

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: NY

APPLICATION YEAR: 2005

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## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

The Letter of Transmittal is to be provided as an attachment to this section.

### **B. FACE SHEET**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. ASSURANCES AND CERTIFICATIONS**

Assurances and Certifications will be kept on file in the office of the Title V Director, New York State Department of Health, Division of Family Health, Corning Tower Room 890, Empire State Plaza, Albany NY 12237-0567.

### **D. TABLE OF CONTENTS**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

#### **I. E. PUBLIC INPUT**

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

1. using a public process called Communities Working Together for a Healthier New York as a basis for forming New York's public health priorities for the decade;
2. placing the document on our public website and making hardcopies available through the Division of Family Health;
3. an active and involved Maternal and Child Health Services Advisory Council, statutorily-established as a method of public input;
4. annually establishing public hearings, rotating locations across the State (five this year);
5. surveying parents of Children with Special Health Care needs;
6. conducting a series of focus groups with Title V consumers and Title V-eligible groups across the State; and
7. accepting phone calls, letters, faxes and e-mails regarding the content of the document.

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

## **II. NEEDS ASSESSMENT**

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

### **III. STATE OVERVIEW**

#### **A. OVERVIEW**

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

- ? to continue to expand insurance coverage to the uninsured and underinsured;
- ? to assure that the health care delivered in New York State is of high quality;
- ? to emphasize prevention and education by involving communities in addressing and improving health; and
- ? to create a seamless health care system whereby our residents may retain continuous health care delivery at a "medical home" irrespective of insurance status.

In addition, Governor Pataki has set these more specific goals for health in New York:

- ? to reduce potentially deadly asthma attacks in children;
- ? to ensure that every child in New York receives all their vaccinations by their second birthday;
- ? to ensure that every newborn is screened for hearing impairment;
- ? to significantly reduce smoking among youth in New York State; and
- ? to protect infants born to HIV-infected mothers to ensure that virtually none develop AIDS.

As previously described, New York has undergone extensive priority-setting processes. The ten priorities that follow, and the specific performance measures related to each, stem specifically from areas of unmet need in the State.

The following are New York's maternal and child health services priority needs:

- ? To improve access to high-quality health services for all New Yorkers, with a special emphasis on prenatal care and primary and preventative for infants and children, including those with special health care needs;
- ? To improve oral health, particularly for pregnant women, mothers and children, and among those with low income;
- ? To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality;
- ? To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;
- ? To reduce tobacco use among children and pregnant women;
- ? To reduce the use of alcohol among children and pregnant women;
- ? To reduce unintended and adolescent pregnancies;
- ? To implement a statewide system of universal newborn hearing screening;
- ? To reduce the rate of self-inflicted injuries and suicide for 15 to 19 year olds; and
- ? To improve parent and consumer participation in the Children with Special Health Care Needs Program, as evidenced by parent scores.

Improving and sustaining access to high-quality, continuous primary health care and treatment services are critical to improving health outcomes for all New Yorkers and achieving our public health and maternal and child health priorities. The hallmarks of success will be prevention, early intervention, and continuity of care through establishing and maintaining a "medical home" for every New Yorker. Success will also depend on the actual delivery of appropriate, high-quality, comprehensive health services to people in need, and requires practitioners to be knowledgeable about and practice good preventive and therapeutic medicine. Title V works closely with the Office of Medicaid Management and the Office of Managed Care to ensure continuity and coordination with public insurance programs and to ensure that any gaps in care are recognized and acted upon.

Please see Section II. Needs Assessment for a more complete description of New York State's geography, population, resources and health care delivery environment.

Measuring success will rely on accurate assessment of progress. Factors that play a role are:

Diversity: Recapping the Needs Assessment, New York's diverse geography can also present interesting public health challenges. The state has both urban centers and sparsely populated rural areas. New York's beautiful natural resources attract tourists year-round to our historic and recreational attractions, which can produce variable seasonal demand on health services, especially in the areas of emergency medical services and public health. Seasonal variations in weather also affect how and when New Yorkers seek services. Heavy "lake effect" snowstorms can delay access to care and make travel dangerous, especially in the northern and eastern areas of the State.

Our population is even more diverse than our geography, more diverse than the nation as a whole, with New York City being the most diverse area. On the 2000 Census, 67.9% of New York residents reported they were White alone, 15.9% reported they are Black or African American alone, 5.5% reported that they were Asian alone, 0.4% reported they were American Indian or Alaskan Native, and 7.1% reported being some other race. 15.1% of the State's total respondents reported that they were Hispanic. Over 3.1% of New Yorkers identified themselves as being of more than one race. Native Americans were severely undercounted.

New York is also home to many new New Yorkers and new Americans. New York ranks higher than the country as a whole for non-Hispanic Black residents, Hispanic residents, and non-citizen residents. We are second among states for non-citizen immigrants, with an estimated 2.2 million resident non-citizen immigrants. 90% of non-citizen immigrants in the State live in New York City. Our foreign-born population was estimated at 3.4 million in 1995, representing 17.7% of the State's population, or about one in six people. The vast majority of the foreign-born in New York are here legally (84%). 4,704,625 New Yorkers speak a language other than English as their primary language. 2,092,875 reported speaking English less than "very well."

Poverty and Health Care: Poverty is major factor for affordability and access to health care services. According to the US Census Bureau, about 14% of New Yorkers lived below the Federal Poverty Level (FPL) in 2002, and 17.9% were below 125% of the FPL. 10.7% of New Yorker families live in households with incomes at or below 100% of the FPL. More New York adults with children than adults without children are poor. 8.8% of those participating in the Behavioral Risk Factor Surveillance Study in 2000 reported not seeking care when they needed it due to cost. Figures are higher among African Americans and Hispanics. Un-insurance rate among children is 9.9%. To address the health care needs of the poor, New York has a generous Medicaid package, Child Health Plus and Family Health Plus.

Pregnancy and Birth Rates: The overall birth rates, had been declining, but took a slight upswing in 2002. Adolescent birth and pregnancy rates are declining and below national averages. African American and Hispanic teens have nearly twice the rate of pregnancy than White teens, though the rate for Hispanic teens declined noticeably from 1999 to 2002. The rate of unintended pregnancy among PRAMS respondents remains mostly stable, but improved from 1998 to 2001. Those most at risk for unintended pregnancy in 2001 were those under age 20 (77.3%), women who were not married (60.0%), African American women (56.6%), women on Medicaid (56.3%), and women with less than a high school education (41.6%).

Prenatal Care: The percentage of women entering prenatal care in the first trimester has shown slight improvement each year since 1993, but leveled off in 2002. The most dramatic increase in first trimester care was among New York City residents (from 55.5% in 1993 to 67.7% in 2001 and 2002) and among Hispanic and African American women (48.1% to 65.9% and 50.8% to 63%, respectively). During that same time period, adequacy and content of prenatal care improved among all regions and among all racial and ethnic groups.

Other positive trends in the PRAMS data were noted from 1995 to 2002:  
? Fewer mothers reported drinking alcohol while pregnant.  
? Fewer mothers reported smoking prior to, during, and after pregnancy.  
? Fewer mothers exposed their babies to second-hand smoke.

- ? Fewer mothers experienced physical abuse during pregnancy.
- ? More mothers initiated breastfeeding.
- ? More mothers place their babies on their backs to sleep.
- ? More mothers had knowledge of the positive effects of folic acid on birth defects.

Prenatal care enrollment increased among HIV+ women and more women presenting for delivery had received counseling and testing during pregnancy. The percent of HIV-exposed infants who received prenatal, intrapartal or neonatal ARV to reduce transmission also increased. As a result of these efforts, neonatal HIV infection rates are declining.

Low and Very Low Birth Weight: Overall rates of low birth weight and very low birth weight have been relatively unchanged over ten or more years. The rate for singleton births has declined, indicating that the increase in multiple births seems to be responsible for the unchanged overall rates. Though disparities in low birth weight rates have shown some improvement over time, they still persist. Rate among African American singleton births have declined, as have rates among Latina births, though less dramatically in the Latinas, who had a slight, single-year increase in 2002.

Maternal Mortality: Wide fluctuations in rates appear to be a result of the rarity of the occurrence and the zealously of ascertainment. Rates are highest in New York City and among African American women. The overall 2001 rate of 14.4 per 100,000 is about five times the Healthy People 2010 goal of 3.3 per 100,000. The overall rate includes rates among White mothers at 9.9, for Hispanic mothers at 22.9, and for African American women at 34.9. The ratio of Black-to-White maternal mortality is about 3.5.

Children: There were some very encouraging and some not-so-encouraging trends.

A survey of WIC participants showed more children are drinking low-fat or skim milk and more fruits and vegetables are being consumed by that group. However, obesity in children is still increasing. The 2003 YRBS found 9.3% of females and 16.4% of males responding were overweight. In 2003, 16.7% of all children ages two to four enrolled in WIC were overweight. Hispanic children in WIC were found to be almost twice as likely to be overweight than Black or White children. The 2003 YRBS found that 43.6% of New York State adolescents surveyed watched three or more hours of television per day.

Asthma hospitalization rates are down from a high in 1999, as are hospitalizations for otitis media. The incidence and prevalence of childhood lead poisoning are declining and childhood immunization rates are rising. The early syphilis rate among teens declined. SIDS deaths and infant mortality rates continued to decline, with Hispanics having the lowest rate at 3.8 per 1,000, compared to 5.2 per 1,000 for the White population and 9.5 per 1,000 for the Black population. Neonatal and post-neonatal rates also continue to show an overall decline.

With regard to risk-taking behavior, the 2003 YRBS showed seat belt and bike helmet use increasing, fewer students using violence, and fewer students feeling sad or hopeless everyday. New York has a lower percentage of sexually active teens than the country as a whole. More New York teens reported using condoms at last intercourse than teens in the rest of the country. However, more children reported being afraid for their safety at school.

Children with Special Health Care Needs and their Families: New York is in receipt of SLAITS data on Children with Special Health Care Needs, and has designed a plan for further analysis. These data will prove helpful in development of further policy affecting this population and their families. At this time, SAITS data will serve as a baseline against which New York measures future progress. However, parents have testified as to what makes medical care a "medical home" and what types of support they need from the system, so New York is already at work on some of these issues. (See program plan.)

Health Insurance: New York's public insurance programs include the Medicaid program, Child Health Plus and Family Health Plus. There are additional health insurance programs that assist small

businesses and people who have lost health insurance with access to insurance products. Data from the National Survey of American Families shows New York to do better than the US average for insuring the poor.

**Health Care Access:** Health care access is most difficult for the uninsured, those with less education and those whose primary language is not English. Other barriers to access include high out-of-pocket expenses, lack of public transportation and a maldistribution of health care professionals, especially dentist and specialists that are willing to accept Medicaid as payment.

## **B. AGENCY CAPACITY**

The New York State Department of Health, as the Title V agency in New York State, plays a major role in assuring quality and access to essential maternal and child health services. Title V, the Maternal and Child Health Services Block Grant, provides the basic framework for provision of all maternal and child health services by the New York State Department of Health.

Please see a full description of agency capacity as it appears in the Needs Assessment.

**Title V Roles and Responsibilities:** The Title V role of the New York State Department of Health includes:

- ? assessing and monitoring maternal and child health status to identify and address problems;
- ? diagnosing and investigating health problems and health hazards affecting women, infants, children and youth in New York State;
- ? informing and educating the public and families in New York State about maternal and child health issues (and we encourage the public to educate and inform us, as well);
- ? mobilizing partnerships between policy makers, providers, families and the public to identify and solve maternal and child health issues in New York State;
- ? providing leadership in priority-setting, planning and policy development to support county and community efforts to assure the health of women, infants, children, youth and their families;
- ? promoting and enforcing legal requirements that protect the health and safety of women, infants, children and youth in New York State and to ensure public accountability for their well being;
- ? linking women, their infants, children and youth to health and other human services and to assure access to comprehensive, quality systems of care;
- ? assuring the capacity and competency of the public health/maternal and child health workforce to effectively address maternal and child health needs within the State;
- ? evaluating the effectiveness, accessibility and quality of personal health and population-based maternal and child health services; and
- ? supporting research and demonstrations to gain insights and innovative solutions to maternal and child health-related problems.

Assessing and monitoring maternal and child health status to identify and address problems: Please refer to the Needs Assessment portion of this document, which reflects our structures and capacity to gather, analyze and report data across a variety of areas and providers.

NYSDOH is able to track problems and hazards specific to the maternal and child health population, including but not limited to:

- ? vital events (births, deaths, fetal losses, causes of death);
- ? vaccine-preventable and other diseases and conditions affecting the maternal and child health population (STDs, lead poisoning, dental caries, unintended pregnancies, injuries);
- ? perinatal conditions of the newborn and mother (low birth weight, very low birth weight);
- ? sentinel events;
- ? service usage;

? knowledge, attitudes and behaviors of mothers and youth; and  
? treatment experience of at-risk infants and toddlers.

Likewise, NYSDOH and the Title V program are able to prepare, analyze and report information about the maternal and child health population to inform needs assessment, planning and policy development, including, but not limited to:

? population demographics (age, race, ethnicity);  
? socioeconomic conditions (poverty, employment, insurance coverage);  
? behavioral and other health risks (teen drinking, smoking, seat belt use, drug use); and  
? health status (morbidity and mortality rates);  
? health services utilization (early trimester prenatal care, immunization coverage); and  
? public perception of health problems and needs (block grant public hearings, focus groups).

NYSDOH maintains an active public website at [www.health.state.ny.us](http://www.health.state.ny.us) and has additional intranet sites for state and local health department use and for the use of health providers. The community health data set is more fully described in the Needs Assessment.

Diagnosing and investigating health problems and health hazards affecting women, infants, children and youth in New York State: Title V and the NYSDOH maintains the capacity for conducting and have conducted a number of special studies involving such areas as communicable diseases, childhood lead poisoning, maternal and infant mortality, substance use, and smoking.

Informing and educating the public and families in New York State about maternal and child health issues: Title V provides the Growing Up Healthy Hotline, provides expertise and fiscal support for development of printed and promotional materials, media campaigns and educational experiences. A more thorough discussion of some of DOH's recent maternal and child health related public education topics.

Through public hearings, focus groups and web postings, we encourage the public to educate and inform the Department, as well. In this grant year, under the auspices of the Maternal and Child Health Services Block Grant Advisory Council, a number of public hearings were held in various locations across the State. An additional twelve focus groups were held. We strive to make all materials and events culturally-, linguistically-, and age- appropriate. Consumers are paid for their time, childcare and travel expenses to participate in the focus groups. We required our contractors to provide translations services, as appropriate, and to provide nutritious, culturally-appropriate snacks.

Mobilizing partnerships between policy makers, providers, families and the public to identify and solve maternal and child health issues in New York State: The Title V agency develops and provides materials and mechanisms for dissemination of information on maternal and child health status and services, needs, and gaps in addressing needs to policy makers, health delivery systems, consumer organizations and the general public. Please refer to the Needs Assessment for a listing of partners and examples of collaborative efforts for the betterment of the maternal and child health population.

Providing leadership in priority-setting, planning and policy development to support county and community efforts to assure the health of women, infants, children, youth and their families: The Title V agency has developed and promoted an MCH agenda using Healthy People 2010 and Communities Working Together for a Healthier New York as our framework. The NYSDOH also provides the infrastructure/communication structures for collaborative partnerships in the development of MCH needs assessments, policies, services and programs through:

? routine communications (newsletters, website postings and links, technical assistance workshops, conferences, "Dear Administrator" letters, mass mailings, and, if the need arises, through a provision of in the Public Health Law called a "Commissioner's Call," which allows the State Commissioner of Health to summon the commissioner or public health director of each county to a meeting);  
? convening advisory councils, task forces or workgroups composed of consumers, business,

community organizations, elected officials and/or others to review health data and make recommendations;

? convening and staffing commissions and advisory councils for the oversight of maternal and child health services planning and recommending resource allocation; and

? providing funding and support for parent networks or coalitions.

It is the information gathered in performance of its essential roles and responsibilities that, taken together with knowledge of the existing trends and systems of care, form the strategic process that determines the priorities for Title V effort.

Promoting and enforcing legal requirements that protect the health and safety of women, infants, children and youth in New York State and to ensure public accountability for their well being: The Department works with our Office of Governmental Affairs and Division of Legal Affairs to help ensure consistency in legislative mandates, to resolve inconsistencies, to write regulations and ensure consistent policy across family and child-serving programs. Title V provides expertise in development of legislation and regulations. Title V requires contractors to adhere to all required regulations and contractual obligations and ensures compliance through program monitoring and audits. Contractors and health plans are required to regularly report on health services process and outcome measures.

To help protect the health and well being of our MCH population, New York State has a strong legislative base for:

? MCH-related governance and the organization and function of advisory bodies;

? MCH practice and facilities standards, including standards for all hospitals and freestanding diagnostic and treatment facilities, for levels of high-risk perinatal care and for educational and practical preparation of health care providers;

? uniform data collection through vital records and statewide registries;

? public health reporting of communicable diseases, births and deaths, child abuse and other adverse events;

? environmental protections, such as indoor smoking laws, firearms control, traffic safety, and regulations covering children's camps, temporary (farmworker) housing, use of pesticides and toxic chemicals in schools, swimming pools and bathing beaches; and

? access and quality assurance monitoring required by public insurance programs; and

The Title V program in New York takes a role in development, promulgation, and regular review of statutes, regulations, standards and guidelines related to health services delivered and funded through the public and private sectors. For example, Title V worked with Medicaid to review and update a provider manual containing standards for health supervision under New York's EPSDT Program, the Child-Teen Health Program. Title V staff regularly interact in such matters with WIC, Title X, Title XIX, and Part H (IDEA). Title V staff have participated in certification, monitoring, onsite reviews and quality improvement activities of health plans and public health providers with respect to MCH services, standards and regulations. Title V staff have also been involve in review of care of children in foster care and detention services.

Linking women, their infants, children and youth to health and other human services and to assure access to comprehensive, quality systems of care: Title V and the NYSDOH provide a range of outreach interventions including street-level outreach and home visiting in targeted efforts to reach MCH populations that can be hard to find, hard to keep engaged and/or hard to keep in services because of their unique life circumstances, such as homeless women who move frequently, geographically isolated women and families, drug abusing women, and those of different languages and cultures.

DOH provides culturally- and linguistically-appropriate staff, resources materials and communications, either directly or through our contractors. The availability and use of toll-free telephone information and referral lines, resource directories, public advertising and enrollment assistance greatly assists in this effort. Please see the description of the Growing Up Healthy Hotline and other health hotlines and

the use of the AT&T Language Line in the Needs Assessment.

Title V monitors public response to health plans, facilities and public provider enrollment practices with respect to consumer understanding of required forms and procedures, orientation of new enrollees, and ease of access to care, and has provided assistance with identifying at-risk, or hard-to-reach individuals and in using effective methods to reach them.

Title V also provides, arranges or administers women's, children's and adolescent health services, and specialty services for children with special health care needs. We provide, generally through contractual services, those gap-filling services not generally available through health plans or mainstream benefits packages, such as school-based primary care and dental services, school-based mental health services, care coordination, public health nursing or social work, community health worker services and dental rehabilitation services. We have universal screening programs for genetic/metabolic disorders, hearing impairment, and perinatal HIV. Statute requires health care providers to screen children for childhood lead poisoning at ages one and two.

Assuring the capacity and competency of the public health/maternal and child health workforce to effectively address maternal and child health needs within the State: NYSDOH provides the infrastructure and technical capacity for efforts to ensure the competency of the public health/maternal and child health workforce training efforts.

? Title V staff serve as faculty to the University at Albany's School of Public Health (SPH), in a unique arrangement where NYSDOH, an active State Health Department, provides the learning laboratory for SPH students.

? Title V provides paid internships and graduate assistantships to graduate students in public health to work on various research projects related to Maternal and Child Health.

? Title V and other NYSDOH staff serve on the University at Albany School of Public Health's Continuing Education and Public Health Leadership Institute Advisory Councils.

? NYSDOH sponsors both a Preventive Medicine Residency Program for physicians and a Dental Public Health Residency Program for dentists.

? Title V sponsors regular satellite broadcasts on current issues in public health and maternal and child health.

? Title V houses the Healthy Child Care New York effort, educating public health nurses and public health educators to become child care health consultants. Staff also participate in efforts with the Office of Children and Family Services to educate child care providers in health and safety issues through their satellite broadcast system.

? Title V and NYSDOH staff work with their community partners to educate the public and providers in their area on important issues, in areas such as asthma and women's health.

? Title V staff provide workshops on community health assessment, use of data, and best practices to improve services to the maternal and child health population.

Evaluating the effectiveness, accessibility and quality of personal health and population-based maternal and child health services: The Department regularly reviews program effectiveness and uses information to formulate responsive policies, standards and programs. DOH has the capacity to develop surveys and profiles of health status, health care access, and health care availability (types of service, provider distribution, hours of service, etc.), as well as profiles of consumer and provider knowledge, attitudes and behaviors. Programs regularly identify and report on barriers to care and collect and analyze information on community and constituent perceptions of needs within their communities.

Title V supports a number of gap-filling direct services programs, such as the School Health Program, Family Planning and the Migrant Health Program. All funded programs are regularly reviewed for quality by DOH staff.

Supporting research and demonstrations to gain insights and innovative solutions to maternal and child health-related problems: Current examples of the research to gain insights and innovative

solutions are the oral health surveillance initiative, SSDI consumer focus groups, and a joint CDC project to further analyze New York State-specific information from the SLAITS survey of Children with Special Health Care Needs. Title V also funds 12 graduate assistantships per semester, allowing graduate students in public health to complete investigations into current research issues in maternal and child health.

The Title V agency continues to play a major role in assuring the quality and access to essential maternal and child health services in New York State. The Title V programs 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, 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, collaboration with other State agencies and private organizations, and State support for local communities.

## **C. ORGANIZATIONAL STRUCTURE**

As previously stated in the Needs Assessment, the responsibility for New York's Title V Program is located within the New York State Department of Health, Center for Community Health, Division of Family Health, which is "responsible for the administration (or supervision of the administration) of programs carried out by Title V." [Section 509(b)]

The New York State Department of Health is an executive agency, with Commissioner Antonia C. Novello, M.D., M.P.H., Dr.P.H., reporting directly to Governor George E. Pataki. Maternal and child health programs are located throughout the Department, but are mostly located in the Center for Community Health and the Division of Family Health, where administrative oversight for the Block Grant is vested. In addition to its responsibility for Title V, the Division of Family Health is responsible for family planning (Title X), early intervention (Part H/IDEA) services, the Prenatal Care Assistance Program, perinatal networks, designation of perinatal centers and CSHCN specialty centers, dental health, lead poisoning prevention, adolescent health, youth development, adolescent pregnancy prevention, universal newborn hearing screening and programs for children with special health care needs.

The State Health Department's organizational chart is included with this submission in the Appendix. Organizational structure and staffing support our mission, vision and values.

Division of Family Health has four Bureaus:

? The Bureau of Child and Adolescent Health;

Title V and Title V-related programs within the Bureau of Child and Adolescent Health include: Childhood Lead Poisoning Prevention, Pediatric Asthma, Healthy Child Care New York, Children with Special Health Care Needs (including the Family Specialist), the Physically Handicapped Children's Program, Youth Development, the School Health Program, the School Health Infrastructure Initiative, ACT for Youth, Abstinence Education, the Community-Based Adolescent Pregnancy Prevention Program, Innovative Pediatric Services, Infant Mortality Review, Interim Housing for Lead Poisoned Children and their Families, the Regional Lead Poisoning Technical Assistance Centers, and the Gay, Lesbian, Bi-Sexual and Trans-gendered Youth Initiative. BCAH will also have responsibility for the Early Childhood Comprehensive Services Initiative.

? The Bureau of Dental Health;

Title V and Title V-related programs within the Bureau of Dental Health include Dental Public Health Education, the Preventive Dentistry for High-Risk Underserved Children's Program, the Fluoride Supplementation Program, the Dental Public Health Residency Program, Oral Health Surveillance and Dental Research, the Dental Rehabilitation (Orthodontia) Program, Innovative Dental Services,

and School-Based Dental Services.

? The Bureau of Early Intervention Services; and

The Bureau of Early Intervention Services administers the Part H/IDEA programs and the Universal Newborn Hearing Screening Program. This Bureau is also responsible for publication of "Welcome to Parenthood," a publication received by all new mothers delivering in any of New York State's hospitals.

? The Bureau of Women's Health.

Title V and Title V-related programs within the Bureau of Women's Health include the Family Planning Program/Title X, the Growing Up Healthy Hotline, the Community Health Worker Program, Comprehensive Prenatal/Perinatal Services Networks, the Prenatal Care Assistance Program (PCAP) and the Medicaid Obstetrical Maternity Services (MOMS) Program, the Lactation Institute, the Preventive Medicine Residency Program, the Coordinated Women's Health Program, Maternal Mortality Review, and SPDS implementation redesignation of all hospitals for perinatal services level. BWH also works with the AIDS Institute on the Community Action for Prenatal Care (CAP-C) Program.

The Division of Family Health directly administers SSDI, the American Indian Health Program, the Columbia Collaborative Public Health Education Project, the Asthma Collaborative and Migrant Health Services. Genetics Services and the Newborn Metabolic Screening Program are administered by NYSDOH's Wadsworth Laboratories. The Congenital Malformations Registry is located within the Center for Environmental Health.

#### **D. OTHER MCH CAPACITY**

The Division of Family Health continues responsibility for coordinating MCH-related programs and directly managing many MCHSBG-funded initiatives.

Statutory Authority: The New York State Public Health Law provides statutory authority for various maternal and child health programs, including establishment of health departments and health care facilities and agencies, qualifications of public health officials, newborn screening, lead poisoning prevention, immunization, and health care financing.

Article 6 of the Public Health Law authorizes payment of State Aid to Localities for certain public health services, including maternal and child health services.

The New York Code, Rules and Regulations (NYCRR) interpret how Public Health Laws are to be implemented.

State Budget Bills delineate the use of State funds, including for public health and maternal and child health programs.

State Finance Law provides the requirements for management of State funds and federal funds coming through the state, and Article 7 of the Public Health Law relates to Grants In Aid.

State Education Law regulates the professions, including physicians, nurses, nurse practitioners, medical social workers, pharmacists, therapists and midwives.

Chapter 884 of the Laws of 1982 outlines the composition and responsibilities of the Maternal and Child Health Block Grant Advisory Council.

Statutory Authority for childhood lead poisoning prevention and intervention is found in Section 206 of the Public Health Law and Title X of Article 13, the Lead Poisoning Prevention Act. Regulations are

contained in Sub-Part 67-1.

Article 25 of the Public Health Law covers Maternal and Child Health, with Title I- General Provisions, Title II - Prenatal Care, Title III - Midwifery, Title IV - Institutions for Children, Title V - Children with Physical Disabilities, Title VI is expired, Title VII - Nutrition Outreach and Public Education.

The Children with Special Health Care Needs Program is authorized by Title V of the federal Social Security Act and New York State Public Health Law 2580.

Article 27-C relates to the Birth Defects Institute, 27-D relates to Burn Care, and 27-E and F relate to HIV and AIDS.

Final regulations on universal newborn hearing screening appear in Subpart 69-8 of 10 NYCRR.

Abstinence Education is authorized by Public Health Law 104-193 and the federal Personal Responsibility and Work Opportunity Act (Welfare Reform).

The American Indian Health Program is administered pursuant to Public Health Law § 201(1)(s), under which the Department is required to "administer to the medical and health needs of the ambulant sick and needy Indians on reservations."

Comprehensive Prenatal/Perinatal Services Networks are authorized under the legislation authorizing the Prenatal Care Assistance Program, Public Health Law 2522, which includes a provision for outreach, public education and promotion of community awareness of the benefits of preconception health care and early and continued prenatal care.

The statewide Early Intervention Program was established in Public Health Law Title II-A, Article 25 in 1992.

Family Planning is authorized under federal Title X and 10 NYCRR 42CFR, 43CFR, 45CFR, BCHS Guidelines.

Laws relating to public health are described on the Department's public website, [www.health.state.ny.us/nysdoh/phforum/phforum.htm](http://www.health.state.ny.us/nysdoh/phforum/phforum.htm) and all New York State laws and regulations are available on the world wide web at this address: <http://unix2.nysed.gov/ils/topics/laws.htm>. All necessary assurances and certifications are kept on file in the office of the Title V director and can also be found on the Department's website; [www.health.state.ny.us/nysdoh/grants/main.htm](http://www.health.state.ny.us/nysdoh/grants/main.htm)

## **E. STATE AGENCY COORDINATION**

The New York State Department of Health has formalized relationships with other state agencies, local public health agencies, federally-qualified health centers, tertiary care facilities, academic institutions and the non-profit voluntary sector, which all enhance the capacity of the Title V program.

### **Agreements with Other State Agencies**

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

? The State Education Department (SED) is responsible for general supervision of all educational institutions in the State, for operating certain educational and cultural institutions, for certifying teachers, and for certifying or licensing practitioners of thirty-eight professions. The department's supervisory activities include chartering all schools, libraries and historical societies; developing and approving school curricula; accrediting colleges and university programs; allocating state and federal financial aid to schools; and providing coordinating vocational rehabilitation services. The State

Education Department administers the Youth Risk Behavior Surveillance System with NYSDOH collaboration.

? The Department has a Memorandum of Understanding with the State Education Department regarding school health infrastructure. This memorandum supports the statewide implementation of comprehensive school health and wellness. Comprehensive School Health and Wellness Centers help school districts across the State create positive learning environments for their students. Schools that model and encourage students to engage in healthy behaviors create an atmosphere for academic success and individual growth.

? As the lead agency for the Early Intervention Program, the Department has letters of agreement with the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the State Education Department, and the Office of Alcohol and Substance Abuse Services related to the implementation of this program.

? The Office of Children and Family Services (OCFS), the Council on Children and Families, and the Office of Alcohol and Substance Abuse Services collaborate with DOH on several very important initiatives such as the NYS Task Force for School/Community Collaboration, the State Incentive Cooperative Agreement, and the New York State Alliance for Family Literacy. The Office of Criminal Justice Services, the Department of Labor and the Office of Temporary and Disability Assistance participate.

? The Office of Children and Family Services also administers the Adolescent Pregnancy Prevention and Services (APPS) Program, providing prenatal support and parenting education to high-risk teens in high need communities.

? The State Legislature allocated funding from the federal Temporary Assistance to Needy Families (TANF) Block Grant to the Department of Health for outreach and education activities to prevent unintended pregnancies and for School Health. The Department has entered into a Memorandum of Understanding with the Office of Temporary and Disability Assistance to provide for the transfer of these funds to the Department. This office is also the lead agency for the Teenage Services Act (TASA) Program, providing services to pregnant and parenting teens on Public Assistance.

? The Office of Mental Health and Office of Children and Family Services collaborate with the Department of Health relative to suicide prevention. All three agencies sent representatives to the Region 1 and 2 Suicide Prevention Planning Conference.

? DOH Title V staff work with the Office of Children and Family Services on health care of children in Foster Care.

#### Other State Agency Collaborations

? The Touchstones Initiative, with the Council on Children and Families as the lead agency, began as a collaborative of 13 New York State agencies that fund programs for children and families. State agencies were challenged to agree on the benefits of funded services in clear, consistent, measurable terms. The Team established a Kids Wellbeing Indicator Clearinghouse (KWIC) on the Internet, the purpose of which is to make vital youth statistical information more timely, accessible and usable to communities.

? The Integrated County Planning Initiative formed partnerships with the involved state agencies (the Offices of Children and Family Services, Mental Health and Alcohol and Substance Abuse Services, and the Department of Health) and their county counterparts, school districts, the business community, civic organizations, the judiciary and academic leaders. The Office of Children and Families is the lead agency in this initiative.

? The Partners for Children collaboration involves the United Way of New York State, 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. Partners work together in developing and strengthening school/ community collaborations and on routine monitoring of health and education outcomes. Collaboration around youth development continues to be the primary agenda item. The Youth Development Team is co-chaired by Dr. Nancy Wade and Newell Eaton, Director of Strategic Planning at the Office of Children and Family Services.

? The goal of Coordinated Children's Services Initiative (CCSI) to improve local service coordination for children and adolescents with serious emotional disturbances and to reduce reliance on residential placements. The lead agencies are the State Education Department and the Office of Alcohol and Substance Abuse Services. Agency partners include the Department of Health, the Office of Children and Family Services, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, and the Office of Alcohol and Substance Abuse Services.

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

? A cross-system team on Runaway/Homeless Youth advises the Office of Children and Family Services on implementation of runaway and homeless youth legislation, policy and program development and monitoring. Members are the Department of Health, the Council on Children and Family, the State Education Department, the Office of Mental Health, the Association of NYS Youth Bureaus and community service providers.

#### Other Collaborations

? Healthy Start: Many of the federal Healthy Start grantees are also grantees of New York State Department of Health under the Comprehensive Prenatal/Perinatal Services Network initiative. The Networks were initially funded under Title V, but have now moved onto a different source of funding. However, the need for close association with Title V programs continues in order to maximize mutual effectiveness. During the past year, Healthy Start grantees met with the Department on a number of occasions to explore opportunities for collaboration. The Department holds periodic meetings (at least two per year) with Healthy Start grantees in order to foster better communication, explore areas for potential collaboration and share late-breaking developments. ***/2005/The Healthy Start consumer group assisted Title V in evaluating focus group methods and provided feedback that will be incorporated in planning for the next wave of consumer focus groups. Regional staff meet with the Networks on a routine basis. The Bureau of Women's Health has applied for a Healthy Start grant this year./2005//***

? Local Health Departments: County health departments continue to play an essential role in the assurance of high-quality, accessible maternal and child health services. They assessed the needs of their local communities, worked with their communities to design and implement programs that meet those needs, and evaluated the effects on their communities.

Under New York State Public Health Law, local health departments extend the powers of the state health commissioner. Local health units 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 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 Public Health Law.

Under Article 6 of the Public Health Law, local health departments perform comprehensive community health assessments, and subsequently produce a Municipal Public Health Service Plan. Plans address the needs of the maternal and child health population in health education, infant mortality prevention, child health, family planning, chronic disease prevention, injury control, disease control and nutrition. Title V provides technical assistance to local health units in plan development, participates in the review process and monitors implementation. Because local health departments know local systems and community needs, Plans address coordination across public and private resources, and across the continuum of primary, secondary and tertiary care. Local health units play a critical role in fostering local collaborations.

? New York State has a long-established system of highly specialized Regional Perinatal Centers (RPCs). These Centers provide tertiary level clinical care to high-risk mothers and newborns, and also serve as important contact points for the Department of Health in our interactions with the health care community. They help ensure that high-risk mothers and newborns receive appropriate levels of care by working with their affiliate hospitals to monitor perinatal morbidity and mortality and to provide education and technical assistance to physicians and others. The Regional Perinatal Centers not only serve as the hub for consultation and transport within a network, but lead quality improvement activities within their network. RPC's reassessed and redesignated in 2001.

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

? The University at Albany School of Public Health is unique in that it is jointly sponsored by a university and a state health department. The New York State Department of Health serves as the laboratory for the University at Albany School of Public Health, with graduate students working shoulder-to-shoulder with practicing professionals in the state health department or in local departments. A number of DOH and Title V staff serve as faculty and advisors to the school. Title V staff also serve on the School's Continuing Education Advisory Board.

? Title V staff coordinate the MCH Graduate Assistant Program, under which fourteen University at Albany graduate students per semester (fall, spring and summer) are supported by block grant funds to work on priority MCH research and planning projects. This arrangement supports the Department of Health's mission through attracting bright, motivated individuals who are interested in gaining theoretical and practical knowledge of public health and maternal and child health. The students enhance the Department's research capacity, and improve the availability of pertinent and timely educational offerings for practicing public health professionals in the region.

? The University at Albany's School of Public Health sponsors the Northeast Public Health Leadership Institute, now serving the northeast corner of the US. Several Title V staff have attended the Institute, including the Title V Director and the Title V Coordinator. Several graduates of the Institute also serve Title V in other states and at the New York City Department of Health. Title V staff serve on their advisory council.

? The Department also maintains a relationship with the Columbia University School of Public Health through a Collaborative Studies Initiative. Metropolitan Area Regional Office staff serve as advisors and contract managers to the program. Columbia students and public health faculty identify current issues in maternal and child health, and apply public health theory and practice in designing and implementing solutions to those issues.

? New York has three University-Affiliated Programs who offer Leadership Education in Neurodevelopmental Disabilities (LEND). They are the University of Rochester, the Westchester Institute at Valhalla, and Jacobi/Albert Einstein Medical Center. LEND Programs provide for leadership training in the provision of health and related care for children with developmental disabilities and other special health care needs and their families. The Department works with the LENDs on a variety of issues related to children with special health care needs and to meet training needs, and the University Affiliated Programs are a great source for physician consultants on a variety of issues.

? 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 the teaching of behavioral pediatrics, scholarship and community service. Fellows who have completed training are board-eligible in pediatrics. The three-year fellowship program includes course work and clinical practice in growth and development, adaptation, injury prevention, disease prevention and health promotion. The program is also available to provide continuing education and technical assistance.

? Montefiore is also the sponsor of the Prenatal Education and Awareness of Safety (PEAS Project), through its Family Health Center. The PEAS Project has implemented a model domestic violence protocol for recognition and intervention with clients who are abused. The model consists of professional education, the addition of an on-site domestic violence coordinator, a public health campaign for patient and community education, the use of a standardized tool as an avenue for disclosing abuse, and systems changes that support the change in practice (chart prompts, documentation forms, inclusion in quality assurance). Their focus is on prenatal patients, but the principles and procedures are applicable to all women and men who are abused.

? The Department of Health, with the School of Public Health at the University at Albany, the New York State Community Health Partnership and the New York State Association of County Health Officials, sponsors monthly Third Thursday Breakfast Broadcasts (T2B2). T2B2 provides statewide continuing education opportunities covering a variety of public health issues. Local site coordinators in each county health department coordinate local logistics. Out-of-state attendees can locate sites by visiting the University at Albany's website: [www.albany.edu/sph/coned/t2b2site.html](http://www.albany.edu/sph/coned/t2b2site.html). Continuing medical and nursing education credits are available. Series have focused on Children's Health, Quality of Life, Emergency Preparedness, Promoting Healthy Behavior, and Model Programs.

? The Office of Children and Family Services also sponsors with partners such as DOH, the SUNY Distance Learning Project, and the New York State Child and Family Trust Fund, monthly satellite broadcasts on child health and safety topics such as SIDS and Risk Reduction.

? DOH strives to maintain positive and collaborative relationships with several not-for-profit, voluntary

groups who share concerns for the health and well-being of mothers, infants, children and women of childbearing age. The Department's Title V program has many active relationships/collaborations.

Please see pages 109-110 in the Needs Assessment section for a list of active collaborations.

## F. HEALTH SYSTEMS CAPACITY INDICATORS

### #01 Health Systems Capacity Indicator

The rate of children hospitalized for asthma (per 10,000 children less than 5 years of age)

Rates went from 65.8 in 1998, to 81.5 in 1999, to 62.9 in 2000, to 66.6 in 2001 and 65.4 in 2002. It appears that 1999 was a "blip" in a downward trend, as rates have been decreasing over the last ten years. Rates continued to be higher in New York City, compared to the rest of the State. We are continuing to monitor these rates as we continue implementing the Statewide Asthma Plan.

### #02 Health Systems Capacity Indicator

The percentage of Medicaid enrollees whose age is less than one year who received at least on initial periodic screen

Idiosyncrasies in data sources and analysis make these data hard to interpret. It appears we are on an upward trend, but have just two years of data consistency. ***/2005/ Percentages were 74.9 in 2002 and 74.9 in 2003.//2005//***

### #03 Health Systems Capacity Indicator

The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen

These data remain about stable ***/2005/or increasing: 62.0 in 2001 and 67.0 in 2002.//2005//***

### #04 Health Systems Capacity Indicator

The percent of women (15through 44) with a live birth during the reporting year whose observed-to-expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index

There data have been trending toward improvement. ***/2005/There was a one-year of decrease from 2000 to 2001, but rates were relatively unchanged from 2001 to 2002, at 63.5% and 63.6%, respectively.//2005//***

### #05 Health Systems Capacity Indicator

Comparison of health systems capacity indicators for Medicaid, non-Medicaid and SCHIP programs for infants (birth to age 1), children and pregnant women

***/2005/In general, health outcomes are less favorable for those of lower socioeconomic status than those that enjoy higher standards of living. Medicaid populations generally fair less favorably than privately insured populations with regard to infant mortality, early entry into prenatal care, low birth weight, and adequacy of prenatal care. This is not necessarily related to the source of payment for their care, but more likely attributable to a confluence of factors.//2005//***

### #06 Health Systems Capacity Indicator

The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (birth to age 1), children and pregnant women

Medicaid: Pregnant women and infants under one year of age, at or below 200% of the Federal Poverty Level (up from 185%), are eligible for Medicaid. Women are eligible for family planning based solely on the woman's income being below 200% of the Federal Poverty Level, regardless of previous Medicaid eligibility or pregnancy. If women are on New York State Medicaid at the time of pregnancy,

then lose their eligibility, they are eligible for 24 months of continuous family planning coverage following their pregnancy.

Children ages one to nineteen are eligible at 133% of the FPL without resource testing.

Family Health Plus Medicaid is available at two levels. Adults with children under the age of 21, whose gross family annual income is up to 150% of the Federal Poverty Level, or \$ 28,275 for a family of four, are eligible. Single adults, with gross family income is up to 100% of the Federal Poverty Level or ~~2005/\$9,310~~ ~~2005~~/per individual, are also eligible.

Children, ages one month to age 19 years, with family incomes at or below 250% of the FPL, are eligible for subsidized health insurance coverage under Child Health Plus. Coverage for those under 160% FPL is free. Premium contribution for families between 160 and 222% is \$9 per child per month, with a maximum of \$27 per family per month. For families with incomes between 222 and 250% FPL, the contribution is \$15 per child per month, with a maximum of \$45 per family. For families with incomes over 250% of the FPL, Child Health Plus is available at full premium. There are no co-payments for services. Table 13 below indicates current eligibility levels.

#### #07 Health Systems Capacity Indicator

The percent of EPSDT-eligible children aged 6 through 9 who have received dental services during the year

It appears that percentages are dropping slightly. We believe this is due to a tightening in the supply of dentists willing to take Medicaid. (The number of clients across all age groups who receive MA-financed dental services is down, despite fees being raised.)

***//2005/In 2002, the percentage was 35.8%; in 2003 the percentage was 35.1%. //2005//***

#### #08 Health Systems Capacity Indicator

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program

This indicator is not particularly applicable to New York, since all SSI recipients automatically have Medicaid, which is more generous than our Physically Handicapped Children's Program.

#### #09A Health Systems Capacity Indicator

The ability of States to assure that the Maternal and Child Health Program and the Title V agency has access to policy- and program-relevant information and data

MCH data is placed on the HIN (NYSDOH's public website) and on the HPN (NYSDOH's provider health network). Regional Perinatal Centers also have access. The Title V application is available on the public website, as well.

#### #09B Health Systems Capacity Indicator

The ability of States to determine the percentage of adolescents in Grades 9 through 12 who report using tobacco products in the past month

This is an item on the YRBS, in which New York participates. Adolescent smoking rates are also available through the Youth Tobacco Survey. The Division of Chronic Disease Prevention and Adult Health employs an epidemiologist for the tobacco program who works with both adult and child smoking data.

#### #09C Health Systems Capacity Indicator

The ability of States to determine the percent of children who are obese or overweight

Obesity data is available both from the WIC program and from the Youth Risk Behavior Survey. We

have no other current sources of data. We have data from an old study (1996) of New York City School children. This year, nutrition/obesity surveillance **/2005/has been incorporated into the/2005//** ongoing dental surveillance initiative, doing height and weight measurements at the same time as dental assessments. Under the PAN (Physical Activity and Nutrition) Initiative, there will be further discussion on gaps in data gathering.

## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

This section profiles New York's maternal and child health priorities, selected performance measures, and program activities and discusses the extent to which National and State objectives were met in this program year.

As previously described, New York has undergone extensive priority-setting processes. Throughout, participants decline to rank priorities, preferring that each of these "opportunities for improvement" be considered of equal importance. Following the last five-year assessment cycle required by Title V, and in consideration of past progress, several performance targets were re-adjusted. The ten priorities that follow, and the specific performance measures related to each, stem specifically from areas of unmet need in the State.

New York Title V is using an Oracle-based system for gathering and managing program information that delineates goals, objectives, sources of funds, staffing and performance measures for the maternal and child health-related programs. Because this is only the third year our system has been in use, there may be some discontinuity of the financial data with previous years' submissions. These data are gathered from program managers in all of the MCH-related programs, whether or not the programs are block grant funded.

Most often, program that address maternal and child health issues initiate services and interventions on a variety of levels. For example, in addressing access to care, we are improving the insurance and charity care infrastructure, targeting population-based messages, enabling clients to access and sustain their relationship to a medical home, and work to remove barriers to accessing high-quality direct medical services. Thus, each of the four levels of the MCH pyramid may be relevant to a particular need.

A brief summary of New York's accomplishments through use of Title V and other funds appears in Section B. New York's progress on Federal and State Performance and Outcome Measures are tracked on Forms 11 and 12.

### **B. STATE PRIORITIES**

After the last full Needs Assessment, priority setting was conducted as a melding process, combining:

- ? The results of the Communities Working Together and other participative processes;
- ? The use of the many and various data sets available to the Department;
- ? The use of program data and provider input to identify trends and issues;
- ? Infrastructure evaluation;
- ? The input of the public and the Maternal and Child Health Services Advisory Council to assist in interpreting these data and identifying important trends, gaps in services or barriers to care; and
- ? The input of key staff within the Department.

The process remains unchanged since the last application. Collaborations and partnerships that contribute to the needs assessment process have also remained unchanged.

As a result of the needs assessment process, the following ten priorities were identified:

1. To improve access to high-quality health care for all New Yorkers, with a special emphasis on prenatal care and primary and preventative care for infants and children, including those with special health care needs, and incorporating dental health and mental health care;
2. To improve oral health, particularly for pregnant women, children and those of low income;
3. To continue toward elimination of health disparities, especially with regard to low birth weight and

infant mortality;

4. To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;
5. To reduce tobacco use among children and pregnant women;
6. To reduce the use of alcohol among children and pregnant women;
7. To reduce unintended and adolescent pregnancies;
8. To implement a statewide system of universal newborn hearing screening;
9. To reduce the rate of self-inflicted injuries and suicide for 15 to 19 year olds; and
10. To improve parent and consumer participation in the Children with Special Health Care Needs Program, as evidenced by parent scores.

This list remains unchanged since the last application. The justification for their selection as priorities may be found in Section II. B.1., and a description of our planning/targeting framework may be found in Section II.A. This same section also contains a table that summarizes the relationship between New York's priority needs and the measurement of their progress through Federal and State Performance and Outcome Measures.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

### a. Last Year's Accomplishments

? /2005/ 254,018 //2004// infants were screened for genetic disorders in /2005/ 2003 /2005/ by NYSDOH's Wadsworth Laboratories Newborn Screening Program.  
? 100% of newborns in NYS are tested for eleven congenital conditions: PKU, MSUD, galactosemia, biotinidase, homocystinuria, congenital hypothyroid, hemoglobinopathies, congenital adrenal hyperplasia, cystic fibrosis, medium-chain acyl-Co-A dehydrogenase deficiency and exposure to HIV-1.  
? /2005/ Of children screened, there were 7 confirmed cases of PKU, 140 confirmed cases of Congenital Hypothyroidism, 3 cases of Galactosemia, 113 of Sickle Cell Disease, 1 of Biotinidase Deficiency, 50 cases of Cystic Fibrosis, 16 cases of CAH, no cases of MSUD, and 12 cases of MCADD. (See Form 6.)  
? Through a series of meetings involving The Newborn Screening Program and the Children with Special Health Care Needs Program, three new types of Specialty Center standards were produced: Cystic Fibrosis, Endocrine and Inherited Metabolic Diseases.  
? Prenatal Genetics Services were provided to 23,712 people in 2003.  
Another 12,302 individuals received Clinical Genetics Services through Title V genetics services grantees. //2005//

### b. Current Activities

? Wadsworth Laboratories continues to screen 100% of the state's newborns for PKU, congenital hypothyroidism, galactosemia, sickle cell disease, biotinidase deficiency, cystic fibrosis, homocystinuria, CAH, MSUD, MCAD and HIV-1. /2005/100% of presumptive positive screens are followed for confirmation; 100% of confirmed cases are followed to ensure treatment. ? Title V continues to monitor follow-up on active cases to ensure that

***infants with positive results receive appropriate follow-up.//2005//***

? Local health units can and do use Article 6 State Aid reimbursement to pay for follow-up visits by public health nurses or bill insurance companies for these services. ? Clinical genetics services, including follow-up genetics counseling for families of children with inborn metabolic errors are available through the Genetics Program. The Wadsworth Center for Laboratories and Research administers 23 contracts that cover services. ? Comprehensive Prenatal/Perinatal Services Networks promote newborn screening and appropriate follow-up through newsletters and provider meetings.

c. Plan for the Coming Year

? Newborn Metabolic Screening will continue.

? The CSHCN and the Genetics Screening Programs will continue to monitor implementation and ensure appropriate follow-up services.

***? /2005/The CSHCN and Newborn Screening Program are planning joint monitoring visits to Cystic Fibrosis, Endocrine and Inherited Metabolic Diseases Specialty Centers. //2005//***

There are no plans for further changes at this time.

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

a. Last Year's Accomplishments

? The CSHCN Program continued to employ a Family Specialist, the parent of a child with special health care needs, and several other employees

? The CSHCN Program continues to broaden in areas of policy development, improving access to health and related services for CSHCN, identifying and referring CSHCN to appropriate services, and collecting information to identify gaps and barriers in order to improve the system of care for CSHCN.

? Parents were invited and participated in consumer focus groups held around the State. Parents participating were reimbursed for their time, travel and child care expenses. Focus groups were held to engage groups most at risk for poor health outcomes and obtain information on their health care needs. The information from the focus groups will help to improve the systems of care for all women, infants, children and youth in New York State, including those with special needs.

? Parents of CSHCN spoke at five public hearings sponsored by the MCHSBG Advisory Council.

? Healthy Start consumers met with Title V staff to discuss consumer involvement. ***/2005/ This group gave Title V staff feedback on consumer focus group methodology. The project received very favorable reviews. //2005//***

? The NYS Medical Home Project ***/2005/ began training local CSHCN programs in medical home concepts and began to require that programs include in their annual workplans enhanced parent involvement.//2005//***

? Family Specialist participated as a member of the state team at the national EMSC conference. The Family Specialist presented to family and EMS providers about how to be prepared for an emergency that involves a child with special needs. As a Family Voices

representative, the Family Specialist represents families of CSHCN at meetings and conferences of regional significance.

#### b. Current Activities

? CSHCN Program staff continues to work with the parent involvement strategic plan formulated in 1999 to improve consumer input into MCH programs and policy development.

? CSHCN Program staff and the Title V Coordinator worked with the SSDI Coordinator to implement parent/consumer focus groups.

? ***/2005/ The CSHCN Program has begun provider training in medical home concepts. //2005//***

? CSHCN Program staff and the Title V Coordinator worked with the SSDI Coordinator to facilitate a meeting of Healthy Start consumer representatives who were invited to critique our focus groups methodology.

? The Early Intervention Program offered leadership training programs, informational bulletins, and parent membership on all clinical practice consensus panels. There is an active Parent Involvement Committee.

? The Early Intervention Program employs a Family Initiatives Coordinator, who is the parent of a child with a disability, to coordinate a range of parent initiatives.

? NYS Title V with CDC to further examine SLAITS data from NYS.

#### c. Plan for the Coming Year

? Further examine SLAITS data.

? Repeat focus groups.

? Continue implementation of the NYS Medical Home Project and improving parent involvement.

? Continue funding local health departments to assist CSHCN and their families.

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

#### a. Last Year's Accomplishments

? The Children With Special Health Care Needs (CSHCN) Program ***/2005/implemented Year 2//2005//*** of NYS Medical Home Project funded by HRSA. The grant is a collaborative activity of families of CSHCN, NYSDOH, District II of the American Academy of Pediatrics, the American Academy of Family Physicians and other key stakeholders. The goal is to develop and implement a statewide medical home plan for New York State and to ensure all NYS CSHCN have access to medical homes.

? The NYS Medical Home Project ***/2005/ trained local CSHCN Programs in medical home and parent involvement concepts.//2005//***

? The CSHCN Program funds local county health departments to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service

needs.

? There were ***/2005/ 5,233 //2005//*** children served by the CSHCN Program. ***/2005/ Fifty-four percent (54%)//2005//*** of children were reported as having a primary care provider, ***/2005/ up from 51% in the previous year.//2005//*** The CSHCN Program is using the presence of a primary care provider as one component for the measure of a medical home.

? ***/2005/ The CSHCN Program worked with the New York State Technology Enterprise Corporation (NYSTEC) to finalize business requirements for the CSHCN Information System. This system will provide relevant program data and make it easier for local programs to track the CSHCN treatment experience. //2005//***

? The Early Intervention Program has an active Medical Home Workgroup to ensure children in their program have access to medical homes.

? The American Indian Health Program and the Migrant Health Program both work to improve access to comprehensive care and to establish a medical home for children. Because of the unique circumstances of migrant children, providers concentrate on connectivity with upstream and downstream providers.

? The Growing Up Healthy Hotline continues to provide information to callers about access to medical homes for children.

? The School Health Program located 186 school-based health centers in areas where morbidity and mortality from preventable and mental health conditions are disproportionately high. School-based health centers in NY are required to provide access to care 24 hours per day, seven days per week.

? All New York State Department of Health Programs dealing with prenatal care (PCAP, MOMS, Community Health Worker) work with expectant parents to help find a provider for their baby.

? Healthy Child Care New York Child Care Health Consultants assist families in child care to locate and enroll in a medical home.

## b. Current Activities

? NYS Title V is working with CDC to further examine SLAITS data from NYS.

? ***/2005/ Medical Home training continues. //2005//***

? The Early Intervention Program has an active Medical Home Workgroup to ensure children in their program have access to medical homes.

? ***/2005/ CSHCN Program staff continue to assist families without medical homes to find medical homes for their children.//2005//***

## c. Plan for the Coming Year

? Continue implementation of the NYS Medical Home Improvement Project. ? Continue to engage key stakeholders in development and implementation of a statewide medical home plan for NYS.

? Ongoing participation in NICHQ Medical Home Learning Collaborative (MHLC) including attendance at all three learning sessions, site visits to all NYS MHLC participating practices.

? More regional provider trainings will be offered.

? Continue funding local health departments to provide CSHCN Program services.

? The CSHCN Program will continue to work with contractors who serve CSHCN to refer children without a primary care provider to health care providers and sources of insurance to access health care providers.

? The CSHCN Program will encourage local CSHCN Programs to become aware of the medical home concepts. Medical home and parent involvement are now required workplan elements.

? Continue analysis of SLAITS. Use as benchmarking.

? Continue Medical Home Workgroup under the Early Intervention Program.

? Increase number of child care health consultants who can assist children to obtain medical home.

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

#### a. Last Year's Accomplishments

? The CSHCN Program continues to fund local county health departments to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service needs.

? The Physically Handicapped Children's Program under the NYS Children with Special Health Care Needs Program continued to provide gap-filling coverage for children with special health care needs birth to age 21 for services that insurances will not cover or for children in special financial circumstances who are ineligible for Medicaid or Child Health Plus.

? In ~~/2005/ 2003, //2005//~~ the Physically Handicapped Children's Program (PHCP) assisted 583 children with payment for diagnostic services and ~~/2005/ 3,244 //2005//~~ children with payment for treatment services. ***/2005/ The more successful programs are in enrolling CSHCN into insurance programs, the less will be the need for these gap-filling services. //2005//***

? Each county within NYS has "facilitated enrollers" who assist families to access public insurance and fill out enrollment forms. Each local health department CSHCN Program is required to have a referral linkage to the facilitated enrollment agency in their area. In some cases, the facilitated enrollment program is within the same agency.

? NY uses a combined Medicaid, Child Health Plus, Family Health Plus and WIC enrollment application.

? All children identified as uninsured and underinsured by the Childhood Lead Poisoning Prevention Program are referred to appropriate local public insurance enrollment source. Lead poisoned children and their families, without health insurance are directed to and assisted with enrollment in MA and/or Child Health Plus to expedite access to care. State program provides technical assistance to local program to expedite enrollment. Systems are in place to help uninsured needing immediate medical attention.

#### b. Current Activities

? Same as above. There have been no major changes in the past year.

#### c. Plan for the Coming Year

? The CSHCN Program will continue to fund local health departments to work with CSHCN and

their families to ensure access to health insurance and medical homes.

? No major changes are planned with regard to Medicaid or Child Health Plus coverage.

? Local programs will continue to link with facilitated enrollers.

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

#### a. Last Year's Accomplishments

? The CSHCN Program continued to fund local county health departments to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service needs.

? The CSHCN Program, under authority of the Physically Handicapped Children's Program legislation, is authorized to approve Specialty Centers. Specialty Centers are expected to provide family-centered, comprehensive, culturally- and language-appropriate care. They are also expected to work in a coordinated fashion with the child's community-based medical home.

? The Early Intervention Program (EIP) is funded by State and other Federal appropriations, but it has strong ties to the MCHSBG programs and services, providing direct services to infants and young children who are identified as having or being at risk for disabilities. The child find mechanism under EI locates and tracks developmental surveillance of at-risk infants and their families and links families with appropriate services. EI is a major source of MCH referrals. In FFY 2004, the Early Intervention Program will continue to work with the Children with Special Health Care Needs Program on cross-program issues, such as parent involvement and sharing of data.

? The Early Intervention Program employed two types of service coordination. The first type assist families through the initial phase of entry into the Early Intervention Program, helping them to deal with the multi-disciplinary evaluation and development of the first Individualized Family Services Plan. The second type of service coordination is ongoing, designed to ensure that families are supported through all aspects of the Early Intervention Program and that EI services are coordinated with other services and supports offered to families for sources outside of the program. ? The Community Health Worker Program assists families to connect to health care services and sustain that connection.

? Consumer focus groups were asked about their experiences with accessing services. This information is shared with program managers and policy makers to ensure incorporation into program planning.

? The Resource Directory for Children with Special Health Care Needs was reprinted and has been distributed to local health departments, hospitals, community agencies, schools, libraries, families and other providers. The directory is available in English, Spanish, Russian, Chinese and French.

? The Congenital Malformations Registry staff sent informational mailings to notify families of children born with malformations of the Early Intervention Program and support groups available statewide.

? Local health department programs actively link lead poisoned children with special healthcare needs to the appropriate services, if available in the communities. In most cases, a lead poisoned child is automatically given a developmental screening and referred to the EIP.

#### b. Current Activities

? The Medical Home Project is being organized to have an impact on the "family friendliness"

of local systems of care.

? Local health department CSHCN Coordinators work with families and providers to enable smooth referrals to specialty providers and other needed services.

? The Early Intervention Program continued to provide initial and ongoing service coordination.

? SLAITS data was received and is undergoing more analysis with the aid of the CDC.

? Results of consumer focus groups are being shared with all MCH and public insurance programs.

### c. Plan for the Coming Year

? The CSHCN Program will continue to fund local health departments to work with CSHCN and their families to ensure access to health insurance and medical homes.

? The CSHCN Program will continue to work with the providers of specialty care to ensure ease of referral and family-centered care.

? EI service coordination will continue.

? Continue implementation of the Medical Home Project.

? Continue Medical Home Training for providers.

? Continue to monitor Specialty Centers for adherence to program standards.

? Continue to make this a topic for the MCH consumer focus groups.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

### a. Last Year's Accomplishments

? The CSHCN Program sends out materials to children enrolled in the program who have reached transitional ages. Materials explain the need for transition planning and give key points to consider.

? ***//2005/ Transition activities are now required for inclusion in the local CSHCN workplans. //2005//***

### b. Current Activities

? CSHCN Program staff continues to work with the State Education Department and the State Department of Labor on transition issues.

? ***//2005/ CSHCN Program staff monitor and provide technical assistance to local programs around transition issues. //2005//***

? Title V staff are working with CDC on further analysis of SLAITS.

### c. Plan for the Coming Year

? DOH will continue to work with the State Education Department and the State Department of Labor on transition issues.

? ***//2005/ CSHCN staff will continue to monitor the performance of local programs on issues related to transition.***

? ***CSHCN staff will continue to work on information systems development that will assist the program to track these activities. //2005//***

? SLAITS data will be further analyzed. Data will be used for benchmarking.

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

#### a. Last Year's Accomplishments

? The Immunization Program provided vaccines through the NYS Vaccines for Children Program, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted local health departments with disease surveillance and outbreak control activities, and continued to develop a statewide immunization registry. CDC categorical grants and State and Local Assistance dollars were used to provide staffing in both central and regional offices and to purchase vaccines. County health departments assist in recruiting VFC providers.

? Over 90% of two year-old children in New York State (outside New York City) are vaccinated in private doctor's offices, not public clinics. Under the Provider-Based Immunization Initiative (PBII), county staff visit pediatricians and assess the medical records of their patients for compliance with immunization and lead screening schedules. The information is then keyed into a computer using CDC-developed software, the Clinical Assessment Software Application, (CASA). CASA calculates the providers' immunization rate and enables them to improve their vaccination protocols, when necessary.

? Comprehensive Prenatal/Perinatal Services Networks provide education and outreach to engage children into the health care system. Some networks conducted outreach for Child Health Plus and to ensure that parents are aware of the need for comprehensive immunization.

? Lead Program has strong programmatic links to the Immunization program via VFC and PBII. Immunization and lead screening records are reviewed, in many instances by SDOH and/or local health department staff. This helps ensure promote provider awareness and compliance.

? Welcome to Parenthood, a packet given to the family of each newborn born in NY, contains information about childhood immunizations.

? State Aid to Localities reimbursed local health departments for the infrastructure that supports immunization surveillance, tracking, parent and provider education and special studies.

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

? The Community Health Worker Program educated parents about immunization, assessed the immunization status of all children in the program, referred and assisted families to obtain immunization, and followed-up with families to assure they actually received the service. In 2003, 82% of the children entering the program were fully immunized. Of those who were not fully immunized, 49% received needed immunizations after they came into the program and an additional 40% were pending. A total of 86% were completely immunized in 2002, and 89% had complete immunizations in 2003.

? PCAP and MOMS teach importance of immunization to pregnant women/new moms.

? Immunization records are reviewed and children are referred or provided with immunizations and for lead screening during clinic visits for WIC, and on home visits to lead-affected children

b. Current Activities

Same as above. No major changes.

c. Plan for the Coming Year

Same as above. No major changes.

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

a. Last Year's Accomplishments

? Family Planning Programs provide community education and public information services, comprehensive medical exams, a full range of contraceptive methods, counseling and testing for sexually transmissible diseases, and special counseling for teens. /2002/ Fifty-nine/**2005// Family Planning Programs provided services to 349,318 low-income, uninsured women in /2005/ 2002, 29%/2005//** of whom were under the age of twenty.

? The Community-Based Adolescent Pregnancy Prevention Program's goal is to reduce teen pregnancies in the highest risk zip codes (now 54 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.

? NYSDOH Bureau of Child and Adolescent Health funded 37 Abstinence Education and Promotion contractors to provide with abstinence education, mentoring, counseling, and adult supervision to promote abstinence from sexual activity in 15 to 19 year olds. They focus on junior high/middle school aged students. The Not Me, Not Now campaign will continue as a statewide, large-scale media campaign to support the community-based initiatives.

? The Comprehensive Prenatal/Perinatal Services Networks promoted reduction of adolescent pregnancy rates through provider and community conferences, outreach and education efforts.

? Article 6 reimbursed local health departments with State Aid for health education and other population-based efforts, and support infrastructure needed to provide data collection, data evaluation, community-based planning and implementing collaborative intervention strategies.

? The Rape Crisis Program developed and implemented policies designed to provide effective and compassionate care to victims of sexual assault and supported professional and community-based prevention education programs.

? The Comprehensive Prenatal/Perinatal Services Networks conducted education and outreach activities to improve the reproductive health of all women, including teens.

? Risk assessment for sexual activity is a part of the initial assessment and anticipatory guidance offered in School-Based Health Centers. Pregnancy testing is done when indicated. Students have access to family planning services, either onsite or by referral. Students are also referred early for prenatal services; practitioners co-manage the students' prenatal care. School-based health centers provided services to approximately 35,000 female students ages 15 to 19 years.

? ACT for Youth continued its youth development focus, building assets for resiliency and resourcefulness among youth.

? The Department met with Healthy Start grantees in order to enhance communication and coordination among grantees and Title V.

b. Current Activities

? No major changes during this program year.

? /2005/ACT for Youth Centers for Excellence provided information statewide and in

c. Plan for the Coming Year

? No major changes planned.

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

a. Last Year's Accomplishments

? The Bureau of Dental Health established dental surveillance in each county. The surveillance grant is currently active across the State, enrolling children for oral health screening and referring children to dental care.

? ***/2005/ Twenty-four of the twenty-six //2005//*** School-Based Preventive Dentistry Programs continued to place sealants in ***/2005/ 2003, //2005//*** serving approximately 44,000 children and providing over 4,000 referrals. This program targeted school children in grades 2, 3, 7, and 8 in low socioeconomic areas and provided children with a point of entry into the dental care system. Students were screened for adverse dental conditions and for the need for application of sealants. Sealant sites increased participation in their program each year. Children who need restorative oral health services are referred. All families in targeted school districts receive promotional and educational information, which appears to contribute to the program's success.

? Beginning in 1999 and continuing into the present, the Preventive Dentistry Program entered into community partnerships involving parents, consumers, providers and public agencies for identifying and addressing community problems related to oral health. This community-based problem solving approach has help to identify effective interventions to suit community needs.

? Other dental programs also promote the use of sealants, including the Preventive Dentistry Fluoride Supplement Program, which provided over 125,000 children with fluoride supplementation in non-fluoridated areas through schools, day care and Head Start programs.

? Article 6 State Aid provided funding for dental health education to each county in New York.

? The American Indian Health Program offered dental services to children under age 20 either onsite or via off-reservation referrals (approximately 2000). The children's fluoride program is on-going for Pre-K through Grade 6 with monitoring of the number of dental caries found.

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

b. Current Activities

? The Preventive Dentistry Program providers have continued to establish community partnerships involving parents, consumers, providers and other organizations for identifying and addressing problems within their communities. This focus has helped to identify effective interventions to suite community needs.

? ***/2005/ The Bureau of Dental Health has convened a workgroup to formulate the state's Oral Health Plan. All key stakeholders are involved.//2005//*** Dr. Thomas Curran, ***/2005/ an oral-maxillary surgeon who is also /2005/ a member of the Maternal and Child Health Services Block Grant Advisory Council has been appointed to that committee. /2005/ The***

***draft plan recognizes school-based dental sealant programs as an effective population-based strategy to improve the oral health of children.***

***? Funding for school-based sealant programs was increased by \$1M in 2003-2004. //2005//***

? The Bureau of Dental Health funded seven projects for Innovative Dental Services to Underserved Areas. Under this initiative, a Technical Assistance Center was funded at the Rochester Primary Care Network. The TAC Director, Dr. Buddhi Shrestha, who has demonstrated success with building community-based organizations responsive to children's dental needs, will provide consultation to developing projects.

***? //2005/ The Bureau of Dental Health //2005// implemented a listserv and an Oral Health Coalition.***

? Ongoing oral health screening and referral was available to all School Based Health Center (SBHC) enrollees. The School Health Program provides funding for school-based health centers to establish and enhance dental services for children and youth served by SBHCs, exhibiting substantial risk for dental health problems. Eight providers with thirty-one school-based health center sites serving 34,000 students will provide a range of services including education and outreach, screening, referral and follow-up, and treatment for students in these schools. Sites will be staffed with a combination of dental assistants, dental hygienists and dentists. Dental students and residents may also be part of the programs to provide them with professional development opportunities and to help expand these services. ***? //2005/ The Department reached an agreement with the State Education Department that will make it easier to establish School-Based Dental Centers. //2005//***

#### c. Plan for the Coming Year

? Enhanced funding to contractors who will expand access to dental sealants.

? Implementation of Innovative Dental Services grants.

? Continue surveillance activities that were started in the past fiscal year.

? Release Dental Surveillance data.

? Formulation of a Statewide Oral Health Plan.

? Monitor provider billing efforts and their efforts to obtain other sources of funding such as grants, donations from local businesses, etc.

? Continue to promote the use of effective preventive services such as community-based fluoride, dental sealants, education and other innovative programs.

? Ongoing oral health screening and referral will be available to all SBHC enrollees.

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

#### a. Last Year's Accomplishments

? Childhood Injury Prevention Projects have built successful coalitions for injury control at the local level, reaching out to diverse segments of the community to ensure that the populace is

well informed on issues related to childhood injury prevention.

? The Injury Prevention Program performs traffic related research and conducts surveillance of traumatic brain injury in NYS.

? The Emergency Medical Services for Children Project compiled data to assist providers in prevention activities and in further enhancing the pediatric trauma care system. ***/2005/ Motor vehicle crashes annually account for about 20.7% of all pediatric trauma cases and are the largest percentage, of all pediatric Dead On Arrivals (about 35%).//2005//***

? The Community Health Worker, PCAP and MOMS Programs all have extensive child safety components, which stress car seat use and other infant safety measures:

? Parents who are enrolled with Community Health Workers are given extensive information about childhood safety. Homes are assessed for hazards and workers role model positive parenting skills.

? American Indian Nations with Community Health Worker Programs all have formalized car seat education components. Other reservation clinics promote vehicle safety during individual health education/risk reduction encounters. Last year, a vehicular accident helped rally the tribal members to address alcohol/substance abuse, vehicle safety and risk reduction.

? PCAP and MOMS have an extensive health education agenda, including infant and child safety, use of safety seats, and burn prevention and other causes of infant injuries.

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

#### b. Current Activities

***/2005/No major changes occurred. //2005//***

#### c. Plan for the Coming Year

No major changes are planned.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

#### a. Last Year's Accomplishments

? State regulation requires each hospital to have a lactation consultant. Regulations specifically forbid the administration of anti-lactation drugs by standing order and the issuance of sample packs of formula without prescription.

? The Department of Health continued to support the New York State Institute for Human Lactation to increase the breastfeeding initiation and continuation rate and to provide continuing education on breastfeeding to physicians, midwives, nurses and other health care providers, helping them to promote and manage breastfeeding effectively. The Institute produces an annual videoconference called the Breastfeeding Grand Rounds that addresses both clinical and public health issues related to breastfeeding and lactation. The conference, which is broadcast statewide to an audience of approximately 500 professionals annually, includes a clinical lecture, a public health lecture, discussion of case studies, and extensive opportunity for audience participation and questions.

? For over 25 years, the WIC Program has been effective in reducing the incidence and

prevalence of nutrition-related disorders of pregnancy, infancy and early childhood, specifically low birth weight, infant mortality and iron deficiency anemia. New York's WIC Program supports a service delivery system of 100 local agencies, 570 delivery sites, 4300 retail food vendors and 475,000 participants. Breastfeeding promotion and support activities were expanded into all local WIC agencies. The ever breastfed rate among WIC participants was 64.1%.

? It is important to initiate discussion about infant feeding choices prior to the antenatal hospital admission. PCAP and MOMS encourage breastfeeding through education during prenatal care and at the postpartum visit.

? The Community Health Worker Program educates all pregnant clients about the benefits of breastfeeding, 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 2003, 62% of the CHWP clients were breastfeeding at hospital discharge, and 63% of them continued breastfeeding six weeks postpartum.

? The Prenatal/Perinatal Networks developed and implemented workshops on the importance of breastfeeding. Part of this strategy in several areas of the State is to work with obstetrical nurses and hospital staff to encourage and support breastfeeding. Based on the work of the Networks, some hospitals have developed breastfeeding support groups as a mechanism to provide ongoing support to breastfeeding women.

? 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](http://www.health.state.ny.us/nysdoh/b_feed/index.htm)).

? The Bureau also conducts periodic hospital surveys to monitor rates.

#### b. Current Activities

There were no major changes in policy or programs.

#### c. Plan for the Coming Year

No changes are planned.

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

#### a. Last Year's Accomplishments

? New York dramatically improved newborn hearing screening rates ***/2005/since the initiation of the Universal Newborn Hearing Screening Program./2005//*** Data collected ***/2005/ from October 2002 to September 2003 //2005//*** from facilities required to administer newborn hearing screening programs indicates that ***/2005/ 98.7% //2005//*** of newborns were screened for hearing impairment prior to hospital discharge. The calendar year 2003 rate was 96.4%.

? ***/2005/ Data collection improved based on new data management guidelines.***

? ***Clinical practice guidelines on assessment and intervention for young children with hearing loss were completed and released in Early Intervention Guidance Memorandum 2003-03 on Newborn Hearing Screening. This memorandum contains information on newborn hearing screening, the program requirements for maternity hospitals and birthing centers and guidance on the role of the Early Intervention Program in facilitating follow-up for infants referred from hospitals.***

? ***Program staff provided training and technical assistance to local program managers and to Early Intervention Programs. //2005//***

? Infants in whom hearing loss is suspected are referred to the Early Intervention Program.

? Although the Community Health Worker Program does not screen for hearing loss, the program initiated the use of the Ages and States Questionnaire (ASQ) in 2001. This is a parent-completed developmental screening tool. Through this process, the Community Health Worker program can potentially identify issues related to the child's development that could include issues with hearing. The program makes referrals to the Early Intervention Program, as appropriate.

#### b. Current Activities

? Currently, all hospitals have systems for testing, tracking and reporting newborn hearing screening.

? Quality Improvement efforts were targeted at data collection from the state's 161 maternity hospitals/birthing centers.

? DOH continued to reinforce links between newborn hearing screening and the Early Intervention Program through dissemination of an Early Intervention Guidance Memorandum on Newborn Hearing Screening.

? DOH continued to provide technical assistance to hospitals and other constituents on newborn hearing screening program implementation.

? Award winning public education/parent education materials on newborn hearing screening were developed and provided to facilities to coincide with the effective date of the regulations. Materials were translated into six languages.

#### c. Plan for the Coming Year

No major changes are planned.

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

#### a. Last Year's Accomplishments

? Children ages one to nineteen are eligible for Medicaid at 133% of the Federal Poverty Level for twelve months of continuous coverage, even if their family's income exceeds eligibility levels during that year.

? Since November 2000, pregnant women and infants are eligible at or below 200% of poverty. All infants born to mothers enrolled in PCAP are MA-eligible for at least the first year of life. PCAPs also refer to programs such as Child Health Plus and/or Family Health Plus as appropriate. The Department has developed an application for all programs to help simplify the application process.

? Eligibility for Family Planning coverage is available up to 200% of poverty, regardless of previous pregnancy or eligibility. Under this waiver, the Federal government pays 90%, the State 10%, and there is no local share. FPBP screens every enrolled family for eligibility for public insurance.

? Facilitated enrollers are available statewide to assist families with public insurance enrollment processes.

? Children's Medicaid is called Child Health Plus A to avoid the stigma associated with Medicaid.

? Families at or below 250% of the Federal Poverty Level are eligible for Child Health Plus B

(New York's State Child Health Insurance Program). Families over 250% of FPL are eligible for participation at full premium.

? Comprehensive Prenatal/Perinatal Services Networks facilitate the implementation of Medicaid Managed Care within their catchments area. Many Networks are facilitated enrollers for health insurance programs. Networks provide outreach, information and education regarding Managed Care and have the ability to identify new and emerging issues related to managed care.

? All MCHSBG funded programs are required to facilitate enrollment in insurance.

? ***/2005/ Children with Traumatic Brain Injury injured before the age of 18 are eligible for Medicaid under a special waiver.***

? ***CSHCN who did not have a source of insurance were assisted by the CSHCN Program to enroll in an insurance program, if eligible. //2005//***

? In ***/2005/ 2003, 15% //2005//*** of the children entering the Community Health Worker Program did not have any form of health insurance, ***/2005/ down from 17% in 2002.//2005//*** Of these children, 53% were subsequently enrolled into Medicaid and 21% were pending at the time of data collection; of the children not eligible for Medicaid, ***/2005/62% of those eligible were subsequently//2005//*** enrolled into Child Health Plus (21%were pending at the time of data collection).

? All children identified as uninsured and underinsured by the Childhood Lead Poisoning Prevention Program continue to be referred to appropriate local public insurance enrollment source. Lead poisoned children and their families, without health insurance are directed to and assisted with enrollment in MA and/or Child Health Plus to expedite access to care. Systems are in place to help uninsured needing immediate medical attention.

#### b. Current Activities

New York continues to implement changes to eligibility levels.

#### c. Plan for the Coming Year

No major changes are planned at this time.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

#### a. Last Year's Accomplishments

? ***/2005/91% of Medicaid-eligible children received a service paid by the Medicaid Program in 2003, compared to 89% in 2002.//2005//***

? New York is currently reviewing EPSDT standards. EPSDT is called Child/Teen Health Plan in New York.

? Title V has been involved with the development of a new EPSDT/Child Teen Health Program Provider Manual. American Academy of Pediatrics standards of care are being adopted, except where State law contravenes. The new Provider Manual makes the case for attention to preventive care and services for children and stresses the need to adhere to periodicity schedules for preventive services.

? Dental fees have been rising over the last three years. Title V staff continue to try to get the word out on enhanced fees.

? The Perinatal Data System is being used to enhance enrollment in Medicaid of infants born to Medicaid-eligible mothers.

? The Community Health Worker Program provides enabling services to assist children and pregnant women with access to care and sustaining contact with the health care system.

? The School Health Program assessed insurance status on enrollment, when children receive an initial assessment and physical. Medicaid is billed for eligible services for those students where MA is indicated as the insurer. Approximately 34% of school-based health center enrollees have Medicaid coverage.

#### b. Current Activities

? Title V has been involved with the development of an EPSDT/Child Teen Health Program Provider Manual. American Academy of Pediatrics standards of care are being adopted, except where State law contravenes.

? The Provider Manual makes the case for attention to preventive care and services for children and stresses the need to adhere to periodicity schedules for preventive services.

? Bureau of Dental Health and Division of Family Health staff are working with the Office of Medicaid Management and the Rural Health Networks on the issue of distribution of dental providers and encouraging more dentists to see Medicaid children.

**? /2005/The Childhood Lead Poisoning Prevention Program has been working with the Office of Medicaid Management (OMM) to determine numbers and percentages of Medicaid children tested for lead. Medicaid/EPSDT will pay for screening and follow-up, and in some managed care plans, home visiting, too, for case management and risk reduction services. //2005//**

#### c. Plan for the Coming Year

**? /2005/No major changes are planned. //2005//**

? Title V will **//2005/assist//2005//** with distribution of the new EPSDT manual.

? Continue working on dental provider issues.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

#### a. Last Year's Accomplishments

? Timely, risk-appropriate, coordinated, comprehensive prenatal care is provided to all Prenatal Care Assistance Program (PCAP)/MOMS Program enrollees. PCAP/MOMS require adherence to Part 85.40 standards of prenatal care, and all managed care plans serving Medicaid women are required to adhere to these comprehensive standards, as well. The provision of high quality prenatal care and appropriate level of care mandated by the standards was shown to reduce low birth weight rates among Medicaid women, particularly minority women, when compared to non-participants. In studies comparing Medicaid women receiving care under these programs with Medicaid women receiving other types of prenatal care, PCAP and MOMS clients had consistently better birth outcomes, and these outcomes were better even at the lower birth weights. Presumptive eligibility helps ensure timely entry into care.

? WIC has directly promoted the birth of healthy infants by preventing low birth weight. In 2002, the percentage of low birthweight was 7.4% among NYS WIC participants, compared to 9.0% of WIC participants nationwide, and compared to a statewide total low birthweight rate of 7.6%.

In 2003, the NYS WIC LBW rate was 7.6%, compared with 8.9% for WIC nationwide.

- ? The Growing Up Healthy Hotline linked women with prenatal, nutrition, psychosocial and supportive services that contribute to healthy pregnancy and improved birth weights.
- ? The Infant Mortality Review process contributed epidemiologic information to promote healthy birth outcomes, to assure adequate prenatal risk assessment, and to encourage follow-up for all high-risk pregnancies.
- ? 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 349,000 low-income, uninsured women in 2003. Family Planning Programs also provided community education and public information in every county in NYS.
- ? The Prenatal/Perinatal Networks and Healthy Start grantees addressed low birth weight through collaboration with a variety of health and human services providers, focusing on low birth weight as a serious issue in their communities and monitoring and disseminating actual data on incidence in their communities. Networks also stress the need for appropriate sites of delivery for high-risk pregnant women.
- ? Prenatal genetics counseling and screening services were provided to approximately 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.
- ? 89% of the women who delivered infants while in the Community Health Worker Program in 2002 delivered a newborn of normal birth weight. 7% of the women delivered low birth weight infants and 1.9% of th%, a slight decrease from 2001.

## b. Current Activities

- ? The Department completed a re-designation process for all birthing hospitals in the State. Under this process, hospitals were required to be able to provide maternal/obstetrical, as well as neonatal, care for high-risk women and their pregnancies.
- ? The Statewide Perinatal Data System is providing real-time internet-based data to providers, networks and local health departments on the occurrence of high-risk births.
- ? Timely, risk-appropriate, coordinated, comprehensive prenatal care is provided to all Prenatal Care Assistance Program (PCAP) and MOMS Program enrollees. PCAP and MOMS require adherence to Part 85.40 standards of prenatal care, and all managed care plans serving Medicaid women are required to adhere to these comprehensive standards, as well. The provision of high quality prenatal care and appropriate level of care mandated by the standards was shown to reduce low birth weight rates among Medicaid women, particularly minority women, when compared to non-participants. In studies comparing Medicaid women receiving care under these programs with Medicaid women receiving other types of prenatal care, PCAP and MOMS clients had consistently better birth outcomes, and these outcomes were better even at the lower birth weights. Presumptive eligibility helps ensure timely entry into care.
- ? WIC continued to promote the birth of healthy infants by preventing LBW.
- ? The Growing Up Healthy Hotline linked women with prenatal, nutrition, psychosocial and supportive services that contribute to healthy pregnancy and improved birth weights.
- ? The Infant Mortality Review process contributed epidemiologic information to promote healthy birth outcomes, to assure adequate prenatal risk assessment, and to encourage follow-up for all high-risk pregnancies.
- ? 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.
- ? The Prenatal/Perinatal Networks and Healthy Start grantees addressed low birth weight through collaboration with a variety of health and human services providers, focusing on low birth weight as a serious issue in their communities and monitoring and disseminating actual data on incidence in their communities. Networks also stress the need for appropriate sites of delivery for high-risk pregnant women.

? Prenatal genetics counseling and screening services were provided to approximately 24,000 women and families.

? 89% of the women who delivered infants while in the Community Health Worker Program in 2002 delivered a newborn of normal birth weight. 7% of the women delivered low birth weight infants and 1.9% of the women delivered very low birth weight infants. There was no data available on 2% of the women. The percent of very low birth weight infants of women in the CHWP in 2002 was 1.9%, a slight decrease from 2001.

### c. Plan for the Coming Year

No major changes in policy or program are planned.

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

### a. Last Year's Accomplishments

? Bureau of Injury Control and the Public Health Information Group make suicide data available and are able to perform additional analyses for use in planning.

? The School Health Program, as part of its initial assessment, has an evaluation for suicide risk. Mental health services, including crisis intervention, were available through the school-based health center or by referral. Referrals may also have been made for more intensive consultation or treatment. School staff, family members and other students are also offered consultation and education. Approximately 16% of SBHC visits indicated emotional issues as a primary reason for the visit.

? The School Health Program, in conjunction with SED and OMH, implemented an expanded school-based mental health initiative in seven schools. This initiative co-located a comprehensive mental health services clinic in seven schools with a school-based health center to provide a range of psychological support, education, consultation and treatment for students and families. School staff education and support were also an integral component of the model.

? Assets Coming Together (ACT) for Youth focuses community attention on asset-building activities for youth as a way of reducing risk-taking behaviors. Through these community collaborations, ACT for Youth has developed youth forums on violence abuse and risky sexual behaviors, as well as peer education materials, conflict resolution training to train peer mediators, and mentoring programs.

? NYS continued implementation of the Lesbian, Gay, Bisexual and Trans-gendered Health Initiative. Over half of the grantees under this initiative are focused on issues related to gay and lesbian youth and issues with alcohol, substance abuse and self-inflicted injuries. Data from other states indicate that gay, lesbian and bisexual youth are approximately 4 times more likely to attempt suicide than their heterosexual counterparts.

### b. Current Activities

? The lead on suicide prevention activities was transferred to the Office of Mental Health, and they are reformulating a suicide prevention plan.

### c. Plan for the Coming Year

? Continued collaboration with the Bureau of Chronic Disease Prevention and Adult Health, Bureau of Injury Prevention, Office of Mental Health and Office of Children and Family Services.

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

a. Last Year's Accomplishments

? NYSDOH recently completed a perinatal re-designation process of all 157 obstetrical hospitals in the State to ensure that all pregnant women and newborns have timely access to the appropriate level of perinatal care. Their designation is based on each hospital's capability to provide care for pregnant and postpartum women and newborns. The last time a designation process took place was 1985, and designations were based solely on newborn care.

? NYSDOH began implementing 11 Regional Perinatal Forums that join the expertise of the hospital provider community with the expertise of the non-hospital community to bring a public health perspective to the regionalization process. Regional Perinatal Centers and Comprehensive Prenatal/Perinatal Networks collaborate in the development and the governance of the forums. Forum membership includes a range of community-based agencies that provide prenatal care, local March of Dimes, Community Health Worker Programs and others. There is one Forum in each borough of New York City, one on Long Island, and five in Upstate.

? Bureau of Women's Health began working with New York City Department of Health and Mental Hygiene to implement a City-wide Forum that brings together the issues from each of the borough Forums.

? All hospitals with Level I, II or III designations are required to by State Hospital Code to have perinatal affiliation agreements with a Regional Perinatal Center that is easily accessible within two hours. There must also be patient transfer agreements, which include transfer criteria, policies and procedures for maternal-fetal, postpartum and newborn transfers and back transfers. Facilities are also required to cooperate in outreach, education and training activities and in onsite quality of care reviews by the Regional Perinatal Center.

? ***/2005/In 2002, the Bureau of Women's Health engaged in a statewide pregnancy-related media campaign to increase awareness of the importance of prenatal care.//2005//***

b. Current Activities

? DOH is continuing to implement Regionalization and Perinatal Regional Forums.

? Perinatal Forums identified a number of public health concerns that on which they plan to work, including: smoking cessation, improving prenatal care and using vital statistics data to identify areas where services are needed.

c. Plan for the Coming Year

? ***/2005/A statewide media campaign on importance of prenatal care is planned for the coming year.//2005//***

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

a. Last Year's Accomplishments

? An important finding of the Department's CDC-funded Maternal Mortality Study was that lack of access to prenatal care in the first trimester was associated with higher risk for maternal mortality; additional data was gathered about barriers to care.

? PCAP and MOMS encouraged early enrollment in prenatal care, offered presumptive eligibility, and ensured timely initiation of services. Public awareness campaigns and the Healthy Baby Hotline helped raise awareness of the need for early prenatal care.

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

? The Community Health Worker Program is a premier enabling service. Specially trained individuals from the target communities and populations educate pregnant women and parents about health needs and instruct/role model the appropriate use of the health care system. They provide enhanced outreach services to engage families and individuals into the health care system and assist them to sustain relationships with appropriate providers. ***/2005/In 2003, 78% of CHW Program enrollees entered prenatal care in the first trimester, compared to 74% in 2002. 16% in 2003 entered care in the second trimester, 3.5% in the third, and 1.5% did not receive prenatal care. There were no data for 1.4% of the women./2005//***

? The Prenatal/Perinatal Networks (CPPSNs) have as their objective to increase the percentage of women entering prenatal care in their first trimester. The networks maintained several outreach and education efforts to promote prenatal care community-wide.

? The School Health Program provided pregnancy testing and reinforced the need for early prenatal care. Access is provided either on-site or through referral to back-up facilities. Nearly 2% of visits indicated pregnancy or contraception as a primary diagnosis.

? The Family Planning Programs make early referrals for women testing positive for pregnancy, thereby improving rates for early access to prenatal care in the populations served.

? The Safe Motherhood Initiative, collaboration between the American College of Obstetricians and Gynecologists (ACOG) and NYSDOH, recommended early entry into high-quality care to deter maternal mortality.

? Early entry into prenatal care continues to be a high priority. The Bureau of Women's Health conducted a statewide media campaign to increase awareness of the importance of early entry into prenatal care and increase awareness of where low-income women can go to obtain prenatal care in 2002. The number of calls for prenatal care to the statewide MCH hotline doubled during the campaign. The CHWP continues to strive to increase the numbers of women entering prenatal care in the first trimester.

## b. Current Activities

No major changes have taken place.

## c. Plan for the Coming Year

? No major changes are planned.

? 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 addressed on an ongoing basis as they arise and PCAPs/MOMS are kept informed about ways to facilitate early entry to care. Providers are offered quarterly meetings with regional office staff in most regions of the state. ***/2005/Funds will be sought to repeat the prenatal care enrollment campaign. //2005//***

? 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. For very high-risk women, the Community Action for Prenatal Care (CAPC) Project will continue.

? Educational materials and media messages will continue to be available through the Bureau of Community Relations.

? Pregnant school-based health center clients were entered into prenatal care immediately. School-based health center staff followed-up to ensure continued enrollment and continuity of care. References were made as needed for additional services.

? Engaging women into early prenatal care is a priority of the Networks.

? In addition to the statewide Growing Up Healthy Hotline, Networks have local toll-free

numbers, resource directories or other mechanisms to provide pregnant women with information and referral to prenatal care. Networks also identify gaps and barriers in the service system, and in collaboration with the Consortium, work to increase accessibility and the quality of the local perinatal service system.

**FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

**General Instructions/Notes:**

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Continue to screen 100% of all New York State newborn infants for eleven congenital conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue to operate a newborn screening laboratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to follow-up on all abnormal screens and tests and assure that 100% of infants needing follow-up get same	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ensure that all newborns with abnormal findings are referred to specialty centers for follow-up	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Monitor specialty centers jointly (BCAH/CSHCN Program and Wadsworth Laboratories)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Continue to employ parents of CSHCN	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue to work with strategic plan for parent involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Monitor local CSHCN Programs for compliance with contract requirements for parent involvement	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Complete data system design activities in 2004-2005	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Complete at least six new parent focus groups in FFY 2005	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

6. Continue implementation of Medical Home Project, including regional trainings	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Implement SLAITS analysis plan; continue analysis of SLAITS data	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Continue funding to local health departments for CSHCN Program	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Meet semi-annually with Healthy Start consumer group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Continue implementation of the Medical Home Project, including regional trainings	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue training local CSHCN Program staff in Medical Home and parent involvement concepts	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Implement SLAITS data analysis plan and continue analysis of SLAITS data	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Pilot two new Medical Home Resource Centers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Continue close collaborations with Medicaid, Child and Family Health Plus Program and facilitated enrollers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to provide gap-filling medical services and enabling services through the Physically Handicapped Children's Program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue to provide medically-necessary orthodontic services through the Dental Rehabilitation Program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Continue implementation of joint application (WIC/MA/CH+/FH+)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to identify underinsured and uninsured children in Title V programs and refer them to public insurance programs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Continue to support local CSHCN Programs at county health departments to provide health information and referral services/enabling services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue implementation of the Medical Home Project, including Medical Home training	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue printing and distribution of Resource Directories	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Share results of consumer focus groups with all program managers and other interested agencies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to monitor Specialty Center for adherence to program standards	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue close linkages with EI service coordination	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Monitor local CSHCN Programs for inclusion of transition activities in program workplans; monitor implementation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue collaborations with State Education Department and State Department of Labor on transition issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide TA to local agencies on transition issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue implementation of SLAITS analysis plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to work with Youth Development (ACT for Youth) Coalitions to include all youth, including those with special health care needs, in asset building and transition to adult life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

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

1. Continue provision of free vaccine through the Vaccine for Children Program	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue active surveillance for vaccine-preventable diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue Physician-Based Immunization Initiative Surveillance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue collaborations with statewide Immunization Program	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to monitor immunization levels of children in Title V-funded or Title V-related programs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

1. Continue provision of comprehensive medical exams and contraceptive services through Family Planning Programs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to implement the Community-Based Adolescent Pregnancy Prevention Program and Abstinence Education	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue risk assessment and referral in School-Based Health Centers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Continue Youth Development focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to provide Abstinence Education Programs throughout New York State	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue ACT for Youth coalition building	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

1. Expand availability of dental sealant to approximately 30,000 children in 2005	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue Oral Health Surveillance	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Complete first draft of Statewide Oral Health Plan in 2004-2005	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

4. Initiate an Oral Health Coalition in 2005	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to promote school-based dental health services as effective strategies for reaching low-income/high-risk/underserved children	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue funding Preventive Dentistry and Innovative Services Programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Convene Task Force on Oral Health in Pregnancy, and formulate and distribute guidelines for oral health care during pregnancy to dentists, obstetricians and others	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Monitor and assist in efforts to find sustainable funding for community-based dental services for underserved individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Continue to collaborate with the Injury Prevention Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to include child safety programming in all Title V and Title V-related programming for pregnant and parenting women, infants and children	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Continue to support the Lactation Institute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue collaboration with WIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide technical support for lactation coordinators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to promote breastfeeding in all Title V and Title V-related programs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to require breastfeeding education and promote breastfeeding in all PCAP/MOMS programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Continue to implement new regulations	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to provide support and technical assistance to birthing hospitals who are implementing the Universal Newborn Hearing Screening regulations	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Target quality improvement activities based on provider data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Continue to implement/promote public insurance initiatives	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue collaborations with Office of Medicaid Management and Office of Managed Care	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to link Title V programs to facilitated enrollers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to identify and refer all uninsured/underinsured children presenting through Title V programs to public insurance programs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. See above.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Monitor re-designation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to implement the Statewide Perinatal Data System	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to require Perinatal Centers to monitor adverse events and take appropriate action	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to provide timely, risk-appropriate, coordinated, comprehensive prenatal care through the PCAP and MOMS programs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue development of Regional Perinatal Forums as Quality Improvement mechanisms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Continue to evaluate suicide risk in all Title V programs serving youth and pregnant women	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue collaborations with the Office of Mental Health and Bureau of Injury Prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Continue to implement Regional Perinatal Forums	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Implement in FFY 2005 a statewide media campaign promoting early and adequate prenatal care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Monitor implementation of perinatal regionalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Continue to promote and monitor early, first trimester entry into prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Implement statewide campaign promoting early and adequate prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to support the Growing Up Healthy Hotline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue production of educational/outreach materials with the Bureau of Health Promotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue implementation of CAPC and PCAP/MOMS Programs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of live births resulting from unintended pregnancies*

a. Last Year's Accomplishments

**? /2005/The Family Planning Program began an outreach initiative called the Family Planning Benefits Program. This program provides family planning services to individuals under 200% of poverty who meet eligibility requirements. Eligibility does not depend on previous pregnancy or previous Medicaid status, and provides a full range of contraceptive services and reproductive health care.**

**? The Family Planning Program continued to provide access to reproductive health care through the Family Planning Extension Program. This program provides family planning benefits to eligible women for 24 months after a pregnancy ends. Family Planning Programs provided over 8,900 community education sessions reaching over 145,000 individuals. //2005//**

? The Community Health Worker Program provided family planning information to all women of childbearing age and referred clients to family planning services. They then follow-up to see that services were received.

? The Community-Based Adolescent Pregnancy Prevention Program's worked to reduce teen pregnancies in the highest risk zip codes across New York State. C-BAPPP promoted abstinence and the delay of sexual activity among teens; encouraged educational, recreational and vocational opportunities as alternatives to sexual activity; taught assertiveness skills; and promoted access to family planning and comprehensive reproductive health services.

? The School Health Program provided risk assessment for sexual activity as part of the initial assessment and anticipatory guidance is offered. Pregnancy testing is done, where indicated. Students have access to family planning services, either onsite or by referral. Students are also referred early for prenatal services; practitioners co-manage the student's prenatal care. School-based health centers provided services to approximately 32,000 female students ages 15-19.

? The Prenatal/Perinatal Networks implemented several activities related to decreasing pregnancies through provision of family planning information and education on the importance of inter-conceptional care. Some Networks have access schools to provide structured educational programs addressing reproductive health and pregnancy care. One Network developed a peer-mentoring program to encourage and model healthy behaviors in adolescents. Others have developed groups such as teen pregnancy coalitions to address local issues related to adolescent pregnancies. Some Networks are also the lead agencies for Community-Based Adolescent Pregnancy Prevention Programs.

? NYSDOH awarded funding to 37 Abstinence Education and Promotion contractors to provide abstinence education, mentoring, counseling, and adult supervision to promote abstinence from sexual activity in 15- to 19-year-olds. Funding included a statewide, large-scale media campaign to support the community-based initiatives. BWH also participated in the Governor's Task Force on Unintended Pregnancy.

#### b. Current Activities

? The new Family Planning waiver is being implemented.

? No major program or policy changes occurred.

#### c. Plan for the Coming Year

**? /2005/The Family Planning Program plans to implement a comprehensive outreach and education initiative, targeting Medicaid providers, in order to increase provider awareness of the Family Planning Benefits Program. The initiative will include a statewide satellite teleconference and training, a brochure and production of a training video or DVD to allow providers to train new staff. //2005//**

? No other major changes are planned.

### State Performance Measure 2: *Hospitalization rate for asthma for children 1-14*

#### a. Last Year's Accomplishments

? The Asthma Coordinator continued to play a pivotal role in coordinating asthma prevention and control efforts across the agency. Title V and the Asthma Coordinator are working with the

Office of Medicaid Management, the Office of Managed Care, The Center for Environmental Health, the Division of Chronic Disease Prevention and Adult Health, the State Education Department, the New York City Department of Health (which has its own major asthma initiative), the Pediatric Pulmonary Center, the Public Health Information Group and Child Health Plus.

? ***/2005/ Asthma hospitalization rates were updated for year 2002. Rates have been generated by age, sex, race/ethnicity, and on the state, regional, and county levels. This information is available on the HIN and HPN.***

? ***User-friendly asthma treatment guidelines were formulated and distributed across the state. The New York State Consensus Asthma Guideline Expert Panel finalized the Clinical Guideline for the Diagnosis, Evaluation, and Management of Adults and Children with Asthma in 2003. Endorsements were obtained from several groups across the spectrum of government, insurance plans, and professional societies.//2005//***

? The Bureau of Child and Adolescent Health continued to award funds to ***/2005/nine //2005//*** regional asthma coalitions across the State to improve the diagnosis, treatment and prevention of childhood asthma, and provide care coordination services to asthmatic children in an effort to reduce asthma-related morbidity and mortality. ***/2005/Newest coalitions are in the South Bronx and East Harlem. The coalitions sponsored over 200 public events over the last year and trained more than 12,000 health care professionals. //2005//***

? Under the Columbia Collaborative Projects, MCHSBG funded asthma-related initiatives that target reduction of asthma in minority communities where there are very high rates of the disease. The manual for child care providers that was produced last year was implemented this year.

? School-Based Health Centers developed for each affected student in coordination with primary care physician that includes all clinical and educational interventions.

? Child care health consultants provide technical assistance to child care providers in the prevention and treatment of asthma.

## b. Current Activities

The regional childhood asthma coalitions continue to provide asthma education, training and case management activities.

***/2005/ An educational needs assessment was completed in January 2004 using a web-based survey instrument. 376 physicians have completed the survey, which confirmed results of earlier focus groups. //2005//***

The program is implementing training around statewide guidelines.

***/2005/ Age-specific asthma rates are being generated on the zip code level. //2005//***

Asthma is currently a topic included in Child Care Health Consultant Training.

School-Based Health Centers provide an individualized careplan or enrolled students with asthma.

## c. Plan for the Coming Year

? Improve financial support for coalition activities.

? Distribute Best Practice Manuals.

? Continue to provide asthma education, training and case management activities through Asthma Coalitions.

? Continue asthma as a topic for Child Care Health Consultant Training.

? Continue School-Based Health Center activities.

### State Performance Measure 3: *Percent of women smoking during pregnancy*

#### a. Last Year's Accomplishments

? PCAP promotes healthy behaviors during pregnancy. PCAPs provide information regarding the impact of smoking on the woman and the fetus and have developed various programs to deal with smoking, including individual counseling and referrals to group or other programs that support smoking cessation.

? The School Health Program continued to screen for tobacco use and make appropriate referrals, including to obstetrical services and smoking cessation programs, and to counsel students accordingly.

? The Comprehensive Prenatal/Perinatal Services Network's priorities included developing and implementing programs to reduce the number of women who smoke or use other substances during pregnancy. Networks provide education and training to health and human services providers on ways to assist women to enhance healthy behaviors, including smoking cessation.

? Although the Community Health Worker Program keeps not specific data on smoking, an important role of the Community Health Worker is to provide education for women to increase their understanding of behaviors that pose a risk to health. This includes the use of tobacco. The Community Health Worker will not only provide this information, but will provide appropriate referrals for those women seeking assistance in this area, including accompanying them to care, if necessary.

? Family Planning Programs refer for smoking cessation.? All Migrant Health and American Indian Health Program providers screen for tobacco use and make appropriate referrals.

? School-based health center staff continue to screen all enrollees, including pregnant adolescents, for tobacco-use, provide counseling and make appropriate referrals.

? New York State recently passed a tough, new Clean Indoor Air Act.

? NYS Medicaid covers smoking cessation products.

#### b. Current Activities

? New York invests heavily in anti-smoking messages.

? The Tobacco Control Program monitors implementation of the new Clean Indoor Air Act.

? A number of the Program's partners implement the EPA's "Smokefree Home Pledge."

? The Tobacco Control Program funds the American Cancer Society for "Make Yours a Fresh Start, a program working with pregnant women.

? A WIC Program in New York City is funded to do a smoking cessation encounter with pregnant and parenting women.

? No major changes.

#### c. Plan for the Coming Year

No major changes in program or policy are planned.

## State Performance Measure 4: *Teenage pregnancy rate for girls ages 15-17*

### a. Last Year's Accomplishments

? MCHSBG funds support 59 local Family Planning Programs across the state. These programs serve low-income, uninsured women, or approximately one third of those estimated in need, and approximately one third of which were under the age of 20. The program strives to ensure that each pregnancy is intended. Family Planning Programs provided community education and public information services, comprehensive medical exams, a full range of contraceptive services, and special counseling to teens.

? Community-Based Adolescent Pregnancy Prevention Programs maintain a roster of about 300 peer counselors in 54 high risk zip codes to effectively counsel their peers, dispel common myths about sexuality, encourage discussions about abstinence and responsible sexual behavior, and provide accurate information about how and where to obtain primary and preventive health services. C-BAPPP worked with schools and parents to increase communication skills and sexual literacy.

? 37 Abstinence Education and Promotion contractors provide abstinence education, mentoring, counseling, and adult supervision to promote abstinence from sexual activity in 15- to 19-year-olds. In this first year, programs were established and services begun. The initiatives initially focused on junior high/middle school aged students and those groups at highest risk for bearing children out-of-wedlock. Funding includes a statewide, large-scale media campaign to support the community-based initiatives.

? The Prenatal/Perinatal Networks provided conferences on adolescent pregnancy prevention for their communities. Each Network takes a localized approach to the issue.

? The School Health Program provided risk assessment on enrollment, consultation, anticipatory guidance, family planning services (either directly or by referral), pregnancy testing, prenatal care (either directly, by co-managing care, or by referral, and follow-up consultation and education).

? The Community Health Worker Program educated women of childbearing age regarding family planning, referred to family planning services and followed up to determine whether appointments are kept and services are received.

? The "Growing Up Healthy" Hotline links women (including adolescents) with prenatal, nutrition, family planning, psychosocial and supportive services, which contributed to healthy pregnancies and improved birth weights. ? Teens may be eligible for PCAP/MOMS.

? ACT for Youth utilizes an assets-based approach to reduce risk-taking behavior among youth.

? The Department continued to work with other agencies, including the Office of Children and Family Services and the State Education Department.

? The 76 Rape Crisis Centers work to reduce the incidence of rape and sexual assault, as well as to ensure effective, compassionate treatment of victims.

? Please refer to materials presented under State Performance Measure 01 on unintended pregnancy.

? The "Not Me, Not Now" Campaign aired statewide.

### b. Current Activities

No major changes have occurred.

### c. Plan for the Coming Year

No major changes are planned.

*NYS WIC Program that were overweight*

a. Last Year's Accomplishments

Please note that this is a newly-selected State Performance Measure. This measure replaces a measure that is now a Health Status Indicator.

**? /2005/A project to impress physicians with the importance of tracking Body Mass Index (BMI) was initiated under the Preventive Medicine Residency and the Bureau of Child and Adolescent Health. A provider education mailing was designed and funds procured. The American Academy of Pediatrics District II New York State and New York State Academy of Family Physicians agreed to co-sign the cover letter and allow use of their academy logos. An evaluation component was designed.**

**? Height and weight measurement was added to Oral Health Surveillance activities.**

**? The Division of Nutrition continued to implement "Eat Well, Play Hard."**

**? The Department's Physical Activity and Nutrition (PAN) grant continued to focus provide leadership for strategies and activities to address overweight and physical activity.**

**? The WIC Program provides nutrition information to all participants. //2005//**

b. Current Activities

**? /2005/ The Department is developing a Physical Activity and Nutrition Plan that will guide future activities in this critical area. Key stakeholders are participating. The plan has not yet been released. //2005//**

c. Plan for the Coming Year

**? /2005/ Division of Chronic Disease Prevention and Adult Health will be testing new interventions that utilize concepts of social marketing and diffusion of innovation on a community-wide level. In this model, fourteen Head Start centers will be targeted, four of which will participate in the intervention, and ten of which will serve as controls. Interventions will include assessment of food and activities policies, environmental assessment, collaborative policy development, and development of training sessions and materials for staff and families. Specifically, environmental and policy changes will promote an increase in physical activity, a decrease in TV/video viewing and a decrease in language and policies that promote overeating and inactivity. A community component will support program changes.//2005//**

? Activities will be shaped by the statewide Physical Activity and Nutrition Plan.

State Performance Measure 6: *Percent of infants placed on their backs to sleep*

a. Last Year's Accomplishments

? The Department continued to implement the "Back to Sleep" first kicked off by First Lady Libby Pataki in 1999. The Department produced T-shirts imprinted on the front and back with, "Put me on my back to sleep." These T-shirts and a flyer on SIDS prevention were distributed thorough all hospitals in the State ? SIDS Prevention Information Cards (the same cards that were made available with the T-shirt) were reprinted in English and Spanish.

? 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 child care providers learn of the importance of sleep positioning and other SIDS prevention messages, a poster listing the information was designed. Posters were distributed to every registered childcare provider in the state as a reminder to place babies on their backs to sleep. Other SIDS prevention messages were included, too.

? Statewide training efforts continue. Police, fire fighters, emergency medical personnel and public health nurses are educated on appropriate responses to SIDS. The Department oversees notification of infant deaths by funeral directors, coroners and medical examiners. The Center for Sudden Infant Death at SUNY Stony Brook and its satellites provide training and family support services. For families that have experienced any infant death in the last year, they provide a 1-800 "warm line" for support, information and referral to self-help groups and other mental health services. The Center also arranges a home visit by a public health nurse. Newsletters are sent on a regular basis, and are a very popular item. The Center also released health education materials about the dangers of placing infants to sleep in adult beds.

? In May 2002, a new State law was passed amending the autopsy provisions of the Public Health Law and requiring standardized protocols for the performance of autopsies in cases of sudden, unanticipated death in infants under the age of one year. Protocols were developed.

? BCAH and DFH staff worked with Office of Children and Family Services Staff on new materials for inclusion in Welcome to Parenthood concerning back-to-sleep and overlaying dangers.

#### b. Current Activities

There have been no major changes.

#### c. Plan for the Coming Year

No major changes are planned.

### State Performance Measure 7: *Hospitalizations for self-inflicted injuries for 15-19 year olds*

#### a. Last Year's Accomplishments

? See National Performance Measure 16. This measure was selected because rates of suicide attempts are higher than rates of completion would indicate.

? All School-Based Health Centers provided psychosocial assessment beginning with the initial visit. Students and families were offered individualized education regarding safety issues and abuse, and mental health services were made available, where indicated. Potential abuse and neglect cases were reported. Staff follow-up on all referrals and behavioral issues.

? Through community collaborations, the ACT for Youth Initiative has developed:

? Youth forums on violence, abuse and risky sexual behaviors;

? Peer education for violence prevention;

? Conflict resolution training to train peer mediators; and

? Mentoring programs.

? The Community-Based Adolescent Pregnancy Prevention Program employs a youth development/youth empowerment approach.

#### b. Current Activities

? Bureau of Child and Adolescent Health is currently working with partners to identify key elements of a statewide suicide prevention plan.

? Emergency Medical Services for Children have improved pre-hospital care for children and youth.

? School-Based Health Centers will continue to assess students for suicide risk, and are implementing enhanced mental health services.

? Youth Development is a continued focus of all youth-focused programming.

#### c. Plan for the Coming Year

No major changes are planned.

### State Performance Measure 8: *Percent of high school students who drank five or more drinks of alcohol in a row at least once in the last month*

#### a. Last Year's Accomplishments

Please note that this measure has been changed. In previous years, the indicator tracked those that reported drinking alcohol at least once in the last month.

? DOH/Title V staff continued to collaborate with our state Office of Alcoholism and Substance Abuse Services (OASAS) on substance abuse and alcohol-related prevention policy. Beginning in 1999, OASAS involved multiple human service agencies at the county level in identifying alcohol and substance abuse risk and protective factors, and in strengthening and expanding local partnerships for alcohol and substance abuse prevention. Fifteen (15) counties were funded for three years to develop and implement countywide, prevention- and results-focused work plans. These work plans identify, re-direct, and leverage state and local resources for a comprehensive, multi-system approach to alcohol and substance abuse prevention at the local level.

? ACT for Youth, (Assets Coming Together for Youth) was developed by DOH in collaboration with Partners for Children and the HIV Prevention Planning Group. The focus is to prevent abuse, violence and risky sexual activities, all of which are associated with low self-esteem; poor decision making related to sexual behavior, alcohol and substance use and abuse; poor nutrition and eating disorders. Community Development Partnerships target the most vulnerable populations (substance abusing/using, those in foster care and group homes, homeless and runaway, orphaned, out-of-school, incarcerated, HIV affected/ infected, migrant, parenting, with disabilities, with different sexual preferences, in special education programs, and Black/African American, Hispanic/Latino, Asian/Pacific Islander and Native American).

? Over half of the Lesbian, Gay, Bi-Sexual, Trans-gendered Health Initiative contractors targeted issues related to alcohol, substance abuse and self-inflicted injury.

? PCAP/MOMS clients are assessed for alcohol and substance abuse issues; referrals are made accordingly.

? The initial assessment in school-based health centers includes questions about tobacco and alcohol use. Students are counseled and educated accordingly. Referral is available.

## b. Current Activities

No major changes. All youth-focused activities continue to employ Youth Development concepts.

## c. Plan for the Coming Year

? All Title V related programs will continue to use a youth empowerment/ youth development focus. No major changes are planned.

## State Performance Measure 9: *Percent of high school students who smoked cigarettes in the last month*

### a. Last Year's Accomplishments

? New York has one of the highest tobacco excise taxes in the nation. Raising the price of cigarettes discourages smoking.

? A new, tough indoor air law was passed, banning smoking in public places, including restaurants and bars.

? Identifying 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.) Not only is age of the buyer an issue, in New York there is a state law requiring that all tobacco products be kept behind the counter.

? The Tobacco Control Program funds 62 Youth Partnerships for Health (YPH) to help youth resist peer pressure and become involved in social and community anti-tobacco activities. These partnerships seek to "de-normalize" the use of tobacco and to counteract the effects of heavy advertising to youth done by tobacco companies.

? The State also funds 26 local Tobacco Control Coalitions in every county of the state to mobilize communities in counter-advertising activities such as banning billboards that promote tobacco near schools and playgrounds.? The Tobacco Control Program has also assisted communities to pass local ordinances on smoking in public places, to remove tobacco products from the reach of youth, and to reduce tobacco advertising in areas frequented by youth.

? The Tobacco Control Program began in 2001 planning for inclusion of tobacco education in School-Based Health Centers. Several centers are now funded to provide tobacco education and cessation.

? The initial assessment in school-based health centers includes questions about tobacco and alcohol use. Students are counseled and educated accordingly. Referral for smoking cessation is available.

? The Program also funds 14 Tobacco Use Cessation Programs.

? PCAP, MOMS and the Community Health Worker Program assess prenatal clients for tobacco use and refer to or provide smoking cessation and other counseling/health teaching.

? Comprehensive Prenatal/Perinatal Services Networks create awareness of the dangers of smoking, particularly in pregnancy.

? The Tobacco Control Program began new youth empowerment "Reality Check" contracts.

? New York recently passed a new, very tough indoor smoking law, which is now being implemented.

### b. Current Activities

? The Tobacco Program is participating in the Oral Health Coalition and helping to formulate the statewide Oral Health Plan.

? No major changes are planned at this time.

### c. Plan for the Coming Year

No major changes are planned.

? Title V will continue to collaborate with Division of Chronic Disease Prevention and Adult Health, who is the DOH lead for smoking related public health programming.

? Effectively Implement the Clean Indoor Air Act.

? Focus youth partnership activities on effective interventions to prevent and reduce tobacco use.

## State Performance Measure 10: *Percent of children in the birth year cohort who were screened for high blood lead before age 2*

### a. Last Year's Accomplishments

? The Childhood Lead Poisoning Prevention Program coordinates efforts to prevent, detect and treat childhood lead poisoning; educates the public and health professionals about prevention, early detection and appropriate medical management of childhood lead poisoning; ensures that families of children with lead poisoning are given appropriate advice and assistance in locating and eliminating sources of lead within the child's environment; provides lead-safe interim housing while lead hazards are being removed; and collects and analyzes statewide data on the extent and severity of childhood lead poisoning.

? In New York, lead testing is done primarily by the child's medical provider. State and local health department employees conducting PBII (Physician Based Immunization Initiative) visits monitor for lead screening when they check records for immunization compliance. Providers are given feedback on missed opportunities for both lead testing and immunization administration.

? The Childhood Lead Poisoning Prevention Program has contracts with 57 local health departments to provide prevention programs and provide care coordination.

? 7 teaching hospitals serve as Regional Lead Resource Centers.

? 9 local health departments and community-based organizations provide interim lead-safe housing.

? Local health departments and State Health Department District Offices provide environmental assessments and lead hazard control services.

? Because NYS has more pre-1950's housing than any other state, New York has a universal screening policy. Health care providers are required to screen children for high blood lead at ages 1 and 2.

? New York has regulations concerning prenatal screening for lead.

? Examination of the percentage of children born between 1994 and 1999 who received a blood lead screening test by 24 months of age shows New York's screening rates have remained steady at approximately 63%. An additional 25% of children are screened beyond age two for an overall total screening rate of 88%. In the year 2000, 76% percent of children enrolled in Medicaid Managed Care plans were screened for blood lead levels by 24 months of age. These reflect improvements. Program and partners try to increase screening using strong media campaign.

? Media campaigns have been developed and implemented to increase screening efforts.

? A focus of the CHWP is to promote an understanding by parents of young children of the importance of immunizations and lead screening. In 2002, 72% of the children received lead screening by 2 years of age. Of children not lead screened before entry to the program, 33%

were assisted to receive screening.

? WIC and PCAP continue to stress the need for preventive services for infants, including lead screening.

? Lead screening was provided to the 1800 children attending migrant day care.

? CISS day care grant, Healthy Child Care New York, provided the infrastructure for reaching the day care centers and family day care providers statewide.

?

### b. Current Activities

? No major changes.

? The program, in conjunction with Center for Environmental Health and the Childhood Lead Poisoning Prevention Advisory Council, submitted a statewide lead elimination plan to the Centers for Disease Control and Prevention in June 2004.

? The program released a new report on the status of childhood lead poisoning prevention in NYS in 2004.

? Additional funding to the Childhood Lead Poisoning Prevention Program is used to assist local health departments with targeting high incidence areas, improve laboratory reporting, perform a Medicaid match of cases, produce an annual report, increase primary prevention efforts, perform community outreach and working through the Division of Housing and Community Renewal to improve information sharing between local health departments and housing agencies.

? Child care health consultants provide technical assistance to child care providers to increase screening for lead.

? Community Health Workers and Healthy Neighborhoods Workers continue to educate parents in high-risk areas about the need for lead screening and follow-through on high lead results.

? Wadsworth Center operates a public health lead-screening laboratory where these specimens are tested.

### c. Plan for the Coming Year

? Release new data.

? ***/2005/Begin implementation of lead elimination./2005//***

? No major changes.

**FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Percent of live births resulting from unintended pregnancies				
1. Continue to support Family Planning Programs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. Continue to support the Community-Based Adolescent Pregnancy Program	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to provide Abstinence Education	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to provide family planning education in the Community Health Worker Program	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Continue to assess for risk of unintended pregnancy in the School Health Program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Continue to support Comprehensive Prenatal/Perinatal Services Networks	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Continue to support assets building and youth development through ACT for Youth	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Continue outreach to low-income families	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Continue participation in collaborative efforts to reduce uninintended pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
10. Continue to implement the Family Planning Waiver and enhance outreach through MA providers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
<b>2) Hospitalization rate for asthma for children 1-14</b>				
1. Continue to coordinate all agency asthma-related activities through the Asthma Coordinator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to make data available to local coalitions and local health departments to enhance decision making/targeting	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue distribution of asthma treatment guides and other materials	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue support of regional Asthma Coalitions and improve financial support for coalition activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue state-of-the-art treatment in school-based health centers and coordination with primary providers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue educating Child Care Health Consultants in asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Continue training around statewide asthma guidelines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Design educational interventions using results of the provider survey completed in 2004	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
<b>3) Percent of women smoking during pregnancy</b>				
1. Promote healthy behaviors through PCAP/MOMS; continue smoking cessation measures as a standard of care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to support development of programs to reduce numbers of pregnant women smoking/using substances, including through the Comprehensive Prenatal/Perinatal Services Networks, the Community Health Worker Program and Family Planning	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue environmental interventions, such as high cigarette taxes,	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

clean indoor air act, adolescent tobacco use enforcement, etc.				
4. Continue reverse marketing strategies/anti-smoking messages	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue Smokers' Quit Line	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue collaborations with American Cancer Society, American Lung Association and others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Teenage pregnancy rate for girls ages 15-17				
1. Continue to support local Family Planning Programs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to support Abstinence Education	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to support Community-Based Adolescent Pregnancy Prevention Programs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to support Comprehensive Prenatal/Perinatal Services Networks	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to collaborate with Healthy Start	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue to support Rape Crisis Centers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Continue to support "Not Me, Not Now"	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Continue to support comprehensive school-based health centers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of low-income children ages 2-4 enrolled in the NYS WIC Program that were overweight				
1. Continue to implement "Eat Well, Play Hard"	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue collaborations with WIC, PAN, Healthy Heart Programs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue implementation of BMI measurement initiative with pediatricians and family practice physicians	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collect data on height and weight through the oral health surveillance activities	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Percent of infants placed on their backs to sleep				
1. Continue to include SIDS education in "Welcome to Parenthood"	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue to support statewide SIDS education through contractor	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to distribute "Back to Sleep" materials	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue collaborations with Office of Children and Family Services and Healthy Child Care New York	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue support for Warm Line and bereavement services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Hospitalizations for self-inflicted injuries for 15-19 year olds				
1. Continue to provide psycho-social assessments for all school-based health center clients	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue to support our Youth Development focus through ACT for Youth and Community-Based Adolescent Pregnancy Prevention Program	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue collaborations with Office of Mental Health, Bureau of Injury Prevention, and others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) Percent of high school students who drank five or more drinks of alcohol in a row at least once in the last month				
1. Continue collaborations with Office of Alcoholism and Substance Abuse Services, State Education Department and Office of Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to support ACT for Youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue to support Gay, Lesbian, Bisexual, Transgendered Health Initiative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Continue to require psycho-social assessments, including for drug and alcohol use, for all clients of school-based health centers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.				

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of high school students who smoked cigarettes in the last month				
1. Continue environmental strategies such as high excise taxes, youth sales enforcement, indoor clean air act	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue support for local Tobacco Coalitions, Reality Check Programs, counter-advertising strategies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue support for Tobacco Cessation Programs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to support programs that make high school students and pregnant women aware of the dangers of tobacco, such as Comprehensive Prenatal/Perinatal Services Networks, PCAP/MOMS, Community Health Worker Programs, ACT for Youth, etc.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue participation in Oral Health Plan activities by tobacco control advocates	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) Percent of children in the birth year cohort who were screened for high blood lead before age 2				
1. Continue to fund local Childhood Lead Poisoning Prevention Programs, Regional Lead Resource Centers, Interim Lead-Safe Housing units	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to enforce statutes related to lead screening at ages one and two	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue inclusion of lead screening audits in the Physician-Based Immunization Initiative	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to develop and distribute media campaigns and materials	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Implement the Lead Elimination Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue screening of children in migrant day care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Continue working with Center for Environmental Health's Healthy Neighborhoods Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Continue educating expectant and new parents on the need for	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

preventive services, including blood lead screening				
9. Continue working with Medicaid on payment for home visits to assess the home environment and teach reduction strategies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Develop Lead Elimination Community Coalitions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

## E. OTHER PROGRAM ACTIVITIES

? Vital Records processed 70,000 birth records; 40,000 death records; 30,000 marriage records; 10,000 divorces; 12,000 research records; and 17,000 genealogy-related requests.

? Wadsworth Center provides public health laboratory facilities to the residents of New York State including, but not limited to, laboratories for testing water purity, for identifying lead levels and strains of microorganism (anthrax, botulism, rabies, E. coli, and other bacterial and viral organisms), for diagnosis of sexually transmitted diseases, for review of cytologic specimens, including pap smear review, for an anatomic pathology analysis, for cytogenetic identification of prenatal and clinical abnormalities, and for identification of reproductive and metabolic disorders. Wadsworth Center operates state-of-the-art clinical laboratory and environmental laboratory evaluation programs to ensure that laboratories offering tests to NYS residents meet appropriate quality requirements and can pass proficiency tests. Wadsworth Center performs basic scientific research to ensure that technologic advances and scientific knowledge have application in public health. Wadsworth Center maintains appropriate laboratory capacity in the event of an epidemic or terrorist attack.

? The SSDI project provides support to the CSHCN program and assists in the development of the CSHCN data system. The CSHCN data system will be linked with other child health data sets.

? The SSDI project worked with all Title V programs and the Integrated Child Health Information System to identify additional analyses and opportunities for collaboration. ? In 2002 the Genetics Centers provided educational opportunities to medical students (approximately 200 programs), practicing health professionals (about 300 programs), people with a diagnosed genetic condition (about 80) and the general public (about 175).

? By operating 24/7, anyone throughout the state is able to connect to the Growing Up Healthy Hotline for information.

? The Maternal Mortality Study activities focused on finalizing, disseminating and promotion of the protocol for maternal mortality review, the notification form, medical record abstraction form and instruction manual. Professionals and specialists were recruited to participate on the clinical review teams and the first batch of applicants have received approval under Section 206(1)(j) of the Public Health Law, which provides confidentiality of findings for the purpose of improving the quality of medical care. Approval of a second batch of applicants is in process. Thirteen maternal deaths have been reported and onsite reviews have been conducted or are scheduled.

? The New York State Preventive Medicine Residency Program provided academic and/or practicum training to five physicians, including three with strong interests in MCH. Residents contributed to a wide variety of initiatives in maternal and child projects, including: professional education to raise pediatric providers' awareness of the importance of tracking Body Mass Index; development of guidelines for dentists and obstetricians about oral health care during pregnancy; analysis of reasons for recent decline in number of births to HIV+ women in NYS; and production of a satellite broadcast promoting breastfeeding in minority communities.

? The Fluoride Supplementation Program provided educational training on early childhood oral health issues to day care centers, Head Start centers and professional educators.

? The Dental Public Health Residency Program graduated three residents from its statewide program. The Program continues its accreditation status and proceeds to collaborate with the other four dental residency programs in New York State.

? The Rape Crisis Program continued to implement the DOH Hospital-Based Sexual Assault Forensic Examiner Program. One hospital has been approved by DOH as a designated center. Several other applications are under review.

? New guidelines for the acute care of adult victims of sexual assault were distributed to hospital administrators, Emergency Departments, Rape Crisis Centers, and other providers. Over 800 copies were distributed since 2002.

? Two pieces of legislation recently passed that will assist survivors and those who provide services for them. All hospitals are now required to provide survivors of sexual assault with information on emergency contraception. The Forensic Payment Act will allow hospitals to bill the Crime Victims Board directly for forensic examinations and other services provided to survivors.

? The Department is implementing the Statewide Perinatal Data System. It is imperative to develop a collaborative relationship with New York City Vital Records, as they are a separate Vital Records district. During 2002, discussions were renewed with NYCDHMH VR staff regarding SPDS. Monthly conference calls have been initiated in 2003 to identify issues and resolutions in order that SPDS can be used in NYC as well as the rest of the state.

? The Rape Crisis Program continued to implement the DOH Hospital-Based Sexual Assault Forensic Examiner Program. One hospital has been approved by DOH as a designated center. Several other applications are under review. The sexual assault forensic examiner and training program standards are currently under review. Revisions will enable a broader scope of eligibility for practitioners interested in being certified. Data system implementation issues are being addressed. Training sessions on changes are being planned.

? The Fluoride Supplement Program continued to expand in non-fluoridated areas across New York State serving children who are at high risk for oral health diseases.

? The Dental Rehabilitation Program initiated pilot in 18 counties in the state that will close regional screening clinics. Planning is underway for extension of the pilot into Western New York.

? There are currently three dental public health residents in training.

? The Congenital Malformations Registry continues to promote and expand HPN Internet reporting to the CMR through conference calls and regional meetings with hospital medical records and information technology staff, continue collaboration in the National Birth Defects Prevention Study to determine the etiologies of birth defects, continue population-based surveillance of Fetal Alcohol Syndrome (FAS) in a 9 county region of Western New York State, continue to send informational mailings to families of children reported to the Registry with special health care needs to inform them of the early intervention programs and support

## **F. TECHNICAL ASSISTANCE**

Due to multiple priorities, New York was unable to participate in technical assistance in FFY 2004.

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

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

Principles for Allocation: Also, please refer to the Principles for Allocation of Maternal and Child Health Services Block Grant Funds, page 13 of the Needs Assessment.

Not all of last year's allocation was spent. Expenditures have been affected by austerity measures, which limit purchases and refilling of budgeted positions under all funding sources.

An allocation review and expenditure disbursement analysis was conducted in April 2004 with reallocations resulting. Concerted efforts are made to reduce unobligated balance, and to address areas of need as indicated via emerging public health issues for mothers and children.

Program areas receiving new and increased allocations include diabetes, nutrition and physical activity within schools, children's cancer initiatives, oral health, pediatric overweight initiatives, and consultation on MCH planning and evaluation.

A reduction to the unobligated balance of \$7.5 Million has been initiated and contractual commitments are in process.

### **B. BUDGET**

Maintenance of Effort: New York meets and exceeds the maintenance of effort requirements of Section 505 (a) (4). The New York State Department of Health plans continued Title V funding for the following efforts in FFY 2005:

- ? The Adolescent Health Initiative, including ACT for Youth and Youth Risk Behavior Surveillance;
- ? The Adolescent Health Coordinator;
- ? American Indian Health Program Community Health Workers;
- ? Asthma Coalitions;
- ? Children with Special Health Care Needs Program, including the Physically Handicapped Children's Program Diagnostic and Evaluation Program;
- ? Columbia Collaborative Projects;
- ? Community-Based Adolescent Pregnancy Prevention;
- ? Congenital Malformations Registry;
- ? Family Planning;
- ? The Genetics Program and Newborn Metabolic Screening;
- ? SUNY School of Public Health MCH Graduate Assistantship Program;
- ? Health Communications;
- ? Immunization Registry activities;
- ? Infant and Child Mortality Review;
- ? Injury Prevention;
- ? The Lactation Institute;
- ? Lead Poisoning Prevention;
- ? Migrant Health;
- ? Newborn Hearing and Metabolic Screening;
- ? Parent and Consumer Focus Groups;
- ? The Statewide Perinatal Data System;
- ? Preventive Dentistry Initiatives and the Dental Residency Program, including an expanded dental sealant program and a Task Force on Oral Health in Pregnancy;
- ? Public Health Information;

- ? School-Based Health Centers and School Health Infrastructure;
- ? STD Screening and Education
- ? Universal Newborn Hearing Screening;
- ? Vital Records; and
- ? Women and Disabilities Teleconference.

The Monroe Consolidated Child and Family Health Grant will continue in FFY 2005. Under this initiative, seven grants are given to the county with an integrated work plan.

Methodology: Effort is made to match funding to the level of unmet need, and to address the four layers of the MCH pyramid and the three target populations. Because funded programs often take more than one structural approach to targeted needs and populations, program appropriations are proportioned out to reflect percentage of effort in infrastructure-building, population-based services, enabling services and direct health care services. Program appropriations also take into account the "30-30-10" requirements of Title V.

New York State uses a fair method to allocate Title V funds among individuals and areas identified as having unmet needs for maternal and child health services. The State uses its MCH funds for the purposes outlined in Title V, Section 505 of the Social Security Act. The MCHSBG Advisory Council assists the Department in determining program priorities and has been instrumental in seeking public input into the application process. The Council developed in 1984 a document entitled "Principles and Guidelines for the Use of Block Grant Funds," which was updated and affirmed each year. New York is using an Oracle-based system of gathering program information which more finely delineates sources of funds for the programs for only the second year.

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

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

Any amount payable to the State under this title from allotments for this fiscal year which remain unobligated at the end of that year are carried forward and obligated in the following fiscal year. The Department and the Office of the State Comptroller maintain budget documentation for Block Grant funding and expenditures consistent with Section 505(a) and Section 506(a)(1) for the purpose of maintaining an audit trail. The grant expenditures are recorded through standard OSC documents.

Reporting requirements and procedures for each particular grant are instituted to comply with conditions specified within each notice of grant award.

The state share in MCH services is considerable, more than meeting the requirements for state match. State appropriations dedicated to MCH include:

- ? AIDS Adolescent Research Network, Adolescent HIV Prevention, Pediatric and Maternal Initiative, Maternal and Child HIV, Ob/Gyn, Homeless and Run-Away Women and Children, HIV Services to Homeless and Run-Away Adolescents;
- ? Child Care;
- ? Early Intervention;

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

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

- ? Abstinence Education;
- ? Centers for Disease Control and Prevention (Lead, Immunization, Public Health Information Infrastructure; Oral Health Surveillance, Oral Health Systems)
- ? CISS Grants;
- ? Emergency Medical Services for Children Grant;
- ? Early Intervention, Part C;
- ? Family Planning;
- ? Rape Crisis;
- ? STD/fertility;
- ? SPRANS Grants;
- ? SSDI Funds;
- ? TANF Funds.
- ? Early Childhood Comprehensive Systems planning grant
- ? Integrated Women's Health Initiative

A regional analysis of Title V external contracts shows that 64.75% of funds are contracted for the metropolitan New York City area, where most of the State's population is located; 15.65% goes to the Western New York area, our second most populous region; 11.43% goes to Central New York; and 8.16% goes to the Northeastern and Capital District areas of the state. These breakdowns are fairly consistent with the proportion of New York's population residing in each of these areas.

The State more than meets "30-30-10 Requirements" for 30% allocation to primary and preventive care to children (\$14,411,725 or 33.73%), for 30% for children with special health care needs (16,629,243 or 38.92%) and under 10% for administration (2,144,882 or 5.02%).

## **VI. REPORTING FORMS-GENERAL INFORMATION**

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

## **VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS**

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

## **VIII. GLOSSARY**

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

## **IX. TECHNICAL NOTE**

Please refer to Section IX of the Guidance.

## **X. APPENDICES AND STATE SUPPORTING DOCUMENTS**

### **A. NEEDS ASSESSMENT**

Please refer to Section II attachments, if provided.

### **B. ALL REPORTING FORMS**

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

### **C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS**

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

### **D. ANNUAL REPORT DATA**

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