Local Health Department Performance Incentive Initiative

Year 4 - 2016-2017

REVISED November 7, 2016

Performance Improvement Primary Focus Area:

Documentation of Core Chronic Disease related Activities linked to Public Health Accreditation Board related Standards

Article 6 Public Health Work Incentive/Overview:

The New York State Department of Health (NYSDOH) General Public Health Work program includes a statewide performance-based incentive program that allows the NYS Commissioner of Health to establish statewide performance standards for delivery of core public health services and to provide additional funding referred to as incentive awards to Local Health Departments (LHDs) that meet or exceed statewide performance standards. $1 million has been appropriated annually for the incentive awards.

The NYSDOH has chosen to focus on chronic disease prevention for Year 4 of the LHD Performance Incentive initiative. Although chronic disease has surpassed communicable disease as the leading cause of death and disability, public health activities to prevent chronic disease may be less established for many LHDs. This year's Performance Incentive initiative encourages LHDs to strengthen those efforts and to demonstrate achievement by providing documentation required to meet chronic disease prevention related standards established by the Public Health Accreditation Board (PHAB). We have tied these standards to the Article 6 required set of chronic disease requirements. All 58 LHDs are eligible to participate in this year's initiative, and there will be no secondary focus areas as there has been in previous years.

Background:

Chronic diseases such as cardiovascular disease (CVD), cancer, diabetes, arthritis, and asthma are among the leading causes of death and disability. These diseases account for approximately 60% of all deaths in the state and affect the quality of life for millions of New Yorkers, causing serious limitations in daily living for about one in ten residents. Chronic diseases are also among the most preventable. Risk factors for the development of CVD, some cancers, diabetes, arthritis, and asthma include physical inactivity, unhealthy eating, obesity, and tobacco use. Although the public is generally aware of the benefit of changing health-related behaviors, often work, school, and community environments make it difficult to adopt and maintain healthy lifestyles.

LHDs promote chronic disease prevention through policy, system, and environmental change activities, as well as other more traditional public health strategies such as assessment and public health marketing and communication. Public Health Law (PHL) § 602 and 10 NYCRR § 40-2.30 require local health departments to conduct a chronic disease prevent program, as a condition of State Aid eligibility. The § 40-2.30

Regulations (see Appendix 2) require the following set of strategies and activities:

- Analysis and utilization of valid public health data and information to shape objectives and strategies related to chronic disease prevention and control. This set of activities includes using data from the LHD's community health assessment or other assessments, identifying communities and/or neighborhoods where the population is at increased risk of chronic diseases and conditions and underlying risk factors; and identifying the specific local factors and available policies, practices, underlying risk factors, and interventions that influence chronic disease (See § 40-2.30 (a) (1) (i) (ii) (iii));
- Leadership of, or active participation in, efforts with multiple sectors in the community to improve social and physical environments to support healthy behaviors to reduce the incidence or prevalence of chronic diseases and conditions such as cancer, cardiovascular diseases, diabetes, asthma, arthritis and obesity, and the underlying risk factors of tobacco use, physical activity and poor nutrition; (§ 40-2.30 (a) (2))
- Public health marketing and communication, including developing or adapting public education materials or campaigns, and promoting or disseminating such materials or campaigns, to reduce risk factors for chronic disease morbidity, mortality and related health disparities; (§ 40-2.30 (a) (3)) and
- Activities to promote the delivery of early detection and guideline-concordant health care by health care providers. (§ 40-2.30 (a) (4))

Each one of these required activities from the regulations can be linked to one or more PHAB standards and measures. The goals of the Year 4 initiative are to strengthen LHD efforts in chronic disease prevention, to demonstrate the alignment of LHD efforts with the Article 6 regulations and the PHAB standards and to expose LHDs to the process of submitting appropriate documentation to encourage pursuit of full PHAB accreditation.

Year 4 Standards and Measures

The Office of Public Health Practice and the Division of Chronic Disease Prevention reviewed the PHAB version 1.5 standards and measures document, and honed in on selected measures that reflect public health activities, strategies and interventions that are essential to chronic disease prevention and that reflect the required Article 6 chronic disease services (Table 1). These standards relate to using public health data, providing education and interventions to support prevention and wellness, identifying public health problems collaboratively with the community at large, and identifying/implementing strategies to improve access to health care services, in this instance chronic disease services.

Table 1. Selected Public Health Accreditation Board Standards and Measures Included in the Year 4 Performance Incentive Program.

Public Health Accreditation Board Standard/Measure
STANDARD 1.3: Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public's health.
Measure 1.3.1 A: Data analyzed and public health conclusions drawn
STANDARD 3.1: Provide health education and health promotion policies, programs, processes, and interventions to support prevention and wellness.
Measure 3.1.2 A: Health promotion strategies to mitigate preventable health conditions Measure 3.1.3 A: Efforts to specifically address factors that contribute to specific populations' higher health risks and poorer health outcomes
STANDARD 4.1: Engage with the public health system and the community in identifying and addressing health problems through collaborative processes.
Measure 4.1.1 A: Establishment and/or engagement and active participation in a comprehensive community health partnership and/or coalition; or active participation in several partnerships or coalitions to address specific public health issues or populations
STANDARD 4.2: Promote the community's understanding of and support for policies and strategies that will improve the public's health.
Measure 4.2.1 A: Engagement with the community about policies and/or strategies that will promote the public's health Measure 4.2.2 A: Engagement with governing entities, advisory boards, and elected officials about policies and/or strategies that will promote the public's health
STANDARD 7.2: Identify and implement strategies to improve access to health care services.
Measure 7.2.1 A: Process to develop strategies to improve access to health care services

The PHAB Standards and Measures describe the purpose and significance of each measure as well as the required documentation including examples of the kinds of documents that would meet the measure, and the time period in which the work must have taken place. For the purposes of this initiative, the DOH has revised the number of documents that are required to be submitted, as well as the time frame for when the work will have taken place (Table 2). The DOH is expecting that for some of these measures, the LHD will have work that it has already conducted that could be submitted, while for others, it will conduct the work this year and submit the documentation by the end of the initiative time frame. Participating LHDs that currently do not have activity related to a measure can use the performance period to conduct such activities and submit the relevant documentation. Accredited local health departments, or those in the process of being accredited, can use material that they have submitted to PHAB as long as it is chronic disease related and the required documentation is dated within the time period prescribed in Table 2.

Table 2. Required Documentation for Selected Public Health Accreditation Board Measures in the Year 4 Performance Incentive Program

PHAB Measure 1.3.1 A: Data analyzed and public health conclusions drawn (see pages 42-44)*			
Required Documentation (RD)	**Guidance**	**Number of Examples**	**Dated Since**
1. Analysis of data and conclusions drawn	1. The health department must document the analysis of data with conclusions drawn from the data.	1 quantitative example related to chronic disease prevention	January 2015
2. Review and discussion of data analysis	2. The health department must document the review of data analysis selected for Measure 1.3.1, Required Documentation 1, above.	1 example related to chronic disease prevention	January 2015
3. Analysis of data that demonstrates the use of information and data from multiple databases or data sources	3. The health department must document the analysis of data that combines data from multiple databases of different data topics, (e.g., the housing department's data and the prevalence of asthma) or data sources to support its conclusion.	1 example related to chronic disease prevention	January 2015
4. Aggregated primary and secondary data and the sources of each	4. The health department must document the aggregation of primary and secondary data.	1 example related to chronic disease prevention	January 2015
PHAB Measure 3.1.2.A: Health promotion strategies to mitigate preventable health conditions (See pages 96-98)			
Required Documentation (RD)	**Guidance**	**Number of Examples**	**Dated Since**
1. A planned approach for developing and implementing health promotion programs	1. The health department must document a planned approach for developing and implementing health promotion materials and activities.	1 example related to chronic disease prevention	January 2015
2. Development and implementation of health promotion strategies	2. The health department must document the development and implementation of health promotion strategies.	1 example related to chronic disease prevention	January 2015
3. Engagement of the community during the development of a health promotion strategy	3. The health department must document that it solicited review, input, and/or feedback from the target audience during the development of the health promotion strategy.	1 example from RD 2, above	January 2015
4. Implementation of strategies in collaboration with stakeholders, partners, and/or the community	4. The health department must document that implementation of the strategies was in collaboration with stakeholders, partners, and/or the community.	1 example from RD 2, above	January 2015

PHAB Measure 3.1.3 A: Efforts to specifically address factors that contribute to specific populations' higher health risks and poorer health outcomes (See pages 99-100)			
Required Documentation (RD)	**Guidance**	**Number of Examples**	**Dated Since**
1. Identification and Implementation of strategies to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or health inequity	1. The health department must document efforts to address health equity among the populations in the health department's jurisdiction.	1 example related to chronic disease prevention	January 2015

PHAB Measure 4.1.1 A: Establishment and/or engagement and active participation in a comprehensive community health partnership and/or coalition; or active participation in several partnerships or coalitions to address specific public health issues or populations (See pages 116-118)			
Required Documentation (RD)	**Guidance**	**Number of Examples**	**Dated Since**
1. Collaborative partnerships with others to address public health issues	1. The health department must document a current, ongoing comprehensive community partnership or coalition in which it is an active member.	1 example related to chronic disease prevention	January 2015
2. Partner organizations or Representation	2. The health department must provide a list of the participating partner organizations for the partnerships(s) or coalitions referenced above.	1 membership list related to above in 4.1.1 RD 1	January 2015
3. Community, policy, or program change implemented through the partnership(s) or coalition(s)	3. The health department must document a change in the community, a change in policy, or a new or revised program that was implemented through the work of the partnership(s) or coalition(s) identified in Required Documentation 1, above.	1 example related to chronic disease prevention	Since January 2015

PHAB Measure 4.2.1 A: Engagement with the community about policies and/or strategies that will promote the public's health (See page 122)			
Required Documentation	**Guidance**	**Number of Examples**	**Dated Since**
1. Engagement of members of the specific community or group that will be affected by a policy and/or strategy to promote the public's health	1. The health department must document engagement with the specific population in the community that will be affected by a policy or strategy.	1 example related to chronic disease prevention	January 2015

PHAB Measure 4.2.2 A: Engagement with governing entities, advisory boards, and elected officials about policies and/or strategies that will promote the public's health (See page 123)			
Required Documentation	**Guidance**	**Number of Examples**	**Dated Since**
1. Engagement with the governing entity, advisory boards, and/or elected officials about policies and/ or strategies that will promote the public's health	1. The health department must document that it communicates and collaborates with the governing entity, an advisory board, and/or elected officials concerning public health policy or strategy.	1 example related to chronic disease prevention	January 2015
PHAB Measure 7.2.1 A: Process to develop strategies to improve access to health care services (See page 185)			
Required Documentation	**Guidance**	**Number of Examples**	**Dated Since**
1. A coalition/ network/council working collaboratively to reduce barriers to health care access or gaps in access	1. The health department must document its involvement in a collaborative process for developing strategies to improve access to health care.	1 collaborative process	January 2015
2. Strategies developed by the coalition/network/council working through a collaborative process to improve access to health care services	2. The health department must provide strategies that the coalition/network/council developed to improve access to health care services and reduce barriers to care.	1 example related to chronic disease prevention	January 2015

Pages referenced refer to Public Health Accreditation Board Standard and Measures Document

DOCUMENTATION REQUIREMENTS

To learn more about documentation that meets PHAB Standards, please review pages 3-6 of the PHAB standards document. The most important aspects of these requirements are that the work must show evidence of authenticity, and must include a date. No draft documents are acceptable. NYSDOH will not review/score documentation that is not in line with PHAB documentation standards.

PROGRAM PARTICIPATION

Each LHD must opt-in to participate in this year's program. LHDs that wish to participate must indicate their intention to do so no later than October 31, 2016 by submitting an email to: chronic.disease.prevention@health.ny.gov

SUBMISSION OF DOCUMENTATION

To ease the review process, rather than submit an entire portfolio of documentation at the end of the incentive period, counties that opt-into the program should submit documentation over the time period of the initiative. NYSDOH recommends that LHDs submit complete evidence for 2-3 measures in December 2016, 2-3 in March 2017 and the final 2-3 in June 2017. All evidence is to be submitted VIA the BML mailbox at chronic.disease.prevention@health.ny.gov. For each document that is submitted, LHDs will be asked for a short one paragraph description that briefly describes how the document meets the requirements. In addition to

sending in the documentation and the brief description, accredited health departments can submit the PHAB scores received for the requested measures. Additional information on the submission process will be discussed at one of the first technical assistance calls.

SCORING METHODOLOGY

To score counties, NYSDOH will assess the quality of documentation submitted using the Likert scale rating system that is utilized by PHAB reviewers. A team of three NYSDOH employees will review submitted documentation and score the evidence submitted in regards to each measure. Documentation for each measure will be scored as "Not Demonstrated," "Slightly Demonstrated," "Largely Demonstrated," or "Fully Demonstrated." Point values will be assigned to each rating as follows:

Rating	Point value
Not Demonstrated	0
Slightly Demonstrated	1
Largely Demonstrated	2
Fully Demonstrated	3

There will be three reviewers for each document/measure. NYSDOH will take the majority rating for each measure, NOT THE AVERAGE. Thus, if two reviewers rate the value of documentation as largely demonstrated, and one rates slightly demonstrated, the assigned rating will be largely demonstrated. If all three reviewers disagree on the rating, the reviewers will meet to discuss and assign a rating following the consensus. LHDs will only receive the final rating for each measure; individual reviewer results will not be shared. As there are a total of 7 measures, the maximum score an LHD can receive is 21 (that is, fully demonstrated documentation supporting each and every measure).

AWARDS

LHD Eligibility for a Potential Award

To be eligible for an award in Year 4 of the performance program, each LHD must receive a minimum score of 10 and no measure may be "not demonstrated."

LHDs that receive composite scores less than 10 or do not demonstrate activity on a measure will be ineligible for an award.

Awards and Ranking

Several counties in NYS have been accredited or are in the process of PHAB accreditation. As recognition of this important achievement, NYSDOH will grant base awards to counties that have been accredited by the end of the Year 4 Performance Improvement period (June 30, 2017). Since the requested documentation in the Year 4 incentive program will require in most cases new documentation, these counties will also be eligible to compete in the competitive portion of the incentive. The total allotment for year 4 base awards for accredited LHDs is $30,000. NYSDOH anticipates individual LHDs will receive up to $7500 each in base awards.

Those LHDs that meet the minimum goals will be eligible (but not guaranteed) for a competitive award. Counties will be grouped based on size of population (attachment 4). Eligible counties will be ranked by their total composite county achievement scores and awards will be given to the top performers as detailed below.

Table 3. Proposed Performance Award Size and Structure for Counties Participating in the Year 4 Performance Incentive Program

County Population Size *	Number of LHDs in Size Group	Number of Awards Available	Amount ($) of Each Award	Total $ Amount
≥250,000	11	4	67,500	270,000
≥75,000-<250,000	21	8	50,000	400,000
<75,000	26	10	30,000	300,000

**Population sizes based on 2010 census, groupings shown in appendix I*

Auditing Results and Awarding Payouts

The NYSDOH reserves the right to audit any and all reports submitted by the counties to ensure the integrity of the evidence and/or data being reported.

The NYSDOH reserves the right to adjust payouts based on substantially poor or substantially exceptional results. It also reserves the right to adjust the timeline and/or amount of award payments.

Proposed Timetable for Moving Forward

LHDs must let the NYSDOH know about their decision to participate in this program no later than October 31, 2016. The NYSDOH will distribute a list of participating counties in November 2016. NYSDOH will host at least two calls during the performance period to provide technical assistance, discuss submission criteria, etc. Awards will be announced in September 2017. Award funds can be used to support costs associated with Article 6 eligible services. These are one time only payments. Incentive award payments will occur between October 2017 and February 2018.

Table 4. Proposed timeline moving forward.

Activity	July 2016	Aug	Sep	Oct	Nov	Dec	Jan 2017	Feb	Mar	Apr	May	Jun	July	Aug	Sep
Initiative Development and finalization	**X**	**X**													
New initiative announced			**X**												
Counties submit opt-in letter				**X**											
Performance period					**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**			
First wave of evidence submission due to NYSDOH						**X**									
Second wave of evidence submission due to NYSDOH									**X**						
Final wave of evidence submission due to NYSDOH												**X**			
Evidence analyzed and scored												**X**	**X**	**X**	
Awards announced at NYSACHO meeting															**X**

Appendix I. County population sizes in 2010 used to determine award groupings for composite score comparisons in the year 4 performance incentive program.

County	Region	Population*
Hamilton County	Capital	4,836
Schuyler County	West	18,343
Yates County	West	25,348
Lewis County	Central	27,087
Schoharie County	Capital	32,749
Seneca County	West	35,251
Essex County	Capital	39,370
Wyoming County	West	42,155
Orleans County	West	42,883
Delaware County	Capital	47,980
Allegany County	West	48,946
Greene County	Capital	49,221
Cortland County	Central	49,336
Montgomery County	Capital	50,219
Chenango County	Central	50,477
Tioga County	Central	51,125
Franklin County	Capital	51,599
Fulton County	Capital	55,531
Genesee County	West	60,079
Otsego County	Capital	62,259
Columbia County	Capital	63,096
Washington County	Capital	63,216
Herkimer County	Central	64,519
Livingston County	West	65,393
Warren County	Capital	65,707
Madison County	Central	73,442
Sullivan County	Metro	77,547
Cayuga County	Central	80,026
Cattaraugus County	West	80,317
Clinton County	Capital	82,128
Chemung County	West	88,830
Wayne County	West	93,772
Steuben County	West	98,990
Putnam County	Metro	99,710
Tompkins County	Central	101,564
Ontario County	West	107,931
St Lawrence County	Central	111,944
Jefferson County	Central	116,229
Oswego County	Central	122,109
Chautauqua County	West	134,905
Schenectady County	Capital	154,727
Rensselaer County	Capital	159,429
Ulster County	Metro	182,493
Broome County	Central	200,600
Niagara County	West	216,469
Saratoga County	Capital	219,607
Oneida County	Central	234,878

Dutchess County	Metro	297,488
Albany County	Capital	304,204
Rockland County	Metro	311,687
Orange County	Metro	372,813
Onondaga County	Central	467,026
Monroe County	West	744,344
Erie County	West	919,040
Westchester County	Metro	949,113
Nassau County	Metro	1,339,532
Suffolk County	Metro	1,493,350
New York City	Metro	8,175,133

APPENDIX 2

Part 40 Regulations

40-2.30 Chronic disease prevention; performance standards.

(a) The local health department shall maintain a program designed to reduce the prevalence or incidence of chronic diseases and conditions such as cancer, cardiovascular diseases, diabetes, asthma, arthritis and obesity, and the underlying risk factors of tobacco use, physical inactivity and poor nutrition. The activities required in this program shall include, at a minimum:

(1) Analysis and utilization of public health data and information to shape objectives and strategies related to chronic disease prevention. This analysis shall:

(i) use available data from the community health assessment and other local assessments;

(ii) identify communities and/or neighborhoods where the population is at increased risk of chronic diseases and conditions and underlying risk factors;

(iii) identify the specific local factors and available policies, practices, underlying risk factors, and interventions that influence chronic disease;

(2) leadership of, or participation in, efforts with multiple sectors in the community to improve social and physical environments to support healthy behaviors;

(3) public health marketing and communication, including developing or adapting public education materials or campaigns, and promoting or disseminating such materials or campaigns, to reduce risk factors for chronic disease morbidity, mortality and related health disparities; and

(4) activities to promote the delivery of early detection and guideline-concordant health care by health care providers.

(b) Any and all health care services for the screening or treatment of chronic diseases are ineligible for State Aid.