NEW YORK CITY EARLY INTERVENTION COORDINATING COUNCIL (LEICC)
MEETING OF MARCH 17, 2017

AGENDA ITEMS	DISCUSSION
MEETING CONVENED 10:10 AM.	The following members were present: **Marie B. Casalino, Assistant Commissioner, Bureau of Early Intervention, NYC DOHMH** **Tracey LeBright, Chair of LEICC** **Cindy Lin Chau** **Agatha Guadagno** **Elizabeth Isakson** **Rosalba Maistoru** **Dawn Oakley** **Karen Samet** **Jacqueline D. Shannon** **Linda F. Silver** **Cynthia Winograd**
INTRODUCTIONS **LEICC OPERATING PRINCIPLES** **DEPARTMENT REPORTS**	**I. Tracey LeBright, Chair, LEICC** 1. Review of procedures for LEICC meetings: a. Attendees should pre-register on the NYC Bureau of Early Intervention (NYC BEI) website for LEICC meetings. b. Meetings are open to the public, but the audience does not address the LEICC members during the meeting. c. Audience members may sign up with Felicia Poteat or Nannette Blaize to speak during the "Public Comment" section. d. As of May 15, 2014, New York City's Local Law No. 103 of 2013 and the New York State Open Meetings Law require "open" meetings to be both webcast and archived. This meeting is being recorded today. e. Transcription is available for this meeting. Written meeting minutes will still be made available. 2. Minutes from last meeting were reviewed and approved. **II. Dr. Marie B Casalino, MD, MPH - Assistant Commissioner** 1. Bureau Transition: a. Position: Director of Early Intervention Services • Continuing to recruit for position which has been modified and reposted as Director of Regional Office Operations (February 2017) • If you have applied for position before modification or if you are still interested, please re-apply to the current posting • Thank you to Agatha Guadagno, Queens Regional Office Director, for assuming these responsibilities from October 2016 to February 2017 • As of February 6, 2017 the Acting Director is Catherine Ayala, Staten Island Regional Director b. Bureau move within Gotham Center (Floor change)

SEICC REPORT	• Phase 1 – March 2017 • Phase 2 – anticipated for June 2017 • No impact on the provider community, Bureau operations, or on services. Services will continue as usual. 2. **Statewide Early Intervention Coordinating Council (SEICC) Agenda Items** • Bylaws Change (SEICC Quorum) • Membership and Vice-Chair Nominations • Open Discussion • Update and Vote on Annual Performance Report • Update on State Systemic Improvement Plan • Joint Task Force on Social-Emotional Development • Medicaid Children's Health Home • Update on Part C Application (**Annual State Application under Part C of the Individuals with Disabilities Education Act as Amended in 2004 Federal Fiscal Year (FFY) 2017)** • Legislation: Early Intervention (EI) Program Proposed Regulations and Executive Budget Proposals 3. **SEICC- Open Discussion** • NYC Department of Health & Mental Hygiene (DOHMH) Public Statement: Public Health Solutions o By: Marie B. Casalino, MD, MPH - *New York City's Early Intervention Program monitors system capacity on an ongoing basis. We are committed to ensuring availability of high quality Early Intervention service coordination for the nearly 50,000 children and families who receive these services in New York City each year. For many years, we have relied on our provider community to support initiatives for development of local procedures and to ensure system stability, as well as to ensure the delivery of high quality services to children and families. Since April 2013, New York City has also dedicated time and effort to working with many new providers to ensure the continuation of a tradition of collegial and professional partnership. I am sad to announce that the largest service coordination provider; Public Health Solutions in New York City, will be ending its Early Intervention Program this summer. I would like to thank the New York State Department of Health for its commitment and efforts to ensuring the transition of children from Public Health Solutions to other agencies will be as smooth as possible. At the same time, we need to take this opportunity to review current payment rates and reimbursement methodology, as well as the challenges created by the 2013 Administrative reforms in order to ensure the long sustainability of this great program.* o The New York State Department of Health (SDOH) responded; ensuring support for the transition and thanked NYC for its efforts. NYC BEI are going to proceed forward working very closely with Public Health Solutions in transitioning a very large number of children.

- SDOH reminder regarding required background checks for EI Professionals. Agencies need to check the following for any interventionist in the system:
  - Justice Center
  - Statewide Central Register (SCR)

4. **SEICC - Membership and Voting**
   a. SEICC membership
   - Current membership = 27 members
   - There will be 30 SEICC members
   - Sixteen (16) members necessary to constitute a quorum; SDOH attorney (new to EI) will review the issue and prepare information for a vote at the upcoming June meeting
   - A Health Plan representative will join the SEICC beginning June 2017; two (2) additional Health Plan representatives will be identified
   - Vice Chair nominations requested
   - Brad Hutton replaced by Nora Yates (Director of the Center for Community Health) as the SDOH representative on the SEICC

5. **SEICC - Social-Emotional Task Force Update**
   a. Mary McHugh, NYS Office of Mental Health, Task Force Chair
   b. Editor: Bob Frawley
   c. Document finalized and approved by SDOH
   d. Discussion of next steps:
   - Initial document distribution by email to stakeholders
   - SDOH Bureau of Marketing and Creative Communications office will take the lead on printing and distribution
   - Advisory Group (sub-committee) to be created from members of the Social-Emotional Task Force (SETF): focus will be on the distribution plan. Will serve to present proposals/ideas, contribute to distribution plan to be sure that the plan is appropriate for the field.

   e. Update:
   - Collaborating with the Bureau of Children, Youth and Families (within the Division of Mental Hygiene) and The New York Center for Child Development
   - Training modules
   - *Zero to Three DC: Zero to Five Diagnostic Classification Training* in development for BEI staff, which will later be offered to the provider community

	6. **SEICC - State Department of Health Activities** a. Part C Application notice being sent out: SDOH submitting its application in April 2017 b. Reviewed Annual Performance Report (APR) and obtained SEICC approval for submission to The Office of Special Education Programs (OSEP) c. State Systemic Improvement Plan (SSIP) Update: • Creation of Advisory Committee • Webinars • Identification of all stakeholders (participants of the project) and how to engage them in the project • SDOH attendance/presentations at LEICC meetings; SDOH will attend NYC meeting in July d. Health Home implementation in EI – being postponed until further notice. 7. **SEICC – EIn Legislative Activities** a. Proposed Regulations b. Executive Budget • Discussion focused on: o Responsible individuals and processes to collect insurance information o Financial responsibilities of statewide fiscal agent and municipalities **LEICC Discussion**: - Linda Silver asked Dr. Casalino if Brad Hutton was present during her reading of the Public Health statement. Dr. Casalino answered that he was not present. Ms. Silver asked if there was any response from the SDOH. Dr. Casalino indicated that the SDOH appreciates NYC's efforts to transition children, and SDOH will do whatever they can to make the transition as smooth as possible. - Tracy LeBright announced that SDOH will be conducting a webinar on EI's integration into Health Homes on March 23, 2017.
CDC SURVEILLANCE PROJECT REPORT	**III. Catherine A. Canary, MD, MPH - Medical Director** 1. The Centers for Disease Control and Prevention (CDC) Surveillance Project - Zika Exposure/Infection and Central Nervous System Birth Defects 2. Surveillance Project Activities • Hiring staff • Chart abstraction initiated for obtaining information requested by the CDC and by the SDOH Congenital Malformations Registry (CMR) • Provider communication materials in development 3. Zika Virus Infection

a. Typically a benign and short-lived infection
   - Fever
   - Rash
   - Conjunctivitis/red eyes
   - Arthralgia/joint pain

b. Acquired mainly via:
   - Mosquito bite (particular type of mosquito that is not endemic to New York transmits the infection)
   - Sexual transmission
   - Blood transfusion or the sharing of injection material

c. Potential harmful effects if acquired during pregnancy
   - Possible infant outcomes for pregnant women who tests positive for Zika:
     - Congenital Zika syndrome
     - Congenital Zika infection
     - Congenital Zika exposure

4. Congenital Zika syndrome
   a. Infant and mother test positive for Zika virus
   b. Infant has nervous system abnormality:
      - microcephaly
      - other central nervous system (CNS) malformation
      - spina bifida
      - eye abnormalities
      - hearing impairment
      - contractures/arthrogryposis
   c. Requires comprehensive pediatric and subspecialty care
      - Auditory brainstem response (ABR)/formal hearing test
      - Eye examination
      - Pediatric neurology
      - Laboratory evaluation
   d. Families with infants with congenital Zika syndrome should refer children to Children with Special Health Care Needs (CSHCN)
   e. Families with infants with congenital Zika syndrome should refer children to the Early Intervention Program for Multidisciplinary Evaluation (MDE) and services, if eligible

5. Congenital Zika infection
   a. Infant and mother test positive for Zika virus

DATA REPORT	b. Infant at birth has normal newborn exam and no evidence of central nervous system abnormality. CDC recommends: • Head ultrasound • Eye examination • ABR/formal hearing test c. Refer child to Children with Special Health Care Needs (CSHCN) d. Infant will need developmental surveillance/screening and can be referred to Developmental Monitoring Unit for every three (3) month Ages & Stages Questionnaires (ASQs) unless they have a medical home and a source of pediatric care. e. These infants are categorized as being at risk due to their congenital infection status so if developmental screening raises concerns, child should be referred for MDE. 6. Congenital Zika exposure a. Infant tests negative for Zika virus b. Has normal newborn exam and no evidence of nervous system abnormality. CDC recommends: • Hearing screen • Head ultrasound c. Refer families to Children with Special Health Care Needs (CSHCN) d. Routine developmental surveillance/screening; can be referred to Developmental Monitoring e. If developmental screening raises concerns, child should be referred for MDE Publication Updates: a. Distributed the EI *City Health Information (CHI)* publication to 40,000+ health care providers b. Distributed the *EI Clinician's Guide and Algorithm* to over 1,000 pediatricians **IV. Nora Puffett, MPA - Director of Administration and Data Management** 1. **Current data: Provider Oversight Annual Monitoring Results 2016** a. Continuing to see a down turn in Ongoing Service Coordinator (OSC) performance and evaluation findings b. Comparing new vs. existing agencies' performance on MDEs. Findings reveal much worse performance by new agencies; but existing agencies are not performing well either **LEICC Discussion** - Ms. Silver asked (in regards to MDE low performance rate), what component of the MDE seems to be the most problematic in the overall rating? Nora Puffett answered that if you take a look at the Self-Assessment Tool, you can see that there are five MDE standards. If you look at your own agency's monitoring report, you can see the exact indicators that you failed. At a systems level, that question would require a comprehensive portfolio analysis that could identify which particular standards were the most common problems). MDE standards range from administrative to more qualitative information.

- **Data Report:**
  - In following the process of a cohort of children through the Early Intervention Program (EIP) (from referral, evaluation, eligibility, to services and transition), 20% of children were re-referred. In further investigation, parents report declining EI services because they didn't want services, or had some family circumstances that prevented them from accessing services
  - Number of referrals per year/by borough have been consistent year to year
  - Focus is now on making sure that children are receiving the appropriate evaluations/assessments. Rates of children progressing from Evaluation to Services have been consistent. The eligibility rate is approximately 50%. Data indicates that, although the evaluation process can be challenging for the family, families ultimately receive services.
  - Data reports for children who have had any type of relationship with the EIP, almost 50,000 children are receiving some type of EI service, including service coordination, evaluation, etc.
  - Data (from each of the boroughs) on the progress of a child in EI from new referral to evaluation was discussed

LEICC Discussion:

- Ms. Silver wanted to know the percentage of children that are evaluated and that are currently eligible for services. Ms. Puffett answered that since the change in criteria for communication delays in 2010, there has been about a 50% eligibility rate
- Dr. Jacqueline Shannon asked if we are able to target within the boroughs by zip codes. Ms. Puffett answered that we know both anecdotally and by data, the zip codes that have lower rates of referrals, especially lower rates of referrals by race. NYC BEI has looked at this, through some of our outreach efforts, focusing on those zip codes. In terms of outreach, NYC BEI found that it is very hard to target a specific zip code, and it is really more a set of neighborhoods we are working with to increase services and referral rates (i.e., Bronx and Brooklyn have lower referrals and availability of services).

V. Lidiya Lednyak, MA, PMP – Director of Policy and Quality Assurance

1. **2018-2019 Executive Budget**
   a. Amend Insurance Law to ensure reimbursement of covered benefits
      - Require insurers to recognize Primary Care Providers' (PCP) referral, order, recommendation, or IFSP signed by the PCP, as meeting precertification, preauthorization, and/or medical necessity requirements
      - Require insurers to pay for covered services delivered by the EIP to the extent that the service is a covered benefit in the child's health plan, including coverage for autism spectrum disorder services
      - Prohibit insurers from denying payment based on location of service or that the child's condition is not subject to improvement within a time specified by the policy
      - Require insurers to notify municipalities, Service Coordinators (SCs), and providers if the child's plan is fully insured or if the insurer is acting as a third party administrator

PROVIDER/AGENCY UPDATE	b. Amend Public Health Law to clarify that: • A municipality can recoup its share of disallowances identified in an audit performed by the municipality c. Amend Public Health Law to: • Require parents to provide insurance information in a format prescribed by SDOH. SCs and providers must collect insurance information • Require municipalities to request from parent, and parents to provide, an order, referral, or recommendation signed by the PCP, on the medical necessity for EI services • Allow municipalities to obtain written consent from the parent to contact the PCP on behalf of the parent to obtain medical necessity documentation • Require providers to submit documentation of medical necessity to the insurer along with required subrogation notices d. Current status: • The NYS Assembly Budget Language only included the provisions to modify insurance law • NYS Senate Budget Language did not include any EI provisions **LEICC Discussion:** - Ms. Silver asked if the City has any position or concerns from a lobbying point of view. Lidiya Lednyak answered that NYC BEI has expressed its concerns to the State in regards to setting up external processes outside the State's fiscal agent to recoup dollars. Furthermore, NYC BEI is concerned about the language that municipalities go directly to PCPs to obtain documentation of medical necessity - Ms. Silver stated that some EI providers' concerns are with the competency of the fiscal agent and how so much of the responsibility is being placed on others instead of the fiscal agent. Ms. Lednyak answered that Sandy Rozza has voiced concern about the fiscal agent and the fact that the city has lost about $35 million dollars in claiming and billing issues - Dr. Shannon asked if there is anything for the LEICC to do? Ms. Lednyak answered that the LEICC members can lobby individually, talk to representatives; in particular the health committees, but NYC remains concerned 1. **Provider/Agency Update** • **New York City Early Intervention Provider Landscape, Pre- and Post- April 1, 2013** o Between April 2013 and November 2016, NYC BEI has experienced a 54% increase in EI providers in NYC. ▪ 152% increase in Applied Behavior Analysis (ABA) Providers (new and existing) ▪ 30% increase in service coordination ▪ 22% increase in Multidisciplinary Evaluations (MDEs) ▪ 76 new and existing providers engaged in the New York City Early Intervention Program (NYC EIP) Technical Assistance • NYC BEI Provider directory has been updated and is available at: http://www1.nyc.gov/site/doh/providers/resources/early-intervention-information-for-providers.page

- Total ABA Providers: 78
  - Home/comm ABA only: 53
  - Group ABA only: 1
  - Home/comm + Group ABA: 24

LEICC Discussion:

- Ms. Silver asked if there is a particular area (borough) that EI is seeing an increase in services. Ms. Lednyak answered that services are uniformly distributed. However, there is a need in Staten Island to expand service coordination there. Overall many providers want to go to Brooklyn. Because of this, NYC BEI is advising service providers what locations are in need of services. However, because the numbers of teachers and therapists are not expanding, the same workforce is being accessed.

2. **Group Developmental Services Update**

a. Background: In order for NYC to ensure compliance with SDOH-issued Group Developmental Intervention (GDI) Service Standards, between 7/20/16 and 8/12/16 NYC BEI collaborated with 15 EI provider agencies to modify group models

b. In March 2017, NYC BEI will issue clarification to ensure system understanding of dual group models in NYC EI:
   - Each group comprising the dual group model must be distinctly different in the following ways:
     - Service setting
     - Rendering service provider
     - Service delivery approach
     - The peer model in the groups

c. EI services are individualized for the child and family and a team-approach must be used when creating or amending a service plan:
   - A dual group model resulting in four (4) to six (6) hours of GDI in a single day must be discussed by the Individualized Family Service Plan (IFSP) team to ensure that this is appropriate to meet the Functional Outcomes developed as part of the IFSP process
   - There must be flexibility on the part of providers to accept children into their group programs when these children are authorized for a portion of what is offered in that setting, e.g., just one (1) GDI session per day, as opposed to the full dual group program, attendance for less than five (5) days per week, or any other combination of services that is feasible
   - Maintenance of learned behaviors and subsequent generalization to everyday activities and routines are crucial parts of any ABA program, and time spent on maintenance and generalization is included in the total number of hours of ABA instruction authorized

INTERVENTION QUALITY INITIATIVES (IQI): CULTURAL COMPETENCE TRAINING	**LEICC Discussion**: - Ms. Silver asked if this clarification (on the dual group model) corresponds with the original requirement so the providers who had to change their models will not find any of these clarifications as a surprise. Ms. Lednyak answered that no provider agency should be surprised. **VI. Jeanette Gong, Ph.D. Director, Intervention Quality Initiatives** 1. **BEI Professional Development Training: Cultural Competency** a. NYC BEI Professional Development Series: • NYC BEI provides free professional developmental trainings to support EI professionals' use of evidence-based, family-centered best practices in their work: o *Supporting and Retaining EI Families through Reflective Practice* (Fall 2015) with Rebecca Shahmoon Shanok, Ph.D., Elaine Geller, Ph.D., CCC-SLP, Phyllis Ackman, Ph.D.,, and Haroula Ntalla, M.S. o *Culturally and Linguistically Appropriate EI Evaluations: What Every Evaluator in NYC Needs to Know* (Spring 2016) with Catherine Crowley, PhD., CCC-SLP, J.D. o *Developing Cultural Competency to Enhance Communication and Collaboration with Early Intervention Families* with Alaina O'Mara, MPH, Christopher Steer, MPH, Lenora Reid-Rose MBA, Nancy Sung Shelton, MA, and Stanley Byrd, Ed.D. (Spring 2017) b. Cultural Competency Definition • Cultural Competency training supports EI professionals in learning about: o The different kinds of "culture" that can exist and how they impact perceptions and attitudes o Providing services that demonstrate respect and consider the family's information, culture and linguistic diversity during referrals, evaluations and services o Enhancing interactions between EI professionals and families in terms of communication and collaboration o Supporting greater retention of EI families c. Cultural Competency Training**:** • Training will be provided by two (2) teams of presenters from Coordinated Care Services, Inc. (CCSI). This is a company who provides technical assistance, program evaluation, and training on cultural competency for organizations such as The New York State Office for People with Developmental Disabilities (OPWDD) and other health government and community organizations • The team that will be running the training will be led by their Director of Cultural Linguistic Diversity, Lenora Reid-Rose who has over 20 years' experience working in the field. She is currently a member of the NYS Multicultural Advisory Committee (SMAC) and the NYSDOH's Minority Health Council (MHC) • Target Audience: o Service Coordinators o Administrators o Clinical Supervisors/Quality Assurance Managers

- Interventionists
- Academic Partners
- BEI Staff

d. Promotion: For all EI agencies, an email will be sent to the contact person listed for each provider agency.

e. Cultural Competency Training Location:

- CUNY School of Law:
  2 Court Square in Long Island City
  Accessible by the 7, E, M, G, N and R trains

f. Three- Day Training Course:

- Day 1: Monday June 26, 2017
- Day 2: Tuesday June 27, 2017
- Day 3: Wednesday June 28, 2017

g. Time: Each day the training is for 2.5 hours and participants will need to register for the same session across the three days:

- Two Morning Sessions
  - 8:30 am - 11:00 am
  - N = 50 participants
- Two Mid- Day Sessions
  - 11:30 am - 2:00 pm
  - N = 50 participants
- Two Afternoon Sessions
  - 2:30 pm - 5:00 pm
  - N = 50 participants
- Total number of participants = 300

h. Main themes for each day of training**:**

- **Day 1**: Laying the Foundation and Core Concepts
  - Understanding family, community, and societal cultures and the impact on engagement with clients
  - Organizational infrastructure that supports culturally responsive services
- **Day 2**: Mental Models/Cultural Humility
  - Understanding mental models and cultural humility and how important this is in service provision
  - Cultural considerations and motivation as they relate to behavior change
- **Day 3**: Cultural Competence in Practice
  - Principles of effective practice
  - Tools to support effective engagement

i. Continuing Education Units (CEUs) for:

- Physical Therapists (PTs)/PT Assistants,

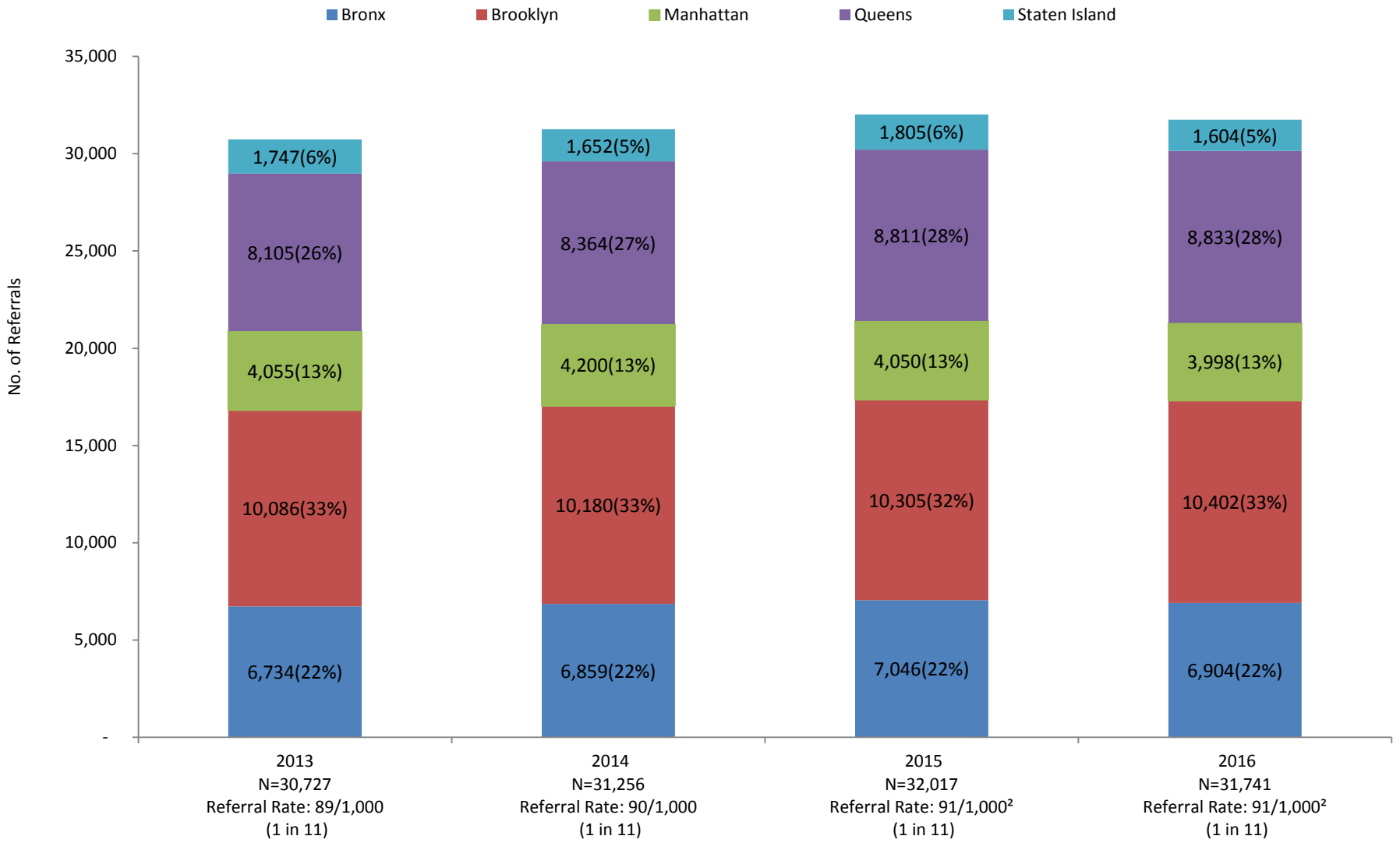
	o Occupational Therapists (OTs)/OT Assistants o Speech-Language Pathologists/Audiologists o Social Workers: Licensed Clinical Social Worker (LCSWs) and Licensed Master Social Worker (LMSWs) j. Participants must complete requirements for Continuing Education Units (CEUs): o Attend one session for each of the three days o They cannot be late and cannot leave early o Complete and submit the pre- and post-tests o Complete and submit the Training Evaluation Survey at the end of their session each day Any additional questions, please email: EmbeddedCoaching@health.nyc.gov **LEICC Discussion**: - Dawn Oakley wanted to see if there is a connection with Ms. Puffett's data information on the discrepancies that existed between referral rates and services. Dr. Gong answered that in order to address the data Ms. Puffett presented, the issue needs to be addressed from multiple perspectives, not just with this training. NYC BEI continues to provide professional development trainings to support the work of EI professionals. In addition, NYC BEI is also working on a health equity project through its Outreach program; working with community organizations and various government agencies such as the Department of Homeless Services (DHS), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and State agencies.
LEICC COMMITTEE REPORTS	**VII. LEICC Committee & Task Force Reports:** **Academic Preparation and Professional Development** Jacqueline D. Shannon, Ph.D., Chair a. Two (2) meetings held (January and March) b. Seven (7) members present (one (1) from each of the participating colleges) c. Two (2) key areas discussed: • Evaluation and the delivery of the services provided for students across varies programs: o Assessment of student courses o Pre/post assessment courses o Fieldwork/ Supervisor feedback o Long term quality (what happens once students complete programs and are in the field) • Field work **Transition Committee** Karen Samet MS, SAS, Chair No meeting because the committee is awaiting a response from the State.

	Policy Review Committee/ Service Capacity Task Force Tracy B. LeBright, LMSW, Chair a. Policy Review Committee - No Report b. Service Capacity Task Force- Held two (2) meetings since the last meeting. Everyone agrees there is an issue with capacity. Need data on: • Has there been a decrease in the number of therapists available to provide services? • Are there children waiting for services? • When therapists are no longer working in EI, can they be deactivated on NYEIS?
PUBLIC COMMENT	Leslie Caraballo – Parent, Citywide Council on Special Ed. (CCSE), Citizens Committee for Children (CCC) NYC Advisory Council. - Leslie Caraballo asked how the interested public can gain access to the LEICC's data report which was presented during this meeting. Dr. Marie Casalino answered that the data report presented during the LEICC meeting will be made available on-line. All other LEICC materials are currently posted on the website. Leslie Caraballo also asked what is being done or can be done to promote careers at the college and graduate levels to incentivize treatment to these hard to service areas? Dr. Shannon answered that the committee she currently serves on (includes SUNY Downstate OT, Hunter College, Brooklyn College, Lehman College) is currently working on expanding the workforce to address all of these issues. Leslie Caraballo asked what is the process to become a LEICC parent-member. Dr. Marie Casalino answered to email A. Felicia Poteat to find out about the process.
MEETING ADJOURNED 11:38 AM.	Next meeting scheduled for July 14, 2017

DATA REPORT
MARCH 17, 2017

NYC Health

Number of Referrals[1] Per Year, by Borough
January 2013 - December 2016

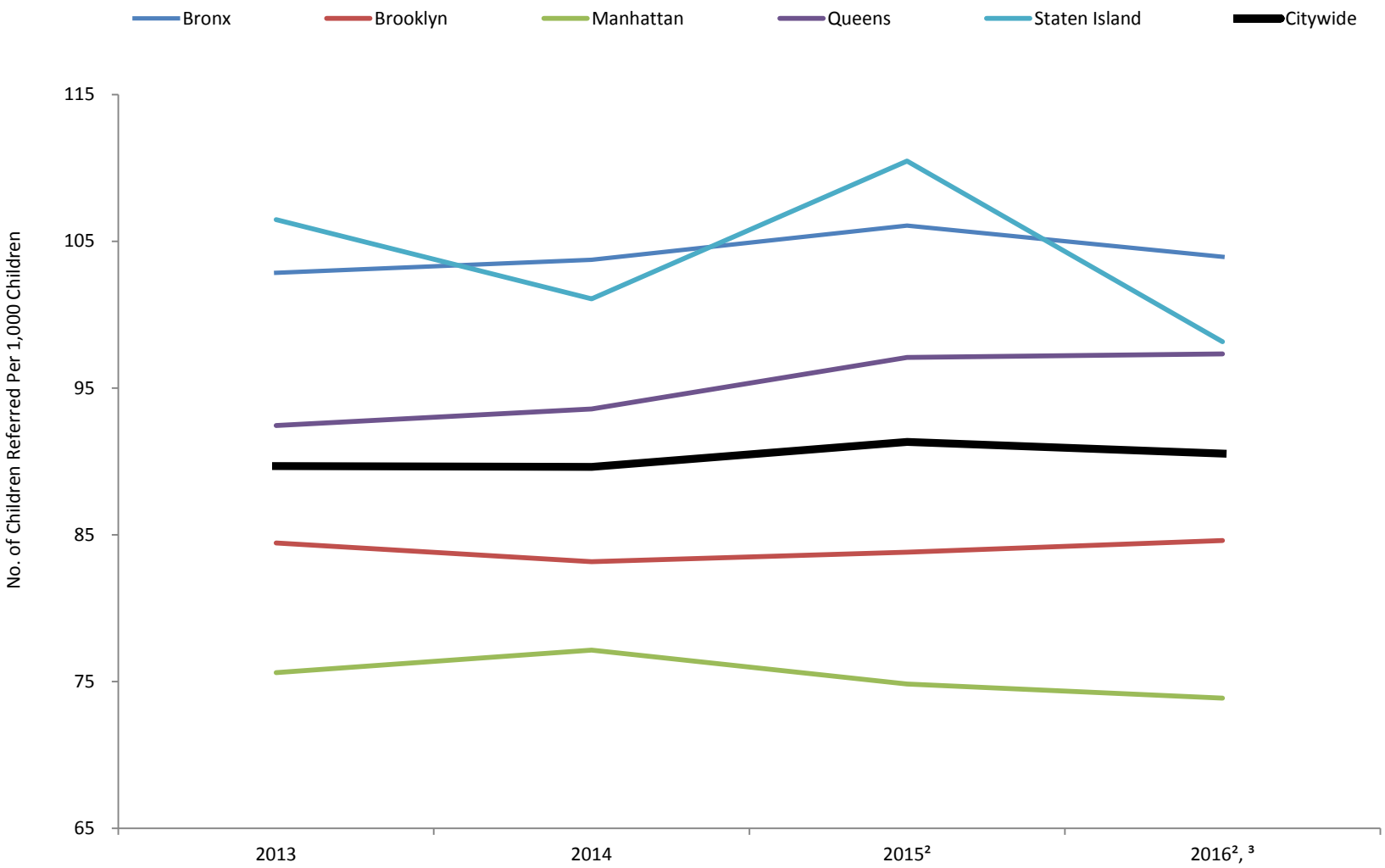


Notes:

1. Includes new and re-referrals.

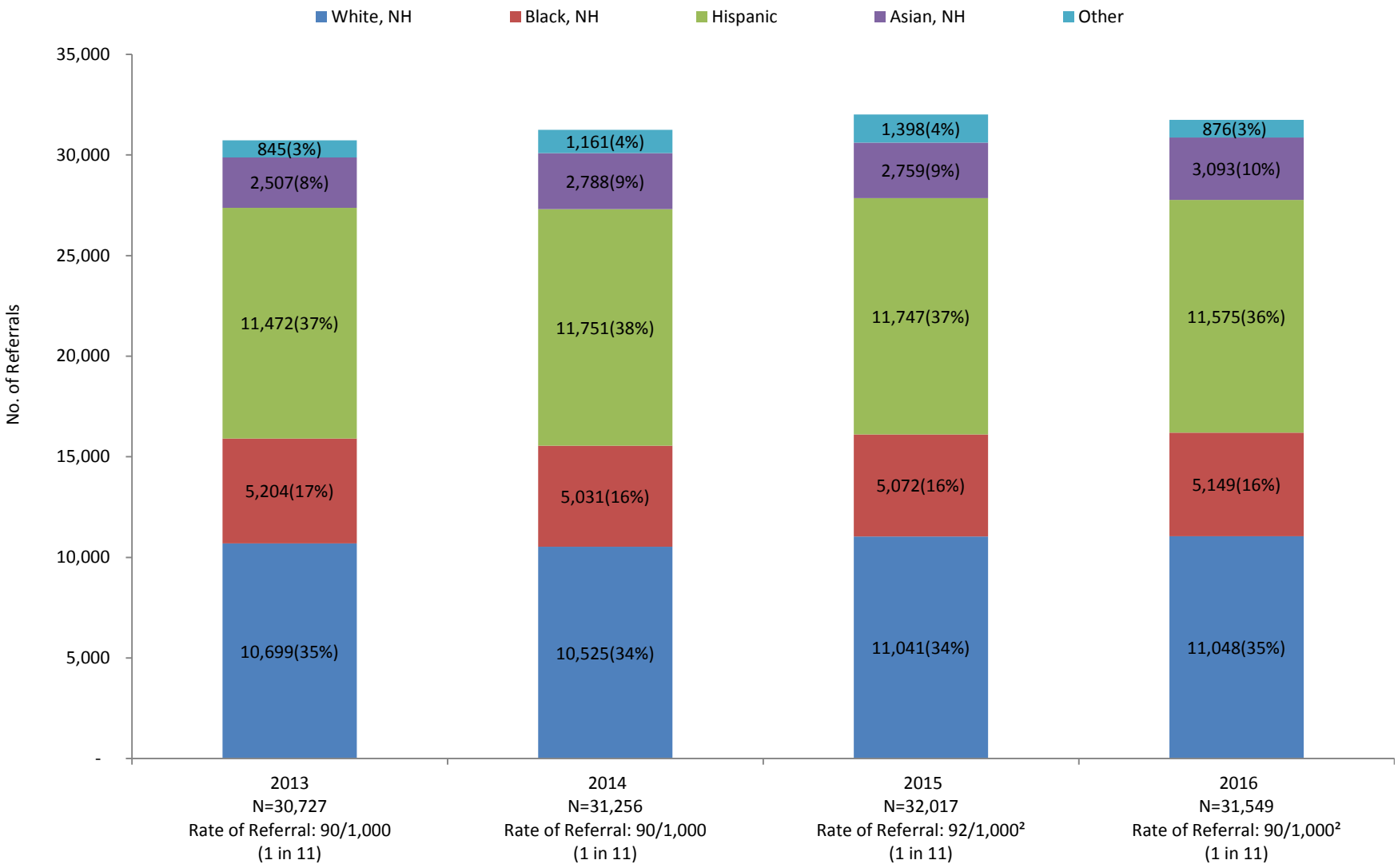
2.. The number of children 0-3 year is drawn from US Census data. For 2016 this chart uses population figures from 2015, which is the most recent data available.

Rate of Referral[1] Per Year, by Borough
January 2013 - December 2016



Note:
1. Referrals include new and re-referrals.
2. The number of children 0-3 years is drawn from US Census data. For 2016 this chart uses population figures from 2015, which is the most recent data available.
3. The citywide referral rate decreased by 1% in 2016 compared to 2015. The 2016 referral rates went down for the Bronx, Manhattan, and Staten Island: Bronx's rate decreased by 2%, Manhattan's rate decreased by 1%, and Staten Island's rate decreased by 11%. Brooklyn's rates increased by 1% and Queens's rates remained the

Number of Referrals[1] Per Year, by Race and Ethnicity
January 2013 - December 2016



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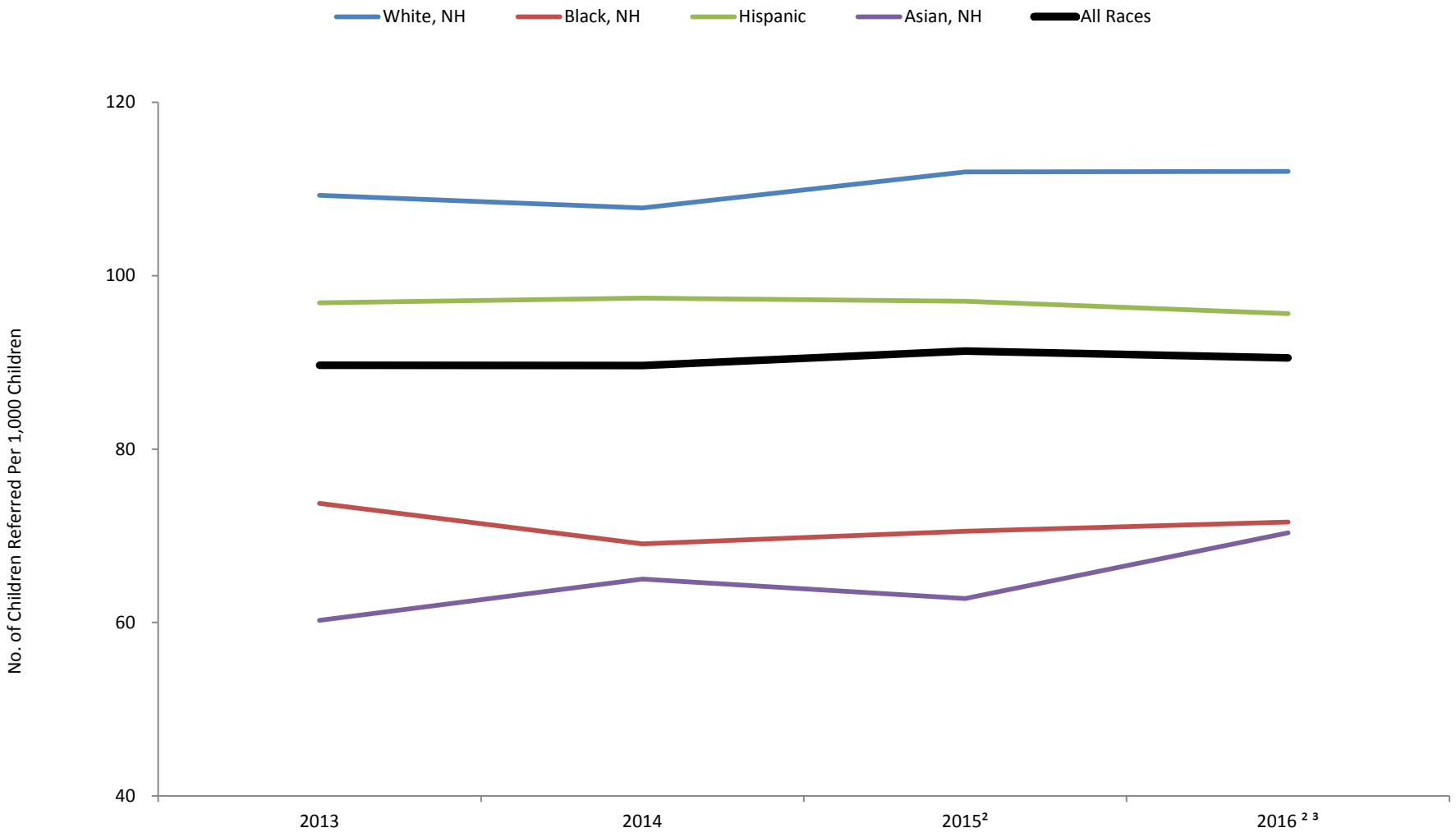
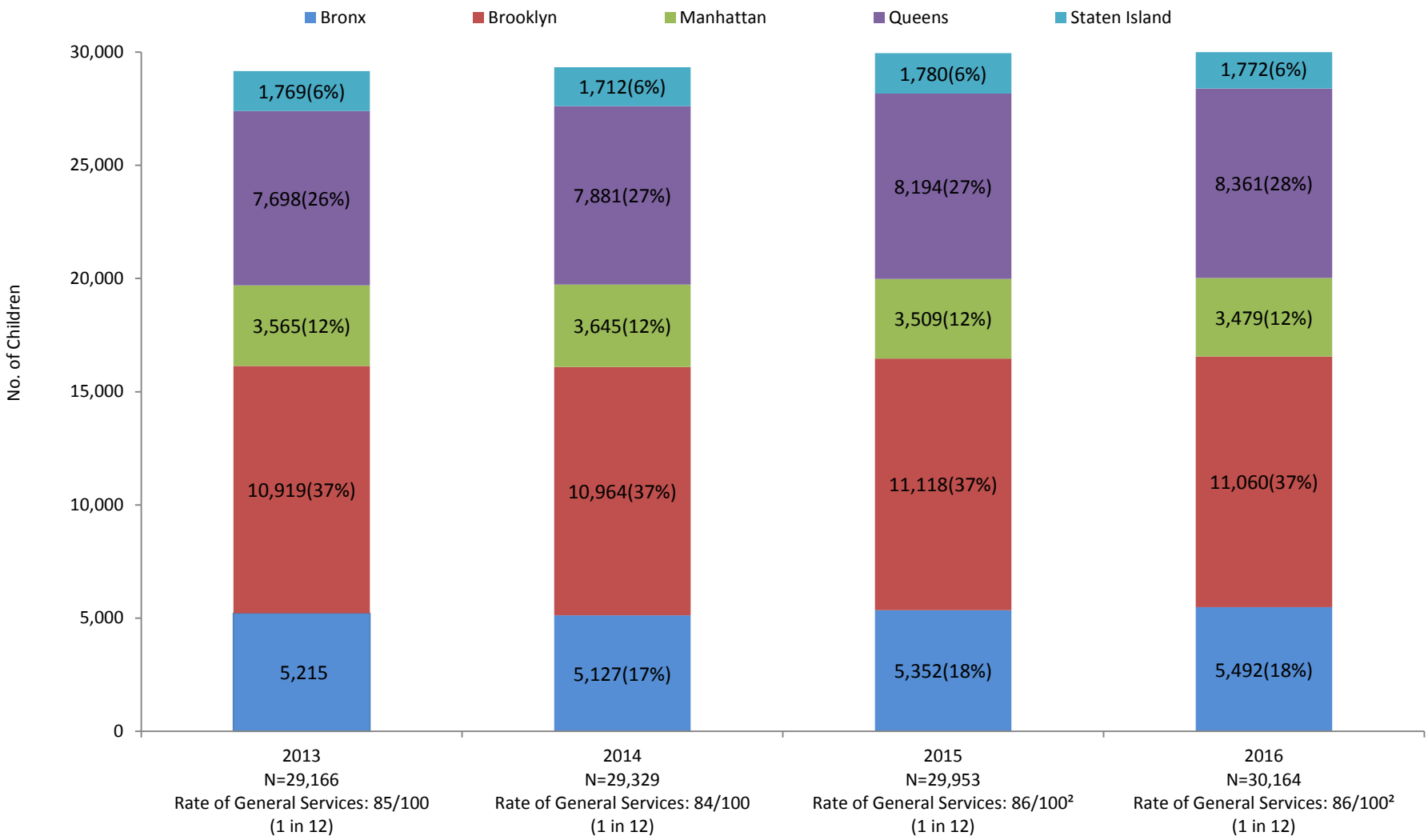
Rate of Referral[1], by Race and Ethnicity
January 2013 - December 2016



Notes:
1. Includes new and re-referrals.
2. The number of children 0-3 years is drawn from US Census data. For 2016 this chart uses population figures from 2015, which is the most recent data available.
3. The citywide referral rate decreased by 1% in 2016 compared to 2015. Black and Asian children's referral rates went up by 2% and 12%. Rates for Hispanic children decreased by 1%. White children's rates remained the same.

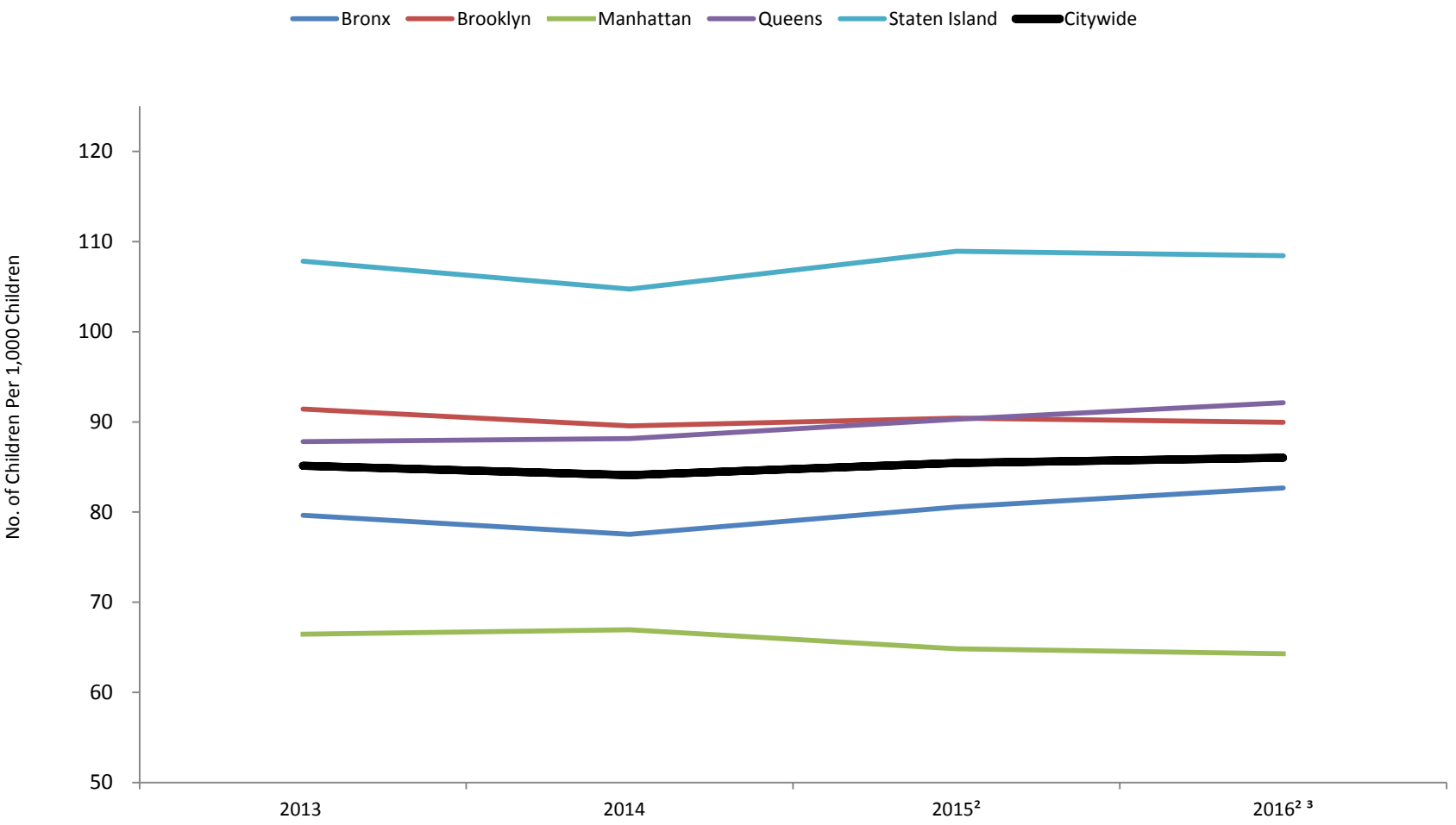
Number of Children Receiving General Services[1] Per Year, by Borough
January 2013 - December 2016



Note:

1. General services include all those but service coordination, evaluation, assistive technology and transportation.
2. The number of children 0-3 years is drawn from US Census data. For 2016 this chart uses population figures from 2015, which is the most recent data available.

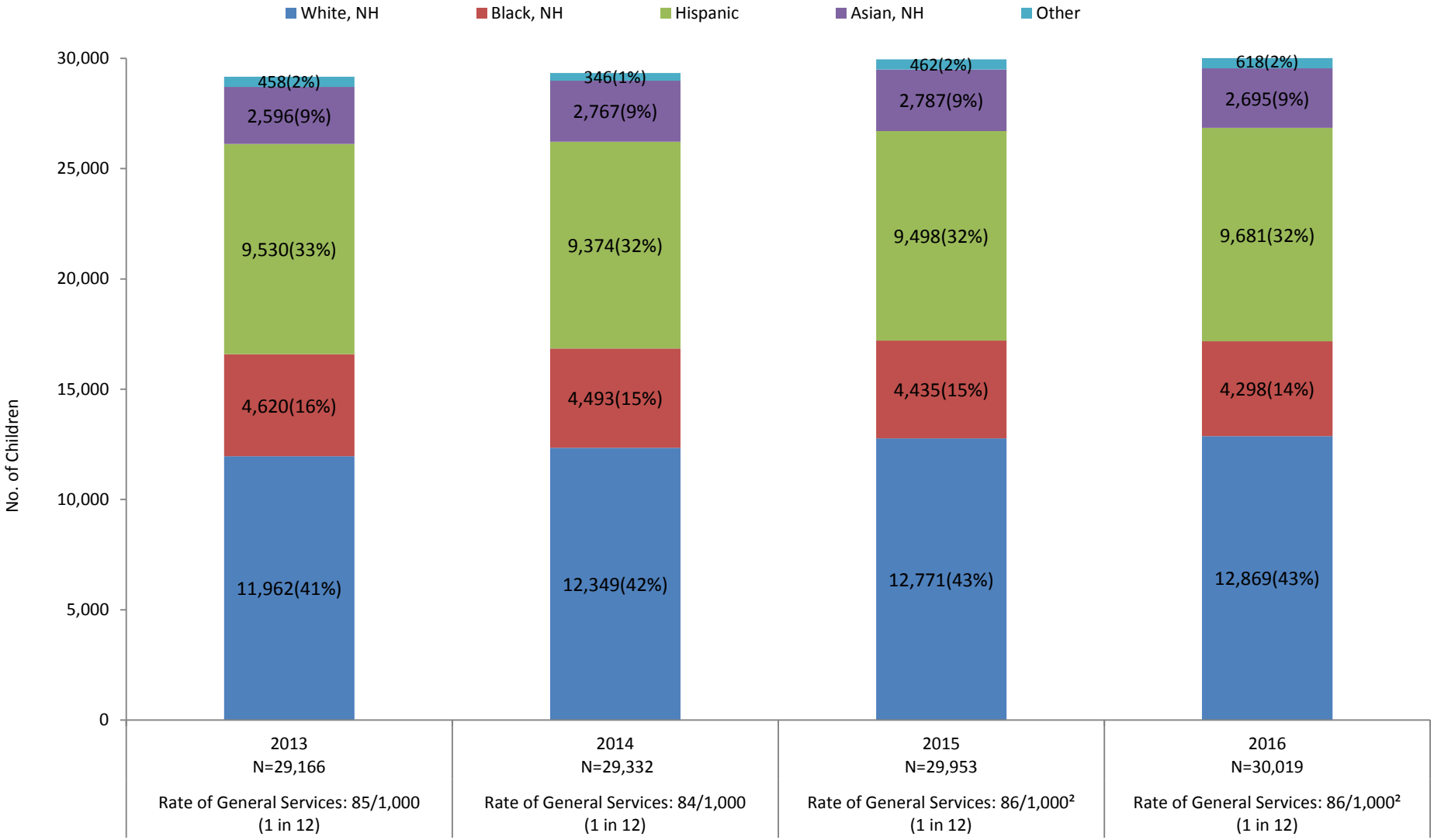
Rate of Children Receiving General Services[1] Per Year, by Borough
January 2013 - December 2016



Note:

1. General services include all those but service coordination, evaluation, assistive technology and transportation.
2. The number of children 0-3 years is drawn from US Census data. For 2016 this chart uses population figures from 2015, which is the most recent data available.
3. The citywide general service rate increased by 1% in 2016 compared to 2015. The 2016 rates went up for the Bronx and Queens: Bronx's rates increased by 3% and Queens's rate increased by 2%. Brooklyn's rates went down by 0.5% and Manhattan's rate went down by 1%. Staten Island's rates remained the same.

Number of Children Receiving General Services[1] Per Year, by Race and Ethnicity, January 2013 - December 2016



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Rate of Children Receiving General Services[1] Per Year, by Race and Ethnicity
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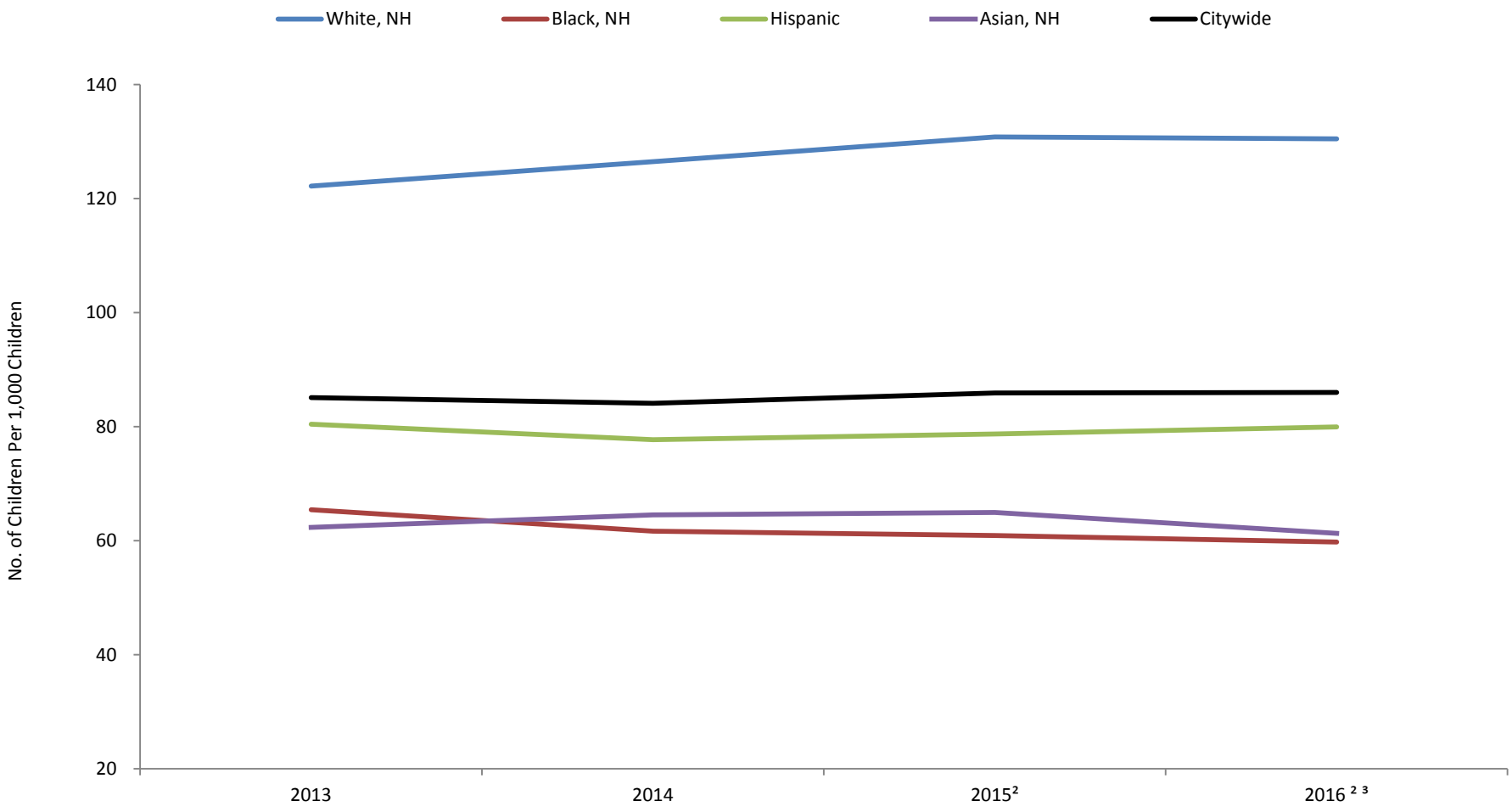
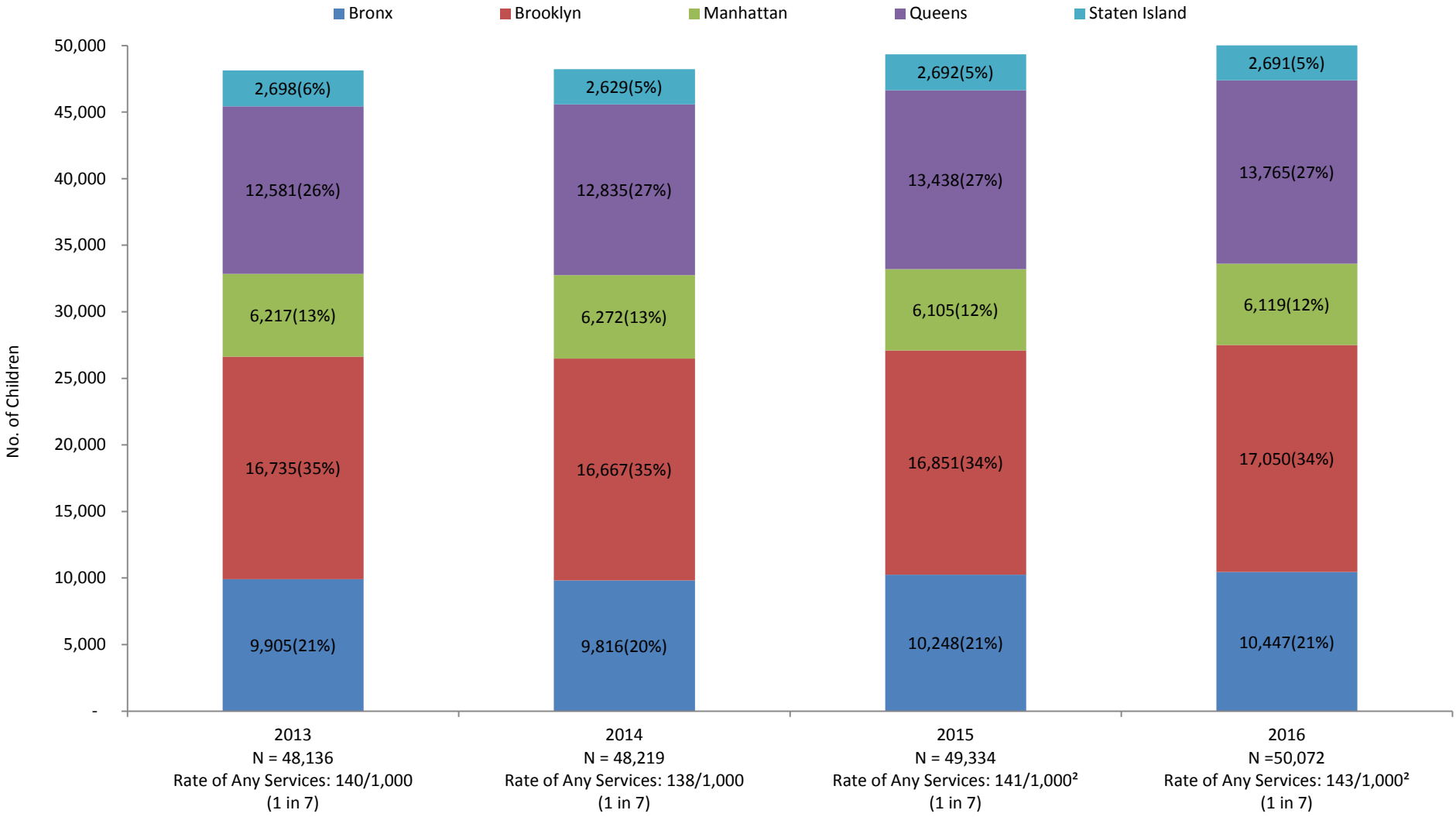


Note:

1. General services include all those but service coordination, evaluation, assistive technology and transportation.
2. The number of children 0-3 years is drawn from US Census data. For 2016 this chart uses population figures from 2015, which is the most recent data available.
3. The citywide general service rate increased by 2% in 2016 compared to 2014.

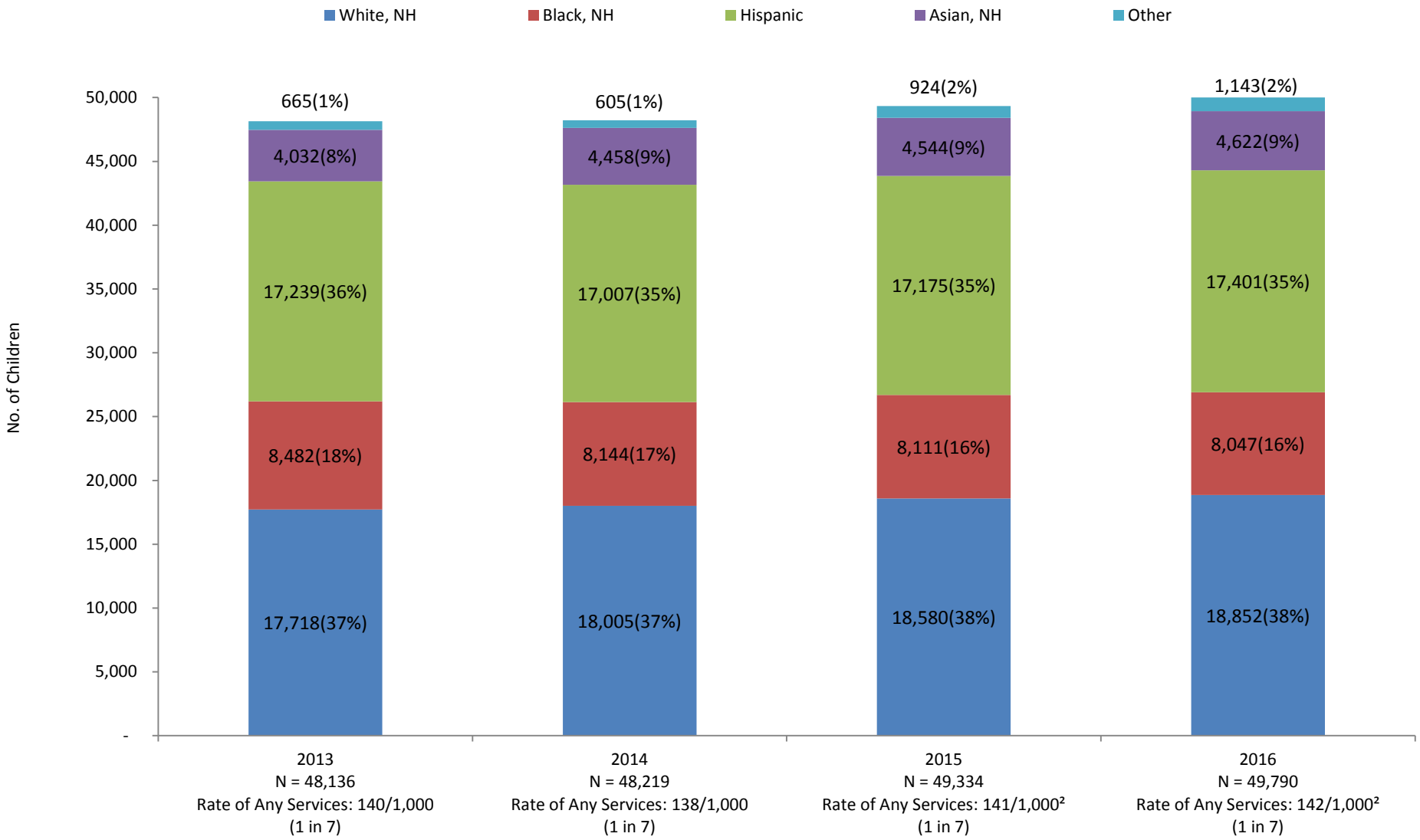
Children Receiving Any Type of Service, by Borough: Service Coordination, Evaluation and/or General Services[1] January 2013 - December 2016



Note:

1. General services include all those but service coordination, evaluation, assistive technology and transportation.
2. The number of children 0-3 years is drawn from US Census data. For 2016 this chart uses population figures from 2015, which is the most recent data available.

Children Receiving Any Type of Service, by Race and Ethnicity: Service Coordination, Evaluation and/or General Services[1] January 2013 - December 2016

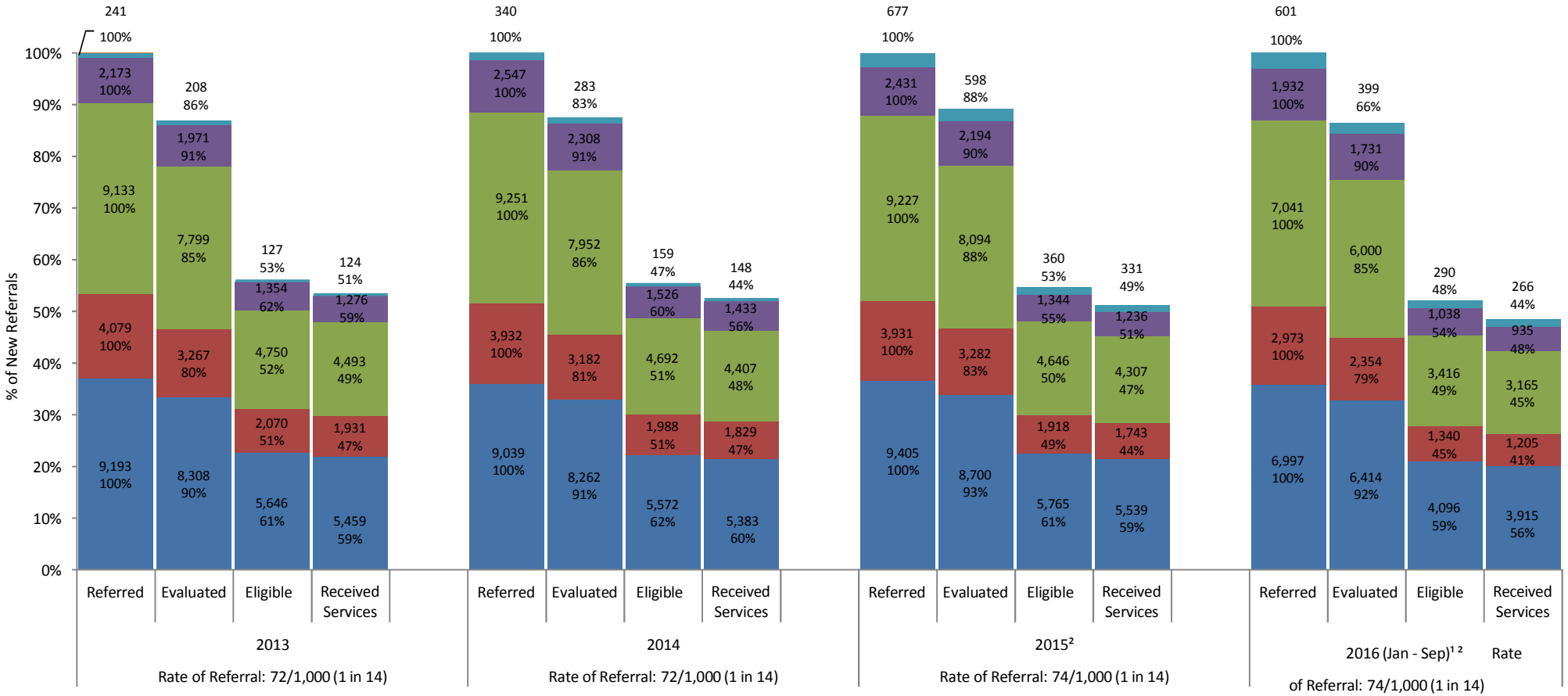


Note:

1. General services include all those but service coordination, evaluation, assistive technology and transportation.
2. The number of children 0-3 years is drawn from US Census data. For 2016 this chart uses population figures from 2015, which is the most recent data available.

Progress of New Referrals Through the EIP by Race and Ethnicity, Citywide, January 2013 - September 2016

	2014			2015, 2016[2]		
	0-3 Pop	*% of Pop*	*Ref. Rate (/1,000)*	*0-3 Pop*	*% of Pop*	*Ref. Rate (/1,000)*
White NH	97,626	28%	93	98,605	28%	95
Black NH	72,825	21%	54	71,918	21%	55
Hispanic	120,621	35%	77	121,039	35%	76
Asian NH	42,884	12%	59	43,961	13%	55
Other	14,746	4%	23	15,077	4%	45



Notes:

1. Progress of new referrals is typically reported on a 3-month lag to ensure that all children have time to reach final resolution. Because including data through December 2016 would have resulted in a lag of less than three months, data is presented only through September 2016.
2. For 2016, this chart uses population figures from 2015 which is most recent data available.

Progress of New Referrals Through the EIP by Race and Ethnicity, Bronx, January 2013 - September 2016

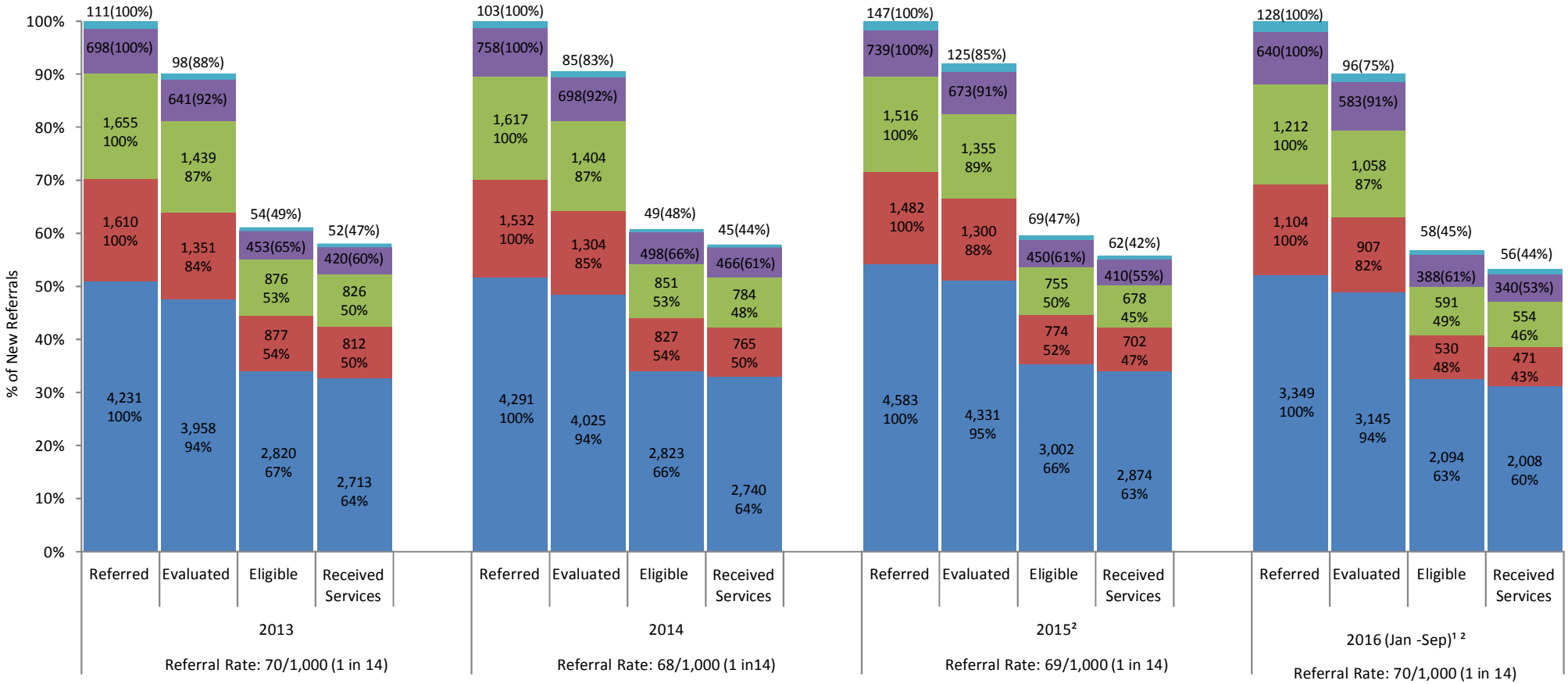
	2014			2015, 2016[2]		
	Pop. 0-3	*% of Pop*	*Ref Rate (/1,000)*	*Pop. 0-3*	*% of Pop*	*Ref Rate (/1,000)*
White NH	4,888	7%	103	4,888	7%	113
Black NH	17,649	27%	65	17,649	27%	66
Hispanic	39,879	60%	87	39,879	60%	88
Asian NH	2,259	3%	37	2,259	3%	46
Other	1,442	2%	35	1,442	2%	58

Notes:

1. Progress of new referrals is typically reported on a 3-month lag to ensure that all children have time to reach final resolution. Because including data through December 2016 would have resulted in a lag of less than three months, data is presented only through September 2016.
2. For 2016, this chart uses population figures from 2015 which is most recent data available.

Progress of New Referrals Through the EIP by Race and Ethnicity, Brooklyn, January 2013 - September 2016

	2014			2015, 2016[2]		
	0-3 Pop	*% of Pop*	*Ref. Rate (/1,000)*	*0-3 Pop*	*% of Pop*	*Ref. Rate (/1,000)*
White NH	44,068	36%	97	44,919	37%	102
Black NH	32,452	27%	47	31,734	26%	47
Hispanic	27,238	22%	59	26,962	22%	56
Asian NH	13,431	11%	56	13,919	11%	53
Other	5,215	4%	20	5,420	4%	27

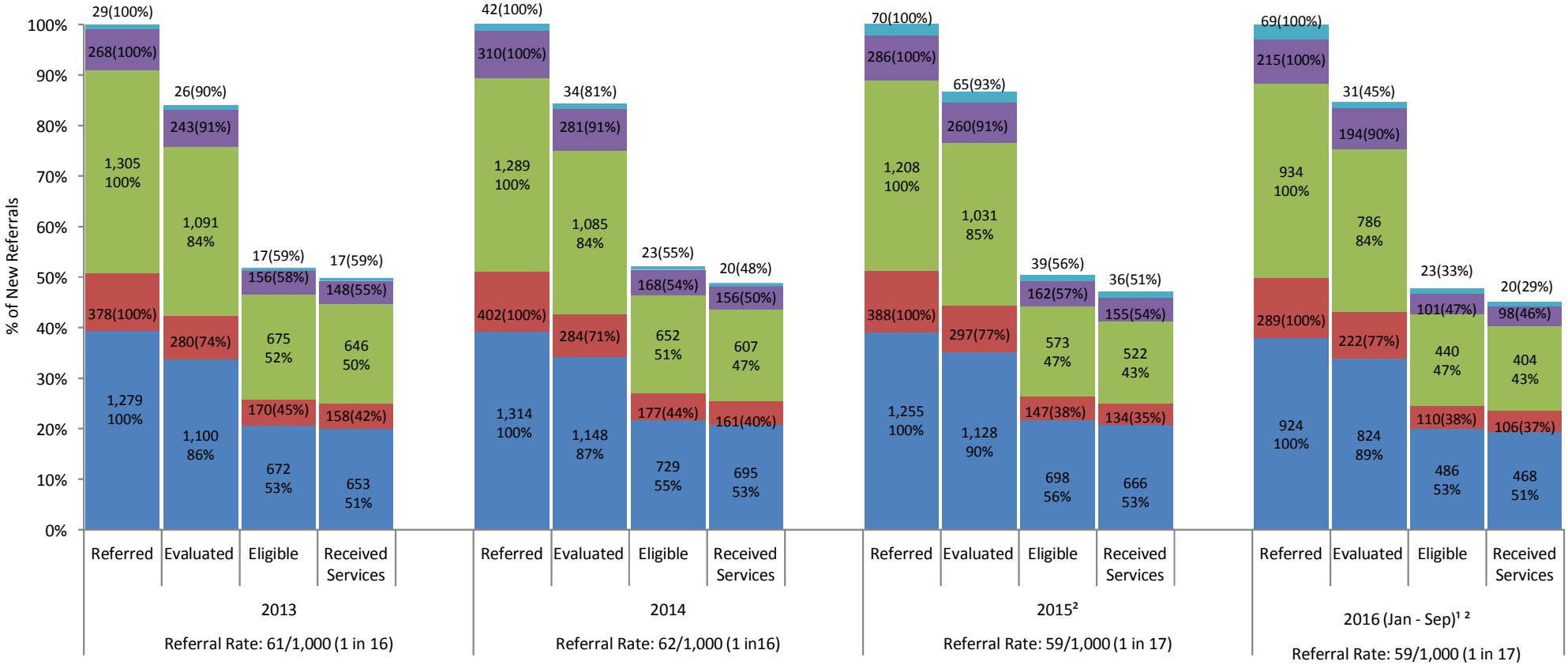


Notes:

1. Progress of new referrals is typically reported on a 3-month lag to ensure that all children have time to reach final resolution. Because including data through December 2016 would have resulted in a lag of less than three months, data is presented only through September 2016.
2. For 2016, this chart uses population figures from 2015 which is most recent data available.

Progress of New Referrals Through the EIP by Race and Ethnicity, Manhattan January 2013 - September 2016

	2014			2015, 2016[2]		
	0-3 Pop	*% of Pop*	*Ref. Rate (/1,000)*	*0-3 Pop*	*% of Pop*	*Ref. Rate (/1,000)*
White NH	21,721	40%	60	21,595	40%	58
Black NH	6,302	12%	64	6,311	12%	61
Hispanic	17,229	32%	75	17,054	32%	71
Asian NH	5,903	11%	53	5,862	11%	49
Other	3,288	6%	13	3,299	6%	21

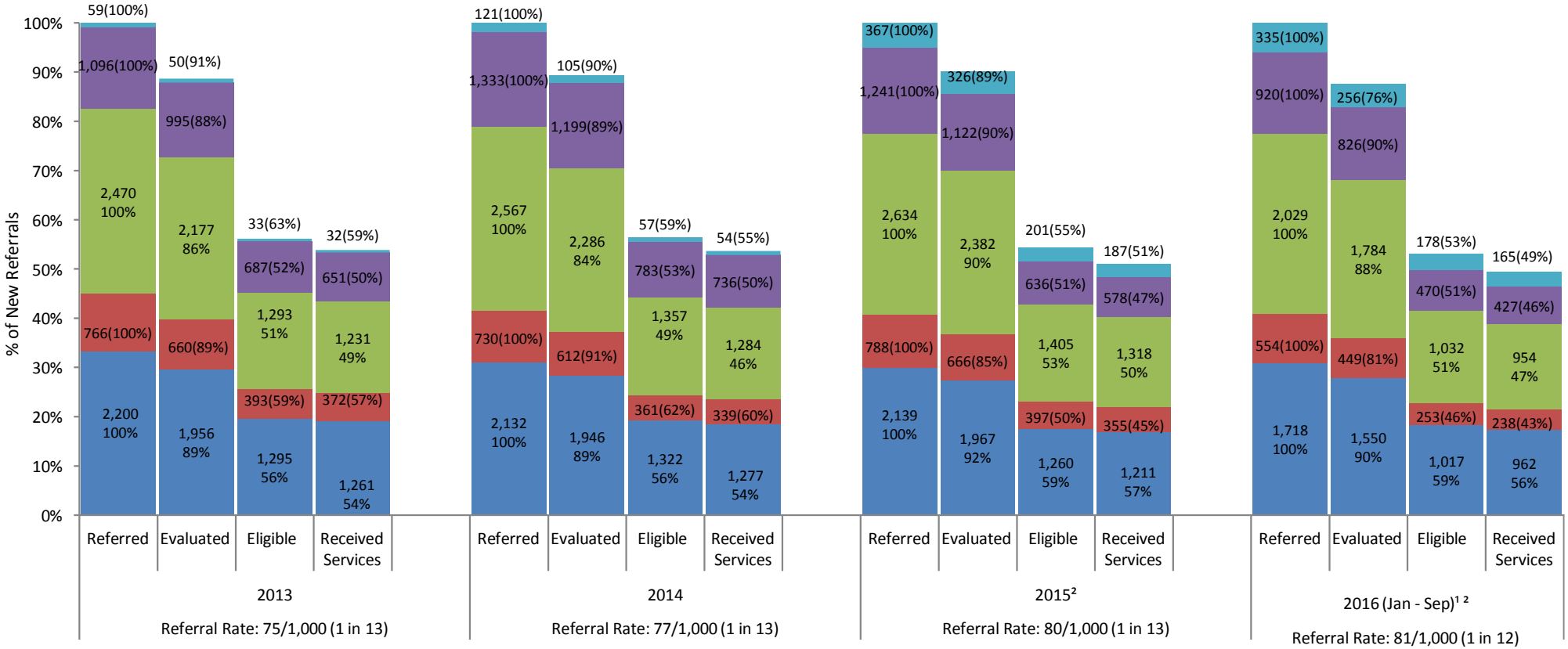


Notes:

1. Progress of new referrals is typically reported on a 3-month lag to ensure that all children have time to reach final resolution. Because including data through December 2016 would have resulted in a lag of less than three months, data is presented only through September 2016.
2. For 2016, this chart uses population figures from 2015 which is most recent data available.

Progress of New Referrals Through the EIP by Race and Ethnicity, Queens, January 2013 - September 2016

	2014			2015, 2016[2]		
	0-3 Pop	*% of Pop*	*Ref. Rate (/1,000)*	*0-3 Pop*	*% of Pop*	*Ref. Rate (/1,000)*
White NH	18,838	21%	113	19,058	21%	112
Black NH	14,375	16%	51	14,243	16%	55
Hispanic	31,763	36%	81	32,338	36%	81
Asian NH	20,217	23%	66	20,785	23%	60
Other	4,200	5%	29	4,336	5%	85

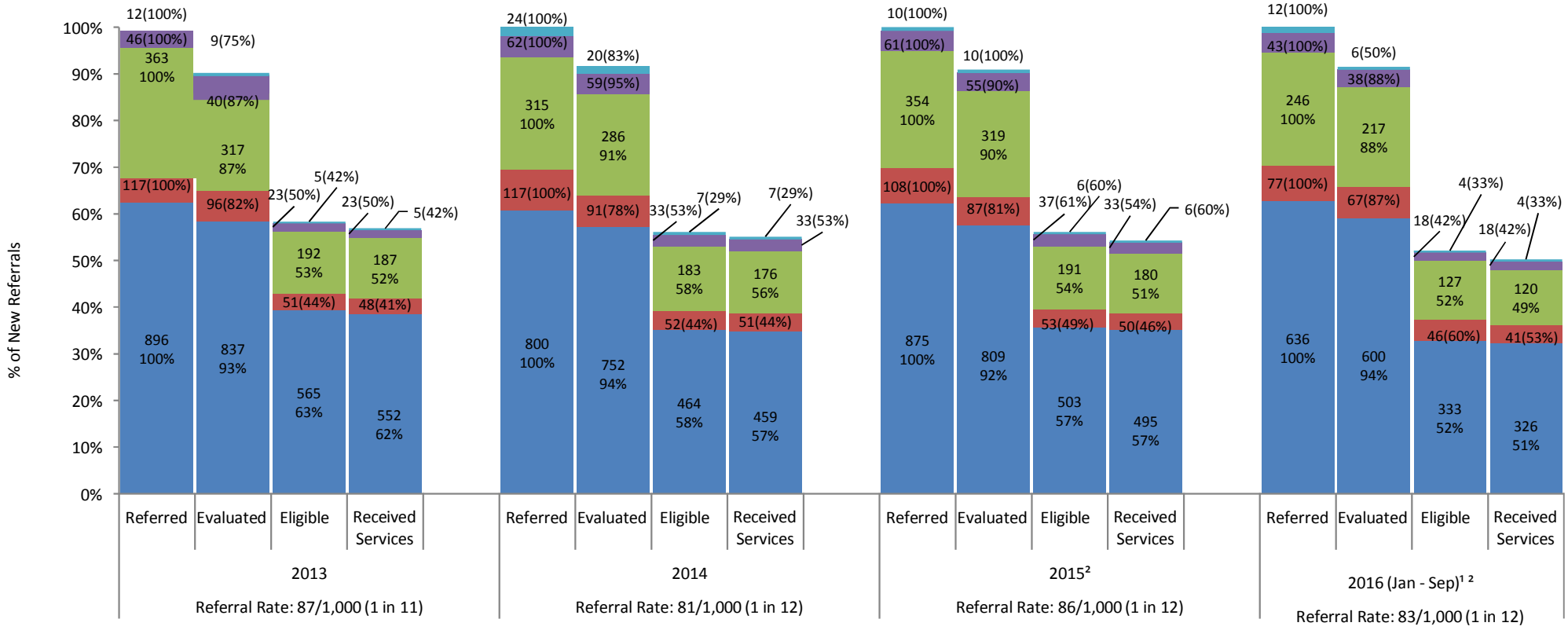


Notes:

1. Progress of new referrals is typically reported on a 3-month lag to ensure that all children have time to reach final resolution. Because including data through December 2016 would have resulted in a lag of less than three months, data is presented only through September 2016.
2. For 2016, this chart uses population figures from 2015 which is most recent data available.

Progress of New Referrals Through the EIP by Race and Ethnicity, Staten Island, January 2013 - September 2016

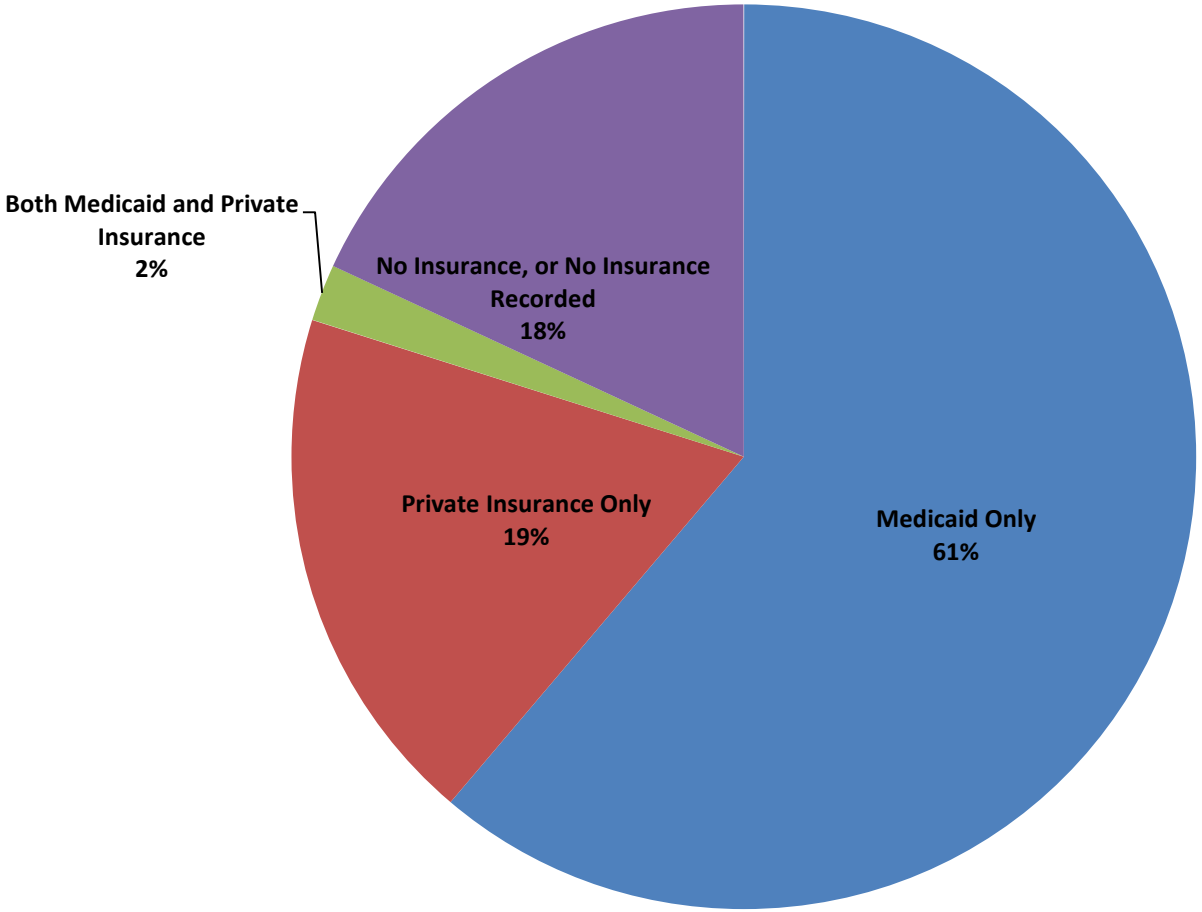
	2014			2015, 2016[2]		
	0-3 Pop	*% of Pop*	*Ref. Rate (/1,000)*	*0-3 Pop*	*% of Pop*	*Ref. Rate (/1,000)*
White NH	8,109	50%	99	8,099	50%	108
Black NH	2,048	13%	57	2,028	12%	53
Hispanic	4,513	28%	70	4,509	28%	79
Asian NH	1,076	7%	58	1,105	7%	55
Other	600	4%	40	599	4%	17



Notes:

1. Progress of new referrals is typically reported on a 3-month lag to ensure that all children have time to reach final resolution. Because including data through December 2016 would have resulted in a lag of less than three months, data is presented only through September 2016.
2. For 2016, this chart uses population figures from 2015 which is most recent data available.

Insurance Status of Children Receiving General Services
January - December 2016
N=30,601



Note: Medicaid Managed Care plans and Child Health Plus are categorized as Medicaid in this chart.