specify)

Screening Programs for Older Children & Women (Specify Tests by name)

(1) Use occurrent births as denominator.
(2) Report only those from resident births.
(3) Use number of confirmed cases as denominator.

Form Notes for Form 6

Sickle cell testing is diagnostic. Therefore, the number of presumed positives is equal to the number of true positives or confirmed case.

See attachment to section 4FC (Other Program Activities) for additional newborn screening for the time period Jan. 1 - Dec. 23, 2006.

Field Level Notes

1. **Section Number:** Main
   Field Name: SickleCellDisease_Presumptive
   Row Name: SickleCellDisease
   Column Name: Presumptive positive screens
   Year: 2007
   Field Note:
   Sickle Cell testing is diagnostic, therefore the number of presumptive positives are true positives or confirmed cases.

2. **Section Number:** Main
   Field Name: SickleCellDisease_Confirmed
   Row Name: SickleCellDisease
   Column Name: Confirmed Cases
   Year: 2007
   Field Note:
   Sickle cell testing is diagnostic, therefore the number of presumptive positves are true positives or confirmed cases.

FORM 7

NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V
(BY CLASS OF INDIVIDUALS AND PERCENT OF HEALTH COVERAGE)

[Sec. 506(a)(2)(A)(i-ii)]

STATE: NY

·rting Year: 2004

	TITLE V	PRIMARY SOURCES OF COVERAGE				
Types of Individuals Served	(A) Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private/Other %	(E) None %	(F) Unknown %
Pregnant Women	387,368	41.3				58.7
Infants < 1 year old	254,293	32.4		59.0	8.6	
Children 1 to 22 years old	5,743,127	32.4		59.0	8.6	
Children with Special Healthcare Needs	446,071	24.4	13.2	56.2	6.2	0.0
Others	486,792	28.6		57.2	14.2	
TOTAL	7,317,651					

Form Notes for Form 7

There is no way to de-duplicate data if clients are served in more than one category. For example, a woman served in the prenatal program might later in the year be served in the Family Planning program. In that case, she may have been counted under the "Pregnant Women" category and the "Other" category in the same year. Similarly, a child born during this year may have been counted in the "Infants < 1 year" category, and later served in the Children with Special Health Care Needs program and be counted in that category.

Field Level Notes

None

FORM 8

DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE XIX

(BY RACE AND ETHNICITY)

[SEC. 505(A)(2)(C-D)]

STATE: NY

orting Year: 2004

I. UNDUPLICATED COUNT BY RACE

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than one race reported	(H) Other and Unknown
DELIVERIES								
Total Deliveries in State	235,708	157,586	45,266	455	20,324			12,077
Title V Served	235,708	157,586	45,266	455	20,324			12,077
Eligible for Title XIX	98,089	53,252	28,192	196	9,708			6,741
INFANTS								
Total Infants in State	240,586	161,097	46,166	460	20,610			12,253
Title V Served	240,586	161,097	46,166	460	20,610			12,253
Eligible for Title XIX	99,360	53,867	28,685	198	9,787			6,823

II. UNDUPLICATED COUNT BY ETHNICITY

				HISPANIC OR LATINO (Sub-categories by country or area of origin)				
	(A) Total NOT Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(B.1) Mexican	(B.2) Cuban	(B.3) Puerto Rican	(B.4) Central and South American	(B.5) Other and Unknown
DELIVERIES								
Total Deliveries in State	180,427	55,281						55,281
Title V Served	180,427	55,281						55,281
Eligible for Title XIX	60,189	37,900						37,900
INFANTS								
Total Infants in State	184,539	56,047						56,047
Title V Served	184,539	56,047						56,047
Eligible for Title XIX	61,043	38,317						38,317

FORM NOTES FOR FORM 8

None

FIELD LEVEL NOTES

None

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: NY

	FY 2007	FY 2006	FY 2005	FY 2004	FY 2003
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 522-5006	(800) 522-5006	(800) 522-5006	(800) 522-5006	(800) 522-5006
2. State MCH Toll-Free "Hotline" Name	The Growing Up Healthy Hotliine	The Growing Up Healthy Hotline	The Growing Up Healthy Hotline	The Growing Up Healthy Hotline	The Growing Up Healthy Hotline
3. Name of Contact Person for State MCH "Hotline"	Rudy Lewis	Rudy Lewis	Rudy Lewis	Rudy Lewis	Lawrence Clark, Bureau (
4. Contact Person's Telephone Number	(518) 474-1911	(518) 474-1911	(518) 474-1911	(518) 474-1911	(518) 474-1911
5. Number of calls received on the State MCH "Hotline" this reporting period	0	0	60,953	59,191	68,079

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM (OPTIONAL)
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: NY

	FY 2007	FY 2006	FY 2005	FY 2004	FY 2003
1. State MCH Toll-Free "Hotline" Telephone Number					
2. State MCH Toll-Free "Hotline" Name					
3. Name of Contact Person for State MCH "Hotline"					
4. Contact Person's Telephone Number					
5. Number of calls received on the State MCH "Hotline" this reporting period	0	0	0	0	0

Form Notes for Form 9

None

Field Level Notes

None

FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE FOR FY 2007
[SEC. 506(A)(1)]
STATE: NY

. State MCH Administration:
(max 2500 characters)

The New York State Department of Health's Division of Family Health administers the Title V Maternal and Child Health Services Block Grant in New York State. The Title V program supports activities designed to improve the health status of women, particularly those of reproductive age, infants, children and adolescents, including those with special health care needs. Funds support public health infrastructure, population-based services, enabling services, and gap-filling direct medical services for those with limited access to high-quality health care. The Division of Family Health encompasses four bureaus and multiple programs. Bureaus include: The Bureau of Child and Adolescent Health, the Bureau of Dental Health, the Bureau of Women's Health, and the Bureau of Early Intervention. The Division also provides leadership and direction for State Systems Development Initiative (SSDI), the American Indian Health Program, the Asthma Coordinator, the MCH Graduate Assistantship Program, and the Migrant and Seasonal Farmworker Health Program.

Block Grant Funds	
2. Federal Allocation (Line 1, Form 2)	$ 41,621,706
3. Unobligated balance (Line 2, Form 2)	$ 0
4. State Funds (Line 3, Form 2)	$ 351,809,825
5. Local MCH Funds (Line 4, Form 2)	$ 242,471,037
6. Other Funds (Line 5, Form 2)	$ 0
7. Program Income (Line 6, Form 2)	$ 268,918,266
8. Total Federal-State Partnership (Line 8, Form 2)	$ 904,820,834

9. Most significant providers receiving MCH funds:

Article 28 Facilities/Hospitals/Diagnostic Centers
School-Based Health Centers
Family Planning Programs
Local Health Departments

10. Individuals served by the Title V Program (Col. A, Form 7)

a. Pregnant Women	387,368
b. Infants < 1 year old	254,293
c. Children 1 to 22 years old	5,743,127
d. CSHCN	446,071
e. Others	486,792

11. Statewide Initiatives and Partnerships:

a. Direct Medical Care and Enabling Services:
(max 2500 characters)

Pregnant women, mothers and infants: Genetics services, lead screening and follow-up, tracking of lead poisoned children, direct primary care services for enrolled tribal members residing on Indian nations, regional lead centers, primary care and dental services for migrant and seasonal farmworkers and their families, community health worker and public health nurse home visiting, early intervention services, the Prenatal Care Assistance/MOMS Program (PCAP/MOMS), immunization, hepatitis B immunization/tracking/follow-up, grief services for bereaved families following infant death. Children and Adolescents: Comprehensive school-based primary care centers, school-based dental services including sealant application, family planning, fluoride tablet/rinse/drops distribution programs in schools and preschools, lead screening and follow-up, services to Native American and migrant children. Children with Special Health Care Needs: Health information and referral, genetics services, follow-up on abnormal metabolic screening and hearing screening, medical rehabilitation services, dental rehabilitation services (medically-necessary orthodontia), Early Intervention services for children with identified handicapping conditions, diagnosis and evaluation through the Physically Handicapped Children's Program, care coordination. General: Translation and transportation, outreach and patient education.

b. Population-Based Services:
(max 2500 characters)

Pregnant Women, Mothers and Infants: Newborn metabolic screening and follow-up, universal newborn hearing screening, population-based health education campaigns, immunization services, lead screening services, lead poisoning prevention services, child find and Growing Up Healthy Hotline. Children and Adolescents: Injury prevention, immunization, nutrition and physical activity programs, adolescent pregnancy prevention programs, fluoridation, supplemental fluoride distribution in non-fluoridated areas, community-based adolescent pregnancy prevention, migrant health outreach and education. Children with Special Health Care Needs: Growing Up Healthy Hotline, early intervention services, child find, health information and referral, newborn metabolic screening follow-up, newborn hearing screening follow-up, genetics services outreach.

c. Infrastructure Building Services:
(max 2500 characters)

Resources are directed and building and maintaining a strong public health infrastructure that will support basic Maternal and Child Health public health functions and forms: surveillance, public health information, vital records, statewide perinatal data system, needs assessment, tracking, evaluation, quality improvement, certification of specialty centers, monitoring, policy development, standards and guidelines development, research, registries, workforce development/evaluation. Education related projects include: Preventive Medicine Residency, Dental Public Health Residency Program, Lactation Institute, School of Public Health MCH internships and graduate assistantships, and other student placements. Collaboration with multiple stakeholders and extra-agency partners is a cornerstone of our infrastructure. Centers for Excellence and Statewide Technical ^ssistance Centers assist NYSDOH to meet the development needs of multiple contractors.

12. The primary Title V Program contact person:

Name

13. The children with special health care needs (CSHCN) contact person:

Name

	Barbara L. McTague		Susan Slade, MS, RN
Title	Director, Division of Family Health	Title	Co-Director, Medical Home Unit
Address	Room 890, Corning Tower	Address	Room 208, Corning Tower
City	Albany	City	Albany
State	NY	State	NY
Zip	12237-0657	Zip	12237-0618
Phone	518-474-6968	Phone	518-474-2001
Fax	518-473-2015	Fax	518-473-8673
Email	BLM01@health.state.ny.us	Email	SJS11@health.state.ny.us
Web	www.nyhealth.gov	Web	www.nyhealth.gov

FORM NOTES FOR FORM 10

None

FIELD LEVEL NOTES

None

FORM 11
TRACKING PERFORMANCE MEASURES
[SECS 485 (2)(2)(B)(iii) AND 486 (A)(2)(A)(iii)]
STATE: NY

Form Level Notes for Form 11

NPM 2, 3, 4, 5, 6: There is only one data point available. These data are not available annually, which makes it very difficult to set realistic goals. Goals will be re-evaluated when additional data points become available. NPM 9: Please see additional data in the Needs Assessment document. In some groups, the HP 2010 goal has been achieved, but not with low-income children. NPM 11: This is similar to a State Negotiated Performance Measure used by NY for a number of years. Past submissions will show this under State Measures. NPM14: This measure is similar to a State Negotiated Performance Measure used by NY for a number of years. Past submissions will show this under State Measures. NPM 15: This measure is similar to a State Negotiated Performance Measure used by NY for a number of years. Past submissions will show this under State Measures. It is unknown if this is a one-time spike in the data or the beginning of an upward trend. These data will be re-examined in the next year.

PERFORMANCE MEASURE # 01

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

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective			100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	255,529	253,545	254,018	250,209	246,243
Denominator	255,529	253,545	254,018	250,259	246,243
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	100	100	100	100	100
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   2003 data are not available for this measure.

PERFORMANCE MEASURE # 02

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

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective			65	70	62
Annual Indicator		60.3	60.3	60.3	60.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	64	66	68	70	
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

2. **Section Number:** Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

   ection Number: Performance Measure #2
   ield Name: PM02
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

PERFORMANCE MEASURE # 03

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

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective			55	60	52
Annual Indicator		51.7	51.7	51.7	51.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	55	58	60	62	
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

2. **Section Number:** Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

3. **Section Number:** Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

PERFORMANCE MEASURE # 04

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

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective			60	65	70
Annual Indicator		59.1	59.1	59.1	59.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	68	70	72	74	74
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

2. **Section Number:** Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

   ection Number: Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

PERFORMANCE MEASURE # 05

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

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective			80	85	78
Annual Indicator		75.3	75.3	75.3	75.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	80	82	85	87	
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

2. **Section Number:** Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

3. **Section Number:** Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

PERFORMANCE MEASURE # 06

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

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective			10	20	7
Annual Indicator		5.8	5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	7	9	13	15	17
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

2. **Section Number:** Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

   ection Number: Performance Measure #6
   ield Name: PM06
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

PERFORMANCE MEASURE # 07

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

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	75	77	79	81	85
Annual Indicator	74.8	75.3	78.8	83.3	82.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	86	87	88	89	90
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data is from the National Immunization Survey. Numerator and Denominator data are not available. Data are for the time period 1/04-12/04 (the latest available).

2. **Section Number:** Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Data is from the National Immunization Survey. Numerator and Denominator data are not available. Data is for the time period 7/03-6/04.

3. **Section Number:** Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   Numerator and Denominator are not available for this measure (survey data). Data year is from 7/2002 - 6/2003.

PERFORMANCE MEASURE # 08

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	17.3	16	15	14	13
Annual Indicator	16.1	15.7	14.9	14.2	14.2
Numerator	5,996	5,867	5,566	5,415	5,415
Denominator	372,422	374,080	373,439	381,221	381,221
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	12	11	11	11	11
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

PERFORMANCE MEASURE # 09

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	31.5	40	50	60	40
Annual Indicator	25.3	57.5	38.2	27.0	27.0
Numerator		1,791	3,961	10,534	10,534
Denominator		3,115	10,369	39,014	39,014
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	30	35	40	45	50
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2002-2004 data is being used as a proxy for 2005.

2. **Section Number:** Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Data is from the 2002-2004 New York State Oral Health Surveillance System

3. **Section Number:** Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   NYS survey of 10,369 students from 272 schools.

PERFORMANCE MEASURE # 10

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

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	0.6	0.6	0.6	0.5	0.5
Annual Indicator	0.8	1.0	0.7	1.4	1.4
Numerator	31	38	27	53	53
Denominator	3,923,707	3,846,325	3,766,916	3,790,880	3,790,880
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	1.1	1	0.9	0.8	0.6
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

PERFORMANCE MEASURE # 11

The percent of mothers who breastfeed their infants at 6 months of age.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					37.2
Numerator					
Denominator					
Is the Data Provisional or Final?					Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	40	43	46	48	50
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.
   Data are from the National Immunization Survey.

PERFORMANCE MEASURE RETIRED 11

Percentage of mothers who breastfeed their infants at hospital discharge.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	72	74	76	78	80
Annual Indicator	69.4	72.1	71.6	71.6	71.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	82	84	85	85	
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Old Performance Measure #11
   Field Name: PM11R07
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2003 data are being used as a proxy for 2005.

2. **Section Number:** Old Performance Measure #11
   Field Name: PM11R07
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   2003 data are being used as a proxy for 2004.

3. **Section Number:** Old Performance Measure #11
   Field Name: PM11R07
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   Numerator and Denominator data are not available for this measure (survey data).

PERFORMANCE MEASURE # 12

Percentage of newborns who have been screened for hearing before hospital discharge.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	80	95	100	100	100
Annual Indicator	61.0	92.3	96.4	99.9	99.9
Numerator	156,000	231,123	227,848	240,577	240,577
Denominator	255,529	250,343	236,259	240,921	240,921
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	100	100	100	100	100
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

PERFORMANCE MEASURE # 13

Percent of children without health insurance.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	10	8	6	5	9
Annual Indicator	9.3	9.9	9.4	8.6	8.6
Numerator	425,000	461,000	432,000	396,000	396,000
Denominator	4,565,000	4,663,000	4,572,000	4,604,000	4,604,000
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	8.5	8	7.5	7	7
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

2. **Section Number:** Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Based on the Current Population Survey, Annual March Supplement (2004 data).

PERFORMANCE MEASURE # 14

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

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					32.1
Numerator					24,562
Denominator					76,566
Is the Data Provisional or Final?					Final

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	32	31	30	29	29
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Numerator and demonminator data is not available.

PERFORMANCE MEASURE # 15

Percentage of women who smoke in the last three months of pregnancy.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					15
Numerator					
Denominator					
Is the Data Provisional or Final?					Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	15	14	14	13	12
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data are from the NYS Prams Survey and are for New York Sate excluding New York City. The latest data available for this measure is 2003.

PERFORMANCE MEASURE # 16

The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	5	4.8	4.6	4.4	4.2
Annual Indicator	5.4	5.3	4.5	5.2	5.2
Numerator	70	68	57	68	68
Denominator	1,287,544	1,279,332	1,279,454	1,297,818	1,297,818
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	4.1	4.1	4	4	3.9
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

2. **Section Number:** Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   2004 estimated data are not available.

PERFORMANCE MEASURE # 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	81	83	85	87	90
Annual Indicator	77.2	84.6	86.2	87.2	87.2
Numerator	2,935	3,401	3,436	3,453	3,453
Denominator	3,800	4,018	3,986	3,962	3,962
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	91	92	92	94	94
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

PERFORMANCE MEASURE # 18

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	75	77.5	80	82.5	85
Annual Indicator	73.0	73.0	74.7	74.9	74.9
Numerator	172,126	172,109	180,870	175,151	175,151
Denominator	235,789	235,766	242,030	233,802	233,802
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	77	78	79	80	81
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005 data.

2. **Section Number:** Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The denominator is the total number of births for which prenatal care initiation is known.

3. **Section Number:** Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   Total births excludes births to moms with unknown prenatal care.

STATE PERFORMANCE MEASURE # 1

Percent of Live Births Resulting from Unintended Pregnancies

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			36.3	36.3	36.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	32.8	32.7	31	31	30.5
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2003 data are being used as a proxy for 2005. Numerator and denominator data are not available. Data are from the NYS Prams Survey for areas in New York Sate outside of NYC.

2. **Section Number:** State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   2003 data are being used as a proxy for 2004 data. Numerator and denominator data are not available. Data are from the NYS Prams Survey for areas in New York State outside of New York City.

STATE PERFORMANCE MEASURE # 2

Hospitalilzation Rate for Asthma in Children 1 to Age 14

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			401.5	384.0	384.0
Numerator			14,119	13,588	13,588
Denominator			3,516,854	3,538,603	3,538,603
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	245	235	235	235	230
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 Data are being used as a proxy for 2005.

STATE PERFORMANCE MEASURE # 3

Percent of women who reported smoking during pregnancy

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			15	15	15
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	9.5	9	9	9	9
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   PRAMS Survey data used. The survey includes information from women recent.y giving birth who reside in areas of New York State, outside of New York City.

STATE PERFORMANCE MEASURE # 4

Teenage Pregnancy Rate for Girls Ages 15-17

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			38.2	37.5	37.5
Numerator			14,276	14,283	14,283
Denominator			373,439	381,221	381,221
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	35	34	34	33	33
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

STATE PERFORMANCE MEASURE # 5

The percent of low income kids ages 2-4 enrolled in the WIC program that were overweight

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

None

STATE PERFORMANCE MEASURE # 6

Percent of infants who are put down on their backs to sleep.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			69	69	69
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	82	84	84	83	83
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2003 data are being used as a proxy for 2005 data. Numerator and denominator data are not availalbe (survey data), Data is from the PRAMS Survey which includes women from areas in NYS outside of NYC.

2. **Section Number:** State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   2003 data are being used as a proxy for 2004. Numerator and Denominator data are not available (survey data). Data are from the PRAMS Survey which includes women from areas in NYS outside of NYC.

3. **Section Number:** State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   Numerator and denominator are not available for this measure (survey data). Data are from the NYS PRAMS survey which includes women from areas in NYS outside of NYC.

STATE PERFORMANCE MEASURE # 7

Hospitalizations for Self-Inflicted Injuries for 15-19 Year Olds

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			0.1	0.1	0.1
Numerator			1,257	1,421	1,421
Denominator			1,279,454	1,297,818	1,297,818
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	0.1	0.1	0.1	0.1	0.1
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

STATE PERFORMANCE MEASURE # 8

Percent of High School Students who had five or more drinks of alcohol in a row at least once in the Last Month

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			25.3	25.3	23.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Final

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	19	18	18	18	18
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** State Performance Measure #8
   Field Name: SM8
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data are from the YRBS.

2. **Section Number:** State Performance Measure #8
   Field Name: SM8
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Data are from the YRBS that is a survey of high school students done on a biannual basis. 2003 data are being used as a proxy for 2004.

3. **Section Number:** State Performance Measure #8
   Field Name: SM8
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   Data are from the 2003 YRBS.

STATE PERFORMANCE MEASURE # 9

Percent of High School Students Who Smoked Cigarettes in the Last Month

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			20.2	20.2	16.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Final

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	5	5	5	5	5
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data are from the 2005 YRBS

2. **Section Number:** State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   2003 data are being used as a proxy for 2004 data. Data are from the YRBs which is a survey of high school students conducted bi-annually

Section Number: State Performance Measure #9
Field Name: SM9
Row Name:
Column Name:
Year: 2003
Field Note:
Data are from the 2003 YRBS.

STATE PERFORMANCE MEASURE # 10

Percent of children in the birth year cohort who were screened for high blood lead before the age of two.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			68	68	68
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	87	87	87	87	87
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** State Performance Measure #10
   Field Name: SM10
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data from 2003 is being used as a proxy for 2005.

2. **Section Number:** State Performance Measure #10
   Field Name: SM10
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Data from 2003 is being used as a proxy for 2004.

3. **Section Number:** State Performance Measure #10
   Field Name: SM10
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   Data are from the NYS lead tracking system. Each data year is for the birth cohort born two years prior to that year. For example 2003 data is for the 2001birth cohort.

STATE PERFORMANCE MEASURE # 11

Percent of High School Students who watched 3 or more hours of TV on an average school day.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			43.6	43.6	41.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Final

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	40	38	36	34	32
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** State Performance Measure #11
   Field Name: SM11
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data are based on the 2005 YRBS.

2. **Section Number:** State Performance Measure #11
   Field Name: SM11
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Data are from the 2003 YRBS. YRBS is a survey of high school students done bi-annually.

3. **Section Number:** State Performance Measure #11
   Field Name: SM11
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   Data are from the 2003 YRBS .

STATE PERFORMANCE MEASURE # 12

Percent of Women that felt down, depressed or hopeless always or often after their baby was born.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator				11.7	11.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	11.5	11.4	11.3	11.2	11.1
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** State Performance Measure #12
   Field Name: SM12
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

2. **Section Number:** State Performance Measure #12
   Field Name: SM12
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Data are from a new question on the PRAMS survey. Unweighted 2004 data are being used as an estimate for 2004. When weighted data becomes available this number will be revised.
   The PRAMS survey collects information from women residing in areas in New York State outside of New York City.

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[SECS 505 (A)(2)(B)(iii) AND 506 (A)(2)(A)(iii)]
STATE: NY

Form Level Notes for Form 12

OUTCOME MEASURE # 01

The infant mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	6.2	6	5.9	5.8	5.7
Annual Indicator	5.7	5.9	6.0	6.0	6.0
Numerator	1,436	1,489	1,518	1,503	1,503
Denominator	253,545	250,691	253,001	248,876	248,876
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	5.6	5.5	5.5	5.5	5.4
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005 data.

2. **Section Number:** Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2003
   Field Note:

OUTCOME MEASURE # 02

The ratio of the black infant mortality rate to the white infant mortality rate.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	1.8	1.7	1.6	1.5	1.4
Annual Indicator	1.8	1.8	2.4	2.2	2.2
Numerator	9.4	9.5	10.9	10.7	10.7
Denominator	5.1	5.2	4.6	4.9	4.9
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	1.4	1.3	1.3	1.3	1.3
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

OUTCOME MEASURE # 03

The neonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	4.3	4.2	4.1	4	3.9
Annual Indicator	3.9	4.2	4.2	4.3	4.3
Numerator	993	1,053	1,060	1,058	1,058
Denominator	253,545	250,691	253,001	248,876	248,876
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	3.9	3.8	3.8	3.7	
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

OUTCOME MEASURE # 04

The postneonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	1.6	1.5	1.4	1.3	1.1
Annual Indicator	1.7	1.7	1.8	1.8	1.8
Numerator	443	436	458	445	445
Denominator	253,545	250,691	253,001	248,876	248,876
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	1.1	1	1	1	1
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

Outcome Measure # 05

The perinatal mortality rate per 1,000 live births plus fetal deaths.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	12.1	12	11.8	11.6	11.5
Annual Indicator	12.2	12.1	6.5	6.0	6.0
Numerator	3,368	3,352	1,654	1,508	1,508
Denominator	275,854	275,975	253,741	249,538	249,538
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	5.9	5.7	5.5	5.3	5.2
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

2. **Section Number:** Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   Perinatal mortality: numerator fetal dths (28+ weeks) + deaths under 7 days
   Denominator: live birhts + fetal deaths (28+ weeks)
   Previous years were based on a different definition. This accounts for the drop in the rate.

OUTCOME MEASURE # 06

The child death rate per 100,000 children aged 1 through 14.

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective	16	14.5	13	11.5	10
Annual Indicator	17.5	16.5	16.2	15.7	15.7
Numerator	643	591	571	557	557
Denominator	3,679,816	3,589,371	3,516,854	3,536,587	3,536,587
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	10	9.5	9.5	9.5	9.4
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005 data.

STATE OUTCOME MEASURE # 1

Maternal Mortality Rate per 100,000 Live Births

Annual Objective and Performance Data

	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator		13.2	20.9	20.5	20.5
Numerator		33	53	51	51
Denominator		250,806	253,001	248,876	248,876
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	20	19.5	19	18.5	18
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** State Outcome Measure 1
   Field Name: SO1
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

Form 13
Characteristics Documenting Family Participation in CSHCN Programs
State: NY

1. Family members participate on advisory committee or task forces and are offering training, mentoring, and reimbursement, when appropriate.

2

2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

2

3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.

2

4. Family members are involved in service training of CSHCN staff and providers.

2

5. Family members hired as paid staff or consultants to the State CSHCN program (a family member is hired for his or her expertise as a family member).

2

6. Family members of diverse cultures are involved in all of the above activities.

2

Total Score: 12

Rating Key
0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

Form Notes for Form 13

None

Field Level Notes

1. **Section Number:** Main
   Field Name: Question1
   Row Name: #1. Family members participate on advisory committee or task forces...
   Column Name:
   Year: 2007
   Field Note:
   • Parents and youth have been sponsored to attend the Annual Meeting of the Association of Maternal and Child Health Programs in Washington, DC. Parents are mentored and prepared by the Family Specialist for their roles in this meeting. Travel, meals and childcare costs are ensuring the families bear no expense to participate.

   • A parent of a child with special health care needs serves on the Emergency Medical Services Advisory Council to ensure that family interests are represented.

   • Families have been recruited and supported to serve on workgroups and committees within the New York State Department of Health. Travel, meals and childcare costs are paid ensuring the families bear no expense to participate.

   • Families are recruited and supported to attend and speak at meetings such as the Developmental Disabilities Committee Meeting of the New York State Conference of Mental Hygiene Directors. As per New York State Department of Health policy, a stipend and travel, meals and childcare costs are paid.

   • Families participated in the Champions for Progress Training meetings. Champions for Progress is an infrastructure building opportunity that assists the Department in increasing the cadre of family leaders in this State. Expenses such as lodging, meals, travel, and childcare were paid for families attending this training opportunity.

2. **Section Number:** Main
   Field Name: Question2
   Row Name: #2. Financial support (...) is offered for parent activities or parent groups.
   Column Name:
   Year: 2007
   Field Note:
   • Parents and youth have been sponsored to attend the Annual Meeting of the Association of Maternal and Child Health Programs in Washington, DC. Travel, meals and childcare costs are paid by the Block Grant ensuring the families bear no expense to participate. The NYSDOH Family Specialist assists parents with making financial arrangements.

   • Families are recruited and supported to attend and speak at meetings, such as the one for the Developmental Disabilities Committee Meeting of the New York State Conference of Mental Hygiene Directors. A stipend and travel, meals, and childcare costs are paid.

   • Champions for Progress utilize Parent Champions to assist with Title V work. Per NYSDOH policy, stipends and expenses are paid by NYSDOH to minimize out-of-pocket expenses for parents who participate.

   • NYSDOH sponsored focus groups with consumers and parents. All parents were paid stipends, and received travel, meal and child care support in order to support their attendance.

3. **Section Number:** Main
   Field Name: Question3
   Row Name: #3. Family members are involved in the Children with Special Health Care Needs...
   Column Name:
   Year: 2007
   Field Note:
   • Parents have been invited to public hearings held for the New York State Maternal and Child Health Block Grant Report and Application and have testified on access to health care.

   • Families are invited and supported to participate in Focus Groups advising the New York State Department of Health on its annual Block Grant Report and Application. Travel, meals and childcare costs are paid by Block Grant ensuring the families bear no expense to participate.

   • The Family Specialist has conducted focus groups with Healthy Start consumers to gather their input to the annual Block Grant Report and Application. The Healthy Start consumer group also advised the Department how to effectively reach consumers and parents, and how to get input from them about block grant-related services.

   • Parents of CSHCN who are NYSDOH employees participate in all aspects of grant application preparation (needs assessment, performance review, program planning, etc.)

   • The Family Specialist mentors new participant parents and arranges for training on Block Grant related topics.

   • Family Champions were trained on Title V and Block Grant related topics.

4. **Section Number:** Main
   Field Name: Question4
   Row Name: #4. Family members are involved in service training of CSHCN staff and providers.
   Column Name:
   Year: 2007
   Field Note:
   • The Family Specialist and other parents provide in-service training for Children with Special Health Care Needs (CSHCN) staff, community providers and organizations, and other state agencies. Parents are actively involved as trainers as part of Medical Home community- based and state teams.

   • Parents were invited to participate as workgroup members for a new initiative to build Early Childhood Comprehensive Systems. Members of the Early Childhood Comprehensive Systems workgroups trained other workgroup members on family issues and concerns. These issues were emphasized in the workgroup report. Parents provided input into training and recruitment needs of service providers.

   • The Family Specialist provides ongoing training about CSHCN and Medical Home activities to other state agencies on an ongoing basis.

   • The Family Specialist and other family program staff provide technical assistance to local CSHCN Programs on family issues.

5. **Section Number:** Main
   Field Name: Question5
   Row Name: #5. Family members hired as paid staff or consultants to the State CSHCN program...
   Column Name:
   Year: 2007
   Field Note:
   • A parent of a child with special health care needs works as the Family Specialist in the Children with Special Health Care Needs Program.

   • Several staff working in the Children with Special Health Care Needs programs are parents of children with special health care needs. They occupy job titles such as Health Program Administrator, Public Health Program Nurse, and Public Health Representative.

• Staff consults parent employees and other parents in designing new programs and initiatives, such as the Medical Home model and the Early Child Comprehensive Systems.

6. **Section Number:** Main
Field Name: Question6
Row Name: #6. Family members of diverse cultures are involved in all of the above activities
Column Name:
Year: 2007
Field Note:
• Families originally from thirty-two countries participated in family professional collaboration training. Translation services were provided at this training so all family members could fully participate.

• Several stakeholders, who participated as advisors to the Champions for Progress training opportunity, represent diverse community-based organizations and the NYSDOH Office of Minority Health. These stakeholders ensured diversity among our selected family leaders.

• Parent diversity is represented through the composite scores for this survey.

• Parent diversity is achieved through culturally diverse focus groups, such as Healthy Start. This group provides NYSDOH with information on gaps in service delivery and provides advice on the Block Grant application process.

• Culturally diverse families have testified before the Block Grant advisory council.

FORM 14
LIST OF MCH PRIORITY NEEDS

[Sec. 505(a)(5)]

STATE: NY FY: 2007

Your State's 5-year Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children and services for Children with Special Health Care Needs. With each year's Block Grant application, provide a list (whether or not the priority needs change) e top maternal and child health needs in your state. Using simple sentence or phrase ,list below your State's needs. Examples of such statements are: "To reduce the barriers .e delivery of care for pregnant women, " and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top 7 to 10 priority needs in an information system for comparison, tracking, and reporting purposes; you must list at least 7 and no more than 10. Note that the numbers listed below are for computer tracking only and are not meant to indicate priority order. If your State wishes to report more than 10 priority needs, list additional priority needs in a note at the form level.

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

FORM NOTES FOR FORM 14

None

FIELD LEVEL NOTES

None

FORM 15
TECHNICAL ASSISTANCE(TA) REQUEST

STATE: NY

APPLICATION YEAR: 2007

No.	Category of Technical Assistance Requested	Description of Technical Assistance Requested *(max 250 characters)*	Reason(s) Why Assistance Is Needed *(max 250 characters)*	What State, Organization or Individual Would You suggest Provide the TA (if known) *(max 250 characters)*
1.	**National Performance Measure Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: 1	Sources of support for comprehensive genetics services	Financial support for local programs	Please suggest.
2.	**National Performance Measure Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: 3	Working with genetics specialty centers on the medical home concept.	Genetics centers provide specialty level care and need assistance with recognizing the medical home concept.	Please suggest.
3.	**Other** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: N/A	The state adolescent coordinators are requesting technical assistance regarding adolescent health, implementation of the National Initiative, capacity building, and updates on current adolescent health topics.	This is a universal (multi-state) need.	To be determined.
4.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
5.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
6.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
7.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
8.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
9.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
10.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this			

	issue pertains by entering the measure number here:			
11.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
12.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			

FORM NOTES FOR FORM 15

None

FIELD LEVEL NOTES

None

FORM 16
STATE PERFORMANCE AND OUTCOME MEASURE DETAIL SHEET
STATE: NY

SP # 1

PERFORMANCE MEASURE:	Percent of Live Births Resulting from Unintended Pregnancies
STATUS:	Active
GOAL	To decrease the number of unintended pregnancies
DEFINITION	Births to women that were unintended. **Numerator:** Number of women surveyed that reported they wanted to be pregnant later or not at all. **Denominator:** Number of women responding to the survey times 100 **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	The NYS PRAMS Survey is the source for these data. One limitation is that the survey is only available for NYS excluding NYC.
SIGNIFICANCE	Unintended pregnancy is a problem among women in all age groups. in 1994 48% of American females aged 15-44 years had at least one unintended pregnancy in their lifetime and nearly 1/3 had one or more abortions.

SP # 2

PERFORMANCE MEASURE:	Hospitalilzation Rate for Asthma in Children 1 to Age 14
STATUS:	Active
GOAL	To reduce asthma morbidity among children.
DEFINITION	
	Numerator: Number of hospitalizations for asthma among children age 1 to 14. **Denominator:** Number of children ages 1 to 14 times 100,000. **Units:** 100000 **Text:** Per 100,000 children ages 1 to 14.
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	The NYS SPARCS Data System is the source for the hospitalization data. The NYSDOH Bureau of Biometrics provides population estimates. .
SIGNIFICANCE	Increased asthma prevalence among children and the associated morbidity due to exacerbations and persistent symptoms present a huge burden to affected individuals and their families. In the US, over 10 million school days are lost anually by children with asthma. Consequently lost productivity of their parents was almost $1M. Patients with inadequately controlled severe asthma have high expenditures in health care costs, especially in terms of hospitalizations. The social and economic burdens of asthma can be alleviated through appropriate asthma preventin and management strategies.

SP # 4

PERFORMANCE MEASURE:	Teenage Pregnancy Rate for Girls Ages 15-17
STATUS:	Active
GOAL	To lower the pregnancy rate among teenagers.
DEFINITION	**Numerator:** Number of pregnancies (including abortions, spontaneous fetal deaths, and births) to females aged 15-17 years old. **Denominator:** Number of females aged 15-17 years of age times 1000. **Units:** 1000 **Text:** Rate
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Vital Records are the source for data on mothers' age and pregnancies. Population numbers are estimated by the Bureau of Biometrics, NYS Health Department.
SIGNIFICANCE	Adolescent sexual activity can have life-changing or life-threatening consequences; unintended pregnancy and infection with sexually transmitted diseases or HIV. Teen parenting is associated with non-completion of high school and the initiation of a cycle of poverty. Adolescent pregnancy reduces employment opportunities leading to increased poverty, and is associated with poorer health coutcomes, less likeliness to marry, and increased dependence on public assistance.

SP # 6

PERFORMANCE MEASURE:	Percent of infants who are put down on their backs to sleep.
STATUS:	Active
GOAL	To increase the number of infants that are placed on their backs to sleep.
DEFINITION	To increase the number of infants that are placed on their backs to sleep. **Numerator:** Number of mothers that reported they placed their babies on there back to sleep. **Denominator:** Number of moms responding to the survey times 100. **Units:** 100 **Text:** 1
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	The PRAMS survey is the source for these data. One limitation is that the survey is only available for NYS excluding NYC.
SIGNIFICANCE	Much research has shown that infants who are placed on their backs for sleeping are at reduced risk for Sudden Infant Death Syndrome (SIDS).

SP # 7

PERFORMANCE MEASURE:	Hospitalizations for Self-Inflicted Injuries for 15-19 Year Olds
STATUS:	Active
GOAL	To reduce self-inflicted, preventable morbidity and mortality.
DEFINITION	hospitalizations **Numerator:** Number of hospitalizations attributed to self-inflicted injures among youth 15-19 years of age. **Denominator:** Number of youth 15-19 years of age times 100,000. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	The New York State SPARCS Data System is the source for the hospitalization data. The Bureau of Biometrics, NYSDOH, provides population estimates.
SIGNIFICANCE	Enhancing the mental health status of communities is, by itself, an important goal. Its significance is magnified by the fact that mental and physical health are often inexorably entwined. Personal characteristics or experiences such as low self-esteem, concerns about social acceptance, the agsence of strong family structure and support, early exposure to violence and abuse, compulsive behavior, and fatalism are often associated with a wide range of risk behaviors and adverse health outcomes. Self-inflicted injury is one of the extreme manifestations of poor emotional health. Among adolescents and young adults, self-inflicted injuries are five times more likely to occur as compared to their older counterparts. A 1993 study of high school students in the state outside of NYC revealed that approximately 10% of those surveyed actually attempted to kill themselves. 25% of them needed medical attention as a result of their attempt.

SP # 8

PERFORMANCE MEASURE:	Percent of High School Students who had five or more drinks of alcohol in a row at least once in the Last Month
STATUS:	Active
GOAL	To reduce alcohol use among adolescents.
DEFINITION	Students who had five or more drinks of alcohol in a row, that is, within a couple of hours, on one or more of the past 30 days. **Numerator:** The number of high school students that reported they drank five or more drinks of alcohol in a row at least once in the last month. **Denominator:** The number of high school students in the survey times 100. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	The YRBS is the source for these data.
SIGNIFICANCE	Alcohol is the most commonly used drug in NYS with approximately one million adult and 100,000 youth drinkers in the state. Alcohol use is also associated with high rates of injuy and contributes to lack of inhibition and irresponsible sexual activity, which in turn may contribute to higher rates of unintended pregnancy, sexually transmitted diseases and HIV transmission.

SP # 9

PERFORMANCE MEASURE:	Percent of High School Students Who Smoked Cigarettes in the Last Month
STATUS:	Active
GOAL	To reduce smoking among adolescents.
DEFINITION	The rate of current smoking among high school students. **Numerator:** The number of high school students that reported smoking at least one cigarette during the last month. **Denominator:** The number of students in the survey times 100. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	The New York State Youth Tobacco Survey is the source for these data.
SIGNIFICANCE	Tobacco is an addictive substance. Tobacco causes more disease and death in NYS than any other pathogen. In 1993, 31,600 New Yorkers died of tobacco-associated conditions, accounting for 19% of all deaths. The direct medical costs related to smoking in NYS is believed to be over $3 billion annually. Tobacco causes 30% of all cancer deaths, 82% of all deahts due to pulmonary disease, and 21% of deaths due to chronic cardiac disease. More than 1,500 fire deaths and 4,600 injuries in the US are attributable to cigarettes. In NYS in 1992 alone, cigarettes caused 33% of fatal fires, taking 733 lives. NYS surveys indicate teen smoking, afterfalling steadily for a number of years, is on the rise in NYS. Most (89%) adult smokers initiated their habit while young, under the ate of 18. 71% of adult smokers reported thay they began smoking daily before age 18.

SP # 10	
PERFORMANCE MEASURE:	Percent of children in the birth year cohort who were screened for high blood lead before the age of two.
STATUS:	Active
GOAL	To identify all children that have been exposed to high levels of lead.
DEFINITION	
	Numerator: Number of children in the birth year cohort who have been screened at least once for high blood lead levels before the age of two. **Denominator:** Number of children times 100. **Units:** 100 **Text:** Per 100 children in th birth cohort.
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	NYS Heavymetals and Childhood Lead Registry, the data base for the NYS Childhood Lead Poisoning Prevention Program, is the source for these data. The NYSDOH Bureau of Biometrics provides population estimates.
SIGNIFICANCE	NYS is committed to screening for lead in children one and two years of age in order to identify all children with high lead levels. High lead levels are associated with learning disabilities and severe physical consequences, including death.

SP # 11

PERFORMANCE MEASURE:	Percent of High School Students who watched 3 or more hours of TV on an average school day.
STATUS:	Active
GOAL	To decrease the amount of time high school students watch TV.
DEFINITION	Number of high school students who indicate they watch 3 or more hours of TV. **Numerator:** Number of high school students who indicate they watch 3 or more hours of TV. **Denominator:** Number of high school students **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	22-11 Increase the proportion of children and adolescents who view television 2 or fewer hours per d
DATA SOURCES AND DATA ISSUES	Youth Risk Behavior Survey.
SIGNIFICANCE	Children who watch more than 2 hours per day of television are at an increase risk for obesity in both childhood and into adulthood.

SP # 12

PERFORMANCE MEASURE:	Percent of Women that felt down, depressed or hopeless always or often after their baby was born.
STATUS:	Active
GOAL	To reduce symptoms of depression in postpartum women.
DEFINITION	x **Numerator:** Number of women participating in the PRAMS survey that always or often felt down, depressed or hopeless after their baby was born. **Denominator:** Women responding to the PRAMs survey. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Pregnancy Risk Assessment Monitoring System
SIGNIFICANCE	Postpartum women are at an increased risk for depression but their symptoms can be controlled through treatment.

SO # 1

OUTCOME MEASURE:	Maternal Mortality Rate per 100,000 Live Births
STATUS:	Active
GOAL	To reduce the number of maternal deaths
DEFINITION	Deaths from causes related to pregnancy **Numerator:** Number of deaths occurring to women from causes related to pregnancy (ICD 9: 630 through 676) **Denominator:** Number of Live Births **Units:** 100000 **Text:** Rate
HEALTHY PEOPLE 2010 OBJECTIVE	Reduce the maternal mortality rate to no more than 3.3 per 100,000 live births
DATA SOURCES AND DATA ISSUES	Source: Vital Records Issues: Maternal deatsh as cause of death are under reported. More aggressive case ascertainment results in what appear to be higher rates.
SIGNIFICANCE	Due to general improvement in social and economic conditions and medical practices, maternal deaths have become more rare and are thought to be mostly preventable.

Form Notes for Form 16

None

Field Level Notes

None

FORM 17
HEALTH SYSTEMS CAPACITY INDICATORS
FORMS FOR HSCI 01 THROUGH 04, 07 & 08 - MULTI-YEAR DATA
STATE: NY

Form Level Notes for Form 17

None

HEALTH SYSTEMS CAPACITY MEASURE # 01

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

	Annual Indicator Data				
	2001	2002	2003	2004	2005
Annual Indicator	66.6	65.4	72.7	67.3	67.3
Numerator	8,255	8,026	8,833	8,381	8,381
Denominator	1,239,417	1,228,144	1,215,052	1,246,045	1,246,045
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

HEALTH SYSTEMS CAPACITY MEASURE # 02

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

Annual Indicator Data

	2001	2002	2003	2004	2005
Annual Indicator	NaN	74.9	74.7	76.5	76.5
Numerator	0	81,213	103,303	110,535	110,535
Denominator	0	108,485	138,216	144,460	144,460
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

2. **Section Number:** Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   Comparable Data not available for 1999 - 2001

HEALTH SYSTEMS CAPACITY MEASURE # 03

The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

Annual Indicator Data

	2001	2002	2003	2004	2005
Annual Indicator	62	67	79	79	79
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2003 data are being used as a proxy for 2005.

2. **Section Number:** Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   2003 data are being used as a proxy for 2004.

3. **Section Number:** Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   We do not have reliable data for Child Health Plus enrollees under age 1. As a proxy, the percentage of children under age 15 months who have received a well child or preventive health visit is used.

   Starting in 1999 a new data source became available. Using this source the percentage is weighted by plan enrollment. Since the rate is a weighted rate the numerator and denominator are not available.

HEALTH SYSTEMS CAPACITY MEASURE # 04

The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Annual Indicator Data

	2001	2002	2003	2004	2005
Annual Indicator	63.5	63.6	63.1	66.4	66.4
Numerator	147,859	147,385	137,129	132,863	132,863
Denominator	232,787	231,785	217,201	200,115	200,115
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

HEALTH SYSTEMS CAPACITY MEASURE # 07A

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Annual Indicator Data

	2001	2002	2003	2004	2005
Annual Indicator	85.7	87.5	91.0	93.4	93.4
Numerator	1,395,907	1,550,279	1,834,078	1,974,655	1,974,655
Denominator	1,627,880	1,770,911	2,015,608	2,113,319	2,113,319
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

HEALTH SYSTEMS CAPACITY MEASURE # 07B

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Annual Indicator Data

	2001	2002	2003	2004	2005
Annual Indicator	34.5	35.8	35.2	36.3	36.3
Numerator	113,096	124,393	134,265	140,454	140,454
Denominator	327,476	347,546	381,935	386,892	386,892
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

HEALTH SYSTEMS CAPACITY MEASURE # 08

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

Annual Indicator Data

	2001	2002	2003	2004	2005
Annual Indicator	NaN	NaN	100.0	100.0	100.0
Numerator	0	0	1	1	1
Denominator	0	0	1	1	1
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   All SSI beneficiaries receive Medicaid, which is a more generous package than that available under the Physcally Handicapped Children's program.

2. **Section Number:** Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   All SSI beneficiaries receive Medicaid, which is a more generous package than that available under the Physically Handicapped Children's Program.

3. **Section Number:** Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   All SSI beneficiaries receive Medicaid which is a more generous package than that available under the Physically Handicapped Children's Program.

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #05
(MEDICAID AND NON-MEDICAID COMPARISON)
STATE: NY

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
a) *Percent of low birth weight (< 2,500 grams)*	2004	Payment source from birth certificate	8.6	8	8.2
b) *Infant deaths per 1,000 live births*	2004	Payment source from birth certificate	5.6	4.2	6
c) *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*	2004	Payment source from birth certificate	68.1	87.1	74.9
d) *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*	2004	Payment source from birth certificate	53.3	73.7	66.4

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(MEDICAID ELIGIBILITY LEVEL)
STATE: NY

INDICATOR #06 *The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.*	YEAR	PERCENT OF POVERTY LEVEL MEDICAID (Valid range: 100-300 percent)
a) *Infants (0 to 1)*	2005	200
b) *Medicaid Children* (Age range 1 to 5) (Age range 6 to 19) (Age range ____ to ____)	2005	133 100 ____
c) *Pregnant Women*	2005	200

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(SCHIP ELIGIBILITY LEVEL)
STATE: NY

INDICATOR #06 *The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women.*	YEAR	PERCENT OF POVERTY LEVEL SCHIP
a) *Infants (0 to 1)*	2005	160
b) *Medicaid Children* (Age range 1 to 19) (Age range ____ to ____) (Age range ____ to ____)	2005	160 ____ ____
c) *Pregnant Women*	2005	200

Form Notes for Form 18

The "All" column under Population includes births with unknown payment source.

Re: SCHIP or Child Health Plus: There is no monthly premium for families whose income is 1.6 times the Federal Poverty Level (FPL). Families with higher incomes pay a monty preioum of $9 or $15 per month per child, depending on their income and family size. If a family's income is higher than 2.5 times the FPL, they pay the full monthly premium charged by the health plan. There are no co-payments for services under Child Health Plus. See http://www.health.state.ny.us/nysdoh/chplus/what_does_it_cost.htm

LD Level Notes

1. **Section Number:** Indicator 06 - SCHIP
   Field Name: SCHIP_Children
   Row Name: SCHIP Children
   Column Name:
   Year: 2007
   Field Note:
   This section of the form is labeled wrong. It should read "Children under SCHIP" and not "Medicaid Children."

2. **Section Number:** Indicator 06 - SCHIP
   Field Name: SCHIP_Women
   Row Name: Pregnant Women
   Column Name:
   Year: 2007
   Field Note:
   Pregnant women are eligible for MA up to 200% of poverty.

3. **Section Number:** Indicator 05
   Field Name: InfantDeath
   Row Name: Infant deaths per 1,000 live births
   Column Name:
   Year: 2007
   Field Note:
   Medicaid and nonmedicaid infant mortality rates are for residents of New York State living in areas outside New York City. Information on method of payment for delivery was not available for 2004 NYC births.
   Infant mortality for all births to NYS residents living outside of NYC was 6.0 per 1,000 births in 2004.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: NY

HEALTH SYSTEMS CAPACITY INDICATOR #09A (General MCH Data Capacity)
(The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Informatioin)

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) *	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	No
Annual linkage of birth certificates and newborn screening files	3	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

*Where:
1 = No, the MCH agency does not have this ability.
2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis.
3 = Yes, the MCH agency always has this ability.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: NY

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

*Where:
1 = No
2 = Yes, the State participates but the sample size is not large enough for valid statewide estimates for this age group.
3 = Yes, the State participates and the sample size is large enough for valid statewide estimates for this age group.

Notes:

1. HEALTH SYSTEMS CAPACITY INDICATOR #09B was formerly reported as Developmental Health Status Indicator #05.

FORM NOTES FOR FORM 19

None

FIELD LEVEL NOTES

None

FORM 20
HEALTH STATUS INDICATORS #01-#05
MULTI-YEAR DATA
STATE: NY

Form Level Notes for Form 11

None

HEALTH STATUS INDICATOR MEASURE # 01A

The percent of live births weighing less than 2,500 grams.

	Annual Indicator Data				
	2001	2002	2003	2004	2005
Annual Indicator	7.7	7.9	7.9	8.2	8.2
Numerator	19,504	19,853	19,966	20,356	20,356
Denominator	253,545	250,691	253,001	248,876	248,876
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

None

HEALTH STATUS INDICATOR MEASURE # 01B

The percent of live singleton births weighing less than 2,500 grams.

Annual Indicator Data

	2001	2002	2003	2004	2005
Annual Indicator	5.9	6.1	6.0	6.2	6.2
Numerator	14,497	14,642	14,691	14,754	14,754
Denominator	244,255	240,032	243,620	239,013	239,013
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

None

HEALTH STATUS INDICATOR MEASURE # 02A

The percent of live births weighing less than 1,500 grams.

	Annual Indicator Data				
	2001	2002	2003	2004	2005
Annual Indicator	1.5	1.6	1.5	1.6	1.6
Numerator	3,800	3,892	3,869	3,962	3,962
Denominator	253,545	250,691	253,001	248,876	248,876
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

HEALTH STATUS INDICATOR MEASURE # 02B

The percent of live singleton births weighing less than 1,500 grams.

Annual Indicator Data

	2001	2002	2003	2004	2005
Annual Indicator	1.1	1.2	1.1	1.2	1.2
Numerator	2,774	2,821	2,754	2,804	2,804
Denominator	244,255	240,032	243,620	239,013	239,013
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

None

HEALTH STATUS INDICATOR MEASURE # 03A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Annual Indicator Data

	2001	2002	2003	2004	2005
Annual Indicator	5.0	4.9	3.4	3.2	3.2
Numerator	198	188	127	121	121
Denominator	3,923,707	3,846,325	3,766,916	3,790,880	3,790,880
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

Health Status Indicator Measure # 03B

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Annual Indicator Data

	2001	2002	2003	2004	2005
Annual Indicator	0.8	1.0	0.7	1.4	1.4
Numerator	31	38	27	53	53
Denominator	3,923,707	3,846,325	3,766,916	3,790,880	3,790,880
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

2. **Section Number:** Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   Motor Vehicle crash deaths do not include pedestrian deaths.

   2003 data are not available.

HEALTH STATUS INDICATOR MEASURE # 03C

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	2001	2002	2003	2004	2005
Annual Indicator	13.9	14.1	12.3	11.8	11.8
Numerator	352	363	319	308	308
Denominator	2,531,853	2,582,142	2,592,776	2,606,675	2,606,675
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 is being used as a proxy for 2005.

2. **Section Number:** Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   Pedestrian deaths are not included in the number of motorvehicle crash deaths.

   2003 data are not available.

HEALTH STATUS INDICATOR MEASURE # 04A

The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2001	2002	2003	2004	2005
Annual Indicator	272.4	262.2	267.5	284.1	284.1
Numerator	10,687	10,084	10,076	10,771	10,771
Denominator	3,923,707	3,846,325	3,766,916	3,790,880	3,790,880
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

HEALTH STATUS INDICATOR MEASURE # 04B

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

Annual Indicator Data

	2001	2002	2003	2004	2005
Annual Indicator	37.1	46.2	12.1	13.6	13.6
Numerator	1,457	1,777	457	517	517
Denominator	3,923,707	3,846,325	3,766,916	3,790,880	3,790,880
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

2. **Section Number:** Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2003
   Field Note:
   In 2003 injuries related to a motor vehicle crash excluded pedestrian injuries to be consistent with HP2010 objectives. This is the reason for the large drop in number of injuries from 2002 and 2003.

HEALTH STATUS INDICATOR MEASURE # 04C

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Annual Indicator Data

	2001	2002	2003	2004	2005
Annual Indicator	130.8	115.1	106.7	110.6	110.6
Numerator	3,311	2,973	2,767	2,882	2,882
Denominator	2,531,853	2,582,142	2,592,776	2,606,675	2,606,675
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

None

HEALTH STATUS INDICATOR MEASURE # 05A

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

	Annual Indicator Data				
	2001	2002	2003	2004	2005
Annual Indicator	22.5	23.9	23.3	25.7	25.7
Numerator	14,082	14,890	15,809	16,279	16,279
Denominator	625,927	623,800	679,390	633,458	633,458
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

Health Status Indicator Measure # 05B

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

	Annual Indicator Data				
	2001	2002	2003	2004	2005
Annual Indicator	6.4	6.9	6.6	7.7	7.7
Numerator	23,061	24,639	26,142	26,824	26,824
Denominator	3,588,005	3,577,048	3,943,484	3,485,833	3,485,833
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   2004 data are being used as a proxy for 2005.

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #06A - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

For both parts A and B: Reporting Year: 2004 Is this data from a State Projection? No Is this data final or provisional? Final

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	254,293	178,348	56,734	745	18,466	0	0	0
Children 1 through 4	991,752	697,987	220,888	4,103	68,774	0	0	0
Children 5 through 9	1,213,572	861,425	262,367	10,663	79,117	0	0	0
Children 10 through 14	1,331,263	941,560	299,021	11,162	79,520	0	0	0
Children 15 through 19	1,297,818	933,471	275,451	10,259	78,637	0	0	0
Children 20 through 24	1,218,857	929,013	268,275	10,772	10,797	0	0	0
Children 0 through 24	6,307,555	4,541,804	1,382,736	47,704	335,311	0	0	0

HSI #06B - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity. (Demographics)*

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	197,002	57,291	0
Children 1 through 4	772,736	219,016	0
Children 5 through 9	968,786	244,786	0
Children 10 through 14	1,077,113	254,150	0
Children 15 through 19	1,071,298	226,520	0
Children 20 through 24	1,044,032	264,825	0
Children 0 through 24	5,130,967	1,266,588	0

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #07A - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

For both parts A and B: Reporting Year: 2004 Is this data from a State Projection? No Is this data final or provisional? Final

CATEGORY TOTAL LIVE BIRTHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	271	128	111	2	2	0	0	28
Women 15 through 17	5,415	3,011	1,888	28	48	0	0	440
Women 18 through 19	11,612	6,987	3,512	58	246	0	0	809
Women 20 through 34	181,710	121,466	33,450	395	16,505	0	0	9,894
Women 35 or older	49,833	35,806	8,057	71	4,116	0	0	1,783
Women of all ages	248,841	167,398	47,018	554	20,917	0	0	12,954

HSI #07B - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)*

CATEGORY TOTAL LIVE BIRTHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	148	123	0
Women 15 through 17	3,062	2,337	16
Women 18 through 19	7,386	4,206	20
Women 20 through 34	138,535	42,654	521
Women 35 or older	42,031	7,615	187
Women of all ages	191,162	56,935	744

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #08A - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

r both parts A and B: Reporting Year: 2004 Is this data from a State Projection? No Is this data final or provisional? Provisional

CATEGORY TOTAL DEATHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	1,502	813	504	9	57	9	0	110
Children 1 through 4	209	130	52	1	10	0	0	16
Children 5 through 9	150	82	45	1	5	0	0	17
Children 10 through 14	197	124	53	0	6	0	0	14
Children 15 through 19	594	396	146	1	16	1	0	34
Children 20 through 24	878	566	246	1	23	0	0	42
Children 0 through 24	3,530	2,111	1,046	13	117	10	0	233

HSI #08B - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)*

CATEGORY TOTAL DEATHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	1,217	274	11
Children 1 through 4	166	43	0
Children 5 through 9	127	22	1
Children 10 through 14	163	34	0
Children 15 through 19	487	105	2
ildren 20 through 24	708	169	1
Children 0 through 24	2,868	647	15

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #09A - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

Is this data final or provisional? Provisional

CATEGORY Miscellaneous Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	5,423,212	3,612,791.0	1,114,461.0	36,932.0	334,514.0	0	0	324,514.0	2004
Percent in household headed by single parent	33.5	23.5	64.9	0	9.8	0	0	0	2004
Percent in TANF (Grant) families	4.6	0	0	0	0	0	0	4.6	2005
Number enrolled in Medicaid	2,113,319	0	0	0	0	0	0	2,113,319.0	2004
Number enrolled in SCHIP	354,630	0	0	0	0	0	0	354,630.0	2005
Number living in foster home care	12,494	3,926.0	5,147.0	47.0	64.0	0	0	3,310.0	2004
Number enrolled in food stamp program	731,586	0	0	0	0	0	0	731,586.0	2004
Number enrolled in WIC	76,566	0	0	0	0	0	0	76,566.0	2005
Rate (per 100,000) of juvenile crime arrests	1,537.0	0	0	0	0	0	0	1,537.0	2004
Percentage of high school drop-outs (grade 9 through 12)	4.3	2.2	7.1	6.7	3.9	0	0	0	2004

HSI #09B - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity.(Demographics)*

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
All children 0 through 19	4,086,935.0	1,001,763.0	0	2004
Percent in household headed by single parent	0	65.7	0	2004
Percent in TANF (Grant) families	0	0	4.6	2005
Number enrolled in Medicaid	0	0	2,113,319.0	2004
Number enrolled in SCHIP	0	0	354,630.0	2005
Number living in foster home care	10,191.0	2,303.0	0	2004
Number enrolled in food stamp program	0	0	731,586.0	2004
Number enrolled in WIC	0	0	76,566.0	2005
Rate (per 100,000) of juvenile crime arrests	0	0	1,537.0	2004
Percentage of high school drop-outs (grade 9 through 12)	0	7.8	0	2004

Form 21
Health Status Indicators
Demographic Data
State: NY

HSI #10 - Demographics (Geographic Living Area) *Geographic living area for all resident children aged 0 through 19 years old. (Demographics)*

Reporting Year: 2001 Is this data from a State Projection? No Is this data final or provisional? Provisional

GEOGRAPHIC LIVING AREAS	TOTAL
Living in metropolitan areas	4,794,878
Living in urban areas	479,878
Living in rural areas	416,373
Living in frontier areas	0
Total - all children 0 through 19	896,251

Note:
The Total will be determined by adding reported numbers for urban, rural and frontier areas.

Form 21
Health Status Indicators
Demographic Data
State: NY

HSI #11 - Demographics (Poverty Levels) *Percent of the State population at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2004 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Total Population	19,005,000.0
Percent Below: 50% of poverty	7.4
100% of poverty	15.0
200% of poverty	31.9

Form 21
Health Status Indicators
Demographic Data
State: NY

HSI #12 - Demographics (Poverty Levels) *Percent of the State population aged 0 through 19 at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2004 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	4,560,000.0
Percent Below: 50% of poverty	10.9
100% of poverty	21.3
200% of poverty	40.7

Form Notes for Form 21

HSI - #07A: Demographics (Live Births) :Totals exclude births to moms with "age not stated". There were 35 births in 2004 with age not stated.

HSI -#010 Demographics (Geographic Living Areas): Data are from the 2000 Census.

Field Level Notes

1. **Section Number:** Indicator 09A
   Field Name: HSIRace_SingleParentPercent
   Row Name: Percent in household headed by single parent
   Column Name:
   Year: 2007
   Field Note:
   Data from American Community Survey 2004

2. **Section Number:** Indicator 09A
   Field Name: HSIRace_TANFPercent
   Row Name: Percent in TANF (Grant) families
   Column Name:
   Year: 2007
   Field Note:
   The rate is based on kids through age 18 since TANF includes kids up to age 18.

3. **Section Number:** Indicator 09A
   Field Name: HSIRace_SCHIPNo
   Row Name: Number enrolled in SCHIP
   Column Name:
   Year: 2007
   Field Note:
   Data represent SCHIP enrollment during December 2005.

4. **Section Number:** Indicator 09A
   Field Name: HSIRace_WICNo
   Row Name: Number enrolled in WIC
   Column Name:
   Year: 2007
   Field Note:
   Enrollment for the first quarter of 2005.

5. **Section Number:** Indicator 09A
   Field Name: HSIRace_JuvenileCrimeRate
   Row Name: Rate (per 100,000) of juvenile crime arrests
   Column Name:
   Year: 2007
   Field Note:
   Data includes 24,648 arrests for violent and property index crimes in NYS outside of NYC among kids aged 10-19. The rate is base on a population figure of 1,603,684 kids age 10-19 in upstate NY. New York City data was not available.

6. **Section Number:** Indicator 09A
   Field Name: HSIRace_DropOutPercent
   Row Name: Percentage of high school drop-outs (grade 9 through 12)
   Column Name:
   Year: 2007
   Field Note:
   Data are for the 2003-2004 school year.

7. **Section Number:** Indicator 09B
   Field Name: HSIEthnicity_DropOutPercent
   Row Name: Percentage of high school drop-outs (grade 9 through 12)
   Column Name:
   Year: 2007
   Field Note:
   Data are for the 2003-2004 school year.

VIII. GLOSSARY

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Article 6 – Refers to Article 6 of the New York State Public Health Law, which sets for the conditions under which local health departments are reimbursed for general public health work.

Assessment - (see Needs Assessment)

ATUPA - an abbreviation for **The Adolescent Tobacco Use Prevention Act.**

BCAH – an abbreviation for the **Bureau of Child and Adolescent Health.**

BDH – an abbreviation for the **Bureau of Dental Health.**

BEIS – an abbreviation for the **Bureau of Early Intervention Services.**

BRFSS – an abbreviation for the **Behavioral Risk Factor Surveillance System.**

BWH – an abbreviation for the **Bureau of Women's Health.**

CACFP - An abbreviation for the **Child and Adult Care Feeding Program,** a program providing reimbursement for nutritional meals and snacks in regulated and approved day care facilities.

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, what does the State need to achieve the results we want?

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)]*

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year's MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one -

those services that assure access to quality preventive and primary care services. *[Title V Sec. 501(b)(4)]*

C-BAPP - an abbreviation for **Community-Based Adolescent Pregnancy Prevention Program** - a program that targets New York State adolescent in the zip codes at highest risk for adolescent pregnancy with public health interventions.

Child Health Plus - New York's subsidized insurance program for the uninsured and underinsured as established by the Health Care Reform Act of 1996 and later supplemented by Federal Child Health Insurance Program funds.

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - ***(For budgetary purposes)*** Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. ***(For planning and systems development)*** Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

CISS - an abbreviation for **Comprehensive Integrated Services Systems**. This is a grant program administered by the Federal Maternal and Child Health Bureau.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under Pregnant Women, Infants, Children with Special Health Care Needs, Children, and Anthers.

CMR – An abbreviation for the New York State **Congenital Malformations Registry.**

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

CPPSN - an abbreviation for **Comprehensive Prenatal/Prenatal Services Network.**

CSHCN - See **Children with Special Health Care Needs**

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

DFH – an abbreviation for the **Division of Family Health -** The division within the New York State Department of Health and Center for Community Health that is responsible for the administration of Title V and Title V-related activities.

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

DOH – an abbreviation for **Department of Health.**

DRM – an abbreviation for **Disaster Relief Medicaid**.

EIP – an abbreviation for the New York State **Early Intervention Program**.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

FPL – an abbreviation for the **Federal Poverty Level.**

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

HCRA – an abbreviation for the Health Care Reform Act. See below for definition.

Health Care Reform Act (or HCRA) - A New York State law passed in 1996 and renewed in 2000 that authorizes, among other things, the financing of health

services, graduate medical education, insurance coverage for the uninsured and rural health networks.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

HIN - an abbreviation for the **Health Information Network,** a Department of Health intranet accessible to local county health departments and state staff, containing community health data.

HPN - an abbreviation for the **Health Provider Network,** a Department of Health intranet accessible to local county health departments, state staff, and health care providers, containing health-related data and notifications.

HPSA - Abbreviation for a **Health Professional Shortage Area**. This designation by the Federal Government means that there are less than the number needed of certain health care professionals, like doctors or dentists.

IMR – an abbreviation for **Infant Mortality Rate**, the rate per 1,000 at which infants under the age of one year die.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. *[Title V, Sec. 501 (b)(2)]*

MA - an abbreviation for **Medicaid,** also known as **Title XIX**.

MCH – an abbreviation for **maternal and child health.**

MCHSBG – An abbreviation for the Maternal and Child Health Services Block Grant, or Title V.

MCH Pyramid of Health Services - (see Types of Services)

MCO - an abbreviation for **Managed Care Organization**, a provider of managed health care.

Measures - (see Performance Measures)

Medical/Health Home - The Maternal and Child Health Bureau and the New York State Department of Health use the American Academy of Pediatrics (AAP) definition of medical/health home. The medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family-centered, coordinated and compassionate. It should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them. These characteristics define the medical/health home and describe the care that has traditionally been provided by pediatricians in the office setting. In contrast, care provided by emergency departments, walk-in clinics, and other urgent-care facilities is often less effective and more costly. (American Academy of Pediatrics, Volume 90, Number 5, November 1992.)

MUA – an abbreviation for **Medically Underserved Area.**

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

1) What is essential in terms of the provision of health services;
2) What is available, and
3) What is missing.

NTD – an abbreviation for **neural tube defect**, a congenital condition involving the brain and the spinal cord.

NYCRR- abbreviation for **New York Code, Rules and Regulations.** These are the regulations that further clarify how New York State Public Health Law will be carried out.

NYSDOH – an abbreviation for the **New York State Department of Health**.

OASAS - an abbreviation for the **New York State Office of Alcoholism and Substance Abuse Services.**

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also Performance Objectives)

OCFS – An abbreviation for the New York State **Office of Children and Family Services.** This is a "sister" agency to the New York State Department of Health.

OHSM – an abbreviation for the **Office of Health Systems Management,** the division of the New York State Department of Health that is responsible for facilities licensing and monitoring.

OMC – an abbreviation for the **Office of Managed Care.** This is an office within the New York State Department of Health.

OMH - an abbreviation for the **New York State Office of Mental Health.** This is a "sister" state agency to the New York State Department of Health.

OMM – an abbreviation for the **Office of Medicaid Management**. This is an office within the New York State Department of Health.

OSC - an abbreviation for the **New York State Office of the State Comptroller.**

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, why does the State do our program?

PBII - an abbreviation for **Provider Based Immunization Initiative** - a program under which county health department staff visit private pediatricians to assess the immunization records of their patients.

PCAP - an abbreviation for the **Prenatal Care Assistance Program** - a New York State program covering prenatal, postpartum and perinatal care for uninsured, underinsured and Medicaid women and newborns who are financially eligible for the program.

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: The rate of women in [State] who receive early prenatal care in 20__. This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

PHCP - an abbreviation for **New York's Physically Handicapped Children's Program** - an insurance type program for children with special heath care needs to assure access to specialty care for medically and financially eligible children. PHCP now operates within the context of a broader Children With Special Health Care Needs Program.

PHL – an abbreviation for (New York State) **Public Health Law.**

PMRP - an abbreviation for **New York's Preventive Medicine Residency Program.**

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - An abbreviation for the **Pregnancy Risk Assessment Monitoring System** - collects population-based information on maternal knowledge, attitudes and behavior, on service access and utilization, and on possible physical and emotional stressors during pregnancy from a sample of women who have recently given birth.

PRC – ***The definition depends on context.*** **PRC** is an abbreviation for **Pediatric Resource Centers -** a program under the New York City Medical and Health Research Administration, targeting infants at high risk who are program eligible. **PRC** may also be an abbreviation for **Perinatal Regional Centers.**

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be

shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State=s MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

QARR or Quality Assurance Reporting Requirements - The QARR is an annual analysis of quality performance of managed care plans in New York State. The annual report includes measures such as childhood immunization, blood lead testing, HIV testing of pregnant women, well child care, cancer screening and the treatment of chronic diseases such as asthma and diabetes, and (since the 1997 report) results of standardized consumer satisfaction surveys for the commercial population.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, why should the State address this risk factor (i.e., what health outcome will this result support)?

RPC – an abbreviation for **Regional Perinatal Center.**

SBHC- an abbreviation for **School Based Heath Center** - a source for primary and supportive health services located within a school setting.

SIDS - an abbreviation for **Sudden Infant Death Syndrome**.

SPARCS - a data system that collects information on every hospital discharge in the state.

SPDS – an abbreviation for New York's **Statewide Perinatal Data System.**

SPRANS - an abbreviation for **Special Project of Regional and National Significance** - a grant program administered by the Federal Government.

SSDI - an abbreviation for **State Systems Development Initiative** - a grant program administered by the Federal MCH Bureau.

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam,

American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Pelau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

STD - an abbreviation for **Sexually Transmitted Disease.**

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include: systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (Medicaid) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (Medicaid) program.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block Grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the State), *Other* Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by State MCH agencies from insurance payments, Medicaid, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," Population Based Services, Enabling Services, and Direct Medical Services.

Universal Coverage - A situation under which the whole population is covered by public or private health insurance coverage.

WIC - an abbreviation for **Women, Infants, and Children** - a nutrition education and supplement program sponsored by the Federal Department of Agriculture for financially and medically eligible prenatal and breast feeding women, infants and at-risk children.

YRBS (Youth Risk Behavior Survey) – A biennial survey conducted in New York State secondary schools by the State Education Department.

YTS (Youth Tobacco Survey) – A survey administered every two years to students in sixth through twelfth grade.

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IX. TECHNICAL NOTES

Technical notes are included throughout the forms section. No separate technical notes are included with this application.

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X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. Needs Assessment – See Section II.
B. All Reporting Forms – See Section IV.
C. Organizational Charts and All Other State Supporting Documents
D. Annual Report Data – See Section IV.
E. Title V – EPSDT Agreement

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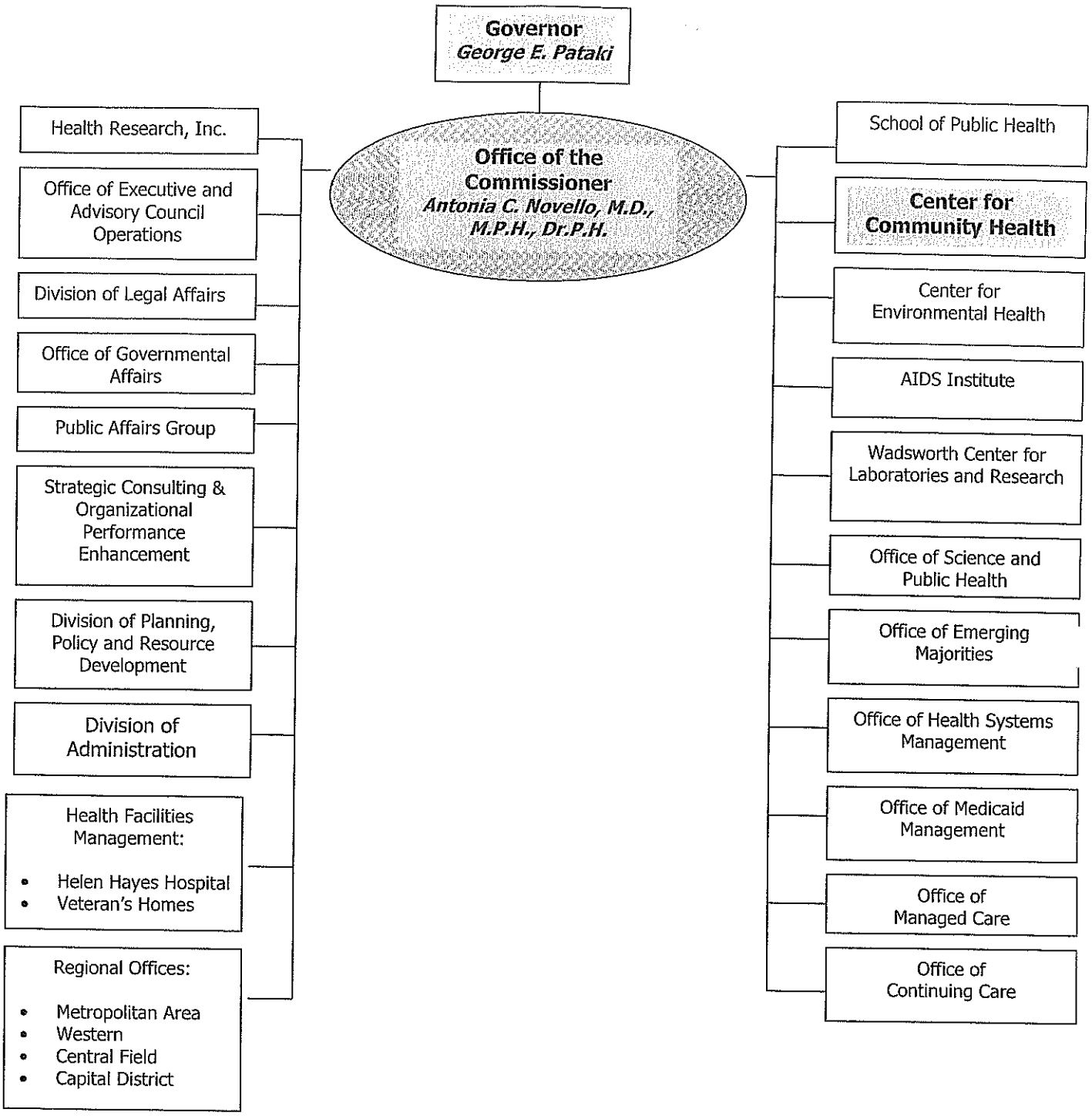
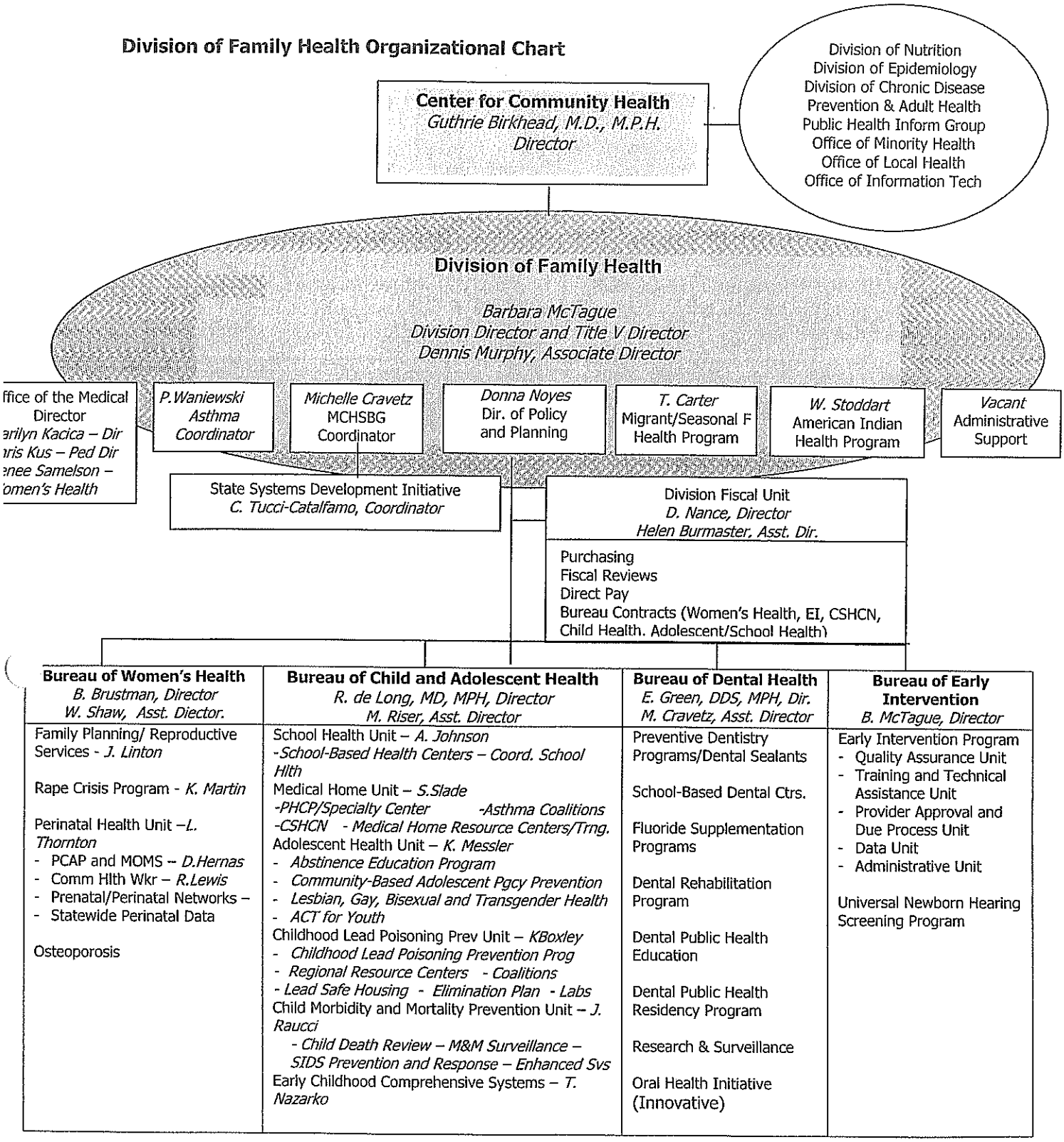
A. Needs Assessment – See Section II.

B. Reporting Forms – See Section VI.

C. NYSDOH Organizational Chart



Division of Family Health Organizational Chart



General Program Objectives –
Title V and Title V-Related Services

(Each program was limited to its top four objectives.)

Act for Youth –

- To promote positive youth development and improve health outcomes for youth;
- To foster models of community mobilization to build and enhance comprehensive prevention systems focusing on youth;
- To prevent abuse and violence and risky sexual activity including prevention of HIV/AIDS.

Abstinence Education –

- By 2008, reduce the pregnancy rate among teenagers aged 15-17, in target communities, from 38.2 per 1,000 in 2003 to 35 per 1,000;
- By 2008, reduce the birth rate among teenagers aged 15-17 from 14.9 per 1,000 in 2003 to 13.5 per 1,000;
- By 2008, reduce the proportion of adolescents aged 17 and younger who have engaged in sexual intercourse in target communities from 42% in 2003 to 36%; and
- By 2008, reduce the incidence of Sexually Transmitted Diseases among adolescents in the targeted communities from 590 per 100,000 in 1998 to 560 per 100,000.

American Indian Health Program –

- To provide for the primary care needs of Native Americans residing on reservations.

Asthma Initiative –

- Maintain and expand asthma surveillance to track the disease and asses the effectiveness of asthma interventions;
- Improve the quality of healthcare for people living with asthma;
- Support regional community based approaches to combat asthma; and
- Educate individuals, health care professionals, schools and communities about environmental and and occupational health factors that affect asthma and how to reduce or eliminate those factors.

Cancer Community Support Services –

- Fund community-based support service initiatives targeted to children with cancer and their families/caregivers.

Childhood Lead Poisoning Prevention Program –

- Coordinate efforts to prevent, detect and treat childhood lead toxicity;
- Educate the public and health professionals about prevention, early detection and appropriate medical management of childhood lead poisoning;
- Ensure that families of children with lead poisoning are given appropriate advice and assistance in locating and eliminating sources of lead within the child's environment. Provide lead-safe interim housing if needed while lead hazards are being removed;
- Collect and analyze statewide data on the extent and severity of childhood lead exposure.

Children with Special Health Care Needs –

- To improve the system of care for CSHCN and their families by assuring that every child has a medical home and strengthening community capacity through the local CSHCN Programs;
- To assist families to obtain health insurance and health services for CSHCN and to fill gaps in health services for these children;
- To assist families of CSHCN to access community resources that will enable them to care for their child with special needs; and
- To develop a CSHCN data system that will gather quality information about CSHCN to identify gaps, barriers, and trends within the system.

Children's Camp Program

- To reduce unintentional injuries among children attending camps across NYS;
- To prevent drownings associated with children's camps;
- To reduce the incidence of child abuse associated with children's camps; and
- To reduce the incidence of illness associated with children's camps.

Community-Based Adolescent Pregnancy Prevention Program –

- By 2008, reduce the statewide adolescent pregnancy rate to 35 per 1,000 females aged 15-17; and
- By 2008, reduce the statewide adolescent pregnancy rate in targeted communities to no more than 90 percent of the 1995 baseline rate (90 per 1,000).

Community Health Worker Program –

- To enroll low-income women into early, continuous and comprehensive prenatal care through assistance in overcoming barriers to accessing acceptable services, including enrollment in Medicaid and WIC, for those eligible;
- To provide education, information and promotion of healthy behaviors in low income women of childbearing age including education about effective methods of family planning, domestic violence, risk factors associated with substance abuse (including tobacco use) and HIV, and other factors;
- Provide support and information to ensure family members, including infants and children are engaged in timely and continuous primary and preventive health care including enrollment in Medicaid, Child Health Plus, Family Health Plus, WIC and other appropriate supports and services. This also includes assisting parents to understand the need for and facilitating the provision of current immunizations for all infants and children in the family; and
- Promote healthy family functioning and independence.

Comprehensive Prenatal/Perinatal Services Networks –

- To develop programs and facilitate access to comprehensive prenatal care for pregnant women, particularly under-served, hard to reach pregnant women who are not engaged in other health or community services; (These high risk women include the uninsured or underinsured, women who abuse substances, are homeless, undocumented, incarcerated, HIV positive, and are likely to have poorer birth outcomes that the general population (such as minority women, women entering prenatal care late or not at all or women whose infants may be at risk for child abuse or neglect.)
- To work collaboratively to develop a community consortium of local health and human service providers and consumers to ensure the availability of a comprehensive system of perinatal care that addresses the continuum of perinatal health services: pre-conceptional, prenatal, intrapartum, postpartum and newborn care; family planning services; intra-conceptional services; infant care; and other related maternal and child services;

- To maximize the utilization of perinatal health care resources within the community through outreach, education and coordinated delivery of services and address community-specific issues that may lead to poor birth outcomes through regional Perinatal Consortia; and
- To promote healthy behaviors in the perinatal period and reduce the impact of risky behaviors on birth outcomes either through direct efforts or collaborative efforts with the Consortium.

Congenital Malformations Registry

- Maintain the Congenital Malformations Registry's (CMR) statewide birth defects surveillance system and improve the completeness, accuracy and timeliness of case reports to the Registry;
- Expand the capacity of the statewide birth defects surveillance system targeting sub-populations at high risk for intervention;
- Serve as a resource for health care programs and professionals. Promote scientific collaboration and epidemiological studies to identify genetic, environmental, occupational and behavioral risk factors for birth defects; and
- Prevent secondary health problems and ensure that families of children reported to the CMR with special health care needs locate available resources so that each child can maximize his or her development.

Dental Public Health Residency Program –

To provide a competency-based public residency experience for dentists with MPH degrees.

Dental Rehabilitation Program –

To provide medically-necessary orthodontic services for financially-eligible children.

Diabetes Prevention and Control Program –

To establish eight regionally dispersed projects throughout NYS, the purpose of which is to implement evidence-based or promising interventions to modify risk factors for the prevention of type 2 diabetes in at-risk children.

Early Childhood Comprehensive Systems Initiative –

- To maintain a cross-sector early childhood strategic partnership in New York State; and
- To implement an early childhood comprehensive systems strategic plan that supports families and communities in raising healthy children age 0-5 in New York State. The system will support: 1.) Healthy Children, 2.) Strong Families, 3.) Early Learning, and 4.) Supportive Communities with Coordinated Systems.

Early Intervention Program -

- To enable children and families to obtain needed services to ameliorate physical and developmental delays and to prevent secondary disability through referral, service coordination, and parent and community education;
- To identify and evaluate as early as possible infants and toddlers whose healthy development is compromised and provide for appropriate interventions to improve child and family development;
- To enhance child development and functional outcomes and improve family life through the delivery of effective, outcome-based, high quality early intervention services; and
- To provide family-centered early intervention services, improving and refining the system for families, and promoting parent involvement at the individual, local and state levels.

Environmental Lead Elimination –

- Identify and reduce environmental lead hazards in targeted housing before children are exposed.

Enhanced Services for Children and Youth in New York City –

- Improve health outcomes for children and youth residing in New York City;
- Increase access to supportive services and enhance benefits received from health care; and
- Enhance systems for primary care delivery.

Eat Well, Play Hard

- To prevent childhood overweight and reduce long-term chronic disease risks through promotion of physical activity and selected dietary practices for children over the age of two.
- To promote specific core strategies to encourage families to:
  a. Increase age-appropriate physical activity;
  b. Increase intake of fruits and vegetables; and
  c. Increase intake of low-fat (1%) or fat-free dairy foods.
- To work across several food and nutrition programs in the community setting to assure and coordinate, within the context of a coalition, that children and families from targeted New York communities receive consistent policies and positive messages about nutrition and physical activity, including: WIC; day care centers, homes, and after school programs participating in the Child and Adult Care Food Program; emergency food programs; and schools.

Fluoride Supplementation Program -

- To reduce the incidence of dental caries through delivery of age-appropriate fluoride supplements delivered through schools, preschools and Head Starts located in areas where children have less than optimum fluoride levels in their drinking water;
- To provide financial and technical assistance to all schools interested in implementing the program; and
- To provide educational and promotional information on fluorides and oral health to teachers, parents, health care providers, and the public health community.

Family Planning Services –

- To reduce unintended pregnancy;
- To reduce teen pregnancy;
- To offer basic primary preventive and treatment services; and
- To provide health education in community settings.

Genetics Services –

- To ensure the availability of comprehensive genetic services to all residents of the state regardless of where they live or their economic status;
- To educate the medical and lay populations of the state about the benefits of genetic services;
- To provide a network throughout the state for the lay community, genetics and non-genetic professionals, and public health representatives to communicate and understand the genetic service strengths and needs of each; and
- To identify means to make comprehensive, noncategorical clinical genetic services fiscally viable.

Growing Up Healthy Hotline – The service operates as The Growing Up Healthy Hotline, 1-800-522-5006 and TTY 1-800-655-1789.

- To provide 24-hour/7-day-per-week telephone information and referral services covering MCH and public health topics in English, Spanish and other languages, to ensure that any caller from across the state has access to this service.
- To maintain and continuously update the hotline database to ensure hotline operators are providing the most current information to callers;
- To assist the Department in tracking and monitoring media impacts when particular programs are being promoted using the hotline (or a hotline-linked) number; and
- To provide periodic and special request reports and analyses of hotline activity.

Healthy Children New York –

- To improve the health and safety of children in child care and group care;
- To identify, train and deploy health professionals as health promotion specialists to child care programs and child-serving agencies;
- To support the sustainability of program objectives; and
- To enhance the use of the child care environment as an access point for health insurance.

Health Promotion and Media Services –

To provide effective, up-to-date health information to consumers, partners, local health departments and media outlets; and

To improve the capacity of public health leaders to respond to public health threats with accurate, understandable information.

Healthy Heart Program -

- By August 31, 2009, to significantly increase in 300 schools, the promotion of healthful foods on the school campus as measured by the School Health Index;
- By August 31, 2009, to significantly increase in 300 schools, those that have accessible facilities where children can engage in physical activity and have physical activity programs that promote lifelong activity as measured by the School Health Index; and
- To increase by 10% the number of schools that have adopted a coordinated approach to school health by using the eight components of coordinated school health model: health education, physical education and activity, health services, nutrition services, counseling and social services, school environment, parent/family/community involvement and staff wellness.

Heavy Metals Registry –

- Review all heavy metal reports and identify any reports missing a date of birth which could be a child and work with the Childhood Lead Poisoning Prevention Program and Local Health Departments to assure follow up is conducted and coordinated;
- Maintain a database of all manual heavy metal reports received for lead testing where manual reports are received from the laboratory;
- Educate code enforcement officials, contractors and do-it-yourselfers regarding lead, it's hazards, methods of identificiation, lead hazards and lead-safe work practices to assure that any lead disturbed in dwellings does not create hazards for women of childbearing age and children; and
- Identify adults with evidence of lead exposure who are women of childbearing age and/or have subsequent exposure to children which interventions and/or primary prevention activities can be performed.

Injury Surveillance and Prevention –

- To identify those injuries having the greatest public health impacts, monitor their frequency and severity and implement programs to reduce the injuries and evaluate their effectiveness;

- To provide education, training and technical assistance to regional and local injury prevention professionals to facilitate and enhance community-wide approaches to injury prevention; and
- To develop and implement injury prevention projects, with an emphasis on best practices and evaluation of the interventions to reduce injury risk.

Innovative Dental Services Initiative –

- To test innovative, community-inspired and –planned strategies to improve access to dental services for high-risk mothers, infants and children, including dental case management, school-based dental centers, mobile vans, social marketing and community organizing;
- To improve the local infrastructure for oral health services; and
- To develop local partnerships and coalitions to support and sustain program activities.

The Lactation Institute –

- To provide continuing education about breastfeeding to physicians, midwives, nurses and other health professionals.

Maternal Mortality Review –

- To publicize the uniform maternal death form and report protocol for maternal deaths in NYS hospitals to hospitals and obstetricians statewide;
- To assist in the use of the uniform maternal death report and protocol whenever a maternal death occurs; and
- To promote prevention of maternal deaths through increased awareness and education of the conclusions drawn from the review of maternal deaths.

Migrant and Seasonal Farmworker Health Program –

- To improved access to primary and preventive care services for migrant and seasonal farmworkers and their families through outreach, screening, transportation, interpretation and case management;
- To assist in enrollment of migrant and seasonal farmworkers and their families in Medicaid, Child Health Plus and Family Health Plus; and
- To promote collaboration and communication among migrant-serving agencies and providers, including Migrant Health contractors, county health departments and other organizations to identify and resolve issues, optimize service delivery and maximize use of community resources/assets.

Newborn Hearing Screening Program –

- To screen newborn infants for hearing loss as early in life as possible;
- To ensure that infants who are referred following their initial hearing screening receive a re-screening no later than 12 weeks after discharge from the birth hospital; and
- To link infants who are suspected of having a hearing loss to the Part C Early Intervention Program for appropriate evaluation and early intervention services.

Newborn Metabolic Screening Program –

- To identify congenital medical conditions which fit the newborn screening criteria:
    - they are relatively common in the population;
    - there are identified treatments which reduce morbidity and mortality;
    - the testing procedures are relatively inexpensive;
    - the test is sensitive enough to identify all affected children and yet specific enough not to identify many children that do not actually have the condition.
- To test all infants born in the state for all conditions in the newborn screening panel; and

- To work with the medical community to evaluate all infants who screen positive so as to confirm the diagnosis or certify that the child does not have the suspected condition.

Oral Health Initiative –

- To implement the comprehensive State Oral Health Plan;
- To develop and enhance the oral disease surveillance system; and
- To coordinate and implement limited community water fluoridation program management.

Osteoporosis Prevention Program –

- To establish a public education and outreach campaign to promote osteoporosis prevention and education that will allow individuals to make informed choices about their health;
- To adapt educational materials for consumers, particularly targeted at high risk groups, disseminated through contractors, local health units, health care providers, and others; and
- To train health care providers in the area of osteoporosis prevention, risk factor identification, diagnosis and treatment.

Pediatric Overweight Prevention Project Mailing –

To assess current health care provider practices related to use of BMI-for-age percentiles as a method of assessing children's weight status;

To evaluate health care providers' learning needs and preferences related to child obesity prevention; and

To improve pediatric practice of current recommendations related to routine use of BMI-for-age percentiles as a means of assessing children's weight status.

Prenatal Care Assistance Program (PCAP) –

- To improve early access to comprehensive prenatal care for women up to 200% of the federal poverty level;
- To ensure a full range of health and related services are available that meet established standards to enable women the best possible pregnancy outcome;
- To provide linkages and referrals to other services (WIC, public health nursing, etc.) to ensure pregnant women have access to appropriate support and services; and
- To ensure uniformity and consistency in the interpretation and implementation of prenatal care standards that guide the program.

Perinatal Regionalization –

- To maintain a system of regionalized perinatal care to ensure access to appropriate level, quality health care services for pregnant women and newborns;
- To promote the development and implementation of a system for quality improvement with Regional Perinatal Centers (RPCs) and affiliative networks to enhance quality of perinatal care throughout the state;
- To facilitate the operation of Regional Perinatal Forums to promote a comprehenisve approach to addressing regional perinatal problems, using a public health model, including development and implementation of an action plan in each region. This will involve RPCs, other hospitals and community organizations in the field of perinatal health and focus on new and emerging public health issues in the field of perinatal health; and
- To promote the development of a Statewide Perinatal Forum to facilitate a comprehensive review of statewide trends in outcomes and data, and based on these findings, recommend future systems changes and/or best practices. This will involve members of the regional perinatal forums and focus on new and emerging public health issues in the field of perinatal health.

Preventive Dental Services for High-Risk, High-Need, Underserved Populations/
Dental Sealant Program –

- To enhance disease prevention, health promotion activities in high need communities;
- To provide underserved children with a point of access for dental services;
- To provide improved access to care for high-need preschool and school-aged children, including those with special needs, and pregnant women and those residing in dental underserved areas of the state; and
- To provide dental sealants to low income children.

Preventive Medicine Residency Program –

- To provide five physicians with competency-based academic and practical training in general preventive medicine/public health;
- To secure stable, renewable funding to support the residency program;
- To increase the number of minority physicians pursuing careers in preventive medicine; and
- To serve as a model Preventive Medical Residency program, promoting development and improvement in preventive medicine education nationally.

Rape Crisis Program –

- To reduce the incidence of rape and sexual assault through prevention activities;
- To ensure crisis intervention and counseling services for victims of sexual assault;
- To improve societal response to the problem of sexual assault.

School-Based Health Centers -

- To improve access to comprehensive, continuous primary and preventive health care for children in high-needs/high-risk communities; and
- To improve the environment for health in high need schools.

School Health Improvement Plan/School Health Index –

- To encourage schools to implement policy and environmental changes that address nutrition and physical activity;
- To provide grant funds for completion of the School Health Index and a School Health Improvement Plan (125 schools will receive a $1,000 base grant, and 100 schools to receive up to a $6,000 mini-grant);
- To provide incentives for schools that serve low-income children, and who have not received prior funding for physical activity and nutrition programs; and
- To ensure, to the extent possible, that the selection of participating schools are geographically dispersed throughout New York State.

Sexual Assault Forensic Examiner Education Program –

- To improve care and standardize data regarding the incidence of sexual assault victims seeking treatment in hospital emergency departments.

Sexually Transmitted Diseases Chlamydia Initiative –

- To provide rapid Chlamydia laboratory screening to women attending STD clinics, universities and family health centers in New York State;
- To control and prevent the spread of sexually transmitted diseases among the residents of New York State. This will be accomplished through a comprehensive array of coordinated intervention activities;
- To identify the populations at increased risk for STD's and to reduce their chances of developing STD's transmitting it to others, and/or developing its complications; and

- To provide STD training to health care professionals in order to enhance their understanding of STD's and their ability to provide services to individuals at risk.

Shaken Baby Syndrome/SIDS Education Initiative –

- To increase awareness about preventing traumatic brain injury, shaken baby syndrome and SIDS through educational interaction between new parents and health professionals prior to hospital discharge.

Statewide Perinatal Data System –

- To develop a modular system to integrate the collection and analysis of normal and high risk birth-related and obstetric-related data at the hospital level, which will result in the provision of near-real time data to the Department;
- To provide a mechanism to collect birth certificate information and provide near real time vital records registration capability to the state, local health departments and vital records registrar;
- To provide an automated mechanism to enroll newborns in Medicaid within 10 days of birth; and
- To enhance the ability of hospitals, Regional Perinatal Centers (RPCs) and the Department to review and improve the quality of perinatal care through review and analysis of SPDS data.

Statewide Systems Development Initiative (SSDI) –

- To expand the linkages among MCH data systems;
- To conduct focus groups among the target MCH populations for the purpose of establishing policies and practices that support high-quality, accessible maternal and child health programs; and
- To strengthen the data linkages described in the Health Systems Capacity Indicator #9.

Sudden Infant Death –

- To provide risk reduction education on SIDS to the public, health care and child care providers;
- To provide educational and supportive services to professionals who initially respond to notification of infant death;
- To connect families who have experienced unexpected infant death with supportive services; and
- To support the development of a comprehensive infant and child death review system.

Vital Records –

- To provide service to the public and governmental agencies pertaining to Vital Records;
- To provide statistical, technical and maintenance support for Vital Records.

Wadsworth Laboratories –

- To ensure that public health laboratory facilities are available to the residents of New York State including, but not limited to, a laboratory for testing water purity, a laboratory for identifying lead levels, a laboratory for identifying strains of microorganism (anthrax, botulism, rabies, E. coli, and other bacterial and viral organisms), a laboratory for diagnosis of sexually transmitted diseases, a tuberculosis testing laboratory, a cytology laboratory (including pap smear review), an anatomic pathology laboratory, a cytogenetic laboratory for diagnosis of prenatal and clinical abnormalities, and laboratories for identification of reproductive and metabolic disorders;
- To operate state-of-the-art clinical laboratory and environmental laboratory evaluation programs to ensure that laboratories offering tests to NYS residents meet appropriate quality requirements and can pass proficiency tests;

- To perform basic scientific research to ensure that technologic advances and scientific knowledge have application in public health; and
- To have the appropriate laboratory capacity available in the event of an epidemic or terrorist attack.

WIC Overweight Prevention Project -

- To teach WIC local agency staff how to interact with WIC parents who have overweight children or want to reduce the risk of having an overweight child;
- To teach WIC local agency staff simple, age-appropriate movement activities to use with WIC participants;
- To promote the incorporation of daily physical activity concepts into WIC educational practices.

Youth Development

- To create a Youth Development Shared Vision and Common Language for use throughout the state;
- To undertake strategic Youth Development collaborations; and
- To measure Youth Development outcomes through the use of specific indicators.

D. Annual Report Data - Included in Text

E. Title V – EPSDT Agreement

Medicaid/EPSDT – Title V Action Plan
New York State Department of Health

This document is a plan for coordination of Title V activities with the Office of Medicaid Management, including activities related to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, which in New York is called the Child/Teen Health Program (C/THP).

Shared goals include:

- Access to health insurance for every New Yorker.
- Comprehensive, high quality and accessible medical services for every New Yorker.
- A medical home for every New Yorker.
- Continuous significant reduction in maternal, infant and child morbidity and mortality.
- Non-discriminatory provision of assistance, and of medical services, to Medicaid applicants and recipients.
- Delivery of all services to Medicaid applicants and recipients in a culturally and language appropriate manner.
- An increase in the public's awareness of Title V and Title XIX services available to them.
- Coordination of services delivery, to ensure services will be provided without duplication of effort, or fragmentation.

Shared specific objectives include:

- Definitions and clarifications of the respective functions and responsibilities of New York State Title V, and Title XIX (Medicaid).
- Shared responsibility for adherence by medical care and health services providers, to Federal and State regulations and current standards of medical care.
    - Title V. reviews utilization, appropriateness, availability and quality of care and services furnished by its contractors and providers to Medicaid recipients and others.
    - Title XIX provides specific instruction on State regulations and standards of care to its Medicaid providers via a Medicaid Manual, which is provided to every enrolled provider, and is updated periodically. Title XIX also provides relevant and pertinent information and updates to its providers via the monthly *Medicaid Update* publication which is sent to every Medicaid provider, and made available on the NYSDOH website, as well.

- Shared responsibility for education of Medicaid recipients within Title V and Title XIX programs relative to services available, and their appropriate use, establishment of a medical home, EPSDT (C/THP) services, and the need to access primary and preventive health services, the importance of oral health, the need for early and continuous prenatal care, and the availability of Family Planning services.

- Title V and Title XIX share de-identified data relative to health outcomes, gaps in services, concerns for placement and proficiency of providers, and the utilization of the Child/Teen Health Program (EPSDT), for the purpose of exploring potential topics for joint planning or intervention.

- Shared responsibility for observing and requiring adherence to Federal and State laws and regulations related to confidentially of records and information. Both Title V and Title XIX agree not to allow examination or disbursal of recipient information or records, except as may be necessary for the purpose of obtaining medical care and health services, assuring the propriety of such care and services, and providing compensation to their providers.

- Shared responsibility for observing and requiring observance of all requirements of the Civil Rights Act of 1964.

- Shared responsibility to designate specific personnel from Title V and Title XIX to be responsible for continuous liaison activities. Specific areas for collaboration include, but are not limited to:

  - Dental Health/Orthodontia
  - Asthma
  - Care Coordination for Children with Special Health Care Needs
  - Lead Poisoning Prevention
  - Cross-systems Children Workgroups
  - Standards setting
  - School Health
  - Antibiotic Use Workgroup
  - Mental Health
  - Alcohol and Substance Abuse Issues

Title V-specific objectives include:

- Maintenance of the Growing Up Healthy Hotline, established under Title V which furnishes toll-free information about location and phone numbers of local Departments of Social Services, and location of facilitated enrollers for Medicaid eligibility determination, the Child/Teen Health Program, availability of Care at Home and other Medicaid Waiver Programs, all Medicaid services for children and adults, information on many specific diseases ,The Medicaid Obstetrical and Maternal Services program, the School Health Program, and various other subjects relevant to the Medicaid community.

- Review of utilization, appropriateness, availability, and quality of care and services furnished by its contractors to Medicaid recipients, and others.

- Provision to Title XIX of lists of institutions and sites approved to provide comprehensive prenatal care services under Part 85.40. (PCAP).

- Provision of consultation to Medicaid on issues related to mothers, infants, children, youth, and women of reproductive age.

- Provision of advice and assistance in the design of data capture instruments.

- Provision of instructions to Title V contractors, regarding provision and documentation of public funded services to assist families in meeting their Medicaid eligibility spend downs.

- Assistance to Title V contractors in qualifying for payment under Title XIX, establishing and maintaining appropriate fiscal records, and provision of information determining payment for services provided to Title XIX recipients.

- Title V entities make referrals to Medicaid, assist in identifying Title V clients of potential eligibility for Title XIX coverage, and refer those clients to their local Depart of Social Services, or facilitated enroller, for eligibility determination.

Title XIX-specific objectives include:

- Access to lists of physicians and other health care providers who are eligible to receive Title XIX reimbursement for services provided to recipients, for distribution to its contractors.

- Access to lists of physicians and other health care providers who are ineligible to receive Title XIX reimbursement due to violation of state and federal law, for distribution to its contractors.

- Oversight/monitoring, guidance, support, and necessary assistance to the State's local Departments of Social Services (LDSS) in matters of Medicaid eligibility, enrollment, and maintenance of client records.

- Oversight/monitoring, guidance, support, and necessary assistance to the fifty-eight Local Departments of Social Services in their administration, and client informing and education, of the Federal and State mandated Child/Teen Health Program (EPSDT).

- Arranging and promoting partnership, communication and cooperation between Title XIX and LDSS Medicaid operations by mutual coordination, and attendance by administration and staff of both entities, at regularly scheduled meetings at various locations around the state.

Plan of Action for Coordination of Title V and Title XIX Responsibilities:
Designated personnel from relevant divisions of Title V and Title XIX will meet on a regular basis, with a minimum of four meetings a year, and as deemed necessary by Title V and Title XIX Administrators, to discuss all areas of mutual and singular responsibility for respective programs, to update each other on new developments, and to maintain and enhance communication and cooperation between the two entities.