Planning and Funding Local Public Health Services in New York State:

The New Public Health Agenda

Interim Report
of the
Public Health Agenda Committee

New York State Department of Health
and the New York State Association of County Health Officials
April 1998

The Public Health Agenda Committee

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--Special thanks to Jo Ann Bennison, Executive Director, New York State Association of County Health Officials--

Executive Summary

Planning and Funding Local Public Health Services in New York: The New Public Health Agenda

Report of the Public Health Agenda Committee

Background

The current system for planning and funding local public health services in New York State, as described in Article 6 of the Public Health Law and Part 40 of the Rules and Regulations, must reflect the rapidly changing needs of local health departments (LHDs) and the New York State Department of Health (NYSDOH). The current requirements for documentation are viewed by all concerned as administratively burdensome. The process no longer meets the needs of today's local health departments for continuing assessment of communities, nor does it allow for flexibility in planning, offering, or modifying services needed to improve the public's health.

Process

At the request of Health Commissioner Dr. Barbara DeBuono, the Public Health Agenda Committee, composed of representatives of the New York State Department of Health and the New York State Association of County Health Officials (NYSACHO), accepted a charge to review and reform, if necessary, the current Article 6 process. The Committee examined and made recommendations regarding the formal processes of state and local planning and funding, including the Community Health Assessment (CHA), the Municipal Public Health Services Plan (MPHSP), performance monitoring, and the State Aid Application (SAA). The Committee also looked at the broader issue of clarifying the current NYSDOH and LHDs relationship.

Vision

The Committee's shared vision for public health is for "healthy people creating healthy communities." This vision is the basis for achieving the public health mission -- promoting physical and mental health and preventing disease, injury, and physical disability -- even in the current dynamic environment.

The role of LHDs is changing to include a larger role in assuring that services are available, accessible, and acceptable to the community the LHD represents, according to the standards of practice set by NYSDOH and LHDs. Despite this change in focus, many LHDs still do and will continue to provide clinical services, especially for those uninsured or hard-to-serve; for those areas where LHDs are the specialists (i.e., TB and STD); where LHDs choose to continue to provide services; or where clinical providers do not currently exist. To continue to provide cost-effective services, LHDs will need to create models of clinical service provision that work in their specific communities.

The role of NYSDOH is changing as well. While the Department legally retains its role in regulation and quality assurance, the focus is shifting to achieving quality with communities and providers, through collaboration and partnership.

The Committee examined how its shared vision for public health can best be achieved in New York, given the historical circumstances of law and practice between the NYSDOH and the LHDs. Article 6, the enabling legislation for State Aid for public health activities in New York, also provides the procedural basis for state and local interaction around most public health activities. Article 6 and Part 40 were thus examined for their relevance to the present and future activities of LHDs in assuring the health of New Yorkers and their communities.

Recommendations

It is the consensus of the Committee that Article 6, as it is presently structured, is flexible enough to accommodate many recommended procedural changes that will markedly improve the value of the State Aid process. At this time, the Committee recommends no statutory changes to Article 6 or to Part 40 regulations.

To improve the administrative process, the following procedural changes are suggested.

- Community health assessment should become a continuous activity for local health units. The following chapters outline how the current Article 6 can accommodate a more useful, streamlined, participative Community Health Assessment (Appendix D) that will then provide a more realistic basis for a restructured MPHSP (Appendix E) and State Aid Application.

- The Committee further recommends the development of a CHA that would meet the needs of **both** Article 6 and the categorical grants, as well as serving others at the community and state level. The CHA should be judged by how well it tells the story of the health of a particular community.

- When the Department requires health assessments by other community providers, they should mandate inclusion of the local health department in the process to limit costly duplication and assure compatibility of plans.

- To make the assessment activity meaningful, the current period of filing a full CHA document should be extended to a period of six years, with interval changes every two years.

- Derived from the CHA, a streamlined Municipal Public Health Services Plan would be developed based on categories defined as the ten essential public health services in ***Public Health in America*** (Appendix A.). The new MPHSP would ideally encompass both Article 6 and categorical grant work plans, and serve as the public health master plan for the jurisdiction.

- Performance monitoring of local health departments must encompass process, capacity, and outcome measures, leading to a comprehensive reporting system covering both Article 6 and categorically funding activities. If performance problems are detected, it should be addressed with a series of progressive responses that include consultation, assistance with problem identification, and training; technical assistance from NYSDOH to build local capacity; and constructive feedback on deficiencies and progress toward desired outcomes.

- The State Aid Application should provide a comprehensive depiction of the resources available to local health units as they carry out their public health mission, using a comprehensive fiscal document that can provide the basis for grant budgets, as well as for Article 6 reimbursement, in a State/Local partnership.

The suggested timing of CHAs and other Article 6 requirements appears in the table below.

ACTIVITY	1998	1999	2000	2001	2002	2003	2004
Full CHA	X						X
Biennial Updates or Supplements			X		X		
Municipal Public Health Services Plan		X		X		X	
State Aid Application	X	X	X	X	X	X	X

Enabling Actions

In order to implement these changes, a number of enabling actions are necessary.

- NYSDOH must achieve and maintain the timely production of needed data for CHA; provide a statewide format for a community report card based on ***Communities Working Together***; expand behavioral risk factor data collection to the community level (e.g., county); and, finally, align categorical grants and their required assessments, work plans, and budgets with the Article 6 process. NYSDOH must begin consolidation of grant making and monitoring processes, beginning with a pilot in 1998 and with full achievement of these goals by the Year 2000.

- Local health departments must move to lead their communities to produce a complete CHA every six years, with updates biennially; to report locally important outcome and performance measures; and to build capacity for assessment within their agencies.

Next Steps

The Committee recommends three areas for additional discussion and investigation. These are areas where final recommendations are not ready to be made, in large part due to the ongoing pilot projects with community-based health assessment, and the local CHAs and MPHSPs/reports that will be generated from them.

- The format of the Community Health Assessment presented in this report should be seen as interim, pending the information gleaned from the Public Health Priorities Partnership Initiative (PHPPI) grants. In mid-1997, the Committee requested a one year extension of the current CHA while many LHDs pilot a more comprehensive process and format.

- A ***Fiscal Workgroup*** should be established to continue to review the financial support for local health departments, including the concept of aligning categorical grant funding with the Article 6 processes and a universal budget document. This workgroup will examine whether changes to Part 40 are necessary to achieve this goal.

- An ***Outcomes and Performance Measures Workgroup*** should be convened to establish a statewide set of performance measures to be used by all local health departments when reporting to the NYSDOH that can serve as the basis for consolidated performance monitoring of the quality of local health in New York.

Time line for Final Recommendations and Products

Issue or Product	Approach	Who Involved	Time Frame
Recommendations on Funding Formulas, Universal Budget Document	Form a Fiscal Workgroup. Investigate consolidation of grants/Article 6.	NYSDOH and NYSACHO representative counties	Workgroup formed by March 1998 Recommendations by September 1998
Performance Standards and Outcome Measures	Develop in concert with Communities Working Together, block grants, local needs.	Public Health Information Group, Local Health Services, NYSACHO representative counties	By May 1998
Restructuring of the Community Health Assessment	Await information from the Public Health Priorities Partnership Initiative (PHPPI) grants.	Committee membership, Local Health Services staff, NYSACHO Assessment Group	By July 1998
Monitoring Tool	Study Monroe and Western NY pilots; Reorient tools to 10 essential services, performance measures, team approach.	NYSDOH (CO and RO) and NYSACHO representative counties	Pilot Completed by September 1998; Full Implementation by January 2000.
Status reports on restructuring MPHSP/ State Aid documents toward 10 essential public health services	Discussion leading to a consensus	Public Health Agenda Committee; Article 6 Committee of NYSACHO	By September 1998

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Chapter 1.
The New Public Health Agenda:
Emerging roles for local public health

Background

The local public health system in New York is in transition. The shifting of some responsibilities to the private sector, the expansion of insurance to the previously uninsured and under insured, and movement toward local government consolidation, all require an examination of new and emerging roles for local public health services.

Fortunately, over the past ten years, a number of initiatives and reports have examined the changes in the organization and funding of public health services in the United States and New York State. In 1988, the Institute of Medicine issued ***The Future of Public Health***, which outlined the three public health functions necessary to improve the health of the nation: assessment, policy development and assurance. Subsequently, in 1994, a coalition of national organizations identified ten essential public health services, in the document ***Public Health in America,*** that were needed to achieve these three functions. In New York, the Public Health Council's ***Organization and Funding of Public Health Services: The Need for Change***, ***Communities Working Together for a Healthier New York*** and the New York State Association of County Health Official's (NYSACHO) ***Public Health Assessment Project Final Report***, presented the ongoing reorientation of New York's local public health services to accompany health system reforms. These efforts have clarified the parts of the public health system that need planned transformation, and have offered useful conceptual frameworks in which to reform the system.

Role and Mission

Local health departments in New York are moving toward strengthening their infrastructure to maintain the health protection and assessment functions that are the unique charge of public health; toward providing population-based services in an efficient and effective manner; toward creating enabling services as needed to improve the community's health and away from the provision of direct personal health care services, except where absolutely necessary to fill gaps in health system capacity.

Unfortunately, there is a substantial divergence between the desired and needed future role of local health departments in New York, and the administrative implementation of Article 6, the New York State Public Health Law that defines the conditions under which LHDs may receive state aid for general public health work. While the prescriptiveness of Article 6 and its Part 40 administrative/paperwork processes in the past *did* serve the very useful purpose of standardizing the expectations of local health departments, the level of specificity that has grown up around this process is deemed by all involved to be cumbersome, limiting, and fundamentally unresponsive to the emerging local priorities. The Article 6 process has, to a great extent, degenerated into a paper exercise.

In discussions with State Health Commissioner Dr. Barbara A. DeBuono, NYSACHO expressed its willingness to collaborate with the Department in creating a strategy to modify the Article 6 administrative processes so that they respond to the recent changes in the health system and accommodate the emerging role change for local health departments. The Public Health Agenda Committee, composed of equal representation from the Department and the New York State Association of County Health Officials (NYSACHO), was convened in April of 1997, and given the following charge.

Commissioner's Charge

To review and reform, if necessary, the current Municipal Public Health Services Plan process, including Community Health Assessment activities, specifically with regard to:

- *The Public Health Law and the regulations that define the Municipal Public Health Services Plan (MPHSP) and Community Health Assessment (CHA).*
- *Current Article 6-related activities and how these processes could be combined with others to create efficiencies and consistent, more comprehensive planning.*
- *Identifying state and local data needs.*
- *Reviewing and analyzing the recommendations of NYSDOH/NYSACHO's Public Health Assessment Group and applying these recommendations to the retooling of the CHA and MPHSP.*
- *Creating and agreeing to principles on which to base this year's MPHSP and future MPHSPs.*
- *Applying the principles to create a new MPHSP and CHA.*

Key Principles and Desired Outcomes

The Committee first adopted several key principles, affirming that this process should be an open, collaborative endeavor wherein the members, as representatives of the state and local health departments, would build the foundation for a new relationship. There was a unanimous desire to make the Article 6 process realistic, efficient, manageable, and timely -- all attributes that the current process does not have. Fundamentally, the Article 6 process must be intrinsically linked with achieving our objectives for the improvement of health for all New Yorkers.

The Committee then endorsed the following as desired outcomes of the process.

- That New York State Department of Health and the 58 local health departments are recognized as full partners in preserving, protecting and promoting the health of New York State residents.
- Acknowledgment that new roles are emerging for state and local health departments, and that the transition to these roles should be consciously managed. These new roles will, of necessity, change the relationship between the local departments and the NYSDOH.
- Use of the Article 6 planning process to strengthen local departments' partnerships within their communities and with the NYSDOH.
- Establishment of a link between the local public health services planning process to the goals described in ***Communities Working Together for a Healthier New York***.
- Improvement in the local health departments' abilities to address in their plans the needs identified in the Community Health Assessment, to address the adequacy of existing community resources to meet local needs and to focus on asset development instead of being strictly needs-based.
- Establishment of a standard set of outcome measures, performance indicators, and performance standards.
- Streamlining of the Article 6 process to make it less onerous and more useful to all involved.
- Examination of the possibility that a local public health master plan can replace the multiple categorical plans and reporting requirements that are major administrative burdens to all involved.

Committee Process

As background, the Committee reviewed Article 6 of the New York State Public Health Law (State Aid to Cities and Counties) as it now stands, current Part 40 regulations, proposed revisions to Part 40 negotiated by the Department and NYSACHO in 1995, the ***Public Health Assessment Project Report***,

current MPHSP guidance documents, and various plan formats.

The Committee worked both as a committee of the whole, and as four subcommittees: Public Health Services Plan, Community Health Assessment, State and Local Roles and Responsibilities, and Performance and Monitoring. Each subcommittee was co-chaired by a representative of NYSACHO and the NYSDOH. (Appendix B.) A steering committee was composed of the eight co-chairs of the subcommittee.

Each subcommittee produced independent reports of their recommendations. The full Committee was then reconvened to discuss areas of consensus between the subcommittee, areas where there are disagreement, and areas where more discussion is needed before the production of this final report. The Committee had access to other Department staff as resources on fiscal, legal, Medicaid and regional office issues.

The Emerging Environment for Local Public Health Services

Any discussion on the restructuring of Article 6 must be based on the changes occurring at the local, state, and federal levels regarding both clinical and public health activities.

Changes at the Local Level

- *There is a greater-than-ever emphasis on outcomes and accountability.*

  At all levels of government, there is a drive to link the use of resources with desired outcomes. In New York, local agencies have joined, and others have led, the movement toward outcome-based accountability. At the state level, as well, there are efforts to establish the relationship from identified needs to targeted activities tied to the achievement of identified performance measures. At the Federal level, the Government Performance and Results Act (GPRA) will soon require all agencies to identify progress toward their objectives with the use of outcome measures and performance indicators. *This rush to use must be coordinated to avoid a cascade of different requirements on local agencies.* Selection of performance and outcome measures must reflect emerging priorities at each level of government and the adoption of performance and outcome measures must be coordinated at these various levels.

- *There is recognition that the achievement of public health objectives is dependent on the involvement of community partners beyond the local health department. Relationships with local partners are rapidly changing.*

  A modern New York State local health department must be involved in community mobilization. If local health departments are charged with recognizing emerging needs, they must also be able to help the community recognize these needs and assist in finding implementors for needed programs. Increasingly, local health departments are conveners, facilitators, planners, organizers and mobilizers. Local health departments must be included in health assessment and planning activities in their communities.

- *The workforce, and the skills needed by the workforce, are changing.*

  The need for traditionally-prepared public health nurses and sanitarians will continue to exist, but local health departments will have a greater need for professionals skilled in data management, data analysis, community assessment, facilitation, community organizing, community health education and marketing.

- *The relationship between the NYSDOH and local health departments is changing.*

  A greater sense of partnership is emerging between the two levels of government. The

relationship is based on mutual respect and understanding, and is affirmed by our mutual goals, our mutual understanding of state and local roles and responsibilities, and our shared values.

- *Local public health departments throughout New York are rethinking their traditional activities. LHDs are now moving rapidly to focus on infrastructure, population-based services, and enabling services. Strategies like the expansion of Child Health Plus and managed care are moving the reimbursable clinic services traditionally offered in local health departments toward private sector providers. Therefore, there are decreasing numbers of uninsured and Medicaid children without a medical home who are accessing health department services. At the same time, access to services for uninsured adults is becoming problematic as welfare reform proceeds and as competition and captation erode the safety net providers.*

  The movement in public health is toward ensuring adequate infrastructure and population-based public health services. Local health departments are building their capacities for community assessment, data collection, evaluation and other skills necessary to ensure the infrastructure, and their improving their capacities for such population-based services as public health information, outreach and universal screening programs.

  Increasingly, they are moving away from the provision of direct medical services, except where there is a documented need to fill gaps in the health care system or to provide needed services for vulnerable, hard-to-serve populations while capacity develops in the private sector. Some county health departments have identified services that are uniquely positioned and able to remain competitive with the private sector. Yet, the increasing cost containment pressure on the health care delivery system due to managed care has led some private providers to seek Article 6 reimbursement for costs not reimbursed under captation. Local health departments are therefore being asked to deficit-fund. In addition, local health departments may be asked to begin subsidizing primary care for adults, as area not traditionally considered to be a public health responsibility.

  If adequate and appropriate capacity fails to develop for certain populations, public health may continue to serve those who do not have access in the mainstream health services, meeting needs by filling gaps. For example, too many rural counties, the operation of a Certified Home Health Agency (CHHA) is a public health reality that counties must continue to carry, despite the cost. They will do so in the face of declining patient census, declining patient care revenues, and a diminished ability to shift the cost of care for the uninsured into Medicaid rates and third party fees.

<u>Changes at the State Level</u>

Local health departments are not alone in their need to adapt to these rapid changes. The State Health Department's role is evolving rapidly as well.

- *Strategic Planning*

  The NYSDOH is undergoing a strategic planning process to better focus the Department's efforts toward a common purpose and direction, the need to keep pace with change, and the needs of the Department's customers. The Department has established its mission, vision, values and key result areas, against which progress will be measured. The process has caused the Department to rethink many fundamental assumptions about the organization, its activities and service to its customers. The impact of this process for local health departments should be improved "customer service" from the NYSDOH, and greater receptivity by the NYSDOH to locally-generated arrangements and activities that meet locally-defined needs.

- *Public Health Priorities and* ***Communities Working Together***

After an extensive statewide public health priority setting process, in which more than 1,400 New Yorkers participated, the document ***Communities Working Together for a Healthier New York*** was issued in 1996. This document lays out the vision for communities to improve the health of their residents by focusing on the underlying causes of disease, death, disability and years of productive life lost.

This document has resulted in at least two fundamental changes at the State level. First, it has set the new agenda for public health in New York by identifying twelve priority areas for action (access to care, education, healthy births, mental health, nutrition, physical activity, safe and healthy work environments, sexual activity, substance abuse, tobacco, unintentional injuries, and violent and abusive behavior). NYSDOH is in the process of aligning all of its public health programs with ***Communities Working Together***. Second, and equally important, the successful implementation of this plan requires each community's involvement in identifying its specific needs and best intervention approaches, with the support of NYSDOH. To achieve this, the State has already provided funding in the amount of $700,000 to county health departments to convene community partnerships. It is also working to develop and improve data systems to help communities measure health status, and will be establishing an intervention's clearinghouse to share successful implementation strategies among communities.

As another outcome to ***Communities Working Together***, NYSDOH is working much more closely with health care provider organizations, academia, the faith community, business councils, the nonprofit voluntary sector and statewide advocacy organizations to achieve statewide goals for community health. With the assistance of a two-year grant from the Robert Wood Johnson Foundation's Turning Point Initiative, the State Health Department has established a broad-based partnership to undertake a strategic planning process to strengthen the public health infrastructure at the state and local levels. These statewide activities provide support and technical assistance for a parallel community-level process in three localities that will be funded by the Kellogg Foundation.

- *New Focus on Behavioral Risk Surveillance*

Communities Working Together has helped to focus attention away from specific disease entities and toward the underlying causes of disease. There is full recognition of the need for better information on the state and local level about the role of individual behaviors and choices play in the development of disease and disability. Unfortunately, such data is not always available. Some data is available only on a statewide level, or may not be available for all localities. The Department is working to improve the information infrastructure and to improve the timeliness and geographic availability of this important data, with the full support and urging of local departments of health.

- *Development of Environmental Health Priorities*

In 1998, the NYSDOH will be continuing the process of priority setting by reaching out to various stakeholders in establishing environmental public health priorities. While ***Communities Working Together*** recognized environmental health activities within the public health infrastructure as part of the essential foundation upon which communities can achieve health, no specific objectives or priorities were established for these vital activities. The timing of these priorities will need to be considered when asking local environmental health staff to respond to any new formulations of the local health services plan.

- *Regionalization*

In December of 1996, a NYSDOH Steering Committee on Regionalization established a vision of a field office structure that effectively targets resources in support of efforts to address the public health priorities established in ***Communities Working Together***. The vision is for seamless

administration of programs and services through a regional office structure that carries the mission, vision and values of the Department closer to its customers and allows for a consistent application of policy statewide. The plan, now being implemented in the Western New York Region, and, more recently, the Metropolitan New York Region, calls for the delegation of authority and responsibility to regional offices. This should enable NYSDOH to anticipate, understand, and rapidly respond to the changing needs of its customers, by improving communication, coordination and working relationships with its partners, customers, and within its own organization.

- *Health Care Reform, including Medicaid Managed Care*

  In January of this year, New York joined 48 other states whose hospitals negotiate their rates with insurers in a free market system, a change shown to lead to lower health care costs through greater operating efficiencies. The Health Care Reform Act also contained other important "public goods" provisions relating to rural health networks, workforce transition and graduate medical education. More recently, New York began implementing a statewide, mandatory Medicaid managed care program for most Medicaid recipients. These are important steps to assure a quality medical home in which primary and preventive health care services are delivered. In essence, the private sector has now become responsible for most of the direct services that had often been provided by local health departments. The effect of these changes has been increased consolidation of and networking among health care providers, with increased competition for clients. Local health departments will need to be highly competitive in cost and quality in order to maintain financing for any direct clinical services that they hope to retain. At the same time, the State Department of Health needs to work with local health departments regarding the potential for cost-shifting to Article 6 by capitated providers. Finally, the State Department of Health needs to begin addressing care for uninsured and under insured adults whose numbers are increasing due to welfare reform and the loss of safety-net providers.

- *Outcomes-based Program Management: the Monroe Consolidated Child and Family Health Grant, and the TOUCHSTONES Project*

  In partnership with the Monroe County Health Department, the Department has been pursuing a federal approval to consolidate eight categorical grants into a single integrated grant. The goals of the initiative are to allow increased flexibility, to maximize the use of resources, and to focus on the desired health outcomes. The program is reducing categorical barriers to care and improving the integration of services. A consolidated monitoring tool is now under construction. This demonstration can serve as the boilerplate for system-wide change in the way the Department establishes contracts with local health departments.

  Under the TOUCHSTONES Project, several communities will be given the opportunity to pilot a collaborative planning process that extends across all child and family services agencies at the local level. This process, managed by the new Office of Child and Family Services, hopes to produce common goals, objectives, and core measures; improve accountability for positive outcomes; and improve local planning to be more comprehensive and effective. The benefit for local agencies will be enhanced collaboration, greater clarity and cooperation in defining and working toward common goals, and greater administrative efficiencies. State agencies have agreed to measure and track progress across a number of clear, consistent, quantifiable measures. Again, if taken system-wide, local health agencies will clearly be impacted.

<u>Changes at the Federal Level</u>

Changes at the federal level are directly impacting NYSDOH and local agencies.

- *The Government Performance and Results Act (GPRA*)

The Government Performance and Results Act, Public Law 103-62, requires each federal agency to establish performance and outcome measures that allow for review the impact of programs on the target population. These measures are to be reported annually to Congress as part of the budgetary process, comparing achievement to what was proposed in the agencies' performance plans, and linking use of resources and decisions about level of funding. Because the State Health Department receives funds through several federal agencies, it is conceivable the Department will be reacting to several sets of performance measures. It is expected that local agencies, because they have a role to play in the achievement of statewide objectives, will have a vested interest in assuring that the selection of performance measures is coordinated between agencies and limited to a manageable number. Otherwise, the effect could be very burdensome.

- *Child Health Insurance*

The Balanced Budget Act of 1997 created a new federal program and funding source for states to provide expanded health insurance coverage to children. Enacted as Title XXI If the Social Security Act, the new State Child Health Insurance Program (S-CHIP) allows states the flexibility to use the new matching funds to either expand Medicaid or create or expand existing state child health insurance programs to reach an additional five million children nationwide. State allocations are being determined by a formula based on their number of uninsured children below 200 percent of federal poverty level.

Since New York has had a model insurance program for children, Child Health Plus, the state has chosen to expand that program. Commissioner DeBuono is using this opportunity to rethink our vision for child health in the state. She is seeking a more seamless system for child find, enrollment, eligibility determination and service delivery. To this end, the state will be working in partnership with local agencies to determine how children are best served and what will be the logical role for local health departments in outreach, education and enrollment.

Chapter 2.
The Community Health Assessment

Background

The Agenda Committee unanimously agrees that the current Community Health Assessment (CHA) is too cumbersome, too detailed, too frequently required, and too resource-intensive for the value it provides to either the localities or the State. Although Article 6 funding earmarks $35,000 annually within the base grant for each local health department to perform the required community health assessment, the amount spent varies in counties and does not appear to have a direct correlation with quality or usefulness.

Due to the level of detail required and the brief time between assessments, most local units prepare the required document without input from other key providers in the community, nor from the public they serve. Many local units feel that the work of preparing the document is too burdensome for their staff, and thus contract out the activity, creating even greater distance from customer and government. These problems have lead to the perception within the NYSDOH and the LHDs that the current CHA is a paper-only process, with little utility beyond allowing the local unit to collect state aid.

Vision of a New Community Health Assessment

The mandated Community Health Assessment should be the basis for all local public health planning. Indeed, the Public Health Law recognizes the importance of this process in making it a requirement in Section 602. Through the community health assessment process, local agencies must be able to recognize important issues with implications for the health of the community, identify and assess the use of local resources, note gaps between expectations and health outcomes, identify needed services, justify the development of needed assets, and translate needs and conditions in the community in a way that is understandable to the wider community.

Specific Recommendations Based on *Public Health In America*

- *The template for the new Community Health Assessment must be based on concepts introduced by the **Public Health in America** document.*

  The Community Health Assessment Subcommittee drafted new guidance for the Community Health Assessment (Appendix D) which responds to the concept in ***Public Health in America***.

- *Information from the current pilot Public Health Priorities Projects should be used in the design of the final recommendations.*

  The Committee strongly recommends that the final format of the new CHA be based on this basic format, with input from the results of the pilots in community assessment that are currently underway. Because a number of local health departments are now piloting new models for community health assessment under the Public Health Priorities Partnership Initiative grants, the Committee recommends that the results of the pilots be compared to the requirements of the Committee's draft.

- *There is a need to pilot a community health assessment that meets the needs of both Article 6 and the categorical grants.*

  It is *strongly* recommended that the concept of a combined CHA, meeting the needs both of Article 6 and categorical grant programs, be piloted in a representative sample of counties.

Key Features of a New Community Health Assessment

- *Local health departments should serve as the lead agency for local health assessment and seek input on the community health assessment from other organizations, community leaders and consumers.*

  The local health department should reach out to community-based organizations, local educational institutions, health care providers, consumers, special interest groups and community leaders for input into the CHA. Local health departments will remain cognizant of the need for other organizations to be involved in assessing the community, and will inform them of the process. In some instances, a regional approach may be desirable. In this case, the local health department should reach out to other health departments and regional resources. In addition, other community health assessments should include local public health input.

- *Community health assessment should be a continuous process toward a simplified, realistic, useful CHA, not solely the production of a single, static document.*

  Community health assessment must be an ongoing process, going beyond the preparation of a single document to meet Article 6 requirements, involving continuously scanning the local health environment for changes in conditions and emerging health issues. Local units should be encouraged to see the assessment process as continuous. All units within NYSDOH should be encouraged to use the CHA in lieu of other assessments in every possible instance.

- *The development of the CHA should be an interactive process, with the NYSDOH providing enhanced training, improved communication of expectations, clear guidelines, and centralized, consistent responses to inquiries.*

  Community health assessment as a process on the local level should be supported by improved technology and more technical assistance from the NYSDOH. Counties should have improved access to sub-county level data, prepared and provided timely with the assistance of NYSDOH. The CHA process should be simple and easily understood so that each local health department will have the capacity to perform its own assessment functions, without requiring the hiring of outside consultants. An annual workshop to teach assessment skills is recommended. There should be a defined role for regional staff.

- *The CHA should have an extended term. The Committee recommends a six-year cycle, with local departments providing biennial updates and/or supplements. Whenever possible, the new CHA should be timed in such a manner as to make best use of new census data and NYSDOH generated vital records, risk factor, and behavioral data.*

  Changing the cycle for a full assessment to six years will have the effect of reducing the paperwork burden for localities, allowing for true collaboration with other local partners and consumers, and for use of much needed NYSDOH generated population-based data.

- *The document, when produced, should have multiple uses and relate to multiple local, state and Federal agencies, organizations and audiences (grant makers, facilities, citizens). The CHA should meet the needs of both state and local government for assessment.*

  Among the multiple uses envisioned for the CHA are:

  - Planning and evaluation of program progress.
  - Documenting the local health departments' fulfillment of legal and regulatory requirements.
  - Cataloging health activities taking place in the community and helping local health departments to meet a wider assurance role in the community.

- Justifying budget appropriations.
- Providing the public with informative and empowering information.
- Helping the local health department determine their staffing needs.
- Reporting on important health outcome measures.
- Providing technical assistance to other agencies.
- As the needs assessment for categorical grant programs.

The local community health assessment process and document should eliminate, to the extent possible, the need to duplicate assessments for NYSDOH grants and replace redundant local processes wherein multiple agencies and facilities are assessing many of the same variables and outcomes. Categorically-funded programs should not require additional assessments. If the assessment is prepared collaboratively with other agencies and organizations, it should be used to fulfill other requirements, as well. For instance, it could serve as a local hospital's community service plan required under Article 28.

- *The format for the CHA should be simple and flexible, setting minimum standards but enabling local health departments to formulate local priorities and benchmark progress toward local priority outcomes. It should address the priorities identified in* ***Communities Working Together****, which focused on the underlying causes of poor health.*

  Communities Working Together provides a workable framework for engaging the various sectors of the community in public health interventions. The format of the CHA and local public health services plan should mirror this important approach.

- *Local health departments should be required to report on their progress toward a uniform set of performance and outcome measures that is used by every LHD in the state and can be used for comparison with other localities.* (Appendix C.)

  There is a myriad of performance measures being developed on virtually every level. As a state, we should embrace the measures used in ***Communities Working Together*** and select other key indicators and health outcomes against which our progress can be measured. Where data is not currently available, the NYSDOH should create such data for local use. The NYSDOH should also expand the collection of behavioral data that is not currently available on a statewide, county-by-county basis. This report would then take the place of the annual performance report.

- *The Community Health Assessment should also include an annual community report card that is easily understood by consumers and local policy makers to inform and empower them.*

  A community health report card is composed of easily interpreted data bench marking progress on a limited set of locally-important public health issues. For example, if a community had particular concerns about motor vehicle collisions involving young drivers, drugs and alcohol, these data would be contained in the report card and reported out to the community on an annual basis. The report card would probably *not* include the whole set of selected performance measures. These measures could be developed in consultation/collaboration with NYSDOH. Again, this report would then take the place of the annual performance report.

- *The CHA should include an organizational capacity assessment, measuring the ability of the local health department to perform a community health assessment and demonstrating the adequacy of their resources, expertise and technical capacity.*

  There is concern that some local health departments would be unable to achieve this level of assessment. This baseline assessment should provide the basis for a statewide work plan to develop or improve these capacities. Working together and using both state and local resources, NYSDOH and the local health departments can then address the development of needed skills within the workforce and to improve the technical capacity of local units.

Chapter 3.
The Municipal Public Health Services Plan

Background

Section 602 of the New York State Public Health Law calls for each municipality to submit biennially, on such dates as fixed by the State Health Commissioner, a municipal public health services plan. The plan must contain, at a minimum, an estimate and description of the immediate and long-term needs for public health services in the community, particularly those services that promote public health and prevent illness, and a statement and description of the objectives the municipality intends to achieve, including how the funded services will maintain and improve health status and assist in containing health care costs. The plan must be based on a comprehensive community health assessment and be accompanied by particular fiscal and administrative information.

The municipal public health services plan is being more widely recognized as a master plan for health care in the community. Because of its broad focus on the improvement and maintenance of health and cost containment, and because the plan must take into account coordination and use of available state and local resources, it is no longer viewed solely as a funding plan for State Aid. Individual county plans are the documentation of the pathways toward our collective vision of "healthy people creating healthy communities."

Key Features of a New Municipal Public Health Services Plan

A proposed model for the 1999-2000 Municipal Public Health Services Plan appears in Appendix E.

- *A simple, flexible format is needed. Wherever possible, the format should make use of standard checklists for routine activities or to assure minimum requirements are met. While the document should be the master plan for public health activities in the community, there must be flexibility to adapt the plan for changing circumstances or issues that emerge quickly.*

  Like the community health assessment, the plan should have multiple uses. It should relate to multiple grant programs, be specific enough to be useful to the public in understanding the activities of the local health department, but fluid enough to adapt to the need for quick changes in strategy.

- *The plan should continue to describe the local agency's infrastructure and capacity, including organization, staffing and skill level, and deployment of resources.*

  A requirement of the plan has always been the description of resources to carry out the local plan. This is important in assessing the feasibility of local units carrying out their plan and serves as a statewide documentation of the infrastructure and resources available in local health units.

- *Local public health planning should be reoriented, based on the local departments' role in the ten essential public health services, not necessarily by the five public health service areas as the plan is now oriented. It is the conclusion of the Committee that this can be done without amendment to the current statute.*

  Section 602 requires that NYSDOH review each locality's plan for the extent to which it satisfies standards set by the Commissioner for reducing morbidity, mortality and hazards to the public's health. Under 602 (b), plans must be reviewed for the extent to which services will promote the public health, enhance or sustain the public health, protect the public from the threats of disease and illness, prevent premature death and help contain the costs of health care. The law goes on to specifically state five areas that promote the public health (family health services, disease control, community health assessment, health education and environmental health), and that the

Commissioner must define activities within these five areas. Section 605 states that the base grant shall apply to services identified in 602 (b). It could be interpreted that reimbursement applies to the narrative description and not solely to the five named service areas. Although the law also states that the list of activities can be changed by the Commissioner in consultation with the public health council and county health officials, the Committee feels the law is flexible enough to accommodate a reorientation of the plans to essential services.

- *There should be specific, clearly articulated criteria for funding direct, enabling, population-based and infrastructure services. The Committee recommends these decisions be made in conjunction with a Fiscal Workgroup.*

The system is shifting toward supporting infrastructure-building and population-based services, creating a need to reorient both the municipal public health services plan, and the funding that supports local public health services. The system must continue to support direct services delivered or paid for by county health departments to the extent that health needs in the community are insufficiently unmet by mainstream providers. Local health departments will continue to be the safety net for populations and individuals whose needs are not met by other providers in the community. Criteria for funding the full range of services need to be revisited, revised and clearly recorded and reported, so that eligibility for funding is clearly and widely understood.

- *Consistent with the recommendation made regarding the community health assessment, the municipal public health services plan should be developed interactively with NYSDOH.*

Local health departments should receive training and workshop presentations in plan development. Expectations for content should be clearly articulated to local health departments.

- *The term of plans should be renewable beyond the present two-year cycle.*

Article 6, as it is presently written, calls for the localities to submit their plans for state review every two years. The Committee recommends an interpretation that allows the locality to file updates or requests to expend present plans every two years, with the body of the plan remaining in force for up to six years.

- *Whenever possible, the municipal public health services plans should meet the needs of categorically funded grants in order to eliminate the need for additional work plans and reporting documents.*

The MPHSP should be the "master plan" for all public health services. Work plans for longstanding renewable grants such as those for lead poisoning prevention and I-CHAP should be incorporated with the plan.

Since the state's funding under categorical federal initiatives is increasingly based on meeting or reporting on progress toward certain federally-selected performance measures, performance measures on the local level should reflect those items on which the State must report to the federal funding sources (i.e., Centers for Disease Control and Prevention, the Federal Maternal and Child Health Services Block Grant and the Preventive Health and Health Services Block Grant). Although these funds are not available to all counties, it is expected that the State will utilize other resources to meet these performance goals. Thus, the State is in the position of having to report these data, even for those counties that do not receive funds. Utilizing consistent performance measures throughout will greatly simplify reporting. In addition, NYSDOH should apprise local health departments of other community-based organizations applying for grant funding so that local commissioners and directors can offer input and assure new grantees will embrace existing community objectives.

Chapter 4.
The State Aid and Fiscal Accountability

Background

The basis of Article 6 is the payment of State Aid for local public health services. Key issues in the re-engineering process are:

- The delineation of "basic" vs. "optional" services and the fiscal implications of this distinction.
- The relationship of categorical public health grants to Article 6.
- The timing of fiscal documents.

Basic vs. optional services

The Committee recommends that a Fiscal Workgroup more fully explore these fiscal issues and recommend specific criteria for funding based on the ten essential public health services as defined in ***Public Health in America*** *and recognizing the evolving roles of county health departments.*

The terms "basic" and "optional" are used in the law to denote services which may be applied toward the agency's base grant, and those for which a lower rate of reimbursement is available. The classification is based on those services that relate to the five required areas of service: community health assessment, health education, family health, disease control and environmental services. Reorienting the local public health services plans toward the ten essential public health services and toward infrastructure and population-based services will mean rethinking which services are truly basic, and whether some service presently deemed to be optional should remain in this category. In some cases, services in the optional category may be more critical to meeting local priorities than services that are presently in the basic classification. Within the context of the ten essential services and the five required service areas, consideration needs to be given as to whether unreimbursed costs due to capitation and/or primary care for uninsured or underinsured adults are eligible for state aid.

Relationship of Categorical Grants to Article 6

The Committee recommends that an aligned grants concept be piloted in a small cross-section of counties with the idea of going to such integration on a full scale basis by 2002.

There has been a great deal of discussion about what should be the relationship of categorical grants with the Article 6 process. There are several possibilities for the better alignment of these funding streams, some of which were discussed earlier in this document:

- The community health assessment could serve as the needs statement for ongoing categorical grants, with flexibility for the county to provide additional data for the categoricals, should they deem it desirable.

- The municipal public health services plan should serve as the master plan for all services of the local health department, whether funded by Article 6 or a categorical budget. This could be done by seamlessly meshing the work plans or through modular additions to the MPHSP for each of the categoricals; the method chosen would depend on the degree of integration desired and the degree to which the Federal grantor is comfortable with the concept.

- Monitoring and reporting requirements should be consolidated, allowing local health departments to report their performance through a standard set of performance measures that related both to Article 6 and the categoricals.

- Grant contracts/budgets could all be put on the same contract year, preferably January 1 through

December 31 in order to match the Article 6 cycle.

- The state aid application could serve as the master budget document for financing local heath services by including Article 6 and categorical grants. Because the categoricals are funded in an entirely different manner from state aid, there may need to be some separation of charges on the counties' vouchers. A possible solution is to append grant work plans and budgets with Article 6 documentation in a letter of agreement as part of a "universal budget". In this way, program and fiscal operations are viewed on a more global basis, while the integrity of the documentation for the use of the various categorical funding streams is maintained.

The concept of a better alignment between Article 6 and the categorical grants is very appealing to both the State and the local agencies because it has the potential to streamline planning, budgeting, the vouchering and payment process and reporting/monitoring requirements. While the Monroe County pilot did not include Article 6, there were administrative efficiencies demonstrated through simply combining categorical grants into one contract and reorienting the work plan toward outcomes. With these actions came the realization that each of the programs works toward the same outcomes, and the responsibility for their achievement is shared by several programs. But there are also potential pitfalls. For one, the categorical nature of Federal funding makes full consolidation a difficult proposition when Federal sources are tapped and combined with State monies. Program quality standards may slip as the emphasis moves toward integration and away from the individual program. When the topic of consolidation was discussed in the past, NYSDOH staff was advised that enabling legislation may be required. Still, integration is viewed as positive, because individuals, families, and communities are better served in an integrated service model.

It is premature to recommend that all NYSDOH grants to localities be integrated with Article 6, but there is support for combining grant program budgets and contracts and for using the community health assessment and municipal public health services plan as the basis for grant funding. County health departments view integration of grant program years and other streamlining processes as welcome relief.

Timing of fiscal documents

The Committee recommends that the timing of fiscal documents remain unchanged.

Each of the counties outside of New York City is on a calendar fiscal year (January 1 to December 31). New York City is on a July 1 to June 30 fiscal year. Article 6 fiscal documents are due at two different times. The Fee and Revenue Plan, which is the part of the Municipal Public Health Services Plan that describes the locality's resources for carrying out their plans, is due with the plan on November first. The State Aid Application, which contains the organizational chart for the local agency, the detailed budget of proposed expenditures for services funded by Article 6, and a certification by the chief executive officer that the application is consistent with the plan, is due February first or thirty days after the adoption of the municipality's budget.

Because the Fee and Revenue Plan (FRP) is due in November, it is almost always based on the budget that the agency submitted or their last fiscal year. Because of the timing, the FRP is not based on actual figures for the adopted budget. The application, on the other hand, *is* based on an adopted budget, and therefore, provides a better estimate of the agency's resources to carry out the plan. Local health departments are uncomfortable about portraying an array of services before their budget is adopted. If their legislature cuts their budget, they will have fewer resources. If they are granted additional resources, they will be able to expand their activities. Either way, the present procedure calls for the local health department to file amendments to their plan. NYSDOH staff needs to remain cognizant of these realities and to process amendments in a flexible and timely fashion.

Relative to the combining of grants with Article 6, this step may require that RFPs be timed to coincide with the State Aid application. This idea should also be explored by the fiscal workgroup.

Chapter 5.
Performance Monitoring

Background

United in their mission and vision for the health of New York's communities, the state and the localities share responsibility for assuring adequate performance and for monitoring the progress and conduct of public health programs. Traditionally, the State has taken the larger and more visible role in oversight, often relegating the regulated agencies to a passive and acquiescent role. Recommendations were often one-sided, requiring the counties to react to the State's findings, as opposed to being actively engaged in diagnosis of problems and generation of possible solutions. Monitoring has lost, in this process, vibrance and creativity. Monitoring should be viewed as a positive and constructive experience, in which full participation by the contractors and counties would help ensure the most beneficial outcomes.

Recommendations

- *The measurement of a local health department's performance should be comprehensive, encompassing process, outcome and capacity indicators, and should include multiple measures within individual program areas. It is recommended that specific, statewide performance and outcome measures be established, with allowance for local health departments to develop additional locally-important performance or outcome measures and to negotiate their level of performance on statewide indicators.*

  NYSDOH should utilize a single, comprehensive reporting system to support the information needs of localities, individual NYSDOH program units and the Federal government. Article 6 site visits should utilize cross-trained generalists from the regional offices and encompass the monitoring of multiple individual programs to the extent possible. When program specialist visits are appropriate, their timing should be coordinated with more broadly-focused assessments.

  The statutory basis for the development of performance standards is contained in both Public Health Law and Part 40 regulations. Article 6, §602.3(a), calls for the Commissioner to review local plans for the extent to which they will meet standards the Commissioner has promulgated. Each section of Part 40 relating to public health activities contains a performance standard and minimum requirements for those activities. These performance standards are not quantitative nor qualitative; they usually represent an ideal. "Children under the age of 21 shall have access to information with regard to dental health." "All children under the age of 21 within the jurisdiction shall have access to comprehensive primary and preventive health services." "Local health units shall promptly respond to all reported nuisances which may affect public health and safety."

  The adoption of a consistent, statewide set of performance and outcome measures would enable localities to compare their progress against state and regional averages and against similar jurisdictions. However, because local priorities differ, local health departments should have some autonomy to select measures that are locally important.

  Counties should also have the ability to negotiate their anticipated level of performance on statewide indicators. The selection of the statewide measures should be a collaborative process involving representatives of local agencies, and indicators should be consistent with other efforts on the State and Federal level. Localities can be assisted in the use of adopted performance standards through improved on-line access, training and technical assistance in selection of measures of local significance and the availability of an inventory of indicators, the source of the data, and their availability by geographic area.

  The experience of the Monroe County Health Department in selecting and reporting on locally-

important outcome measures can be used as a model for wider adoption in other counties.

As part of the Monroe County Child and Family Health Grant work plan, state and local health department staff defined and negotiated a set of specific, quantifiable, practical objectives against which progress in improving the health status of county residents can be measured. Consistent with the principles in ***Communities Working Together,*** the measures are obtainable from existing data, understandable by policy makers and the general public, and meaningful on a local level. These measures also meet the need for accountability in the use of State resources.

The negotiated measures then served as the basis for the county's child and family health work plan. The county reports on their progress toward these measures on a quarterly basis. In doing so, the orientation of performance reporting and monitoring changes from only including process indicators toward reporting on outcomes. (Quarterly reports obviated the need for an annual report.) Outcomes are also reported as part of a community report card that is issued annually by the Monroe County Health Department. Monroe County's experience with public reporting of health status indicators has been positive to date.

This type of performance monitoring, of course, has as its cornerstone timely access to needed data.

- *NYSDOH should take the lead in conducting population-based surveys and analyzing statewide data bases (like vital statistics and SPARCS) and should feed this data back to the local health department in a timely fashion.*

There is a paucity of knowledge, attitudes, and behavior (KAB) studies. The State Health Department should take the lead in developing additional behavioral data. As appropriate, measures should be available on a sub-county level and identify high-risk groups of individuals.

- *NYSDOH should assist local health departments with capacity development.*

LHDs should routinely conduct self-evaluative management audits of their programs as part of their routine quality assurance program. The status of their infrastructure, resources and expertise in executing their programs and initiatives in a dialogue with their NYSDOH partners should become part of the capacity assessment section of the community health assessment.

Local health departments need assistance with capacity assessment, workforce redesign, and skill development. A structured public health workshop series should be designed, based on identified needs, and conducted throughout the state on an annual basis, and a structured NYSDOH/NYSACHO mentoring program should be developed and offered to all new local health department directors. Areas in need of capacity development are community assessment, data generation and interpretation, community engagement and mobilization skills, information transfer and information resource management skills, marketing and public information.

Capacity-building incentives should be developed and targeted to those local health departments with relatively low capacity, fewer financial resources and relatively serious public health problems. These incentives should be based on the needs documented in the organizational capacity assessment contained in the county's community health assessment. Where there is the greatest magnitude of health problems, there are usually the fewest resources available through local property taxes. Therefore, state aid should help provide balance to build local capacity.

- *Consistent substandard performance should be recognized and addressed. At the same time, superior performance should be recognized and lauded.*

NYSDOH should construct a schema that addresses substandard performance based on a progressive series of responses. Initially, enhanced training, technical assistance and monitoring

support, provided without county cost by NYSDOH or NYSACHO, are appropriate responses. Capacity-building incentives are appropriate, as well. A plan for improvement could also be required. Administrative penalties, including more intense monitoring, should follow if there is lack of progress.

Public recognition of superior performance may provide an incentive to improve public health activities and programs. ***Communities Working Together*** suggested a clearinghouse for successful intervention strategies. Local agencies who design and implement successful public health interventions should have their accomplishments highlighted through this means, which may then serve to reinforce good performance.

Roles and Responsibilities

The Roles and Responsibilities Subcommittee also provided a matrix of suggested delineation of state and local responsibilities, based on the ten core functions of health departments. The matrix follows this document in Appendix F.

New Models for Performance Monitoring

The purpose of performance monitoring is to maintain program accountability, both for the use of public funds and for the protections of the public's health and safety. The ultimate goal of evaluation is to assure the best possible outcomes for the public. It is a goal shared by the state and local health departments alike. Therefore, local health departments and the State Health Department should be full partners in performance monitoring. Both have a vested interest in the outcome. Both are committed to supporting and strengthening local efforts. The local agency must be an active participant in the review and evaluation process, actively evaluating its own progress and operation.

As a key principle of this new model for monitoring, whenever and wherever possible, program evaluation should be comprehensive in its approach, consolidating existing mechanisms and minimizing duplication of effort. Integration of program elements is to be encouraged and redundancy is to be reduced. Evaluation must occur within a consultation process. The role of NYSDOH staff is *not* to solve the local department's problems, but rather to provide insight into operational issues, to offer a statewide viewpoint, to assist program staff to generate possible responses and to gather resources and technical assistance in support of selecting solutions.

On-site review teams should be composed of a team of NYSDOH staff of varying program and professional backgrounds. When a team approach is utilized, DOH staff will not necessarily be monitoring only their traditional program components. Staff may be cross-trained to complete review tool items derived by other programs. The approach should mirror the comprehensive approach of Article 6.

Reviews should be organized around certain key elements: the capacity and infrastructure of the local agency; common elements from programs consolidating their review with Article 6; and individual program elements that cannot or should not be waived or consolidated based on safety concerns or State or Federal statutory requirements. There are a surprising number of review criteria that overlap from program to program. The team leader, with a team consensus, may choose to focus on some areas and defer review of others based on the local health department's past history and concerns or interests of the program staff. Review could be deferred, for instance, in areas where there has been no significant change in operations or beneficial outcome, and no significant finding of nonperformance.

The model for team monitoring and two sample or "dummy pages" for the model monitoring tool appear in Appendix G. The actual tool should be designed with input from the county health departments.

Appendices

Appendix A. Core Functions and Essential Public Health Services from *Public Health in America*

Appendix B. Subcommittee Membership and Tasks

Public Health Services Subcommittee
Community Health Assessment Subcommittee
Performance and Monitoring Subcommittee
State and Local Roles and Responsibilities Subcommittee

Appendix C. Sample Performance Measures

Appendix D. Draft Community Health Assessment Guidance and Format

Appendix E. Suggested Format for the Local Public Health Plan

Appendix F. Sate and Local Roles in Core Functions

Appendix G. Team Monitoring Model and Sample Pages from a Monitoring Tool

Appendix A.

Core Functions
and
Essential Public Health Services
from
Public Health in America

PUBLIC HEALTH IN AMERICA

VISION:
Healthy People in Healthy Communities

MISSION:
Promote Physical and Mental Health and Prevent Disease, Injury and Disability

Public Health:

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

Essential Public Health Services

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insight and innovative solutions to health problems

Adopted Fall 1994, Source: Public Health Functions Steering Committee.

Appendix B
Subcommittee Membership and Tasks

Community Health Assessment Subcommittee	
Task:	To review and assess the existing Community Health Assessment (CHA) and offer recommendations relative to local participation in development of community partnerships, content and structure of the CHA, the linkage of the CHA to the plan process, term and timing of the assessment, and the relationship to state and local objectives and outcomes.
Product:	**Recommendations for the change of the CHA process and format**
Members:	JoAnn Seiler and David Momrow /Chris Maylen (Co-chairs). Dean Palen, Perry Smith/John Grabau
Performance and Monitoring Subcommittee	
Task:	To evaluate issues related to performance monitoring and fiscal accountability, and to offer recommendations as to balancing financial and programmatic flexibility with accountability, performance assessment systems and rewarding superior results.
Product:	**Recommendations for performance monitoring and rewards.**
Members:	Joanne Bennison and Ron Tramontano/Bob Burhans (Co-chairs). Benjamin Mojica and Michael Rampolla.
State and Local Responsibilities Subcommittee	
Tasks:	To focus on broad areas of state and local partnership-building that could be addressed through the public health services assessment and planning process, to consider the potential for the Municipal Public Health Services Plan to serve as a "master plan" with multiple uses, and to offer recommendations relative to balancing local needs and priorities with statewide concerns and issues.
Product:	**Recommendations for the change in the relationship between state and local partners with regard to the MPHSP/CHA process.**
Members:	David Dorrance and Ann Willey/Betty Kusel (Co-chairs). Arnold Lubin, Robert Walsh.
Public Health Services Subcommittee	
Task:	To assess the existing Municipal Public Health Services Plan and offer recommendations relative to the definition of essential and non-essential services, the linkage of the plan to the community health assessment process and the use of measurable objectives and targets.
Product:	**Recommendations for the change of the MPHSP process and format.**
Members:	Lauren Snyder and John Cahill (Co-chairs). James Crucetti, Nancy Barhydt.

Appendix C
Sample Performance Measures

Sample Performance and Outcome Measures
(By age/population groupings)

Maternal and Infant Health-*Performance Measures*	Where used	Qualifiers
% infants born to moms receiving 1st trimester prenatal care (90%)	MCHSBG	
Percent of births with short (<yr.) birth interval (TBD)	CFHG	Based on LMP--quality
Neonatal drug-related discharges (≤6 per 1000)	CWT	Comparability
Percent of very low birth weight neonates that are delivered at facilities for high-risk deliveries and neonates (85%)	MCHSBG	Facility definition
Percent infants breast-fed at hospital discharge (33%) & 5 mo. (8%)	CFHG	Available upstate only
Percent of pregnant women who use alcohol (5%)	CWT	Upstate only via PRAMS
Percent of pregnant women who smoke (<10%)	CWT	Upstate only via PRAMS
Percent eligible women enrolled in WIC in the 1st trimester (56.6%)	CFHG	Uneven eligibility
Proportion of repeat newborn screenings completed (100%)	MCHSBG	
Percent of infants born to HepBSA+ moms with immunizations and serology completed by age 1 yr.	CFHG	
Number of hospitalizations for otitis media in infants birth to one (<290/100,000)	CWT	
Rate of AIDS cases as a rate of perinatal transmission (0.30/1000LB)	MCHSBG	Based on seropositivity
Percent of live births with at least adequate prenatal care (Kotelchuck)	---	
Percent of MA-eligible women enrolled in PCAP	---	Eligibility hard to define
Percent of women with live births who receive postpartum visit within 8 wks	---	Upstate only via PRAMS
Percent of infants receiving recommended EPSDT visits during 1st yr of life	---	Denominator?
Percent of postpartum women who gained less than 15 lbs. during pregnancy	---	WIC data/data quality?
Percent of children having untreated vision, hearing or health problems at school entry	---	Not presently collected

Maternal and Infant Health-*Outcomes*		
Percent of low birth weight (5.5%)	CWT	
Percent very low birth weight infants (1%)	CWT	
Perinatal Mortality Rate (13.0/1,000)	MCHSBG	Need to define dates
Neonatal Mortality Rate (5.1/1,000)	MCHSBG	Need to define dates
Postneonatal Mortality Rate (2.0/1,000)	MCHSBG	Need to define dates
Infant Mortality Rate (7.0/1,000)	MCHSBG	Need to define dates
Maternal Mortality Rate (12/100,000)	MCHSBG	
Disparity between Black and White Infant Mortality Rates (1.7:1)	MCHSBG	

Child Health-*Performance Measures*		
Percent of children with elevated blood leads	CDC/CLPPP	Define elevated
Percent of homes of lead poisoned children remediated	CFHG	
Percent children <10th percentile weight for age	CFHG	Define age/Source:WIC
Percent children >90th percentile weight for stature	CFHG	Define age/Source:WIC
Percent of children without health insurance	MCHSBG	Data availability
Percent of potentially MA-eligible children who have MA	MCHSBG	Definition of eligibility
Proportion of children who are fully immunized at age 2 years	MCHSBG	
Percent of children who received protective sealants on ≥1 molar	MCHSBG	No data now
Percent of 6-8 year olds free of dental caries (≥75%)	CWT	DNA in most counties
Percent of 15 year olds free of dental caries (≥50%)	CWT	DNA in most counties
Number of hospitalizations for asthma birth to 14 (<100/100,000)	CWT	
Number of indicated cases of abuse and neglect children ≤18 (4/1000)	CWT	
Vaccine for Children providers that screen for lead (80%)	VCF	
Percentage of overweight for 2nd through 5th graders (15%)	CWT	
Percent who participate in regular and sustained physical activity (20%)	CWT	
Unintentional injury hospitalization rate birth to 14 year olds (385/100,000)	CWT	
Percent of children with confirmed elevated leads (>20 ug/dl) whose levels decrease on average by 5 ug/dl per quarter	CFHG	

Child Health-*Outcome Measures*		
Child Death Rate (23/100,000)	MCHSBG	Very crude measure
Child Death Rate from specific causes	----	Less crude

Children with Special Health Care Needs-*Performance Measures*		
ICHAP.-eligible children receiving developmental screening within required time frame	CFHG	Define denominator
EI-eligible children with IFSP within required Time frame	CFHG	
Percent of newborns with confirmed positive newborn screening test who are receiving appropriate treatment (100%)	MCHSBG	
CSHCN with a source of insurance for primary and specialty care (100%)	MCHSBG	
Percent of CSHCN who have a "medical home"	MCHSBG	
Percent of SSI beneficiaries under age 16 who receive rehabilitative services through PHCP	MCHSBG	Data availability
PHCP provides or pays for specialty or subspecialty services, including care coordination, not otherwise accessible or affordable to CSHCN	MCHSBG	Data availability
LHD assures family participation in PHCP program and policy activities	MCHSBG	Yes or no answer
Adolescent Health-*Performance Measures*		
Adolescent pregnancy rate (2/1,000-for 10 to 14 y/o, 50/1,000-for 15 to 19 y/o)	MCHSBG	
Percent of births to teens that are repeat pregnancies	---	
Adolescent STD rate	MCHSBG	
Percent of daily adolescent smoking ($\leq$10%)	CWT	Statewide only
Percent of high school students who use alcohol ($\leq$6%)	CWT	Statewide only
Percent of high school students who: -ever use marijuana (<15%) -use inhalants (<10%) -abuse prescription analgesics (<10%) -cocaine (<2%)	CWT	Statewide only
Unintended injury rate 15-24 (475 per 100,000)	CWT	
Adolescent Health-*Outcome Measures*		
Adolescent fatality rate	---	Crude; include causes
Rate of adolescent (15-19) suicide	MCHSBG	
Adult and General Population-*Performance Measures*		
Percent of women who use family planning	CFHG	Program data/ PRAMS
Prevalence of overweight individuals ($\leq$20%)	CWT	
Percent of adults that smoke ($\leq$10%)	CWT	
Rate of binge drinking ($\leq$7%)	CWT	
Rate of HIV infection	CWT	
Age-adjusted homicide rate ($\leq$10 per 100,000)	CWT	
Number of lower extremity amputations per # diabetics	CWT	
Rate of hospitalizations due to assault ages 25-64	CWT	
Unintentional injury rate 25-64 (420 per 100,000)	CWT	
Motor vehicle injury rate	---	
Hospitalizations due to self-inflicted injuries (<50/100,000)	CWT	
Hepatitis B case rate	---	
Tuberculosis case rate (subsets)	---	
Syphilis case rate (subsets)	---	
Colposcopy is available in the county	---	
Percent of persons with negative HIV results who get post-test counseling	---	
Adult and *General-Outcome* Measures		
Heart disease death rate and hospitalization rate		
Stroke death rate and hospitalization rate		
Case rates and death rates for breast, cervical, lung, colorectal cancer		Stage at diagnosis
Environmental- *to be determined by consensus process-Summer '98*		
Rates of food borne illness		
Reported cases of vector-borne disease per 100,000 population		
Percent of required inspections completed		

Objectives from "Communities Working Together"

Access to and Delivery of Health Care

By the year 2006, decrease the percentage of New Yorkers who are unable to see a doctor because of cost to no more than 7% (baseline: 13.7% BRFSS, 1994).

By the year 2006, to increase the percentage of New Yorkers receiving age- and sex-appropriate preventive health services, as measured by a preventive health services index to at least:

- 75% from men 18-49 years old (baseline: 51.8%, BRFSS, 1993);
- 90% for men 50+ years old (baseline: 80.2%, BRFSS, 1993);
- 75% for women 18-49 years old (baseline: 53.0%, BRFSS, 1993);
- 65% for women 50+ years old (baseline: 38.7%, BRFSS, 1993);
- 90% for two-year old children (baseline: 58%, Retrospective Kindergarten Study, 1994); and,
- 85% for women giving birth (baseline: 68.2%, Vital Statistics, 1994).

By the year 2006, increase access to ambulatory health and dental services, so that:

- the number of hospitalizations for asthma for children aged birth-14 is no more than 290 per 100,000 children (baseline: 581, SPARCS, 1993);
- the number of hospitalizations for otitis media for children aged birth-4 years is no more than 100 per 100,000 (baseline: 190, SPARCS, 1993);the number of lower extremity amputations due to diabetes mellitus is no more than 4 per 1,000 diabetics (baseline: 6.9 per 1,000 diabetics, SPARCS, 1993); and,
- the proportion of children free of dental caries is increased to more than 75% for 6-8 year olds and 50% for 15 year olds (baseline: not available statewide; data system to be developed; national baseline 47% and 22%, respectively; National Survey, 1986-7).

By the year 2006, reduce the disparities in cultural financial and system barriers to accessing and receiving health care for members of special populations at the community level.

Education

By the year 2000, increase the high school completion rate to at least 90% and maintain it at this level through the year 2006 (baseline: 80.9%, NYSED, 1993-4).

Healthy Births

By the year 2006, reduce the percent of all births that are low birth weight (<2500 gms) to no more than 5.5% and very low birth weight to no more than 1.0% (baseline: 7.7% and 1.5%, respectively; VS, 1994).

Mental Health

By the year 2006, reduce the rate of hospitalizations due to self-inflicted (intentional) injuries among persons aged 10 and older to no more than 50 per 100,000 persons (baseline: 62.5, SPARCS, 1991-3).

Nutrition

By the year 2006, reduce the prevalence of overweight to no more than:

- 20% among adults 18 years of age and older (baseline: 27%, BRFSS, 1994);
- 15% of the second and fifth grade school children (baseline: 34.5% NYC, 27.9% rest of state, NYSDOH Nutrition Survey, 1990).

Physical Activity

By the year 2006, increase the percentage of New Yorkers (young people ages 12-21) participating in regular and sustained physical activity:

- to at least 30% of adults 18 years of age and older (baseline: 14.8%, BRFSS, 1994);
- by 20% of young people ages 12-21 (baseline: not available; data system to be developed).

Safe and Healthy Work Environment

By the year 2006, reduce the incidence of work-related illness, injury and death in every workplace by at least 20%. (Individual companies should establish their own baseline rate).By the year 2006, decrease total absence from work due to illness among working adults in New York State by at least 20% (baseline: not available; data system to be developed).

Sexual Activity

By the year 2006, to reduce the adolescent pregnancy rate (births, fetal deaths and induce

abortions) to no more than 2 per 100,000 girls aged 10-14 and to no more than 50 per 100,000 girls aged 15-17 (baseline: 3.2 and 65.6, respectively; VS 1993).

By the year 2006, reduce unsafe sexual practices so that the percentage of adults 18 years of age and older who have had to be treated for a sexually transmitted disease in the previous five years is decreased by at least 20% (baseline: BRFSS asking for this information in the

1996 questionnaire).

Substance Abuse: Alcohol and Other Drugs

By the year 2006, reduce alcohol abuse so that:

- the percent of adults 18 years of age and older who report binge drinking five or more alcoholic drinks on one or more occasion in the past month) is no more than 7 percent (baseline: 15.1%, BRFSS, 1993);
- the percent of high school students who use alcohol heavily (five or more alcoholic beverages at a time, at least once a week) is no more than 6% (baseline: 12%, OASAS, 1994); and,
- the percent of pregnant women who report drinking during pregnancy is no more than 5% (baseline: 9.7%, PRAMS, 1993).

By the year 2006, reduce the percentage of adults and adolescents who abuse drugs so:

- the age-adjusted drug-related mortality is no more than 3 per 100,000 people (baseline: 7.5, VS, 1993);
- no more than 15% of high school students ever used marijuana, 10% ever used inhalants, 10% ever abused prescription analgesics, and 2% ever used cocaine (baseline: 35% marijuana, 21% inhalants, 18% analgesics, 5% cocaine, OASAS, 1994); and,
- the neonatal drug-related discharge rate is no more than 6 per 1,000 births (baseline: 10.6 per 1,000, SPARCS, 1994).

Tobacco Use

By the year 2006, reduce the prevalence of smoking so that:

- the percentage of adults 18 years of age and older smoke is no more than 15 percent (baseline: 21%, BRFSS, 1994);
- the prevalence of daily smoking among adolescents is no more than 10% (baseline: 17%, OASAS, 1994); and,
- the prevalence of smoking among pregnant women is no more than 10% (baseline: 19.5%, PRAMS, 1993).

Unintentional Injury

By the year 2006, reduce the incidence of unintentional injury among children, young adults, adults and seniors so that the rate of hospitalizations due to unintentional injuries is no more than:

- 385 per 100,000 children aged birth to 14 (baseline: 487, SPARCS, 1990-93);
- 475 per 100,000 young adults aged 15-24 (baseline: 597, SPARCS, 1990-93);
- 420 per 100,000 adults aged 25-64 years (baseline: 527 per 100,000, SPARCS, 1990-93); and,
- 1,615 per 100,000 seniors aged 65 years and older (baseline: 2,024 per 100,000, SPARCS, 1990-93).

Violent and Abusive Behavior

By the year 2006, reduce the domestic violence, abuse and neglect so that:

- the number of indicated abuse and neglect cases in children under 18 years of age is no more than 4 cases per 1,000 children ages birth to 17 years of age (baseline: 7.8, DSS Bureau of Child Protection Services, 1993-95);
- the number of women reporting being a victim of a physically violent act by an intimate partner during the previous year is no more than 3 per 100 couples (baseline: 5.6 per 100 couples, BRFSS, 1994);
- the rate of abuse or neglect of seniors is reduced by at least half (baseline: not available; data system to be developed).

Appendix D
Community Health Assessment
Guidance and Format

The Municipal Public Health Services Plan

Community Health Assessment

Guidance and Format

Introduction

Community health assessment is a fundamental tool of public health practice. Its aim is to describe the health of the community, by presenting information on health status, community health needs, resources, and epidemiologic and other studies of current local health problems. It seeks to identify target populations that may be at increased risk of poor health outcomes and to gain a better understanding of their needs, as well as assess the larger community environment and how it relates to the health of individuals. It also identifies those areas where better information is needed, especially information on health disparities among different subpopulations, quality of health care, and the occurrence and severity of disabilities in the population.

The Community Health Assessment should be the basis for all local public health planning, giving the local health unit the opportunity to identify and interact with key community leaders, organizations and interested residents about health priorities and concerns. This information forms the basis of improving the health status of the community through a strategic plan.

Key Features the New Community Health Assessment

A number of changes are being made for the 1999 Community Health Assessment (CHA).

- *The term of the written CHA document has been extended to six years for the full document, with biennial updates or supplements.*

  Local health departments no longer need to undergo the full community health assessment process every two years. Instead, updates may be submitted. Ideally, the CHA should be available electronically to encourage frequent update of the information.

- *CHAs can be submitted to NYSDOH on a diskette to allow for electronic access via the HIN.*

  Counties electing electronic submission do not have to submit a hard copy of the document, except to their regional office.

- *The critical role for the local health department is the interpretation of the data, not the regurgitation of data.*

  Local health departments are encouraged to use templates (charts, maps, averages, displays, etc.) provided by the State Health Department via the HIN, as well as to generate local data when appropriate and important to understanding local issues. The emphasis with this submission should be on analyzing and explaining the meaning of the data and using this information in a meaningful way to plan for future public health services.

- *Local health departments are being asked to formulate local priorities and benchmark progress toward local priority outcomes.*

  Local agencies should address the areas identified in ***Communities Working Together***, which focused on the underlying causes of poor health. ***Communities Working Together*** also provides a workable framework for engaging the various sectors of the community in public health interventions. The format of the CHA should mirror this important approach.

  The Community Health Assessment will include an annual community report card that is easily understood by consumers and local policy makers to inform and empower them. The report card should be composed of easily interpreted data benchmarking progress on a limited set of locally-important public health issues. For example, if a community had particular concerns about motor vehicle collisions involving young drivers, drugs and alcohol, these data would be contained in the report card and

reported out to the community on an annual basis. The report card should *not* include the whole set of selected performance measures. These measures can be developed in consultation/collaboration with NYSDOH and replace parts of the annual performance report.

- *The emphasis has shifted to community health assessment being a continuous, interactive local process. The goal is not solely the production of a static document.*

  The process involves continuously scanning the local health environment for changes in conditions and emerging health issues. The local health department should serve as the lead agency for local health assessment and seek input on the community health assessment from other organizations, community leaders and consumers. In some instances, a regional approach may be desirable. In this case, the local health department should reach out to other health departments and regional resources.

- *The CHA will include an organizational capacity assessment which describes the local agency's infrastructure, including organization, staffing and skill level, and adequacy and deployment of resources, as well as the agency's expertise and technical capacity to perform a community health assessment.*

  A requirement of the Municipal Public Health Services Plan has always been the description of resources to carry out the local plan. This is important in assessing the feasibility of local units carrying out their plan and serves as a statewide documentation of the infrastructure and resources available in local health units. This assessment replaces parts of the Fee and Revenue Plan.

- *Local health units and units within the state health department will be encouraged to use the document for multiple purposes.*

  Among the multiple uses are:

  - Planning and evaluation of the progress of programs.
  - Documenting the local health department's fulfillment of legal and regulatory requirements.
  - Cataloging multiple health-related activities taking place within the community, helping to meet a wider community-wide assurance role.
  - Justifying budget appropriations and program development.
  - Providing the public with empowering information.
  - Determining staffing needs.
  - Reporting on important health outcome measures.
  - Providing technical assistance to other agencies.
  - Needs assessment for categorical grants.

Format Guidelines

General Information on Preparation and Submission

1. The Community Health Assessment is due by the close of business on October 1, 1998 unless counties are otherwise notified.

2. Counties are encouraged to submit the Community Health Assessment electronically on the pre-formatted diskette that accompanies this guidance. Included on the diskette is a copy of the guidance, the format for the Community Health Assessment, and a copy of Part 40 regulations related to the required Community Health Assessment. A completed diskette including all narrative, charts and supporting documents should be labeled with the county name and submitted to Local Health Services with a hard copy of a letter of transmittal identifying the county health department contact for questions on the Community Health Assessment and containing any special instructions for accessing the information. A hardcopy of the letter and assessment should be sent to the appropriate regional office, as well.

3. Submitters are encouraged to use the headings, as written and in the order they are presented below in the body of the document and in the table of contents for the document.

4. Within each section, relevant data should be integrated within or referenced in the text. Detailed data may be placed in an appendix at the end of each program-specific section. County data should be compared to national, statewide and/or New York State exclusive of New York City data, where appropriate. County-to-county comparisons may be illustrative, but are not required. Consider using county health unit program enrollment data to provide insight into the health status of the community (recognizing selection bias). Other community assessments prepared locally by such organizations as hospitals, or other local and nonprofit agencies may prove useful. Statistical information should be explained in simple narrative form, describing health issues, and current and projected statistical trends.

5. Wherever possible, compare the local circumstances with priority health concerns identified in ***Communities Working Together for a Healthier New York*** and/or ***Healthy People Year 2000 Objectives for the Nation.***

Suggested Format

Cover Sheet -

The cover sheet should identify the document as the Community Health Assessment and name the county. The name, address, phone and fax numbers and e-mail addresses of the county health department should appear on the cover page, as well.

Section One - Populations at Risk

A. Demographic and Health Status Information

This section should provide a narrative and statistical description of the county population. A comprehensive description would include overall size and breakdowns by age, sex, race, income levels/socioeconomic indicators, percent employed, educational attainment, housing and any other relevant characteristics. Data provided by the State Department of Health, local data and/or other reliable sources of data may be used. Natality, morbidity, mortality and relevant demographic data should be compiled and analyzed, using small areas, such as minor civil divisions, zip codes or census tracts within counties, wherever possible and meaningful. Particular emphasis should be on interpreting demographic trends for their relationship to poor health and needs for public health services.

B. Access to Care

Access to care is an important component of safeguarding the health of communities. This section should

discuss health resources in a general way. Describe the availability of hospitals, clinics and private providers, and information about access to health care providers. This section may also discuss actual utilization of primary care and preventive health services, if the information is available. The Behavioral Risk Factor Survey will soon be a source of local data on access to health care. Discuss whether any of the following commonly-identified barriers exist and any subgroups who are disproportionately affected:

- Financial barriers — inadequate resources to pay for health care, inadequate insurance, Medicaid eligibility vs. Medicaid enrollment vs. access to providers.
- Structural barriers — insufficient primary care providers, service sites or service patterns.
- Personal barriers — the cultural, linguistic, educational, or other special factors that impede access to care.

These data may be anecdotal or documented following an anecdote.

C. Behavioral Risk Factors

Statewide, community-specific and/or locally-developed estimates for the prevalence of health risk behaviors can be used to identify and discuss population subgroups that are at increased risk due to unhealthy behaviors. Local circumstances related to priority health concerns identified in ***Communities Working Together for a Healthier New York*** should be considered.

D. The Local Health Care Environment

Identify and discuss aspects of the physical, legal, social, and economic environment that influence the attitudes, behavior and the risk of community residents for poor health. Components of the health-related environment include institutions (e.g., schools, work sites, health care providers), geography (e.g., transportation), media messages (e.g., TV, radio, newspapers), and laws and regulations (smoking policies). *There is no need for a community health assessment that relates to regulatory environmental programs.*

Section Two - Local Health Unit Capacity Profile

This section should profile staff and program resources that are available for public health activity in the county. It is suggested that the CHA include a profile of the local agency's infrastructure, including organization, staffing and skill level, and adequacy and deployment of resources, as well as the agency's *expertise and technical capacity* to perform a community health assessment.

The APEX*PH* model for assessment and planning includes an Organizational Capacity Assessment, which is recommended to assist you in this process. The APEX*PH* process enables the agency to assess and improve its internal organizational structure. It focuses on administrative capacity, basic structure, and the role of the agency in the community.

Section Three - Problems and Issues in the Community

A. Profile of Community Resources

Profile community resources that are available to help meet the health-related needs of the county. Include all groups that may have the capacity and interest to work either individually or in collaboration with the local health unit to improve the health status of the community. Mention collaborative efforts, if any, on development of hospital community service plans (CSP) or other collaborative assessments and planning processes. If possible, assess for availability, accessibility, affordability, acceptability and quality and what issues may surround utilization of these services such as hours of operation, transportation, sliding fee scales, etc. Discuss any significant outreach or public health education efforts and whether they are targeted

to the general population or identified high-risk populations. A summary of the available clinic facilities and private provider resources for Medicaid recipients should also be discussed. The PATCH model may be useful.

B. Profile of Unmet Need for Services

Identify and discuss additions to and changes in services that will improve the health of the identified at-risk groups. Discuss which types of changes would best serve the target group (e.g., lower/no cost, better hours, transportation assistance, increased sensitivity to population in need, language, increased acceptance of Medicaid, and integration and/or co-location of services). Identify the gaps in services and their location (e.g., township, city or census tract). Discuss problems that might be encountered in providing these services. This identification of needed services may also serve as a blueprint for other providers in the pursuit of federal, state and local financial support.

Section Four -Local Health Priorities

This section should describe new (or intractable) areas of public health which rank as high local priority identified by more recent collaborative efforts between the Local Health Unit and other community-based organizations, health care providers, consumers. This section may describe current strategies and a general evaluation of the effectiveness of current strategies. Whenever possible, assessment should be substantiated by data, critical incident, client reports, etc. A summary of the process (i.e., how recent, who was involved, how were priorities determined) that lead to identification of the public health priority(ies) should be provided.

The section may also be used to discuss noteworthy accomplishment for both the local health unit and other community public health partners. Cite efforts that have fostered new partnerships at the community level among schools, health agencies, etc. to maximize local assets which contribute to successful outcomes. The topic(s)/problem area(s) may not be the areas of high priority throughout NYS or in any other county in the state.

Section Five - Opportunities for Action

Building on all of the above sections, identify those opportunities that the local health unit can pursue, either individually or in partnership if it chooses, that could alleviate the priority public health problems. Where appropriate, these opportunities should include the contribution/role played by community-based organizations; businesses, labor and work sites; schools, colleges and universities; government; health care providers and insurers; the food industry; and the media. These actions would not have to be implemented by the LHD alone or at all. These actions are proposed so members or groups within the community might seize the opportunity to implement these activities or other activities that could reduce or eliminate the priority public health issue.

Section Six - Report on Statewide Performance Measures

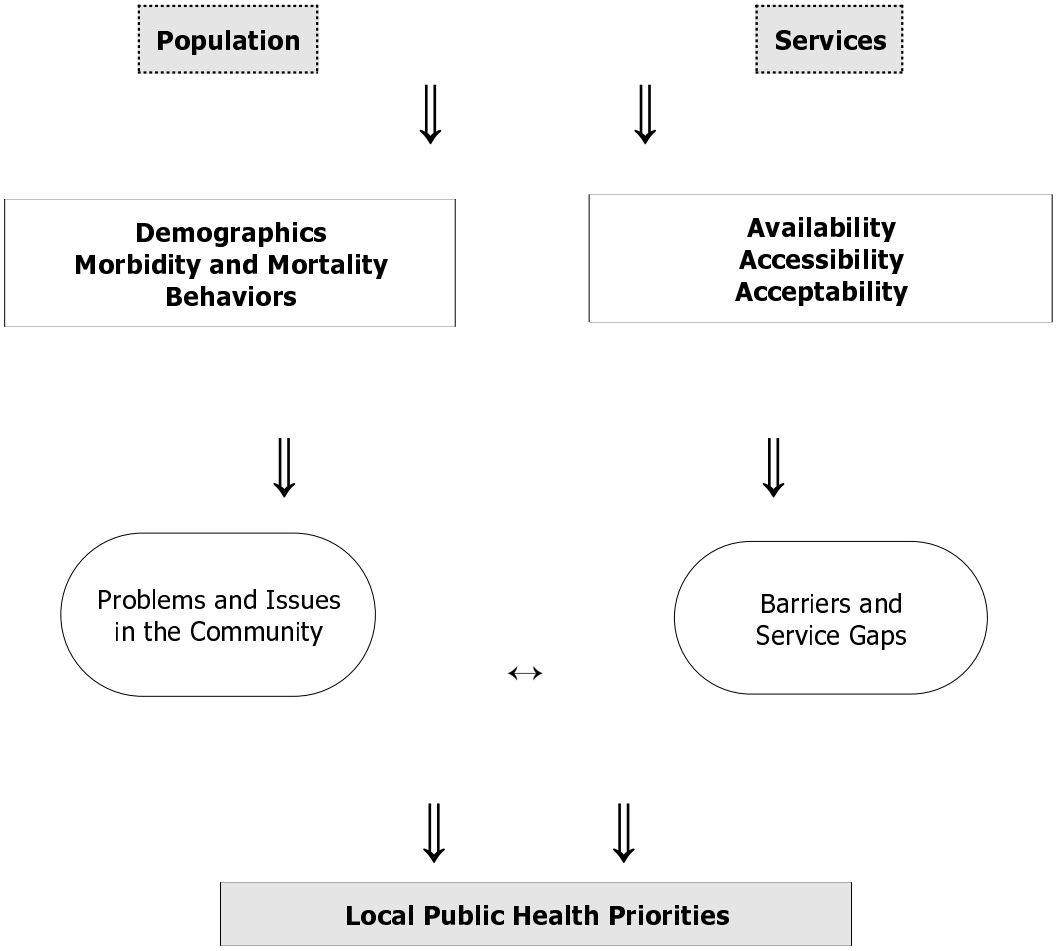
In this section, the local health department would report on the as-yet-to-be-determined statewide performance measures. This part of the assessment will follow a standardized format, as decided by the workgroup.

Section Seven - Community Report Card

Here, the county may attach its community report card and explain the distribution of the document.

Conceptual Model

Community Health Assessment Process and its Relationship to the Municipal Public Health Services Plan



Part 40 Regulations on Community Health Assessment:

40-2.150:	"Local health units shall analyze the health status of residents within their jurisdiction with regard to morbidity, mortality, maternal and child health , and other parameters as reasonable and appropriate. This analysis shall include a description of the demographic characteristics of the locality, with special attention to those demographic parameters predictive of increased risk of excessive morbidity and mortality to the extent that such data are readily available."
40-2.151:	"The municipal public health services plan shall include, at a minimum: (a) provision for the analysis of available birth, death, fetal death certificates, and other pertinent health and environmental health data to monitor trends in demographics, health and medical characteristics deemed necessary to establish baseline data and to monitor and assess health status and the need for public health services; (b) compilation of results of the annual community health assessment for distribution to those who may benefit from the information. Those who may benefit include: local, regional and State health department staff; nonprofit health agencies; hospitals; nursing homes; medical societies; libraries; schools; government facilities; or other agencies and organizations..."

Appendix E
Suggested Format
Local Public Health Plan

Appendix E. Suggested Format for the Local Public Health Plan

Essential Service	Approach/Strategy/ Activity	Direct/Contract Collaboration/ Others	Priority Needs	Performance Measures	Baseline	Actual
1- Monitor health status to identify community problems [40-2.150]	-Community health assessment [40-2.71a ,2.61, 2.121] -Vital records review [40-2.21d,2.41] -Surveillance [40-2.81, 2.101,2.111] -Profile of community resources, providers, agencies [40-2.21a,2.111,2.41, 2.51,2.11] -Population-based interviews/surveys [no reference] -Cooperation to establish performance standards [40-2.151]					

Essential Service	Approach/Strategy/ Activity	Direct/Contract Collaboration/ Others	Priority Needs	Performance Measures	Baseline	Actual
2-Diagnoses and investigates health problems and hazards in the community	-Communicable disease detection [40-2.91] -Outbreak investigation and control [40-2.101c] -Contact tracing, notification and testing [40-2.81c,2.91,2.101] -Chronic disease detection [40-2.121] -Injury detection [40-2.71a,b] -Environmental risk evaluation, sampling and laboratory services [40-2.31,2.161] -HazMat response [40-2.221] -Diag. Lab services [40-2.81b,2.91] -Population-based screening [40-2.31]					

Essential Service	Approach/Strategy/ Activity	Direct/Contract Collaboration/ Others	Priority Needs	Performance Measures	Baseline	Actual
3-Inform, educate and empower people about health issues [40-2.140-2.141, and 2.11.b 2.21c 2.31.b 2.41.b 2.51.b,.c 2.61.b 2.71.c 2.81.d. 2.91.d 2.101 2.111.d 2.121.c 2.131.c 2.140-141]	-Population-wide health promotion and risk reduction programs -Individual health promotion and risk reduction activities -Identifies sites with greatest possibilities for engaging target populations					

Essential Service	Activity	Direct/Contract Collaborative/Other	Performance Measure	Baseline	Actual
4-Mobilize community partnerships to solve health problems [40-2.11.a 2.21.c 2.31.c 2.41.c 2.51.a,.c 2.61.b,.c 2.71.d 2.81.b,.c 2.101.a 2.111.a,.b,.c 2.121 2.131.b 2.141.d,.e]	Community and provider participation in community health assessment Coalition-building activities Public health advocacy Partnering at every level of government--local, state, federal Serves as a resource to other community partners				
5-Develop policies and plans that support individual and community health efforts [40-2.111]	Participate in community planning Promote access to cost-effective quality health care (Medical home??) Set clear objectives for public health programs Legislative advocacy for policies and programs that promote improved health				

6-Enforce laws and regulations that protect health and ensure public safety [40-2.230,.231, 40-2.91 San Code] *Full service county health departments must provide these environmental services directly.*	Emergency systems Communicable disease control [40-2.101] Immunization regulations [40-2.181] Rabies control [40-2.100] Environmental- Housing Lead Abatement [40-2.170,2.31] Sewage [40-2.200,.201] Food establishments [40-2.181] Vector and rodent Children's camps Air quality Mobile home parks Lead abatement Farm worker housing Radon mitigation Pools and beachfronts				

Essential Service	Activity	Direct/Contract Collaborative/Other	Performance Measure	Baseline	Actual
7-Link people to needed personal health services and assure the provision when none is available [40-2.10 2.21 2.31 2.41 2.51 2.81 2.91 2.121 2.131]	Maintain community provider inventory Provide information and referral Provide enabling services, outreach, care coordination, case management, community health worker Provide personal health services to the extent that they address an unmet community need: Primary care Dental services Home health services Hospice services Immunization and lead services				
8-Assure a competent public health workforce [40-1.30]	Meet minimum standards under Part 11 Recruit and retain qualified professionals Orient new staff Provide continuing education of staff and leadership development Develop language and cultural competency among staff				

Essential Service	Activity	Direct/Contract Collaborative/Other	Performance Measure	Baseline	Actual
9-Evaluate effectiveness of public health programs [40-1.20]	Self-assess performance on an ongoing basis Monitor local programs and personal health services				
10-Research for new insights and innovative solutions to health problems [No reference]	Preventive and clinical investigations Health services research				
Maintain needed infrastructure	Buildings and grounds MILOR Computer support Clerical services Legal and accounting services		See completed State Aid Application		

Certification
2000-2006 Local Public Health Plan

A. Term of the Plan

The term of this Plan shall be for a period commencing January 1, 1999 and ending December 31, 2005, subject to biennial review and approval of its provisions, including the projected two-year plan of expenditures and the fee and revenue plan required by section 602 of the Public Health Law; as hereto appended, and to such amendments and revisions as the parties shall agree upon in writing; provide, further, that the term of this Plan may be extended, upon the same terms and conditions, for such additional six-year periods as the parties hereto shall mutually agree upon in writing.

B. Assurances

In signing the certification below, the signatory agrees to meet the following conditions:

Assurances		Citation
1.		
2.		
3.		
4.		
5.		
6.	This section could be used to detail requirements of grant programs.	
7.		
8.		
9.		
10.		

C. Certification

The undersigned certifies that the attached Local Public Health Plan, including a Community Health Assessment and Fee and Revenue Plan, for _____ County(ies) will serve as the basis for its public health service and activities for 1999-2006. Further, it is agreed that the County(ies) shall forward amendments and revisions to the plan to the New York State Department of Health for their approval whenever services are significantly altered by emerging or changing needs; by a change in the availability, assignment or deployment of resources; or by changing responsibility for health issues within the community.

_____
Title: _____
_____ County

Appendix F
State and Local Roles in Core Functions

Appendix F.
State and Local Roles in Core Public Health Functions

1. Monitor health status to identify community health problems	
STATE : Maintain and update statewide information systems for vital statistics, disease and injury registries, immunization status tracking, public health laboratory information, environmental epidemiology and other similar data bases. Provide in a timely manner public health information from all available sources in an accessible and useful format Monitor statewide data for surveillance and trend analysis and provide such information to LHDs and the federal authorities, and issue alerts as needed Incorporate reportable laboratory data in statewide surveillance activities to enhance information on the incidence of disease and/or infection, toxicity, or other reportable condition provided by LHDs Link data sets and surveys for population-based applications	**LHD:** Develop a Community Health Assessment (CHA) that collects, integrates and analyzes health statistics and identifies problems, available resources and needed public health services Compile results of community assessment in a format suitable for distribution to community entities that may benefit from such information, including hospitals, nursing homes, medical societies, libraries, and nonprofit health agencies Report demographic information and epidemiologic and individual case data to the State as required by Public Health Law and conduct ongoing review of such data for surveillance and trend analysis Provide for the analysis of birth, death and fetal death data and other pertinent local, state and national health information to determine baselines; identify patterns of disease, illness and injury; detect emerging trends; and prioritize services within the locality Provide mechanisms for intercounty transmittal of birth, death and fetal death certificates and inter-county notification of nonresident disease occurrence

2. Diagnose and investigate health problems and health hazards in the community	
STATE : Fund population-based prevention and control programs.	**LHD:** Conduct prevention and control programs to meet Part 40 standards.
Define public health areas that are of heightened significance and require reporting of incidents/cases of such to and from the LHD.	Perform surveillance and trend analysis through ongoing review of local case data, timely reporting to the State and monitoring of State and national data.
Fund the cost of maintaining and operating clinics and/or programs to detect, investigate, prevent and control problems of public health significance and identify persons with at-risk behaviors.	As provided in the Local Public Health Services Plan, maintain and operate clinics and programs to detect, prevent, and control problems of public health significance and identify persons with at-risk behaviors.
Establish performance standards to detect and minimize sexually transmitted disease, tuberculosis, communicable disease, chronic disease and other public health concerns, and to maximize immunization.	Ensure access to diagnostic services, either through direct provision by the county or through referral.
Establish requirements for clinical and environmental laboratory services to support population-based health activities, and support the delivery of diagnostic services at the local level. Provide timely access to reference laboratory services, including highly complex testing or deployment of "state of the art" procedures (e.g., fingerprinting of disease agents) to identify disease outbreaks and trends, verify rare and unusual diseases, and detect environmental health threats. Monitor statewide disease data for surveillance and trend analysis and provide such information to LHDs and the federal authorities, and issue alerts as needed	Employ laboratory services to prevent and detect problems, and perform surveillance activities in the following areas: infant and child health; sexually transmitted and communicable disease; sources of illness, including those of a carcinogenic and mutagenic nature; water supplies and food service establishments; lead toxicity; and environmental monitoring, including toxic sites.
Provide technical assistance as part of coordinated outbreak response.	Conduct investigations to verify or rule out reported disease outbreaks and health hazards.

3. Enforce laws and regulations that protect health and ensure safety	
STATE : Promulgate laws and regulations to establish requirements and performance standards for services that detect, control and reduce exposure to environmental and personal hazards, conditions or factors that may cause disability, illness or death. Provide services and/or funding related to environmental and personal safety, and consumer protection and sanitation activities, including assisting LHDs in meeting statutory and regulatory requirements by direct service provisions where the LHD is not able to provide services. Encourage LHDs to establish and collect fees for issuance of permits for environmental health services (or activities integral to issuance, such as inspections) related to food service establishments, camps and recreational facilities, community and non-community water systems, realty subdivisions, and individual water and sewage systems. Provide backup technical and legal support as necessary Assure coordination with other State agencies providing health services to eliminate duplication and facilitate enforcement (i.e. OHSM, Agriculture and Markets, DEC).	**LHD:** As provided by local and State rules, implement programs to monitor, control and reduce exposure to environmental and personal hazards, conditions, or factors that may cause disability, illness or death. Develop and maintain emergency response systems. As elected, provide environmental health surveillance and consumer protection services, including inspection and issuance of permits for food service establishments, camps and recreational facilities, community and non-community water systems, realty subdivision and individual water and sewage systems. Train and maintain an adequate field staff for enforcement, and provide technical support to towns/villages/cities.

4. Inform, educate and empower people about health issues	
STATE : Establish requirements for health education and guidance activities across all public health services, to reinforce the significance of education in the promotion of public health.	**LHD:** Coordinate individualized education with delivery of all LHD-provided services. Provide information and training in the control of disease and injury directly to the affected persons and their care givers. Initiate programs that promote the public's understanding of environmental health hazards. Assure that community-wide educational activities are appropriate to target population sub-segments.
Directly provide and provide funding for educational materials and media campaigns on significant public health topics and encourage distribution to the public. Develop health promotion campaigns to communicate the importance of healthy lifestyles and risk reduction. Report to the Governor and Legislature on cooperative public/private education efforts.	Develop educational programs that encourage people to assume personal responsibility for maintaining and improving their own health. Provide community access to health-enhancing information.

5.Mobilize community partnerships to identify and solve health problems	
STATE : Establish standards for community outreach activities, including identification of consumer concerns and definition of target groups.	**LHD:** Compile assessment information in a format suitable for dissemination to community entities that may benefit from such information, including hospitals, nursing homes, medical societies, libraries, and nonprofit health agencies.
In concert with NYSACHO, facilitate/develop/or maintain coordination with the private sector. Coordinate cooperative outreach efforts through invitation for assistance to licensed health professionals, hospitals, corporations operating under Insurance Law Article 43, trade associations, the media and voluntary groups. Seek assistance from sister agencies, including the departments of education, social services and mental hygiene, to achieve statewide public health objectives.	Provide information and assistance to stimulate community action on social and physical factors that impact on public health. Implement community-wide programs that inform target populations, clinical health care providers and health agencies involved in primary care about key issues in areas such as immunization perinatal health, family planning, and disease control.

6. Link people that need personal health services and assure the provision of health care when otherwise unavailable	
STATE : Fund the provision of community-based personal health services. Develop health care delivery systems that accommodate unserved and underserved populations (e.g., Medicaid Managed Care).	**LHD:** Develop primary care services in underserved areas to assure that vulnerable populations receive adequate health care. Provide or arrange for supportive enabling or "wrap around" services such as care coordination, case management, transportation and language interpretation services to improve outcomes of care. Monitor delivery and coordination of personal care services by private providers and develop referral networks. Develop and maintain client-based data systems which support LHD-delivered personal and school-based health services. Provide trained staff to provide outreach services to individuals in other-than-clinical settings (e.g., public health nurse home visits).

7. Evaluate effectiveness, accessibility and quality of personal and population-based health services	
STATE : Promulgate regulations that establish performance standards and facility licensing criteria for health care service providers and service delivery systems, including hospitals, laboratories and diagnostic and treatment centers. Conduct ongoing inspection monitoring and to ensure the quality of health care. Require periodic assessment of the community to evaluation effectiveness and accessibility of public health activities and services within counties. Establish uniform financial and program performance reporting systems in consultation with NYSACHO and other appropriate local health officials. Establish public health service requirement and performance standards for essential and nonessential services in conjunction with State and Federal mandates. Produce an annual report measuring progress toward public health objectives and offer recommendations for improvement.	**LHD:** Seek to assure that appropriate quality services are available and accessible to all community residents. Conduct ongoing monitoring and evaluation of public health service as detailed in the local public health services plan. Report performance information to the State as part of biennial updates to the CHA.

8. Ensure a competent public health and personal health care workforce	
STATE : Establish criteria for health and environmental professional licensure, and establish requirements for regulated health facilities concerning standards for non-licensed health care professionals. Provide professional development and continuing education opportunities. Coordinate public health education through initiation for assistance to license health professionals, hospitals, corporations operating under Insurance Law 43, trade associations, the media and voluntary groups. Coordinate with academic institutions that support training of the local public health workforce (e.g., schools of public health).	**LHD:** Hire qualified staff and offer continuing cross-training of existing staff. Educate physicians and other health services providers regarding disease detection, prevention and control, risk reduction, injury prevention, and healthy lifestyles. Maintain scientific awareness of emerging issues in public health, including an understanding of advanced detection and monitoring technologies and their impact on case definitions.

9. Develop policies and plans that support individual and community health efforts	
STATE:	**LHD:**
Develop a statewide agenda for public health and design a planning process to implement the agenda	Develop policy and administer local public health plans consistent with State and Federal policies.
Participate in legislative activities, including drafting of legislation and development of agency budgets	Convene and participate in task forces on the local level
Provide leadership and guidance in policy development through policy directives, guidance documents and formation of issue-oriented task forces which include LHDs	
Develop, maintain and administer a statewide public health infrastructure in collaboration with LHDs, other State agencies and Federal government	Identify and prioritize areas of public health need through the community health assessment
Establish a uniform program performance reporting system in consultation with NYSACHO and other appropriate health officials	Develop and submit for state approval a local public health services plan with input from the Board of Health, local agencies, community boards, task forces and planning groups, community health care providers and other interested parties, in consultation with the NYSDOH
Establish public health service requirements and performance standards for essential and nonessential services in conjunction with State and Federal mandates	Submit a detailed annual report on all expenditures on Article 6 funded services
Review, make recommendations for modification and approve a local public health services plan for every LHD	
Fund approved public health services	
Provide information, materials and technical assistance to support local public health services	

10. Research for new insights and innovative solutions to health problems	
STATE:	**LHD:**
Conduct and support epidemiologic, biomedical and preventive research and clinical investigations in coordination with academic institutions (e.g., emerging infections research)	Participate in and support research and demonstration projects, including the provision of local data and staffing
Conduct and transmit results of LHD program evaluations to the LHDs to encourage new insights	Evaluate delivery of local health services to identify innovative solutions to health issues
Promote and support innovation in the delivery of public health services	Maintain awareness and responsiveness to new ways of approaching health care delivery

Appendix G
Team Monitoring Model
and
Sample Monitoring Tool Format

Appendix G. Team Monitoring Model and Sample Monitoring Tool Format

New Models for Performance Monitoring

The purpose of performance monitoring is to maintain program accountability, both for the use of public funds and for the protections of the public's health and safety. The ultimate goal of evaluation is to assure the best possible outcomes for the public. It is a goal shared by the state and local health departments alike.

Local health departments and the State Health Department are full partners in this initiative. Both parties are committed to supporting and strengthening local efforts. Therefore, the local agency must be an active participant in the review and evaluation process, actively evaluating its own progress and operation.

As a key principle of this new model for monitoring, whenever and wherever possible, program evaluation must be comprehensive in its approach, consolidating existing mechanisms and minimizing duplication of effort. Integration of program elements is to be encouraged and redundancy is to be reduced. Evaluation must occur within a consultation process. The role of NYSDOH staff is *not* to solve the local department's problems, but rather to provide insight into operational issues, to offer a statewide viewpoint, to assist program staff to generate possible responses and to gather resources and technical assistance in support of selecting solutions.

Methods

The performance review process should use a self-evaluation with subsequent validation by an on-site review team. Local program staff should have the opportunity to monitor their own compliance with each performance standard, monitor progress in their achievement of program objectives, and request technical assistance throughout the monitoring process.

On-site review teams should be composed of NYSDOH staff of varying program and professional backgrounds. When a team approach is utilized, DOH staff will not necessarily be monitoring only their traditional program components. Staff may be cross-trained to complete review tool items derived by other programs. The approach should mirror the comprehensive approach of Article 6.

Reviews should be organized around certain key elements: the capacity and infrastructure of the local agency, common elements from programs consolidating their review with Article 6, and individual program elements that cannot be waived or consolidated based on statutory, safety or Federal requirements. There are a surprising number of review criteria that overlap from program to program. The team leader, with a team consensus, may choose to focus on some areas and defer review of others based on the local health department's past history and concerns or interests of the program staff. Review could be deferred, for instance, in areas where there has been no significant change in operations or beneficial outcome, and no significant finding of nonperformance.

Site Visit Tool Design

The review tool should be formatted to reflect key functions (assessment, policy development and assurance) and the ten essential public health services.

The site visit tool should reflect all of the key principles of the monitoring model. Since the review process utilizes a team approach, the tool must be responsive to a review that combines program staff of various expertise and emphasizes the contractor as a full partner in the assessment. The tool must support a more comprehensive approach to monitoring, reduce the need for repetition across multiple programs, and must minimize disruption in its application to the monitored agency. The site visit tool should be based on the concept of cyclic performance monitoring for the purpose of quality improvement, and to assure safe practice and effective use of resources.

The sample tool displays three fields of information:

- *Performance measures*

These measures are based on performance standards, RFP and contractual requirements, pertinent

regulations, and "best practices," or those measures that are widely regarded as fundamental to a quality public health program.

- *Results* of the local health department's *self-assessment* against the performance measures.

- *Subsequent validation* of the self-assessment by the monitoring team.

The tool can be used to obtain a baseline assessment of the local health department or can be used for periodic monitoring. Uniformity and specificity of the individual performance items allow for future comparison with other local departments and contribute to a very complete picture of "the local public health story". It also allows for assessment across the system of widespread training and technical assistance needs.

The Site Visit Process

The review process should include the following steps:

- All local health departments should be thoroughly oriented to the site visit tool and process. (Previous pilots of program tools in this format underscored the need for guided orientation to the tool and its application.)

- The local health department performs a self-assessment. The site visit tool will be sectioned and can be assigned to various program staff within the agency to complete. Past experience shows that self-assessment is most effective when a team of local agency staff complete the various pieces of the assessment and then meet as a group to discuss the findings. This gives the local agency the opportunity to self-correct some of the items found to deviate from the standard, to clarify the standard, if necessary, or to begin local problem-solving. If the agency is making progress toward achievement of the standard, this can be noted, as well.

- The self-assessment is returned to the team leader and distributed to the monitoring/validation team. Team members have the opportunity to review the self-assessment prior to the on-site visit and to communicate any areas that appear problematic. The validation team may choose to perform a very comprehensive review that includes all items on the tool, or may choose instead to focus on problematic areas or areas that are receiving a special program emphasis.

- A monitoring visit is arranged and the review team validates the self-assessment findings. Team members will indicate whether performance standards are being met, whether progress is being made, or whether additional technical assistance and support are needed. It must be anticipated that the validation team may not always agree with the self-assessment. In these cases, additional discussion and clarification are warranted. The process should be wholly interactive throughout, so findings should not be a surprise to local health department staff. The team then meets together with the team leader to submit their findings and to reach agreement on the process and content of the exit interview. Prior to the exit, the validation team provides summaries of program strengths and weaknesses, and comes to general agreement on the priority ranking of the team's various recommendations.

- The exit interview is conducted, allowing for full discussion of the findings and the agency's reaction. Then, an improvement plan is constructed, with agreement reached on order of priority for the corrections, the responsible party for each action, and a Time frame for completion. This plan then becomes a part of the agency's annual work plan.

- Follow-up technical assistance is arranged as needed. Progress is then monitored. If there are areas of long-term nonperformance or failure to progress on agreed upon goals, the quality improvement strategy must be examined, discussed and altered. NYSDOH should take incremental steps to enforcement.

Advantages of Consolidating the Monitoring Process

The advantages of adopting this new model for monitoring are fairly straightforward:

- A unified review process is less disruptive to the agency being monitored when it replaces reviews by individual program staff.

- The review process is more comprehensive, allowing for a clearer view of the agency's overall effectiveness.

- The review identifies technical assistance needs across program lines.

- Data generated allows for creation of a technical assistance matrix, outlining needs across the state and allowing better targeting of TA methods and models.

- The model brings capacity and quality issues to the forefront.

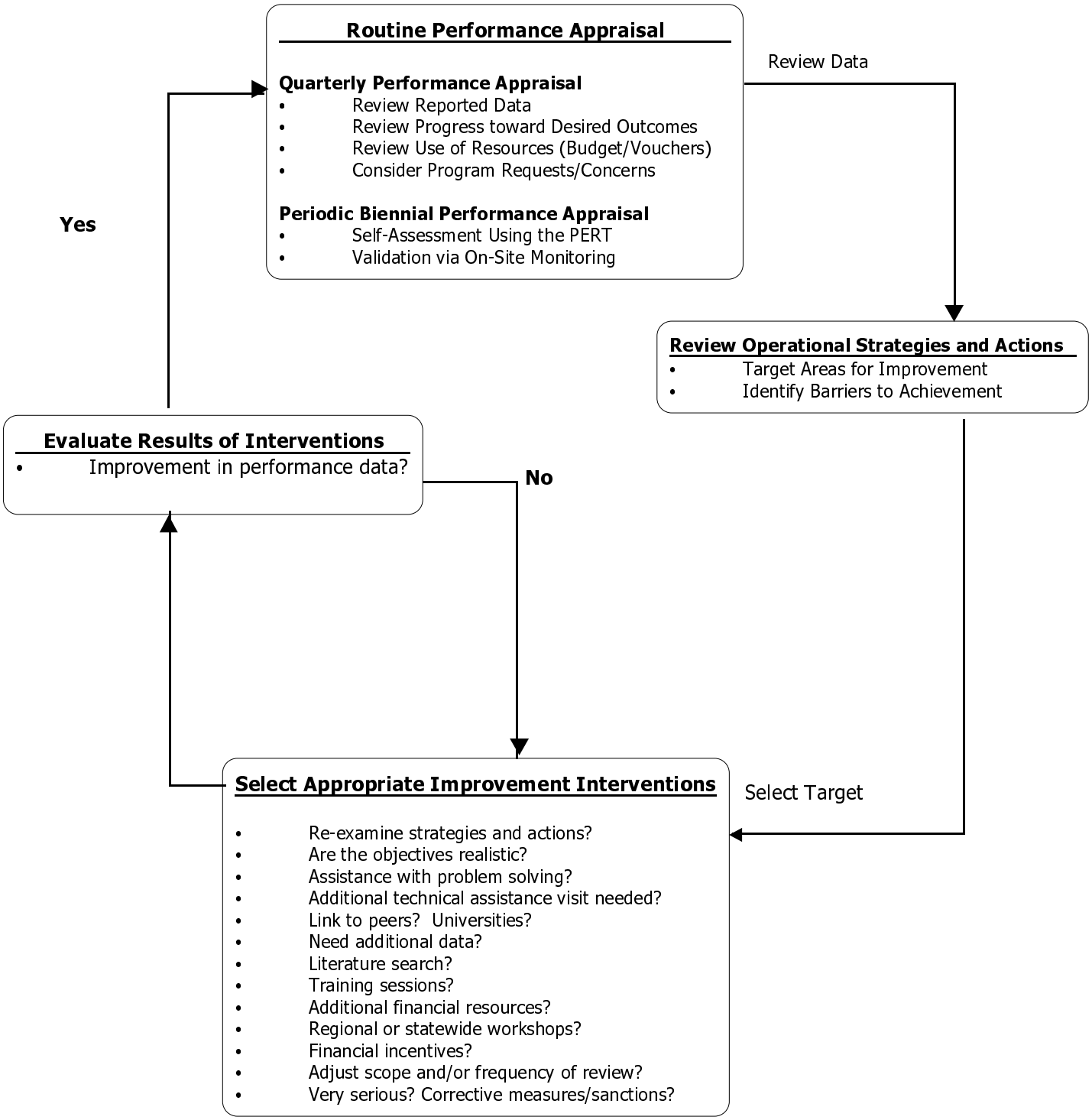
Sample Monitoring Tool

Two sample or "dummy pages" for the model monitoring tool follow. The actual tool should be designed with input from the county health departments.

Conceptual Framework

The framework for the monitoring model follows.

NEW YORK STATE DEPARTMENT OF HEALTH
LOCAL HEALTH SERVICES PERFORMANCE MONITORING MODEL



NEW YORK STATE DEPARTMENT OF HEALTH **Project Monitored:**
CENTER FOR COMMUNITY HEALTH
Consolidated Monitoring Pilot/Performance Effectiveness Review Tool

Introduction

Under consolidated contracting, a new model of monitoring is needed. Consolidated contracting, while outcome-focused, has as its underpinnings a clear understanding of program precepts and quality processes. This tool brings together outcomes-based evaluation with program process standards to define the effectiveness of local public health services. Desired outcomes are achievable through well conceived and well implemented strategies and processes.

Methods

The monitoring tool engages a process of self-evaluation and subsequent validation by a review team. Under this framework, the agency being monitored is an active participant in all aspects of the monitoring process. Monitoring is tailored to the site through selection of appropriate monitoring modules, designed to evaluate and validate performance in each of the areas in which NYSDOH has a contractual or regulatory relationship with the agency under review.

On the far left side of the document, program standards are listed with a citation as to their origin. These standards represent items required by contract, RFP, or regulation, or they may be derived from current practice, so-called "best practice" items.

The middle portion of each page is designed as a self-assessment to be done by the local program staff. In this area, program staff code the document as to whether the standard is met (M), or unmet (U) and , if unmet, whether there is progress (P) toward meeting the standard. Staff has the opportunity to describe progress being made or how the standard is met. Staff may also request additional technical assistance (TA) in interpreting or meeting the standard.

The portion on the right of each page is used by the reviewer or review team to validate the status of each standard. The validation process takes place in the context of site visits to the individual programs and utilizes the self-assessment data, contract documentation, and information gathered onsite. Onsite reviews end in an exit interview during which the findings are summarized. Local staff then have the opportunity to discuss the various findings, clarify their assessments and request any consultation or technical assistance that is needed.
The overall evaluation of the project is then summarized in the "Reviewer Summary" on the final pages. Here, reviewers and the program jointly prioritize areas for improvement in the form of key recommendations. The items contained in this prioritized list should be incorporated into the agency's quality improvement process/work plan.

Contents

Self-Assessment and Reviewer Coding

M The standard as stated is MET.
TA TECHNICAL ASSISTANCE is requested in interpreting or meeting standards.
U The standard as stated in UNMET.
NA The standard is NOT APPLICABLE.
P Though unmet, there is evidence of PROGRESS toward meeting this review.
ND Whether or not the standard was met was NOT DETERMINED by the standard.

I: Interview **P/P:** Policy/Procedure Manual Review
O: Observation **Min:** Review of Minutes
MRR: Medical Record Review

Each item is coded by symbols indicating the programs that utilize each item. The programs from which the standards are delivered. BP indicates that the program considers the item a best practice:

▲=Diagnostic and treatment center/Article 28 ✓=WIC ◆=Lead ✱=EI
●=Immunization □=Fiscal Unit/Contract Procedures ✖=PCAP ■=Article 6
▼=HIV/AIDS ❍=Infant Mortality ⌂=Community Health Worker

RECORDS REQUEST

The following records should be organized and readily available to reviewers for the on-site visit:

Record	Location
1. Organizational chart.	
2. All MCH-related Policies and Procedures Manuals and Medical Protocols for the encompassed grants, the diagnostic and treatment center and home visiting.	
3. Staff lists and job descriptions.	
4. Most recent community health assessment and MPHSP.	
5. Grant workplans and budgets, including WIC Nutrition Services Plan if applicable.	
6. Minutes of MCH-Related Advisory Councils, LEICC and Board of Health.	
7. Transfer agreements and resource directories.	
8. Employee time and effort records.	
9. Back-up fiscal documentation for vouchers submitted.	
10. Required WIC logs and ledgers.	
11. Copies of patient forms, including consent forms.	
12. Encounter data.	
13. Personnel folders, including records of continuing education and qualifications.	
14. QA activities documentation and results (i.e documentation from IPRO).	
15. Medical/client records.	
16. WIC: • alpha listing • computer manual check registers • previous management evaluations • nutrition education materials review forms • anthropometric check lists	

NEW YORK STATE DEPARTMENT OF HEALTH
CENTER FOR COMMUNITY HEALTH
Consolidated Maternal and Child Health Monitoring Pilot--Performance Effectiveness Review Tool

Service Sites						
Name and Address of Service Sites	Contact and Phone #	Services Available at this Site	Hours of/Days of Operation	Staffing	Caseload Handed at this Site	Records on site? If no, how accessed?

NOTE: WIC reviewers are required to visit a minimum of 20% or one clinic of the service sites for every two years, whichever number is greater.

NEW YORK STATE DEPARTMENT OF HEALTH
CENTER FOR COMMUNITY HEALTH
Consolidated Maternal and Child Health Monitoring Pilot--Performance Effectiveness Review Tool

I. Essential Services/Core Functions Assessment

A. Monitor Health Status to Identify Community Maternal and Child Health Problems

1. Community Health Assessment

Performance Standard	Self-Code	Self-Assessment (Explain if necessary)	Rev'r Code	Validation by Reviewer(s)
1. The agency has appropriate capacity for monitoring the health status of the community and target populations. Indicators: There is/are (a) data collection system(s). There is adequate technology (hardware/ software) available. There is/are (a) person responsible for data collection. There is/are (a) person(s) responsible for data analysis. There is a protocol or a system for initiating action based on data analysis. There is the capacity to collect and integrate data from other sources. Program data are available to use to determine the need for program change. ✓Fed Reg 246.4(7) ◆NYCRR67-1 ●BP ■Art.6 ❍Contractual	☐	Data collection systems include: □ Access to computers and appropriate programs. □ Intranet (HIN) and Internet access. □ Data analysis by: □ Protocol available. □ Integrates data from other sources, including: □ Uses program data to indicate need for program change.	☐	□ PCAP-Presurvey Questionnaire □ WIC-Nutrition Services Plan I (How is data used?), O, P/P
2. The agency performs a population-based community health assessment to ascertain predominant and changing needs of the population using available behavioral risk, critical event, morbidity and mortality data. ✓Fed Reg 246.4 ◆Part 40 ●BP■Art.6 ❍Contractual ⌂RFP	☐	Analysis performed by: □ agency □ contractor: Analysis includes: □ birth, death and fetal death data □ pertinent baselines (national, state, regional, like-county or local) □ patterns of disease, illness or injury □ displays emerging trends □ detects gaps and prioritizes needs □ Analysis successfully identifies needed action. Partners involved include:	☐	□ WIC-Nutrition Services Plan I,O

3. The community health assessment process allows for community input. ●■ BP	☐		☐	I,O
4. Community health assessments are published and distributed within the community and to interested/ appropriate other parties. Article 6 ■ Part 40 ◆	☐	Distributed to: □ Local Providers □ Hospitals □ Libraries □ Regional Office □ Local Health Services Unit/DOH □ Others_____ _____	☐	I, O
5. Community health assessment data are used to locate services in areas of highest need. ✓BP ● Contractual ■ Art. 6 ⌂ BP	☐		☐	I, O (review assessment)
6. Population-based data are used to target high-risk groups for public health interventions. ◆ BP ● Contractual ■ Art. 6 ⌂ BP	☐	□ Population-based data available □ Proxy information used: □ Program data □ Focus groups/surveys □ Others _____	☐	I,O
7. Outreach plans are revised and implemented on at least an annual basis. ✓ 246.4(7) ◆ Contractual ● Contractual ✖ 85.40(c) ■ BP ⌂ Contractual	☐		☐	□ WIC - Nutrition Services Plan □ Have strategy for early enrollment in prenatal care P/P, I

I. A. 2. Information Management and Program Reporting

1. The agency has a mechanism for intercounty transmittal of birth, death and fetal death information and inter-county notification of non-resident disease occurrence. ◆ BP ■ Art. 6 ⌂ BP ● Contractual	☐		☐	I

2. Where patient data is used, access to the data and use of the data is restricted to ensure patient confidentiality. ▲ ✓ 246.26(d) ◆BP ●Statutory ■PHL ❍PHL 206 ⌂BP ✱69-4.17(c)(1)	☐	□ Confidentiality is insured. □ Identifiers removed.	☐	O, I, P/P
3. Client records and related documents are stored in a locked cabinet except when in use and electronic client records are secure from unauthorized use. ▲Reg✓NYSWIC Manual 1305, 1305B ◆●⌂BP✖85.40(1) ■PHL ❍Contractual ✱Reg	☐		☐	O,P/P
4. Client information is not released to outside sources without the written, informed consent of the client. ▲✓◆BP●Statutory⌂ BP✱69-4.8(a)	☐		☐	P/P, I, MRR
5. Data are input to data bases in a timely manner. ✓BP◆●■⌂✱BP	☐	Agency's standard for data input:	☐	I,O
6. Required program reports are reviewed for accuracy on a sample basis. ◆■⌂✱BP●Contractual	☐		☐	I
7. Quarterly and/or progress report data are reviewed to assess performance. ◆■⌂✱BP ●Contract✖85.40❍Contract	☐		☐	PCAP - Presurvey Questionnaire, HIV enrollment quarterly reports are accurate and complete. I
8. Quarterly reports and workplan progress reports are submitted to DOH within 30 days of the end of the reporting period. ◆■⌂BP●Contract✖85.40❍ Contract	☐		☐	❍ (Check print date/cover letter date)