AFFORDABLE CARE ACT
MATERNAL, INFANT AND EARLY CHILDHOOD HOME VISITING PROGRAM

NEW YORK STATE
UPDATED PLAN FOR A STATE HOME VISITING PROGRAM

New York State Department of Health
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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) of 2010 authorized the creation of the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) to promote and improve the health, development and well-being of at-risk children and families through evidence-based home visiting programs. Beginning in FY10, $4.1 million annually has been allocated to New York State, with the potential for increased annual funding through a future competitive application.

The New York State Department of Health was designated as the lead entity to accept and administer New York State's MIECHV funds. The submission of a State Plan is the required third and last step in the process established to receive funding under this initiative, following the previous submission and approval of an initial application and a subsequent statewide needs assessment.

The primary purpose of the State Plan as defined by HRSA is to: identify the at-risk communities where home visiting services are to be provided; assess the particular needs of those communities in terms of risk factors, community strengths, and existing services; identify home visiting services proposed to be implemented to meet identified needs in those communities; describe the State and local infrastructure available to support the program; specify any additional infrastructure support necessary to achieve program success; and, propose a plan for collecting benchmark data, and conducting continuous quality improvement.

New York State proposes to use available MIECHV funding to enhance and expand existing evidence-based home visiting programs in three very high need communities, based on a comprehensive statewide needs assessment. Building on the previously-submitted initial needs assessment, New York's State Plan incorporates further assessment of needs and resources in 14 designated at-risk communities, including the three communities targeted for initial funding. The State Plan reflects over a year of intensive assessment and planning work, led by the New York State Department of Health, in collaboration with a core group of state agency partners. The plan reflects updated input from more than 100 community-based organizations and home visiting programs in the 14 high risk counties, building on the extensive stakeholder input previously received during the development of the state's needs assessment.

The goal of New York State's MIECHV initiative is to improve the health and well-being of at-risk families through implementation of evidence-based home visiting programs operating within a comprehensive, coordinated system of perinatal and early childhood services. Based on a detailed assessment of needs and existing resources in the 14 at-risk communities documented in the previous statewide Needs Assessment, currently available annual funding will be targeted to the three highest-risk upstate and New York City communities: **Erie** and **Monroe** Counties upstate, and **Bronx** County in New York City. Funding will support enhancement of established home visiting programs that meet federal criteria for evidence-based, are currently operating within these three target communities, and have demonstrated positive outcomes in the specific priority areas of maternal health, child health and/or child maltreatment; eligible programs designated through these criteria include **Nurse Family Partnership (NFP)** and Healthy **Families New York (HFNY)** programs in the Bronx, HFNY in Erie county, and NFP in Monroe

County. Funding for local programs will be distributed proportionately among the three target communities, and within them among specific eligible programs, based on a defined funding distribution methodology that takes into account both population demographics and current service volume of individual programs. It is anticipated that all 14 high-risk counties will have an opportunity to apply for any annual increases in the state's MIECHV grant award amount through a competitive application process.

The New York State Department of Health (NYSDOH) will implement the state's MIECHV initiative in continued collaboration with the Office of Children and Family Services (OCFS) and several other key state agency partners, as well as national program developers. Funding to support the enhancement/expansion of Nurse Family Partnership programs and activities will be procured directly to the NFP programs and NYSDOH will work with the NFP National Service Office (NFP NSO) to assure implementation with fidelity to the model. Funding to support the enhancement/ expansion of Healthy Families New York programs and activities will be transferred to OCFS via a Memorandum of Understanding (MOU) to assure integration and alignment with the existing OCFS-administered HFNY program.

To meet the legislatively mandated benchmarks, the State Plan proposes collection of individual-level data for all constructs to measure improvement within each of the six required benchmark areas: 1) improved maternal and newborn health; 2) prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; 3) improvement in school readiness and achievement; 4) reduction in crime or domestic violence; 5) improvements in family economic self-sufficiency; and 6) improvements in the coordination and referrals for other community resources and supports. In addition, a new Perinatal Health Center of Excellence will be established to support the MIECHV initiative, including supplemental training, technical assistance, data management and evaluation activities; facilitate quality improvement strategies; align data collection methods and standardize measures across NFP and HFNY program to support federal reporting requirements; and coordinate enhancements to existing programs to address priority challenges such as mental health, domestic violence and substance abuse.

This State Plan demonstrates New York State's strong experience and capacity to administer and implement the MIECHV initiative to strengthen and sustain the capacity of home visiting services in at-risk communities, and to integrate home visiting within broader perinatal and early childhood systems, as a critical approach to improving the health and well-being of children and families in New York State.

Glossary of Abbreviations

ACA	Affordable Care Act
ACF	Administration for Children and Families
CCF	Council on Children and Families
CA	Central Administration
CHSR	Center for Human Services Research
CHWP	Community Health Worker Program
CMS	Centers for Medicare and Medicaid Services
COE	Center of Excellence
CPPSN	Comprehensive Prenatal Perinatal Services Network
EBC	Electronic Birth Certificate
EBRS	Electronic Birth Registration System
ECAC	Early Childhood Advisory Council
ECCS	Early Childhood Comprehensive System
FY10	Fiscal Year 10
GUHH	Growing Up Healthy Hotline
HFA	Healthy Families America
HFNY	Healthy Families New York
HMHB	Health Mom Healthy Baby
HRSA	Health Resources and Services Administration
LHD	Local Health Departments
MIECHV	Maternal, Infant and Early Childhood Home Visiting
NFP	Nurse Family Partnership
NFPNSO	Nurse Family Partnership National Service Office
NYS	New York State
NYSDOH	New York State Department of Health
NYSED	New York State Education Department
NYSSONQC	NYS Obstetric and Neonatal Quality Collaboration
OASAS	Office of Alcoholism and Substance Abuse Services
OCFS	Office of Children and Family Services
OMH	Office of Mental Health
OPDV	Office for the Prevention of Domestic Violence
OTDA	Office of Temporary and Disability Assistance
PCANY	Prevent Child Abuse New York
RFA	Request for Application
RPC	Regional Perinatal Centers
SCAA	Schuyler Center for Analysis Advocacy

Introduction

The Patient Protection and Affordable Care Act (ACA) of 2010 included a provision that authorized the creation of the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV). This historic legislation marks a significant commitment to promote and improve the health, development and well-being of at-risk children and families through evidence-based home visiting programs. The Act targets the majority of resources to implementation of specific designated home visiting programs that have demonstrated positive outcomes for child and family well-being through rigorous scientific studies, and emphasizes home visiting as one type of service integrated within a comprehensive, high-quality early childhood system.

This State Plan represents the third key step in a multi-step process established by the federal Health Resources and Services Administration (HRSA), in partnership with the federal Administration for Children and Families (ACF), to make MIECHV funding available to states. In the first step, in July 2010, the New York State Department of Health (NYSDOH) was designated as the lead entity for the State to accept and administer funds allocated to New York State. In the second step, in September 2010, a comprehensive statewide Needs Assessment was completed and approved by HRSA/ACF. The submission of an Updated State Plan for a State Home Visiting Program (State Plan) is the required third and last step in this process. In February 2011, HRSA and ACF released guidance to states through a Supplemental Information Request (SIR) outlining the specific requirements for completion and submission of State Plans. Following the submission and approval of a State Plan, funds allocated to each state will be fully released and implementation of that state's MIECHV initiative can begin. HRSA has indicated that states also will have an opportunity to apply for increased federal funding on a competitive basis in the future.

The primary purpose of the State Plan, as defined by HRSA through the SIR is to:

- identify the at-risk communities where home visiting services are to be provided;
- assess the particular needs of those communities in terms of risk factors, community strengths, and existing services;
- identify home visiting services proposed to be implemented to meet identified needs in those communities;
- describe the State and local infrastructure available to support the program, and specify any additional infrastructure support necessary to achieve program success; and
- propose a plan for collecting benchmark data, and conducting continuous quality improvement.

New York State's (NYS') MIECHV State Plan reflects over a year of intensive assessment and planning work, led by the NYSDOH and conducted in collaboration with a core group of state agency partners and many other stakeholders joined by a common commitment to improving the well-being of at-risk children and families in New York State. The plan is based on the detailed assessment of needs and existing resources described in the *New York State – Statewide Home Visiting Needs Assessment* previously submitted and approved under the process referenced above. It addresses all of the requirements outlined by HRSA in the SIR.

The plan outlines an ambitious but achievable approach to enhancing the provision of evidence-based home visiting services as a component of comprehensive perinatal and early childhood systems within at-risk communities across New York State. Based on the current annual funding of $4.1 million allocated to New York State, the plan describes a phased approach, beginning in the three highest risk target communities in New York City and upstate, while establishing a foundation for further expansion to additional at-risk communities in anticipation of potential increased annual federal funding to the state, pending additional information from HRSA about that process.

I. Identification of Targeted At-Risk Communities

Selection of At-Risk Communities

The previously-submitted NYS MIECHV Needs Assessment identified communities with high rates of maternal, infant and child health risk indicators, and the existing home visiting programs and supportive resources in those communities. The methodology utilized to conduct that analysis and designate communities as "at-risk" was detailed in the previous needs assessment and is summarized below.

With input and assistance from a group of state agency partners, NYSDOH collected and analyzed a set of 23 indicators based on HRSA criteria and additional state-defined criteria. County was used as the geographic unit of analysis. Given the large number of indicators used to identify at risk communities, a Z-score methodology was used, resulting in a Z-score for the rates of each indicator and a Z-score for the number of cases (burden) for each indicator for each county. A Z-score allows for a standardized score that indicates how many standard deviations the data are above or below the mean. The average Z-score was then calculated for each county (where each indicator was treated with equal weight), thus providing a composite index for ranking the counties from highest to lowest in overall need, relative to the statewide value. This was repeated for both rates and burden (cases) so that counties could be prioritized by ranking with respect to both rates and overall burden. On this basis, counties were assigned to one of four groups:

- Group 1 (8 counties) positive Z-score for both rate and burden
- Group 2 (6 counties) positive Z-score for burden only.
- Group 3 (21 counties)positive Z-score for rate only
- Group 4 (27 counties) negative Z-score for both rate and burden

The Needs Assessment indentified the 14 counties in Group 1 and Group 2 as the at-risk communities in NYS, shown in **Table 1** below. These counties include all five boroughs of New York City (Bronx, Kings, New York, Queens, and Richmond), the three counties in the immediate New York City metropolitan area (Nassau, Suffolk, and Westchester) and the upstate counties with major urban centers (Orange/Newburgh, Albany/City of Albany, Oneida/Utica, Onondaga/Syracuse, Monroe/Rochester, and Erie/Buffalo).

Table 1. At-Risk Counties for New York State MIECHV Initiative			
Group 1 Counties		**Group 2 Counties**	
Albany	Monroe	Nassau	Richmond
Bronx	New York	Orange	Suffolk
Erie	Oneida	Queens	Westchester
Kings	Onondaga		

A detailed analysis of ZIP code level data, utilizing the same Z-score methodology employed at the county level, was completed as a step in the development of this State Plan in order to inform further targeting of services within the 14 high risk counties. See **Attachment A** for results of this analysis within the three initial target communities.
The Needs Assessment also included an inventory of existing home visiting programming in NYS, including county-specific inventories for each of the 14 at-risk counties. Additional

outreach to home visiting programs and community based organizations in the 14 at-risk counties was conducted for the development of this State Plan to expand information about existing services, and gaps in services.

Overall, the 14 counties identified through the Needs Assessment as at-risk communities are the target communities for NYS' MIECHV initiative. Because the annual funding to NYS (based on the FY10 allocation) is insufficient to support new activities in all 14 counties, funding initially will be targeted to a subset of the highest need counties from within this larger group. Specifically, the Department proposes to award available funding to strengthen and enhance existing capacity for delivery of evidence-based home visiting services in three high need communities from within Group 1. The three target counties were selected by ranking of total Z-score (i.e., combined rate Z-score and the cases Z-score), shown in **Table 2** below. In order to gain statewide coverage, the Department will award available funding to the two highest rest-of-state counties and highest NYC county. Based on this methodology, the initial target counties for the State Plan are **Erie**, **Monroe** and **Bronx** counties. (See **Attachment B** for entire selection and funding methodology).

Table 2. Ranking of At-Risk Counties in Group 1

Group	County	Rate Z-score	Cases Z-score	Total Z-score
Rest of State:				
1	**Erie**	**0.54**	**1.79**	**2.33**
1	**Monroe**	**0.28**	**1.17**	**1.45**
1	Onondaga	0.38	0.75	1.13
1	Albany	0.53	0.3	0.83
1	Oneida	0.64	0.1	0.74
New York City:				
1	**Bronx**	**1.75**	**3.16**	**4.91**
1	Kings	0.5	4.1	4.6
1	New York	0.42	2.03	2.45

Should increased annual funding become available for this initiative in subsequent years, additional projects within the 14 at-risk counties will be funded through a competitive RFA process.

Assessment of Needs and Existing Resources in Target Communities

As part of the process to develop the state's plan, the Department solicited input from home visiting programs and stakeholders in the 14 designated high-risk counties. Input was received from more than 100 community-based organizations, local government agencies and home visiting programs through a structured on-line survey (**Attachments C1 and C2**), as well as conference calls and in-person meetings with several stakeholder organizations and groups. This information further enhances the extensive data analysis and significant input from stakeholders previously collected during the development of the state's needs assessment. Through these processes, home visiting stakeholders identified:

- specific characteristics of their communities that contribute to the high need;
- specific characteristics of home visiting program participants which put them at risk for poor maternal and child health outcomes;
- community strengths;
- gaps in services;
- referral resources; and
- mechanisms for screening and identifying high-risk families.

This input, along with extensive previous input and feedback from stakeholders, was essential in developing the State Plan. As noted above, the state has determined that currently available (FY10) funding will be targeted to three high-risk communities: **Erie** and **Monroe** Counties upstate and **Bronx** County in New York City. Detailed profiles assessing the community needs, risk factors, strengths and existing services are provided in **Attachment D.**

Coordination among existing programs and resources

Enhancing coordination among home visiting programs and other community resources – including coordination *between* home visiting programs in communities where more than one program operates – has been a longstanding emphasis of New York's strategic planning efforts. This theme was reiterated throughout the development of the state's MIECHV needs assessment and state plan, including input from community stakeholders as well as state agency partners.

At the local level, all MIECHV sub-grantees, as a condition of funding, will be expected to participate in community-wide perinatal and early childhood systems, including coordination with other home visiting programs and other health and human service providers. As noted in the profiles of target communities in **Attachment D**, a variety of strategies and systems are already in place or under development to develop and sustain coordination of services within target communities. MIECHV sub-grantees will be required to submit information to NYSDOH about implementation of home visiting programs within the target communities, to include a description of existing and planned strategies for coordination with other community perinatal and early childhood services.

Additionally, it is anticipated that within the next year, NYSDOH will complete a competitive RFA process to distribute grant funding for several NYSDOH-administered perinatal public health programs; this RFA is expected to be the mechanism by which any additional MIECHV sub-grantees will be selected, subject to successful application for increased annual federal MIECHV funding for NYS. Grants resulting from this RFA also will require partnerships and coordination with home visiting providers – including both initial and potential new MIECHV grantees– and with other community health and human service providers.

Please refer to **Section II** below for additional description of state capacity to integrate the proposed home visiting services into perinatal and early childhood systems.

Communities Not Selected for Implementation of the State Home Visiting Program

The following eleven communities identified as at-risk in the initial needs assessment were not selected for the first phase of NYS' MIECHV initiative due to limitations on available annual funding (based on FY10 award level):

- Albany County
- Kings County (Brooklyn)
- New York County (Manhattan)
- Nassau County
- Oneida County
- Onondaga County
- Orange County
- Queens County
- Richmond County (Staten Island)
- Suffolk County
- Westchester County

As noted above, should NYS be awarded further increases in annual federal MIECHV funding, it is anticipated that all 14 at-risk communities will have an opportunity to apply for grant funding through a competitive application process.

Through the survey process noted above, additional input also was solicited from stakeholders within these eleven at-risk communities. This builds on the detailed information about these eleven communities included in the previously-submitted statewide needs assessment. Survey respondents from these eleven communities reported many similar risk factors including poverty, unemployment, illiteracy, teenage pregnancy and births, lack of prenatal care, lack of insurance, substance abuse, poor graduation rates, child maltreatment and domestic violence.

Selected highlights of input obtained through this process include:

Risk Factors:

- The combination of multiple individual risk factors, in the context of inadequate access to health care and education, puts residents at risk for poor maternal and child outcomes.
- Socioeconomic risk factors include high rates of unemployment, stress due to fear of deportation and inability to find affordable housing and decent paying jobs.
- Most of the risk factors and participant characteristics were similar across programs, such as poverty, unemployment, low literacy, low graduation rates, teen pregnancy and births, delayed or inadequate availability of prenatal care, substance abuse, domestic violence and child maltreatment.
- Significant and persistent racial and ethnic disparities, especially in birth outcomes, were noted by many respondents.
- There were also some risk factors specific to individual communities. Several downstate communities noted a much larger homeless and immigrant population than in upstate counties, and language can be a barrier in communities with large immigrant populations. Several upstate communities are experiencing steady growth in refugee populations. Childhood lead poisoning associated with old homes is a major problem in several counties. Several upstate counties noted an increase in gang activity.

Gaps in available services:

- Many home visiting programs echo the lack of mental health services, dental services and prenatal care services for Medicaid eligible populations.
- Several respondents noted the absence of centralized intake processes for home visiting services as a challenge.
- Most counties report they have resources for food, housing, temporary shelter, WIC, primary care, etc., however, due to the downturn in the economy these programs are even more in demand. It is often difficult to find these same services for the Medicaid population. Many providers require waiting times for obtaining initial services.
- Commonly-reported gaps in services include transportation, jobs, early childhood education, child care and service providers who accept Medicaid, especially for dental and mental health services.

Community Strengths:

- In some communities, the operation of multiple home visiting program models with different eligibility criteria, primary outcomes and/or staffing models is an asset to address the needs of the community.
- Many home visiting providers use outreach, word of mouth, hospital and prenatal and primary care providers as a source of referrals. Good working relationships with other agencies are noted as a means of "triaging" referrals to the most appropriate worker based on language spoken, needs, urgency and other factors.
- "Peer Place" a web based referral and case management tool is used in a few counties to facilitate intake, referral and coordination.
- There are a multitude of home visiting programs and models operating in these counties. Some but not all of these are included in the list of program models designated by HRSA as "evidence-based."
- There is also much strength and uniqueness in these counties, including dedicated providers, committed partnerships and a willingness to collaborate and work harder to provide better maternal, infant and early childhood services.

As NYS' MIECHV initiative continues to evolve, further detail about additional target communities will be collected and developed. As noted above, it is anticipated that a competitive RFA will be completed within the next year to select additional projects within the 14 at-risk communities, in anticipation of potential increased annual federal funding. Applications submitted in response to that RFA will be required to include local assessments of needs, strengths and existing services that will further enrich our understanding of this dimension of the MIECHV initiative.

II. Program Goals and Objectives

NYS' MIECHV initiative aims to improve the health and well-being of at-risk families through implementation of evidence-based home visiting programs operating within a comprehensive, coordinated system of perinatal and early childhood services. The initiative is driven by three over-arching goals:

- **Improve pregnancy outcomes for high-risk women and babies**
- **Improve children's health and development**
- **Strengthen multi-generational family functioning and life course**

While no single program alone can accomplish these ambitious goals, well-designed home visiting programs have the potential to impact meaningful outcomes across multiple domains for children, parents and communities. The **NYS MIECHV Logic Model** (see **Attachment E**) highlights specific outcomes that will be improved through NYS' MIECHV initiative, encompassing changes in individual-level factors, behaviors and longer-term outcomes. In addition, the logic model reflects the expected impact of MIECHV manifested over the life course for both babies and parents, beginning before birth and persisting well beyond the time frame of service delivery through childhood, adolescence and adulthood.

Of central concern for NYS are health outcomes in the prenatal and perinatal periods. As illustrated in the state's previously-submitted Needs Assessment, key population health indicators - including use of early prenatal care, infant mortality, low birth weight, and prematurity - have not improved significantly over the last decade in NYS, and in some instances have actually gotten worse. Moreover, there are striking and persistent disparities in these measures, with significantly higher rates of adverse measures among black, Hispanic and low income populations. Even in measures where trends are improving – such as reductions in adolescent pregnancy and birth rates – there are significant racial, ethnic and economic disparities.

In order to address these persistent outcomes, NYSDOH increasingly is adopting a life course approach, with specific emphasis on preconception, prenatal, postpartum and infancy as critical periods for prevention and early intervention. As demonstrated by the studies highlighted in the Mathematica review of home visiting programs, well-designed and rigorously-implemented interventions that support family wellness and development during these earliest critical periods can lay a foundation for well-being across the life span, manifested as positive outcomes that range from physical health to educational achievement to economic self-sufficiency. The critical importance of these earliest life periods is increasingly recognized across historically "siloed" efforts to improve individual and family well-being through various sectors of the health, human service, educational, criminal justice and other systems. Specifically, the state's Early Childhood Advisory Council (ECAC) – building on the foundation of several previous and ongoing strategic planning initiatives – has identified prenatal and postpartum home visiting as a core strategy that can contribute to positive life long outcomes for children and families.

NYS is fortunate to have a number of established home visiting programs among a rich array of other health, education and human services for families. Our challenge is to strengthen and expand this existing capacity to engage and serve all families in need of home visiting, and to enhance and sustain community systems to deliver services more seamlessly, so that the impact

of home visiting and other services can be achieved not just within individual programs, but at the community level. To address these challenges, several specific objectives have been established for NYS' MIECHV initiative:

1. Strengthen the capacity of existing home visiting programs to identify, engage and serve at-risk families within target communities;
2. Increase the number of at-risk families receiving evidence-based home visiting services;
3. Demonstrate improvements in measurable outcomes for families participating in funded home visiting programs;
4. Build, strengthen and sustain coordination and integration of home visiting programs within larger community perinatal and early childhood service systems; and
5. Demonstrate population-level improvements, including reduction of racial, ethnic and economic disparities, in measurable outcomes within target communities.

It is expected that progress can be achieved in accomplishing Objectives #1, 2 and 3 beginning within the first year of implementation, while accomplishment of Objectives #4 and #5 will require a longer time period and additional resources.

Integrating Home Visiting with Other State Program and Systems

In addition to directly supporting enhanced capacity of specific home visiting programs within the initial target communities, the infusion of new federal funding through MIECHV should serve as a catalyst for further development of comprehensive perinatal and early childhood systems that promote and support maternal and child health and well-being. Already the announcement of available funding, needs assessment and initial planning work has helped to energize many partners, both within and outside of government and at the state and local levels, related to longstanding efforts in the state to build and sustain comprehensive, coordinated systems. Stakeholders have noted that the MIECHV initiative serves not only as a source of much-needed additional funding for the state, but as a "call to action" to highlight the compelling science of early brain development and relationships, and the benefits of investing resources – both public and private – in evidence-based home visiting programs and systems.

As noted under **Section I**, at the local level, all MIECHV sub-grantees, as a condition of funding, will be expected to participate in community-wide perinatal and early childhood systems, including coordination with other home visiting programs and other health and human service providers. It is anticipated that within the next year, NYSDOH will complete a competitive RFA process to distribute grant funding for several NYSDOH-administered perinatal health programs; grants resulting from this RFA also will require partnerships and coordination with home visiting providers – including MIECHV grantees – and other health and human service providers.

At the state level, an interagency state work group, established to support completion of NYS' MIECHV Needs Assessment and State Plan, will continue. This group serves as an ongoing resource to identify, prioritize and coordinate needs, strategies and resources related to NYS' MIECHV initiative. A specific strategy that will lend further support to these efforts will be the allocation of a portion of NYS' MIECHV funding to support MIECHV-related activities of a new Perinatal Health Statewide Center of Excellence. This Center will provide new state-level infrastucture to coordinate and facilitate the development, dissemination and implementation of evidence-based and promising practices through training, technical assistance, research-to-

practice information and resources, and evaluation – thereby integrating support for MIECHV and other home visiting initiatives within a broader focus on perinatal health interventions and outcomes. The Center will serve as a focal point for development and dissemination of new resources, while also supporting coordination with other existing key resources and organizations including national program developers and state and local program administrators. This infrastucture is expected to help support further integration of home visiting with other perinatal and early childhood programs and systems.

In particular, the state workgroup has identified three priorities as a focus for enhancing home visiting program capacity and effectiveness through cross-sector coordination: **mental health**, **substance abuse** and **domestic violence**. These were repeatedly identified through the state's needs assessment and other strategic planning discussions as complicating factors that present additional challenges in identifying, engaging and effectively intervening with at-risk families. As illustrated in the Mathematica review, even high-quality home visiting programs have limited success in these areas. Further integrating home visiting programs within state and community systems offers an opportunity to better meet these additional needs for families. With further training, tools, supports and community linkages, home visiting programs ideally can enhance their capacity to identify and address family risk factors and needs related to mental health, substance abuse and addiction and domestic violence. The Center of Excellence can serve as a key resource for coordinating these efforts.

III. Selection of Proposed Home Visiting Models

Criteria for Selection

The evidence-based home visiting models to be implemented through the first phase of NYS' State Plan were selected based on the state's needs assessment, including data on population outcomes and needs as well as assessment of existing programming and capacity in the three target counties.

In the first phase of NYS' plan, in order to effectively utilize immediately available funding --the first (FY10) allocation of which must be fully expended by September 30, 2012--the State plans to focus on enhancing the capacity of established evidence-based home visiting programs currently operating within the target communities. As described in **Section II** above, the primary focus for this first phase of NYS' initiative is to improve core outcomes related to maternal and child health, with a primary focus on measures of prenatal, postpartum, interconception and infant health. In line with this focus, the initial phase of New York's MIECHV initiative will target available new resources to specific home visiting programs that have demonstrated effectiveness in improving measurable outcomes of maternal health, child health and/or child maltreatment. This approach reflects New York's commitment to implementing a life course approach that emphasizes primary prevention and early intervention during these critical early periods to lay a foundation for lifelong well-being.

To accomplish this, the following criteria were established to select specific home visiting programs within the three target communities for phase one:

- The program meets HRSA/Mathematica criteria for evidence-based;
- The program is currently operating within the target community and serves at least one high-need ZIP code (defined by combined Z score > 0) within the county; and
- The program must have demonstrated favorable outcomes in the Mathematica review in at least two of the three following domains: **Child Health**, **Maternal Health**, or **Child Maltreatment.**

Based on these criteria, the programs eligible for funding in the first phase of NYS' initiative include the **Nurse Family Partnership (NFP),** operating in Bronx and Monroe counties, and **Healthy Families New York (HFNY),** operating in Bronx and Erie counties.

Other home visiting models designated as "evidence-based" in the HRSA/Mathematica review that were not deemed eligible for the first phase of New York's initiative include: Early Head Start, Family Check Up, Healthy Steps, HIPPY and Parents as Teachers. These models are not eligible for funding in this first phase following the criteria above because they are not currently operating in one of the initial target communities and/or because the outcomes demonstrated for those programs in the Mathematica review are in other domains including Family Economic Self-Sufficiency, Child Development and School Readiness and/or Positive Parenting Practices. Should increased annual federal funding become available to New York State, additional program models potentially will be considered for funding through a competitive RFA process, to be completed within the first year of NYS' MIECHV initiative.

Additionally, NYS is required to award a specified portion of its annual MIECHV grant ($673,000 annually) to an established project in Rochester, New York that previously was directly funded by ACF through a federal Evidence-based Home Visiting initiative that preceded the ACA MIECHV Program. This Building Healthy Children project, operated by the Society for the Protection and Care of Children integrates several home visiting curricula and models including Nurse Family Partnership, Parents as Teachers, and Incredible Year. NYSDOH has already established a sub-grant to SPCC to support this project and will continue to work closely with them to support integration with other NYS MIECHV activities and to inform the continued development of NYS' MIECHV initiative.

Summary of Selected Evidence-Based Home Visiting Program Models

Nurse Family Partnership (NFP) is a nurse-led evidence-based home visiting program targeted to low-income first-time mothers designed to improve maternal and child health, pregnancy outcomes, children's subsequent health and development, and economic self-sufficiency of the family. It includes one-on-one home visits by trained public health nurses to participating clients. Visits begin early in the woman's pregnancy with program enrollment no later than 28th week of gestation, and conclude when the woman's child turns two years old. During visits, nurse work to reinforce maternal behaviors that are consistent with program goals and that encourage positive behaviors and accomplishments. In NYS, there are currently three NFP programs in operation in Monroe County, Onondaga County and New York City. All three programs are accredited by the NFP National Service Office (NFP-NSO). The New York City NFP program, providing services in all five boroughs of the city, is the largest urban NFP program in the nation.

Healthy Families America (HFA) is a national program model that encourages the use of paraprofessionals to deliver home visiting services to expectant mothers and parents with infants less than 3 months of age considered at high-risk for child abuse and neglect. Once enrolled, services are provided to families until the child enters kindergarten or Head Start. The program aims to reduce child maltreatment, increase use of prenatal care, improve parent-child interactions and school readiness, ensure healthy child development, promote positive parenting, promote family self-sufficiency and decrease dependency on public assistance and other social services. In NYS, the HFA program is implemented as **Healthy Families New York** (HFNY), through 36 HFA-accredited sites throughout the state, including programs in Erie and Bronx counties. The HFNY program is administered by the New York State Office of Children and Family Services

Both NFP-NSO and HFA have provided letters of agreement to NYSDOH to implement their respective programs as proposed in the State Plan (See **Attachment F**). NYSDOH, in collaboration with OCFS, will work with NFP-NSO and HFA/HFNY to implement their models as proposed, collaborate on required data collection/reporting and the anticipated national evaluation of the MIECHV program and coordinate programmatic training and technical assistance.

Mechanisms for awarding funds to sub-grantees

As described in detail in **Section VI**, NYS, NYSDOH and OCFS have well-defined policies and procedures for awarding and managing state-administered funds. In order to implement MIECHV sub-awards and expend available federal funding within the time frames required by federal funders, approval will be sought from necessary state control agencies to award funds to the organizations currently operating NFP and HFNY programs within the target communities designated for the first phase of NYS' MIECHV initiative on a non-competitive basis, based on the selection criteria described above in **Section I** and **III**. Available annual funding, based on New York's SFY10 allocation level, will be distributed proportionately among the three target communities, and within them, among specific eligible programs, based on a defined funding distribution methodology that takes into account both population demographics and current service volume of individual programs (see **Attachment B**).

As noted previously, it is anticipated that within the first year of NYS' MIECHV initiative, NYSDOH will complete a competitive RFA process to select additional MIECHV sub-grantees within the 14 designated at-risk communities. Ability to fund awards to any additional sub-grantees selected through this process will be subject to the availability of increased annual federal MIECHV funding for this initiative in NYS. Given the significant remaining need in NYS identified through the MIECHV needs assessment, the strong local capacity and interest in these additional communities to implement evidence-based home visiting programs, and the enhanced state-level capacity to be supported through phase one of NYS' MIECHV initiative, it is anticipated that NYS will be competitive for additional increases in federal MIECHV funding.

Experience and Capacity to Implement Models Selected

Nurse Family Partnership (NFP):

There are currently three NFP programs operating in the state, implemented by local health departments (LHDs) in Monroe and Onondaga counties, and New York City (serving all five boroughs). Together these three local programs provide services to approximately 2,628 families annually. As described further below, funding is a combination of local, private foundation, various flexible state to local funding streams, and one-time state-administered federal TANF funds. NYSDOH has a longstanding collaborative relationship with these local health departments and their NFP programs, including:

- ***Coordination with other DOH Home Visiting Initiatives***: The NYSDOH funds a Community Health Worker Programs (CHWP), a DOH-developed paraprofessional home visiting program, in communities across the state, including Bronx and Erie counties. Local CHWPs are required to coordinate outreach, screening and referrals with the NFP, HFNY, and other home visiting programs in their target communities. Additionally, NYSDOH recently has worked with LHDs in six counties, including Erie, Monroe and Bronx, to develop and implement Healthy Moms-Healthy Baby (HM-HB), a NYSDOH-developed systems initiative to improve birth outcomes for Medicaid-eligible pregnant and postpartum women and their newborns through building and strengthening county systems for early identification and outreach, engagement in prenatal care, assessment of health and social risks, and referral for health and supportive services, including home visiting services. HM-HB grantees collaborate with all home visiting programs in their counties, and will be

required to collaborate with the MIECHV-funded programs in the designated target communities.

- ***Administration of Grant Funding to local NFP programs***: In partnership with the NYS OTDA, the Department currently supports enhancement of the state's three existing NFP programs through provision of one-time state-administered federal TANF funding totaling $7 million for a two-year period of January 2010 through December 2011. The goal of this project is to improve pregnancy outcomes and the health, well being and self-sufficiency of TANF-eligible (Family Assistance applicants and recipients and the 200% of federal poverty level population) first-time mothers and their children by helping high-risk women engage in preventive health care, including prenatal care. Funding has helped strengthen and expand capacity of the established NFP programs, though ongoing funding is needed to maintain and further enhance this expanded capacity.

- ***Establishment and Implementation of Medicaid reimbursement***: In 2010, through a collaboration of NYSDOH Title V and Medicaid programs, NYSDOH received approval from CMS for a Medicaid State Plan Amendment to provide Medicaid reimbursement for Targeted Case Management (TCM) activities of Monroe County and New York City NFP programs. TCM activities include assessment of medical, education, social and other service needs; development of a care plan to help the woman engage in good preventive health practices, and referral, follow-up and assistance in gaining access to needed services. The two NFP programs began Medicaid billing of NFP TCM activities in January 2011. While Medicaid reimbursement provides an important funding stream to support these programs, it covers only a portion of program costs, reiterating the need for other ongoing funding to maintain and expand capacity of these critical services.

In this capacity, the NYSDOH has worked extensively with the NFP-NSO, NSO regional office program staff, and local NFP programs to support implementation, enhancement and coordination of NFP services within the initial target areas and other at-risk communities in NYS. The NFP-NSO in turn has extensive experience and capacity to support establishment and operation of local NFP programs, including in the areas of:

- Recruitment and hiring of qualified staff. NFP-NSO provides job descriptions, recruitment and interviewing resources, and guidance to assist new supervisors and administrators to attract capable candidates to nursing roles.
- Competency-based core education required for all nurses in the program based on theories that support the model: visit structure, building self-efficacy, promoting behavior change and goal setting and attainment.
- Delivery of culturally and linguistically relevant services built on the nursing practice's ecological framework for human development.
- Promotion of high quality clinical supervision through reflective supervision.
- Client retention. Promotion of strategies to minimize attrition, such as motivational interviewing.

As such, NYSDOH and the initial target communities of Monroe and Bronx counties are well positioned to enhance NFP services through the MIECHV initiative.

Healthy Families New York (HFNY)

The HFNY program is part of the Healthy Families America (HFA) initiative. The NYS Office of Children and Family Services (OCFS) plans, administers and delivers HFNY program services in accordance with the HFA program model. The HFNY program began in 1995 with 10 local programs, and currently operates 36 local programs in 44 sites throughout NYS. The program is funded by $23 million (state general funds) and is present in 31 counties and the 5 boroughs of NYC, serving approximately 6,000 families annually. The HFNY multisite system consists of the NYS Office of Children and Family Services (OCFS), Prevent Child Abuse NY (PCANY), and the University at Albany Center for Human Services Research (CHSR), along with the program managers and staff of funded sites. Each of these parties have identified responsibilities that contribute to ensuring that HFNY program meets the requirement of Healthy Families America and that quality home visiting services are provided to families. OCFS with PCANY and CHSR act as the administrative team that supports the programs in their provision of services and continuous quality improvement. All HFNY programs receive technical assistance, quality assurance, and site support from the three branches of Central Administration (CA). CA supports program improvements by providing training, technical assistance, and site support that directly address each individual program's needs. Specific activities provided by each of the CA partners include:

- **OCFS:** OCFS staff provides on-site training and technical assistance for individual programs. HFNY programs receive a site visit every one to two years, tailored for each program. The OCFS Program Contract Manager will review a group of credentialing standards from the program's self-assessment during the visit. At the end of the visit, staff may discuss appropriate follow-up activities for reaching program goals. A summary of findings will be sent with a request for a response and/or corrective action plan for items noted in the findings if needed. OCFS also oversees a randomized controlled trial at three sites including Erie, a cost-benefit analysis, coordination of meetings and training forums, and the contracts with the tow other entities responsible for continuous quality assurance.
- **PCANY Training and Staff Development Team:** Provide HFA-approved Core (Role Specific) Training by HFA certified trainers; on-going and advanced training; and workshops, seminars and conferences at the regional and state level. An annual needs assessment of each program is conducted to best tailor training. PCANY provides a quality assurance and site support visit every 2 years.
- **CHSR:** CHSR staff provides on-site training and technical assistance for individual programs. CHSR developed and manages the MIS used by HFNY. All HFNY programs submit data to CHSR monthly. CHSR uses this data to generate quarterly data reports, and semi-annual performance indicator reports which include data on the individual program level and aggregate data for the entire HFNY program. Programs have the capacity to access reports at their sites and can utilize them to identify strengths, concerns and trends; and develop quality improvement plans.

NYSDOH and OCFS have collaborated extensively on HFNY, partnering on curriculum development, training activities, establishing program outcomes, and encouraging cross referrals and support in communities with HFNY and other home visiting programs. This partnership will be strengthened and enhanced through the state's MIECHV initiative. Federal MIECHV funds allocated for enhancement of HFNY programs within the designated target communities

will be transferred from NYSDOH to OCFS, to be administered by OCFS within the structure of their existing grant administration of the HFNY program.

Plan for Ensuring Implementation with Fidelity to the Model

In conjunction with the new Center of Excellence, NYSDOH will work with NFP -NSO and OCFS to utilize, and enhance as needed, their existing management information systems (MIS) to collect information from the point of the initial eligibility screen to case closing. MIS information and reports are critical tools to assess fidelity to the model (e.g., delivering core program components according to the prescribed schedule and dose), to monitor program performance, and to improve the quality of services provided. The MIS will inform continuous quality improvement at the state and individual program levels. Working with the model developers, the MIS may be expanded and redesigned to accommodate and align with the reporting requirements specified in the Supplemental Request for Information on the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP). As needed, supplemental data may be collected through the proposed new Perinatal Health Center of Excellence to meet all federal reporting requirements for this initiative.

To ensure MIECHV programs are implemented with fidelity to the chosen models and to support continuous quality improvement, NYSDOH also will work with OCFS, the Center of Excellence and the model developers to augment technical assistance, quality assurance, and site support to local programs. The new Perinatal Health Center of Excellence will provide essential new state-level infrastructure to coordinate site-specific as well as overlapping training, technical assistance, research-to-practice information and resources, and evaluation activities. In this capacity, the Center of Excellence will serve a key coordinating function between local home visiting programs, state agencies, national program developers and other state and local partner organizations. The Center of Excellence will supplement and help coordinate training, technical assistance and quality improvement activities provided by the administrating bodies of NFP and HFNY to ensure required goals and objectives of the MIECHV are satisfied.

Regular site visits will be conducted to provide technical assistance and ensure programs are implementing proscribed activities and meeting required goals and objectives. Site visits typically include a review of roles of supervisors and home visitors, client charts, outreach and referral plans, and fiscal processes. At the end of the review, feedback is provided to program supervisors and management summarizing findings, and suggesting appropriate follow-up activities for reaching program goals and addressing any deficiencies identified. NYSDOH, NFP and OCFS will use, at a minimum, annual data and performance reports for individual programs to support individual program’s quality assurance and improvement efforts. Programs will be encouraged to integrate Quality Assurance activities to review progress toward achieving MIECHV goals and objectives and address identified areas of improvement.

Anticipated Challenges

Challenges to maintaining quality and fidelity are anticipated to vary across communities and programs. Recruiting and retaining staff that meet required minimum qualifications and credentials is a common challenge faced by home visiting programs. Coordination of home visiting programs in communities where more than one program model operates is both an opportunity and a challenge to be addressed. Other possible challenges to model fidelity include

engagement and retention of families experiencing domestic violence, mental health substance abuse; engagement of both parents especially when parents live apart, working, or attending educational programs; enrolling families early in pregnancy; and engagement and retention of families with undocumented status. The new Center of Excellence will serve a key function in coordinating and/or providing training, tools and technical assistance to local programs and state agency leaders to address these and other challenges.

IV. Implementation Plan

Engagement of At-risk Communities in Development of State Plan

As described in **Section I**, fourteen counties were identified through the New York State Needs Assessment as "at-risk" communities for NYS' MIECHV initiative. As part of the plan development process, a structured on-line survey was distributed to stakeholders in those 14 counties to further identify: community risk factors, strengths and resources; characteristics of target populations; mechanisms for screening identifying and referring families to home visiting programs; and referral resources currently available and needed. Additionally, in-person and conference call discussions were held with several stakeholder groups during the plan development process. Respondents include local home visiting programs as well as other stakeholder organizations. A list of specific organizations that provided input through this process is provided in **Attachment G**.

This survey process complemented ongoing work over the last year to engage stakeholders in providing input on the development of NYS' MIECHV plan. The NYSDOH Healthy Mom-Healthy Baby initiative (See **Section VI** for detail on this initiative) has provided a specific forum for engaging local health departments from at-risk communities, including the three initial MIECHV target communities, in discussion of local home visiting services in the context of broader perinatal health systems-building efforts. In collaboration with OCFS, local departments of social services have provided input through a workshop on home visiting at the annual NY Public Welfare Administration conference, conducted jointly by NYSDOH, OCFS and the Commissioner of Social Services from Monroe County. All of these venues have provided critical insight and input regarding needs, strengths, gaps and challenges in target communities that have informed the development of NYS' MIECHV plan. As the initiative continues to evolve, additional steps will be taken to further engage organizations implementing NFP and HFNY programs within the initial designated target communities to support implementation of new enhancement funding.

A state agency work group, initially established to support completion of the state's MIECHV needs assessment, continued to meet regularly to support development of the state plan. Core participating agencies include:

- NYS Office of Children and Family Services (OCFS)
- NYS Council on Children and Families (CCF)
- NYS Office of Mental Health (OMH)
- NYS Office for the Prevention of Domestic Violence (OPDV)
- NYS Education Department (SED)
- NYS Office for Alcoholism and Substance Abuse Services (OASAS)

State agency partners actively contributed to the State Plan, including: development of the process for the selection of high-risk communities and the selection of the Home Visiting Models; identifying the scope and reach of the State Plan; identifying priorities for MIECHV goals and objectives; providing feedback on draft documents; and, writing sections the State Plan.

Development of Policy and Standards

In continued collaboration with state agency partners, national program developers and other key stakeholders, NYSDOH will develop and/or enhance policy and set standards for the State Home Visiting Program that promote and support comprehensive home visiting programs in the target communities. As a condition of funding, local home visiting programs funded under this State Plan will be required to submit plans to meet the following requirements:

- Complete a local needs assessment of community-level data, existing home visiting programs and their quality and capacity, existing community resources, gaps in services, and characteristics of high-risk populations (building on the data and information collected through previous steps in the process);
- Demonstrate agency experience and capacity to administer maternal, infant and early childhood home visiting programs, including and working across systems and in partnerships with diverse stakeholders;
- Describe specific activities to implement the home visiting model, including projected numbers to be served, expected outcomes, and monitoring fidelity of implementation;
- Demonstrate strong working partnerships, including letters of collaboration from county health, social services, mental health and substance abuse services agencies, other local home visiting programs, and other local health and human services provider organizations;
- Demonstrate agency capacity to collect and analyze data across an array of indicators, including a plan for meeting required federal benchmarks and agreement to fully participate in any statewide training, technical assistance and/or evaluation activities.

Because it is proposed that awards to the local programs funded through the first phase of New York's state plan (i.e., the NFP and HFNY programs in Bronx, Erie and Monroe counties) will be made through a non-competitive process (see **Section III** above), these grantees will be required to submit these local plans as a grant deliverable within the established contract period. Continued funding will be contingent on successful completion of these requirements.

For any additional grantees, as described in **Section III**, the above requirements are anticipated to be addressed within local applications developed pursuant to a competitive Request for Applications (RFA) process. Applications will be reviewed and scored and awards made on a competitive basis that includes consideration for satisfactory response to these requirements. Any additional awards through this process are subject to New York State being awarded increased federal MIECHV funds through a future federal application process, and to all applicable state control agency approvals.

Technical Assistance and Support

Plan for Working with National NFP

NYSDOH, in conjunction with the new Perinatal Health Center of Excellence, will work with the Nurse Family Partnership National Service Office to ensure programs implementing the NFP model:

- Adhere to the 18 required model elements, use NFP-specific implementation tools, and adhere to agency selection requirements contained in their Implementation Plan and Guidance documents.
- Ensure nurses receive: NFP-specific education, adequate support and reflective supervision; ongoing professional development on topics determined by nursing supervisors; engage in activities designed to reflect the team's own practice, review program performance data, and enhance the program's quality and outcomes over time; and utilize ongoing nurse consultation for ongoing implementation success.
- Participate in all NFP quality initiatives including, but not limited to, research, evaluation, and continuous quality improvement.
- Assure all organizations use data and reports from the NFP web-based Efforts to Outcomes data system to foster adherence to the model elements and achieve outcomes comparable to those achieved in the randomized, controlled trials. This may include creating necessary interfaces between local or state-based data and with information systems of the national web-based data systems.

Plan for Working with HFA

The Department, in conjunction with the new Perinatal Health Center of Excellence, will work with Healthy Families America and the NYS Office of Children and Family Services/HFNY Central Administration Team to ensure programs implementing the HFA model:

- Are affiliated with Healthy Families America as required by Prevent Child Abuse (PCA) America. HFA affiliation includes many training and technical assistance opportunities and requirements.
- Receive core HFA training curriculum for home visitors. National HFA staff are available to provide support to the state and individual sites around program planning, development, implementation and accreditation. A comprehensive train-the-trainer mentoring process to certify and license state trainers is also available.
- Implement critical HFA elements in a way that meet the needs of the community served. OCFS, PCANY and CHSR provide training and technical assistance to local communities, including help in tailoring the HFA critical elements and adapting the HFA program to meet the needs and conditions of the local communities. Communities are encouraged to seek technical assistance throughout the planning process to ensure the HFA critical elements are reflected. Program planning and technical assistance are available from HFA state leaders and state trainers as well as HFA regional resource centers. During the coming year, NYS will be going through the multi-site re-accreditation process with HFA.
- Collect and enter specified data into the HFNY MIS on a quarterly basis.
- Adhere to the policies and procedures set forth in the statewide HFNY manual.

Provision of Training and Technical Assistance

As noted in other sections of this plan, a central component of New York State's plan will be the establishment of a new **Perinatal Health Center of Excellence (COE),** to be supported in part with federal MIECHV funding. A key component of the new COE's scope of work will be the coordination of training, technical assistance, data management and evaluation to support NYS' MIECHV initiative. The COE will support the statewide It is anticipated that the COE will be

selected through a competitive Request for Applications (RFA) process to be completed within the first year of New York's MIECHV initiative.

The home visiting programs to be supported by the State Plan are established programs with staff trained using the national model developers' required core curricula. Training for any new staff will be coordinated with the model developers and delivered by qualified instructors. Trainings will be scheduled within two to four weeks of staff start date. Any ongoing training for new and existing staff will be scheduled as needed and in accordance with any set schedules. Additionally, the Department will work with the Center of Excellence and other agency partners to identify and/or develop and discuss the appropriateness of use of other training curricula, tools or other resources to support enhancement of local program capacity and services, including identification of gaps in training. The Department and COE will work with each home visiting program to integrate a plan for supplemental training that assures access to and ongoing tracking and monitoring of these activities.

Similar to program-specific activities described for ensuring model fidelity, both NPP and HNY have plans in place for both training and technical assistance. Common elements to both include orientation to program goals, services, policies and procedures, core curriculum for home visits, intensive and role-specific training, training to use data forms and data management systems, orientation to issue of confidentiality and overviews of the quality assurance systems. In addition to these common activities, the specific programs also offer training and technical assistance activities that reflect the unique priorities and features of their respective models.

The Nurse-Family Partnership National Service Office (NSO) provides competency based core education that is required for all nurses in the program. The education model is based on: the theories that support the model; visit structure; tools for building self-efficacy; promoting behavior change and goal setting and attainment; and methods to encourage parents to become emotionally available and responsive parents. The NSO provides a required multi-step orientation and education process for new home visitors and an additional training and consultation process for supervisors.

The HFA role-specific training curriculum is organized into six training modules that support the goals and objectives of the HFA initiative and the twelve research-based critical elements that guide HFA program functioning. Training is provided by PCANY over four consecutive days. Families cannot be assigned to workers until they have completed their Core Training. Program Managers receive the FSW and/or FAW Core training before supervising staff. Program Managers receive the New Program Manager Overview and Supervisor Core Training within 6 months of hire.

Recruiting and Retaining Appropriate Staff

In order to support effective oversight and implementation of NYS' MIECHV initiative at the state level, funding has been allocated in the budget for three core positions: two within the NYSDOH and one within the NYS OCFS (See Section 6 for detail). Staff within both agencies will work with their respective Personnel Management units to seek necessary approvals to fill positions through established recruitment procedures. Once hired, staff will be oriented to their respective agencies and to the goals and objectives of the MIECHV initiative.

Recruitment of Subcontractor Organizations

As described extensively in Sections I and III, based on currently available annual funding (based on FY10 award level), the State Plan will support the enhancement of existing home visiting programs (NFP and HFNY) within three target communities (Erie, Monroe and Bronx counties). Should increased annual funding become available to the state, additional awards will be made within the 14 designated at-risk communities through a competitive RFA process. The Department encourages community-based subcontractors to recruit and hire staff representative of the language and culture of the population served and who, to the extent possible are hired from the community targeted for services. The Department will work with OCFS, NFP- NSO and the subcontractors to ensure subcontractors recruit and hire staff that meet any required minimum qualifications for program management, supervision and home visiting positions. Each program must have a written policy on Equal Opportunity that states its recruitment, selection, transfer, and internal promotion procedures. Programs are required to conduct reference checks to verify education requirements and employment history. Programs conduct appropriate, legally permissible and mandated inquiries into the background of prospective employees and volunteers who will have responsibilities where participants are children.

Staff retention is often an issue for home visiting programs, with trained staff moving on for promotional opportunities. In order to retain longevity in staff programs will:

- Seek opportunities for staff development
- Recognize staff achievement
- Diversify caseloads to avoid burnout
- Provide supportive supervision
- Develop a staff level system for career development

Clinical Supervision and Reflective Practice for Home Visitors and Supervisors

New nurses in the NFP program learn through required weekly reflective supervision, a process through which home visitors discuss their most challenging issues and situations with their supervisors to reflect on their practice and discern what may and may not be working in their approach. NFP supervision is designed to promote skill development and provide deeper knowledge of the NFP model. A full time Nurse Supervisor provides supervision to no more than eight individual nurse home visitors, given the expectation for one-to-one supervision, program development, referral management and other administrative tasks. The NFP supervisor provides a supportive and safe framework for practice, reflection, building community relationships, discussing complex cases and provides resources for professional development and quality improvement. Nurse home visitors also participate in team meetings and case conferencing with their peers and with multi-disciplinary consultants to foster learning and the exchange of successful practices. Nurse supervisors conduct joint home visits with nurse home visitors to provide opportunities for feedback and skill development. Nurse home visitors also participate in case conferencing with their peers and with multi-disciplinary consultants to foster learning and the exchange of successful practices. Nurse supervisors receive ongoing clinical consultation from their assigned NSO Nurse Consultant or City/State Nurse Consultant. NFP Nurse Consultants support the nurse supervisor through consultation in clinical issues, program operations and continuous quality improvement.

Each HFNY home visitor receives weekly, protected and reflective supervision. The primary roles of a supervisor are to: create an environment that encourages staff growth; provide motivation and support; provide quality assurance and safety; and facilitate open, clear communication. Each fulltime home visitor receives a minimum of 1½ hours of regularly scheduled individual supervision per week. To ensure that regular, on-going and effective supervision can occur, each supervisor directly supervises no more than 5 FTE home visiting staff. Supervision includes skill development, professional support and accountability for work quality. Supervisory sessions focus on Parent-Child Interaction, Child Development, Family Strengths, Parent Support and Family Functioning (i.e., self-sufficiency). Professional support includes utilizing reflection, being available when staff is in the field, and assuring a nurturing, positive work environment conducive to productivity. Each program develops a protocol for assuring supervisory policies and procedures provide staff with professional support.

In addition, HFNY programs are strongly encouraged to have team or staff meetings at least every two weeks at a regular set time. Effective supervision includes file reviews of all participants. To assure quality services are being provided to all program families, it is important for the supervisor to review all families that had a visit due, or were seen, the previous week.

Estimated number of families to be served

The Department will work with funded programs to determine the number of families to be served with the additional funding and establish specific performance measures. Target numbers will be based on the number of births in a specified target area along with the costs associated with serving each family based on model developer estimates.

Recruitment and Retention of Program Participants

NFP and HFNY programs will identify high-risk women eligible for program participation within the high-risk target communities. Home visiting program sites will partner with local hospitals, prenatal care providers, private physicians, schools, WIC clinics, community based organizations, and other agencies serving high-risk pregnant and newly parenting families to promote referrals. Home visiting programs will maintain working relationships with various referral sources within the community and keep up-to-date referral resource information.

Programs will outreach to hard-to-reach families, including those not already receiving prenatal care. Such outreach may include seeking the assistance of community organizations that come in contact with hard-to-reach families to help to build family trust so that parents are more likely to accept services. Program outreach includes:

- individual and family recruitment - word of mouth, self-referrals, current program participants.
- community level - regular and routine visits to referral sites to leave information and meet with staff, posting flyers, staffing tables at fairs, speaking at faith based settings, community meetings, schools, etc.)
- organizational level - agreements with screening sites, regularly scheduled meetings with agencies, regular and routine visits to pick up screens.

Client attrition is common to home visiting programs as participation is voluntary. Attrition can be due to any number of contributing or influencing factors such as family mobility, returning to

school or employment, attrition of home visitors, mistrust of misunderstanding of the services provided, death of the infant, client disengagement/needs not being met. Home visitors and supervisors will use various strategies to help minimize attrition, including:

- Scheduling home visits when both the child and the caregiver are available.
- Development of consistent schedules of visits.
- If a family does not have a phone and is not available for a scheduled visit, the worker may attempt an unscheduled visit.
- Visits scheduled nights and weekends.
- Provision of a supportive non judgmental approach to service delivery.
- Motivational interviewing.
- Emphasizing the program is client-centered, and based on the family's needs and strengths.
- Delivery of services responsive the family's needs.
- Provision of referrals responsive to family's needs.
- Discussing strategies to enhance client retention during staff/team meetings.
- Review of program statistics related to number of home visits per client and retention rates per program.
- Hiring staff that are representative of the culture and language spoken by the target population.
- Providing services in a strength-based manner.

In addition, programs will be provided technical assistance from the NYSDOH and from the model developers to help with issues related to attrition as needed.

It is anticipated that programs will reach full caseload within 10 months of the start date of the program, and after new home visiting staff are trained.

Operational Plan for Coordination Between Programs

NYS' MIECHV home visiting programs will be required to coordinate outreach and referrals with other home visiting programs in the community, as well as to establish referral agreements with prenatal care providers and local supportive service agencies including substance abuse, mental health, domestic violence, child protective services, and other health and social services agencies. The NYSDOH will work with its state agency partners to ensure knowledge-based training of home visitors, and screening and referrals of clients related to domestic violence, substance use, child maltreatment, maternal depression. The Center of Excellence will provide additional support to facilitate coordination through the identification and dissemination of best practices, training and technical assistance to local programs and state program administrators.

Continuous Quality Improvement and Monitoring Fidelity to the Model

The NYSDOH will work with the NFP-NSO and OCFS to utilize their management information systems (MIS) to track families involved in the NYS' MIECHV programs from the point of the initial eligibility screen to case closing. Paralleling similarities in efforts to maintain fidelity to their models and in training and technical assistance, the data systems for the selected programs also collect and store information related to: screening, assessment, outreach efforts and results; participant characteristics, needs, and presenting issues; frequency and content of home visits;

service referrals; and participant safety, health and well-being outcomes. For both NFP and HFNY, the MIS systems are fundamental to program operations and success by offering quick and easy access to automated reports to assist with informing service delivery, and meeting performance targets. The MIS is a critical tool to assess whether programs are being implemented with fidelity to the model (e.g., delivering core program components according to the prescribed schedule and dose), to monitor program performance, and to improve the quality of services provided. The MIS will inform continuous quality improvement by enabling programs to identify and rectify impediments to effective performance and to document improvement. As the state expands or initiates new program sites, the programs' information systems will sustain the level of information that is already provided to sites and administrators regarding implementation, progress, and program quality; and be expanded and redesigned to accommodate and align with the reporting requirements specified in the Supplemental Request for Information on MIECHVP. The MIS enhancements will be made in conjunction with the model developers and the new Center of Excellence and aligned where possible.

To ensure NYS' MIECHV programs are implemented with fidelity to the chosen models and to support continuous quality improvement, the NYSDOH, in conjunction with the new Center of Excellence, will work with OCFS and the model developers to provide technical assistance, quality assurance, and site support. Quality assurance activities will provide individual program sites an outside perspective on staff competence and program performance. Training, technical assistance, and site support will be provided that directly addresses each individual program's needs.

Similar to the process described for monitoring fidelity to the model, the NYSDOH, NFP and OCFS will use quarterly, semi-annual and/or annual data and performance reports for individual programs to support individual program's quality assurance and improvement efforts. Programs will have access to all reports at their sites to utilize them to (a) identify strengths, concerns and trends, and (b) develop quality improvement plans. Programs will be encouraged to integrate Quality Assurance activities to review progress toward achieving goals and objectives and address identified areas of improvement.

Anticipated challenges to maintaining quality and fidelity can vary from community to community. Some challenges include working with very high-need, multiple-risk and diverse communities, and recruiting and retaining staff that meet required minimum qualifications and credentials. In conjunction with the new Center of Excellence, the NYSDOH will work with sub-grantees and state agency partners to coordinate and provide training, technical assistance and other needed supports to local programs to assure maintenance of quality and fidelity.

Collaborative Partnerships

As evidenced throughout this state plan and the previously-submitted state needs assessment, the NYSDOH is committed to building, strengthening and sustaining meaningful partnerships with a broad range of public and private stakeholders at the national, state and local levels. Specific state agencies that have and will continue to work closely with NYSDOH to support the state's MIECHV initiative are listed in **Section IV** above. A list of organizations statewide that have provided input to support the development of the state plan is provided in **Attachment G**. As the NYSDOH works with local sub-grantees within the target communities, these lists of partners will continue to be expanded.

Assurances

Through this State Plan, the State provides assurances that it will implement a New York State Maternal Infant and Early Childhood Home Visiting program responsive to the requirements of the establishing legislation and guidance materials, including:

- The State home visiting program will be designed to result in participant outcomes noted in the legislation;
- Individualized assessments will be conducted of participant families and services will be provided in accordance with those individual assessments;
- Home visiting services will be provided on a voluntary basis;
- The State will comply with the Maintenance of Effort Requirement; and
- Priority will be given to serve eligible participants who:
  - Have low income.
  - Are pregnant women who have not attained age 21.
  - Have a history of child abuse or neglect or have had interactions with child welfare services.
  - Have a history of substance abuse or need substance abuse treatment.
  - Are users of tobacco products in the home.
  - Have, or have children with, low student achievement.
  - Have children with developmental delays or disabilities.
  - Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside the United State.

V. Plan for Meeting Legislatively-Mandated Benchmarks

NYSDOH, in conjunction with the new Perinatal Health Center of Excellence and in collaboration with the model developers and NYS OCFS, will collect data on individual participants for all constructs to measure improvement within each of the six benchmark areas, including:

1) improved maternal and newborn health;
2) prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits;
3) improvement in school readiness and achievement;
4) reduction in crime or domestic violence;
5) improvements in family economic self-sufficiency; and
6) improvements in the coordination and referrals for other community resources and supports.

The Center of Excellence will work with NFP and HFNY to bridge data collection and standardized measures across the two programs, to facilitate the development of any new measures or data collection tools as needed to meet federal MIECHV requirements, and to coordinate reporting for the MIECHV initiative.

Current Data Collection Processes

Currently, NFP and HFNY collect data in each of the benchmark areas and on many of the constructs within each area as well as extensive demographic and service utilization data on program participants, and information on model fidelity. This information is entered into a Management Information System (MIS) maintained by each program. The data needed to construct the legislatively-mandated benchmarks and required information on demographic characteristics and service utilization for program participants will be obtained by modifying and expanding these existing data collection systems.

Nurse Family Partnership

NFP has established processes that address the requirements for meeting the legislatively-mandated benchmarks. NFP collects data on demographics of each client and family, use of the program (number of visits, duration of sessions, etc.), language and socioeconomic indicators. In addition to data required for the State Plan, NFP collects data to monitor fidelity to the model including caseload, home visitor characteristics and supervision. Assessment data are collected primarily through interviews, self-reporting and self-administered scales such as the Edinburgh Scale to screen for maternal depression. Data are collected by the NFP Nurse Home Visitor (NHV) and entered directly into the national NFP web-based information system.

NFP uses two specific tools that have psychometric validity and reliability: the Ages and Stages Questionnaire and the Edinburgh Depression Scale. The questions asked of clients to gather other data have been tested formatively to assure clarity of interpretation by the client and nurse home visitor, and connection to the constructs being assessed. Additional reliability and validity testing of particular data elements is ongoing and targeted to those items for which the risk is greatest for interpretive problems.

Healthy Families New York

HFNY home visitors conduct an intake interview to collect information on individual and family characteristics and needs (e.g., gender, age, race/ethnicity, language, family composition, education, employment, domestic violence, etc.). The home visitor completes a log for each home visit, indicating the date, duration, and types of activities provided; records each service referral made; and follows up to determine whether services were received. In addition, the home visitor records information on well-child visits and immunizations, administers the Ages to Stages Questionnaire (ASQ) to monitor the child's developmental progress, and conducts the Parental Stress Index (PSI) to measure changes over time of the parent-child interaction and parents' level of stress. The data collected are entered into the statewide HFNY MIS. Also entered into the system are Home Visitor credentials and characteristics and the training they have received.

Reporting on Specific Benchmarks and Constructs

In completing this state plan, significant work has been done to develop a detailed plan for data collection and analysis for all of the MIEHV benchmark areas established through the authorizing legislation and corresponding constructs defined by HRSA. To date, a preliminary plan has been developed for the HFNY program, which is presented in **Attachment H**. The tables in **Attachment H** display each construct along with a description of the proposed data source, definition of how the construct will be measured, how improvement will be quantified, and specification of the population to be assessed by each measure. Provided in the text following these tables is an overview of the data collection plan and schedule, along with the justification of specific measures and, where appropriate, the measure's associated reliability and validity. Although NFP has not developed a formal plan for addressing the benchmark requirements, it has provided guidance to assist states in the form of a crosswalk between the data collected by NFP and the benchmark requirements, which is displayed in **Attachment I.** In developing the plan for HFNY, an effort was made to select measures and data collection methods that align as closely as possibly with those used by NFP.

As a next step, NYSDOH will work closely with NFP, HFNY and the new Center of Excellence to develop a companion plan for NFP and for New York's MIECHV initiative overall.

Plan for Ensuring the Quality of Data Collection and Analysis

Nurse Family Partnership

Data quality and data security is monitored by the NFP Program Quality and Information Technology staffs through a formal process. Training on the reporting system is provided to nurse home visitors, supervisors, data assistants and administrators through online modules, manuals, webinars and in-person nursing education. Technical assistance is continuously available through NFP Information Technology and Program Quality.

Healthy Families New York

The HFNY MIS has been in place since the inception of HFNY in 1995 and plays a critical role in program management and operations, performance monitoring, and continuous quality improvement. The HFNY central administration team provides on-site and regional training to Home Visitors, Family Assessment Workers, supervisors and other HFNY staff in the administration of standardized instruments and completion of other forms, data entry, and the use of the MIS to generate reports to support program management and performance monitoring.

Plans for Gathering and Analyzing Demographic and Service-Utilization Data

Nurse Family Partnership

NFP currently collects, and will continue to do so, data on demographics of each client and family, use of the program (number of visits, duration of sessions, etc.), language and socioeconomic indicators.

Healthy Families New York

HFNY currently collects and analyzes, and will continue to do so, demographic and service-utilization on the families and children served, including the frequency, duration, and content of home visits; referral to and receipt of community services; retention rate; the child’s gender, age, and race/ethnicity; the parent’s age, language, education, and employment; and other relevant information.

Plan for Using Benchmark Data for CQI

Nurse Family Partnership

Data are collected on each client and a variety of reports are available on demand at the agency level. Data and reports are analyzed by Nurse Consultants and Regional Quality Coordinators quarterly and the results are used for quality improvement activities. Outcomes are reported directly to each implementing agency and on-demand reports can be pulled at each agency.

Healthy Families New York

The HFNY MIS produces quarterly reports that summarize performance on the targets and indicators at the state and site level. These reports enable HFNY Central Administration to identify areas in need of improvement, to craft strategies to improve performance, and to document the effects of policy and practice changes. Individual programs are encouraged to use the performance reports to identify strengths, concerns, and trends, and to inform the development of quality improvement plans.

Plan for Data Safety and Monitoring

Nurse Family Partnership

NFP utilizes a software platform into which only designated, NFP-approved persons may enter data collected about clients and the Program and obtain reports for managing and evaluating Program implementation and results. The web-based information system is secured against

unauthorized use by VeriSign® 128-bit Security Encryption, the industry standard in Internet site protection. Authorized access to the database and website can only be provided by NFP.

NFP complies with the rules and regulations concerning the privacy and security of protected health information (PHI) under HIPAA and the HiTech Act as if it were a Covered Entity, as defined by those regulations. NFP enters into HIPAA Business Associate Agreements to ensure all its implementing agencies, vendors and agents agree to the same restrictions. NFP protects against non-permitted use or disclosure of PHI using no less than a reasonable amount of care and will promptly report any non-compliance of which they become aware.

Healthy Families New York

All data procedures and protocols are reviewed and approved by the University at Albany Institutional Review Board, the compliance office to ensure that data are protected, client confidentiality is maintained and informed consent procedures are followed. All data are encrypted and only program and research staff assigned to the project have access to the data according to predetermined levels of access. Participant rights are protected in accordance with agency policy and federal and state requirements, and HFNY programs inform families of their rights. HFNY programs notify families at enrollment of confidentiality both verbally and in writing, including the limits of confidentiality, and obtain informed consent from families every time information is shared with a new external source. Officials or institutions required to report a case of suspected child abuse or maltreatment must follow all applicable federal and state laws and the guidelines developed for HFNY Home Visiting Programs. All HFNY program managers, supervisors, Family Assessment Workers, Home Visitors, interns and volunteers receive orientation prior to direct services with families or supervision of staff, which addresses issues of confidentiality and family rights.

Plan for analyzing the data at the local and at the State level.

Nurse Family Partnership

The NYSDOH will work closely with NFP and the new Center of Excellence to develop a plan for obtaining data from the NFP MIS in a form that will facilitate analysis at the local and state level. For purposes of obtaining data on the child maltreatment constructs, NFP will be asked to prepare a data file for OCFS containing the names, DOBs, and other identifying information of children participating in MIECHV-funded NFP programs. OCFS will use this identifying information to perform a manual search of its CONNECTIONS database, which houses data on reports of child abuse and neglect made to the Statewide Central Register for Child Abuse and Maltreatment (SCR) and the outcome of their investigation by local departments of social services (i.e., indicated, unfounded, or alternative response). Researchers within OCFS's Bureau of Evaluation and Research will analyze the data extracted from the CONNECTIONS database to create the child maltreatment constructs (for all MIECHV-funded NFP programs combined, by community, and by selected family and child characteristics). An Excel spreadsheet including the aggregate counts, percentages, and rates will be shared with NYSDOH and the Center for Excellence, which will compile local and state level summaries across the MIECHV-funded home visiting programs.

Healthy Families New York

With the exception of the constructs pertaining to child maltreatment, CHSR will analyze the MIECHV data housed in the HFNY MIS and will summarize the data into aggregate counts, percentages, and rates for all the funded HFNY programs combined, by community, and by selected family and child characteristics. CHSR will provide the aggregated information to OCFS, most likely in the form of an Excel spreadsheet. For purposes of obtaining data on the child maltreatment constructs, CHSR will prepare a data file for OCFS containing the names, DOBs, and other identifying information of children participating in HFNY. As described above, OCFS will use this identifying information to extract data from its CONNECTIONS database. OCFS researchers will analyze the data to create the child maltreatment constructs (for all MIECHV-funded HFNY programs combined, by community, and by selected family and child characteristics), and then will combine this information with the aggregate data generated by CHSR. An Excel spreadsheet including the aggregate counts, percentages, and rates will be shared with NYSDOH and the Center for Excellence, which will compile local and state level summaries across the NYS' MIECHV-funded home visiting programs.

VI. Plan for Program Administration

Lead Agency:

The NYSDOH has been designated as the lead agency and has overall administrative responsibility for the MIECHV program. Within the Department, the Bureau of Maternal and Child Health (BMCH) has direct programmatic management responsibility for the initiative and MIECHV will be integrated into their comprehensive public health efforts to improve the well-being of women and children. BMCH is located within the Division of Family Health, in the Center for Community Health, under the Office of Public Health. BMCH manages nearly 500 contracts with service providers located throughout New York State; oversees more than $137 million in state and federal funding; and has a staff of over 60 individuals including bureau management, program directors, contract managers, data and evaluation specialists, fiscal administration, and support staff.

Within the Bureau, the NYS' MIECHV initiative will be organizationally located in the Perinatal Health Unit. This unit supports several public health programs and initiatives to improve maternal and child health outcomes for high-risk pregnant and parenting women and their families through evidence-based and promising models, including:

- **Community Health Worker Program** (CHWP), a targeted paraprofessional home visiting program that provides outreach, education, advocacy, and referrals to Medicaid-eligible women at high risk for poor birth outcomes, particularly low-birth weight and infant mortality. The program's focus is on getting women into early and consistent prenatal care and ensuring their families receive primary and preventive health care services.
- **Nurse-Family Partnership** (NFP), a nurse-led home visiting program targeted to low-income first-time mothers designed to improve pregnancy outcomes, children's subsequent health and development, and parents' economic self-sufficiency. The Department supports enhancement of existing programs through one-time TANF funding through an MOU with the Office of Temporary and Disability Assistance. Through this arrangement, TANF funding is provided to 3 certified NFPs in NYS through 2011.
- **Healthy Mom – Healthy Baby** Prenatal and Postpartum Home Visiting (HMHB) program, designed to improve birth outcomes for Medicaid eligible pregnant and postpartum women and their newborns through early identification, outreach, referral and home visiting through an organized county system of perinatal health and home visiting services that ensure referral and access to needed health care and social services, including home visiting.
- **Comprehensive Prenatal-Perinatal Services Network Programs** (CPPSNs) are located in areas at high risk for poor outcomes of pregnancy. CPPSNs collaborate and coordinate work with key community stakeholders to implement broad population-based interventions that enhance, promote and improve the perinatal health care system and improve access to and utilization of perinatal services. Networks target communities with high rates of low birth weight, infant mortality, late or no prenatal care, teen pregnancies and births, and births to mothers on Medicaid.
- **Statewide Perinatal Data System** was developed to make data available on a timely basis for the Department and hospitals for monitoring and quality improvement. Web-based and modular in design, the Core module is built around the electronic birth certificate (EBC), and an additional module captures data on high risk newborns admitted to neonatal intensive care

units. Note: EBC data for births in NYC hospitals are captured in a separate by coordinated system known as the Electronic Birth Registration System (EBRS).

- **Growing Up Healthy Hotline**, a 24-hour statewide hotline to promote earlier recruitment of low-income women into Medicaid and prenatal care. The Growing Up Healthy Hotline (GUHH) is available 24/7, 365 days a year to provide callers with information and referral resources on over 30 maternal and child health programs including WIC, prenatal care, Medicaid, and Child Health Plus. The hotline has English and Spanish speaking tele-counselors, and the capacity to respond to over 20 other languages.
- **Perinatal Regionalization -** Perinatal care in NYS is organized into a regionalized system to ensure that high risk pregnant women, fetuses and newborns receive care at the appropriate level. Perinatal affiliate networks are headed by **Regional Perinatal Centers** (RPC), which provide the highest level of care, and conduct oversight, education and quality improvement activities for Level I, II and III hospitals within their affiliate network. There are 16 RPCs comprised of 18 hospitals. RPCs are currently engaged in the New York State Obstetric and Neonatal Quality Collaborative, a quality improvement project to reduce elective deliveries prior to 39 weeks and improve neonatal outcomes through the development of enteral feeding protocols.
- **New York State Obstetric and Neonatal Quality Collaborative** (NYSONQC) was launched to improve maternal and neonatal outcomes and eliminate disparities. Through NYSONQC, RPCs implement quality improvement interventions designed to improve maternal and newborn patient safety.
- **Maternal Mortality Review** works to develop and implement strategies to prevent maternal deaths, with a particular focus on racial disparities and on developing a long-term system for investigating maternal mortality.

Collaborative Partners:

Bureau of Maternal and Child Health staff are responsible for facilitating a work group of State agency representatives to help inform the direction of the program. To coordinate NYS' MIECHV activities, DOH established a work group of representatives from State agencies that have responsibility for managing programs for women, children and families. Work group participants include relevant staff (e.g. program managers, data system managers, evaluators/researchers, etc.) from the Department of Health (DOH), Office of Children and Family Services (OCFS), Office of Alcohol and Substance Abuse Services, Council for Children and Families, Office of Mental Health, Office for the Prevention of Domestic Violence, and State Education Department. In addition we have and will continue to reach out to other agencies as needed to provide information, data or other input to support the development and implementation of MIECHV activities. Work group partners have provided extensive assistance in completing both the needs assessment and the current state plan documents. As evidenced by the letters of agreement in **Attachment J,** these partner agencies are committed to collaboration, are in agreement with the proposed plan for the state, and will help ensure that home visiting is part of a continuum of perinatal and early childhood services within New York State.

In addition to this core state agency work group, BMCH staff will continue to participate in an external home visiting workgroup convened by the Schuyler Center for Analysis and Advocacy (SCAA), a statewide, not-for-profit, policy analysis and advocacy organization working to shape policies that improve health, welfare and human services in New York State. Working closely

with home visiting stakeholders in New York State has been, and continues to be, an integral component of the State's efforts to address families' needs for home visiting services. Many of the working relationships and collaborative efforts regarding the home visiting needs in New York State occurred prior to the passage of the Affordable Care Act and the corresponding creation of the NYS' MIECHV Program. This broad group of stakeholders includes representatives from state agencies, county health departments and a wide array of home visiting programs and advocacy organizations. The MIECHV initiative was discussed at several meetings of this workgroup during the needs assessment and plan development process, providing a valuable source of input for both documents. In addition, SCAA provided significant assistance in soliciting input from a broad range of stakeholders on the home visiting needs of families around the State by disseminating meeting invitations and web-based surveys developed by DOH to an extensive mailing list of stakeholders that includes representatives from relevant programs funded by the state agencies (e.g. home visiting programs such as Community Health Worker Programs, Healthy Families NY, Healthy Start and Nurse Family Partnerships, child abuse prevention programs, substance abuse prevention and treatment programs, early childhood development programs, etc.), HRSA-funded Healthy Start grantees, inter-agency coordinating groups (e.g. Early Childhood Advisory Council), county health departments and departments of social services, advocacy groups, community-based organizations, academic institutions and others. It is expected that this work group will continue to provide a forum for statewide community feedback on implementation of the MIECHV program. Please refer to **Attachment K** for a list of SCAA Home Visiting Workgroup members.:

Management Plan

State agency administration

As noted above, NYS' MIECHV initiative will be managed within the NYS Department of Health Bureau of Maternal and Child Health Perinatal Health Unit. The unit manager, with guidance and support from bureau management, will be responsible for ensuring the successful implementation of the MIECHV initiative. Placement of the MIECHV initiative within this unit will allow coordination and integration with other core public health initiatives described above.

Fiscal management of NYS' MIECHV funding will be the responsibility of the Bureau's Administrative Unit, with additional oversight and support from the Division of Family Health (DFH) Administration Unit. Together these administrative teams have extensive experience and expertise in administering State and Federal funds (e.g. HRSA, CDC) for large statewide initiatives including the Title V Maternal and Child Health Services Block Grant. Division of Family Health and BMCH have well-established systems and internal controls in place to monitor receipt of funds, track expenditures, develop and process contracts with service providers with standardized budget guidance and work plan deliverables, assure the appropriate use of funds, adhere to funding agencies' standards, and comply with all reporting requirements. Currently, the Federal funding administered by DFH includes six awards from the Department of Health and Human Services and two awards from the Department of Education totaling over $100 million.

The NYSDOH has well-defined policies and procedures for managing grant projects and overseeing the activities of sub-awards (i.e. contractors). On a quarterly basis, sub-awardees will be required to report on the activities they conducted to achieve the objectives and outcomes that

define the program initiative. Sub-awardees will report on the successes they achieved, the challenges they encountered, and the strategies they employed to overcome the challenges. Information about activities the program conducted to foster community-wide involvement to enhance services for the target population will also be required. In addition to a narrative description of their activities, sub-awardees will report on the number of clients served, their demographic characteristics, the type and number of the services provided, and the outcomes of the services. The annual report will require sub-awardees to reflect and report on their program's overall achievements and progress toward meeting the anticipated outcomes. The annual report, in combination with the quarterly reports, will be used by DOH to document and report on the successes and challenges the overall initiative experienced.

The NYSDOH will monitor the activities of the sub-awardees through regular communication (phone, email), site visits, and periodic meetings of all the sub-awardees (face-to-face, conference calls, webinars). Per BMCH guidelines, comprehensive on-site monitoring visits will be conducted for all sub-awardees during the grant period. The visit will consist of a comprehensive review of the program services delivered, the fiscal management systems used by contract agencies, program management operations, data collection and program evaluation activities. Visits typically include interviews with the contractor's executive staff, program management staff, direct service staff, fiscal staff and clients. Contractors are sent comprehensive monitoring reports that detail the findings from the visit and resulting recommendations for program improvement including timelines for the implementation of the recommendations. BMCH staff follow up with contractors to assess progress in implementing the recommendations and to offer technical assistance to help contractors improve program operations and service delivery.

Because the Healthy Families New York (HFNY) program is administered by the NYS Office of Children and Family Services, MIECHV funds allocated to enhance HFNY programs will be transferred to OCFS through a Memorandum of Understanding (MOU) between the two state agencies. Funding for local HFNY programs in turn will be sub-awarded by OCFS through grant contracts, subject to all required control agency approvals. Effective communication between the DOH and OCFS will be accomplished through regularly scheduled conference calls and face-to-face meetings and provision of all necessary written reports and other documentation needed to meet state and federal reporting requirements.

Organizational charts (**Attachment L**) and descriptions of key positions (**Attachment M**) are included.

As described in Section xx, program management will be augmented by a new statewide Perinatal Health Center of Excellence to provide and coordinate training, technical assistance, data management, evaluation and other related key supports to the Department, other state agency partners and local funded programs. It is anticipated that the Center of Excellence will be selected and funded through a competitive Request for Applications (RFA) process, to be completed within the first year of NYS' MIECHV initiative. The scope of the Center potentially will incorporate other Perinatal Health initiatives and strategies in addition to home visiting, subject to identification of additional appropriate funds for this purpose; federal MIECHV funding will support Center activities related to the MIECHV initiative outlined in this plan.

Community Coordination of Referrals

Coordination of services – including coordination of referrals, assessment and intake processes across home visiting programs – will be a significant focus of New York's proposed initiative, both for programs to be funded through the MIECHV grant as well as other existing or potential new home visiting programs within target communities.

In the first phase of New York's proposed MIECHV initiative, based on the selection criteria detailed in **Section III**, funding will support enhancement of NFP within Monroe County, HFNY within Erie County, and both NFP and HFNY within Bronx County. Because there are several home visiting programs operating within all three of these counties, coordination of services will be a focus of all projects. The targeted MIECHV enhancements to two specific programs in the Bronx provides additional challenge and opportunity related to coordination in that community. NYSDOH and OCFS will work with the local programs to assess and strengthen existing mechanisms operating within the Bronx to assure coordination of referrals. It is anticipated that assessment and intake processes will determine the most appropriate program for the family and cross agency referrals will be facilitated by the enhanced relationships developed through this initiative. Community organizations will be encouraged to develop memorandum of understanding to facilitate coordinated strategic planning related to potential program expansion, as well as systems for coordinating intake, assessment and referrals.

As noted in **Section III,** in order to implement MIECHV sub-awards and expend available federal funding within the time frames required by federal funders, approval will be sought from necessary state control agencies to award funds to the organizations currently operating NFP and HFNY programs within the target communities designated for the first phase of NYS' MIECHV initiative on a non-competitive basis, based on the selection criteria described above in **Section I** and **III**. Available annual funding, based on New York's SFY10 allocation level, will be distributed proportionately among the three target communities, and within them, among specific eligible programs, based on a defined funding distribution methodology that takes into account both population demographics and current service volume of individual programs (see **Attachment B**). It is anticipated that within the first year of NYS' MIECHV initiative, NYSDOH will complete a competitive RFA process to select additional MIECHV sub-grantees within the 14 designated at-risk communities. Ability to fund awards to any additional sub-grantees selected through this process will be subject to the availability of increased annual federal MIECHV funding for this initiative in New York State.

State and Local Evaluation Efforts

The Office of Children and Family Services (OCFS) has a long established relationship with Center for Human Services Research (CHSR) at the University at Albany for data management and assistance with evaluation of the Healthy Families New York program. All HFNY programs are contractually obligated to submit data to CHSR monthly. While the primary purpose for collecting and reporting this data is accountability and evaluation of the entire HFNY program, this information also supports individual program's quality assurance and improvement efforts. Nurse Family Partnership projects across the state report their data to national office for feedback to the local programs. The new Center of Excellence will play a key role in facilitating information sharing between individual programs and coordinating potential additional evaluation efforts specific to NYS' MIECHV initiative.

Plan to Meet Legislative Requirements

As described earlier in this section, the Division of Family Health and the Burean of Maternal and Child Health (BMCH) have extensive experience administering federal funding. The BMCH currently has five federally-funded programs with funds received through grants or cooperative agreements. Staff within BMCH have many years of experience administering programs, including project development, budgeting and oversight. Many staff are also licensed health professionals, with years of clinical and community experience in maternal and child health that provides additional leadership and guidance to the programs. OCFS similarly has well-established infrastructure and experienced staff to oversee administration of enhanced funding for targeted HFNY programs. Proposed new state agency staffing will further ensure adequate capacity to meet the grant deliverables and requirements.

The NYS Department of Health and OCFS will assure that individual local sub-grantees have appropriate staff, including supervisory staff, consistent with the requirements of Nurse Family Partnership and Healthy Families America. All proposed organizations implementing these models within Bronx, Erie and Monroe counties are in good standing with DOH and OCFS and have verified that they have the organizational capacity to expand their programming.

The Center of Excellence will assist the communities in development of mechanisms to support coordination of referrals and build on the current service networks to support the identified needs. The workgroup of state agency representatives will assist also assist communities in identifying adequate resources to meet the needs of clients served in this initiative. The Center will also develop an implementation checklist to confirm that programs are being implemented with fidelity to the specified model.

Coordination with other state early childhood initiatives

As described in **Section II**, several specific approaches will be used to coordinate and integrate the state's MIECHV initiative with other state perinatal and early childhood initiatives.

At the state level, MIECHV activities will be developed and implemented in collaboration and coordination with multiple partners. Within the Department of Health, established partnerships will be enhanced with several key programs including Medicaid, Injury Prevention, Early Intervention (including the state's Newborn Hearing Screening initiative), Children with Special Health Care Needs, WIC, Adolescent Pregnancy Prevention and Family Planning. Partnerships with other state agencies also will be further strengthened, building on the significant collaboration that has occurred to develop the state's needs assessment and plan. These relationships will help strengthen the capacity of home visiting programs to identify, engage and effectively address the needs of at-risk families within the target communities.

As described in Section 2, the interagency work group established to support these previous steps will continue to support implementation of the state plan. All the state agencies required by HRSA and ACF to provide letters of concurrence for the state plan are active participants in this workgroup, along with a number of other agency partners; membership may be expanded further as the initiative evolves.

The new Center of Excellence will provide enhanced state-level infrastructure for implementation and evaluation, serving as a focal point for development and dissemination of

new resources as well as coordination with existing key resources and organizations, including national program developers and state and local program administrators.

Home visiting continues to be a core priority for the NYS's Early Childhood Advisory Council (ECAC). This Council includes over 40 individuals with early childhood expertise across a broad range of sectors including early care and education, health care and public health, child welfare, mental health, substance abuse and public assistance, and representing state and local governments, institutions of higher education, advocacy organizations, unions, private foundations and many community-based organizations. Several NYSDOH staff integrally involved in the new NYS' MIECHV initiative, including the Principal Investigator, actively participate in the ECAC and will continue to identify and facilitate opportunities for exchange of information and coordination of activities. The ECAC also directly links MIECHV to the state's Early Childhood Comprehensive Systems (ECCS) initiative, which is coordinated by the New York State Council on Children and Families and integrally connected to ECAC activities.

VII. Plan for Continuous Quality Improvement

Continuous quality improvement (CQI) will be an essential component of NYS' MIECHV initiative. CQI provides a mechanism to generate meaningful commitments from all levels of the program, including local communities, state agencies, and local and state stakeholders. Central to this commitment is creating an environment where everyone strives to meet common goals, understands the targets they are being measured against, critically assesses and reflects on their own progress and performance, shares what they have learned, and has accountability to the overall initiative. Meaningful CQI efforts recognize that one learns as much from challenges and failures as from successes. Consistent, frequent, and timely feedback to local projects will increase transparency and encourage open communication.

In conjunction with the Center of Excellence, NFP-NSO and OCFS, NYSDOH will ensure that home visiting programs collect data in each benchmark and construct area for all program participants. Data will also be collected on participant demographics including socioeconomic indicators. Fidelity to the evidence-based models implemented, including caseload, home visitor characteristics and supervision, will be monitored.

The new Perinatal Health Center of Excellence will be a critical component of the continuous quality improvement plan. Initially, the Center will be utilized to provide orientation and on-going training for state and local staff participating in this initiative regarding funding implementation and reporting requirements. This training will complement and enhance, not replace, training already required/provided for implementation of individual models. This training is essential to assure that all staff is made aware of the goals of the initiative to enhance local buy-in. Staff at all levels will be provided opportunities to provide feedback to program administration on project implementation, community acceptance, and potential improvements. The Center will provide ongoing training and professional development opportunities for local grantees; assess local program implementation with fidelity to the evidence-based home visiting model chosen; facilitate new quality improvement strategies; and provide supplemental technical assistance to grantees. This Center will provide essential academic support to the NYSDOH and funded communities for MIECHV home visiting activities, and other NYSDOH perinatal health work through: training and technical assistance; identification and implementation of evidence-based and best practices; data collection, analysis and reporting; and evaluation to support the needs of the state and local programs, inform further development of the State's MIECHV initiative, and meet federal funding requirements.

Examples of quality improvement activities at the community-level will include:

- Collection of data on each client.
- Analysis of data by the home visiting program.
- Reporting data collected to the model developer's information system which in turn will be shared with Center of Excellence and NYSDOH.
- Training and technical assistance to home visiting staff by the Center of Excellence and model developers through online modules, manuals, webinars and in-person education.
- Promoting and strengthening referral networks to support families.

Quality improvement activities at the state level will include:

- Provision of training and technical assistance responsive to program needs.
- Help monitor fidelity of program implementation.
- Generation of aggregate data reports for programs to help monitor performance and inform quality improvement strategies.

Continuous quality improvement will be a central theme in the regularly scheduled meetings with the state agencies involved in the MIECHV program, and will be further developed as the state's initiative is implemented. The Center of Excellence will support these efforts with periodic meetings in the local communities to provide open communication on data collection, quality improvement, implementation, adaption, and lessons learned. The Department of Health will meet on a regular basis with the Center of Excellence, model developers, and state agency partners to review data and progress towards benchmarks, identify effective performance and areas in need of improvement. This review will include local projects to facilitate quality improvement efforts directly back to the communities.

VIII. Technical Assistance Needs

New York State will be implementing expansion of NFP and HFA programs with this initial funding.

It is anticipated that the NFP and HFA programs will provide technical assistance in the following areas, through their current mechanisms:

- Implementing programs with fidelity to the model;
- Data collection methods and information systems supports.
- Recruitment and retentions of home visiting staff;
- Recruitment and retention of program participants;
- Ensuring appropriate referrals responsive to participant needs.
- Use of data collection tools.
- Use of data management information systems.

While specific additional technical assistance needs are not yet fully identified, it is anticipated that there may be needs related to the enhancement of home visiting within broader community systems. The State anticipates potential technical assistance needs in the following areas:

- Developing common data and information systems to satisfy benchmark requirements that are compatible with the established systems for these models;
- Identifying specific evidence-based or other promising approaches to integrating home visiting programs within comprehensive perinatal and early childhood community systems (including coordination of multiple home visiting models and coordination of home visiting with other community services); Balancing the maintenance of fidelity to evidence-based program models with the need to improve program effectiveness in key areas (see discussion below);
- Identifying and implementing specific evidence-based or promising approaches to reduce racial and ethnic disparities;
- Effective models for meeting special needs of at-risk sub-populations, including tribal and rural communities;
- Developing central intake, assessment and referral processes and systems;
- Participant recruitment and retention, including “hard to reach” populations; and
- Recruiting and retaining qualified staff for local home visiting programs.

As referenced above, a specific concern is that many families in need of additional supports may have health and social issues that interfere with their acceptance of or full participation in home visiting services. These issues may also impact the outcomes achieved by even the best implementation process. Discussions within the State agency workgroup have identified special topical issues requiring further attention, including mental health, domestic violence, and substance abuse. Technical assistance is needed with identifying effective strategies and tools that improve client engagement and retention, screening/assessment and effective follow-up in these priority areas, while maintaining fidelity to the individual EB model and balancing potential concerns about “overwhelming” clients with additional information and services. While the State’s Center of Excellence will have a key role in facilitating further exploration of these challenges, additional needs for technical assistance are anticipated.

IX. Reporting Requirements

Through this State Plan, the State provides assurances that it will comply with the legislative requirements for submission of an annual report to the Secretary regarding the activities carried out under this program. The annual report will include the following sections and information:

State Home Visiting Program Goal and Objectives

- Progress made under each goal and objective during the reporting period including a discussion of barriers to progress and steps taken to overcome those barriers;
- Any updates or revisions to goals and objectives;
- Summary of the State's efforts to contribute to a comprehensive, high-quality, early childhood system.

Implementation of State Home Visiting Program

- Summary of planning and implementation activities for the home visiting programs for each targeted community, including descriptions of:
    - Progress for engaging the at-risk communities around the State Plan;
    - Work conducted with national model developers and the technical assistance and support provided by the national models;
    - Progress on securing curriculum and other materials for the home visiting program;
    - Staff recruitments, hiring and retention for all positions including subcontracts;
    - Participant recruitment and retention efforts;
    - Status of home visiting program caseload with each at-risk community;
    - Coordination between home visiting programs and other existing programs and supportive services in those communities;
    - Anticipated challenges to maintaining quality and fidelity of each home visiting program, and the proposed response to the issues identified.
- Discussion of any barriers or challenges encountered with program implementation and steps taken to overcome those barriers.

Progress Toward Meeting Legislatively Mandated Benchmarks

- Summary of data collection efforts for each of the six benchmark areas, including an update on data collected on all constructs within the benchmark areas along with definitions of what constitutes improvement, sources of data for each measure utilized, barriers/challenges encountered during data collection efforts, and steps taken to overcome them.

X. Attachments

A. Zip Code-Level Analysis

B. Funding Distribution Methodology

C. C-1 State Plan Survey of Community Stakeholders
C-2 State Plan Survey of Home Visiting Programs

D. Target Counties Needs Profile

E. NYS MIECHV Logic Model

F. Model Developer Letters of Agreement

G. Organizations Providing Input to State Plan

H. HFNY Benchmark Data Collection Plan

I. NFP Benchmarks

J. Letters of Concurrence

RATE Z SCORES				CASE Z SCORES				
ZIP code	P.O. Name	Primary County	SUM	ZIP code	P.O. Name	Primary County	SUM	Combined Rate/Case Z score
12206	Albany	Albany	15.554	12206	Albany	Albany	11.179	26.733
12202	Albany	Albany	19.264	12202	Albany	Albany	5.570	24.834
12210	Albany	Albany	15.030	12210	Albany	Albany	2.770	17.801
12207	Albany	Albany	16.765	12207	Albany	Albany	-3.576	13.189
12303	Schenectady	Albany	1.257	12303	Schenectady	Albany	6.072	7.329
12204	Albany	Albany	6.844	12204	Albany	Albany	-1.641	5.204
12047	Cohoes	Albany	0.581	12047	Cohoes	Albany	1.127	1.708
12208	Albany	Albany	-2.942	12208	Albany	Albany	3.001	0.060
10456	Bronx	Bronx	14.634	10456	Bronx	Bronx	82.277	96.911
10457	Bronx	Bronx	13.432	10457	Bronx	Bronx	69.645	83.077
10453	Bronx	Bronx	10.932	10453	Bronx	Bronx	63.571	74.503
10452	Bronx	Bronx	10.896	10452	Bronx	Bronx	60.983	71.880
10467	Bronx	Bronx	8.271	10467	Bronx	Bronx	58.699	66.969
10458	Bronx	Bronx	9.244	10458	Bronx	Bronx	57.686	66.930
10472	Bronx	Bronx	11.055	10472	Bronx	Bronx	49.795	60.850
10468	Bronx	Bronx	8.327	10468	Bronx	Bronx	48.354	56.680
10460	Bronx	Bronx	11.858	10460	Bronx	Bronx	44.693	56.551
10466	Bronx	Bronx	10.382	10466	Bronx	Bronx	44.635	55.017
10454	Bronx	Bronx	17.073	10454	Bronx	Bronx	37.020	54.093
10459	Bronx	Bronx	14.673	10459	Bronx	Bronx	37.107	51.780
10451	Bronx	Bronx	15.372	10451	Bronx	Bronx	35.229	50.601
10455	Bronx	Bronx	14.485	10455	Bronx	Bronx	36.045	50.530
10473	Bronx	Bronx	7.867	10473	Bronx	Bronx	31.312	39.179
10469	Bronx	Bronx	5.990	10469	Bronx	Bronx	28.986	34.976
10462	Bronx	Bronx	2.769	10462	Bronx	Bronx	31.601	34.370
10474	Bronx	Bronx	16.355	10474	Bronx	Bronx	8.973	25.328
10463	Bronx	Bronx	-1.550	10463	Bronx	Bronx	17.507	15.958
10461	Bronx	Bronx	0.002	10461	Bronx	Bronx	13.544	13.546
10475	Bronx	Bronx	2.198	10475	Bronx	Bronx	7.690	9.888
10465	Bronx	Bronx	-0.014	10465	Bronx	Bronx	7.791	7.777
10470	Bronx	Bronx	1.393	10470	Bronx	Bronx	0.881	2.275
14215	Buffalo	Erie	15.984	14215	Buffalo	Erie	34.160	50.144
14211	Buffalo	Erie	16.808	14211	Buffalo	Erie	22.178	38.986
14203	Buffalo	Erie	38.902	14203	Buffalo	Erie	-2.702	36.200
14202	Buffalo	Erie	36.319	14202	Buffalo	Erie	-0.827	35.492
14213	Buffalo	Erie	9.664	14213	Buffalo	Erie	15.757	25.422
14212	Buffalo	Erie	16.536	14212	Buffalo	Erie	6.733	23.269
14207	Buffalo	Erie	9.682	14207	Buffalo	Erie	11.430	21.112
14201	Buffalo	Erie	12.007	14201	Buffalo	Erie	4.322	16.328
14208	Buffalo	Erie	12.123	14208	Buffalo	Erie	3.843	15.966
14214	Buffalo	Erie	8.131	14214	Buffalo	Erie	4.959	13.090
14209	Buffalo	Erie	13.463	14209	Buffalo	Erie	-0.532	12.931
14204	Buffalo	Erie	8.828	14204	Buffalo	Erie	1.134	9.962
14206	Buffalo	Erie	4.479	14206	Buffalo	Erie	4.865	9.344
14210	Buffalo	Erie	3.240	14210	Buffalo	Erie	2.643	5.883
14218	Buffalo	Erie	2.110	14218	Buffalo	Erie	2.803	4.914
14150	Tonawanda	Erie	-2.316	14150	Tonawanda	Erie	5.692	3.376
14220	Buffalo	Erie	-1.322	14220	Buffalo	Erie	3.893	2.571
14225	Buffalo	Erie	-2.899	14225	Buffalo	Erie	3.717	0.818
14216	Buffalo	Erie	-1.604	14216	Buffalo	Erie	2.029	0.425

RATE Z SCORES					CASE Z SCORES				
ZIP code	P.O. Name	Primary County	SUM		ZIP code	P.O. Name	Primary County	SUM	Combined Rate/Case Z score
11212	Brooklyn	Kings	17.812		11212	Brooklyn	Kings	83.996	101.808
11207	Brooklyn	Kings	15.073		11207	Brooklyn	Kings	80.032	95.105
11221	Brooklyn	Kings	15.079		11221	Brooklyn	Kings	67.475	82.554
11208	Brooklyn	Kings	11.911		11208	Brooklyn	Kings	68.761	80.672
11226	Brooklyn	Kings	9.817		11226	Brooklyn	Kings	69.114	78.931
11233	Brooklyn	Kings	16.471		11233	Brooklyn	Kings	56.135	72.606
11206	Brooklyn	Kings	8.214		11206	Brooklyn	Kings	54.400	62.614
11220	Brooklyn	Kings	1.062		11220	Brooklyn	Kings	57.359	58.420
11236	Brooklyn	Kings	7.066		11236	Brooklyn	Kings	48.122	55.188
11213	Brooklyn	Kings	8.191		11213	Brooklyn	Kings	42.379	50.570
11203	Brooklyn	Kings	7.934		11203	Brooklyn	Kings	40.129	48.063
11216	Brooklyn	Kings	10.715		11216	Brooklyn	Kings	33.052	43.766
11237	Brooklyn	Kings	7.927		11237	Brooklyn	Kings	31.329	39.256
11225	Brooklyn	Kings	6.844		11225	Brooklyn	Kings	30.109	36.953
11211	Brooklyn	Kings	-2.808		11211	Brooklyn	Kings	34.953	32.145
11219	Brooklyn	Kings	-4.473		11219	Brooklyn	Kings	35.102	30.628
11224	Brooklyn	Kings	8.861		11224	Brooklyn	Kings	20.484	29.345
11234	Brooklyn	Kings	-0.732		11234	Brooklyn	Kings	23.154	22.421
11210	Brooklyn	Kings	0.178		11210	Brooklyn	Kings	20.724	20.901
11205	Brooklyn	Kings	3.752		11205	Brooklyn	Kings	17.138	20.890
11218	Brooklyn	Kings	-2.636		11218	Brooklyn	Kings	22.275	19.639
11214	Brooklyn	Kings	-1.166		11214	Brooklyn	Kings	20.500	19.334
11223	Brooklyn	Kings	-1.893		11223	Brooklyn	Kings	19.584	17.690
11230	Brooklyn	Kings	-4.502		11230	Brooklyn	Kings	22.122	17.620
11235	Brooklyn	Kings	-1.101		11235	Brooklyn	Kings	17.756	16.655
11238	Brooklyn	Kings	1.297		11238	Brooklyn	Kings	15.284	16.581
11229	Brooklyn	Kings	-2.712		11229	Brooklyn	Kings	16.987	14.276
11231	Brooklyn	Kings	1.654		11231	Brooklyn	Kings	10.389	12.043
11201	Brooklyn	Kings	-1.002		11201	Brooklyn	Kings	11.882	10.880
11232	Brooklyn	Kings	2.083		11232	Brooklyn	Kings	8.714	10.797
11204	Brooklyn	Kings	-6.163		11204	Brooklyn	Kings	14.784	8.620
11217	Brooklyn	Kings	-0.235		11217	Brooklyn	Kings	7.449	7.214
11209	Brooklyn	Kings	-4.627		11209	Brooklyn	Kings	11.630	7.003
11215	Brooklyn	Kings	-5.330		11215	Brooklyn	Kings	11.034	5.704
11239	Brooklyn	Kings	2.966		11239	Brooklyn	Kings	0.115	3.081
14621	Rochester	Monroe	15.312		14621	Rochester	Monroe	29.546	44.858
14611	Rochester	Monroe	18.410		14611	Rochester	Monroe	14.949	33.359
14608	Rochester	Monroe	22.106		14608	Rochester	Monroe	9.434	31.540
14609	Rochester	Monroe	7.925		14609	Rochester	Monroe	23.524	31.450
14613	Rochester	Monroe	16.027		14613	Rochester	Monroe	10.744	26.771
14605	Rochester	Monroe	15.677		14605	Rochester	Monroe	9.382	25.059
14619	Rochester	Monroe	13.423		14619	Rochester	Monroe	7.093	20.516
14604	Rochester	Monroe	22.351		14604	Rochester	Monroe	-4.204	18.147
14606	Rochester	Monroe	5.701		14606	Rochester	Monroe	10.774	16.475
14615	Rochester	Monroe	3.756		14615	Rochester	Monroe	2.181	5.937
14607	Rochester	Monroe	5.742		14607	Rochester	Monroe	-0.282	5.460
14620	Rochester	Monroe	-1.375		14620	Rochester	Monroe	3.082	1.707

RATE Z SCORES				CASE Z SCORES				
ZIP code	P.O. Name	Primary County	SUM	ZIP code	P.O. Name	Primary County	SUM	Combined Rate/Case Z score
11550	Hempstead	Nassau	8.273	11550	Hempstead	Nassau	37.801	46.074
11520	Freeport	Nassau	2.237	11520	Freeport	Nassau	16.406	18.643
11590	Westbury	Nassau	1.827	11590	Westbury	Nassau	15.796	17.623
11575	Roosevelt	Nassau	9.489	11575	Roosevelt	Nassau	7.227	16.716
11553	Uniondale	Nassau	4.104	11553	Uniondale	Nassau	7.620	11.724
11003	Elmont	Nassau	-1.581	11003	Elmont	Nassau	7.977	6.396
11096	Inwood	Nassau	5.061	11096	Inwood	Nassau	-1.982	3.079
11801	Hicksville	Nassau	-2.533	11801	Hicksville	Nassau	4.571	2.038
11561	Long Beach	Nassau	-2.848	11561	Long Beach	Nassau	4.499	1.651
10038	New York	New York	50.283	10038	New York	New York	28.886	79.169
10029	New York	New York	11.848	10029	New York	New York	54.191	66.039
10027	New York	New York	10.210	10027	New York	New York	37.819	48.029
10035	New York	New York	15.010	10035	New York	New York	27.505	42.515
10031	New York	New York	7.892	10031	New York	New York	30.438	38.330
10002	New York	New York	1.188	10002	New York	New York	37.092	38.279
10039	New York	New York	15.800	10039	New York	New York	17.854	33.653
10032	New York	New York	5.504	10032	New York	New York	26.588	32.092
10026	New York	New York	11.039	10026	New York	New York	19.324	30.363
10030	New York	New York	13.768	10030	New York	New York	16.516	30.285
10025	New York	New York	-1.922	10025	New York	New York	25.276	23.354
10033	New York	New York	1.829	10033	New York	New York	19.187	21.016
10037	New York	New York	13.314	10037	New York	New York	6.766	20.080
10009	New York	New York	3.790	10009	New York	New York	15.016	18.805
10040	New York	New York	1.600	10040	New York	New York	13.617	15.217
10034	New York	New York	2.057	10034	New York	New York	12.629	14.686
10005	New York	New York	18.711	10005	New York	New York	-4.472	14.239
10036	New York	New York	12.619	10036	New York	New York	1.521	14.140
10001	New York	New York	5.850	10001	New York	New York	7.904	13.754
10019	New York	New York	-0.898	10019	New York	New York	7.597	6.699
10003	New York	New York	-5.564	10003	New York	New York	9.322	3.758
10023	New York	New York	-5.750	10023	New York	New York	8.992	3.242
10012	New York	New York	-1.609	10012	New York	New York	3.932	2.323
10016	New York	New York	-4.753	10016	New York	New York	6.052	1.299
10011	New York	New York	-2.623	10011	New York	New York	3.782	1.159
13501	Utica	Oneida	12.392	13501	Utica	Oneida	23.050	35.441
13502	Utica	Oneida	6.579	13502	Utica	Oneida	11.701	18.281
13440	Rome	Oneida	1.374	13440	Rome	Oneida	11.092	12.467
13495	Yorkville	Oneida	6.323	13495	Yorkville	Oneida	-4.830	1.493
13494	Woodgate	Oneida	5.691	13494	Woodgate	Oneida	-5.218	0.473
13204	Syracuse	Onondaga	17.249	13204	Syracuse	Onondaga	16.287	33.536
13205	Syracuse	Onondaga	17.835	13205	Syracuse	Onondaga	14.382	32.217
13202	Syracuse	Onondaga	25.386	13202	Syracuse	Onondaga	1.820	27.205
13208	Syracuse	Onondaga	11.899	13208	Syracuse	Onondaga	11.965	23.864
13207	Syracuse	Onondaga	10.097	13207	Syracuse	Onondaga	5.988	16.085
13203	Syracuse	Onondaga	9.765	13203	Syracuse	Onondaga	5.105	14.869
13210	Syracuse	Onondaga	1.639	13210	Syracuse	Onondaga	4.190	5.829
13206	Syracuse	Onondaga	2.941	13206	Syracuse	Onondaga	1.900	4.841
13224	Syracuse	Onondaga	4.552	13224	Syracuse	Onondaga	-1.254	3.298

RATE Z SCORES				CASE Z SCORES				
ZIP code	P.O. Name	Primary County	SUM	ZIP code	P.O. Name	Primary County	SUM	Combined Rate/Case Z score
12550	Newburgh	Orange	3.566	12550	Newburgh	Orange	25.982	29.548
10940	Middletown	Orange	2.946	10940	Middletown	Orange	19.742	22.688
10975	Southfields	Orange	17.248	10975	Southfields	Orange	-5.322	11.926
10963	Otisville	Orange	9.212	10963	Otisville	Orange	-4.511	4.701
10950	Monroe	Orange	-6.964	10950	Monroe	Orange	10.410	3.445
12771	Port Jervis	Orange	1.436	12771	Port Jervis	Orange	0.856	2.292
12746	Huguenot	Orange	6.748	12746	Huguenot	Orange	-5.195	1.553
11368	Corona	Queens	5.333	11368	Corona	Queens	58.056	63.389
11691	Far Rockaway	Queens	8.724	11691	Far Rockaway	Queens	40.885	49.609
11434	Jamaica	Queens	10.294	11434	Jamaica	Queens	35.769	46.063
11373	Elmhurst	Queens	0.670	11373	Elmhurst	Queens	37.145	37.815
11385	Ridgewood	Queens	0.732	11385	Ridgewood	Queens	33.514	34.246
11370	East Elmhurst	Queens	15.489	11370	East Elmhurst	Queens	17.800	33.289
11433	Jamaica	Queens	11.106	11433	Jamaica	Queens	19.883	30.989
11377	Woodside	Queens	0.801	11377	Woodside	Queens	27.782	28.584
11435	Jamaica	Queens	4.229	11435	Jamaica	Queens	24.163	28.393
11432	Jamaica	Queens	4.660	11432	Jamaica	Queens	23.563	28.222
11412	Saint Albans	Queens	10.848	11412	Saint Albans	Queens	16.898	27.745
11372	Jackson Heights	Queens	2.124	11372	Jackson Heights	Queens	22.918	25.042
11692	Arverne	Queens	13.709	11692	Arverne	Queens	9.730	23.439
11420	South Ozone Park	Queens	4.180	11420	South Ozone Park	Queens	16.909	21.089
11436	Jamaica	Queens	12.151	11436	Jamaica	Queens	7.985	20.136
11369	East Elmhurst	Queens	5.423	11369	East Elmhurst	Queens	14.158	19.581
11419	South Richmond Hill	Queens	2.480	11419	South Richmond Hill	Queens	15.434	17.914
11355	Flushing	Queens	-3.619	11355	Flushing	Queens	20.460	16.840
11102	Astoria	Queens	5.688	11102	Astoria	Queens	10.404	16.092
11413	Springfield Gardens	Queens	3.652	11413	Springfield Gardens	Queens	12.426	16.077
11429	Queens Village	Queens	8.150	11429	Queens Village	Queens	7.615	15.765
11101	Long Island City	Queens	6.518	11101	Long Island City	Queens	8.182	14.700
11106	Astoria	Queens	3.404	11106	Astoria	Queens	10.152	13.556
11421	Woodhaven	Queens	1.545	11421	Woodhaven	Queens	11.743	13.287
11418	Richmond Hill	Queens	1.820	11418	Richmond Hill	Queens	10.932	12.752
11422	Rosedale	Queens	3.674	11422	Rosedale	Queens	7.689	11.364
11693	Far Rockaway	Queens	9.400	11693	Far Rockaway	Queens	1.758	11.158
11411	Cambria Heights	Queens	7.428	11411	Cambria Heights	Queens	3.658	11.085
11423	Hollis	Queens	2.762	11423	Hollis	Queens	6.929	9.691
11417	Ozone Park	Queens	1.281	11417	Ozone Park	Queens	5.086	6.368
11416	Ozone Park	Queens	1.706	11416	Ozone Park	Queens	4.393	6.099
11103	Astoria	Queens	-0.296	11103	Astoria	Queens	5.913	5.617
11354	Flushing	Queens	-3.822	11354	Flushing	Queens	8.023	4.200
11428	Queens Village	Queens	-0.494	11428	Queens Village	Queens	1.634	1.140
11365	Fresh Meadows	Queens	-4.330	11365	Fresh Meadows	Queens	4.946	0.615
11378	Maspeth	Queens	-3.549	11378	Maspeth	Queens	3.774	0.224
10304	Staten Island	Richmond	5.672	10304	Staten Island	Richmond	20.047	25.719
10303	Staten Island	Richmond	7.435	10303	Staten Island	Richmond	12.299	19.733
10301	Staten Island	Richmond	3.695	10301	Staten Island	Richmond	15.409	19.104
10310	Staten Island	Richmond	7.598	10310	Staten Island	Richmond	11.485	19.083
10302	Staten Island	Richmond	6.494	10302	Staten Island	Richmond	6.560	13.054
10314	Staten Island	Richmond	-7.359	10314	Staten Island	Richmond	10.960	3.601
10305	Staten Island	Richmond	-4.334	10305	Staten Island	Richmond	6.806	2.472

RATE Z SCORES				CASE Z SCORES				
ZIP code	P.O. Name	Primary County	SUM	ZIP code	P.O. Name	Primary County	SUM	Combined Rate/Case Z score
11717	Brentwood	Suffolk	5.025	11717	Brentwood	Suffolk	33.250	38.275
11706	Bay Shore	Suffolk	1.146	11706	Bay Shore	Suffolk	21.067	22.214
11722	Central Islip	Suffolk	4.323	11722	Central Islip	Suffolk	15.969	20.292
11798	Wyandanch	Suffolk	9.605	11798	Wyandanch	Suffolk	7.064	16.669
11701	Amityville	Suffolk	6.448	11701	Amityville	Suffolk	8.382	14.830
11746	Huntington Station	Suffolk	-2.195	11746	Huntington Station	Suffolk	14.834	12.639
11901	Riverhead	Suffolk	3.862	11901	Riverhead	Suffolk	7.918	11.779
11951	Mastic Beach	Suffolk	4.929	11951	Mastic Beach	Suffolk	2.997	7.926
11726	Copiague	Suffolk	3.952	11726	Copiague	Suffolk	3.363	7.315
11950	Mastic	Suffolk	1.489	11950	Mastic	Suffolk	2.988	4.477
11772	Patchogue	Suffolk	-4.087	11772	Patchogue	Suffolk	7.651	3.564
11967	Shirley	Suffolk	-1.284	11967	Shirley	Suffolk	4.590	3.306
11757	Lindenhurst	Suffolk	-4.362	11757	Lindenhurst	Suffolk	6.349	1.988
11704	West Babylon	Suffolk	-3.592	11704	West Babylon	Suffolk	5.160	1.568
11729	Deer Park	Suffolk	-1.546	11729	Deer Park	Suffolk	2.761	1.215
10701	Yonkers	Westchester	8.128	10701	Yonkers	Westchester	36.860	44.989
10550	Mount Vernon	Westchester	11.150	10550	Mount Vernon	Westchester	21.451	32.601
10705	Yonkers	Westchester	5.720	10705	Yonkers	Westchester	17.985	23.705
10553	Mount Vernon	Westchester	12.648	10553	Mount Vernon	Westchester	1.036	13.684
10801	New Rochelle	Westchester	0.882	10801	New Rochelle	Westchester	9.963	10.844
10703	Yonkers	Westchester	3.397	10703	Yonkers	Westchester	4.075	7.472
10566	Peekskill	Westchester	0.446	10566	Peekskill	Westchester	5.636	6.082
10601	White Plains	Westchester	4.438	10601	White Plains	Westchester	-0.239	4.199
10573	Port Chester	Westchester	-2.491	10573	Port Chester	Westchester	6.463	3.971
10505	Baldwin Place	Westchester	6.168	10505	Baldwin Place	Westchester	-5.357	0.811
10606	White Plains	Westchester	-0.655	10606	White Plains	Westchester	0.786	0.131

Funding Distribution Methodology

This methodology will be used to distribute available funds (based on FY10 annual allocation) amongst selected programs in target communities.

Note that a different methodology may be utilized for future increases in funding, subject to department and control agency approvals for awarding of those funds through an RFA.

1) From the available amount, total funding is allocated for each **target county,** based on the number of annual births in that county, in accordance with the following:

Number of births (2009)	Funding allocation
2,500 – < 5,000	$300,000
5,000 - < 10,000	$500,000
10,000 - < 20,000	$1,000,000
20,000+	$1,500,000

2) Any remaining balance (that is not sufficient to make an additional whole award) will be distributed among the **target counties** proportionately based on the annual number of births.

3) If there is more than one eligible program within a targeted county, the funding allocated to that county will be distributed amongst those **eligible programs** based on the number of clients served.

The application of the above funding methodology results in the following awards:

County	Program	Award
Erie	Healthy Families NY*	$547,355
Monroe	Nurse Family Partnership	$541,472
Bronx	Nurse Family Partnership	$1,022,024
	Healthy Families NY* (3 projects)	$589,149
TOTAL		**$2,700,000**

* - *Funds will be transferred to NYS OCFS via MOU, to award to OCFS HFNY grantees*

ATTACHMENT C

Stakeholder Surveys

NYS Home Visiting State Plan - Stakeholders

1. Survey Background

The "Patient Protection and Affordable Care Act"(ACA), signed into law on March 23, 2010, created the "Maternal, Infant & Early Childhood Home Visitation Program." This legislation provides a funding opportunity for states to improve health and developmental outcomes for at-risk children and families through a coordinated system of evidence-based only home visiting programs,and defines "at-risk" individuals as those "coming from communities with concentrations of premature birth, low-birth weight infants, and infant mortality,including infant death due to neglect or other indicators of at-risk prenatal, maternal, newborn or child health, such as poverty, crime, domestic violence, high rates of high school drop outs, substance abuse, unemployment and child maltreatment."

A required step to receive funding under this grant initiative was the development of a state home visiting needs assessment to identify high-need communities and the existing home visiting programs and supportive resources in those communities. The resulting needs assessment identified 14 high-need counties, Group 1 had both high rates and high burden, and Group 2, high burden:

Group 1: Albany, Bronx, Erie, Kings, Monroe, New York, Oneida, Onondaga

Group 2: Nassau, Orange, Queens, Richmond, Suffolk, Westchester

The final step to receive grant funding under this initiative is the development of a State Plan for a State Home Visiting Program. The purpose of the State Plan is to:

--Identify the at-risk communities where funding will be targeted.
--Assess the particular needs of those communities in terms of risk factors, community strengths, and existing services.
--Identify home visiting services proposed to be implemented to meet identified needs in those communities.
--Describe the state and local infrastructure available to support the program.
--Specify any additional infrastructure support necessary to achieve program success.

We are requesting input from stakeholders, such as yourself, to inform the New York State Home Visiting State Plan, and would appreciate if you could answer the following questions. Please feel free to add comments that you think would help us in this undertaking. Thank you.

* 1. Which of the 14 high-risk counties are you responding about?

- Albany
- Bronx
- Erie
- Kings
- Monroe
- Nassau
- New York
- Oneida
- Onondaga
- Orange
- Queens
- Richmond
- Suffolk
- Westchester

*** 2. Indicate if you (choose one):**

- Work in a home visiting program
- Work in county/local government (indicate type below, e.g., social services, health, etc.)
- Work in a community-based organization (indicate type below, e.g., substance abuse, child abuse, etc.)
- Work in a health center or hospital
- Work for a managed care plan
- Other (indicate below)

Other (please specify)

3. What are the specific characteristics or conditions of your community that may contribute to poor maternal and child health outcomes, or other associated risk indicators such as poverty, crime, domestic violence, high rates of high school drop outs, substance abuse,unemployment and child maltreatment?

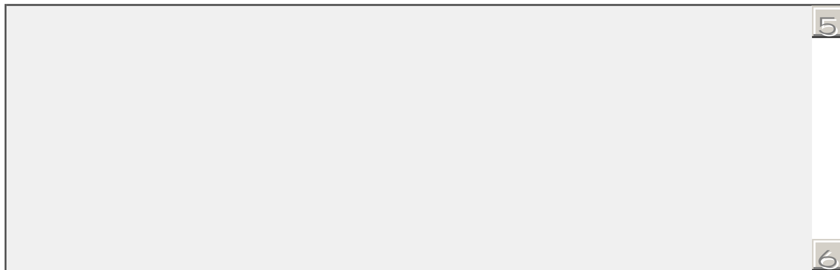
4. What are the biggest strengths of your community in terms of being able to address these risk factors?

5. What service systems are currently available for families in your community? Are the needs of at-risk pregnant women, children and families met in your community/program? What needs are still not met? Are there more families to serve?

6. What are the gaps in services, and barriers to services within your community?

7. What is the one thing your community needs to overcome these issues?

8. Other comments?



NYS Home Visting State Plan - Home Visiting Programs

1. Survey Background

The “Patient Protection and Affordable Care Act” (ACA), signed into law on March 23, 2010, created the “Maternal, Infant and Early Childhood Home Visitation Program.” This legislation provides a funding opportunity for individual states to improve health and developmental outcomes for at-risk children and families through an effective, coordinated system of evidenced-based home visiting programs, and defines “at-risk” individuals as those “coming from communities with concentrations of premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect or other indicators of at-risk prenatal, maternal, newborn or child health, such as poverty, crime, domestic violence, high rates of high school drop outs, substance abuse, unemployment and child maltreatment.”

A required step to receive funding under this initiative was the development of a state home visiting needs assessment to identify high-need communities and the existing home visiting programs and supportive resources in those communities. The resulting needs assessment analyzed the rates and number of cases (burden) for each of 23 indicators at the county-level, so that counties could be prioritized by ranking with respect to both rates and overall burden. The resulting needs assessment identified 14 high need counties, Group1 had both high rates and high burden, and Group 2, high burden:

Group 1: Albany, Bronx, Erie, Kings, Monroe, New York, Oneida, Onondaga

Group 2: Nassau, Orange, Queens, Richmond, Suffolk, Westchester

The final step to receive grant funding under this initiative is the development of a State Plan for a State Home Visiting Program. The purpose of the State Plan is to:
• Identify the at risk communities where funding will be targeted.
• Assess the particular needs of those communities in terms of risk factors, community strengths, and existing services.
• Identify home visiting services proposed to be implemented to meet indentified needs in those communities.
• Describe the state and local infrastructure available to support the program.
• Specify any additional infrastructure support necessary to achieve program success.

We would like to request input from home visiting programs in the 14 high need counties identified, to inform the New York State Home Visiting State Plan. Please answer the following questions related to your home visiting program, and feel free to add comments you think would help in this undertaking. Please return the survey by Wednesday May 11, 2011. Thank you.

* 1. Name of Home Visiting Program:

- CHWP
- Early Head Start
- Healthy Families NY
- Healthy Start
- Healthy Steps
- HIPPY
- Nurse Family Partnership
- Parents as Teachers
- Parent Child Home

Other (please specify)

* **2. County Served:**

- Albany
- Bronx
- Erie
- Kings
- Monroe
- Nassau
- New York
- Oneida
- Onondaga
- Orange
- Queens
- Richmond
- Suffolk
- Westchester

3. What are the specific characteristics and needs of your program participants which put them at risk for poor maternal and child health outcomes, or other associated risk indicators such as poverty, crime, domestic violence, high rates of high school drop outs, substance abuse, unemployment, and child maltreatment?

4. What other home visiting programs exist in your community? What home visiting models do they use?

5. What mechanisms exist in your program/ community for screening, identifying and referring families and children to home visiting programs? Is there a centralized intake procedure, or process for coordination among existing home visiting programs? If so, please describe.

6. What referral resources are currently available and needed in the future to support families residing in your community. Are there gaps in available resources?

7. Are there existing efforts to develop a coordinated early childhood system that promotes maternal, infant and early childhood health in your community? If so, pelase describe.

8. Other comments?

Target Counties Needs Profile

Bronx County

Community Needs

The estimated population of the Bronx is 1,397,287 (2010 Census), including 52% Hispanic and Latino (of all races), 31.2% Black or African-American, 12.4% White, and 3.8% Asians. The median household income in 2008 was $35,108; 62% percent of the population graduated high school; and 27.3% live below the federal poverty level, (compared to 13.7% for NYS.) In February, 2011, the unemployment rate for the Bronx was 12.7% (NYS Labor Statistics), compared with the NYS average unemployment rate of 8% during this same period.

The Bronx had the fourth highest number of live births (23,000) in 2009, but the highest birth rate in New York City (NYC), at 16.5 live births per 1,000. The percentage of low birth weight babies born in the Bronx in 2009 was 11%, increased from a low of 9.2% in 2002. In 2009, 13.8% of babies born were premature. The Bronx has the highest infant and neonatal mortality rates in NYC, at 6.6 per 1,000 births and 4.6 per 1,000 live births respectively. The Bronx had the highest percentage of live births to women on Medicaid in New York City at 75%. In 2009, 11 percent of the total live births were to adolescents (up to age 19) in the Bronx – the highest percentage of teen births in NYC.

The Bronx ranked last among all 62 counties in New York State, according to a county-by-county health study by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation (February, 2010). The borough came in last statewide in premature deaths, low birth weight, number of sick days and overall wellness. The study also measured factors that influence the health of a community. The Bronx ranked worst in the state for socioeconomic factors that affect health, such as unemployment, poverty, street crime and low education. Key findings include:

- Teen birth rate of 50 per 1,000 births (54% higher than the citywide average)
- 63% of Bronx children live in a single-parent household (over 20% higher than that of Brooklyn, which has the second-highest rate in the city.)
- Infection rate for Chlamydia, is double the city average. Based on 2008 data from the NYSDOH Vital Statistics, eight in every 1,000 Bronx adolescents (ages 15-19) is infected with Chlamydia.

Existing Home Visiting Services

Bronx County is currently served by six evidenced-based home visiting programs: Nurse Family Partnership (NFP), Healthy Families New York (HFNY), Home Instruction for Parents of Preschool Youngsters (HIPPY), Early Head Start (EHS) Healthy Start and Healthy Steps. In addition, the Community Health Worker Program (CHWP) and Parent Child Home Program (PCHP) provide home visiting services to at risk populations. Based on data reported through the statewide needs assessment for 2009 these programs currently serve approximately 1,617

families a year, providing home visits to prenatal women and children. The majority of women in the programs are low income, predominately Hispanic, and between the ages of 20-29.

- The NYC NFP, operated in the Bronx by Visiting Nurse Service of New York, provided home visits to 654 families. The population was 62% Hispanic, and the average income of households was $10,500.
- HFNY served 377 families through three programs in the Bronx: South Bronx Healthy Families, Healthy Families Morris Heights, and Healthy Families Parkchester. Similarity exists across all three programs, with the majority of the population being Hispanic and the majority of the mothers between the ages of 20-29. Average household income for all programs was less than $10,000.
- Bronxswork HIPPY provided home visits to 78 families. The population was 58% Hispanic; 58% of mothers were between the ages of 20-29. with an additional 20% between the ages of 30-39. Of household income, 35% of families earned less than $10,000, and 26% earned between $10,000-$19,000.
- Four EHS operated in the county: Kingsbridge Heights Community Center, Bronx Lebanon (new), Episcopal Social Services of NY, and Graham Windham/Bronx. Two of the four reported their numbers of families (243), but the data does not indicate whether they were home-based or centered-based clients. No other information was reported.
- CHWP served 385 families in 2 programs: the Morris Heights Health Center (targeting Highbridge and Mt. Eden, Morris Heights, Concourse, Claremont Village), and Urban Health Plan (targeting Morrisania, Tremont, Soundview, Hunts Point). The programs were similar with race and age categories. In Morris Heights, 89% were Hispanic with 58% of mothers between the ages of 20-29 (15% were between 15-19). In Urban Health Plan, 77% were Hispanic with 59% of women between the ages of 20-29 (23% were between 15-19). All families were Medicaid eligible.
- PCHP provided home visits to 123 families in 2 programs in the Bronx: Graham Windham/Bronx, and The Parent-Child Home Program-Inwood House. In Graham Windham/Bronx, the population was 72% Hispanic; 30% of mothers were between the ages of 20-29 (20-24=10%; 25-29=20%) with an additional 46% between the ages of 30-39; 58% of families earned less than $10,000, and 31% earned between $10,000-$19,000. In The Parent-Child Home Program-Inwood, the population was 80% Hispanic; 60% of mothers between the ages of 15-19, and 40% between the ages of 20-24; 80% of the household income was less than $10,000.
- Federal Healthy Start (FHS) has five programs in NYS (Rochester, Onondaga, Central Harlem, Brooklyn, and Queens/Nassau/Suffolk). Three of NY's FHS programs use home visiting/case management strategies to manage the care of pregnant and parenting (interconceptional) women. The FHS program provides home visits to a total of 1,262 families.
- Healthy Steps program at Montefiore now has two sites, a comprehensive family care center (CFCC) that has served over 459 families at the CFCC in 2009, and a new family care center (FCC) that began in the summer of 2010. Healthy Steps serves 75-88% of families with Medicaid who are predominantly Hispanic (51-62%), and African American (31-33%), for an average duration of 12 months.

Stakeholder Input

Home visiting programs in the Bronx were surveyed to provide input as to: specific characteristics and needs of their program participants; other home visiting programs in their target communities; mechanisms for screening and referrals; referral resources available; and current efforts to develop a coordinated early childhood system.

Home visiting programs identified poverty, crime, substance use, domestic violence, high unemployment, housing and child maltreatment as major issues in the Bronx. One of the biggest challenges, the HIPPY home visiting program reports, is that resources for Bronx residents are spread across several sectors, making coordination difficult. The need for good maternal health, including prenatal care, health education, primary health care and follow up for chronic health conditions such as diabetes, HIV or obesity are also needed to improve birth outcomes. In fact, quality prenatal care and pediatric care are listed as much needed, said an Early Head Start Program respondent.

Healthy Steps in the Bronx reports their participants as 56% Hispanic, 24% African American, 78% of children are on Medicaid or uninsured, 20% of mothers are teenagers (age 13-19). The Mean age of mothers: 24, with 37% 21 or under. Seventeen percent of mothers do not have a HS degree. There is also a significant history of medical concerns in parents (or grandparents) with 62% having High BP, 59% having Diabetes and 58% with asthma. In addition, there is also a significant history of mental health concerns of parents (or grandparents) that are raising children a Healthy Steps survey states (15% learning disabled, 29% anxiety/depression, 35% mental illness, 17% alcoholic and 12% drug abuse). Most at risk communities responding to these surveys have said there is a major gap in Medicaid eligible mental health service providers for children and families.

Many Bronx residents are undocumented immigrants with language barriers. They are often isolated, afraid to seek out health care, social services or prenatal care for fear of being "found out" and deported. Bronxworks states they serve many undocumented and have seen an influx of Central and West African, and Central American immigrants who speak languages indigenous to their respective tribes or communities. They further state that most require different recruitment techniques because they are very leery of any services or providers.

Evidence based Home Visiting programs in the Bronx include HIPPY, Healthy Families NY and the Nurse Family Partnership (NFP). The NFP states they have an ambitious long term goal to make the program available to all low-income, first time mothers and their families in NYC but only have funding to serve 2,250 clients in all five boroughs. To demonstrate what a small amount that is compared to the need, in the Bronx alone there are over 7,000 first time mothers on Medicaid <u>each</u> year that could benefit from increased capacity at the NFP.

No centralized mechanisms for screening, identifying and referring families to home visiting exist in the Bronx, home visiting program's respond. Most programs collaborate with each other, utilizing outreach and sharing referrals. In addition, the Healthy Mom, Healthy Baby initiative is a collaborative project between the Bronx Health Link perinatal network and the NYC Department of Mental Health and Hygiene, Bureau of Maternal, Infant and Reproductive

Health, in a statewide push to organize the delivery of perinatal health and home visiting services in the South Bronx.

Project Launch (Linking Action for Unmet Needs in Children's Health) is a SAMHSA-funded initiative currently being implemented by the NYC Department of Health and Mental Hygiene, Bureau of Children, Youth and Families, the Nurse Family Partnership reports. The primary mission of Project launch is to develop a holistic system to support the wellness of all children from birth through age 8. It is located in one of the Bronx's highest need neighborhoods, Hunts Point.

An Even Start home visiting provider summed up their thoughts on coordination by saying they would like to see greater coordination at the city level in shaping family friendly policies and at the direct service level to ensure there is a continuum of service that is appropriate and comprehensive."

Community-based organizations in the Bronx were surveyed to determine community strengths; current service systems; and gaps and barriers to services. Respondents expressed lack of affordable housing as a major community risk factor. Bronx outreach teams have an average of 1,458 contacts (engagement conversations) with street homeless people every month. These contacts result in an average of 81 monthly placements into shelters or drop-in centers. In addition to shelters, the Bronx has a 24-hour drop-in center and 9 faith-based organizations that provide beds for those on the streets. There is no official estimate of the number of individuals living on the streets and in other public spaces in the Bronx. However, outreach teams report higher concentrations of street homeless individuals in Mott Haven, Hunts Point, Tremont, and Baychester.

Key stakeholders from the Bronx said many of the same characteristics of the community and risk factors as the home visiting providers, including poverty, low health literacy, obesity, diabetes, mother's poor health before she becomes pregnant, substance abuse, unemployment, high teen pregnancy, and undocumented immigrants with language barriers. While they say their biggest strength is adequate health resources, most providers are overwhelmed by the demand.

Respondents say the need is not met and would require additional capacity, housing, Medicaid eligible mental health and substance abuse services, better economic opportunities and additional program funding. Other gaps mentioned are education, access to fresh and healthy food, and having an easy "one stop shopping" health facility for families that coordinates all services.

Surveys also suggest the community would benefit from more comprehensive delivery of services, which the Healthy Mom, Healthy Baby initiative is working on. Community education, provision of no cost health services to individuals/families as well as adequate funding would help to increase capacity and begin to overcome these issues.

Monroe County

Community Needs

According to 2009 census data, Monroe County had a population of 733,703 and the city of Rochester, 210,565. Rochester is the third largest city in New York after NYC and Buffalo. The majority of Monroe County residents are White, while the population is more racially diverse in the city of Rochester. Based on the 2009 population estimates (US Census 2000), approximately 75% are White (non Hispanic), 14.8% are Black/African American, 6.2% are Hispanic or Latino, and 2.8% are Asian, and 1.7% identified by two or more races. In Rochester, 41% of the population is African American, and 14% Hispanic or Latino. In Monroe County, 5.8% of the population is under 5 years of age, 7.3% are foreign born, and 12.1% speak a different language than English at home.

In 2009, the poverty level for a single person in Monroe County was $10,712 per year and $22,000 for a family of four. In Monroe County poverty is concentrated in Rochester's nine highest risk zip codes. In 2010, one in five families in these zip codes lived below the poverty level compared to 3% in the suburbs. Over 57% of female headed households with children in this area were below the poverty level. Sixteen percent of Monroe County women 18-44 reported that they had at some time been a victim of intimate partner violence. Women with less than a college degree and residents of these nine zip codes were significantly more likely to report having been a victim. Rochester has an unemployment rate of 9.3%, compared to the national average of 6.9%.

In Monroe County, 11% of adults ages 25-64 years old and 31% of adults aged 65 years and older do not have a high school diploma (2000 US Census). Percentages are higher in the city compared to the suburbs. Not having a high school diploma is also correlated with low birth weight. Mothers without a high school diploma in these zip codes (14605, 14606, 14607, 14608, 14609, 14611, 14613, 14619, 14621) have a 30% higher rate of low birth weight than high school graduates. In suburban Monroe County mothers without a high school diploma have 42% higher rates of low birth weight than high school graduates. Latinas living in the nine at risk zip codes have the highest rate of less than high school education, followed by African Americans living in the city.

In Monroe County, 136,214 children and adults are Medicaid eligible, or approximately 18.5% of the county's population (NYS Vital Statistics 2010). Latinas and women without a high school degree were most likely to have been without coverage. Younger women (18-29) were significantly more likely than older women (30-44) to have been discontinuously covered. The Monroe Plan for Medical Care enrollees (the dominant provider for Medicaid managed care in the community), reports less than two thirds (61%) of women were continuously enrolled for the entire year (Monroe County Adult and Older Adult Report Card, 2008).

Existing Home Visiting Services

Monroe County has a variety of local home visiting programs, including, Healthy Moms, Baby

Love/Strong, Perinatal Home Visiting Program, and Monroe Plan for Medical Care and Visiting Nurse.

- The Perinatal Home Visiting Program, PHVP, in the Department of Public Health, offers services to pregnant women. Each woman who joins the program receives visits in her home from a Community Health Worker. The support and information provided by the Community Health Worker help women to have a healthy pregnancy. Visits are continued until the baby is one year of age. After delivery, the Community Health Worker discusses ways that parents can help their child to grow and develop.
- The County's Peer Home Visiting uses peers to assess the risks of pregnant women and their care coordination, including referrals for needed services, intervention for behavioral and social issues, health care referral and transportation to medical appointments, support services including counseling, financial help, and childbirth classes, etc.
- Monroe Plan for Medical Care provides case management and support for members with high risk medical conditions or who are psychosocially at risk. A Perinatal Nurse, Maternal Child Health Specialist, and Behavioral Health staff offer support, education and linkages to health and community services for women and children. MP contracts with Baby Love to offer intensive outreach to those pregnant women with the highest social risk factors.

Monroe County is also served by three evidence-based home visiting programs: Nurse Family Partnership (NFP), Parent as Teachers (PAT), and Early Head Start (EHS). In addition, Building Healthy Children (BHC) is an ACF Evidence-Based Home Visiting Program. These programs served approximately 744 families providing home visits to prenatal women and children. The majority of women in the programs were low income and predominately Black and ages varied.

- Monroe County Department of Public Health, NFP, provided home visits to 210 families in Rochester. The population was 52% Black and 21% White, and the average household income was $7,500.
- PAT provided home visits to 40 families. Race, age, and income varied by zip codes.
- Action for a Better Community, EHS, served 297 families throughout the county, but the data does not distinguish between home based and centered-based clients. No other information was reported.
- BHC provided home visits to 197 families in the county. The population was 66% Black with 44% of mothers between the ages of 15-19 and 55% between the ages of 20-24; 34% of household income was less than $10,000 and 40% between $10,000-$19,000.

Stakeholder Input

Home visiting programs in Monroe County were surveyed to provide input as to: specific characteristics and needs of their program participants; other home visiting programs in their target communities; mechanisms for screening and referrals; referral resources available; and current efforts to develop a coordinated early childhood system.

Survey feedback identified nine high risk zip codes in the city of Rochester (14605, 14606, 14607, 14608, 14609, 14611, 14613, 14619, 14621), as the most in need. Poverty, unemployment, teen pregnancy, teen mothers/single family households, domestic violence, substance use, felony crime, a high drop-out rate and child maltreatment are reported from the various home visiting providers as their most significant issues. Needs include capacity in general, and specifically for mental health services and funding.

Healthy Steps (HS) reported serving high risk inner city families with children ages zero to five (the healthy steps program criteria for age was expanded). Young mothers, single parent families, poverty, illiteracy and domestic violence are among the most common issues Healthy Steps sees. By providing child development assessments and anticipatory guidance to their families, HS is decreasing child abuse, increasing school attendance and increasing positive relationships between parents and children, the primary care practice and the community Healthy Steps states they are the only program that adds a home visiting piece to their primary care appointments with the physician. This gives the family additional support and builds the relationship between the physician's office and the family.

The Nurse Family Partnership also serves a very high risk population of first time mothers, they say. The poverty level is very high in Rochester, with 42% of Rochester children living in poverty compared to 19% in NYS. While NYS has the 3rd highest number of teen pregnancies across the U.S., data from Monroe County and NYSDOH state that four of the eight zip codes across NYS with the highest 15-19 year old birth rates ranging from 135-159 per 1,000, are within Rochester. In fact, over 80% of pregnant and parenting teens in Rochester rely on public assistance.

Monroe County has 13 home visiting programs, of which four have improving perinatal health outcomes as part of their objectives, the others are focused on improved parenting, child development, and prevention of child abuse. Given the continued high rates of premature delivery and low birth weight, the lack of capacity in these programs is a significant gap, states a Monroe County health director. Funding could provide more evidence based home visiting programs for these populations that are more likely to experience poor birth outcomes.

Prior to the Monroe County Healthy Mom, Healthy Baby grant, each agency relied on independent work and referrals from the community and medical providers. Each also conducted its own assessments, screening and identification process. Since the Healthy Mom, Healthy Baby grant there is a large stakeholder collaborative (represented by county, perinatal networks, community agencies and service providers, medical providers, managed care plans, the Children's Agenda and more), geared to the development of a coordinated health continuum and strong infrastructure around identification, risk assessment, referral and service delivery.

Four of Monroe County's home visiting programs are evidence-based, including Nurse Family Partnership, Healthy Steps, Early Head Start, and Parents as Teachers. Add to those, their two home visiting programs that are not evidence based, the Perinatal Home Visiting Program and Healthy Mom, Healthy Baby, which has a home visiting component, and even when utilizing the full capacity of these six home visiting programs, it only meets 30% of Rochester's need.

Community-based organizations in the Monroe County were surveyed to determine community strengths; current service systems; and gaps and barriers to services.

Stakeholders identified poverty, unemployment, high drop-out rates/low literacy, domestic violence, child maltreatment, substance abuse and teen pregnancies and births as community risks. One stakeholder wrote, "Because teen mothers earn an average of $5,600 per year during the first 13 years of motherhood, their children are much more likely to live in poverty."

Domestic Violence is also a major issue in Monroe County a survey respondent from a community based organization said. While average rates of domestic violence in New York State hover around 85 incidents per 10,000 residents, the rate in Monroe County is 199 domestic violence incidents per 10,000 residents which is more than double the New York State average (DVC). The national average of forcible rapes per 100,000 persons is 33 but according to Rochester's 2002 crime index, the local rate is 48 per 100,000 persons. The local battered women's shelter, Alternatives for Battered Women (ABW), found that an average of 65 families with children ages 0-6 seek Orders of Protection or other court-based remedies each month (780 families per year).

The biggest strengths in Monroe County according to key stakeholders are; a coordinated, community wide collaborative effort to deliver evidence based home visiting programs, a community rich in resources and a true culture of collaboration. The vast majority of surveys talked about the effective collaboration of Rochester providers.
Many surveys say the needs of at risk pregnant women and children are not met because of capacity. For example, in 2009, there were 3027 Medicaid births in Monroe County.

The county has approximately 15 programs that provide some type of non-medical perinatal support with a total capacity to serve 2,044 families. By subtracting their 2009 capacity from the Medicaid births, they can obtain a very rough assessment of approximately 983 families unable to receive services in 2009. This number does not include the uninsured.

Capacity is identified as the biggest gap on the survey responses, followed by lack of funding, lack of awareness, lack of mental health services.

Erie County

Community Needs

Erie County is located in the western part of the state. As of the 2009 population estimate (based on 2000 US Census), the population was 909,247. Thes the city of Buffalo, which is also the largest city in upstate New York. In the 2000 census, the ethnic makeup of the county was 82.18% White, 13.00% Black or African American, 3.27 Hispanic or Latino, 0.61% Native American, 1.46% Asian, 1.42% from other races, and 1.31% from two or more races. The city of Buffalo's population is 276,059 (2006) and is more racially and ethnically diverse.

At the 2005–2007 American Community Survey Estimates, the city's population was 52% White, 40% Black or African American, 7% of the total population was Hispanic or Latino, 1% American Indian and Alaska Native, 2% Asian, and 2% from two or more races. According to the 2009 population estimates, 5.4% of Erie County's population is under 5 years of age, 4.5% were foreign born, and 9% spoke a language other than English in the home. In 2009, Buffalo was ranked as the third poorest city in the nation by the US Census Bureau.

In 2008, Erie County's low birth weight was 8.2%, slightly above the HP 2020 7.8% goal. In 2009, their rate of premature infants was 11.3% slightly below the HP 2020 11.4% goal.

Erie County has several Medicaid prenatal care providers including Women and Children's Hospital of Buffalo, Sisters of Charity Hospital, the Community Health Center of Buffalo and the Northwest Buffalo Community Health Center (both federally qualified health centers.) The Medicaid Managed Health Care programs are also active in trying to improve birth outcomes for at risk women. Independent Health, Univera, Blue Cross and Blue Shield, and Fidelis meet monthly to discuss issues and work collaboratively to solve problems. The insurance companies also provide some case management services to their pregnant members, primarily via the telephone.

Buffalo's disparate outcomes include education, cardiovascular health and cancer rates, high rates of teenage pregnancy, late entry into prenatal care, obesity, premature births, and high rates of STI's. Poverty in the Buffalo area is concentrated in communities of color, historically the East side (African American), and West side (Latino and new immigrant). Many of these households that live in poverty are headed by single mothers. Residents in Buffalo living below the poverty level in 2009 were 27%, compared with the New York State rate of 16%.

Erie County has several Medicaid prenatal care providers including Women and Children's Hospital of Buffalo (also a Regional Perinatal Center), Sisters of Charity Hospital, Kaleida Health, Erie County Medical Center, the Community Health Center of Buffalo and the Northwest Buffalo Community Health Center (both federally qualified health centers.)

Exiting Home Visiting Services

Erie County has several local home visiting programs and the following five statewide home visiting programs: Healthy Families New York (HFNY), Community Health Worker Program

(CHWP), Parent Child Home Program (PCHP), Early Head Start (EHS), and Head Start (HS). These programs served approximately 734 families throughout the county, providing home visits to prenatal women and children. The majority of women in the programs are low income, black, and between the ages of 15-24.

Buffalo Prenatal-Perinatal Network (BPPN) implements the Community Health Worker Program and Healthy Family New York Program. Additional, Visiting Nurse Association of Western New York (VNA), and McAuley-Seton Home Care (part of the Catholic Health System) provide home visiting services.

- Buffalo Home Visiting Program, HFNY, provided home visits to 461 families throughout Erie County. The population was 65% Black, with 71% of mothers between the ages of 15-24 (15-19=34%; 20-24=37%). All families earned less than $10,000.
- Buffalo Prenatal-Perinatal Network, CHWP, home visited 161 families in Buffalo. The population was 57% Black and 66% Hispanic with 70% of mothers between the ages of 15-24 (15-19=38%; 20-24=32%). All families were Medicaid eligible.
- PCHP served 73 families in 2 programs in Buffalo: the King Center, and the Jericho Road Ministries. King Center reported the population as 92% Black and 84% Hispanic, with 57% of mothers between the ages of 20-29 (20-24=36%; 25-29=21%) with an additional 29% over 40; 50% of the household income was less than $10,000, and 33% earned in the range of $30,000-$39,000. The Jericho Road Ministries reported only the number of families served.
- The Community Action Organization of Erie County, Inc, EHS, served 39 families, but no other information was reported.
- Head Start operates three programs in the county: Bethel Head Start, Inc, CAO Head Start, and Holy Cross Head Start. No other information was reported.

Stakeholder Input

Home visiting programs in the Erie County were surveyed to provide input as to: specific characteristics and needs of their program participants; other home visiting programs in their target communities; mechanisms for screening and referrals; referral resources available; and current efforts to develop a coordinated early childhood system.

Poverty, lack of education, high unemployment, high rates of teen pregnancy, child abuse and single parent households are all significant risk factors for poor maternal, infant and child health outcomes, say survey responses from Erie County home visiting programs. To be eligible for Early Head Start (EHS), families must be primarily at 100%, with a small percentage at 130% of the Federal Poverty Level. Many of the pregnant women entering EHS are undocumented, have never had medical insurance, do not have a medical home and have not started to receive prenatal care until the second trimester. This puts their clients immediately at high risk for abnormal births, especially if there is a history of substance abuse or domestic violence.

The Buffalo Prenatal-Perinatal Network's (BPPN) Comprehensive Prenatal-Perinatal Services Network (CPPSN) focuses its' work program activities on Erie County which had 10,667 births in 2002 (according to data from the Western New York Perinatal Data System). Erie County is

the home for almost one million people and concurrent with national trends, the "older city", urban areas display the greatest need for our services and assistance. In 2002 Erie County and the City of Buffalo had infant mortality rates of 8.0 and 11.1 respectively, and fall short of the Healthy People 2010 goal for reducing infant mortality, to 4.5 infant deaths per 1000 births. With the East and West Sides of Buffalo as well as Riverside as our target geographic area, the Buffalo Home Visiting Program will concentrate its' efforts on certain high risk zip codes in the City of Buffalo, that also have statistically high z-scores (14201, 14202, 14203, 14204, 14206, 14207, 14208, 14209, 14210, 14211, 14212, 14213, 14214, 14215, 14216, 14218, 14220, 14150 and 14225).

Healthy Families NY (HFNY) of Erie County say these targeted zip codes are home to 90,000 women of childbearing age and over 13,000 are teens between the ages of 15-19 years old. With the exception of 14225 and 14150, these zip codes are 100% urban, populated by a diverse population mix. Buffalo has one of the highest percentages of single mother households (27%), too, HFNY continues, with children less than 18 years of age; 41% of these households are living at or below the federal poverty level.

Additional gaps in service are limited access to health care often due to limited transportation, inconvenient hours of providers, long waiting lists and limited or no available child care reports Early Head Start. While most home visiting programs do outreach, it would be beneficial for them to collaboratively work together, provide referrals and coordinate services.

Only Early Head Start in Erie County says they use a centralized intake procedure for identifying and referring families. Others, including the Buffalo Perinatal Prenatal Network report using a resource directory (Women and Children First) with health care services for drug counseling, WIC, parenting classes, domestic violence and housing. All agencies state they do some form of outreach to identify at risk pregnant and parenting teens and women and most, including, Healthy Families NY and the Community Health Worker Program screen eligible families themselves.

Erie County has a Community Health Worker Program, Healthy Families NY, Head Start, Early Head Start, Visiting Nurse, and Seton-McAuley home visiting programs. Only Healthy Families and Early Head Start are evidence based programs.

Two surveys also mentioned a "Health Services Advisory Committee" that meets monthly to discuss current health trends and share information, as well as a "Healthy Mom, Healthy Baby" program that is coordinating maternal and child health programs and home visiting services.

The Early Head Start program said on their survey that the City of Buffalo is ranked the third poorest city in the U.S. with high birth defects, low literacy, high unemployment, high rates of teenage pregnancies, high rates of high school drop outs. Furthermore Buffalo has over 2100 families who are homeless and over 10,000 referrals to Child Protective Services per year. Buffalo is in great need of funding, states one respondent, particularly since the county had a large budget deficit a few years ago that resulted in closing 3 out of 4 public health clinics, closing a Title X Family Planning program and a pregnancy prevention program for teens.

Community-based organizations in the Erie County were surveyed to determine community strengths; current service systems; and gaps and barriers to services.

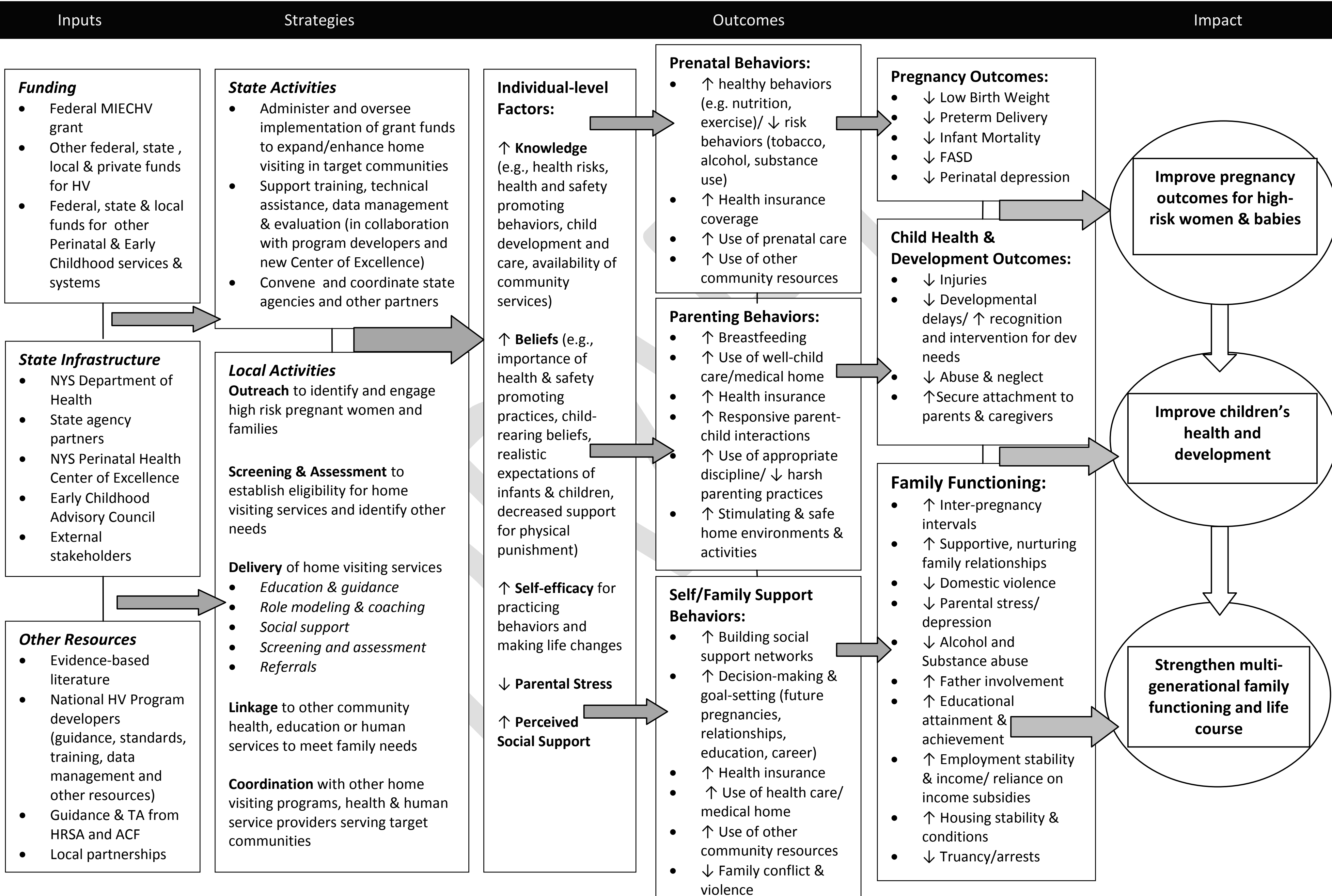
Stakeholders identified poverty, unemployment, high teen birth rate, substance use, domestic violence, child maltreatment and low literacy as major issues. School drop-out rates are consistently high, especially for African American males, leaving a low probability of sufficient long-term employment and the ability to afford or receive adequate health insurance and medical care. Often times this leads to transgenerational poverty that persists in Buffalo in spite of an increased focus on these issues, comments an Erie County stakeholder who self identifies as working in a health center or hospital.

The poverty level and teen pregnancy rate in Buffalo is higher than anywhere else in the state (except NYC). This often leads to late entrance into prenatal care, if any, due to denial or uncertainty on the part of lower literacy teens and women. Fortunately, there are a few Medicaid prenatal providers though transportation to their offices is often taxing. Some facilities and home visiting programs have recognized this and offer tokens for the bus and child care. Often by the time Medicaid transportation is approved, said one survey, the woman has already delivered a premature baby. Other barriers to receiving services is stated by an individual from a not for profit agency dealing with maternal and child health; intermittent phone service and frequent moving and location changes so difficult for follow-up, language barriers, limited transportation, little or no child care, and the negative attitude projected by staff is a disincentive to clients to continue care.

Surveys said that Buffalo’s strength is in having a variety of good community based organizations, medical providers, a top rated children’s hospital and health facilities. The biggest gaps are educational attainment, job training, dental health and mental health providers who accept Medicaid, lack of or no health insurance and insufficient funding to provide programs to meet Buffalo’s increasing needs.

New York State Maternal, Infant & Early Childhood Home Visiting Initiative

Logic Model



ATTACHMENT F

MODEL DEVELOPERS

April 19, 2011

Rachel de Long, M.D. M.P.H.
Director, Bureau of Maternal and Child Health
New York State Department of Health
1805 Corning Tower, ESP
Albany, NY 12237

Dear Dr. de Long:

Based on the information provided in your state plan, I am pleased to grant approval from the Nurse-Family Partnership National Service Office (NFP NSO), so you may include the Nurse-Family Partnership® Program (NFP) in your revised state plan submission to the Health Resources and Services Administration as part of the Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP). Specifically:

- NFP NSO verifies that we have reviewed New York's plan as submitted and that it includes the specific elements required in the SIR; and
- NFP NSO is supportive of New York's participation in the national evaluation and any other related HHS effort to coordinate evaluation and programmatic technical assistance.

Because the Updated State Plan, as required by the SIR, must include additional information on how you will implement the model(s) chosen, it will be important to provide a copy of this to the NFP NSO. We would like to review the following additional details in order to better support the implementation of NFP in your state:

- Identification of the evidence-based home visiting model(s) to be implemented in the State and describe how each model meets the needs of the community(ies) proposed;
- A description of the State's current and prior experience with implementing the model(s) selected, if any, as well as their current capacity to support the model;
- A plan for ensuring implementation, with fidelity to the model, and include a description of the following: the State's overall approach to home visiting quality assurance; the State's approach to program assessment and support of model fidelity; anticipated challenges and risks to maintaining quality and fidelity, and the proposed response to the issues identified;
- Any anticipated challenges and risks of selected program model(s), and the proposed response to the issues identified, and any anticipated technical assistance needs.

As part of our ongoing partnership to support implementation with fidelity to the model, and as part of our required processes, as referenced in the SIR, NFP NSO expects that New York will enter into a service agreement with NFP NSO and implement NFP in accordance with that agreement. This agreement will outline expectations for the State as well as what supports will be provided by the NFP NSO to include:

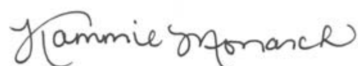
- Working directly with the NFP NSO and designated program development staff to implement NFP as designed, including:

- Understanding the 18 required model elements;
    - Using NFP-specific implementation planning tools;
    - Accessing NFP support as appropriate with RFP processes and a list of program requirements for inclusion in such processes; and
    - Adhering to NFP agency selection requirements contained in the Implementation Plan and Guidance documents.
- Ensure that every team of nurses employed to deliver NFP will:
    - Receive NFP-specific education as well as expert NFP nursing practice consultation to develop basic competencies in delivering the program model successfully;
    - Receive adequate support and reflective supervision within their agencies;
    - Receive ongoing professional development on topics determined by nursing supervisors to be critical for continued growth. Professional development may be offered within a host agency or through more centralized or shared venues;
    - Engage in individual and collective activities designed to reflect on the team's own practice, review program performance data, and enhance the program's quality and outcomes over time; and
    - Utilize ongoing nurse consultation for ongoing implementation success.
- Participate in all NFP quality initiatives including, but not limited to, research, evaluation, and continuous quality improvement;
- Assure that all organizations implementing NFP use data and reports from our web-based Efforts to Outcomes ™ data system to foster adherence to the model elements in order to achieve outcomes comparable to those achieved in the randomized, controlled trials. This may include creating necessary interfaces between local or state-based data and information systems with our national web-based data system.

This letter also affirms our commitment to work with you as your state implements NFP using designated funds from the MIECHVP. In order to further assist you, we have a set of online resources that can serve as your guide for our continued work together. We are particularly eager to partner with you to consider the kind of support that would enable you to successfully establish NFP in the communities identified in the statewide needs assessment.

Successful replication of Nurse-Family Partnership as an evidence-based home visitation program is dependent on both unwavering commitment to program quality as well as creative and sensitive adaptability to local and state contexts and available resources. We are excited to partner with you to plan how best to support the successful development of Nurse-Family Partnership.

Sincerely,



Kammie Monarch.
Chief Operating Officer
Nurse-Family Partnership National Service Office

228 S. Wabash, 10th Floor
Chicago, IL 60604
312.663.3520
healthyfamiliesamerica.org

April 19, 2011

Ms. Rachel de Long
New York State Department of Health

Re: Documentation of Approval to Utilize the HFA Model

Dear Ms. Long:

This letter is in response to the Supplemental Information Request (SIR) from the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program (MIECHV Program) requirement to receive documentation of approval by the model developer to implement the model as proposed. We have had an opportunity to review the information provided regarding implementation of HFA in New York. This letter outlines the provisional approval of use of the HFA model.

Currently, HFA is present in 35 states and DC. Healthy Families New York is unique in our network. It is one of largest and most experienced multi-site accredited systems in our network and currently operates 36 accredited HFA programs through the oversight and support of an accredited Central Administration at the Office of Child and Family Services.

When a state system of sites is accredited through our multi-site process it means there is a Central Administration providing critical functions such as training, quality assurance, technical assistance and ongoing evaluation and quality improvement to ensure model fidelity and quality. The Central Administration in New York provides an infrastructure that allows the HFA National Office to grant certain privileges. These privileges include the following:

1. Any sites currently existing in this multi-site infrastructure are automatically approved from the HFA National Office to receive any funding that would be allocated from the MIEC Home Visiting Program. Included is a listing of sites accountable to the Healthy Families New York Central Office. Therefore, if any of the federal funds were to be allocated to these lead agencies to increase their current capacity or to implement enhancements to the HFA model they are automatically approved by the HFA National Office.
2. Healthy Families New York's Central Administration can affiliate and disaffiliate sites within its state network. Any new Healthy Families lead entities interested in implementing the Healthy Families model would have to be approved by the Healthy Families New York Central Administration. These new lead agencies would become a part of the current statewide system and be accountable to the Healthy Families New York Central Administration. The Central Administration will work with the HFA national office to get final approval of any proposed new lead agencies that were not in existence prior to the budget cut made this year.
3. Because Healthy Families New York is an accredited multi-site system, the annual affiliation fee for each project is $1150 versus $1350.
4. Healthy Families New York Central Administration has its own certified trainers, allowing for a cost effective process in training new hires and providing the in-service and ongoing wraparound training required by the HFA national standards.

Prevent Child Abuse America

To maintain the fidelity of the model which is required by the federal legislation, it is critical that any new sites in New York be a part of Healthy Families New York, the current multi-state system administered by the Central Administration which would collaborate with the HFA national office and the Office of Children and Family Services in the planning, development, approval and implementation of any HFA program in the state From our perspective the multi-site infrastructure creates the highest level of model fidelity and greater outcomes in the most cost effective manner.

If you would like to discuss this further, I can be reached at lkosanovich@preventchildabuse.org or 703-888-3135. I appreciate your commitment to New York's children and families and look forward to our continued work together.

Sincerely,

Lynn H. Kosanovich

Cc: Bernadette Johnson
Lisa Gordon

Cydney M. Wessel, MSW
Senior Director of HFA
Prevent Child Abuse America

Organizations Providing Input to the State Plan

- Albany County Health Department
- Bronx Health Link Perintal Network
- Buffalo Prenatal-Perinatal Network
- Caribbean Women's Health Association
- Community Cradle (Maternal Infant Network of the Capital Region)
- Erie County Department of Health
- Lower Hudson Valley Perinatal Network
- Mohawk Valley Perinatal Network
- Monroe County Public Health Department
- Maternal Infant Services Network
- Nassau County Health Department
- New York City Department of Health and Mental Hygiene
- Northern Manhattan Perinatal Partnership
- Oneida County Department of Health
- Onondaga County Health Department
- Orange County Department of Health
- Perinatal Network of Monroe County
- Queens Health Coalition
- REACH Central New York
- Schuyler Center for Analysis and Advocacy
- Suffolk County Department of Health
- Suffolk County Perinatal Coalition
- Westchester County Department of Health

Plan for Benchmark Measurement and Data Collection for Healthy Families New York

This attachment provides a detailed plan for benchmark measurement and data collection for HFNY. For ease of presentation, the following tables display each construct along with a description of the proposed data source, definition of how the construct will be measured, how improvement will be quantified, and specification of the population to be assessed by each measure. An overview of the data collection plan and schedule, along with the justification of specific measures and, where appropriate, the measure's associated reliability and validity are provided in the text following the tables. In most cases, data will be gathered by the HFNY Home Visitor and entered into the HFNY MIS, the statewide system for monitoring and reporting.

PROPOSED BENCHMARKS FOR HFNY IMPROVED MATERNAL AND NEWBORN HEALTH				
Construct	**Data Source**	**Definition**	**Quantifiable Improvement Measure***	**Relevant Population**
Prenatal Care	Participant report / conducted by home visitor	% receiving a prenatal visit between time of enrollment and focal child's birth	Increase in rate over time	Mothers who enroll by 32 wks of pregnancy
Parental use of alcohol, tobacco or illicit drugs	Screens administered by home visitor: Alcohol– AUDIT-C; Drugs– DAST-10 Tobacco– 2 items	% using or severity of use from enrollment to birth ------------ % using or severity of use, enrollment to 1 year post-enrollment	Decrease in rates or level of severity over time	Mothers who enroll by 32 wks of pregnancy ------------ Mothers at birth or post-partum
Preconception care	Participant report / conducted by home visitor	% receiving prenatal care after the birth of focal child through conception of subsequent pregnancy that occurs while in the program	Increase in rate over time for mother	Enrolled first-time mothers ------------ All other enrolled mothers
Inter-birth intervals	Participant report / conducted by home visitor	% subsequent pregnancies (by one year post-partum)	Decrease in rate over time	All enrolled mothers
Screening for maternal depressive symptoms	Screens administered by home visitor: Edinburgh Postnatal Depression Scale	% screened for depression from enrollment to birth ------------ % screened for depression enrollment to 1 year post-enrollment	Increase in rate of screens administered	Mothers who enroll by 32 wks of pregnancy ------------ Mothers enrolled at birth or post-partum
Breastfeeding	Participant report / conducted by home visitor	% of clients breastfeeding (initiation to 12 months post partum)	Increase in rate over time for mother & infant	Mothers who enroll by 32 wks of pregnancy
Well-child visits	Participant report / conducted by home visitor	% children in compliance with recommended well-child visit schedule (within 2 months of focal date) while in the program	Increase in rate over time for infant/child	All enrolled children
Maternal & child health insurance status	Participant report / conducted by home visitor	% mothers with health insurance ------------ % children with health insurance	Increases in rates over time for mother & infant/child	All enrolled mothers and children
* Note: The changes in rates or levels over time are for mothers unless otherwise specified.				

PROPOSED BENCHMARKS FOR HFNY CHILD INJURIES, CHILD ABUSE, NEGLECT, OR MALTREATMENT & REDUCTION OF EMERGENCY DEPARTMENT VISITS				
Construct	**Data Source**	**Definition**	**Quantifiable Improvement Measure**	**Relevant Population**
Visits for children to the emergency department from all causes	Participant report / conducted by home visitor	# emergency department visits / # of children enrolled, birth to one year post birth	Decrease in rate over time for children	Children enrolled
Visits of mothers to the emergency department from all causes	Participant report / conducted by home visitor	# emergency department visits / # of mothers enrolled, enrollment to one year post enrollment	Decrease in rate over time for mothers	All enrolled mothers
Information provided or training of participants on prevention of child injuries	Documentation provided by home visitor on home visit log	# of enrolled mothers who receive info or training / total # families enrolled, enrollment to one year post enrollment	Increase in rate over time for mothers	All enrolled mothers
Incidence of child injuries requiring medical treatment	Participant report / conducted by home visitor	# of children with injuries requiring medical attention / all enrolled children, birth to one year post-birth	Decrease in rate over time for children	Enrolled children
Reported suspected maltreatment for children in the program	State administered, child protective services data	# of suspected cases of maltreatment among focal children in the program / number of focal children in the program	Decrease in rate over time for children	Enrolled children*
Reported substantiated maltreatment for children in the program	State administered, child protective services data	# of substantiated cases of maltreatment among focal children in the program / number of focal children in the program	Decrease in rate over time for children	Enrolled children*
First-time victims of maltreatment for children in the program	State administered, child protective services data	# of focal children in program who are first-time *victims* / number of focal children in the program	Decrease in rate over time for children	Enrolled children*
* Will be reported overall and broken down by age category (0-12, 13-24, 25-36, 37-84) and by type of maltreatment				

PROPOSED BENCHMARKS FOR HFNY IMPROVEMENTS IN SCHOOL READINESS & ACHIEVEMENT				
Construct	**Data Source**	**Definition**	**Quantifiable Improvement Measure**	**Relevant Population**
Parent support for children's learning & development	Participant report on Attachment-Mastery-Interaction-Support (AIMS)/ conducted by home visitor	% mothers rated with strengths on mastery subscale, Birth or post-partum enrollment to one year after birth or enrollment	Increase in rate over time for mother	All mothers enrolled
Parent knowledge of child development & of their child's developmental progress	Participant report on ASQ-3 at various times in infancy and toddlerhood / conducted by home visitor	% children achieving age-appropriate developmental milestones, Birth or post-partum enrollment to one year after birth or enrollment	Increase in rate over time for mother	All mothers enrolled
Parenting behaviors & parent-child relationships	Participant report on AIMS / conducted by home visitor	% mothers rated with strengths on parent-child interactions subscale, Birth or post-partum enrollment to one year after birth or enrollment	Increase in rate over time for mother	All mothers enrolled
Parent emotional well-being or parenting stress	Participant report on Parental Stress Index (PSI), conducted by home visitor	# of mothers showing high levels of stress / all enrolled mothers	Decrease in rate over time for mother	All mothers enrolled
Child's communication, language & emergent literacy	Participant report on Ages & Stages Questionnaire (ASQ-3) in infancy and toddlerhood, conducted by home visitor	% of children at risk as calculated on communication subscale score; Birth or post-partum enrollment to one year after birth or enrollment	Increase over time in % of enrolled children not at risk	All enrolled children
Child's general cognitive skills	Participant report on ASQ-3 in infancy and toddlerhood, conducted by home visitor	% of children at risk for cognitive problems as calculated on problem solving subscale score; Birth or post-partum enrollment to one year after birth or enrollment	Increase over time in % of enrolled children not at risk	All enrolled children
Child's positive approaches to learning, including attention	Participant report on PSI & ASQ-3 in infancy and toddlerhood, conducted by	% of children at risk for distractibility / hyperactivity as calculated on PSI	Increase over time in % of enrolled children not at risk	All enrolled children

	home visitor			
Child's social, behavior, emotion regulation & emotional well-being	Participant report on Ages & Stages – Social Emotional Questionnaire (ASQ-SE) in infancy and toddlerhood, conducted by home visitor	% of children at risk for social and emotional delays as calculated on corresponding scale scores	Increase over time in % of enrolled children not at risk	All enrolled mothers and children
Child's physical health & development	Participant report on ASQ-3 in infancy and toddlerhood & of child's weight & height, conducted by home visitor	% of children at risk for physical health problems or developmental delays as calculated on gross and fine motor subscale scores; Birth or post-partum enrollment to one year after birth or enrollment	Increase over time in % of enrolled children not at risk	All enrolled children
* Note: The changes in rates or levels over time are for mothers unless otherwise specified.				

PROPOSED BENCHMARKS FOR HFNY CRIME OR DOMESTIC VIOLENCE (states must report on one)				
Construct	**Data Source**	**Definition**	**Quantifiable Improvement Measure***	**Relevant Population**
Crime	---	---	---	---
Screening for Domestic Violence	Screen administered by home visitor: Hurt, insult, threaten, scream	# screened for domestic violence / # of participating mothers	Increase in rate of screens administered	All enrolled mothers
Referrals for domestic violence services for families with identified need	Screen administered by home visitor: Hurt, insult, threaten, scream	# of referrals made to relevant domestic violence services / # of positive screens for domestic violence	Increase in rate of referrals over time	All enrolled mothers / families
Safety plan completed for families with identified need	Safety plan conducted by home visitor	# of safety plans developed / # of families served	Increase in rate over time for families	All enrolled families
* Note: The changes in rates or levels over time are for mothers unless otherwise specified.				

PROPOSED BENCHMARKS FOR HFNY FAMILY ECONOMIC SELF-SUFFICIENCY				
Construct	**Data Source**	**Definition**	**Quantifiable Improvement Measure**	**Relevant Population**
Household income & benefits	Participant report / conducted by home visitor	Total household income and public benefits received, including TANF, food stamps, WIC, emergency assistance & ssi/ssd (the amount of each source needs to be specified)	Increase in combined total over time	All enrolled families
Employment of adult members of the household	Participant report / conducted by home visitor	# actively employed / all enrolled (>=18 years) at enrollment and one year post enrollment ------------ # paid hours worked plus unpaid hours devoted to care of an infant by all adults (>=18 years) in participating households at enrollment and one year post enrollment	Increase in rate of employment over time ------------ increase in # hours over time	Mothers and other adults living in household who were 18 years of age or older at time of enrollment
Education of adult members of the household	Participant report / conducted by home visitor	# engaged in educational attainment, training, or certification program / # enrolled at enrollment and one year post enrollment ------------ # adults participating in educational activities and # of hours spent participating by each adult at enrollment and one year post enrollment	Increase in rate of educational attainment over time for each adult ----------- Increase in # of adults participating in and in hours spent by each adult	Mothers and other adults living in household
Health insurance status	Participant report / conducted by home visitor	# of household members who have health insurance, total and by individual, @ enrollment & one-year post enrollment	Increase in the number over time	Mothers and others living in household

PROPOSED BENCHMARKS FOR HFNY COORDINATION & REFERRALS FOR OTHER COMMUNITY RESOURCES & SUPPORTS				
Construct	**Data Source**	**Definition**	**Quantifiable Improvement Measure**	**Relevant Population**
# of families identified for necessary services	Kempe Participant report / conducted by Family Assessment Worker	# families screened / # participating families	Increase in proportion of families screened over time	All enrolled families
# of families that required services and needed a referral	Documentation provided by home visitor (referral form)	# of referrals provided / # of participating families identified as having a need	Increase in the proportion of families with a need who receive an appropriate referral (when available)	All enrolled families who were identified as needing a service
# of MOUs or other formal agreements with other social service agencies	Direct measurement of agency administrative data	# MOUs or formal agreements that the home visiting program has with outside organizations at time of implementation & each year thereafter (annually)	Increase in # of formal agreements with other social service agencies	All funded programs
# of agencies with which hv provider has a clear point of contact in collaborating agency	Direct measurement of agency administrative data	# of social service agencies with MOU or other regular point of contact (person charged with communicating with the home visiting program)	Increase in # of points of contact over time	All funded programs
# of completed referrals	Documentation provided by home visitor (referral form)	% of families with referrals for which receipt of services can be confirmed	Increase in % over time	All enrolled families

I. Improved Maternal and Newborn Health.

Prenatal care. As is currently the practice within the HFNY program, data regarding prenatal care will be based on participant reports and gathered by the Home Visitor using several standardized questions regarding timing and dates of receipt of prenatal care during the mother's pregnancy with the focal child. Baseline data will be gathered for pregnant women at the time of enrollment, which is defined as the first home visit. A repeat assessment will be conducted following the focal child's birth. Analyses of the quantifiable measure of improvement, an increase in the rate of women receiving a prenatal visit, will be restricted to the subpopulation of

women who enroll by their 32nd week of pregnancy to allow the program opportunity to facilitate prenatal care and to make HFNY's aggregate statistic comparable to the other home visiting program(s) proposed to receive federal funding.

Parental use of alcohol, tobacco or illicit drugs. While the HFNY program helps families move toward healthy outcomes by building on resources and strengths, it also conducts an assessment of risky behaviors prior to enrollment. However, the risk assessment is very general and does not distinguish between alcohol or substance use, nor is it used at subsequent time periods. To meet the federal benchmark requirements and to enhance service delivery, we propose to incorporate the Alcohol Use Disorder Identification Test – Consumption (AUDIT-C) and Drug Use Questionnaire for Adults (DAST-10) measurement tools to document engagement in and the severity of alcohol and drug use, respectively. The two measures were selected given their ease of use, brevity, appropriateness for diverse populations, established levels of reliability, and ability to determine risky behaviors. Home visitors will administer the tools to all women at the time of their enrollment. For women who enter the program during pregnancy, subsequent assessments will take place at a minimum when the focal child is born and again when the child turns six months and one year. For these women, similar to the outcomes for prenatal care, analyses will be restricted to the population of pregnant women who enter during their 32nd week of pregnancy or earlier and will involve either determinations of use or severity. For women who enroll in the program at or following the focal child's birth, subsequent assessments will occur at a minimum at six months and one year post-enrollment. Analyses of improvement for this later group will involve all women who enter at or after the focal child's birth. Tobacco use will be summarized in a similar manner and will be derived from two standardized questions to assess use and frequency. The measures proposed to determine alcohol and substance use and severity are described below.

> The AUDIT-C (Bush, Kivlahan, McDonell, Fihn, Bradley, 1998) is a three-item screen with five response options (0-4). Items are summed for a possible total scale score of 0-12 points. A score of three or more is indicative of any or risky alcohol use among women, unless all of the points were from the first item. The tool performs well in identifying true positives, with sensitivity results reaching 100% for alcohol dependence in the past year, and in identifying true negatives (specificity = .71% or higher) (Burns, Gray, Smith, 2010). The measure has also been tested in populations with similar racial/ethnic backgrounds of the women primarily participating in the sites targeted to receive the home visiting program (Frank et al., 2008).
>
> The DAST-10 (Skinner, 1982) is a ten-item measure with "yes/no" response options. One point is assigned and summed for each affirmative response, with total scores ranging from 0-10 points. A score of 0 indicates no reported problems, while scores of 3 or higher indicate moderate to severe problems and suggest symptoms consistent with drug abuse. The measure has high internal consistency (α=.86 to .94; Yudko, Lozhkina, Fouts, 2007) and correlates highly with other longer measures of substance use and days since last drug use (Cocco & Carey, 1998).

Preconception care. Currently, information about having a primary care provider is collected at intake and each home visit during which the "follow-up" form is administered. This information

will be expanded to include other indicators of preconception care such as approaches to family planning. The home visitor will use a series of standardized questions to assess these areas. Baseline data will be gathered for pregnant women during the first visit following the target child's birth. The baseline assessment for all other women will be conducted at the time of enrollment. Repeat assessments will be conducted at six months and twelve months and annually thereafter or through the time of the first subsequent pregnancy. Analyses of the quantifiable measure of improvement (see Table A) will be conducted for all enrollees.

Inter-birth intervals. Currently, the focal child's date of birth and the date of birth of subsequent children are housed within the HFNY MIS. To estimate the inter-birth interval in a manner consistent with other home visiting programs, the home visitor will also document the date of subsequent pregnancies, which will in turn facilitate a calculation of the spacing between subsequent pregnancies and births. Baseline data will be gathered for pregnant women during the first visit following the target child's birth and at the time of enrollment for all other women. Repeat assessments will be conducted at every home visit through the time of the first subsequent pregnancy. Analyses of the quantifiable measure of improvement (see Table A) will be conducted for all enrollees.

Screening for maternal depressive symptoms. As mentioned above, prior to enrollment, participants are assessed for risks, including poor mental health, lack of supports and coping skills. To adequately attend to the issue of depressive symptoms, the program will incorporate the Edinburgh Postnatal Depression Scale as a screening tool. The measure was selected for its ease of use, brevity, appropriateness for diverse populations, established levels of reliability, and use in other evidence-based home visiting programs. Similar to the approach for alcohol, tobacco and substance use, home visitors will administer the tool to all women at the time of their enrollment. For women who enter the program during pregnancy, the follow-up assessment will take place when the focal child is born and again, at least when the child turns six months and one year. For this latter group of women, analyses will be restricted to the population of pregnant women who enter during their 32nd week of pregnancy or earlier and will involve either determinations of use or severity. For women who enroll in the program at or following the focal child's birth, the follow-up assessment will occur at a minimum at six months and one year post-enrollment. Analyses of improvement for this later group will involve all women who enter at or after the focal child's birth.

> The Edinburgh Postnatal Depression Scale (Cox, Holden, Sagovsky, 1987) assesses self-reported symptoms experienced during the past seven days with a ten-item scale. Response options are rated on a 0-3 scale, and items are summed for a possible total scale score of 0-12 points. A score of 12 is indicative of risk for depression. The tool has reasonably high degrees of sensitivity and specificity (Cox, Holden, Sagovsky, 1987), good internal consistency, and has demonstrated its usefulness with urban African American and Latina American women (Morris-Rush, Freda, & Bernstein, 2003; Yonkers et al., 2001).

Breastfeeding. As is currently the practice for HFNY, data regarding breastfeeding will be based on participant reports and gathered by the Home Visitor using several standardized questions related to the initiation and duration of breastfeeding following the focal child's birth. Baseline data will be gathered for pregnant women only at the time of the focal child's birth. Follow-up

data will be collected at subsequent home visits (as appropriate) up through twelve months after the focal child's birth. Analyses of the quantifiable measure of improvement, an increase in the rate of women initiating breastfeeding, will be restricted to the subpopulation of women who enroll by their 32nd week of pregnancy.

Well-child visits. As is currently the practice for HFNY, data will be based on participant reports regarding the dates of child well-visits and gathered by the home visitor. Data will be used to estimate the timeliness of the visits, allowing for a two month grace period around the focal date. Baseline data will be gathered for pregnant women during the first visit following the target child's birth and at the time of enrollment for all other women. Repeat assessments will be conducted about medical information at each subsequent visit through the time of the focal child's first birthday. Analyses of the quantifiable measure of improvement will be conducted for all enrollees; rates of timely well-child visits are expected to increase over time.

Maternal and child health insurance status. Data regarding the mothers' and the focal child's health insurance status is currently based on participant reports and gathered by the home visitor using a series of standardized questions regarding presence and type of health insurance. Baseline data will be gathered for pregnant women during the first visit following the target child's birth and at the time of enrollment for all other women. Repeat assessments will be conducted at each follow-up assessment, which occur at 6 months, one year, and annually thereafter. Analyses of the quantifiable measure of improvement will be conducted separately for all enrolled mothers and all enrolled focal children, and rates are expected to increase over time.

II. Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits.

Visits for children to the emergency department from all causes. Currently, the home visitor collects data from the primary care giver, typically the mother, about the focal child's use of the emergency department. At 6, 12, 24, and 36 months, caregivers are asked to report on the number of visits to the emergency room the child has had since the last follow-up assessment (six months or one year ago), and to report up to five primary reasons for the visits. Baseline and subsequent assessments will be conducted during the follow-up assessments at six and twelve months post-enrollment, which collect information about the entire preceding periods. As is shown in the corresponding table, the rate of visits will be calculated by dividing the number of emergency department visits between birth and year one by the number of children enrolled in the program for this period. Analyses of the quantifiable measure of improvement will include all enrolled focal children, with rates of visits to the emergency department decreasing over time.

Visits of mothers to the emergency department from all causes. The home visitor currently collects data from the mother about her use of the emergency department. At 6, 12, 24, and 36 months, participants are asked to provide the dates and corresponding reasons for all emergency room visits since the last follow-up assessment. Baseline and subsequent assessments will be conducted during the follow-up assessments at six and twelve months post-enrollment, which collect information about the entire preceding periods. Analyses of the quantifiable measure of

improvement will examine the rate of emergency department use among all enrolled mothers; rates of visits are expected to decrease over time.

Information provided or training of participants on prevention of child injuries. Information and training are integral to the HFNY home visiting program. HFNY staff receives training, information, and updates on the prevention of child injuries related to Shaken Baby Syndrome, proper car seat installation, child proofing the home, Fetal Alcohol Syndrome, and co-sleeping. In turn, this information is transferred and shared with participants through discussion, modeling of behaviors, activities, pamphlets, and videos during home visit and group sessions, and documented by the home visitor in the Home Visit Log, which is subsequently entered into program's MIS system. Of particular relevance are activities the home visitor engages the mother in regarding her interactions with the child, such as addressing infant basic care needs, viewing a video together on Shaken Baby Syndrome, providing equipment to help child proof the home, reviewing car seat safety, and discussing the risks associated with co-sleeping. In addition, home visitors also record activities related to providing support and strategies to help parents minimize parenting stress, addresses issues of violence in the household or substance use and fostering communication skills. To quantify whether information or training of participants occurred related to the topic of prevention of child injuries, the number of enrolled mothers who completed activities with the home visitor about parent child interaction and family functioning between enrollment and one-year post enrollment will be divided by the total number of families enrolled. Decreases are expected overtime.

Incidence of child injuries requiring medical treatment. Currently, the HFNY home visitor collects information from the parent regarding the number and five primary reasons for visits to the emergency room and for hospitalizations at each follow-up assessment, which is administered at 6, 12, 24, and 36 months. Each reason has a specific numeric code, with accidents and injuries being assigned a value of 1 through 16. Focal children who have emergency room visits and hospitalizations with these reason codes (1-16) will be defined as having an incident of an injury requiring medical attention. This number will then be divided by the number of children enrolled from birth to one-year post-birth to calculate the rate of children with injuries requiring medical attention. Rates are expected to decrease over time. At this time, data documenting visits to a primary care or other provider for medical attention outside of the context of the emergency room or hospital settings are not collected and will therefore not be considered as part of the numerator.

Reported suspected maltreatment for children in the program. Consistent with the preference stipulated in the guidance supporting the home visiting legislation, the Supplement Information Request (SIR) stated that, "It is preferred that data [on child abuse, neglect, and maltreatment be collected through administrative data provided by the State and local child welfare agencies." Although the SIR allows for data collection through self-report or direct measurement if a valid and reliable tool is used, the only source of accurate information on suspected versus confirmed reports of child maltreatment is child welfare administrative data. Thus, New York State proposes to gather data on reports of child abuse and neglect made to the Statewide Central Register for Child Abuse and Maltreatment (SCR) for all focal children enrolled in the home visiting programs. In New York State, these reports and their outcomes, which are investigated by local departments of social services (i.e., indicated, unfounded, or differential response) are

housed in the OCFS CONNECTIONS data system. CONNECTIONS provides identifying and basic demographic information on each individual named in a report, their role in the report (victim, perpetrator, no role), the allegations they are involved in (e.g., inadequate guardianship, emotional neglect, malnutrition, etc.), and whether or not each allegation was substantiated. This information will facilitate OCFS's ability to break the data down by type of maltreatment (i.e., neglect, physical abuse, sexual abuse, emotional maltreatment, other), as specified in the SIR.

OCFS staff who have experience in doing CONNECTIONS person searches perform manual searches of CONNECTIONS, looking up the name/DOB of each child separately, and then using additional information such as gender, parents' names, address, etc. to confirm that the match is credible. For each study participant found to have a CONNECTIONS match, OCFS staff will conduct a computerized extraction from the CONNECTIONS system. Data will then coded by staff at OCFS for the type of abuse specified in the allegation, whether or not the allegation was substantiated, and whether or not the allegation was the first-report involving the focal child as a victim. OCFS has considerable experience with this approach, including completing a similar process for families from both the HFNY and NFP programs who were involved in experimental and longitudinal evaluations of the two programs.

The procedure outlined above will make it possible to determine the number and proportion of children in the program suspected as being a victim of maltreatment (i.e., those for whom there was at least one allegation that was reported but not necessarily substantiated. As shown in the corresponding benchmark table, the rate of children experiencing a report of maltreatment will be calculated by dividing the number of suspected cases of maltreatment occurring between birth and the focal child's first birthday by the total number of focal children enrolled in the program for the corresponding duration. As specified in the SIR, the data for these constructs will be broken down by type of maltreatment and by age cohort

Reported substantiated maltreatment for children in the program. As described above, indicators regarding maltreatment for children in the program will result from an extensive search of OCFS's CONNECTIONS database, which houses information from the SCR. Consistent with the definition stated in the SIR, substantiated maltreatment will include reports involving the focal child as a victim that are investigated and result in a substantiation, or assigned to New York State's Family Assessment Response track. The rate of children experiencing a substantiated report of maltreatment will be calculated by dividing the number of substantiated cases of maltreatment occurring between birth and the focal child's first birthday by the total number of focal children enrolled in the program for the corresponding duration. As the SIR specifies, data for these constructs should be broken down by type of substantiated maltreatment and by age cohort.

First-time victims of maltreatment for children in the program. As mentioned above, records extracted from OCFS's CONNECTIONS database will be coded to determine whether or not the allegation was the first report involving the focal child as a victim. The rate of first-time victims of maltreatment will be calculated by dividing the number of focal children who are involved as a victim in their first report between birth and their first birthday by the total number of focal children enrolled in the program for the corresponding duration.

III. Improvements in School Readiness and Achievement.

Parent support for children's learning & development. The HFNY home visiting program actively promotes healthy parent child interactions and activities that encourage the child's development, including support for learning. This focus is ongoing from the time of enrollment until exiting the program. However, the activities that support the program's work in this area, and the parent's role and interactions with the child shift as the child's developmental needs and capabilities change. To adequately capture these dynamics, and to provide the home visitors with a tool for channeling feedback about a parent's behaviors back into the home, we propose that the program integrate the Attachment-Interaction-Mastery-Support (AIMS) systems tool into the service delivery and data collection process (Partridge & Marsh, 1996).

The AIMS assessment and practice system is specifically designed to enhance the emotional development of the child from birth to age five along with his or her family (Partridge & Marsh, 1996). The assessment tool was developed and tested with families with limited economic resources. Consistent with HFNY's strength-based approach, the AIMS provides a means for the identification of young children at risk for or presenting with problems, while also assessing the nature of the child's and family's strengths and difficulties, and making recommendations for appropriate, supportive interventions. Following a training session via a trained instructor or course on a DVD, the home visitor will assist the mother/parent in completing the Parent Questionnaire for children aged 2 weeks (baseline) and again at 4 months, 12 months, 15 months, and 2 and 3 years of age. The questionnaire forms are age-appropriate and offer different modules for different developmental stages. Each age-specific Parent Questionnaire asks a parent to report on their family's experience in four areas: attachment between mother and child, mother and child interactions, mastery of developmental tasks and the parent's role in supporting the child's development, and receipt of formal and informal support. These areas have been confirmed by factor analysis, in which a four-factor solution was preferred to a single factor construct (Hornstein & Marsh, 2001), and generally consist of about 10 questions within each area. Items are worded to tap strengths and resources, except for two items within each subscale that help pinpoint developmental challenges. All items are individually scored on a 1-5 point response scale, with lower values indicating that behaviors occur with greater frequency. Thus, strengths are indicated when a parent reports that the strength-based items queried occur very often (1) or often (2), while problems are indicated when the two potential challenge items occur with greater frequency.

To measure improvement for the construct "support of child's learning and development", the home visitor will administer the appropriate AIMS Parent Questionnaire on the schedule described above and will record the number of strength-based items denoted as occurring very often (1) or often (2) within the age-appropriate "mastery" subscale ($\alpha > .65$), which assesses basic skills, specific developmental milestones, the child's ability to learn, and parent activities that encourage or support skill and knowledge development (Hornstein & Marsh, 2001; Partridge & Marsh, 1996). A mother is rated as demonstrating strengths when 60% or more of the strength-based items within the scale are scored as a 1 or 2. The percent of mothers demonstrating strengths is expected to increase over time. Home visitors will work on providing additional support when strengths are absent or rarely occur or when problems are indicated as occurring often.

Parent knowledge of child development & of their child's developmental progress. The construct of parent knowledge of child development and the child's developmental progress is currently and will continue to be assessed using the Ages and Stages Questionnaire (ASQ-3) (Squires, Bricker, Twombly, & Potter, 2009), which age appropriately screens children between the ages of 1 to 66 months for developmental delays in the areas of communication, gross motor, fine motor, problem solving, and personal-social functioning. A series of varying questionnaires and scoring sheets are completed by parents or caregivers with the assistance of the home visitor when children are at the following intervals: 4, 8, 12, 16, 20,24,30, 36, 48, and 60 months with optional intervals at six and eighteen months. Families answer questions on a three-item response scale, answering yes (10 points), sometimes (5 points) or no (0 points). Each questionnaire takes between 10 to 15 minutes to complete and only 1 to 3 minutes to score. As directed by the measure's developer, items are summed and compared to age-specific subscale cutoffs to determine if developmental delays are suspected. Once complete, a child development specialist typically reviews the completed ASQ and the home visitor provides families with feedback. Data for each subscale and cutoffs are currently recorded and maintained for each individual and for each administration in the HFNY MIS. The instrument has excellent validity, ranging from .82 to .88, with high test-retest reliability (.91) and strong inter-rater reliability (.92.).

The ASQ-3 also provides a series of overall questions that allow the home visitor to inquire about the parent's knowledge of the focal child's functioning on key developmental milestones and for the parent to report on his/her perception of the child's functioning on these milestones relative to other children of the same age. Within the program, the home visitor will help to educate and support the parent and/or make appropriate referrals when the parent expresses concern regarding the child's functioning relative to others or if the parent is unaware of an age-specific milestone. To quantify and measure improvement within this construct, the number of children who achieve age-appropriate milestones across all domains of functioning will be tallied and divided by the number of children enrolled in the program. The percent of children meeting this standard is expected to increase over time.

Parenting behaviors & parent-child relationships. The home visitor will also use the AIMS Parent Questionnaire (as described above) to measure improvement for the construct "parenting behaviors and parent-child relationships." For this construct, home visitors will record the number of strength-based items denoted as occurring very often (1) or often (2) within the age-appropriate "interactions" subscale (α>.70), which gathers a report of exchanges between parent and child across a variety of situations and day-to-day activities, including information about routines, quality of care giving, limit setting, and communication (Hornstein & Marsh, 2001; Partridge & Marsh, 1996). A mother is considered to demonstrate strengths when 60% or more of the strength-based items within the scale are scored as a 1 or 2. The percent of mothers demonstrating strengths is expected to increase over time. As noted above, home visitors will work on providing additional support when strengths are absent or rarely occur or when problems are indicated as occurring often.

Parent emotional well-being or parenting stress. In addition the newly introduced Edinburgh Postnatal Depression Scale, the program will continue to monitor parent stress and parent-child interactions with the Parenting Stress Index (PSI) – Short Form. Of particular interest is the

subscale representing parenting distress. The home visitor is responsible for getting the participant to complete the form. The first administration occurs within one month of the focal child's birth or within one-month of enrollment. Subsequent administrations occur when the focal child is 6 months, 1 year, 2 years, 3 years 4 years, 5 years old, and at time of discharge. Home visitors ensure that parents understand the instructions, have a relatively quiet place to fill out the test forms, and that the instrument is complete. Ticklers are built into the data system to assist with the timely administration of the measure. Home visitors receiving training on the measure, have supporting documentation available to them in the HFNY Policy Manual, and receive assistance from their supervisor or a member of the Quality or Technical Assistance teams.

> The Parenting Stress Index - Short Form (PSI-SF; Abidin, 1995) is a 36-item screen designed to assess stress in parent-child interactions within three specific domains: parental distress, difficult child, and parent-child dysfunctional interaction. Items are scored using a 5-point scale, ranging from strongly agree (1) to strongly disagree (5). The PSI is completed by parents or caregivers. Each administration takes between 15 to 20 minutes to compete. Psychometric properties of the instrument have been established by researchers other than the authors and suggest satisfactory internal consistency and test-retest reliability (Bigras, LaFreniere, & Dumas, 1996; Haskett, Ahern, Ward, & Allaire, 2006; Hutcheson & Black, 1996; Loyd & Abidin, 1985; McKelvey, Whiteside-Mansell, Faldowski, Shears, Ayoub, & Hart, 2009; Solis & Abidin, 1991; Whiteside-Mansell, Ayoub, McKelvey, Faldowski, Hart, & Shears, 2007). The three factor structure of PSI-SF has also been confirmed among a low-income, primarily African-American population (Reitman, Currier, Stickle, 2002).

A parent's stress is considered worthy of action if the parenting distress subscale is the highest among the three subscales or if the total 36-item scale's raw total is 90 or above. Improvement is noted if the percent of women experiencing high levels of distress or total distress decreases.

<u>Child's communication, language & emergent literacy</u>. Age-appropriate items from the ASQ-3 screen will be used to determine the score for the communication subscale, which detects developmental delays in the area of communication. To quantify and measure improvement for the construct of "child's communication, language and emergent literacy", the number of children who achieve age appropriate milestones within the communication subscale will be tallied and divided by the number of children enrolled in the program. As noted above, the ASQ-3 will be administered during the following intervals: 4, 8, 12, 16,20,24,30, 36, 48, and 60 months with optional intervals at six and eighteen months. The percent of children meeting this standard is expected to increase overtime.

<u>Child's general cognitive skills</u>. Age-appropriate items from the ASQ-3 screen will be used to determine the score for the problem-solving subscale, which detects developmental delays in cognitive functioning. To quantify and measure improvement for this construct, the number of children who achieve age appropriate milestones within the problem-solving subscale will be tallied and divided by the number of children enrolled in the program. The percent of children who meet this standard is expected to increase overtime.

Child's positive approaches to learning, including attention. To measure improvement for the construct of "positive approaches to learning", the number of children who achieve age appropriate milestones within the personal-social subscale of the ASQ-3 will be tallied and divided by the number of children enrolled in the program. The behaviors comprising this subscale, including responsibility, organization, independence, and cooperation, all represent behaviors that promote learning. In addition, to more appropriately assess indicators of attention, we will also extract data from mother's reports on the PSI (see above description) from the difficult child subscale (α=.85), which asks about child behaviors that contribute parenting stress such as distractibility, hyperactivity, and demandingness. Following the procedure outlined by the measure's developer, the appropriate items will be summed and compared to normed tables to determine appropriate percentile rankings. The percent of children not at risk will be estimated based on the rankings, and compared over time.

Child's social, behavior, emotion regulation & emotional well-being. In conjunction with the ASQ-3, the program will use the Ages and Stages Questionnaire: Social Emotional (ASQ-SE) to identify children at risk for social-emotional difficulties and administered at 6, 12, 18, 24, 36, and 48 months of age. It takes approximately 10 to 15 minutes to complete each series and just a few minutes to score. Validity is strong, ranging from 81 to 95%, with test-retest reliability at 94% (Squires, Bricker, & Twombly, 2002). Scoring will follow the procedure outlined by the measure developer, and will involve totaling points assigned to each response and then comparing the total to a pre-determined age-appropriate cutoff score. Scores falling below the cutoff indicate risk for social and emotional developmental delays. The percent of children falling above the cutoff are considered not at risk for a delay, and the rate off children not at risk is expected to increase over time.

Child's physical health & development. Age-appropriate items from the ASQ-3 screen will be used to determine the score for the gross and fine motor subscales, which detect developmental delays in these two areas of functioning. To quantify and measure improvement for the construct of "child's physical health and development", the number of children who achieve age appropriate milestones across both the gross motor subscale and the fine motor subscale will be tallied and divided by the number of children enrolled in the program. The percent of children meeting this standard is expected to increase overtime.

IV. Crime or Domestic Violence.

Crime. There are no plans to measure indicators of crime at this time.

Screening for Domestic Violence. HFNY currently documents the likelihood of domestic violence in the home in two ways. First, prior to enrollment, the Family Assessment Worker (FAW) conducts a semi-structured interview using the Kempe Family Stress Checklist. From this assessment and observations made during the interview, the FAW indicates risk associated with potential for violence and indicates whether or not domestic violence is a current issue. In addition, at and post enrollment, the home visitor indicates whether there is suspected intimate partner violence based on observation made on interactions with family members. Moving forward, we propose to introduce a more systematic approach to screening for domestic violence at and post-enrollment by integrating the Hurt, Insult, Threaten, Swear (HITS) measurement tool. The measure was selected given its ease of administration, brevity, and established levels of

reliability with diverse populations. Home visitors will administer the tool to all women at the time of their enrollment. For women who enter the program during pregnancy, subsequent assessments will take place when the focal child is born and again when the child turns six months and one year. For these women, analyses will be restricted to the population of pregnant women who enter during their 32nd week of pregnancy or earlier, as shown in the corresponding table. For women who enroll in the program at or following the focal child's birth, subsequent assessments will occur six months and one year post-enrollment. Analyses of improvement for this later group will involve all women who enter at or after the focal child's birth. The rate of women screens is expected to increase over time.

> The HITS (Sherin, Sinacore, Li, Zitter, Shakil, 1998) contains four relatively non-threatening items, each with five response options (1-5). Items are summed for a possible total scale score of 4-20 points. A score of 10 or more is considered a positive screen and indicates the presence of domestic violence. The tool performs well in identifying true positives, with sensitivity results reaching over 90% (Sherin et al., 1998), and has good internal consistency ($\alpha>.80$). The measure has also been tested in populations with similar racial/ethnic backgrounds as the women targeted to receive the home visiting services although measures of internal consistency were slightly lower, as were the cutoff scores, but sensitivity and specificity remained very high (Chen, Rovi, Vega, Jacobs, Johnson, 2005).

<u>Referrals for domestic violence services for families with identified need</u>. Currently, service referrals of any nature, which were discussed or arranged during a home visit, are recorded and logged into the program's data system. The service code, family member referred, nature and date of referral are all recorded, as well as receipt of these services. This process will enable home visitors to assess whether families with an identified need for domestic violence services (i.e., those who screened positive) were referred for domestic violence services. As is the current practice, information about referrals and the subsequent status of the referral is collected by the home visitor at every visit. Analyses of the quantifiable measure of improvement will be conducted for all enrolled families; rates of referrals are expected to increase over time.

<u>Safety plan for families with identified need</u>. To help satisfy federal benchmark requirements and to enhance the delivery of services, HFNY will systematically develop safety plans for families with identified needs and add this activity to its MIS. The need for and development of a safety plan will be documented at the time of enrollment and conducted at each subsequent visit thereafter. Analyses of the quantifiable measure of improvement will be conducted for all enrolled families. The rate of identified families with a service plan is to increase over time.

V. Family Economic Self-Sufficiency.

<u>Household income and benefits.</u> HFNY home visitors currently collect income information from families at intake, 6 months old, 1 year old, 2 year old, 3 year old, 4 year old, and 5 year old follow-ups until graduation from the program. Receipt of public benefits is also documented on the same schedule. Data collection regarding benefits will be expanded at each time period to also include the actual amount of each benefit received by families. Analyses of the quantifiable

measure of improvement will be conducted for all enrolled families, with total household income and benefits expected to increase over time.

Employment of adult members of the household. Currently, HFNY home visitors collect information on the employment and number of hours employed for mothers and one other adult member of the household at intake, 6 months old, 1 year old, 2 year old, 3 year old, 4 year old, and 5 year old follow-ups until graduation from the program. Data collection will need to be expanded to include employment and the number of unpaid hours devoted to care of an infant by all adults in the household. Analyses of the quantifiable measure of improvement will be conducted for all participants who were 18 years of age or older at enrollment, with an increase in the number of paid hours worked plus unpaid hours devoted to care of an infant by all adults in participating households over time and an increase in the rate of employment over time.

Education of adult members of the household. HFNY home visitors collect education information from mothers and one other adult member of the household at intake, 6 months old, 1 year old, 2 year old, 3 year old, 4 year old, and 5 year old follow-ups until graduation from the program. Data collection includes highest grade completed, and engagement in an educational, employment or training program. Data collection will need to be expanded to collect data on educational attainment, employment, and training for all adults in the household and the number of hours spent participating in these activities by each adult as HFNY does not currently collect this information. Analyses of the quantifiable measure of improvement will be conducted for all participants, with an increase in the rate of educational attainment expected over time for each adult and an increase in the number of adults participating in and hours spent by each adult in educational, employment and training programs.

Health insurance status. Currently, HFNY home visitors collect health insurance information on the mother at intake, the target child within one month of birth or intake, and both at 6 months old, 1 year old, 2 year old, 3 year old, 4 year old, and 5 year old follow-ups until graduation from the program. Data collection will need to be expanded to include health insurance coverage for all others living in the household, adults and children, as this information is not currently collected. Analyses of the quantifiable measure of improvement will include increases in the number of household members who have health insurance, total and by individual, over time.

VI. Coordination and Referrals for Other Community Resources and Supports.

Number of families identified for necessary services. HFNY Family Assessment Workers (FAW) currently use the Kempe Family Stress Checklist (Kempe, 1976) to screen and identify families who are eligible for services. The Kempe is a 10-item standardized, semi-structured inventory designed to assess families' strengths and needs. The FAW uses the instrument's semi-structured format to evaluate a variety of domains, including history of childhood abuse, substance abuse, mental illness or criminality, the presence of life stressors, and attitudes and expectations regarding children. Items are scored as being "no problem" (0), "mild problem" (5) or "severe problem" (10). Scores can range from 0 to 100. Families are deemed eligible for

HFNY home visiting services if either parent receives a score of 25 or higher. The instrument is also used to facilitate referrals to other community resources and supports as families' specific needs are identified. Analyses of the quantifiable measure of improvement will include increases in the proportion of families screened for needs over time, as a function of the total number of families screened divided by the total number of participating families.

Number of families that required services and received a referral. HFNY currently documents all needed service referrals generated from the completion of the screen, as well as those identified during home visits with families. Analyses of the quantifiable measure of improvement will include increases in the proportion of families with a need who received an appropriate referral, when services are available in the community to meet the need. The relevant population for this benchmark includes all enrolled families who were identified as needing a service.

Number of MOUs or other formal agreements with other social service agencies. Each home visiting program generates MOUs or formal agreements with various outside organizations in their communities. HFNY does not currently document these agreements outside of the agency setting. The Program Contract Manager will therefore need to systematically collect a count of the number of working agreements and MOUs from each site in order to report improvement on this benchmark from the time of implementation and annually thereafter. It is expected that all funded programs will show an increase in the number of formal agreements with other social service agencies.

Number of agencies with which the home visiting provider has a clear point of contact in collaborating agency. While each home visiting program develops MOUs and identifies regular points of contact with other social service agencies as part of their normal activities, information about these collaborations currently is not collected in a systematic way by the HFNY administration. The Program Contract Manager will need to obtain this information from each site. It is expected that all funded programs will show an increase in the number of points of contact with other social service agencies over time.

Number of completed referrals. HFNY currently documents the outcome of referrals arranged for or informed/discussed with participants. This information is updated during every home visit. Analyses of the quantifiable measure of improvement will include increases in the percentage of families with referrals for which receipt of services can be confirmed. The relevant population for this benchmark includes all enrolled families.

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Crosswalk of NFP Data Collected with MIECHV Data Requirements

Benchmark Area (from SIR)	Constructs (from SIR)	Data Currently Collected by NFP	Quantifiable Improvement Measure	Data Source	Data Format
	Prenatal Care	Maternal entry point & routine prenatal care.	Changes over time for mothers	Interview	% receiving prenatal visit by trimester.
	Parental use of alcohol, tobacco or illicit drugs.	Use & reduction of use from intake to 36 weeks pregnancy & at one year post-partum.	Changes over time for mothers	Interview	% change intake to 36 weeks of pregnancy.
	Preconception care	Care received after the birth of the first child through conception of the second child, while the woman is in the program.	Changes over time for mothers	Interview	% of clients who receive preconception care between birth of first child & conception of second child.
Improved Maternal & Newborn Health	Inter-birth intervals	Maternal subsequent pregnancies while in the program.	Changes over time for mothers	Interview	% subsequent pregnancies.
	Screening for maternal depressive symptoms.	Edinburgh Postnatal Depression Scale (Optional for agencies) - pregnancy through one year postpartum. Screening tool with client self-report.	Changes over time for mothers	Edinburgh Scale	Rate change over time.
	Breastfeeding	Length of time infant received breast milk.	Changes over time for mothers & infants	Interview	% of clients breastfeeding (initiation - 24 months postpartum).
	Well-child visits	While child is in the program.	Changes over time for infants	Interview	% of well-child visits over time.
	Maternal & child health insurance status	Maternal & child health insurance status: Medicaid, SCHIP, private insurance.	Changes over time for mothers & infants	Interview	% & number with insurance.

Benchmark Area (from SIR)	Constructs (from SIR)	Data Currently Collected by NFP	Quantifiable Improvement Measure	Data Source	Data Format
	Visits for children to the emergency department from all causes.	Child visits to emergency care, urgent care, or hospital for injury or ingestion.*	Decreases over time	Participant report	Emergency Department visits divided by number of children enrolled in the program.
	Visits of mothers to the emergency department from all causes.	Data not currently collected.*	Decreases over time	Participant report	Emergency Department visits divided by the number of mothers enrolled in the program.
Child Injuries, Child Abuse, Neglect, or Maltreatment & Reduction of Emergency Department Visits	Information provided or training of participants on prevention of child injuries topics such as safe sleeping, shaken baby syndrome, or traumatic brain injury, etc.	Recorded in individual client records, currently not collected in the data collection system.*	Increases over time	Participant report	Rate: Number of participants receiving information or training on injury prevention divided by total number of families participating in program.
	Incidence of child injuries requiring medical treatment.	Recorded in individual client records, currently not collected in the data collection system.*	Decreases over time	Participant report with comparison s to local & state child welfare data	Rate: Number of child injuries requiring treatment divided by the total number of children participating in program. Data from child welfare system will be verified by the states.
	Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated).	Referral to Child Protective Services (CPS): Nurse Home Visitor awareness of referral to CPS including referral only, not whether the case was substantiated.	Decreases over time	Participant report with comparison s to local & child welfare data	Rate: Number of suspected cases of maltreatment of children in the program divided by the number of children in the program.

Benchmark Area (from SIR)	Constructs (from SIR)	Data Currently Collected by NFP	Quantifiable Improvement Measure	Data Source	Data Format
	Reported substantiated maltreatment (substantiated/ indicated /alternative response victim) for children in the program.	Referral to Child Protective Services (CPS): Nurse Home Visitor awareness of referral to CPS including referral only, not whether the case was substantiated.	Decreases over time	Interview with comparisons to local & child welfare data	Rate: Number of reported cases of maltreatment of children in the program divided by the number of children in the program. Verification of maltreatment by welfare system will be completed by the states.
Child Injuries, Child Abuse, Neglect, or Maltreatment, & Reduction of Emergency Department Visits **(Cont'd)**	First-time victims of maltreatment for children in the program.	Referral to Child Protective Services (CPS): Nurse Home Visitor awareness of referral to CPS including referral only, not whether the case was substantiated.	Decreases over time	Interview with comparisons to local & child welfare data.	Rate: Number of children in the program who are first-time victims divided by the number of children in the program. Data will be reported overall for program & broken down for each construct by: 1. Age category (0-12 mo., 13-24 mo. & 2. For child abuse, neglect or maltreatment only: Maltreatment type (i.e. neglect, physical abuse, sexual abuse, emotional maltreatment, other).

Benchmark Area (from SIR)	Constructs (from SIR)	Data Currently Collected by NFP	Quantifiable Improvement Measure	Data Source	Data Format
Child Injuries, Child Abuse, Neglect, or Maltreatment, & Reduction of Emergency Department Visits **(Cont'd)**	First-time victims of maltreatment for children in the program. **(Cont'd)**				First-time victim is defined as: Had a maltreatment disposition of "victim" & never had a prior disposition of victim. Verification of maltreatment by welfare system will be completed by the states.
Improvements in School Readiness & Achievement	Parent support for children's learning & development (e.g., appropriate toys available; read & talk with child).	Parent knowledge through observation and documentation in the client record * and the parent response to the Ages and Stages Questionnaire (ASQ) at various times in infancy & toddlerhood. Screening tool utilizing parent-report.	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	Observation, parent-report, sample of child's work & ASQ score collected through parent report &/or nurse observation	Scale scores. Scores will be calculated for individual scales in the measures. The ASQ scale score is calculated as directed by the measure developer.
	Parent knowledge of child development & of their child's developmental progress.	Parent knowledge through observation and documentation in the client record * and the parent response to the Ages and Stages Questionnaire (ASQ) at various times in infancy & toddlerhood.	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	Observation, parent-report, sample of child's work & ASQ score collected through parent report &/or nurse observation	Scale scores. Scores will be calculated for individual scales in the measures. The ASQ scale score is calculated as directed by the measure developer. Rates of children at risk.

Benchmark Area (from SIR)	Constructs (from SIR)	Data Currently Collected by NFP	Quantifiable Improvement Measure	Data Source	Data Format
	Parenting behaviors & parent-child relationships (e.g. discipline strategies, play interactions).	Teaches & observes parenting behaviors. Parenting behaviors & parent-child relationship (e.g. discipline strategies & play interactions. Observations are documented in the individual client chart, not recorded in the data system.*	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	Interview & observation	Rates of children at risk.
	Parent emotional well-being or parenting stress.	Data collected at Maternal Intake on Personal Beliefs.	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	Interview & observation	Rates of children at risk.
Improvements in School Readiness & Achievement **(Cont'd)**	Child's communication, language & emergent literacy.	Early childhood development in the domains of communication, gross motor, fine motor, problem solving & personal social & early detection & referral for delays utilizing the Ages & Stages Questionnaire (ASQ) at various times in infancy & toddlerhood.	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	Observation, direct assessment, parent – report. ASQ score collected through parent report and/or nurse observation	Scale scores. Scores will be calculated for individual scales in the measures. The ASQ scale score is calculated as directed by the measure developer. Rates of children at risk.
	Child's general cognitive skills.	Early childhood development in the domains of communication, gross motor, fine motor, problem solving & personal social & early detection & referral for delays utilizing the Ages & Stages Questionnaire (ASQ) at various times in infancy & toddlerhood.	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	Observation, direct assessment, parent-report. ASQ score collected through parent report and/or nurse observation	Scale scores. Scores will be calculated for individual scales in the measures. The ASQ scale score is calculated as directed by the measure developer. Rates of children at risk.

Benchmark Area (from SIR)	Constructs (from SIR)	Data Currently Collected by NFP	Quantifiable Improvement Measure	Data Source	Data Format
	Child's positive approaches to learning including attention.	Early childhood development in the domains of communication, gross motor, fine motor, problem solving & personal social & early detection & referral for delays utilizing the Ages & Stages Questionnaire (ASQ) at various times in infancy & toddlerhood.	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	Observation, direct assessment, parent-report. ASQ score collected through parent report and/or nurse observation	Scale scores. Scores will be calculated for individual scales in the measures. The ASQ scale score is calculated as directed by the measure developer. Rates of children at risk.
Improvements in School Readiness & Achievement **(Cont'd)**	Child's social behavior, emotion regulation & emotional well-being.	Early childhood social-emotional development & early detection & referral for delays utilizing the Ages & Stages—Social-Emotional Questionnaire (ASQ-SE) Screening tool utilizing parent-report during home visit at various times in infancy & childhood.	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	Observation, direct assessment, parent-report. ASQ-SE score collected through parent report and/or nurse observation	Scale scores Scores will be calculated for individual scales in the measures. The ASQ-SE scale score is calculated as directed by the measure developer. Rates of children at risk
	Child's physical health & development.	Weight, height, BMI collected on all children, currently not reported. Head circumference collected on infants, currently not reported.*	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	Direct assessment	Rates of children at risk.
Crime or Domestic Violence * *states must report on at least one domain (crime or domestic violence)*	Crime Arrests Convictions	NFP is working to integrate the collection of this data with other data that is currently collected in this benchmark area.*	For family-level crime rates, improvement will be defined as rate decreases over time.	Interviews validated using local administrative data	Annual aggregate rates for parents participating in the program, broken down by reason for the arrest and/or conviction.

Benchmark Area (from SIR)	Constructs (from SIR)	Data Currently Collected by NFP	Quantifiable Improvement Measure	Data Source	Data Format
	Crime • Arrests • Convictions **(Cont'd)**				Verification of arrests & conviction using administrative data will be completed by the states.
	Domestic Violence Screening for domestic violence	Maternal self report of experience of intimate partner violence during pregnancy & after delivery.	For screenings: Increases in the rate compared to the population served completed over time.	Interview	% of screening for domestic violence of program participants.
Crime or Domestic Violence **(Cont'd)**	Domestic Violence: Referrals for domestic violence services for families with identified need.	Families identified for the presence of domestic violence, # of referrals made to relevant domestic violence services (e.g. shelters, food pantries). Data collected on Use of Government & Community Services which includes referrals to domestic violence services, etc.	Increases over time	Interview	Rate of referrals made divided by total number of participants in need of services.
	Domestic Violence Safety plan completed for families with identified need.	Families identified for the presence of domestic violence, # of families for which a safety plan was completed Recorded in the client chart.*	Increases in the number of safety plans developed compared to population served over time.	Interview	Rate of families for which a safety plan was completed divided by total number of participants in need of services. Rate of appropriate services identified in safety plans made divided by total number of identified participants in need of services.

Benchmark Area (from SIR)	Constructs (from SIR)	Data Currently Collected by NFP	Quantifiable Improvement Measure	Data Source	Data Format
	Household income & benefits.	Data collected at intake & four other time points through client graduation.	Increase in total household income & benefits over time.	Interview	Each source of income or benefits & the amount gathered from each source. Public benefits & child support data will be verified by the states.
	Employment of adult members of the household.	Number of months of maternal employment for program participants who were 18 years of age or older at enrollment in the program.*	Increase in the number of paid hours worked plus unpaid hours devoted to care of an infant by all adults in participating households over time.	Interview	Number of adult household members employed during the month.* Average hours per month worked by each household member.* Family level data can be verified by the state using unemployment insurance data.
Family Economic Self-Sufficien cy	Education of adult members of the household.	Maternal enrollment in education programs & attainment of educational degree or certificate.*	Increase in the educational attainment of adults in participating households over time. This will be defined by the completion not only of academic degrees, but also of training & certification programs.	Interview	Rates of educational benchmarks achieved: (e.g. program completion, degree attainment) by each household member.* Number of adult household members participating in educational activities since the previous survey.* Hours per month spent by each adult household member in educational programs.*
	Health insurance status.	Health Insurance Status: Data collected at intake & four other time points through client graduation.*	Increase in the number of household members who have health insurance over time.	Interview	Rate of health insurance status of all household members.*

Benchmark Area (from SIR)	Constructs (from SIR)	Data Currently Collected by NFP	Quantifiable Improvement Measure	Data Source	Data Format
	Number of families identified for necessary services.	Maternal referrals to additional services collected. Maternal use of Government & community services is collected as well, but completion of referrals is not currently collected.*	Increase in the proportion of families screened for needs.	Direct measurement	Number of families with identified need for referral divided by the total number of participating families.*
Coordination & Referrals for Other Community Resources & Supports	Number of families that required services & received a referral to available community resources.	Maternal referrals to additional services collected. Maternal use of Government & community services is collected as well, but completion of referrals is not currently collected.*	Increase in the proportion of families identified with a need who receive an appropriate referral, when there are services in the community.	Direct measurement	Number of referrals provided divided by the total number of participating families. Proportion of referrals of participating families with identified needs whose receipt of service was verified divided by the total number of participating families with identified needs.*
	MOUs or other formal agreements with other social service agencies in the community.	Presence of a Community Advisory Council (CAB) whose objectives include development & maintenance of referral sources & linkages for program participants based on staff assessment of participant needs & preferences. Plans for development of a CAB collected by the NSO prior to implementation of an agency & annually.	Increase in the number of formal agreements with other social service agencies that engage in regular communication with the home visiting provider.	Direct measurement and agency administrative data	Total number of social service agencies with MOU or other regular communication.

Benchmark Area (from SIR)	Constructs (from SIR)	Data Currently Collected by NFP	Quantifiable Improvement Measure	Data Source	Data Format
Coordination & Referrals for Other Community Resources & Supports **(Cont'd)**	Information sharing	Community referral sources & documentation of team meetings that include community agencies.*	Increase in the number of formal agreements with other social service agencies that engage in regular communication with the home visiting provider.	Direct measurement and agency administrative data	Total number of social service agencies with MOU or other regular communication.
	Number of completed referrals	Maternal referrals to additional services collected. Maternal use of Government & community services is collected as well, but completion of referrals is not currently collected.*	Increase in the % of families with referrals for which receipt of services can be confirmed.	Direct measurement & agency administrative data	Proportion of referral of participating families with identified needs whose receipt of service is verified divided by the total number of participating families with indentified needs.*

*** NFP is adding these constructs to its reporting portfolio.**

ATTACHMENT J

LETTERS OF CONCURRENCE

Council on Children and Families

52 Washington Street * West Building, Suite 99 * Rensselaer, NY 12144 * Phone: (518) 473-3652 * Website: http://www.ccf.state.ny.us

May 26th, 2011

Audrey M. Yowell, PhD. MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
16B-26
Rockville MD 20857

Dear Ms. Yowell:

As the Director of the NYS Council on Children and Families, which serves to coordinate the state health education and human services agencies on cross system issues, I am writing to express my concurrence with the New York State Maternal, Infant & Early Childhood Home Visiting State Plan submitted by the New York State Department of Health.

As the agency that administers the NYS Early Childhood Advisory Council and the NYS Head Start Collaboration Project, building a system that identifies vulnerable families and links them to high quality, comprehensive home visiting programs is a significant priority. We are committed to continuing our collaborative work with the Department of Health and others and are in agreement with implementation of the evidence-based home visiting programs as described in the State Plan. We look forward to working with the Department of Health to ensure that home visiting is part of a continuum of early childhood services in New York State.

Thank you for the opportunity to express my support of New York State's Updated State Plan for a State Home Visiting Program.

Sincerely,

Deborah Benson
Executive Director

State of New York
Andrew M. Cuomo
Governor

Office of Mental Health
44 Holland Avenue
Albany, New York 12229
www.omh.ny.gov

May 31, 2011

Audrey M. Yowell, Ph.D., MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
16B-26
Rockville MD 20857

Dear Dr. Yowell:

As Commissioner of the Office of Mental Health, I am writing to express my concurrence with the New York State Maternal, Infant & Early Childhood Home Visiting State Plan submitted by the New York State Department of Health. We are committed to collaboration and are in agreement with implementation of the evidence-based home visiting programs as described in the State Plan, and look forward to working with the Department of Health to ensure that home visiting is part of a continuum of early childhood services in New York State.

New research shows the critical impact of a child's "environment of relationships" on developing brain architecture during the first months and years of life. We have long known that interactions with parents, caregivers, and other adults are important in a child's life, but new evidence shows that these relationships actually shape brain circuit and lay the foundation for later developmental outcomes, from academic performance to mental health and interpersonal skills. Parent's well-being, including physical and mental health, substantially affects the quality of parenting. A critical parental health problem is maternal depression which is known to adversely affect a child's cognitive, social/emotional and behavioral development early in life with long-term implications for a child's learning abilities and physical and mental well-being. Evidence-based home visiting programs offer the opportunity to screen for maternal depression and provide support and referral when indicated and change this outcome.

Thank you for the opportunity to express my support of New York State's Updated State Plan for a State Home Visiting Program.

Sincerely,

Michael F. Hogan, Ph.D.
Commissioner

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

**New York State
Office of
Children &
Family
Services**

www.ocfs.state.ny.us

Andrew M. Cuomo
Governor

Gladys Carrión, Esq.
Commissioner

Capital View Office Park
52 Washington Street
Rensselaer, NY
12144-2834

May 27, 2011

Audrey M. Yowell, PhD., MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane, 16B-26
Rockville, MD 20857

Dear Ms. Yowell:

As Commissioner of the New York State Office of Children and Family Services (OCFS), I am writing to express my concurrence with the New York State Maternal, Infant & Early Childhood Home Visiting State Plan submitted by the New York State Department of Health. OCFS is the State's Child Welfare agency and administers:

- Title II of the Child Abuse Prevention and Treatment Act (CAPTA)
- Title IV-E
- Title IV-B
- Child Care and Development Fund (CCDF)
- Healthy Families New York (HFNY) Home Visiting program

We are committed to collaboration with the Department of Health and are in agreement with implementation of the evidence-based home visiting programs as described in the State Plan. We look forward to working with the Department of Health to ensure that home visiting is part of a continuum of early childhood services in New York State.

OCFS and its partners on the HFNY Central Administration team— currently the Center for Human Services Research and Prevent Child Abuse New York— will continue to manage, support and evaluate these valuable early intervention services and will continue to coordinate with our federal, state and local partners and providers.

Thank you for the opportunity to express my support for New York State's Updated State Plan for a State Home Visiting Program.

Sincerely,

Gladys Carrión, Esq.
Commissioner

OASAS Improving Lives.
NEW YORK STATE
OFFICE OF ALCOHOLISM & SUBSTANCE ABUSE SERVICES
Addiction Services for Prevention, Treatment, Recovery

Governor
Andrew M. Cuomo

Commissioner
Arlene González-Sánchez, M.S., L.M.S.W.

June 2, 2011

Audrey M. Yowell, PhD. MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
16B-26
Rockville MD 20857

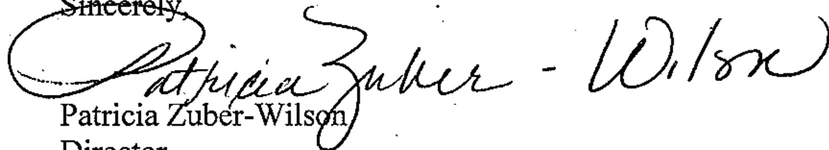
Dear Ms.Yowell:

In partnership with local, State and Federal entities, the New York State Office of Alcoholism and Substance Abuse Services (OASAS) plans and monitors addiction services throughout New York. OASAS is the primary authority for prevention, treatment and recovery in the state. OASAS oversees one of the nation's largest systems with more than 1, 550 programs in communities across the State.

I am writing to express my support for the New York State Maternal, Infant & Early Childhood Home Visiting State Plan submitted by the New York State Department of Health. We are committed to this collaboration and are in agreement with implementation of the evidence-based home visiting programs as described in the State Plan. We look forward to working with the Department of Health to ensure that home visits are part of a continuum of early childhood services in New York State.

Thank you for the opportunity to express my support of the State Plan for New York State Affordable Care Act Maternal, Infant & Early Childhood Home Visiting Grant.

Sincerely,



Patricia Zuber-Wilson
Director
Office of Federal Policy and Grants Management

State of New York
Office for the Prevention of Domestic Violence

Andrew M. Cuomo
Governor

Amy Barasch, Esq.
Executive Director

May 25, 2011

Audrey M. Yowell, PhD. MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
16B-26
Rockville MD 20857

Dear Ms. Yowell:

As Executive Director of the New York State Office for the Prevention of Domestic Violence ("OPDV"), which as the only state agency dedicated to the issue of domestic violence, has as its mission the improvement of New York State's response to and prevention of domestic violence. OPDV meets its mission by serving as an in-house "think tank" on the issue of domestic violence, providing policy and training assistance to all branches of state government. OPDV has a contract with the NYS Department of Health to train maternal and child health staff, and are looking to begin work in the area of adolescent health and pregnancy prevention. OPDV also has a contract with the NYS Office of Children and Family Services ("OCFS") to train child welfare and child protective workers. In addition, OPDV recently developed a curriculum specifically for OCFS' Healthy Families workers that address challenges faced by workers when families they are serving are suffering from domestic violence. I am writing to express my concurrence with the New York State Maternal, Infant & Early Childhood Home Visiting State Plan submitted by the New York State Department of Health.

We are committed to collaboration and are in agreement with implementation of the evidence-based home visiting programs as described in the State Plan, and look forward to working with the Department of Health to ensure that home visiting is part of a continuum of early childhood services in New York State. We feel strongly that domestic violence is a public health problem that can seriously negatively impact the wellbeing of mothers and children, and as such should be integrally incorporated into any program that has maternal and child health as its goal.

Thank you for the opportunity to express my support of New York State's Updated State Plan for a State Home Visiting Program.

Sincerely,

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