Title V Maternal and Child Health Services Block Grant

Five Year New York State Action Plan
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Today’s Presentation

• Overview of MCHSBG 2016-2020
  – Needs Assessment
  – Domain Area highlights
• Article 6
• Public Health Detailing
• Questions and Discussion
What is the Maternal and Child Health Services Block Grant (MCHSBG)?

• Federal funding supports NY’s effort to extend and improve health services for mothers and children
• Administered by federal Maternal and Child Health Bureau within HRSA
• Title V grants have operated as Federal-State partnerships to 59 states and jurisdictions for more than 75 years
  • Established in 1935 under Title V of the Social Security Act
  • Consolidated several categorical grants in block grants in 1981
Title V funding & requirements

- More than $6 billion available annually for maternal and child health programs (MCH) programs in states & territories
- New York State receives $37 million per year in core federal funding for MCH services
- States and jurisdictions must match every $4 of Federal Title V money with at least $3 of State and/or local money
- 30% of Title V funds must be spent on preventive and primary care services for children
- 30% must be spent on services for children with special health care needs
MCH Essential Services

1. Provide access to care
2. Investigate health problems
3. Inform and educate the public
4. Engage community partners
5. Promote/ implement evidence-based practices
6. Assess and monitor MCH health status
7. Maintain the public health workforce
8. Develop public health policies and plans
9. Enforce public health laws
10. Ensure quality improvement
MCHSBG application nuts & bolts

- States and territories must apply annually
- Full application submitted every 5 years, with complete needs assessment
- Interim application submitted for each of 4 ensuing years, with updated needs assessment
- Application includes annual report for the previous year and the plan for the next year
MCHSBG
2016-2020
MCHSBG (Title V): What’s New for 2016

• New 5-year funding cycle began 10/1/15
• New guidance to “transform” Title V
  – Paradigm shift to a life course perspective
  – Primary emphasis on prevention and population health
  – Elevate the importance of MCH as a primary driver for improved health for all Americans
  – Strong focus on data, evidence based strategies and performance measures

NY’s complete application:
Population Health Domains

Cross Cutting and Life Course

- Maternal & Women’s Health
- Perinatal Health
- Child Health
- Adolescent Health
- Children & Youth with Special Health Care Needs
Application Framework

Needs Assessment

Priorities

Objectives

Strategies

Outcome Measures
- National (39)
- State (TBD)

Performance Measures
- National (8/15)
- State (3-5, TBD)

Evidence-Based Strategy Measures (TBD)

NA Summary

5-Year Action Plan
Needs Assessment (NA)

- Developed with input from internal staff, MCHSBG Advisory Council and other MCH Partners
- Summary profiles for each of six population domains: health status, trends, disparities, capacity, successes and challenges
  - Quantitative data analysis: 20+ population health and public health data sources
  - Qualitative stakeholder input: received from over 150 health and human service providers and over 300 families and youth
Highlights of NA: Maternal & Women’s Health

- 87% women 18-44 have health insurance
- 69% got preventive visit last year
- 39% talked with a doctor about planning a healthy pregnancy
- 73% of women began prenatal care in the first trimester of pregnancy.
- 2.7% experience domestic violence prior to pregnancy
- 50% of pregnancies (26% live births) unintended
- 30% low-risk first births delivered via C-section
- 10-20% of women experience postpartum depression
- 18.8 maternal deaths per 100,000 live births – 4x higher among black vs. white women

“‘It takes me too long to see my doctor – I have to work’”
Highlights of NA: Perinatal & Infant Health

• 10.8% births preterm - increased but now declining
• Low birth weight stable at 8% births
• Infant mortality declining but with striking disparities
• 70% of infant deaths occurred in first month of life
• 75%/64% (NYC/Rest of state) infants are placed on backs to sleep
• Dramatic increase in neonatal abstinence syndrome/ drug-related discharges for newborns since 2008
• Declining use of tobacco during pregnancy
• High coverage for newborn screening (93-97%)
• 84% babies any breastfeeding; 17% exclusive at 6 mos
• 80-90% babies get recommended well visits

“Mothers need support to be healthy and to keep their babies healthy”
Highlights of NA: Child Health

• One in five NYS children live in poverty
• Child mortality declining, highest among children age 1-4, black and male children
• Injuries, cancer, birth defects and heart disease leading causes of death among children
• 97% of children have health insurance yet only 78% had coverage adequate to all services needed
• 92% had preventive medical visit in past year
• 63% of 3 year olds had full recommended immunization series
• 21% of young children got developmental screening
• One in five school age children is obese
• 25% 6-11 year olds are physically active 20 minutes per day

“It’s not that families don’t want to be healthy – they have more important things to deal with”
Highlights of NA: Adolescent Health

• Suicide 2nd cause of death and increasing among youth 15-19
• 24% youth report feeling sad/hopeless for 2+ weeks; 13% seriously considered suicide
• 15% are obese, 15% overweight, 20% active 20+ minutes/day
• 40% teens 3+ hours/day on non-school related computer/video games and 27% report 3+ hours/day watching TV
• 64% of teens on MA had a preventive health visit
• 66% of teens with mental health problems receive treatment;
• Declining use of tobacco, alcohol, cocaine; steady use of marijuana; increased use of heroin
• Teen pregnancy and birth rates dramatically declining
• 38% have had sex, condom use decreasing while use of other effective methods increasing
• 22% girls & 17% boys experience bullying
• 12% experienced physical or sexual dating violence

“Get us involved. The minute I feel like my word matters, I will stay involved...I will think and I will make better choices”
Highlights: Children with Special Health Care Needs (CSHCN)

- 20.8% children have special health care needs – up since 2003
- 18% of children have had two or more adverse childhood experiences
- 28% of CSHCN health conditions affect their daily activities
- 17% of CSHCN missed 11+ days of school due to illness
- 97% CSHCN have health insurance, but only 57% consistent and adequate to cover all services needed
- 38% received care meeting medical home criteria
- 17% of CSHCN families indicate that child’s needs created financial problems; 14% spent 11+ hours/week providing or coordinating care
- 25% CSHCN who needed referrals had difficulty getting
- Half of CSHCN needing care coordination did not receive or were not satisfied with communication between providers
- 39% received services necessary to transition to adult health care, work and independence

“I am told I am an important member of my child’s health care team, but I don’t feel like I really am”
Highlights of NA: Cross-Cutting & Life Course

• 19% of children 0-17 have one or more oral health problems
• 45% of third graders experienced tooth decay (24% untreated decay)
• 60% children on Medicaid had preventive dental visit
• 29% of NYS residents live in areas without fluoridated water systems
• 20% of parents believe that their child’s neighborhood is unsafe
• 58% of young people live in neighborhood that has a park, recreation center, library and sidewalks; 85% have 3+ of these resources
• 17% young people live in neighborhoods with 2+ distracting elements (vandalism, rundown housing, litter)
• 19% young people live in a household where someone smokes
• Common household environmental hazards identified through neighborhood programs include missing smoke detectors, lead paint hazards, rodent & insect pests, mold & structural disrepairs
• Striking racial, ethnic, economic disparities across all domains

“My kids would be healthier if they could go out to play instead of watching TV”
NYS MCH Priorities FY16-20

1. Reduce maternal mortality & morbidity
2. Reduce infant mortality & morbidity
3. Support and enhance social-emotional development and relationships for children and adolescents
4. Increase supports to address the special health care needs of children and youth
5. Promote oral health and reduce tooth decay across the life course
6. Increase the use of preventive health care services across the life course:
   – Preconception/Interconception (“well woman”, including family planning)
   – Prenatal & Postpartum
   – Infants (“well baby”)
   – Children (“well child”)
   – Adolescents (“well teen”, including family planning)
7. Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course
8. Reduce racial, ethnic, economic and geographic disparities and promote health equity for the MCH population
Preliminary 5-Year NYS Action Plan

• Themes:
  • MCH Essential Services
  • Strategies that move us closer to integration (across the life course, across systems)
  • Need for Title V leadership
  • Continuum of mature and developmental strategies

• For each domain:
  • Priorities (selected & reported 2016 NYS application)
  • SMART objectives
  • National Performance Measures (selected & reported in 2016 NYS application)
  • Strategies (preliminary, will be refined)
NYS National Performance Measures

- % women with a past year preventive visit
- % very low birthweight babies born in a hospital with Level III+ NICU
- % infants placed to sleep on their backs
- % children age 10-71 months receiving a developmental screening using a parent-completed tool
- % children and teens who are physically active at least 60 minutes/day

- % adolescents with a preventive medical visit in past year
- % adolescents with and without special health care needs who receive services to transition to adult care
- % women with a dental visit during pregnancy
- % children and teens with a preventive dental visit
<table>
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<tr>
<th>Domains</th>
<th>State Priority Needs</th>
<th>Objective</th>
<th>Strategies</th>
<th>National Performance Measures</th>
<th>National Outcome Measures</th>
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| Maternal and Women’s Health     | Reduce maternal mortality and morbidity                   | By September 30, 2020                   | - Finalize and institutionalize maternal death case ascertainment and review process, issue regular reports of maternal death review findings and trends and expand surveillance and reporting activities to include severe maternal morbidity.  
- Apply information learned from maternal death and morbidity reviews to policy, community prevention and clinical quality improvement strategies to address key contributing factors.  
- Collaborate with Medicaid and OQPS to integrate pregnancy planning and contraception in routine primary care and care management for all women of reproductive age, including linkage to NYS Health Innovation Plan/Advanced Primary Care, Medicaid Health Home and other state health systems reform initiatives.  
- Provide enhanced support to assist women in getting health insurance, engaging in health care services and practicing healthy behaviors through evidence-based home visiting and community health worker program models, and expand availability of evidence-based home visiting and community health worker services through Medicaid/DSRIP, Pay for Success, Federal MIECHV and state budget funding.  
- Collaborate with OMFF to develop and implement strategies to increase screening and follow-up for maternal depression. | NPM 1-Percent of women with a past year preventive medical visit | NOM #2 Percent of delivery or postpartum hospitalizations with an indication of severe maternal morbidity.  
NOM #3 Maternal mortality rate per 100,000 live births.  
NOM #7 Percent of non-medically indicated deliveries at 37.38 weeks gestation among singleton deliveries without pre-existing conditions. |
| Increase use of preconception and interconception (“well woman”) health care services among | By September 30, 2020:  
- Increase the percentage of women with a past year preventive medical visit to [TBD]  
- Reduce the rate of unintended pregnancy to [TBD] | Integrate performance standards, measures and improvement strategies related to health insurance and health care service utilization across all Title V programs serving women of reproductive age.  
- Collaborate with Medicaid and OQPS to integrate pregnancy planning and contraception in routine primary care and care management for all women of reproductive age, including linkage to NYS Health Innovation Plan/Advanced Primary Care, Medicaid Health Home and other state health systems reform initiatives. | NPM 1-Percent of women with a past year preventive medical visit | NOM #2 Percent of delivery or postpartum hospitalizations with an indication of severe maternal morbidity.  
NOM #3 Maternal mortality rate per 100,000 live births. |
Year One Action

1. Establish baselines and set ambitious but achievable 2020 targets for all objectives
2. Develop additional state performance measures
3. Refine strategies for each domain & develop strategy measures
4. Identify specific action steps, leaders and partners to implement
MCH Leadership Development

- Partnering with UNC and U of Illinois to transform workforce
- Year One Work in eight domains using Adaptive Leadership strategies
Family Health Article 6

• Performance standards:
  – Improve the health of persons under 21 years including children with special health care needs
  – Increase the proportion of persons under 21 years who receive comprehensive well child primary and preventive care, including oral health;
  – Improve birth outcomes, decrease maternal and infant mortality and morbidity; increase the number of pregnant and postpartum women who receive early, continuous and comprehensive prenatal and postpartum care, including oral health care, and other supportive services;
  – Decrease the rate of unintended pregnancies; increase optimal birth spacing of pregnancies, decrease the prevalence and morbidity of sexually transmitted disease, and improve the availability and accessibility of comprehensive reproductive health care and family planning services to men and women of reproductive age.
Family Health Focus

• Focus of Family Health under Article 6:
  – Child Health
  – Maternal and Infant Health
  – Reproductive Health
Article 6 Family Health

- Utilize public health data;
- Public health marketing and communication;
- Information, referral and assistance;
- Outreach, education, training and technical assistance for health; and human service providers;
- Policy, environmental and system change; and,
- Insurance enrollment.
Utilizing Public Health Data

- Use community health assessment or other data to identify populations at risk.
  - The NYSDOH Dashboard for county level data

- Develop a comprehensive understanding of factors influencing health outcomes.
Utilizing Public Health Data

Examples of activities to better understand individual and community needs:

– Conduct focus groups of individuals and providers
– Facilitate community forums, discussion groups or networks of formal and informal community leaders
– Conduct surveys of community members, providers and leaders
– Conduct or facilitate the Oral Health Third Grade Survey
– Other activities to better understand what is impacting the health of the population that results in poor health outcomes
Public Health Marketing and Communication

• Prioritize health messages and determine the most effective way to reach individuals to address specific behavioral determinants.

• Examples are:
  – Promoting enrollment of Text 4 Baby
  – Identify location that can best reach the target population and provide information and education (e.g., WIC sites, home visiting programs, schools, community centers, laundromats, etc.)
  – Work with business leaders, community groups and health and human service providers to conduct targeted public awareness campaign (local free TV PSAs, radio PSAs, other local resources.)
Information, Referral and Assistance

• Assist women, men and families to access and effectively use available services.

• Examples include:
  – Establish a connection with Health Navigators to facilitate enrollment
  – Outreach to local dentists to encourage acceptance of Medicaid eligible pregnant women and children or FQHC to encourage the development of these services
  – Make referrals to programs such as WIC, EIP, home visiting programs (NFP, HFNY), support groups and other services
  – Provide one-on-one support by a community health worker to engage families into a range of services
Outreach, Education, Training and TA for Health and Human Service Providers

- Improve the delivery of comprehensive primary and preventive care to men, women and families.
- Examples include:
  - Sponsor a community forum to increase awareness of maternal and child outcomes
  - Conduct Public Health Detailing outreach to primary health care providers and others to deliver key messages (benefits of fluoride varnish, LARCs, benefits of 17 P, outreach to NICUs to promote interconception care, among others)
  - Outreach to schools regarding reproductive health
  - Inform local providers regarding educational opportunities, webinars etc.
  - Sponsor educational forums to increase their knowledge of standards of practice to improve health outcomes (local medical society, ACOG, community water fluoridation.)
Public Health Detailing

• Fluoride Varnishing program
• LARCs
• NYSACHO Training in this essential skill
Policy, Environmental and Systems Change

• Engage in efforts with multiple sectors in the community to address population and community factors impacting health.

• Examples include:
  – Participate as an active member of the local MICHC
  – Participate in a local child fatality group
  – Work with community leaders and consumers to implement a Preconception-Interconception community action plan
  – Work with community leaders to promote water fluoridation
  – Facilitate linkages, referral protocols and agreements among community providers
  – Engage consumers including families and adolescents with special health care needs and high-need families in program and policy development, work groups, advisory committees
  – Work with local stakeholders, providers and elected officials to develop health and supportive services in the community
Insurance Enrollment

• Identify uninsured individuals and facilitate enrollment.
• Examples include:
  – Establish a connection with Health Navigators; facilitate Navigator’s access to uninsured community.
  – Refer individuals for enrollment.
  – Work with community leaders and providers to identify gaps and barriers for uninsured individuals.
Linkage of Article 6 and NYS Title V MCH Action Plan

• Review NYS Title V State Action Plan
• Review data to identify MCH issues
• Identify problem statement and metrics
• Identify available Article 6 resources
• Develop evidence-based or evidence-informed strategies that meet the need of the population
• Assess impact and adjust
Title V MCH State Action Plan

• Transformation to accomplish goals
• Working with localities to improve health of New Yorkers
• Keeping MCH in the forefront as a public health function
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