



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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I. APPLICATION AND ANNUAL REPORT - COMMON REQUIREMENTS

1.1 Letter of Transmittal



**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.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

July 19, 2000

Grants Management Officer, MCHB
HRSA Grants Application Center
1815 N Fort Meyer Drive
Suite 300
Arlington VA 22209

Grants Application Center:

RE: **Maternal and Child Health Services Title V Block Grant Program
New York State 2001 Needs Assessment and Application and
1999 Annual Report**

With this letter, I transmit New York's 2001 Maternal and Child Health Services Block Needs Assessment and Grant Application, combined with the 1999 Annual Report. This transmittal includes one original hard copy version and a disk containing the captioned documents, as well. We are also sending additional hard copies to the Region II office, to the attention of Dr. Margaret Lee, Ms. Shirley Smith and Ms. Mona Martin. The previous draft version of the document, mailed July 14th, 2000, should be discarded.

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

Sincerely,

Dennis P. Murphy
Acting Director
Division of Family and Local Health

Copies: Dr. Margaret Lee
Ms. Shirley Smith
Ms. Mona Martin

1.2 Application Face Sheet

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1.4 Overview of the State

Title V, the Maternal and Child Health Services Block Grant, provides the basic framework for provision of maternal and child health services in New York State. New York's Title V activities take place within the larger context of a complicated and varied health care delivery and social environment and, therefore, it is important to understand the needs of the entire state population to understand the fit of our maternal and child health programs.

Geographic and Population Characteristics

New York State, the third most populous state in the United States, is characterized by its diversity.

Geography: New York State has a land mass of 47,831 square miles that includes 8,000 lakes, nine major rivers, a six million acre rugged Adirondack park, hundreds of small, rolling valleys, fertile glacial plains, awe-inspiring gorges and waterfalls, rural villages and one of the most vibrant metropolitan areas in the world. Bordered by the Great Lakes Ontario and Erie, the Atlantic Ocean, Canada to the north and west, Pennsylvania to the south and west, and Vermont, Massachusetts and Connecticut to the east, the geography of New York is both vast and diverse. Winters can be severe, particularly for the Tug Hill plateau region that is subject to frequent and heavy "lake effect" snow storms. While the Finger Lakes and the Catskill and Adirondack mountain ranges are among our most beautiful natural resources, these attributes can also impede transportation and delay access to health care. Areas that are attractive to tourists often experience a striking seasonal demand on limited health services, especially in the areas of emergency medical services and public health. (See Figure 1.)



Population Growth: Over 18 million 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 then rose, then leveled off. (See Table 1 and Figure 2.) It was the second most populous state until the late 1990's, when it's population growth slowed to less than 1%. New York is now the third most populous state, behind California and Texas. According to the US Census Bureau, the 2000 population for New York State was projected to be 18,146,000.

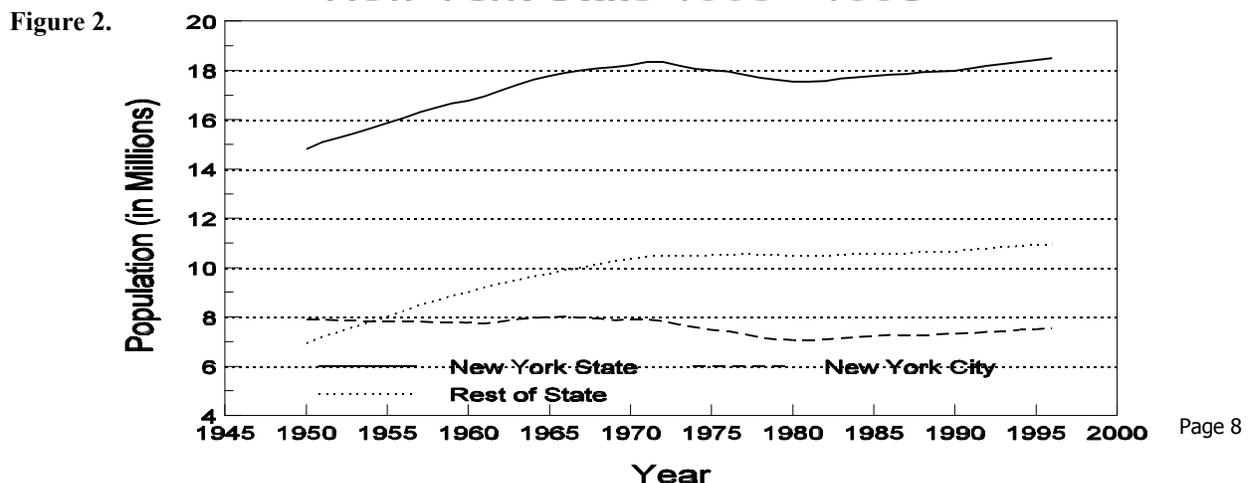
Population Density: Population density often determines the number and types of health services that an area can support. Population density within New York varies widely. New York City is 104 times more densely populated than the rest of the state, and New Yorkers are more likely to live in urban areas than residents of other states. Twenty-six percent of New Yorkers live in rural areas, compared to 36% nationwide. About 40% of the state's residents live in New York City. 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).

Table 1. Population of New York State 1950-1998

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

Population New York State 1950 - 1996



Employment, Per Capita Income and Poverty: The 1998 unemployment rate for New York is 5.6%. New York's economy has grown moderately since 1992, with most of the growth in the areas of construction, services, wholesale and retail services. The number of manufacturing jobs has declined. Residents of New York, however, have a higher-than-average per capita income, \$28,000 compared to \$23,000 nationwide in 1995.

While New Yorkers are better off on average, New York has a higher percentage of children living in poverty as compared to the country as a whole (25% vs. 22% nationally). The comparison is more dramatic in New York City, where 44% of the children live in poverty.

In 1998, 1,210,458 children between the ages of birth and 19 years live below the Federal poverty level. This represents 25.6% of all children in this age group. About one third of all New York State families live at or below 185% of the Federal poverty level. About 44.6% of all children in the state lived in families with income levels below 200% of the Federal poverty level in 1998.

Poverty is more common in families headed by single females, and single-female headed households with children under age 5 are more likely than not to be living below poverty. According to the 1998 Current Population Survey, 50% of the people in female-headed households lived below poverty in the state. 58% were below 125% of the poverty level. This is true regardless of race or ethnicity. Also, child poverty is twice as common in New York City as it is in the rest of the state. The Bronx, where half the children are poor, holds the highest child poverty rate in the State.

In comparing poverty levels among age groups, the 1996 Current Population Survey found that there is a general decrease in poverty as individuals grow older. In 1996, the percent of those living in households earning less than 100% of the poverty level were: 24% for children birth to age 9, 21% for 10 to 19 year-olds, 16% for 20 to 29 year olds, 13% for 30-39 year olds, and 12% for those over 50.

Education: Unfortunately, many of New York's students do not complete high school. The National Center for Education Statistics reports that, based on the 1990 census, 10.1 % of New Yorkers aged 16-19 were not enrolled in school and had not graduated from high school. This was slightly lower than the national percentage of 11.2. Within the state, the percentages varied from 5.2 % in Nassau County to 18.0 % in the Bronx.

Statewide, according to the 1990 census, 18% of mothers with children under the age of 18 had not completed high school. Mothers in New York City were nearly three times as likely (30% vs. 11%) as mothers in the rest of the state 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. Mothers in the Bronx (37%) were least likely to have graduated, and mothers from Saratoga (6%) and Nassau Counties (8%) had the lowest rates of not completing high school.

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, having 2.2 million non-citizen residents in 1996. Almost 90% of New York's non-citizen immigrants live in New York City.

According to the 1998 Current Population Survey, 17.7% of New York State's population are Black, 76.4% are white, 14.4% identify themselves as Hispanic and 5.5% identify themselves as Asian or Pacific Islanders. (Note that the figure for Hispanics includes both white and non-white Hispanics.) About 74% of Blacks and 80% of Hispanics in the state reside in New York City. About 30% of New York City's population is Black, and about 24% is Hispanic. Several counties outside of New York City have significant Hispanic population, as well. In Rockland, Nassau, Orange, Suffolk, Sullivan and Westchester Counties, Hispanics make up at least 6% of the population.

Private Sector Resources: New York remains a center of 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. In addition, business has helped to set the health care agenda and to assist New York in meeting goals for health insurance enrollment. 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 will be required from all sectors of our society, including business and private concerns.

Overall Goals for Health Care in New York State

The overall goals for health care delivery in New York are:

- C to place greater emphasis on prevention and education by involving communities in addressing and improving health;
- C to continue to expand insurance coverage to the uninsured and underinsured;
- C to assure that the health care delivered in New York State is of high quality; and
- C 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 goals for health in New York in this year's State of the State Address:

- C to reduce potentially deadly asthma attacks by 50%;
- C to ensure that every child in New York receives all their vaccinations by their second birthday;
- C to ensure that every newborn is screened for deafness; and

C to protect infants born to HIV-infected mothers to ensure that virtually none develop AIDS.

The Health Care Delivery Environment in New York State

Over the past few years, the health and social care environment in New York has been greatly altered. The delivery of maternal and child health services is also being altered by these changes. An understanding of these many changes is important to providing the context for New York's Title V activities.

In the summer of 1996, the **New York State Health Care Reform Act (HCRA)** was adopted, changing our state's reimbursement system from an all-payor system to a free market system and providing new and innovative ways to pay for "public goods." 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 makes available 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 between the ages of 18 and 65 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 will access services through participating managed care plans, and parents will be able to join the same plans as their Child Health Plus- or Medicaid-enrolled children. Income eligibility will vary depending on the applicant's family size and whether or not he/she lives with a child. Family Health Plus will become available in January of 2001.

Health Needs of the Population in General

Improving and sustaining access to high-quality, continuous primary health care and treatment services are critical to eliminating disparities in health outcomes and in achievement of 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 health services, which requires practitioners to be knowledgeable about and practice good preventive and therapeutic medicine.

The most significant barrier to health care is still the lack of health insurance. In 1990, 12 percent of New Yorkers were uninsured, and by 1995, this number had risen to 16 percent statewide and 21 percent in urban areas. Approximately 2.9 million New Yorkers had no health insurance coverage in 1995. The young are disproportionately affected, with more than 25 % of young adults and 14 % of

children under age 18 lacking coverage. By 1997, it was estimated that between 400,000 and 680,000 children under the age of 18 were uninsured. The U.S. Census Bureau reported that the three year average percentage of uninsured for children with family incomes at or below 200% of poverty for 1996, 1997 and 1998 was 9.8%.

The uninsured rate for children rose in the mid-90s despite the availability of Child Health Plus (New York's low cost health insurance program for the uninsured and underinsured) and an expansion of Medicaid. For the first time in four years in 1998, the proportion of children between the ages birth and 17 declined to 13.8%. Prior to this, it had been steadily increasing since 1990, with the exception of 1995, when it dropped to 11.9%. The reasons are many. One reason: the change in the state's industrial base from predominantly manufacturing to lower paying service sector jobs. With this change there has been a rise in the proportion of jobs that offer few or no benefits. Many offer insurance for the employee only, and offer family coverage only at unaffordably high rates, too high for the families to "buy in" to family coverage. These are the children that we are targeting for Child Health Plus. For this reason, there are many families where only the mother is uninsured. Another very significant reason for the high rate of uninsurance is thought to be that the public is not understanding the difference between cash assistance and Medicaid. Fewer people are applying for cash assistance and may be waiting until they have a medical need before applying for Medicaid-only benefits. The high number of immigrants in New York State must certainly be another factor.

Ensuring access to health care coverage for the uninsured and underinsured remains a high priority in New York State. In addition to the efforts of Title V, New York State addresses the need to ensure access to care through major public insurance programs: **Medicaid, Managed Care, Child Health Plus** and (soon) **Family Health Plus**.

■ **Medicaid**

There have been major expansions in New York's Medicaid Program over the last few years, many of them relative to the maternal and child health population.

Most children under age 19 who have been determined eligible for Medicaid (with family incomes up to 133% FPL) will now receive **12 months of continuous coverage**, even if their family's income exceeds eligibility levels during that year.

The **Family Planning Extension Program** extends Medicaid eligibility for family planning services. 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. The benefit package includes all services normally provided by family planning programs for their patients, with the exception of abortion.

There has also been a **Family Planning Program Expansion**. One of the major limitations of the Family Planning Extension Program was a woman needed 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 woman's income being below 200% of the Federal Poverty Level, regardless of previous Medicaid eligibility or pregnancy. New York is one of a limited number of states that have pursued this approach. A Medicaid waiver will be required before the program can be implemented. If the waiver is obtained, the Federal government will support 90% of the cost of contraceptive services for eligible women. There will be a number of difficult issues that will need to be addressed in order to obtain the waiver, but this legislation represents a major milestone.

There has also been an **expansion of Medicaid eligibility for pregnant women** in our most recent state budget. Women at or below 200% of the Federal Poverty Level (up from 185%), should they become pregnant, will now be eligible for full services under the **Prenatal Care Assistance Program**. Services under this program include prenatal care, nutrition screening and referral, psychosocial screening and referral for needed services, health education on a wide variety of topics, laboratory services, prescriptions, inpatient care, intrapartum and postpartum services, and related services such as dental services and home visiting, as needed.

■ **Managed Care**

More New Yorkers than ever before are receiving care through managed care providers. Mandatory Medicaid managed care represents the single greatest effort the State has made to ensure that every New Yorker with Medicaid has access to high-quality primary care in a "medical home" model. This move also helps to ensure 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.

The quality of managed care is being monitored in a coordinated fashion. Health Plans that contract with the state through Child Health Plus and Medicaid are required to submit reports to New York's Quality Assurance Reporting Requirements (QARR) data base, on an annual basis. Among other measures, the QARR contains measures of preventive care and health measures 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 five years of QARR data (1994-1998), we have seen a trend in which the difference between the historically underserved Medicaid population and those individuals with private insurance has narrowed or disappeared with respect to primary care access and receipt of preventive services. There has been continuous improvement in usage of screening mammograms, cervical cancer testing, and immunizations. In addition, with respect to care of people with chronic diseases like asthma, heart disease and diabetes,

there has been an improvement in the delivery of recommended interventions that will positively impact health outcomes. The Department, providers and plans are engaged in prioritizing areas for further quality improvement, which is further advancing the health status of New Yorkers.

■ **The Child Health Plus Program**

Child Health Plus provides free or low-cost private health insurance to children from birth to age 18 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. New York's Child Health Plus served as a model for the national program, and has been used as a model in New York to design the new Family Health Plus Program.

The program holds the potential for near universal coverage of New York's children. Eligibility for Child Health Plus was increased this year to 230% Federal Poverty Level (FPL), or \$38,477 for a family of four, making 11,500 more children eligible for service. As of July 1, 2000, families with incomes at or below 250% of the FPL, or \$41,684 for a family of 4, are eligible for subsidized coverage, making another 34,770 children eligible. Coverage for those under 160% FPL is free. Premium contributions for families between 160 and 222% is \$9 per child, with a maximum of \$27 per family. For families between 222 and 230% FPL, the contribution is \$15 per child, with a maximum of \$45 per family. 486,015 children were enrolled in Child Health Plus as of May 1, 2000. Enrollment is occurring at the rate of about 20,000 children per month. See Table 2 for the number of children enrolled in each age group. Over one third of all the children enrolled in the national child health insurance program are New York State-enrolled Child Health Plus children.

Age Group	December 1997		May 1998		May 1999		March 2000	
	#	%	#	%	#	%	#	%
Birth to 1 yr	3708	2.3	5013	2.6	9086	3	13,122	2.7
1-9 yrs	94427	59.3	110845	57.7	180528	55	260,018	53.5
10-14 yrs	43946	27.6	52019	27	87851	27	133,168	27.4
15-19.1 yrs	17079	10.8	24354	12.7	49716	15	79,707	16.4
Totals	159,160		191,385		327,181		486,015	

■ **The Family Health Plus Program**

As previously mentioned, with the enactment of the Health Care Reform Act of 2000, the Governor and the Legislature established the **Family Health Plus Program**. Modeled after the **Child Health Plus Program**, this program will offer comprehensive health insurance at no cost to low-income, uninsured adults who do not qualify for Medicaid or Medicare. To qualify, the individuals must be between the ages of 18 and 65 and not meet the criteria for Medicaid but meet the following income criteria:

- C In the case of a parent who lives with a child under the age of 21, gross family annual income is up to 150% of the Federal Poverty Level or \$25,600 for a family of four.
- C In the case of a child not living with a minor child under the age of 21, gross family income is up to 100% of the Federal Poverty Level or \$8,400 per individual.

Family Health Plus will not consider assets and other non-income resources in determining eligibility. Once accepted into the program, participants will be guaranteed six months of coverage. Because Family Health Plus will be a Medicaid program, it will not cover undocumented immigrants or legal permanent residents who arrived in the country after August 22, 1996, for a five-year period following their arrival to the U.S. (This differs from Child Health Plus, which covers all children regardless of their immigration status.) Also because it is a Medicaid program, the implementation of Family Health Plus will require applying to the Federal government for a waiver to the State's Medicaid Plan.

The Family Health Plus benefits package will be similar to that of Child Health Plus, covering physician and nurse practitioner services, laboratory tests, diagnostic x-rays, prescription drugs, durable medical equipment, inpatient hospital stays, radiation and chemotherapy, hemodialysis, emergency room visits and ambulance services, inpatient and outpatient mental health services, alcohol and substance abuse services, dental services (except orthodontia and cosmetic surgery), vision care, speech and hearing services, diabetic supplies and equipment, and early and periodic screening, diagnosis and treatment services for enrollees ages 19 to 21.

The calendar for phase-in is as follows:

- C The program will be open to parents with a family income up to 120% of the Federal Poverty Level and single adults with incomes up to 100% of the Federal Poverty Level as of January 1, 2001.
- C Parents with incomes up to 133% of the Federal Poverty Level will be added to the program as of October 1, 2001.
- C Parents with incomes up to 150% of the Federal Poverty Level will be added to the program as of October 1, 2002.

■ **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.

- C Facilitated enrollers reach out to and enroll to both Medicaid and Child Health Plus.
- C The Department piloted a joint Medicaid-Child Health Plus-WIC application, which is now being used in a facilitated enrollment initiative.
- C To facilitate children's retention of their primary care provider, most Child Health Plus providers are also Medicaid managed care providers. The design of Family Health Plus will allow adults to stay with their provider as they transition to or from Medicaid, as well.
- C Quality is also being monitored in a coordinated fashion, with plans participating in Child Health Plus and Medicaid required to submit reports annually.

The Title V programs continue to have a role in outreach, enrollment, standards development, quality assurance and evaluation.

■ **Other Primary Care and Insurance Initiatives**

The **Primary Care Initiative**, through use of HCRA funds, improves access to primary and preventive health services for vulnerable communities and populations through grants to hospitals, free-standing health clinics and private practices to build, equip and expand primary care services in designated underserved areas of the State. Additional HCRA funding is designated to encourage education of minorities in health professions, and monies are available for loan repayment.

The **Small Business Insurance Partnership Program** is available to pay health insurance premiums for employers with few employees. Employers will pay 45% and the employees will contribute up to 10% of the premium. 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 to improve health care delivery. The **AIDS Drug Assistance Program** helps employed persons with HIV or AIDS purchase expensive medications that they need to control their illness.

■ **Primary Care Shortage Area Designation**

There are other concerns in addition to lack of health insurance. Many communities in New York State, especially rural and inner-city areas, are considered underserved. Though NYS ranked second in the country in 1994 for number of doctors per 100,000 civilian population, there is a distinct maldistribution. There are 105 federally-designated primary care shortage areas in New York with more than 3.8 million people residing in these 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. The problems are exacerbated by a shortage of health personnel and the deepening fiscal problems of rural health care facilities. HCRA 2000 continued numerous provisions designed to assist rural areas.

■ **New York State Council on Graduate Medical Education**

The New York State Council on Graduate Medical Education has also 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.

Current MCH Priorities and Initiatives

Title V programs exist within a dynamic, rapidly changing environment: devolution of decision-making to the states, welfare reform, the expansion of child health insurance initiatives, and the expansion of managed care, to name a few. Title V programs have responded to these changes by re-assessing their relevance, based on their continued need and value, and with consideration of competing factors such as welfare reform and the movement toward a market-based health care economy. The growth of

managed care and insurance programs for the uninsured and underinsured has had an effect on traditional maternal and child health services programs.

The State Health Department, as 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. Even prior to the approval of the 1115 Waiver for the "Partnership Plan" in July 1997, the Title V programs have worked to ensure that the transition to a negotiated rate system and the expansion of Medicaid managed care enable women, infants and children to receive high-quality, comprehensive, appropriate services. Our priority is to assure that essential maternal and child health services are strengthened by this transition 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.

In the summer of 1996, the New York State Public Health Council undertook an inclusive process to recommend priority areas for public health action for the next ten years. The Council then appointed a 19-member Public Health Priorities Committee to seek statewide input and to recommend health objectives for the State. More than 1,400 New Yorkers participated in regional forums held in six different locations across NYS, bringing forward the most serious public health issues in their communities, the underlying causes of these problems, and the interventions that could be most effective. The Committee also enabled input from state and local public health professionals and other New York agencies, surveyed other states for their experiences identifying health objectives, and reviewed indicators of New York's current health status compared to the rest of the nation and with the Healthy People 2000 national objectives. In formulating the health priorities report, the Committee's overall goals were to focus community attention and stimulate action in those areas that can lead to the most significant improvement in the functional lifespan of all New Yorkers and reduce health disparities among New York residents. The Committee relied heavily on community input received at the regional workshops and 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*, identified 12 priority areas, most of which had a maternal and child health component, and addressed these priorities as "opportunities for action":

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

The outgrowth of this community exercise has been a convergence of planning and implementation activities across the state. In 1997, the Maternal and Child Health Services and Preventive Services Block Grant Advisory Councils reviewed the report and affirmed their priorities in light of the Communities Working Together report. Local health units were given grants to convene community planning groups to begin the local implementation process. Key local stakeholders were invited in 1997 to attend a statewide workshop entitled Focusing the Message: Mobilizing Communities for Public Health Priorities. The workshop showcased effective collaborative projects from across the state, presented key information about collaborative approaches, and gave participants the opportunity to improve their team-building and meeting skills. In 1998, stakeholders attended a second conference, which included a recognition ceremony that celebrated the progress made by local communities in their quest for a healthier New York. This exciting event allowed communities to share their successes and learn from the success of others. The 62 featured collaborations were described in a publication of the New York State Community Health Partnership and the Milbank Foundation entitled, Partners in Community Health: Working Together for a Healthier New York 1998, which was distributed to over 2,700 agencies and individuals.

As a state health agency, we continue to use the principles and goals enumerated in Communities Working Together as a guiding framework to approach health issues.

New York State also is a **Turning Point** State and Title V benefits from their many activities ranging from Social Marketing initiatives to workforce capacity-building.

The Maternal and Child Health Services Block Grant Advisory Council

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 NYS 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. The Council is composed of a cross-section of New Yorkers. By mandate, the Council is composed of twelve individuals, six of which are appointed by the Governor, three of which are appointed by the Temporary President of the Senate and three of which are appointed by the Assembly Speaker. Members include:

- C Dr. William Grattan, M.D.,** Council Chairperson
Seton Health Systems, Troy, New York and former Health Commissioner of Albany County
(Governor's appointment)

- C Richard Aubrey, M.D.**
SUNY Health Science Center, Syracuse, New York
(Senate appointment)

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

- C Joan Ellison, R.N.**
Livingston County Health Department, Mt. Morris, New York
(Governor's appointment)

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

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

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

- C Joseph S. Sanfilippo**
Mental Health Association of the Southern Tier, Binghamton, New York
(Assembly appointment)

C Stanley Skinner

Schenectady Municipal Housing Authority, Schenectady, New York
(Senate appointment)

There are currently three vacancies. The Block Grant Advisory Council has recommended to the appointing authorities that these vacancies be filled by parents or other consumers of MCH services and/or a dental professional, and that the appointees reflect the diverse population served by Title V.

Over the last few program years, the MCHSBG Advisory Council:

- C was represented on the Public Health Priorities Committee through its Chair, Dr. Grattan. The Council provided the Priorities Committee with a clear interpretation of MCH need and helped to maintain a focus on the needs of women, infants and children in the State.
- C annually 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 new structure for the MCHSBG reflected by the MCH Pyramid, guide decision-making about reductions in program allocations, redirection of program focus or elimination.

Principles of Allocation of Maternal and Child Health Block Grant Funds

- I. Programs must support MCH functions and be consistent with the purposes of Title V - the Maternal 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:**
 - C identification of populations at greatest risk or need based on geographic/ demographic/social-cultural and economic factors;**
 - C mortality and morbidity;**
 - C availability of effective and cost effective interventions;**
 - C ability to measure program outcomes; and**
 - C availability of adequate funds from other services 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 which 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 to which all New York residents should have access.**

- C met jointly with the Preventive Health and Health Services Block Grant Advisory Council to discuss areas of mutual concern, overlapping program interests, and coordination of program funding.
- C affirmed the relevance of Communities Working Together to maternal and child health issues and priorities for MCH services in the State of New York.
- C advised the Department in several issues of concern including, but not limited to: public health assessment, lead poisoning prevention and abatement programs, expanded insurance coverage for the uninsured, expanded eligibility for the Prenatal Care Assistance Program, perinatal and other public health data systems, services under managed care, parent involvement, and development of systems of care for CSHCN.

The State's Title V Role: The role of New York State's Title V program is defined within the present health care environment of New York State and by the priority needs of New York's large and diverse population.

Title V:

- C provides the infrastructure and guiding conceptual framework for the delivery of all Department of Health maternal and child health programs;
- C provides for the surveillance and assessment of the needs of the maternal and child health population, determining the impact of emerging and persistent issues, and planning for their amelioration within the context of available resources;
- C advocates for necessary resources commensurate with the level and significance of the need;
- C identifies and fills gaps in the health care system through delivery of direct health care services where other resources are not available;
- C monitors the delivery of health care and the effect of systems changes on the maternal and child health population and recommends changes in policy, law or regulation, where needed; and
- C enables high-risk populations to establish and maintain a meaningful relationship with the health care system.

1.5 The State Title V Agency: The New York State Department of Health

The State Title V Agency in New York State remains the New York State Department of Health (NYSDOH).

1.5.1 State Agency Capacity

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 include: 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 Special Representative to UNICEF, Dr. Novello has a solid record of leadership and commitment to maternal and child health, and has 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 and Local Health, where administrative oversight for the Block Grant is vested.

In addition to its responsibility for Title V, the **Division of Family and Local Health** is also responsible for family planning (Title X), early intervention (Part C) services, the Prenatal Care Assistance Program, dental health, lead poisoning prevention, adolescent health, adolescent pregnancy prevention, universal newborn hearing screening and programs for children with special health care needs. It also is the central point of contact with the 58 municipal health departments in New York. This division is located within the **Center for Community Health**. The State Health Department’s organizational chart is included with this submission (Figures 3 and 4) and is further described in Section 1.5.1.1. Organizational structure and staffing support our mission, vision and values.

Dennis Murphy, M.A., is serving as Acting Director of the Division of Family and Local Health (DFLH). 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, and he directed New York State’s STD Control Program of a number of years. He served as Assistant Director of the Division for two years before becoming the Acting Director, and for a part of that time he was simultaneously

Acting Director of the Division's Bureau of Child and Adolescent Health. As Acting Director, Mr. Murphy has overall responsibility for the Division's four bureaus.

Within the Director's office, Michelle Cravetz, MS, RN-C, coordinates MCHSBG-related activities, strategic planning, grant submission and grant management activities. Ms. Cravetz has twenty-five years of maternal and child health experience at the local, regional and state level. Prior to becoming MCH Block Grant Coordinator, she served as a regional MCH Consultant, Regional Director of Preventive Health Services, Clinical Consultant to the Migrant and Indian Health Programs, Director of the School Health Program, and Director of Rural Health and Primary Care. Ms. Cravetz provides oversight to the State Systems Development Initiative, the Consolidated Family Health Grant Project and the family and consumer forums.

Christopher Kus, M.D., M.P.H., also serves within the office of the Director as the Pediatric Medical Director for the Division of Family and Local Health. Dr. Kus is the State's Children with Special Health Care Needs contact to the Federal Bureau of Maternal and Child Health. Dr. Kus 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 six years. He provides overall leadership in pediatrics within the Division and serves as a liaison with the State Medicaid Program and the Office of Managed Care. Dr. Kus chairs the Association of Maternal Child Health Programs (AMCHP) Service Delivery and Financing Systems committee and co-chairs the MCH-Medicaid Technical Advisory Group. In the coming year, Dr. Kus will be significantly involved in the development of an improved Children with Special Health Care Needs data system and with school health issues.

Dr. Barry Sherman has recently been welcomed to the Division of Family and Local Health to lead evaluation efforts related to family and local health programs. Dr. Sherman, a Ph.D. social psychologist, most recently led the child health unit within the Bureau of Child and Adolescent Health. He has been the principal investigator on several DOH grants, and is nationally known as an innovator and author related to prevention and treatment of substance abuse in pregnant women, respite services for families with chronically ill children and the prevention of child abuse and neglect. Dr. Sherman is an Associate Professor in the Department of Health Policy, Management and Behavior in the University at Albany School of Public Health.

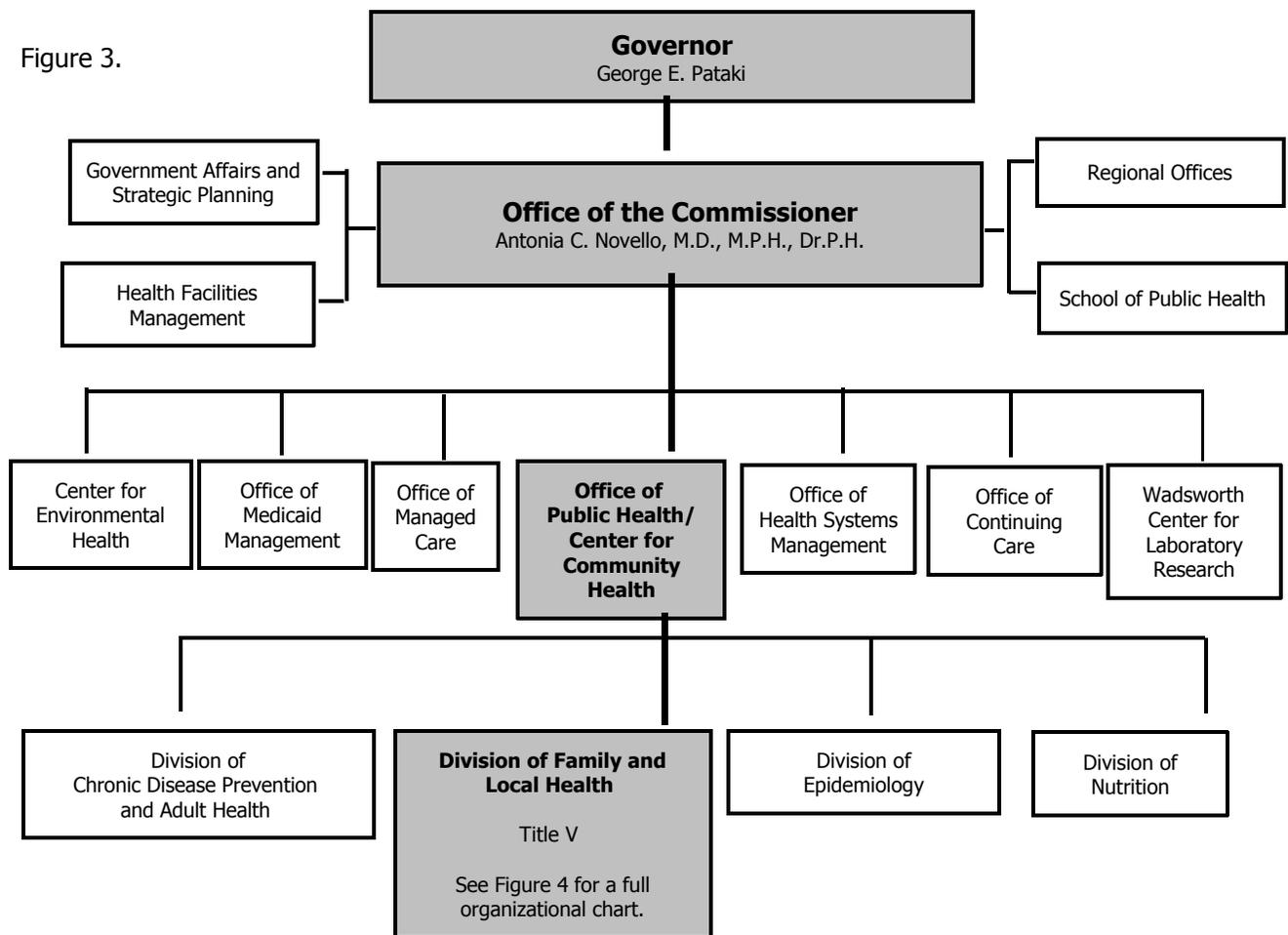
Dr. Thomas Carter continues to coordinate the multiple cross-systems, cross-agency partnerships and collaborations in which the Division of Family and Local Health is involved. Dr. Carter is actively involved in Partners for Children, the Adolescent Project Team, Success By Six, School Health Infrastructure Initiative, and Touchstones, to mention a few.

1.5.1.1 Organizational Structure

Please see Figure 3 and 4 for an organization chart depicting the structure of the Department of Health as it relates to Title V programs.

Through the various centers, divisions, bureaus and programs herein described, NYSDOH assumes the "responsibility for the administration or supervision of the administration of the programs carried out with allotments under Title V" [Section 509(b)]. (See Section 1.5.1.2.)

Figure 3.



S

See Figure 4 (next page) for the organizational structure within the Division of Family and Local Health.

Figure 4.

Division of Family and Local Health						
D. Murphy, Acting Director and Director, Title V M. Cravetz, MCHSBG Coordinator/Special Projects C. Kus, Pediatric Director T. Carter, Partnerships and Collaborations B. Sherman, Program Evaluation/Special Projects						
DFLH Fiscal Unit D. Nance, Director			DFLH Administrative Support S. Stislow, Coordinator		State Systems Development Initiative	
Contract Unit J. Zeccolo, J. Sterling, G. Wood	Fiscal Review Unit G. Helton	Direct Pay Unit W. Legnard	M. Maury, Secretary 2 E. Lester, Secretary 1		C. Tucci-Catalfamo	
Bureau of Women's Health B. McTague, Director M. Applegate, Med. Director B. Brustman, Actg. Asst. Dir.		Bureau of Child and Adolescent Health C. Lee, Acting Director M. Riser, Assistant Director			Local Health Services Unit S. Pirani, Acting Director	Bureau of Dental Health E. Green, Director J. Kumar, Asst. Director
Family Planning Program J. Linton	Prevention of Violence Against Women K. Martin	Child Health Unit J. Lecomb J. Raucci	Children's Special Services Unit N. Kehoe, D. Noyes	Youth Development Unit F. Zollo T. Carnahan	Article 6 State Aid to Localities	Dental Public Health Education
Perinatal Health Unit W. Shaw		Infant/Child Mortality Review	Children with Special Health Care Needs	School Health Program	Turning Point	Dental Residency Program
Perinatal Health Services Programs M. Grygelko	Community-Based Perinatal Services L. Thornton	Childhood Lead Poisoning Prevention	Physically Handicapped Children's Program	Comprehensive School Health Infrastructure Project	American Indian Health Program	Preventive Dentistry Programs
		Pediatric Asthma	Early Intervention	ACT for Youth	Migrant Health	Research and Epidemiology
		Childhood Preventive Dentistry	Universal Newborn Hearing Screening	Gay and Lesbian Health Initiative		
		Healthy Child Care New York		Community-Based Adolescent Pregnancy Prevention		
				Abstinence Education		

State Statutes Relative to Title V Program Authority

The Title V agency is supported by a number of statutes and regulations that provide the legislative authority for various maternal and child health programs. Among them are:

- C The Public Health Law, which covers everything from establishment of the Public Health Council to establishment health departments and health care facilities and agencies, to qualifications of public health officials, to newborn screening, to lead poisoning prevention, to immunization, to health care financing. Article 6 of the Public Health Law outlines the payment of State Aid to Localities for certain public health services, including MCH services.
- C New York Code, Rules and Regulations, which interpret the implementation of Public Health Laws.
- C Education Law, which covers the regulation of the professions, including physicians, nurses, nurse practitioners, medical social workers, pharmacists, therapists and midwives.

Laws relating to public health are described on the Department's public website, www.health.state.ny.us/nysdoh/phforum/phforum.htm and all NYS laws and regulations are available on the world wide web at this address: <http://unix2.nysed.gov/ils/topics/laws.htm>.

1.5.1.2 Program Capacity

The New York State Department of Health, as the State Title V agency, has the capacity to provide:

- C preventive and primary care services for pregnant women, mothers and infants;
- C preventive and primary care services for children; and
- C services for children with special health care needs, including the capacity to provide and promote family-centered, community-based, coordinated care, and to facilitate the development of community-based systems for such children and their families.

The Center for Community Health

The **Division of Family and Local Health** is within the Center for Community Health (CCH). Dr. Dale Morse is the Interim Director of the Center for Community Health. Associate Center Director is Mr. Dennis Graziano. The Center for Community Health also contains the Division of Epidemiology, the Division of Chronic Disease Prevention and Adult Health, and the Division of Nutrition. The majority of the Title V programs are based in these four divisions, but are mostly within Family and Local Health.

The **Division of Family and Local 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 Bureaus of Women's Health, the Bureau of Local Health Services, and the Bureau of Dental Health. The Division has an Acting Director, as stated. Associate Director of the Division, Mr. Dennis Murphy, is currently acting as Director. Christopher Kus, M.D., M.P.H, the former Director of the Bureau of Child and Adolescent Health, serves as Pediatric Director to the Division. As BCAH Bureau Director, Dr. Kus provided leadership to the Department's child- and adolescent-focused programming and issues relating to children with special health care needs. Ms. Cravetz coordinates block grant-related activities and grant submission within the Division and also provides oversight to the State Systems Development grant and strategic planning. Also within the Division, Dr. Thomas Carter coordinates interagency collaboratives, and Dr. Barry Sherman has recently been recruited to lead MCH-related evaluation activities.

The Division of Family and Local Health is also administrative home to New York's **State Systems Development Initiative (SSDI)** grant, directed by Ms. Cathy Tucci-Catalfamo. The goal of this year's SSDI grant is to assist in ensuring meaningful measurement of attainment of Block Grant Performance Measures. To this end, Ms. Tucci-Catalfamo has been assisting with the development of the Children with Special Health Care Needs Data System and in gathering parent and consumer input to this grant's needs assessment.

The **Bureau of Child and Adolescent Health** (BCAH) has a newly appointed Bureau Director; Ms. Claudia Lee. Ms. Lee came to the Bureau from the Local Health Services unit. Previously, she had

served in the AIDS Institute and with the Family Planning Program. 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 **Children with Special Health Care Needs Program** is located now with the Early Intervention Program within BCAA's **Children's Special Services Unit**. The unit is co-directed by Dr. Donna Noyes and Ms. Nancy Kehoe. Dr. Noyes leads the unit's policy efforts, while Ms. Kehoe is charged with responsibility for operations.

The **Children with Special Health Care Needs Program** continues to provide services to children, ages birth to 21, that are not provided through Medicaid or SSI Medicaid. Two years ago, the program embarked on an infrastructure and capacity-building initiative to strengthen the ability of the program to identify, report and act on identified needs for the CSHCN population and their families. As a part of this effort, the program launched a new data system for the use of the 58 local health department-based Children with Special Health Care Needs Programs, which is now producing data for NYSDOH analysis. The program continues to identify and communicate with specialty centers that promote access to a comprehensive evaluation and treatment services by specialists for those children in whom a severe chronic illness or physical disability is suspected.

The program employs three parents of children with special health care needs, only one of which is officially employed as a parent. (The other two are employed as a public health program nurse and the SSDI Coordinator). The parents help link our agency to parent groups like Family Voices, Parent-to-Parent, MUMS and other statewide parent advocacy agencies. These measures are helping to improve our focus on comprehensive, family-centered, community-based, culturally-competent, coordinated care. This is the unit that houses the **Universal Hearing Screening Program**. This unit will be implementing a new state law on universal hearing screening and the new HRSA newborn hearing screening grant.

Family Specialist Ms. Ruth Walden, our official "Title V Parent", with the MCH Block Grant Coordinator and the SSDI Coordinator, has been leading efforts to improve the inclusion of families in policy and systems design, and design, implementation and evaluation of CSHCN services in the future. We take great pride in the results of our efforts of the last two years to improve parent and consumer involvement in our Block Grant. 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.

The Children with Special Health Care Needs Program now works even more closely with the **Early Intervention Program (EIP)**. The Early Intervention Program provides therapeutic and supportive

services for children from birth to age 3 and their families. Through the Infant-Child Health Assessment Program (I-CHAP), one component of the program's child find initiative, staff ensure that children at risk for disabilities have a "medical home" and receive developmental surveillance and screening from their primary health care provider. Children referred to EIP receive a comprehensive multidisciplinary evaluation to assess the child's cognitive, physical, communication, social/emotional, and adaptive development.

A **Child Health Unit** has been formed within the Bureau of Child and Adolescent Health that includes the **Childhood Lead Poisoning Prevention Program**, leadership for the Department's **asthma** efforts, and the **Community Integrated Service Systems (CISS)** grant. This unit is headed by Ms. Judith LeComb, who comes to the Bureau from the Immunization Program; she is assisted by James R. Raucci, who also directs the Childhood Lead Poisoning Prevention Program.

The **Community Integrated Service Systems (CISS)** grant, Healthy Child Care New York, coordinated by Ms. Mary Huber, though located within the Bureau of Child and Adolescent Health works very closely with the Office of Children and Family Services (which is another executive agency outside of the Health Department) in an effort to improve the health and safety of children in child care.

The Bureau of Child and Adolescent Health also contains a **Youth Development Unit**, headed by Mr. Frank Zollo and Dr. Taimi Carnahan. This unit encompasses the **School Health Program** and adolescent pregnancy prevention efforts, including the **Abstinence Education Program** and **Community-Based Adolescent Pregnancy Prevention**. Ms. Lorraine McCann, New York's **Adolescent Coordinator**, is also assigned to this unit, as is the School Health Infrastructure Coordinator.

Ms. Barbara McTague directs the **Bureau of Women's Health**, with the assistance of Dr. Barbara Brustman and Mary Applegate, M.D., M.P.H., who serves as that bureau's medical director. The Bureau of Women's Health has responsibility for the Department's perinatal, family planning, adolescent pregnancy prevention, maternal mortality review 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"**. Dr. Applegate leads the **Preventive Medicine Residency Program**. The Bureau is also the liaison with **Healthy Start**.

Ms. Sylvia Pirani is Acting Director of **Local Health Services**. This unit within the Division of Family and Local Health is the touch point for communication and coordination between the 58 local health units and our Department's central and regional offices. 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. This unit administers over \$160 M in State Aid to local health units. The **Turning Point Initiative**, a grant from the Robert Wood Johnson Foundation, is located within this unit.

The **Bureau of Dental Health** is directed by Dr. Elmer Green, with Dr. Jay Kumar serving as his Assistant Director. The bureau implements and monitors statewide dental health programs to prevent, control and reduce dental diseases and other oral health conditions, and promote healthy behaviors. Bureau staff coordinate the provision of dental services for targeted populations through the management of the community-based preventive dentistry, dental sealant, school-based supplemental fluoride and dental rehabilitation programs. The bureau conducts oral health surveys for collecting data to monitor progress toward health objectives, designs research projects to address public health problems, and operates an accredited dental public health residency program. In addition to maintaining its focus on children, this bureau develops and administers programs to promote dental health among adult populations.

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

The **Division of Chronic Disease Prevention and Adult Health** has as its mission increasing the years of healthy and independent life for New Yorkers. This 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 continues to administer several programs which affect the maternal and child health population.

Within the Division of Chronic Disease Prevention and Adult Health , their **Bureau of Health Risk Reduction**, directed by Mr. Chris Maylahn, oversees prevention efforts to reduce tobacco use and change diet and physical activity patterns. This bureau has also been integral to the Department's asthma prevention and control efforts.

Also within in the Division of Chronic Disease Prevention and Adult Health, the **Bureau of Injury Prevention**, directed by Ms. Susan Hardman, addresses injuries associated with motor vehicles, bicycles, recreation, poisoning, assaults, and suicide. The primary prevention of violence, particularly intimate violence, is a priority with the Department for the coming years.

Mr. Thomas Blake, Associate Division Director, currently leads this division following the retirement of its former director. He was for many years the Assistant Director in the Bureau of Child and Adolescent Health and is well acquainted with MCH issues.

The **Division of Nutrition**, 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. DON 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 DON/Title V collaboration include the Monroe County contract consolidation project and joint WIC/Medicaid/Child Health Plus application pilot. 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**, directed by Dr. Perry Smith, is responsible for disease control and disease prevention efforts within the State Health 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 the **Bureau of Communicable Disease Control**. Title V programs worked with the Division of Epidemiology throughout the Communities Working Together process and the Division continues to work with the Title V workgroup on birth outcomes. This Division is charged with responsibility for new initiatives in HIV reporting and partner notification. Dr. Smith is the State Epidemiologist.

Information and data needs related to Title V activities are met through the Center for Community Health’s **Public Health Information Group**. Directed by Mr. Michael Medvesky, PHIG provides data access and technical assistance to central office, regional office and local county health departments. Bolstered 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. The PHIG provides services such as preparing the MCH needs assessment and developing MCH data sets. This unit also has responsibility for the **Pregnancy Risk Assessment Monitoring Survey (PRAMS)**.

This Group is 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. Data sets used to develop the Community Health Data Set include birth, death and fetal death files for natality and mortality data, SPARCS (a data set containing information on all hospital discharges in the state), Department of Health disease registries, and 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 latter allows comparisons between counties. The sections are:

Demographic and Socioeconomic Characteristics	Chronic Conditions
Physical Activity and Fitness	HIV Infection
Nutrition	Sexually Transmitted Diseases
Tobacco Use	Immunization
Substance Abuse and Other Drugs	Infectious Diseases
Family Planning	
Violent and Abusive Behavior	
Unintentional Injuries	
Environmental Health	
Oral Health	
Maternal and Infant Health	
Child and Adolescent Health	
Heart Disease and Stroke	
Cancer	

Mr. Medvesky has over 20 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.

The **Office of Emerging Majorities**, formerly the **Office of Minority Health**, is headed by Ms. Wilma Waithe. This office assists the Department and Center in assuring cultural and linguistic competency and appropriate representation for the concerns of minority communities. This office has been particularly helpful to the Title V programs in facilitating community awareness of MCH services, helping to assure access to care, as well as appropriateness and acceptability of services.

Fiscal expertise for preparation of the MCHSBG application is provided by Mr. Ronald DeCarr of the **Center for Community Health** and by the DFLH's **Fiscal Unit**, directed by Ms. Deborah Nance. Mr. DeCarr provides the Division of Family and Local Health with fiscal analyses of block grant spending, while contract management for MCH contracts is handled by the Fiscal Unit. It is important to note that New York externally appropriates block grant dollars to support MCH services at the local and statewide level. In Division of Family and Local Health alone, approximately 600 contracts are administered annually.

Assistance from Outside the Center for Community Health

The **Bureau of Community Relations** 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** was created within DOH a few years ago. This move has resulted in a closer organizational relationship to maternal and child health programs for the Medicaid population. The Office of Medicaid Management administers the Child/Teen Health Plan, 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 Plan standards established by the DOH. 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 new Family Health Plus Program will be located within the Office of Medicaid Management.

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 and Local Health with the incorporation of Prenatal Care and Assistance Program standards into Medicaid Managed Care.

The OMC 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, including advising on the content of the benefits package.

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 **Office of Rural Health (ORH)**, also located within the Division of Planning, Policy and Resource Development, provides the Department with guidance on the unique issues faced by rural communities in New York State. ORH issues reports on managed care/rural health issues, the issues faced by rural hospitals, birthing center issues in rural communities and special issues in emergency medical services. ORH also administers several grant programs, including those for Rural Health Networks.

The **AIDS Institute (AI)**, directed by Dr. Guthrie Birkhead, continues to take the lead for the Department in responding to the AIDS epidemic. The AI oversees the continuum of AIDS services from prevention services (outreach and education, risk reduction, harm reduction, counseling and testing) to client services (case management, housing, mental health services, premenstrual planning and other support services) to medical care (primary and specialty care in a number of settings, the AIDS Drug Assistance Program and ADAP+, acute care, clinical education and guidelines) to chronic care (adult day care, home health care, nursing homes and hospice).

New York has recently developed 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. The AIDS Institute is the lead Center for Title IV in New York State, and has established have 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.

Title V programs also work in collaboration with programs within our **Center for Environmental Health (CEH)**. CEH provides overall direction for environmental health. In addition to direct supervision of central and regional office staff, CEH provides environmental services through ten district offices to counties whose local health departments do not provide environmental services. CEH's **Bureau of Environmental and Occupational Epidemiology** takes responsibility for monitoring of adverse reproductive outcomes using the Congenital Malformations and Chromosome Registries and conducts studies evaluating possible causes of these outcomes, and for 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.

The **Office of Health Systems Management (OHSM)** is the arm of the Department that licenses and regulates health facilities and agencies. OHSM staff perform annual 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 health population.

The **Emergency Medical Services for Children (EMSC) Program** is administered by the Bureau of Emergency Medical Services, Division of Standards and Surveillance, in the Office of Health Systems Management. The EMSC Program is working to strengthen the focus on children across the continuum of emergency care. Title V staff have been involved in the program since its inception in 1997. Title V staff participated in the first statewide EMSC forum that identified gaps and priorities for children in the emergency care system. In addition, a Title V staff person has been appointed to serve on the EMSC Subcommittee, the program's advisory body, to ensure MCH program input and collaboration. Title V staff from the Children With Special Health Care Needs and School Health Program collaborated with EMSC Program on identifying and addressing the emergency care needs for children served by these programs.

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 a variety of specialized diagnostic and reference laboratory services, manages comprehensive statewide newborn 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 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.

1.5.1.3 Other Capacity

Outstationed Staff: The cornerstone of our assessment, monitoring and technical assistance capacity in the regions are the approximately 100 **Regional Public Health Program Nurses, Public Health Nutritionists, Epidemiologists, Public Health Representatives** and **Sanitarians** that are in contact with MCHSBG-funded and other MCH 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.

The Department is continuing with the implementation of a regionalization plan that aims to strengthen our capacity for customer service and technical assistance, to improve integration and the articulation of Department policy, and to improve our capacity for information and performance management. Under

this new regionalization plan, regional staff are broadening their scope of responsibility, developing cross-functional teams, and receiving additional organizational and technological support. Title V staff are currently involved in the implementation of our regionalization, phase 2, in further defining central office and regional office relationships relative to performance management, personnel and regional budgets. The impact on Title V and other programs should be beneficial, as our resident, local programs and contractors will be better served.

Family Specialist: There was previous mention of our **Family Specialist**, whose role it is to maintain communication and linkages with families of CSHCN. Ms. Ruth Walden, herself a parent of a child with special needs, 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. Ms. Walden and Ms. Mary Huber, of the Family Professional Training Institute, assisted a panel of consumers and Title V staff in drafting a strategic plan to increase meaningful consumer involvement in the MCHSBG. In May and June, based on that consumer plan, they piloted four consumer forums. Feedback from those forums was then used to launch a full-scale consumer involvement plan for this year. The Family Specialist led twelve additional consumer and parent focus groups that provided needed input to the needs assessment.

MCH-funded vs. Non-MCH-funded Positions: Currently, there are 227 filled Title V-funded positions within the Department of Health and approximately 380 filled, non-MCHSBG-funded positions working on Title V-related programs and activities. Since MCH activities are distributed throughout the Department, staff positions are located in the Department's central, regional and district offices. They cover the gamut of MCH activities, including child health, women's health, dental health, local health services, nutrition, injury control and risk reduction, AIDS/HIV prevention, epidemiology and surveillance, laboratory operations, human genetics, data and information systems infrastructure, health communications, child safety, managed care, and facility surveillance.

Federally Qualified Health Centers/Community Health Centers: As the state primary care agency, DOH is a partner to a three-way **cooperative agreement** with the US Public Health Services and the Community Health Center Association of New York State, the organization representing the bulk of the Federal 330 contractors in NY. This cooperative agreement provides the basis for mutual support of primary care development. CHCs are often contractors for DOH initiatives under MCH, Family Planning, School-based Health Center and the Primary Care Initiatives.

Local Health Departments: 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. Most counties 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.

Relationships with local health departments are coordinated through the Division of Family and Local Health, specifically with the **Local Health Services Unit** that also administers our local assistance/state aid program. Collaboration is yielding better use of data, better local plans, and more attention to outcomes of public health activities. Currently, this division is working on the consolidation of county contracts, using Monroe County as a pilot site. Under a new form of contracting, Monroe County's appropriation under eight categorical grants has been bundled to use toward producing a certain set of negotiated public health outcomes. As a "**Turning Point**" grantee, DOH works closely with selected local partnerships to build and improve the public health infrastructure.

The Division and Regional Offices have also piloted (and will be expanding) consolidated monitoring of maternal and child health programs. Under this model, local grantees are visited by a team of reviewers for a concentrated and comprehensive assessment of the effectiveness of MCH programs. The model uses a self-assessment/subsequent validation procedure that actively involves monitored entities in the improvement of quality and adherence to standards. The tool for the consolidated assessment is organized around the Ten Essential Services model for local health departments.

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, collection and use of perinatal data.

A statewide perinatal data system is currently being 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 (e.g. perinatal networks) use data for needs assessment, planning and quality improvement activities. Many upstate regions are now operational, with the expectation that New York City and Long Island will soon be on board. The internet-based system is almost fully operational, with some corrections being made.

The Department of Health worked collaboratively with the Regional Perinatal Centers to re-examine the designated 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. New designations are being prepared.

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. NYSDOH serves as the laboratory for the 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 education. Title V has utilized the School of Public Health as the continuing medical education provider for its annual Breast-feeding Grand Rounds, and for forums on public health genetics, women's health and female circumcision.

Title V staff in the Division of Family and Local Health coordinate the **MCH Graduate Assistant ship**, under which SUNY and other graduate students are supported by block grant funds to work on priority MCH research and planning projects in the NYSDOH. This arrangement supports DOH's mission through attracting bright and motivated individuals who are interested in gaining both theoretical and practical knowledge of public health/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 SUNY School of Public Health sponsors the **Northeast Public Health Leadership Institute**, now serving the northeast corner of the US. Seven DOH employees attended the 1998-1999 Institute, including some working with Title V.

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. Two collaborative projects have been selected for this year; they address collaboration within a public school in Harlem and an asthma screening initiative.

DOH's Maternal Mortality Program was funded by the CDC via a cooperative agreement with the **Association of Schools of Public Health**.

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 UAPs are a great source for physician consultants on a variety of issues. For example, the Bureau of Child and Adolescent Health has been working with staff at Jacobi/Albert Einstein to improve identification of children with special health care needs. Most recently, the Department has participated in joint planning with the Westchester Institute, and we are jointly exploring the possibility of a policy internship for LEND faculty at the Department of Health and to have Department of Health staff participate in the LEND training.

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.

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 Program**. Training grants from the Federal Maternal and Child Health Bureau support faculty who demonstrate leadership and expertise in behavioral pediatrics teaching, scholarship and community service and fellows who have completed training to be 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.

The **State University of New York at Buffalo**, Division of Family Medicine has recently become an **Area Health Education Center (AHEC)**. Title V will be exploring a relationship with the AHEC, who currently has a liaison through the Office of Rural Health, which is the section of the Department that administers the state funding for the AHEC. Plans currently call for the establishment of 10 AHEC offices by the year 2010, three in New York City and seven in the rest of the state.

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:

- C Family Voices
- C Parent-to-Parent, New York State
- C The New York State Public Health Association
- C The New York State Perinatal Association
- C The New York State Association of County Health Officials
- C The New York State Association of Counties
- C The New York State Nurses Association
- C New York State March of Dimes
- C New York State United Teachers
- C The New York State Community Health Partnership
- C University Affiliated Programs at Westchester, Rochester and Jacobi/Albert Einstein
- C The American Academy of Pediatrics, District 2
- C The New York Academy of Medicine
- C The American College of Obstetricians and Gynecologists, New York State Chapter
- C The American Academy of Family Practice, New York State Chapter
- C American College of Nurse Midwives, New York State Chapter
- C The New York State Association of Perinatal Programs
- C The Medical Society of the State of New York
- C The Healthcare Association of New York State (representing hospitals)
- C The Greater New York Hospital Association
- C The State Communities Aid Association
- C Cornell University Cooperative Extension
- C The United Way
- C The New York State Association of Youth Bureaus
- C The New York State School Boards Association and School Nurses statewide

- C The University at Albany School of Public Health
- C Columbia University
- C Leadership Education in Adolescent Health at University of Rochester

and many others who enhance the capacity of Title V programs to operate effectively.

1.5.2 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.

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.

- C 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.
- C The Department has a Memorandum of Understanding with the State Education Department regarding **school health infrastructure**. This MOU supports the statewide implementation of comprehensive school health and wellness programs.
- C **Office of Children and Family Services and the Council on Children and Families** collaborate with DOH on several very important initiatives such as the NYS Task Force for School/Community Collaboration and the Partners for Children Adolescent Project Team. The **Office of Criminal Justice Services**, the **Department of Labor** and the **Office of Temporary and Disability Assistance** participate, as well.
- C In 1997, 1998 and 1999, the State Legislature allocated \$7 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. The Department has entered into a Memorandum of Understanding with the **Office of Temporary and Disability Assistance** (the state agency administering the TANF Block Grant) to provide for the transfer of these funds to the Department. The funds are used to supplement the contracts of family planning providers and community-based adolescent pregnancy prevention projects, providing for expanded outreach to low-income adolescents and adults.
- C The **Office of Mental Health** and **Office of Children and Family Services** have just begun a new collaboration with the Department of Health relative to suicide prevention. All three agencies sent representatives to the Region 1 and 2 Suicide Prevention Planning Conference in June.
- C The **State Education Department** administers the Youth Risk Behavior Surveillance System with NYSDOH collaboration.

Task Force on Out-of-Wedlock Pregnancies and Poverty: In recognition of the significant personal, health, societal and economic costs of unwed pregnancy, Governor Pataki issued Executive

Order 55 establishing this task force. With the Council on Children and Families as the lead agency, the goal is to study the problem of out-of-wedlock pregnancy, with special emphasis on teen pregnancy, and develop a ten year plan and goals for reduction of out-of-wedlock pregnancies.

Touchstones: 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. These measures, called "Touchstone Life Areas," are now being used to measure and track progress across a number of life areas (economic security, physical and emotional health, education, citizenship and community). An Executive Guidance Team has been established to develop a plan to "operationalize" Touchstone outcomes, indicators and measures.

The Integrated County Planning Initiative: In June 1998, Governor George E. Pataki announced more than \$1.5 M in grants to 30 New York counties for the establishment of integrated county-wide planning processes for services to children and families. The project formed partnerships with the involved state agencies (Department of Health, and the Offices of Children and Family Services, Mental Health and Alcohol and Substance Abuse Services) and their county counterparts, school districts, the business community, civic organizations, the judiciary and academic leaders. Participating counties went beyond planning for professional services and programs to build on neighborhood networks and mobilize local interest in meeting the needs of children, youth and families. Counties included youth, parents and service providers in identifying local needs and assets, in identifying appropriate planning strategies, and in putting programs into place.

The Partners for Children Collaboration: The Partners for Children collaboration involves the United Way of NYS, the New York State Association of Counties, the New York State Association of County Health Officials, the State Departments of Health, Education, Labor and Corrections, the Offices of Mental Health, Alcohol and Substance Abuse, Temporary Disability Assistance Council on Children and Families, as well as the state associations for nurses, teachers, school board members and youth bureaus. These partners work together in developing and strengthening school/ community collaborations and on routine monitoring of health and education outcomes. A major goal is to develop and implement an array of strategies that support communities for enabling youth to reach appropriate developmental milestones and their full potential by preventing and reducing risky, unhealthy behaviors. Development of a NYS youth development policy agenda has become a recent goal of the Adolescent Project Team of Partner for Children. A related legislative initiative, the Task Force on School/Community Collaboration, is promoting school-community collaboration and promoting greater support for prevention programs and youth development. The Department is using the Partners for Children group to help drive its adolescent health agenda.

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

This section profiles New York's program activities, records expenditures of MCHBG funds and discusses the extent to which National and State objectives were met in the 1999 program year. Please refer to the appropriate Expended columns on Form 3 and 4. Form 5 profiles New York's State Title V program budget and expenditures by types of service.

A regional analysis of Title V external contracts shows that 64.6% of funds are contracted for the metropolitan New York City area, where most of the State's population is located; 15.6% goes to the Western New York area, our second most populous region; 11.2% goes to Central New York; and 8.5% goes to the Northeastern and Capital District areas of the state. These breakdowns are consistent with population figures for those regions.

A brief summary of New York's accomplishments through use of Title V and other funds appears in Section 2.4. The relationship of the program accomplishments outlined in Section 2.4 to levels of the MCH pyramid is demonstrated in Figure 5, although many, many programs have some level of activity in more than one level of the pyramid. Figure 6 goes on to illustrate how the various program activities relate to performance measures and health outcomes.

2.2 Annual Number of Individuals Served

Please refer to Forms 6, 7, 8, and 9.

2.3 State Summary Profiles

Please refer to Form 10.

Figure 5

**CORE PUBLIC HEALTH SERVICES
DELIVERED BY MCH AGENCIES
In New York State**

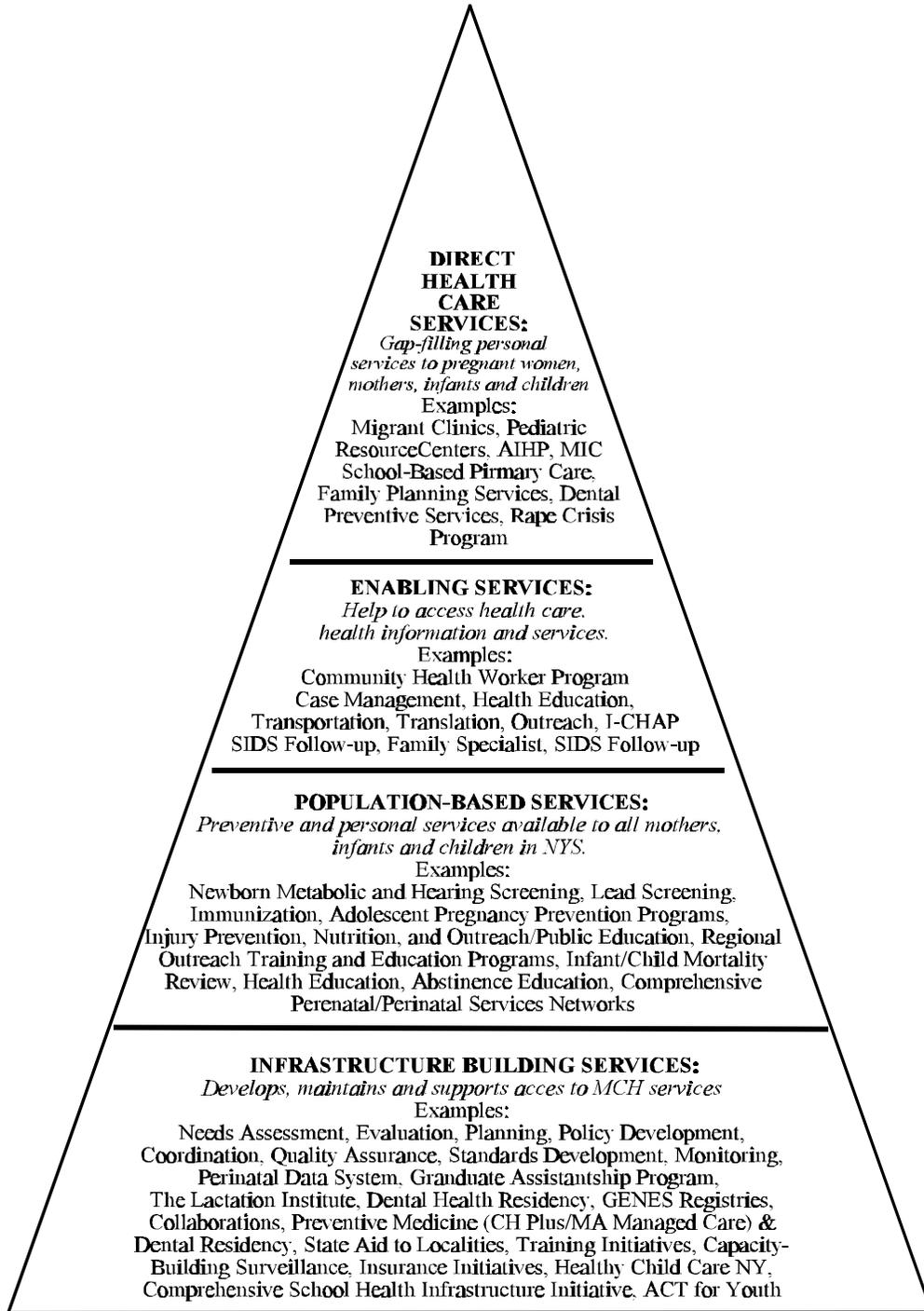
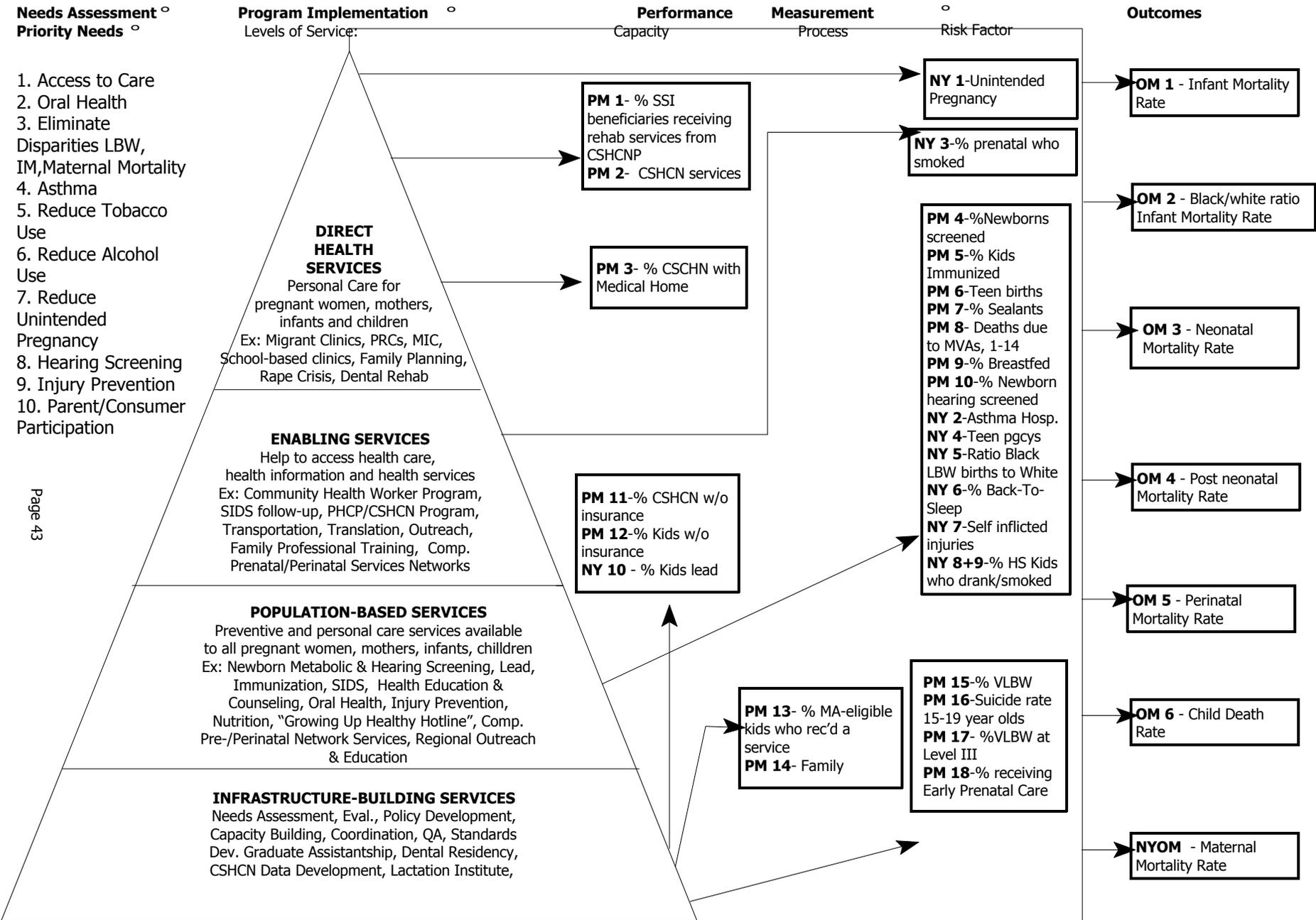


Figure 6.

**TITLE V BLOCK GRANT
PERFORMANCE MEASUREMENT SYSTEM**



2.4. Progress on Annual Performance Measures

NYSDOH strives for its programs to have a collective, positive impact on health outcomes. Please see the accompanying diagrams of the MCH Pyramid (Figures 5 and 6) to gain an understanding of how New York's programs relate to direct services, population-based services, enabling services and infrastructure, and for which performance measures relate to the various levels of the pyramid. Please see Form 11 to track New York's progress/status relative to each of the National and State-Negotiated Performance Measures. The tables that follow link performance objectives with 1999 program activities.

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1997	1998	1999	Change
01	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	Direct	Capacity	Children with Special Health Care Needs (CSHCN)	N/A	N/A	N/A	----
Role of Title V and Title V-Related Programs/Discussion of Progress								
<p>Please Note: Since all SSI beneficiaries in New York State are cared for under Medicaid, which provides more expansive coverage than the Physically Handicapped Children's Program, this question is not particularly applicable to New York's Children with Special Health Care Needs Program.</p> <p>C The Physically Handicapped Children's Program (PHCP) - the payment portion of the Children with Special Health Care Needs Program - continued to operate both its Treatment Program and the "Diagnostic and Evaluation" (D&E) component under the auspices of a revitalized Children with Special Health Care Needs Program. Approximately 1,500 children received case management services in 12 counties, and approximately 5,000 children received specialty care under the treatment program in 1999.</p> <p>C The Early Intervention Program provides therapeutic and supportive services for children birth to age 3 with disabilities and their families. In the 1999 program year, over 27,000 children were referred to the program for multi-disciplinary evaluation, out of which about 18,000 children were found eligible and received an Individualized Family Services Plan (IFSP).</p> <p>C The "Growing Up Healthy Hotline" is a resource for the general public and for providers, offering information on a variety of MCH issues, including on eligibility for programs and the location of the nearest services. In 1999, over 94,000 calls were handled, about 4,000 less than last year, but still an increase of 205% over two years ago. The increased volume over the last two years was attributed to the expanded interest in and advertising for Child Health Plus. The hotline fielded over 60,000 calls related to Child Health Plus.</p> <p>C The Dental Rehabilitation Program provided orthodontic services to over 27,000 CSHCN exhibiting a medical need for orthodontic care in the Medicaid and Physically Handicapped Children's Program.</p>								

National Performance Measure	Level of Service	Type	Population	Progress Reported			
				1997	1998	1999	Change
02 The Degree to Which the State Children with Special Health Care Needs Program Provides or Pays for Specialty Services, Including Care Coordination, Not Otherwise Accessible or Affordable to its Clients	Direct	Capacity	Children with Special Health Care Needs	Pay for all 9 services	Pay for all 9 services	Pay for all 9 services	No change. Goal met.
Role of Title V and Title V-Related Programs/Discussion of Progress							
<p>C The Physically Handicapped Children's Program (PHCP) provided State Aid reimbursement for specialty services for approximately 5,000 Children with Special Health Care Needs (CSHCN) statewide who did not have another source of payment for these services.</p> <p>C The Diagnosis and Evaluation Program under PHCP provided 3,600 provider visits to children in which a severe, chronic illness or physical disability was suspected. Under this aspect of the program, children are provided with diagnostic work-ups leading to a diagnosis and appropriate treatment plan. This program was available statewide in 1999.</p> <p>C SSDI staff worked with BCAH to transition the PHCP to the statewide CSHCN Program and to develop the new data system. New data management pilots began in 1999. All counties in the state began collecting data on the experiences of children with special health care needs who requested assistance from their department. A data dictionary, currently being finalized, will help to ensure that data gathered has the necessary integrity.</p> <p>C The Dental Rehabilitation Program provided services to over 27,000 children with special health care needs exhibiting a medical need for orthodontic care in the Medicaid or Physically Handicapped Children's Program.</p> <p>C The Early Intervention Program (EIP) provided therapeutic and supportive services to children from birth to age 3 with disabilities and their families. Through the Infant-Child Health Assessment Program (I-CHAP), one component of the Early Intervention child find, local agency staff ensured that children at risk for disabilities have a medical home and receive developmental surveillance from their primary health care provider. Children referred to the EIP received a comprehensive multidisciplinary evaluation to assess the child's cognitive development, physical development (including vision and hearing), communication development, social/emotional development, and adaptive development. In addition, children may receive supplemental physician or non-physician evaluations such as neurological or audiological evaluations, as appropriate. The program gets approximately 30,000 children referrals annually for a multi-disciplinary evaluation.</p> <p>C The graduates of the Family Professional Training Institute helped DOH to improve parent and consumer participation in Title V systems change. Networks of parents helped to diffuse information into the community about parent and consumer forums and helped to ensure wide participation by reaching out to additional families and bringing them into the policy development process. In 1999, the department and parent contacts held four consumer forums to gather information about problems and barriers within the health care system and recommendations for systems change. This effort was lead by the Title V Coordinator, the Family Specialist and the SSDI Coordinator. Graduates were also trained to be parent readers of Block Grant applications through the Federal MCHSBG Reader Training.</p> <p>C The Childhood Lead Poisoning Prevention Program paid for staff in local health units to perform nutrition assessment and intervention and care coordination for affected children under the age of 6 years.</p>							

National Performance Measure	Level of Service	Type	Population	Progress Reported				
				1997	1998	1999	Change	
03	The percent of CSHCN in NYS who have a "medical/health home"	Enabling	Capacity	Children with Special Health Care Needs	--	--	--	--

Role of Title V and Title V-Related Programs/Discussion of Progress

The **Early Intervention Program**, the **Physically Handicapped Children's Program**, the **Genetics Program**, and the **Newborn Screening Program** all targeted children with special health care needs for education, case finding and services, and all programs emphasize the need for a medical home. Unfortunately, no satisfactory data base exists for measuring what percentage of this population was actually reached. Nor is there currently a defensible figure for how many of New York's children with special health care needs have medical or health care homes. We have been working, and will continue to work for the next few years, to adopt a universal definition of children with special health care needs, to improve identification and data capture instruments. NYS is collaborating with national efforts to develop these estimates.

- C Under the **Early Intervention Program**, ensuring the child's and family's primary health care is an essential role for the service coordinator, who can assist the family to locate a medical home and who is responsible for coordinating services with medical and health care providers. **I-CHAP** staff, doing childfind activities, ascertain whether a child is receiving primary health care and ensure the child and family remain engaged with the health care system to the extent possible. The primary role of I-CHAP staff is to ensure that at-risk children are referred to, engaged with, and receiving developmental screening from appropriate primary health care providers.
- C The **"Growing Up Healthy Hotline"** fielded over 94,000 calls in 1999, about 2,000 of which concerned finding prenatal care or pregnancy testing and 62,000 of which sought information about Child Health Plus or Medicaid in order afford access to a medical or health care home for children.
- C Assuring a medical home is a primary goal of the **American Indian Health Program**, but the percentage of children with medical homes on any given reservation is difficult to ascertain for two reasons: first, reservation clinics serve a majority, but not all of the residents, and second, because the population resists enumeration. In 1999, the reservation clinics provided a comprehensive medical home to over 500 CSHCN.
- C Migrant agricultural workers face unique and intractable impediments in accessing and sustaining contact with health care systems. Migrant farm workers and their families are often distanced from health care not just by geography but also by culture, language and lack of knowledge and material resources. In addition, rapid movement from location to location makes the continuity of care difficult. During the growing season, migrants may need to make a choice between seeking medical care or being paid. Medical conditions often reach serious levels before attention is sought. The **Migrant Health Program** contracted with 14 local providers statewide: 8 county health departments, 4 migrant health centers, 1 BOCES (county) migrant day care center, and the statewide migrant day care system, covering a total of 20 counties. With combined funding from the MCHS and Preventive Health and Health Services Block Grants totaling \$695,000, access was provided to approximately 83% of the migrant and seasonal workforce and their families (as measured by camp capacity). Approximately 14,000 migrants, 3,500 of which were children, received medical, dental and other support services. Annually, the program has served approximately 250 pregnant women and 220 children with special health care needs. The program continues to access the linkages made under the Robert Wood Johnson tuberculosis control initiative to help ensure that services are available to migrant families further up- and down-stream.

National Performance Measure 03 - The percent of CSHCN in NYS who have a "medical/health home" (cont.)

- C The movement of children into the Child Health Plus and Medicaid managed care programs continue to have an effect on the **Pediatric Resource Centers (PRCs)**: fewer consumers are relying on the PRCs as a source of care, but those that do have very high need. The PRCs are pediatric ambulatory programs, serving children at particularly high risk for poor health outcomes who reside in high-need health areas of New York City. The MCHS Block Grant supported the PRCs to provide an array of services, including medical, nursing/education, nutrition, speech and hearing, vision, social and family support services. In 1999, the PRCs served 24,548 children (down from 27,533 children in 1996) and reported 78,081 medical encounters (down from 98,836 encounters in 1996), averaging 3.2 encounters per child (up from 2.9 in 1998). In 1999, the PRCs continued programs to provide for the changing needs of their patient population, including a social service program that incorporated domestic violence education and referrals into its standard agenda, weekly HIV/AIDS presentations in the waiting area with referrals for interested clients, a developmental screening clinic, "Back-to-Sleep" and "Reach Out and Read" programs, and active parenting programs. Only 62% of PRC clients are covered by Medicaid, and leaving about 38% uninsured that the PRCs could potentially enroll in Medicaid or Child Health Plus.
- C The **School Health Program** located 168 school-based health centers in areas where morbidity and mortality from preventable and mental health conditions are disproportionately high. In 1999, the program served over 185,000 children in 20 counties. Through contracts with 58 local providers, children received comprehensive primary and preventive care on-site in their schools. New York's school-based health centers are supported with a combination of Title V dollars, State and Local Assistance appropriations, Foundation funding, local (in-kind) contributions and program income (Medicaid, insurance). Again in this program year, a great deal of effort went toward obtaining support for school-based health centers (SBHCs) through the managed care organizations (MCOs) whose clients are served by the centers. As mandatory Medicaid managed care becomes a reality, the need for both fiscal and clinical integration between the SBHCs and the MCOs becomes more pressing. A Workgroup on Health Services Integration for SBHCs and MCOs developed service integration protocols that ensure appropriate communication and coordination of health care for students enrolled in both systems. These guidelines are undergoing minor refinements, and are scheduled to be distributed this summer. The exemption to allow school-based health centers to continue fee-for-service Medicaid billing has been extended to April 1, 2001. During this time the Department will continue to explore fiscal integration of school-based primary care with managed care.
- C **LEND Projects** at the University Affiliated Programs, while offering direct specialty level care, also worked with local physicians and facilities to improve local care for children with neurodevelopmental problems.

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1997	1998	1999	Change
04	Percent of Newborns in NYS with at Least One Screening for Each of PKU, Hypothyroidism, Galactosemia, Hemoglobinopathies (Combined)	Population-Based	Risk Factor	Infants	100	100	100	GOAL MET

Role of Title V and Title V-Related Programs/Discussion of Progress

- C** Under mandate of **New York State Public Health Law §2500(a)**, all newborns must be screened for the following disorders: 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 which, if untreated, lead to mental retardation or other disability. Local health units can use Article 6 State Aid reimbursement to pay for follow-up visits by public health nurses or bill insurance companies for these services. In 1999, 257,326 newborns were tested. (A complete listing of numbers served by newborn screening appears on Form 6 in Section 5.4.) The Newborn Screening Program consistently achieves 100% follow-up on confirmed cases.
- C** Clinical genetics services, including follow-up genetics counseling for families of children with inborn metabolic errors is available through the **Genetics Program**. NYSDOH's Wadsworth Center for Laboratories and Research administers the 23 contracts which provide services to over 24, 000 people annually. In 1999, services reached 24,136 individuals with prenatal clinical services: 6,043 Hispanics, 4,173 African Americans, 11,083 Whites, 1,595 Asians and 138 Native Americans. Non-prenatal services were reported as follows: 1,573 to Hispanic individuals, 1,779 to African Americans, 4,979 to Whites, 255 to Asians, and 39 to Native Americans, for a total of 9,534 individuals served.
- C** In 1999, the **Genetics Services Centers** provided educational opportunities to medical students (~200), practicing health professionals (~300) , people with diagnosed genetic conditions (~80), and to the general public (~175).
- C** In 1999, **GENES, the Genetic Network** of New York, Puerto Rico and the Virgin Islands, hosted two general business meetings attended by approximately 50 people each, a sickle cell disease symposium attended by about 150 people, a prenatal genetic conference attended by about 150 people, and a conference on genetic therapy attended by about 100 people.
- C** **Comprehensive Prenatal/Perinatal Services Networks** promote newborn screening and appropriate follow-up through newsletters and provider meetings.

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1997	1998	1999	Change
05	Percent of Children Through Age 2 Who Have Completed Immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Hemophilus Influenza, Hepatitis B	Population-Based	Risk Factor	Infants & Children	66.0 **	68.0 **	82.5 **	**
					Retro	Retro	NIS	

Role of Title V and Title V-Related Programs/Discussion of Progress

**Please Note: In the past, New York has used data from the Kindergarten Retrospective Study to track this performance measure. We now have better access to data from the CDC National Immunization Survey, which can now be used to track performance on this measure more contemporaneously. However, this will create a discontinuity with previous tracking. Also, previously we could not include Hepatitis B in the tracking of the indicator. These data are now included in the calculation.

C 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 staff also assist in recruiting VCF providers.

MCHSBG funds are used by the Immunization Program to support local activities. A primary use of these funds by county health departments is for assessments under the **Provider Based Immunization Initiative (PBII)**. 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 PBII, 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.

C **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.

C MCHSBG dollars were used to support Monroe County's regional efforts to complete an **immunization registry** in Western New York. (Other registry efforts in the State are paid from other funds.)

C Up-to-date immunizations were provided to the 1800 children in **migrant day care** settings in NYS.

C 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. In 1999, 92% of the children visited were fully immunized (up from 86.5% in 1998). **PCAP** and **MOMS** also educated parents in the need for preventive services, including immunization.

C Immunization records are reviewed and children are referred or provided with immunizations during clinic visits for **WIC** and for **lead screening**, 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.

C **CISS** grant activities related to Health Systems Development in Child Care reminded providers about immunization requirements for day care and referral of all children lacking immunizations a provider.

- C **Comprehensive Prenatal/Perinatal Services Networks** raised awareness of the need for immunization through community awareness campaigns.
- C The "**Growing Up Healthy Hotline**" fielded more than 94,000 calls last year, 443 of which concerned immunization.
- C Through a CDC grant, 2 **school-based health centers** in Yonkers provided immunizations to children, ages birth to 2, and assisted in connecting them to a medical home.
- C All **American Indian Health Program** clinics and contractors promoted and provided immunizations. Automated tracking systems were developed at Indian Nation clinics.
- C As a part of the Immunization Program, the **Perinatal Hepatitis B Program** received laboratory reports of Hepatitis B surface antigen-positive mothers and provided follow-up of each to ensure that infants of Hep B surface antigen positive mothers received appropriate vaccines.

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
06	The Rate of Births (Per 1,000) for Teenagers Aged 15-17 - Changed	Population-Based	Risk Factor	Adolescents	25.6	23.2	21.8	-6.0%

Role of Title V and Title V-Related Programs/Discussion of Progress

- C The **Community-Based Adolescent Pregnancy Prevention Program's** goal is to reduce teen pregnancies in the highest risk zip codes (now 50 statewide) 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.
- C In every county in New York State, **Family Planning Programs** provided community education and public information, comprehensive medical exams and access to a full range of contraceptive methods, STD counseling and testing, and special counseling for teens. In 1999, 63 Family Planning Programs provided services to over 320,000 low income, uninsured women, about one third of whom were under the age of 20.
- C The **Community Health Worker Program** provided family planning information to all women of childbearing age and referred to family planning services. They then follow-up to see that services are received.
- C The **School Health Program** provided services to about 185,000 children in 1999. Risk assessment for sexual activity is 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 32,000 female students ages 15-19.
- C Through the **Healthy Choices Initiative**, a pregnancy prevention peer education program was developed with included parents, adolescents, educators, physicians, nurses, school and health administrators. The peer educators engage at-risk adolescents in pregnancy prevention education as well as to impart life-building and self-esteem-enhancing skills. A total of 16,561 peer educators were trained and provided informational sessions in school and community settings to 121,873 youth. 4,587 parent education sessions were provided to 25,036 parents. 875 educational sessions were provided to 7,788 health and human service workers. 84,888 adolescents received free and confidential family planning services in 99,079 visits. There were 370,853 media spots including radio, television, newspaper and flyers.
- C The **Comprehensive Prenatal/Perinatal Services Networks** and **Regional Outreach and Education Programs** promoted reduction of adolescent pregnancy rates through provider and community conferences, outreach and education efforts.
- C NYSDOH Bureau of Women's Health awarded funding to 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. 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 included a statewide, large scale media campaign to support the community-based initiatives.

National Performance Measure 06 - Adolescent births

- C **Article 6** reimburses local health departments with State Aid for health education and other population-based efforts, and supports infrastructure needed to provide data collection, data evaluation, community-based planning and implementing collaborative intervention strategies.
- C The **Rape Crisis Program** administered 55 contracts to local rape crisis providers, 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. In 1999, the program worked on the development of program performance measures, coordinated an ad hoc workgroup on issues related to implementing post-exposure prophylaxis after a sexual assault, revised hospital guidance documents pertaining to the acute care of the patient reporting sexual assault, and began formulating a manual on managed care for Rape Crisis Centers.

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
07	Percent of Third Grade Children Who Have Received Protective Sealants on at Least One Permanent Molar Tooth	Population-Based	Risk Factor	Children	22*	---	25.3*	+15.7%

Role of Title V and Title V-Related Programs/Discussion of Progress

Approximately 50,000 of the 230,000 children in this age group have sealants, as ascertained by **the NYS Oral Health and Treatment Survey**. *These data refer to a study conducted in Upstate New York, only. The use of dental sealants has been promoted in public and private dental and health care settings, by the Department of Health and its contractors.

C Thirteen of the eighteen **School-Based Preventive Dentistry Programs** placed sealants in 1999. This year, the program served a total of approximately 44,000 children and provided over 4,000 referrals. In 1999, this school-based program targeted school children in grades 2,3,7, and 8 in low socioeconomic areas to provide 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 have increased participation in their program consistently each year. Children who were found to need restorative oral health services were referred. All families in targeted school districts receive promotional and educational information, which appears to have been the key to the program's success.

In 1999, the program began planning to re-focus the program on establishing community partnerships involving parents, consumers, providers and public agencies for identifying and addressing community problems related to oral health.

There were several other dental initiatives in 1999, all of which promoted the placement of sealants and the use of other preventative dental services:

C The **Preventive Dentistry Fluoride Supplement Program** provided over 125,000 children with fluoride supplementation in non-fluoridated areas through schools, day care and Head Start programs. The program goal is to prevent tooth decay; to educate students, faculty and providers about healthy teeth and bodies; and to network with other community-based public health programs (like WIC, Head Start and local health departments) to expand the program's reach. This year, the Dental Hygienist/Program Manager provided a number of Train-the-Trainer presentations on Baby Bottle Tooth Decay. The program staff that attended will now educate the populations they serve.

C The **Dental Rehabilitation Program** provides orthodontic services to 27,000 financially-eligible children with special health care needs exhibiting a medical need for orthodontia in the Medicaid and PHCP programs.

C The **Dental Residency Program** was visited by the Commission on Dental Accreditation in 1999, and once more received its accreditation. Sites include: the University of Rochester Eastman Dental School, Albany, Montefiore in the Bronx, and the Columbia University College of Dental and Oral Surgery. Being the only one of its kind in New York State, the program was able to offer the dental residents a unique public health experience, conducting needs assessments, evaluating dental programs, and researching public health/oral health issues.

C **Article 6** State Aid provided funding for dental health education to each county in NY.

C The **American Indian Health Program** offered dental services to children under age 20 either onsite (858 children made 1,743 visits) or via off-reservation referrals (approximately 2066). The children's fluoride program is on-going for Pre-K through Grade 6 with monitoring of the number of dental caries found.

C Dental services were offered to approximately 3500 children through our **Migrant Health Program** in 1999. Sealants are promoted in this setting.

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
08	The Rate of Deaths to Children Aged 0 to 14 Caused by Motor Vehicle Crashes per 100,000 Children	Population-Based	Risk Factor	Children	1.2	1.4	0.9	-35.7%

Role of Title V and Title V-Related Programs/Discussion of Progress

- C **Bureau of Injury Control (BIC)** takes the lead on this objective. BIC implements a traffic safety program focusing on the distribution and promotion of child safety seats; bicycle, in-line skating, pedestrian and motor vehicle passenger safety; and ongoing surveillance. BIC's Prevention Director co-chairs the state Child Safety Seat Task Force. In 1999, the Bureau mailed child safety information to over 7,000 health care professionals, supported child safety seat county distribution programs, and co-sponsored technician training with the New York State Public Health Association and the EMS for Children Program.

- C **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.

- C The **Community Health Worker, PCAP** and **MOMS Programs** all have car seat education components:
 - Parents who are enrolled with **Community Health Workers** are given extensive information about childhood safety. Homes are assessed for hazards and CHWs role model positive parenting skills.

 - Federally-funded **American Indian Nation** communities and those reservations with Community Health Worker Programs all have formalized car seat education components. Other reservation clinics promote appropriate vehicle safety recommendations during individual health education/risk reduction encounters. During this reporting period, an 8 year-old died in a vehicular accident (not seat belt-related) and this 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, burn prevention and other causes of infant injuries.

- C The **School Health Program** began a "Healthy Choices" initiative in 1998, awarding 12 contracts to support innovative pilot programs that address primary prevention of critical risk behaviors in adolescents, such as violence and pregnancy. Training for grantees began in late September 1998, during the planning phase of the grant. During this planning phase, grantees worked on expanding and strengthening their collaborations and ensuring productive partnerships. Full implementation (Phase 2) began January 1999. A mid-year showcase of successful projects was very well received.

- C All **school-based health centers** provide psycho-social and health risk assessment beginning with the initial visit. Student and family education about safety issues and abuse are included.

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
09	Percentage of Mothers Who Breastfeed Their Infants at Hospital Discharge	Population-Based	Risk Factor	Infants	62.2	63.0	65.4	+3.8%

Role of Title V and Title V-Related Programs/Discussion of Progress

Please note: Our source of data for this performance measure counts number of women who initiated breast feeding, which is slightly different than women who breast-fed their infants at hospital discharge.

- C 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 birthweight, 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. Breast-feeding promotion and support activities have expanded into all local WIC agencies and, in 1998, raised the breast-feeding rate among WIC participants to 46.4%, an increase of 5% since 1996. New York State's program is in the middle of a five-year automation of the WIC Program including certification, check printing, and nutrition services, and conversion to electronic benefit tracking (EBT).
- C The **Community Health Worker Program** educates all pregnant clients about the benefits of breast-feeding, collects data at birth and 6 weeks postpartum, home visits moms shortly after birth to assess adjustment and help with techniques, refers for special assistance (if needed), and provides support to the moms through home visitation. In 1999, 54% of the CHWP clients were breast-feeding at hospital discharge, up from 50% in 1998.
- C The department co-sponsored the **Lactation Institute** with the SUNY School of Public Health (which is done annually) to educate health care professionals. The offering was broadcast to over 50 hospitals in the state and attended by pediatricians, obstetricians, family physicians, nurses and other health providers.
- C The **Comprehensive Prenatal/Perinatal Services Networks** address this topic in their newsletters and collaborated with lactation consortia to sponsor conferences.
- C Federally-funded **American Indian Nation** communities and those with **Community Health Worker Programs** educated all pregnant clients about the benefits of breast-feeding. Other reservation clinics made appropriate recommendations during individual health education/ risk reduction encounters.
- C **State regulation** requires each hospital to have a **lactation consultant** and forbids the administration of anti-lactation drugs by standing order and the issuance of sample packs of formula without prescription.

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1995	1996	1997	Change
10	Percentage of Newborns Who Have Been Screened for Hearing Impairment Before Hospital Discharge	Population-Based	Risk Factor	Infants	6	11	11	0%

Role of Title V and Title V-Related Programs/Discussion of Progress

NYSDOH, using Early Intervention funds, conducted a seven-site demonstration program to assess the feasibility and costs associated with **Universal Newborn Hearing Screening** in NYS.

C Over a three-year period, 69,761 newborns were screened, 97% of them before hospital discharge and 4% were referred for out-patient re-testing. 72% of the infants with failed inpatient tests returned for out-patient testing. The prevalence of hearing loss in NICU graduates was found to be 8/1000, while the well baby nursery graduates had losses at the rate of 0.9/1000. The positive predictive value based on in-patient screening was 12.5% in the NICU and 2.2% in the well baby nursery, similar to those of metabolic tests currently performed in hospital nurseries. Children were eligible for and referred to the Early intervention Program and the Physically Handicapped Children's Program if they had a hearing impairment. Ages of identification of hearing loss, hearing aid fitting and initiation of early intervention services were earlier than for those studies in areas where there was no universal screening program in place. The median age for discovery of hearing loss and enrollment in early intervention was 3 months, and median age for fitting of first hearing aid was 7.5 months.

Several papers describing and evaluating the pilot program were published in a special edition of Ear and Hearing: The Official Journal of the American Auditory Society, April 2000, volume 21, number 2.

C **Governor Pataki** has declared in his annual **State of the State Address** that one of the State's health priorities is to screen 100% of New York's newborns for hearing loss.

C In 1999, the New York State Legislature passed and the Governor signed a **bill requiring Universal Newborn Hearing Screening** in all birthing hospitals in New York State. As follow-up, the Department has convened an expert panel that is formulating the guidance for statewide expansion of the program.

C NYSDOH **surveyed all birthing hospitals** in the state to assess the status of newborn hearing screening. Close to 25% of hospitals reported some level of in-hospital newborn screening.

C New York applied for and was given a **grant** from the Federal Health Resources and Services Administration for \$141,851 for four years to ensure that babies are appropriately screened, diagnosed and tracked for the timely receipt of needed services. (Announced March 30, 2000.)

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
11	Percent of Children with Special Health Care Needs in the NYS CSHCN Program with a Source of Insurance for Primary and Specialty Care	Infrastructure-Building	Capacity	Children with Special Health Care Needs	---	---	---	---
Role of Title V and Title V-Related Programs/Discussion of Progress								
<p>Theoretically, 100% of our children are eligible for specialty care under the Physically Handicapped Children's Program (PHCP) and/or under expansions of Child Health Plus and Medicaid. New York should be approaching universal coverage for all children under these expansions. However, the Current Population Survey currently has our uninsured rate at 13.8 %, indicating that greater efforts must be made to improve enrollment.</p> <p>C In 1999, DOH began asking local health departments to report this information on the insurance status and treatment experience of their PHCP/Children with Special Health Care Needs enrollees. However, adherence to reporting instructions and format were inconsistent, contributing to a problem with integrity of the data. Improvements in data collection have been made to improve the quality of reporting and the integrity of these data.</p> <p>C Local county PHCP Coordinators refer uninsured or potentially eligible children and families to Medicaid and Child Health Plus, as do service coordinators for the Early Intervention Program (EIP). EIP regulations require that service coordinators obtain information about health care coverage and make appropriate referrals, including to Medicaid, Child Health Plus, Social Security programs and PHCP.</p> <p>C Children are being enrolled in Child Health Plus at the rate of about 20,000 per month.</p> <p>C New York is now focusing SSDI funds on improving our data on this Performance Measure.</p>								

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
12	Percent of Children Without Health Insurance	Infrastructure-Building	Capacity	Infants and Children	15.1	15.5	13.8	-12.3%

Role of Title V and Title V-Related Programs/Discussion of Progress

The high rate of uninsured children is particularly disturbing in light of the expansions of Medicaid and Child Health Plus. Lack of progress is thought to be due to the increasing number of service sector jobs where no fringe benefits are available and on a misunderstanding between eligibility for cash assistance and Medicaid.

- C Enrollment in **Child Health Plus** is increasing dramatically, at a rate of about 20,000 children per month. Awareness of Child Health Plus is also increasing referrals to **Medicaid**. The joint MA-Child Health Plus-WIC application was approved for statewide use this year. In October 1999, DOH awarded 32 contracts for facilitated enrollment totaling nearly \$4M, representing an annualized amount of \$10. The community-based organization that received awards will provide families with necessary information about eligibility and enrollment, assists them in completing applications and route the required paperwork to the health plan for enrollment in Child Health Plus, or to the local social services district, if the child is Medicaid eligible. In the case of Medicaid, the enrollers will be authorized to conduct the Medicaid interview and to provide information to families on managed care options under both programs. Enrollers reflect the cultural and language diversity of the areas they serve and are open evenings and weekends to make enrollment easier for working families. A toll-free hotline provides families with assistance and information.
- C Children of women enrolled in Medicaid while pregnant are **automatically eligible** for Medicaid for the first year of life. Approximately 25-45% of all enrollees (45,000) were not previously enrolled in Medicaid.
- C The **Statewide Perinatal Data System** will allow for automatic enrollment of newborns into Medicaid.
- C The **School Health Program** assess insurance status as part of their enrollment process. Students who were not insured were referred to Medicaid or Child Health Plus for eligibility determination. (Insurance coverage is not a requirement for program participation. Block grant dollars are used to provide direct and enabling services to the uninsured.) An estimated 42% of school-based clinic enrollees have no health insurance. Multiple enabling services were performed on a routine basis by the School Health Program. Also, through a CDC grant, two school-based health centers in Yonkers provided immunizations to children ages birth to two and assisted in connecting them to a medical home.
- C The **Children with Special Health Care Needs Program/Diagnosis and Evaluation Component**, which also covers **Dental Rehabilitation Services**, has no means test and provides up to three visits to specialists when an PHCP-eligible condition is suspected. Meanwhile, local coordinators work with families to enroll them in health insurance.
- C The **Community Health Worker Program** assesses insurance status of all children enrolled, assist eligible children to apply and follow up to determine enrollment status. In 1999, 25% of the children enrolled were without insurance.
- C The **Comprehensive Prenatal/Perinatal Service Networks** promoted New York's expanded Child Health Plus program. The Prenatal/Perinatal Services Networks sub-contracted with the Department to promote enrollment in Child Health Plus.
- C **Dental programs** now refer to Child Health Plus, which has dental benefits as part of its comprehensive package.
- C Children of **migrant and seasonal farm workers** are referred to Medicaid and Child Health Plus as appropriate.
- C Child Health Plus enrollment has been promoted among all of the **American Indian Health Program** Nations.
- C Child care providers were provided information about Child Health Plus through the **CISS** grant on Health Systems Development in Child Care.

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1997	1998	1999	Change
13	Percent of Potentially Medicaid Eligible Children Who Have Received a Service Paid by the Medicaid Program	Infrastructure-Building	Process	Infants & Children	85.3	85.8	84.7	0.7%

Role of Title V and Title V-Related Programs/Discussion of Progress

- C **The New York State Medicaid Program** reached 1,376,328 (84.7%) of the 1,624,563 eligibles in FFY 1999. This percentage is fairly consistent with data from 1996, 1997 and 1998, when 85.7, 85.3 and 85.8% were reached, respectively.
- C In a 1992 study, only about 18% of New York's MA-enrolled children have received **preventive dental services** under the program. (66% of our Region's Head Start Programs listed dental carries as a major health problem. 33% said baby bottle syndrome was a major problem.)
- C The **School Health Program** assesses insurance status on enrollment, when children also receive an initial assessment and physical. Medicaid is billed for eligible services for those students where MA is indicated as the insurer. Approximately 33% of school-based clinic enrollees have Medicaid coverage.
- C Of **Community Health Worker Program** clients, 66% of the adults and 91% of the children are enrolled in Medicaid.
- C The **Statewide Perinatal Data System** will enroll infants in Medicaid at birth.
- C The Department began implementing a joint **WIC-Medicaid-Child Health Plus application** and gave grants to local agencies for **facilitated enrollment**.
- C Medicaid pays for **lead screening and risk-reduction home visits** by staff of local health units; local units assist needy families to apply.
- C The **American Indian Health Program** encounters reluctance on the part of Native Americans to determine eligibility or enroll in the Medicaid Program.

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1997	1998	1999	Change
14	The Degree to Which New York State Assures Family Participation in Program and Policy Activities in New York State Children with Special Health Care Needs Program	Infrastructure-Building	Process	Children with Special Health Care Needs	Score 7	Score 6.27	Score 6	- 0.27 points GOAL NOT MET

Role of Title V and Title V-Related Programs/Discussion of Progress

- C New York attains this ranking by asking parents to rank statewide effort; no agency staff participate in the scoring. In canvassing parents for their feelings about the system of care for Children with Special Health Care Needs, DOH is able to obtain very important input from parents on the shortfalls of present efforts. The CSHCN Program transition will make use of this information in planning program changes. An important part of the transition involves enhancing parent involvement in the program on the State and local levels.
- New York recognizes that the 1999 score is lower than previous years. As a result, careful review of areas where scores have decreased will be undertaken in an effort to improve parent participation and satisfaction in future years. Scores will also be shared with a panel of parents for their suggestions. On preliminary inquiry, parents have stated that they believe that the block grant form used to score parental responses is at too high a reading level (grade 11) for some of the parents who scored, and that the numeric scores should be changed to words that actually describe levels of involvement. New York will discuss with parents piloting a revised form.
- C In 1999 CSHCN parents were involved in **writing a strategic plan** for increased parent/consumer involvement in the Block Grant. Using this input, DOH staff piloted **parent/consumer focus groups** in four locations in late 1999/ early 2000. The pilots were then expanded to eight additional parent/consumer focus groups across several geographical and demographic areas in order to provide additional information for the Y2000/Y2001 Needs Assessment.
- Our goal in offering the forums is to improve maternal and child health services in our State based on the experiences of consumers and expressed customer needs. The rationale for this is that consumer and family experiences with the health care system may provide the best insight into where the system needs to be changed. Our customers have ideas about how the system should work, but we were stymied by the traditional "public hearing format." Parents and teen consumers almost never attended, and when they did attend, they found the public hearing format to be somewhat intimidating. The forums provided a less formal, more comfortable, more personal atmosphere in which consumers could share with us their experiences and suggestions.
- C The CSHCN Program continued to employ a **Family Specialist** who is a parent of a child with special health care needs. She is the State liaison to the NY Parent-to-Parent and Family Voices. The Public Health Program Nurse and the SSDI Coordinator are also parents of special needs children. Though not employed expressly as parents, each provides a valuable parent and family focus in policy deliberations. These staff were often involved in advising parents and agencies on issues related to CSHCN and often provide local agencies with information on resources and linkages to improve their program capacity. All three parents were involved in the parent/consumer forums. They also enlisted parent graduates of the Family Professional Training Institute and Federal MCH Block Grant Reviewer Training. Each of these parents and the Family Specialist have also reviewed other state's block grants as specialty reviewers. The graduates were instrumental in helping set up and populate the forums.
- C Parents were involved in transition planning for the **Children with Special Health Care Needs Program (policy development)**.
- C An important goal for the **Early Intervention Program** is to support families in meeting their responsibilities to nurture and enhance their child's development. Families are supported in their roles to participate in the process at every step and are integral member of the team. Families are also encouraged to participate in a variety of family initiatives with the purpose of building advocacy skills, enhancing communication between the

National Performance Measure 14 - Degree of Family Participation (continued)

department and families and obtaining family input. These activities include leadership training programs, an informational bulletin for families, parent membership on all clinical practice consensus panels and an active Parent Involvement Committee, a committee of the Early Intervention Coordinating Council.

The Early Intervention Program funded a **Family Initiatives Coordinator**, who is the parent of a child with a disability, to work with program staff and the Parent Involvement Committee to coordinate a range of family initiatives. Because Early Intervention and the Children with Special Health Care Needs Program are now co-located in the same unit, it is anticipated that they will be working together much more closely.

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
15	Percent of Very Low Birth Weight Births	Infrastructure	Risk Factor	Infants	1.5	1.6	1.5	-6.2%

Role of Title V and Title V-Related Programs/Discussion of Progress

- C Timely, risk-appropriate, coordinated, comprehensive prenatal care is provided to all PCAP and MOMS 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 program reduces low birthweight among Medicaid women, particularly minority women, 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.
- C The **Perinatal Regional Outreach and Education** efforts focused on reaching high-risk pregnant women who typically may get late or no prenatal care with the intent of reducing public perceptions of financial and other barriers to prenatal care. The effort emphasized early entry into prenatal care in an effort to reduce the need for high-risk care for mother and baby. A population of approximately 100,000 women were targeted by this population-based effort.
- C **WIC** has directly promoted the birth of healthy infants by preventing low birthweight,. In 1999, infants born to WIC-enrolled women weighed 8 grams more on average than their non-WIC counterparts.
- C The **Growing Up Healthy Hotline** linked women with prenatal, nutrition, psychosocial and supportive services which contribute to healthy pregnancy and improved birth weights.
- C 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.
- C Poor spacing of pregnancies contributes to poor birth outcomes. The **Family Planning Program**, funded by both Titles V and X, provided direct services, including comprehensive medical exams and a full range of contraceptive services, to over 320,000 low-income, uninsured women in 1999, about a third of which were under age 20. Family Planning Programs also provided community education and public information in every county in NYS.
- C The **Comprehensive Prenatal/Perinatal Services Networks** 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.
- C The **Regional Outreach and Education Programs** encouraged early prenatal care, and continuous, high-quality prenatal care.
- C **Prenatal genetics counseling** and screening services were provided to approximately over 24,000 women and families. Genetics services can identify a genetic or other congenital defect in the fetus before birth, enabling the parents, physician and birth facility to make available any necessary interventions before the birth.

National Performance Measure 15 - Very Low Birth Weight Infants

C The **MIC - Women's Health Services Project** under New York City's Medical and Health Research Association is a longstanding and essential provider of prenatal and family planning services to women residing in the City's medically and socially underserved communities. In 1999, MIC continued to evolve in response to the constantly changing health care environment of New York City. The eight MIC centers served 25,938 unduplicated patients in 1999. Of those patients, 9,985 came for prenatal care and 17,150 came for family planning services. Maternity visits decreased by 9.85; family planning visits increased by 10.2%

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
16	Rate per 100,000 of Suicide Deaths among Youth Aged 15-19	Infrastructure-Building	Risk Factor	Children & Adolescents	6.2	5.9	5.5	-6.8%

Role of Title V and Title V-Related Programs/Discussion of Progress

- C In 1999, the Director of the Bureau of Injury Control participated in the **National Suicide Prevention Conference**.
- C The Northeast (Region 1 and 2) Injury Control Directors and Title V staff later met to plan appropriate follow-up conference for the two regions.
- C New York held the first annual **Hope Conference** on suicide prevention in May 1999, followed by a second in May 2000. The conference was attended by agency people, hotline and counseling providers, injury control practitioners and survivors who had a loved one commit suicide.
- C The Title V Coordinator and the Injury Prevention Director are participating on an interagency team to formulate a **statewide suicide prevention plan**. The plan will be comprehensive, including each age group and all at-risk populations. The team also includes the Adolescent Health Coordinator, representatives of the Office of Mental Health, the State Education Department and the Office of Children and Family Services.
- C 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. New York participated in the Suicide Data Book project sponsored by the Northeast Injury Control Directors Group.
- C The **School Health Program** has as part of its initial assessment an evaluation for suicide risk. Mental health services, including crisis intervention, are available through the school-based health center. Referrals are made for more intensive consultation or treatment. Family members and other students are also offered consultation and education. Approximately 12% of SBHC visits indicated emotional issues as a primary reason for the visit.
- C The **Healthy Choices Initiative** is an effort to expand school-based health center services to include population-based prevention activities that reduce adolescent risk behaviors. One focus was the development of programs that focus on violence prevention. The activities include conflict resolution seminars for adults and students, peer mediation, mentoring, after-school activities and violence prevention forums.
- C **ACT for Youth** focuses community attention on asset building activities for youth as a way of reducing risk-taking behaviors.
- C In 1999, New York launched a new **Lesbian and Gay Health Initiative**. The focus of these grants is to increase knowledge and raise sensitivity to issues that impede access and quality of health care for lesbian and gay individuals and their families, to enhance and improve access to existing services, to create needed services not currently in existence, where needed, and to promote collaborations and integration between specialized and mainstream services. Eleven contractors were selected statewide. Over half of the grantees under this initiative are focusing 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.

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
17	Percent of Very Low Birth Weight Infants Delivered in Facilities for High Risk Deliveries and Neonates	Infrastructure-Building	Risk Factor	Infants	75.9	77.5	76.9	-1%

Role of Title V and Title V-Related Programs/Discussion of Progress

These data had improved in 1997, after taking a dip from 77.9% in 1994. They dropped a single percentage point in 1998. The initial drop was thought to be related to the implementation of managed care, which caused a temporary shuffle in relationships between obstetrical providers and their usual sources for high-risk care. These relationships are now more normalized, but DOH is monitoring this trend carefully.

- C The **Prenatal Care Assistance Program** has as a condition of participation risk assessment at various intervals and matching the appropriate level of care to risk status. Quality assurance visits validate that this is occurring.
- C Access to facilities for high-risk deliveries is a measure in the **Quality Assurance Reporting Requirements** for commercial and Medicaid managed care plans.
- C A primary focus of the **Comprehensive Prenatal/Perinatal Services Networks** is to ensure that pregnant women and infants are treated at the appropriate levels of care. CPPSNs worked with area hospitals and other providers to ensure appropriate sites for delivery of high-risk women.
- C A **redesignation process** was undertaken in 1998 to determine whether all hospitals are now properly designated as Level II and Level III facilities. This work continued into 1999, and is now nearing closure.
- C The **School Health Program** provides pregnancy testing and reinforces the need for early prenatal care. Staff in school-based health centers co-manage prenatal care of their students and help to ensure that pregnant students are referred to the appropriate level of care.
- C 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.
- C The **Statewide Perinatal Data System** continued being phased in across NYS in 1999. The SPDS will provide the information infrastructure to support surveillance of care provided to high-risk women and neonates. The SPDS will allow hospitals and freestanding birthing centers to make informed interventions where needed, pinpoint populations and geographic areas where access to prenatal care is problematic, help target services, and facilitate assessment of the functioning and effectiveness of perinatal regional centers. The Perinatal Data System, where fully functioning, was (and is) a source for community- and provider-specific ambulatory care data to determine whether referral protocols were followed.
- C The **Prenatal Genetics Program** seeks to, whenever possible, identify high-risk births in order for parents, physicians and birthing hospitals to plan and provide interventions as is appropriate.
- C The **MIC - Women's Health Project** rebid for partner facilities during 1999. MIC's new partners share in their vision of a model of care that is responsive to the cultural, linguistic and financial needs of the women they serve. Each of these facilities has appropriate Letters of Agreement in place with MIC to ensure the appropriate level of care.

National Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
18	Percent of Infants Born to Pregnant Women Receiving Prenatal Care Beginning in the First Trimester	Infrastructure-Building	Risk Factor	Pregnant Women and Infants	70.4	73.1	73.8	+1%

Role of Title V and Title V-Related Programs/Discussion of Progress

- C A 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.
 - C The eight **Maternal Infant Care-Women's Health Services (MIC-WHS)** centers served 25,938 unduplicated patients in 1999. Of those patients, 9,985 came for prenatal care and 17,150 came for family planning services. Maternity visits decreased by 9.85; family planning visits increased by 10.2%.
 - C **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.
 - C 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. The MCH-funded portion of the program which provides services to two Indian Nations; they visited 44 pregnant women, 35 infants, 73 children and 231 others in 1999.
- Overall, CHWP helped over 10,000 individuals in 1999: 2,136 pregnant women, 1,181 infants, 3,558 children and 3,680 others. The Community Health Worker Program conducted outreach to pregnant women in areas with poor outcomes, educated women on the importance of early prenatal care, referred women to prenatal care (accompanying them if necessary), assisted in making arrangements for transportation and child care, and followed-up to determine that appointments are kept.
- C The **Comprehensive Prenatal/Perinatal Services Networks (CPPSNs)** have as their primary objective to increase the percentage of women entering prenatal care in their first trimester. CPPSNs maintained several outreach and education efforts to promote prenatal care community-wide.
 - C **Regional Outreach and Education Projects** target women who would typically enter prenatal care late or not at all. The intent is to minimize perceived barriers, financial or otherwise, to prenatal care, engaging women early in their pregnancy and, hopefully reducing the need for high-risk, more expensive care. About 100,000 women are targeted by this population-based, media effort through contracts with community-based organizations or Prenatal/Perinatal Networks in geographic areas with a higher percentages of late and no prenatal care. New York's ten perinatal outreach and education projects conducted active multi-media advertising and promotional campaigns in their broad geographic regions during 1999. Using low-literacy, graphically appealing messages, local campaigns advised women of the availability of pregnancy testing, pregnancy care and pregnancy hotline. While promoting pregnancy care, the campaigns also conducted broad public education on the hazards of alcohol, tobacco and recreational drugs in pregnancy. Successful campaign methods included Yellow Page ads, FM radio, brochures/flyers, weekly Penny Saver ads and back printed grocery store receipts. As a result, call volume to the **Growing Up Healthy Hotline** and local pregnancy help lines increased.
 - C 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.
 - C The **Family Planning Program** makes early referrals for women testing positive for pregnancy.

State "Negotiated" Performance Measures

There are ten additional performance measures selected by New York State:

New York State Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
01	Percent of Unintended Pregnancies Resulting in a Live Birth (New Indicator)	Direct	Risk Factor	Women and Infants	34.1	38.4	35.3	-8%

Role of Title V and Title V-Related Programs/Discussion of Progress

- C The PRAMS Survey is the source of these data.
- C New York State has enacted a **Family Planning Extension Program** which provides an additional 24 months of family planning benefits to women who were on Medicaid while pregnant, and lost Medicaid coverage.
- C The **Community-Based Adolescent Pregnancy Prevention Program's** goal is to reduce teen pregnancies in the highest risk zip codes (now 50 statewide) 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.
- C **Family Planning Programs** provided community education and public information, comprehensive medical exams and access to a full range of contraceptive methods, STD counseling and testing, and special counseling for teens. On 1999, 63 Family Planning Programs provided services to over 320,000 low income, uninsured women, about one third of whom were under the age of 20.
- C The **Community Health Worker Program** provided family planning information to all women of childbearing age and refer to family planning services. They then follow-up to see that services were received.
- C The **School Health Program** provided risk assessment for sexual activity is 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 32,000 female students ages 15-19.
- C Through the **Healthy Choices Initiative**, a pregnancy prevention peer education program was developed with included parents, adolescents, educators, physicians, nurses, school and health administrators. The peer educators engage at-risk adolescents in pregnancy prevention education as well as to impart life-building and self-esteem-enhancing skills.
- C The **Comprehensive Prenatal/Perinatal Services Networks** and **Regional Outreach and Education Programs** promoted reduction of adolescent pregnancy rates through provider and community conferences, outreach and education efforts.
- C NYSDOH Bureau of Women's Health awarded funding to 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. 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 included a statewide, large scale media campaign to support the community-based initiatives.
- C **Article 6** reimburses local health departments with State Aid for health education and other population-based efforts, and supports infrastructure needed to provide data collection, data evaluation, community-based planning and implementing collaborative intervention strategies.

State Performance Measure 01 - Unintended Pregnancies

- C The **Rape Crisis Program** administered 55 contracts to local rape crisis providers, 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.

New York State Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
02	Hospitalizations Rate per 100,000 for Asthma in Children Ages 1 to 14 - (Changed from birth to 14)	Population-Based	Risk Factor	Infants, Children & CSHCN	509.8	496.8	365.7	-26.4%

Role of Title V and Title V-Related Programs/Discussion of Progress

- C There were **multiple cross-agency efforts** to assess and intervene in the increasing incidence of asthma. BCAH is working with the Office of Managed Care, the Division of Chronic Disease Prevention and Adult Health, the State Education Department, New York City Department of Health and Child Health Plus.
- C New York convened regional Asthma Summits and began working on a comprehensive **statewide plan** on asthma.
- C The Center for Environmental Health targeted asthma as part of its **Healthy Neighborhoods Program**. This initiative supported contracts with local health departments in eight communities.
- C The Wadsworth Center for Laboratories and Research is began testing long-term effectiveness of an **integrated pest management** approach to reduce the presence of cockroaches in apartments and homes. This project has the potential to develop better methods for reducing roach infestations and for evaluating the presence of roaches.
- C Under the **Primary Care Initiative Program**, the Department provides 2-3 grants to New York City Hospitals to increase availability of primary care clinics and services for asthma-related care.
- C **Thirty-five Medicaid managed care plans** participated in a study jointly designed by DOH, the Island Peer Review Organization (IPRO), and the managed care plans to evaluate the quality of care delivered to moderate to severe asthmatics, ages 5-39. They found that the care to the Medicaid population with asthma can be significantly improved. Quality of care standards established under the program being routinely monitored.
- C New York State's 163 **school-based health centers** bring comprehensive health services to schools where children and youth spend their day. All school-based health center clients are assessed on their initial history and physical, then diagnosis is made based on the findings. There is on-going management of the condition, including monitoring student and family education in self-management and intervention. Specific programs to deal with asthma have been instituted in some of the school-based health centers:
 - C Montefiore Medical Center is implementing an asthma program that involves school-based health center staff, school staff, parents and students. A care plan is developed for each affected student which includes all clinical and educational interventions.
 - C The Monroe County Health Department in conjunction with Genesee Hospital and P.S. 33 is piloting an educational program for children with moderate to severe asthma, grades two to six. Parent education will be a key component and will consist of classroom activities and home visits.
 - C Sisters Hospital in Buffalo has implemented the "Open Airways" Program in conjunction with an advanced health education component in the schools they serve. When students complete "Open Airways" they are phased into advanced health education which provides more specific information on contributing factors and management of asthma.
- C A **Request for Proposals** was issued entitled, "A Systems Approach to Reducing the Burden of Asthma." to facilitate or strengthen cross-system regional collaborations, to include those involved in the diagnosis, treatment, prevention and management of asthmatic children to reduce asthma-related morbidity and mortality. Seven applicants went on to win contracts in 2000.
- C **Mini-grants** from the Office of Emerging Majorities targeted for reduction the high asthma rates in several minority communities.

New York State Performance Measure 02 - Hospitalizations for Asthma (continued)

- C Under the **Columbia Collaborative Projects**, MCHSBG funded an asthma-related initiative related to screening and education. The program will test out a system for conducting asthma screening through a network of family day care providers in Northern Manhattan. In partnership with the Northern Manhattan Community Voices Collaborative, the Harlem Congregations for Community Improvement and the Alianza Dominicana, the project began developing asthma education modules to add to the existing family day care training programs. After training, participants will screen for asthma among the children and families they serve. Referral networks have been worked out, and families needing assistance will have access to high-quality asthma care.
- C The **New York State Education Department** has initiated an "Open Airways" Program outside of New York City. State Education funded Regional Comprehensive School Health and Wellness staff to train school nurses in 40 schools to support implementation of the program and ongoing activities. A one-year evaluation component, consisting of data collection and student pre and post-testing, will be administered in collaboration with SUNY Binghamton and the Regional Comprehensive Health and Wellness Centers.

New York State Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
03	Percent of Women Who Reported Smoking During Pregnancy	Enabling	Risk Factor	Women & Infants	15.6	18.6	13.8	-25.8% MET

Role of Title V and Title V-Related Programs/Discussion of Progress

- C Data are from the **PRAMS Survey**. In 1996, this indicator had a 20.4 % rate of change, showing the rate of prenatal smoking decreasing from 19.6% to 15.6%. In 1997, the PRAMS data indicated a jump back to higher levels. In 1998, the level dropped back down to 14%, exactly meeting our goal for this year. Smoking rates are consistently higher in New York City than in the rest of New York.
- C **Patient education materials** for waiting rooms and patient education areas are available from DOH free of charge by the Bureau of Community Relations. Bill boards and other ads target pregnant women for anti-smoking messages.
- C **PCAP and MOMS** performed substance use screening on all pregnant women in the Medicaid and Prenatal Care Assistance Program. Referral for smoking cessation is a program requirement.
- C The **Community Health Workers** educated and referred pregnant smokers. They offered extensive support through home visitation.
- C The **School Health Program** continued to screen for tobacco use and make appropriate referrals, including to obstetrical services, and to counsel student accordingly.
- C The **Statewide Perinatal Data System** facilitate surveillance of this problem and allow better targeting of resources.
- C There are multiple smoking cessation programs across the state targeted to pregnant women. One example comes from the **Mothers and Babies Perinatal Service Network**. "Quit Kits" were formulated, and included with the program was a weekly supportive phone call to pregnant and parenting women and other household members who enrolled in the program. Efforts were also coordinated with the physicians, where possible, so that consistent messages were provided to encourage follow-through with the quit plan.

New York State Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
04	Teenage Pregnancy Rate Per 1000 for Girls Ages 15-17 (Changed from 15-19)	Population-Based	Risk Factor	Women & Adolescents	59.7	56.6	50.7	-10.4%
Role of Title V and Title V-Related Programs/Discussion of Progress								

- C The MCHSBG funds supported 63 local **Family Planning Programs** across the state. In 1999, these programs served over 320,000 low-income, uninsured women, or approximately one third of those estimated in need. The program continues to strive 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.
- C A targeted **Chlamydia Testing Program** was available statewide through the Family Planning Program sites. Through direct testing, the STD program is able to track trends in the occurrence of Chlamydia, which is still not a reportable disease in NYS.
- C **Community-Based Adolescent Pregnancy Prevention Program** maintained a roster of about 300 peer counselors in 28 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.
- C NYSDOH Bureau of Women's Health awarded funding to 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. 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 included 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. Process evaluation and data collection tools were developed and implemented after a training for all contractors in June of 1999.
- C The **Comprehensive Prenatal/Perinatal Services Networks** provided conferences on adolescent pregnancy prevention for their communities.
- C 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).
- C 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.
- C The **"Growing Up Healthy" Hotline** links women (including adolescents) with prenatal, nutrition, psychosocial and supportive services, which contributed to healthy pregnancies and improved birth weights.
- C Teens may be eligible for **PCAP/MOMS**.
- C **ACT for Youth** utilizes an assets-based approach to reduce risk-taking behavior among youth.
- C The Department continues to work with other agencies, including the Office of Children and Family Services and the Governor's Task Force on Unintended Pregnancies.
- C 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.

New York State Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
05	Ratio of Black Low Birth Weight Rate to White Low Birth Weight Rate - (New)	Population-Based	Risk Factor	Women & Infants	2.0	1.8	1.8	0%

Role of Title V and Title V-Related Programs/Discussion of Progress

- C **PCAP and MOMS** provided care to approximately 100,000 women in 1999. This translated to approximately 72,000 deliveries, with enabling services offered to about 110,000 individuals. Both programs conducted outreach to hard-to-enroll populations, which contributed to reduced rates of late/no prenatal care.
- C **Regional perinatal outreach campaigns** targeted traditionally hard-to-reach groups, contributing to an increase in early and mid-term entry into prenatal care. The protective effect of improved access to prenatal care was greatest for the Black and Hispanic population. Outreach projects also collaborated with health and human services providers to improve the user-friendliness of their systems, thereby increasing early enrollment and fuller utilization of services.
- C The **Community Health Worker Program** conducted outreach in both traditional and non-traditional locations. Clients are assisted or referred for non-medical supportive services, like clothing and housing assistance, and quick-tracked for prenatal care. There were frequent and consistent home visits and assistance in dealing with life situations/problems. Community Health Workers are hired from the communities they serve.
- C The **Maternal Mortality Study** examined specific barriers to care for women who died of pregnancy-related causes.
- C 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.
- C Pregnant **school-based health center** clients were entered into prenatal care immediately. Staff followed-up to ensure continued enrollment.

New York State Performance Measure - NEW		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
06	Percent of Infants Who are Put Down to Sleep on their Backs (New)	Population-Based	Risk Factor	Women & Infants	34.5	45.2	53.0	+17.3%

Role of Title V and Title V-Related Programs/Discussion of Progress

- C The **PRAMS Survey** is the source for these data.
- C **First Lady Libby Pataki** kicked off New York's "**Back to Sleep Project**" to reduce SIDS risk. The Department of Health expanded a local program developed by the Mohawk Valley SIDS Alliance and 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 Capital District hospitals. With the cooperation of the SIDS Alliance and funding from the Child Health Plus program, the Department produced 50,000 T-shirts in both English and Spanish. Each shirt was packaged as a kit with a SIDS prevention information card and information on Child Health Plus. These kits were then distributed to the local health departments in the 21 counties with infant mortality rates higher than the New York State average.
- C **SIDS Prevention Information Cards** (the same cards that were made available with the T-shirt) have been reprinted. To date, 40,000 English and 5,000 Spanish information cards were distributed through the Department's **Bureau of Health Promotion**.
- C **SIDS Prevention Posters** were developed after staff learned of the lack of awareness of the "Back to Sleep" message in the child care community. To help day care providers learn of the importance of sleep positioning and other SIDS prevention messages, a poster listing the information was designed and printed by DOH. 10,000 posters have been printed, and a distribution was done to all child care providers, including day care centers and family day care providers.
- C Staff provided **statewide training** for police, fire fighters, emergency medical personnel and public health nurses 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 an 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.
- C New York is participating in an **HHS/HRSA Region 2** project to produce SIDS prevention materials in a variety of languages for distribution in New York, New Jersey, Puerto Rico and the Virgin Islands.

New York State Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
07	Hospitalization Rate Per 100,000 for Self-Inflicted Injuries for 15-19 Year Olds - (Changed from 10-19 Year Olds)	Population-Based	Risk Factor	Children & Adolescents	118.4	118.4	109.8	-7.3%

Role of Title V and Title V-Related Programs/Discussion of Progress

- C All **school-based health centers** provided psycho-social assessment beginning with the initial visit. Student 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 are reported. Staff follow up on all cases.
- C See information under National Performance Measure 15.

New York State Performance Measure		Level of Service	Type	Population	Progress Reported			
					1995	1997	1999	Change
08	Percent of High School Students Who Drank Alcohol in the Last Month	Population-Based	Risk Factor	Children & Adolescents	53	48	49.6	+3.3% NOT MET

Role of Title V and Title V-Related Programs/Discussion of Progress

- C These data are collected every two years by the State Education Department through the **Youth Risk Behavioral Survey (YRBS)**.
- C DOH/Title V staff collaborated with our state **Office of Alcoholism and Substance Abuse Services (OASAS)** on a State Agency Collaboration Survey to gather baseline information on state agency knowledge and collaboration in developing substance abuse and alcohol-related prevention policy. In 1999, OASAS released a request for proposals (RFP) to incorporate the roles of multiple human service agencies at the county level in identifying alcohol and substance abuse risk and protective factors and to strengthen and expand local partnerships for alcohol and substance abuse prevention. Community partnerships in 15 New York counties were funded for three years to develop and implement county-wide, prevention- and results-focused work plans. These work plans serve as a vehicle to identify, re-direct, and leverage state and local resources to bring about a comprehensive, multi-system approach to alcohol and substance abuse prevention at the local level.
- C **ACT for Youth, (Assets Coming Together for Youth)** was developed by DOH in collaboration with its State level partners: **Partners for Children** and the **HIV Prevention Planning Group**. The initiative integrated prevention strategies and developmental assets for and with youth in communities throughout the state. The focus of the initiative is the prevention of 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 actively the state's most vulnerable populations (e.g. 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).
- C Over half of the **Lesbian and Gay Initiative** issues related to lesbian, gay and bisexual youth, including alcohol, substance abuse and self-inflicted injury.
- C **PCAP/MOMS** clients are assessed for alcohol and substance abuse issues; referrals are made accordingly.
- C The initial assessment in **school-based health centers** includes questions about tobacco and alcohol use. Students are counseled and educated accordingly. Referral is available.

New York State Performance Measure		Level of Service	Type	Population	Progress Reported			
					1995	1997	1999	Change
09	Percent of High School Students Who Smoked Tobacco in the Last Month	Population-Based	Risk Factor	Children & Adolescents	37	33	31.8	-3.6% GOAL MET

Role of Title V and Title V-Related Programs/Discussion of Progress

- C These data are collected every two years by the State Education Department using the **Youth Risk Behavioral Survey (YRBS)**.
- C MCHSBG funds were pooled with Prevent Block Grant funds and National Cancer Institute ASSIST funds for both fiscal years 98 and 99. With these funds Center for Environmental Health carry out **Adolescent Tobacco Use Prevention Act (ATUPA)** activities through the 58 local health departments in the state. Their activities included:
 - C Promotion of **Youth Partnerships for Health (YPH)** which help youth to resist peer pressure and to become involved in social and community anti-smoking activities.
 - C **Funding of coalitions** that mobilize communities in counter-advertising activities such as the ban on tobacco advertisement billboards near schools and playgrounds in New York City.
 - C Helping the Center for Environmental Health identify youth to become active in **unannounced compliance checks** on retail sales of tobacco to minors. (New York State provided \$2 million to this enforcement effort so that every retail outlet would receive an unannounced compliance check.)
 - C Helping communities to pass **local ordinances** on smoking in public places and remove tobacco products from the reach of youth.
- C **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.
- C 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.
- C **Comprehensive Prenatal/Perinatal Services Networks** create awareness of the dangers of smoking, particularly in pregnancy.
- C The **Adolescent Coordinator** and **staff of the Tobacco control program** began planning a statewide youth summit on tobacco which took place in June of 2000, with the active participation and attendance of **Commissioner Novello** and **Executive Deputy Commissioner Whalen**.

New York State Performance Measure		Level of Service	Type	Population	Progress Reported			
					1996	1997	1998	Change
10	Percent of Children in the Birth Year Cohort Who Were Screened for High Blood Lead Levels Before Age 2	Infrastructure-Building	Capacity	Children	70.3	68.7	Data Not Avail.	?

Role of Title V and Title V-Related Programs/Discussion of Progress

- C The **Lead Poisoning Prevention Program** in 1999 had nearly 15,000 children in active case management to lower elevated blood leads; 2,109 children had blood leads greater than 20 µcg/dl. The environments of all of the 2,109 children with positive lead levels were reviewed for risk.
- C Because NYS has more pre-1950's housing than any other state, CDC has supported our **universal screening policy**. However, the CDC guidelines released in November of 1997 impacted the numbers of physicians who are willing to universally screen. Physicians, seeing low numbers of positives in their practices, have either become more selective in screening their clients, or have decided to screen only once, at age 1 or 2. In areas with low prevalence, screening has declined the most. Where the highest prevalence is found, rates of screening are up. The program continues to implement strategies to increase screenings in high risk populations and released a Physicians' Handbook on Childhood Lead Poisoning in 1999.
- C The most encouraging news is a **40% decrease in new cases** greater than 20µgm/dl. Although screening is down about 40% overall, the number of positives are down only 14%. Local health departments have noted that they have fewer middle class children being affected, and much fewer cases that are due to home renovations. This would indicate that education had an effect. Cases in the range of 15-19 µgm/dl have declined, as well.
- C The **Office of Managed Care** includes lead screening in its quality reporting system, and they have reported to the Lead Program that screening in also down slightly in the managed care plans. A forum to discuss this problem with managed care plans is ongoing.
- C The **Community Health Worker Program** educates parents regarding lead poisoning and screening, assesses children's records for lead screens and refers and follows those who were not screened.
- C **WIC and PCAP** continue to stress the need for preventive services for infants, including lead screening.
- C CISS day care grant, **Healthy Child Care 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.
- C Lead screening was provided to the 1800 children attending **migrant day care**.
- C New York has regulations concerning prenatal screening for lead .

2.5 Progress on Outcome Measures

Please refer to Form 12, Section 5.4, which tracks New York's progress toward the six required outcome measures. Outcome measures are indicative of the collective efforts of New York's public and private health system to obtain optimum health for all New Yorkers. Local health units, who monitor health outcomes through their required community health assessment process, usually use State Aid to Localities to pay for surveillance of these outcomes. However, MCH funding supports training and technical assistance, data production, and posting of information on the DOH.

Progress can be reported as follows:

National Outcome Measure		Progress Reported			
		1996	1997	1998	Change
01	Infant Mortality Rate per 1,000 Live Births	6.9	6.7	6.2	-7.5%

Role of Title V and Title V-Related Programs/Discussion of Progress

All of the Department's Maternal and Child Health programs, but especially **PCAP, MOMS, Medicaid** and **Managed Care** promoted the provision of prenatal and related support services, coordination of care through the intrapartum and postpartum periods, risk management and risk appropriate care. PCAP standards have been applied to all pregnancy-related care under Medicaid.

C The **Community Health Worker Program** provided home visits from pregnancy through the infant's first year of life. They provided health education and parenting information, ensured the child/family was enrolled in primary health care and insurance, assessed safety hazards in the home, and made appropriate referrals with follow-up. The program has served over 2500 pregnant women annually.

C **Infant Mortality Review** allowed communities to improve maternal and child health care through information learned in infant death reviews. Community review panels analyzed de-identified results from perinatal records and patient interviews to decide where best to intervene. Each family received a supportive nursing home visit and opportunities for referral. This process contributed timely, local epidemiologic information to promote healthy birth outcomes, assured adequate prenatal risk assessment, and encouraged follow-up for high-risk pregnancies. While mostly a population-based intervention, enabling services were offered to grieving families through formal linkages with the local Departments of Social Service, community-based organizations, hospitals, Protective Services, and WIC.

The program contracted with eight county health departments and one perinatal network to visit every mother in 11 counties who experienced an infant loss in 1999. The program:

- C provided support to parents by ensuring families who experience the death of an infant were offered immediate and ongoing support, including home visits by professional nurses and social workers trained in the bereavement process;
- C provided first responder training to ensure that the first responders in infant deaths were knowledgeable about sudden, unexpected infant deaths and had the necessary skills to respond in a family-friendly, culturally-competent manner;
- C provided outreach education for risk factor reduction using an array of educational approaches; and
- C conducted surveillance to collect, analyze and disseminate epidemiological data on infant death.

C **Comprehensive Prenatal/Perinatal Services Networks** worked collaboratively with county health departments, the New York City Department of Health and other health and human services agencies to reduce the infant mortality rates in their areas. Often, this took the form of sharing program information through newsletters and coordination of outreach and educational efforts. One network is a contractor for the infant mortality review program.

C See the description of the **Statewide Perinatal Data System** under Performance Measures. The SPDS enabled development and tracking of risk-adjusted infant mortality rates by hospital, community, region, (soon) statewide and health care plan. The risk-adjusted rates could then be used to determine areas where interventions and improvements were needed.

C Unintended or poorly spaced pregnancies are related to poor birth outcomes. The **Family Planning Program**, funded by Titles V and X, provided direct services, including comprehensive medical exams and a full range of contraceptive methods, to over 300,000 women, about a third of whom were teens under age 20, in 1999. Family Planning Programs also provided community education and public information in every county in New York State.

C It is anticipated that recent **Medicaid and Child Health Plus expansions** will improve mortality rates.

National Outcome Measure		Progress Reported			
		1996	1997	1998	Change
02	Ratio of Black Infant Mortality Rate to the White Infant Mortality Rate	2.2	2.0	2.0	0%

Role of Title V and Title V-Related Programs/Discussion of Progress

Eliminating disparities in health outcomes between racial groups was, and continues to be, a high priority.

- C See discussion under National Outcome Measure 01, above.
- C **PCAP** and **MOMS** have been shown to have their greatest positive impact on the birth outcomes of Black women. **PCAP** is the standard of care for all pregnancy care delivered under Medicaid.
- C The **Community Health Worker Program** is located in areas where there is a large percentage of minority women, as are the Comprehensive Prenatal/Perinatal Services Networks. (See interventions listed in preceding section.)
- C By targeting the zip codes at highest risk of teen pregnancy, the **Community-Based Adolescent Pregnancy Prevention Program** worked toward preventing high risk pregnancies.
- C Title V staff collaborate with Federal **Healthy Start** projects. In many cases, the Comprehensive Prenatal/Perinatal Services Networks are the lead agency.
- C See the description of the **Statewide Perinatal Data System** under Performance Measures. The SPDS will be helpful in pinpointing populations and geographic areas where access to care is problematic.

National Outcome Measure		Progress Reported			
		1996	1997	1998	Change
03	Neonatal mortality rate per 1,000 live births	4.8	4.7	4.4	-6.4%

Role of Title V and Title V-Related Programs/Discussion of Progress

- C The **Community Health Worker Program** encouraged early enrollment into prenatal care, assisted pregnant women to maintain prenatal appointments and to engaged in healthy behaviors (quit smoking, stop using alcohol and drugs, improve nutrition, exercise), and encouraged the first newborn medical visit 2-4 weeks after the birth of the baby. Breast-feeding is also encouraged.
- C **Regional Outreach and Education** targeted 100,000 hard to reach women for early entry into prenatal care. In their efforts to reach women at high risk for late or no prenatal care, the program tries to assure that the babies born are of lower risk, thus avoiding neonatal deaths.
- C The **Genetics Program** provided prenatal genetics counseling and screening which can help identify a genetic or other congenital defect in the fetus before birth. This enabled parents, physicians, and birth facilities to make available necessary interventions before birth.
- C See previous descriptions of the **Infant Mortality Review Process**, the **Family Planning Program**, the **Genetics Program**, the **Statewide Perinatal Data System** and the **Comprehensive Prenatal/Perinatal Services Network**.

National Outcome Measure		Progress Reported			
		1996	1997	1998	Change
04	Post-neonatal Mortality Rate per 1,000 Live Births	2.2	2.0	1.8	- 10% Goal met

Role of Title V and Title V-Related Programs/Discussion of Progress

- C The **Community Health Worker Program** encourages consistent primary care, assists in WIC enrollment, and provides monthly home visits for assessment, education and referral.
- C The **Bureau of Injury Control** developed a media/patient education package on **Shaken Baby Syndrome**. These were widely distributed across the state, with the child care community and with regional WIC staff. Further distribution is being planned.
- C See descriptions of the **Infant Mortality Review Process**, the **Genetics Program**, the **Family Planning Program** and the **Statewide Perinatal Data System**.

National Outcome Measure		Progress Reported			
		1996	1997	1998	Change
05	Perinatal Mortality Rate* per 1,000 Live Births	13.9	13.3	12.8	-3.8%

Role of Title V and Title V-Related Programs/Discussion of Progress

- C *New York State uses twenty plus weeks of gestation to 28 days of age for perinatal rate calculations.
- C After a one-year rise in 1996, perinatal mortality dropped in 1997 and again in 1998. It appears to have risen in 1996 because of an increased number of spontaneous fetal deaths. Because other death rates are decreasing, staff believe this is an anomaly of reporting. Spontaneous fetal deaths have historically been under-reported. With the recent emphasis on improving vital records reporting, it is believed facilities are improving their reporting and correcting an undercount.
- C See descriptions of the **Infant Mortality Review Process**, the **Family Planning Program**, the **Genetics Program**, the **Statewide Perinatal Data System** and **Regional Outreach and Education**.

National Outcome Measure		Progress Reported			
		1996	1997	1998	Change
06	Child Death Rate per 100,000 Children Aged 1-14	22.7	20.1	17.8	-11.4%

Role of Title V and Title V-Related Programs/Discussion of Progress

- C The **"Healthy Child Care New York" Program**, initiated under a CISS grant, continued to provide guidance and assistance in building the infrastructure for health and safety in child care. **"Healthy Child Care New York"** activities stressed safe and healthy child care through standards development, information dissemination and personnel training. Guidelines published in 1998 have become widely accepted. Most, if not all, of the guidelines are expected to be a part of a final regulatory package. In 1999, the program continued to work with the Emergency Medical Services for Children Program to identify opportunities for input on the state's day care regulations. EMSC stakeholders then provided recommendations on the emergency care section of the guidelines for development of health care plans in day care and family home care settings. Guidelines stress environmental safety, abuse and neglect issues, emergency procedures and disease control.
- C The **Bureau of Injury Control** heavily promoted car safety seat and bike helmet use, and trained technicians to assure their availability in each county. The Bureau also enlisted collaborations with other agencies and networks with concern for the well-being of children. Bureau of Injury Control was also involved in planning statewide conferences on suicide prevention and in bringing together collaborative efforts to write a statewide suicide prevention plan.
- C Many injury and disease prevention and control activities are supported by **Article 6** State Aid to Localities, as are many infant mortality prevention efforts. Article 6 supports infrastructure-building, population-based, enabling and direct services. Direct services may be clinically based or delivered through home visitation.
- C The **Community Health Worker Program** assisted in enrollment in primary care, in health insurance and in WIC, educated, assessed, referred, followed-up, collected data on immunization, lead screening and use of primary care, and educated parents in safety issues like use of bike helmets and car seats.
- C Primary and preventive health care is provided to 3500 children of **migrant and seasonal farm workers**.
- C Approximately 650,000 children attended New York State's 2,300 children's camps in 1999. The **Children's Camps Program** under the Center for Environmental Health continued to set standards for children's camp programs, inspected and monitored for adherence to state laws and regulations (Sub-Part 7-2 of the State Sanitary Code), and surveilled for injuries and illnesses, with a goal of preventing unintentional injuries and illnesses and to reduce the incidence of drownings associated with children's camps. The camper death rate 1994-1999 is less than 1 per year (ages up to 17).
- C Population-based **Immunization Programs** contribute to the decline in vaccine-preventable diseases.

New York State-Selected Outcome Measure		Progress Reported			
		1996	1997	1998	Change
NYOM	Maternal Mortality Rate per 1,000 Live Births	10.2	9.3	9.7	+4.3%
Role of Title V and Title V-Related Programs/Discussion of Progress					
<p>C Reporting of maternal mortality is extremely variable, in our State and elsewhere. In a study conducted by our Bureau of Women’s Health, active surveillance yielded many more deaths than passive surveillance (the Vital Statistics system). Maternal mortality rates show wide disparities between the rate for Blacks and Whites. Please refer to data in the Needs Assessment portion of this application.</p> <p>C Due to general improvements in social and economic conditions, as well as improvements in medical practices, most cases of maternal death are thought to be preventable. While New York State women have experienced a steady decline in maternal mortality, marked racial differences still exist, and the rate compared to other states remains high.</p> <p>C The Bureau of Women’s Health is currently working to secure they system for designating hospitals by levels of maternal care, similar to the system that exists for designation of levels of care for newborn nurseries.</p> <p>C The Statewide Perinatal Data System will help identify maternal mortality and its causes.</p>					

Accomplishments Not Related to a Specific Performance Measure:

Population-Based and Enabling Services

The Bureau of Women’s Health supervises the operation of the 1-800-English/Spanish **“Growing Up Healthy” Hotline**, which provides information to pregnant women, mothers, infants, children and adolescents and helps the State work toward goals for improved maternal and child health outcomes.

In order to maximize its usefulness, the “Growing Up Healthy” hotline provides services for the hearing-impaired and to people who are not English speaking through the AT&T Language Line, extending the number of languages available to callers. In 1999, the hotline provided resources and information to 94,218 callers regarding a variety of MCH issues, including information on eligibility for programs and the location of the nearest services. The primary emphasis of the hotline has traditionally been on prenatal care, but callers were also provided referrals for WIC, child health services, the Child Health Plus program, pregnancy testing, family planning, social services, Medicaid, food stamps, fetal alcohol services, measles, lead poisoning, genetic screening, and STDs. In fact, Child Health Plus calls in 1999 accounted for 64.2% (60,513) of all of the “Growing Up Healthy” calls.

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

Callers are also given other toll-free hotline numbers where questions regarding AIDS, child abuse, domestic violence, substance abuse, and assistance for people with disabilities can be obtained.

Growing Up Healthy Hotline - Call Tally Report - 1999		
<u>Call Type/Topic Requested</u>	<u># of calls</u>	<u>Percentage of Total Calls</u>
Prenatal Care	1,733	1.8%
WIC	11,555	12.3%
Medicaid for children	1,612	1.7%
Child Health Plus	60,513	64.2%
Pregnancy testing	249	0.3%
Social service	452	0.5%
Immunizations	443	0.5%
WIC complaint	485	0.5%
Farmer's Market	574	0.6%
Talking to Teens	9	0.0%
Hysterectomy	32	0.0%
Educational material only	1,216	1.3%
Other	3,571	3.8%
HIV related	5	0.0%
Breast and Cervical Screening	792	0.8%
Early Intervention	523	0.6%
Newborn Screening	398	0.4%
Health Department	751	0.8%
Erroneous Calls	8,656	9.2%
Child/Adult care food program	176	0.2%
Summer Food Service program	278	0.3%
<u>Adult Insurance</u>	<u>195</u>	<u>0.2%</u>
GRAND TOTAL	94,218	
Of total, number of callers asking about immigration status: <u>897</u>		

New York also has a **toll-free hotline for Child Health Plus** calls, which is linked to take roll-over calls from the National Governor's Association (NGA) hotline. However, the volume of CHIP-related calls is greater on the Title V "Growing Up Healthy" hotline. The "Growing Up Healthy" hotline receives 2.5 calls for every call received by the Child Health Plus hotline. Excess Child Health Plus calls are automatically rolled over to the Title V hotline. The Child Health Plus hotline can provide the public with more in-depth information on the Child Health Plus and Medicaid programs than can the "Growing Up Healthy" hotline. The number for the Child Health Plus hotline is 1-800-698-4KIDS (1-800-698-4543)

Other hotlines which continued to serve the maternal and child health population in the State include:

- C the Child Abuse and Maltreatment Hotline, used to report suspected child abuse and neglect, 1-800-342-3720.

- C the Domestic Violence Hotline, which offers information and referrals to battered women’s shelters, safe homes, counseling, support groups and legal assistance, 1-800-942-6906.
- C the Missing Children Hotline, which provides assistance and referrals to locating missing children, 1-800-FINDKID.
- C the New York Child Care Coordinating Council Information Service, which provides information on licensed day care centers and family day care providers, 1-800-463-8663.
- C the Disabilities Information Line, which provides information about services available to people with any kind of disability, 1-800-522-4369.
- C the AIDS Information Service, 1-800-541-AIDS, and the HIV Counseling and Testing Hotline, 1-800-872-2777, provide information on HIV/AIDS infection and local referrals for counseling, testing, support groups and free pamphlets.
- C The Cancer Information Service provides information about specific cancers, 1-800-4-CANCER.
- C the New York State Department of Social Services operates a hotline which provides referrals for social service programs including Aid to Dependent Children, Emergency Assistance for Families, Home Relief, Home Energy Assistance, the Medical Assistance Program, and the Child Support Enforcement Program, 1-800-342-3009.
- C the Day Care Complaint Hotline, 1-800-732-5207, also administered by the Department of Social Services, hears complaints and concerns about day care centers.
- C the New York Parent Connection Hotline, which provides information and referrals for services to children and families.

In addition to these statewide hotlines, many Comprehensive Prenatal/Perinatal Services Networks also operate local hotlines where callers can get information on availability of local services, remediation of problems with obtaining prenatal care and linkage to services. These Networks are state-funded, but work very closely with MCHSBG- and Medicaid- funded services.

Local health departments and local departments of social services are very often called directly by members of the public in their counties for direct assistance. Both health departments and social services departments are generally very active in providing information and referral services on a county level. Local agencies also have access to hotline numbers and directories in order to handle calls for people outside their counties.

During the past year, the **Bureau of Community Relations** planned, developed, produced, distributed and/or evaluated the following MCHBG-related activities:

- C “1% Milk” Posters (2)
- C “Asthma: It takes children’s breath away.” Statewide Media Campaign (English, Spanish, French, Chinese, Russian)
- C “Child and Adult Care Food Program” TV spots
- C “Child Health Month” Information Kit

- C "Child Safety Helmets" Information Kit
- C "EMS & You" Video (Grades K--3)
- C "Ear Infections in Children" Brochure
- C "Eat Well, Play Hard" Nutrition & Physical Activity Initiative (Preschoolers)
- C "Female Circumcision" Brochure
- C "Fetal Alcohol Syndrome" Statewide Conference
- C "Folic Acid Awareness Week" Information Kit
- C "Having a Baby" Booklet (English & Spanish)
- C "Maternity Information Law" (Special Procedures in Childbirth) Brochure
- C "Parents' Resource Directory" - Children with Special Health Care Needs Program Information Kit (English, Spanish, French, Russian Chinese)
- C "Physicians' Guidelines for the Treatment of Otitis Media" Brochure
- C "Protect Your Baby from Smoke" Brochure (English & Spanish)
- C "School Violence Prevention" Focus Groups & TV spots
- C "Shaken Baby Syndrome" Brochure, Poster, Information Kit
- C "Take Folic Acid Every Day" Emery Boards w/Counter-top Display Holders
- C "Welcome to Parenthood" Booklet (English & Spanish)
- C "Your Guide to a Healthy Birth" Booklet (English & Spanish)

Infrastructure-Building Services

Since most of the maternal and child health services delivered in this state are not provided directly by NYSDOH, not only is state level infrastructure important, but the local infrastructure is also critical to the provision of quality services. NYSDOH employs various mechanisms to ensure that services are coordinated and make good use of precious resources. Through the New York State Public Health Law, health regulation, data collection and analysis, technical assistance processes, oversight of contractual arrangements and letters of agreement with the providers of service, NYSDOH has been able to remain apprised of local MCH conditions and issues, and is able to ensure the stability of the MCH infrastructure.

County health departments have continued to play an essential role. They assessed the needs of their communities, worked with the community to design and implement programs to meet those needs, and evaluated the effects in their communities. Under Article VI of the Public Health Law, local health department performed a comprehensive community health assessment on a two-year cycle, and subsequently produces county-wide (or, in the case of New York City, a city-wide) Municipal Public Health Services Plans (MPHSPs). The MPHSPs explicitly addressed the needs of the MCH populations in sections on infant mortality prevention, child health, family planning, chronic disease prevention, injury control, disease control, and nutrition. The Title V program staff provided technical assistance to local health units in plan development and participated in the review and approval process, as well as in the oversight of the implementation of the plans. Because local health departments know their local systems and community needs, MPHSPs addressed the coordination across public and private resources, and

across the continuum of primary, secondary and tertiary care providers. Local health units continued to play a critical role in fostering local collaborative efforts.

The Department of Health continued to support a variety of **regional and local collaboratives** to improve needs assessment, identify and build local resources, 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 Initiatives, Comprehensive Planning for Youth Services, Partners for Children, Early Intervention Coordinating Council, Regional Perinatal Centers affiliated facilities networks, Emergency Medical Services Regional and State EMS Councils, Infant Mortality Review Community Review Boards, HIV/AIDS Prevention Planning Groups, and many more.

The Department of Health continued to improve accessibility of local MCH 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 the Department now routinely posts Requests for Proposals on the web. Beginning in 1997, the MCHSBG application, with e-mail links to the Block Grant Coordinator, became available to the public on our website.

The **Perinatal Data System** continued to undergo development as it expanded from a Central New York Regional Perinatal Data System to the statewide version. The system is continuing to develop as an internet-based network, consisting of a subset of data from the Electronic Birth Certificate and data collected from all hospitals and free-standing birthing centers in NYS. The SPDS will be used to assess birth outcomes at three levels: within hospitals, in integrated health care systems and for communities, and will enable DOH to identify, in real time, problems in health care delivery and public health that allows local stakeholder to conduct quality assurance, quality improvement, and community health assessment.

MCH Indicators have been built into the **Quality Assurance Reporting Requirement (QARR) System** for monitoring managed care and Child Health Plus providers. Title V is working with the Office of Managed Care to make health plan performance data available to local county health departments in order that they may monitor services delivered to their county population.

III. REQUIREMENTS FOR THE APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

Activities regarding maternal and infant health needs assessment, critical to accurate program targeting, to program development, and for monitoring for the effectiveness of interventions, require an ongoing source of information on:

- C Pregnancy and health outcomes (fetal deaths, infant morbidity and mortality, maternal morbidity and mortality, low birth weight/prematurity, causes of death)
- C Maternal and child risk factors (age, socioeconomic status, previous pregnancy history, habits such as alcohol and drug use, tobacco use, nutritional status, physical and emotional stressors, wantedness of pregnancy)
- C Access to appropriate health care (entry into prenatal care, adequacy of prenatal care, barriers to access for prenatal care, appropriate intrapartum care, access to pediatric care, access to specialty/tertiary level care, availability and use of ancillary/enabling services)

Optimally, this information should be collected on an ongoing basis, be population-based, be able to describe the sociodemographic characteristics of the population and be available not only for New York State, but also for the county and sub-county levels.

The New York State Department of Health has employed several methods to identify the need for preventive and primary services for pregnant women, mothers, infants and children, including children with special health care needs.

3.1.1 Needs Assessment Process

In this assessment cycle, the needs of the MCH population have been ascertained through:

- C routine surveillance of vital statistics;
- C census data;
- C registries;
- C provider-generated or program data;
- C special studies;
- C community-based assessment data;
- C the Communities Working Together public participation process;
- C the input of families and consumers;
- C the input of those who testified at public hearings; and

C the input of the MCHSBG Advisory Council.

Many of the data displayed herein are available on the HIN, the New York State Department of Health's Health Information Network. Local health departments are able to access a wide variety of data on this network.

Vital Statistics Data: Historically, birth, death and fetal death certificates have been the main source of information for MCH surveillance. They offer information on birth outcomes, maternal sociodemographic characteristics, prenatal and intrapartum care on an annual basis on the state, county and sub-county level. From these sources, we are able to generate information on the 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 census is a classic and elegant source of data down to a sub-county level. Unfortunately, data from the 2000 census are not yet available and data extrapolated from 1990 figures are questionable.

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 Diseases, Cancer and Heavy Metals (lead), Trauma, and Immunization Registries.

The State Education Department maintains a Physician Licensure registry, which is a source of data on physician age, specialty and practice location. This information is useful in assessing access to care in various areas of the state and predicting or verifying health personnel shortages.

Provider-Generated or Program Data: Considerable data is generated by programs such as WIC, the Prenatal Care and Assistance Program (PCAP), Immunization, Family Planning, the Lead Poisoning Prevention Program, the Early Intervention Program, the Newborn Screening Program and the Community Health Worker Program. These data are often useful in profiling different segments of the community. Caution must be used in generalizing based on these data, in that they are program-based, rather than population-based, and they reflect only characteristics of those who are program-eligible.

Hospital discharge data offer detailed medical information and sociodemographic characteristics on mothers, infants and children. 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), costs, and rates of hospitalization for particular morbidities such as asthma, gastroenteritis, otitis media, head injuries and other conditions. Information is also available on how many hospitalizations are drug-related. As more care is handled on an outpatient basis, information in this system becomes less helpful in assessing community health. Recommendations have been made for the collection of ambulatory care data.

Medicaid utilization data has been very useful in the past. As less of Medicaid is fee-for-service and more of Medicaid is covered by managed care, newer systems are being developed and refined. These systems will 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 through New York's Quality Assurance Reporting Requirements (QARR) System. QARR measures for many MCH 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 post-partum check-ups, access to facilities for high-risk deliveries, completion of Child Health Plus preventive health measures, adult preventive and mental health measures, lead screening rates, 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 - 20.

The NYS Perinatal Data System, now on-line in several regions, and is able to provide information on the course of prenatal, perinatal and newborn care. There are prenatal care, inpatient, NICU and outpatient modules. The internet-based system, when fully activated, will allow real-time access to important perinatal information on an individual, institutional, regional and statewide basis.

Special Studies: The Pregnancy Risk Assessment Monitoring Surveys or PRAMS 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. Examples of the kind of data available through PRAMS include: percentages of moms who drank and/or smoked during pregnancy, who experienced physical violence in the year prior to delivery, who were satisfied with the number of prenatal visits, and who breastfed beyond the first week. PRAMS also gives us an indication of the percentage of pregnancies that were unintended, that is, not wanted or wanted later. New York initiated PRAMS in 1993 with assistance from the CDC. For now, the PRAMS study covers New York, with the exception of New York City. New York City has now obtained funds to initiate a PRAMS for the City. NYSDOH is offering technical assistance.

Each year, the Analysis of Birth Outcomes Study is conducted. This is an annual match of birth certificate data with Medicaid records to evaluate prenatal care programs for Medicaid-enrolled women.

The Youth Risk Behavior Survey (YRBS) collects knowledge, attitude and behavior information from high school students. This study, until 1996, excluded New York City. 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 chronic diseases and use of health resources. For the first time

this year, BRFSS data are being collected on a county and regional level. County health departments are now able to select the modules they would like added to the basic survey.

The Census Bureau's Current Population Survey reflects sociodemographics such as age, race, sex and socioeconomic status. These data are available on the state geographic level only. The last available year is 1999.

Community-based assessment data: Each of the state's 58 local health units are required to submit a Community Health Assessment every six years, with updates 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 need for direct medical services and for enabling services.

A special Public Health Agenda Committee, composed of key state and local players, recently reformulated the requirements for local community health assessments. The committee recommended that community health assessments should reflect the unique needs of the community, should engage community input and should provide a more realistic basis for each county's public health services plan, restructured to match the Institute of Medicine's ten essential public health services. In 1998, local health departments completed new six-year assessments based on these recommendations. A review of these documents indicates that many local departments are developing more comprehensive assessments. As this process is repeated locally throughout the state, more detailed regional and local profiles will emerge. Gaps in services are more readily recognized and addressed on the local level.

The Communities Working Together Public Participation Process: DOH continues to assist localities in identifying and addressing local priorities through a collaborative, open, community process. The Public Health Information Group is working closely with the Division of Family and Local Health to help local health units identify and meet their training needs, further advance their local assessment skills, select their greatest opportunities to impact public health in their area, and define next steps as communities. This year, a satellite version of the CDC training program, "Public Health Data: Our silent partner" was televised with the assistance of the Division of Family and Local Health Local Health Services Unit, the Public Health Information Group, the SUNY Albany School of Public Health and the New York State Association of County Health Officers.

Input of Families and Consumers: The Department is working to improve parent and consumer input in the design and implementation of Title V programs. Family and Consumer Forums were conducted this year to augment usual public input processes. The goal in conducting these forums was to have families and consumers identify, through their experiences, parts of the health care system that are not welcoming or not working for them. The idea is to improve maternal and child health services based on the expressed needs of consumers. The Family Specialist, the SSDI Coordinator and the MCHSBG Coordinator met with parents and graduates of the "Making the Pieces Fit" training to write a strategic

plan to improve consumer participation in the Block Grant. Parent planners also assisted in designing the agenda for the forums. The Family Specialist and the SSDI Coordinator then worked to implement that plan, with partners in local agencies and regional offices of NYSDOH. Forums were held for families with children with special health care needs; Head Start, Healthy Start and workfare moms; teens, including some that were pregnant and parenting; migrant and seasonal farmworkers; Native Americans; and women/moms with substance abuse issues. All participants completed a short demographic survey to help document the diversity of the groups. Groups of no larger than 16 people were facilitated by DOH staff, themselves parents of children with special needs, and a teen facilitator for the teen groups.

Testimony at Public Hearings: Each year, the MCHSBG Advisory Council and the Department of Health sponsor a series of hearings at which members of the public or provider agencies may have an opportunity to address the Council and Title V staff. This year, hearings were held in New York City, Syracuse and Albany. They were among the better attended hearings in recent years. Altogether, a total of 32 people testified, ten consumers and family members and 22 providers. An additional eight people attended without testifying, and seven sent letters at the invitation of the hearing notice.

Input from the MCHSBG Advisory Council: The Council members, in their advisory capacity, bring to the table a wealth of experience and information in the area of maternal and child health services. Advisory Council members often bring new information encountered in their daily professional lives and pass on information from others who have approached them with issues. Often these issues and subsequent discussions result in recommendations made to the Governor and/or the Commissioner.

■ **Processes Used to Assess the Need for Direct Medical Services**

Comprehensive assessment of the MCH population's ability to access health care and to determine gaps in the health care delivery system is based on both state and local activities.

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 discharge, can be used for assessing hospitalizations due to ambulatory care sensitive conditions and payment source at time of delivery. The Physician Licensure File helps identify areas with shortages of physicians. NYSDOH program data is used to monitor immunization and lead screening status statewide, access to WIC and family planning services, and linkages to early intervention, specialty care and case management. QARR outlines access and quality of health care for Medicaid Managed Care, Child Health Plus and commercial Health Maintenance Organization enrollees. The Behavioral Risk Factor Survey questions respondents as to whether they were unable to see a physician due to cost. Enrollment in private or public insurance and insurance status can relate directly to access to care, but should be interpreted with caution; enrollment in insurance, especially public insurance, does not guarantee access to care.

Valuable information about high risk populations, health needs and service delivery is obtained through local county health departments when they prepare their biennial community health assessments. Often

local information is also gleaned from contractor workplans. Rural Health Networks and Perinatal Services Networks complete needs assessments of their target areas as an integral part of the program planning process. Local agencies are usually the best source of information on the treatment experience of children with special health care needs. The new data generated by the Children with Special Health Care Needs program will fill a gap that has existed in our knowledge of this population.

■ **Processes Used to Assess the Need for Enabling Services**

Disease and disability do not affect all segments of society equally. The need for enabling services often becomes apparent as health outcome data is analyzed. When communities have adequate sources of care, it is troubling to note disparities in health status related to differing access and usage of those resources. Disparities often result from the interplay of financial, structural and personal issues like socioeconomic conditions, culture, language and education. Often, the need for enabling services (transportation, translation, referral services or case management) become more apparent as communities look for reasons for underutilization of resources.

Certain populations present unique access issues which make them particularly vulnerable to poor health outcomes. Migrant and seasonal farmworker 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. 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, 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 resources, both in their present location and future locations, is imperative to improving the health status of migrant workers and their families.

■ **Processes Used to Assess the Need 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 known to be safe, accepted, economical and effective. Examples of factors assessed to determine the need for population-based services are immunization levels, blood lead levels, incidence of anemia, oral health status, injury rates or the recognition of a widespread need for certain knowledge. These needs may become known through analysis of vital statistics data, population-based Knowledge, Attitude and Behavior studies (PRAMS, Behavioral Risk Factor Survey, Youth Behavioral Risk Factor Survey), health information queries, registries, or other types of special studies.

■ **Processes Used to Determine the Need for Infrastructure-Building Services**

The protection and promotion of the public's health is not possible without an adequate public health infrastructure. The ability to perform adequate needs assessments, to appropriately evaluate public

health issues and programs, to develop meaningful policy and standards, to coordinate existing resources, to assure quality, and to adequately train public health personnel are all critical roles for public health agencies. NYSDOH is able to assess the infrastructure through:

- C establishing and maintaining regular two-way communication with county health departments, local contractors, other units within DOH and other State and Federal agencies.
- C monitoring the quality of the biennial community health assessments and municipal public health services plans completed by local health departments.
- C monitoring the ability of our contractors and county health departments to achieve effective results.
- C monitoring and auditing the use of available resources, including available technical assistance.
- C special assessments, like those recently completed by the SUNY School of Public Health on the need for public health leadership training and by the New York State Association of County Health Officials (NYSACHO) on ability to perform core functions.

■ Overall

The overall responsibility for New York's ongoing health planning cycle is shared. The monitoring of health status is a responsibility of local health units and every division and unit within the state health department. This effort is successful because:

- C As a state health department, we have entered a partnership with consumers and families, local health agencies and local communities.

Through NYSDOH's contacts with consumers and families, local agencies and through the development of the Health Information Network, we are able to identify the need for additional information and act on those needs.

- C We are united in a common vision for New York and the health of New Yorkers.

Thanks to the Communities Working Together process, our multiple collaborations and partnership, and the Department's legislative and administrative initiatives, localities are playing a larger role in assessing local needs, designing programs to effectively address local need, and evaluating local results.

- C We are willing to support this process through the dedication of needed monetary and staff resources.

Title V programs, the Public Health Information Group and the Local Health Services Unit within the State Health Department provide much needed support for local agencies and other State Health Department divisions and bureaus.

3.1.2 Needs Assessment Content

Please refer to **Section 1.4** for a general overview of New York State and the health care environment.

3.1.2.1 Overview of the Maternal and Child Health Population Health Status

Please note: The New York State Department of Health uses geo-mapping to help identify areas of high needs or with poor health outcomes. Incompatibility of the electronic formats make the maps difficult to transmit within the Title V Information System. The printed versions of this application will contain maps in an Appendix.

Women of Childbearing Age: The population of women of childbearing age has been decreasing (4% since 1990). In 1998, it is estimated that there were 4,128,490 females between the ages of 15 and 44 in New York State. A total of 584,960 of these women were young women between the ages of 15 and 19. An additional 63,502 females were between the ages of 10 and 14.

Children: The number of children under the age of 20 in 1998 was just over five million (5,122,129), broken down by age groups as follows:

<u>Age in Years</u>	<u>Number</u>
<1	244,071
1-4	1,016,056
5-9	1,364,787
10-14	1,302,479
15-19	1,194,736

Approximately 40% of these children (2,048,852) live in New York City.

Race and Ethnicity: Between 1990 and 1998, there have 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 is 72% white, 22% African American, and 18% Latino. Approximately 6% are identified as Asian/Pacific Islander. Form 12 in the Appendix of this document contains a racial and ethnic breakdown for all 1998 New York State births.

Education: In 1990, eighteen percent of all mothers in New York State lacked a high school diploma. 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 also with higher infant mortality. In New York State,

19% of women giving birth in 1998 had less than a high school education. Among Black and Hispanic women, the percentage was even higher (26% and 40%, respectively).

Poverty: Poverty is highly associated with poor health outcomes for New Yorkers, especially for women and children. In 1998, 1,310,458 children between the ages of birth and 19 years lived in households with incomes below the Federal poverty level. This represents 25.6% of children in this age group. About one third of all New Yorkers had income below 200% of poverty; 44.6% of all children ages birth to 19 in the state live in families where incomes are below 200% of poverty in 1998.

Households headed by single females are most at risk for poverty. According to the 1999 Current Population Survey, 50% of people in female-headed families with children lived below the Federal poverty level in New York State. 58% of such households were below 125% of the poverty level.

Income Disparities: The Center for Budget and Policy reported that despite a tighter labor market and strong economic growth in recent years, income disparities in New York and most other states grew significantly in the late 1990s. The average income of the richest fifth of New York families was more than eleven times as great as the average income of the bottom fifth. Incomes of the poorest 20% of New York families declined by \$2900, which the highest income of the top five percent of New York families grew by nearly \$108,000 per family. This is thought 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 minimal 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.

Access to Care

Health Insurance: The proportion of children between birth and 17 years of age that are uninsured declined in 1998 for the first time in three years to 13.8%. Prior to this, the percentage had been steadily increasing since 1990, with the exception of 1995, when it had dropped to 11.9%. The rate of uninsured in the general population (17.2%) did not experience a similar decline and was almost unchanged from the 1997 rate. (See table below.) The percentages of the child population insured by both public and private insurances rose. For adults, the percentage of those who reported being privately insured rose only very slightly, by 0.3%. Adults who reported they were insured by public insurance declined by a slight 0.1%.

Percentages of Children Insured by Type of Insurance and Uninsured						
Source: Current Population Survey, 1990, 1994-1998						
Type of Insurance	1990	1994	1995	1996	1997	1998
Public						
Birth to 17 years	21.2%	25.7%	28.8%	29.1%	26.3%	27.4%
Total Population	23.3%	26.7%	27.6%	27.0%	26.8%	26.7%

Private						
Birth to 17 years	69.2%	60.2%	59.3%	55.7%	58.2%	58.7%
Total Population	64.4%	57.3%	57.2%	55.9%	55.7%	56.0%
Uninsured						
Birth to 17 years	9.5%	14.1%	11.9%	15.1%	15.5%	13.8%
Total Population	12.3%	16.0%	15.2%	17.0%	17.5%	17.2%

This decrease in numbers of uninsured children does little to allay concerns for the remaining 13.8% who still are uninsured. Concern remains that there are Medicaid- and Child Health Plus-eligible children who are not enrolled. Office of Medicaid data showed 84.7% of Medicaid-eligible children were enrolled in 1999, up from 80.3% in 1994. The birth to 4 age group and the 15 to 19 year-olds are enrolled at the lowest rates, while the 5 to 9 year-olds and 10-14 year-old age groups have better percentages enrolled. Facilitated enrollment projects are helping to reach unenrolled children and enroll them in either Medicaid or Child Health Plus.

Access to Primary Care: According to the New York State Behavioral Risk Surveillance System, 9% of those surveyed in 1998 did not see a doctor when needed because of cost. Among Blacks and Hispanics, 14% and 18%, respectively, indicated cost prevented them from seeing a doctor.

More and more individuals 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 a managed care plan.

Access to Dental Care: Only half of all New Yorkers have dental insurance to cover their care. Unlike medical insurance, out-of-pocket dental expenses have a significant impact on uninsured families. Dental insurance plans tend to be difficult to purchase and, even when available, tend to cover a limited number of procedures. Fortunately, New York State provides a comprehensive coverage package for those enrolled in Child Health Plus and Medicaid. Unfortunately, coverage does not ensure access to preventive or therapeutic care. Other factors, such as the availability and distribution of practitioners and providers, parent and patient knowledge and attitudes may play a major role in access to dental care. According to the Behavior Risk Factor Surveillance System, only 71.3% of New York State respondents reported a dentist visit in the last year. 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 screenings or care, and those with special health care needs or chronic conditions.

Health Workforce: It has been said that there is no shortage of health care physicians in New York, but there is a decided maldistribution. New York is near the national average for number of primary care physicians (40.3 per 100,000 population vs. 40.5 as the national average), but physician workforce is most concentrated in the metropolitan areas. The distribution of active primary care physicians as a rate per 100,000 population is 141.7 in metropolitan areas and 63.5 in non-metropolitan areas. Under-represented minority physicians, which include Black, Hispanic and American Indian/Alaskan Natives, were 14.1% of the physician workforce in 1998, compared to 12.0% in the rest of the nation.

In addition to physicians, we have higher than the national average of physician assistants, which in 1998 was 18.9 per 100,000 population, as compared to the national rate of 10.5 per 100,000. Registered nurses are concentrated at 911 per 100,000 population, compared to the national figure of 798 per 100,000. Nurses with Baccalaureate Degrees or higher are 42.6% of our nurse workforce, compared to the national average of 41.6%. Dentists per 100,000 are 72.3 in New York, compared to 55.0 as the national average.

Again, the distribution of these professionals is sometimes problematic. 75.8% of our counties were designated all or in part as Medically Underserved Areas (MUAs) in 1999. 83.9% of our counties were designated all or in part as a Health Professional Shortage Area (HPSA) in 1999. Counties with one or the other of these two designations account for 91.9% of our 62 counties. 77.4% of our counties contain Primary Care HPSAs, 37.1% have official designations as dental shortage areas, and 29% of the counties have designations as mental health HPSAs. It is believed that more counties would ask for designation as dental and mental health shortage areas, but that this mechanism is not as well known as the primary care designation process.

According to HRSA, New York has 36 Community Health and/or Migrant Health Centers, 14 Health Care for the Homeless grantees, and 1 Health Services in Public Housing grantee. New York also has 93 State loan repayers, 30 National Health Services Corps "in school" Scholars, 117 participants in the National Loan Repayment Program, 2 Rural Health Outreach grantees, 3 Rural Health Network Development Grants, and 1 State Rural Hospital Flexibility Program participant. New York also has 23 MCH Title V Special Programs of Regional and National Significance (SPRANS) grantees, 7 Community Integrated Service Systems (CISS) grants, 2 Emergency Medical Services for Children grants, 5 Healthy Start programs and 1 Traumatic Brain Injury grant.

Ambulatory Care Sensitive Conditions: Between 1994 and 1997, asthma hospitalizations for children ages 0-4 increased 7% to 86.6 per 100,000. According to 1998 hospitalization data, the 1998 rate was 63.9 per 100,000, resulting in a 26% drop from the previous year. We are still evaluating this data to discover whether this is a true decline or a problem with the data. Asthma hospitalizations among children in this age group that reside in New York City are more than three times higher than the rates for residents in the rest of the state (107.5 vs. 63.9).

Otitis media hospitalizations have declined sharply over the past five years. In 1998, 8.4 per 100,000 children ages 0-4 were hospitalized for Otitis Media. This is down 53% from 1994 when the rate was 17.7. A significant difference exists between rates in New York City and the rest of New York. Rates in New York City have declined 56% from a high of 30 per 100,000 in 1994 to 13.1 per 100,000 in 1998. The rest of the state also experienced a significant decline, although the rates are much lower.

Asthma and otitis media have been identified as pediatric ambulatory care sensitive conditions; the rate of hospitalization for each of these conditions may be seen in the table below.

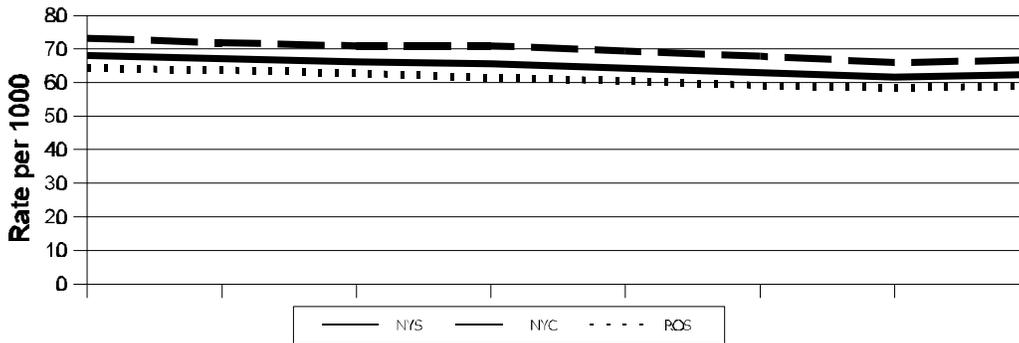
Asthma and Otitis Media Hospitalization Notes (per 100,000)						
Children 0-4 Years of Age, New York State, Upstate New York, New York City, 1994 - 1998						
Condition	Region	1994	1995	1996	1997	1998
Asthma	Rest of the State	39.4	43.2	38.3	40.8	31.8
	New York City	137.9	156.8	148.2	148.9	107.5
	New York State Total	80.6	90.9	84.7	86.6	63.9
Otitis Media	Rest of the State	9.0	7.7	5.9	5.9	5.0
	New York City	30.0	23.6	19.4	17.4	13.1
	New York State Total	17.7	14.4	11.6	10.8	8.4

Nativity and Maternal Risk Factors

Birth Rates: Birth rates remain fairly steady, with New York City rates (at 66.0 per 1000 females in 1998) higher than rates for the rest of the State (59.0 per 1000 females).

Births per 1000 females (15 - 44)

New York State by Region 1991 - 1998

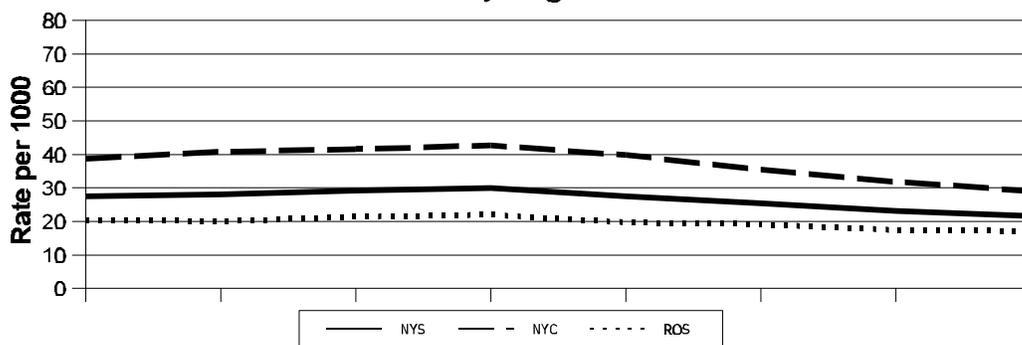


Year	1991	1992	1993	1994	1995	1996	1997	1998
NYS	68.1	67.2	66.3	65.6	64.3	63.0	61.8	62.4
NYC	73.2	72.0	71.0	71.0	69.4	68.0	66.0	66.0
Rest of State	64.4	63.7	62.8	61.5	60.5	59.2	58.6	59.0

Adolescent Birth Rates: The adolescent birth rates showed more of a decline; the 1998 rate of 21.8 was a 21% decrease from 1991.

Births per 1000 Females Ages 15 - 17

New York State by Region 1991 - 1998

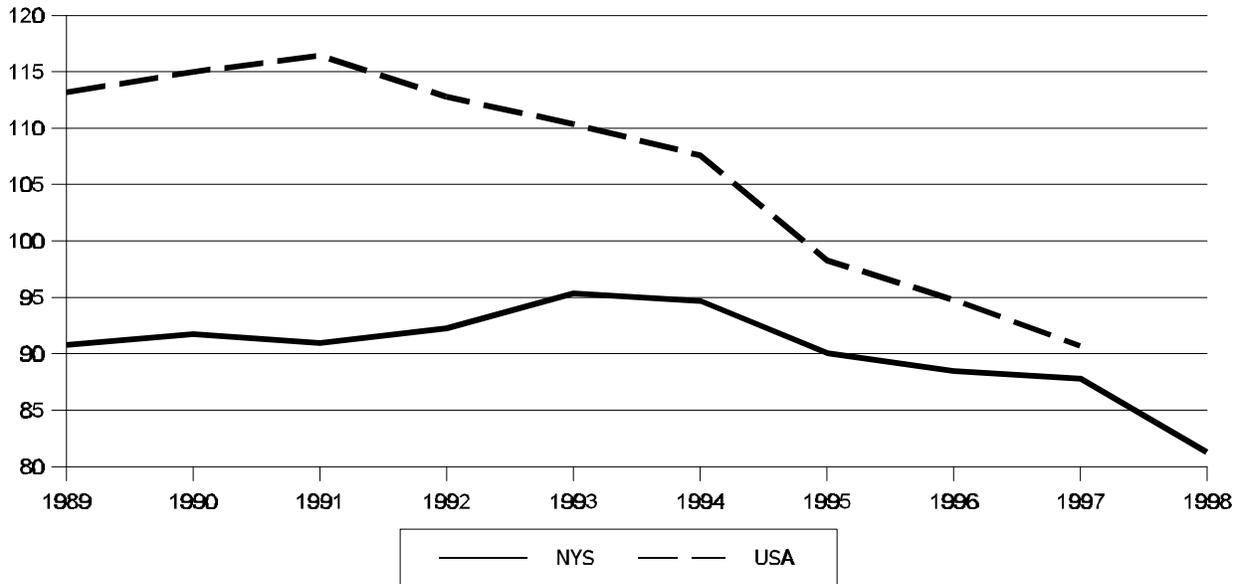


Year	1991	1992	1993	1994	1995	1996	1997	1998
NYS	27.6	28.2	29.3	30.0	27.6	25.6	23.2	21.8
NYC	38.9	40.9	41.7	42.8	39.9	35.6	31.9	29.1
Rest of State	20.6	20.2	21.6	22.1	19.9	19.2	17.6	17.1

Adolescent Pregnancy: Although New York’s adolescent pregnancy rate is lower than the national average, the 1998 rate of 81.3 per 1,000 girls 15 - 19 years old is still unacceptable. Among Black and Hispanic teens in this age group, the rates are more than double the rates for White teens. Although the rates declined between 1997 and 1998 among White and Black teens, Hispanics experienced an increase to 150.3 per 1,000.

Adolescent Pregnancy Rate - Per 1000 Women Aged 15 - 19

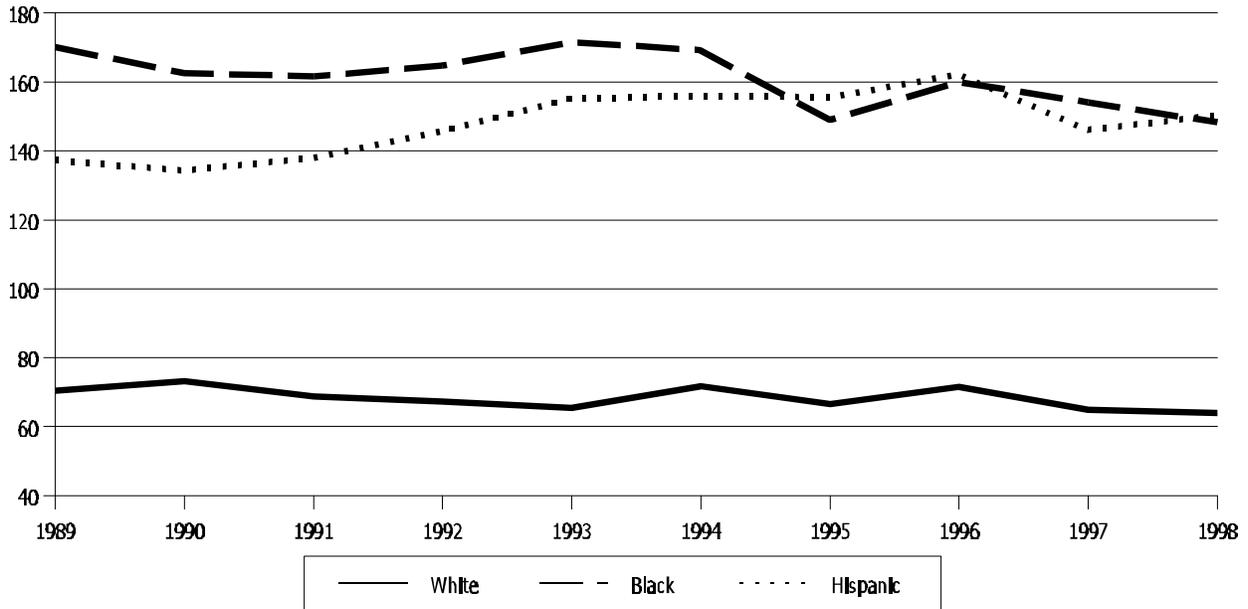
New York State and United States, 1989-1998



Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
NYS	90.8	91.8	91.0	92.3	95.4	94.7	90.1	88.5	87.8	81.3
USA	113.2	115.0	116.5	112.8	110.4	107.7	98.3	94.8	90.7	n/a

Adolescent Pregnancy Rate - Per 1000 Women Aged 15 - 19

New York Residents By Race, 1989 - 1998

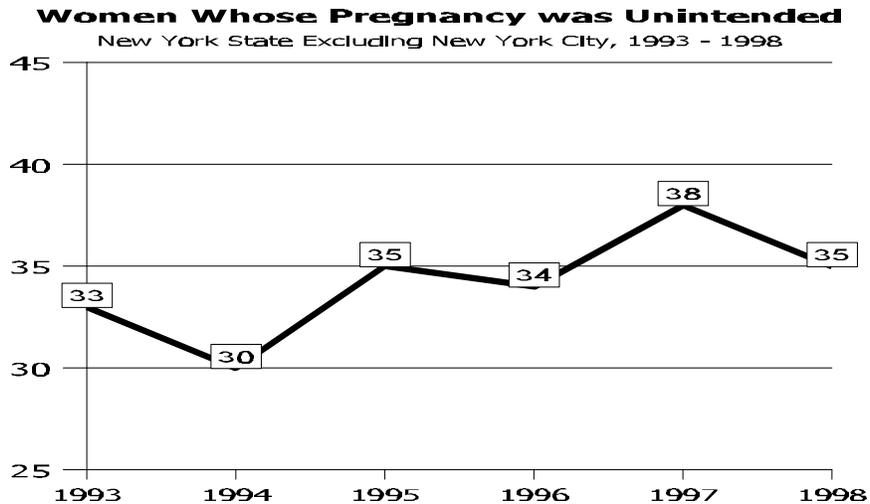


Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
White	70.5	73.2	68.7	67.3	65.5	71.7	66.5	71.6	64.9	64.0
Black	170	162.5	161.3	164.8	171.5	169.2	149.1	160	154	148.3
Hispanic	137.3	134.3	137.9	145.7	155.1	155.9	155.6	162.2	146.2	150.3

Unintended Pregnancy: In 1998, over one third of mothers responding to the PRAMS Survey indicated that their pregnancy was unwanted or mistimed (35.3%). This rate is lower than the previous year (38.4%), but the trend in unintentional pregnancy rates has been stable over the last six years.

Groups at highest risk for unintended pregnancies in 1998 were: women under the age of 20 (84.1%); women who were not married (66.0%); Black women (62.0%); women on Medicaid (60%); and women with less than a high school education (53.6%).

Most women (46%) reported that they wanted their pregnancy when it occurred, while 19% wished that it had occurred earlier.



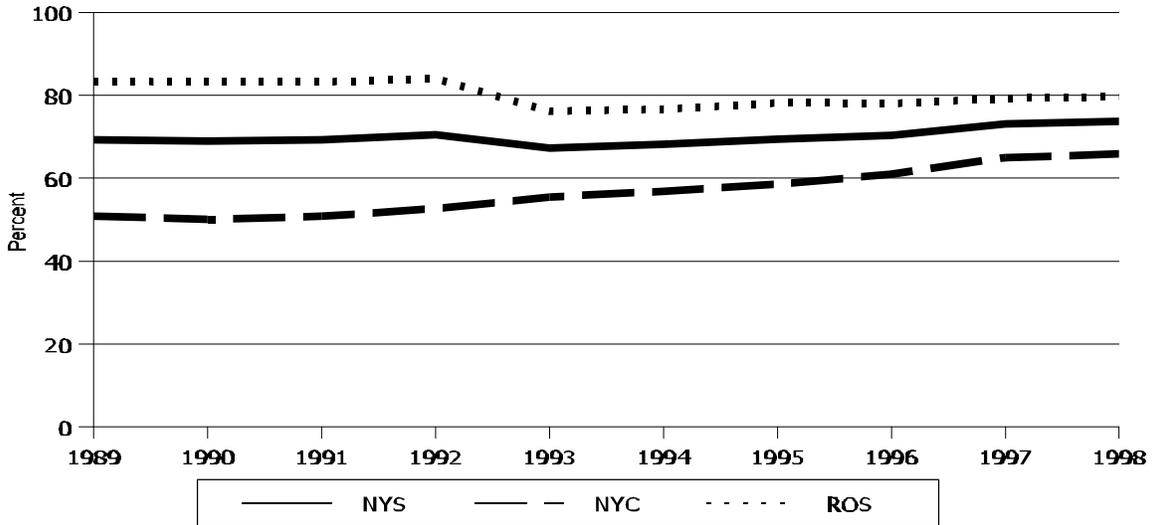
Maternal Knowledge, Attitudes and Behaviors: Vital Statistics and PRAMS Survey data for 1998 reveals that, with regard to maternal behaviors and attitudes during pregnancy, some trends are moving in a positive direction.

Prenatal Care: There has been some improvement in rates of women receiving prenatal care in the first trimester of pregnancy. In New York State since 1994, the percent of women receiving early prenatal care has increased 8.2% to 73.8% in 1998. Much of the improvement occurred among New York City residents where the percent increased from 56.8% in 1994 to 65.9% in 1998. In the rest of the state, the gains were smaller. The rate went from 76.7% in 1994 to 79.7% in 1998. Although an improvement, the 1998 rate of 73.8% is well below the Healthy People 2010 goal of 90%.

While early prenatal care rates for Black and Hispanic New Yorkers have been increasing since 1991, the Black/White ratio of early prenatal care is 0.79, based on rates of 61.3% vs. 77.9%.

Early (First Trimester) Prenatal Care

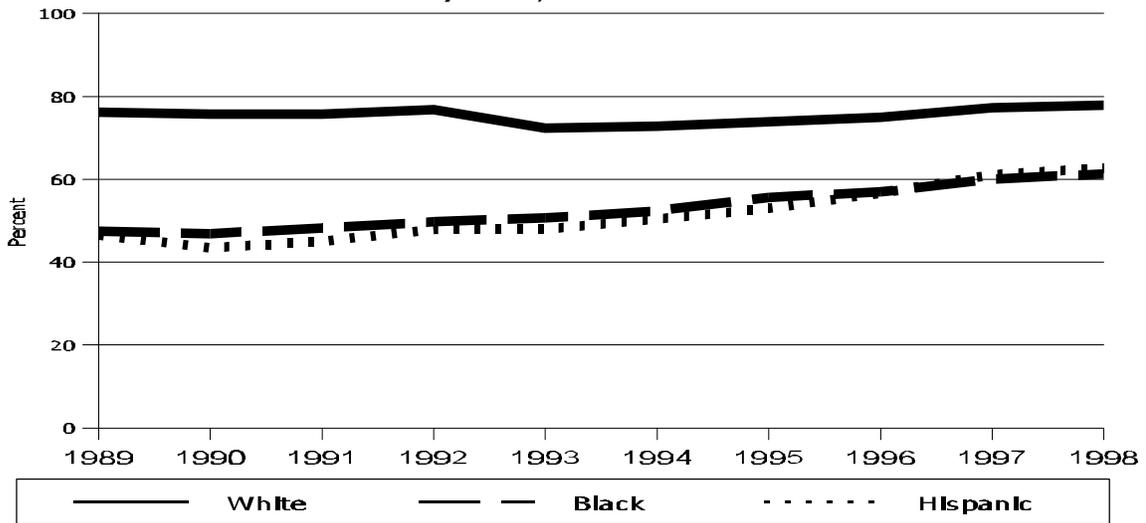
New York State, New York City and Rest of State, 1989 - 1998



Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
NYS	69.3	69.0	69.3	70.5	67.3	68.2	69.4	70.4	73.1	73.8
NYC	50.9	50.1	50.9	52.7	55.5	56.8	58.5	61.0	64.9	65.9
ROS	83.4	83.3	83.2	84.0	76.2	76.7	78.1	78.0	79.2	79.7

Early (First Trimester) Prenatal Care

By Race, 1989-1998



Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
White	76.2	75.8	75.8	76.9	72.4	72.9	73.9	75.0	77.4	77.9
Black	47.6	46.9	48.3	49.8	50.8	52.4	55.7	57.0	60.2	61.3
Hispanic	83.4	83.3	83.2	84.0	76.2	76.7	78.1	78.0	79.2	79.7

Hispanic	46.6	43.6	45.1	48.0	48.1	50.5	53.1	56.8	61.2	62.7
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Adequacy of Prenatal Care: There has been some progress in securing adequate prenatal care for New York's pregnant women.

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 care visits is greater than 80%. In other words, it 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 were as follows:

Adequacy of Prenatal Care (Kotelchuck Index)											
Women Age 15 - 44 Who Gave Birth in That Year											
Year °		1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Region	NYC	42.8	41.0	42.3	43.9	44.4	45.8	48.7	52.5	55.4	56.1
	Upstate	77.6	76.3	75.4	77.1	70.5	71.9	72.3	71.5	73.2	73.9
	NYS	62.5	61.0	61.0	62.7	59.2	60.3	61.8	63.1	65.6	66.4
Race	White	69.6	68.2	68.0	69.5	65.4	65.9	66.9	67.9	70.5	71.2
	Black	39.2	37.3	37.7	40.3	39.7	42.0	38.6	41.5	51.0	51.7
	Hispanic	38.1	36.5	38.0	40.8	39.5	42.0	46.0	50.1	54.0	55.5

Location of Prenatal Care: PRAMS responses in 1998 indicate that 75% or more of women receive prenatal care in private physician's offices. Other sources of care included hospital clinics (10.4%), community health centers (5.7%) and health department clinics (also 5.7%).

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. Education apparently makes a difference in the area of HIV testing. Of those women who recall receiving education on HIV testing from their provider, 76.6% went on to be tested during their pregnancy.

The proportion of women who reported, via PRAMS having heard or read about the importance of folic acid in preventing birth defects increased from 67.9% in 1996 to 77.3 in 1998.

Use of Alcohol and Tobacco: Approximately 30% of women who responded to the PRAMS survey in 1998 reported that they smoked in the three months prior to pregnancy, and though most reported that they reduced smoking during pregnancy (13.8% in last three months), many returned to more frequent smoking after pregnancy than during pregnancy, thereby exposing their infants to second hand smoke.

The percentage who smoked after pregnancy, however, was consistently lower than the percentage that smoked prior to pregnancy.

Women reduced the use of alcohol during pregnancy. In 1998, 51.3% reported drinking alcohol in the three months prior to pregnancy, but only 7.4% drank alcohol during pregnancy.

Maternal Stress and Violence: Stress during pregnancy is linked to a number of social and reproductive risks. In 1998, PRAMS respondents reported stress in an average of 1.8 life areas during the 12 months prior to delivery. These life circumstances may include such issues as economic difficulties, difficulties in the relationship with a spouse or partner, or sickness or death of someone close. Not surprising, the greater the number of stressors that the woman reported, the less likely the woman was to report that pregnancy was “one of the happiest times of [her] life.” Those describing pregnancy as “one of the happiest times of [their] li[ves]” reported on average 1.2 stressors, while those who described pregnancy as “one of the worst times of [their] li[ves]” averaged 4.2 stressors.

In 1998, over three fourths of those surveyed reported it was “one of the happiest times of [their] li[ves]”, while 3.1% felt it was “one of the worst times of [their] li[ves].” Most reported that their pregnancy fell somewhere in between:

- C 47.3% reported that it was “a happy time with a few problems.”
- C 13.8% reported it was a “moderately hard time.”
- C 6.0% reported it was a “very hard time.”

PRAMS respondents in 1998 also reported that they experienced less physical abuse during pregnancy than in the 12 months before they were pregnant. 5.6% of women (more than one in 20) reported that they were physically abused in the 12 months prior to pregnancy, while 3.0% (more than 1 in 35 pregnant women) reported being abused during pregnancy.

Tracking of Selected PRAMS Responses, 1995-1998				
Percent of mothers that reported they...	1995	1996	1997	1998
...drank alcohol during pregnancy	8.2	9.0	8.3	7.4
...smoked prior to pregnancy	31	29	32	28
...smoked during pregnancy	19.6	15.7	18.6	13.8
...smoked after pregnancy	28.0	22.5	26.0	21.7
...experienced physical abuse during pregnancy	8.5	4.4	4.9	3.0
...the birth was unwanted or wanted later	35	34	38	35
...initiated breast feeding	Question was not on the 1995 survey	62.2	63.0	65.4

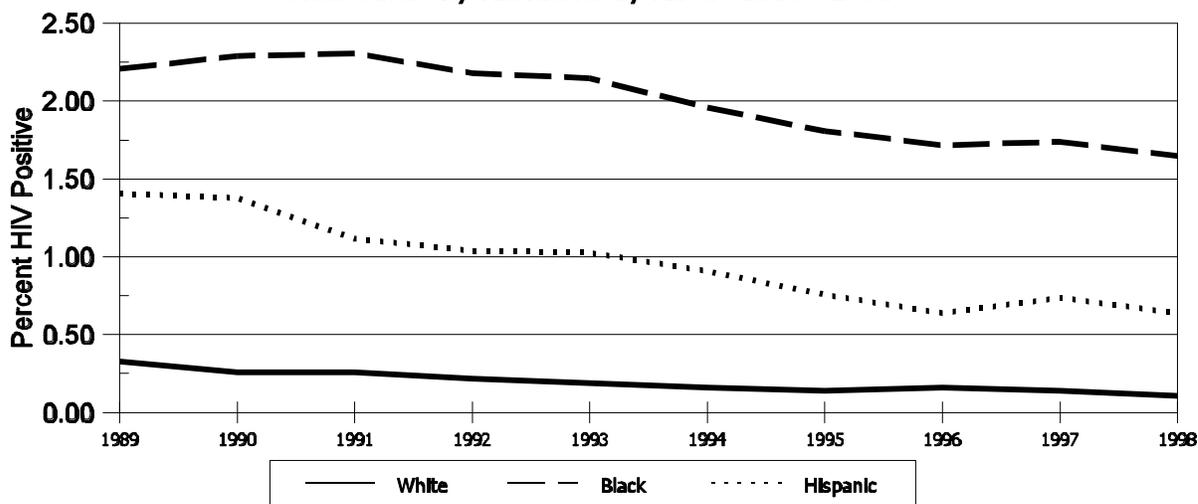
...they put their baby to sleep on their side back stomach	Question was not on the 1995 survey	42 34 24	35 45 20	30 53 17
...their babies are exposed to second hand smoke	Question was not on the 1995 survey	11.4	9.4	6.0

Prenatal HIV Counseling and Testing: An increasing percentage of prenatal women are receiving HIV counseling and testing. As of January 2000, a review of hospital data indicates that 84% of birthing women have documentation of their HIV status before delivery, up from 64% in August of 1999. New York has implemented expedited testing in childbirth settings. This means that about 210,000 of the 250,000 women giving birth probably know their HIV status before delivery. Approximately 40,000 women statewide still required testing at time of delivery. Just under 1,000 HIV infected women gave birth in 1998 in New York State, a 47% decrease over 10 years. Of these women, about 15% did not obtain prenatal care, based on chart reviews. Therefore, about 150 women in 1998 learned of their HIV status for the first time at the time of delivery from testing conducted in a childbirth setting. Expedited testing means fewer missed opportunities for ZDV prophylaxis of newborns.

Perinatal HIV Seroprevalence and Transmission Rates: Perinatal HIV transmission rates are declining in New York State. Preliminary 1998 data indicate the transmission rate to be 8.2%, down from 10.9% in 1997. Though rates of perinatal transmission of HIV have shown a decline, they are still a cause for great concern. Rates are significantly higher in Black and Hispanic women and significantly higher in New York City residents. (See the two figures that follow.) Currently in New York, perinatal HIV counseling and testing is a recommended standard of care.

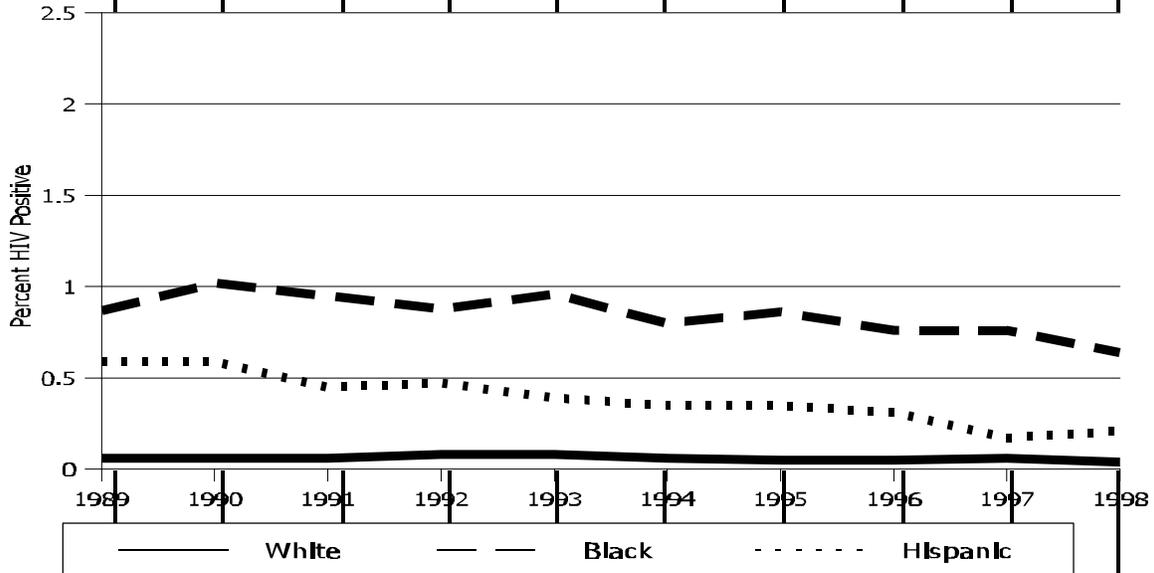
HIV Prevalence in Childbearing Women

New York City Residents by Race 1989 - 1998



HIV Prevalence in Childbearing Women

NYS, Excluding NYC Residents by Race, 1989-1998



Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
White	0.35	0.33	0.26	0.26	0.19	0.16	0.14	0.16	0.14	0.11
Black	2.11	2.21	2.29	2.31	2.15	1.96	1.81	1.72	1.74	1.65
Hispanic	1.35	1.41	1.38	1.12	1.03	0.91	0.76	0.64	0.74	0.64

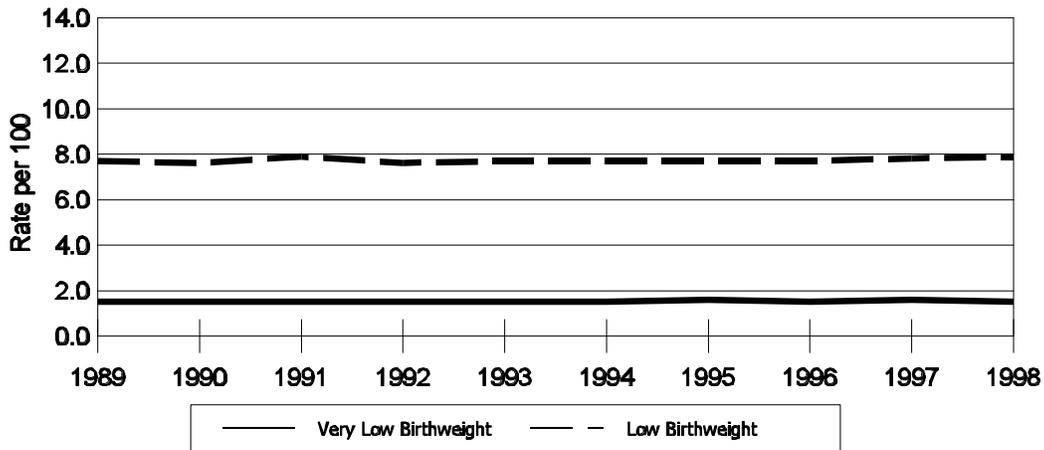
Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
White	0.06	0.06	0.06	0.08	0.08	0.06	0.05	0.05	0.06	.04
Black	0.87	1.02	0.95	0.88	0.96	0.80	0.86	0.76	0.76	.64
Hispanic	0.59	0.59	0.45	0.47	0.39	0.35	0.35	0.31	0.17	.21

New York's partner/spousal notification law went into effect recently. New York will be tracking the effects on HIV transmission rates. It is important to note that the law contains a mandate that providers screen for the risk of domestic violence.

Infant and Child Risk Factors

Low Birth Weight: Changes in low birth weight rates in 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. The 1998 low birth weight rate is 58% greater than the Healthy People 2010 goal of 5.0%, and the 1998 very low birth weight rate of 1.5 per 1000 is 67% greater than the Healthy People 2010 goal of 0.9%. When low birth weight rates for total births are compared to rates for singleton births, the latter shows a decreasing trend in low birthweight rates. Multiple births seem to be responsible for the lack of change in the low birthweight rate over the last 10 years.

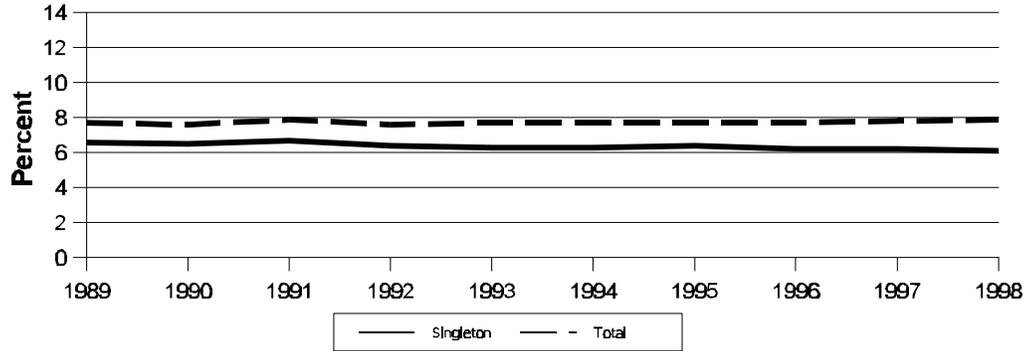
Very Low (<1.5kg) & Low (<2.5kg) Birthweight New York State 1989 - 1998



Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Very Low Birth Weight	1.5	1.5	1.5	1.5	1.5	1.5	1.6	1.5	1.6	1.5
Low Birth Weight	7.7	7.6	7.9	7.6	7.7	7.7	7.7	7.7	7.8	7.9

Low Birthweight (< 2500 Grams)

New York Singleton and Total Births 1989 - 1998

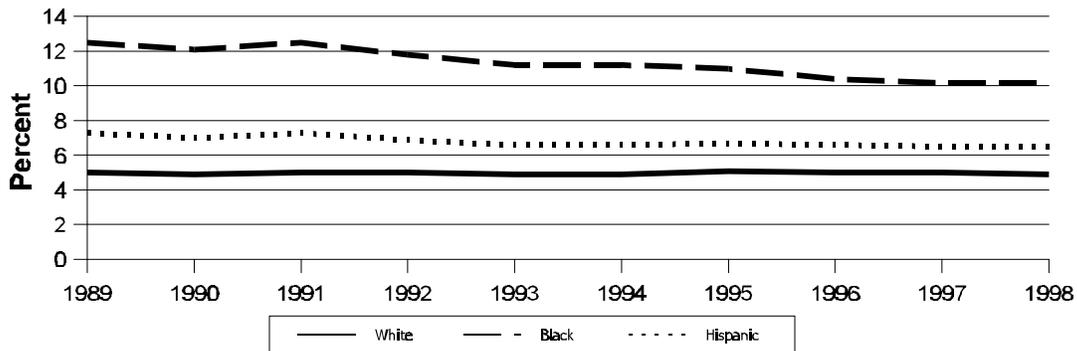


Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Singletons	6.6	6.5	6.7	6.4	6.3	6.3	6.4	6.2	6.2	6.1
Total	7.7	7.6	7.9	7.6	7.7	7.7	7.7	7.7	7.8	7.9

Disparities in low birth weight rates also remain unacceptably high. The 1998 Black/White ratio for low birth weight is 1.8 (all births) based on rates of 11.9 to 6.7, an improvement on the 1989 ratio of 2.2. A similar trend is seen in the Black/White low birth weight ratios for singleton births, a reduction from 2.5 in 1989 to 2.1 in 1998.

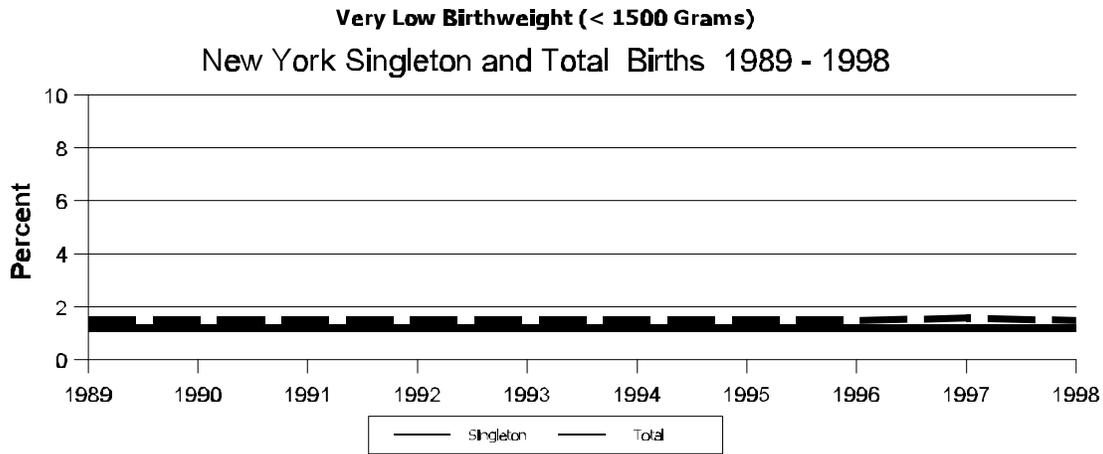
Low Birthweight (< 2500 Grams)

New York Singleton Births by Race 1989 - 1998



Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
White	5.0	4.9	5.0	5.0	4.9	4.9	5.1	5.0	5.0	4.9
Black	12.5	12.1	12.5	11.8	11.2	11.2	11.0	10.4	10.2	10.2
Hispanic	7.3	7.0	7.3	6.9	6.6	6.6	6.7	6.6	6.5	6.5

The very low birth weight rates for total and singleton births show absolutely no change over the past decade.



Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Singleton	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2
Total	1.5	1.5	1.5	1.5	1.5	1.5	1.6	1.5	1.6	1.5

Childhood Nutrition: A study conducted among a representative sample of second and fifth graders in 1990 showed that 35% of the children in New York City are overweight, as were 28% of the children in the rest of the state. Among preschoolers in the 1998 WIC population, there are twice as many overweight children as would be expected. Research indicates that adult morbidity and mortality are increased by childhood obesity, even if the condition does not persist into adulthood. Among adolescents responding to the 1999 YRBS, 37.6% of the females and 23.5% of the males thought they were overweight. Further, 62% of females and 28% of the males were attempting to lose weight.

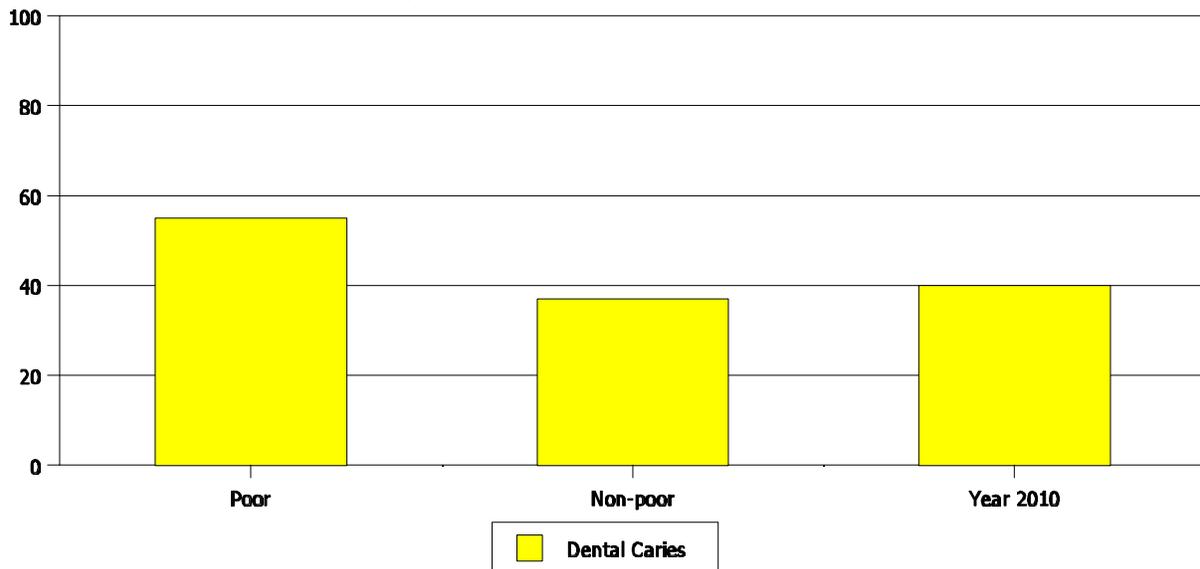
According to the US Department of Agriculture, food insecurity in New York State is thought to be in the range of 10% ($\pm 0.74\%$) and food insecurity with hunger is thought to be in the range of 3.9% ($\pm 0.31\%$).

Oral Health: Dental caries is the most common infectious disease in New York's and the Nation's children. By the time children graduate from high school, 84% will have experienced dental caries. Untreated dental disease has a significant impact on the quality of life. Unless treated, dental caries go on to destroy teeth, creating pain and infection in the surrounding oral tissue. Dental disease has an impact on children's ability to learn and on economic productivity in adults. Recent studies suggest that dental disease may be linked to a number of other adverse health conditions, including cardiac disease and premature birth.

Over the last thirty years, dental decay has been declining among school aged children nationally. However, there are wide disparities between poor and non-poor children. A survey of 2,474 second grade students drawn from 74 upstate New York schools showed that the prevalence of dental caries was 55% and 37% in poor and non-poor children, respectively. This is a decline from a baseline of 54% in 1987-1988. The proportion of children with untreated disease was 44% for poor children and 29% in non-poor children in 1998. The statewide rate is still above the Healthy People 2010 goal of 42%.

Comparison of Percent of Children with Caries to the HP 2010 Objectives

Upstate Survey of 2nd Graders, 1996-1999



Fluoridation is a very effective, easy, cheap way to prevent dental caries. New York has many rural and urban areas that are not served by fluoridation. Fortunately, New York City and 40 Upstate water systems are fluoridated. A total of 65% of New York’s population are served by fluoridated water systems, slightly higher than the national percentage of 62%, but still under the Healthy People goal of 75%. In the NYSDOH study of fluoridated Newburgh and non-fluoridated Kingston, it was shown that the greatest disparity in dental caries between the poor and non-poor was in the absence of fluoridation.

Dental sealants are another safe, effective, cost efficient way to prevent caries on the fissured surfaces of molars. Dental sealants have been applied to 25.3% of second graders, according to a recent (1997) survey by the Bureau of Dental Health. The national baseline for dental sealants is 23%, with the Healthy People goal set at 50% for this age group.

During 1998, 425 children in this state, at a rate of 15.3 per 100,000 live births, were born with cleft lip, palate or both. New York has a effective mechanism for identifying, recording, and referring these infants for treatment.

Child Care: The United States Census Bureau estimates that 50% of the children in New York under age 6, in 1995, lived in households where both parents work. Additionally, 41.0% of children ages 6 to 12 live in households where both parents work. The Office of Children and Family Services, who licenses and regulates these facilities in this State, reports in 1999 there are a total of 25,152 licensed facilities in the State, providing day care to 484,428 children, when they are at capacity. A total of 45,608 New York children participated in the Federal Head Start program in FFY 1998.

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

The Centers for Disease Control and Prevention recently reported on immunization levels in the Morbidity and Mortality Weekly Report (July 7, 2000). This information was based on the National Immunization Survey, which asked about immunization for children aged 19-35 months of age. Immunization rates were reported at the "4:3:1" level, meaning children who had completed 4 doses of diphtheria-tetanus toxoid-pertussis vaccine, three doses of polio virus vaccine and one dose of a measles containing vaccine, and a the "4:3:1:3" level, meaning those children who had completed that same series, plus three doses of Haemophilus influenza B vaccine. New York rates are leveling off, but at a rate better than the U.S. rate. Here are reports for New York State, New York City and the rest of the state under the 1999 National Immunization Survey:

Estimated vaccine coverage with the 4:3:1* and 4:3:1:3** series among children ages 19-35 months in New York State, New York City and the Rest of the State National Immunization Survey, 1999				
Area	4:3:1		4:3:1:3	
	%	(95% confidence level)	%	(95% confidence level)
New York State Total	83.4	(± 3.3)	81.0	(± 3.5)
New York City	81.5	(± 5.1)	78.3	(± 5.3)
Rest of State	85.0	(± 4.2)	83.3	(± 4.5)

*4:3:1 level=percentage of children who had completed 4 doses of diphtheria-tetanus toxoid-pertussis vaccine, three doses of polio virus vaccine and one dose of a measles containing vaccine.

**4:3:1:3 level=percentage of children who had completed 4 doses of diphtheria-tetanus toxoid-pertussis vaccine, three doses of polio virus vaccine, one dose of a measles containing vaccine, plus three doses of Haemophilus influenza B vaccine.

Immunization at the 4:3:1 Level among children ages 19-35 months in New York and the U.S. National Immunization Survey					
	July '94 - June '95	Jan - Dec '96	July '96 - June '97	July '97 - June '96	July '98 - June '99
N.Y.S.	78%	82%	77%	84%	82%
U.S.	75%	78%	78%	79%	80.2%

The table below shows very little change in the incidence of vaccine-preventable diseases, with the exception of mumps* cases in 1998. 91% of these cases occurred in New York City.

Occurrence of Vaccine-Preventable Diseases, 1994-1998										
Vaccine-Preventable Disease:	1994		1995		1996		1997		1998	
	Cases	Rate								
Hepatitis B	948	5.2	942	5.1	942	5.1	849	4.6	651	3.5
Hemophilus Influenza B (HIB)	104	0.6	81	0.4	81	0.4	95	0.6	131	0.7
Measles	43	0.2	6	0	6	0	12	0.1	4	-
Mumps	45	0.2	50	0.3	50	0.3	28	0.2	157*	0.8
Pertussis	477	2.6	320	1.7	320	1.7	533	2.9	364	2.0

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 1997 Youth Risk Behavior Survey (YRBS) revealed the percentage of teens who have experienced sexual intercourse increases with age, from 30% of ninth graders to 56% of 12th graders. Although these numbers are cause for great concern, they are still below the national average of 38% of ninth graders and 60% of all seniors. According to the 1999 YRBS, six percent of students report having had sexual intercourse for the first time before the age of 13, compared to eight percent nationally. Thirty percent of New York State high school students describe themselves as currently sexually active, compared to 36% nationally. Responses show no significant change from '97.

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 1999 YRBS:

- C The percentage of New York teens reporting condom use during their last sexual intercourse was 63%. Nationally, condom use during last intercourse was 58%.
- C New York State adolescent males reported higher use of condoms during their last sexual intercourse than do adolescent females-- 67.6% of adolescent males and 58.9% of adolescent females. Nationally, 65.5% of adolescent males and 50.7% of adolescent females reported condom use on last intercourse.
- C In New York State, 15 % of high school students (compared to 16.2% nationally) reported using birth control pills during their last sexual intercourse.
- C Alcohol or drug use at last sexual intercourse was reported by 36% of New York adolescents males and 20% of adolescent females. Nationally the figures were 31% and 18%, respectively. Use of alcohol is generally associated with reduced inhibitions and negatively associated with effective use of contraceptives.

Sexually Transmitted Diseases and AIDS in Adolescents: 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. In 1998, the case rate for early stage syphilis and gonorrhea in adolescents were much higher in New York City than in the rest of the state, which also fits the pattern for adult disease. The case rate for both syphilis and gonorrhea in females age 15-19 was higher in both New York City and the rest of the State than that for males in the same age group. The early syphilis rate in New York City among adolescents 15 - 19 has dropped significantly from 46.4 in 1993 to 3.8 in 1998. The rest of the state experienced a similar drop from 8.0 to 0.5 in that same time period.

1998 Adolescent Case Rates per 100,000				
	Syphilis (Early Stage*)		Gonorrhea	
	New York City	Rest of State	New York City	Rest of State
Males, Ages 15-19	2.9	-	321.0	185.4
Females, Ages 15-19	4.7	1.1	848.7	471.8
Total, 15-19	3.8	0.5	581.9	324.7

* Any of the first three stages of syphilis (primary, secondary or latent of less than one year's duration) are termed early syphilis.

Source: NYSDOH Bureau of Sexually Transmitted Diseases

As of April 1998, adolescents age 13-19 make up 0.4% of the AIDS cases in New York State. 53% of these cases were males and 47% were female. Of those diagnosed in the young adult age group, a significant portion 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. In 1999, that percentage has increased to 91%.

Other Youth Risk Behavior: The Youth Risk Behavior Survey offers a great deal of information about high school students across the State, including risk for both unintentional and intentional injuries, and risk for use and abuse of alcohol, drugs and tobacco.

Risk for Unintentional Injuries: According to the 1999 Youth Risk Behavior Survey, more than 4 out of 5 (83.4%) students who rode bicycles in the past 12 months reported they never or rarely wore a bike helmet. Students at highest risk were older (87.4% of seniors vs. 75.8% for ninth graders), and New York City students were less likely to wear helmets than those in the rest of the State.

In 1999, 16% reported they never or rarely wore seatbelts when in a car driven by someone else. 23% reported this behavior in 1997.

25.7% reported they rode in a car with someone who had been drinking alcohol. 8.4% reported they had driven a car or other vehicle when drinking alcohol; males were more likely to report doing so than females (10.2% vs, 6.6%).

Risk for Intentional Injuries: 1999 YRBS data indicate that males were three times more likely to carry a weapon to school than females (26.8% vs. 8.2%).

7.5% 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 9% and males at the rate of 6%.

9.3% of students reported being threatened or injured with a weapon while on school property. More males were threatened than females (11.5% vs. 7%). Ninth graders were threatened or injured at a rate double that of seniors (12.2% vs. 5.9%).

More than a third of the students (35.4%) reported participating in a physical fight. Ninth graders were again more likely to report this behavior than seniors (42.3% vs. 27.9%). 8.5% of students reported being slapped or being physically hurt by a boyfriend or girlfriend. Rates outside New York City (9.6%) were higher than for New York City students (6.5%). 9.2% of females and 5.3% of males reported being forced to have sexual intercourse when it was not wanted.

30.2% (almost a third) of students reported feeling sad or hopeless almost every day for 2 weeks or more. The rate for females (36.2%) was higher than for males (24%). Almost 18% of students seriously considered attempting suicide. Females were more likely to have considered this than males (22.5% vs. 13%). Over 14% of students actually made a plan for how they would attempt suicide. Almost 8% reported attempting suicide one or more times. Females attempted at a rate twice that of males (10.3% vs. 5.1%). Almost 3% needed medical care.

Alcohol, Tobacco and Substance Abuse: 67.6% of students participating in the Youth Risk Behavior Survey in 1999 reported they had tried smoking. 22.2% reported smoking a whole cigarette before the age of 13. 31.8% reported smoking one or more cigarettes in the last 30 days. 15.3% smoked cigarettes on 20 of the last 30 days; these students are considered frequent cigarette users. This is a slight improvement from 1997, when 32.9% reported smoking in the last 30 days and 16.3% were frequent users. 20.4% smoked two or more cigarettes on the days they smoked. Of the 28.7% of students under age 18 who were able to purchase cigarettes, 64.1% were not asked their age. 20.5% of males and 6.6% of females reported smoking cigars, cigarillos, or little cigars.

Alcohol use seems to be rising among New York State high school students. In 1999, 80.3% of all students had at least one drink of alcohol on one or more days of their lives; in 1997, 48.2% had used alcohol. In 1999, 31% had their first drink before age 13. In 1999, 49.6% had at least one drink of alcohol in the last 30 days, where 48.2% were current users in 1997. In 1999, nearly one third or 32.6% of males and one quarter or 24.9% of females reported they had five or more drinks of alcohol in a row on one or more days in the last 30 days.

The use of drugs other than alcohol was consistently higher for males than for females. 41.3% of students reported they had tried marijuana, and 23.4% used marijuana one or more times in the last 30 days. 6.8% of students reported using cocaine. 11.8% of students reported they had sniffed glue or breathed the contents of aerosol cans to get height. 6.4% reported using methamphetamines. 2.6% reported using heroin. 5.4% of males and 2% of females reported the use of steroid pills or shots without a doctor's prescription.

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 these children in our State in order to better serve them and better serve their families.

New York was a participant in the recent Brandeis "Your Voice Counts!!" study. This study used self-administered questionnaires to capture a wide range of information from parents that is relevant to families' experiences in obtaining health care for their children with special health care needs. Between March 1998 and April 1999, surveys were mailed to families of special needs children in 20 states, including New York. States were chosen for their geographic location and the market penetration by managed care providers. Samples were drawn from Family Voices mailing lists and from those served by Title V. We were asked to randomly select 100 families, Family Voices provided an additional 100-115 names. To be eligible for inclusion in the analysis, the following criteria needed to be met:

- C the respondent was a parent or grand/parent of a child with special health care needs;
- C the child lived at home with the respondent;
- C the child was under age 18; and
- C the child had a health or medical condition that is expected to last for at least one year; needed frequent medication, special diets, medical technology, assistive devices, or occupational, physical or speech therapy or personal assistance; or needed care from physicians, mental health or other health professionals over and above what is usual for a child of the same age.

New York's tallies include the responses on 150 families, which were compared to a sample of 2,220 responding families nationwide. Because of the relatively small numbers involved in the analysis, readers need to be cautioned about the interpretation of results. Minor shifts in responses can produce dramatic differences when small numbers of respondents are involved.

Of those responding to the survey, 91% were mothers, 7% were fathers, and 2% were others. Only 1% had less than a high school education. 27% were high school graduates, 45% had some college, and 26% had a Bachelor's or post-graduate degree. 84% were married (compared to 70% nationwide) and 11% were divorced or separated. Only 31% were employed more than 30 hours a week outside the home. 29% were employed part-time. 19% had more than one child with special health care needs in the family. Mean income was \$39,414, compared to the national mean of \$34,337.

Relative to the health status of the children, the most common special needs identified were orthopedic or bone problems (41%), cerebral palsy or other neuromuscular conditions (37%), allergies or sinus trouble (37%), and mental retardation (23%). Paraplegia or quadriplegia were reported by 15%. 19% of those responding said the health of their child was fair or poor. 24% said their child's condition changed all the time, while 44% said their child's condition changes only once in a while. 29% reported their child was usually stable. 21% said their children were technology dependent, and 13% said their child had missed more than 30 days of school due to their condition.

While 99% of the respondents reported some form of insurance from primary health care, 59% said they had no choice of plans. Only 2% said that their child had been without coverage over the last 12 months. Of those insured, 65% had insurance that was at least partly paid by their employer; 17% were fully covered by the employer, and 48% had part-employer/part-family paid insurance. 21% had Medicaid and 2% were covered by other government programs. 10% of families paid for their own insurance totally.

Overall satisfaction with their health plan varied: 6% were very dissatisfied, 11% were somewhat dissatisfied, 42% were somewhat satisfied, and 40% were definitely satisfied. 85% had never filed a formal grievance or appeal with their health insurer. 3% had, but it was not resolved at the time of the survey, 3% had and the problem was resolved to their satisfaction, and 6% had the complaint resolved but not to their satisfaction (twice the national average).

3% of the New York respondents responded that their primary care provider lacked the skills and expertise needed to appropriately care for their child. 20% of respondents stated their provider kept them waiting more than 15 minutes, and 14% felt the provider did poorly in giving information on medical research. 8% felt the provider did poorly in communicating with the child's school or early intervention program.

9% reported out-of-pocket expenses of \$5,000 or more and 13% had expenses of \$3,000 - \$4,999 in the last 12 months. Only 15% reported having expenses of less than \$500 in the last 12 months.

The public forums that were held during FFY 2000 reinforced some of this information. Parents reported that they had difficulties obtaining needed durable medical equipment, that there is a shortage of qualified nurses to care for their technology dependent children, and that providers could do a better job of sharing information with parents. They also related that they have high out of pocket expenses.

Leading Causes of Death: The leading causes of death in 1998 for New York State, New York City, and the rest of the state are reflected on the table that follows. The figures show:

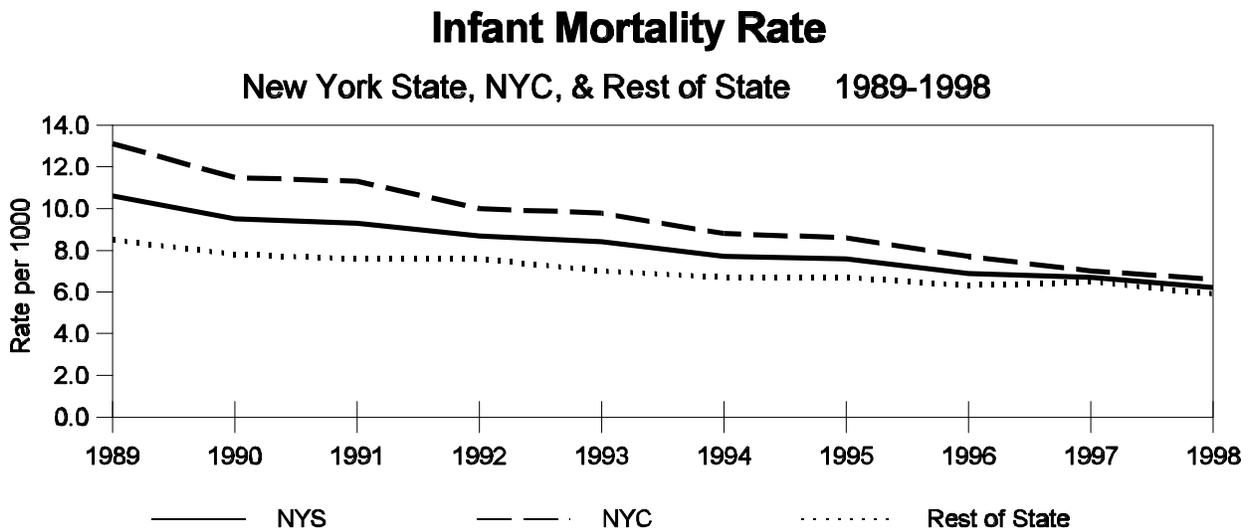
- C Unintentional injuries are the leading cause of death among children ages 1 to 19 years.
- C More than half of the infant deaths in the state are caused by conditions arising in the perinatal period.
- C SIDS deaths are dropping.
- C In children who live outside of New York City, the leading cause of death in 15- to 19-year-olds is unintentional injury; in their New York City counterparts, the leading cause of death is homicide and legal intervention.
- C In New York City, 21.6% of deaths among 10- to 19-year-olds are the result of homicide and legal intervention, down from 36% in 1996 and 22.6% in 1997.
- C 8.8 % of deaths among New York State 10- to 19-year-olds are the result of suicide, and when New York City is excluded, suicides account for 10.4% of deaths among 10- to 19-year-olds in the rest of the state.

Though the number of annual AIDS deaths has declined dramatically over the period of the last 5 years, New York remains an epicenter for AIDS. June 1999 reports indicate that the AIDS death rate per 100,000 was 14.8, compared to 5.8 nationally. The number of persons living with AIDS in the state was 49,036 (48,233 were adults; 803 were children under the age of 13 years). The number of newly reported cases per 100,000 population was 42.1 in New York, compared to 17.1 nationally. New York's rate for female adults and adolescents was 29.7, compared to 9.4 nationally, and for males the rate was 74.6, compared to 33.2 nationally.

Table 7. LEADING CAUSES OF DEATH 1998, New York State Children, Birth to Age 19

All Ages						Ages <1					
Cause	Number	Percent	Cause	Number	Percent						
All Causes	155,651		All Causes	1,608							
Diseases of the Heart	59,241	38.1	Cond Orig in Perinatal Period	876	54.5						
Malignant Neoplasms	36,844	23.7	Congenital Anomalies	333	20.7						
Cerebrovascular Disease	7,747	5.0	Sudden Infant Death Syndrome	100	6.2						
Pneumonia	6,799	4.4	Diseases of the Heart	36	2.2						
Chronic Obstructive Pulmonary	6,408	4.4	Pneumonia	33	2.1						
Ages 1-9			Ages 10-19								
All Causes	495		All Causes	805							
Unintentional Injuries	135	27.3	Unintentional Injuries	286	35.5						
Malignant Neoplasms	68	13.7	Homicide & Legal Intervention	113	14.0						
Congenital Anomalies	48	9.7	Malignant Neoplasms	79	9.8						
Homicide & Legal Intervention	31	6.3	Suicide	71	8.8						
Diseases of the Heart	22	4.4	Diseases of the Heart	39	4.8						
New York State - Excluding New York City											
All Ages			Ages <1								
All Causes	95,792		All Causes	816							
Diseases of the Heart	34,069	35.6	Cond Orig in Perinatal Period	406	50.0						
Malignant Neoplasms	23,315	24.3	Congenital Anomalies	179	21.9						
Cerebrovascular Disease	5,685	5.9	Sudden Infant Death Syndrome	67	8.2						
Chronic Obstructive Pulmonary Dis	4,740	4.9	Diseases of the Heart	27	3.3						
Pneumonia	4,106	4.3	Accidents	18	2.2						
Ages 1-9			Ages 10-19								
All Causes	253		All Causes	471							
Unintentional Injuries	83	32.8	Unintentional Injuries	217	46.1						
Malignant Neoplasms	34	13.4	Suicide	49	10.4						
Congenital Anomalies	26	10.3	Homicide & Legal Intervention	41	8.7						
Diseases of the Heart	12	4.7	Malignant Neoplasms	40	8.5						
Pneumonia	10	4.0	Diseases of the Heart	19	4.0						
Homicide & Legal Intervention	10	4.0									
New York City											
All Ages			Ages <1								
All Causes	59,859		All Causes	792							
Diseases of the Heart	25,172	42.1	Cond Orig in Perinatal Period	470	59.3						
Malignant Neoplasms	13,529	22.6	Congenital Anomalies	154	19.4						
Pneumonia	2,693	4.5	Sudden Infant Death Syndrome	33	4.2						
Cerebrovascular Disease	2,062	3.4	Pneumonia	18	2.3						
AIDS	1,918	3.2	Homicide and Legal Intervention	12	1.5						
Ages 1-9			Ages 10-19								
All Causes	242		All Causes	334							
Unintentional Injuries	52	21.5	Homicides and Legal Intervention	72	21.6						
Malignant Neoplasms	34	14.0	Unintentional Injuries	69	20.7						
Congenital Anomalies	22	9.1	Malignant Neoplasms	39	11.7						
Homicide & Legal Intervention	21	8.7	Suicide	22	6.6						
Diseases of the Heart	11	4.5	Diseases of the Heart	20	6.0						

Infant Mortality: The infant mortality rate has declined by approximately 35% over the last decade. The 1998 infant mortality rate was the lowest ever for New York City and the rest of New York State. 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; the rate is now 6.2 per 1000. The new Healthy People 2010 goal of 4.5 per 1000 seems to be within reach.

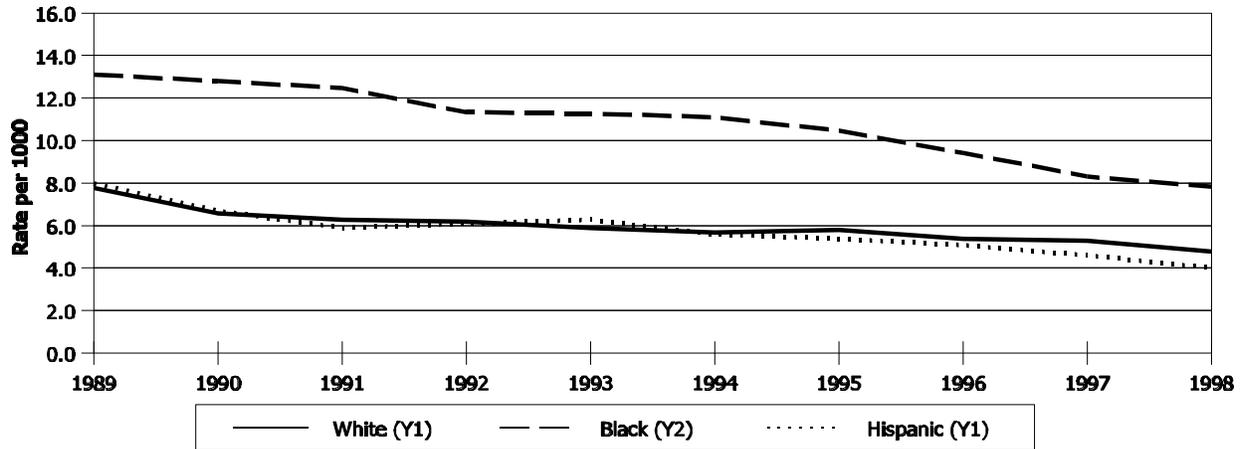


Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
NYS	10.6	9.5	9.3	8.7	8.4	7.7	7.6	6.9	6.7	6.2
NYC	13.1	11.5	11.3	10.0	9.8	8.8	8.6	7.7	7.0	6.6
ROS	8.5	7.8	7.6	7.6	7.0	6.7	6.7	6.3	6.5	5.9

There is a marked racial disparity in infant mortality rates. In 1998, infant mortality continued to decline in the White, Black and Hispanic populations, and the rate of disparity was relatively unchanged. The Black/White ratio for infant mortality peaked in 1990 at 2.7, based on rates of 16.0 and 6.0, then declined slightly between 1991 and 1997, when it fell to 2.0. It remained at 2.0 in 1998, when the white infant mortality rate was 4.8 per 1000 and the Black rate was 9.8 per 1000. Hispanics have continued to experience the lowest rates, and at 4.0 per 1000 the rate for this population has already met the Healthy People 2010 goal of 4.5 per 1000.

Infant Mortality Rate

New York State Residents by Race 1989-1998

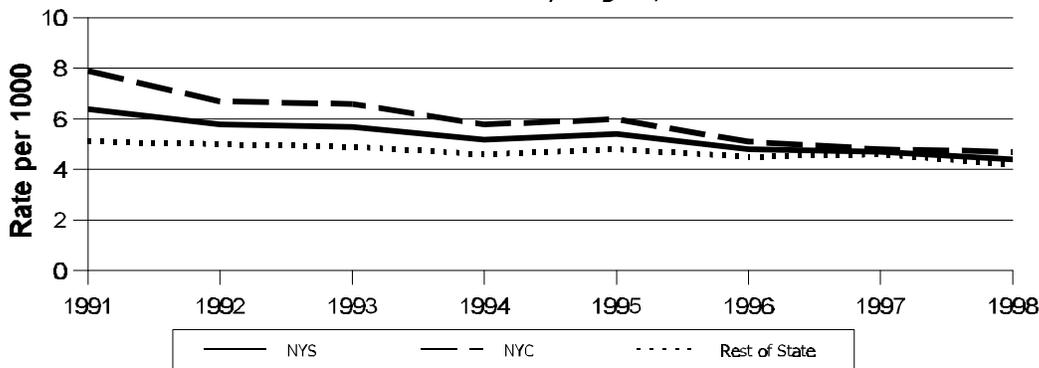


Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
White	7.8	6.6	6.3	6.2	5.9	5.7	5.8	5.4	5.3	4.8
Black	16.4	16.0	15.6	14.2	14.1	13.9	13.1	11.8	10.4	9.8
Hispanic	8.0	6.7	5.9	6.1	6.3	5.6	5.4	5.1	4.6	4.0

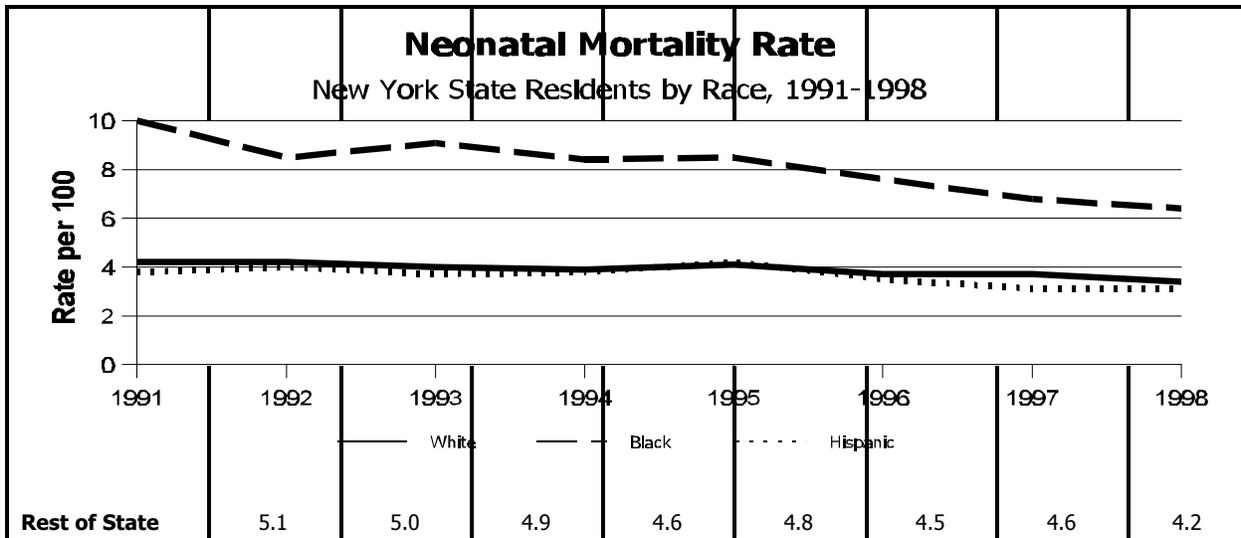
Neonatal Mortality: Trends in neonatal mortality mimic those of infant mortality. Between 1991 and 1998 neonatal mortality declined 31% to 4.4 per 1000 births. New York City residents experienced slightly higher rates as compared to the rest of the state. Similar to infant mortality, there is a significantly higher neonatal mortality rate among Black births. In 1998, the Black neonatal death rate was 6.4 per 1000 births, almost double the rate for Whites (3.1 per 1000). This disparity, while still significant, is improving. In 1991, the Black/White ratio was 2.3. In 1998, it was 1.9.

Neonatal Mortality Rate

New York State Residents by Region, 1991 - 1998

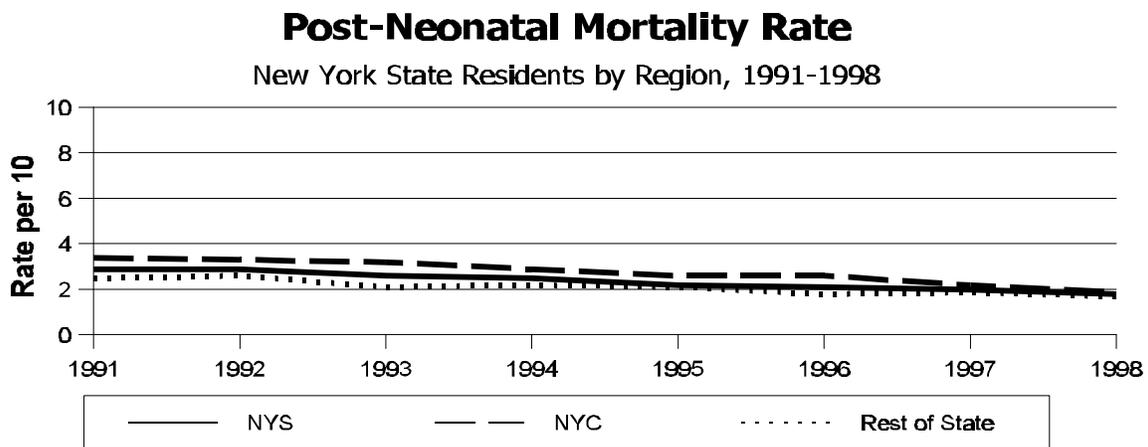


Year	1991	1992	1993	1994	1995	1996	1997	1998
New York State	6.4	5.8	5.7	5.2	5.4	4.8	4.7	4.4
New York City	7.9	6.7	6.6	5.8	6.0	5.1	4.8	4.7



Year	1991	1992	1993	1994	1995	1996	1997	1998
White	4.2	4.2	4.0	3.9	4.1	3.7	3.7	3.4
Black	10.0	8.5	9.1	8.4	8.5	7.6	6.8	6.4
Hispanic	3.8	4.0	3.7	3.8	4.2	3.5	3.1	3.1

Post-Neonatal Mortality Rate: The post-neonatal mortality rate in New York State has also declined significantly. Between 1991 and 1998, it declined 38% to 1.8 per 1000 live births. Declines have been seen in both New York City and the rest of the State. In 1998, there was little difference in the rates for the two areas. The disparity in rates between Blacks and Whites that were seen in both infant and neonatal mortality rates are also seen here. In 1998, the Black post-neonatal mortality rate was 3.4 per

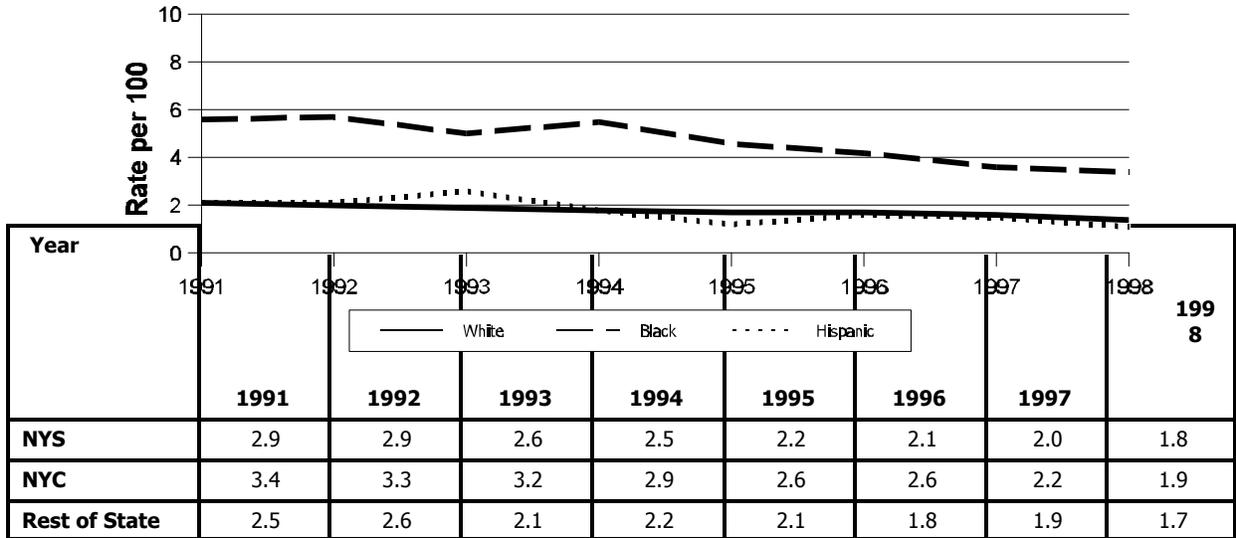


rate stood at 1.4 per 1000. The Black/White ratio of 2.4 is down only slightly from 2.6 in 1991.

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Post-Neonatal Mortality Rate

New York State Residents by Race, 1991-1998



Year	1991	1992	1993	1994	1995	1996	1997	1998
White	2.1	2.0	1.9	1.8	1.7	1.7	1.6	1.4
Black	5.6	5.7	5.0	5.5	4.6	4.2	3.6	3.4
Hispanic	2.1	2.1	2.6	1.8	1.2	1.6	1.5	1.1

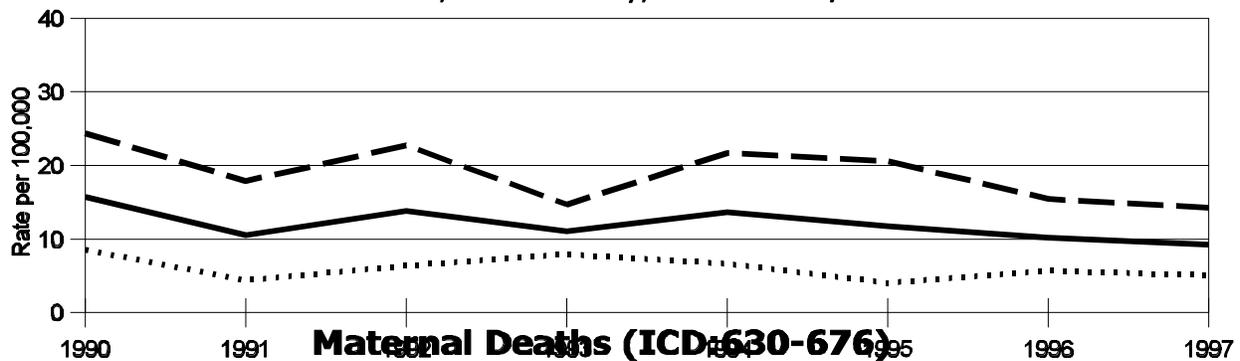
Sudden Infant Death Syndrome: The table below illustrates the relationship between occurrence of SIDS deaths as a subset of total infant and post-neonatal deaths. The table also contains PRAMS Survey responses indicating mothers who reported putting their infants to sleep on their backs. The trend is that as more infants are placed on their backs to sleep, the number and proportion of SIDS deaths is decreasing.

Year	1995	1996	1997	1998
All deaths < 1 Year	2062	1829	1728	1608
Post-neonatal deaths	610	570	520	467
SIDS deaths	154	146	118	100
SID/Post-Neonatal	25.2%	25.6%	22.6%	21.4%
% PRAMS Moms responding that they put their infants on their back to sleep	Not on the 1995 Survey	34.5%	45.2%	53.0%

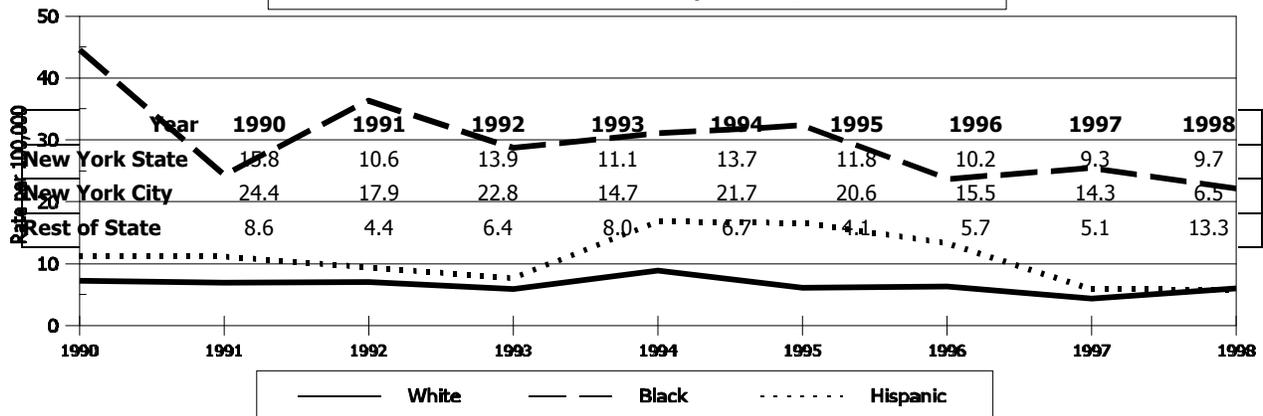
Maternal Mortality: New York's maternal mortality rate peaked in 1990 with a rate of 15.8 per 100,000 births and 44.6 per 100,000 for Black births. The rate has decreased 33% in the last decade. The racial disparity in maternal mortality in New York exceeds even the differences seen in infant mortality and low birth weight. The 1998 Black maternal mortality rate of 22.2 per 100,000 births compared to the White rate of 6.0 per 100,000 births, results in a Black to White ratio of 3.7. The maternal mortality rate in 1998 of 9.7 per 100,000 births is three times the Healthy People 2010 goal of 3.3 per 100,000.

Maternal Mortality (ICD:630-676) Rate

New York State, New York City, Rest of State, 1990-1998



New York State Residents by Race, 1990-1998



Year	1990	1991	1992	1993	1994	1995	1996	1997	1998
White	7.3	7.0	7.1	5.9	8.9	6.1	6.3	4.4	6.0
Black	44.6	24.4	36.4	28.8	31.1	32.4	23.7	25.5	22.2
Hispanic	11.3	11.2	9.4	7.7	16.9	16.6	13.4	5.9	5.8

■ **Identified Needs of New York’s Maternal and Child Health Population**

Needs identified through New York’s MCH Needs Assessment process and the data indicating that need are outlined on the tables that follows:

3.1.2.2 Need for Direct Medical Services

Direct Medical Care - Preventive and Primary Care for Pregnant Women, Mothers and Infants	
Need Identified	Supporting Data/Documentation
<p>Improved access to comprehensive, continuous, family-focused, community-based, age- and sex-appropriate primary and preventive care, including access to:</p> <ul style="list-style-type: none"> C family planning information and services; C medical homes; C dental services; C prenatal care; C mental health services; C health insurance; C statewide availability of services C referral to appropriate levels of care; and C prevention of secondary disability. 	<p>Continued high rate of reported unwanted, mistimed pregnancies Adolescent pregnancy rates Continued high rates of low birth weight High rates of perinatal and infant mortality Rates for early entry into prenatal care Kotelchuk Index Significant disparities in birth outcomes between population groups Maternal mortality study Behavior Risk Factor Survey results on access to care High numbers 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 the Community-Based Adolescent Pregnancy Prevention Program, the Children with Special Health Care Needs program, the Family Planning Program, the Migrant Health Program, the American Indian Health Program, and School-based Health Centers</p>
<p>Healthier births</p>	<p>Continued high rates of low birth weight High rates of perinatal and infant mortality Lower than acceptable rates for early entry into prenatal care Significant 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 Cost of hospitalization for NICU both in human suffering and dollars</p>

Direct Medical Care - Preventive and Primary Care Services for Children, Ages 1 through 21

Need Identified	Supporting Data/Documentation
<p>Improved access to comprehensive, continuous, family-focused, community-based, age- and sex-appropriate primary and preventive care, including access to:</p> <ul style="list-style-type: none"> C family planning information and services; C medical homes; C dental services; C mental health services; C health insurance; C counseling on risk-taking behaviors; C statewide availability of services C referral to appropriate levels of care; and C prevention of secondary disability. 	<p>Immunization Rates Rates of dental caries Rates for placement of dental sealants 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</p>

Direct Medical Care - Children with Special Health Care Needs

Need Identified	Supporting Data/Documentation
<p>Improved access to comprehensive, continuous, age- and sex-appropriate primary and preventive care and specialty level care, including access to:</p> <ul style="list-style-type: none"> C medical homes; C referrals to appropriate speciality services and higher levels of care; C needed durable medical equipment and supplies; C supportive services, like respite; and C family involvement. 	<p>Parent and consumer input Public hearings MCHSBG Advisory Council input Family Voices study Children with Special Health Care Needs Program data Early Intervention Program data Local community health assessments</p>

Discussion: New York employs multiple strategies to ensure access and availability of primary and preventive maternal and child health services to its population. Primary among those strategies is:

- C providing low income and disabled New Yorkers with a generous Medicaid and Child Health Plus insurance package;
- C 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;
- C 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;
- C providing sufficient regulatory authority to ensure necessary programs are of high quality;
- C ensuring adequate infrastructure at the level of the State Health Department;
- C ensuring, in some cases by mandate, linkages between levels of care, such as between Level One birthing hospitals and Level Two and Three hospitals;
- C raising awareness of health services in vulnerable populations through extensive health outreach and health education campaigns;
- C assisting providers to become more culturally competent;
- C encouraging cross-system collaborations to better meet the human services needs of New Yorkers;
- C providing state local assistance funds to ensure public health capacity at local county health departments; and
- C active monitoring of gaps in services and access issues at the community level through local community health assessment.

The shift in recent years from a rate-setting to a free-market environment, and the expansions in Medicaid, managed care and Child 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 is presently moving toward mandatory Medicaid managed care.

Welfare reform has had a noticeable effect on Title V populations. Welfare to work programs are moving mothers into the workplace, often to jobs with limited benefits, and placing more stress on the child care system. New York is working to remedy the trauma of entry into the work place with job training, extended supportive benefits, and expanding capacity in the child care system. Welfare reform is also changing the way MCH services must be delivered. There is no longer a reliance on day time clinic visits or home visits. No one is at home during the day, and low income workers often are not allowed days off with 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 a new Family Health Plus Program, modeled on Child Health Plus, is very exciting. This program will provide benefits similar to those under Child Health Plus to low income, working adults who

are not eligible for regular Medicaid. Family Health Plus will be a Medicaid program, and a Federal waiver will be necessary. The program is scheduled to take effect in January 2001, pending approval of the waiver.

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. In the area of dental treatment, for instance, even ensured children have difficulty accessing the services they need, especially if they live in a rural area. Other factors, such as the maldistribution of physicians, 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 trend 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.

Please refer to the discussion in Section 1.4 Overview of the State/The Health Care Delivery Environment.

3.1.2.3 Need for Enabling Services

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: <ul style="list-style-type: none"> C enhanced and sustained outreach; C transportation; C translation services; C insurance programs; C assistance with locating and accessing services; and C referral and support services. 	Medicaid utilization and QARR data Poor rates of early entry into prenatal care Kottelchuk 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
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.
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.	Family Voices study Parent and consumer input MCHSBG Advisory Council input Early Intervention and Children with Special Health Care Needs data

Discussion: 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 Perinatal Data System will allow an in-depth examination of referral patterns between community-based providers and differing levels of perinatal care.

3.1.2.4 Need for Population-Based Services

Population-Based Services - Primary and Preventive Care for Pregnant Women, Mothers and Infants	
Need Identified	Supporting Data/Documentation
Healthier births	Rates of early entry into prenatal care Rates of late and no prenatal care Kottelchuk Index Perinatal Hepatitis B and HIB 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 Advisory Council and Public Hearings input

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 Poor rate of Medicaid children who receive a dental preventive service Data on lack of dental insurance and high out-of-pocket expense Family and Consumer Input Public Hearings input Advisory Council input
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: <ul style="list-style-type: none"> C family planning information and services; C medical homes; C mental health services; C health insurance; C counseling on risk-taking behaviors; C statewide availability of services C referral to appropriate levels of care; and C 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 input MCHSBG Advisory Council input

Need Identified	Supporting Data/Documentation
Completion of high school and compulsory health education	Data on drop out rates and associated socio-economic consequences Level of maternal education data Rates of high school non-completion among teen moms
Improved 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 sexual activity, 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)
Improve nutrition and higher levels of physical activity	Nutrition surveillance studies WIC program data
Reduced use of tobacco, alcohol and other drugs	Youth Behavioral Risk Survey Rates of injuries where drugs and alcohol are involved
Reduction of violence/intentional injuries	Youth Behavioral Risk Survey SPARCS data on hospitalizations for injuries Calls to the child abuse and neglect hotline Rape Crisis Program data

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: C readily accessible information about the location and availability of services; and C access to and insurance for accessing appropriate levels of care and appropriate specialty services.	Family Voices study Parent and Consumer input Public Hearings input MCHSBG Advisory Council input

Discussion: With the changes in the health care delivery system, public health and MCH are going away from direct medical services and moving toward more population-based services. Title V is involved in the delivery of number of population-based services, which are described both in the listing of accomplishments by performance measure and in the program plan section of this application.

New York’s population-based services are many from newborn metabolic screening to lead screening and immunization services to prenatal care and family planning services. Generally, DOH ensures appropriate geographic distribution through its grant procedures. Requests for proposals and other procurement methods will denote whether funds are targeted or to be used more generally. Contractors or local health departments are selected as recipients of funds based on their organizational capacity to deliver services to the designated population(s) and for the soundness of their program plan. DOH program managers are expected to ensure that funds are utilized as intended, and that services are effectively reaching and helping the selected or general population. Regional Office staff carefully monitor programs, review program data, and provide valuable intelligence about the penetration of services and program effectiveness. Regional staff also provide needed technical assistance to contractors and local health departments.

3.1.2.5 Need for Infrastructure Services

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	<p>There is a continued need for the infrastructure to support:</p> <ul style="list-style-type: none"> C Assessment of problems and conditions that affect the MCH population; C Ability to identify and bring resources to bear on priority health issues; C Coalition-building and collaboration skills; C Availability and access to necessary technical assistance; C Appropriate numbers, types and distribution of MCH/public health personnel; C Statewide accessibility, availability and acceptability of MCH services at all levels of care; C Form effective linkages between/across systems of care; C 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	<ul style="list-style-type: none"> 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

Infrastructure Services - Primary and Preventive Services for Pregnant Women, Mothers and Infants	
Need Identified	Supporting Data/Documentation
<p>An infrastructure that promotes healthier births:</p> <ul style="list-style-type: none"> C affordability and access to insurance for prenatal and intrapartal care; C appropriate array of services/locations; C regionalized system of perinatal care; C family planning education and services that promote appropriate spacing of children; C content of care that includes risk assessment and patient education; and C linkages to nutrition and other support services. 	<ul style="list-style-type: none"> Data on uninsured Vital Statistics and SPARCS data on payment for obstetrical 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 tertiary level 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 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 that supports comprehensive child health and school health and wellness in order to promote: <ul style="list-style-type: none"> C access to insurance; C access to a full array of screening and treatment services for medical, dental and mental health issues; C responsible sexual behavior; C reduced use of tobacco, alcohol and other drugs; C reduction in unintentional injuries; and C 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 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: <ul style="list-style-type: none"> C better assessment of the needs of children with special health care needs and their families; C family-centered care/enhanced family participation in care; C easy access to necessary services; C compassionate, coordinated delivery of care. 	There is very poor data on this population Family Voices 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

Discussion: New York’s Title V program determines need through assessment of delivery systems 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.

Accurate assessment and the design of effective intervention strategies are required to build a comprehensive, coordinated system of care. This involves the collaboration of all stakeholders in a particular issue. It would be impossible to fully describe all of the collaborations between Title V programs and other stakeholders. Please refer to the discussion in Section 1.5.1 related to relationships within our Department and with outside agencies and providers. To better understand the number and the nature of various collaborations, it might be helpful to use the Children with Special Health Care Needs Program as an example. The program is presently engaged in collaborations with:

- C the Office of Managed Care and the Office of Medicaid Management, working to improve health care standards, policies, and systems of care for children with special health care needs;
- C the Division of Nutrition and the State Education Department, trying to improve school nutrition services for children with special health care needs;
- C Healthy Child Care New York, focusing on improving inclusion of special needs children and improving the child care consultation services;
- C the School Health InFrastructure Team, building the infrastructure to support comprehensive school health and wellness, advocating for students with special needs;
- C the Social Security Administration, concerning SSI and disability determination issues;
- C the Emergency Medical Services for Children Program, advising on special needs children;
- C Family Voices and Parent-to-Parent New York, endeavoring to pull parents in as partners in policy;
- C parent graduates of DOH's various training initiative, soliciting their advice and assistance; and
- C 58 local health departments and Children with Special Health Care Needs Programs, re-aligning and re-designing the infrastructure for serving children with special health care needs on the local level.

3.2 Health Status Indicators

New York served as a pilot state for the Federal Health Status Indicators. Please refer to Appendix 5.6, 5.7, 5.9 and 5.10 for New York data and “detail sheets” on the Core and Developmental Health Status Indicators.

3.2.1 Priority Needs

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 this year’s five year assessment cycle required by Title V, and in consideration of past progress, several performance targets were re-adjusted. The ten priorities that follows, and the specific performance measures related to each, stem specifically from areas of unmet need in the State.

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.

The following are New York’s maternal and child health services priority needs for FFY 2001:

- C* To improve access to high-quality health care for all New Yorkers, with a special emphasis on prenatal care and primary and preventative for infants and children, including those with special health care needs;
- C* To improve oral health;
- C* To eliminate disparities in health outcomes, especially with regard to low birth weight, and in maternal and infant mortality;
- C* To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;
- C* To reduce tobacco use among children and pregnant women;
- C* To reduce the use of alcohol among children and pregnant women;
- C* To reduce unintended and adolescent pregnancies;
- C* To implement a statewide system of universal newborn hearing screening;
- C* To reduce the rate of self-inflicted injuries and suicide for 15 to 19 year olds; and
- C* 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:

- C 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.
- C Dental services for children should include fluoridation or fluoride treatment and dental sealants.
- C 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.
- C 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.
- C 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.
- C 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 services in each community.
- C Further, violence related to homicide, child abuse and neglect, other domestic violence and assault are clearly issues.
- C The Advisory Council stressed the need for families to provide nurturing care to their children.
- C The Advisory Council continually re-affirms the value of parent and consumer input in their decision-making process.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

Please refer to budget columns on Forms 2,3,4, and 5.

3.3.2 Other Requirements

Maintenance of Effort

New York meets and exceeds the maintenance of effort requirements of Sec. 505 (a)(4). NYSDOH plans continued Title V funding for several ongoing initiatives in FFY 2001:

- C The Adolescent Health Initiative, including ACT for Youth and Youth Risk Behavior Surveillance
- C Children with Special Health Care Needs Program
- C Physically Handicapped Children's Program Diagnostic and Evaluation Program
- C Preventive Dentistry Initiatives and the Dental Residency Program
- C Columbia Collaborative Projects
- C SUNY School of Public Health Graduate Assistantship Program
- C The Lactation Institute
- C Community-Based Adolescent Pregnancy Prevention
- C Family Planning
- C The Genetics Program and Newborn Screening
- C Immunization Registry activities
- C Infant and Child Mortality Review
- C American Indian Health Program Community Health Workers
- C Injury Prevention
- C Lead Poisoning Prevention
- C MIC - Women's Health Services
- C Migrant Health
- C Pediatric Resource Centers
- C Perinatal Data Systems
- C School-Based Health Centers
- C STD Screening and Education

Newly funded expanded initiatives for FFY 2001 include:

- C The Statewide Asthma Initiative
- C Universal Newborn Hearing Screening
- C Parents as Partners
- C Parent and Consumer Focus Groups
- C Women and Disabilities Teleconference

The Monroe Consolidated Child and Family Health Grant will continue in FFY 2001. Under this initiative, eight previously categorical grants are given to the county under a single work plan and a single contract budget. WIC continues to be closely aligned but not fiscally under the approved Cost Allocation Plan; it is tracked as a traditional line item budget. In fiscal year 2001, the plan is to explore bringing Article 6 State Aid to Localities funds under the rubric of the consolidated grant.

Justification

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.

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

- C Appropriate cost centers, representing specific areas of activity related to MCH, are identified.
- C Data tapes for the appropriate fiscal period are obtained from the Office of the State Comptroller (OSC).
- C Data for selected cost centers are extracted on a quarterly basis.
- C Quarterly data is compiled from relevant cost centers to reflect expenditures made during the federal fiscal year.
- C All expenditure data represent payments made on a cash (vs. accrual) basis.
- C 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 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:

- C 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
- C Early Intervention
- C Family Planning
- C Genetic Screening and Human Genetics
- C Health Care Reform Act of 2000 Allocations
- C Immunization, Vaccine Distribution and State Aid for Immunization
- C Lead-Control and Prevention, Lead Poisoning Prevention Local Assistance and Lead Interim Housing
- C Physically Handicapped Children's Treatment Program/Children with Special Health Care Needs Program
- C School-Based Health Centers
- C State Aid to Local Health Departments
- C SIDS and Infant Death
- C Tobacco Settlement Dollars

Federal sources of MCH dollars other than the block grant include:

- C Abstinence Education
- C Adolescent Health Coordinator
- C Centers for Disease Control and Prevention (Lead, Immunization, Public Health Information Infrastructure, Community Assessment Grants)
- C CISS Grant (currently Healthy Child Care New York)
- C Emergency Medical Services for Children Grant
- C Early Intervention, Part C
- C Family Planning
- C National Cancer Institute ASSIST Funds
- C Rape Crisis
- C SSDI Funds (currently the re-design of the CSHCN Program)
- C STD/fertility
- C SPRANS Grants
- C SSDI Funds (currently the re-design of the CSHCN Program)
- C TANF Funds

3.4 Performance Measures

The table below summarizes the relationship between New York’s FFY 2001 priority needs and Federal and State Performance and Outcome Measures.

Priority Area	Applicable Federal Perf. Measures	Applicable State Perf. Measures	Applicable Outcome Measures
Access to Care	1-18	1,2,4,5,and 10	1-6 and NY
Oral Health	7	--	---
Disparities	11,15,17,18	5	1-6 and NY
Asthma	---	2	6
Tobacco	---	3,9	1,2,3,5
Alcohol	---	3,8	6
Resp. Sexual Activity	6	1,4	---
Lead Screening	---	10	6
Self-Inflicted Injury	16	7	6
Parent Partnership	14	---	---

3.4.1 National “Core” Five Year Performance Measures -and-

3.4.1.1 Five Year Performance Targets

New York has changed its targets from those developed under the pilot of the new MCHSBG format. Although many goals were surpassed last year, there was a reluctance to make significant readjustments to the targets based on improvements in a single program year. For many of the measures, we now have a three-year improvement trend. Therefore, for the Fiscal Year 2001 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 this application.

The table that follows summarizes the National Performance Measures by level and type of service.

NATIONAL PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
	1) 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.	X				X	
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
16) Percent of very low birth weight live births.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

3.4.2 State "Negotiated" Five Year Performance Measures

3.4.2.1 Development of State Performance Measures - and -

3.4.2.2 Discussion of State Performance Measures

New York's State Performance Measures initially developed its state performance measures and performance targets under the pilot of the new 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.

The table below summarizes New York State's State-Selected Performance Measures with the level and type of service.

STATE-SELECTED PERFORMANCE MEASURES SUMMARY SHEET							
State Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) Unintended pregnancies	X				X		
2) Hospitalization rate for asthma in children 1-14	X						X
3) Percent of women who reported smoking during pregnancy		X					X
4) Teen pregnancy rates for girls ages 15-17			X				X
5) Ratio Black to White low birth weight rate			X				X
6) Percent of infants placed on their backs to sleep			X				X
7) Hospitalizations for self-inflicted injuries for 15-19 year-olds.			X				X
8) Percent of high school students who drank alcohol in the last month.			X				X
9) Percent of high school students who smoked tobacco in the last month.			X				X
10) Percent of children in birth cohorts who were screened for high blood lead at ages 1 and 2				X	X		

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
 IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2.3 Five Year Performance Objectives

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.

For National Performance Measure #2 and 4, we aspire to retain the maximum score of 9 and 100%, respectively. On Performance Measures # 10 and 14, we aspire for 100% ratings by 2002.

For National Performance Measures #7, 16, and 18, for State Performance Measures #1, 3, 6, and 8, and for Outcome Measure #1, 3, and 5, and our State Outcome Measure, the performance target was set at the level of the Healthy People measure.

The following targets were set based on linear projection starting with current trends: Performance Measure #8, State Performance Measures #2, 4, 5 and 7, Outcome Measures #1, 3 and 5, and the State Outcome Measure (end point set at Healthy People 2010). Other measures were set based on trends in current progress and setting what is believed to be a realistic endpoint (which may be above or below the Healthy People 2010 Objectives): Performance Measures #5, 6, 9, 12, 13, 15, and 17, State Performance Measures # 9 and 10, Outcome Measures #2, 4, and 6.

We did not set a goal for Performance Measure #1, since that measure is not applicable to New York.

In areas where there are not good data (Performance Measure #3, 11, our objective is to improve our data capacity, with the help of SSDI.

3.4.2.4 Review of State Performance Measures

Review of State measures with the Federal staff and parent reviewers took place in 1999. Changes were made to the measures; additional discussion with Federal reviewers will be necessary before final adoption.

3.4.3 Outcome Measures

Please refer to Form 12. New York last year added an additional outcome measure: maternal mortality.

IV. THE ANNUAL PLAN FOR FFY 2001

New York's FFY 2001 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. Program activities planned for FFY 2001 will be described 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.

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 and Child 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.

4.1 Program Activities Related to Performance Measures

Please refer to Figure 5, which summarizes this section by placing New York's MCHSBG-funded services on the MCH pyramid by levels of service. Figure 6 portrays needs and programs relative to performance and outcome measures.

A. Direct Medical Care

1. Pregnant Women, Mothers and Infants

The **Genetics Services Program** has as its goal to ensure that individuals affected with, at-risk for transmission or concerned about a genetic disorder are able to access comprehensive genetics services including diagnostic, counseling and preventive services. The contracted providers operate prenatal and clinical (non-prenatal) genetic clinics. Through these clinics, clients may access clinical evaluations, pedigree analysis, laboratory testing, diagnosis (where possible), discussion of the array of treatment options for the patient and the family, and coordination of treatment protocols with primary and specialty medical practitioners. The Genetics Services Component also has population-based and infrastructure building aspects, which will be discussed later in the plan. The goal for the program is to continue to achieve 100% follow-up rates on all newborns screened who have abnormal results.

The **American Indian Health Program** provides direct services to enrolled members of New York's Native Americans of the Iroquois Confederacy (Onondaga, Cayuga, Seneca, Oneida, St. Regis Mohawk, Tonawanda and Tuscarora Nations), as well as the Shinnecock and Unkechaug (Poospatuck) Nations, based on a treaty that pre-dates the formation of the United States government. Following a family

practice model, the program serves pregnant women and infants on their national territory, with primary, preventive, dental and prenatal services; prescription drugs; durable medical equipment; laboratory services; and off-site referrals and arrangements with specialty clinics. The program will continue to serve children and adolescents, including those with special health care needs. The American Indian Health Program also has enabling, population-based and infrastructure-building aspects, which will be discussed later in the plan. The program will strive to meet a goal of 100% immunization and lead screening of all children served.

New York is a universal lead screening state. The **Lead Poisoning Prevention and Control Program** will continue moving away from a direct service model, encouraging families to seek lead screens from their routine provider at their "medical home." However, lead screening, follow-up testing, and nutritional and developmental assessments are preformed by all local programs. These activities will continue to focus on high risk populations, generally because they are uninsured or underinsured and underserved by the medical establishment. Efforts are made by the program to find each child who does not have one a "medical home." The program also serves children, primarily in the younger age groups, and considers lead-poisoned children to have a special health care need, at least for the time they are served by the program. Use of interim housing is available, operated by several of the larger/regional programs.

The **Migrant Health Program's** goal is to ensure the accessibility and availability of quality, culturally-appropriate medical and dental care and social support services for migrant and seasonal farmworkers and their families. Coordinated programs offer comprehensive primary and preventive health care services specifically targeted to children up to the age of 18 years. There are also enabling, population-based and infrastructure aspects to the program which will be described under those respective sections. MCHSBG funds will be used to provide health care services to children enrolled in Migrant Head Start and the Migrant Education Program and to ensure appropriate treatment, referral and follow-up.

Through the Medical and Health Resource Association, NYSDOH will continue to fund the **Pediatric Resource Centers (PRCs)** and the **Maternal Infant Care-Womens Health Services Project (MIC-WHS)**.

The **Pediatric Resource Centers** provide special service to children who are identified as at high-risk for adverse health outcomes. The children who are the first priority for PRC services are those that are children of parents with a past history of, or conditions predisposing, to child abuse; children who are failing to thrive or who have significant nutritional problems; children under age 4 who were born less than 2,000 grams; sheltered or dislocated children; children of adolescent parent(s); siblings of any of the above; or adolescents who are parents. Priority II children are those who are over age 4 but had birthweights between 2,000 and 2,500 grams; children with lead levels elevated over 10 mcg/dl; children with other significant medical diagnoses or problems requiring frequent, comprehensive health care; and siblings of any of the above. These Centers provide comprehensive multidisciplinary pediatric services and care coordination. As a traditional public health provider, the Centers are finding that their caseload

is being integrated into managed care. As a result, the PRCs are seeing a greater percentage of underinsured and uninsured children. The PRCs and MIC will continue activities begun in the last fiscal year to enroll more of their clients in Medicaid and Child Health Plus. The PRCs are being evaluated by Division of Family and Local Health in this program year for continued need and utilization.

The **MIC-Womens Health Services** project has as its major objectives to prevent high-risk pregnancies, to promote healthy pregnancies, to reduce low birth weight and infant mortality, to promote healthy infancy and to reduce the adolescent pregnancy rate through comprehensive prenatal and family planning services to high-risk, low income women in high risk, medically underserved areas of the Bronx, Brooklyn, Queens and Manhattan. The project also has enabling aspects, in that they offer WIC and MA certification, health education, HIV and substance abuse counseling, outreach, follow-up services and breastfeeding support. This year, the project will continue its efforts to contract with additional managed care organizations and to enroll more of the infants born to MIC-WHS clients into Medicaid and Child Health Plus.

The **Early Intervention (EI) Program** is funded by State and other Federal appropriations, but 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 handicapping conditions. The childfind mechanism under EI, called the Infant/Child Health Assessment Program (I-CHAP), locates and periodically home visits at-risk infants and their families to assess health and developmental issues and to link families with appropriate services. This is at once a direct service and an enabling service. EI and I/CHAP are a major source of MCH referrals. In FFY 2001, the Early Intervention Program will work more closely with the Children with Special Health Care Needs Program on cross-program issues, such as sharing of data, parent involvement and transition services.

The **Prenatal Care and Assistance Program (PCAP)/Medicaid Obstetrical Maternity Services** was established in 1985 as a grant program to improve birth outcomes among women whose incomes are below 185% of poverty. The PCAP and MOMS programs have since been incorporated into Medicaid and managed care. Designated PCAP providers agree to comply with comprehensive standards established by the Department in return for an enhanced Medicaid rate. Under the program, low income women receive outreach, obstetrical care from a physician or certified nurse midwife, care coordination, nutrition services, health education, home visits, transportation, specialty medical care (when needed), and inpatient services. As a major purchaser of prenatal, perinatal and post-partum services, PCAP/MOMS has a major influence over the quality of prenatal care for low income women. Title V will continue to collaborate in standards and policy development and in the evaluation of the program. Title V staff remain involved in monitoring the performance of managed care and other providers in the provision of prenatal and postpartum care.

The **Family Planning Program** seeks to reduce unintended pregnancy by assisting women and families with the information and means to exercise personal choice in determining the number, timing and

spacing of their children. The program especially targets low-income, uninsured women, adolescents and men for access to services that help them avoid unintended pregnancies, sexually transmitted diseases and HIV/AIDS. Title V and Title X funds are used to conduct community education and public information services and to provide comprehensive medical histories, physical exams and laboratory testing; contraceptive and natural family planning services; pregnancy testing and counseling; Level I infertility services; breast and cervical cancer screening; special counseling to help clients avoid unintended pregnancy; HIV counseling and testing; Sexually Transmitted Disease counseling, testing and treatment; and pharmaceutical and laboratory services. The program will continue to serve women statewide, with sites in each county.

Chlamydia is the most common sexually transmitted bacterial pathogen, but currently it is neither routinely tested for, treated nor reported. Through a special collaboration between the Bureau of Disease Control and Women's Health, clients in Family Planning Program clinics will continue to test high-risk women for chlamydia at all initial and annual visits. A special preferred provider laboratory arrangement enables the projects to obtain quality testing at a low cost. The program serves adolescents, pregnant women and women of childbearing age.

Infant Mortality Review and **Sudden Infant Death Syndrome Program** plan to continue community-based initiatives to improve maternal and child health outcomes through information learned in infant death reviews and through home visiting. One key component to the programs is to maximize available personal and health and human service system support on behalf of the grieving family, enabling them to process the grief experience in a positive way and to ameliorate any correctable conditions that may have contributed to the poor outcome. Ongoing case management is offered to each family. Referrals will be made to long-term counseling, when necessary. During this fiscal year, the programs, along with the Community Health Worker Program, will continue their efforts to link with a larger child death review system in place at the Office of Children and Families and to coordinate **home visiting efforts** on a wider scale. The programs also provides infrastructure for data collection and analysis relative to infant death.

Because of the number of affected individuals in New York, there is a need to ensure statewide access to HIV-related services for pregnant women, mothers, infants and children. The **AIDS Institute's HIV Maternal and Pediatric Initiative** develops HIV-specific services in areas where there have been none. The program focuses on early identification of HIV positive individuals, counseling, testing and appropriate care. The program is funded through state dollars. Title V programs will continue to collaborate.

2. Children and Adolescents

The **School Health Program** will continue to offer comprehensive, primary and preventive medical and mental health services in school setting for children and youth enrolled by parental consent. Services consist of a comprehensive history and assessment for both medical and emotional health, developmental screening, diagnosis, treatment and management of chronic conditions and, when appropriate, referral with active follow-up. Providers engage families, whenever possible, to effectively address wellness and identified medical and mental health concerns. To reduce duplication and ensure continuity of care, school-based health center staff coordinate care with the child's primary care provider of record. This year, 168 sites are operating and are expected to continue throughout FFY 2001. A major thrust for this program year is to settle issues related to financial and clinical integration with managed care organizations. The present fee-for-service carve out is being continued. The number of sites is expected to increase based on present requests for authorization to start-up.

Oral health services are an essential component of primary health care. Poor oral health affects the ability to speak, to eat and to be free from pain and infection. The Bureau of Dental Health will continue to administer several programs that serve children at high risk for oral problems. During FFY 2001, the Bureau of Dental Health will be working with local partnerships to expand the community focus on oral health, to improve access to preventive and therapeutic dental services, and to enhance the infrastructure for dental public health.

The **Emergency Medical Services for Children (EMSC) Program** aims to reduce child and youth morbidity and mortality due to severe illness and trauma through institutionalizing emergency medical services for children in the state's EMS organizational structure. Title V staff participate in an EMSC committee to implement recommendations for the continuum of emergency care for children. The program reinforces prehospital pediatric skills through education, works with EMS providers to develop injury prevention activities, and engages collaboratively with various MCHSBG programs and community and statewide organizations to improve the emergency care of children.

See the descriptions under **A. 1. Pregnant Women, Mothers and Infants** for the Genetics Program, the American Indian Health Program, Migrant Health, the Pediatric Resource Centers, the Lead Poisoning Prevention and Control Program, Family Planning and the chlamydia initiative. These programs all have components that target children and/or adolescents.

3. Children with Special Health Care Needs (CSHCN)

Please refer to sections **A. 1. Pregnant Women, Mothers, Infants and Children** and **2. Children** for program descriptions that also target or serve Children with Special Health Care Needs. Although more complete program descriptions appear above, this section will describe the involvement of the programs with CSHCN.

Genetics Services often come into play after the birth of a genetically-affected child. The program will continue to assist in arriving at a diagnosis of the genetic illness, and by linking the family to appropriate services and support groups.

American Indian Health Program, because it operates on a family practice model, often treats, as a direct service, and/or enables a referral for children with special health care needs. AIHP enrollees have access to a wide variety of care options and services, including durable medical equipment and home care.

The various MCHSBG-funded **dental programs** see, evaluate, treat and/or refer roughly 27,500 children with special health care needs a year. Often, these children are victims of baby bottle mouth syndrome, a condition the programs seek to eliminate through population-based education or children with disfiguring, disabling dental conditions.

Children with handicapping oral conditions are covered by the **Physically Handicapped Children's Program Orthodontia Program**, but often also need enabling services in order to access Medicaid or other insurance programs, to locate a physician and to complete the appropriate follow-up. These services will be offered on a county level, with assistance from the Bureaus of Dental and Child and Adolescent Health. During FFY 2001, the new data system will be fully implemented and give information on the types of services needed by families of children with special health care needs who come to the local health department for assistance. The data system will also enable tracking of sources of payment for various services.

The **Lead Poisoning Prevention and Control Program** at the local level is often involved in providing and locating care and assistance for lead-poisoned children. Often the Lead Program staff, sometimes in conjunction with the local Infant/Child Health Assessment Program staff, must locate willing providers, coordinate referrals to regional lead treatment centers, arrange transportation, or perform other enabling services, as well. They may also need to locate safe, lead-free housing while the child is in treatment and thereafter. It is planned that these activities will continue.

Children of migrant and seasonal farmworkers who have special health care needs face very special challenges. The **Migrant Health Program** will continue to provide initial evaluation, then enable specialty level care through a variety of supportive mechanisms. The family can find that their migratory status disrupts the plan of care and creates secondary or unnecessary disability. For this reason, enabling services are critical in working with this population. Migrant Health Program providers may be the first to recognize a child's special needs through their in-camp casefinding activities and day-care based services. Sometimes the presence in the family of a child with special needs will require that the family drop out of the migrant stream, as frequent travel becomes impossible.

The **Pediatric Resource Centers (PRCs)** were essentially set up to find and serve children with special needs. Their admission requirements allow them to serve only those at-risk and those with

special needs. The comprehensive, multi-disciplinary PRCs will continue to model best practice in the care of children with special health care needs. Again, the PRCs are undergoing evaluation by the Division of Family and Local Health staff to determine the current need for these services and the possibility of diversifying their funding.

Because most children with handicapping conditions are able to be mainstreamed, the **School Health Program** providers will continue to provide services to children with special health care needs. The staff at the school-based health center can be instrumental in preventing acute exacerbations and serious sequelae of chronic conditions. In addition, they often perform medical evaluations as a part of the assessment for special education. In some cases, amelioration of the medical condition or assisting a family to sustain contact with the medical system may obviate the need for special education. The program is giving greater emphasis in FFY 2001 to mental health issues, from screening and diagnosis to long-term follow-through for children with mental conditions.

The **Early Intervention Program**, especially the Infant/Child Health Assessment Program, based on their childfind activities, is often the program that provides children with special health care needs with their first entree into the special needs health care system. The Early Intervention Program and I/CHAP will continue to provide initial screens of at-risk children. The bulk of their work with the population, however, is in the area of enabling services. Care coordinators ensure that care is coordinated and that families have knowledge of and full access to services for which they are eligible.

B. Enabling Services

Many of the enabling services have already been described in previous sections. Please refer to program descriptions for the Genetics Program, American Indian Health Program, Infant Mortality Review, Migrant Health, the Pediatric Resource Centers, the Lead Poisoning Prevention Program, and the School Health Program. Additional enabling features will be highlighted here.

One enabling program that reaches across all MCH population groups is the **Community Health Worker Program**. Although funded with state and local assistance funds and Federal Medicaid Fiscal Participation, the program has strong linkages to the Title V programs. Community Health Workers are individuals who are recruited from the community in which they will work. They are then educated in casefinding, communication, health promotion and community resources and offer culturally-sensitive, language-appropriate, "low or no tech" assistance to families in accessing and sustaining contact with health care providers in the community. Community Health Workers are supported and supervised by experienced public health nurses or public health social workers, and are engaged in a multidisciplinary team approach for their clients. These programs have as a goal improved linkages to managed care providers that serve their clients.

1. Pregnant Women, Mothers and Infants

The **Genetics Program** provides linkage and referrals to specialty and family support services to pregnant women, mothers and children in whom a genetic condition is suspected or identified.

The **American Indian Health Program** provides health promotion activities, community health worker services, referral and linkage to ancillary, specialty and support services for pregnant women, mothers and infants. Whenever possible, eligible pregnant women are enrolled in **PCAP**.

With the transition to managed care, more and more Medicaid-eligible women will be enrolled in managed care plans. **PCAP/MOMS** will continue efforts to decrease the rate of late or no entry into prenatal care by assisting plans with the development of "in-reach" methods and development of internal monitoring programs.

Migrant Health Program providers provide bi-lingual services and are available for translation and transportation services to off-site locations, assistance with accessing food stamps and emergency food supplies, facilitation of WIC enrollment, and linkage with appropriate providers up- and downstream of their New York residence. Most pregnant migrant workers and family members are able to be enrolled in PCAP.

Health care workers are required by law to screen all pregnant women to determine their Hepatitis B surface antigen status and report positive mothers to the local health department. The **Perinatal Hepatitis B Prevention Program** will continue to track and assist mothers who are surface antigen positive for Hepatitis B to remember vaccination schedules, locate a source for the needed vaccine for their infant, and learn about the ramifications of the disease. The program will also continue to screen and vaccinate susceptible sexual and household contacts of the positive mother.

2. Children and Adolescents

The **Lead Poisoning Prevention Program** also provides some enabling services: environmental risk assessment, health education home visits, case management services, and referral with active follow-up to specialty lead services. The Lead Program can also assist children who do not have one to find a "medical home."

The **School Health Program** will continue to be instrumental in locating supportive services (such as Medicaid, Child Health Plus, Food Stamps and WIC) for families of enrolled children. School-based health centers address wellness and mental health care, as well, through education, referrals and coordination with other services and providers. All referrals made receive active follow-up to ensure that vulnerable children and families are able to access needed services.

The **American Indian Health Program** will continue to provide enabling services to children and adolescents through the **Community Health Worker** component and through health promotion activities.

As previously described, the **Migrant Health Program** serves children and adolescents through the migrant education and Head Start programs. A priority for enabling services will be to continue to support the educational process, to provide health education services and to assure sustained contact with the health care system in their host community and in up- and downstream locations.

Early Intervention will continue to enable children and families to obtain needed services to ameliorate physical and developmental delays and to prevent secondary disability, through referral, case management, parent and community education, and local contact numbers advertised in the community. State Aid is given to **Local Health Departments** for providing family health services including dental health education, perinatal care, child health services, family planning, nutrition services, injury control, tobacco use prevention, health education and communicable disease control. Local health departments are most often the “experts” in their communities on the location, operation and quality of local services. As such, they are often called upon by the community to provide health information, referral, and other enabling services. Many local health departments contract with DOH to provide Title V-funded MCH services in addition to the services covered under State Aid.

3. Children with Special Health Care Needs

The **Physically Handicapped Children’s Program** portion of the **Children with Special Health Care Needs Program** provides financial assistance to families who are ineligible for Medicaid. Financial and clinical eligibility are determined on a county level. Local programs outreach for the program, respond to inquiries from the public, determine eligibility, enroll eligible children, and assist parents to locate resources, particularly specialty level care. A number of the local programs continue to provide case management services. Local case managers coordinate the child’s care and support families with education, linkage to support groups, advocacy and referral. Again, the new data system is expected to be fully implemented in FFY 2001, and will provide the program with information on the types of services needed by families of children with special health care needs who come to the local health department for assistance. The program will be able to quantify the numbers of families who have need of transportation, respite and other services. The data system will also enable tracking of sources of payment for various services.

Please refer to previous descriptions for the **American Indian Health Program**, the **Community Health Worker Program**, the **Migrant Health Program**, and **Early Intervention**.

C. Population-based Services

1. Pregnant Women, Mothers and Infants

Under mandate of New York State Public Health Law §2500(a), all newborns must be screened for the following disorders: 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 which, if untreated, lead to mental retardation or other disability.

Several **immunization activities** will continue to target women who have given birth and their infants. Immunization information is included with every birth certificate that is mailed out and is included in the text of "Welcome to Parenthood", a NYSDOH publication given out by hospitals to each new family. The **Perinatal Hepatitis B Program** assures that each infant born to a Hepatitis B surface antigen positive mother is identified, vaccinated and tracked. The program purchases and distributes Hepatitis B vaccine for babies at high risk because they were born to mothers who are Hepatitis B surface antigen positive. The infants are identified at or before birth, then entered into the Infant/Child Health Assessment Program tracking system. Initial vaccines are given while the infant is still hospitalized. Later, public health nurses follow-up on each child to assure the series of vaccinations are appropriately completed. Services are without charge.

2. Children

The **Injury Prevention Program** provides injury surveillance, develops statewide strategies to address injury, provides technical assistance to local agencies on identifying local injury problems, and assists with coalition building, program design and evaluation of implemented strategies. The program also provides coordination of various local, state, private and academic agencies and institutions in order to address injury from a multidisciplinary perspective. The program will implement community-based educational programs focusing on childhood injuries from motor vehicle crashes, bicycle and in-line skating related injuries and pedestrian safety. In addition, the Injury Prevention program increased its involvement in suicide prevention activities in this fiscal year, and will in FFY 2001 lead several partnering State agencies in the re-formulation of a statewide suicide prevention plan.

The **Immunization Program**, through the **Vaccines For Children Program**, will continue to provide vaccines to public clinics, health care facilities and private physicians' offices serving uninsured, Native American, and under-insured children. The **Immunization Program** has also initiated a focus on universal immunization against Hepatitis B. The Immunization Program will continue to encourage local health departments to move away from direct provision of immunization services and toward an

assurance role in the community. In FFY 2001, local health department staff will continue to review the immunization records of private physicians in their community and help build the infrastructure for better immunization in their communities. Work on a functional statewide vaccine registry will continue in FFY 2001.

The **Dental Fluoride Program** will continue to target communities where the water supply is fluoride deficient to provide fluoride supplements in an effort to assure that fluoride is available to every child in New York State. The oral health programs all have a population-wide educational focus, as well.

Under the **Childhood Lead Prevention Program**, local health units and hospital-based regional lead poisoning prevention resource centers provide the public with primary preventive health education. Lead screening is population-based; New York is a universal screening state.

The **Division of Nutrition** in recent years launched a new initiative called, "Eat Well, Play Hard." This is a comprehensive public health intervention to prevent childhood obesity and long-term chronic disease through promotion of targeted dietary practices and increased physical activity. Specifically, the core themes are: consume more low fat dairy products, eat more fruits and vegetables, increase physical activity, and begin prevention at age 2. The program builds on existing food and nutrition programs, such as WIC, Hunger Prevention, and the Child and Adult Care Food Program. In FFY 2001, the EWPH will target 400,000 children participating in these programs.

The **Community-Based Adolescent Pregnancy Prevention Program (C-BAPPP)** conducts community needs assessments related to adolescent pregnancy prevention, coordinates services with other community-based organizations, and focuses community messages on teen pregnancy prevention. C-BAPPPs are expected to engage other community-based organizations to identify available resources and address gaps in preventive programming. Projects will continue in the highest risk zip codes in the state. In the last grant year, C-BAPPP targeted the 27 highest zip codes. In FFY 2000, 50 zip codes were targeted. FFY 2001 will continue targeting these 50, and increase the number of zip codes, if funding allows.

Several programs target adolescents community-wide for education. The **Chlamydia** Program provides population-based health education and information, focusing on all high risk populations, but particularly adolescents. **Family Planning Programs** provide community education and public health information on services, avoidance of unplanned or poorly timed pregnancies and avoidance of STDs and HIV. The **School Health Program** works with entire school populations to improve health care access and information.

The **Migrant Health Program** also targets migrants, population-wide, with the dissemination of health care information. Migrant Health Providers work with the migrant day care centers, education programs

and Head Starts to assure access for the whole migrant family and to empower the population with health information so that they may make informed choices. Contractors also provide in-camp educational sessions at appropriate (evening) hours in appropriate languages.

3. Children with Special Health Care Needs

The **Early Intervention Program**, the **Children with Special Health Care Needs Program**, the **Genetics Services Program**, and the **Newborn Screening Program**, all of which were previously described, all have population-based components that target all children in the population with special health care needs for education and services. The "Welcome to Parenthood" book, received by each mother at the time of delivery, contains information on children with special health care needs.

D. Infrastructure-Building Services

Many State and Federal resources are directed at building and maintaining the public health infrastructure. NYSDOH will seek to maintain and improve the ability of local agencies to perform appropriate needs assessments, evaluate public health issues and interventions, formulate local policy and standards, coordinate existing resources, assure quality, and adequate levels of appropriately educated public health personnel. For this reason, the Department will continue to serve its present role in needs assessment, policy development, quality monitoring, applied research, evaluation, standards development, education, training and technical assistance.

The Department is continuing major infrastructure-building efforts to operationalize the key concepts and processes of Communities Working Together. These efforts call for data improvement strategies, skill-building around working together effectively in teams, community engagement and planning. Local health agencies will work with community stakeholders in order to examine the local needs and engage community partners in reducing adverse health outcomes. The **Turning Point Initiative** is fully engaged in building local health department capacity in these areas. A special social marketing initiative is expected in FFY 2001. Also, NYSDOH will be implementing a clearinghouse for information about successful strategies to address community health problems, improving data access and continuing with skill-building activities aimed at local agencies. The Department continues to develop the capacity of the **HIN (Health Information Network)** in order to facilitate convenient transfer of data to local units.

1. Pregnant Women, Mothers and Infants

The purpose of **Infant Mortality Review** is to strengthen the infrastructure of prenatal and perinatal care in order to reduce adverse outcomes for mothers and infants. Through community-based interdisciplinary review of every infant death occurring in the eleven designated counties, specific local public health, human service and social interventions are identified and policies to address preventable

factors in infant death are formulated. Community review teams are composed of representatives of medicine, nursing, public health, social service, local government, public advocacy, and other professional and community organizations. Local projects make recommendations regarding State policy to improve maternal and child health outcomes as a result of the community-level review. In FFY 2001, this process will be expanded to include Child Mortality Review.

The **Sudden Infant Death Program** will provide the infrastructure and data to evaluate the occurrence of sudden, unexplained infant death in New York State for the purpose of evaluation of family services, planning, policy development, coordination and quality assurance. The program will continue to collaborate with the Infant Mortality Review counties and their community review teams in policy development and public health education.

The **New York State Institute for Human Lactation** increases knowledge statewide about human lactation and breastfeeding management among physicians and other health professionals. The Institute also works to improve physician practices related to breastfeeding support and management, promote adoption of the New York State Best Practices for Breastfeeding in hospitals statewide, and to increase the rate and duration of breastfeeding statewide. Jointly sponsored by the SUNY School of Public Health and the Department, the Institute will again in FFY 2001 conduct a statewide professional education offering via video conference that features nationally known speakers. Continuing Medical Education (CME) credit is offered.

2. Children

The **Lead Poisoning Prevention Program** develops local infrastructure by providing funding for the development of comprehensive policy manuals, for improving use of local data in program planning, for monitoring provider compliance with screening regulations, and for basic training and continuing education of local health unit staff. The Lead Program's data system, LEADTRAC, provides the Department with information on a statewide and county basis.

The **School Health Program** will continue to have primary responsibility for the administration and oversight of the provision of primary and preventive health care services in school settings. In conjunction with the Office of Medicaid Management and the Comprehensive Health and Pupil Services Program at the State Education Department, the School Health Program reviews and approves applications to establish school-based health centers throughout the state. The program develops policies and guidelines which govern quality of care, fiscal management and community relations. A system for monitoring and providing technical assistance has been developed to ensure consistency and quality of service, determine the need for provider education, and to assess capacity. The priority for the early part of FFY 2001 is to improve the delivery of school-based mental health and dental services.

The **Preventive Dental Programs** contribute to the public health infrastructure for improving oral health. The **Dental Sealant Program** has contributed to nationwide policy development through a collaborative workshops. The program provides statewide data that is used to evaluate the effectiveness of the program. Following the issuance of a new request for proposals in 2000, the Dental Program will be concentrating on involving local coalitions on improving oral health in their communities and re-focusing direct services toward **oral health infrastructure development**.

The **Public Health Dental Residency** provides training and experience in public health practice to qualified dentists. Residents in FFY 2001 will assist the Bureau in conducting statewide needs assessment and program evaluation. Research efforts include evaluation of sealant programs, migrant dental health efforts and the risks and benefits of fluoride.

The **Community-Based Adolescent Pregnancy Prevention Programs** conduct community needs assessment and profile community areas relative to adolescent pregnancy prevention resources. Like CBAPP, the **Family Planning Programs** are also expected to assess community need, plan services to fill gaps in access to family planning services, assure quality of their services and evaluate the effectiveness of their interventions. A goal for the coming grant year is to improve consumer knowledge of the family planning carve out and to fully implement the two year post-pregnancy eligibility provisions under Medicaid.

The **Tobacco Control Program** will continue to meet the requirements of the Federal Synar amendment by enhancing enforcement of the Adolescent Tobacco Use Prevention Act (ATUPA). Local health departments will continue to be supported to conduct compliance checks and other enforcement. Funds will be used to conduct the annual survey of ATUPA compliance and to purchase television time to promote public awareness of ATUPA. In FFY 2001, following a kick-off in 2000, there will be more emphasis on youth involvement in community efforts to keep kids away from tobacco. Commissioner Novello has been personally involved in these efforts.

3. Children with Special Health Care Needs (CSHCN)

The focus of New York's **Children with Special Health Care Needs (CSHCN) Program** will be to improve the health of CSHCN and their families by improving the public health infrastructure relating to this population and to improve parent involvement in policy making at the State and local level. Infrastructure development involves the transition of the existing "insurance model" program to the development of one with a broader public health perspective. Emphasis in FFY 2001 will be in ensuring that the new data system is workable and providing the types of data needed for effective policy decisions.

Program Activities Related to Specific Performance and Outcome Measures

Performance Measure 01 -	
The Percent of State SSI Beneficiaries Less than 16 Years Old Receiving Rehabilitative Services from the State Children with Special Health Care Needs Program	
Program Plans:	
C	The Medicaid Program covers all SSI enrollees in New York State and continues to be more generous than the Children with Special Health Care Needs package.

Performance Measure 02 -	
The degree to which the State Children with Special Health Care Needs Program Provides or Pays for Specialty Services, including Care Coordination, Not Otherwise Accessible or Affordable to its Clients	
Program Plans:	
C	The Department has convened a CSHCN Data Systems Development Team to revise the current data system so that the data reporting will become more consistent and data analysis will allow NYS to address this measure. The team consists of state, regional and county representatives. In FFY 2001, we will enable development of a system that better meets the needs of children and families.

Performance Measure 03 -	
The Percent of Children with Special Health Care Needs Who Have a "Medical/Health Care Home"	
Program Plans:	
C	The Early Intervention Program , the "Growing Up Healthy" Hotline , the American Indian Health Program , the Migrant Health Program , the Pediatric Resource Centers , the School Health Program and the LEND Projects all work with families to establish and maintain a medical home. The Preventive Dentistry Program also works with families to try to obtain a dental medical home. These programs will continue in FFY 2001 to work toward assuring every child in New York State has a medical dental home.
C	Healthy Child Care New York is seeking to increase the number of all children, including CHSCN who have insurance and a medical home. The Program is exploring addition of items to the required state form for day care admission that would indicate insurance status and medical home. This information will then be used to give information to the families on new programs.

Performance Measure 04 -	
The Percent of Newborns with at least One Screening for Inborn Metabolic Errors	
Program Plans:	
C	The Newborn Screening Program will endeavor to maintain their 100% rate of testing and follow-up rates for all infants born in New York State.
C	100% of newborns in New York State will be tested for 8 congenital conditions: PKU, MSUD, galactosemia, biotididase, homocystinurea, hypothyroid, hemoglobinopathies, and
C	HIV. The Comprehensive Prenatal/Perinatal Networks will address genetic counseling by promoting the genetic screening of newborns through newsletters and provider meetings.

Performance Measure 05 -	
The Percent of Children through age 2 Who Have Completed Immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilis influenza B, and Hepatitis B.	
Program Plans:	
C	The Immunization Program is striving for a 90% immunization rate. They plan to expand registries, continue to supply publicly-funded vaccine, increase education and technical assistance, continue to assess immunization levels, and support local health departments through contracts for the provision of immunization-related services. They will also assist them with disease surveillance and outbreak control activities. The Provider Based Initiative will continue to send local staff into private physicians offices to check immunization records and help them improve their immunization rates.
C	The School Health Program provides immunization services in school-based health centers.
C	The Comprehensive Prenatal/Perinatal Services Networks will continue to work to improve awareness on this issue.
C	The Community Health Worker Program will increase education to parents on immunization, assess immunization status of all children in the program, provide referral and assistance to obtain immunizations, and will follow-up to determine if the immunizations were received.
C	PCAP and MOMS provide immunization reminders.
C	"Growing Up Healthy" hotline will continue to direct consumers to immunization services.
C	The American Indian Health and Migrant Health Programs will provide immunization services to their populations.
C	The Perinatal Hepatitis B Program will continue to receive laboratory reports and follow-up on all infants born to Hepatitis B surface antigen-positive mothers.

National Performance Measure 06 -

The Rate of Births (Per 1,000) for Teenagers Aged 15-17.

Program Plans:

- C The **Community-Based Adolescent Pregnancy Prevention Program's** goal is to reduce teen pregnancies in the highest risk zip codes (now 50 statewide) across New York State. C-BAPPP will promote 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.
- C In every county in New York State, **Family Planning Programs** will provide community education and public information, comprehensive medical exams and access to a full range of contraceptive methods, STD counseling and testing, and special counseling for teens.
- C The **Community Health Worker Program** will provide family planning information to all women of childbearing age, refer to family planning services and follow-up to see that services are received.
- C The **School Health Program** will provide risk assessment for sexual activity as part of the initial assessment. Anticipatory guidance, pregnancy testing (where indicated) and referral to family planning or prenatal care services will be offered.
- C The **Comprehensive Prenatal/Perinatal Services Networks** will promote reduction of adolescent pregnancy rates through provider and community conferences, outreach and education efforts.
- C NYSDOH Bureau of Women's Health awarded funding to 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 will initially focused on junior high/middle school aged students. The "Not Me, Not Now" campaign will continue as a statewide, large scale media campaign to support the community-based initiatives.
- C **Article 6** will reimburse 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.
- C The **Rape Crisis Program** will develop and implement policies designed to provide effective and compassionate care to victims of sexual assault and supported professional and community-based prevention education programs.

**Performance Measure 07 -
Percent of Third Grade Students Who Have Received Protective Sealants on at Least One Permanent Molar Tooth**

Program Plans:

- C A new **Request for Proposals** was issued in 2000. The Bureau of Dental Health will work with new grantees to support local coalitions/collaboratives on oral health. New grantees will be expected to work with their communities to improve access to dental services, expand availability of dental sealants, enhance community awareness of dental public health needs.
- C In FFY 2001, the Bureau of Dental Health will continue to provide dental needs assessment, health education materials and support, expanded dental residency programs, and the infrastructure for widespread collaboration on dental public health issues across the State.
- C The Bureau of Dental Health will continue an innovative program at Bellevue Hospital in New York City for deaf children and adolescents.

**Performance Measure 08 -
The Rate of Deaths to Children Aged 10 to 14 Caused by Motor Vehicle Crashes per 100,000 Children**

Program Plans:

- C The **Bureau of Injury Control** will continue to work with local health departments, coalitions and state and local agencies to improve traffic safety across New York State. BIC will implement a traffic safety program focusing on the distribution and promotion of child safety seats; bicycle, in-line skating, pedestrian, and motor vehicle passenger safety; and on-going surveillance. All school-based health centers will provide psychosocial and health risk assessment beginning with the initial visit. Student and family education about safety issues and abuse will be included. Bureau of Injury Control also works with enforcement agencies who implement sobriety check points and other disincentives to unsafe, driving-related behavior.
- C The **Community Health Worker, PCAP and MOMS** programs will all continue to include car seat education.
- C The **American Indian Health Program** sponsors formalized car seat education.

Performance Measure 09 -

The Percent of Mothers who Breastfeed their Infants at Hospital Discharge

Program Plans :

- C The Bureau of Women’s Health will continue to support breastfeeding through provider and community education, surveillance of breastfeeding rates and practices, and promotion of best practices in hospitals, workplaces, and managed care settings. Through the **New York State Institute for Human Lactation**, the Bureau and the School of Public Health broadcast an annual **Breastfeeding Grand Rounds** videoconference, providing physicians and nurses with continuing education on clinical and public health issues related to breastfeeding.
- C 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).
- C The Bureau also conducts periodic **hospital surveys** to monitor breastfeeding rates, and is currently implementing a Statewide Perinatal Data System which 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.
- C **WIC** will continue to support breastfeeding in the WIC population.
- C The **PCAP/MOMS**, the **Comprehensive Prenatal/Perinatal Services Networks** and the **Community Health Worker Program** will continue to provide education to all pregnant clients about the benefits on breastfeeding. The Community Health Worker Program will collect data at birth and six weeks postpartum.

Performance Measure 10 -

The Percentage of Newborns Who Have Been Screened for Hearing Impairment before Hospital Discharge

Program Plans:

- C In FFY 2001, New York State will be implementing a new **Universal Newborn Hearing Screening Program** based on the success of our pilot program and new public health law mandating screening. As a part of this implementation, the DOH has convened an expert panel on newborn hearing to assist with implementation guidelines for statewide expansion. Staff will be working with all birthing hospitals in the state.

Performance Measure 11 -

The Percent of Children with Special Health Care Needs in the New York State CSHCN Program with a Source of Insurance for Primary and Specialty Care

Program Plans:

- C Theoretically, 100% of children in the State are eligible for specialty care under the **Physically Handicapped Children's Program**, and/or under expansions of **Child Health Plus** or **Medicaid**. New York should be approaching universal coverage for all children under these expansions. However, the Current Population Survey currently has our uninsured rate at 13.8%, indicating that greater efforts must be made to improve enrollment. Facilitated enrollment will be fully operative in FFY 2001. In addition, all Title V and Title V-related programs are instructed to inquire about coverage and to help uninsured families to access Medicaid and Child Health Plus. The statewide Media Campaign and the various population-based outreach strategies will continue.

Performance Measure 12 -

The Percent Children without Health Insurance

Program Plans:

- C The high rate of uninsured children is particularly disturbing in light of the expansions of Medicaid and Child Health Plus. Lack of progress is thought to be due to the increasing number of service sector jobs where no fringe benefits are available and on a misunderstanding between eligibility for cash assistance and Medicaid.
- C The **Medicaid Program** covers all SSI enrollees in New York State.
- C The **joint MA-Child Health Plus-WIC application** was approved for statewide use this year and 32 contractors were approved for facilitated enrollment. **Facilitated enrollers** will provide families with necessary information about eligibility and enrollment in Child Health Plus, or to the local social services district if the child is MA eligible. In the case of Medicaid, the enrollers will be authorized to conduct the Medicaid interview and to provide information to families on managed care options under both programs. Enrollers reflect the cultural and language diversity of the areas they will serve and will be open evenings and weekends to make enrollment easier for working families. A toll-free hotline will provide families with assistance and information about the program.
- C Children of women enrolled in Medicaid while pregnant are **automatically eligible** for Medicaid for the first year of life.
- C The **Statewide Perinatal Data System** will be more fully operational and will automatically enroll newborns.
- C **All Title V programs** care for children without regard for third party insurance. No consumer is asked to pay for services if they cannot afford it.

Performance Measure 13 -

The Percent Potentially Eligible Children Who Have Received a Service Paid by the Medicaid Program

Program Plans:

- C The **Medicaid Program** covers all SSI enrollees in New York State.
- C **All Title V Programs** reinforce the need for appropriate primary, preventive and treatment services. Please see program descriptions of enabling services.

Performance Measure 14 -

The Degree of Family Participation in the Children with Special Health Care Needs Program

Program Plans:

- C Improving family participation in the CSHCN Program is a program priority for FFY 2001.
- C New York attains this ranking by asking parents to rank statewide effort; no agency staff participate in the scoring. In canvassing parents for their feelings about the system of care for CSHCN, DOH is able to obtain very important input from parents on the shortfalls of present efforts. The CSHCN program transition will make use of this information in planning program changes. An important part of the transition involves enhancing parent involvement in the program on the state and local levels. All Title V staff will be given summaries of parent and consumer input for program improvement activities.
- C The **strategic plan for parent involvement** will be implemented. Staff will be studying areas where the rating decreased in an effort improve satisfaction in the next program year. We will be asking parents to help us in this effort.
- C The **Family Specialist** and **Early Intervention** will continue to engage parents and lead efforts to engage parents in the local programs.

Performance Measure 15 -

Rate per 100,000 of Suicide Deaths Among Youth Aged 15-19

Program Plans:

- C New York in FFY 2001 will reformulate its statewide **suicide prevention plan**. Title V is a full participant in the process, as are the Office of Children and Families and the Office of Mental Health.
- C **Healthy Choices Initiative** will expand school-based health center services to include population based prevention activities that reduce adolescent risk behaviors. One focus will be the development of programs the reduce violence. The activities will include conflict resolution seminars for adults and students, peer mediation, mentoring, after school activities and violence prevention forums.
- C The **Lesbian and Gay Health Initiative** will focus on increasing knowledge and raising sensitivity to issues that impede access and quality of health care for lesbian and gay individuals and their families, enhancing and improving access to existing services, creating needed services not currently in existence, and promoting collaborations and integration between specialized and mainstream services. Data from other states indicate that gay, lesbian and bisexual youth are approximately four times more likely to attempt suicide than their heterosexual counterparts.

Performance Measure 16 -

The Percent of Very Low Birth Weight Births

Program Plans :

- C Please see descriptions of the **PCAP, MOMS Program, Perinatal Regional Outreach and Education, WIC and Family Planning Programs**. All Title V direct services and enabling programs are focused on eliminating low birth weight.
- C The **Comprehensive Prenatal/Perinatal Services Networks** will address 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. The Networks continue to examine and improve the perinatal services systems at the local level, and advocate for comprehensive, quality services for high risk mothers.
- C **PCAP** and **MOMS** providers are required to adhere to Part 85.40 standards of prenatal care, and all managed care plans serving Medicaid women will be given ongoing technical assistance to enable them to adhere to these comprehensive standards, as well.
- C The **Community Health Worker Program** will promote optimal health status among high-risk and low-income pregnant and parenting families through one-on-one outreach, education, referral and follow-up, advocacy, service coordination and home visiting.
- C The **Statewide Perinatal Data System** will provide real-time internet-based data to providers, networks and local health departments on the occurrence of high risk births.

Performance Measure 17 -

The Percent of Very Low Birth Weight Infants Delivered in Facilities for High-Risk Deliveries and Neonates

Program Plans :

- C **All birthing hospitals** are required to have appropriate referral networks and transport agreements with higher level hospitals.
- C The **Perinatal Data System** will provide real-time data on the occurrence of high-risk births outside of level 3 hospitals.
- C The **Comprehensive Prenatal/Perinatal Services Networks** will assume an increasing role in monitoring the perinatal system through co-chairing, with the Regional Perinatal Centers, the **Perinatal Forums**. The Forums will examine issues such as delivery of infants at appropriate level hospitals. They will also continue to stress with both consumers and providers the need for appropriate delivery sites for high-risk babies and mothers.
- C Standards of Prenatal/Perinatal Care used by **PCAP/MOMS** and **Medicaid** address risk assessment and the need for adequate planning and transfer arrangements.
- C The **Community Health Worker Program** will assist low-income women to enroll early in comprehensive and continuous prenatal care.
- C The **re-designation** process for newborn and maternal care will continue.
- C **Prenatal genetics** counseling and screening services can identify a genetic or other congenital defect in the fetus before birth. This will enable the parents, physician and birth facility to make available any necessary interventions before birth.
- C The **School Health Program** will provide pregnancy testing and reinforce the need for early prenatal care. Staff in school-based health centers will co-manage prenatal care of their students and help to ensure that pregnant students are referred to the appropriate level of care.

Performance Measure 18 -

The Percent of Infants Born to Pregnant Women Receiving Prenatal Care Beginning in the First Trimester

Program Plans :

- C **PCAP/MOMS** will continue to encourage early enrollment in prenatal care, offer presumptive eligibility, and ensure timely initiation of services. Potential barriers to early entry are address on an ongoing basis as they arise and PCAPs/MOMS are kept informed about ways to facilitate early entry to care.
- C "Growing Up Healthy" **Hotline** will continue to refer women to prenatal care providers in their community.
- C **Family Planning** will continue to make early referrals for women testing positive for pregnancy.
- C **Outreach and Education** projects will target women who would typically enter prenatal care late or not at all. The intent will be to minimize perceived barriers, financial or otherwise, to prenatal care, engaging women early in their pregnancy and, hopefully, reducing the need for high risk, more expensive care.
- C **Prenatal genetics counseling and screening services** can identify a genetic or other congenital defect in the fetus before birth. This will enable the parents, physician and birth facility to make available any necessary interventions before birth.
- C The **School Health Program** will provide pregnancy testing and reinforce the need for early prenatal care. Staff in school-based health centers will co-manage prenatal care of their students and help to ensure that pregnant students are referred to the appropriate level of care.
- C The **Community Health Worker Program** will continue to be a premier enabling service. Specially trained individuals from the target communities and populations will educate pregnant women and parents about health needs and instruct/role model the appropriate use of the health care system.
- C The **Comprehensive Prenatal/Perinatal Care Networks** will continue to have as their primary objective to increase the percentage of women entering prenatal care in their first trimester.
- C **Educational materials** and media messages will continue to be available through the Bureau of Community Relations.

State Performance Measures

State Performance Measure 01 - The Percent of Unintended Pregnancies Resulting in a Live Birth	
Program Plans:	
C	The Family Planning Extension Program will provide an additional 24 months of family planning benefits to women who were on Medicaid while pregnant and lost Medicaid coverage.
C	The Family Planning Program will provide community education and public information, comprehensive medical exams, and access to a full range of contraceptive methods, STD counseling and testing, and special counseling for teens.
C	The legislature approved an expansion of Medicaid to 200% of poverty for family planning services, and preparation of a Medicaid waiver is underway.
C	The Community-Based Adolescent Pregnancy Program will continue its efforts to reduce teen births in the 50 highest risk zip codes in the state.
C	The Community Health Worker Program will continue to promote postpartum family planning visits through education, care coordination/case management and home visits.
C	The Healthy Choices Initiative will engage peer educators to teach at-risk adolescents about pregnancy prevention, as well as to impart life-building and self-esteem enhancing skills.
C	Abstinence Education and Promotion Program contractors will continue to provide abstinence education, mentoring, counseling, and adult supervision to promote abstinence from sexual activity in 15-19 year-olds.
C	Educational materials and media messages will continue to be available through the Bureau of Community Relations.

**New York State Performance Measure 02 -
Hospitalization Rates for Asthma in Children Ages 1-14**

Program Plans:

- C In FFY 2001, NYS will develop a **statewide comprehensive plan** for the prevention, early diagnosis and appropriate treatment of asthma.
- C **Multiple, cross-agency efforts** to assess and intervene in the increasing incidence will continue. The Bureau of Child and Adolescent Health will work with the Office of Managed Care, the Division of Chronic Disease Prevention and Adult Health, the State Education Department (Open Airways Project), the New York City Department of Health and Child Health Plus.
- C **School-Based Health Centers** will bring comprehensive health services to schools where children and youth spend their day. All school-based health center clients will be assessed on their initial history and physical, then a diagnosis will be made based on the findings.
- C In 2000, a **new request for proposals** was released, "A Systems Approach to Reducing the Burden of Asthma." In FFY 2001, DOH will be working with seven grantees under that initiative.
- C Under the **Columbia Collaborative Project**, Columbia University School of Public Health students and faculty will initiate a community-based, family day care-based asthma screening project in Northern Manhattan.

**New York State Performance Measure 03 -
Percent of Women Who Reported Smoking During Pregnancy**

Program Plans :

- C A pregnancy **smoking cessation demonstration project** is under development, and pending funding, will be initiated in 5 areas of the state in FFY 2001.
- C **Patient education and media materials** are available statewide, including several aimed at pregnant women, mothers and adolescents.
- C **Medicaid** covers smoking cessation programs for pregnant women.
- C **Prenatal care standards** in the state will continue to include assessment for maternal smoking and the need for referral for smoking cessation.
- C The **Community Health Worker Program** will focus on the education of families concerning the risk factors associated with substance abuse, including tobacco, and will be assisted with receiving appropriate referrals.
- C A recommended objective of the **Comprehensive Prenatal/Perinatal Services Networks** is to develop and implement programs to reduce the percent of women who smoke or use other substances during pregnancy.

New York State Performance Measure 04 -

Teenage Pregnancy Rate for Girls 15-17 Years of Age

Program Plans:

- C Please refer to materials presented under **State Performance Measure 01** on unintended pregnancy.
- C The “Not Me, Not Now” Campaign will continue to air 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.

New York State Performance Measure 05 -

Ratio of Black Low Birth Weight to White Low Birth Weight

Program Plans:

- C **PCAP and MOMS** will continue to conduct outreach to hard-to-enroll populations. Both programs have repeatedly demonstrated their success in reducing disparities in low birth weight compared to other Medicaid and non-Medicaid programs.
- C The **Community Health Worker Program** will continue to conduct outreach in both traditional and non-traditional locations. Clients will be assisted or referred for non-medical supportive services, like clothing and housing assistance, and quick-tracked for prenatal care. Frequent and consistent home visits and assistance in dealing with life situations/problems will continue to be offered. Community Health Workers are hired from the communities they serve.
- C The **Maternal Mortality Study** examined specific barriers to care for women who died of pregnancy-related causes. Findings indicate that non-medical conditions often contribute to negative outcomes.
- C The **Infant Mortality Review Process** will continue to contribute epidemiologic information to promote healthy birth outcomes, to assure adequate prenatal risk assessment, and to encourage follow-up for all high-risk pregnancies.
- C **School-based health centers** are located in very high risk areas of the state, which tend to have higher populations of minority students. Pregnant school-based health center clients were entered into prenatal care immediately. Staff followed-up to assure continued enrollment.
- C The **Comprehensive Prenatal/Perinatal Services Networks** will focus on developing and implementing programs to increase access to prenatal and perinatal care, with particular emphasis on serving hard-to-engage, at-risk women.

New York State Performance Measure 06 -

The Percent of Infants Who are Put Down to Sleep on their Backs

Program Plans:

- C The **Statewide SIDS Prevention Program** will continue New York's Back-To-Sleep Campaign. Tee-shirts and cards have been re-printed and will be available for distribution throughout FFY 2001. All new daycare providers will receive packets, including those who deliver family day care.

New York State Performance Measure 07 -

Hospitalizations for Self-Inflicted Injuries for 15-19 Year Olds

Program Plans:

- C Please see information under **National Performance Measure #15**, especial with regard to the new Statewide Suicide Prevention Planning Process.
- C **School-based health centers** will continue to provide psycho-social assessments beginning with the initial visit. Students and families will be offered individualized education regarding safety issues and abuse, and mental health services will be made available.

New York State Performance Measure 08 and 09 -

**The Percent of High School Students Who Drank Alcohol -and-
The Percent of High School Students Who Smoked Tobacco in the Last Month**

Program Plans:

- C DOH/Title V staff will continue to collaborate with our state **Office of Alcoholism and Substance Abuse Services (OASAS)** on a State Agency Collaboration Survey to gather baseline information on state agency knowledge and collaboration in developing substance abuse and alcohol-related prevention policy. In 1999, OASAS released a request for proposals (RFP) to incorporate the roles of multiple human service agencies at the county level in identifying alcohol and substance abuse risk and protective factors and to strengthen and expand local partnerships for alcohol and substance abuse prevention. Community partnerships in 15 New York counties were funded for three years to develop and implement county-wide, prevention- and results-focused work plans. These work plans serve as a vehicle to identify, re-direct, and leverage state and local resources to bring about a comprehensive, multi-system approach to alcohol and substance abuse prevention at the local level.
- C **ACT for Youth, (Assets Coming Together for Youth)** was developed by DOH in collaboration with its State level partners: **Partners for Children** and the **HIV Prevention Planning Group**. The initiative integrated prevention strategies and developmental assets for and with youth in communities throughout the state. The focus of the initiative is the prevention of 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** will target actively the state's most vulnerable populations (e.g. 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).
- C Over half of the **Lesbian and Gay Initiative** issues related to lesbian, gay and bisexual youth, including alcohol, substance abuse and self-inflicted injury.
- C **PCAP/MOMS** and the **Community Health Worker Program** clients are assessed for alcohol and substance abuse issues; referrals are made accordingly.
- C The initial assessment in **school-based health centers** includes questions about tobacco and alcohol use. Students are counseled and educated accordingly. Referral is available.
- C Local coalitions will mobilize communities in counter-advertising activities such as the ban on tobacco advertisement billboards near schools and playgrounds in New York City.
- C The Center for Environmental Health will continue to identify youth to become active in unannounced compliance checks on retail sales of tobacco to minors. (New York State provided \$2 million to this enforcement effort so that every retail outlet would receive an unannounced compliance check.
- C 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.
- C **Comprehensive Prenatal/Perinatal Services Networks** create awareness of the dangers of smoking, particularly in pregnancy.
- C The **Adolescent Coordinator** and **staff of the Tobacco control program** began planning a statewide youth summit on tobacco which took place in June of 2000, with the active participation and attendance of **Commissioner Novello** and **Executive Deputy Commissioner Whalen**.

New York State Performance Measure 10-

The Percent of Children in the Birth Year Cohort Who Were Screened for High Blood Lead Levels before the Age of Two

Program Plans:

- C The **Lead Poisoning Prevention Program** will continue to enroll children in active case management to lower elevated blood lead levels.
- C Because NYS has more pre-1950's housing than any other state, we will continue to support **universal screening**. The program will continue to implement strategies to increase screenings in high risk populations and to make the Physicians' Handbook on Childhood Lead Poisoning available
- C The goal for FFY 2001 will be to continue to **decrease numbers of new cases** greater than 20µgm/dl.
- C The **Office of Managed Care** will continue to include lead screening in its quality reporting system. A forum to discuss this problem with managed care plans is ongoing.
- C The **Community Health Worker Program** will continue to educate parents regarding lead poisoning and screening, assesses children's records for lead screens and refers and follows those who were not screened.
- C **WIC and PCAP** will continue to stress the need for preventive services for infants, including lead screening.
- C CISS day care grant, **Healthy Child Care New York**, will provide the infrastructure for reaching the day care centers and family day care providers statewide. Mailings and teleconferences will 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.
- C Lead screening will continue to be provided to the 1800 children attending **migrant day care**.

National Outcome Measures 01 to 05 -

Infant, Ratio Black to White, Neonatal, Postneonatal and Perinatal Mortality Rate

Program Plans:

- C All of the Department's Maternal and Child Health programs, but especially **PCAP, MOMS, Medicaid** and **Managed Care** will continue to promote the provision of prenatal and related support services, coordination of care through the intrapartum and postpartum periods, risk management and risk appropriate care. PCAP standards have been adopted as the standard for all pregnancy-related care under Medicaid.
- C The **Community Health Worker Program** will provide home visits from pregnancy through the infant's first year of life (health education and parenting information, ensured the child/family was enrolled in primary health care and insurance, assessed safety hazards in the home, and made appropriate referrals with follow-up). The program will over 2500 pregnant women in FFY 2001.
- C **Infant Mortality Review** community review panels will continue to analyze de-identified results from perinatal records and patient interviews to decide where best to intervene. Each family will receive a supportive nursing home visit and opportunities for referral. This process contributes timely, local epidemiologic information to promote healthy birth outcomes, assured adequate prenatal risk assessment, and encouraged follow-up for high-risk pregnancies. While mostly a population-based intervention, enabling services will be offered to grieving families through formal linkages with the local Departments of Social Service, community-based organizations, hospitals, Protective Services, and WIC.
- C **Comprehensive Prenatal/Perinatal Services Networks** will continue to work collaboratively with county health departments, the New York City Department of Health and other health and human services agencies to reduce the infant mortality rates in their areas. The Networks are either primary recipients or major collaborators in all Healthy Start Projects funded in New York.
- C See the description of the **Statewide Perinatal Data System** under Performance Measures.
- C Unintended or poorly spaced pregnancies are related to poor birth outcomes. The **Family Planning Program**, funded by Titles V and X, will provide direct services, including comprehensive medical exams and a full range of contraceptive methods, to over 300,000 women, about a third of which are teens under age 20. Family Planning Programs will also provide community education and public information in every county in New York State.
- C It is anticipated that recent **Medicaid and Child Health Plus expansions** will improve mortality rates.

Outcome Measure 06 -

Child Death Rate per 100,000 Children Aged 1 - 14

Program Plans:

- C The "Healthy Child Care New York" **Program**, initiated under a CISS grant, continued to provide guidance and assistance in building the infrastructure for health and safety in child care.
- C The **Bureau of Injury Control** will continue to promote injury control strategies, including car safety seat and bike helmet use, and will train car seat technicians to assure their availability in each county.
- C Bureau of Injury Control was also involved in planning statewide conferences on suicide prevention and in bringing together collaborative efforts to write a statewide suicide prevention plan.
- C Local health departments will provide injury and disease prevention and control activities supported by **Article 6** State Aid to Localities.
- C Primary and preventive health care and treatment is provided to 3500 children of **migrant and seasonal farm workers**.
- C The **Children's Camps Program** under the Center for Environmental Health continues to set standards for children's camp programs, inspect and monitor for adherence to state laws and regulations (Sub-Part 7-2 of the State Sanitary Code), and monitor for injuries and illnesses, with a goal of preventing unintentional injuries and illnesses and to reduce the incidence of drownings associated with children's camps. The goal is to keep the camper death rate at less than 1 per year (ages up to 17).
- C Population-based **Immunization Programs** contribute to the decline in vaccine-preventable diseases.

New York State Outcome Measure -

Maternal Mortality Rate

Program Plans:

- C Reporting of maternal mortality is extremely variable, in our State and elsewhere. In a study conducted by our Bureau of Women's Health, active surveillance yielded many more deaths than passive surveillance (the Vital Statistics system).
- C Due to general improvements in social and economic conditions, as well as improvements in medical practices, most cases of maternal death are thought to be preventable. While New York State women have experienced a steady decline in maternal mortality, marked racial differences still exist, and the rate compared to other states remains high.
- C The Bureau of Women's Health is currently working to secure the system for designating hospitals by **levels of maternal care**, similar to the system that exists for designation of levels of care for newborn nurseries.
- C The **Statewide Perinatal Data System** will help identify maternal mortality and its causes.

4.2 Other Program Activities

As required by Federal statute, the NYSDOH operates a **statewide toll-free hotline** that provides information about health care issues and the availability of health care providers for Title V and Title XIX services. Known as the "Growing-Up Healthy " **Hotline**, this bilingual information and referral service operates 24 hours a day, seven days per week. The service includes capacity to communicate with those who are hearing impaired and who speak languages other than English or Spanish. The 1-800-522-5006 number is published in local telephone directories and used in every public information campaign directed at the maternal and child health population by the Department. The hotline's computerized database includes a comprehensive information and referral resource directory and a log of call intake and disposition data. Updated information is provided on prenatal care providers by location, site-by-site, county-by-county. Information is also provided on local social service agencies, local health departments, adolescent pregnancy programs, family planning agencies, other toll-free human service hotlines, immunization, WIC sites, Medicaid benefits, Child Health Plus, and managed care plans approved to care for Medicaid clients.

Other hotlines which serve (and are expected to continue to serve) the maternal and child health population in the State include:

- C the Child Abuse and Maltreatment Hotline, used to report suspected child abuse and neglect, 1-800-342-3720.
- C the Child Health Plus Hotline, which offers in-depth information about our State's Child Health Insurance Program, 1-800-698-4KIDS (1-800-698-4543). The Growing Up Healthy Hotline backs-up this number and receives a fair amount of calls about Child Health Plus. Also, each of the Child Health Plus providers have 800 or 888 numbers, and these are advertised on the NYSDOH brochure and billboards across the State.
- C the Domestic Violence Hotline, which offers information and referrals to battered women's shelters, safe homes, counseling, support groups and legal assistance, 1-800-942-6906.
- C the Missing Children Hotline, which provides assistance and referrals to locating missing children, 1-800-FINDKID.
- C the New York Child Care Coordinating Council Information Service, which provides information on licensed day care centers and family day care providers, 1-800-463-8663.
- C the Disabilities Information Line, which provides information about services available to people with any kind of disability, 1-800-522-4369.
- C the AIDS Information Service, 1-800-541-AIDS, and the HIV Counseling and Testing Hotline, 1-800-872-2777, provide information on HIV/AIDS infection and local referrals for counseling, testing, support groups and free pamphlets.
- C the Cancer Information Service provides information about specific cancers, 1-800-4-CANCER.
- C the New York State Office of Temporary and Disability Assistance operates a hotline which provides referrals for social service programs including Aid to Dependent Children, Emergency Assistance for

Families, Home Relief, Home Energy Assistance, the Medical Assistance Program, and the Child Support Enforcement Program, 1-800-342-3009.

- C the Day Care Complaint Hotline, 1-800-732-5207, administered by the Office of Children and Family Services, hears complaints and concerns about day care centers.
- C the New York Parent Connection Hotline, which provides information and referrals for services to children and families.

In addition to these statewide hotlines, many Comprehensive Prenatal/Perinatal Services Networks also operate local hotlines where callers can get information on availability of local services, remediation of problems with obtaining prenatal care and linkage to services. These Networks are state-funded, but work very closely with MCHSBG- and Medicaid- funded services.

Local health departments and departments of social services will continue to provide information on county/city services. Though the "Growing Up Healthy" hotline has information about the various providers in each county and in New York City, local departments are able to provide information on local happenings and resources.

All collaborations described in Section 1.5.1. and 2. are expected to continue.

4.3 Public Input

Public input in this application has improved dramatically over the last two years.

We began efforts to improve public input subsequent to the submission of the 1998 and 1999 application. In 1998 and 1999, staff of Division of Family Health took the application out to the various regions in a "roadshow" fashion, seeking additional input and support for community involvement in improving MCH indicators. A display, featuring the MCH Pyramid, explained Block Grant Services and invited input. The display was viewed by about 400 individuals. In addition, the Block Grant document was for the first time placed on the NYSDOH public website in 1998 with e-mail links to the Director's Office.

In 1999 and 2000, the Family Specialist, SSDI Coordinator and Title V Coordinator began working intensively with families to identify better ways with which to engage families in our grant processes. A strategic plan for family involvement was formulated with the help of parents and graduates of past family involvement programs. Parents told us we should use existing, known and trusted groups to help us reach out to families. They also told us that small groups, with just a few staff attending, would be more effective than the public hearing format. They assisted the Department with reformulating outreach and informational pieces on the Block Grant. In 1999, we piloted our new plan with four focus groups. After careful evaluation, again involving the parents, we proceeded to hold an additional eight focus groups in 2000. The groups were attended and facilitated by the Family Specialist and SSDI Coordinator, with the exception of the teen group, which was facilitated by a teen with talk radio and teen hotline experience. The efforts resulted in a wealth of information for our needs assessment and high praise from the participants.

Three traditional public hearings were also held. Attendance was excellent. A number of parents also provided input to the Advisory Council and Department through this process.

These were the major themes obtained through the 1999-2000 public input sessions:

- C Consumers need more education and information about their health care in language they can understand. It was specifically recommended that the Department of Health develop and disseminate information and resources for children with special health care needs through hospitals, clinics, providers, local health departments, Children with Special Health Care Needs programs, libraries and schools. The information should be available in a variety of languages and formats.
- C Consumers complained that they sometimes received mixed messages. This was especially problematic for teens.
- C Oral health services are not accessible in many areas of the state. Consumers stated that there is a need to ensure local capacity statewide for dental and orthodontic providers who accept Medicaid and Child Health Plus.
- C Access to mental health services is also an issue. Consumers recommended that the State ensure better local capacity and access statewide for mental health providers who accept Medicaid and Child Health Plus.
- C Access to specialty services is a problem in rural parts of the state. Consumers are traveling great distances to reach urban centers for care or they are forgoing services.
- C Parents of children with special health care needs report shortages of qualified home care nurses, problems obtaining appropriate durable medical equipment, and difficulties with the Medicaid approval process. They felt the Medicaid prior approval process was not sensitive to or understanding of children with special health care needs and their families.
- C MCHSBG provides important safety net services and they should not be withdrawn until there is greater certainty that the new models of care (namely, managed care) is providing accessible, available, acceptable, comprehensive, quality care.
- C Teens and parents felt they were not treated with respect by people they had gone to for help. Adolescents felt that they needed local services that were designed to meet the needs of adolescents.
- C Consumers recommended that Child Health Plus cards be accepted at all hospitals and pharmacies rather than limit enrollees to specific geographic areas.
- C Consumers felt providers needed training on delivering unexpected news and sharing timely diagnostic information with families.
- C Family Health Plus benefits should mirror Child Health Plus benefits.

The Block Grant Advisory Council was presented with the information from the forums, and staff sessions are planned throughout 2000 and the FFY 2001 grant year in order to make effective use of consumer information.

4.4 Technical Assistance

In FFY 2000, the Department requested Technical Assistance (TA) to help implement agreements between local health departments and managed care organizations for such essential public health services as home visiting for pregnant women, visits to at-risk families to reduce risk for child abuse/neglect, enrollment into Early Intervention, communicable disease control and other services. This TA request was filled through another HRSA contract related to managed care and public health that was administered through the National Association of County Health Officials. Title V and managed care staff were able to link up with this group and work with them to construct a training that met New York's needs.

Instead, Technical Assistance dollars were tapped to enable the State Perinatal Association to conduct a multi-state meeting for cross-state planning of perinatal services. This meeting involved several surrounding states' practitioners and consumers in an effort to begin cross-state collaborations.

The Department has just been informed that its request for Technical Assistance through the Association of Maternal and Child Health Programs (AMCHP) for building data capacity related to youth assets development will be fulfilled. Staff are presently working with AMCHP to arrange the appropriate TA. This training will take place either in late FFY 2000 or in FFY 2001.

The Department will be requesting training and technical assistance this year to refresh staff on cultural competency and diversity. This assistance is viewed as critical in helping the Department work toward the elimination of racial and ethnic disparities in health outcomes. This request appears in the Appendix. Should additional funds become available, the Department will request help with system-to-system transition issues for children with special health care needs.

V. SUPPORTING DOCUMENTS

5.1 Glossary

5.2 Assurances and Certifications

5.3 Other Supporting Documents - None are included. None were necessary.

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All other forms

5.9 National "Core" Performance Measures Detail Sheets

5.10 State "Negotiated" Performance Measures Detail Sheets - These are labeled Form 16.

5.11 Outcome Measure Detail Sheets

5.1 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.

Assessment - (see "Needs Assessment")

ATUPA - an abbreviation for **The Adolescent Tobacco Use Prevention Act**

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 "Others."

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/Perinatal 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).

DFLH - Division of Family and Local 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 - The Department of Health

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.

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.

Health Care Reform Act (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.

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.

I-CHAP - an abbreviation for the **Infant-Child Health Assessment Program**- A New York State program providing tracking of high risk infants and young children. I-Chap serves as one of the child find mechanisms for the Early Intervention Program.

IMR - 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 know as Title XIX

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 essential 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 - 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.

NYSDOH - The New York State Department of Health

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

OSC - an abbreviation for the **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 19__." 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 health 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.

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 - 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.

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)?"

SBHC- an abbreviation for **School Based Health Center** - a source for primary and supportive health services located with a school setting.

SIDS - an abbreviation for **Sudden Infant Death Syndrome**.

SPARCS - a data system that collect information on every hospital discharge in the state.

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 Belau.

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 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

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.

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.

5.2 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 will 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 (PFCRA)

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.

5.3 Other supporting documents

None are included.

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Detail Sheets

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

5.9 National "Core" Performance Measure Detail Sheets

5.10 State "Negotiated" Performance Measure Detail Sheets

5.11 Outcome Measure Detail Sheets