Attachment B

Agency Programs/Activities: Inventory and Key Data
AIDS INSTITUTE

Page	Relation to Core Mission (H/M/L)	Program/Activity	Spending Category (SO, ATL, CAP)	3/31/09 FTEs (All Funds)	General Fund Disbursements ($000s)				State Special Revenue Funds Disbursements ($000s)				Capital Projects Funds Disbursements ($000s)			
					2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected
1	H	Community Service Programs (CSP)	ATL		$3,072	$1,884	$1,700	$1,700	$18,720	$18,484	$18,178	$18,178	$0	$0	$0	$0
3	H	Community Service Program ATL transfer	SO	**3**	$125	$125	$125	$125	$0	$0	$0	$0	$0	$0	$0	$0
5	H	Multiple Service Agency (MSA)	ATL		$2,489	$1,974	$1,814	$1,814	$9,259	$8,794	$8,631	$8,631	$0	$0	$0	$0
7	M	Families in Transition	ATL		$589	$669	$531	$531	$1,664	$1,493	$1,471	$1,471	$0	$0	$0	$0
8	M	General Legal Services	ATL		$0	$0	$0	$0	$587	$538	$529	$529	$0	$0	$0	$0
9	H	Harm Reduction	ATL		$0	$17	$800	$800	$3,046	$2,920	$2,869	$2,869	$0	$0	$0	$0
10	H	Criminal Justice HIV Prevention Services	ATL		$0	$0	$0	$0	$2,396	$2,314	$2,273	$2,273	$0	$0	$0	$0
12	M	Housing and Supportive Services for Homeless Person with HIV	ATL		$0	$0	$0	$0	$2,926	$2,156	$2,121	$2,121	$0	$0	$0	$0
13	M	Access to Clinical HIV Trials and Experimental Treatments	ATL		$0	$0	$0	$0	$74	$100	$98	$98	$0	$0	$0	$0
14	H	HIV Clinical Fellowship Program	ATL		$0	$0	$0	$0	$1,444	$1,427	$1,407	$1,407	$0	$0	$0	$0
15	H	HIV/AIDS Specialized Training	ATL		$0	$0	$0	$0	$1,498	$1,419	$1,395	$1,395	$0	$0	$0	$0
16	H	HIV Clinical Education Initiative (CEI)	ATL		$0	$0	$0	$0	$1,589	$1,478	$1,455	$1,455	$0	$0	$0	$0
17	H	Treatment Adherence AIDEMO	ATL		$408	$368	$581	$581	$0	$0	$0	$0	$0	$0	$0	$0
18	H	Nutrition Services for HIV Positive Individuals	ATL		$0	$0	$0	$0	$1,545	$1,449	$1,423	$1,423	$0	$0	$0	$0
19	L	Specialty Targeted Contracts	ATL		$312	$1,085	$587	$587	$0	$0	$0	$0	$0	$0	$0	$0
20	L	COLA to Direct Service Providers	ATL		$108	$3,930	$4,790	$4,790	$0	$0	$0	$0	$0	$0	$0	$0
21	H	HIV Surveillance and Partner Notification	ATL		$0	$0	$0	$0	$3,957	$4,064	$4,022	$4,022	$0	$0	$0	$0
22	H	HIV Special Needs Plans	ATL		$1,297	$380	$2,100	$2,100	$0	$0	$0	$0	$0	$0	$0	$0
23	H	ADAP	ATL		$0	$0	$0	$0	$30,000	$45,000	$45,000	$45,000	$0	$0	$0	$0
25	H	Continuing Medical Education (CME) For Physicians to Promote HIV Testing & Treatment	ATL		$0	$0	$0	$0	$106	$65	$64	$64	$0	$0	$0	$0
26	M	ACT for Youth - Assets Coming Together for Youth	ATL		$0	$0	$0	$0	$1,217	$1,213	$1,197	$1,197	$0	$0	$0	$0
27	H	MOU - HIV Prevention and Services in State Prisons (suballocation from DOCS)	SO	**13**	$693	$738	$779	$779	$0	$0	$0	$0	$0	$0	$0	$0
28	H	HIV Prevention and Primary Care in Substance Abuse Treatment Programs	ATL		$0	$0	$0	$0	$2,858	$2,727	$2,689	$2,689	$0	$0	$0	$0
30	H	HIV Prevention and Primary Care in Community - Based Health Care Settings	ATL		$0	$0	$0	$0	$3,210	$2,966	$2,920	$2,920	$0	$0	$0	$0
32	H	HIV Prevention and Care for Communities of Color	ATL/OLTC		$3,122	$5,016	$6,931	$7,031	$0	$0	$0	$0	$0	$0	$0	$0
34	H	Hepatitis C Program	ATL		$0	$0	$395	$1,580	$0	$0	$0	$0	$0	$0	$0	$0
35	M/L	Legislative Adds	ATL		$0	$811	$967	$501	$0	$0	$0	$0	$0	$0	$0	$0
36	M	National Black Leadership Commission on AIDS	ATL		$179	$335	$173	$173	$0	$0	$0	$0	$0	$0	$0	$0
37	M	New York AIDS Coalition	ATL		$66	$87	$164	$164	$0	$0	$0	$0	$0	$0	$0	$0
38	H	HIV Related Risk Reduction Program	ATL		$0	$0	$400	$870	$0	$0	$0	$0	$0	$0	$0	$0
39	H	AIDS Intervention Management System	ATL		$0	$279	$371	$371	$3,108	$2,349	$2,410	$2,410	$0	$0	$0	$0
41	H	Community Development Initiative (CDI)	ATL		$0	$0	$0	$0	$2,421	$2,293	$2,250	$2,250	$0	$0	$0	$0
42	H	Women's Adolescent and Supportive Services (WA&SS)	ATL		$0	$0	$0	$0	$9,932	$9,658	$9,493	$9,493	$0	$0	$0	$0
44	H	(WASS) HIV Prevention and Health Care for Adolescents ATL Transfer	SO	**4**	$116	$116	$114	$114	$0	$0	$0	$0	$0	$0	$0	$0
46	H	(WASS) CBO's for Education and Prevention ATL Transfer	SO	**2**	$75	$75	$74	$74	$0	$0	$0	$0	$0	$0	$0	$0
48	H	Gay/MSM, Lesbian, Bi-Sexual, Transgender and Peer Delivered HIV Prevention Services	ATL		$0	$0	$0	$0	$3,972	$3,743	$3,677	$3,677	$0	$0	$0	$0
50	H	HIV Provider Education Program	ATL		$0	$0	$0	$0	$722	$528	$520	$520	$0	$0	$0	$0
51	M	Cornell Cooperative Agreement - Parent and Care Provider HIV/AIDS Education Project	ATL		$0	$0	$0	$0	$142	$184	$181	$181	$0	$0	$0	$0
52	M	New York New York III Housing Initiative	ATL		$0	$340	$3,780	$3,780	$0	$0	$0	$0	$0	$0	$0	$0
53	H	Family Centered Health Care (FCHC)	ATL		$0	$0	$0	$0	$5,311	$5,406	$5,323	$5,323	$0	$0	$0	$0
55	H	(FCHC) Maternal and Child ATL Transfer	SO	**5**	$250	$250	$246	$246	$0	$0	$0	$0	$0	$0	$0	$0
57	H	General Fund- State Operations- AIDS Institute	SO	**63**	$9,128	$9,213	$9,688	$9,688	$0	$0	$0	$0	$0	$0	$0	$0
		AIDS Grand Total	ALL	**90**	$22,029	$27,691	$37,110	$38,399	$111,703	$122,767	$121,596	$121,596	$0	$0	$0	$0

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: Community Service Programs (CSP)

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: CSPs were established in 1984 as a regional approach to providing comprehensive HIV/AIDS prevention and support services, training and technical assistance to local health and human service providers, and leadership in the development of a comprehensive approach to addressing HIV/AIDS in specific catchment areas. CSPs provide services to the entire State through satellite sites and collaborations with other providers. Also included in their array of HIV/AIDS services are HIV counseling and testing, crisis intervention, case management, transportation, housing, home assistance, nutrition, syringe exchange and substance use services. They were the first HIV/AIDS service programs funded in NYS and remain the backbone of HIV/AIDS services. Of this amount, $49,000 is awarded to the Long Island Association for AIDS Care as a discrete line item.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: Diverse populations and sub-populations most impacted by HIV/AIDS statewide.

Performance Measures: New York State's prevention programs have had tremendous documented successes over the years including 1) a 98% reduction in mother-to-child transmission of HIV (from a high of 500 at the height of the epidemic to 10 in 2006); 2) a 70% reduction in reported seroprevalance among injection drug users (from 54% to 13%); 3) a 25% higher rate of persons in New York State who report ever having had an HIV test than the national average (40% nationally and 50% in NYS); 4) a 4.2% decrease in the number of reported HIV cases among men who have sex with men between 2001 and 2006; 5) a significantly higher rate of reported condom use among African Americans for purposes of contraception than is found in other areas of the United States. Efforts to help achieve these successes came from programs across numerous separate expenditure plans.

The CSPs serve approximately 10,500 individuals with over 79,000 one-on-one encounters (e.g., case management, support services, individual education

sessions) each year. Outreach and specific health education including HIV and STD prevention for persons at high risk and living with HIV/AIDS included over 5,100 events/sessions with an approximate number of 155,703 participants in 2007/08.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: Community Service Programs (CSP)

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: A portion of funding is transferred to the general fund – state purposes account for the administration of this program.

CSPs were established in 1984 as a regional approach to providing comprehensive HIV/AIDS prevention and support services, training and technical assistance to local health and human service providers, and leadership in the development of a comprehensive approach to addressing HIV/AIDS in specific catchment areas. CSPs provide services to the entire State through satellite sites and collaborations with other providers. Also included in their array of HIV/AIDS services are HIV counseling and testing, crisis intervention, case management, transportation, housing, home assistance, nutrition, syringe exchange and substance use services. They were the first HIV/AIDS service programs funded in NYS and remain the backbone of HIV/AIDS services. Of this amount, $49,000 is awarded to the Long Island Association for AIDS Care as a discrete line item.

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Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: Multiple Services Agencies (MSA) – HIV/AIDS Prevention and Supportive Services

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: MSAs are funded to develop the capacity for a continuum of HIV prevention and service programs in organizations serving high-need communities. Prevention education, case management, and supportive services are the major service components to be provided, which are culturally sensitive to the special social and cultural needs of the at-risk population. Funding also assists contractors in developing agency infrastructure to support the delivery of HIV services. These programs were originally created to provide capacity building and related services in minority community based organizations through their own strong advocacy efforts. These agencies were an expansion in service delivery capacity as the epidemic grew. MSAs are also designed to encourage organizations to develop the three components of this service model: outreach and prevention, client services and community building.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: Communities of Color at high risk for HIV in targeted hard-to-reach populations statewide.

Performance Measures: New York State's prevention programs have had tremendous documented successes over the years including 1) a 98% reduction in mother-to-child transmission of HIV (from a high of 500 at the height of the epidemic to 10 in 2006); 2) a 70% reduction in reported seroprevalance among injection drug users (from 54% to 13%); 3) a 25% higher rate of persons in New York State who report ever having had an HIV test than the national average (40% nationally and 50% in NYS); 4) a 4.2% decrease in the number of reported HIV cases among men who have sex with men between 2001 and 2006; 5) a significantly higher rate of reported condom use among African Americans for purposes of contraception than is found in other areas of the United States.

Approximately 10,000 clients are served annually with over 89,000 one-on-one encounters. Outreach and education events targeting persons at high risk for

HIV infection and living with HIV/AIDS in communities of color included over 4,500 events with the participation of about 123,000 individuals.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: Families in Transition

Mandate: Chapter 477 of the Laws of 2000

Mandated Funding Level: None

Brief Description/History/Background: Since the inception of Permanency Planning and Support Services for Families Affected by HIV Initiative in 1995, a deeper understanding of the service needs of families infected and affected by HIV has been gained. The advent of combination antiretroviral therapy and the concomitant improvement in the course and treatment of HIV disease have additionally altered the needs of families and caregivers, requiring evolution in models of service delivery. Key components of this evolution entail the articulation of a continuum of health care, supportive and legal services available to families living with HIV and enhanced linkages among these service providers. Such a continuum provides support for families coping with HIV, addresses the emotional and psychosocial needs of children, families and youth in transition, and enables families to begin the process of planning for the future care and custody of their children at multiple points along the continuum.

State Legislation (The Families in Transition Act) requires the Commissioner of Health to submit an annual report to the Governor and the Legislature identifying services provided to children and adolescents who lose their primary caregivers to HIV/AIDS.

Economies of scale may be achieved by consolidating activity in the Office of Children & Family Services.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: Family members of persons with HIV/AIDS

Performance Measures: In 2007, these programs served more than 1,400 families, including more than 3,700 individuals (1,526 adults and 2,221 children).

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: General Legal Services

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: Legal Services enable low income, HIV-infected persons to gain access to legal professionals for assistance in writing wills, making child custody arrangements, combating discrimination, receiving health care services and entitlements, developing advance directives, and maintaining or acquiring housing. In addition, the initiative's six contracts support the provision of standard legal services such as settling insurance disputes, bankruptcy proceedings, and other civil matters that many individuals with HIV-related disease could not otherwise manage or afford. Providers are successful in enlisting the services of attorneys to do pro bono work for individuals and families affected by HIV, greatly expanding access to legal services for those in need. Legal service agencies are also active in providing training and technical assistance about HIV-related legal matters to staff and clients of health and human services agencies.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate. Economies of scale may be achieved by consolidating activity in a single agency

Population Served: HIV positive individuals statewide in need of legal services.

Performance Measures: During 2007, contractors served almost 900 clients with 1,770 separate legal cases.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: Harm Reduction

Mandate: Public Health Law Article 33, Section 3381

Mandated Funding Level: None

Brief Description/History/Background: There are 17 community-based organizations authorized to conduct harm reduction in New York State. These agencies received a waiver from the State Health Commissioner under Section 80.135, Title 10 of the Official Codes, Rules and Regulations of NYS. Agencies under this waiver provide comprehensive harm reduction services to injecting drug users with the purpose of reducing the transmission and acquisition of HIV, Hepatitis B & C and other blood-borne diseases. Funds continue to be awarded to these agencies to implement new sites, improve client utilization, build program infrastructure, enhance quality of educational interventions, improve data reporting, continue outreach activities, increase community support and conduct syringe exchange activities.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: Hard to reach substance users statewide.

Performance Measures: Over a 130,000 cumulative participants have utilized the services of syringe exchange programs (SEPs) since 1992. The impact of the syringe exchange programs in New York has been well-documented. Beth Israel Medical Center's (BIMC) Edmund de Rothschild Chemical Dependency Institute has conducted an annual evaluation of NYSDOH Syringe Access Initiatives including Syringe Exchange Programs (SEPs) since inception of the initiative. Evaluation of the program found that 1) it did not increase drug use; 2) it diminished the sharing of syringes; 3) it did not result in increased needle sticks among the general public; 4) it stabilized the transmission of HIV; and 5) it decreased the transmission of Hepatitis B.

The Chemical Dependency Institute, in an outcome evaluation of the SEPs, interviewed 3,436 participants. This study found that the borrowing of syringes declined by over 62% after enrollment; the buying or rental of syringes "on the street" declined by more than 75% and the use of alcohol pads almost tripled. Because of improved syringe access and education among injection drug users, risk-taking behaviors by injectors have been reduced and the HIV seroincidence

and seroprevalence among this population has dropped significantly. Seroprevalence prior to syringe exchange reached approximately 50% in 1984 in New York City and continued at that level through 1992. Soon after the introduction of syringe exchange programs, risk-taking behaviors were noted to have declined. The most recent seroprevalence rates among injection drug users are lower than 13%.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: Criminal Justice HIV Prevention Services

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The Criminal Justice Initiative (CJI) provides a comprehensive, seamless continuum of quality HIV prevention and supportive services to individuals in a correctional setting and ex-offenders returning to their home communities. These services are designed to diminish HIV transmission and improve the health and well-being of individuals living with HIV and AIDS. The CJI uses multiple strategies to ensure effective service delivery. The services provided in correctional settings include HIV prevention interventions, peer educator training, anonymous HIV counseling and testing (with the option to convert to confidential), HIV supportive services and transitional planning. This initiative also funds community-based organizations to provide re-entry assistance for ex-offenders living with HIV/AIDS. Funded activities for these populations include transportation, supportive services, risk reduction counseling, coordination of health and human services and referral to community case management.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: Inmates and parolees at risk or living with HIV/AIDS statewide.

Performance Measures: Approximately 5000 clients served annually. For the past decade (1988 to present) NYSDOH has conducted blinded HIV seroprevalence studies of incoming inmates to the NYS Department of Correctional Services (DOCS) facilities. Six waves of data collection have demonstrated a HIV seroprevalence declined over time for both male and female inmates in these studies. HIV seroprevalence rates dropped 74% between 1988 and 2003 for male inmates. HIV seroprevalence rates dropped less than 40% over the same time period for female inmates. Recent year studies demonstrate that similar trends of declining HIV rates. Overall HIV prevalence rates in new admissions are 4.5% for males and 11.4% for females. This demonstrates a drastic reduction from 1988 where HIV infection rates were 17% for males and 19% for females.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: Housing & Supportive Housing Services for Homeless Persons with HIV

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: This initiative provides enhanced supportive housing services to persons with HIV/AIDS. Supportive services address the housing needs of special and underserved populations including those who are at risk of losing housing or who are significantly challenged to remain in housing. Persons who are multi-diagnosed (e.g., HIV/AIDS and mental illness, substance abuse, Hepatitis B, Hepatitis C or tuberculosis) present a unique array of housing and supportive service needs in order to maintain appropriate housing and access to care.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate. Economies of scale may be achieved by consolidating activity in DHCR.

Population Served: Homeless persons with HIV.

Performance Measures: In 2007, through the AIDS Institute's housing initiative, almost 3,000 people avoided homelessness.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: Access to Clinical HIV Trials and Experimental Treatments

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The purpose of this initiative is to help people living with HIV understand the potential benefits, risks and the important role clinical trials play in accessing appropriate clinical therapy. Ongoing clinical trials for HIV are collected under this initiative and health and human service providers are trained to offer this information to clients, explore with patients the potential benefits of their participation in a clinical trial, and make referrals as appropriate.

Issues: While clinical trials for experimental treatments are essential to the development of new therapies and are an important option for individuals who have failed or are intolerant to approved therapies, federally funded clinical trials also perform their own outreach and education.

Population Served: Individuals with HIV/AIDS do not receive direct services through this program. Community Research Initiative on AIDS (CRIA) works with the Medical Director's Office seeking advice from consumers, providers, and community-based organizations in the development of the training program. CRIA also works closely with health and human service providers statewide identifying agencies targeted for training and who serve individuals living with HIV/AIDS.

Performance Measures: None

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: HIV Clinical Fellowship Program

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The HIV/AIDS epidemic introduced unparalleled complexity in both medical management and a wide range of social issues that traditional social services systems are not adequately prepared to handle. There is a currently a shortage of HIV specialists in many regions of the State. The HIV Clinical Scholars program assists with workforce training. This program recruits and trains health professionals in the delivery of HIV primary care and the development of expertise in HIV program planning, management and health policy within a public health context. The program trains health professionals to deliver HIV primary care and other services to HIV infected populations, to expose them to the broad social and public issues around HIV/AIDS and to develop a cadre of leaders in the field. The HIV Clinical Fellowship Program encourages health professionals to work in clinical settings, providing care and treatment to persons with HIV infection. These settings include designated hospital outpatient clinics, substance use treatment programs, mental health clinics, and family planning and prenatal clinics.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: The HIV Clinical Fellowship Program is not a direct service provider. The HIV Clinical Fellowship Program trains health care professionals statewide in hospitals, community health centers, outpatient and extension clinics, community services programs/community-based organizations, substance abuse treatment programs, long term care facilities, and mental health providers providing care and treatment to persons living with HIV/AIDS.

Performance Measures: There are currently 12 scholars supported under this initiative including: 7 medical doctors, 2 registered nurses, 2 physician's assistants, and 1 dentist.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: HIV/AIDS Specialized Training

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The HIV/AIDS Training Services initiative is designed to provide non-physician health and human services providers, case managers and others with training opportunities in a variety of topics related to HIV/AIDS. Training topics include: New York State counseling and testing requirements, HIV reporting and partner notification, community prevention education and health education, behavioral science, harm reduction, advanced case management topics, entitlements and advocacy, cultural diversity, adherence and clinical updates. Additional training topics are added as dictated by emerging trends in the epidemic.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: Trains non-physician health and human service providers statewide in topics related to HIV/AIDS.

Performance Measures: Approximately 550 days of training on various topics are delivered annually. Between January and June 2008, 5,636 individuals attended the sponsored trainings.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: HIV Clinical Education Initiative (CEI)

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: Under the direction of the AIDS Institute's Office of the Medical Director, this initiative provides for the development and continuation of HIV/AIDS clinical educational programs for primary care providers and other health care professionals treating persons with HIV infection. The primary goals of the HIV CEI are to increase both the clinical skills and the number of community based health care practitioners providing care for people with HIV infection and AIDS and to enhance the quality of care provided by those practitioners through trainings on state-of-the-art clinical information. A secondary goal is to improve and solidify referral relationships involving HIV care among community health care providers, community support service programs, and tertiary care centers.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: CEI works closely with community health centers, substance abuse treatment sites, community hospitals, residential health care facilities, and other diagnostic and treatment centers and managed care plans Statewide. Managed care plans are an important target of this initiative, especially those with large numbers of community office-based practitioners who lack expertise in the recognition and management of HIV disease. This program also supports easy and prompt access to HIV specialists by community based primary care practitioners. Via telephone, HIV specialists are available 24/7 to provide education regarding established guidelines and current standards in today's HIV practice.

Performance Measures: From July 1, 2007- June 30, 2008, 13,127 clinicians attended 611 education events provided by the Clinical Education contractors. Participants at these events who identified their profession included 2817 medical doctors, 226 dentists, 496 physician's assistants, 668 nurse practitioners, 4026 registered nurses, 300 licensed practical nurses, 99 nursing assistants, 47 psychologists, 96 nutritionists, 109 dental hygienists, 915 social workers, 26 nurse midwives and 449 pharmacists.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: Treatment Adherence

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The efficacy of highly active antiretroviral therapy (HAART) is dependent upon viral suppression to undetectable levels in the bloodstream, a goal attained only when 95% or greater adherence to HAART is sustained. Less than 95% adherence can result in incomplete suppression of viral replication, which may lead to viral resistance to treatment and can limit future treatment options for HIV. Drug-resistant strains of HIV can be transmitted to previously uninfected persons or treatment-naïve individuals, thereby decreasing the chances of these populations to benefit from HAART.

The goal of this initiative is to help individuals prepare for, achieve and maintain adherence to antiretroviral therapy. The objectives of this initiative are to provide clients access to treatment adherence and supportive services, assist clients in developing the skills to ensure treatment adherence, enhance and integrate the treatment adherence service structure into the continuum of HIV care, provide client-centered HIV and social services which support treatment adherence, and implement a system that ensures the coordination and collaboration of services being provided to the client.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: HIV positive individuals who struggle with adherence to antiretroviral therapy in the Finger Lakes, Long Island, Northeast and Western New York regions.

Performance Measures: Approximately 300 clients are served annually.

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Program: Nutrition Services for HIV Positive Individuals

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: Good nutrition is essential to the management of HIV infection. Nutritious food profoundly affects the immune system, may delay disease progression, increases tolerance of medical treatments, and can have a major impact on quality of life. The food and nutrition initiative seeks to improve, maintain and/or delay the decline of the nutritional status of persons living with HIV and AIDS by providing a continuum of nutrition services that helps individuals to remain healthy and that enhances their independence and ability to care and provide for themselves. The AIDS Institute continuum of nutrition services consists of the provision of nutritional screenings, assessments, counseling, and group nutrition education; and the following food and meal components: home-delivered meals, congregate meals, groceries/food pantry bags, and food vouchers. The initiative was recently re-designed to address the retention of persons living with HIV/AIDS in health care and to assess health status as it relates to nutrition.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: HIV positive individuals in need of nutritional services statewide.

Performance Measures: In 2007, more than 300,000 meals were provided to more than 3,000 persons living with HIV/AIDS through the nutrition initiative.

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Program: Specialty Targeted Contracts

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The specialty initiative provides annual additional funding for one-time expenses to existing AIDS service providers targeting special populations. The existing service providers are funded under a variety of initiatives managed by the Division of Health Care and the Division of HIV Prevention. These contracts are limited in scope and target specific geographic areas and/or populations such as women, children, adolescents, MSM, WSW, and people living with HIV and AIDS. The intent of these contracts is to diminish the spread of HIV and AIDS through education, training, and the coordination of care and health and human services.

Issues: There are a large number of contracts funded under this appropriation. Due to the fact that this funding is distributed over hundreds of contracts targeting special populations, the amount distributed to each of these contracts is minimal.

Population Served: This funding provides a small enhancement (less than $3,000) to most existing AIDS Institute service providers for one-time expenses to enhance program services.

Performance Measures: Amounts to each contractor are too minimal to have a measurable impact on service delivery.

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Program: COLA to Direct Service Providers

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: Cost of living adjustments have been added to not for profit AIDS Institute contractors under a variety of AIDS Institute initiatives managed by the Division of HIV Health Care and the Division of HIV Prevention since October 2006. COLA rates applied to contract amounts were 2.18% in 06/07, 5.6% in 07/08 and will be 8.53% in 08/09.

The COLA has posed problems for contractors that want to plan for annualized salary increases, but must limit such increases to one- time bonuses due to the uncertainty around the amount of the annual COLA. The COLA cannot be factored into contract amounts until the percentage calculation is determined by the consumer price index.

Issues: None

Population Served: Existing AIDS Institute contractors serve persons with HIV and populations at risk for HIV statewide.

Performance Measures: Contractors are asked to certify that the COLA is used for retention of staff or other essential non personal service expenses prior to reimbursement.

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Program: HIV Surveillance and Partner Notification

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: This funding is distributed to twelve commissioned counties and the New York City Department of Health and Mental Hygiene to perform partner notification activities in response to legislation signed into law in 1998 and implemented in June 2000 that requires the reporting of HIV infection and HIV-related illness in addition to AIDS by physicians and laboratories.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: These contracts fund partner notification activities that serve New Yorkers statewide, specifically the following counties: Albany, Schenectady, Onondaga, Erie, Chautauqua, Monroe, Nassau, Suffolk, Rockland, Orange, Westchester and Dutchess as well as New York City.

Performance Measures: The total number of unduplicated index cases and partners served was approximately 2,392 in 2007.

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Program: HIV Special Needs Plans

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The Managed Care Act of 1996 created HIV SNPs as comprehensive managed care delivery networks for Medicaid recipients with HIV and AIDS. HIV SNPs are intended as an alternative to mainstream managed care that provides quality care for people with HIV under a capitated reimbursement system. Currently there are three SNPs: MetroPlus Partnership in Care, NY Presbyterian System SelectHealth and VidaCare. Enrollment authorization is limited to the 5 boroughs of New York City. Enrollment has reached over 3,300 as of August 2008. SNPs are expected to continue their steady enrollment growth**.**

Issues: The Department is exploring removal of the HIV exemption and transition to mandatory managed care enrollment for persons with HIV. Mandatory enrollment would be phased-in in the five boroughs of New York City over a projected 12 month period. Twenty-five to thirty- thousand Medicaid recipients with HIV infection would have a choice of enrolling in a mainstream managed care plan or an HIV SNP for their care.

Population Served: HIV SNPs are Medicaid managed care plans designed to serve Medicaid recipients with HIV/AIDS and their children.

Performance Measures: The most recent performance measurement is a comparison of SNPs, fee-for-service and regular managed care, the results of which were released by the Department on August 1, 2008. DOH conducted a study to determine how the three delivery systems compared on performance for a variety of quality of care and service utilization measures. The SNPs performed better than the statewide average for five of eight measures; with higher rates of viral load measurement, cholesterol screening and breast cancer screening and lower rates of general inpatient admissions and admissions with a pneumonia diagnosis.

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Program: AIDS Drug Assistance Program

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The AIDS Drug Assistance Program (ADAP) began in 1987 as part of a national program to provide free HIV/AIDS drugs to low-income individuals not covered by Medicaid or adequate third-party insurance. Creation of the federal Ryan White CARE Act in 1990 allowed New York State to expand the program to include ambulatory care and home care services. The insurance continuation program began in July 2001 both to control costs and provide access to comprehensive health care coverage. Both federal and state statute/regulation govern the programs. The federal Ryan White CARE Act includes statutory authority for HIV care and treatment primarily in the form of AIDS Drug Assistance Programs throughout the nation, and associated appropriations provide federal funding to support the programs. In addition, State regulation in NYCRR, Title 10, Sub-part 43-2 governs the application and eligibility determination process and establishes the rights and responsibilities of applicants, participants, and providers. The State Health Care Reform Act has provided annual allocation authority for the programs since 1996.

Issues: Health Care Reform Act expenditures by the Program are committed as a part of NYS matching requirement for federal F-SHRP funding during the period 10-06 through 9-09.

Population Served: Uninsured and underinsured persons living with HIV/AIDS statewide.

Performance Measures: Since inception, the programs have served more than 80,000 persons. The programs provide medications and medical care to approximately 22,000 persons annually. Seventy percent of those served are persons of color.

The program has achieved efficiencies, with very low overhead and systems to ensure coordination with Medicaid, Medicare, and private insurance. In addition, prospective and retrospective quality assurance functions assure that services are appropriate and of high quality and prevent the use of contraindicated medications. In addition, the quality of care provided to persons living with

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HIV/AIDS through ADAP Plus is measured through the AIDS Institute's quality management program, which is based on indicators that are linked to optimal care outcomes. Quality data show that HIV/AIDS health care facilities score consistently high on several key quality indicators, including highly active antiretroviral therapy in patients with viral load above 100,000; antiretroviral therapy management; substance abuse assessment; and tobacco use. Data also show steady improvement in scores associated with mental health screening, CD4 tests; and viral load tests. In all of these measures, median performance in New York State exceeds national median performance.

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Program: Continuing Medical Education (CME) Program for Physicians to Promote HIV Testing and Treatment

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The purpose of this initiative is to focus physicians' attention on key aspects of the need for patients to know their HIV status and seek treatment if tested positive. It is imperative that individuals at risk for HIV infection know their status and gain access to treatment. It is known that many clinicians do not ask questions related to HIV risk factors and do not consider HIV as a disease that could be present among their patients.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: Physicians and patients.

Performance Measures: None

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Program: Assets Coming Together (ACT) for Youth

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The ACT for Youth initiative focuses on mobilizing communities to advance youth development strategies and promote the involvement of young people, families and diverse community sectors to improve healthy outcomes for young people in NYS. Various populations of youth are adversely and sometimes disproportionately affected in the areas of abuse, violence and risky sexual activity. This initiative enhances the capacity of communities to build developmental assets for youth.

Data from the New York State Department of Health Bureau of HIV/AIDS Epidemiology indicates that New York State leads the nation in the number of reported AIDS cases among adolescents ages 13-24. As of December 31, 2006, 5,722 young people aged 13 to 24 were reported to be living with HIV/AIDS in New York State.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: The contracts funded under this initiative perform community development activities. Population served is youth statewide.

Performance Measures: Cornell University conducted an evaluation of the initiative in 2006. The evaluation included a review of all the outcomes achieved by each of the contractors as well as intensive case studies of a sampling of the contractors. Key findings from the evaluation included: all of the communities served strengthened and created services, opportunities and supports that enabled youth to transition to adulthood; substantial progress was made toward increasing authentic youth engagement and voice in community decision making roles; and all of the communities successfully created and maintained functioning collaborations that were used to achieve and further the goals of the ACT for Youth Initiative.

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Program: HIV Prevention and Services in State Prisons

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The New York State Department of Health (DOH) and the State Department of Correctional Services (DOCS) have executed a Memorandum of Understanding (MOU) for interagency cooperation in the implementation of HIV prevention services in State correctional facilities. Additionally, DOH supports HIV rapid and confirmatory HIV testing conducted by DOCS staff through purchasing of devices and Wadsworth Center Laboratory services.

The AIDS Institute Criminal Justice Initiative was established to: educate civilian, officer staff and inmates in the State prison system about HIV transmission, risk reduction, and the importance of early medical intervention for HIV infected persons; provide anonymous and confidential HIV counseling and testing services for inmates on a voluntary basis, and provide ongoing resource capability at numerous facilities through staff and peer training.

Issues: None

Population Served: Civilian, officer staff and inmates in the State prison system.

Performance Measures: As of December 2007, the Criminal Justice Initiative provides HIV/AIDS prevention education services to 7,737 correctional staff and 117,742 inmates at DOCS facilities statewide.

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Program: HIV Prevention and Primary Health Care in Drug Treatment Programs

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The Substance Abuse Initiative has developed a co-located continuum of comprehensive HIV prevention and primary care services within substance abuse treatment settings throughout New York State. At its core, the co-located model operates on the principles of integration of HIV services within the drug treatment environment and the seamless transition from testing to care. For those actively using, it is ushering the willing into treatment and toward recovery. The initiative has been instrumental in broadening the mission of the substance abuse treatment community from a singular focus on rehabilitation to a focus on public health. Recent modifications to the program model include routine provision of counseling and testing by medical staff of substance abuse treatment programs, enhanced outreach to active users not in care, a shift from primary prevention to prevention with positives and retention in care, and the initiation of transitional case management to connect active substance users with the continuum of addiction treatment services.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: Substance users in Central New York, Northeastern NY, Finger Lakes, Manhattan, Brooklyn, Queens and the Bronx.

Performance Measures: The AIDS Institute's health care programs have reached targeted populations and have resulted in improved access to care. The Substance Abuse Initiative has demonstrated a care retention rate of more than 80 percent. Transitional case management targeted to substance users has resulted in a more than 90 percent entrance rate into drug treatment. The initiative has reached traditionally underserved populations including persons of color and women. Seventy-seven percent of clients tested are African American or Hispanic and 37 percent are female. Eighty-four percent of clients enrolled in HIV primary care are African American or Hispanic, and 36 percent are female. Further, initiatives targeted to substance users have led to a decline in the infection rate among injection drug users from 27 percent to 7 percent.

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The quality of care provided to persons living with HIV/AIDS is measured through the AIDS Institute's quality management program, which is based on indicators that are linked to optimal care outcomes. Quality data show that HIV/AIDS health care facilities score consistently high on several key quality indicators, including antiretroviral therapy management; clinical visits; adherence to ARV therapy; substance abuse assessment; hepatitis C screening; and tobacco use. Data also show steady improvement in scores associated with mental health screening, CD4 tests, and viral load tests. In all of these measures, median performance in New York State exceeds national median performance.

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Program: HIV Prevention and Primary Care in Community Based Health Care Settings

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: This funding supports the Community HIV Prevention and Primary Care Initiative. The initiative's goals are: (1) to promote public health through health behavior change to prevent transmission of HIV and (2) to increase access to and provide continuous quality health care for persons with HIV disease. Contractors funded are responsible for providing HIV primary care to their HIV-infected patients and coordinating each patient's care needs.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: Serves HIV positive and high risk, low income populations statewide.

Performance Measures: The AIDS Institute's health care programs have reached targeted populations and have resulted in improved access to care. The Primary Care Initiative has provided more than 300,000 HIV tests, identified approximately 8,000 infected persons, and brought more than 25,000 persons into care. The initiative has a care retention rate of more than 80 percent. The initiative continues to succeed in reaching target populations. African Americans and Hispanics accounted for 74% of those receiving counseling and testing and 75% of primary care patients.

The AIDS Institute's health care programs have also resulted in reduced hospital costs and reduced morbidity and mortality from HIV/AIDS. Hospital discharge data show a reduction in HIV/AIDS hospitalizations from 63,684 in 1995 to 49,566 in 2006 -- a decrease of 25 percent. The average HIV/AIDS hospital length of stay was 13.1 days in 1995 and 9.5 days in 2006 -- a reduction of more than 27 percent. Between 1995 and 2006, there has been a decline in deaths among persons with HIV/AIDS of more than 80 percent.

The quality of care provided to persons living with HIV/AIDS is measured through the AIDS Institute's quality management program, which is based on indicators that are linked to optimal care outcomes. Quality data show that HIV/AIDS

health care facilities score consistently high on several key quality indicators, including antiretroviral therapy management; clinical visits; adherence to ARV therapy; substance abuse assessment; hepatitis C screening; and tobacco use. Data also show steady improvement in scores associated with mental health screening, CD4 tests, and viral load tests. In all of these measures, median performance in New York State exceeds national median performance.

These programs respond to several Healthy People 2010 objectives: 13-7 Increase the number of HIV-positive people who know their serostatus; 13-13 Increase the proportion of HIV-infected persons who receive testing and treatment consistent with current PHS treatment guidelines; 13-14 Reduce deaths from HIV.

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Program: HIV Prevention and Care in Communities of Color

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The Communities of Color Initiative has three components:

- The purpose of the first component in the amount of $3,810,000 is to support and effectively integrate participation of HIV-infected and/or at risk individuals in communities of color in prevention interventions, health care and supportive services. Contractors funded under this initiative will provide direct client services or referral to services including but not limited to case management, primary care, counseling, support groups, crisis intervention, transportation, meals/nutrition, legal services, counseling and testing, and information and referral. Funded interventions have proven to be effective and use a science/evidence-based model and risk reduction strategies and supportive services. These funds are awarded to smaller minority-based agencies to provide discrete services.
- The purpose of the second component in the amount of $2,561,200 is to fund approximately 80 contractors originally identified by the Legislature. In 2008/09, this funding was included in the executive budget. The budget allocates these funds in a subschedule to specific contractors with designated amounts for each limiting the AIDS Institute's discretion in contract negotiation and the use of the funding. Funding is used to support the needs of specific AIDS service providers to facilitate HIV prevention, outreach and supportive services for communities of color.
- The purpose of the third component in the amount of $200,000 is to fund an ambulatory care facility to develop a demonstration project to identify, implement and evaluate promising practices and successful strategies to engage and retain people of color living HIV/AIDS in care. This funding was first awarded in 08/09. An RFA needs to be developed to award these funds.

Issues: None

Population Served: Communities of color statewide.

Performance Measures: For the first component, over 5,000 individuals are served annually. 100% of the individuals served are people of color. For the second component, the amounts are too minimal to have a measurable impact

on service delivery. For the last component, since the funding was first awarded in 08/09, no contracts are currently in place.

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Program: Hepatitis C Program

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: This funding was first appropriated in the 2008/2009 executive budget for the development of a Hepatitis C Program to begin to address effective prevention interventions, screening programs, and access to quality medical care and treatment. The goal of the Hepatitis C Program is to identify Hepatitis C virus (HCV) infected individuals early during infection and to ensure timely access to medical care, treatment and other supportive services, thus reducing the overall morbidity, mortality and economic impact associated with this disease.

Understanding how to engage active IDUs in HCV and HIV/HCV treatment will be critical to mitigating the scope and consequences of these twin epidemics and the extraordinary morbidity and mortality expected to result.

Issues: New Funding

Population (to be) Served: Persons at risk for and living with HCV. It is estimated that over 240,000 New Yorkers are living with Hepatitis C, of which only 40% know that they are infected. Most of them have difficulty accessing the necessary HCV-related health care services. Many individuals with chronic HCV are unaware that they are infected because the disease is often asymptomatic until advanced liver damage develops. Furthermore, approximately one-third of persons living with HIV/AIDS are co-infected with HCV, and complications from liver disease are emerging as the leading cause of death among people with AIDS in many communities.

Performance Measures: None

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Program: Legislative Adds

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Appropriations totaling $2,659,000 added by the Legislature in FY08-09 as follows:

Additional Grants to CSPs
$575,000 (split proportionally among the Community Service Programs)

Additional Grants to CBOs
$575,000 (split proportionally among the Multiple Service Agencies)

New York AIDS Coaltion	$25,000
Legal Aid Society of New York City	$134,000
Legal Services for New York City	$134,000
AIDS Testing and Prevention Initiatives	$575,000
Latino Commission on AIDS	$150,000
Gay Men's Health Crisis	$89,000
Gay Men's Health Crisis	$44,000
National Black Leadership Commission on AIDS	$179,000
Latino Commission on AIDS	$179,000

Issues: None

Population Served: Targeted populations served by the selected organizations.

Performance Measures: These programs are not required to be evaluated or to have goals and it is difficult to determine effectiveness.

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Program: National Black Leadership Commission on AIDS

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The National Black Leadership Commission on AIDS (NBLCA) goal is to coordinate and organize volunteer efforts of community leadership around issues involving HIV/AIDS. NBLCA established six regional affiliates in NYC, Albany, Buffalo, Long Island, Rochester and Syracuse. The regional affiliates maintain five committees; Ecumenical, Fund Development, Legislative & Public Policy, Media & Public Affairs and Medical. The NBLCA conducts policy, research and advocacy on HIV/AIDS.

This organization is a NYC-based provider educating, organizing and mobilizing indigenous African American Leaders in the black community around HIV/AIDS policy issues within 6 targeted cities of NYS (NYC, Albany, Buffalo, Nassau, Rochester and Syracuse). This contract supports capacity building workshops, basic and advanced customized technical assistance that allow leaders to build service capacity of community based organizations in targeted communities, and infrastructure for the expansion of other programs.

Issues: None

Population Served: This is not a direct service contract. The purpose of this contract is to provide technical assistance, training, and development of public policy on HIV/AIDS to community based and public health related organizations serving African American communities.

Performance Measures: These programs are not required to be evaluated or to have goals and it is difficult to determine effectiveness.

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Program: New York AIDS Coalition

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The New York AIDS Coalition (NYAC) works collaboratively with the New York State Department of Health, AIDS Institute for the purpose of scheduling, coordinating and delivering presentations, trainings, and technical assistance to its members, AIDS service providers and consumers on new policies to be implemented under the Ryan White HIV/AIDS Treatment Modernization Act.

Issues: None

Population Served: This is not a direct service program. NYAC provides statewide training and technical assistance to help members, AIDS service providers, and consumers to implement new policies under the Ryan HIV/AIDS Treatment Modernization Act.

Performance Measures: These programs are not required to be evaluated or to have goals and it is difficult to determine effectiveness.

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Program: HIV Related Risk Reduction Program

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: This funding was first appropriated in the 2008/2009 Executive budget to address a broad spectrum of issues that influence sexual behaviors that put people at risk for HIV infection and STDs. This appropriation will help improve the availability of and access to both HIV testing and STD screening and increase the availability of condoms in New York State. As a result of these efforts, it is expected that there will be a reduction in new HIV infections and STDs in specific target populations. In the first year, this funding will enhance the NYS Condom Program to provide funding for at least 5 million condoms per year to be distributed to health and human services organizations. This will mirror and expand upon the New York City condom distribution efforts and will concentrate in areas of the state outside of the five boroughs

The funding will:

a) Support the design and implementation of pilot projects to increase HIV/STD prevention, screening and treatment efforts reaching individuals who are HIV-infected and at high risk for HIV and STD in communities of color, particularly gay men/men who have sex with men, young men of color who have sex with men, women and young women of color.
b) Support a variety of activities designed to enhance agencies' ability to provide HIV/STD screening services including training and technical assistance to community- based organizations and health care providers, quality assurance activities, and the costs of lab kits and processing of lab results.
c) Support and promote the development of educational materials about sexual health including the utilization of the Internet, public health campaigns regarding HIV/STDs, education to parents and health care providers working with young people.

Population to be Served: The greatest proportion of newly reported HIV infections, gonorrhea, syphilis and Chlamydia are among persons of color.

Performance Measures: New funding

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Program: AIDS Intervention Management System

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The AIDS Intervention Management System (AIMS) is intended to monitor health care services provided to persons with AIDS. The AIMS program provides for the conduct of utilization and quality of care reviews of services provided to persons with HIV and AIDS as well as the development, maintenance and analysis of patient service, quality of care, utilization and billing databases. The contractor reviews acute, ambulatory and chronic care delivered to persons with HIV infection throughout the State of New York. The purpose to the AIMS program is three-fold: 1) to assure that the care provided to persons with HIV/AIDS is both necessary and appropriate; 2) to assure that care is delivered in accordance with established clinical standards and protocols; and 3) to develop and maintain data systems that support review activities and that permit programmatic evaluation and policy development.

The contractor (IPRO) conducts annual utilization review of HIV Medicaid programs.

Issues: None

Population Served: The program monitors the utilization and quality of care delivered to persons living with HIV/AIDS throughout the State.

Performance Measures: The quality of care provided to persons living with HIV/AIDS is measured through the AIDS Institute's quality management program, which is based on indicators that are linked to optimal care outcomes. Quality data show that HIV/AIDS health care facilities score consistently high on several key quality indicators, including antiretroviral therapy management; clinical visits; adherence to ARV therapy; substance abuse assessment; Hepatitis C screening; and tobacco use. Data also show steady improvement in scores associated with mental health screening, CD4 tests; and viral load tests. In all of these measures, median performance in New York State exceeds national median performance.

The contractor (IPRO) conducts annual utilization and quality reviews of HIV Medicaid programs. In FFY 2007, AIMS conducted more than 30,000 quality reviews and more than 15,000 utilization reviews. AIMS utilization review has resulted in an annual average of $4.6 million in Medicaid reimbursement denials each year.

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Program: Community Development Initiative (CDI)

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: Funding is awarded for the development and implementation of strategies designed to increase awareness, educate, and facilitate the organization of minority communities. The primary goal of the program is to establish community leadership networks to affect a community-based response to the HIV epidemic.

CDIs have organized AIDS Leadership Coalitions (ALCs), comprised of community leaders who represent priority populations and/or a geographic area. It is the responsibility of the ALCs to identify HIV-related emerging needs of the priority populations and strategies that will raise awareness and address the identified needs. CDIs also work with other HIV and non-HIV service providers to successfully implement these strategies. CDIs closely monitor policy at the national, state, and local levels with a focus on laws and regulations that impact people who are HIV infected or those at risk. CDIs provide recommendations to policy makers and act as a source of information for their communities. CDIs continue to be actively involved in activities at the state and national levels to address the devastating impact of the HIV epidemic on communities of color.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: The CDI community network serves to mobilize and organize minority communities statewide to affect a community response to the HIV epidemic.

Performance Measures: None

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Program: HIV Prevention and Supportive Services for Women and Adolescents

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: Adolescent Prevention Programs conduct outreach and provide HIV prevention and risk reduction education, information and referral, crisis intervention, case management and supportive services for youth statewide. Women's Prevention Services include a variety of interventions targeting women at high risk for HIV/STD infections and women living with HIV/AIDS. These interventions are intended to increase condom use (both male and female condoms), develop client's skills to reduce both high-risk drug use and sexual behaviors, promote HIV counseling and testing, and assist clients in disclosing their HIV status and accessing care and support services. Women's Supportive Service programs serve women living with HIV, their partners and families. Supportive services provided include transportation, support groups, individual/family group counseling, childcare, health education, prevention interventions, escort services, home visits and client advocacy.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: HIV positive and high-risk women and adolescents statewide.

Performance Measures: Adolescent HIV Prevention Programs were required to submit reports that documented their performance in four outcome areas for the period January 1, 2007 through June 30, 2007. The outcomes were measured for young people who received multiple-session individual and/or group-level interventions. A sample of 391 young people completed 26 distinct multiple-session group-level interventions. Based on a comparison of pre-test and post-test results for those 391 individuals, there was a 27% increase in knowledge, and 18% increase in positive attitudes, a 15% increase in the number who received HIV testing, an 11% increase in the number who learned their HIV status, and a 7% increase in the number of young people who reported that they used condoms all the time when having sex. From July 2007 to June 2008, Women's Prevention Programs delivered 90,624 encounters (individual and group) to 36,258 clients. Over 30,000 women received counseling and testing services. In the Women's Supportive Services program in 2007, 314 non-

Medicaid eligible HIV-infected women received family-centered case management services, and 1,304 infected women received supportive services. The Women's Supportive Services initiative was recently evaluated by The Center for Health, Identity, Behavior and Prevention Studies (CHIBPS) of New York University. The evaluation was an assessment of the impact of both supportive and case management services on the lives of HIV-infected women currently receiving these services through the initiative. The evaluation found that 1) supportive and case management services have increasingly helped HIV-infected women stabilize and manage their lives; 2) clients who regularly access supportive services wait shorter periods of time to see their usual source of HIV care; 3) supportive services were instrumental in helping women address substance use and mental health concerns; and 4) supportive and case management services were essential support mechanisms.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: HIV Prevention and Supportive Services for Women and Adolescents

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: A portion of funding is transferred to the general fund – state purposes account for the administration of this program.

Adolescent Prevention Programs conduct outreach and provide HIV prevention and risk reduction education, information and referral, crisis intervention, case management and supportive services for youth statewide. Women's Prevention Services include a variety of interventions targeting women at high risk for HIV/STD infections and women living with HIV/AIDS. These interventions are intended to increase condom use (both male and female condoms), develop client's skills to reduce both high-risk drug use and sexual behaviors, promote HIV counseling and testing, and assist clients in disclosing their HIV status and accessing care and support services. Women's Supportive Service programs serve women living with HIV, their partners and families. Supportive services provided include transportation, support groups, individual/family group counseling, childcare, health education, prevention interventions, escort services, home visits and client advocacy.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: HIV positive and high-risk women and adolescents statewide.

Performance Measures: Adolescent HIV Prevention Programs were required to submit reports that documented their performance in four outcome areas for the period January 1, 2007 through June 30, 2007. The outcomes were measured for young people who received multiple-session individual and/or group-level interventions. A sample of 391 young people completed 26 distinct multiple-session group-level interventions. Based on a comparison of pre-test and post-test results for those 391 individuals, there was a 27% increase in knowledge, and 18% increase in positive attitudes, a 15% increase in the number who received HIV testing, an 11% increase in the number who learned their HIV status, and a 7% increase in the number of young people who reported that they

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Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: HIV Prevention and Supportive Services for Women and Adolescents

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: A portion of funding is transferred to the general fund – state purposes account for administration of this program.

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Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: HIV positive and high-risk women and adolescents statewide.

Performance Measures: Adolescent HIV Prevention Programs were required to submit reports that documented their performance in four outcome areas for the period January 1, 2007 through June 30, 2007. The outcomes were measured for young people who received multiple-session individual and/or group-level interventions. A sample of 391 young people completed 26 distinct multiple-session group-level interventions. Based on a comparison of pre-test and post-test results for those 391 individuals, there was a 27% increase in knowledge, and 18% increase in positive attitudes, a 15% increase in the number who received HIV testing, an 11% increase in the number who learned their HIV status, and a 7% increase in the number of young people who reported that they

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Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: Lesbian, Gay, Bi-sexual, Transgender and Peer HIV Prevention Services

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background:
The Lesbian/Gay/Bisexual/Transgender initiative educates clients including MSM of color, gay men, young men of color who have sex with men, women who have sex with women and people of trans-experience to develop risk reduction strategies to prevent HIV/STDs. The focus of these programs is to provide interventions that will address and facilitate: HIV counseling and testing, STD screening and referrals, linkages into care and support services and increase condom use and skills building to practice safer sexual and substance using behaviors. The challenge in developing and delivering effective HIV prevention services to the large and diverse group of MSM, WSW, and/or transgender individuals is to ensure programming responds appropriately to the general and specific experiences and situations and the cultural, clinical, psychological and behavioral needs of these individuals. Peer delivered prevention education is culturally sensitive to the specific social and cultural needs of high-need, high-risk communities.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: New York City and upstate cities with large LGBT populations.

Performance Measures: From July 2007 to June 2008, programs delivered 15,649 encounters (individual and groups) to approximately 5,000 clients. Central to the AIDS Institute's efforts at addressing sexual risk is the implementation of an expanded condom access program in November 2007. The New York State Condom Program (NYSCondom) is currently furnishing over 500,000 male condoms per month, and of the more than 200 agencies participating in this program, almost 70% have indicated that the individuals they serve include at least 10% gay men. According to the June 27, 2008 MMWR, New York and New Jersey had a 4.2% decrease in estimated MSM/AIDS HIV diagnoses between 2001 and 2006, while the rest of the nation showed increased incidence within this group. However in New York City, incidence has

increased among young men between the ages of 13-19 and 20-29. It is important to continue to focus our efforts on these vulnerable populations.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: HIV Provider Education Program

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: This program provides educational material geared to clinicians who treat persons with HIV infection and other HIV service providers through the development of HIV clinical practice guidelines. These guidelines are disseminated in a variety of formats. The overall goal of this program is to achieve real and measurable improvements in the quality of care delivered to persons with HIV/AIDS in New York State by maintaining vigilant efforts to keep providers abreast of the latest clinical and scientific advances and developments. The changing nature of the HIV epidemic makes it critical to provide clinicians caring for HIV-infected patients with timely, state-of-the-art information. This program will assure that this information is readily available, understandable, and useful to the provider community. Through this program, clinical guidelines and best practices are disseminated to hundreds of providers and support the provision of appropriate, quality care to persons living with HIV/AIDS throughout the State.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: The funding supports education and training for providers who deliver care and services to persons living with HIV/AIDS. Areas served are statewide.

Performance Measures: From October 1, 2006--September 31, 2007, the clinical guidelines contractor posted 27 new and updated HIV clinical guidelines to the website that can be downloaded via pda/pdf. In addition, 15 flash emails were sent to the website mailing list, 41 conference calls were held with clinical guidelines committees and 3 publications were updated, printed and disseminated by mail and by website order/download.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: Cornell Cooperative Agreement – Parent and Care Provider HIV/AIDS Education Project

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The Parent and Care Providers HIV/AIDS Education Project provides resources and training to parents, care givers, and staff working with young people on teaching children and youth about primary and secondary HIV/AIDS prevention. The overall goal of this project is to contribute to the reduction in the incidence of HIV infections among children and youth. Workshops provide accurate HIV/AIDS information and a specific structure for parents and staff working with youth to initiate discussion of HIV/AIDS prevention with children and youth. The Parent HIV/AIDS Education Project was founded in 1989. In 1993/1994, the Cornell Cooperative Extension was funded by a Legislative Member Item for this project.

Issues: Other providers are also funded by the AIDS Institute to perform this activity.

Population Served: General public, statewide.

Performance Measures: Approximately 4,000 clients served annually.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: New York, New York III Housing Initiative

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The New York New York III (NYNY III) is a cooperative agreement between New York City and New York State agencies to provide 9,000 units of supportive housing over a ten year period (through 2016) to the chronically homeless population, including those with HIV/AIDS. The New York State Department of Health AIDS Institute is charged with the development of 500 supportive housing units during the ten year period: 300 congregate and 200 scattered site. The overall goal of this initiative is to reduce homelessness and provide safe, affordable housing and support services to people with HIV/AIDS who have a history of chronic homelessness and also suffer from either mental illness or substance abuse. Fifty scatter site units in New York City are currently funded.

The NY NY III housing program has a phased in implementation plan for scattered site and congregate units. As such, the appropriation was originally expected to increase annually.

Issues: Economies of scale may be achieved by consolidating this activity in DHRC.

Population Served: Homeless persons in NYC with HIV/AIDS suffering from co-morbidities such as substance abuse issues and mental health issues. Eighty-five percent are minorities.

Performance Measures: In 2007, 50 scattered site units were developed and filled.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: Family Centered Health Care & Centers of Excellence in Pediatric Care

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The purpose of Family Centered Health Care is to develop or enhance comprehensive, integrated programs that provide high quality HIV health care and support services to women with HIV/AIDS and their children. The key to family centered care is integration and coordination of services. Multicultural, multidisciplinary teams that integrate medical care, including HIV specialty care, with mental health, substance use, case management and other HIV related services can best manage the complex medical and social issues faced by HIV affected families. Centers of Excellence in Pediatric HIV Care are designed to meet the complex medical management needs and the unique psychosocial and educational support needs of children as they grow and develop while living with HIV. Funding for the Centers of Excellence is expected to improve the health status of children with HIV, support adherence to HIV care and treatment, encourage optimal child development, and produce a high level of satisfaction with services.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: HIV Positive Women, Adolescents, Young Adults and Children, Statewide

Performance Measures: In 2007, Family Centered programs served almost 1,000 HIV-positive adults with over 2,500 dependent children who received case management services. There were 268 children who received other services onsite at the programs. In 2007, the Centers of Excellence in Pediatric Care served almost 1,000 children aged birth to 20. Of these, about 300 are exposed infants less than 2 years of age. The remaining children all have HIV. Of these, 90 are young children aged birth to 8 years, 200 are preadolescents aged 9 to 12, and 400 are adolescents/young adults aged 13 to 24.

As a result of clinical advances and the State's grant and regulatory programs over the past decade, the number of new cases of HIV infections

among children has declined dramatically in NYS. This decline is due to fewer HIV-positive women giving birth (1,898 in 1990 to 584 in 2006), an increase in the percentage of women tested prenatally (67% in 1997 to more than 95% in 2007), an increase in the percent of HIV infected mothers and their exposed infants who received antiretroviral medication to reduce HIV transmission (63.8% in 1997 to 99% in 2007), and a much lower perinatal HIV transmission rate (from 25% in 1990 to less than 2% in 2007). The number of pediatric deaths attributable to AIDS has also significantly declined.

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: Family Centered Health Care & Centers of Excellence in Pediatric Care

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: A portion of funding is transferred to the general fund – state purposes account for administration of this program.

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Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

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Attachment B

Agency Programs/Activities: Inventory and Key Data
Department of Health -- Center for Community Health (CCH)

	Relation to Core Mission		Spending Category (SO, ATL, CAP)	3/31/09 FTEs (All Funds)	General Fund Disbursements				State Special Revenue Funds Disbursements				Capital Projects Funds Disbursements			
Page	(H/M/L)	Program/Activity			2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	**2009-10 Projected**
1	H	Alzheimer's Disease	ATL		$793	$740	$2,215	$2,215	$0	$0	$0	$0	$0	$0	$0	$0
2	H	Alzheimer's Disease	SO	1.35	$40	$42	$43	$45	$463	$568	$736	$737	$0	$0	$0	$0
3	H	American Indian Health	ATL		$0	$0	$0	$0	$15,428	$16,834	$17,120	$17,150	$0	$0	$0	$0
4	H	American Indian Health	SO	1.10	$0	$4	$100	$117	$94	$97	$100	$104	$0	$0	$0	$0
5	H	Arthritis	ATL		$88	$224	$650	$650	$0	$0	$0	$0	$0	$0	$0	$0
6	H	Arthropod-Borne Disease	ATL		$482	$106	$159	$159	$0	$0	$0	$0	$0	$0	$0	$0
7	H	Arthropod-Borne Disease	SO	13.30	$12	$12	$12	$13	$1,231	$1,269	$1,308	$1,361	$0	$0	$0	$0
8	H	Asthma- Children's Asthma Coalition	ATL		$50	$1,340	$1,035	$1,035	$0	$0	$0	$0	$0	$0	$0	$0
9	H	Asthma- Children's Asthma Coalition	SO	1.20	$15	$16	$16	$17	$94	$97	$100	$104	$0	$0	$0	$0
10	H	Breast, Cervical, Colorectal Screening	ATL		$4,184	$5,716	$10,165	$10,165	$16,096	$20,076	$21,318	$21,318	$0	$0	$0	$0
12	H	Breast, Cervical, Colorectal Screening	SO	0.65	$0	$0	$0	$0	$61	$63	$65	$68	$0	$0	$0	$0
14	L	Cancer Permanency Planning	ATL		$419	$580	$397	$397	$0	$0	$0	$0	$0	$0	$0	$0
15	H	Cancer Registry	SO	4.30	$0	$7	$37	$37	$404	$417	$429	$447	$0	$0	$0	$0
17	H	Community Based Cancer Support	ATL		$101	$407	$398	$398	$228	$295	$265	$265	$0	$0	$0	$0
18	H	Community Health Care Workers	ATL		$0	$0	$0	$0	$422	$308	$304	$304	$0	$0	$0	$0
19	H	Comprehensive Adolescent Pregnancy Prevention	ATL		$7,490	$2,626	$6,463	$11,000	$0	$0	$0	$0	$0	$0	$0	$0
20	H	Comprehensive Adolescent Pregnancy Prevention	SO	2.95	$154	$159	$164	$171	$85	$87	$90	$93	$0	$0	$0	$0
21	H	Diabetes Prevention and Control	ATL		$313	$1,232	$2,482	$2,482	$0	$0	$0	$0	$0	$0	$0	$0
22	H	Diabetes Prevention and Control	SO	1.10	$0	$0	$0	$0	$105	$107	$122	$126	$0	$0	$0	$0
23	H	Early Intervention	ATL		$199,187	$185,297	$124,037	$124,037	$0	$0	$0	$0	$0	$0	$0	$0
24	H	Early Intervention	SO	4.70	$342	$353	$364	$379	$0	$0	$3	$3	$0	$0	$0	$0
25	H	Electronic Clinical Laboratory Reporting System	SO	0.95	$36	$551	$1,641	$1,642	$14	$15	$15	$16	$0	$0	$0	$0
26	H	Electronic Laborartory Reporting - Health Information Technology	SO	1.70	$65	$67	$3,969	$3,972	$0	$0	$0	$0	$0	$0	$0	$0
27	H	Emergency Preparedness	ATL		$22,481	$34,757	$11,741	$11,741	$0	$0	$0	$0	$0	$0	$0	$0
29	H	Family Planning	ATL		$17,819	$21,075	$23,341	$23,341	$2,486	$2,793	$7,186	$7,186	$0	$0	$0	$0
30	H	Family Planning	SO	1.35	$67	$69	$71	$74	$0	$0	$0	$0	$0	$0	$0	$0
31	H	General Public Health Work	ATL		$211,466	$246,217	$248,514	$311,567	$0	$0	$0	$0	$0	$0	$0	$0
33	H	General Public Health Work	SO	4.00	$54	$56	$58	$60	$282	$291	$300	$312	$0	$0	$0	$0
35	H	General Public Health Work-Emergency	ATL		$0	$27	$500	$500	$0	$0	$0	$0	$0	$0	$0	$0
36	H	General Public Health Work-Emergency	SO	1.00	$0	$0	$0	$0	$94	$97	$100	$104	$0	$0	$0	$0
37	H	Genomics	SO		$0	$0	$17	$17	$0	$0	$0	$0	$0	$0	$0	$0
38	H	HIV/AIDS Epidemiology	ATL		$0	$0	$0	$0	$387	$342	$339	$339	$0	$0	$0	$0
39	H	HIV/AIDS Epidemiology	SO	21.20	$861	$888	$915	$952	$0	$0	$0	$0	$0	$0	$0	$0
40	H	Hospital Acquired Infection Reporting	ATL		$0	$120	$980	$980					$0	$0	$0	$0
41	H	Hospital Acquired Infection Reporting	SO	10.00	$0	$829	$963	$994	$0	$0	$0	$0	$0	$0	$0	$0
42	H	Hypertension	ATL		$1,068	$246	$284	$284	$713	$747	$727	$727	$0	$0	$0	$0
43	H	Hypertension	SO	3.75	$30	$31	$32	$33	$315	$325	$335	$348	$0	$0	$0	$0
44	H	Immunization	ATL		$0	$0	$0	$0	$6,411	$4,879	$7,800	$7,800	$0	$0	$0	$0

Attachment B

Agency Programs/Activities: Inventory and Key Data
Department of Health -- Center for Community Health (CCH)

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45	H	Immunization	SO	2.30	$99	$102	$105	$109	$103	$107	$110	$114	$0	$0	$0	$0
46	H	Lead Poisoning Prevention - Childhood	ATL		$0	$0	$0	$0	$5,821	$6,060	$4,233	$4,233	$0	$0	$0	$0
48	H	Lead Poisoning Prevention - Childhood	SO	0.42	$2	$2	$2	$2	$38	$39	$40	$42	$0	$0	$0	$0
50	M/L	Legislative Member Items	ATL		$0	$68	$1,622	$1,622	$0	$0	$0	$0	$0	$0	$0	$0
51	H	Migrant/Seasonal Farmworker Health	ATL		$0	$371	$376	$376	$0	$0	$0	$0	$0	$0	$0	$0
52	H	Minority Health	ATL		$49	$631	$639	$639	$0	$0	$0	$0	$0	$0	$0	$0
53	H	Minority Health	SO	4.00	$34	$35	$36	$37	$329	$339	$350	$364	$0	$0	$0	$0
54	H	Obesity Prevention	ATL		$0	$0	$1,896	$1,896	$1,506	$1,223	$1,251	$1,251	$0	$0	$0	$0
55	H	Obesity Prevention	SO	4.15	$105	$109	$112	$116	$258	$266	$275	$286	$0	$0	$0	$0
56	H	Osteoporosis Prevention and Education	ATL		$0	$0	$115	$115	$0	$0	$0	$0	$0	$0	$0	$0
57	H	Osteoporosis Prevention and Education	SO	0.05	$4	$4	$4	$4	$0	$0	$0	$0	$0	$0	$0	$0
58	H	Perinatal Health	ATL		$0	$150	$2,928	$2,928	$2,273	$2,799	$2,605	$2,605	$0	$0	$0	$0
61	H	Perinatal Health	SO	1.25	$342	$2,105	$3,233	$3,234	$94	$97	$100	$104	$0	$0	$0	$0
64	H	Physically Handicapped Children	ATL		$0	$0	$0	$0	$1,088	$1,783	$1,783	$1,783	$0	$0	$0	$0
65	H	Physically Handicapped Children	SO	0.60	$15	$16	$16	$17	$38	$39	$40	$42	$0	$0	$0	$0
66	H	Public Health Campaign - STD	ATL		$0	$0	$0	$0	$665	$644	$640	$640	$0	$0	$0	$0
67	H	Public Health Campaign - STD	SO	14.80	$598	$617	$636	$661	$9	$10	$10	$10	$0	$0	$0	$0
68	H	Public Health Campaign - TB	ATL		$0	$0	$0	$0	$5,982	$5,794	$5,756	$5,756	$0	$0	$0	$0
69	H	Public Health Campaign - TB	SO	1.05	$12	$12	$12	$13	$80	$82	$85	$88	$0	$0	$0	$0
70	H	Public Health Leaders of Tomorrow	ATL		$0	$600	$600	$600	$0	$0	$0	$0	$0	$0	$0	$0
71	H	Regional Epidemiology	SO	12.50	$344	$363	$374	$389	$573	$591	$609	$634	$0	$0	$0	$0
72	H	School Based Health Centers	ATL		$0	$3,882	$4,854	$4,854	$14,128	$17,146	$20,569	$20,569	$0	$0	$0	$0
73	H	School Based Health Centers	SO	1.55	$11	$12	$12	$12	$132	$136	$140	$145	$0	$0	$0	$0
74	H	Sexuality Related	ATL		$851	$3,523	$5,345	$5,345	$0	$0	$0	$0	$0	$0	$0	$0
75	H	Sexuality Related	SO	0.90	$0	$0	$0	$0	$85	$87	$90	$93	$0	$0	$0	$0
76	H	SNAP/HPNAP	ATL		$10,634	$11,275	$16,177	$16,177	$0	$0	$0	$0	$0	$0	$0	$0
78	H	SNAP/HPNAP	SO	17.00	$0	$0	$739	$1,478	$0	$0	$4	$4	$0	$0	$0	$0
80	H	SNAP/WIC	ATL		$20,811	$22,399	$16,391	$16,391	$0	$0	$0	$0	$0	$0	$0	$0
81	H	SNAP/WIC ATL Transfer to St Ops	SO		$687	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
82	H	STD Center for Excellence	ATL		$490	$490	$480	$480	$0	$0	$0	$0	$0	$0	$0	$0
83	H	Tobacco Use Prevention and Control	SO	10.20					$43,582	$73,891	$72,357	$72,386	$0	$0	$0	$0
84	H	Tuberculosis NYC Hospital Directly Observed Therapy	ATL		$0	$0	$0	$0	$595	$675	$650	$650	$0	$0	$0	$0
85	H	Tuberculosis NYC Hospital Directly Observed Therapy	SO	0.25	$0	$0	$0	$0	$23	$24	$25	$26	$0	$0	$0	$0
86	H	Zoonoses	ATL		$1,609	$1,668	$1,544	$1,544	$0	$0	$0	$0	$0	$0	$0	$0
87	H	Zoonoses	SO	5.05	$55	$56	$58	$60	$385	$397	$409	$426	$0	$0	$0	$0
88	M	Counseling and Testing in Family Planning Clinics	ATL		$0	$0	$0	$0	$4,961	$4,840	$4,766	$4,766	$0	$0	$0	$0
89	M	Cystic Fibrosis	ATL		$645	$708	$701	$701	$0	$0	$0	$0	$0	$0	$0	$0
90	M	Health Promotion	ATL		$0	$0	$3,924	$3,924	$0	$0	$0	$0	$0	$0	$0	$0

Attachment B

Agency Programs/Activities: Inventory and Key Data
Department of Health -- Center for Community Health (CCH)

	Relation to Core Mission		Spending Category (SO, ATL, CAP)	3/31/09 FTEs (All Funds)	General Fund Disbursements				State Special Revenue Funds Disbursements				Capital Projects Funds Disbursements			
Page	(H/M/L)	Program/Activity			2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	**2009-10 Projected**
92	M/L	Legislative Member Items	ATL		$1,655	$3,055	$13,675	$13,675	$0	$0	$0	$0	$0	$0	$0	$0
96	M/L	Prostate/Testicular Cancer Res./Ed	SO		$0	$0	$0	$0	$1	$0	$0	$0	$0	$0	$0	$0
97	M	SIDS	ATL		$41	$41	$39	$39	$0	$0	$0	$0	$0	$0	$0	$0
98	M	SIDS	SO	0.20	$15	$16	$16	$17	$0	$0	$0	$0	$0	$0	$0	$0
99	M	Statewide Health Broadcasts	ATL		$0	$46	$170	$170	$0	$0	$0	$0	$0	$0	$0	$0
100	M/L	American Red Cross	ATL		$3,525	$8,277	$3,973	$5,397	$0	$0	$0	$0	$0	$0	$0	$0
101	M/L	Breast Cancer Hotlines	ATL		$0	$0	$0	$0	$498	$102	$300	$300	$0	$0	$0	$0
102	L	Cost of Living Adjustment - CCH	ATL		$67	$17,961	$17,700	$17,700	$0	$0	$0	$0	$0	$0	$0	$0
103	L	Cost of Living Adjustment - OMH	ATL		$0	$0	$29	$29	$0	$0	$0	$0	$0	$0	$0	$0
104	M/L	Dor Yeshorim	ATL		$0	$500	$369	$369	$0	$0	$0	$0	$0	$0	$0	$0
105	L	Eating Disorders	ATL		$0	$179	$808	$808	$547	$2,226	$1,000	$1,000	$0	$0	$0	$0
106	L	Eating Disorders	SO	0.60	$15	$16	$16	$17	$38	$39	$40	$42	$0	$0	$0	$0
107	M/L	Infertility	ATL		$5,928	$5,240	$1,801	$1,801	$122	$990	$4,900	$4,900	$0	$0	$0	$0
108	M/L	Infertility	SO	0.05	$4	$4	$4	$4	$0	$0	$0	$0	$0	$0	$0	$0
109	M/L	Interim Lead Safe Housing	ATL		$0	$0	$0	$0	$511	$844	$850	$850	$0	$0	$0	$0
110	L	Maternal and Early Childhood Foundation	ATL		$0	$0	$0	$0	$1,300	$1,300	$1,300	$1,274	$0	$0	$0	$0
111	L	Nutrition Outreach and Education	ATL		$1,849	$1,850	$1,820	$1,820	$0	$0	$0	$0	$0	$0	$0	$0
112	M/L	NYS Prostate Cancer Research	ATL		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
113	L	Rape Crisis	ATL		$1,452	$1,756	$1,596	$1,596	$79	$118	$131	$131	$0	$0	$0	$0
114	L	Rape Crisis	SO	0.25	$19	$19	$20	$21	$0	$0	$0	$0	$0	$0	$0	$0
115	L	Shaken Baby Syndrome	ATL		$0	$0	$65	$65	$0	$0	$0	$0	$0	$0	$0	$0
		CCH Grand Total	ALL	151.77	$519,582	$591,948	$546,794	$616,724	$131,255	$172,393	$184,178	$184,424	$0	$0	$0	$0

Department of Health – AIDS Institute
PROGRAM INFORMATION SHEET

Program: AIDS Institute Management and Operations

Mandate: Public Health Law, Article 27-E, Section 2276

Mandated Funding Level: None

Brief Description/History/Background: The AIDS Institute was created within the State Department of Health in 1983 by legislative mandate. The AIDS Institute is responsible for directing and coordinating New York State's response to the HIV/AIDS epidemic. The Institute formulates HIV/AIDS policy; initiates, develops and evaluates HIV prevention, health care and supportive service programs; guides regional and statewide HIV/AIDS planning; and educates health care providers and the public. The AIDS Institute is responsible for managing over $520 million in State and federal funding, excluding Medicaid and overseeing more than 500 contracts providing services those infected or at risk of HIV infection.

The AIDS Institute has two major divisions: The Division of HIV Prevention and the Division of HIV Health Care. The Division of HIV Prevention manages and oversees New York State's comprehensive HIV prevention program. This program delivers primary and secondary HIV prevention interventions to individuals, families, and communities directly through community-based agencies and staff located in regional offices throughout New York State. The Division of HIV Health Care ensures the availability and accessibility of quality care and services for individuals and families affected by HIV through the development of a continuum of care which addresses the needs of individuals from asymptomatic infection through the acute and chronic stages of HIV disease. The components of the continuum include: ambulatory care in a variety of settings; therapeutic drugs; inpatient hospital care; long term care; supportive housing; case management; mental health; substance abuse services; nutrition; and supportive services.

The AIDS Institute oversees the development, implementation, and evaluation of health care services for Medicaid-eligible persons living with HIV/AIDS, including designated AIDS Center hospitals, ambulatory care programs, chronic care programs, and managed care plans for persons with HIV/AIDS, known as HIV Special Needs Plans (SNPs). In addition, the AIDS Institute oversees the AIDS Intervention Management System (AIMS), through which quality assurance and utilization review of HIV services are conducted.

The AIDS Institute's Office of the Medical Director provides clinical expertise to all AIDS Institute programs, manages the AIDS Institute quality of care program, and manages educational programs for a variety of providers of care and services.

The general fund also supports critical contracts including the following:

- In 2000, the New York State Legislature changed the Public Health Law to authorize a demonstration program to expand access to sterile hypodermic needles and syringes. This is a public health measure to prevent blood borne diseases, most notably HIV/AIDS and hepatitis B and hepatitis C. ESAP became effective January 1, 2001 and is in effect until September 1, 2011. This funding provides small supplemental funding to registered ESAP providers.

- The Foundation for AIDS Research, which purchases, stores and distributes syringes and condoms to direct service providers is also funded on the general fund.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Alzheimer's Disease

Mandate: Chapter 590 of the laws of 1999
PHL Sections 2600, 2700 and 2701

Mandated Funding Level: None

Brief Description/History/Background: Alzheimer's disease and other dementias affect about 330,000 New Yorkers. The Department of Health provides grants to support: the Alzheimer's Disease Assistance Centers (ADAC's), medical centers serving as centers of excellence for the diagnosis and management of Alzheimer's Disease and other dementias; the Alzheimer's Disease Community Assistance Program (AlzCAP), a coalition providing statewide coordination of support services for people with Alzheimer's Disease, their families and caregivers; and the Alzheimer's Community Service Programs, community based agencies providing family/caregiver support, respite care, information and referral services to patients with Alzheimer's Disease and their families. Providers are hospitals, community based organizations, Alzheimer's Association Chapters, and Alzheimer's Foundation. Legislation passed in 07-08 establishing a new Alzheimer's Disease Advisory Council.

Issues: Economies of scale may be achieved by consolidating activities related to Alzheimer's disease in the State Office for the Aging.

Population Served: Dementia patients, their families and caregivers

Performance Measures:

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

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PHL Sections 2600, 2700 and 2701

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Issues: Economies of scale may be achieved by consolidating activities related to Alzheimer's disease in the State Office for the Aging.

Population Served: Dementia patients, their families and caregivers

Performance Measures:

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: American Indian Health Program (AIHP)

Mandate: Public Health Law § 201(l)(s)

Mandated Funding Level: None

Brief Description/History/Background: Pursuant to Public Health Law, the Department of Health is required to "administer to the medical and health needs of the ambulant sick and needy Indians on reservations." To meet the health care needs of the nine New York State recognized American Indian Nations and Indians living on tribal lands, the AIHP provides primary medical care, dental care, and preventive health services for approximately 25,000 Native Americans living within reservation communities. State funded clinics on tribal lands have been in existence for more than 3 decades. Seven of the nations have primary care clinics serving the people living on their tribal lands. Care is provided by four contracted hospitals, directly by nation clinics, by statewide vision and pharmacy providers and by specialty providers.

Issues: As it is true across the health care system, costs have increased in the AIHP, particularly in the area of pharmacy.

Population Served: This program is available to the 25,000 American Indians residing on tribal lands

Performance Measures: The Healthy People 2010 goal 1-4a is to increase the proportion of persons who have a specific source of ongoing care to 96%. The New York State rate in 2006 was 85%.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

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Brief Description/History/Background: Pursuant to Public Health Law, the Department of Health is required to "administer to the medical and health needs of the ambulant sick and needy Indians on reservations." To meet the health care needs of the nine New York State recognized American Indian Nations and Indians living on tribal lands, the AIHP provides primary medical care, dental care, and preventive health services for approximately 25,000 Native Americans living within reservation communities. State funded clinics on tribal lands have been in existence for more than 3 decades. Seven of the nations have primary care clinics serving the people living on their tribal lands. Care is provided by four contracted hospitals, directly by nation clinics, by statewide vision and pharmacy providers and by specialty providers.

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Population Served: This program is available to the 25,000 American Indians residing on tribal lands

Performance Measures: The Healthy People 2010 goal 1-4a is to increase the proportion of persons who have a specific source of ongoing care to 96%. The New York State rate in 2006 was 85%.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Arthritis Program

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The 2008-09 budget contained language specifying that the funds appropriated for this initiative would go to the Arthritis Foundation for services and other expenses. In New York, the Foundation has four chapters: Long Island, New York (Manhattan), Northeastern (Albany) and Upstate (Rochester). One contract is in place with the Arthritis Foundation – New York Chapter; this chapter then divides the funds equally among the four chapters.

These funds are used to support Arthritis Disease Management Programs, enhance public understanding of disease management, train individuals to teach arthritis management classes, conduct a multi-tier marketing and public education campaign, and implement arthritis education initiatives.

Issues:

- Limited funding to address extent of the problem.
- Federal Arthritis grant of $139,899 annually ended on 6/30/08.

Population Served: Approximately 3.7 million adult New Yorkers report having doctor-diagnosed arthritis, with more than 36% of them reporting limitations in their daily activities.

Performance Measures:

HP 2010:

- 19-1 Reduce the proportion of adults who are obese to 15%. The New York State rate was 22.9% in 2006.
- 22-1 Reduce the proportion of adults who engage in no leisure-time physical activity to 20%. The New York State rate was 27.1% in 2005. .

Prevention Agenda:

- Increase the percentage of adults who are physically active.
- Reduce the percentage of adults who are obese.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Arthropod-Borne Disease Program (ABDP)

Mandate: Public Health Law Article 6; Public Health Law Article 27H

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law Article 6 requires NYSDOH to review, approve and reimburse local health departments (LHDs) conducting public health based programs directed against vector borne diseases. Regulation mandates reporting of 60 communicable diseases, including arthropod-borne diseases. The ABDP is responsible for the surveillance and prevention of arthropod-borne diseases in New York State. The ABDP works primarily with Local Health Departments (LHDs) to perform arthropod-borne disease prevention and investigation, including West Nile virus (WNV) and Lyme disease. Effective surveillance for vector-borne disease includes human case surveillance and specimen testing; vector research, surveillance, and host specimen tracking; and state-wide data analysis. Technical guidance and education regarding appropriate interventions, disease surveillance, and vector surveillance and control are provided to LHDs, the medical community and the public.

The Tick-Borne Disease Institute (TBDI) was first authorized in 1988. Local Health Departments, whose reported cases represent 90% of tick-borne diseases in NYS, provide coordinated information regarding the cause, prevention, detection, and treatment of tick-borne diseases, especially Lyme disease.

Issues: The incidence of potentially fatal Tick Borne Diseases is now endemic in previously non-affected areas.

Population Served: Residents throughout New York State. Enhanced efforts in thirteen contracted counties with 5,638,000 residents.

Performance Measures: Reduce Lyme disease to the Healthy People's 2010 target incidence rate of 9.7 new cases per 100,000 population. New York's rate was 27.9 per 100,000 in 2003-2005.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Arthropod-Borne Disease Program (ABDP)

Mandate: Public Health Law Article 6; Public Health Law Article 27H

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law Article 6 requires NYSDOH to review, approve and reimburse local health departments (LHDs) conducting public health based programs directed against vector borne diseases. Regulation mandates reporting of 60 communicable diseases, including arthropod-borne diseases. The ABDP is responsible for the surveillance and prevention of arthropod-borne diseases in New York State. The ABDP works primarily with Local Health Departments (LHDs) to perform arthropod-borne disease prevention and investigation, including West Nile virus (WNV) and Lyme disease. Effective surveillance for vector-borne disease includes human case surveillance and specimen testing; vector research, surveillance, and host specimen tracking; and state-wide data analysis. Technical guidance and education regarding appropriate interventions, disease surveillance, and vector surveillance and control are provided to LHDs, the medical community and the public.

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Population Served: Residents throughout New York State. Enhanced efforts in thirteen contracted counties with 5,638,000 residents.

Performance Measures: Reduce Lyme disease to the Healthy People's 2010 target incidence rate of 9.7 new cases per 100,000 population. New York's rate was 27.9 per 100,000 in 2003-2005.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Childhood Asthma Coalitions, Children's Asthma

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: In 2005, asthma affected over 1.1 million New York State (NYS) adults and 370,000 children. During 2003-2005, an average of 300 deaths per year occurred due to asthma in NYS. The total cost of asthma hospitalizations in NYS was approximately $502 million, for an average cost of $12,700 per hospitalization in 2005. Eleven community coalitions are prominent mechanisms for building local capacity to address health concerns like asthma. The coalition goal is to reduce asthma-related morbidity and mortality. Regional coalitions enlist major stakeholders (hospitals, clinics, private practice, health plans, schools, community organizations, public health, businesses) who are involved in the prevention, diagnosis, treatment and management of asthma.

In addition, the National Initiative for Children's Health Care Quality develops and promotes quality improvement processes.

Issues: None

Population Served: Children with asthma and their families NYS.

Performance Measures: In New York State there has been a reduction of asthma related hospitalizations for children ages 0-14 from 53.6 cases per 10,000 in 1995 to 34.3 cases per 10,000 in 2005. The Healthy People 2010 goal 1-9a is to reduce asthma related hospitalizations per 10,000 among children aged birth to 17 years to no more than 17.3. The New York State rate in 2003 to 2005 was 34.1 per 10,000 children.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Childhood Asthma Coalitions, Children's Asthma

Mandate: None

Mandated Funding Level: None

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Issues: None

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Breast, Cervical, and Colorectal Screening

Mandate: Public Health Law Sections 2405 and 2406

Mandated Funding Level: None

Brief Description/History/Background: The goal of the program is access to statewide comprehensive breast, cervical and colorectal cancer screening and early detection services so that women and men in New York are aware of and able to participate in screening according to recommended guidelines. The program provides approximately 73,000 breast and cervical screenings to women annually and almost 14,000 colorectal cancer screenings annually to both men and women. All individuals are un- or underinsured and have difficulty accessing these vital services. Funding supports contracts with 47 cancer services partnerships statewide; providers include hospitals, diagnostic and treatment centers, community based organizations and local health departments. Partnerships receive funding to conduct screenings and for contracts with providers for screening services, program promotion, and care coordination; the partnerships also act as fiscal agents to pay providers for screening. Funding also supports 9 mobile mammography projects, educational services and the activities of 3 advisory councils.

Issues: Limited funding to address the extent of the problem.

Population Served: Approximately 87,000 uninsured and underinsured individuals in need of cancer screening:

- Women ages 40 and over – breast cancer screening
- Women ages 18 and over – cervical cancer screening
- Men and women ages 50 and older – colorectal cancer screening
- Men in need of prostate cancer work-ups

Performance Measures:

HP 2010:

- 3-12 Increase the proportion of adults over the age of 50 who receive a colorectal cancer screening exam to 50%. The New York State has already exceeded this goal with a rate of 63.9% in 2006.
- 3-3 Reduce the breast cancer death rate to 21.3 per 100,000 females. The New York State rate was 25.5 from 2001-2005.
- 3-4 Reduce the death rate from cancer of the uterine cervix to 2.0 per 100,000. The New York State rate was 2.6 per 100,000 from 2001-2005.

Prevention Agenda:

- Increase the percentage of cancer cases diagnosed at an early stage (breast, cervical, colorectal) to 80% breast (New York State rate was 64% from 2000-

2004); 65% for cervical (New York State rate was 52% from 2000-2004); and 50% for colorectal (New York State rate was 40% from 2000-2004).

- Reduce cancer mortality rate to 158.6 per 100,000; New York State rate was 215.8 for males and 155.6 for females from 2001-2005.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

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Mandated Funding Level: None

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Prevention Agenda:

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- Reduce cancer mortality rate to 158.6 per 100,000; New York State rate was 215.8 for males and 155.6 for females from 2001-2005.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Cancer Permanency Planning

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Permanency planning is assistance and support in planning for long and short term legal, financial, and medical needs of individuals and families impacted by cancer. Services may include estate planning, preparation of wills, access to health care services and entitlements, settlement of insurance disputes, preparation of advance directives, and issues related to child custody. Approximately 24% of adults with cancer are parents who have a child 18 years or younger living in their homes. Permanency planning needs related to child custody may include legal adoption, foster care, guardianship, and standby guardianship. This funding is used to contract with 6 legal services agencies to provide permanency planning to people with cancer. Economies of scale may be achieved by consolidating per many planning activities in the Office of Children and Family Services.

Issues: Economies of scale may be achieved by consolidating permanency planning activities in the Office of Children & Family Services.

Population Served: It is estimated that over 85,000 individuals are newly diagnosed with cancer in New York State each year. Cancer is the second leading cause of death among New Yorkers.

Performance Measures:

HP 2010:

- 3.1 Reduce overall cancer death rate to 158.6 per 100,000. The New York State rate for males was 215.8 per 100,000 for males and 155.6 per 100,000 for females from 2001-2006.

Prevention Agenda:

- Reduce cancer mortality rate.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Cancer Registry

Mandate: PHL Sections 2400, 2401(1), and 2401(7)

Mandated Funding Level: None

Brief Description/History/Background: Cancer is the second leading cause of mortality among New Yorkers. The New York State Cancer Registry is one of the oldest operating population-based cancer registries in the United States and has been certified at the "gold" (highest) level by the North American Association of Central Cancer Registries since 1996. Annually, the Registry adds over 125,000 new cases. Reports are received from hospitals, managed care organizations, laboratories, physicians, dentists and other facilities. To ensure the quality and completeness of reported information, the Cancer Registry provides training programs for staff of reporting facilities. Data from the Cancer Registry are used by numerous Department of Health programs (Breast and Cervical Cancer Screening Program, Colorectal Cancer Program, Public Health Information Group, Cancer Surveillance etc.) for program planning, evaluation, small area cancer studies ("cancer clusters"), and cancer mapping. In addition, Registry staff and external researchers use these data to produce reports on time trends in cancer incidence and mortality, conduct research projects into the causes of cancer, and examine patterns of cancer care.

Issues: The Department must implement the new cancer mapping legislation, enacted in 2008.

Population Served: All New Yorkers interested in cancer surveillance, including researchers, scientists and the public. Mandated reporting providers include hospitals, managed care organizations, ambulatory surgery centers, laboratories and others.

Performance Measures:

HP 2010:

Reduce cancer mortality rate

- Breast cancer mortality to 21.3 per 100,000; the New York State rate was 26.1 per 100,000 from 2000-2004.
- Cervical cancer mortality to 2.0 per 100,000; the New York State rate was 2.6 per 100,000 from 2000-2004.
- Colorectal cancer mortality to 13.7 per 100,000; the New York State rate was 20.1 per 100,000 from 2000-2004.

Prevention Agenda:

Increase the percentage of cases diagnosed at an early stage

- Increase early stage diagnosis of breast cancer to 80%; the New York State rate was 64% from 2000-2004.
- Increase early stage diagnosis of cervical cancer to 65%; the New York State rate was 52% from 2000-2004.
- Increase early stage diagnosis of colorectal cancer to 50%; the New York State rate was 40% from 2000-2004.
- Reduce lung cancer incidences to 62.0 per 100,000 for males and 41.0 per 100,000 for females. The New York State rate was 82.2 for males and 53.9 for females from 2000-2004.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Community Based-Cancer Support Services Programs

Mandate: PHL Section 2406

Mandated Funding Level: None

Brief Description/History/Background: Community-based agencies deliver support, training, respite, and counseling services to people who have or have had cancer or are at high risk of developing cancer due to family history or other factors, their family members and caregivers. All funds are contracted to providers for services. Contractors include hospitals, diagnostic and treatment centers, the American Cancer Society, community based organizations and local health departments.

Issues: None

Population Served: There are over 14,000 cases of breast cancer and approximately 500 childhood cancers diagnosed each year among residents of New York State. These individuals and their families may seek community support services through these programs.

Performance Measures:

HP 2010:

- Reduce overall cancer death rate to 158.6 per 100,000. The New York State rate was 215.8 per 100,000 for males and 155.6 per 100,000 for females from 2001-2005.
- Reduce the breast cancer death rate to 21.3 per 100,000. The New York State rate was 25.5 per 100,000 from 2001-2005.

Prevention Agenda:

- Reduce cancer mortality rate.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Community Health Care Workers

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The purpose of this initiative is to demonstrate that targeted and coordinated education, outreach and case management neighborhood services related to issues of health, substance abuse and HIV/AIDS, which are conducted by trained community residents, can have a positive impact on the reduction of drug and alcohol abuse and related health problems of a given community. Community Health Workers have been successful in working with families who have rejected the services of other care providers. One of the reasons for this success is that the program employs workers who are indigenous to the community and, therefore, knowledgeable about the community, the population, the culture, the community's problems and resources.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: Hard-to-reach women and their families in communities statewide.

Performance Measures: The Community Health Worker Program requires semiannual and annual narrative reports from each contractor. It includes in-service education, training needs, and problems that have been identified and their proposed solutions. Quantitative data (caseload, demographics, types of service referrals, service utilization, client outcomes) are submitted quarterly via the Community Health Worker Program Data Management System.

Success and continuation of the program is based upon level of attainment of work plan objectives, which will be monitored by the Division of Family Health. Each worker's average case load is approximately 25 families in addition to short-term encounters (normally 1-3 contacts per client). In the last year, 2,749 women and families were served and more than 18,942 referrals were made for health and supportive services statewide, with an average accomplishment rate of 87%.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Comprehensive Adolescent Pregnancy Prevention

Mandate: Public Health Law Article 25, amended, title 1-B Section 2515

Mandated Funding Level: None

Brief Description/History/Background: Adolescent pregnancies result in increased Medicaid costs, dependence on public programs, poor birth outcomes, and lower educational attainment. Severe racial and ethnic disparities and emergence of new cultural norms and attitudes on sexuality require ongoing public health action. The Adolescent Pregnancy Prevention and Services (APPS) program was established in 1984 to develop teen pregnancy prevention and parenting services. APPS was transferred from the Office of Children and Family Services to the Department of Health on July 1, 2008 as part of the 2008-09 Executive Budget. The Public Health Law authorizes the Department of Health to request, review, approve, select, fund and provide technical service to support community service project plans developed by local community councils.

The Community Based Adolescent Pregnancy Prevention Program focuses on sexuality education, access to family planning services, and other supportive services. The Community Based Adolescent Pregnancy Prevention Program (CBAPP) was established in 1995 to prevent teen pregnancies, focusing on areas with high adolescent pregnancy rates.

Due to increasing restrictions and lack of evidence, last year New York chose to no longer accept federal abstinence-only funding.

Issues: None

Population Served: Adolescents living in zip codes with high teen pregnancy and birth rates.

Performance Measures: Adolescent pregnancy rates have declined by 38% since peaking in 1993 in NYS and continue to decline despite national increases in 2006. Currently over 466,000 adolescents receive educational and supportive services through the programs. The specific Public Health Agenda goal is to reduce pregnancies among adolescent females ages 15-17 to no more than 28 per 1,000 females in that age group. The New York State rate was 36.5 in 2005. New York has met the Healthy People 2010 goal of 43 pregnancies per 1,000 females aged 15-17 years.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Diabetes Prevention and Control

Mandate: Public Health Law 2796

Mandated Funding Level: None

Brief Description/History/Background: Diabetes is the most rapidly growing chronic disease of our time. New York State has witnessed nearly a 100% increase in diabetes since 1994. In 2004, New York State Medicaid program expenditures for the nearly 284,000 fee-for- service members with diabetes totaled approximately $5.5 billion. Of greatest concern is the recent trend that children, especially minority children, are now developing type 2 diabetes, once thought of as strictly a disease of adults, at alarming rates. Fifteen Community Coalitions for Diabetes Prevention are regionally-based partnerships that expand, enhance and improve services for people with diabetes and those who are at risk for developing diabetes. Five Diabetes Centers of Excellence have been designated to translate science into effective, replicable, and cost-effective clinical strategies and to develop tools to prevent diabetes and its complications. Providers include hospitals, local health departments, community based organizations and the National Kidney Foundation.

Issues: Limited funding to address extent of the problem.

Population Served: Over 1 million New Yorkers are currently diagnosed with diabetes and 1/3 more have diabetes but have not been diagnosed.

Performance Measures:

HP 2010 goal:

- 5-5 Reduce the diabetes death rate to 45 persons per 100,000. New York State rate was 18.8 per 100,000 (2004-06).

Prevention Agenda:

- Reduce prevalence of diabetes to 5.7%. New York State rate was 7.6% in 2006.
- Reduce percentage of adults who are obese to 15%. New York State rate was 22.9% in 2006.
- Increase percentage of adults who are physically active to 80%. The New York State rate was 74% in 2006.

Department of Health – Center for Community Health

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Early Intervention Program

Mandate: 20 U.S.C.A. §1431-1445; Public Health Law §2540

Mandated Funding Level: None

Brief Description/History/Background: The Early Intervention Program is authorized under Part C of the Individuals with Disabilities Education Act (IDEA) as a statewide, comprehensive, multidisciplinary interagency service delivery system for infants and toddlers with special needs and their families. Statewide implementation of the program was effective July 1, 1993. All states currently participate in this federal program. Early intervention services are required to be provided at no cost to parents. The Early Intervention Program serves approximately 70,000 infants and toddlers, birth to 3 years of age, with disabilities and their families in New York State. Services are financed through a combination of state funding and third party reimbursement such as private health insurance or Medicaid. Remaining costs are shared by localities and the State. State reimbursement at 49% is provided to counties for expenses for services that remain unreimbursed after third party and Medicaid payment. Due to a number of reforms, growth in expenditures has stabilized after several years of rapid growth in the earlier years of the program. The program is jointly administered by the state and counties.

Issues:

- Federal grant funding from the U.S. Department of Education which supports state and local costs to administer the program continues to decline.
- The program is designing a new information system, the New York Early Intervention System, which is expected to be piloted during SFY 2008-09 with full implementation in 2009-10.
- The reimbursement methodology, was established on an interim basis when the program was established in 1993.
- New statute signed into law by Governor Paterson earlier this year requires the Department to issue best practice protocols for autism screening, potentially increasing program costs to serve children with autism who are identified at an earlier ages.

Population Served: 70,000 infants and toddlers and their families annually are served through 58 municipal programs by more than 20,000 agencies and individuals approved by the Department to deliver early intervention services.

Performance Measures: Federal indicators for the program are established by the U.S. Department of Education and published annually for the state and each locality on the department's public web site.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Electronic Clinical Laboratory Reporting System (ECLRS)

Mandate: Public Health Law 576-c

Mandated Funding Level: None

Brief Description/History/Background: Reporting of communicable diseases is mandated under the New York State Sanitary Code (10NYCRR2.10). Electronic laboratory reporting is mandated under PHL 576-c. ECLRS provides a single point for laboratories to meet public health reporting requirements. Laboratory reports from ECLRS trigger public health disease investigations conducted by local health departments (LHDs). ECLRS is also a first alert tracking system for monitoring of bioterrorism related events. ECLRS information is used to electronically monitor trends in non-specific symptoms of illness at a community level for early detection of outbreaks. This system is in daily use by laboratories, hospitals and LHDs and supports the critical response to over 75 reportable disease conditions.

Issues: None

Population Served: All New Yorkers.

Performance Measures: Federal Healthy People 2010 goal 14-2 is to reduce chronic Hepatitis B virus infections in infants and young children (perinatal infections) to 400 infections or a 76% improvement. New York has achieved this goal. Healthy People 2010 goal 14-3 is to reduce Hepatitis B infections for adults 19 to 24 years of age to 2.4 per 100,000 population; adults aged 25 to 39 years of age to 5.1 per 100,000 population, and adults aged 40 years and older to 3.8 per 100,000 population. These goals have also been met

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Electronic Laboratory Reporting - Health Information Technology (ELR-HIT)

Mandate: Public Health Law 576-c

Mandated Funding Level: None

Brief Description/History/Background: Reporting of communicable diseases is mandated under the New York State Sanitary Code (10NYCRR2.10). Electronic laboratory reporting is mandated under PHL 576-c. The ability to enhance situational awareness and rapidly detect public health events, manage the events and appropriately mobilize resources is a public health priority. This funding supports the technical personnel and other resources required for a bi-directional data and information exchange system between public health and clinical care settings, a communicable disease outbreak management system to enhance public health event monitoring and rapid response, and integration with existing data systems to provide a framework for the sharing of data with providers in a manner consistent with public health laws

This appropriation appeared in the 2008-2009 Executive budget as a new initiative.

Issues: None

Population Served: All New Yorkers.

Performance Measures:

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Health Emergency Preparedness

Mandate: DOH is the lead state response agency for Pandemic Influenza, radiological emergencies, biological emergencies and plays a key response role in all-hazard events including natural disasters, chemical emergencies, and intentional acts. The Federal Pandemic and All-Hazards Preparedness Act (PAHPA) signed into law December 2006 (Public Law No. 109-417) reauthorizes public health preparedness cooperative agreements and hospital preparedness cooperative agreements to establish minimum health security capabilities and requires state investments in preparedness.

Mandated Funding Level: Continuation of federal cooperative agreement funds depends on matching of state funds and maintenance of state efforts in preparedness. (Combined total of $33,076,216 million in 2008-09 for CDC Public Health Emergency Preparedness and HHS Healthcare Preparedness Planning) State funding levels cannot be less than those required by PAHPA (Title II Public Health Security Preparedness, section 201). Beginning in FY 2009, States must make available non-Federal contributions to preparedness in an amount equal to: for the first fiscal year, not less than 5%, and for subsequent fiscal years, not less than 10%, of Federal funds provided in the cooperative agreement. An entity that receives an award shall maintain efforts for public health security at a level not less than the average level of such expenditures maintained for the preceding 2 year period.

Brief Description/History/Background: Since 2002, DOH has worked closely with federal, state and local public health and healthcare partners to improve the state's ability to respond to emergency events. Three state-funded FTEs are assigned to the program. Since 2006, state funding for a Medical Emergency Response Cache (MERC) has ensured a stockpile of critical pharmaceutical and other medical equipment and supplies is available for health emergencies or a pandemic event.

Issues: Downsizing of the healthcare facility infrastructure has reduced the system's ability to surge during an emergency. Reductions in federal funding, coupled with increasing restrictions on how grant dollars are spent, present a serious impediment to sustaining critical local capacity and capability.

Population Served: The entire population of New York State is served and specifically the public health and health care sectors.

Performance Measures: DOH submitted a state Pandemic Influenza operations plan that meets the DHHS acceptability criteria on July 9, 2008. The federal Strategic National Stockpile (SNS) – has rated DOH's federal Technical Assistance Review score of 97 out of 100. On average, 98% of Incident

Management System (IMS) staff acknowledge notification within 25 minutes (federal target = mean of 60 minutes); IMS staff report to the Emergency Operations Center within 48 minutes (federal target = mean of 2 1/2 hours.

LHD contract deliverables include assuring mass prophylaxis capability, redundant communication capacity and capability, updating and submitting Local Health Emergency Response Plans and County Strategic National Stockpile plans. MERC assets are available for immediate deployment to a requesting locality; and once the request is approved, will be delivered within 4 hours anywhere in the state.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Family Planning and Reproductive Health Services

Mandate: PL 91-572

Mandated Funding Level: None

Brief Description/History/Background: Federal authorizing legislation and state regulations authorize grants to establish and operate family planning programs providing a broad range of effective family planning methods. State regulation also provides general standards for operation of family planning programs. The Family Planning and Reproductive Health Services program provides a full range of contraceptive and family planning services to women statewide through a network of 53 contractors at over 200 sites. These services have been available in NYS since the 1970s, and make up a critical part of our statewide safety net providers. Family planning services save over $4 for every dollar spent on the program. This is a key safety net program serving a large group of at risk, uninsured women and men, including a large proportion of adolescents, and provides the only contact with the service system for a significant proportion of clients. The program does not fund abortion.
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Federal funds require state match of a minimum of 10%. The match can include family planning programs' financial resources from other sources such as program income generated from client fees or other means.

Issues: None

Population Served: Over 300,000 women of reproductive age are served annually, with over 600,000 visits. Approximately one-third of those served are adolescents

Performance Measures: Healthy People 2010 and Prevention Agenda goals include:

- Reduce pregnancies among adolescent females ages 15 to 17 to no more that 28 per 1,000 females in this age group. The New York State rate was 36.5 in 2005. New York State has met the Healthy People 2010 goal of 43 per 1,000 females in this age group.
- 9-1: Increase the percent of pregnancies that are intended to at lease 70%. In 2006, in New York State, excluding New York City, the rate was 66.6

Department of Health – Center for Community Health

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: State Aid for General Public Health Work

Mandate: Public Health Law, Article 6

Mandated Funding Level: None

Brief Description/History/Background: The Article 6 Program provides partial reimbursement for expenses incurred by municipalities for approved public health activities. Through Article 6 of the Public Health Law, aid is provided to local county health departments (LHDs), including the City of New York, for public health activities, including: disease control, family health, public health education, community health assessment, environmental health and some optional programs including emergency medical services, certified home health agencies, and public health laboratories.

Public Health Law establishes the formula and rate of reimbursement to local health departments. Public Health Law also establishes eligible and ineligible expenses. After spending on basic services exceeds the base grant, expenditures are reimbursed at 36%. Other or optional services are reimbursed at 36%, without benefit of the base grant reimbursement amount. Municipalities are required to make “reasonable effort” to collect payment for services from other sources.

LHDs are required to submit a Municipal Public Health Services Plan (MPHSP), which describes the services provided; and a State Aid Application (SAA), which provides information on the gross cost and revenues (fees, fines, grants, etc), and a calculation of net eligible expenses for reimbursement with projected amount of state aid reimbursement. The MPHSP, once approved, is the controlling document and determines the activities and programs which can be reimbursed. The SAA, once approved, forms the basis for claims for reimbursement under the formula described in PHL 605, above.

PHL § 616 both limits the total amount of state aid provided to the amount of the annual appropriation made by the legislature, and provides that the state aid appropriation not be less than the amount necessary to provide the full base grant and the basic and optional reimbursement required.

New York City accounted for approximately 58% of the claims in calendar year 2007.

Issues: Reimbursement through Article 6 is influenced by the level of local funding and revenues collected during the calendar year.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Population Served: The residents of New York State

Performance Measures: This program supports the following Healthy People 2010 Infrastructure goal: 23-12: Increase the proportion of Tribes, States, and the District of Columbia that have a health improvement plan and increase the proportion of local jurisdictions that have a health improvement plan linked with their State plan from 32%-80%. New York has 100% (58/58) of LHDs with a health improvement plan in the form of the Municipal Public Health Services Plan. The GPHW program supports a number of Healthy People 2010 goals associated with the disease control, family health, public health education, community health assessment, environmental health and optional programs carried out by local health departments.

Department of Health – Center for Community Health

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Public Health Emergencies

Mandate: PHL Article 6

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law allows the state Commissioner or a county or municipality health department, with the approval of the state Commissioner, to determine there is an imminent threat to public health (ITPH). The State Department of Health is authorized to reimburse county and the City of New York Health Departments fifty (50%) percent of the cost of responding to an ITPH when all funds included in the appropriate line of the State Aid Application related to the activities have been expended. This reimbursement is also subject to SDOH approvals of the declaration of the emergency and the emergency measures, and is subject to the approval of the state director of the budget. From time to time, ITPH arise that require extraordinary effort and local resources to mount an appropriate response. The state has recognized the nature and cost of these response activities and reimburses the local health departments involved at a rate of reimbursement higher than normally provided by GPHW-Article 6.

Issues: None

Population Served: The residents of New York State

Performance Measures: There are numerous Healthy People 2010 goals associated with the program areas affected by emergencies such as communicable diseases and environmental health.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Public Health Emergencies

Mandate: PHL Article 6

Mandated Funding Level: None

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Issues: None

Population Served: The residents of New York State

Performance Measures: There are numerous Healthy People 2010 goals associated with the program areas affected by emergencies such as communicable diseases and environmental health.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Genomics

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The purpose of this program is to incorporate new information from the Human Genome Project and related research into medical practice and chronic disease public health programs in New York State. Funds are to be used to convene expertise to create a genomics program for health practitioners.

Issues: None

Population Served: Primary care and family practice physicians in New York State and their patients.

Performance Measures: None

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: HIV AIDS/Epidemiology

Mandate: Public Health Law Section 2139; Article 21, Title III; Chapter 163 of the Laws of 1998 (amendment to PHL Article 27-F)

Mandated Funding Level: None

Brief Description/History/Background: The program conducts HIV and AIDS surveillance. Information is provided to target resources and to evaluate service and education programs. The data collected through HIV/AIDS surveillance are used by the Centers for Disease Control and Prevention (CDC) to track the state and national epidemic and provide a basis for determining the amount of federal funds New York receives for HIV/AIDS-related prevention and treatment programs. The analysis and presentation of these data form the foundation on which decisions about services and programs for the HIV/AIDS-infected and affected population of New York State is based.

Issues: On August 3, 2008, CDC made available new methodology for estimating new HIV infections. Per these estimates, approximately 30% more New Yorkers were infected with HIV than were diagnosed with HIV in 2006.

Population Served: All New Yorkers infected with, or at potential risk for HIV/AIDS infection.

Performance Measures: Specific performance measures defined by CDC include but are not limited to:

- Maintain a universal lab reporting system with 90% of HIV-related lab reports for NYS reported within one month of collection date, with a minimum of 99% including name, 95% sex, 95% the true provider, 95% date of birth and 15% race or ethnicity. New York's rates are 91%, 99%, 97%, 99%, 99% and 24% respectively.
- Assure that 90% of new diagnoses of HIV and AIDS are reported by NYS providers within two months of diagnosis date, with a minimum of 100% including the name, 99% sex, 75% race/ethnicity, and 75% a CDC defined risk. New York's rates are 64%, 100%, 98%, 99% and 57% respectively.
- Conduct active field investigations on all newly reported suspect or confirmed HIV infections and on cases originally reported without sufficient information or behavioral risk. Investigations will be completed in a timely manner (90% complete within 3 months; 100% within 6 months). 98.7% of investigations in New York are completed within 6 months.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: HIV AIDS/Epidemiology

Mandate: Public Health Law Section 2139; Article 21, Title III; Chapter 163 of the Laws of 1998 (amendment to PHL Article 27-F)

Mandated Funding Level: None

Brief Description/History/Background: The program conducts HIV and AIDS surveillance. Information is provided to target resources and to evaluate service and education programs. The data collected through HIV/AIDS surveillance are used by the Centers for Disease Control and Prevention (CDC) to track the state and national epidemic and provide a basis for determining the amount of federal funds New York receives for HIV/AIDS-related prevention and treatment programs. The analysis and presentation of these data form the foundation on which decisions about services and programs for the HIV/AIDS-infected and affected population of New York State is based.

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Population Served: All New Yorkers infected with, or at potential risk for HIV/AIDS infection.

Performance Measures: Specific performance measures defined by CDC include but are not limited to:

- Maintain a universal lab reporting system with 90% of HIV-related lab reports for NYS reported within one month of collection date, with a minimum of 99% including name, 95% sex, 95% the true provider, 95% date of birth and 15% race or ethnicity. New York's rates are 91%, 99%, 97%, 99%, 99% and 24% respectively.
- Assure that 90% of new diagnoses of HIV and AIDS are reported by NYS providers within two months of diagnosis date, with a minimum of 100% including the name, 99% sex, 75% race/ethnicity, and 75% a CDC defined risk. New York's rates are 64%, 100%, 98%, 99% and 57% respectively.
- Conduct active field investigations on all newly reported suspect or confirmed HIV infections and on cases originally reported without sufficient information or behavioral risk. Investigations will be completed in a timely manner (90% complete within 3 months; 100% within 6 months). 98.7% of investigations in New York are completed within 6 months.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Hospital-Acquired Infection Reporting Program (HAIR)

Mandate: Chapter 284 of the Laws of 2005 (Public Health Law Section 2819)

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law required an HAI reporting system by July 1, 2006 with hospitals reporting data by January 1, 2007. Ongoing audits to ensure the completeness and accuracy of reporting are required. A pilot phase report was required by June 30, 2008 and annual reports are required by May 1 in subsequent years. Other program functions include training hospitals on use of the system and consulting with a Technical Advisory Workgroup to develop appropriate risk adjustment methods to ensure fair and meaningful comparisons of hospital infection rates.

Issues: None

Population Served: All acute care hospitals in New York State and the populations served in these facilities.

Performance Measures: Reduce central line associated blood stream infections in intensive care unit patients by 2010. This newly established program recently completed first year collection of baseline data and is in the process of establishing quantifiable goals for reducing targeted infections.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Hospital-Acquired Infection Reporting Program (HAIR)

Mandate: Chapter 284 of the Laws of 2005 (Public Health Law Section 2819)

Mandated Funding Level: None

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Issues: None

Population Served: All acute care hospitals in New York State and the populations served in these facilities.

Performance Measures: Reduce central line associated blood stream infections in intensive care unit patients by 2010. This newly established program recently completed first year collection of baseline data and is in the process of establishing quantifiable goals for reducing targeted infections.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Hypertension (Healthy Heart Program)

Mandate: Public Health Law 2722

Mandated Funding Level: None

Brief Description/History/Background: Cardiovascular diseases (CVD) are the leading causes of death, disability and health care expenditure among New York State residents, accounting for more than 41% of all deaths in New York. CVD is the leading cause of death of middle-aged New Yorkers, taking the lives of approximately 8,500 persons between the ages of 35 and 64 each year. In 2007, the total cost for cardiovascular disease (direct costs + lost productivity due to illness and death) was estimated to $31.5 billion.

This funding is used to support community-based contractors who work to increase opportunities for physical activity and healthier eating and worksite contractors who are charged with making improvements in policies and environmental changes for physical activity and healthy eating. Funding supports contracts with hospitals, local health units, one diagnostic and treatment center, one research foundation, community based organizations, and one Heart association.

Issues: Limited funding to address extent of the problem.

Population Served: Adult New York State residents.

Performance Measures:

HP 2010:

- Reduce the proportion of adults who are obese to 15%. The New York State rate was 22.9% in 2006.
- Reduce the proportion of adults who engage in no leisure-time activity to 20%. The New York State rate was 26% in 2006.
- Reduce coronary heart disease deaths to 162 per 100,000. The New York State rate was 221.8 per 100,000 from 2002-2004.
- Reduce the proportion of adults with high blood pressure to 16%. The New York State rate was 27.2% in 2007.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Hypertension (Healthy Heart Program)

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Immunization

Mandate: Public Health Law Sections 613 & 2168 ; 42 U.S.C. Sec. 1396s

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law Section 613 established a program to reduce the incidence of vaccine preventable diseases (VPD). Federal law created the Vaccines for Children (VFC) Program to make federally purchased vaccines available to health care providers at no cost. Public Health Law 2168 requires all health care providers to report immunizations given to children up to age 18 to a registry, beginning January 1, 2008. The Immunization Program was established in 1982, with a primary objective to reduce VPDs by increasing immunization rates. Secondary objectives are to ensure adequate vaccine supplies for all primary health care providers and promote timely administration of vaccines to persons at greatest need and with the least ability to pay. Funding is used to purchase vaccines and to fund local health department (LHD) contracts

Issues: None

Population Served: All NYS residents, exclusive of New York City.

Performance Measures: Healthy People 2010 objectives to increase the proportion of young children who receive all recommended immunizations is set at 90%. The National Immunization Survey shows New York State (outside of NYC) as second in the nation with an immunization rate of 89.4% for children 19 to 35 months of age. Statewide the rate in 2007 was 85.8%.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Immunization

Mandate: Public Health Law Sections 613 & 2168 ; 42 U.S.C. Sec. 1396s

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Childhood Lead Poisoning Prevention Program (CLPPP)

Mandate: Title X, Section 1370

Mandated Funding Level: None

Brief Description/History/Background: Exposure to lead is associated with serious health effects for young children. Despite steady declines in incidence and severity, lead poisoning remains a serious problem concentrated in high-risk impoverished communities. The Department is required to establish a lead poisoning prevention program to prevent lead poisoning including lead screening and follow-up of children and pregnant women, interagency agreements to coordinate lead poisoning prevention activities, a statewide registry of children's blood lead levels, a pilot program for primary prevention of lead poisoning in designated high-incidence communities, abatement of lead hazard conditions and a state advisory council on lead poisoning prevention. The statewide program was established in 1993 to prevent and eliminate childhood lead poisoning. The comprehensive approach includes education, surveillance, lead screening, case management, and primary prevention administered through local health departments and hospital based lead resource centers. The primary prevention program was established in 2007. It currently funds efforts in eight counties that have the highest levels of childhood lead poisoning, and will soon be expanded to an additional six counties.

Issues:

- Federal funding dedicated to lead poisoning prevention may be threatened as CDC expands its focus to more general healthy housing approaches.
- Limited State funding to address the extent of the problem.

Population Served: Children to age 18 years, with emphasis on high-risk children up to age six.

Performance Measures: In 2007, 3,872 children under age 6 years were diagnosed with lead poisoning (defined as blood lead level greater than or equal to 10 mcg/dL) in New York State, down nearly 60% since a decade ago. 83% of children born in NYS in 2004 were screened for lead at least once by age three, but only 41% were screened twice by age three. The Healthy People 2010 goal 8-11 is to eliminate elevated blood lead levels in children under age 6.

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Childhood Lead Poisoning Prevention Program (CLPPP)

Mandate: Title X, Section 1370

Mandated Funding Level: None

Brief Description/History/Background: Exposure to lead is associated with serious health effects for young children. Despite steady declines in incidence and severity, lead poisoning remains a serious problem concentrated in high-risk impoverished communities. The Department is required to establish a lead poisoning prevention program to prevent lead poisoning including lead screening and follow-up of children and pregnant women, interagency agreements to coordinate lead poisoning prevention activities, a statewide registry of children's blood lead levels, a pilot program for primary prevention of lead poisoning in designated high-incidence communities, abatement of lead hazard conditions and a state advisory council on lead poisoning prevention. The statewide program was established in 1993 to prevent and eliminate childhood lead poisoning. The comprehensive approach includes education, surveillance, lead screening, case management, and primary prevention administered through local health departments and hospital based lead resource centers. The primary prevention program was established in 2007. It currently funds efforts in eight counties that have the highest levels of childhood lead poisoning, and will soon be expanded to an additional six counties.

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Legislative Initiatives that Enhance Community Health

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Legislative Member Items are directed to the department. The Center for Community Health staff process contracts for the contractors designated to receive the funds.

Organizations receiving funds are named in the appropriations, appropriation sub-schedules, or via Legislative Intent Forms (LIFs). LIFs are required in order to initiate contracts for the organizations.

- Alzheimer's Disease Assistance Centers $100,000 (GF-ATL)
- Alzheimer's Disease Assistance Centers $300,000 (GF-ATL)
- Family Planning $675,000 (GF-ATL)
- Ovarian Cancer Hotline $160,000 (GF-ATL)
- School Based Health Centers $675,000 (GF-ATL)

Issues: While the intent of this funding is laudable, in some cases, it is not used as one of the core functions of the agency.

Population Served: Varies by population to be targeted.

Performance Measures: These programs are not required to be evaluated or to have goals and it can be difficult to determine effectiveness.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Migrant/Seasonal Farm Worker Health Program

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The vast majority of New York's migrant and seasonal farm workers have no health insurance and are likely unable to qualify for publicly funded programs. Health needs are greater than in the general population due to the nature of their work and access to health services. Infections and injuries are common problems. Healthy migrant and seasonal farm workers are key to the state's $3 billion agricultural industry and economy. Since 1988, community based organizations, hospitals and local health departments provide migrant and seasonal farm workers with access to primary and preventive health services.

Issues: None

Population Served: Disparate and vulnerable; predominantly male, ages 18-45, predominantly Hispanic, uninsured, traveling without family. A total of 18,000 adults + 6,000 children (0-18).

Performance Measures: Annually provide a minimum of 11,500 (of 24,000) migrant and seasonal farm workers and their family members with access to health and human services. The Healthy People 2010 goal 1-4a is to increase the proportion of persons who have a specific source of ongoing care to 96%. The New York State rate in 2006 was 85%.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Office of Minority Health (OMH)

Mandate: Public Health Law, Section 241

Mandated Funding Level: None

Brief Description/History/Background: The OMH 1) integrates and coordinates select state health care grant and loan programs established specifically for minority health care providers and residents, including development of a coordinated application for use by minority providers and others in seeking funds and/or technical assistance on pertinent minority health care programs and services; 2) applies for grants to improve and enhance minority health care services and facilities; 3) together with the minority health council, serve as liaison and advocate for the department on minority health issues, provides staff support to the minority health council; 4) assists medical schools and state agencies to develop comprehensive programs to improve minority health personnel supply by promoting minority clinical training and curriculum improvement; 5) promotes community strategic planning or new or improved health care delivery systems and networks in minority areas; 6) reviews the impact of programs, regulations, and health care reimbursement policies on minority health services, delivery and access; 7) prepares and distribute biennial Minority Health Report.

Issues: None

Population Served: Racial and ethnic minorities.

Performance Measures:

HP 2010 Goals:

- Increase the percentage of racial/ethnic minorities (in target populations) with a regular provider to 90%. New York State's rate in 2007 is 83.9% but among black non-Hispanic the rate is 81.5% and among Hispanics, 69.4%
- Increase early stage breast cancer diagnosis to 80%. The New York State rate was 64% in 2000-2004.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Office of Minority Health (OMH)

Mandate: Public Health Law, Section 241

Mandated Funding Level: None

Brief Description/History/Background: The OMH 1) integrates and coordinates select state health care grant and loan programs established specifically for minority health care providers and residents, including development of a coordinated application for use by minority providers and others in seeking funds and/or technical assistance on pertinent minority health care programs and services. Because several reports document widespread racial/ethnic minorities in the quality of care received, treatments offered, and health outcomes, OMH carries out this function by administering grants that focus exclusively on minority health disparities; 2) applies for grants to improve and enhance minority health care services and facilities; 3) together with the minority health council, serve as liaison and advocate for the department on minority health issues, provides staff support to the minority health council; 4) assists medical schools and state agencies to develop comprehensive programs to improve minority health personnel supply by promoting minority clinical training and curriculum improvement; 5) promotes community strategic planning or new or improved health care delivery systems and networks in minority areas; 6) reviews the impact of programs, regulations, and health care reimbursement policies on minority health services, delivery and access; 7) prepares and distribute biennial Minority Health Report.

Issues: None

Population Served: Racial and ethnic minorities.

Performance Measures:

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- Increase the percentage of racial/ethnic minorities (in target populations) with a regular provider to 90%. New York State's rate in 2007 is 83.9% but among black non-Hispanic the rate is 81.5% and among Hispanics, 69.4%
- Increase early stage breast cancer diagnosis to 80%. The New York State rate was 64% in 2000-2004.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Obesity Prevention

Mandate: PHL Sections 2599-a and 2599-b and Education Law 903 and 904

Mandated Funding Level: None

Brief Description/History/Background: Epidemic increases in the prevalence of overweight and obesity have been noted in New York and the US. Obesity significantly increases the risk of serious chronic diseases including hypertension, dyslipidemia, cardiovascular disease, diabetes, asthma, arthritis and depression. Costs due to obesity are estimated at $117 billion per year in the US and exceed $6 billion per year in New York State. In New York State, almost 25% of elementary school children are obese and approximately 29% of high school students are overweight or obese. In pre-school age children, the prevalence of obesity among children aged 2 to 5 years and enrolled in the WIC program was 50% higher than among a US sample. This funding is used to support three Centers of Excellence for Obesity Prevention (pre-natal/infancy, early childhood, school age), community-based interventions, community coalitions, a child care obesity prevention initiative, and to support activities for Body Mass Index surveillance including physician adherence, school nurse training, software development and data analysis. Providers include hospitals; a professional association; diagnostic and treatment Centers; local health departments; community based organizations; a school district; and the New York State Child Care Coordinating Council. Additional funds are provided to train providers in child care settings about the Eat Well, Play Hard Program.

Issues: Limited funding to address extent of the problem.

Population Served: New York State residents

Performance Measures:

HP 2010:

- Reduce the proportion of adults who are obese to 15%. The New York State rate was 22.9% in 2006.
- Reduce the proportion of adults who engage in no leisure-time activity to 20%. The New York State rate was 27.1% in 2005.

Prevention Agenda:

- Reduce percentage of adults who are obese.
- Increase percentage of adults who are physically active.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Obesity Prevention

Mandate: PHL Sections 2599-a and 2599-b and Education Law 903 and 904

Mandated Funding Level: None

Brief Description/History/Background: Epidemic increases in the prevalence of overweight and obesity have been noted in New York and the US. Obesity significantly increases the risk of serious chronic diseases including hypertension, dyslipidemia, cardiovascular disease, diabetes, asthma, arthritis and depression. Costs due to obesity are estimated at $117 billion per year in the US and exceed $6 billion per year in New York State. In New York State, almost 25% of elementary school children are obese and approximately 29% of high school students are overweight or obese. In pre-school age children, the prevalence of obesity among children aged 2 to 5 years and enrolled in the WIC program was 50% higher than among a US sample. This funding is used to support three Centers of Excellence for Obesity Prevention (pre-natal/infancy, early childhood, school age), community-based interventions, community coalitions, a child care obesity prevention initiative, and to support activities for Body Mass Index surveillance including physician adherence, school nurse training, software development and data analysis. Providers include hospitals; a professional association; diagnostic and treatment Centers; local health departments; community based organizations; a school district; and the New York State Child Care Coordinating Council. Additional funds are provided to train providers in child care settings about the Eat Well, Play Hard Program.

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Prevention Agenda:

- Reduce percentage of adults who are obese.
- Increase percentage of adults who are physically active.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Osteoporosis Prevention and Education Program

Mandate: Public Health Law 2706 and 2707

Mandated Funding Level: None

Brief Description/History/Background: In 1997, the Osteoporosis Education Bill established authority for the Commissioner to develop the Osteoporosis Prevention and Education Program to provide outreach, education and prevention, and also established an Advisory Council to advise the department on matters relating to osteoporosis prevention The purpose of the program is to ensure the provision of education and training to consumers and professionals regarding the prevention and treatment of osteoporosis. Current contractors consist of three academic medical centers, two community based agencies and a resource center at Helen Hayes Hospital.

Issues: None

Population Served: Individuals, predominantly women, residing in areas that have a regional osteoporosis education center.

Performance Measures: The Prevention Agenda goal is to reduce fall related hospitalizations among persons 65 years old and older to 155 per 10,000. The New York State rate in 2004-2006 was 206.3 per 10,000.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Osteoporosis Prevention and Education Program

Mandate: Public Health Law 2706 and 2707

Mandated Funding Level: None

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Issues: None

Population Served: Individuals, predominantly women, residing in areas that have a regional osteoporosis education center.

Performance Measures: The Prevention Agenda goal is to reduce fall related hospitalizations among persons 65 years old and older to 155 per 10,000. The New York State rate in 2004-2006 was 206.3 per 10,000.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Perinatal Health

-- Maternal Mortality/Safe Motherhood:

-- Perinatal Regionalization which includes Regional Perinatal Centers (RPC) and the Statewide Perinatal Data System (SPDS):

-- Prenatal/Postpartum Home Visiting and the Prenatal Care Assistance Program (PCAP), which includes the Comprehensive Prenatal-Perinatal Services Networks (CPPSN), Community Health Worker Program (CHWP), Growing Up Healthy Hotline (GUHH) and oversight of the Medicaid PCAP program.

Mandate: Public Health Law, Sections 405.21 and Section 400.22; Public Health Law 2522.4

Mandated Funding Level: None

Brief Description/History/Background: The Maternal Mortality program was first funded in 2003 to conduct statewide outreach and education regarding maternal mortality, and maternal mortality reviews at obstetrical hospitals to improve birth outcomes and decrease maternal mortality and morbidity. The Safe Motherhood Initiative (SMI) through the American College of Obstetricians and Gynecologists (ACOG) focuses on identifying factors associated with maternal deaths and strategies to improve clinical practice to improve outcomes, particularly among minority women who have a higher risk of maternal death. Regional perinatal centers (RPCs) provide care to the highest risk women and newborns and are required to deliver support, transport, education and quality improvement (QI) services to affiliated hospitals. There are 16 RPCs comprised of 18 hospitals. Other hospitals receive perinatal designation levels (1-4) based on their capacity to serve mothers and newborns. The SPDS, captures electronic birth certificate data for all upstate deliveries and information on high risk newborns admitted to neonatal intensive care units (NICUs) statewide. Since 42.6 percent of births statewide are to women on Medicaid, the RPC program has been eligible for approximately 20 percent Medicaid match. The Welcome Baby! Universal Prenatal and Postpartum Home Visiting Program is designed to improve pregnancy outcomes and infant health and development through universal contact to identify women who are not receiving prenatal care, as well as women at higher risk for poor birth outcomes. The program is designed to ensure all pregnant women enter prenatal care in the first trimester and receive the support they need to have healthy babies, including home visits. Home visiting funding first appeared in the 2007-08 Executive budget as a new initiative recognizing the effectiveness of home visiting in improving health, vocational and educational outcomes. Home visiting has been widely documented as an evidence based intervention that improves family outcomes. Funding is directed to local health departments or close collaborations between local health departments and community-based organizations. CPPSNs conduct grassroots

level outreach and education to promote entry of women into prenatal care programs and organize the service system at the local level to improve perinatal health. The CHWP was developed in 1988 to identify high risk pregnant women not enrolled in prenatal care, and ensure they obtain comprehensive prenatal care and other needed services. The CHWP provides one-on-one outreach, education and home visiting services to pregnant women at highest risk for poor birth outcomes. In operation since 1986, the GUHH was initiated to be a referral resource to prenatal care assistance programs statewide. The GUHH has become the hotline of choice for department programs needing to provide information on a timely basis statewide, and serves to fulfill the federal Maternal and Child Health requirement to operate a statewide hotline. The GUHH is operated by the Association for the Blind and Visually Impaired, which is affiliated with Industries for the Blind of NYS.

Issues: Hospitals are not required to undergo maternal mortality reviews. Data security issues have prevented full sharing of data with RPCs.

Population Served: Hospitals serving approximately 50 women per year in NYS who have died as a direct result of pregnancy or delivery, receive maternal mortality reviews. All women delivering infants or receiving obstetrical care in NYS, as well as infants admitted to NICUs are included in the SPDS. Home visiting is targeted to counties or boroughs with over 5,000 births in 2007, specifically high-risk zip codes or high-risk populations (e.g., teen mothers). Counties with fewer than 5,000 births in 2007 are expected to offer home visiting to every new mother (pregnant and postpartum). The PCAP serves women of reproductive age and their families statewide.

Performance Measures: The Healthy People 2010 goal 16-4 is to reduce maternal mortality to no more than 3.3 maternal deaths per 100,000 live births. The New York State rate was 18.3 in 2004-2006. The Healthy People 2010 goal 16-8 is to increase the proportion of very low birth weight infants delivered at level III hospitals. Analysis of very low birth weight births for the period 2004-2006, following redesignation of hospitals, indicated a drop in overall newborn mortality to 10.56 percent, with similar decreases noted by designated level. Healthy People 2010 objectives for the home visiting program include:

- 16-6: Increase the proportion of women delivering babies who receive early and adequate prenatal care to 90%. The New York State rate was 65.9% in 2006.
- 16-10: Reduce low birth weight and very low birth weight births to 5.0 per 1,000 births and 0.9 per 1,000 births respectively. The New York State rates were 8.3% and 1.5% respectively in 2006.
- 16-17: Increase abstinence from alcohol (94%), cigarettes (99%), and illicit drugs (100%) among pregnant women. In New York, excluding New York City, in 2006, 92% of pregnant women abstained from alcohol and 88% of women abstained from cigarettes.

- 16-9: Increase the percent of mothers who breastfeed their infants at 6 months of age to 50%. New York State has met this goal. In New York in 2004, 50% of mothers breastfed their infants for 6 months.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Perinatal Health

-- Maternal Mortality/Safe Motherhood:

-- Perinatal Regionalization which includes Regional Perinatal Centers (RPC) and the Statewide Perinatal Data System (SPDS):

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Mandate: Public Health Law, Sections 405.21 and Section 400.22; Public Health Law 2522.4

Mandated Funding Level: None

Brief Description/History/Background: The Maternal Mortality program was first funded in 2003 to conduct statewide outreach and education regarding maternal mortality, and maternal mortality reviews at obstetrical hospitals to improve birth outcomes and decrease maternal mortality and morbidity. The Safe Motherhood Initiative (SMI) through the American College of Obstetricians and Gynecologists (ACOG) focuses on identifying factors associated with maternal deaths and strategies to improve clinical practice to improve outcomes, particularly among minority women who have a higher risk of maternal death. Regional perinatal centers (RPCs) provide care to the highest risk women and newborns and are required to deliver support, transport, education and quality improvement (QI) services to affiliated hospitals. There are 16 RPCs comprised of 18 hospitals. Other hospitals receive perinatal designation levels (1-4) based on their capacity to serve mothers and newborns. The SPDS, captures electronic birth certificate data for all upstate deliveries and information on high risk newborns admitted to neonatal intensive care units (NICUs) statewide. Since 42.6 percent of births statewide are to women on Medicaid, the RPC program has been eligible for approximately 20 percent Medicaid match. The Welcome Baby! Universal Prenatal and Postpartum Home Visiting Program is designed to improve pregnancy outcomes and infant health and development through universal contact to identify women who are not receiving prenatal care, as well as women at higher risk for poor birth outcomes. The program is designed to ensure all pregnant women enter prenatal care in the first trimester and receive the support they need to have healthy babies, including home visits. Home visiting funding first appeared in the 2007-08 Executive budget as a new initiative recognizing the effectiveness of home visiting in improving health, vocational and educational outcomes. Home visiting has been widely documented as an evidence based intervention that improves family outcomes. Funding is directed to local health departments or close collaborations between local health departments and community-based organizations. CPPSNs conduct grassroots

level outreach and education to promote entry of women into prenatal care programs and organize the service system at the local level to improve perinatal health. The CHWP was developed in 1988 to identify high risk pregnant women not enrolled in prenatal care, and ensure they obtain comprehensive prenatal care and other needed services. The CHWP provides one-on-one outreach, education and home visiting services to pregnant women at highest risk for poor birth outcomes. In operation since 1986, the GUHH was initiated to be a referral resource to prenatal care assistance programs statewide. The GUHH has become the hotline of choice for department programs needing to provide information on a timely basis statewide, and serves to fulfill the federal Maternal and Child Health requirement to operate a statewide hotline. The GUHH is operated by the Association for the Blind and Visually Impaired, which is affiliated with Industries for the Blind of NYS.

Issues: Hospitals are not required to undergo maternal mortality reviews. Data security issues have prevented full sharing of data with RPCs.

Population Served: Hospitals serving approximately 50 women per year in NYS who have died as a direct result of pregnancy or delivery, receive maternal mortality reviews. All women delivering infants or receiving obstetrical care in NYS, as well as infants admitted to NICUs are included in the SPDS. Home visiting is targeted to counties or boroughs with over 5,000 births in 2007, specifically high-risk zip codes or high-risk populations (e.g., teen mothers). Counties with fewer than 5,000 births in 2007 are expected to offer home visiting to every new mother (pregnant and postpartum). The PCAP serves women of reproductive age and their families statewide.

Performance Measures: The Healthy People 2010 goal 16-4 is to reduce maternal mortality to no more than 3.3 maternal deaths per 100,000 live births. The New York State rate was 18.3 in 2004-2006. The Healthy People 2010 goal 16-8 is to increase the proportion of very low birth weight infants delivered at level III hospitals. Analysis of very low birth weight births for the period 2004-2006, following redesignation of hospitals, indicated a drop in overall newborn mortality to 10.56 percent, with similar decreases noted by designated level. Healthy People 2010 objectives for the home visiting program include:

- 16-6: Increase the proportion of women delivering babies who receive early and adequate prenatal care to 90%. The New York State rate was 65.9% in 2006.
- 16-10: Reduce low birth weight and very low birth weight births to 5.0 per 1,000 births and 0.9 per 1,000 births respectively. The New York State rates were 8.3% and 1.5% respectively in 2006.
- 16-17: Increase abstinence from alcohol (94%), cigarettes (99%), and illicit drugs (100%) among pregnant women. In New York, excluding New York City, in 2006, 92% of pregnant women abstained from alcohol and 88% of women abstained from cigarettes.

- 16-9: Increase the percent of mothers who breastfeed their infants at 6 months of age to 50%. New York State has met this goal. In New York in 2004, 50% of mothers breastfed their infants for 6 months.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Physically Handicapped Children's Program (PHCP)

Mandate: Public Health Law 2580-2584; Public Health Law 608

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law and regulation authorizes New York State to provide services for the treatment and rehabilitation of children with disabilities and requires the state to reimburse Local Health Departments (LHDs) at 50% of the cost of authorized services for physically handicapped children (100% for children on Indian reservations). Since its inception in 1925, the PHCP has provided reimbursement for medical services and associated costs for children with special health care needs (CSHCN) birth to 21 years who are underinsured and meet county medical and financial eligibility. A total of 47 out of 58 counties participate in PHCP. PHCP is the only funding source for orthodontia for uninsured children with significant malformations. PHCP also approves Article 28 facilities as specialty centers to receive referrals of children who screen positive on newborn screening tests.

A total of 2,395 children were served through the PHCP in 2007. Orthodontia expenses accounted for 69% of the 2007 annual expenditures

Based on 2005-2006 national survey data, 7.4 % of CSHCNs are uninsured at some point during the year; another 13.5% have unmet needs for specific health care services.

Issues: County participation in PHCP is voluntary, and financial and medical eligibility criteria are determined by each locality. The degree of assistance available to families varies across the state.

Population Served: Children birth to 21 years with physical disabilities or suffering from long term disease.

Performance Measures: In NYS 91.6% of children under 18 were insured during 2006. The Healthy People 2010 goal of 100% includes both children and adults. The Healthy People 2010 goal is to increase the proportion of children less than age 17 who have a specific source of ongoing care to 97%. In New York State 92.6% of CSHCNs were insured without a break in coverage during 2005-2006. Among CSHCNs, 86.5% had no unmet needs for specific health care services.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Public Health Campaign (PHC) Sexually Transmitted Disease Control

Mandate: Public Health Law Article 23, Title 1 sections 2300 – 2311, and Chapter 1 Part 1 of the State Sanitary Code

Mandated Funding Level: None

Brief Description/History/Background: In the late 1980s and early 1990s, NYS experienced some of the highest rates of reported syphilis and gonorrhea in the U.S. Implementation of a syphilis initiative, supported by PHC funding, bolstered the local public health infrastructure and contributed to dramatic declines in morbidity. However, over the past several years, there has been an increase in reported STD morbidity.

PHC funds support local health departments located in areas with the highest STD morbidity statewide. To conduct screening in high risk venues, provide diagnosis and treatment of individuals who test positive for STDs, provide testing and treatment of exposed partners, and reduce complications of STD in women and newborns, in whom such complications occur more commonly and with greater severity. An STD Center for Excellence provides clinical training for practitioners.

STDs are the most commonly reported communicable infections in NYS. Yearly, case numbers of gonorrhea and syphilis total more than 41% of all reported infections. Control of STD infections presents a unique challenge because of the stigma attached to disease linked to sexuality and reproduction.

Issues: Currently, STDs are on the rise in New York State. In 2007, a total of 38,092 cases of STDs including Chlamydia, gonorrhea and syphilis were reported in Update New York. This represents a 42% increase in 2001. Chlamydia has increased 79% since 2001; early (infectious) syphilis has increased nearly 800% from a historic low of 34 cases in 2000 to 302 reported cases in 2007. Federal STD grant funds have been cut over the past 5 years.

Population Served: Sexually active adults, ages15-50. Minority communities are the primary target for STD Disease Intervention interventions.

Performance Measures: Healthy People 2010 goal 25-2 is to reduce the incidence of gonorrhea in the general population to no more than 19 new cases per 100,000 population. New York's rate was 90.7 per 100,000 in 2006.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Public Health Campaign (PHC) Sexually Transmitted Disease Control

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Public Health Campaign – Tuberculosis (TB) Program

Mandate: Public Health Law section

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law section 2202 mandates local health departments (LHDs) to secure tuberculosis (TB) services. Public Health Campaign (PHC) funding was initiated in 1992 to support TB and sexually transmitted disease control and prevention at the local level. In 2007, the number of TB cases in New York State was 1,175. PHC funds support contracts with LHDs, including the New York City (NYC) Department of Health, for clinical and outreach staff, testing and treatment of TB cases and contacts and educational services. Additionally, these funds support a directly observed therapy program critical to assure that patients are adherent to medication therapy and remain non-infectious.

Issues: TB incidence is increasing among foreign-born residents of New York State, from 30% of TB cases in 2003 to over 70% of reported cases in 2007. Foreign born clients have cultural, social, political, economic, and language issues not present in the typical American-born TB patient of the early 1990's. Federal has steadily decreased: most recently a 17% decrease from 2007 to 2008. Future Federal reductions are anticipated.

Population Served: Individuals with TB who reside in the jurisdictions that are funded through these grants.

Performance Measures: The Healthy People 2010 goal is to reduce the incidence of TB to one case per 100,000. The NYS rate was 6.2 per 100,000 in 2007. The number of TB cases decreased 74% from 1992 to 2007.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Public Health Campaign – Tuberculosis (TB) Program

Mandate: Public Health Law section

Mandated Funding Level: None

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Public Health Management Leaders of Tomorrow

Mandate: Part 14, Section 3 of Part B of Chapter 57 of the Laws of 2006 as amended by Chapter 109 of the laws of 2006

Mandated Funding Level: None

Brief Description/History/Background: PHMLOT was established in 2006 to provide state and local health department staff with opportunities to strengthen public health skills by taking courses at the University at Albany School of Public Health (SPH) and for SPH students to gain practical experience in public health governmental agencies. The program addresses the current shortage of public health workers by developing a cadre of competent public health professionals with experience in governmental public health agencies. The entire appropriation supports the SUNY Albany School of Public Health, specifically tuition and internship support and other costs associated with strengthening the skills of the public health workforce.

Issues: None

Population Served: State and local health departments.

Performance Measures:

Healthy People 2010 goal:

- 23.10: Increase the proportion of Federal, Tribal, State and local public health agencies that provide continuing education to develop competency in essential public health services for their employees. In 07-08, one-third of local health departments in New York State participated in the Public Health Leaders of Tomorrow program.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Regional Epidemiology Program (REP)

Mandate: Public Health Law § 2100

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law and regulation mandates disease reporting requirements for 76 communicable diseases. The REP is responsible for investigating at least 46 of the 76 diseases, 15 of which are considered priority diseases, warranting immediate intervention. In addition, hospitals and nursing homes are required to report facility-acquired communicable diseases, outbreaks or increases in incidence of diseases.

All NYS physicians, laboratories, and health care facilities are required to report suspected or confirmed cases of communicable diseases, as well as any infectious disease outbreaks, clusters, or unusual or emerging diseases or syndromes. The program investigates and confirms reports and provides technical and epidemiological expertise local health departments, hospitals and nursing homes to find the source of infection and implement control measures.

Issues: The complexity and volume of disease reports has risen significantly. Since 2001, the number of nosocomial outbreaks increased over 40%. During 2006-07, the program responded to over 975 nosocomial reports and 75 large community outbreaks. There has also been an increase in reports of serious antibiotic resistant infection, requiring immediate attention.

Population Served: Community acquired infections: all NYS residents, exclusive of NYC. Nosocomial infections: all hospital inpatients and outpatients in 236 acute care facilities, residents of 654 nursing homes and over 500 adult and assisted living facilities.

Performance Measures: The Healthy People 2010 goal 14-6 is to reduce hepatitis A infection to 4.5 new cases per 100,000 population. New York's 2006 rate was 1.1 new cases per 100,000 population. The Healthy People 2010 goal 14-9 is to reduce hepatitis C to one new case per 100,000 population. The New York State rate in 2006, excluding New York City where data is not available, was .4 per 100,000 population.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: School Based Health Center (SBHC) Program

Mandate: New York Laws of 1994, Chapter 170 Section 402

Mandated Funding Level: None

Brief Description/History/Background: New York Laws of 1994 authorizes the Commissioner to establish, support, and provide improved and expanded school health services for pre-K and school aged children The SBHC program was established in 1978 to expand access to comprehensive primary and preventive physical and mental health services for youth in areas where these services are limited or nonexistent. Services are provided on-site at schools at no cost to families. Grants are provided to 52 of 59 Article 28 SBHC sponsors funding 147 of 213 extension clinic sites. SBHCs seek Medicaid/ third party health insurance reimbursement, and can bill Medicaid for eligible visits. SBHCs are paid by Medicaid fee-for-service outside of managed care rates. No Child Health Plus reimbursement mechanism exists.

Issues: None

Population Served: School aged children grades PreK-12 in high-need school districts statewide.

Performance Measures: SBHCs provide basic primary health care services to approximately 165,000 students through 213 SBHC clinics across the state. The Healthy People 2010 goal 1-4a is to increase the proportion of persons who have a specific source of ongoing care to 96%. The New York State rate was 85% in 2006.

Department of Health – Center for Community Health

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Issues: Repeated attempts to access Medicaid managed care and Child Health Plus reimbursement for children enrolled in SBHCs, whose families are plan members have been unsuccessful.

Population Served: School aged children grades PreK-12 in high-need school districts statewide.

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Sexuality Related Programs

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Established in 2003 as the only such health and wellness program for lesbian, gay, bisexual and transgender (LGBT) individuals in the nation, this initiative increases access to non HIV-related health and human services and improves health outcomes and quality of life for LGBT individuals, their families and support systems.

Issues: None

Population Served: LGBT individuals, families, adolescents through seniors statewide; many projects targeting high-need populations and communities.

Performance Measures: The Healthy People 2010 goal 1-4a is to increase the proportion of persons who have a specific source of ongoing care to 96%. The New York State rate was 85% in 2006.

Department of Health – Center for Community Health

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Hunger Prevention and Nutrition Assistance Program (HPNAP)

Mandate: Chapter 820 section 2598 of the Public Health Law

Mandated Funding Level: None

Brief Description/History/Background: HPNAP funds feed the poor and working poor including mothers, children and the elderly. In addition to providing emergency food, HPNAP's mission is to improve the health and nutrition status of people in need of food assistance. HPNAP funds provide nutrition education and nutrient dense low-fat foods including fresh fruits and vegetables and low-fat milk to address the obesity epidemic. Through HPNAP's Food Transportation Project, over 10 million pounds of nutritious food is transported from across the country to NYS at an extremely efficient cost to the state of about 3 cents per pound. Supplemental Nutrition Assistance Program (SNAP) funding is allocated to 49 HPNAP contractors and leverages over $200 million of other funding, donations and support to provide 125 million meals annually through 2,500 emergency food relief organizations (EFROs). These EFROs are primarily volunteer run, community based soup kitchens and food pantries. Most are located in or affiliated with churches and religious organizations. In response to rising food costs which makes it difficult for low-income New Yorkers to acquire healthy food items, HPNAP has mandated that emergency food assistance contractors purchase fresh produce and low-fat milk. Over $2 million is allocated annually for these food items; these funds are received by the local farm community. These successful policies along with establishing client selection of nutrient dense foods (Client Choice Project), and encouraging local purchasing and sourcing of food (Food Purchasing and Sourcing activities) support the Department's obesity and chronic disease prevention strategies as well as the Governor's Council on Food Policy which is actively pursuing better ways to feed people through local agriculture.

Contractors are regional food banks, the United Way of NYC, and other direct service contractors throughout the state. Over 2,500 soup kitchens and food pantries are supported by HPNAP contractors.

Issues: Funding not sufficient to address the extent of problem.

Population Served: HPNAP serves all low-income populations in NYS as well as those persons affected by disasters and in crisis.

Performance Measures:

HP 2010 Goals:

- 16-19 Increase the proportion of mothers who breastfeed their babies at 6 months of age to at least 50%. The New York State rate among Women,

Infant and Children (WIC) mothers was 35.5% in 2006. Among all mothers in New York State the rate was 50%.

- 19-5 Increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit to 75%.
- 19-6 Increase the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one-third being dark green or orange vegetables, to 50%.
  In New York State, 27.4% of adults consumed at least 5 servings of fruits and vegetables a day in 2007.

Department of Health – Center for Community Health

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  In New York State, 27.4% of adults consumed at least 5 servings of fruits and vegetables a day in 2007.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Special Supplemental Food Program for Women, Infants and Children (WIC)

Mandate: Public Law 95-627 Federal Child Nutrition Act,
New York State Public Health Law - Chapter 539

Mandated Funding Level: None

Brief Description/History/Background: WIC provides low-income pregnant, breastfeeding, and postpartum women, infants, and children up to age five with nutritious supplemental foods. The program also provides nutrition education and referrals to health and social services.

The WIC Program provides Value Enhanced Nutrition Assessments (VENA), replacing traditional nutrition education with client centered counseling with WIC mothers to assist them in making healthier food choices and increase physical activity for themselves and their families.

WIC staff encourage WIC moms to breastfeed their newborns through increased support utilizing peer counselors who are WIC mothers that receive special training from the WIC program.

Providers are 100 not-for-profit local agency contracts (local departments of health, hospitals, and community based organizations.

Issues: None

Population Served: The program receives funding from USDA and SNAP/WIC to provide services to over 500,000 women, infants and children each month. Thirty seven percent (37%) of WIC participants are Hispanic, twenty eight percent (28%) White; twenty eight (28%) African American and seven percent (7%) are Other. Participants receive their services at 530 WIC clinic sites operated by 100 WIC local agency providers under contract with the New York State Department of Health.

Performance Measures:

HP 2010 Goal:

- 16-19 To increase the proportion of mothers who breastfeed their babies at 6 months of age to at least 50%. The New York State rate among WIC mothers was 35.5% in 2006 and among all mothers the New York State rate was 50%.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: STD Center for Excellence (STDCFE)

Mandate: Public Health Law Article 23, Title 1 sections 2300 – 2311; Chapter 1 Part 1 of the State Sanitary Code

Mandated Funding Level: None

Brief Description/History/Background: The STDCFE at Montefiore Medical Center provides state-of-the-art, hands-on, clinical training on the diagnosis, management and treatment of STDs. Clinical training is provided to a diverse group of health care professionals, including physicians, physician's assistants, nurses, nurse practitioners, medical students, medical technicians, and armed services medics. Over 29,000 providers have been trained to date. The STDCFE also provides patient care in a South Bronx clinic serving primarily a Hispanic population. The STDCFE is a critically important resource to the community and the state in terms of clinical care, medical education, and quality assurance. The program evaluates and conducts quality assurance reviews of local health department STD clinics; and offers trainings for local public health providers.

Issues: Currently, STDs are on the rise in New York State. In 2007, a total of 38,092 cases of STDs including Chlamydia, gonorrhea and syphilis were reported in Upstate New York. This represents a 42% increase since 2001. Chlamydia has increased 79% since 2001; early (infectious) syphilis has increased nearly 800% from a historic low of 34 cases in 2000 to 302 reported cases in 2007.

Population Served: Training is provided to a diverse group of health care professionals. Patient care is provided to sexually active adults, ages 15-50. Minorities bear a disproportionate burden of STD morbidity when compared to the rest of the population

Performance Measures: Healthy People 2010 goal 25-2 is to reduce the incidence of gonorrhea in the general population to no more than 19 new cases per 100,000 population. New York's rate was 90.7 per 100,000 in 2006.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Tobacco Control

Mandate: PHL 1399 aa-mm.

Mandated Funding Level: None

Brief Description/History/Background: Tobacco use is the leading preventable cause of death in New York and the US. Each year, more than 25,000 New Yorkers die as a result of smoking and 570,000 New Yorkers suffer from serious smoking caused diseases, costing an estimated $8 billion in health care expenditures. Youth and adult smoking prevalence has declined since this program's inception, but more work needs to be done. There are 2.7 million smokers in New York (14% of New Yorkers) half of whom will die as a result of smoking, losing an average of 14 years of life. Funds are used to support evidence based tobacco use prevention and control activities in the following areas: Community Partnerships, Youth Action Programs , Tobacco Free Tribal communities Smoke Free Homes Initiatives , School Policy Programs Cessation Centers, Community Resource Center , Tobacco Dependence Treatment Programs , Tobacco-free mental health facilities Public Relations Resource Center, Center of Excellence in Tobacco Prevention , New York State Smokers Quitline, Nicotine Replacement Therapy , Promising Interventions , Training and Other Services , Health Communication Campaigns , Research and Evaluation , Consultant Services and Smoke Free Movies . Contractors include hospitals, Local Health Departments; BOCES; Diagnostic and Treatment Centers; professional associations; Cornell Cooperative Extensions; community based organizations; and research organizations.

CDC recently revised its recommendations for levels of state funding for Tobacco Control Programs, recommending New York invest $254.3 million annually, with a minimum investment of no less than $155.1 million and a maximum recommended funding level of $339.4 million.

Issues: New York raised its cigarettes by $1.25 in 2008, the highest in the nation. This increase is expected to motivate up to 100,000 adult smokers to quit and prevent more than 243,000 New York kids from starting to smoke.

Population Served: This program serves the entire population of the state, including smokers and non-smokers, youth and adults, those exposed to secondhand smoke and friends and family members of smokers.

Performance Measures:

HP 2010:

- 27.1a: Reduce adult smoking prevalence to 12%. The New York State rate was 18.2% in 2006.

- 27.2b: Reduce youth smoking prevalence to 16%. The New York State rate was 16.2% in 2005.

Prevention Agenda:
Reduce youth and adult smoking prevalence to 12%.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Tuberculosis NYC Hospital Directly Observed Therapy (DOT)

Mandate: Public Health Law 2202

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law 2202 mandates to local health departments and the City of New York (NYC), the responsibility of providing and securing tuberculosis (TB) services. The purpose of the DOT program is to address the high rate of TB in NYC through hospital based programs where community personnel observe the ingestion of medication by infected individuals.

Issues: TB incidence is increasing among foreign-born residents of New York State, from 30% of TB cases in 2003 to over 70% of reported cases in 2007. Foreign born clients have cultural, social, political, economic, and language issues not present in the typical American-born TB patient of the early 1990's. Federal has steadily decreased: most recently 17% decrease from 2007 to 2008. In 2008, Federal funds were reduced an additional 30%. Future Federal reductions are anticipated.

Population Served: Individuals living in NYC with TB who are uninsured, underinsured, and indigent.

Performance Measures: The Healthy People 2010 goal is to reduce the incidence of TB to one case per 100,000. The NYS rate was 6.2 per 100,000 in 2007. The number of TB cases decreased 74% from 1992 to 2007.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Tuberculosis NYC Hospital Directly Observed Therapy (DOT)

Mandate: Public Health Law 2202

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law 2202 mandates to local health departments and the City of New York (NYC), the responsibility of providing and securing tuberculosis (TB) services. The purpose of the DOT program is to address the high rate of TB in NYC through hospital based programs where community personnel observe the ingestion of medication by infected individuals.

Issues: TB incidence is increasing among foreign-born residents of New York State, from 30% of TB cases in 2003 to over 70% of reported cases in 2007. Foreign born clients have cultural, social, political, economic, and language issues not present in the typical American-born TB patient of the early 1990's. In 2008, Federal funds were reduced an additional 30%. Future Federal reductions are anticipated.

Population Served: Individuals living in NYC with TB who are uninsured, underinsured, and indigent.

Performance Measures: The Healthy People 2010 goal is to reduce the incidence of TB to one case per 100,000. The NYS rate was 6.2 per 100,000 in 2007. The number of TB cases decreased 74% from 1992 to 2007.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Zoonoses Program

Mandate: Public Health Law Title IV, Article

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law Title IV, Article 21 addresses the suppression of rabies by the local boards of health, exclusive of New York City, including the requirement for prompt investigation of reports of possible exposures to rabies. The Zoonoses Program's mission is to prevent the transmission of diseases from animals to humans and to minimize associated public health impacts, primarily the control and prevention of rabies. The program sets statewide standards for rabies prevention, provides guidance and consultation to Local Health Departments (LHDs) regarding exposure with the primary objective of preventing human rabies cases, conducts statewide surveillance of animal rabies cases and potential human exposure, and coordinates statewide health education campaigns. Reimbursement is provided to LHDs for expenses associated with rabies prevention, including the cost of human rabies treatment. The Department also vaccinates raccoons by dropping vaccination bait in key areas.

Issues:

- Public health professionals have found that unrecognized bat bites appear to be the leading cause of human rabies mortality in NYS and nationwide. This has prompted increased attention to and treatment for human exposure to bats.
- Raccoon rabies persists on Long Island and is threatening northern New York from Canada and Vermont.

Population Served: The residents of New York State

Performance Measures: In 2007, 3,400 humans received post-exposure treatment; the goal for counties to respond 24 hours a day to rabies concerns is met; and in 78% of human rabies treatment cases, the animals' rabies status is not determined.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Zoonoses Program

Mandate: Public Health Law Title IV, Article

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law Title IV, Article 21 addresses the suppression of rabies by the local boards of health, exclusive of New York City, including the requirement for prompt investigation of reports of possible exposures to rabies. The Zoonoses Program's mission is to prevent the transmission of diseases from animals to humans and to minimize associated public health impacts, primarily the control and prevention of rabies. The program sets statewide standards for rabies prevention, provides guidance and consultation to Local Health Departments (LHDs) regarding exposure with the primary objective of preventing human rabies cases, conducts statewide surveillance of animal rabies cases and potential human exposure, and coordinates statewide health education campaigns. Reimbursement is provided to LHDs for expenses associated with rabies prevention, including the cost of human rabies treatment. The Department also vaccinates raccoons by dropping vaccination bait in key areas.

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Counseling and Testing in Family Planning Clinics

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Family planning clinics currently provide HIV counseling services with a clinical recommendation for HIV testing to low income women at the time of initial and annual visits for family planning services. Efforts are made to increase access of this population to family planning and HIV services. Family planning settings, where large numbers of high-risk adult and adolescent women are seen for pregnancy tests and other gynecological services, have received little or no federal grant funding for the development of HIV services. Over 300,000 women are served annually by the initiative including high percentages of adolescents.

Issues: The AIDS Institute receives federal assistance under the Ryan White HIV/AIDS Treatment Modernization Act which requires a state match. The match requirement is $1 in state funds for every $2 of federal funding and is based on actual expenditures. Expenditures under this appropriation are used to meet the match mandate.

Population Served: Women at high risk for HIV statewide.

Performance Measures: All contractors are required to submit a work plan delineating the objectives to be met and the projected number of clients to be served during each contract period. Contractors are also required to submit monthly or quarterly reports detailing the objectives they have completed and the number of clients served during the reporting period.

This program helps NYS meet numerous HP 2010 goals, including 9-3, 9-4, 9-5, 9-10 (all related to decreasing rates of unintended pregnancy). NYS has significantly decreased the rate of adolescent pregnancy, and has been asked to share lessons learned with other states.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Cystic Fibrosis Program

Mandate: Public Health Law 2795

Mandated Funding Level: None

Brief Description/History/Background: Recent advances in the diagnosis and treatment of cystic fibrosis continue to reduce mortality from this disease. The median life expectancy for a person with cystic fibrosis is now 37, and many cystic fibrosis patients now reach middle age. Due to the high cost of medical care combined with expensive insurance premiums, many patients over the age of 21 are on public assistance and Medicaid. Employment can result in the loss of eligibility for Medicaid, while providing insufficient income to support the high cost of insurance premiums and uncovered medical treatment. The Adult Cystic Fibrosis Assistance Program exists to fill the medical care reimbursement gap that has prevented many cystic fibrosis patients from achieving their maximum employment potential.

Issues: Limited funding to address extent of the problem.

Population Served: Individuals 21 years and older diagnosed with Cystic Fibrosis who have resided in NY for at least 12 continuous months, must not be eligible for medical benefits under any group or individual health insurance policy and may not be eligible for medical assistance pursuant to title eleven of article five of the social services law solely due to earned income.

Performance Measures:

HP 2010:

- Increase the proportion of persons with health insurance to 100%. The New York State rate was 86.5% in 2006.

Prevention Agenda:

- Increase the percentage of adults with health care coverage.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Health Promotion Campaign

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: This initiative includes health campaigns which address prenatal care, colorectal cancer prevention, mammography quality, and risk behaviors which lead to disease. The goal of prenatal care health promotion is to increase the use of prenatal care among low-income women and teens by raising awareness of the availability of comprehensive, quality health care services through the Prenatal Care Assistance Program (PCAP). Eligible New Yorkers will be directed to contact the Growing Up Healthy Hotline (GUHH) for information and referrals to services in their communities. The colorectal cancer prevention health campaign will provide statewide physician Grand Rounds with continuing education credits focused on the etiology of colorectal cancer, benefits of early detection and methods of prevention, current screening guidelines, risk assessment, effective patient education and incorporating CRC screening into clinical practice. The mammography quality program will focus on improving mammography quality by providing continuing education for radiologists through the American College of Radiology and providing support for breast imaging fellowships for radiologists in association with the Council on Graduate Medical Education. The health promotion campaign will address the lifestyle changes that are needed to reduce the causes of cardiovascular disease, cancer, diabetes, asthma and obesity. Social marketing campaigns are an evidence based, population based intervention, to impact lifestyle choices such as smoking, unhealthy eating, physical inactivity and inadequate use of primary and preventive health services. This funding will be used for media to address these major behavioral risks. In addition a campaign addressing the safety and critical importance of childhood vaccines is to be aired.

Issues: None

Population Served: The prenatal campaign will serve women of reproductive age and their families. The colorectal cancer prevention program will reach clinicians who provide services to individuals with or at risk for colorectal cancer. The mammography quality campaign will reach clinicians serving individuals with or at risk for breast cancer. The health promotion campaign will serve populations disproportionally impacted by the leading causes of morbidity and mortality.

Performance Measures:

Prenatal Campaign:

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Healthy People (HP) 2010 and Prevention Agenda:

- 16-6 I Increase the proportion of women enrolling early in prenatal care to 90%. The New York State rate was 75.4% in 2005.

Colorectal Cancer Prevention Campaign:
HP2010:

- 3-12 Increase the proportion of adults aged 50 and over who receive colorectal cancer screening exams to 50%. The New York State rate was 63.9% in 2006.
- 3-1 Reduce the overall cancer mortality rate to 158.6 per 100,000. The New York State rate is 215.8 for males and 155.6 for females from 2001-2005.

Prevention Agenda:

- Reduce cancer mortality rate.

Mammography Campaign:
HP2010:

- 3-3 Reduce the breast cancer death rate to 21.3 per 100,000. New York State's rate was 26.1 from 2000-2004.
- 3-1 Reduce the overall cancer mortality rate to 158.6 per 100,000. The New York State rate was 215.8 for males and 155.6 for females from 2001-2005.

Health Promotion Campaign:
HP2010 Goal:

- 3-1 to reduce the overall cancer mortality rate to 158.6 per 100,000. The New York State rate was 215.8 for males and 155.6 for females from 2001-2005.

Prevention Agenda:

- To reduce the congestive heart failure hospitalization rate per 10,000 (age 18+ years) to 33.0. The New York State rate was 44.3 from 2005-06.
- To reduce asthma related hospitalizations per 10,000 to 16.7.The New York State rate was 22.2 from 2003-2005.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Legislative Member Items

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Legislative Member Items are directed to the department. The Center for Community Health staff process contracts for the contractors designated to receive the funds.

Organizations receiving funds are named in the appropriations, appropriation sub-schedules, or via Legislative Intent Forms (LIFs). LIFs are required in order to initiate contracts for the organizations.

A list of 08-09 member items is attached.

Academic Health Care Consortium	$500,000(GF-ATL)
AIDS Testing and Prevention Initiative	$575,000(GF-ATL)
Alice Hyde Medical Center	$300,000(GF-ATL)
Alzheimer's Association	$250,000(GF-ATL)
Alzheimer's Coordinating Council (SOFA sub allocation)	$50,000(GF-ATL)
American Red Cross	$496,700(GF-ATL)
American Red Cross	$1,000,000(GF-ATL)
Amyotrophic Lateral Sclerosis	$100,000(GF-ATL)
Arnot Ogden Medical Center	$250,000(GF-ATL)
Arthritis Foundation	$100,000(GF-ATL)
Brain Trauma Foundation	$200,000(GF-ATL)
Breast Cancer w/subschedule	$218,541(GF-ATL)
Catskill Area Hospice	$125,000(GF-ATL)
Catskill Regional Medical Center	$300,000(GF-ATL)
Center for Health Care Access	$135,000(GF-ATL)
Chernobyl Thyroid Cancer Screening	$540,000(GF-ATL)
Coalition for Community Well Being	$50,000(GF-ATL)
Coalitional for Inst. Aged and Disabled	$100,000(GF-ATL)
Community Blood Svcs Orange Co Bloodmobile	
Cortland Regional Medical Center	$125,000(GF-ATL)
Eating Disorders	$300,000(GF-ATL)
EI COLA	$16,700,000(GF-ATL)
Elizabethtown Hospital	$300,000(GF-ATL)
Ellenville Regional Hospital	$200,000(GF-ATL)
Glens Falls Hospital	$200,000(GF-ATL)
Good Samaritan Hospital	$500,000(GF-ATL)
Health Care Based Literacy	$100,000(GF-ATL)
Health Information Technology	$3,000,000(GF-ATL)
Huntington’s Disease Society	$50,000(GF-ATL)

Infertility	$1,000,000(GF-ATL)
Information Tech-Nursing Homes	$200,000(GF-ATL)
Latino Commission on AIDS	$150,000(GF-ATL)
Long Island Health Network	$100,000(GF-ATL)
Lymphatic Res Foundation	$100,000(GF-ATL)
Medical Homes Demo Program	$225,000(GF-ATL)
New York Organ Donor Network	$25,000(GF-ATL)
North County Health Care Providers	$300,000(GF-ATL)
North Shore LIJ Huntington Hospital	$250,000(GF-ATL)
North Shore LI Jewish Health Ret Vets Program	$200,000(GF-ATL)
Northeast Health Electronic Medical Records	$400,000(GF-ATL)
Northeast Health GPS Tracking-Home Care Svcs	$150,000(GF-ATL)
Northern Reg Fed Qual Comm Hlth Ctrs	$1,000,000(GF-ATL)
NY University College of Dentistry	$250,000(GF-ATL)
NY Wellness Program	$500,000(GF-ATL)
Nyack Hospital Foundation	$150,000(GF-ATL)
NYS Breast Cancer Network	$50,000(GF-ATL)
Perinatal Health Care Networks	$125,000(GF-ATL)
Potsdam-Canton Hospital	$250,000(GF-ATL)
Primary Care Devel Corporation	$525,000(GF-ATL)
Primary Care Physician Training	$200,000(GF-ATL)
Putnam Hospital Center	$500,000(GF-ATL)
Research Foundation/SUNY HIV Ctr. Women	$125,000(GF-ATL)
Rheonix Pilot Program/Wadsworth Lab	$200,000(GF-ATL)
Rome Hospital	$230,000(GF-ATL)
Rota Care	$50,000(GF-ATL)
Saratoga Hospital Foundation	$500,000(GF-ATL)
Schenectady Hlth Care Pract Vol Program	$350,000(GF-ATL)
School Based Health Clinics (w/subschedule)	$875,140(GF-ATL)
School Based Health Coalition	$50,000(GF-ATL)
Sexually-Related Programs (w/subschedule)	$2,048,300(GF-ATL)
Sexually-Related Programs(w/subschedule)	$375,000(GF-ATL)
Sexually-Related Program (w/subschedule)	$2,048,300(GF-ATL)
Sexually-Related Program (w/subschedule)	$375,000(GF-ATL)
St. Luke's Cornwall Hospital	$500,000(GF-ATL)
Taconic IPA, Inc.	$500,000(GF-ATL)
The Children's Annex/Autism Support Ctr.	$250,000(GF-ATL)
Universal Primary Care Center	$600,000(GF-ATL)
Village Care of New York	$750,000(GF-ATL)
Westchester Reg Emerg Services	$110,000(GF-ATL)

Issues: While the intent of this funding is laudable, in some cases, it is not used as one of the core functions of the agency. These programs are not required to be evaluated or to have goals and it can be difficult to determine effectiveness.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Population Served: Varies by member item.

Performance Measures:

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Prostate/Testicular Cancer Research/Education

Mandate: Motor Vehicle and Traffic Law 404 and State Finance Law 97CCC

Mandated Funding Level: None

Brief Description/History/Background: Funding comes from the Drive for the Cure license plate deposits made by individuals registering motor vehicles. Funds are used to purchase publications such as “Treatment Choices for Men with Early Stage Prostate Cancer.”

Issues: While the intent of this funding is laudable, it is not one of the core functions of the agency.

Population Served: 14,500 men are diagnosed with prostate cancer in New York State each year.

Performance Measures: This program is not evaluated or required to have goals and it is difficult to determine effectiveness.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Sudden Infant Death Syndrome (SIDS)

Mandate: Public Health Law 2500-b

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law requires the department to develop a program to study the sudden deaths of infants which are unexpected by medical history, and for which adequate causes of death have not been demonstrated. It stipulated that the program include epidemiological investigation, family counseling and evaluation. SIDS remains as a leading cause of death among infants between 28 days and 1 year of age. The African American population is disproportionately impacted. The program's dissemination of information regarding evidence based risk reduction measures has reduced the incidence of SIDS by 45% from 1997 to 2006. Continuous education statewide is needed to inform the new cohort of caregivers how to practice these important risk reduction measures. The New York State Center for Sudden Infant Death located at SUNY Stony Brook with subcontracted regional offices in NYC, Buffalo, Albany and Liverpool conducts significant risk reduction education to priority communities, agencies and professionals serving high risk families.

The SIDS program also provides bereavement counseling to families of deceased children via phone contacts, home visits, referrals to counseling services and support groups. SIDS staff and their subcontractors are members of 10 Office of Children and Family Services child fatality review teams (CFRT).

Issues: Economies of scale may be achieved by consolidating activity in the Office of Children and Family Services, also charged with review of child deaths.

Population Served: All pregnant women and individuals caring for infants; first responders to an infant death; families experiencing a sudden unexpected infant death.

Performance Measures: Survey data indicates, for the first time in recent history, that fewer mothers of infants are practicing critical risk reduction techniques. The federal Healthy People 2010 objective for this program is to reduce deaths from sudden infant death syndrome to 0.25 deaths per 1,000 births. The New York State rate was .24 deaths per 1,000 births in 2006.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Sudden Infant Death Syndrome (SIDS)

Mandate: Public Health Law 2500-b

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law requires the department to develop a program to study the sudden deaths of infants which are unexpected by medical history, and for which adequate causes of death have not been demonstrated. It stipulated that the program include epidemiological investigation, family counseling and evaluation. SIDS remains as a leading cause of death among infants between 28 days and 1 year of age. The African American population is disproportionately impacted. The program's dissemination of information regarding evidence based risk reduction measures has reduced the incidence of SIDS by 45% from 1997 to 2006. Continuous education statewide is needed to inform the new cohort of caregivers how to practice these important risk reduction measures. The New York State Center for Sudden Infant Death located at SUNY Stony Brook with subcontracted regional offices in NYC, Buffalo, Albany and Liverpool conducts significant risk reduction education to priority communities, agencies and professionals serving high risk families.

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Statewide Health Broadcasts

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Public Health Live - Third Thursday Breakfast Broadcasts (T2B2) is a series of satellite broadcasts produced by the University at Albany School of Public Health. The program provides continuing education opportunities to address the public health workforce's need for accessible ongoing education and training. The program addresses the current shortage of competent public health workers by developing accessible distance learning education on new and emerging public health issues. 100% of the appropriation is used for staff and production costs associated with the broadcasts.

Issues: Due to increased production costs and flat funding, the series is now offering 8 instead of 12 monthly broadcasts per year.

Population Served: Local public and community health professionals

Performance Measures: This program supports Healthy People 2010 goal 23-10 (developmental): Increase the proportion of Federal, Tribal, State, and local public health agencies that provide continuing education to develop competency in essential public health services for their employees. In 2008, 50% of local health departments participated in at lease one broadcast per year.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: American Red Cross

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The American Red Cross in New York State is comprised of 35 chapters and the New York-Penn Blood Services Region. For more than 100 years, the Red Cross has helped New Yorkers prepare for emergencies and has provided assistance when disasters strike and is the primary provider of blood products in 46 counties in the state. The ARC health and safety programs train citizens in life-saving skills including first aid, CPR and aquatics. ARC disaster services programs train citizens in basic disaster preparedness.

Issues: None

Population Served: Residents of New York State.

Performance Measures: ARC contracts include an agreed upon work plan. Progress reports are submitted with vouchers to NYSDOH describing the work accomplished against the work plan.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Breast Cancer Hotlines

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Contractor (Adelphi) provides information to callers about access to cancer services for men and women in the Metropolitan New York area.

Issues:

- These services are duplication of the services currently available through the New York State Department of Health, Bureau of Chronic Disease Services toll free number.
- This hotline is not available statewide.

Population Served: Residents of New York Metropolitan area

Performance Measures: HP 2010 – None; Prevention Agenda – None

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Human Services Program Cost of Living Adjustment – Center for Community Health

Mandate: Part C, Section 1 of Chapter 57of the Laws of 2006, as amended by Part I, Section 1 of Chapter 58 of the Laws of 2008.

Mandated Funding Level: None

Brief Description/History/Background: This funding provides a cost of living adjustment based on the U.S. consumer price index (CPI) published by the United States Department of Labor, Bureau of Labor Statistics for a particular budget year.

Issues: None

Population Served: Public health service providers listed in the statute and the range of populations served by those providers.

Performance Measures: None

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Human Services Program Cost of Living Adjustment – Office of Minority Health

Mandate: Part C, Section 1 of Chapter 57of the Laws of 2006, as amended by Part I, Section 1 of Chapter 58 of the Laws of 2008.

Mandated Funding Level: None

Brief Description/History/Background: This funding provides a cost of living adjustment based on the U.S. consumer price index (CPI) published by the United States Department of Labor, Bureau of Labor Statistics for a particular budget year.

Issues: None

Population Served: Minority health service providers to promote community strategic planning or new or improved delivery systems and networks.

Performance Measures: None

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Dor Yeshorim (Pre-marital genetic screening)

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: These funds support Dor Yeshorim (Committee for the Prevention of Jewish Genetic Diseases) to provide anonymous genetic testing to Orthodox and ultra-Orthodox (Chasidic) Ashenazic and Sephardic Jewish young men and women, prior to marriage, for genetic diseases prevalent in this ethnic group. These diseases include: Tay-Sachs disease, cystic fibrosis, Canavan Disease, familial dysautonomia, Fanconi Anemia type C, Bloom syndrome, Gaucher disease type I, mucolipidosis type IV, and glycogen storage disease type II. Dor Yeshorim is named in the appropriation bill.

Issues: The current contract is not yet executed. This organization was the subject of an audit that held up contract renewal until recently.

Population Served: 3,200 young men and women attending yeshivas (Jewish parochial schools) in New York State are screened annually.

Performance Measures: None

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Eating Disorders Program

Mandate: Public Health Law Article 27J

Mandated Funding Level: $ 1 Million (Public Health Law 2799-l)

Brief Description/History/Background: In 2004, legislation was passed requiring the Department of Health to identify Comprehensive Care Centers for Eating Disorders and fund the development of comprehensive models of care for individuals with eating disorders. Three hospitals were identified by the Department in April 2008.

Issues: Economies of scale may be achieved by consolidating activity in the Office of Mental Health.

Population Served: Residents of New York State with eating disorders (primarily young women, but the disorder occurs in both males and females of all ages). Approximately 13,100 units of service were provided in 2007.

Performance Measures: None

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Eating Disorders Program

Mandate: Public Health Law Article 27J

Mandated Funding Level: $ 1 Million (Public Health Law 2799-l)

Brief Description/History/Background: In 2004, legislation was passed requiring the Department of Health to identify Comprehensive Care Centers for Eating Disorders and fund the development of comprehensive models of care for individuals with eating disorders. Three hospitals were identified by the Department in April 2008.

Issues: Economies of scale may be achieved by consolidating activity in the Office of Mental Health.

Population Served: Residents of New York State with eating disorders (primarily young women, but the disorder occurs in both males and females of all ages). Approximately 13,100 units of service were provided in 2007.

Performance Measures: None

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Infertility Demonstration Program

Mandate: Public Health Law § 3 of Subdivision 1 of section 2807-v

Mandated Funding Level: Per PHL 2807-v, $5 million in 2008-2009.

Brief Description/History/Background: Public Health Law in 2002 directed the commissioner of health to develop a grant program to improve access to higher level infertility services such as in vitro fertilization (IVF). The program is required to be offered by at least one upstate and one NYC provider. All providers meeting volume and success standards, per federal Centers for Disease Control data, are offered contracts. Eligible families are insured and have exhausted their insurance benefits. Currently there are 16 providers participating. Services are paid on a sliding fee scale, with NYS paying the remainder of the providers' fees after patient contributions and insurance.

Issues: In vitro fertilization services average over $12,000 per cycle, and generally fewer than one cycle out of every three results in a live birth. IVF pregnancies are more likely to be high risk pregnancies, resulting in multiple births, low birth weight births, and preterm babies. Poor pregnancy outcomes have significant emotional and economic impact on families, and insurance costs, including Medicaid, which is available to a high proportion of very sick babies.

Population Served: Insured women 21-44 who are infertile and have exhausted lower level infertility services as well as any insurance funding that supports this service.

Performance Measures: All providers must deliver at least 100 cycles of IVF annually and meet success standards, per the federal Centers for Disease Control.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Infertility Demonstration Program

Mandate: Public Health Law § 3 of Subdivision 1 of section 2807-v

Mandated Funding Level: Per PHL 2807-v, $5 million in 2008-2009.

Brief Description/History/Background: Public Health Law in 2002 directed the commissioner of health to develop a grant program to improve access to higher level infertility services such as in vitro fertilization (IVF). The program is required to be offered by at least one upstate and one NYC provider. All providers meeting volume and success standards, per federal Centers for Disease Control data, are offered contracts. Eligible families are insured and have exhausted their insurance benefits. Currently there are 16 providers participating. Services are paid on a sliding fee scale, with NYS paying the remainder of the providers' fees after patient contributions and insurance.

Issues: In vitro fertilization services average over $12,000 per cycle, and generally fewer than one cycle out of every three results in a live birth. IVF pregnancies are more likely to be high risk pregnancies, resulting in multiple births, low birth weight births, and preterm babies. Poor pregnancy outcomes have significant emotional and economic impact on families, and insurance costs, including Medicaid, which is available to a high proportion of very sick babies.

Population Served: Insured women 21-44 who are infertile and have exhausted lower level infertility services as well as any insurance funding that supports this service.

Performance Measures: All providers must deliver at least 100 cycles of IVF annually and meet success standards, per the federal Centers for Disease Control.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Interim Lead Safe Housing

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The Interim Lead Safe Housing (ILSH) program was instituted in 1994 to provide temporary relocation of children with lead poisoning and their families while their homes are undergoing lead hazard remediation and abatement. In 2004, the declining use of ILSH resources prompted the Department to redesign the program and now resources are provided to local health departments (LHDs) to coordinate relocation services as part of the LHDs broader lead case management responsibilities. This model was successfully implemented outside of New York City.

Issues: ILSH housing in New York City is not consistently occupied. In 2006, 11 families accessed ILSH at Bushwick and 13 at Northern Manhattan. In 2007, 1 family accessed services at Bushwick and 17 at Northern Manhattan.

Population Served: Children to age 18 years and their families for the period of time that their housing is in the process of lead abatement

Performance Measures: The Healthy People 2010 goal 8-11 is to eliminate elevated blood lead levels in children. In New York State, excluding New York City, in 2001-2003, 1.7% of children under 72 months of age had confirmed blood lead levels greater than 10 micrograms per deciliter.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Maternity and Early Childhood Foundation (MECF)

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: This program was a legislative add dating back to 1998 that appeared in the Executive Budget in 2008. One community based agency (MECF) receives this funding, most of which is then awarded through a number of small grants to agencies across the state supporting prenatal and postpartum programs, primarily for low income women.

Issues: None

Population Served: Pregnant and postpartum women and infants.

Performance Measures: This program is not required to be evaluated or to have goals and it is difficult to determine effectiveness.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Nutrition Outreach and Education Program (NOEP)

Mandate: Chapter 820 section 2598 of the Public Health Law
Article 3-title 2 section 62 of Social Services Laws

Mandated Funding Level: None

Brief Description/History/Background: NOEP is dedicated to enrolling low-income New Yorkers into Food Stamps, Summer Food and School Breakfast programs. The mission of the NOEP is to fund community based organizations to provide outreach to eligible non-participants of federal nutrition programs and to assist them through the enrollment process, and to establish federal nutrition programs where they don't exist.

New York State funding is matched with funding from the United States Department of Agricultural (USDA) allowing dollar to dollar draw down of federal Food Stamp funding.

Issues: Economies of scale may be achieved by consolidating activity in the Office of Temporary and Disability assistance, under whose auspices the Food Stamp program and the local offices of social services operate.

Population Served: NOEP serves low-income communities in which incomes are up to 185% of the federal poverty household level.

Performance Measures.

HP 2010 Goals:

- 19-5 To increase the proportion of persons aged 2 years and older who consume at least two daily services of fruit to 75%.
- 19-6 To increase the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one-third being dark green or orange vegetables, to 50%.
  In New York State, 27.4% of adults consumed at least 5 servings of fruits and vegetables a day in 2007.
- 19-2 To reduce the proportion of adults who are obese to no more than 15%.
  The New York State rate was 22.9% in 2006.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: NYS Prostate Cancer Research, Detection and Education Fund

Mandate: State Finance Law Sections 95-E and 97 CCC

Mandated Funding Level: The state must match, on a 1:1 basis, all monies collected and deposited into the Prostate Cancer Research, Detection and Education Fund. Funding is available to the program through business and personal income tax donations, interest and the annual general fund transfer.

Brief Description/History/Background: Per statute, all funds must be contracted to The New York State Coalition to Cure Prostate Cancer. The Coalition will then make grants to support research, detection and education projects undertaken at institutions located in New York State.

Issues: While the intent of this funding is laudable, it is not one of the core functions of the agency.

Population Served: Research to ultimately benefit the approximately 14,300 New York State men diagnosed with prostate cancer annually.

Performance Measures:
This program is not evaluated or required to have goals and it is difficult to determine effectiveness.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Rape Crisis Services, Primary Prevention Initiative, and SAFE Initiative

Mandate: Public Health Law §695-b; Public Health Law § 2803 and 2805

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law authorizes the department to contract for the provision of rape crisis intervention and prevention services and mandates development of the Sexual Assault Forensic Examination (SAFE) program. Rape Crisis services provided by a statewide network of contractors include 24 hour hotlines, accompaniment of rape victims by trained volunteers, counseling services, outreach, and education. The program focus has changed in recent years due to a federal Centers for Disease Control (CDC) requirement that CDC funding, comprising over 50% of the programs' funding, be directed to primary prevention of sexual violence.

Issues:

- Federal funds for this program have been reduced.
- As CDC's focus has shifted to primary prevention, fewer dollars are available for victims' services.
- Victims' services, funded through state dollars, are similar to services offered by the Crime Victims Board (CVB) of the Division of Criminal Justice Services (DCJS). Economies of scale might be realized if the victims' services portion of this program were shifted to CVB.

Population Served: The program serves mostly women under the age of 25 for rape crisis services, though rape occurs to both women and men of all ages.

Performance Measures: The Healthy People 2010 goal 15-35 is reduction in rates of rape and attempted rape to .7 per 1,000 persons. Rape is underreported. For the 2006-2007 contract period, 169,936 individuals accessed services including hotline, crisis intervention, counseling, advocacy and accompaniment, referral and other services. 101,028 individuals participated in educational programs conducted by the programs.

Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

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Department of Health – Center for Community Health

PROGRAM INFORMATION SHEET

Program: Shaken Baby Syndrome

Mandate: Chapter 110 or 2006 – Penal and Public Health.

Mandated Funding Level: None

Brief Description/History/Background: Violently shaking a child can lead to traumatic brain injury, retinal hemorrhages, blindness, spinal injury, paralysis and death. In New York State, there were 29 shaken baby related hospitalizations and at least 3 deaths in 2005. This funding is used to support media awareness campaigns.

Issues: Economies of scale may be achieved by consolidating activity in the Office of Children and Family Services, where other child abuse prevention programs are supported.

Population Served: Parents with children under the age of 5.

Performance Measures:

HP 2010:

- Reduce deaths caused by unintentional injuries to 17.1 per 100,000. The New York State rate was 19.9 per 100,000 from 2003-2005.

Prevention Agenda:

- Reduce unintentional injury hospitalizations to 44.5 per 10,000. The New York State rate was 59.3 per 10,000 from 2003-2005.
- Reduce unintentional injury mortality rate to 17.1 per 100,000. The New York State rate was 19.9 per 100,000 from 2003-2005.

Agency Programs/Activities: Inventory and Key Data
Department of Health - Center for Environmental Health CEH

Page	Relation to Core Mission (H/M/L)	Program/Activity	Spending Category (SO, ATL, CAP)	3/31/09 FTEs (All Funds)	General Fund Disbursements ($000s)				State Special Revenue Funds Disbursements ($000s)				Capital Projects Funds Disbursements ($000s)			
					2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected
1	H	Water Supply Protection Program	ATL	0	5,595.9	5,859.9	6,086.8	6,086.8								
3	H	Tobacco Control Enforcement	ATL	0					5,707.0	5,768.0	5,800.0	5,800.0				
5	H	Childhood Lead Primary Prevention	ATL	0	-	69.0	-	-			2,674.4	2,674.4				
7	H	Healthy Neighborhoods Program	ATL	0	-	-	1,982.8	1,982.8	842.6	2,189.5	-	-				
9	M	OSH Training and Education	ATL	0	165.1	250.0	195.9	195.9								
10	H	Tobacco Control Enforcement	SO	22					776.2	915.9	1,122.2	1,122.2				
12	H	Food Borne Disease Control	SO	31	2,903.8	2,850.8	2,903.5	2,903.5								
14	H	Childhood Lead Poisoning Control	SO	6	571.2	560.8	571.2	571.2								
16	H	Recreational Sanitation & Safety	SO	17	1,618.5	1,589.0	1,618.3	1,618.3								
18	H	Drinking Water	SO	56	666.5	654.3	666.4	666.4	4,871.5	5,826.2	6,094.1	6,094.1				
20	H	Contaminated Sites	SO	82					324.1	286.4	301.1	301.1	7,207.2	6,351.7	7,155.8	7,155.8
23	H	Radiological Protection & Safety	SO	39					3,867.0	4,504.5	4,481.3	4,707.3				
25	H	Toxic Substance Assessment	SO	7	666.5	654.3	666.4	666.4								
27	H	Pesticide Registration	SO	3					237.4	183.2	251.0	251.0				
29	H	Environmental Epidemiology	SO	19	571.2	560.8	571.2	571.2	1,141.0	1,183.5	1,403.4	1,403.4				
31	H	Occupational Health Clinics	SO	4					5,910.8	6,766.7	5,939.6	5,939.6				
32	H	Healthy Neighborhood's Program	SO	5	476.0	467.3	476.0	476.0								
33	H	Occupational Health	SO	5	476.0	467.3	476.0	476.0								
35	H	Asbestos Safety Training	SO	6	190.4	186.9	190.4	190.4	417.2	467.0	481.5	481.5				
36	H	Clean Air Operating Permit	SO	5					674.8	668.2	599.6	599.6				
38	M	Tattoo and Body Piercing Regulation	SO	1	95.2	93.5	95.2	95.2								
39	M	Bottled / Bulk Water Facility Certification	SO	1	95.2	93.5	95.2	95.2								
40	M	Radon Detection Devices	SO	0					20.5	20.4	25.0	25.0				
41	M	Migrant Farm Worker Housing	SO	3	238.0	233.7	238.0	238.0								
42	L	Ultraviolet Radiation Device (Tanning) Regulation	SO	0												
43	M/L	Food Worker Training Certification	SO	0	-	-	134.7	134.7								
45	L	Certification of Water System Backflow Device Testers	SO	1	95.2	93.5	95.2	95.2								
46	L	Legislative (Environmental Health) Task Forces	SO	1	47.6	46.7	47.6	47.6								
47	L	Temporary Residences & Mobile Home Parks	SO	3	238.0	233.7	238.0	238.0								
		Center for Environmental Health Grand Total	ALL	315	14,710.5	14,965.0	17,348.6	17,348.6	24,790.2	28,779.4	29,173.3	29,399.3	7,207.2	6,351.7	7,155.8	7,155.8

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Water Supply Protection Program – Aid to Localities
[Drinking Water Protection Enhancement Program (DWE)]

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The DWE was established in 2000 to increase the capacity of 36 County Health Departments and the New York City Department of Health and Mental Hygiene (NYCDHMH) to oversee and implement the public drinking water system protection program, as well as conduct other activities that enhance the implementation of the drinking water protection program. DWE funds are utilized to investigate water borne disease outbreaks, eliminate public health hazards at impacted public water supplies, initiate enforcement actions to correct public health hazards, and monitor required public notifications. Environmental health staff employed by the county/city health departments conduct drinking water quality surveillance monitoring, assist water systems to create emergency response plans and improve system security, review drinking water operator credentials, and implement all new and existing drinking water programmatic and regulatory requirements. In addition, technical assistance is provided to public and non-public water systems in an effort to protect consumers of drinking water. Data are captured in an electronic database management system known as the Safe Drinking Water Inspection System and analyzed and evaluated for program performance. This database system was developed by the U.S. Environmental Protection Agency and Center Staff and is used to report to EPA activities funded in EPA's grant to New York and required by New York's Primacy Delegation.

Issues: Drinking water enhancement activities help the Department comply with a 100% match component for the Annual Federal Safe Drinking Water Act Grant the Department receives.

Population Served:

- 36 County Health Departments and NYCDHMH
- Public drinking water system consumers
- Water system operators

Performance Measures:

Annual deliverables include approximately 5000 sanitary surveys, 20,000 surveillance samples collected, 50 emergency responses, the review of almost 60,000 monthly

operation reports as well as the activities involving engineering plan review of capital improvements, consumer notification, operator training and certification, special sampling and transmittal of new regulatory requirements at approximately 10,000 water systems statewide.

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Tobacco Control Enforcement – Aid to Localities

Mandate: Public Health Law, Articles 13-E and 13-F

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law prohibits the sale of tobacco products, herbal cigarettes, rolling papers, or pipes to any individual under the age of 18. In addition the Adolescent Tobacco use Prevention Act was designed to reduce morbidity and mortality caused by tobacco use by reducing children's access to cigarettes and other tobacco products, thereby helping to keep them from starting the habit. The Clean Indoor Air Act (CIAA), enacted in 1975, prohibits smoking in all indoor public areas and workplaces. Funds are provided from the Health Care Reform Act, Health Care Services Act, and NYS Insurance Department to 36 local health departments, the NYC Departments of Health and Consumer Affairs to enforce the ATUPA and CIAA by conducting unannounced compliance checks using underage youth, educating facility operators, responding to public inquiries/complaints, initiating enforcement actions against violators, and reviewing CIAA waiver requests submitted by facility operators.

ATUPA - In New York, over 42,000 compliance investigations are conducted annually by local health department enforcement officials at approximately 25,000 tobacco retailers licensed to sell tobacco products. City and county staff are required to maintain an up-to-date inventory for registered and unregistered tobacco retail dealers and vendors (including cigarette vending machines) within their jurisdiction. At least one compliance check using underage youth (15, 16 or 17 years old) must be completed at each retail tobacco facility annually. The ATUPA uses a point system for facilities that sell tobacco products to minors. A six-month suspension of the operator's license to sell tobacco products (and Lottery License where applicable) is enforced upon accumulation of three or more points. Each retailer's enforcement and point history is tracked by local enforcement officials and by bureau staff on a statewide database. Increased frequency of inspections is required at facilities where a violation has occurred.

CIAA - Local enforcement officials are responsible for responding to verbal inquiries and/or complaints, and written correspondence from the public and regulated facilities. They are also responsible for distributing program guidance to facilities. Waivers from compliance with specific provisions of the CIAA may be granted where an applicant can demonstrate that compliance with a specific provision of the CIAA created an "undue financial hardship" or other factors exist that make compliance unreasonable.

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Issues: None

Population Served:

ATUPA - Underage youth
CIAA - NYS Citizens and visitors
County and City Health Departments
Facility operators

Performance Measures: Performance is measured by the number of inspections, compliance rate, enforcement actions taken, and penalties issued.

ATUPA - Current statistics (DOH's Annual Report dated October 1, 2006-September 30, 2007) indicate that in the last 10 years (1997-2007) the rate of non-compliance by retailers has declined from 19% to 7.6% statewide. Monitor non-compliance rates to determine if it is continuing to decline.

CIAA compliance is assessed based upon a six-month survey distributed to the counties requesting the number of complaints received, number of investigations conducted, number of enforcement actions initiated, amount of penalties issued, and waivers issued or rescinded.

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Childhood Lead Primary Prevention – Aid to Localities

Mandate: Public Health Law Sections 1370-a (3)

Mandated Funding Level: None

Brief Description/History/Background: Approximately 5,000 children are diagnosed with lead poisoning each year in NYS that could result in adverse health affects and substantial costs to the health care industry. An environmental investigation is prompted when a child's blood lead level exceeds a certain threshold. These investigations are designed to identify the source of the lead in the child's environment.

In April 2007, PHL was revised to add a primary prevention program in target areas of the state that have a high incidence rate for children with elevated blood lead levels to prevent the lead exposure from occurring. This program supports eight county and city health departments in the development of primary prevention plans and the implementation of a housing inspection and enforcement program. It will soon be expanded to an additional six counties. The housing inspection and enforcement program includes: prioritization of dwellings within target areas for inspections; inspection of high-risk dwellings for potential lead hazards; correction of identified lead hazards using effective lead-safe work practices; appropriate oversight of remediation work; and clearance by certified inspectors. The local health departments are responsible for inspection and oversight of lead remediation activities in targeted high-risk zip codes. In addition, collaborative partnerships with other local agencies and programs have been identified to assist property owners in lead remediation activities. The local health departments are developing and implementing lead safe work practices training for property owners, contractors, and residents, and promoting the development and use of a certified workforce for lead remediation activities.

Issues: Limited funding to address the extent of the problem.

Population Served: Children in targeted high-risk areas that are being exposed to lead in their home environments from deteriorating lead-based paint, lead contaminated dust, and lead contaminated residential soil.

Performance Measures: Monitor the number of children reported with elevated blood lead levels to determine if the rates are declining in order to assess the impact of the prevention efforts.

Determine the number of properties where lead hazards were remediated to monitor work plan compliance by the local health departments.

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Programs at seven county health departments and the New York City Department of Health and Mental Hygiene began in the fall of 2007; annual statistics will not be available until the end of 2008.

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Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Healthy Neighborhoods Program (HNP) – Aid to Localities

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Funds support thirteen local health departments in carrying out the Healthy Neighborhoods Program in their jurisdictions. The Healthy Neighborhoods Program was designed in 1985 to provide preventive environmental health services to targeted geographic areas in neighborhoods with a disproportionate number of residential hazards, usually occupied by low-income families and often minorities. Economically disadvantaged people often have less opportunity to improve their housing conditions and surrounding environment. Home assessments are conducted to provide interventions and preventive measures to achieve healthy homes. This primary prevention program has evolved from a housing sanitation, rodent control, and building code violation program to a healthy home assessment program that is the model used by the U.S. Centers for Disease Control and Prevention for the future of primary prevention activities. During home assessments, potential health hazards are identified, smoke/fire detector deficiencies corrected, carbon monoxide levels checked, lead conditions evaluated, asthma triggers identified, and indoor air quality evaluated including tobacco smoke and injury prevention issues are addressed. Improving home environments is a critical tool for improving public health. The more than 10,000 home visits conducted each year provide the opportunity to link the residents with other services concerning health care.

Issues: None

Population Served:

- Low-income families living in neighborhoods with a disproportionate number of residential hazards.
- Local Health Departments

Performance Measures: The U.S. Department of Health and Human Services (DHHS) "Healthy People 2010" states that "More than 6 million housing units across the country meet the Federal Government's definition of substandard housing." By 2010, the goal of the DHHS is to show a 52% improvement in reducing the proportion of occupied housing units that are substandard. HNP is designed to help eliminate substandard housing throughout the state and to create a healthier home environment for the citizens of New York.

Attachment C

Department of Health - Center for Environmental Health

PROGRAM INFORMATION SHEET

Performance is measured by the number of home assessments conducted, hazards identified and corrected, referrals for services, and follow-up visits.

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Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Occupational Safety and Health Training and Education

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The Occupational Safety and Health Education and Training program supports lead educational activities performed by industrial hygienists from the Mount Sinai School of Medicine, Irving J. Selikoff Center for Occupational and Environmental Medicine. This program offers consultations to unions, employers, workers and people from the community concerning lead exposures. The program benefits thousands of lead exposed and at risk workers to minimize, control or eliminate their exposure which helps prevent illness and save health care costs. Consultations by industrial hygienists are comprised of lengthy telephone interviews and/or actual employee or work-site evaluations, all of which are done at little or no cost. In addition, industrial hygienists present educational sessions at weekend screenings, teaching 60-100 workers per session. Finally, the program develops written educational materials for workers that can be widely disseminated.

Issues: None

Population Served: Workers, employers, and residents in the NYC metropolitan area with lead exposures or concerns.

Performance Measures:

Measure	Annual Result
Workers trained on health and safety topics	500
Respirator fit tests conducted	100
Education and information consultations	100

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Tobacco Control Enforcement

Mandate: Public Health Law, Articles 13-E and 13-F

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law prohibits the sale of tobacco products, herbal cigarettes, rolling papers, or pipes to any individual under the age of 18. In addition the Adolescent Tobacco Use Prevention Act (ATUPA) was designed to reduce morbidity and mortality caused by tobacco use by reducing children's access to cigarettes and other tobacco products. The Clean Indoor Air Act (CIAA), enacted in 1975, prohibits smoking in all indoor public areas and workplaces. Funds provided from the Health Care Reform Act, Health Care Services Act, and NYS Insurance Department support staff and program activities. Funds are provided to 36 local health departments, the NYC Departments of Health and Consumer Affairs to enforce the ATUPA and CIAA which includes: conducting unannounced compliance checks using underage youth, educating facility operators, responding to public inquiries/complaints, initiating enforcement actions against violators, and reviewing CIAA waiver requests submitted by facility operators.

Department staff are responsible for the implementation and oversight of the ATUPA and CIAA programs. Staff develop annual statewide work plans for the 36 county health departments, the NYC Departments of Health and Mental Hygiene and Consumer Affairs and monitor compliance checks that are performed at over 25,000 tobacco retailers. Staff oversee the necessary enforcement actions initiated as required under the law. Staff approve the statewide Tobacco Sales Training Program. Staff provide program data to the NYS Office of Alcoholism and Substance Abuse Services for compliance with the federally mandated Synar National Survey. Staff develop and provide educational materials to regulated facilities, monitor training provided to facility operators, and inform facility operators of new or updated amendments to the laws.

Issues: None

Population Served:

Owners of public work places
ATUPA - Underage youth
CIAA - NYS Citizens and visitors
County and City Health Departments

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Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Performance Measures: Performance is measured by the number of inspections, compliance rate, enforcement actions taken and penalties issued.

ATUPA - Current statistics (DOH's Annual Report dated October 1, 2006-September 30, 2007) indicate that in the last 10 years (1997-2007) the rate of non-compliance by retailers has declined from 19% to 7.6% statewide. Continue to monitor compliance to determine if the non-compliance rate is continuing to decline.

In 2007, there were approximately 1,800 registered retailers in 22 upstate counties covered by NYS Department staff, and 2,600 inspections were conducted. This resulted in a non-compliance rate of 2%.

CIAA compliance is assessed based upon a six-month survey distributed to the counties requesting the number of complaints received, number of investigations conducted, number of enforcement actions initiated, amount of penalties issued, and waivers issued or rescinded.

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Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Food Borne Disease Control

Mandate: Public Health Law, Subsections 225 & 201-1(m) and Section 1350

Mandated Funding Level: None

Brief Description/History/Background: Public Health Laws grant the Commissioner authority to inspect and supervise all public places in the state in which food is prepared, sold or served. Subparts 14-1, 14-2, 14-4, and 14-5 of the State Sanitary Code and equivalent county/city sanitary codes regulate over 90,000 food service operations in order to protect the health of the individuals eating at these facilities. Department staff are responsible for training and standardizing food safety inspection officers employed at 46 local health departments field offices and for coordinating the investigation of food borne disease outbreaks and other food related complaints and the removal of contaminated food products that have entered the food distribution system, and monitoring and for evaluating the food protection programs conducted by local health departments. Center staff also coordinate food protection related activities with Federal (Food and Drug Administration, Centers for Disease Control and Prevention, Department of Agriculture) and State (Agriculture and Markets, Environmental Conservation) partners. In addition, staff conduct food protection inspections for sites operated by the State Education Department as part of the Summer Nutrition Program and the State Office for the Aging (SOFA) for the Senior Nutrition Program to safeguard these high risk groups. Staff train local health departments in the monitoring of statewide nutrition sites for the elderly. Training sessions for food safety and sanitation are provided to project directors, site managers, cooks, and food preparation staff across the state. Sites are inspected for the proper food storage, preparation, and handling in an effort to identify and correct hazards which may result in illness.

This core public health program is consistent with the Department's mission to protect New Yorkers from disease and injury by monitoring the overall safety of the food served at regulated facilities. In addition, a statewide food borne disease surveillance system is established to monitor and investigate reports of illnesses that may be associated with improperly handled foods. The system is designed to work in cooperation with the Wadsworth Center for Laboratory and Research, Bureau of Communicable Disease Control, local health departments, public affairs and other state and federal regulatory agencies to rapidly detect and advise the public of an illness outbreak. When a contaminated food product is identified, information is shared with the food industry to have the contaminated product removed from the market, with the public to advise them of the problem and the need for medical treatment if appropriate, and with the medical community to advise them of the concerns and recommended procedures for responding to suspected case of illness.

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Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Issues: None

Population Served/Interested Parties:

- All citizens and visitors of New York State
- Food service establishment operators
- County and City Health Department staff
- State Education Department, State Office for the Aging, Department of Environmental Conservation, Agriculture and Markets

Performance Measures: Program outcome measures match national objectives stated in the U.S. Department of Health and Human Services (DHHS) “Health People 2010.” Objective 10-1, reducing infection caused by key food borne pathogens, and objective 10-2, reduce outbreaks of infection caused by key food borne bacteria, and tracked by the surveillance system and are core performance measures of the program. During the years 1980-2005, the surveillance system reflected the investigation of over 2,600 outbreaks of food borne disease in NYS, involving over 55,000 cases of illness, 1,745 hospitalizations and 44 deaths.

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Childhood Lead Poisoning Control

Mandate: Public Health Law Sections 206(1)(n) and 1370-1375 (Title X)

Mandated Funding Level: None

Brief Description/History/Background: In 1970, PHL Title X authorized a lead poisoning control program to establish and coordinate activities to prevent lead poisoning and to minimize risk of exposure to lead. The program goal is to protect children from lead exposure in their environment. Prolonged exposure to lead is associated with a range of serious health effects in children, including detrimental effects on behavioral development with serious personal and social consequences that may persist throughout their lifetime. Children six years of age and under are at highest risk of being exposed to lead in their home environments from deteriorating lead-based paint, lead contaminated dust, and lead contaminated residential soil.

Approximately 5,000 children are diagnosed with lead poisoning each year in NYS that could result in adverse health affects and substantial costs to the health care industry. An environmental investigation is prompted when a child's blood lead level exceeds a certain threshold. These investigations are designed to identify the source of the lead in the child's environment. In April 2007, a primary prevention program was established to target areas of the state that have a high incidence rate for children with elevated blood lead levels to prevent the lead exposure from occurring.

Staff are responsible for providing technical guidance and training to the local health departments (LHDs), developing department regulations and procedures, monitoring program activities, and conducting program audits for adherence to program guidelines. Staff assist in the development and management of LHD contracts, review work plans and budgets, monitor work plan activities and review quarterly progress reports for adherence to work plan deliverables. Staff evaluate exposures to identify possible health risks of childhood lead poisoning in the home environment. Staff evaluate data on the use of lead in toys, jewelry, novelty items and other consumer products in an effort to identify, restrict, and eliminate the non-essential use of lead. Staff develop and implement strategies to reduce people’s exposure to lead from these sources. A toll free hotline will create a communication link with the public. Staff provide information to the public on lead safety, lead hazard control, and lead poisoning. In addition, outreach and education efforts are developed for targeted audiences, focusing on exposure to lead-based paint and dust.

Issues: Limited funding to address the extent of the problem.

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Population Served: Children to age 18, with an emphasis on high-risk children up to age six.

Consumers of toys, jewelry, novelty items and other products that are purchased with the expectation that the product is free of lead.

Performance Measures: In 2007, 3,872 children under age 6 years were diagnosed with lead poisoning (defined as blood lead level greater than or equal to 10 mcg/dL) in New York State, down nearly 60% since a decade ago. 83% of children born in NYS in 2004 were screened for lead at least once by age three, but only 41% were screened twice by age three. The Healthy People 2010 goal 8-11 is to eliminate elevated blood lead levels in children under age 6.

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Program: Recreational Sanitation and Safety

Mandate: Public Health Law Sections 201.1(m), 225(5)(a), 225(5)(o), 1340 and 1391

Mandated Funding Level: None.

Brief Description/History/Background: PHL requires the Department to protect the health, safety and welfare of children attending day and overnight camps. Annually, it is estimated that 650,000 children attend approximately 2,600 children's camps in NYS. Center staff coordinate a permit and inspection program with 36 local health departments, the NYC Department of Health and Mental Hygiene, and the Department's nine district offices. The PHL mandates two inspections per year per camp. Department staff train and standardize local health department personnel. The Department also investigates certain reported injuries, illnesses, exposures to rabid animals, and abuse allegations. Staff monitor the mandated screening of camp directors against the State Central Abuse and Maltreatment Register, and State Sex Offender Registry for other staff. The PHL established the State Camp Safety Advisory Council to advise and consult with the Department on matters relating to youth camp safety.

PHL requires the Department to protect the health, safety and welfare of the public while swimming at regulated pools and beaches and while using spray ground facilities. There are approximately 6,400 pools, 45 spray grounds, and 1,300 public bathing beaches throughout NYS which millions of people frequent each year. A permit and inspection program is coordinated with 36 local health departments, the NYC Department of Health and Mental Hygiene, and the Department's nine district offices. Engineering plan reviews are required for new construction. The majority of the inspections occurs during the summer season but numerous pools and spray ground facilities operate year round. Staff are responsible for the investigation of any reported illnesses or injuries occurring at these facilities.

PHL and State Sanitary Code also requires a permit and inspection program for the approximately 6 mass gatherings, 922 campgrounds, and 52 agricultural fairgrounds in an effort to protect the public at these recreational settings. The Department is required to coordinate the permit and inspection program with 36 local health departments, the NYC Department of Health and Mental Hygiene, and nine district offices. The sanitary code has specific requirements for the operation of a mass gathering to provide safe water, food, emergency medical care, overnight accommodation, and transportation of individuals attending these events. These events are expected to draw more than 5,000 people for 24 hours or more. While the number of events is relatively few each year, the planning is very labor intensive. Campgrounds and agricultural fairgrounds are

inspected each year to verify that the water supply, food, and overnight accommodations are in compliance with the Sanitary Code.

Issues: None

Population Served:

- Facility operators
- Children between the ages of 3-17 years old from NYS and the rest of the country attend camps. It is also common for international campers to attend. The regulated bathing facilities are visited by millions of bathers of all ages. The mass gatherings, campgrounds and agricultural fairgrounds are visited by millions of individuals of all ages.
- Local Health Departments

Performance Measures: Program outcome measures match National objectives stated in the US "Healthy People 2010" specifically objectives 15-29 "To reduce drownings." This measure is tracked by maintaining an injury surveillance system and database, investigating all drowning deaths at regulated bathing facilities, analyzing data from the data base and surveillance system and developing and implementing intervention strategies based upon the analysis.

The incidence of drowning deaths in NYS has been maintained at less than 0.82 per 100,000 population.

Program performance is measured by the number of: inspections conducted, engineering and safety plan reviews performed, and permits issued. In addition, program effectiveness is evaluated by reviewing the number of reported illness outbreaks, injuries, and deaths that are associated with the use of these recreational venues.

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Program: Drinking Water

Drinking Water Program – Compliance
Drinking Water Program – Drinking Water State Revolving Fund

Mandate: Public Health Law Sections 201.1(L) and 225 (5)(a)

Mandated Funding Level: None

Brief Description/History/Background: DOH oversees the delivery of drinking water so that it is suitable for consumption. The Department also coordinates the regulation of the operation, design and water quality of public water systems and water source protection activities; reviews and approves engineering plans for proposed water system improvements and realty subdivisions, and sets standards for design of individual water wells and individual on-site wastewater systems (septic systems).

The DWSRF program, created in 1996, provides financial assistance for municipally and privately-owned public water systems to undertake needed drinking water infrastructure improvements. Since its first loan in December 1997, the DWSRF program has provided more than $2.3 billion in financial assistance to over 600 projects statewide. The criteria for funding projects that apply for assistance is based on protecting public health, with those public water system projects addressing compliance issues and threats to public health receiving top priority. An annual application for a federal capitalization grant is made to EPA, with a minimal amount of the award used for staffing and programmatic needs and the majority of the award used to provide the financial assistance to infrastructure projects. To date, DOH has received 11 awards totaling over $576 million. Federally mandated state matching funds of 20% for each capitalization grant are currently provided by monies from the 1996 Clean Water/Clean Air Bond Act. Also, federally mandated state matching funds of 100% for Program Management are provided through in-kind services from the State's Drinking Water Enhancement program.

Data are captured in an electronic database management system known as the Safe Drinking Water Inspection System. Data is analyzed and evaluated for program performance. This database system was developed by the U.S. Environmental Protection Agency and Center Staff.

Issues: Despite program successes, providing greater than $2.3 billion in financial assistance to over 600 projects since 1997, significant improvements are needed to the aging drinking water infrastructure in New York.

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Population Served: Nearly ninety-five percent of all New Yorkers receive water from public water systems. Public water systems range in size from New York City, the largest engineered water system in the nation serving more than nine million people, to small municipally-owned water supplies or privately-owned water supply companies, to schools with their own water supply, to small stores in rural areas serving customers water from their own wells. In total, there are over 10,000 public water systems in New York State.

Performance Measures: Program outcome measures match National objectives stated in the U.S. Department of Health and Human Services (DHHS) "Health People 2010", specifically objective 8-5 to "increase the proportion of persons served by community water systems who receive a supply of drinking water that meets the regulation of the Safe Drinking Water Act. This measure is tracked by comparing the percentage drop in the number of community water systems with either pubic health hazard violations cited or maximum contaminant level violations cited from year to year. Similarly DHHS objective 8-6 – "Reduce waterborne disease outbreaks arising from water intended for drinking among persons served by community water systems," serves as a program performance measure. Such outbreaks are extremely rare in NYS.

One of the program's best measures is determination of the percent of community water systems that provide drinking water that meets all applicable health-based drinking water standards. EPA national target level of 91%. In New York, no bacteriological contamination was detected in 97.7 percent of systems, and no public health hazards occurred in 96.9 percent of systems. Systems were also able to provide water meeting both contaminant and treatment requirements 94.9 percent of the time.

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Program: Contaminated Sites – Site Investigation and Remediation (Superfund), Brownfield Cleanup Program and Emergency Oil Spill Program

Mandate: Public Health Law, Article 13, Title XII-A; Environmental Conservation Law, Article 27, Titles 9, 13 and 14, and Article 56, Title 5; Comprehensive Environmental Response, Compensation and Liability Act (CERCLA), 42 U.S.C. Sections 9601 and 9604; Navigation Law Section 177-a; and Public Health Law Section 206

Mandated Funding Level: None

Brief Description/History/Background:

The Program has four components:

- Identifying how and how much people might be exposed to contamination (in the past, present, and future) and reducing or eliminating the exposure (environmental exposure investigations and interventions),
- Identifying the potential health impacts associated with any possible exposures (risk assessment),
- Assessing the health status of people with possible exposures, studying possible health effects from that or similar exposures (environmental epidemiology) and providing medical consultations to physicians of those possibly exposed, and
- Providing information about possible exposures, possible health impacts, and health status or studies (outreach and education).

The four components provide an integrated approach for providing a health response from contaminated sites.

<u>Environmental Exposure Investigations and Interventions</u>

This component assures that investigations of contaminated sites, whether done by the state or the entity responsible for the contamination, provide data appropriate to evaluate human exposures. These data are necessary from a health prospective to mitigate any possible past, existing or future exposures and to estimate the magnitude of any exposures so that the possible health impacts can be identified. Environmental testing must identify all possible pathways of potential exposure, including to any media (e.g. air, water, soil, food, etc.) by any route of exposure (breathing, eating or skin contact). The data are then used to assess the nature and magnitude of past, existing or potential exposures. Recommendations are made to the Department of Environmental Conservation on specific actions required at contaminated sites to

eliminate or minimize human exposure. Staff also oversee the implementation of site specific health and safety plans to minimize exposure of nearby community members during cleanup efforts.

The Contaminated Sites Program also includes petroleum spills. More than 15,000 petroleum spills occurred in New York State in 2007. These spills present somewhat different issues than other contaminated sites in that an immediate response is often necessary to protect public health. When a spill occurs, staff assess possible health risks to people residing in the area of the spill, respond to citizens' requests to be relocated during spill cleanups (through the legislatively mandated petroleum spill relocation network), and evaluate the adequacy of spill cleanup efforts.

Risk Assessment:

Health risk assessment is used to determine the nature and magnitude of the health risk from a contaminated site. When people were, are or maybe exposed to a contaminant, the types of health effects that it can cause are identified. In addition, how much of the contaminant causes those health effects is also determined. Department of Health (DOH) also develops chemical specific cleanup standards and guidelines that the Department of Environmental Conservation included in its 2006 "Environmental Remediation Programs" regulation, as required by amendments to the Environmental Conservation Law. These soil cleanup objectives differ by land use (i*.e.,* unrestricted, residential, restricted residential, commercial and industrial) since possible human exposures differ by land use. These soil cleanup objectives will be updated every five years as required by the Environmental Conservation Law.

Environmental Epidemiology:

DOH conducts health outcome studies for people who were, are or may be exposed to contaminants a site. Environmental data used to evaluate human exposure and human health risk, guide decisions on designing and carrying out human health studies. Community input is also sought in designing studies. Health studies may include community-wide evaluations of existing data from the Department's childhood blood lead registry, birth certificate data, congenital malformations registry, cancer registry, hospital admissions data (which includes asthma and other diseases related to environmental exposure) and other sources. In certain circumstances we do in-depth analyses that require gathering information about individual exposure histories or health problems. In some situations, DOH gathers biological samples from individuals so we may better understand exposures or as part of analytic studies of exposures and health effects. In addition, medical staff consult with private physicians to help them address the concerns or health consequences of their patients.

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Outreach and Education:

The health issues associated with contaminated sites can be difficult to explain to a community. Expertise and plans for interacting with the community are essential. Public meetings are held throughout the State near contaminated sites to discuss health issues with local citizens. Letters explaining the possible health consequences of sampling results are sent to residents in affected communities. Fact sheets are developed to provide information to citizens and health care professionals about the nature of contaminants at sites, potential health effects, ways of preventing or minimizing exposure to contaminants and the design and results of health studies.

Issues: Limited funds to address the extent of the problem.

Population Served:

Residents throughout the State benefit from the health assessment and monitoring of contaminated sites or spills, cleanup activities and other public health interventions. During the investigation and cleanup process, the Department of Health works closely with the party responsible for the contamination.

Performance Measures:

In the last fiscal year, DOH was involved at over 700 sites. During the year over 1300 specific recommendations were made to eliminate or reduce exposures and 242 recommendations were made that defined site clean up requirements at contaminated sites. These recommendations were based on environmental investigations and risk assessment. DOH provided health information to over 4000 people and provided responses to 50 medical inquiries. DOH sent letters to 741 individuals, explaining the health implications of test results. Twenty-two reports on environmental exposure investigations and interventions and risk assessments were completed in addition to completing five environmental epidemiologic investigations.

In 2007 DOH investigated 375 petroleum spills, resulting in 22 relocations of 85 people because of unacceptable exposures.

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Program: Radiological Protection and Safety – Radiological Health Protection Program and Low-Level Radioactive Waste

Mandate: Public Health Law Sections 201 and 225, Articles 24-C, Section 2485 and Article 35; Public Health Law, Article 35; US Atomic Energy Act, 42 U.S.C. Section 2011; Chapter 673 of the Laws of 1986 (New York State Low-Level Radioactive Waste Management Act of 1986)

Mandated Funding Level: None

Brief Description/History/Background: The Bureau of Environmental Radiation Protection carries out activities designed to protect the public from exposure to radiation sources that occur in the environment or that are used in medical, industrial/commercial and/or educational facilities in NYS. Bureau employees are responsible for registering and inspecting approximately 10,700 x-ray facilities; regulating the transfer, receipt, possession, use and disposal of radioactive materials at approximately 1,200 facilities; licensing and registering 16,500 radiologic and radiation therapy technologists; and overseeing radiologic technology schools in NYS. Additionally, employees respond to radiological incidents and accidents, including medical misadministrations, and ensure proper follow-up and the implementation of corrective actions. The Bureau's regulatory activities are funded through the Radiological Health Protection Program Account. Funds are generated through fees paid by the regulated facilities.

The NYS Low-Level Radioactive Waste Management Act of 1986 directed the Department to develop an educational program. Information and education on the public health and safety implications of low-level radioactive waste management are essential for the general public to participate and have meaningful input in the process of selecting a site and disposal methodology. The Act gave the Department the responsibility for the education program that includes a basic explanation of the types of materials that make up the waste, why the material needs special handling and care, and information on alternative disposal methods and their probable effects. The program continues to maintain public information materials and an updated document repository.

Additional security requirements that were established by the federal Nuclear Regulation Commission after September 11, 2001 have resulted in an increase of inspections and licenses. The Department has also been involved in development of a program for the detection of illegal radioactive sources.

Issues: As allowed by the Low-Level Radioactive Waste Policy Act of 1985, some states have formed regional compacts and can exercise the right to exclude New York State's radioactive waste. For several years, only the Barnwell Facility in South

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Carolina was available to New York State waste generators. Effective July 1, 2008, this facility is no longer accepting waste from NYS.

Population Served: All residents of NYS benefit from the protective activities of this program. Patients who have x-rays or radiation treatments along with the facilities that use radioactive materials or radiation producing equipment are directly served through the inspection and licensure activities. Further, security of radioactive materials is a key component of the State's anti-terrorism efforts.

Education regarding radioactive materials and waste is beneficial for all State residents. Emphasis is placed on educating residents who live near contaminated sites and sites proposed for the eventual location of a disposal facility.

Performance Measures:

Measure	**Annual Result**
Number of radioactive materials facilities inspected	392
Number of x-ray facilities inspected	574
Number of radiologic and radiation therapy technologists licensed	1275
Number of responses to radiological incidents and accidents including medical misadministrations	43

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Program: Toxic Substance Assessment

Mandate:

- Public Health Law Sections 201(1)(g), 201(l), 201(1)(n), 206(1)(a), (d) and (j), 225(5)(a), 1100(1).
- Safe Drinking Water Act, 42 United States Code §300(f), *et seq*.
- Comprehensive Environmental Response, Compensation and Liability Act, 42 United States Code §9604(i)(15).
- Environmental Conservation Law Section 11-0325(1) and 33-0303

Mandated Funding Level: None

Brief Description/History/Background: Program staff assess potential human health risks from toxic substances and non-infectious biological agents in air, water, soil and consumer products (including food). Assessments are used for regulatory programs and policy recommendations (e.g. mold, algae). Examples of the kinds of exposures evaluated include chemicals found in fish, oil and hazardous materials spills, and chemicals in soil, water, and consumer products. For example, in response to chemical spills (*e.g.*, mercury spills in schools), program staff may conduct on-site investigations to assess whether a public health threat exists, recommend decontamination/cleanup measures and meet with the public to answer questions they may have. Some examples include assessment of health risks to children due to lead in jewelry/toys; health risks due to contaminants in food, drinking or bottled water, or soil; and in products such as skin creams, alternative medicines, or dietary supplements. Staff procures, calibrates and maintains sampling equipment to use for investigations and emergency response. Program staff routinely provides the public, other offices within the Department, local health units and other state agencies with information and recommendations addressing environmental human health issues. The Program also provides the public with timely, accurate, and objective information about the public health risk potentially posed by environmental contaminants so that informed decisions about their own health can be made.

In addition to state general purpose funds, the core capacity of the program is substantially supported by special revenue other funds (State Superfund, Brownfields, Oil Spill Relocation, Clean Air Operating Permit, Safe Drinking Water), federal grants and special revenue federal funds (the Cancer Mapping Improvement Initiative, Preventative Health and Human Services, Agency for Toxic Substances and Disease Registry and Hazardous Substances Emergency Events Surveillance).

Issues: None

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Population Served: All New York State residents.

Performance Measures:

Measure	**Annual Result**
Sportfish Consumption Advisories Circulated	1.2 million
Educational Materials Developed for Specific Toxic Substance Issues	10
Responses to Toxic Substance/Health Related Inquires	500
Environmental Public Health Training	650 building code enforcement officials trained on mold contamination
Investigations and Human Health Risk Evaluations Conducted	100

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Program: Pesticide Review Program

Mandate: Environmental Conservation Law §33-0303 and Public Health Law §206(1)(a), (d) and (j)

Mandated Funding Level: None

Brief Description/History/Background: All pesticides that are used, distributed or sold in NYS must be registered by the Department of Environmental Conservation (DEC). The Department assists the DEC in this program by assessing the potential public health impacts of pesticides and making recommendations about registration to the DEC. In 1992, Environmental Conservation Law (ECL) Article 33 was amended to ensure that pesticide registration reviews were conducted in a timely manner. In addition to the mandated activities of the pesticide registration program for evaluating candidate products, DOH assists DEC in evaluating for possible regulatory action those currently registered pesticides that pose risks of particular concern. DOH also assists in the development of public education materials aimed at reducing risks posed by both pesticides and pests. Additionally, DOH supports DEC in rule making actions.

The pesticide registration program assesses whether pesticides registered in the state can be used for their intended purpose without posing unreasonable risks to workers and the general public. Pesticides evaluated by the DOH include products used to control important insect/tick-borne diseases (*e.g.*, Lyme disease, West Nile virus, Eastern Equine Encephalitis virus), prevent infections (*e.g.*, human immunodeficiency virus (HIV), methicillin-resistant *Staphylococcus aureus*) in critical settings and control invasive species. In addition, many of the pesticides evaluated are products important to sustain agriculture in the state, and to control nuisance vegetation in waterways, power lines and railroad/vehicular rights-of-way.

Apart from registrations, DOH is involved in other pesticide-related activities. For example, DOH receives numerous inquiries from the public on pesticides. While the subject of these inquiries can be broad, they often center on concerns for lawn care pesticides, insect repellents and sanitizers and disinfectants. DOH pesticide registration staff also assists in evaluating pesticide exposure cases reported to the Department's Pesticide Poisoning Registry.

The Department enters into a three year memorandum of understanding (MOU) with DEC (reauthorized in July 2008) to delineate the responsibilities of both parties in implementing the 1992 amendments to the ECL. Funds are sub-allocated from DEC to support three positions to carry out the department’s responsibilities under the MOU.

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Issues: None

Population Served: The population served by the registration program include all state residents who use pesticide products (both professional applicators and homeowners) as well as others who may be affected by pesticide use. The program also serves those in agriculture, both the farmers and farm workers. Additionally, the program assists state, county and local governments in issues regarding pesticides. Pesticide manufacturers and registrants also are served by the timely and thorough reviews and registration decisions provided by the registration program.

Performance Measures:

Measure	**Annual Result**
Timeliness of Pesticide Product Reviews-Meeting Statutory Time Frames	100%
Number of Pesticide Product Reviews	87
Registration Requests Modified or Denied based on Public Health Concerns	17
Pesticide Educational Materials Developed	6
Responses to Pesticide Related Inquiries	150

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Program: Environmental Epidemiology

Mandate:

Emergency Response to Incidents of Environmental Contamination Affecting Public Health:
Public Health Law 210(1)(n), 206(1)(a), (d), (j) & 1389-b
Health Advisories:
Public Health Law 206(1)(a), 201(1)(g)
Health Studies:
Public Health Law 201(1)(n)
Environmental Disease Registries:
Public Health Law 225(5)(t), 206(I)(j)
Superfund Health Studies & Health Assessments for ATSDR:
Public Health Law, Article 13, Title XII-A, Environmental Conservation Law, Article 27, Titles 9&13, CERCLA, 42 U.S.C., 9604(i)(15), 42 U.S.C., 9604(i)(1)(E), 9604(i)(7), 9604(i)(8), 9604(i)(9)
Brownfield Sites:
Environmental Conservation Law, Article 27, Title 14

Mandated Funding Level: None

- **Brief Description/History/Background:** This program focuses on the human health side of environmental issues. The program had its origin in response to the discovery of Love Canal and the creation of the Federal and State Superfund programs. Program staff study, monitor the health status and characterize the risks of exposure to toxic substances at home, at work, and in the community and evaluate the health effects. Epidemiological methods are used to identify and measure the influence of environmental factors on human disease in the community. The program is engaged in health, exposure, and surveillance studies, creating and maintaining registries for Congenital Malformations (CMR) and Volatile Organic Compounds (VOC), and public education regarding exposure and health risks. The CMR is used to identify and investigate unusual patterns of birth defects throughout NYS and study suspected causes. The VOC registry is used to study adverse health effects in individuals and families who have been exposed to volatile organic compounds.

The Environmental Epidemiology Program is primarily supported by several special federal and state revenue funds including State Superfund, Brownfields, the Cancer Mapping Improvement Initiative, Maternal and Child Health Services (MCHS), and Environmental Public Health Tracking (EPHT). In addition, this program currently receives approximately $3.7 million in grant awards annually from several Federal Agencies including the Centers for Disease Control and Prevention (CDC), Agency for

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Toxic Substances and Disease Registry (ATSDR), National Institute for Health (NIH) and the Environmental Protection Agency (EPA). These federal funds support 31 Department staff.

- **Issues:** None

Population Served: Communities, general public, NYS residents, NYS women & children, scientific research community, expert advisory panels, environmental advocacy groups, state and local government agencies, and special interest groups.

Annual Performance Measures:

Measure	Annual Results
Studies and Investigations Completed	10-15
Reduction in the Birth Prevalence of Neural Tube Defects in NYS	TBD
Informational Communication to Families of Children with Birth Defects	1800
Medical and Environmental Health Inquiries Processed	50
Environmental and Health Outcome Data Sets Released	4
Publications Prepared	25
Volume of Environmental Epi Web Inquiries	5500

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Program: Occupational Health Clinics

Mandate: Public Health Law Sections 2490, 2490-A and 3900 k, and Workers Compensation Law §151(2)(a)

Mandated Funding Level: None

Brief Description/History/Background: In 1987, the Legislature commissioned a study on the status of occupational health in NYS. The Mount Sinai School of Medicine completed the study and recommended the creation of a statewide network of public health based occupational health clinics. Since 1988, the NYS Occupational Health Clinic Network (OHCN) has grown to eleven occupational health clinics across NYS. The OHCN is the nation's only state-based occupational health clinic network. It serves as a resource that diagnoses and treat work-related disease, screen workers at increased risk for certain occupational diseases, evaluate workplace hazards and promote prevention activities. These services not only benefit the patient but can help to minimize or eliminate exposure to co-workers through the work of industrial hygiene intervention services at the work site. Every five years the Department releases a Request for Applications (RFA) to competitively select the clinics that encompass the OHCN. The last RFA was released in 2007, with new five-year contracts beginning April 1, 2008. The clinics provide comprehensive occupational health services, including medical diagnosis and treatment, industrial hygiene intervention services, social services including guidance through the Workers' Compensation system.

Issues: Within the OHCN, there has been a steady increase in the diagnosis of diseases of the musculoskeletal system, repetitive stress disorders and work-related respiratory disease diagnoses since the network's inception. The chronic nature of these conditions necessitates multiple visits dramatically increasing the patient load.

Population Served: Part of the mission of the OHCN is to provide both clinical and prevention services to the more than 9,000,000 workers in NYS. Other interested parties include many labor organizations, the NYS Business Council, Department of Labor, Workers' Compensation Board, and the US Department of Labor's OSHA.

Performance Measures:

Measure	**Annual Result**
Number of industrial hygiene interventions conducted	400
Number of workers educated or trained	70,000
Number of new patients seen	3,800
Number of patient visits (initial and follow-up)	13,000

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Program: Healthy Neighborhoods Program

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The Healthy Neighborhoods Program was designed in 1985 to provide preventive environmental health services to targeted geographic areas in neighborhoods with a disproportionate number of residential hazards, usually occupied by low-income families and often minorities. Economically disadvantaged people often have less opportunity to improve their housing conditions and surrounding environment. Home assessments are conducted to provide interventions and preventive measures to achieve healthy homes. This primary prevention program has evolved from a housing sanitation, rodent control, and building code violation program to a healthy home assessment program that is the model used by the U.S. Centers for Disease Control and Prevention for the future of primary prevention activities. During home assessments, potential health hazards are identified, smoke/fire detector deficiencies corrected, carbon monoxide levels checked, lead conditions evaluated, asthma triggers identified, and indoor air quality evaluated including tobacco smoke and injury prevention issues are addressed. Improving home environments is a critical tool for improving public health. The more than 10,000 home visits conducted each year provide the opportunity to link the residents with other services concerning health care.

Issues: None

Population Served: Low-income families living in neighborhoods with a disproportionate number of residential hazards.

Performance Measures: The U.S. Department of Health and Human Services (DHHS) "Healthy People 2010" states that "More than 6 million housing units across the country meet the Federal Government's definition of substandard housing." By 2010, the goal of the DHHS is to show a 52% improvement in reducing the proportion of occupied housing units that are substandard. New York State's Healthy Neighborhoods Program is designed to help eliminate substandard housing throughout the state and to create a healthier home environment for the citizens of New York.

Performance is measured by the number of home assessments conducted, hazards identified and corrected, referrals for services, and follow-up visits.

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Program: Occupational Health

Mandate: Public Health Law Sections 206(1)(d), (j), (n), 206(2), 225(5)(t), and 2100

Mandated Funding Level: None

Brief Description/History/Background: In 1981 New York Codes, Rules and Regulation (NYCRR) Title 10, Parts 22.4, 22.5, 22.6 and 22.7 were promulgated and in 1990 NYCRR Parts 22.11, 22.12. These regulations require health care providers, clinical laboratories, and health facilities to report the occurrence or suspicion of the occurrence of several diseases and poisonings including but not limited to: (occupationally related) coal workers lung disease, silicosis, asbestosis/asbestos-related disease, bronchitis due to occupational exposure, hypersensitivity pneumonitis, and asthma; as well as threshold levels for lead, mercury, arsenic, cadmium, and suspected pesticide poisonings.

Workplace injuries, illness and deaths are preventable. Information about where, how, and why working people in New York are getting sick, hurt or killed on the job provides information used to develop effective prevention strategies. The public health data collected guides the development of new, safer technologies, educational activities, and regulatory and policy changes to make workplaces healthier and safer. In addition to the State funding support of this program, staff is supported by federal funding.

In order to promote the health, safety and quality of life of the workforce, the Department: collects, analyzes, interprets and disseminates information about work-related injuries, illnesses, and hazards in New York; uses this information to target intervention activities, guides the development of prevention programs and policies, and raises public awareness of workplace risks. Program staff also educates workers, employers, and health care providers to understand and address occupational health and safety problems, placing special emphasis on reaching under served worker populations and those at highest risk for injury and illness.

In addition, program staff provide local health departments and State communicable disease programs with oversight and assistance on environmental control and worker protection issues related to outbreaks and other communicable disease transmission in facilities such as hospitals and public health clinics. This assistance includes control measures such as personal protective equipment, evaluation of engineering controls and isolation for communicable disease patients.

Issues: None

Population Served:

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New York State's 9,000,000 workers, along with employers, labor organizations and the Workers' Compensation Board.

Performance Measures:

Measure	**Annual Result**
Number of persons reported with an occupational lung disease	1,200
Number of persons reported with a possible pesticide poisoning	250
Number of traumatic work-related fatalities identified	130
Number of persons interviewed to identify the source of heavy metals exposure and provide measures to reduce or eliminate the exposure	1,400
Number of industrial hygiene interventions conducted	570

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Asbestos Safety Training

Mandate: Labor Law Article 30 Section 905

Mandated Funding Level: None

Brief Description/History/Background: Section 905 was enacted in 1986 to establish "comprehensive and standardized training programs for those individuals who disturb asbestos, asbestos exposure to the general public will be minimized." The purpose of the program is to ensure that asbestos workers receive training and have the skills and knowledge necessary to permit them to remove or contain asbestos using work methods that will protect the public health as required by state and federal regulations. The Commissioner of Health has the authority to approve asbestos safety programs to comply with the requirements of the State and Federal laws and regulations. In addition the law states that the Department shall asses a fee for each asbestos safety program completion certificate and these fees will be used to offset program costs. This program is partially supported by the fees collected for trainings.

Issues: None

Population Served: Workers in the asbestos removal industry, companies in the asbestos abatement industry, and training providers who provide asbestos safety training. In addition the Department of Labor relies on the program to ensure proper training when issuing asbestos related licenses. Ultimately, the general public is served by the assurance that both public and private buildings have been properly abated.

Performance Measures:

Measure	Annual Results
Number of instructor qualifications reviews completed	15
Number of announced and unannounced on-site and records audits of training providers	50
Number of curriculum reviews completed	45
Number of training course notifications monitored	4,200
Number of training certificates issued	26,600
Number of training history verification completed	3,500
Number of equivalency determinations conducted	400

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Clean Air Operating Permit Program

Mandate: Public Health Law Sections 201(1)(n), 206(1)(a), (d) and (j); Environmental Conservation Law §§ 3-0301, 72-0201, 72-0303; and Federal Clean Air Act. 42 U.S.C. §7401-7671q.

Mandated Funding Level: None

Brief Description/History/Background: The federal Clean Air Act Amendments of 1990 require NYS to conduct certain programs related to assessing and controlling chemical emissions to air from industrial facilities and other sources. The NYS Department of Environmental Conservation (DEC) conducts these programs and NYS DEC relies on DOH for its expertise in assessing public health risks for air pollutants. The critical DOH expertise is in the area of toxic substances. For example, DOH provides support to DEC's air permitting programs by assessing the public health risks from toxic chemical emissions from hazardous waste incinerators, power plants, municipal waste incinerators and other sources. DEC uses this information in determining whether or not to grant an air permit for a facility and in determining the kind of emission controls that are needed for facilities. DOH also develops human health based air criteria values that DEC uses in its permitting process and reviews/comments on proposed federal standards for air pollutants. DOH conducts health studies of communities to evaluate health effects that may be caused by air pollution. DOH also makes health outcome data available by ZIP Code for the public and for use by DEC in considering its environmental justice policy.

This DOH program conducts numerous other activities related to outdoor and indoor air pollution such as assessing the health risks associated with dry cleaning chemicals and developing programs to reduce people's exposure to those chemicals, evaluating specific air pollution sources such as backyard burn barrels and outdoor wood boilers, and issuing public health advisories on days with elevated air pollution levels. This DOH program is also playing a critical role in the development of the NYS Energy Plan pursuant to the Governor's Executive Order. Program staff also provides essential information directly to the public by responding to hundreds of telephone, email and letter inquiries annually on diverse issues related to air pollution and public health.

Issues: None

Population Served: Staff assists DEC Central Office and Regional air programs in carrying out statutory and regulatory responsibilities. Staff provides numerous forms of assistance to NYS citizens. Examples of citizen populations served include people residing near industrial facilities; people affected by dispersed pollutant sources (*e.g.*,

dry cleaners in residential buildings; people with neighbors who burn, garbage, people affected by emissions from diesel vehicles); people with health-related questions about air pollution. Staff works with various regulated parties such as applicants for DEC air permits, owners/operators of dry cleaning facilities and applicants proposing to build new electric generating facilities. Staff routinely provides assistance to other state, county and local government officials. Examples of this assistance include county health departments seeking help in investigating a pollutant source; elected officials with questions or concerns about air pollution; other state agencies seeking assistance on air pollution issues (*e.g.*, Department of Transportation, NYSERDA).

Performance Measures:

Measure	Annual Results
Facilities Assessed	5
Criteria/guidelines for Air Pollutants Reviewed or Developed	5
Responses to Siting Related Inquiries	150

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Tattoo & Body Piercing Regulation

Mandate: Public Health Law Article 4-A

Mandated Funding Level: None

Brief Description/History/Background: Chapter 562 of the Laws of 2001 and Chapter 607 of the Laws of 2002 amended the Public Health Law and State Finance Law regarding the regulation of body piercing and tattoo establishments and artists in New York State. The law requires tattoo and body piercing establishments to obtain a permit in order to operate and requires the artist to be licensed to practice. It is estimated that there are more than 900 tattoo/body piercing establishments and 3,000 artists throughout NYS. Staff are responsible for the development of program rules and regulations, policies, and technical standards to be utilized statewide to ensure uniformity in interpretation and enforcement of the regulations. Staff are responsible for developing health and safety information for operators and artists of these establishments.

The program would be implemented by environmental health staff in 36 county health departments, New York City Department of Health and Mental Hygiene (NYCDHMH) and the Department's 9 district offices.

Issues: Currently 12 county health departments and the NYCDHMH have active tattoo and body piercing regulatory programs required by city/county sanitary codes. Economies of scale may be achieved by consolidating activity in the Department of State.

Population Served:

- Facility owners/operators
- Patrons of the Body Piercing/Tattoo Establishments

Performance Measures:

Performance is measured by the number of inspections conducted, permits issued and enforcement actions taken against those facilities found in non-compliance.

Although data is available from the 12 county/city programs, state statistics are not available since a regulation has not been enacted to commence a statewide program.

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Bottled/Bulk Water Facility Certification Program

Mandate: Public Health Law, Sections 225-5(u) and 225(5)a

Mandated Funding Level: None

Brief Description/History/Background: Since 1988, all bottled/bulk water facilities who produce, sell or distribute water for human consumption, food preparation or culinary purposes in NYS must be certified by the DOH. In 2007, the total number of bottled and bulk water facilities certified by the Department reached 213 and enforcement actions were initiated against 12 facilities for violations of Subpart 5-6. Chapter 789 of the Laws of 1990 added Section 225-5(u) to the PHL regarding testing and standards for bottled water. The Law indicated that costs incurred by DOH for random shelf sampling and testing, be recovered by fees.

Issues: The Food and Drug Administration (FDA) has national standards for bottled water, but unlike the U.S. Environmental Protection Agency, has no State programs or financial assistance to implement the Federal standards

In the absence of dedicated resources, program efforts have been supported by federal monies. Limited funding to address extent of the problem.

Population Served: New York State consumers who purchase bottled water. There are 213 DOH certified owners/operators of bottled/bulk water facilities. Of the 213, 57% of bottled water facilities are located out of state and 19% located out of the country.

Performance Measures:

Approximately 20 plans/specifications and initial applications are submitted and reviewed annually, along with almost 200 re-certifications. Approximately 10 enforcement actions are issued annually, resulting from maximum contamination level violations, consumer complaints, unsatisfactory inspections, uncertified distribution and labeling violations.

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Radon Detection Devices

Mandate: Chapter 645 of the Laws of 1986 (New York State)

Mandated Funding Level: None

Brief Description/History/Background: There are approximately 22,000 radon related lung cancer deaths in the United States each year. In 1986, the Legislature directed the Department to purchase radon detectors and distribute them, upon request and at cost to the general public, to encourage radon testing. The testing identifies radon levels and provides residents with information for determining the need to mitigate radon exposures to reduce adverse long-term health outcomes. The Bureau of Environmental Radiation Protection maintains a contract for the purchase, distribution and analysis of radon test kits. The Radon Detection Device Account serves as a revolving fund for the purchase of additional detectors.

The Bureau developed and maintains a database of radon test results and prepares bi-annual updates of radon statistics by county and townships. These statistics help to identify areas with high radon levels so that targeted education and outreach programs can be implemented. Since 2007, radon testing in daycare centers in high-risk counties is required by the New York State Office of Children and Family Services. This requirement has significantly increased the number of radon test kits distributed. In total 10,877 radon kits were distributed during fiscal year 2007-2008 and more than 135,000 homes in NYS have been tested since the program began in 1987.

Issues: None

Population Served: State residents purchase radon detectors for home testing and assessment of health risks. Test kits are provided to schools and daycare centers at a reduced cost.

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Migrant Farm Worker Housing

Mandate: Public Health Law, Subsections 206(1)(h), and 225 (5)(m)

Mandated Funding Level: None

Brief Description/History/Background: PHL Section 225(5)(m) requires the inspection of approximately 380 migrant farm worker housing facilities throughout NYS. Inspections of these facilities include: sanitation, water, fire hazards, maintenance, light and ventilation, flooring, sleeping quarters, operation of appliances and heating units, sewage, food preparation and service, and electric service. There are approximately 8,000 migrant farm workers hired annually to assist the farm owners in the cultivation and crop planting/picking/packaging of produce throughout the State.

Issues: Farm worker housing is also inspected by Federal Labor and State Labor Departments – a MOU exists between the two agencies to prevent redundancy and exchange information.

Population Served:

- Migrant farm workers
- Farmers
- Federal and State Agencies – Department of Labor, Agriculture and Markets, Division of Housing and Community Renewal

Performance Measures: Performance is measured by the number of inspections conducted, permits issued and enforcement actions taken against those facilities found in non-compliance. Data collected in a data management reporting system are analyzed for program performance. Typically there are 800 inspections annually with 2-3 legal actions taken.

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Ultraviolet Radiation Device (Tanning Facility) Regulatory Program

Mandate: Public Health Law Article 35-A

Mandated Funding Level: None

Brief Description/History/Background: Article 35-A the Department to license tanning facilities and inspect ultraviolet radiation devices in tanning facilities. There are approximately 1,800 tanning facilities throughout NYS. One goal of the program is to increase consumer knowledge of the hazards of ultraviolet tanning and to minimize user injuries. UV rays from artificial sources of light, such as tanning beds and sunlamps, can cause skin cancer. In 2006, Chapter 573 of the Laws of 2006 amended Article 35-A prohibiting children under age 14 from using these facilities, and required children 14 – 18 years of age to have parental consent forms on file at the facility if they intend to use the tanning beds.

The program would be implemented by environmental health staff in 36 county health departments, New York City Department of Health and Mental Hygiene (NYCDHMH) and the Department's 9 district offices.

Issues: Since 1986, the labeling and performance requirements of ultraviolet radiation devices have been regulated by FDA.

Economies of scale may be achieved by consolidating activity in the NYS Department of State because it also licenses barbers and beauty salons.

Population Served:

- Facility owners/operators
- Patrons of the tanning parlors

Performance Measures: Performance is measured by the number of inspections conducted, permits issued and enforcement actions taken against those facilities found in non-compliance.

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Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Food Worker Training Certification

Mandate: Chapter 635 of the Laws of 2007, Public Health Law Section 1352(4)

Mandated Funding Level: None

Brief Description/History/Background: Chapter 635 effective August 27, 2008, requires the operators of food service establishments to have in their employment at least one individual trained and certified in food safety. The food safety training must be provided by an organization whose course materials are acceptable to the Department. The course should include instruction on the proper handling, preparation, cooking, storage, serving, delivery, removal, and disposal of food. Approximately 75,000 food service establishments, preparing billions of meals annually, would be required to comply. Part 14 of the State Sanitary Code must be amended to include regulations for trainers to follow in order to implement the Chapter Law.

Staff will need to develop standards for training courses, review and approve training courses and proposed course examinations, develop application forms for use by trainers when submitting curriculum and examinations for review, and develop guidance for local health departments concerning implementation, enforcement and monitoring compliance. Staff would notify local health departments of acceptable training providers and will provide training to the local health departments on the procedures for assessing compliance at food service establishments during routine inspections.

Issues: Currently 62% of all food service establishments in NYS are required to employ a trained certified food manager in compliance with city or county health department regulations.

Population Served:

Food safety training organizations
Operators of food service establishments
NYS Citizens and the visitors of NYS
Local Health Departments

Performance Measures: Performance would be measured by the number of approved trainers and compliance by food service establishment operators to retain trained staff.

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Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Certification of Water System Plumbing Back Flow Prevention Device Testers

Mandate: Public Health Law Sections 225.9 and 225.10

Mandated Funding Level: None

Brief Description/History/Background: PHL requires that persons who test backflow prevention devices installed on water system plumbing satisfactorily complete a DOH approved course in testing backflow prevention devices. Part 5 of the State Sanitary Code requires suppliers of water to protect their water systems against potential backflow contamination by the installation of approved backflow prevention devices (BFPs). These devices, once installed, must be tested annually by BFP testers, certified by the DOH. To obtain tester certification from DOH, a person must submit proof of satisfactory completion of an approved training course. Re-certification is required every three years and is obtained by a submittal of proof to DOH that the testers continue to be routinely engaged in BFP testing activity.

Issues: Limited funds to address the extent of the problem.

Population Served: Approximately 2,700 backflow prevention testers are currently certified through the DOH. Seven BFP training schools are DOH approved.

Performance Measures: Annually approximately 40 training courses are approved, 350 initial certifications and 540 re-certifications are issued and 10 educational outreach presentations are conducted with testers, trainers and local health departments.

Attachment C

Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Legislative Task Forces

Mandate: Chapter 387 of the Laws of 2004, Chapter 356 of the Laws of 2005, Chapter 178 of the Laws of 2006, Public Health Law Article 12

Mandated Funding Level: None

Brief Description/History/Background: Over the past four years legislation has created task forces on specific environmental health issues with requirements to assemble experts and prepare reports with recommendations to the governor and the legislature. These task forces include the Task Force on Flame Retardant Safety, the Toxic Mold Task Force, the Advisory Council on Children's Environmental Health and Safety and the Task Force on Toll Plaza Air Quality in NYC.

Issues: The appointment of members has delayed the startup of the task forces. To a large extent these activities have been or are being carried out by other state or federal initiatives and the required recommendations could be provided in a more efficient yet still inclusive manner. Limited funding to address the extent of the problem

Population Served: Each subject has varied interested parties.

Performance Measures: None

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Department of Health - Center for Environmental Health
PROGRAM INFORMATION SHEET

Program: Temporary Residences and Mobile Home Parks

Mandate: Public Health Law Sections 201-1(m) and 225 (5a) and (7)

Mandated Funding Level: None

Brief Description/History/Background: Subpart 7-1 of the State Sanitary Code requires the operators of approximately 3,550 temporary residences (hotels, motels, cabins) to obtain a permit to operate from the Department. The code establishes standards that must be met and authorizes compliance inspections. The standards pertain to fire safety, general sanitation, food protection, drinking water quality and bathing facilities in order to prevent illnesses or injuries to patrons of these facilities.

Part 17 of the State Sanitary Code requires a permit and inspection of approximately 1,850 mobile home parks located throughout NYS. These parks range in size from 5 to 450 homes, housing from 1 to 8 people per unit. Inspections include: fire safety, utilities, drinking water, site size, mobile home stands, anchoring of mobile homes, supervision, construction, refuse storage and disposal, storage of toxic materials, insect and rodent control, and sewage. Additionally, inspection of any on-site pool/beach or food service establishment is also required.

Center staff coordinate a permit and inspection program with 36 county health departments, and nine department district offices for both facility types.

Issues: There is regulatory redundancy of some activities. Economies of scale may be achieved by consolidating these activities.

Population Served:

- Temporary residences are utilized by individuals of all ages traveling throughout NYS.
- Facility operators of temporary residences (hotels/motels).
- Residents of mobile home parks
- Mobile home park owners

Performance Measures: Temporary Residences - Performance is measured by the number of permits issued, safety and engineering plans reviewed, inspections conducted, legal actions taken in response to violations, and deaths associated with fires at temporary residences.

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Department of Health - Center for Environmental Health

PROGRAM INFORMATION SHEET

In 2007, there were approximately 3,400 temporary residences (motels and hotels) permitted and approximately 100 enforcement actions taken for non-compliance.

In 2007, nearly 1,600 of the 1,876 mobile home parks in the state were inspected, and 25 enforcement actions were taken.

Attachment B

Agency Programs/Activities: Inventory and Key Data
Wadsworth Center for Laboratories and Research

Page	Relation to Core Mission (H/M/L)	Program/Activity	Spending Category (SO, ATL, CAP)	3/31/09 FTEs (All Funds)	General Fund Disbursements ($000s)				State Special Revenue Funds Disbursements ($000s)				Capital Projects Funds Disbursements ($000s)			
					2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected
1	H	Laboratory Safety, Compliance & Support Services	SO	191	$17,224	$18,479	$19,050	$19,050	$0	$0	$0	$0	$2,431	$4,825	$15,600	$12,000
3	H	Infectious Disease Testing	SO	59	$4,715	$5,059	$5,215	$5,215	$0	$0	$0	$0	$0	$0	$0	$0
5	H	Environmental Disease Testing	SO	54	$4,085	$4,382	$4,518	$4,518	$0	$0	$0	$0	$0	$0	$0	$0
7	H	Scientific Investigations and Preparedness for Emerging and Chronic Diseases	SO	97	$12,051	$12,929	$13,328	$13,328	$0	$0	$0	$0	$0	$0	$0	$0
9	H	Newborn Screening Program [1]	SO (SID)	69	$841	$902	$930	$930	$10,855	$10,655	$11,200	$11,200	$0	$0	$0	$0
11	H	Clinical Lab Reference System Program	SO	122	$1,447	$1,552	$1,600	$1,600	$18,945	$18,201	$19,611	$19,611	$0	$0	$0	$0
13	H	Environmental Lab Accreditation Program	SO	30	$118	$126	$130	$130	$3,946	$3,693	$4,493	$4,493	$0	$0	$0	$0
15	H	Clinical Laboratory Sciences Educational Training [2]	SO	-	$0	$0	$0	$200	$0	$0	$0	$0	$0	$0	$0	$0
16	H	Empire State Stem Cell Program [2]	SO	14	$0	$0	$0	$0	$0	$168	$15,017	$40,000	$0	$0	$0	$0
17	H	Sickle Cell Screening Program	ATL	-	$135	$277	$212	$212	$0	$0	$0	$0	$0	$0	$0	$0
18	H	Genetic Disease Screening Program	ATL	-	$753	$687	$686	$686	$0	$0	$0	$0	$0	$0	$0	$0
20	M	Breast Cancer Research Program	SO	0	$90	$97	$100	$100	$612	$1,666	$1,060	$1,060	$0	$0	$0	$0
21	M	Spinal Cord Injury Research Program [3]	SO	3	$0	$0	$0	$0	$9,125	$11,173	$10,650	$13,637	$0	$0	$0	$0
22	M	Multiple Sclerosis Research Program [2]	SO	-	$0	$0	$0	$0	$0	$0	$0	$20	$0	$0	$0	$0
23	L	Umbilical Cord Blood Banking Program [2]	SO	-	$0	$0	$48	$193	$0	$0	$0	$0	$0	$0	$0	$0
25	M/L	Center for Translational Neurological Research [2]	SO		$0	$0	$50	$100	$0	$0	$0	$0	$0	$0	$0	$0
		Wadsworth Laboratories Grand Total	ALL	639	$41,459	$44,490	$45,867	$46,262	$43,483	$45,556	$62,031	$90,022	$2,431	$4,825	$15,600	$12,000

1) For 08-09 funding for Newborn Screening was transferred to the State Insurance Department. The DOH fiscal plan includes only the $735K carry-in portion of the 08-09 projected amount.

2) Increased disbursements for 09-10 reflects phase-in of new initiative.

3) Increased disbursements for 09-10 reflects disbursements related to multi-year research contracts supported using reappropriated funding.

Department of Health – Wadsworth Center for Laboratories & Research
PROGRAM INFORMATION SHEET

Program: Laboratory Safety, Compliance and Support Services

Mandate(s):

- Public Law 107-88 US Statutes at Large 116 Stat 574, Public Health Security and Bioterrorism Preparedness and Response Act of 2002
- NYS General Business Law, Article 79-A (89e-89w), Security Guard Act
- NYS Public Health Law Section 225, Inspections, Surveys, Check and Tests, Vacating, Installations, Securing Radiation Sources
- 29 U.S.C. 651 et seq, William-Steiger Occupational Safety and Health Act of 1976
- Public Law 107-56, US Statutes at Large 115 Stat 272 (2001), Patriot Act
- NYS Labor Law Article 2, Section 27a: Public Employee Safety and Health Act
- NYS PHL Article 13, Title 13, Sections (1389-aa-1389-gg) Storage, Treatment and Disposal of Regulated Medical Waste.
- Environmental Conservation Law- numerous sections regarding Solid Waste Management, Radiation, Hazardous Wastes, and Air Permits.

Brief Description/History/Background: Laboratory safety, compliance and support services provide the foundation for the safe and proper operation of the Center's four laboratory facilities. Laboratories must comply with a voluminous number of laws, regulations and codes given the nature of laboratory work. Failure to comply can result in a shut down of the state's environmental and infectious disease testing laboratories. Accordingly, facility and plant maintenance support systems are essential to a safe and operational working environment. Clean stem generators, deionized water systems, liquid nitrogen systems, heating, ventilation and air conditioning systems, highly-efficient filtered exhaust systems, central uninterruptible power sources and conditioned power systems and ultra-low refrigeration systems are maintained by engineering staff, refrigeration mechanics, electricians, plumbers and steamfitters. The proper handling of these highly integrated and very sophisticated mechanical, electrical and plumbing systems is essential to ensuring a safe working environment for Center staff and to protecting the quality of scientific testing. Safety and security is responsible for biological safety, radiation safety, occupational safety, security, industrial hygiene and environmental programs.

<u>Biggs Laboratory (Empire State Plaza-ESP)</u>
The Biggs Laboratory at the Empire State Plaza is thirty-one years old. This facility was named in honor of Herman M. Biggs, M.D. Commissioner of Health from 1914-1923. The 500,000 gross square feet of BSL-2 laboratory space at Biggs Laboratory represents 56 percent of Wadsworth Center's total square

footage.

David Axelrod Institute (DAI)
The David Axelrod Institute facility houses portions of the Infectious Disease Program. DAI was constructed and funded by the Dormitory Authority State of New York through the issuance of New York State bonds. The bonds were refinanced in 2004. During this refinancing the Building and Equipment Reserve Fund was capped.

Griffin Laboratory (GL)
Griffin Laboratory is the site of various service and research laboratories of the Infectious Disease Program. This older campus consists of twenty two buildings (most built in the 1930's) on 205 acres in rural Albany Country, Town of Guilderland. Laboratory and support buildings total 76,000 gross square feet. Its size and location make this facility the focus of our 5-year capital plan and NIH construction activity. The NIH funded Insectary is at Griffin Lab. A draft master plan prepared in 2005 for this campus will be the background for new capital construction bonding discussions. The draft master plan also serves as a guide for the 5-year planning activities at this campus. It offers a thoughtful schedule for short term improvements as well as long term capital development while incorporating responsible natural resource management.

Population Served: This program serves the professional, technical and administrative units within the Wadsworth Center and other parts of the DOH, which in turn allows the public health laboratory to serve all citizens of the state.

Performance Measures: N/A

Department of Health – Wadsworth Center for Laboratories & Research
PROGRAM INFORMATION SHEET

Program: Infectious Disease Testing

Mandates:

- NYS Public Health Law, Article 5, Title 5: Clinical Laboratories and Blood Banks
- NYS Public Health Law, Article 13, Title 8: Good handling
- NYS Public Health Law, Section 1389 AA-GG: Regulated Medical Waste
- NYS Public Health Law, Article 21, Control of Acute Communicable Diseases
- NYS Public Health Law, Article 22, Control of Tuberculosis
- NYS Public Health Law, Article 23, Control of Sexually Transmissible Disease
- NYS Public Health Law, Article 24A, Protection of Human Subjects
- NYS Public Health Law, Article 27E, The Acquired Immune Deficiency Syndrome Institute
- NYS Public Health Law, Article 27F, HIV and AIDS Related Information
- NYS Public Health Law, Article 27H, The Tick-Borne Disease Institute
- NYS Public Health Law, Article 32, Live Pathogenic Microorganisms of Viruses
- NYS Public Health Law, Article 32A, Recombinant DNA Experiments

Mandated Funding Level: None

Brief Description/History/Background: The Division of Infectious Disease laboratories test specimens from New York State citizens for the presence or absence of infectious agents. These agents include pathogenic bacteria, viruses, fungi and parasites that infect humans. Some examples include anthrax, West Nile Virus, Lyme disease, Salmonella, E. coli O157:H7 and meningitis among thousands of other diseases and agents of disease. Testing is performed for public health outbreaks as well as when specific laboratory testing is not available elsewhere in the state. Testing by the Wadsworth Center is also done when warranted on the basis of clinical and public health seriousness of the disease. In addition, both clinical and environmental samples are analyzed during outbreaks of disease, typically but not limited to, foodborne and waterborne outbreaks. Outbreaks of disease occur on a daily or weekly basis, though very few are reported by the news media and thus much of the work is 'behind the scenes.' Perhaps one of our most visible testing efforts was helping to quell the fears of the public regarding the anthrax attacks in 2001. Staff also performs molecular fingerprinting of disease agents which enables the definitive tracing between a contaminated food and a patient illness. Rapid and sophisticated testing has enabled early intervention during many serious outbreaks that has reduced the spread of disease. The laboratories play a vital

role in the Department's mandated "Reporting Communicable Diseases" by confirming the laboratory diagnosis of critical agents of disease.

Issues: Laboratory testing has evolved from traditional slow, growth-based assays into rapid and accurate molecular-based testing. This process is ongoing and has revolutionized patient diagnosis and treatment.

Population Served: The entire citizenry of New York State is potentially served by laboratory testing for infectious agents.

Performance Measures: Laboratory performance is measured by regular assessment of turnaround times for test results. In addition, improvements in the sensitivity and accuracy of testing methods are monitored to ensure technical progress on the advancement of scientific methods. All laboratories in infectious diseases are also evaluated by the NYS proficiency testing program which sends unknown samples several times per year and testing must be accurate to maintain our permit to conduct clinical laboratory testing. All laboratories are currently authorized to perform clinical testing.

Department of Health – Wadsworth Center for Laboratories & Research
PROGRAM INFORMATION SHEET

Program: Environmental Disease Testing

Mandates:
Potable Water: Federal Safe Drinking Water Act (PL93-523); The Clean Water Act (PL95-500); NY State Environmental Conservation Law (ECL 17-0303-5), NYSPHL, section 225, and NYS Public Health Law, Article II, Public Water Supplies

Non-Potable Water/Hazardous Waste: NYS Environmental Conservation Law 17-0303, PL96-486; Comprehensive Environmental Response Compensation and Liability Act of 1980 (CERCLA - Superfund) PL 96-510, Article 19, Section 3-0301 the USEPA Toxic Substance Control Act and the USEPA Resource Conservation and Recovery Act (RECRA).

Ambient Air Quality Surveillance: Federal Clean Air Act, and New York State Environmental Conservation Law, Article 19,

Toxic Air Contaminants and Chemical Terrorism: Anti-Terrorism Preparedness Act of 2004 (Chapter 1 of the Laws of 2004).

Lead Poisoning: NYS Public Health Law Article 13, Title 10, Control of Lead Poisoning

Detection of Microbial Pollution of Water and Food. NYS PHL, Article 5, Title 1, Section 502

Environmental Radioactivity, Nuclear Emergency and Terrorism: Atomic Energy Act of 1954 and amendments (to regulate the use of radioactive materials), Occupational Safety and Health Act and amendments;

Mandated Funding Level: None

Brief Description/History/Background:
The environmental testing laboratories determine the presence and concentration of harmful agents in environmental samples and in human samples to minimize exposure and limit adverse health effects. Drinking and surface water, air, wildlife, soil and surface wipes are all tested for toxic chemicals, infectious agents and radioactivity. In the field known as biomonitoring, the laboratories also test human samples including blood, urine and saliva for chemical contamination to assess an individual's exposure to pesticides and industrial chemicals. The laboratories have developed methods for determining levels of lead and other toxic heavy metals on painted surfaces of toys and in jewelry to minimize the potential for adverse health effects in children who may handle these consumer products. The radiological sciences laboratory detects and quantifies several dozen radiological components in association with surveillance, reactor monitoring incidents and terrorism investigation. This capability promotes both State and national preparedness

in case of terrorist attack using chemical, microbiological or radiological warfare agents. As the EPA-designated Principal Laboratory in New York State, the environmental testing laboratories serve as the state reference laboratory for the analysis of potable and nonpotable water. The laboratories are accredited by the National Environmental Laboratory Accreditation Program (NELAP) and the technical and scientific expertise is not available elsewhere in the state. In addition to performing environmental testing, scientific staff develop new methodologies to meet analytical challenges, provide more efficient and less costly analysis methods, and design or modify instruments to increase the sensitivity of our analytical techniques.

Issues: Limited funding to address extent of the problem.

Population Served:
Samples are tested for the Department of Health's Bureaus of Public Water Supply and Protection, Environmental Radiation Protection, and Environmental Exposure Investigation. Other clients include local health departments, district offices, and state agencies Including Department of Environmental Conservation and Agriculture and Markets. The laboratory therefore serves the entire population of NYS.

Performance Measures:
The Laboratory is committed to routinely performing laboratory work in conformance with the standards of the National Environmental Laboratory Accreditation Conference, A2LA, NIST and EPA or other national or international standards setting organizations.

Department of Health – Wadsworth Center for Laboratories & Research
PROGRAM INFORMATION SHEET

Program: Scientific Investigations and Preparedness for Emerging and Chronic Diseases

Mandate(s): NYS PHL Article 5, Title 1, section 500 "establishes the Wadsworth Center and authorizes original investigations in matters affecting public health. NYS PHL Article 2, section 201(d) engage in research into morbidity and mortality, (e) produce, standardize and distribute diagnostic prophylactic and therapeutic products; 206(1)(j) cause to be made such scientific studies and research which have for their purpose the reduction of morbidity and mortality and the improvement of the quality of medical care.

Mandated Funding Level: None

Brief Description/History/Background: Public health science at the Wadsworth Center advances the goals defined in the DOH Healthy People 2010 Focus areas in fields such as cancer, infectious disease, disabilities, environmental health and child health. In addition, the scientific programs play a major role in enhancing our preparedness for emerging diseases and bioterrorism threats. Through its activities, the laboratory maintains its position at the forefront of scientific knowledge so that new understanding and technology are transformed rapidly into useful diagnostic methodologies and advice. When the SARS outbreak occurred, for example, the laboratory immediately developed a sensitive assay for the virus, because of the knowledge and expertise gained from studies at Wadsworth on related viruses. The same was true in response to earlier public health threats such as West Nile virus, anthrax and HIV; and not only in the area of infectious disease. New York State is recognized for its leadership in newborn screening, for example, because of the laboratory's scientific strengths in genetics and genomics. Studies are also focused on older adults where scientists are exploring both genetic and environmental factors influencing susceptibility to Parkinson's disease. Working with patients who have severe neurological problems following stroke or as a consequence of ALS disease, scientists at Wadsworth have made ground-breaking advances in the ability of individuals to communicate using a brain-computer interface system.

In other programmatic areas, knowledge provided by cell biologists, molecular biologists, and cancer and neuroscience specialists is critical to our extramural funding programs in stem cell biology, breast cancer and spinal cord injury research. Additionally, many Wadsworth scientists perform essential activities in areas such as laboratory testing, method development and validation and in regulatory review of new testing methodologies where scientific experience gained through ongoing studies is essential for continued high performance .

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Issues: Wadsworth Center faces a highly competitive environment with academia and private industry for recruiting and retaining doctoral level public health science staff.

Population Served: NYS citizens.

Performance Measures: None

Department of Health – Wadsworth Center for Laboratories & Research
PROGRAM INFORMATION SHEET

Program: Newborn Screening Program

Mandate: Public Health Law Article 25, Title I, Section 2500a Test for Phenylketonuria and other diseases; NYS Public Health Law Article 27-C "Birth Defects Institute".

Mandated Funding Level: None

Brief Description/History/Background: Since New York's Newborn Screening Program (NSP) began in 1965, more than ten million babies have been screened and more than 20,500 cases have been identified.

New York State's Public Health Law 2500-a originally required testing for only one genetic disorder, phenylketonuria (PKU), a metabolic disorder which, if left untreated, causes brain damage. Today newborns are tested for more than 40 inherited metabolic conditions, congenital hypothyroidism, hemoglobinopathies including sickle cell disease and HIV exposure. The NSP detects those infants with serious but treatable neonatal conditions and refers them for immediate medical intervention. Prior to 2004, the NSP had tested approximately 267,000 newborns annually for 11 genetic congenital disorders – phenylketonuria (PKU), homocystinuria, branched-chain ketonuria, galactosemia, biotinidase deficiency, sickle cell disease, congenital hypothrodism, cystic fibrosis (CF), congenital adrenal hyperplasia (CAH), medium-chain acyl-CoA dehydrogenase deficiency (MCADD), and an infectious disease – HIV exposure. In November 2004, the program expanded its testing profile, adding 20 new conditions that increased its testing profile to 31. In May 2005, the program added another 13 new conditions to its testing profile, increasing its testing profile to 44 conditions. In 2006, the program implemented Kabbe Disease screening, which increased the program's testing profile to 45 conditions and its test reporting to over 11 million test results annually. Additional tests may be added to the testing profile in the future. These test results are reported to the newborn's hospital of birth and supervising physician in a timely and accurately fashion.

Issues: Limited funding to address the extent of the problem.

Population Served: All newborns born in New York State are in the target population. In addition, a very small number of adopted children born elsewhere are screened.

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Performance Measures: The number of children tested for 45 conditions is a major measure of productivity. All suitable specimens are tested within established timeframes.

These test results are reported to the newborn's hospital of birth and supervising physician in a timely and accurate manner. Follow up is conducted for every baby with one or more aberrant test results to ensure that timely and appropriate treatment has been obtained.

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PROGRAM INFORMATION SHEET

Program: Clinical Lab Reference System

Mandate: NYSPHL Article 5, Title V, "Clinical Laboratory and Blood Banking Services." NYSPHL Article5, Title VI "Laboratory Business Practices"

Mandated Funding Level: None

Brief Description/History/Background: In 1965, New York became the first State to initiate certification and licensure of clinical laboratories and blood banks, The purpose of the clinical laboratory reference system is to monitor the quality of laboratory testing via its on-site inspections, proficiency testing and enforcement activities; to promote quality laboratory testing through outreach, education, and the review and approval of novel laboratory methods; and to establish and promote advancements and improvements to laboratory practices through cooperative research. The infrastructure and resources of the clinical laboratory reference system enable the Department to meet its public health mandate in the following areas: characterizing statewide laboratory capability and capacity for response to bioterrorism; monitoring and enforcing the reporting of communicable disease and other reportable conditions; facilitating epidemiological surveillance; investigating infectious disease outbreaks, and responding to public health threats and emergencies.

Issues: As diagnostic assays become more technically advanced, the material required for method validation also grows in length and complexity. Wadsworth scientists who are required to perform the method validation review also perform multiple roles including directing diagnostic testing labs. Limited funding to address the extent of the problem.

Population Served: This program ensures the quality of clinical laboratory services supplied to all New York State residents through oversight of 970 clinical laboratories, 3,600 limited service laboratories and 2,800 laboratory directors.

Performance Measures: Surveys are performed using standards for laboratory practice that have been developed through consultation with Center scientific staff, federal requirements outlined in 42 CFR, under the authority of the Clinical Laboratory Improvement Act of 1988, other accreditation agencies, and the laboratory industry. Written reports of laboratory surveys are forwarded to the program office electronically and are reviewed for accuracy and consistency with program requirements.

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Complaints about laboratory practices are investigated. Complaints are referred to a compliance surveyor or investigator and appropriate follow-up measures are initiated, to induce an on-site survey if necessary. Complainants are informed of the disposition of the complaint and any corrective action taken.

Proficiency testing challenges consisting of materials designed to simulate patient specimens are sent to laboratories and laboratory performance is used as a criteria for permit approval. Samples are prepared and validated according to procedures that are reviewed and approved by the program and determined to be consistent with laboratory practice. Challenges are graded and administered in accord with federal guidelines for proficiency testing programs outline in 42 CFR, under the authority of the Clinical Laboratory Improvement Act of 1988.

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Program: Environmental Lab Accreditation Program

Mandate: Public Health Law, Article 5, Title 1, Section 502; ELAP standards are consistent with the standards promulgated by the National Environmental Laboratory Accreditation Conference (NELAC).

Mandated Funding Level: None

Brief Description/History/Background: The Program's mission is to regulate laboratories performing environmental analysis to assure that the resulting data are accurate. Criteria used to determine the competency of a laboratory include credential review of laboratory personnel, biennial inspection of the facility and semi-annual proficiency testing for the analyses for which the laboratory is certified. Certification is granted in four categories: potable water (drinking water), non-potable water, air and emissions, and solid and hazardous waste which include a contract laboratory protocol (CLP) certification tier, and environmental critical agent testing.

Issues: The United States Environmental Protection Agency (USEPA), is requiring, under the federal Safe Drinking Water Act, that primacy states develop accreditation programs for laboratories conducting Cryptosporidium testing in drinking water. An accreditation program for testing of Legionella species in drinking and cooling-tower water needs to be developed. Proficiency testing for Enterococcus in Non-Potable Water is newly required under NELAC.

Autonomous Detection Systems, such as those used by the US Postal Service for airborne anthrax detection, are being used increasingly for on-site testing of anthrax and other biological critical agents. An accreditation program must be developed to assure these devices are accurate and that appropriate response actions and confirmatory testing are applied.

Implementation of revised regulation NYCRR-55-2 has enabled the accreditation of home inspectors conducting radon testing with continuous monitors. Since that time, the number of accredited entities has increased from 10 to 25, all requiring inspection and administrative resources.

Population Served: The program ensures that quality environmental testing being conducted on behalf of New York State residents and/or entities, through continuous monitoring of 648 participant laboratories, 210 of which are located out-of-state.

Performance Measures: Since the proper performance of laboratory analysis of environmental samples is necessary to insure the health and safety of the

general public and to protect the environment, proper and complete analysis must be adhered to, to ensure that potentially hazardous situations do not go unnoticed and unaddressed. Proper identification of toxins in drinking water, ground water, air and waste sites is necessary before adequate remediation and corrective action occurs. Failure to take such action can result in illness and even death.

The program provides regulatory oversight to all laboratories testing environmental samples collected in New York State. This includes bi-annual on-site assessment and analysis of proficiency test samples which are manufactured by program staff. Regulated laboratories analyze these samples and return results to the program for grading. There are more than 650 laboratories in 31 states and 9 foreign countries accredited by the program. More than 59,000 accreditations or approvals to test analytes are processed by the program each year.

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Program: Clinical Laboratory Sciences Educational Training Program

Mandate: NYS PHL Article 5, Title 1 section 500(2)

Mandated Funding Level: None

Brief Description/History/Background: In order to continue to recruit and employ persons qualified to perform the testing expected of the Wadsworth Center it is imperative that the Center continue to recruit personnel with unique expertise and provide a formal training mechanism to assure the necessary expertise for the types of testing conducted in a public health reference laboratory. The existence of this degree granting program will also allow the Wadsworth Center to compete for classes of extramural grant funds where eligibility is restricted to such programs.

For SFY 2008-2009 the Clinical Laboratory Sciences Education Program will develop a curriculum and submit it to the NYS Education Department (SED) for approval. The 18-24 month full time academic program will provide didactic courses in various areas of clinical laboratory sciences as adapted to the public health laboratory setting as well as intensive rotations through the various laboratory sections to fully prepare the graduates for their contribution to the centers mandated activities. It is expected that approximately 10 students will be enrolled in the program annually from applicants eligible for entry level laboratory specialist and research scientist positions in the center.

Issues: This program is in its developmental stages. It is expected the first class of students might be admitted in the fall of 2010.

Population Served: The Program will primarily serve the Department and state residents, regulated parties, and health care providers served by the Department.

Performance Measures: None.

Department of Health – Wadsworth Center for Laboratories & Research
PROGRAM INFORMATION SHEET

Program: Empire State Stem Cell Board-NYS Stem Cell Science Program (NYSTEM)

Mandate: Public Health Law Article 2, Title VA, Empire State Stem Cell Board
State Finance Law, Article 6, Section 99-P

Mandated Funding Level: None

Brief Description/History/Background: Funds, which are expected to total $600 million over the next decade, are intended to support New York State researchers and institutions to further basic, applied, and translational research and development activities and advance scientific discoveries related to stem cell biology. Funds may not be used for research involving reproductive cloning. The board has adopted a Strategic Plan emphasizing five areas of commitment: advancing the science of stem cell biology in New York State; training stem cell researchers; developing infrastructure for stem cell research; ethical, legal and social implications and education in stem cell research; and administration of the trust fund. In its first year, the Board authorized multiple Requests for Applications. The first round of contracts to support institutional development awarded $14.5 million in funding. The diversity and level of interest among the research community is outstanding; the Department of Health received more than 500 letters of intent from researchers in more than 15 distinct research areas (e.g., cardiovascular disease, Parkinson's disease, technology development, induced pluripotent stem cells) to apply for $109 million in available funding (approximately 140 anticipated awards for four RFAs).

Issues: None.

Population Served: Stem cell research is the foundation of regenerative medicine, which aims to extend healthy life spans by restoring cells, tissues, or organs lost to disease or injury. In this regard, countless individuals with a wide variety of known diseases and conditions may be helped.

Performance Measures: An annual report to the Governor provides the following: information regarding the board and its operations; research awards and activities; and evaluative measures such as the number of postdoctoral and innovative research specialists trained in New York State via support from NYSTEM, their research accomplishments including publications, patents, and licenses. Additionally, an RFP is being developed to allow an assessment and evaluation of economic and other benefits of the program and its funding.

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PROGRAM INFORMATION SHEET

Program: New York State Expanded Comprehensive Sickle Cell Services Program

Mandate: Public Health Law Article 2-C “Birth Defects Institute”

Mandated Funding Level: None

Brief Description/History/Background: The NYS Expanded Comprehensive Sickle Cell Services Program began in 1988 with contracts to twelve Sickle Cell Specialty Care Centers through a competitive request for applications. These Care Centers provide case management to children identified through the NYS newborn screening program with sickle cell disease and other hemoglobinopathies. Care Centers provide services to families whose infants are identified with trait hemoglobinopathy, since there is a risk that future children in the family might have sickle cell disease or another hemoglobinopathy.

Issues: Each year approximately 155 children are identified by the NYS newborn screening program with sickle cell anemia. An additional 121 children are identified with another hemoglobinopathy. In addition, approximately 9,700 infants are identified annually as carriers of a hemoglobinopathy, meaning that at least 9,700 parents are carriers or have disease. These parents benefit from counseling about sickle cell disease and testing to identify their true hemoglobin status. Life-long case management for people with sickle cell disease is crucial to ensure that they receive adequate routine care and timely intervention when complications arise.

Population Served: It is the goal of this program to improve the array of services currently available to affected individuals and their families and thereby improve the health of a sizable group of New York State citizens.

Performance Measures: Continuous program monitoring includes: submission of quarterly progress reports by contractors; site visits; and guidance from the Sickle Cell Advisory Consortium, a group of physicians, genetic counselors, social workers, nurses, public health representatives and consumer representatives of genetic disease groups.

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PROGRAM INFORMATION SHEET

Program: Genetic Disease Screening Program

Mandate: Public Health Law Article 27-C “Birth Defects Institute”

Mandated Funding Level: None

Brief Description/History/Background: The NYS Genetic Services Program began providing contracts to Genetic Centers in medical institutions throughout the state in 1978. At first the funds were provided through the National Genetic Disease Act of 1976. Categorical maternal and child health services were consolidated into the MCH Block Grant in 1981. Since that time, both MCHBG and state local assistance funds have been made available to support high-quality genetic screening, diagnosis, counseling and preventive services throughout the state.

The program's goals are to ensure that individuals affected with, at-risk for transmitting, or concerned about a genetic disorder are able to make informed health decisions, and that all such individuals are provided access to comprehensive genetics services including diagnosis, counseling and preventive services regardless of their economic, geographic or social situation.

Presently, twenty-five comprehensive, noncategorical genetic service programs receive funds. There is at least one funded center in each geographic region of the state. Funds are allocated based on population, the number of live births and the proportion of services provided to the catchment population by each center. Services are roughly categorized into prenatal (concerning a current pregnancy) and clinical (everything else). There is a minimum annual award of $50,000 and all applicants that meet general standards receive funding.

Issues: Diagnosis and ordering of genetic diagnostic or screening laboratory tests are primarily performed by physicians who are board-certified in clinical genetics. Genetic counseling services are primarily provided by master’s-level, American Board of Genetic counseling-certified or -eligible genetic counselors. Most genetic counseling requires considerable pre- and post-visit work to construct family pedigrees to identify risk, research symptoms to put them into identifiable syndromes, review physical examination and laboratory results, and work with the geneticist to develop prognoses and treatment options. While there are CPT codes (reimbursement codes for insurance companies) for genetic counseling and the few free-standing genetic counseling services have negotiated with insurance companies for limited payment, it fails to cover the breadth of time and effort needed. In addition, by-and-large, medical institutions have interpreted the codes to preclude billing for the services of a genetic

counselor unless the physician is present during the counseling session, negating much of the utility of using genetic counselors in the first place. Since

1978, New York State has provided grants to ensure access to comprehensive and noncategorical genetic counseling services throughout the state.

Population Served: More than 53,000 individuals receive services from the funded genetic centers annually.

For prenatal patients from 2005-2007: 67% received services in NYC; 38% had private insurance; 29% had HMO (public or private); 27% had Medicaid fee-for-service; 4% had no insurance; 2% were unknown

For clinical patients from 2005-2007: 41% received services in NYC; 14% were less than 1 year old; 21% were 1-10 years of age; 10% 11-20 years of age; 6% 21-30 years of age; 14% 31-40 years of age; 33% >40 years of age; 2% unknown; 27% had private insurance; 33% had HMO (public or private); 29% had Medicaid fee-for-service; 5% had no insurance; 6% were unknown

Performance Measures: The program ensures the availability of comprehensive counseling services throughout New York State regardless of geographic location, economic status, and ability to pay for services.

Practitioners, payers and the public are informed about genetic diseases, genetic services and other related issues through coordinated educational campaigns. Program progress is collected by program staff and reported to each service provider to assist in planning outreach programs, and program staff report findings at professional meetings and conferences.

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PROGRAM INFORMATION SHEET

Program: Breast Cancer Research & Education-Health Research Science Board

Mandate: Public Health Law, Article 24, Title 1-A, Sections 2410-2413
State Finance Law, Article 6, Section 97-YY

Mandated Funding Level: None

Brief Description/History/Background: The Breast Cancer Research and Education Fund supports research and education grant contracts. Now in its eleventh year, the Board has committed more than $8 million to breast cancer research and education projects. The Board is mandated to evaluate ongoing Federal and State research investigations that target breast, prostate and testicular cancer causation and to issue competitive requests for applications for breast cancer research and education. The Board is also mandated to review and approve applications for access to the confidential data elements contained in the Department of Environmental Conservation's (DEC) Pesticide Applications Database.

The Breast Cancer Research and Education Fund is financed by (i) voluntary donations made on corporate and personal income tax forms; (ii) individual gifts and requests; and (iii) proceeds from "Drive for the Cure" specialty license plates. Contributions are matched dollar-for-dollar by NYS.

Issues: Legislation passed in 2007 increased Board voting membership from 11 to 17. The remaining six vacancies have made it difficult to obtain a quorum.

Population Served: The program serves all residents of the State of New York at risk of breast cancer. Each year, about 13,800 women and 150 men are diagnosed with breast cancer in New York State. More than 3,000 die.

Performance Measures: A biennial report to the Governor provides the following: information regarding the board and its operations; recommendations for pesticide data collection activities of DEC; research and education awards and activities; and evaluative measures such as the number of postdoctoral and innovative breast cancer researchers trained in New York State via support from the Fund, their research accomplishments including publications, patents, licenses, and the development and dissemination of effective training and education for health professionals and the public.

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Program: Spinal Cord Injury Research-Spinal Cord Injury Research Board

Mandate: Public Health Law: Article 2, Title IV, Sections 250-251 Chapter 338, Laws of 1998, as amended by chapter 612, Laws of 1999 State Finance Law, Article 6, Section 99-F

Mandated Funding Level: None

Brief Description/History/Background:
The Spinal Cord Injury Research Trust Fund supports spinal cord injury research in support of cures and treatment for acute and chronic injury. Now at its ten year mark, the Board has committed $65.2 million to spinal cord injury research.

Financed by a surcharge on fines for certain moving violations, up to $8.5 million is transferred annually to the Fund.

Issues: An audit issued recently by the Office of the State Comptroller revealed administrative weaknesses including lack of on-site contract monitoring and incomplete records. These concerns have been addressed through development of the Extramural Grants Administration unit and the provision for additional staff to manage contracts. The Board is rebounding after several years of operational difficulties due to quorum issues.

Population Served: The long range goal is to treat and cure spinal cord injury and its paralytic effects. More than 600 New York residents suffer a traumatic spinal cord injury (SCI) each year. Most of them are between the ages of 16 and 30. They join the estimated 16,000 New Yorkers who are living with paralysis and other effects of SCI.

Performance Measures: An annual report to the Governor provides the following: information regarding the board and its operations; research awards and activities; and evaluative measures such as the number of postdoctoral and innovative spinal cord injury research specialist trained in New York State via support from the Fund, and their research accomplishments including publications, patents, and licenses.

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Program: Multiple Sclerosis Research Program

Mandate: State Finance Law Article 6, Section 95(d) "The New York State Multiple Sclerosis Research Fund."

Mandated Funding Level: None

Brief Description/History/Background: The New York State Multiple Sclerosis Research Fund was established to fund research into the causes and treatment of pediatric multiple sclerosis (MS). Multiple sclerosis is thought to be a lifelong, chronic, inflammatory, demyelinating autoimmune disease that affects the central nervous system consisting of the brain, spinal cord and optic nerves. Onset of the disease usually occurs in young adults and permanent neurological damage can occur in all stages of this disease. Consequently, research must continue to determine specific causes of MS and to develop new therapies and treatments.

Revenue for this initiative comes from a $25 annual service charge on the purchase of special NYS license plates in support of multiple sclerosis research.

Issues: This new account was established in the SFY 2008-2009 for the expenditure of receipts of the MS Research Fund enacted by Section 95-d of the State Finance Law. The available funds accrued have not been sufficient to award a research grant as yet.

Population Served: These funds can only be used for research into the causes and treatment of pediatric multiple sclerosis (MS). MS Care Centers are facilities licensed under Article 28 of the Public Health Law that are affiliated with the national MS Society that provide health care to individuals with MS and conduct research into the causes and treatment of MS approved by the Department of Health. Consequently, the population served is children with MS residing in New York State.

Performance Measures: None.

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PROGRAM INFORMATION SHEET

Program: Umbilical Cord Blood Banking Program

Mandate: PHL Article 43-C Umbilical Cord Blood Banking Program

Mandated Funding Level: None

Brief Description/History/Background: NYS PHL 43-C as enacted in 2007 establishes the NYS public and private umbilical cord blood banking program within the Department of Health to promote public awareness of the potential benefits of public or private cord blood banking, to promote research into the uses of cord blood, and to facilitate pre-delivery arrangements for public or private banking of cord blood donations. The administrative responsibility of the program has been delegated to the Wadsworth Center. The statute requires the department to develop a public education and outreach campaign to promote awareness of options for public or private cord blood banking. The program is also to promote education programs for health care providers regarding the benefits of public or private cord blood banking. A toll-free telephone number is specified to receive requests for information and to direct potential cord blood donors to available public or private cord blood banks serving the area in which such potential donor resides or is planning to deliver. The statute also requires the department to develop criteria regarding the appropriate collection and storage of cord blood for public or private banking. Regulations requiring progenitor stem cell tissue bank license of all cord blood banks providing services in New York already exist under the authority of NYS PHL Article 43-B and its implementing regulations 10 NYCRR 52. The Wadsworth Center has posted a series of frequently asked questions and a program contact number on the Department's web page. Very few inquiries have been received. Staff is trying to establish/maintain working relationships with relevant professional organizations. The authorizing statute states that the commissioner shall accept and expend any grants, awards, or other funds or appropriations as may be made available for the purposes of this article, subject to limitations as to the approval of expenditures and audit as prescribed for state funds by the state finance law.

Issues: The largest public cord blood bank, the New York Blood Center in NYC, accepts donations only from deliveries at 5 birthing institutions, none of which are in upstate NY. There are no other public cord blood banks located in New York State. The primary option for families wishing to bank their infant's cord blood is private banking where the family must bear the cost of collection and storage of the unit for the rare possibility of medical use by the donor or an immediate family member. In addition the private banking option does not expand the availability

of a genetically diverse pool of cord blood units available for transplant to those in medical need.

Population Served: Statewide. All inquiries are handled from parents and professionals.

Performance Measures: Current performance measures include the number of web based contacts and queries received from the public.

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PROGRAM INFORMATION SHEET

Program: Center for Translational Neurological Research (CTNR)

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Many thousands of people throughout New York State (NYS) struggle constantly with the devastating long-term consequences of a broad range of neuromuscular disorders. At the same time, recent and ongoing laboratory discoveries produce knowledge that could be developed into new therapeutic methods to help restore the functions that people have lost due to these disorders – therapies that would enable them to lead longer, more enjoyable, more independent and productive lives, and that would decrease their need for intensive ongoing services of caretakers. However, there is currently no effective and efficient means to translate these promising laboratory advances into clinically practical therapies that could help this severely disabled population. The central problem is the lack of programs that enable laboratory scientists and clinicians to work together smoothly and effectively to translate laboratory progress into practical clinical methods. The goal of this public health initiative is to take advantage of the unique laboratory and clinical resources of the New York State Department of Health to create such a translational program to meet the needs of this extremely disabled population in New York State.

Funds will be used by the Wadsworth Center and Helen Hayes Hospital to begin the establishment of the Center for Translational Neurological Research (CTNR). The CTNR will establish and nurture an ongoing translational research endeavor that develops new techniques for restoring function to patients with strokes, traumatic brain injuries, spinal cord injuries, amyotrophic lateral sclerosis (ALS), Parkinson's disease, multiple sclerosis, muscular dystrophies, cerebral palsy, and other devastating nervous system disorders, and then translate these new treatment methods into clinical practice. These efforts will improve neurologically impaired patients' independence and participation in society; reduce the enormous personal, societal and financial burdens of these disorders; and partner existing department clinical and research resources to advance patient care.

Issues: None

Population Served: New York State residents with neuromuscular disorders.

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Performance Measures: The core of the CTNR Program is a set of research projects. Each project starts from a particular body of ongoing basic research, and from that work, develops a clinical research agenda that: 1) produces new therapeutic methodology to address particular clinical problems; 2) establishes the clinical practicality and value of the methodology; and 3) results in unique clinical services that increase the ability of Helen Hayes Hospital to address the needs of patients with severe neurological impairments. The functions and problems to be targeted include: walking; communicating; eating; bowel; bladder, and sexual function; pressure sores; and pain management.

Each project was designed to develop over a period of two years. Treatment methods are developed in the research laboratory, transferred to the clinical laboratory for patient validation and are ultimately translated to new therapeutic regimens that Helen Hayes provides to its patient population. Through research publications, these regimens will be disseminated to other hospitals and clinical facilities throughout NYS.

Agency Programs/Activities: Inventory and Key Data
NYS Department of Health -- Office of Health Insurance Programs

					General Fund Disbursements ($000s)				State Special Revenue Funds Disbursements ($000s)				Capital Projects Funds Disbursements ($000s)			
Page #	Relation to Core Mission (H/M/L)	Program/Activity	Spending Category (SO, ATL, CAP)	3/31/09 FTEs (All Funds)	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected
1	H	Medicaid Policy & Coverage	SO	10	$231	$661	$768	$732	$853	$624	$734	$734	$0	$0	$0	$0
3	H	Medicaid Special Populations Group	SO	10	$265	$655	$769	$737	$768	$562	$661	$661	$0	$0	$0	$0
5	H	Medicaid Primary Care/Quality Improvement	SO	13	$300	$860	$998	$952	$1,109	$812	$954	$954	$0	$0	$0	$0
	H	Medicaid Pharmacy Initiatives (see Pharmacy Program)	ATL	0	$2,590	$5,045	$6,800	$6,800	$0	$0	$0	$0	$0	$0	$0	$0
6	H	Medicaid Pharmacy Program	SO	32	$739	$2,116	$2,458	$2,342	$2,731	$1,998	$2,349	$2,349	$0	$0	$0	$0
8	H	Medicaid Finance and Reform	SO	12	$231	$661	$768	$732	$1,344	$1,433	$1,529	$1,637	$0	$0	$0	$0
10	H	Medicaid Utilization Management Modernization	ATL	0	$1,894	$1,213	$1,000	$1,000	$0	$0	$0	$0	$0	$0	$0	$0
11	H	Medicaid Retrospecive Utilization Review Project	ATL	0	$0	$0	$2,500	$2,500	$0	$0	$0	$0	$0	$0	$0	$0
12	L	Medicare Part D Notifications to Medicaid Dual Eligibles	ATL	0	$1,684	$2,053	$2,500	$2,500	$0	$0	$0	$0	$0	$0	$0	$0
13	H	Medicaid Chronic Illness Demonstration Projects	ATL	0	$0	$0	$6,000	$6,000	$0	$0	$0	$0	$0	$0	$0	$0
14	H	Medicaid SUNY Contract	ATL	0	$0	$0	$6,000	$6,000	$0	$0	$0	$0	$0	$0	$0	$0
15	M	Medicaid Primary Care Case Management Programs	ATL	0	$0	$0	$0	$0	$1,360	$2,451	$3,600	$3,200	$0	$0	$0	$0
16	H	Financial Management, Oversight and Premium Development for Government Managed	SO	33	$1,768	$1,945	$2,496	$2,488	$306	$257	$340	$340	$0	$0	$0	$0
19	M	Managed Care Development & Implementation	SO	29	$852	$1,607	$1,930	$1,869	$1,960	$1,475	$1,877	$1,877	$0	$0	$0	$0
21	M	Managed Long Term Care Development, Implementation and Monitoring	SO	8	$425	$489	$623	$620	$85	$62	$73	$73	$0	$0	$0	$0
22	H	Medicaid Managed Care Enrollment Broker	ATL	0	$14,386	$20,663	$20,400	$21,900	$0	$0	$0	$0	$0	$0	$0	$0
23	M	Medicaid & Family Health Plus Helplines	SO	4	$92	$264	$307	$293	$411	$313	$650	$650	$0	$0	$0	$0
24	H	Medicaid Management Information Systems Contractual Services	SO	0	$35,892	$28,579	$165	$31,250	$53,600	$43,100	$24,100	$0	$0	$0	$0	$0
25	H	Medicaid Management Information Systems Staff Costs	SO	49	$1,177	$3,162	$3,689	$3,523	$4,061	$3,005	$3,570	$3,570	$0	$0	$0	$0
27	H	Medicaid Program Opeartion and System Support	SO	36	$842	$2,308	$2,689	$2,567	$3,037	$2,255	$2,689	$2,689	$0	$0	$0	$0
28	H	Medicaid Statistics and Program Analysis	SO	18	$484	$969	$1,157	$1,117	$1,312	$968	$1,243	$1,243	$0	$0	$0	$0
29	H	State Enrollment Center	SO	0	$0	$0	$1,063	$3,400	$0	$0	$0	$0	$0	$0	$0	$0
31	H	Payment Error Rate Measurement (PERM)	SO	0	$0	$833	$1,550	$1,550	$0	$0	$0	$0	$0	$0	$0	$0
32	H	Medicaid Eligiblity Quality Control (MEQC)	SO	0	$0	$833	$1,550	$1,550	$0	$0	$0	$0	$0	$0	$0	$0
33	H	Medicaid Administration	SO	48	$1,016	$2,909	$3,379	$3,221	$4,264	$3,161	$3,859	$3,859	$0	$0	$0	$0
34	H	Medicaid Provider Credentialing and Enrollment	SO	23	$542	$1,449	$1,691	$1,615	$1,936	$1,464	$1,703	$1,703	$0	$0	$0	$0
35	M	Medicaid Claims Policy Development	SO	7	$162	$463	$538	$512	$597	$437	$514	$514	$0	$0	$0	$0
36	M	Medicaid Provider Relations, Education & Communications	SO	6	$115	$331	$384	$366	$529	$329	$416	$416	$0	$0	$0	$0
37	H	Medicaid File Maintenance	SO	11	$254	$727	$845	$805	$939	$687	$808	$808	$0	$0	$0	$0
38	M	Medicaid Utilization Review	SO	41	$947	$2,711	$3,149	$3,001	$3,499	$2,560	$3,010	$3,010	$0	$0	$0	$0
39	M	Medicaid Systems Design, Development & Testing	SO	5	$115	$331	$384	$366	$427	$312	$367	$367	$0	$0	$0	$0
40	H	Medicaid Fair Hearings	SO	2.5	$58	$165	$192	$183	$213	$156	$184	$184	$0	$0	$0	$0
41	H	Medicaid/Other Rate Setting	SO	86	$4,873	$3,612	$4,685	$4,671	$1,485	$928	$1,176	$1,177	$0	$0	$0	$0
42	H		ATL	-	$0	$25	$228	$228	$0	$0	$0	$0	$0	$0	$0	$0
43	L	Hospital Institutional Cost Report	ATL	-	$0	$0	$0	$0	$78,260	$50,067	$47,800	$42,200	$0	$0	$0	$0
44	L	Public Hospital Recruitment and Retention Grants	ATL	-	$0	$0	$0	$0	$24,285	$13,338	$8,000	$5,300	$0	$0	$0	$0
45	L	Public Nursing Home Recruitment and Retention Grants	ATL	-	$0	$0	$0	$0	$642	$464	$2,500	$2,500	$0	$0	$0	$0
46	L	Non Public Hospital Grants 2807c(30)c	ATL	-	$0	$0	$0	$0	$0	$0	$9,850	$4,900	$0	$0	$0	$0
47	L	Non Public Hospital Grants 2807c(25)(e)	ATL	-	$0	$0	$0	$0	$4,885	$4,853	$4,800	$4,800	$0	$0	$0	$0
48	M	Poison Control Grants	ATL	-	$0	$0	$0	$0	$33,771	$36,892	$83,400	$54,300	$0	$0	$0	$0
49	H	Regulation/Medicaid State Plan Administration	SO	8	$0	$0	$0	$0	$1,153	$1,218	$1,294	$1,294	$0	$0	$0	$0
50	H	DSRIP/Uncompensated Care Financial Analysis	SO	8	$0	$0	$0	$0	$1,153	$1,218	$1,294	$1,294	$0	$0	$0	$0
51	H	HCRA/Cash Assessment Revenue Collection	SO	23	$0	$0	$0	$0	$3,315	$3,503	$3,721	$3,721	$0	$0	$0	$0
52	H		ATL	-	$0	$0	$0	$0	$106	$104	$5,500	$7,800	$0	$0	$0	$0
53	H	HCRA Compliance Audits	ATL	-	$0	$0	$0	$0	$2,712	$3,250	$2,700	$2,700	$0	$0	$0	$0
54	H	GME/Physician Shortage Initiatives HCRA Pool Administration	SO	4	$0	$71	$132	$132	$0	$0	$0	$0	$0	$0	$0	$0

Agency Programs/Activities: Inventory and Key Data
NYS Department of Health -- Office of Health Insurance Programs

					General Fund Disbursements ($000s)				State Special Revenue Funds Disbursements ($000s)				Capital Projects Funds Disbursements ($000s)			
Page #	Relation to Core Mission (H/M/L)	Program/Activity	Spending Category (SO, ATL, CAP)	3/31/09 FTEs (All Funds)	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected
55	H		ATL	-	$0	$0	$348	$348	$0	$0	$0	$0	$0	$0	$0	$0
56	H	Center For Workforce Studies at School of Public Health	ATL	-	$0	$0	$39	$39	$0	$0	$0	$0	$0	$0	$0	$0
57	H	SUNY Minority Participation in Medical Education	ATL	-	$0	$0	$200	$200	$0	$0	$0	$0	$0	$0	$0	$0
58	M	CUNY Minority Participation in Medical Education	ATL	-	$0	$0	$0	$0	$383,410	$359,238	$345,800	$341,690	$0	$0	$0	$0
59	H	GME Distributions, Incentive/Innovations Pool & ECRIP	ATL	-	$0	$0	$0	$0	$0	$0	$2,500	$4,900	$0	$0	$0	$0
60	H	Ambulatory Training	ATL	-	$0	$0	$0	$0	$0	$0	$1,900	$1,960	$0	$0	$0	$0
61	H	Physician Loan Repayment	ATL	-	$0	$0	$0	$0	$0	$0	$4,900	$4,900	$0	$0	$0	$0
62	H	Physician Practice Support	ATL	-	$0	$0	$0	$0	$0	$0	$300	$590	$0	$0	$0	$0
63	H	Physician Studies	ATL	-	$0	$0	$0	$0	$0	$0	$1,000	$2,500	$0	$0	$0	$0
64	H	EPIC - State Operations Diversity in Medicine Post Baccalaureate	SO	29	$46	$132	$154	$146	$9,538	$17,849	$17,250	$20,164	$0	$0	$0	$0
65	H	EPIC Aid to Localities	ATL	-	$0	$0	$0	$0	$754,830	$563,791	$545,000	$481,700	$0	$0	$0	$0
67	H	NYS Drug Discount Card	SO	0	$0	$0	$0	$0	$0	$0	$500	$2,500	$0	$0	$0	$0
68	H	Managed Care Organization Oversight & Operations	SO	16	$793	$918	$1,168	$1,161	$315	$277	$309	$309	$0	$0	$0	$0
70	H	Facilitated Enrollment	SO	4	$23	$66	$77	$73	$7,827	$7,662	$8,283	$8,767	$0	$0	$0	$0
71	H	Child Health Plus Marketing	SO	0	$0	$0	$0	$0	$2,543	$1,191	$1,325	$1,325	$0	$0	$0	$0
72	H	Child Health Plus Administration	SO	34	$139	$397	$461	$439	$4,339	$2,570	$3,465	$3,576	$0	$0	$0	$0
73	H	Child Health Plus Premiums	ATL	-	$0	$0	$0	$0	$325,363	$300,329	$342,000	$342,000	$0	$0	$0	$0
74	L	Regional Pilot Program/Individual Subsidy	ATL	-	$0	$0	$0	$0	$1,300	$1,238	$1,270	$1,270	$0	$0	$0	$0
75	H	Quality, Measurement and Improvement	SO	14	$678	$797	$1,012	$1,005	$306	$257	$340	$340	$0	$0	$0	$0
76	H	Outcomes Research	SO	15	$701	$863	$1,089	$1,078	$358	$204	$269	$269	$0	$0	$0	$0
77	L	Pay for Performance Demonstrations	SO	1	$57	$60	$78	$78	$0	$0	$0	$0	$0	$0	$0	$0
78	M	Administrative Support for OHIP Programs	SO	32.5	$796	$2,071	$2,422	$2,316	$2,653	$1,974	$2,359	$2,359	$0	$0	$0	$0
79	L	Medicare Balance Billing	SO	0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
80	H	Local District Medicaid Administration	ATL	-	$298,386	$405,621	$400,300	$420,800	$0	$0	$0	$0	$0	$0	$0	$0
81	H	Hospital and Clinics Medicaid Provider Payments	ATL	-	$1,569,012	$1,489,133	$1,615,500	$1,937,913	$1,255,405	$1,140,238	$1,236,500	$1,157,087	$0	$0	$0	$0
82	H	Nursing Homes Medicaid Provider Payments	ATL	-	$2,223,028	$2,109,582	$2,414,583	$2,843,628	$815,280	$634,626	$584,600	$584,600	$0	$0	$0	$0
83	H	Managed Care Medicaid Provider Payments	ATL	-	$1,412,933	$1,341,000	$1,509,000	$1,692,000	$0	$0	$0	$0	$0	$0	$0	$0
84	H	Home Care Medicaid Provider Payments	ATL	-	$1,879,485	$1,783,800	$2,147,800	$2,473,800	$216,200	$266,200	$204,200	$204,200	$0	$0	$0	$0
85	H	Non-Institutional and Other Care Medicaid Provider Payments	ATL	-	$863,541	$819,579	$158,900	$289,400	$178,800	$178,800	$178,800	$178,800	$0	$0	$0	$0
86	H	Pharmacy Medicaid Provider Payments	ATL	-	$647,146	$614,200	$552,893	$945,000	$599,313	$667,800	$863,107	$722,000	$0	$0	$0	$0
87	H	Family Health Plus Medicaid Provider Payments	ATL	-	$416,399	$395,200	$350,000	$285,000	$438,883	$482,800	$553,600	$575,000	$0	$0	$0	$0
88	L	Adirondack Cancer Center	ATL	-	$0	$0	$0	$0	$0	$0	$4,900	$0	$0	$0	$0	$0
		Commissioner/Senate/Assembly Priority Pools	ATL	-	$0	$0	$0	$0	$35,268	$35,637	$12,000	$5,000	$0	$0	$0	$0
	SID	Healthy NY Program - suballocation out	ATL	-	$0	$0	$0	$0	$72,229	$93,520	$139,500	$219,940	$0	$0	$0	$0
	SID	Entertainment Employees Insurance Pilot - suballocation	ATL	-	$0	$0	$0	$0	$841	$612	$2,000	$1,960	$0	$0	$0	$0
	SID	HMO Direct Pay Market -suballocation	ATL	-	$0	$0	$0	$0	$40,000	$40,000	$39,200	$39,200	$0	$0	$0	$0
	SID	Physician's Excess Medical Malpractice - suballocation	ATL	-	$0	$0	$0	$0	$130,000	$109,000	$127,400	$127,400	$0	$0	$0	$0
		GRAND TOTAL	ALL	672	$9,385,096	$9,051,131	$9,239,809	$11,011,948	$5,512,110	$5,090,071	$5,451,846	$5,199,133	$0	$0	$0	$0

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid, Policy and Coverage

Mandate: Title XIX Federal Social Security Act, Social Services Law

Mandated Funding Level: None

Brief Description/History/Background: Policy and Coverage has responsibility for policy development and program implementation promoting the delivery of medically necessary health care to Medicaid enrollees. Policy and Coverage's goal is to ensure that the highest quality of health care is available to participants within the Program's fiscal constraints. Responsibilities include:

- Integrate the Medicaid reform initiatives to promote access to primary care services, including a new payment methodology (Ambulatory Patient Groups) for clinic/emergency department/ambulatory surgery, as well as enhanced fees for practitioner services provided under the Medicaid fee-for-service program;
- Develop, coordinate and implement maternal and child health program initiatives including services provided under the federally mandated Early and Periodic Screening and Treatment Program, School Based Health Clinics, and Early Intervention Program;
- Coordinate and integrate Office of Public Health program initiatives into the Medicaid program (e.g., Family Planning, HIV, Tuberculosis, Cancer Services Program, Dental services);
- Develop and implement a monitoring program and evaluation protocols to ensure that patient health care needs are being met;
- Assess program coverage of new medical procedures and technology;
- Review/monitor/implement federal Medicaid regulation and policy coverage decisions to ensure NYS Medicaid compliance;
- Propose, write and implement state legislative initiatives to enhance medical care to the state's Medicaid population in a cost effective manner;
- Fiscal and data analysis of current and proposed changes in the fee for service program;
- Respond to provider and recipient inquiries regarding policy questions and initiatives;
- Provide outreach, training and program guidance for providers and enrollees;
- Initiate, develop and coordinate provider payment system changes, including payment edits, to ensure the fiscal integrity of the Medicaid Program;
- Coordinate with local social services districts in the provision of medical transportation (ambulance, ambulette, taxi, public transit); maintain/update the Medicaid program's State Plan.

Issues: The redirection of health care services to lower cost settings will promote primary care delivery and improve patient access to health care. Managing rising costs of transportation services.

Population Served: The Medicaid program provides payment for services for approximately 4.5 million low income or medically needy beneficiaries.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Performance Measures:

- Improved patient access to primary and preventive care (includes prenatal care as well as medical services provided to the adolescent and children population);
- Timely review and decisions on key policy implementation including new technology assessment, regulations, transportation fees and other coverage decisions.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid, Special Populations Group

Mandate: Title XIX Federal Social Security Act
NYS SSL Title II § 363-369

Mandated Funding Level: None

Brief Description/History/Background: Within OHIP's Division of Financial Planning and Policy, the Special Populations Group (SPG) carries out the State Medicaid agency's role in ensuring access to medically necessary and quality behavioral health services for the Medicaid population, including Mental Hygiene certified State Plan Services, federal 1915c Home and Community Based Waiver Services and Targeted Case Management Services.

Special populations served by OMRDD, OMH and OASAS account for almost 75% of Medicaid's total expenditures. The SPG, on behalf of the State Medicaid Agency, has ongoing responsibility and a federal mandate for liaison and oversight of programs and policies governing a wide range of behavioral health services provided by OMRDD, OMH and OASAS under the Medicaid Program. The programs include but are not limited to: OMRDD certified Intermediate Care Facilities for the mentally retarded (ICF/MRs), OMH certified Residential Treatment Facilities (RTFs), OMRDD, OMH and OASAS Clinics and OASAS, OMH and OMRDD rehabilitation services, free-standing clinics, rehabilitation services, OMRDD and OMH Home and Community Based Services (HCBS) Waivers, OASAS Detoxification and Methadone Maintenance Programs, OMH residential programs, Assertive Community Treatment (ACT), the Prepaid Mental Health Plan (PMHP), and OASAS Chemical Dependence Programs. Responsibilities include:

- Integrating the Governor's Medicaid reform initiatives which promotes access to primary care services, including a new payment methodology (Ambulatory Patient Groups) for OMRDD, OMH and OASAS clinics;

- Developing, coordinating, and implementing the new Federal Targeted Case Management regulations for 12 separate case management programs including HIV/AIDs, OMRDD, OMH and Teenage Services Act case management programs;

- Managing DOH's efforts within all three mental hygiene agencies to revisit and modify payment rates;

- Coordinating new Mental Hygiene Agency initiatives so that they comport with State and federal regulations of the Medicaid program; and

- Serving as primary liaison to Federal CMS for all Mental Hygiene Agency State Plan Services and OMRDD and OMH Waivers.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Issues: Special populations are among the highest cost individuals in Medicaid. Developing interventions for these populations is critical to improving care and controlling costs. New Federal regulations have significant impact targeted case management programs. These programs must be in compliance with new regulations in order to continue receiving federal financial participation.

Population Served: The Medicaid program provides payment for services to over 800,000 "special population" beneficiaries including individuals who are developmentally disabled, children with serious emotional disturbance, adults with severe and persistent mental illness, people with a chemical dependence, and individuals receiving case management such as pregnant and parenting teenagers and people with HIV/AIDS.

Performance Measures: Medicaid programs comport with federal and State regulations; and CMS assessment on six key quality assurance areas for home and community based waivers.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Primary Care/Quality Improvement

Mandate: SSL § 365-a, PHL § 2803

Mandated Funding Level: None

Brief Description/History/Background: The work conducted by the Primary Care/Quality Improvement Program supports the Department's mission to provide all New Yorkers with access to high-quality health care and to improve health outcomes while using our resources wisely.

IPRO Utilization Review/Quality Improvement Contract- State and Federal law impose requirements regarding appropriateness of care reviews provided under the Medical Assistance Program. The Commissioner of Health is required to review the appropriateness and necessity of health care services provided to Medical Assistance beneficiaries as well as review of case-based payments made to hospitals through the Medicaid Program. In accordance with these laws, the UR agent will operate a program of continuous quality improvement for Medicaid beneficiaries treated in NYS hospitals and in outpatient settings.

Under this contract, the UR/QI agent is responsible for operating a cost effective review system to assure that services provided to Medicaid beneficiaries are medically necessary, appropriate and are provided at the most appropriate level of care. The contractor conducts quality of care reviews and works to identify Medicaid providers who are not meeting professionally recognized standards, and works with the Department to address found issues. As part of this contract, the Department sponsors outpatient Asthma and Diabetes Quality Improvement Projects (QIPs).

Primary Care Enhancements- The 2008-09 Executive Budget amends the Social Services Law to require coverage of asthma and diabetes self-management training services to Medicaid beneficiaries diagnosed with diabetes and/or asthma when such services are ordered by a physician, registered physician's assistant, registered nurse practitioner, or a licensed midwife. Self-management training services are to be provided by a New York State licensed, registered, or certified health care professional who is also certified as an educator by the National Asthma Educator Certification Board (CAE) or the National Certification Board for Diabetes Educators (CDE).

Issues: The current contract is being reprocured, with an anticipated selection of a new contractor in February 2009.

Population Served: Approximately 4.1 million Medicaid beneficiaries

Performance Measures: Clinical performance indicators for Asthma and Diabetes; and contractual standards for UR agent.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid Pharmacy Program

Mandate: Title XIX Federal Social Security Act, Medicaid State Plan, NYS SSL § 363-369. The laws and regulations impact the administration of most of the pharmacy programs in place, including but not limited to, the Preferred Drug Program, Clinical Drug Review Program, Federal Drug Rebate Program, Drug Utilization Program and pharmacy drug reimbursement.

Mandated Funding Level: None

Brief Description/History/Background: The Medicaid pharmacy program is a federal, state and locally funded program that provides comprehensive drug coverage to eligible low-income persons in the State. The New York State Medicaid Pharmacy program covers medially necessary Food and Drug Administration approved prescription drugs. The program also covers certain over-the-counter (OTC) drugs. Only those drugs on the New York State Medicaid list of reimbursable drugs are eligible for reimbursement. Certain drugs/drug categories require the doctor or other authorized prescribers to obtain prior authorization before the drug will be covered by Medicaid. The Medicaid program is designed to provide payment for drugs only after all other resources available for payment have been exhausted, as Medicaid is the payer of last resort. Medicaid enrollees must obtain drugs from a participating Medicaid pharmacy provider are responsible for any applicable co-pays. The Medicaid pharmacy program is responsible for administrative functions including the development of program policies and regulations, establishment of payment rates, drug utilization review, operations associated with claims transmission and systems, procurement development/contract management and drug rebate resolution/disputes.

Issues: Pharmacy expenditures continue to be a significant portion of the Medicaid budget. From 1996 through 2005, annual gross expenditures increased at a rate of approximately 15% to 20% per year. Pharmacy expenditures reached about $5.5 billion in SFY 05-06, but have been significantly reduced with the advent of Medicare Part D. NYS receives rebates on drugs from manufacturers under the Federal Rebate Program (described below) and through a supplemental rebate program. Optimizing rebates is key to controlling prescription drug spending.

Population Served: Approximately 4.1 million eligible Medicaid recipients, including, as of October 1, 2008, persons enrolled in Family Health Plus. Approximately 4,500 participating Medicaid pharmacies.

Performance Measures: The pharmacy program uses several cost/utilization management techniques/programs to ensure that drugs are being utilized in a clinically appropriate and cost effective manner.

Operate Mandatory General Drug Program (MGDO): With the exception of drugs subject to the Preferred Drug Program, state statute excludes coverage of brand-name drugs in the Medicaid

program when the Federal Food and Drug Administration (FDA) has approved a general product, unless a prior authorization is received.

Manage Preferred Drug Program (PDP): The PDP encourages providers to prescribe drugs that are therapeutically appropriate and cost effective within a particular drug class through the use of a Preferred Drug List (PDL). Preferred drugs on the PDL do not require prior authorization (PA), non-preferred drugs require PA. Total gross savings attributable to the PDP for SFY 06-07 was $82.5 million.

Operate Clinical Drug Review Program (CDRP): The CDRP is designed to ensure specific drugs are utilized in a medically appropriate manner. These drugs require PA because there are specific safety issues, public health concerns, the potential for fraud and abuse or the potential for significant overuse and misuse associated with these drugs. PA seeks to assure that the most medically appropriate, cost effective drug therapy is prescribed.

Capture Federal Rebates: The Federal Drug Rebate Program requires pharmaceutical manufacturers to sign a rebate agreement in order to have their drugs covered by state Medicaid programs. For SFY 06/07, Medicaid drug expenditures were $3.3 billion with $917 million (gross) in rebates invoiced. In addition, $7.3 million (gross) was obtained through the rebate resolution process which is used by the pharmacy to resolve drug manufacturer invoicing disputes.

Implement State Maximum Acquisition Cost (SMAC): SMAC prices are applied when determining the estimated acquisition cost (i.e. reimbursement amount) of multi-source generic drugs. The SMAC price is applied when it is the lowest referenced price available. The Medicaid program applies a SMAC price to many generic drugs because it is often the lowest price when compared to other pricing alternatives available to the pharmacy program. For SFY 06/07, the estimated SMAC cost avoidance was $72,807,625.

Implement Drug Utilization Review (DUR): DUR assess on a retrospective basis the proper use of outpatient drugs in the Medicaid program. Pharmacies and prescribers are notified of potential adverse effects, drug interactions, over utilization, etc. when appropriate. Total cost savings associated with DUR for 2006 were $142.7 million and for 2007 $145.3 million.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid – Finance and Reform

Mandate: Title XIX Federal Social Security Act
NYS SSL § 363-369

Mandated Funding Level: None

Brief Description/History/Background: The core mission of the Financial Planning and Fiscal Analysis (FPFA) Group is to assure Medicaid services are provided in an effective and efficient manner, such that Medicaid recipients have access to appropriate services at appropriate cost to the State and Federal Governments. The FPFA group performs the following critical functions:

- Reforming Medicaid rate and payment policies;
- Working with stakeholders to identify opportunities for the Medicaid reimbursement system to support a patient-centered Medicaid program that focuses on primary and preventive care;
- Analyzing Medicaid data to identify and address areas needing improvement;
- Propose reimbursement alternatives, and estimate related costs and savings; and
- Interface with policy, program and systems staff, as well as rate setters and other state agencies in these efforts.

The FPFA group, in conjunction with others, is currently in the midst of implementing the most sweeping reform of Medicaid ambulatory care reimbursement since the inception of NYS's Medicaid program more than four decades ago. Specifically, the group is actively engaged in implementing the provisions of Public Health Law section 2807(2-1), enacted in the SFY 08-09 budget, which requires a new ambulatory care reimbursement system based on ambulatory patient groups (APGs). This reimbursement methodology provides greater reimbursement for high intensity services and relatively less reimbursement for low intensity services.

By linking payments to the specific array of services rendered, APGs will make Medicaid reimbursement more transparent. Further, the investments of new funding in ambulatory care enacted in the SFY 08-09 budget will provide strong fiscal incentives for health care providers to improve the quality of, and access to, preventive and primary care services. This is a marked departure from the current ambulatory care reimbursement, which is a mix of out-of-date methodologies that have been, over the years, so frozen and capped as to no longer realistically reflect the cost of providing such care. These methodologies are mostly based on fixed dollar payments that do not vary by severity of illness.

Issues: Future budgets must continue ambulatory care reimbursement reform to end Medicaid's over-reliance on high cost inpatient services.

Population Served: Approximately 4.1 million Medicaid enrollees.

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Performance Measures: The FPFA group analyzes Medicaid data in an effort to assess areas that are appropriate for cost containment.

- Implement APGs for hospitals by December 1, 2008 and for Freestanding programs by March 1, 2009; and

- Implement Physician Fee updates by January 1, 2009.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid Utilization Management Modernization (UMM)

Mandate: Social Services Law

Mandated Funding Level: None

Brief Description/History/Background: UMM initiative would provide more rigorous clinical evaluations of the utilization threshold override applications (TOAs) similar to those used in the private health insurers, broaden the range of services and the number of recipients covered by the current Utilization Threshold Program (UTP), and restrict the use of approved overrides to the provider who requested them.

The new thresholds will be recipient centered. The clinical review process is focused only on high Medicaid service utilizing recipients. The modernized utilization review process brings Medicaid closer to the operational norms of health insurance plans, including value based purchasing. Accordingly, DOH is using the services of the SUNY Stony Brook School of Medicine through an Interdepartmental Service Agreement with DOH (8/10/06) to develop a modernized utilization review program through the development of relevant and current clinical standards for the utilization thresholds and the application of an enhanced clinical review of threshold override requests. Also, the use of modern web-based technology which would lighten providers' administrative burdens when requesting a override request.

The current utilization threshold review program enacted more than a decade ago, places arbitrary limits on the number of visits and prescriptions a patient can receive before the provider has to ask for approval of additional services for the patient. Existing utilization thresholds have no relation to the health of the patient and have no clinical foundation. At present, 99.8% of the 950,000 override requests received annually are approved in a perfunctory manner that does not improve the quality of recipient care. Services approved above the utilization thresholds can be provided by any Medicaid provider, thereby reducing provider and patient accountability and care management. The current program achieves minimal, if any, Medicaid program savings.

Issues: None

Population Served: Over 1 million Medicaid beneficiaries not enrolled in a managed care plan.

Performance Measures: Implement UMM program in the fall of 2008, review UMM criteria against nationally recognized evidence based criteria.

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Office of Health Insurance Programs
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Program: Medicaid Retrospective Utilization Review Project

Mandate: Social Services Law, Title XIX Federal Social Security Act

Mandated Funding Level: None

Brief Description/History/Background: The Retrospective Utilization Review Project (Retro UR) is a major component of the Department's initiative to upgrade and modernize its management of Medicaid utilization. The Department issued a Request for Proposal for the Retro UR contractor on April 30, 2008. The anticipated award dates is in November, 2008. Bids are due to the Department on August 15, 2008. Almost all fee-for-service Medicaid claims (including pharmacy and labs) will be retroactively reviewed against existing medical evidence and accepted treatment protocols. When inconsistencies are found between the evidence and current provider practice, the provider will be notified by the contractor. Providers that are repeatedly flagged for questionable clinical practices will be referred to DOH, and possibly the OMIG, for further follow-up.

The retrospective utilization review project is an essential component of the Medicaid program's utilization management modernization initiative. The project will: identify patterns of inappropriate health care using evidence based rules and by assessing resource utilization; provide analysis of the utilization of high-cost and high-risk Medicaid beneficiaries, many with co-morbidities; develop individual provider and beneficiary utilization histories; identify deficiencies in the level of care or quality of service by providers and their treatment protocols; provide documentation of excessive Medicaid program payments due to inappropriate utilization; and also identify providers who may benefit from education or other intervention concerning more appropriate service utilization.

Issues: None

Population Served: Approximately 4.1 million Medicaid beneficiaries

Performance Measures: The Retro UR contractor will be evaluated based on the quality of their utilization review of the Medicaid fee-for-service recipient population and also by the successful production of individual recipient profiles, individual provider profiles, standard and ad hoc reports required by the RFP, reviews of diseases /conditions and appropriateness of services. The expectation is that the contractor will be able to perform a thorough statistical and evidence based analysis to identify inappropriate Medicaid utilization.

- Implement Retro UR through contractor – Fall 2008.

- Evaluate contractor for quality of UR production of profiles and other statistical standards in UR contract.

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Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicare Part D Notifications to Medicaid Dual Eligibles

Mandate: Section 1935 (d)(1) of the Social Security Act

Mandated Funding Level: None

Brief Description/History/Background: Effective January 1, 2006, the federal government established a permanent prescription drug program for Medicare beneficiaries called the Medicare Part D Prescription Drug Program. This program is based on Section 1935 (d)(1) of the Social Security Act, requiring Medicaid to stop paying for prescription drugs as soon as Medicare starts to pay. New York State Medicaid also provides a "wrap-around" program which covers medications when the recipient is unable to receive them from their Part D plan.

Prior to July 1, 2006, the Medicaid program provided a complete wraparound drug coverage to ensure all Medicaid coverage drugs were readily available. Effective July 1, 2006, State legislation established limited wraparound coverage. Medicaid continues to provide Medicare Part D wrap around coverage for the following drug categories:
atypical antipsychotics, antidepressants, antiretrovirals used in the treatment of HIV/AIDS and anti-rejection drugs used in the treatment of tissue and organ transplants

The Department plans to conduct an extensive outreach effort to provide dual eligible enrollees, other Medicaid enrollees and Medicaid providers with information that will improve their understanding, knowledge, and appropriate use of the Medicare and Medicaid pharmacy benefit. The purpose of the notifications is to reduce Medicaid payment liability on Part D wrap claims and improve understanding and appropriate utilization of the pharmacy benefit by dual eligibles and other Medicaid enrollees.

Issues: None

Population Served: Medicaid/Medicare dual eligibles (approximately 600,000)

Performance Measures: The utilization associated with wrap around coverage is monitored on a monthly basis. Monthly expenditures associated with wrap around coverage average $500,000 per month. Enrollees, pharmacist and prescribers issues are monitored by DOH pharmacy staff against criteria standard.

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Program: Medicaid Chronic Illness Demonstration Projects

Mandate: Social Services Law § 364.1

Mandated Funding Level: None

Brief Description/History/Background: Legislation passed in January 2007, authorized the Department of Health (DOH) to establish Chronic Illness Demonstration Projects (CIDPs) in consultation with the Office of Mental Health and Office of Alcohol and Substance Abuse Services, for recipients with chronic medical and behavioral health conditions. The CIDP Program will fund multiple care management and coordination programs in across the State. The CIDPs are being procured to test care coordination activities and to develop replicable approaches to address the health needs and social barriers to care for medically and behaviorally complex beneficiaries exempt or excluded from mandatory managed care. Through a competitive procurement, the Office of Health Insurance Programs (OHIP) will select four or five contractors to undertake care coordination/management programs that will provide innovative interventions to the target population. It is anticipated that the CIDPs will result in improved health outcomes, improved, appropriate utilization of health care services and a more cost-effective use of Medicaid funds. A detailed evaluation will be completed by OHIP in concert with an external evaluator to review both the processes and outcomes of the demonstrations. CIDP staff will be responsible for programmatic and technical monitoring of the CIDPs.

Issues: None

Population Served: Primarily disabled Medicaid-only, FFS recipients, 19 years or older, who are medically and behaviorally complex and receive services across multiple provider agencies, have multiple co-morbid chronic conditions, such as: asthma, cardiovascular disease, chronic kidney disease and renal failure, diabetes, HIV/AIDS, and sickle cell anemia; and may also be diagnosed with mental illness and chemical dependence, either singularly or co-occurring.

Performance Measures: Each awarded CIDP will be fully evaluated for cost savings and Medicaid services utilization.

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Program: SUNY Contract

Mandate: Social Services Law 369-cc, Social Services Law 367-a, Public Health Law 276-b.

Mandated Funding Level: None

Brief Description/History/Background: This contract with SUNY is for the provision of various services to the Office of the Medicaid Inspector General and DOH/Office of Health Insurance Programs including but limited to: clinical and medical experts to support the review of claims, reviewing requests for medical prior approvals, and conducting clinical eligibility reviews of disabled individuals.

SUNY has subcontracted with the University of Massachusetts Medical School to provide support to OHIP for the implementation and improvement of the retrospective drug utilization review (Retro-DUR) process. To ensure that Medicaid patients receive safe, appropriate and effective medication therapy, OHIP is responsible for retrospective reviews of pharmacy claims. This process is designed to improve prescribing trends by educating physicians and pharmacists to potential issues, (e.g., over utilization, under utilizations, etc.) and determining if interventions are warranted. Under OHIP supervision, UMASS conducts the clinical review of approximately 2,000 selected cases per month.

SUNY has also subcontracted with UMASS to implement a pilot Medication Therapy Management Program. The Medication Therapy Management Program is currently in development and requires federal approval. Under OHIP supervision, UMASS will provide a management system, which will address medication adherence, patient self-care knowledge, pharmaceutical interventions, and referrals to medical treatment when necessary.

OHIP also utilizes the services of SUNY Stony Brook University Medical Center to assist in modernizing the Medicaid's Utilization Threshold Program over a two-year period; perform prior authorization activities for dental services, and support fraud detection initiatives.

Issues: None

Population Served: Medicaid fee-for-service beneficiaries

Performance Measures: OHIP utilizes a third party to evaluate the impact of the UMASS reviews by reporting pre- and post- intervention group changes in comparison to a control group. These results are reported in both percentage and dollar changes. OHIP will also monitor cases reviewed by UMASS to ensure that the review proves it is meeting OHIP's needs.

With the Medication Therapy Management Program in the development stages, it will be the responsibility of the subcontracted UMASS staff to develop a system of reports detailing the performance and cost impacts of the program.

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Office of Health Insurance Programs
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Program: Medicaid Primary Care Case Management Programs

Mandate: § 2111 of Public Health Law

Mandated Funding Level: None

Brief Description/History/Background: Legislation passed in 2005 provided the authority for the Department to establish no less that six geographically diverse disease management demonstration programs to eligible entities including for-profit, not-for profit and local government agencies. The Disease and Care Management Demonstration (CMD) Program were established via a competitive RFP process to test new and innovative interventions for selected FFS recipients to achieve improved enrollee health outcomes and cost savings for the Medicaid program. Recipient enrollment in a CMD was to be voluntary and a CMD could not prohibit a recipient from obtaining Medicaid services to which they were entitled. Originally six CMD programs were funded (March 1, 2006- through February 29, 2008), of the original six demonstrations, two were selected for a one year contract renewal for the period of March 1, 2008 through February 28, 2009. The Office of Health Insurance Program's (OHIP), Divisions of Quality and Evaluation and Financial Planning and Policy is responsible for the management, and evaluation of the health and fiscal outcomes of the demonstration programs.

Based on findings from the original 6 CMDs and the 2 extended CMDs, OHIP plans to release another RFP for recipients in rural communities, in the winter of 2008 to continue to refine and test strategies to manage this complex population. in non-mandatory managed care counties. Utilizing a Primary Care Case Management (PCCM) model. This federally authorized model of care management which includes matching federal support will focus on the same medically complex patients but in rural settings. The basic premise of the PCCM model is the connection of a patient to appropriately skilled primary care provider who will be supported in care coordination activities by on site or remote (via telephone) clinical support staff. It is the experience in patient recruitment and retention from the first round of CMDs in western and northern New York rural areas that led to this revision in the focus of the demonstrations.

Issues: None

Population Served: Medicaid beneficiaries with chronic disease states (e.g., asthma, diabetes, congestive heart failure, chronic kidney disease) and others with high utilization of Medicaid services.

Performance Measures: Each awarded CMD will be evaluated for cost savings and reduction in Medicaid services utilization. Expectations include a 5% cost savings in Medicaid expenditures including CMD program costs, a reduction in the number of inpatient hospital admissions and emergency room visits, an increase in primary care provider visits, and increased adherence to prescribed medication appropriate for the diagnosed condition.

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Program: Financial Management, Oversight and Premium Development for Government Managed Care Programs

Mandate: PHL Article 44; SSL Section 364-j, 369-ee and 369-ff; Section 1115 Waiver

Mandated Funding Level: None

Brief Description/History/Background:
Premium development for government programs

- The Bureau of Managed Care Financing (BMCF) establishes plan-specific premiums for seven managed care government programs, for each participating plan: the mainstream Medicaid Managed Care Program, the Family Health Plus Program, the AIDS/HIV Special Needs Program, the PACE Long Term Care Program, the partially capitated Managed Long Term Care Program, the Primary Care Partial Capitation Program, and the Medicaid Advantage and Medicaid Advantage Plus Programs for Dually Eligible recipients. Together the premiums paid to these programs represent almost $7 billion in annual Medicaid expenditures.
- Premium proposals are submitted by each managed care plan (currently 26 mainstream and FHP plans and 16 MLTC plans) and bureau staff negotiate premiums with each individual plan based on each plan's benefit package and service areas.
- A new risk-adjusted rate setting approach is being phased in beginning April 2008 for the Family Health Plus and 1115 Waiver Medicaid Managed Care Program. The soundness of this reimbursement approach is vital to ensure that the managed care industry continues to support the provision of health insurance coverage to both Medicaid and uninsured Family Health Plus New York State residents.

MCO fiscal solvency and cost report monitoring:

- For each of the seven government-managed care programs described above, plan-specific cost reports are submitted on a quarterly and annual basis that provide financial, enrollment, and utilization data from each plan. Program staff monitors reports on a quarterly basis and conduct sometimes extensive followup on specific reporting problems or anomalies.
- Databases incorporating a high level of detail are maintained for each managed care program for each year of operation.
- For Prepaid Health Service Plans, Managed Long Term Care Plans and PACE plans, program staff is responsible for ensuring that each plan meets minimum reserve and escrow deposit requirements in accordance with Article 44, PHL and Part 98 Commission Rules and Regulations.

New program initiatives and cost containment (FHP Buy-In):

- Legislation was passed in 2007, allowing employers and Taft-Hartley funds to purchase Family Health Plus coverage for their employees via a new program called the Family Health Plus Employer Partnership Program (referred to as the FHP Buy-In Program). DOH must establish appropriate community-rated premiums for this program. This program is seen as a first step towards the Governor's Partnership for Coverage

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- Initiatives. Program staff in this bureau will need to review employer health insurance plans to determine whether they qualify for participation in the Family Health Plus Partnership Program, develop managed care plan premium rates based on community rating methodology, and develop reporting capability to track enrollment and payments for Family Health Plus Program eligibles who enroll in employer sponsored plans.
- Numerous budget-driven cost savings proposals are also developed by program staff, identifying areas for cost containment.

MCO/Provider Risk Contract Review:

- The financial provisions of managed care plan/provider contract must be reviewed and approved whenever substantial financial risk is passed on to the provider. This entails review of hundreds of contracts over an annual period.

FQHC Supplemental Payment Program:

- Federal law requires that supplemental payments be made to FQHCs who contract with managed care plans, for the amount that the FQHC's Medicaid fee-for-service prospective payment system rate exceeds the amount of payments provided under the managed care contracts for services rendered by the FQHC. These supplemental payments total over $130 million per year.
- There are currently 45 FQHCs participating in Medicaid managed care and eligible for such payments. Each FQHC must submit a copy of all MCO contracts annually, as well as a summary of payments received by the plans, and an FQHC-specific supplemental payment is calculated by bureau staff and loaded onto the MIS system.

Managed Care roster, provider and payment systems development and maintenance:

- Systems support is necessary to maintain monthly enrollment rosters for each of the seven payment programs, by county, by premium group.
- Monthly enrollment reports are prepared and distributed to a broad audience including CMS.

Budget Neutrality Monitoring of Section 1115:

- The state's Medicaid Managed Care and Family Health Plus Programs are supported via a federal 1115 waiver. This waiver has a budget neutrality requirement that must be tracked and reported on a quarterly, annual, and life of waiver basis. More recently, an additional waiver for the Federal State Health Reform Partnership was obtained, requiring a second set of reports. The continuation of the state's managed care program depends upon demonstrating cost "savings" adequate to support the programs.

Issues: Capitation rates must be cost effective for the state, adequate to support plan operations, and meet federal actuarial soundness tests.

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The 1115 waiver expires September 30, 2010 were a complete set of cost, eligibility and enrollment projections plus budget neutrality demonstration must be submitted by April 1, 2009.

Populations Served: Medicaid, Family Health Plus, Managed Long Term Care, PACE, Medicaid Advantage dual eligibles, Medicaid Advantage Plus Dual eligibles, HIV Special Needs Plans

Performance Measures: Plan rates for all programs are established timely and appropriately and are actuarially sound.

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Program: Managed Care Development and Implementation

Mandate: PHL Articles 44 and 49; SSL Sections 364-j, 369-ee and 369-ff; Section 1115 of the Social Security Act, Federal regulations at 42 CFR 438

Mandated Funding Level: None

Brief Description/History/Background:

- Section 1115 Waiver maintenance and reporting: Ensure compliance with the federal Centers for Medicare and Medicaid Services (CMS) Terms and Conditions for New York's Section 1115 waivers – the Partnership Plan authorizes a mandatory program for most Medicaid recipients and the Federal-State Health Reform Partnership (F-SHRP) aims to reconfigure and "right size" the State's health care delivery system.
- Legislation, regulation and policy review and development: Review proposed law/regulations to determine the impact on the waiver programs and consistency with Federal and State law/regulations and propose law/regulations/waivers changes as necessary.
- Program development for special populations: Analysis, planning and technical assistance provided for the addition of new populations (e.g., SSI) to the Section 1115 waiver to ensure continuity and quality of care.
- Consumer assistance: MMC consumers, health plans and providers rely on staff to resolve problems involving eligibility, enrollment, access to care, covered benefits and claims payment issues.
- Contract administration: Administer 82 contracts with managed care plans for MMC, FHPlus, HIV Special Needs, Medicaid Advantage, Medicaid Advantage Plus and managed long term care. Consultant services contracts include: MMC enrollment broker; actuarial consultant; a contract for specialized computerized modeling programs to model proposals to achieve universal health coverage; the evaluation of the waiver programs; and a MMC technical assistance contract.
- Local program development: Provide technical assistance and training to health plans, local districts, facilitated enrollers, stakeholders and other state agencies in development and implementation of MMC programs.
- Marketing Oversight: Review MMC organizations' marketing plans, marketing materials, member handbooks and member notices to ensure compliance with DMC's marketing guidelines and program requirements.
- Stop-loss payments: Review and adjudicate stop-loss claims from MMC plans for enrollees who receive unusually costly services.
- Retroactive disenrollments: Work with local districts to coordinate the recovery of inappropriately paid capitation premiums to Medicaid managed care plans. To date, the program has recovered slightly over $10 million in voided premiums.

Issues: The 1115 waiver expires September 30, 2010 and must be extended.

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Population Served: Medicaid population (TANF, Safety Net, SSI), FHPlus population, local social services departments, managed care plans, health care providers serving managed care enrollees, enrollment facilitators, community based organizations, and other state agencies.

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Program: Managed Long Term Care (MLTC) Development, Implementation and Monitoring

Mandate: Public Health Law §4403-f

Mandated Funding Level: None

Brief Description/History/Background: Long Term Care Integration and Finance Act of 1997 consolidated authority and requirements for several existing managed long term care demonstrations and authorized new MLTC plans as selected by the legislature. Legislation in 2005 and 2006 permitted additional plans to be selected by the legislature and DOH up to a maximum of 50. Pursuant to the authorization of Special Needs Plan under the 2003 Medicare Modernization Act, a new MLTC model, Medicaid Advantage Plus was implemented in 2007 that allowed DOH to combine primary acute services funded by Medicare Advantage Plan with long term care services offered via capitated Medicaid plans thereby providing fully comprehensive package of services. Currently, there are three operational models in NYS, the Medicaid Advantage Plus, Programs of All-Inclusive Care for the Elderly (PACE) and partially-capitated managed long-term care.

Responsibilities include developing MLTC plan policy; MLTC plan certification, monitoring and surveys to assure compliance with statutory, regulatory and contractual requirements; developing and monitoring contracts; MLTC data collection and analysis; providing technical support and guidance to local districts, and investigating plan member complaints.

Issues: Federal (CMS) moratorium on special needs plans has halted development of integrated models for Medicare and Medicaid.

Population Served: Chronically ill or disabled nursing home eligible individuals in need of long term care services to remain in the community. With the exception of the Program of All Inclusive care for the Elderly (PACE), enrollees must be least 18 years of age. PACE participation requires member to be at least 55. As of July 2008, 17 operational plans serving over 24,000 members; 10 new MLTC plans or additional products at various stages of development; 21 additional plans could be designated by the Legislature and DOH.

Performance Measures: Conduct on-site surveys to evaluate plan compliance with statutory, regulatory/contractual requirements; annual performance improvement projects; review and approval quality plans annually, satisfaction surveys. Plans submit financial, semi-annual assessment of members, grievances and appeals, fraud and abuse, enrollment/disenrollment, provider networks, and encounter data.

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Program: Medicaid Managed Care Enrollment Broker

Mandate: SSL 364-j, SSL 369-ee

Mandated Funding Level: None

Brief Description/History/Background: In 1996, the Department of Health issued a Request for Proposals (RFP) to obtain the services of a contractor to provide managed care education, outreach and enrollment services in support of the Medicaid managed care program. In April, 1998, Maximus, Inc. was awarded the contract as a result of this procurement. Since then, the contract has been reprocured twice (2001 and 2005) and Maximus was the winning bidder on both occasions. The enrollment broker began operations in New York City in 1998. Maximus expanded services in 2007/08 to include mandatory enrollment of the SSI population in NYC and 323 upstate counties.

Currently, Medicaid managed care is mandatory in 23 counties throughout NYS. There are 13 counties in addition to New York City that utilize the services of Maximus. The current contract requires Maximus to establish and implement consumer education and outreach programs in NYC, including group presentations at local districts; provide group and one-on-one presentations regarding managed care information to prospective enrollees; provide one-on-one enrollee counseling, either by telephone or through face-to-face counseling sessions; establish enrollment and disenrollment procedures and support systems; provide routine reports regarding enrollments, disenrollments and complaints; and operate a toll-free HelpLine. The broker also provides enrollment services for HIV, SNP, the Medicaid Advantage program, and Managed Long Term care enrollment in NYC.

Issues: Broker costs will increase in the event mandatory enrollment is expanded to include additional populations and as additional counties request their services.

Population Served: Medicaid and Family Health Plus enrollees and applicants in NYC and other counties using contractor services.

Performance Measures: The contractor is required to provide reports to the Department, which are used to evaluate the quality, appropriateness and timeliness of contractor services. The contractor reports include enrollments, auto-assignments, exemptions/exclusions; HelpLine inquiries; complains and resolutions; and enrollee satisfaction survey results.

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Program: Medicaid and Family Health Plus HelpLines

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The Medicaid HelpLine is a toll-free line that receives calls related to Medicaid co-payment, fraud, eligibility, and general Medicaid information. The HelpLine receives approximately 60,000 calls per month, of which approximately 1,000 are about suspected fraud. Though the number of fraud calls received increased by only 19% from April 2007 to April 2008, the number of reports submitted to the Office of the Medicaid Inspector General increased by 47% for the same period. Multi-lingual capability is available. The Family Health Plus HelpLine answers inquiries regarding the Family Health Plus program.

Issues: Effective with the start-up of the Enrollment Center, the responsibility for the calls received by the HelpLines will be assumed by the contractor.

Population Served: Callers to the Medicaid HelpLine include Medicaid clients, providers and callers requesting general information regarding Medicaid. Callers to the FHP HelpLine include FHPlus clients as well as members of the general population interested in learning about or enrolling in the Family Health Plus program.

Performance Measures: Number of calls received, average wait time, number and percentage of abandoned calls.

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Program: Medicaid Management Information System (MMIS) Contractual Services

Mandate: Title XIX of Federal Social Security Act, Chapter 407 of the Laws of 1978

Mandated Funding Level: None

Brief Description/History/Background: NYS undertook development of an MMIS to pay all Medicaid provider claims in the late 1970s. MMIS operations are currently maintained through a contract with Computer Sciences Corporation (CSC). CSC provides contractual services as the MMIS fiscal agent (eMedNY), processing Medicaid payments to medical providers for services provided to Medicaid clients. FOX is the business consultant which assists the Department in quality assurance activities and development of the request for proposal to secure the services for a successor eMedNY contract. The eMedNY contract is a technologically advanced claims processing system that incorporates features for efficient front-end processing and information storage and retrieval. Additional abilities include on-line adjudication of claims, verification of Medicaid eligibility, and fraud control functions and operation of the Medicaid data warehouse. The data warehouse provides the capability for enhanced monitoring and analysis in targeting, evaluating and managing the Medicaid program for cost containment, quality of care, fraud and abuse, audits and utilization surveillance. Federal reimbursement is available for all activities at 90 percent for development, 75 percent for operations and 50 percent for some overheads.

Issues: The Fiscal Agent contract must be re-procured in the next 24 months.

Population Served: Approximately 4.1 million Medicaid beneficiaries; providers who participate in the Medicaid program; DOH, DOB, OMIG and other state agencies that receive and rely on data from MMIS for program development, monitoring, budgeting and auditing.

Performance Measures: The eMedNY contract requires CSC to prepare monthly operations reports. These reports are the basis by which staff measure and determine CSC's performance according to contract standards. In addition, CSC's performance on the eMedNY contract is reviewed and assessed by FOX.

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PROGRAM: Medicaid Management Information System (MMIS) Staff Costs

Mandate: Federal Social Security Act, NYS Social Services Law

Mandated Funding Level: None

Brief Description/History/Background: Medicaid Management Information staff include information technology professionals and subject matter experts who analyze the business needs of the Medicaid program and work with the contractor or other state agencies to ensure that the systems meet the needs of the program and comply with requirements of federal and state law. They are responsible for designing and overseeing three major information systems as described below.

Under the direction and oversight of Department staff, New York State's federally certified MMIS, eMedNY, is operated and maintained under a fiscal agent contract with Computer Sciences Corporation (CSC). eMedNY operates 24 hours a day, 7 days a week. It is large and complex, comprising 11 subsystems, hundreds of modules and over 16 million lines of code. eMedNY processes more than 100 million eligibility verification requests, 350 million claims and payments in excess of $40 billion annually to providers participating in Medicaid. It supports statewide eligibility verification, claims processing and the New York Medicaid Web site. The eMedNY call center handles nearly a million telephone calls a year from Medicaid providers. The system supports over 8,700 system users and more than 60,000 participating medical providers.

The Medicaid Data Warehouse is one of largest of its type and supports Medicaid by providing Department staff and staff at the Office of the Medicaid Inspector General, Division of the Budget, Office of the State Comptroller and other agencies involved in administering the Medicaid program with the information needed to design, analyze and audit the Medicaid program.

The Welfare Management System (WMS) is operated by the Office of Temporary Disability and is used by the local social services district to process and determine eligibility for Medicaid. In addition, Medicaid Management Information staff has developed and continues to expand a system called EEDSS. EEDSS is a question set that allows the user to respond to a set of questions and determines eligibility based on business rules. EEDSS is already used by many local social services districts and will be used by the enrollment center to process eligibility applications.

Issues: eMedNY has long had a backlog of evolution projects. These projects are essentially system changes that are needed to comply with changes in federal and/or state law and to improve program integrity. Significant progress is being made in reducing the backlog of projects.

WMS is an old system and often lacks the flexibility needed to make timely changes to comply with eligibility rules and implement new programs.

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Both the Medicaid Data Warehouse and eMedNY are in the process of being reprocured. They are among the largest technology procurements in the State. OTDA is also in the process of redesigning WMS. These activities place significant additional demands on staff.

Population Served: Approximately 4.1 million Medicaid beneficiaries, local social services districts, State agencies involved in the administration of Medicaid, and providers of medical and other services

Performance Measures: Contracts contain service level agreements and associated penalties.

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Program: Medicaid Program Operation and System Support

Mandate: Title XIX of the Federal Social Security Act, Social Services Law

Mandated Funding Level: None

Brief Description/History/Background: Eligibility criteria for Medicaid have become more complex over the last 30 years. To assist the local districts in undertaking this activity, the State has developed numerous systems that provide automated support for determining eligibility and recertifying recipients as well as providing timely notice of actions taken. Specifically, system support includes: system design and processing rules for the Medicaid component of the Welfare Management System (WMS), design, development and maintenance of the Medicaid Electronic Eligibility Decision Support System, design and rule definition for the Medicaid Budget Logic system and the Medicaid portion of the Client Notices Subsystem of WMS as well as staffing a help desk and providing training to local district staff. All these activities are reimbursable from CMS at 50 percent.

Issues: Timely implementation of changes across all systems to meet new state & federal legislation. Development of edits/enhancements to prevent and/or respond to legal actions that ensue when the processes for a specific client situation do not appropriately manage eligibility and enrollment.

Population Served: Approximately 4.1 million Medicaid beneficiaries and those applying for coverage. Local social services districts who currently determine program eligibility and the soon to be established Enrollment Center.

Performance Measures: None

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Program: Medicaid Statistics and Program Analysis

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Bureau staff is responsible for conducting analysis of various programs and providers in Medicaid fee-for-service, evaluating demonstration programs and producing numerous cost and utilization reports for various users including Department staff, DOB and the Legislature. They provide cost estimates for new programs and forecast future spending. They evaluate the success of programs designed to control spending and improve outcomes, especially for persons with multiple conditions. Staff also provides analytic support for multiple drug rebate programs.

Issues: None

Population Served: Medicaid recipients

Performance Measures: Ad hoc performance measures developed in response to various program needs. Longitudinal studies are used to assess the impact of new programs.

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Program: State Enrollment Center

Mandate: PHL §206(24), as added by §39 of Part C of Chapter 58 of the laws of 2008

Mandated Funding Level: None

Brief Description/History/Background: Eligibility for the public health programs is determined by the 58 Local Departments of Social Services (LDSS) for Medicaid and the 23 participating health plans for the Child Health Plus (CHPlus) program. This decentralization has led to the inconsistent application of program rules across the state, duplication of efforts, and greater inefficiency. In addition, the volume of applications and renewals has strained the resources at many local districts, leading to delays in enrollment.

The Enrollment Center is being developed to improve consistency and efficiency and to reduce the backlogs in some areas of the state. As the only entity able to enroll and renew for both Medicaid and Child Health Plus, it will ease the transitions between the two programs. The centralization of some aspects of the Medicaid, FHP, and CHPlus enrollment process will eliminate duplication of efforts across local districts and health plans. The Enrollment Center is also an ideal entity to use technology to improve both the timeliness and efficiency of enrollment and program integrity. Over time the volume of applications/renewals processed at the local districts and health plans will decline, producing overall cost administrative savings for the program.

The Enrollment Center's initial focus will be on improving renewals. By creating a centralized telephone renewal option, renewals should be completed faster with fewer people losing coverage at renewal. Since most of those who lose coverage are eligible and return to enroll within a few months of losing coverage, preventing the gap in coverage will improve continuity of care for the enrollee and eliminate the administrative costs of processing new applications from failed renewals.

The enrollment center will also:

- Combine and operate the current Medicaid and CHPlus hotlines;
- Test new innovative techniques for maintaining enrollment in public health insurance programs;
- Administer the Premium Assistance and the Family Health Plus Employer Buy-in programs; and
- Process new applications and other renewals.

The Enrollment Center will be located in New York State. A Request for Proposals (RFP) has been developed.

Issues: None

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Populations Served:

- Individuals covered by or eligible for Medicaid, FHPlus and CHPlus;
- Local Departments of Social Services (LDSS); and
- Health insurance providers.

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Payment Error Rate Measurement (PERM)

Mandate: Improper Payments Information Act (IPIA) of 2002, Pub. L. 107-300

Mandated Funding Level: None

Brief Description/History/Background: The IPIA requires Federal agencies to:

- Review programs that are susceptible to significant erroneous payments;
- Estimate the amount of improper payments;
- Report those estimates to Congress; and
- Outline actions to be taken to reduce erroneous expenditures.

As a result, the Centers for Medicare and Medicaid Services (CMS) published regulations, which set forth the methodology for measuring improper payments in Medicaid and CHPlus. The methodology requires states to undergo a combination of reviews:

- Fee-for-service claiming (which includes medical reviews);
- Managed care claiming; and
- Eligibility determinations.

A national improper payment estimate is computed based on the aggregate of the state-specific review results.

In accordance with the timeframes established by CMS, NYS implemented its PERM program in July 2007. Currently, contract staff are conducting the required monthly eligibility reviews, as well as compiling the data requested by CMS for the fee-for-service and managed care claiming reviews. The first review cycle is expected to be completed by June 2010. Activities for the next review cycle are expected to begin in July 2010.

Issues: None

Population Served: CMS

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid Eligibility Quality Control (MEQC)

Mandate: §1902(a)(4) and §1903(u) of the Social Security Act

Mandated Funding Level: None

Brief Description/History/Background: For approximately 30 years, the Centers for Medicare and Medicaid Services (CMS) have required states to conduct an annual Medicaid Eligibility Quality Control (MEQC) review. Since 1998, as a result of meeting the federally mandated error rate tolerance level of three percent, CMS has allowed NYS to conduct an annual review that targets a specific part of the Medicaid program in lieu of a traditional MEQC review, which must include a sample of cases from the entire Medicaid program. Reviews are conducted in accordance with federal regulations and the audit plan, which is annually reviewed and approved by CMS.

In November 2007, this function was transferred from OTDA to DOH. Contract staff is currently working to complete the 2007 review, which was approved by CMS in August 2007. Additionally, work has begun the 2008 review, which was approved by CMS in March 2008.

Furthermore, this group conducts the annual review of the Family Planning Benefit Program, which is also required by CMS under the Partnership Plan (a Medicaid section 1115 demonstration).

Issues: None

Population Served: CMS

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid Administration

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The Medicaid program is a Federal/State partnership that provides services to low income families who meet proscribed eligibility criteria. The Bureau of Medicaid/FHPlus Enrollment is responsible for developing and disseminating the policy and enrollment rules for Medicaid and Family Health Plus. It provides support to the local districts in understanding and complying with the rules of the programs. It manages the Training Institute that provides training to all local district eligibility workers and facilitated enrollers. It interprets policy for local districts and resolves consumer complaints. The Bureau also coordinates with any third-party coverage. It provides program expertise to the Division of Legal Affairs for litigation against the Medicaid program. It also prepares all documents required by the Center for Medicare and Medicaid Services including state plan amendments and communicates with CMS on behalf of the Medicaid and Family Health Plus Program.

Issues: None

Population Served: Low income families who are eligible for Medicaid. Department staff provides direction to the Local Departments of Social Services, legislature staff, Department staff and potential applicants.

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid Provider Credentialing and Enrollment

Mandate: Social Security Act Sections 1128, 1156, 1892

Mandated Funding Level: None

Brief Description/History/Background: The Rate Based Provider Bureau enrolls New York State Medicaid and out of state institutional providers who currently bill using rate codes. Staff use the eMedNY system to perform provider file maintenance such as activating providers, designating locator codes and range of services approved by certification of need and Medicare. The Bureau interacts with certifying entities through the Certificate of Need process in DOH, OMRDD, OASAS and OMH and addressing over 3,000 calls and e-mails per month from rate-based providers.

The Fee for Service Bureau processes 15,000 provider applications each year for New York State Medicaid in state and out of state fee for service providers, specifically Businesses (including Pharmacy, DME, Laboratory, Licensed Practitioners and Transportation) confirming their credentials in accordance with applicable Stare and federal law and regulations. The Bureau also maintains the provider files, such as, ensuring licenses are updated and any discrepancies are resolved, ensuring that specialties are processed and updated and changes are made to the provider's status as requested by the provider or OMIG. The Bureau also responds to approximately 3,000 telephone inquiries each month.

Issues: The Bureaus are heavily involved with systems and file maintenance work related to National Provider ID implementation and will be a focal point in APG implementation.

Population Served: Medicaid Fee for Service beneficiaries, Managed Care beneficiaries for whom institutional rate based services are carved out of the benefit package, providers of service.

Performance Measures: Accurate provider file enrollment and maintenance in accordance with the certifying entity and Medicaid law and regulations.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid Claims Policy Development

Mandate: Social Security Act

Mandated Funding Level: None

Brief Description/History/Background: The Division is responsible for policy development for Dental, Durable Medical Equipment, Prosthetics, Orthotics, Supplies, Private Duty Nursing and Hearing Services. The specific duties involve developing standards and coverage criteria, researching applicable laws and regulations, updating and developing position papers, policy manuals and regulations, servings as experts on the various policies and interfacing with government, beneficiary and provider stakeholders.

Issues: Coverage policies and processes for durable medical equipment (DME) has received much scrutiny and press over recent months. DOH has revised prior authorization and coverage policies and has greatly improved turnaround time on coverage requests.

Population Served: Medicaid Fee for Service beneficiaries and Medicaid Managed Care beneficiaries for whom certain services are carved out of the benefit package.

Performance Measures: Maintaining current policy sections for the provider manuals, providing adequate notice on policy changes and responsiveness to stakeholder concerns are the most applicable measures.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid Provider Relations, Education and Communications

Mandate: Social Security Act

Mandated Funding Level: None

Brief Description/History/Background: The Division maintains a toll free number for providers who require information regarding prior approvals, pended claims, fees and rates, coverage criteria and billing assistance. In addition, the Division is responsible for the fee schedule, procedure code and some policy section revisions to the Medicaid Provider Manuals. Staff also maintain critical interfaces with provider groups with regards to changes in Medicaid, compliance with rules and regulations and receiving input on improvements to the program.

Issues: Access to certain provider types, including primary care and specialists, is limited in some areas of the State. In 2009, with increases in the physician fee schedule and the Governor's Doctors Across New York, there will be a renewed effort to recruit providers in these areas.

Population Served: Medicaid Fee for Service beneficiaries and Medicaid Managed Care beneficiaries for whom certain services are carved out of the benefit package, and providers of service.

Performance Measures: The Division maintains phone record reports regarding the volume of calls handled and efficiency.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid File Maintenance

Mandate: Social Security Act

Mandated Funding Level: None

Brief Description/History/Background: The eMedNY rate files are maintained by the Rate Based Provider Bureau. Rate codes are the primary method of reimbursement for clinics, nursing homes, outpatient treatment and habilitation facilities, and residential programs. This includes loading and review of rates, locator codes and ranges of services approved by certificate of need and Medicare, maintenance of the Service Intensity Weight (SIW) payment table. In addition the Bureau incorporates any changes in the rate-based payment methodology into payment file changes. Significant coordination is required with rate-setting entities in DOH, OMRDD, OMH and OASAS.

The eMedNY procedure (CPT and HCPCS) and diagnosis (ICD-9) files are maintained by the Program Innovation and Coordination Bureau. It maintains and updates these files so that eMedNY can process claims accurately for fee-for-service and rate based providers. The files are updated quarterly, annually and as needed. The Bureau is responsible for ensuring that all file parameters are accurate in accordance with Medicaid program policies and regulations. This involves coordination with various policy areas and researching information on medical products and services as a basis for determining pricing and other program parameters.

Issues: None

Population Served: Medicaid Fee for Service beneficiaries and Medicaid Managed Care beneficiaries for whom certain services are carved out of the benefit package.

Performance Measures: Timely, accurate and documented rate file maintenance. Claim payment accuracy.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid Utilization Review

Mandate: Social Security Act

Mandate Funding Level: None

Brief Description/History/Background: The Medical Pended Claims Bureau is responsible for reviewing, after service but before payment, claims that are pended for manual review and pricing within the eMedNY system based edits set to enforce program requirements on the payment of services. Staff review documentation to verify that the service performed is within the scope of the Medicaid program. The Bureau also reviews and processes all claims for payment over two years old.

The Medical Prior Approval Bureau is responsible for managing the interface of policies, standards and guidelines on the eMedNY system for the adjudication of Medicaid prior approvals and electronic prior authorizations. Services reviewed and authorized include durable medical equipment, medical supplies, private duty nursing, hearing aids and dental services. The requests are generally reviewed prior to service delivery and must be completed within regulator timeframes. Reviewers determine whether documentation is present supporting Medicaid payment for the services requested.

The Dental Pended Claims Bureau is responsible for reviewing all Medicaid dental claims pended within the eMedNY system based edits set to enforce program requirements on the payment of services. Staff review documentation to verify that the service performed is within the scope of the Medicaid program.

The Dental Prior Approval Bureau is responsible for managing the interface of policies, standards and guidelines on the eMedNY system for the adjudication of Medicaid prior approvals and electronic prior authorizations for dental services. The requests are generally reviewed prior to service delivery and must be completed within regulatory timeframes. Reviewers determine whether documentation is present supporting Medicaid payment for the services requested.

Issues: Utilization review is an important tool to ensure high quality, cost-effective care. More emphasis and specialization of Utilization Management is planned for 2009.

Population Served: Medicaid Fee for Service beneficiaries and Medicaid Managed Care beneficiaries for whom certain services are carved out of the benefit package and medical providers.

Performance Measures: Performance measures include, cost avoidance and approval turn-around time.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid Systems Design, Development and Testing

Mandate: Social Security Act

Mandated Funding Level: None

Brief Description/History/Background: Core processes occur through transactions in the eMedNY provider, reference, prior authorization, and claims subsystems subsystems. Whenever system changes need to be made to address legislative and departmental initiatives, respond to audit findings, address fraud and abuse and improve operations, subject matter experts (SMEs) become highly involved with design and development and ultimately testing. SMEs are closely involved with identifying and determining requirements for replacement systems as well.

Issues: None

Population Served: Medicaid Fee for Service beneficiaries and Medicaid Managed Care beneficiaries for whom certain services are carved out of the benefit package.

Performance Measures: The performance measures for the eMedNY system are maintained by the systems division.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid Fair Hearings

Mandate: Title XIX of Social Security Act

Mandated Funding Level: None

Brief Description/History/Background: Under Medicaid law and regulations, Medicaid beneficiaries have the right to a fair hearing should they disagree with determinations made by the Department with regard to provision of services. Fair Hearings are requested when medical and dental prior approval staff determine that insufficient documentation was presented to support medical necessity or if the requested service is beyond the scope of the Medicaid Program. Staff prepares a detailed agency response in preparation for the fair hearing and are often called to participate in the hearing and charged with implementing the decision of the fair hearing officer. If patterns emerge relating to overturning agency decisions, legal and policy areas are requested to provide input and evaluation of current processes and policies.

Issues: None

Population Served: Medicaid Fee for Service beneficiaries and Medicaid Managed Care beneficiaries for whom certain services are carved out of the benefit package.

Performance Measures: Compliance with Fair Hearing decisions.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicaid/Other Rate Setting

Mandate: Public Health Law Article 25, 28, 36, and 40
Social Services Law Article 5

Mandated Funding Level: None

Brief Description/History/Background: DOH staff sets Medicaid reimbursement rates and other authorized payments for Hospitals, Nursing Homes, Diagnostic and Treatment Centers, Certified Home Health Agencies, Long Term Home Health Care Programs, Personal Care, Hospice, Private Duty Nursing, Foster Care and Early Intervention. Rate setting methodologies are continuously re-evaluated and modified as changes are made to the Medicaid program.

Issues: None

Population Served: Medicaid recipients and providers

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Hospital Institutional Cost Report

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: DOH executes a contract with a contractor to update and maintain the software used to collect hospital annual cost and statistical data required by the Department to establish Medicaid reimbursement rates. This collection of data is used to calculate Medicaid rates and provides information for database analysis of the hospital industry. The Department has been collecting this data since the early 1970's. Until 1988, this data was collected manually and keyed into a computer system. In the late 1980's, this collection process was automated into a computer software application and has been continually enhanced over the years. The contractor reports to DOH on progress during development and shares software for testing and evaluation. The contractor also annually accompanies DOH staff on statewide training and update sessions provided to hospitals. Ongoing collection of this data is critical to ensuring appropriate Medicaid payments to hospitals.

Issues: None

Population Served: Medicaid recipients and NYS Article 28 certified hospitals.

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Public Hospital R&R Grants

Mandate: Public Health Law 2807-c(30)

Mandated Funding Level: None

Brief Description/History/Background: PHL provides authority for the commissioner to make grants to public general hospitals for the purpose of recruitment and retention of health care workers.

Issues: None

Population Served: Hospitals and their non-supervisory labor force.

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Public Nursing Home R&R Grants

Mandate: Public Health Law 2808-(18)(b)

Mandated Funding Level: None

Brief Description/History/Background: PHL provides authority for the Commissioner to make grants to public RHCFs without a competitive bid or request for proposal process, for the purpose of recruitment and retention of health care workers.

Issues: None.

Population Served: Nursing Homes and their non-supervisory labor force.

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Non Public Hospital Grants 2807c(30) c

Mandate: PHL 2807-c(30)(c)

Mandated Funding Level: None

Brief Description/History/Background: Under Federal Law, Medicaid Disproportionate Share Hospital (DSH) payments cannot exceed each hospital's net loss for treating Medicaid and uninsured patients. Increases to hospitals' Medicaid revenue can potentially result in them incurring fewer Medicaid losses, thus displacing some or all their DSH payments. For this reason, HCRA funds were allocated from the Tobacco Control and Insurance Initiatives Pool to mitigate any potential displacement of DSH that might result from Medicaid increases for added worker recruitment and retention Medicaid rate adjustments. Available funds are allocated proportionally among hospitals based on the amount of each facility's displaced Federal DSH that resulted from such increased Medicaid payments to the total of such displaced Federal DSH for all hospitals.

Issues: None

Population Served: NYS Article 28 Hospitals

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Non Public Hosp Grants 2807c(25)(e)

Mandate: Public Health Law 2807-c(25)(e)

Mandated Funding Level: None

Brief Description/History/Background: Under Federal Law, Medicaid disproportionate share hospital (DSH) payments cannot exceed each hospital's net loss for treating Medicaid and uninsured patients. Therefore, increases to hospitals' Medicaid revenue can potentially result in them incurring fewer Medicaid losses, thus displacing some or all of their DSH payments. For this reason, HCRA funds were allocated from the Tobacco Control and Insurance Initiatives Pool to mitigate any potential displacement of DSH that might result from recently enacted Medicaid increases for graduate medical education. Available funds are allocated proportionally among hospitals based on the amount of each facility's displaced Federal DSH that resulted from such increased Medicaid payments to the total of such displaced Federal DSH for all hospitals.

Issues: None

Population Served: NYS Article 28 Teaching Hospitals

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Poison Control Grants

Mandate: Public Health Law 2807- l (1)(c)(iv)

Mandated Funding Level: None

Brief Description/History/Background: DOH staff perform calculations to distribute funding to the 5 regional poison control centers including 1 poison education center to offset costs of providing poison control services that are not reimbursed by payers statewide. Part 68.5 of the Commissioner of Health's Rules and Regulations provides the methodology for the distribution of these funds.

Issues: Because there are no variations necessitating regional approach, DOH recommends one consolidated Statewide contract.

Population Served: NYS residents in need of Poison Control Services and 6 hospital providers currently designated to provide these services.

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: D&TC Uncompensated Care

Mandate: Public Health Law 2807-p

Mandated Funding Level: None

Brief Description/History/Background: DOH Staff perform calculations and disburse funds which subsidize Comprehensive Diagnostic and Treatment Centers for losses they incur in providing health care services to the uninsured. Monies are allocated in HCRA to support this program and Section 2807-p of the Public Health Law sets forth the methodology for disbursement of these funds.

Issues: None

Population Served: Comprehensive Diagnostic and Treatment Centers and the uninsured patients they serve.

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Regulation/Medicaid State Plan Administration

Mandate: Title XIX of the Federal Social Security Act
Public Health Law 2808, Articles 25, 28,36 and 40
Social Services Law Section 367

Mandated Funding Level: None

Brief Description/History/Background: Various State Laws require regulations to be prepared by Staff to implement statutory provisions. Further, staff submit changes and modifications to Medicaid ratesetting and payment policies to the federal government by submitting Medicaid State Plan amendments.

Issues: Frequent statutory changes to the Medicaid program require extensive modifications to the State's federally approved Medicaid State Plan.

Population Served: NYS Medicaid recipients and providers

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Financial Analysis

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Activity involves analyzing the impact of existing and proposed health care financial payment and State revenue collection approaches. Also involves an assessment of the financial solvency of NYS health care provider industry and individual health care provider facilities to insure maintenance of a sufficient health care delivery system for residents. This activity will be critical in developing proposals to achieve changes to Medicaid program and in monitoring their affects.

Issues: None

Population Served: Medicaid recipients and health care providers

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: HCRA /Cash Assessment Revenue Collection

Mandate: Public Health Law 2807-c, 2807-d, 2807-j, 2807-s, and 2807-t

Mandated Funding Level: Surcharge and assessment rates are established in PHL. The law also allocates a portion of collected proceeds for State administration.

Brief Description/History/Background: The Public Health Law requires payment of authorized surcharges and assessments by specified payors and providers of health care services. Annual State collections from these surcharges and assessments exceed $3.5 billion annually. Payments are collected through a contract with a Pool Administrator. Staff administer this contract and related audits, monitor account and transfer transactions, and respond to issues raised by affected parties and constituents.

Issues: None

Population Served: None

Performance Measures: Meeting related State Fiscal Plan collection targets

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: HCRA Compliance Audits

Mandate: Public Health Law 2807-v

Mandated Funding Level: None

Brief Description/History/Background: DOH executes an audit contract with an independent certified public accounting firm to audit third-party payer and health care providers compliance with Health Care Reform Act (HCRA) surcharge and assessment obligations.

Issues: None

Population Served: None

Performance Measures: Related State Fiscal Plan collection target from these audits is $80 million annually.

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Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: HCRA Pool Administration

Mandate: Public Health Law 2807-d and 2807-v

Mandated Funding Level: None

Brief Description/History/Background: DOH executes a contract with Excellus of Central New York to administer collection and OSC transfers of Health Care Reform Act and Health Facilities Surcharge and Assessment payments.

Issues: None

Population Served: None

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: GME/Physician Shortage Initiatives

Mandate: Public Health Law 2807-m

Mandated Funding Level: None

Brief Description/History/Background: New York has the largest GME program in the country training over 16,000 residents annually. In addition, it has one of the largest physician to population ratios in the nation. However, serious physician shortages exist in rural and inner-city communities as well as among several specialties. The initiatives in this package help to reform GME program to train a diverse pool of physicians in the specialties and areas in need. In addition, it provides a substantial package of incentives to help place physicians in vital areas in need. This activity is critical to implement the Governor's Doctor's Across New York initiative.

Issues: None

Population Served: General population

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Center for Workforce Studies at School of Public Health

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Funding is used to support health workforce studies and to monitor key health professions in New York State that include: physicians, nurses, dentists and workers in local public health departments. This is accomplished through professional surveys that are included in license registries and exit interviews. Data is published in reports that are distributed to policymakers, educators, health care providers and the public on the health workforce supply and distribution. The program conducts the physician survey in coordination with the current physician license registration process managed by the NY State Education Department until completion of the current cycle of approximately 80,000 physicians. The program also surveys residents and fellows completing training in NYS residency programs. Approximately 4,500 residents each years completed the training. The survey responses are scanned, and the data is analyzed, the annual reports are prepared.

Issues: None

Population Served: General population

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: SUNY Minority Participation in Medical Education

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The goal of the Medical Scholars Program is to ensure that minorities are given educational opportunities in order to gain admission into medical school. The program provides minority students with scholarship funds for tuition and expenses. Upon successful completion of the program, the graduates earn an MS degree and are guaranteed admission into the SUNY's School of Medicine.

Issues: None

Population Served: Minority college students

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: CUNY Minority Participation in Medical Education

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: This program provides minority and economically disadvantaged high school and college students with educational experiences in order to gain admission to medical school. The program would enroll students in their junior year in high school in a five year program that would provide enrichment and support. Funds in the first year are for planning and program development with medical schools.

Issues: None

Population Served: Minority and economically disadvantaged students

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Graduate Medical Education (GME) Distributions, Incentive/Innovations Pool and Empire Clinical Research Investigator Program (ECRIP)

Mandate: Public Health Law 2807-m

Mandated Funding Level: None

Brief Description/History/Background: The GME "supplemental" pool provides monies to teaching hospitals and GME consortia to promote State medical education policy objectives in their institutions. Funds are distributed using a formulaic methodology based on the following objectives: (1) increasing minorities in medicine; (2) training opportunities for residents in ambulatory care sites, particularly in underserved communities; (3) training in cultural competence; and (4) reducing the number of specialty residents.

ECRIP, another component of this program, provides funding to train physicians in clinical research in order to advance biomedical research in New York's academic health centers. Awards are provided for one or two years for experienced researchers to mentor physicians in a specific clinical research project. Supplemental GME and ECRIP awards are calculated based on data and information submitted to DOH by teaching hospitals through the Health Provider Network.

Beginning in 2009, the GME Innovations Pool will provide funding on a competitive basis in order to assist teaching hospitals to reform their GME programs that meet State policy objectives. This activity is critical to implement the Governor’s Doctor's Across New York initiative.

Issues: None

Population Served: Teaching hospitals

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Ambulatory Training

Mandate: PHL 2807-m

Mandated Funding Level: None

Brief Description/History/Background: This program improves quality and continuity of care and provide unique clinical training experiences by providing stable GME funding to free-standing ambulatory settings. Residents provide a large amount of health care services to New York's patient population. As services shift from inpatient to outpatient settings, including free-standing ambulatory care sites, appropriate reimbursement is needed to support GME in all settings. Presently, free-standing ambulatory settings are not provided funding to support training. As the costs of inpatient services increase, less expensive preventive primary care services are being utilized. As a result, residents are transitioning to outpatient settings to receive training and provide care. In return, free-standing ambulatory care sites require appropriate support to provide training and patient care. Funds are allocated to sponsoring institutions and directed to free-standing ambulatory care sites. Two-thirds of the available funding is allocated to New York City. This activity is critical to implement the Governor’s Doctor's Across New York initiative.

Issues: None

Population Served: General population, including vulnerable populations that receive care in ambulatory care settings

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Physician Loan Repayment

Mandate: PHL 2807-m

Mandated Funding Level: None

Brief Description/History/Background: There is a serious shortage of physicians in rural and poor urban areas throughout New York. Over one-quarter of the State's population live in areas that lack an adequate supply of primary care physicians. Not only does New York State have shortages of primary care physicians, but many areas have shortages of critical specialists including OB/GYNs, general surgeons and child psychiatrists. This program provides up to $150,000 in a loan repayment award to physicians who agree to practice in an underserved area within New York State for five years. This program, in conjunction with the Physician Practice Support Initiative, and other incentives to reimbursement physicians in underserved communities, provides up to a quarter of a million dollar package to physicians to work in these shortage areas. This activity is critical to implement the Governor’s Doctor's Across New York initiative.

Issues: Requires amendment to statute to clarify eligible applicants.

Population Served: General population in underserved communities, including rural and inner-city areas

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Physician Practice Support

Mandate: PHL 2807-m

Mandated Funding Level: None

Brief Description/History/Background: There is a shortage of physicians in rural and poor urban areas throughout New York more than one-quarter of the State's population live in areas that lack an adequate supply of primary care physicians. Not only does New York State have shortages of primary care physicians, but many areas have shortages of critical specialists including OB/GYNs, general surgeons and child psychiatrists. This program provides up to $100,000 in physician practice support funding to physicians who agree to practice in an underserved area within New York State for four years. This program in conjunction with the Physician Loan Repayment Program, and other incentives to reimbursement physicians in underserved communities, provides up to a quarter of a million dollar package to physicians to work in these shortage areas. This activity is critical to implement the Governor’s Doctor's Across New York initiative.

Issues: None

Population Served: General population in underserved communities, including rural and inner-city areas

Performance Measures: None

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Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Physician Studies

Mandate: Public Health Law Section 2807-m

Mandated Funding Level: None

Brief Description/History/Background: There is lack of data on the need for access to services from health care professionals. Rapid assessment of data is necessary in order measure need and supply. An adequate supply of physicians, as measured by the number of primary care and specialty providers and their distribution across the state, is essential to the overall health care of New York citizens. This program provides funding to support the development of periodic information and analysis of the current and future physician workforce needs in the communities across NYS. The resulting data on residency programs is useful to develop State policy and help teaching institutions to reconfigure residency positions toward needed specialties. Funds are used for grant awards to conduct workforce studies. Data published in reports will be distributed to policymakers, educators, health care providers and the public on the health workforce supply and distribution. This activity is critical to implement the Governor's Doctor's Across New York initiative.

Issues: None

Population Served: General population

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Diversity in Medicine Post Baccalaureate

Mandate: Public Health Law Section 2807-m

Mandated Funding Level: None

Brief Description/History/Background: The goal of the program is to provide stable funding to support the current post-baccalaureate program and develop a second post-baccalaureate program. This will increase minority and economically disadvantaged students in medical school in New York, producing a diverse physician workforce reflective of the state's population. The present post-baccalaureate program allows medical schools to nominate 1-2 students for one year of supplemental training in an interdisciplinary curriculum of science and mathematics designed to strengthen the student's academic skills for medical school admission and enhance competitiveness for the rigors of medical school curriculum. The Associated Medical Schools of New York has implemented this program for over twenty years and graduated over 260 students. This activity is critical to implement the Governor’s Doctor's Across New York initiative.

Issues: None

Population Served: Minority and economically disadvantaged students.

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Elderly Pharmaceutical Insurance Coverage (EPIC) Program – State Operations

Mandate: Title 3, NYS Elder Law

Mandated Funding Level: None

Brief Description/History/Background: The EPIC Program was implemented in 1987 in accordance with Chapter 913 of the Laws of 1986. As defined in State statute, the program is administered under the oversight of the EPIC Panel. The Panel consists of the Commissioner of Health, Director of the Budget, Director of the Office for the Aging, Department of Education, and Superintendent of Insurance. The program utilizes a fiscal agent contractor, competitively procured by the Panel approximately every five years. A 12-member EPIC Advisory Committee is appointed by the Governor and Legislature to advise the Panel and Program Director on program activities and policies.

DOH staff is responsible for contract management, policy development and evaluation, data analysis and research, pharmacy audits, manufacturer rebate receivables and disputes, drug utilization review, budgeting, and coordination of benefits.

First Health Services Corporation is the current EPIC contractor, accounting for $17M of the EPIC administrative budget.

Issues: None

Population Served: Low and moderate income elderly – age 65 or older, non-Medicaid, income under $35,000 ($50,000 if married). 325,000 elderly individuals are currently enrolled

Performance Measures: The fiscal agent contract provides performance measures for all primary operations to help ensure quality and timely performance of all areas. The following key areas are measured:

Application Processing and Eligibility Determination – Contract performance standards are measured monthly, and are designed to ensure timely and accurate processing in accordance with program requirements. The primary performance measure for this area is the processing of applications and renewals, which must be processed on average within seven calendar days; actual performance in June 2007 was under two days on average.

Pharmacy Claim System – The online claim system must be operational 22 hours daily, with set times for maintenance. Any breaches are subject to penalty at $100/minute.

EPIC Participant and Provider Helplines – Performance measures defined in the contract require at least 85% of all calls for each helpline be answered; actual performance in June 2008 was measured at 94% on the Participant line and 93% on the Provider line.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Elderly Pharmaceutical Insurance Coverage (EPIC) Program – Aid to Localities

Mandate: Title 3, NYS Elder Law

Mandated Funding Level: None

Brief Description/History/Background: In accordance with Chapter 913 of the Laws of 1986, EPIC was implemented October 1, 1987 to provide prescription drug coverage for NYS residents 65 years of age and older with low and moderate incomes, who are not receiving Medicaid benefits. Seniors pay an annual fee or meet an annual deductible to participate, and then pay only a co-payment for each prescription at a participating retail pharmacy located in the State. Nearly all prescription drugs are covered, plus insulin and insulin syringes and needles. Since 1991, manufacturers have been required to pay rebates to EPIC for their drug products covered by the program. EPIC currently receives the same rebate rates as the federal Medicaid program.

The program has been improved and expanded significantly over the years to relieve the increasing burden on seniors of rising drug costs and reduction in other available drug coverage, by expanding income eligibility and reducing senior cost share. Income levels have more than doubled to the current limits. EPIC enrollees pay for their coverage, and share in their drug costs. Low income seniors pay an annual fee ($8 to $300), and then co-payments ($3 to $20) for each prescription. Instead of a fee, higher income seniors must satisfy an annual deductible ($530 to $1,715) before paying the EPIC co-payments.

Most EPIC seniors are eligible for Medicare Part D drug coverage, which became available January 1, 2006. EPIC members gradually transitioned into Medicare Part D, initially on a voluntary basis and then required in July 2007 as a condition of EPIC eligibility. Some exceptions apply, to protect seniors from increased health care costs. EPIC provides premium assistance and wraparound coverage for Part D enrollees – covering Part D deductibles, co-payments, coverage gap, and drugs not covered by Part D plans.

Issues: Medicare Part D has significantly changed the EPIC program in recent years.

Population Served: Low and moderate income elderly – age 65 or older, non-Medicaid, income under $35,000 ($50,000 if married).
Current enrollment – 325,000.

Performance Measures:
Enrollment – EPIC monitors enrollment levels and various demographics to identify progress and issues in reaching vulnerable elderly populations that need assistance paying for their prescription drugs.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Part D Enrollment – Percent of Enrollees with Part D coverage measures progress in transitioning EPIC enrollees to Medicare Part D. Currently 80% enrolled in Part D, with 20% exempt.

Drug Costs – Average prescription cost ($108.29), Part D cost share (50%), EPIC cost share (39%), senior cost share (11%)

Manufacturer rebates – Percent of EPIC drug costs paid by manufacturer rebates (currently 26%); projected $217.7 million in 2008/09.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: NYS Drug Discount Card

Mandate: Public Health Law, Section 280

Mandated Funding Level: None

Brief Description/History/Background: The budget legislation enacted in 2008 establishes a drug discount card program in the Department of Health effective April 1, 2009, which is currently being implemented. The card is intended to help uninsured individuals afford the medicines they need, by providing access to manufacturer and pharmacy discounts negotiated by the State of New York. The card will be available to those between the ages of 50 and 64, as well as disabled individuals regardless of age, with income up to $35,000 for single individuals and $50,000 for married individuals.

Issues: The success of the program is dependent upon a high level of participation by manufacturers and pharmacies, and the level of negotiated discounts.

Population Served: Disabled (regardless of age) and ages 50 to 64, non-Medicaid, with income under $35,000 ($50,000 if married). Enrollment estimated at 35,000.

Performance Measures: Number of persons enrolled. Discounts achieved. Service levels by contractor administering the program.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Managed Care Organization Oversight and Operations

Mandate: Public Health Law Articles 44 and 49, Social Services Law Sections 364-j, 369-ee, Workers' Compensation Law Article 10-A, Section 1115 of the Social Security Act

Mandated Funding Level: None

Brief Description/History/Background: Since 1984, this program certifies and oversees Managed Care Organizations (MCO) operating in NYS for commercial populations and government-sponsored programs. Includes 41 full risk MCOs, with 6.1 million enrollees or 32% of the State's population. About 2.7 million beneficiaries are enrolled in the State's Medicaid managed care(MMC) and Family Health Plus (FHP) programs. There are 20 certified Workers' Compensation PPOs; seven actively contract representing 950,000 covered lives and as of July 1, 2008 saving, employers an estimated $28 million in premiums. The program also oversees four certified primary care partial capitation providers and certified three Medicare Advantage MCOs. The program:

- Certifies all MCOs: At application and ongoing, reviews character and competence of the owners/board; corporate structure; provider and management contracts; network adequacy; rights of enrollees and providers; and complaint, grievance, medical necessity review and appeal procedures. Changes to certification require program approval.

- Qualifies MCOs for 1115 waiver programs (MMC, FHP, Medicaid Advantage): MCOs must meet requirements for special populations; quality assurance; member services; provider network access and availability; and complaints and appeals.

- Registers independent utilization review agents (URAs): Currently 100 agents registered. MCOs may delegate medical necessity determinations to URAs through contract.

- Surveys MCOs for compliance with applicable law and 1115 requirements: Operational requirements reviewed annually; disclosure, network adequacy and access to care requirements also reviewed quarterly or semiannually. PPOs reviewed biennially.

- Investigates enrollee and provider complaints against MCOs: includes assurance of access to care, trend analysis and regulatory action for non-compliance.

- Oversees government-sponsored MCO fraud and abuse prevention activity: includes case referral; analysis of Fraud and Abuse Prevention Plans; and MCO annual reports.

Issues:

- Evolving managed care industry: Current emphasis on providing affordable insurance options causes MCOs to create new models, merge, sell, or liquidate, requiring program approval of these transactions to protect enrollees and providers. Increased complexity of

enrolled populations, additional federal requirements, and continual influx of new statutory requirements increases the program's responsibilities for certification and surveillance.

Population Served: Commercial, Medicaid, FHP, Child Health Plus enrollees; providers serving managed care enrollees; MCOs; URAs; Independent Practitioner Associations; state agencies

Performance Measures:

- Review MCO/provider contracts within 30 days if no high risk capitation; else 90 days. In 2007, reviewed 386 contracts; 88% (30 day)/ 66%(90 day) on time.

- Review of MCO management function delegation agreements within 90 days.

- Annual and periodic surveys of MCOs following survey policy and procedures. In 2007, 175 Statement of Deficiencies/Findings were issued as a result surveillance activities.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Facilitated Enrollment (FE)

Mandate: Section 2511 of the Public Health Law

Mandated Funding Level: None

Brief Description/History/Background: The FE program was created through state legislation signed in 1998 to expand children's health insurance coverage in New York State. The legislation called for the design of locally tailored outreach and facilitated enrollment strategies for CHPlus and children's Medicaid. The FE program expands the accessibility and enhances the ease of applying for health insurance through community based organizations as an alternative to the LDSS. In 1999, state legislation was passed that expanded the FE program to adults for Medicaid and Family Health Plus. The Department issued a Request for Proposal and currently contracts with 42 community based organizations to help facilitate enrollment into public health programs.

Issues: None

Population Served: Low income families who are eligible for Medicaid or their children are eligible for Medicaid or CHPlus.

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Child Health Plus (CHPlus) Marketing

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The goal of the CHPlus program is to provide access to comprehensive inpatient and outpatient health care services to low income children. NYS implemented CHPlus in 1991 as a state-only funded program. Many changes have been made over the years to expand eligibility and benefits. Additionally, NYS began receiving federal funding on April 15, 1998 as a result of the Balanced Budget Act of 1997, which created the State Children's Health Insurance Program (SCHIP). Currently, DOH contracts with 22 health plans to provide statewide CHPlus coverage via a managed care insurance product.

An important building block to universal coverage is to maximize enrollment in Medicaid, Family Health Plus and CHPlus. The State has been committed to increasing access to and enrollment in these programs through simplification, systems improvements and marketing and outreach initiatives. The goal of the program is to enroll every uninsured child eligible for the program. Funding is set aside to market the program to these families. The Department, through the Public Affairs Group, uses a multimedia approach buying time or space in newspapers, radio and television.

Issues: Enrollment goals depend on successful marketing efforts.

Population Served: There are approximately 356,000 children in New York State uninsured but eligible for public health insurance programs.

Performance Measures: The number of uninsured children decreases over time.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Child Health Plus (CHPlus) Administration

Mandate: Title XXI of the Social Security Act, Sections 2510 & 2511 of the Public Health Law

Mandated Funding Level: None

Brief Description/History/Background: The goal of the CHPlus program is to provide access to comprehensive inpatient and outpatient health care services to low income children.

NYS implemented CHPlus in 1991 as a state-only funded program. Many changes have been made over the years to expand eligibility and benefits. Additionally, NYS began receiving federal funding on April 15, 1998 as a result of the Balanced Budget Act of 1997, which created the State Children's Health Insurance Program (SCHIP).

Currently, DOH contracts with 22 health plans to provide statewide CHPlus coverage via a managed care insurance product. CHPlus has a uniform benefit package that must be provided by each approved health plan. The state pays the approved health plans a per member per month amount (determined by the State Insurance Department), less any family premium contribution, for the children enrolled each month.

The Bureau of Child Health Plus Enrollment is responsible for developing and disseminating the policy and enrollment rules for the Child Health Plus Program. It disseminates and interprets federal and state law and regulation as well as guidelines established by the CHPlus program. It oversees annual training programs for health plan employees to promote compliance with the rules and regulations of the program. The Bureau also serves as the contact for applicants who are having problems obtaining coverage. It provides support to health plans and facilitated enrollers to ensure that they comply with program rules. It also prepares all documents required by the Center for Medicare and Medicaid Services including state plan amendments, the SCHIP annual report and communicates with CMS on behalf of the SCHIP program. The Bureau administers the facilitated enrollment program. The Bureau also serves as a liaison to the Division of Managed Care and Program Evaluation for quality reporting, consumer satisfaction and other managed care issues on behalf of Child Health Plus. CHPlus administration is required to monitor the health plans, fulfill all State and Federal requirements, and to provide policy direction for the program.

Issues: None

Population Served:
There are approximately 365,000 children enrolled in CHPlus.

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Child Health Plus (CHPlus) Premiums

Mandate: Title XXI of the Social Security Act, Sections 2510 & 2511 of the Public Health Law

Mandated Funding Level: None

Brief Description/History/Background: The goal of the CHPlus program is to provide access to comprehensive inpatient and outpatient health care services to low income children.

NYS implemented CHPlus in 1991 as a state-only funded program. Many changes have been made over the years to expand eligibility and benefits. Additionally, NYS began receiving federal funding on April 15, 1998 as a result of the Balanced Budget Act of 1997, which created the State Children's Health Insurance Program (SCHIP).

Currently, DOH contracts with 22 health plans to provide statewide CHPlus coverage via a managed care insurance product. CHPlus has a uniform benefit package that must be provided by each approved health plan. The state pays the approved health plans a per member per month amount (determined by the State Insurance Department), less any family premium contribution, for the children enrolled each month.

Issues: None

Population Served:
There are approximately 365,000 children enrolled in CHPlus.

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Regional Pilot Program/Individual Subsidy

Mandate: PHL §2807-l(1)(b)(i)(A)

Mandated Funding Level: None

Brief Description/History/Background: The individual subsidy program assists low-income individuals with the purchase of health care insurance. A subsidy payment is made by the State to the contractor to reduce the premium cost realized by individuals and/or their dependents purchasing health care insurance under the individual subsidy program.

Issues: The one existing health plan providing this program has not been to accepting new enrollment in this program since January 1, 2001.

Population Served: The individual subsidy project is located in New York City. Through the program, uninsured individuals in the Bronx and Manhattan counties at 200 percent or less of federal poverty guidelines have a portion of their premium costs covered based on a sliding scale. The individual or family is responsible for the remainder of the costs associated with such coverage.

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Quality Measurement and Improvement

Mandate:
Public Health Law § 206 Commissioner; General Powers and Duties
Public Health Law § 579 Scope and Exceptions
Public Health Law § 2168 Statewide Immunization Registry
Public Health Law § 2511 Child Health Insurance Plan
Public Health Law §2803 (c) Commissioner and council
Public Health Law § 2805-J Medical, Dental and Podiatric Malpractice Prevention
Public Health Law § 2807-C General Hospital Inpatient Reimbursement for Annual
Public Health Law § 2995-C Health Care Plan and Preferred Provider Organization
Public Health Law § 4403-F Managed Long Term Care Plans
Social Services Law § 364-J Managed Care Programs
Social Services Law § 366 Eligibility
Insurance Law § 210 Annual Consumer Guide of Health Insurers
Federal Peer Improvement Act
Omnibus Reconciliation Act of 1986

Mandated Funding Level: None

Brief Description/History/Background: The Bureau of Quality Measurement and Improvement is responsible for all performance measurement in commercial, Medicaid and Child Health Plus managed care plans. This includes the annual collection and dissemination of Quality Assurance reporting Requirements (QARR) data, Consumer Assessment of Health Providers (CAHPs) data and focused study information. The Bureau maintains performance reports on the DOH website that describe health plan performance and information. Bureau staff design, print and disseminate printed guides and other literature that inform consumers about health plan choices. Bureau staff works closely with plans to address any issues related to plan performance and disseminate best practice information. The Bureau also administers the $3.5 million external quality review organization (EQRO) contract. Through this contract the Bureau conducts focused clinical studies, administers member-level surveys, audits health plan data and oversees the specialized work of a variety of vendors.

Issues: None

Population Served: Commercially and publicly insured (Medicaid, CHP, FHP).

Performance Measures: Standardized measures of quality are used to measure plan performance and include: children's preventive health measures, women's health measures, chronic disease measures, behavioral health measures and access and availability measures. Standardized consumer satisfaction survey data, such as CAHPS, is also collected. Current statistics: available at
http://www.health.state.ny.us/health_care/managed_care/reports/eqarr/2007/index.htm

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Outcomes Research

Mandate:
Public Health Law § 2511 Child Health Insurance Plan
Public Health Law § 4403-C Comprehensive HIV Special Needs Plan Certification
Public Health Law § 4410 Health Maintenance Organizations
Social Services Law § 364-J Managed Care Programs
Public Health Law § 2807-c General Hospital Reimbursement

Mandated Funding Level: None

Brief Description/History/Background: The Bureau is the lead organization for evolution and research in the Medicaid program, including analysis of cost effectiveness and financial impact of new initiatives. The Bureau of Outcomes Research is responsible for collecting and analyzing Medicaid claims and encounter data for the purpose of monitoring quality in the Medicaid and Child Health Plus programs and for establishing risk-adjusted capitation payments for health plans. Researchers in the Bureau conduct studies which examine access to care and utilization of services for vulnerable populations such as persons with asthma and persons with HIV.

Bureau staff oversees the collection and dissemination of health plan provider network information which is used in determining adequacy of health plan networks and in research focused on network attributions and their effect on quality. Hospital-based outcomes research is also conducted in the Bureau and supports the Department's efforts in selective contracting.

Issues: None

Population Served: Publicly (Medicaid, CHP and FHP) and commercially insured residents of New York State.

Performance Measures: Bariatric surgery outcomes, breast cancer surgery outcomes, preventive quality indicators (PQIs), HEDIS measures, health services utilization statistics and clinical risk groupings (CRGs). Current statistics: pending publication

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Pay for Performance Demonstrations

Mandate: Public Health Law §2999, Pay for Performance

Mandated Funding Level: None

Brief Description/History/Background: The Pay for Performance Demonstration Program was created in statute in the spring of 2005. Per the legislation, a Commissioner's workgroup was established and developed recommendations for implementation. An RFA was issued in May 2006, applications were due in August 2006 and awards were announced in February 2007. Grants were awarded to the following applicants: THINC RHIO, Independent Health Association (IHA), the New York Health Plan Association (NYHPA) and Montefiore Medical Center. Three contracts were executed in the fall of 2007 and the fourth was executed in March 2008.

Issues: Challenges in implementing the program will likely result in a need to extend the contracts beyond the original end of the two year cycle.

Population Served: Medicaid, CHP and FHP and commercially insured members of health plans

Performance Measures: Each grantee has a set of measures they are responsible for collecting data on and include standardized preventive health, chronic disease and inpatient measures. Measure sponsors include the National Commission for Quality Assurance, American Medical Association, National Quality Forum and Centers for Medicare and Medicaid Services. Baseline measurement will use data from 2007 and will be submitted by grantees in the fall of 2008. In 2009, grantees will submit 2008 data and use this information to reward participating physicians who achieve agreed upon benchmarks.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Administrative Support for OHIP Programs

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Staff provides human resource management, fiscal and procurement, and contracting support to all OHIP divisions in carrying out required tasks.

Issues: None

Population Served: Benefits accrue to public health insurance and other programs administered by the OHIP

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Medicare Balance Billing

Mandate: Public Health Law §19

Mandated Funding Level: None

Brief Description/History/Background: New York State legislation enacted in 1990 limits the amount a physician (who doesn't accept assignment) may charge a Medicare beneficiary for services provided. Initial limit was 15% over what Medicare approves. Limit was changed to 10% and now 5%. A physician may be subject to a hearing and fined for violations.

OHIP responds to inquiries from Medicare beneficiaries and physicians regarding the New York State limiting charge for physicians who do not accept assignment of Part B claims and processes complaints from Medicare beneficiaries regarding overcharges for Medicare physician services. As the number of physicians who accept assignment has increased, there have been few inquiries and complaints in recent years.

Issues: None

Population Served: Medicare beneficiaries who are served by physicians who do not accept assignment for Part B claims.

Performance Measures: Number of inquiries and complaints processed.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

PROGRAM: Local District Medicaid Administration

MANDATE: Section 368-a of the Social Services Law; Part C of Chapter 58 of the Laws of 2005

MANDATED FUNDING LEVEL: None

BRIEF DESCRIPTION/HISTORY/BACKGROUND: Medicaid is a locally administered, State supervised program. Pursuant to an MOU, the Department of Health suballocates funds to the Office of Temporary and Disability Assistance which is responsible for adjudicating and paying NYC and the counties for their administrative claims. Prior to January 2006, local districts paid 50% of the non-federal share of Medicaid administrative costs. With the implementation of the cap on the local share of Medicaid costs, local districts pay maximum annual amount as defined in statute which includes both administrative and program costs.

ISSUES: Limited incentives for local district social service districts to contain Medicaid administrative costs.

POPULATION SERVED: Medicaid enrollees and applicants, local government

PERFORMANCE MEASURES: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Hospital and Clinics Medicaid Provider Payments

Mandate: Federal Social Security Act, Social Services Law

Mandated Funding Level: None

Brief Description/History/Background: Medicaid covers medically necessary inpatient hospital and clinic services for eligible persons.

Issues: The 2008-09 budget began the process of transitioning funding from inpatient hospital care to ambulatory (outpatient) care. A new ambulatory payment methodology called Ambulatory Payment Groups will be implemented starting December 1, 2008.

Population Served: Eligible Medicaid beneficiaries

Performance Measures: Payments are subject to retrospective review and audit by the Office of the Medicaid Inspector General.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Nursing Home Medicaid Provider Payments

Mandate: Title XIX of the Federal Social Security Act, Social Services Law

Mandated Funding Level: None

Brief Description/History/Background: Medicaid covers nursing home services for eligible persons.

Issues: None

Population Served: Eligible Medicaid beneficiaries

Performance Measures: Payments are subject to retrospective review and audit by the Office of the Medicaid Inspector General.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Managed Care Medicaid Provider Payments

Mandate: Title XIX of the Federal Social Security Act, Social Services Law

Mandated Funding Level: None

Brief Description/History/Background: Over 2 million Medicaid eligible persons are enrolled in managed care plans for most of their Medicaid services. Another 25,000 frail elderly or disabled persons are enrolled in Managed Long Term Care plans. Under federal rules, payments to managed care plans must be actuarially sound.

Issues: None

Population Served: Eligible Medicaid beneficiaries enrolled in managed care plans.

Performance Measures: Managed care plans are subject to annual quality and satisfaction measures. Financial performance is measured through the Medicaid Managed Care Operating Report.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Home Care Medicaid Provider Payments

Mandate: Title XIX of the Federal Social Security Act, Social Services Law

Mandated Funding Level: None

Brief Description/History/Background: Medicaid covers home care services for eligible persons.

Issues: The total cost and per beneficiary cost of home care services has increased significantly in recent years making this one of the fastest growing components of Medicaid costs.

Population Served: Eligible Medicaid beneficiaries.

Performance Measures: None

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Non-Institutional and Other Care Medicaid Provider Payments

Mandate: Title XIX of the Federal Social Security Act, Social Services Law

Mandated Funding Level: None

Brief Description/History/Background: Medicaid covers a range of non-institutional and other services for eligible persons.

Issues: None

Population Served: Eligible Medicaid beneficiaries.

Performance Measures: Payments for services are subject to retrospective review and audit by the Office of the Medicaid Inspector General. Retrospective utilization review programs currently being implemented to also ensure adherence to accepted clinical treatment guidelines.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Pharmacy Medicaid Provider Payments

Mandate: Title XIX of the Federal Social Security Act, Social Services Law

Mandated Funding Level: None

Brief Description/History/Background: Medicaid covers most prescription drugs and over the counter drugs with a fiscal order. In recent years, a number of program features including mandatory generic substitution, the preferred drug program and the clinical drug review program have helped contain the costs of these services.

Issues: Recent budgets have reduced reimbursement to retail pharmacies.

Population Served: Eligible Medicaid beneficiaries and effective October 1, 2008, Family Health Plus enrollees.

Performance Measures: Payments are subject to retrospective review and audit by the Office of the Medicaid Inspector General.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

Program: Family Health Plus Medicaid Provider Payments

Mandate: Title XIX of the Federal Social Security Act, Social Services Law Section 369-ee

Mandated Funding Level: None

Brief Description/History/Background: Over 500,000 persons are enrolled in Family Health Plus under a federal 1115 waiver which allows the state to expand eligibility to higher income levels. With the exception of prescription drugs (effective October 1, 2008) Family Health Plus enrollees receive all services through their health plan. Under federal rules, payments to managed care plans must be actuarially sound.

Issues: None

Population Served: Eligible Family Health Plus beneficiaries.

Performance Measures: Managed care plans are subject to annual quality and satisfaction measures. Financial performance is measured through the Medicaid Managed Care Operating Report.

Attachment C

Office of Health Insurance Programs
PROGRAM INFORMATION SHEET

PROGRAM: Adirondack Cancer Center

MANDATE: None

MANDATED FUNDING LEVEL: None

BRIEF DESCRIPTION/HISTORY/BACKGROUND: SFY 2006-07 $5 million HCRA legislative add for the Center for Functional Genomics at the State University of New York at Albany for the purposes of the Adirondack network for cancer education and research in rural communities grant program to improve access to health care.

ISSUES: These funds have not been spent,

POPULATION SERVED: None

PERFORMANCE MEASURES: None

Attachment B

Agency Programs/Activities: Inventory and Key Data
OFFICE OF LONG TERM CARE

Page	Relation to Core Mission (H/M/L)	Program/Activity	Spending Category (SO, ATL, CAP)	3/31/09 FTEs (All Funds)	General Fund Disbursements ($000s)				State Special Revenue Funds Disbursements ($000s)				Capital Projects Funds Disbursements ($000s)			
					2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected
1	H	Nursing Home Surveillance	SO	190	$8,297	$10,228	$11,709	$11,712	$10,317	$9,769	$10,479	$10,479	$0	$0	$0	$0
3	H	ICF/MR	SO	2	$82	$102	$132	$132	$103	$98	$105	$105	$0	$0	$0	$0
4	H	Home Care Surveillance	SO	42	$1,812	$2,236	$2,913	$2,913	$2,270	$2,149	$2,305	$2,305	$0	$0	$0	$0
5	H	Hospice Surveillance	SO	3	$124	$152	$199	$199	$155	$147	$157	$157	$0	$0	$0	$0
6	H	Adult Care Facility Surveillance	SO	61	$2,635	$3,252	$4,237	$4,237	$3,302	$3,126	$3,353	$3,353	$0	$0	$0	$0
7	H	Adult Home Quality of Care Enchancement 339HQ	SO	0	$0	$0	$0	$0	$0	$0	$268	$0	$0	$0	$0	$0
8	H	ACF/ALR/ALP Licensure & Cert	SO	13	$281	$411	$501	$501	$722	$684	$734	$734	$0	$0	$0	$0
9	H	Assisted Living Residence Oversight	SO	9	$181	$264	$322	$322	$581	$506	$942	$1,222	$0	$0	$0	$0
10	H	Home Care & Nursing Home Licensure & Cert	SO	9	$201	$294	$358	$358	$516	$488	$524	$524	$0	$0	$0	$0
11	H	Criminal History Record Check	SO	23	$1,099	$1,114	$3,000	$3,000	$0	$0	$0	$0	$0	$0	$0	$0
12	H	Professional Credentialing	SO	4	$129	$129	$134	$138	$2,603	$2,955	$3,265	$3,500	$0	$0	$0	$0
13	H	Continuing Care Retirement Comm	SO	0	$0	$0	$0	$0	$4	$30	$168	$168	$0	$0	$0	$0
14	L	Home Medical Equipment Licensure	SO	0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
15	H	Long Term Care Quality Improvement Activities	SO	10	$221	$323	$394	$394	$567	$537	$576	$576	$0	$0	$0	$0
16	M	Adult Care Facility Resident Air Conditioning	ATL		$0	$0	$0	$0	$0	$615	$2,000	$2,000	$0	$0	$0	$0
17	M	Adult Home Initiatives	ATL	0	$0	$919	$0	$0	$2,222	$4,156	$2,451	$0	$0	$0	$0	$0
18	M	Quality Incentive Payment Program	ATL		$0	$0	$5,500	$2,750	$1,859	$596	$295	$0	$0	$0	$0	$0
19	M	Enriched Housing Subsidy Program	ATL		$546	$546	$540	$535	$0	$0	$0	$0	$0	$0	$0	$0
20	L	Telemedicine Demonstration Prgrm	ATL		$0	$0	$0	$0	$1,486	$2,376	$2,000	$1,000	$0	$0	$0	$0
21	M	Nursing Home Transition & Diversion Housing Subsidies	ATL		$0	$0	$1,600	$2,500	$0	$0	$0	$0	$0	$0	$0	$0
22	H	Traumatic Brain Injury (TBI) program administration	SO	1	$73	$84	$87	$90	$0	$0	$0	$0	$0	$0	$0	$0
23	H	TBI Program Waiver Management	ATL		$2,541	$2,764	$3,077	$3,365	$0	$0	$0	$0	$0	$0	$0	$0
24	M	TBI Program Housing Subsidies	ATL		$8,182	$8,898	$9,906	$10,835	$0	$0	$0	$0	$0	$0	$0	$0
25	H	Nursing Home Quality Improvement Grants (339/QC)	SO	0	$0	$0	$0	$0	$0	$0	$800	$0	$0	$0	$0	$0
26	H	Hospice Quality Assessment	SO	0	$0	$0	$500	$500	$0	$0	$0	$0	$0	$0	$0	$0
27	H	Long Term Care Restructuring Administration	SO	1	$20	$29	$36	$36	$52	$49	$52	$52	$0	$0	$0	$0
28	H	Long Term Care Restructuring	ATL		$5,294	$5,996	$16,000	$16,000	$0	$0	$0	$0	$0	$0	$0	$0
29	H	LTC Reform Improvements	SO	0	$0	$0	$1,100	$1,100	$0	$0	$0	$0	$0	$0	$0	$0
30	H	Medicaid (MA) LTC Services	SO	15	$321	$470	$573	$573	$825	$782	$838	$838	$0	$0	$0	$0
31	H	Medicaid (MA) LTC Waivers	SO	16	$342	$499	$609	$609	$877	$830	$891	$891	$0	$0	$0	$0
32	H	LTC Partnership	SO	6	$121	$176	$215	$215	$310	$293	$314	$314	$0	$0	$0	$0
33	M	LTC Insurance Education/Outreach	ATL		$0	$0	$0	$0	$3,765	$1,042	$1,900	$1,800	$0	$0	$0	$0
34	M/L	LTC Delivery Demo	ATL		$0	$0	$0	$0	$153	$471	$600	$300	$0	$0	$0	$0
35	M/L	Long Term Care Community Coalition	ATL		$0	$70	$139	$69	$0	$0	$0	$0	$0	$0	$0	$0
		Office of Long Term Health Grand Total	ALL	405	$32,501	$38,958	$63,781	$63,082	$32,690	$31,698	$35,017	$30,318	$0	$0	$0	$0

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Nursing Home Surveillance

Mandate: OBRA 1987, Title 1864 Agreement between NYS and the Center for Medicare and Medicaid Services (CMS)
Public Health Law Article 28

Mandated Funding Level: None

Brief Description/History/Background: DOH is responsible for ensuring that the federally-mandated functions of nursing home surveillance and quality assurance, and related administrative activities, are properly carried out. Program functions are performed pursuant to the Title 1864 agreement between the State and CMS.

The federal and/or state surveillance workload includes the surveillance and oversight of:

- 649 nursing homes; five of these nursing homes must be surveyed at least twice each year because of ongoing quality of care issues;
- 168 Adult Day Health Care programs;
- Four Transitional Care Units (TCUs), located at hospitals, licensed as nursing homes and surveyed as such.

DOH works closely with CMS to update data in the federal reporting systems. Extensive Quality Improvement initiatives are conducted for the collecting, tracking and reporting of data to Regional Directors, LTC Program Directors and surveyors to ensure timely and accurate monitoring of program performance against federal and state requirements. In FFY-2007, 661 recertification surveys and 3,800 on-site complaint surveys at nursing homes were conducted. In addition, the program renders decisions on another 3,000 complaints per year at the Central Office. During FFY-2007 over 5,800 citations were issued, of which over 300 citations involved harm or immediate jeopardy to the resident.

Extensive training and evaluation programs are provided to ensure statewide consistency and compliance to policies and protocols in each of the DOHs' seven field offices. Frequent meetings are conducted with providers and their health care organizations to review survey findings and collaborate on interventions to enhance the health and well-being of nursing home residents. All complaints reported to DOH regarding nursing home operations and resident services to ensure resident protection from abuse, neglect and mistreatment are documented, triaged and investigated.

Surveillance activities are also required for 168 adult day health care (ADHC) programs licensed under 10 NYCRR Part 425.1 and funded by Medicaid. There are triennial onsite surveys, complaint investigations and a yearly administrative review of each program to determine compliance with the state requirements.

The Department is responsible for conducting annual recertification at 649 nursing homes and 3,800 on-site complaint investigations, resulting in nearly 6,000 citations. Much of this effort

requires highly trained clinical staff capable of making survey determinations. More extensive resources and review is exerted on nearly 200 surveys per year that result in resident harm or immediate jeopardy to the resident.

There is increased surveillance demand due to the growth and expansion of mandatory surveillance protocols, an increase in the volume of concerns rising to the level of immediate risk to resident health and safety, and the influx of new surveyors who require guidance and mentoring.

Issues: The Department continues to experience difficulty with recruiting and retaining survey staff, as we lose the experienced, credentialed staff through retirement. In response, the Division is expecting final approval for a team of credentialed, trained surveyors capable of mobilization anywhere in the state to meet the gaps in surveillance.

Population Served: All New York State residents who could potentially use long term home and community based and institutionalized care: 649 nursing homes with 108,000 nursing home residents; and 168 adult day health care programs with a 9,000 person daily capacity.

Performance Measures: There are fourteen Federal (CMS) Performance Measures related to nursing home surveillance.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: ICF/ MR Intermediate Care Facilities for Persons with Mental Retardation

Mandate: Title XIX of the Social Security Act

Mandated Funding Level: None

Brief Description/History/Background: Under Title XIX, DOH conducts surveillance and provides certification for the fifteen (15) larger State Office of Mental Retardation and Developmental Disabilities (OMRDD) operated developmental center units. These state operated units provide day programs and residential services to more than 1,600 mentally retarded individuals not able to be served at home.

DOH provides oversight of the survey activities of the Office of Mental Retardation and Developmental Disabilities (OMRDD) for 552 community based facilities. These facilities are surveyed by OMRDD and receive certification for Title XIX Provider Agreement participation by DOH. Survey and certification responsibilities are defined in a Memorandum of Understanding (MOU) between OMRDD, DOH and CMS.

DOH is the primary liaison to CMS and disseminating information regarding the ICF/MR program within the DOH.

Issues: None

Population Served: There are approximately 6,500 developmentally disabled/mentally retarded living in the community plus 1,600 living in Developmental Centers.

Performance Measures: There are fourteen Federal (CMS) Performance Measures related to nursing home surveillance.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Home Care Surveillance

Mandate: Public Health Law Article 36. DOH has an agreement with CMS to conduct federal surveillance activity.

Mandated Funding Level: None

Brief Description/History/Background: Surveys of Certified Home Health Agencies (144), Long Term Home Health Care Programs (112), Licensed Home Care Services Agencies (1040), Home Health Aide Training Programs (345) and waiver programs, including Traumatic Brain Injury (TBI) (268) and Nursing Home Transition and Diversion Waivers (new program) are performed every three years and all complaints within 90 days of receipt. Surveys include a review of patient/client/student records, personnel records, quality improvement policies and records and home visits to patients/clients/classroom to observe the rendering of services by the provider and to interview the recipient of the services regarding their experience with the program. Information management support for these surveillance activities includes management of the ASPEN, OSCAR and OASIS databases as well as Department developed databases. These databases are also utilized to populate and update the Department's home care web page. The Home Health Hotline is a toll free line maintained to provide information regarding the availability of home care services and a referral source for complaints against these providers (1200 calls per year). Providers identified as providers of poor care with actual or potential negative outcomes as the result of surveillance activity (ies) are referred to Division of Legal Affairs for enforcement action.

Issues: The Office of the Attorney General's finding of fraud associated with the certification of home health aides by training programs has resulted in an increased of surveillance activities of home health aide training programs.

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Population Served: Persons with post-hospitalization care needs, frail elderly, chronically ill and/or disabled individuals of all ages including those with traumatic brain injury, and those eligible for nursing home placement. In 2004, approximately 600,000 persons received home care services.

- **Performance Measures:** Federal (CMS) Performance Standards and CMS 1915 Waiver required assurances.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Hospice Surveillance

Mandate: Public Health Law Article 40 . DOH has an agreement with CMS to conduct federal surveillance activity.

Mandated Funding Level: None

Brief Description/History/Background: Surveys of 49 hospices are performed every four years and all complaints within 90 days of receipt. Surveys include a review of patient/client/student records, personnel records, quality improvement policies and records, life safety code surveys for inpatient units and hospice residences and home visits to patients/families to observe the rendering of services and to interview the recipients of services regarding their experience with the program. Information management support for these surveillance activities includes management of the ASPEN and OSCAR databases as well as Department developed databases. These databases are also utilized to populate and update the Department's hospice web page. Providers identified as providers of poor care with actual or potential negative outcomes as the result of surveillance activity (ies) are referred to Division of Legal Affairs for enforcement action.

Issues: CMS has issued revised Conditions of Participation for hospices that become effective 12/2/08, which will require substantial changes to State regulations. These revised regulations include substantial changes regarding an outcome-based quality improvement requirement, content and timeliness of patient assessments and requirements for hospice care to nursing home residents.

Population Served: Persons with a life expectancy of six months or less should their illness run its expected course. In 2006, approximately 40,000 persons received hospice services.

Performance Measures: Federal (CMS) Performance Standards.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Adult Care Facility Surveillance

Mandate: Public Health Law Article 46B
Social Service Law Article 7

Mandated Funding Level: None

Brief Description/History/Background: The Adult Care Facility Quality and Surveillance Program include inspection, enforcement, and monitoring of services and activities provided to residents residing in adult care facilities in New York State. Adult Care Facilities consist of Adult Homes, Enriched Housing, Residences for Adults, Assisted Living Programs (ALP) and Assisted Living Residences (ALR). The Assisted Living Residences (ALR) regulations were adopted in 2008, expanding the scope of surveillance activities and staff workload to include assisted living residences. The Department has received 285 ALR applications. Based on a recent '07-'08 budget initiative and recommendations from The Commission for the 21st Century, a total of 2,042 additional ALP beds are available for application, expanding the ALP as well.

In 2007, there were 486 Adult Care Facilities operating in New York State, which include 331 Adult Homes, 51 Adult Home/ALPs, 89 Enriched Housing, 13 Enriched Housing/ALP and 2 Residences for Adults and approximately 285 Assisted Living Residences pending approval. Surveys of these facilities are unannounced and performed at 12 or 18 month intervals, or whenever a serious incident, death, or complaint is received that indicates an immediate review of the facility is required. The scope of surveillance activities consists of a comprehensive review of resident rights, resident financial accounts, dietary, medication, case management, supervision, emergency and disaster procedures, as well a review of compliance with sanitation and safety codes. Activities of the ACF Surveillance Program inform the policy direction of the ACF/ALR Task Force and the gubernatorial ACF Futures Group. Information management support for these surveillance activities includes management of the ASPEN, ACO and UCT databases. The Adult Care Facility Hotline is a toll-free hotline used as a referral source for requests for information and complaints against facilities (2,675 calls received in 2007). Facilities identified with repeat violations or serious care issues are referred to the Division of Legal Affairs for enforcement action (65 referrals made in 2007).

Issues: None

Population Served: The population served is persons age 18 or over who are appropriate to reside in an ACF including ALR or ALP facilities**.** An ALP admission requires the resident to need nursing home level of care. In 2007, approximately 31,000 persons resided in adult care facilities.

Performance Measures: SSL and PHL require certain timeframes for surveillance activities.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Adult Home Quality Enhancement Fund

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: This program supplements other grants to adult care facilities, including EnAbLE, for the development of programs targeted to the specific needs and interest of residents to improve quality of life, and also includes funding for four targeted wellness activities, and payments for temporary operators of ACFs. A goal of EnAbLE is to improve the ability of resident to live more independently.

EnAbLE grants may fund independent living skills training, vocational or educational programs; peer specialists; employment specialist; or services and supports to allow residents to maintain independence in their activities of daily living, and similar innovative activities. The wellness grants target improving food quality; diabetes management; chronic disease self-management; and smoking cessation. Funds may be used for overall health, advocacy and legal support as well.

Temporary Operator Contracts provide funds to pay temporary operators of adult homes, who are appointed when facilities are mismanaged, resulting in fiscal insolvency or poor quality of care placing resident's imminent danger. These contracts are short term to stabilize a facility while a more permanent solution is identified and implemented.

This account is funded through penalties imposed under Social Services Law § 460-d received from ACFs. The amount of annual spending authority is dependent on the funding levels in the account and the amount of the annual appropriation.

Issues: None

Population Served: All ACFs are eligible. In distributing these funds, the Department gives priority to those applicants whose residents are recipients of Supplemental Security Income (SSI) or other safety net supports. A preference in funding is granted to applicants for use of program funds which would serve residents receiving supplemental security income and/or safety net. Between 2005 and 2007, 63 facilities received grant awards benefiting 5,189 residents, and 3 temporary operators were paid more than $3 million.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: ACF/ALR/ALP Licensure and Certification

Mandate: Social Services Law Article 7
Public Health Law Article 46B

Mandated Funding Level: None

Brief Description/History/Background: Article 7, Section 461-L of (SSL) and Article 46B (PHL) requires DOH to review Adult Care Facility (ACF), Assisted Living Residence (ALR), and Assisted Living Program (ALP) applications for Public Need, Character and Competence, Architectural and Environmental Standards Compliance Review, Legal, Financial Feasibility, and Program Sufficiency/Appropriateness. Applications are submitted for approval of new facilities, change of ownerships, management contracts, structural and programmatic changes. Once review is completed staff creates and issues/reissues the appropriate license/operating certificate within required timeframes. Databases are maintained for tracking application status and technical assistance is provided to all applicants to insure timely completion of reviews. All activity is conducted and coordinated within the Division of Home and Community Based Services. Additional responsibilities include review of Respite and Social Day Care applications and the coordination and processing of Annual Financial Reports.

Issues: None

Population Served: The population served are those adults over 21 years of age appropriate for an Adult Care Facility, an Assisted Living Residence, or an Assisted Living Program.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: ALR Oversight

Mandate: Public Health Law Article 46B

Mandated Funding Level: None

Brief Description/History/Background: Since SFY 2005-2006 the Department has received over 280 Assisted Living Residences (ALR) applications. Application fees are deposited into the SRO account to be used for program development and implementation. Regulations pertaining to ALR, Enhanced Assisted Living Residences (EALR) and Special Needs Assisted Living Residences (SNALR) licensure were promulgated in March, 2008. Review of all applications received and issuance of licenses are currently underway. These reviews include determination of need, character and competence, financial feasibility, and architectural and legal compliance with appropriate statute and regulations for each applicant. Surveillance staff located in Department of Health Regional Offices, are required to review the programmatic component of each application and conduct pre-opening and follow-up surveys of ALR, EALR and SNALR facilities to ensure compliance with applicable laws and regulations governing these entities.

Issues: The Department will need to evaluate workload when the program is fully operational.

Population Served: The population served are those adults over 18 appropriate for an Adult Care Facility and Assisted Living Residence, (EALR or SNLR).

Performance Measures: PHL require certain timeframes for surveillance activities.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Home Care and Nursing Home Licensure and Certification

Mandate: Public Health Law Articles 28, 36 and 40

Mandated Funding Level: None

Brief Description/History/Background: Public Health Law Articles 36 and 40 require DOH to perform character and competence as well as program reviews of applications for establishment and construction (program changes) of home care agencies including Licensed Home Care Services Agencies, Certified Home Health Agencies and Long Term Home Health Care Agencies as well as Hospices, including inpatient units and hospice residences. Program reviews and approval of management agreements are also conducted.

Public Health Law Article 28 requires DOH to process applications for establishment and construction of nursing homes and Adult Day Health Care (ADHC) providers, requests to become a receiver of a nursing home, de-certification of nursing homes, and change services provided in a nursing home. These applications include a review for character and competence program integrity.

Once reviews are completed, reports are prepared for State Hospital Review and Planning Council (SHRPC) and Public Health Council (PHC) action. Staff process Medicare transactions for provider agreements to the Centers for Medicare and Medicaid Services as applicable. Databases are maintained for tracking application status and issuance of licenses and operating certificates. Technical assistance is provided to applicants as requested.

Licensure and certification activities also include implementation of restructuring initiatives including the Nursing Home Rightsizing Initiative and participation in completion of projects related to the Commission for the 21st Century and HEAL.

Issues: None

Population Served: The population served are those persons requiring home care services from Licensed Home Care Services Agencies, Certified Home Health Agencies, Long Term Home Health Care Agencies, Hospices and/or Nursing Homes and Adult Day Health Care Programs.

Performance Measures: None.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Criminal History Record Check Program

Mandate: Public Health Law Article 28; Executive Law Section 845-B

Mandated Funding Level: None

Brief Description/History/Background: DOH is required to review the criminal history information of prospective unlicensed employees of nursing homes and home health care agencies who provide direct care or supervision to patients, residents and clients and to make a legal determination with respect to the suitability of each prospective employee for employment or use by the health care provider. CHRC enrolls and maintains a roster of Authorized Persons (AP) for each provider. Fingerprints and an associated processing fee are submitted to CHRC by the AP. Fingerprints are processed and transmitted electronically to the Division of Criminal Justice Services (DCJS) and to the FBI for a statewide and national review. Based on these checks, criminal history information is provided to CHRC for legal review and a determination of eligibility for employment. DOH attorneys evaluate the employment determination based on the severity of the criminal history. Fifteen percent of those processed have a criminal background and require legal review and determination. To date, CHRC Legal has made 3,500 denials of employment. The Department is evaluating the use of electronic fingerprint technology.

The CHRC program was implemented in September of 2006. To date, over 130,000 initial criminal history record checks have been processed, along with over 30,000 payment checks.

Issues: To improve both communications and provider compliance, CHRC must provide training to nursing homes and home care providers across NYS on the policies, procedures and the requirements of the CHRC program.

Population Served: All New York State residents who could potentially use long term home and community based and institutionalized care: 108,000 nursing home residents; 698,000 home care recipients; 1,300 health care providers; 90,000 health care employees per year.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Professional Credentialing Professional and Para-Professional Credentialing

Mandate: **Nursing Home Nurse Aides:** Federal OBRA of 1987; Federal SSA, Titles 18 & 19; 42 CFR Part 483 Subparts D & E; Public Health Law §2803-d(g) & j; **Nursing Home Administrators:** Federal SSA §1919; Public Health Law §2895 – 2898

Mandated Funding Level: None

Brief Description/History/Background: Federal statutes and regulations require each state to identify, approve and periodically re-approve nurse aide training programs (NATPs) and competency evaluation programs to ensure that they meet federal requirements, and to maintain a registry of certified nurse aides. Federal statutes and regulations require each state to license nursing home administrators and establish and enforce standards of practice for such professionals. Federal statute requires each state to establish a Board or Council to achieve these ends. NYS statute requires the Department to provide staff to support the activities of the Board of Examiners of Nursing Home Administrators (BENHA). State regulations require all personal care aides employed by home care services agencies to successfully complete a personal care aide training program approved by the Department of Health or Education.

Issues: A 2007 OSC audit of the contract supporting the NATP recommended strengthened internal controls to reconcile revenues to expenses. The recommendations plan will maximize the revenue generated by this contract.

Population Served: There are currently 1,322 NYS registered Nursing Home Administrators and approximately 348,50 certified nurse aides (CNAs) listed in the New York State RHCF Nurse Aide Registry. Of the CNS listed, 92,125 are active. There are 112 approved Personal Care Aide Training programs facilitated at 199 sites.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Continuing Care Retirement Communities (CCRCs)/Fee-for-Service Continuing Care Retirement Communities (FFSCCRCs)

Mandate: Public Health Law Articles 46 and 46-A

Mandated Funding Level: None

Brief Description/History/Background: CCRCs/FFSCCRCs

Description: Residential alternatives for seniors offering independent living with access to a continuum of long term care services. Provides the review and approval of Certificate of Authority applications and community oversight monitoring and surveillance to assure compliance with Article 46 and 46-A. Maintains interagency coordination and liaison with State Agency reviewers, State Insurance Department and OAG. Communicates regulatory and procedural information and support to sponsors and developers. Provides staff support to the Continuing Care Retirement Community Council, and conducts resident complaint investigation.

History/Background:

- Chapter 689 of the Laws of 1989 established authority for the development of CCRCs, originally offering only life care contracts, which include unlimited LTC services;
- Chapter 66 of the Laws of 1994 permitted use of escrowed entrance fees in construction and financing by county industrial development agencies;
- In 1997, Article 46 amended to allow CCRCs to offer modified contracts, with a limited RHCF benefit. Additional revisions were made in 2003 allowing communities flexibility in meal plan offerings and a streamlined IDA refinancing process;
- Chapters 519 and 545 of the Laws of 2004 established Article 46-A of the PHL, the FFSCCRC Demonstration Project. Article 46-A communities offer a fee-for-service contract which includes independent living, with all LTC paid for as needed by the resident;
- Chapter 700 of the Laws of 2006 increased the RHCF beds to 2,000.
- Currently, there are 9 operational CCRCs. Three additional communities (2 CCRCs and 1 FFSCCRC) have received a final Certificate of Authority and are under construction. Two CCRC projects are signing contracts with prospective residents under a conditional Certificate of Authority. One proposed FFSCCRC project has initiated the Certificate of Authority process.

Issues: Access to IDA financing expired on January 31, 2008.

Population Served: Seniors, generally age 62 or older. Currently, operational communities serve 1714 independent living units, 297 adult care facility units, and 339 skilled nursing facility beds.

Performance Measures: With the State Insurance Department, conduct triennial on-site surveys to evaluate community compliance with statutory, regulatory and contractual requirements.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Home Medical Equipment Licensure

Mandate: Public Health Law Article 36-A

Mandated Funding Level: None

Brief Description/History/Background: PHL Article 36-A establishes licensing and regulatory procedures for home medical equipment (HME) providers and authorizes the Commissioner to prescribe rules and regulations for standards for the provision of HME services. Such standards must to the maximum extent possible, incorporate standards established for the provision of these services by "a national accrediting agency approved by the Department." This process will ensure that the agencies providing such complex services are reputable and competent.

Issues: Medicaid already requires prior approval for home medical equipment and therefore reviews standards for such equipment. The licensure of HME is duplicative of the Medicaid provider enrollment process.

Population Served: Potentially users and providers of home (durable) medical equipment.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Long Term Care Quality Improvement Activities

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Oversight and management of grant programs to improve the quality of long term care services, including EnAbLE, EnAbLE Air Conditioning, Quality Incentive Payment Program, Enriched Housing Subsidy Program, the Telemedicine Demonstration Program, Nursing Home Transition and Diversion Housing Subsidies, TBI Program, and Quality Improvement Grants. These programs are described in accompanying Attachments C.

Issues: None

Population Served: All certified Adult Care Facilities, including ALR and ALP. ACFs serve persons who are 18 or over and appropriate for ACF or ALR facilities. ALP residents must be nursing home eligible. As well as home care recipients using telemedicine equipment.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Adult Care Facility Resident Air Conditioning

Mandate: Public Health Law § 2807-v(bbb)

Mandated Funding Level: None

Brief Description/History/Background: The purpose of air conditioning grants is to assist Adult Care Facility (ACF) operators with low-income residents (residents who receive Supplemental Security Income (SSI)) in the purchase and operation of air conditioning systems for resident rooms. Air conditioning is to be provided at no additional cost to residents. Resident Council approval of proposed air conditioning initiative is required as part of the application.

Since the SFY 2004-05 amendment to HCRA, the Enhancing Abilities and Life Experience (EnAbLE) Program has annually provided grants to operators of ACFs for air conditioning. All of the funding provided in this appropriation is to be expended for grants to ACFs. Such expenditures are included in a State Purposes appropriation.

Issues: None

Population Served: All ACFs are eligible to apply for funds. In distributing funds for the air conditioning initiative, the Department gives priority to those applicants whose residents demonstrate the highest level of need, including but not limited to, those with psychiatric disabilities and the elderly, and consideration to applicants in the greatest financial need of such assistance. In 2007, 51 facilities received grant awards benefiting approximately 5,500 residents.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Adult Home Initiatives

Mandate: Public Health Law Section 2807-v(nn)

Mandated Funding Level: None

Brief Description/History/Background: This program supplements other grants to adult care facilities (ACF), including EnAbLE, for the development of programs targeted to the specific needs and interest of residents to improve quality of life, and also includes funding for four targeted wellness activities, and payments for temporary operators of ACFs. A goal of EnAbLE is to improve the ability of residents to live more independently.

EnAbLE grants may fund independent living skills training, vocational or educational programs; peer specialists; employment specialist; or services and supports to allow residents to maintain independence in their activities of daily living, and similar innovative activities. The wellness grants target improving food quality; diabetes management; chronic disease self-management; and smoking cessation. Funds may be used for overall health, advocacy and legal support as well.

Temporary Operator Contracts provide funds to pay temporary operators of adult homes, who are appointed when facilities are mismanaged, resulting in fiscal insolvency or poor quality of care, placing residents in imminent danger. These contracts are short term to stabilize a facility while a more permanent solution is identified and implemented.

Issues: The Quality Enhancement Account portion of these appropriations is funded through penalty payments by ACFs.

Population Served: All ACFs are eligible. In distributing these funds, the Department gives priority to those applicants whose residents are recipients of Supplemental Security Income (SSI) or other safety net supports. A preference in funding is granted to applicants for use of program funds which would serve residents receiving supplemental security income and/or safety net. Between 2005 and 2007, 63 facilities received grant awards benefiting 5,189 residents.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Quality Incentive Payment Program

Mandate: Chapter 735 of the Laws of 1994 and Chapter 464 of the Laws of 1996

Mandated Funding Level: None

Brief Description/History/Background: The purpose of QUIP is to enhance the quality of care provided to SSI/Safety Net residents of ACFs by providing funding to certified operators to improve service delivery and to encourage the admission of new eligible residents into these facilities. Funds may be used for facility maintenance and repairs, staff training, furnishings, equipment, or other purposes that directly improve the quality of care and services provided to residents.

QUIP was established in Chapter 735 of the Laws of 1994, and has been funded each year. The payment amount is based on the number of SSI/Safety Net residents in a facility.

Issues: None

Population Served: All certified Adult Home and Enriched Housing Program operators are eligible to apply for funds. Funds distributed through QUIP are based on the number of SSI and safety net recipients in the facility. Benefiting populations include adults who are substantially unable to live independently, due to physical or other limitations associated with age, physical or mental disabilities or other factors, including frail elderly, and younger adults with mental health diagnoses. In 2008, 264 facilities received QUIP awards. These facilities serve approximately 23,000 residents.

Performance Measures: Funds are not awarded to operators with pending revocations or suspensions or to operators with unpaid penalties.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Enriched Housing Subsidy Program

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The Enriched Housing (EH) program was established in 1979 as an alternative living arrangement for elderly adults who do not require institutional care but who need some assistance with daily living activities. EH sponsors provide care and services to residents who live in their own apartments in buildings that also have common space areas for dining and leisure activities.

The purpose of the EHSP is to further support EH programs serving SSI eligible residents and to avert closings. EH provides a cost effective alternative for SSI eligible persons who would otherwise live in the community with home care services provided under the Medical Assistance Program.

Issues: None

Population Served: Not-for-profit EHPs, with residents who are SSI recipients. In 2008, 34 enriched housing programs received subsidies benefiting approximately 1,500 residents.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Telemedicine Demonstration Program

Mandate: Public Health Law Article 36

Mandated Funding Level: None

Brief Description/History/Background: To date, the Department has issued two separate requests for applications for the implementation of new or expansions of existing programs. Fifty-two home care agencies have been awarded nearly $7 million in response to these requests for applications. Of these, 29 agencies ended their 2 year contracts with the DOH on December 31, 2007 and the remaining 22 contracts are expected to end on December 31, 2008. Subsequent to the expiration of grant funds, demonstration rates of payment have been authorized in Section 3614 of PHL to ensure the availability of technology-based patient monitoring, communication and health management. Request for applications for the third and fourth demonstrations are currently being developed for the remaining $3 million.

Issues: With the enactment of a Medicaid rate for telehealth services rendered in a home care context, the purpose of this program needs to be refined.

Population Served: Individuals receiving home care services through a home care agency licensed or certified under Article 36 of the Public Health Law. Between 2005 and 2007, 51 agencies received telemedicine grant awards benefiting approximately 9,500 patients.

Performance Measures: None.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Nursing Home Transition and Diversion (NHTD) Housing Subsidy Program

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The 2008-09 Enacted Budget includes funding for housing subsidies to address waiver participants' barriers to community based care due to the limited availability of affordable accessible housing in New York State. The NHTD housing subsidy funding level is $4,950,000 for 2008-09 appropriations.

Waiver management staff is working collaboratively with NYS Division of Housing and Community Renewal (DHCR) to phase-in a statewide network of local administrators contracted to assist NHTD Service Coordinators and Regional Resource Development Specialists identify/develop appropriate housing opportunities for NHTD waiver participants.

The NHTD waiver serves MA eligible individuals who are at least 18 years of age and would otherwise require nursing home care. DOH was authorized by the federal Centers for Medicare and Medicaid Services (CMS) in September 2007 to enroll up to 5,000 participants by 2010. Accordingly, expenditure of the housing subsidies will reflect the gradual increase in the number of participants, their individual housing needs, and the State's ability to identify/develop an appropriate affordable and accessible housing base.

Issues: This program is being developed with DHCR via a MOU.

Population Served: Up to 5,000 NHTD waiver participants in need of housing assistance.

Performance Measures: Number of participants provided subsidy.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Traumatic Brain Injury (TBI) Program Administration (SO)

Mandate: Public Health Law Article 28

Mandated Funding Level: None

Brief Description/History/Background: The 2008-09 Enacted Budget includes a $14.6 million local assistance appropriation to support the Traumatic Brain Injury Program. The funds are used for contracted administrative and waiver management functions, housing subsidies for waiver participants, and other specialty services to assist participants whose disability may challenge their ability to remain in the community. A portion of the appropriation is transferred to state operations for the administration of the program. Operated since 1996, this Medicaid (MA) waiver provides individuals with TBI the oversight and services necessary to meet their health and welfare needs in the community.

Staff manage a range of activities/contracts under the appropriation, including:

- Network of ten Regional Resource Development Centers (RRDC) responsible for local administration of the waiver;
- Quality assurance (QA) and management activities to ensure the State's ability to meet federal waiver QA requirements;
- A Statewide Neurobehavioral Resource for direct consultative services and technical assistance to RRDC and DOH staff, provider training, and direct intervention to enable waiver participants with challenging behaviors to remain in the community;
- A TBI Family Helpline for public information and TBI Waiver Complaint Line for participants and their families; and
- Financial support for the statutorily required TBI Services Coordinating Council that provides guidance and recommendations to DOH regarding the full range of NYS TBI issues.

Issues: None

Population Served: NYS residents eighteen years or older with a primary diagnosis of TBI and who would otherwise require nursing facility level of care. The TBI Family Helpline is available to everyone. There are 2300 waiver participants, of which 1800 receiving housing subsidies.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Traumatic Brain Injury (TBI) Program Waiver Management

Mandate: Public Health Law Article 28

Mandated Funding Level: None

Brief Description/History/Background: The 2008-09 Enacted Budget includes a $14.6 million local assistance appropriation to support the Traumatic Brain Injury Program. The funds are used for contracted administrative and waiver management functions, housing subsidies for waiver participants, and other specialty services to assist participants whose disability may challenge their ability to remain in the community. Operated since 1996, this Medicaid (MA) waiver provides individuals with TBI the oversight and services necessary to meet their health and welfare needs in the community.

Staff manage a range of activities/contracts under the appropriation, including:

- Network of ten Regional Resource Development Centers (RRDC) responsible for local administration of the waiver;
- Quality assurance (QA) and management activities to ensure the State's ability to meet federal waiver QA requirements;
- A Statewide Neurobehavioral Resource for direct consultative services and technical assistance to RRDC and DOH staff, provider training, and direct intervention to enable waiver participants with challenging behaviors to remain in the community;
- A TBI Family Helpline for public information and TBI Waiver Complaint Line for participants and their families; and
- Financial support for the statutorily required TBI Services Coordinating Council that provides guidance and recommendations to DOH regarding the full range of NYS TBI issues.

Issues: None

Population Served: NYS residents eighteen years or older with a primary diagnosis of TBI and who would otherwise require nursing facility level of care. The TBI Family Helpline is available to everyone. There are 2300 waiver participants, of which 1800 receiving housing subsidies.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Traumatic Brain Injury (TBI) Program Housing Subsidy

Mandate: Public Health Law Article 28

Mandated Funding Level: None

Brief Description/History/Background: The 2008-09 Enacted Budget includes a $14.6 million local assistance appropriation that includes housing subsidies for waiver participants.

Staff manages a range of activities/contracts under the appropriation including directly managing housing subsidies for eligible waiver participants as well as a contracted housing locator to assist participants with find housing, and a housing payment agent.

Issues: The Department will need to evaluate the program as the waiver population grows.

Population Served: NYS residents eighteen years or older with a primary diagnosis of TBI and who would otherwise require nursing facility level of care. The TBI Family Helpline is available to everyone. There are 2300 waiver participants, of which 1800 receiving housing subsidies.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Nursing Home Quality Improvement Grants

Mandate: Public Health Law Article 28

Mandated Funding Level: None

Brief Description/History/Background:

On-Time Quality Improvement for Long Term Care: Grants support strategies to reduce the development of pressure ulcers in nursing home residents at risk for developing them. Clinical guidelines and clinical information are integrated into each nursing home's daily routine and processes using health information technology (HIT). Using HIT will reduce documentation time and eliminate redundancies.

Long Term Care Quality Improvement Initiative (LTCQII): Program dedicated to improving the quality of the nursing home experience in NYS facilities. Projects funded by this award must meet at least one of the following objectives: improve resident quality of life; improve quality of care; improve the use of data in decision making; and/or improve cross-provider communication and information sharing.

Issues: None

Population Served: Seventy-Five percent of the 108,000 NYS nursing home residents are at risk for pressure ulcers, currently, 81,000 residents at risk.

LTCQII will involve 33 nursing homes that will be participating in the grant program.

EQUIP will be utilized in the Capital District Region before it is used across the State. Currently there are 71 facilities in the Capital Region with 9,664 residents.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Hospice Quality Assessment

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Funding in the amount of $1,000,000 was included in the '08-'09 Budget for the implementation of quality improvement programs in hospices. The initiative seeks to improve the quality of hospice care, improve outcomes and prepare hospices for upcoming changes in federal requirements. The initiative is intended to assist providers to develop measures, which focus on indicators that are related to improved palliative outcomes and on the end-of-life support services provided and take action to demonstrate improvement in hospice performance.

Issues: Four out of nine hospice surveys in the prior 24-month period conducted as part of the state's ongoing surveillance activities have resulted in findings of condition level non-compliance. The revised federal conditions of participation, which became effective in June 2008, require that hospices develop, implement and maintain an effective, ongoing, hospice-wide data driven quality assessment and performance improvement programs. Surveillance findings to date indicate that few hospice providers in NYS have developed the organizational framework necessary to implement this new requirement. Development of formal quality assessment and performance improvement programs will equip hospices to identify problems; focus on indicators related to improved palliative care outcomes and end-of-life support services provided to patients' develop and implement solutions and measure the effectiveness and sustainability that demonstrates improvement in hospice performance. In addition, a data driven system and a mechanism to maintain documentary evidence of quality assessment and performance improvement programs will be created.

Populations Served: Persons with a life expectancy of six months or less should their illness run its expected course.

Performance Measures: This initiative will create quality measures and develop templates to achieve standardized formats and consistent data collection protocols to be used by hospice providers across NYS.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Long Term Care (LTC) Restructuring administration (SO)

Mandate: NY Connects - New York State (NYS) Elder Law Sec. 203 (8); Nursing Home Transition and Diversion (NHTD)- Social Services Law Section 366 (6-a); Most Integrated Setting Coordinating Council (MISCC) - Chapter 551 of the Laws of 2002

Mandated Funding Level: None

Brief Description/History/Background:

In 2004, the Governor's Workgroup on Health Care Reform issued a report recommending broad-based improvements in the State's LTC system. The Workgroup formulated a vision for an "accessible, coordinated and person-centered long term care system that …will support self determination; promote personal responsibility; provide services that meet consumer needs; provide quality care; and ensure accountability, efficiency and affordability." The Department charged to realize this major restructuring effort. Key activities include policy research, analysis, evaluation, and development focused on the reform of LTC. Initiatives include the development of LTC policy and budget reform proposals; collaboration with NYSOFA in the implementation of NY Connects (single point of entry); NHTD waiver program administration; development of a cash and counseling demonstration program; review and analysis Article 36 (home care) analysis of the Adult Day Health Program need methodology; review of NYS and federal nursing home regulations; coordination and support for the LTC Advisory Committee; participation on the MISCC; coordination and development of central data resources for LTC; quantitative evaluation, analysis, and modeling of LTC information; assistance with waiver renewal processes; and collaboration with internal and external stakeholders regarding shared program initiatives and policy development goals. The State's LTC restructuring initiatives are driven by dramatic shifts in NYS demographics that predict steep growth in the number of elderly and persons with disabilities who will require LTC services, changing consumer preferences for home and community based care, a shrinking workforce, and inadequate numbers of informal caregivers. This situation creates an imperative for the State to develop initiatives that focus on cost-effective, and sustainable alternative approaches.

Issues: None

Population Served: Over 300,000 Medicaid consumers of LTC services, 2,000 LTC providers, and policy makers. Family caregivers statewide.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Long Term Care (LTC) Restructuring (ATL)

Mandate: NY Connects - New York State (NYS) Elder Law Sec. 203 (8); Nursing Home Transition and Diversion (NHTD)- Social Services Law Section 366 (6-a); Most Integrated Setting Coordinating Council (MISCC) - Chapter 551 of the Laws of 2002

Mandated Funding Level: None

Brief Description/History/Background:

In 2004, the Governor's Workgroup on Health Care Reform issued a report recommending broad-based improvements in the State's LTC system. The Workgroup formulated a vision for an "accessible, coordinated and person-centered long term care system that …will support self determination; promote personal responsibility; provide services that meet consumer needs; provide quality care; and ensure accountability, efficiency and affordability." The Department charged to realize this major restructuring effort. Key activities include policy research, analysis, evaluation, and development focused on the reform of LTC. Initiatives include the development of LTC policy and budget reform proposals; collaboration with NYSOFA in the implementation of NY Connects (single point of entry); NHTD waiver program administration; development of a cash and counseling demonstration program; review and analysis Article 36 (home care) analysis of the Adult Day Health Program need methodology; review of NYS and federal nursing home regulations; coordination and support for the LTC Advisory Committee; participation on the MISCC; coordination and development of central data resources for LTC; quantitative evaluation, analysis, and modeling of LTC information; assistance with waiver renewal processes; and collaboration with internal and external stakeholders regarding shared program initiatives and policy development goals. The State's LTC restructuring initiatives are driven by dramatic shifts in NYS demographics that predict steep growth in the number of elderly and persons with disabilities who will require LTC services, changing consumer preferences for home and community based care, a shrinking workforce, and inadequate numbers of informal caregivers. This situation creates an imperative for the State to develop initiatives that focus on cost-effective, and sustainable alternative approaches.

Issues: None

Population Served: Over 300,000 Medicaid consumers of LTC services, 2,000 LTC providers, and policy makers. Family caregivers statewide.

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Long Term Care Reform Improvements

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Given the complexity and fragmentation of NYS' long term care system and the variations by which information is gathered by multiple data users, the Governor and NYS Legislature authorized the creation of a uniform data set that would support an integrated, statewide LTC informational system. Currently, data related to patient specific needs is only available in multiple unrelated systems with no connection to Medicaid billing and encounter data. This lack of coordinated data has hampered the creation of payment mechanisms that reflect the needs of the individuals receiving services.

The Department is developing a unified, electronic data system to enhance patient service coordination. These funds also support other LTC system improvements including: development of supporting tools to expedite nursing home rate appeals, review of financial restructuring plans for financially disadvantaged nursing homes; support for restructuring officers; and review of regulatory and statutory changes aimed at reducing nursing home length of stay and increasing acuity levels in nursing homes.

Issues: None

Population Served: When fully implemented, such a data set will impact on all LTC recipients in NYS.

Performance Measures: Creation of such a data set will provide mechanism to establish performance measures.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Medicaid (MA) LTC Services

Mandate: (1) Home Health Services (CHHA): SSL 365-a and PHL Article 36; (1a) Personal Emergency Response Services (PERS): Chapter 438 of the Laws of 1989 ,SSL 367-g; (2) Hospice: Title 42 CFR Part 418; Public Health Law, Article 40 Title 10; (3) Personal Care Services (PCS): 42 CFR 440.167 and SSL365-(a)(2)(e); (3a) Assisted Living Program (ALP): Chapter 165 of the Laws of 1991, SSL3677-h and 461-l; (3b) Limited License Home Care Services Agencies (LLHCSA): Chapter 81 of the Laws of 1995, SSL Section 367-p; (3c) Consumer Directed Personal Assistance Program (CDPAP): Chapter 81 of the Laws of 1995, SSL365-f; (3d) Foster Family Care Demonstration Program: SSL364-h

Mandated Funding Level: None

Brief Description/History/Background: Staff manage a range of MA State Plan home care services/programs. CHHA services, available since 1967, are the only federally mandated service. Personal Care Services (PCS) and Hospice are both optional services added to the State Plan in 1974 and 1983, respectively. The Home Health and PCS benefits have been used as service mechanisms for other MA funded home care initiatives such as ALP, PERS, CDPAP and LLHCSA.

DOH is statutorily required to provide State Plan services/programs on a state-wide basis available to all qualified MA recipients. The services have been developed and expanded over time in response to increasing consumer demand for home and community based care. Administrative responsibilities have grown due to new program/services with discrete participant eligibility criteria, operational and administrative requirements, and claiming/reimbursement/system requirements. Staff provide technical assistance regarding the programs/services to State agencies, DOH units, the NYS Legislature, Local Department of Social Services staff, providers, and consumers.

Issues: None

Population Served: MA recipients who have a medical need for the service. For 2006, the following recipients were served: 60,885 received $440 million of Home Health Services; 84,601 received $2.1 billion of PCS; and, 7,410 received $94.2 million of Hospice Services.

Performance Measures: In 2006, state plan home care services were provided to 152,896 recipients at an average cost lower than that of institutional care.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Medicaid (MA) LTC Waivers

Mandate: Social Services Law 367-c & 367-e (LTHHCP); SSL 366.6 & 366.7 (CAH); TBI: Public Health Law, Article 280-CC; SSL 366 (6-a) (NHTD); SSL 366(12)(a) & 366(12)(b)(B2H)

Mandated Funding Level: None

Brief Description/History/Background: To promote community integration and avoid institutionalization, the New York State MA program includes waivers operated in compliance with Section 1915c of the Social Security Act. Each waiver has unique policies and administrative infrastructure as set forth in separate federal applications. All include services not otherwise MA coverable but needed to assure health and welfare of participants who choose an alternative to institutional care.

Four waivers are managed directly by staff: Long Term Home Health Care Program (LTHHCP) (1983); Care at Home I/II (CAH) (1985); Traumatic Brain Injury (TBI)(1996), and Nursing Home Transition and Diversion (NHTD)(2008). Six are managed by other Agencies with oversight: OMR/DD: CAH III, IV and VI (1991, 1994, and 2000 respectively) and three OCFS Bridges to Health (B2H) waivers (2008).

Staff oversee local districts and/or regional contractors that are charged with a range of administrative responsibilities, define provider/service qualifications, provide technical assistance, fulfill federal reporting requirements, submit renewal applications every five years, and maintain ongoing quality assurance (QA) and cost neutrality compliance documentation.

To further promote community integration of all NYS residents, enhanced federal matching funds for individuals transitioned from nursing homes was secured under a five year federal Money Follows the Person (MFP) grant. Through contracts, MFP initiatives will expand outreach, housing education and assistive technology supports regardless of MA eligibility.

Issues: None

Population Served: Individuals with disabilities and/or seniors who would otherwise require institutional care, their families, and waiver providers. Number of individuals served: 27,000 LTHHCP; 800 CAH I/II; 2300 TBI; 600 CAH III/IV/VI; up to 3300 B2H.

Performance Measures: Required Federal Assurances by CMS.

Program: LTC Partnership

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Mandate: Long Term Care Partnership

Mandated Funding Level: None

Brief Description/History/Background: Established in 1993, The Partnership for LTC links private long term care (LTC) insurance coverage to Medicaid eligibility, allowing a policyholder who exhausts his or her private LTC insurance benefits to access Medicaid while protecting assets. Partnership insurance policies must comply with standards established by the Superintendent of Insurance in order for policy-holders to access Medicaid Extended Coverage. This program assists individuals in planning for needs and saves Medicaid funding. There are over 62,000 active policies today.

In addition to the State Insurance Department, the Partnership program is closely coordinated with the State Office for the Aging's Long Term Care Insurance Education and Outreach Program (LTCIEOP) – responsible for operating local county LTCIEOP informational centers - and with the private insurance industry. This public/private initiative is actualized through a governing Evolution Board, providing insurer input into the program.

Staff is responsible for training insurance agents and brokers; maintaining and tracking claims data; assisting policy holders; and conducting a broad media and outreach campaign.

Issues: The Department needs to increase public awareness, information, and education about Partnership and other long term care insurance policies, and develop alternatives that serve those who, because of insurer underwriting and health status, are unable to purchase long term care insurance.

Population Served: Partnership and non-Partnership LTC insurance is intended for use by anyone wishing to insure against the need for long term care not covered by Medicare or private health insurance. Benefits are generally triggered by advanced age or disability. Sales are most attractive to younger individuals, because coverage is less expensive for those who are younger.

Performance Measures: Performance is measured by the number of Partnership policies sold. The program's goal is to increase the number of policies sold by 10% by December 31, 2009.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: LTC Insurance Education and Outreach

Mandate: Social Services Law Section 367 f. (Partnership Extended Medicaid Coverage); Executive Law Section 544 (Long Term Care Education and Outreach Program); and Public Health Law Section 206, Sub. 21

Mandated Funding Level: None

Brief Description/History/Background: Established in 1993, The Partnership for LTC links private long term care (LTC) insurance coverage to Medicaid eligibility, allowing a policyholder who exhausts his or her private LTC insurance benefits to access Medicaid while protecting assets. Partnership insurance policies must comply with standards established by the Superintendent of Insurance in order for policy-holders to access Medicaid Extended Coverage. This program assists individuals in planning for needs and saves Medicaid funding. There are over 62,000 active policies today.

In addition to the State Insurance Department, the Partnership program is closely coordinated with the State Office for the Aging's Long Term Care Insurance Education and Outreach Program (LTCIEOP) – responsible for operating local county LTCIEOP informational centers - and with the private insurance industry. This public/private initiative is actualized through a governing Evolution Board, providing insurer input into the program.

Staff is responsible for training insurance agents and brokers; maintaining and tracking claims data; assisting policy holders; and conducting a broad media and outreach campaign.

Issues: The Department needs to increase public awareness, information, and education about Partnership and other long term care insurance policies, and develop alternatives that serve those who, because of insurer underwriting and health status, are unable to purchase long term care insurance.

Population Served: Partnership and non-Partnership LTC insurance is intended for use by anyone wishing to insure against the need for long term care not covered by Medicare or private health insurance. Benefits are generally triggered by advanced age or disability. Sales are most attractive to younger individuals, because coverage is less expensive for those who are younger.

Performance Measures: Performance is measured by the number of Partnership policies sold. The program's goal is to increase the number of policies sold by 10% by December 31, 2009.

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: LTC Delivery Demos

Mandate: 2005 Unconsolidated Law

Mandated Funding Level: None

Brief Description / History / Background: As part of the 2005 – 2006 budget, two Long Term Care (LTC) delivery demonstrations were authorized. The first demonstration was at the Village Care Center in Manhattan. A contract was awarded to help build a community based service capacity and integrate care across all settings. There were workforce investments made as well. The second demonstration was awarded to the Loretto System for activities to increase the home and community based capacity of the system and to help re-orient the workforce.

Issues: None

Population Served: Parts of Manhattan and Onondaga County

Performance Measures: None

Attachment C

Department of Health – Office of Long Term Care
PROGRAM INFORMATION SHEET

Program: Long Term Care Community Coalition

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The Long Term Care Community Coalition (LTCCC) is a non-profit organization dedicated to improving long term care in New York State. LTCCC plays a unique role in the State, bringing together over two dozen consumer, community, civic and professional organizations and individuals from across New York whose collective mission is to protect and improve the quality of life and quality of care for people who use and/or reside in nursing homes and other types of long-term care facilities and programs throughout New York. LTCCC uses the perspective gained from its diverse members to identify important developments, trends and emerging issues; collaborate with prestigious academics on research to gain understanding of these issues; and develop expertise and formulate strategies for overcoming challenges and barriers.

The organization provides advocacy and education on long term care issues, principally affecting the elderly and the disabled with a cadre of individuals with direct access to residents of nursing homes, adult homes, and enriched housing programs as well as the families of these residents. It is because of this direct access to those receiving services that the Department depends on LTCCC to provide feedback and advocacy from the consumers of the services in the development of policy.

Executive staff from the Office of Long Term Care meets with staff from LTCCC on a quarterly basis to discuss current long term care concerns, nursing home surveillance trends and opportunities where a collaborative partnership may ultimately result in improved quality of life outcomes for seniors residing in our NYS nursing homes.

Issues: None

Population Served: Individuals age 60 and older which total approximately 3.4 million.

Performance Measures: None.

Attachment B

Agency Programs/Activities: Inventory and Key Data
Office of Health Systems Management

Page	Relation to Core Mission (H/M/L)	Program/Activity	Spending Category (SO, ATL, CAP)	3/31/09 FTEs (All Funds)	General Fund Disbursements ($000s)				State Special Revenue Funds Disbursements ($000s)				Capital Projects Funds Disbursements ($000s)			
					2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected
					2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected
1	H	Office of Professional Medical Conduct	SO	146	$0	$0	$0	$0	$16,029	$14,029	$19,203	$19,203	$0	$0	$0	$0
2	H	Patient Safety Center/Patient Safety Awards Administration	SO	5	$143	$219	$348	$349	$2,378	$2,770	$2,870	$2,870	$0	$0	$0	$0
3	H	Patient Safety Awards	ATL		$0	$0	$1,200	$1,176	$1,249	$490	$0	$0	$0	$0	$0	$0
4	H	Patient Health Info & Quality Imp Init	ATL		$0	$0	$514	$350	$348	$0	$0	$0	$0	$0	$0	$0
5	M	Funeral Directing (Licensure & Investigation)	SO	3	$0	$0	$0	$0	$289	$303	$387	$387	$0	$0	$0	$0
6	H	Bureau of Narcotic Enforcement	SO	35	$64	$64	$67	$69	$15,010	$10,919	$10,804	$10,804	$0	$0	$0	$0
8	H	Official Prescription Program	SO	13	$128	$128	$134	$138	$6,758	$5,166	$4,856	$4,856	$0	$0	$0	$0
10	H	Emergency Medical Services Administration	SO	45	$186	$186	$195	$201	$15,505	$15,242	$16,522	$16,522	$0	$0	$0	$0
12	H	Hospital Services, Surveillance & Complaints	SO	182	$5,923	$8,659	$13,374	$13,397	$8,999	$8,521	$9,843	$9,843	$0	$0	$0	$0
13	M	Miscellaneous Councils, Outreach Registry	SO	5	$138	$210	$334	$334	$237	$224	$259	$259	$0	$0	$0	$0
15	L	Public Awareness Campaign for Donor Registry Letter	SO	0	$0	$0	$500	$0	$0	$0	$0	$0	$0	$0	$0	$0
16	H	Center for Liver Transplant	ATL		$0	$0	$145	$145	$117	$125	$0	$0	$0	$0	$0	$0
17	L	NY Alliance for Donation	ATL		$0	$0	$220	$220	$205	$225	$0	$0	$0	$0	$0	$0
18	H	Public Awareness Campaign for Donor Registry Letter	ATL		$378	$616	$150	$245	$0	$0	$0	$0	$0	$0	$0	$0
19	H	Contract Management	SO	5	$143	$218	$348	$348	$247	$234	$270	$270	$0	$0	$0	$0
20	L	Brain Trauma Foundation	ATL		$500	$692	$606	$490	$0	$0	$0	$0	$0	$0	$0	$0
21	H	Cardiac Advisory Council/Services Administration	SO	4	$93	$142	$226	$226	$173	$164	$189	$189	$0	$0	$0	$0
22	H	Cardiac Advisory Council/Services Grants	ATL		$0	$0	$2,000	$2,000	$956	$1,462	$0	$0	$0	$0	$0	$0
23	M	Section 405.4 Audits administration	SO	1	$36	$55	$87	$87	$62	$58	$68	$68	$0	$0	$0	$0
24	M	Section 405.4 Hospital Audit contract	ATL		$0	$0	$0	$0	$3,338	$2,856	$2,700	$2,700	$0	$0	$0	$0
25	H	NYPORTS / Incident Reporting administration	SO	17	$473	$721	$1,147	$1,150	$815	$771	$891	$891	$0	$0	$0	$0
26	H	NYPORTS contract	ATL		$0	$5	$1,039	$665	$196	$425	$0	$0	$0	$0	$0	$0
27	H	Medicaid UR program administration	SO	2	$57	$87	$139	$139	$99	$94	$108	$108	$0	$0	$0	$0
28	H	Medicaid Utilization Review	ATL		$4,353	$5,659	$5,600	$5,600	$7,288	$7,288	$7,288	$7,288	$0	$0	$0	$0
29	H	Certificate Of Need & Health Planning	SO	46	$96	$96	$101	$104	$4,055	$3,811	$6,583	$6,583	$0	$0	$0	$0
30	H	Health System Restructuring (includes Berger & HEAL NY)	SO	13	$373	$568	$904	$906	$642	$908	$702	$702	$0	$0	$0	$0
	H	HEAL NY - Hard Dollar	CAP		$0	$0	$0	$0	$0	$0	$0	$0	$25,000	$63,174	$99,700	$115,000
	H	HEAL NY - Bonded	CAP		$0	$0	$0	$0	$0	$0	$0	$0	$0	$28,356	$52,300	$100,000
	H	F-SHRP	ATL		$0	$0	$0	$0	$0	$776	$210,000	$300,000	$0	$0	$0	$0
	H	Health Facility Restructuring	ATL		$0	$0	$0	$0	$20,000	$0	$19,600	$19,600	$0	$0	$0	$0
32	H	Health Care Stabilization Grant Program	ATL		$0	$0	$0	$0	$16,614	$2,036	$2,200	$0	$0	$0	$0	$0
33	H	Primary Care and Health Personnel Programs	SO	3	$128	$128	$134	$138	$128	$128	$134	$138	$0	$0	$0	$0
35	H	Workforce Development Programs	SO	7	$128	$128	$134	$138	$640	$640	$670	$690	$0	$0	$0	$0
36	M	Health Workforce Retraining Initiative grants	ATL		$0	$0	$0	$0	$37,774	$34,157	$25,000	$31,500	$0	$0	$0	$0
38	H	Rural Health Program Administration	SO	4	$0	$0	$0	$0	$512	$512	$536	$552	$0	$0	$0	$0
39	H	Rural Health Care Access Development grants	ATL		$0	$0	$0	$0	$13,089	$10,807	$10,400	$10,400	$0	$0	$0	$0
41	H	Rural Health Network Development grants	ATL		$0	$0	$0	$0	$8,467	$5,643	$6,700	$6,700	$0	$0	$0	$0
42	M	Area Health Education Center Program (AHEC)	ATL		$0	$0	$0	$0	$1,397	$1,537	$2,100	$2,500	$0	$0	$0	$0
43	H	CHCCDP (Community Health Care Conversion Demo Prog)	ATL		$0	$0	$0	$0	$162,020	$56,709	$10,000	$0	$0	$0	$0	$0
		Grand Total includes SRO/GF		535	13,340	18,581	29,646	28,615	345,636	189,030	370,883	455,623	25,000	91,530	152,000	215,000

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Professional Medical Conduct (PMC)

Mandate: Public Health Law §230 & Education Law, Article 131, §6530/6531

Mandated Funding Level: None

Brief Description/History/Background: The OPMC's critical mission is to protect the public's health & safety from medical negligence, incompetence, illegal or unethical practices by any of the over 90,000 licensed physicians, certified physician assistants & specialist assistants in NYS (target group). The Office, mandated to investigate complaints, receives & closes about 8,000 complaints annually, 30% more than five years ago. The Board adjudicates cases & imposes penalties against licensees found guilty of misconduct. The Office also annually monitors over 1,250 licensees who are guilty of misconduct or are mentally, emotionally or physically impaired. History: The Education Dept. was responsible for physician licensing & discipline. Law enacted in 1991 granted sole responsibility for physician discipline to the DOH. Recent patient safety law mandates investigations of medical malpractice actions, mandates publication of misconduct charges, & strengthens the Board and DOH's ability to improve patient safety through better infection control practices & training.

Issues: Registration fees have not increased since 1996. The patient safety law is expected to increase investigation volume.

Population Served: Public and patients who access healthcare system

Performance Measures: Annual statistics for 06 and 07:

	06		07		Change	
Complaints Received	8,022		8,163		141	2%
Complaints Closed	7,372		7,965		593	8%
Investigations Opened	3,805		4,060		255	7%
Investigations Closed	3,287		3,670		383	12%
Average Number of Days to Complete Cases	217		223		6	3%
Investigations Referred to Counsel for Charges	400		544		144	36%

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Patient Safety Center Administration – (Office Based Surgery Program, Stroke Designation, etc.)

Mandate: PHL, Article 29, § 2998 establishes the Patient Safety Center.

Mandated Funding Level: None

Brief Description/History/Background: Law enacted in 2000 created the Patient Safety Center. The Center's mission is to maximize patient safety, reduce medical errors, and improve health care quality by improving systems of data reporting, collection, analysis and dissemination, and to improve public access to health care information. Since its creation, the Center has developed and implemented public profiles on more than 81,000 licensed physicians, over 240 hospitals, more than 600 nursing homes, and most recently, over 600 home care providers. The Center helps consumers make informed health care decisions and protects the public by making comparative information about quality and other dimensions of performance publicly available. In January 2008, the Center implemented a statute that requires physicians who practice office-based surgery to report adverse events to the Center. The Center's analysis of these reports will improve patient safety through information dissemination to the medical community and the general public. The Center will implement a requirement for these office-based providers to become accredited in July 2009, establishing additional patient safety protections by mandating that these providers meet specific quality and safety standards.

Issues: Recently-signed patient safety law assigns new mandates to the Center including developing medical malpractice review criteria with the OPMC, review and revision of infection control training curriculum with the Council on GME, development of DOH information brochures to be distributed to physician offices in NYS and monitoring physician compliance with the new requirement to update their physician profile within six months of re-registration.

Population Served: All consumers of New York's health care system.

Performance Measures: Highlight program statistics:

- About 300 office-based surgery adverse events reported through July 2008
- About 82,400 monthly visits to the Physician Profile
- About 53,570 monthly visits to the Hospital Profile
- About 32,628 monthly visits to the Nursing Home Profile

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL-Patient Safety Award Grants

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The Patient Health Information and Quality Improvement Act of 2000 requires the Patient Safety Center to "serve as a clearinghouse of information for health care providers concerning quality improvement strategies and developing and adapting health care best practices." Accordingly, the New York State Patient/Resident Safety Award Program was created to highlight best quality and safety practices developed and implemented in facilities and agencies statewide.

Awards are based on quality improvement systems and evidence that these quality improvement efforts and error reduction strategies have been implemented. These programs may include such quality improvement strategies as falls prevention, medication management systems, and "quality of life" activities specific to individual needs. Applications must include a description supported with data, for the areas that have been targeted for improvement, the interventions implemented, and evidence that the strategy or process undertaken resulted in improvement.

Issue: None

Population Served: Health care facilities and consumers of health care.

Performance Measures: Grants recognize programs utilizing performance measures to improve quality of care.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL-Patient Safety Center/Patient Health Information and Quality Improvement

Mandate: PHL Article 29

Mandated Funding Level: None

Brief Description/History/Background: The Patient Health Information and Quality Act of 2000 calls for the creation of a statewide health information system designated to collect a wide range of data on health care providers, practitioners and plans and to make such information available to the public on an ongoing basis.

This mandate is implemented through the creation of both hospital and health care plan "report cards" as well as the creation of physician profiles. This data is published on the DOH public website and includes clinical performance (tracking infections, mortality, etc.) as well as enforcement activities.

The purpose of this statewide health information system is to improve quality of care by increasing the public's understanding about the performance of health care providers, practitioners and plans.

Issue: Managing the data and assuring its accuracy for the 80,000 physicians, 241 hospitals, hundreds of nursing homes and thousands of home care agencies is a significant operational challenge.

Population Served: Residents, patients and health professionals seeking to better understand clinical and other performance measures for health care providers and facilities.

Performance Measures: Track web utilization by unique visitors, hits and sessions. For example, the Physician Profiles average 82,000 visits per month with 1.2 million hits. The hospital website averages 53,500 visits per month and in 2007 had over 28 million hits.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Bureau of Funeral Directing

Mandate: PHL section 3401 investigation of alleged violations of the law; section 3420 license to practice; section 3428 registration of licensees/funeral firms; section 3429 continuing education; section 3450 suspension/revocation of licensees to practice.

Mandated Funding level: None

Brief Description/History/Background: BFD originated in 1926 and regulates all activities related to the business and practice of funeral directing. These activities include:

- Education and training of prospective practitioners;
- Issuance of licensure and registration of funeral directors, undertakers and embalmers;
- The inspection and registration of funeral firms;
- The registration of providers of continuing education including approval of all course offerings and periodic audit of courses;
- Investigations of consumer/provider complaints related to quality of care and alleged fraud in pre-need arrangements;
- Providing mass fatality training and collaboration on other disaster preparedness activities with other units in DOH, as well as other state and local agencies;
- Providing continuing education courses on the laws and regulations regarding funeral directing.

Issues: None

Population Served:

- 1899 funeral firms; 4096 practitioners; 109 registered residents (individuals in training) and 476 funeral directing students;
- consumers; average of 350 complaints annually-65 require extensive investigations.

Performance Measures: 65 investigations currently being conducted.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Narcotic Enforcement

Mandate: Public Health Law, Article 33, Section 3385

Mandated Funding Level: None

Brief Description/History/Background: The Narcotic Enforcement Program has unique authority to investigate the abuse and diversion of prescription controlled substances. By eliminating the flow of legally manufactured controlled substances into illicit channels, the program advances the vital mission of the Department to safeguard public health and ensure the quality of patient care of all New Yorkers. The Narcotic Enforcement Program is staffed primarily by investigators who are certified Peace Officers empowered to make arrests. One of the program's top priorities is to investigate drug diversion among healthcare professionals who obtain controlled substances through illegal and fraudulent activities. Through the program's enforcement actions taken to remove impaired professionals from the healthcare system, the program contributes significantly to protecting patient safety. The program has also been instrumental in investigating and prosecuting the illegal Internet sale of anabolic steroids, which when abused cause debilitating and irreversible side effects.

The alarming rise in prescription drug abuse, especially among teenagers, threatens the public safety and drives up healthcare costs. Studies have shown that the abuse of prescription controlled substances is higher than the abuse of heroin and cocaine combined. Overdose deaths from prescription narcotics have risen, both nationally and in New York. In 2007, the Department identified 66 deaths related to abuse of fentanyl, a highly potent prescription narcotic. A dramatic rise in prescriptions for narcotics and amphetamines—1.7 million in 2002 to 3.4 million in 2006—increases their availability for abuse and illegal sale. Pharmacy burglaries and robberies are also prevalent, and the National Association of Boards of Pharmacy reports that 99% of Internet drug outlets operate illegally.

Issues: None

Population served: All New York State residents are protected by this program. 480,000 healthcare professionals including physicians, nurses, pharmacists, dentists and physician assistants, as well as 397 hospitals and 1,473 nursing homes are also served.

Performance measures: In 2007, the Narcotic Enforcement Program:

* Completed 530 investigations involving controlled substance diversion.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

* Completed 111 cases involving healthcare professionals resulting in criminal or civil actions.
* Issued over 2,200 controlled substance licenses to pharmaceutical manufacturers, distributors, hospitals and nursing homes.
* Performed 183 inspections of individuals and healthcare facilities.
* Approved 3,579 requests from healthcare facilities for permission to destroy controlled substances.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

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Program: Official Prescription Program

Mandate: Public Health Law Article 1, Section 21, Public Health Law Article 33, Section 3332, 3333

Mandated Funding Level: None

Brief Description/History/Background: The Official Prescription Program has proven to be a vital tool for ensuring patient safety, protecting New Yorkers from the dangers of prescription drug abuse, and decreasing the excessive costs of prescription drug fraud.

The Official Prescription Program requires the use of tamper-resistant, state-issued prescription forms for all written prescriptions. The prescriptions contain security features that deter alterations and forgeries, as well as serial numbers for tracking purposes. The program requires pharmacies to report prescription data to the Department when dispensing controlled substances. The information is closely analyzed to detect and prevent illegal controlled substance activity. Established by Public Health Law in 1972, the program initially monitored Schedule II controlled substances, such as oxycodone, but was expanded in response to widespread abuse of controlled substances in other schedules.

The abuse of prescription drugs has risen to become a significant threat to the public health. Treatment admissions for abuse of prescription opiates have surged 321% from 1995 to 2005. Deaths involving prescription opiates increased 160% from 1999-2004. The program is pursuing measures to allow for the electronic prescribing of controlled substances. Electronic prescribing will dramatically decrease prescription fraud, thereby increasing the savings to Medicaid and third party insurers, as well as protect patient safety by minimizing medical errors due to handwritten prescriptions.

Issues: None

Population Served: All New York State residents are protected by this program. 480,000 healthcare professionals including physicians, nurses, pharmacists, dentists and physician assistants, as well as 397 hospitals and 1473 nursing homes are also served.2

Performance Measures: In 2007 the Official Prescription Program:

* Issued 168 million official prescriptions to prescribers and healthcare facilities.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

* Received 16 million controlled substance prescription records from pharmacies.
* Processed 434 requests from regional and outside agencies for controlled substance prescription records.
* Received a total of $1.4 million in federal grants to perform outreach programs regarding prescription drug abuse.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Emergency Medical Services Administration- (NYS Trauma Program, Emergency Management/Disaster Planning

Mandates: Articles 30, 30-A and 30-B of the Public Health Law

Mandated Funding Level: None

Brief Description/History/Background: Consistent with the Department's mission to "ensure that high quality appropriate health care services are available to all New York State residents..", the Bureau of EMS assures New Yorkers have access to quality prehospital and trauma services. This achieved by the certification of ambulance services and emergency medical technicians (EMTs) and the training programs authorized to teach prehospital medicine and the designation of hospitals to provide advanced trauma care to critically injured patients. By statute, fifty percent of dedicated EMS account funds are directed to support the training and certification of EMT in NYS consistent with national and state training standards. The Bureau of EMS also manages through contracts, a regional EMS system that is responsible for identifying community need and distribution of EMS services and training programs, and regional medical protocols.

The Bureau of EMS supports two patient registries, which are used to monitor the access to prehospital and trauma care, and the services provided to patients. The registry data are also used by regional organizations (EMS and Trauma) for local quality assurance, planning and development purposes.

The Bureau of EMS supports the Department and State mission to "...ensure appropriate readiness and response to potential public health threats." It has a defined role in the state's preparedness for, and response to declared disasters.

Issues: Diminishing federal health care disaster preparedness funds will impact the Bureau of EMS's support of the NYS and NYSDOH's disaster preparedness planning and response duties.

Population Served: All NYS residents and visitors and the Prehospital System

- 1,098 ambulance services (5,137 ambulance vehicles), 119 ALS response agencies, and 690 non-transporting BLS first response agencies.
- 147 Certified EMS training academies.
- 58,000 certified Emergency Medical Technicians. Annually, 22,000 EMT students enroll in approved EMT classes. Of this number, 19,800 are administered the NYSDOH Certification Examination, and 20,600 are certified

by the Bureau of EMS to practice prehospital medicine in NYS (through examination and CME program).

Performance Measures: The following performance measures were completed by the EMS Bureau in calendar year ending 12/31/2007:

- Conducted 248 full service inspections of ambulance services.
- Completed 541 case investigations.
- Conducted 15 Part 18 mass gathering inspections.
- Reviewed/approved and funded 881 EMT training programs for 22,000 students
- Provided examinations for 19,800 students who completed training.
- Issued 20,600 EMT certifications (exam students and CME students)
- Delivered disaster preparedness exercise design courses to eight hospitals and Incident Command instruction courses in eight counties.
- Held and provided staff support for 14 full day State EMS Council, State Medical Advisory Committee and State Trauma Committee meetings.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Hospital Services, Surveillance and Complaint

Mandate: None

Brief Description / History / Background: Program staff conduct periodic inspections of Primary and Acute Care Healthcare Facilities to ensure compliance with Federal and State regulatory requirements (Federal Surveillance: CMS State Operations Manual; State Certificate of Need Surveillance: 10 NYCRR 710.9; State Complaint and non-Medicare Surveillance: 10 NYCRR Sections 405 & 750) in order to protect the public health by insuring quality of care and patient access to care. Activities include: federal inspections of Medicare Providers as mandated by the Centers for Medicare and Medicaid Services [CMS] (with a simultaneous state inspection), state Certificate of Need inspections, federal and state investigations of patient complaints, and periodic survey of non-Medicare clinics.

Issues: Federal surveillance activities are supplemented with federal monies. State surveillance activities are funded from the state budget.

Population Served: There are 241 hospitals, 520 clinics and 1849 extension clinics in New York State providing health care to New York State's 19 million residents.

Performance Measures:

- 2,342 complaint investigations in 2007.
- 300 Diagnostic and Treatment Center surveys per year.
- Federal Surveys (approximately 100) are assigned annually by CMS.
- Complaint surveys (approximately 100) are assigned annually by CMS.
- Surveys of non-Medicare clinics (80 per year) are conducted based on a 4 year review cycle.
- CMS staff and Division of Primary and Acute Care Surveillance staff monitor the timeliness and quality of the surveys.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Miscellaneous Councils, Outreach, Registry

Community Service Plans	PHL Section 2803-l
Health Care Proxy Outreach	PHL Section 207
Poison Control Centers	PHL Section 2500-d
Child Death Protocol	PHL Section 2805-l
Organ and Tissue Donation Registry	PHL Section 4310
Transplant Council	PHL Section 4361
Organ and Tissue Donation Outreach	PHL Section 207

Mandated Funding: None

Brief Description/History/Background:

- Community Service Plans: Adopted in 1996 as a mechanism for hospitals to report to the Department their efforts to meet community health needs.
- Health Care Proxy Outreach: Adopted in 2007 to increase the Department's efforts in promoting the use of the Health Care Proxy among the general public.
- Poison Control Centers: Adopted in 1986 to create a statewide network of poison control centers. The statute also requires the Department to develop an annual report to provide to the Legislature.
- Child Death Protocol: The statute requires the Department, in collaboration with other governmental agencies, to create a protocol for use by hospital personnel when persons under the age of 18 die in transport to or at the hospital.
- Organ and Tissue Donation Registry: The registry began in 1999, with the intent to capture the names of potential organ donors, thereby increasing the public's access to potential organs. The Laws of 2006 furthers this mission by turning the existing registry into a consent registry. Legislation passed recently includes donation information with voter registration.
- Transplant Council: This council assembles clinical experts that develop quality guidelines for transplantation, provide comments on regulations, support quality initiatives, and advise the Department in matters related to transplantation.

- Organ and Tissue Donation Outreach: This legislation requires the Department raise the public's awareness of the need for organ donation and encourage participation in the Organ and Tissue Donation Registry.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Population Served: All of these activities have the ability to influence the health and safety of hospitalized New Yorkers. In regard to organ and tissue donation, 8-10,000 New York residents are currently waiting for donation.

Performance Measures:

- Community Service Plans: Reports are registered and reviewed as they are submitted to the Department to ensure compliance with requirements.
- Poison Control Centers: The Department reviews the data submitted by the Poison Control Centers to determine the level of statewide utilization. Once data is analyzed, a report is generated that reports these statistics to the Legislature.
- Organ and Tissue Donation Outreach: Approximately 10,000 new enrollees per month register with the Organ and Tissue Donor Registry due to outreach efforts.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Public Awareness Campaign for Donor Registry/Letter

Mandate: Subdivision 7 of Section 4310 PHL

Mandated Funding Level: None

Brief Description/History/Background: Chapter 639 of the Laws of 2006 required the Department of Health to convert the established New York State intent to donate Organ/Tissue Donor Registry (family permission required) to one of legal consent to donation. One provision of the law requires the Commissioner of Health to contact all those registered in the intent registry, in writing, and explain the differences between the intent and consent registry and allow them the opportunity to enroll in the new consent registry.

Issue: There are currently more than 1.4 million people registered in the NYS intent registry. A more effective and less costly way to educate the public regarding these changes would be to follow the example of other states that have converted from an intent registry to a consent registry and run a statewide public awareness campaign.

Population Served: There are currently 10, 000 New Yorkers awaiting organ transplantation. Organ transplantation is the end stage treatment for many forms of kidney, heart, liver and lung disease.

Performance Measures: Increased enrollment in the NYS Donate Life Consent Registry as a direct result of this mass mailing.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL-New York Center for Liver Transplantation, Inc. (NYCLT)

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The New York Center for Liver Transplantation, Inc. (NYCLT) is dedicated to monitoring the quality of care provided by liver transplant centers in NYS and improving access to care for New Yorkers awaiting liver transplant. The organization has been supported by this funding and by membership dues from the 6 liver transplant programs in NYS since 1988. NYCLT provides the Department with peer review of volumes and outcomes for NYS liver transplant centers including living liver donors and expanded criteria liver recipients. They also pilot clinical approaches to increasing the available pool of liver for donation. A current pilot project will allow surgeons the ability to view donor liver biopsies on-line – biopsy results are a crucial factor in the acceptance of liver for transplant. This technology could increase the number of liver transplants available for transplant in NYS. NYCLT is the only organization in the U.S. which supports collaboration and quality improvement amongst competing transplant centers.

Provides the liver transplant centers a mechanism via the NYCLT website for lifetime tracking of living liver donors to determine the long-term the health and psychosocial issues associated with donation as required by 10NYCRR 405.22. Currently it is the only organization providing information on volume and outcomes for living liver donors in NYS.

Issues: None

Population Served: Currently there are over 2,000 New Yorker's on the liver transplant waiting list. Liver transplant is the end stage treatment for individuals suffering from Hepatitis B&C and Cirrhosis.

Performance Measures: None

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL- New York Alliance for Donation

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The dollars support the New York Alliance for Donation, Inc. (NYAD) a non-profit organization with the primary mission of increasing organ/tissue donation through public education and awareness. NYAD was originally known as the Task Force to Increase Organ and Tissue Donation, a task force created in 1999 by the Department of Health that was charged with recommending ways to increase organ and tissue donation.

Issue: In its early years the Task Force assisted the Department in developing an agenda to increase organ and tissue donation. That agenda included the creation of an organ/tissue donor registry, the creation of a donor recognition program (donor medal of honor) and the creation of an organ donor license plate. All of these initiatives have been achieved.

Population Served: New Yorkers in need of organ transplants, the four NYS organ procurement organizations, NYS tissue and eye banks and other interested parties.

Performance Measures: None

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL - Public Awareness Campaign for Donor Registry

Mandate: Article 43 PHL (Sec. 4310) and PHL 207

Mandated Funding Level: None

Brief Description/History/Background: The dollars support an educational /promotional campaign by New York Alliance for Donation Inc. (NYAD) to educate New Yorkers about the critical need for organ and tissue donation and the new NYS Organ and Tissue Donor Consent Registry. The dollars are used for a media campaign that includes written materials, radio/cable PSAs and on-line advertising.

Issue: None

Population Served: Its target audience is to educate healthy New Yorkers ages 18-54 about organ donation. Approximately 10,000 New Yorkers are currently on organ transplant waiting lists. Any person suffering from end stage kidney, liver or heart disease is a potential candidate for an organ transplant.

Performance Measures: None

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Contract Management - Division of Health Care Standards and Surveillance & Division of Primary & Acute Care Services

Mandate: None

Mandated funding Level: None

Description/History/Background: The Grants Clearinghouse (GCH) administers the development, implementation, and management of grants and contracts in new and emerging areas that impact the health and safety of New Yorkers and the delivery of health care services. The GCH handles contracts for Bureaus in the Division of Health Care Standards and Surveillance as well as other Bureaus in the Office of Health Systems Management. The GCH also has assisted other DOH offices with contract processing. These contracts fund projects and programs in areas such as emergency management and planning, patient safety, health care quality assurance, health care reform act initiatives, legislative initiatives related to these areas, new technologies and a host of other research and development projects. Each year approximately 400 contracts are formulated and executed, and amount to funding in excess of $80 million. The GCH was established in 2000 as a central office to manage the large volume of contracts within OHSM to ensure consistency and that required procedures are adhered to. The office modifies their contract processing procedures to be in line with new directives from FMG, OSC and OAG.

Issues: None

Population Served: NYSDOH and entities receiving state grants by assuring compliance with state law and rules.

Performance Measures: None

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL - Brain Trauma Foundation

Mandates: None

Mandated Funding Level: None

Brief Description/History/Background: These dollars are used to support services and expenses incurred by the Brain Trauma Foundation (BTF). The BTF is a not-for-profit organization founded in 1986 to improve the outcomes of head injured patients through clinical guideline development, education, quality improvement programs and clinical research. The Department of Health endorsed the Guidelines for Traumatic Brain Injury in 1996 and recommended all New York State Hospitals follow the guidelines. The Guidelines were developed in a joint venture under the American Association of Neurological Surgeons. There are currently 21 hospitals participating in a TBI quality improvement program which is funded both through Medicaid rate disbursement and a department managed contract. Medicaid funding is established through contracts between the participating hospital and TBI.

Issues: None

Population Served: Individuals affected by brain trauma and the twenty one hospitals participating in the BTF quality improvement program.

Performance Measures: As of December 31, 2007, 2,486 severe or moderately severe traumatic brain injured patients entered into the TBI database who were treated in hospitals participating in the Guideline implementation.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Cardiac Advisory Council and Cardiac Services (Access & Quality)

Mandate: None

Mandated Funding Level: None

Brief Description/'History/Background: The Cardiac Program – ensures and enhances the provision of high quality appropriate cardiac services in New York State through the development and implementation of statewide policy in the areas of planning, surveillance, program evaluation/outcomes measurement, and public health. The program:

- Reviews and evaluates strategies for improving outcomes for patients with Acute Myocardial Infarction;
- Evaluates barriers (race, ethnicity, gender, linguistic background, or socioeconomic status) to appropriate care and implements strategies aimed at reducing the inequities identified and improving access to high quality cardiac care for all New Yorkers;
- Incorporates quality improvement and public health initiatives into the planning process and has pioneered the use of sophisticated statistical analyses along with direct physician participation in the assessment of patient outcomes process. Reports are available at http://www.health.state.ny.us/statistics/diseases/cardiovascular/; and
- Develops and implements policies and guidelines that enhance the quality of care for NYS residents with cardiovascular disease.

Issues: None

Population Served: All residents of NYS.

Performance Measures:

- Mortality rates for Coronary Artery Bypass Graft (CABG) surgery
  - in-hospital mortality rate for CABG in 2005 was the lowest ever at 1.56%, down from 3.08% in 1991.
- Mortality rates for Percutaneous Coronary Interventions (PCI).
  - mortality rate has dropped from 1.86% in 1995 to 0.52% in 2005
  - In 1995 there were 21,707 cases, compared to 56,058 in 2005.
- NY is the only state to release outcomes for pediatric patients undergoing surgery to correct congenital heart defects.
- Length of stay for Cardiac Surgery
- Length of stay for Cardiac Catheterizations
- Morbidities (e.g. stroke, infections etc.) in association with procedures

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL - Cardiac Advisory Committee/Services (Access & Quality)

Mandate: None

Mandated Funding Level: None

Brief Description/'History/Background: These dollars support contracts with the SUNY Albany School of Public Health to support the work of the CAC. The dollars cover the cost of expert cardiac consultants for developing performance measures and standards and the cost of conducting meetings with the CAC. (The CAC is comprised of National and State cardiac care clinicians and scientists).

Issues: None

Population Served: All resident of NYS.

Performance Measures:

- Mortality rates for Coronary Artery Bypass Graft (CABG) surgery
  - in-hospital mortality rate for CABG in 2005 was the lowest ever at 1.56%, down from 3.08% in 1991.
- Mortality rates for Percutaneous Coronary Interventions (PCI).
  - mortality rate has dropped from 1.86% in 1995 to 0.52% in 2005
  - In 1995 there were 21,707 cases, compared to 56,058 in 2005.
- NY is the only state to release outcomes for pediatric patients undergoing surgery to correct congenital heart defects.
- Length of stay for Cardiac Surgery
- Length of stay for Cardiac Catheterizations
- Morbidities (e.g. stroke, infections etc.) in association with procedures

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: 405.4 Audits (Working Hours and Conditions of Medical Residents)

Mandate: Public Health Law Section 2803, 9 (a)

Mandated Funding: None

Brief Description/History/Background: These dollars support an ongoing contract to annually survey all state teaching hospitals (120) to assure compliance with the State regulations that limit the number of working hours for NY medical residents. There are approximately 13,000 medical residents trained each year at the State's training hospitals.

Issues: None

Population Served: Medical residents and all New Yorkers.

Performance Measures: Through the life of the contract, the Department has noted a decrease in the percentage of non-compliance, from 64% in the first year to 16% in year 6 of the contract.

- The current year of surveillance is registering a 14% non-compliance rate to date.
- Approximately 120 annual onsite visits are conducted.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL - 405.4 Hospital Audits

Mandate: Public Health Law Section 2803, 9 (a)

Mandated Funding: None

Brief Description/History/Background: These dollars support an ongoing contract to annually survey all state teaching hospitals (120) to assure compliance with the State regulations that limit the number of working hours for NY medical residents. There are approximately 13,000 medical residents trained each year at the State's training hospitals.

Issues: None

Population Served:

Performance Measures: Through the life of the contract, the Department has noted a decrease in the percentage of non-compliance, from 64% in the first year to 16% in year 6 of the contract.

- The current year of surveillance is registering a 14% non-compliance rate to date.
- Annual onsite visits are conducted in approximately 120 visits per year.
- Complaint investigations are conducted as part of the contract.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: New York Patient Occurrence Reporting and Tracking System Administration (NYPORTS)

Mandate: Public Health Law Section 2805 – l

Mandated Funding Level: None

Brief Description/History/Background: These dollars support the ongoing operations and management of NYPORTS; the state's healthcare facility adverse reporting program. The functions and activities supported include maintaining databases that house the reports submitted by hospitals (i.e. medical errors or incidents); investigating the reports; and working with the hospital to finalize the investigation.

Issues: Assuring compliance with reporting and improving the consistency of hospitals' analysis of incidents.

Population Served: All patients that seek medical care at Hospitals or Diagnostic and Treatment Centers within New York State benefit from NYPORTS activities aimed at increasing the quality of care and protection of public health in NYS.

Performance Measures:

- The total number of NYPORTS reports was 16,339 and 11,626 for 2006 and 2007 respectively. Of those, 3,293 and 2,949 are considered more serious events for 2006 and 2007 respectively.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL - New York Patient Occurrence Reporting and Tracking (NYPORTS)

Mandate: Public Health Law Section 2805 – l

Mandated Funding Level: None

Brief Description/History/Background: These dollars support the ongoing operations and management of NYPORTS. The functions and activities supported include maintaining databases that house the reports submitted by hospitals (i.e. medical errors or incidents); investigating the reports; and working with the hospital to finalize the investigation.

Issues: None

Population Served:

Performance Measures:

- The total number of NYPORTS reports was 16,339 and 11,626 for 2006 and 2007 respectively. Of those, 3,293 and 2,949 are considered more serious events for 2006 and 2007 respectively.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Medical Necessity and Utilization Review Administration (Medicaid & AIDS)

Mandate: Federal Mandate-Article 19 of the Social Security Act

Mandated Funding: None

Brief Description: These dollars support a contract to conduct utilization review of Medicaid hospital inpatient utilization. In addition, the dollars support specific surveillance investigations identified from the utilization review.

Issues: None

Population Served: All New York taxpayers, Medicaid clients in NYS

Performance Measures: From April 2006 through March 2008, 308,516 reviews were conducted including:

- 228,482 Utilization/DRG/Quality reviews
- 5,079 Cost outlier reviews
- ALC reviews, IPRA reviews, state selected cases, quality improvement project reviews, NYPORTS reviews and D&TC billing reviews make up the remaining 74,955 reviews.
- In 2006-2007 review period, approximately 140,000 reviews were completed. and the care provided to approximately 25% of all Medicaid patients will receive some type of review.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL - Medical Necessity and Utilization Review (Medicaid & AIDS)

Mandate: Federal Mandate- Article 19 of the Social Security Act

Mandated Funding Level: None

Brief Description: These dollars support a contract to conduct utilization review of Medicaid hospital inpatient utilization. In addition, the dollars support specific surveillance investigations identified from the utilization review.

Issues: None

Population Served:

Performance Measures: From April 2006 through March 2008, 308,516 reviews were conducted including:

- 228,482 Utilization/DRG/Quality reviews
- 5,079 Cost outlier reviews
- ALC reviews, IPRA reviews, state selected cases, quality improvement project reviews, NYPORTS reviews and D&TC billing reviews make up the remaining 74,955 reviews.
- In 2006-2007 review period, approximately 140,000 reviews were completed and the care provided to approximately 25% of all Medicaid patients will receive some type of review.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Certificate of Need and Health Planning

Mandate: Public Health Law, Sections 2801 and 2802

Mandated Funding Level: None

Brief Description/History/Background: Begun in 1965, the Certificate of Need (CON) program and associated health planning activities review the establishment and construction of hospitals, nursing homes, clinics and other health care facilities and home care agencies, to ensure that these providers meet a public need, are financially feasible and are competently operated. In 2007, the program reviewed more than 300 CON applications having a total cost of more than $1.9 billion. It further reviewed more than 400 lower-level applications requiring staff review but not formal CON review.

It also assists the Dormitory Authority (DASNY) in reviewing proposed health facility construction projects supported by publicly guaranteed debt, to help safeguard DASNY's $8 billion health care portfolio.

Issues:

There is a growing need for accurate, timely and comprehensive health planning data to help ensure that projects subject to CON result in services that address community health needs.

Population Served: All patients of health care facilities or home care agencies. Hospitals, nursing homes, clinics and other providers subject to CON review, plus an indeterminate number of new facilities and agencies seeking initial approval every year.

Performance Measures: In 2007:

- 115 full review projects worth $1.3 billion
- 190 administrative review projects worth more than $600 million
- 392 limited review applications valued at $429 million.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Health System Restructuring
- Healthcare Efficiency and Affordability Law for New Yorkers (HEAL NY)
- Commission on Health Care Facilities in the Twenty-First Century (the Berger Commission)
- Health Care Restructuring Pool – PHL Section 2815

Mandate: HEAL: Public Health Law, Section 2818 and Public Authorities Law, Section 1680-j.
Commission: Chapter 63 of the Laws of 2005

Mandated Funding Level: None

Brief Description/History/Background: The Commission was established in 2005 to develop recommendations for the restructuring of the health care system to reduce excess inpatient hospital and nursing home bed capacity in favor of lower-cost ambulatory and community-based care appropriate to identified health care needs. The 2006 enabling legislation for HEAL authorizes $1 billion in State bond funds and legislative appropriations for the implementation of the Berger Commission's legally binding mandates on individual facilities, as well as for the implementation of longer-range projects to foster greater stability, efficiency and quality of service throughout the health care system. HEAL funds are supplemented by $1.5 billion granted to DOH under the Federal-State Health Reform Partnership (F-SHRP).

The Health Care Reform Act of 1996 created the authority and funding for a health facility restructuring pool to assist struggling hospitals fund restructuring activities. Section 2815 of the Public Health Law directs the Dormitory Authority and the Department of Health to jointly administer the receipt, management and expenditure of funds for the development and implementation of business plans for hospital service delivery strategies and business affiliations that are designed to provide long-term financial stability.

HEAL and FSHRP: To date, more than $1.2 billion in HEAL and F-SHRP funds has been made available as grants.

Health Facility Restructuring Pool: In excess of $200 million has been authorized by the legislature and issued as loans to health facilities to develop and implement strategic turnaround plans. This mechanism for financing restructuring activities has become an important tool for rightsizing health care facilities.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Issues: None

Population Served: All health care facility patients; Health care facilities throughout the State.

Performance Measures:

Number of HEAL requests for grant applications (RGA's) issued and number of contracts awarded.

- Nine RGA's issued to date, resulting in more than $850 million in awards and more than 125 projects. An additional $280 million will be awarded before the end of 2008, for an anticipated 60 or more additional projects.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Health Care Stabilization

Mandate: Section 3 of Part B of Chapter 58 of the Laws of 2005
Section 2807 – v(1)(ss) of the Public Health Law

Mandated Funding Level: None

Brief Description/History/Background: The Health Department had a $28 million appropriation supported by the Health Care Reform Act to provide financial assistance to health care providers and health programs, which are vital community health assets, but whose financial viability and stability was threatened by excessive debt or other adverse factors to the extent that their ability to continue providing health services was endangered. The program was initiated in 2005. The majority of the $28 million dollars has been disbursed with the exception of three remaining contracts that have experienced unforeseen delays in the implementation of their remediation plans.

Issues: None

Population Served: The grant awardees have served all population types including but not limited to providers that fulfill unmet health care needs for the community.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Primary Care and Health Personnel Programs

Mandate:

- Doctors Across New York, Physician Loan Repayment, Public Health Law 2807-m (5-a) (d)
- State-30 J-1 Visa Waiver Program-Federal Public Law 109-477
- National Health Service Corps and Regents Physician Loan Forgiveness Award Program-Federal Public Law 91-623(NHSC) and State Education Law (RPLFAP)
- NYS Limited Medical and Dental License Programs-State Education Law, Articles 131 and 133

Mandated Funding Level: None

Brief Description/History/Background: The Division administers 6 separate programs and/or functions that support the development of health personnel in medically underserved areas of the state. The Primary Care Initiatives is a monitoring account that supports staff who implement and manage the program initiatives described below.

- The Primary Care Cooperative Agreement derives its funding from a small grant from the Health Resources Services Administration (HRSA) and supports staff which implement and oversee the National Health Service Corp Program and the reviews of Health Professional Shortage Area and Medically Underserved Area applications on behalf of HRSA.
- The Doctors Across New York (DANY) Program is a new initiative that will address the maldistribution of primary care and specialist physicians in rural and inner-city communities, by offering up to $150,000 in loan repayment awards to physicians who agree to practice for up to 5 years in these underserved communities and up to $100,000 in practice support in exchange for a 2-year service obligation.
- The State-30 J-1 Visa Waiver Program supports waivers of the “J” visas home residency requirements for a maximum of 30 J-1 visa holder physicians annually who either agree to practice in federally designated underserved areas or to provide services to persons who live in such areas.
- The Division assists the Federal government with the administration of the National Health Service Corp (NHSC) program which has been in existence for over 35 years and whose goal to place clinicians/health care professionals in medically underserved areas in exchange for scholarships or loan repayment.
- The Division assists the NYS Education Department with the administration of the Regents Physician Loan Forgiveness Award Program which places

primary care physicians and psychiatrists in medically underserved areas in exchange for loan forgiveness.
- The Division assists the State Education Department in helping physicians, dentists and dental hygienists who possess J, O and H, or other non-immigrant work visas obtain professional licenses in exchange for agreeing to work in Regents designated underserved areas.

Most of these programs have been in existence for at least 10 years. By all accounts these programs have been effective in placing hundreds of physicians, dentists and other health care professionals in medically underserved areas and helping address the health disparities faced by these underserved populations.

Issues: None

Population served: Physicians interested in practicing in shortage areas, and residents of Health Professional Service Areas, Medically Underserved Areas and Regents Designated Underserved Areas and Populations.

Performance Measures:
- Number of practitioners placed in, or serving, defined underserved areas;
- Number of J-1 visas recommended annually by DOH;
- Number of newly designated or re-designated federal shortage areas in NYS.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Workforce Development Programs

Mandate: Health Workforce Development Program (HWRI)**,** Section 2807(g) of the Public Health Law.
Supplemental General Hospital Recruitment and Retention Rate Adjustment Program (SGHRRRAP), Section 2907(i) of the Public Health Law.
Community Health Care Conversion Demonstration Program (CHCCDP), Federal Waiver/Partnership Plan

Mandated Funding Level: None

Brief Description/History/Background: The Division has administered 4 separate grant programs during the past 10 years whose goals are to: train health care workers to address persistent shortages in various documented health care occupations; provide health care workers who are impacted by Berger Commission recommendations with job-counseling, placement and short-term training to maintain existing jobs or obtain new jobs; or to train workers to help meet the evolving demands of the health care system as it transitions to managed care. These include the Health Workforce Retraining Initiative (HWRI), the Displaced Health Care Worker Program (DHCWP), the Supplemental General Hospital Recruitment and Retention Rate Adjustment Program (SGHRRRAP) and the Community Health Care Conversion Demonstration Program (CHCCDP). Over 300,000 workers have received training under these programs during the past 10 years including over 2600 new LPNs and RNs, over 17,000 nurses in specialty areas such as gerontology, critical care, nurse leadership, pediatrics and emergency care, over 5,000 patient care associates, 8,000 personal care aides, home care aides and other long term care and geriatric titles, 8,000 medical coders and billers, as well as numerous workers as technicians, technologists, physician and occupational therapists, social workers, direct care generalists, dental hygienists and health information specialists. Tens of thousands of other workers were trained in computer skills, process improvement/customer service and foreign language skills. The Health Occupation and Workplace Demonstration Account supports several staff that implement and monitor the HWRI and other workforce programs.

Issues: None

Population Served: Healthcare workers, health care facilities, educational institutions, unions, patients and underserved populations.

Performance Measures: Tracking the number of individuals served by these programs and monitoring contract compliance:

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL - Health Workforce Retraining Initiative

Mandate: Section 2807(g) of the Public Health Law

Mandated Funding Level: None

Brief Description/History/Background: The HWRI was authorized in 1997 in response to the expectation that health care workers would require assistance in developing needed skills for new or redesigned jobs as the health care system moved to a greater reliance on market forces and increased emphasis on managed care. Over the years, the programs emphasis evolved to focus on the health care industry's persistent shortages of health care workers particularly, but not limited to, the nursing field.

Since its inception, the program has received an average annual appropriation of approximately $30 million and made 5 rounds of awards totaling $305 million to support 436 grantees and 1,273 distinct training projects. The most recent round of awards was made in November of 2006 in which the Department announced $56 million in grants to 89 organizations to support 217 separate training projects.

Over 130,000 workers have been trained to date including over 2,600 new LPNs and RNs, over 17,0000 nurses in specialty areas such as gerontology, critical care, nurse leadership and pediatrics, over 5,000 patients care/clinical care associates, 8,000 personal care aides, home care aides and other long term care and geriatric titles, 8,000 medical coders and billers, as well as numerous workers as technicians, technologists, physical therapists, social workers, direct care generalists, dental hygienists and health information specialists. Over 40,000 additional workers were trained in computer skills, process improvement/customer service and foreign language skills.

Issues: None

Population Served: This program is targeted to health care workers especially in shortage occupations are well as their hospital, nursing home and home health care employers. State and private universities and colleges, nursing schools and BOCES also directly or indirectly are the beneficiaries of these funds and provide the majority of the education/training under this program.

Performance Measures: Number of workers:

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- Retrained to address persistent shortages in documented health care occupations; and
- Trained to help meet the evolving demands of the health care system as it transitions to managed care.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: Rural Health Care Administration
Administration of Rural Health Care Access Development Grants and Rural Health Network Development Program Grants

Mandate: Section 2952 and 2958 of the Public Health Law

Mandated Funding Level: None

Brief Description/History/Background: The Health Care Delivery Account supports the administration of the Rural Health Network Development Program (RHNDP), and the Rural Health Care Access Development Program (RHCADP) programs. These programs are designed to add efficiencies and increase access to high quality health care for rural communities. These programs were initially funded under the New York State Health Care Reform Act of 1996 (HCRA 1) with a combined annual appropriation of $17 million. HCRA 2000 and the HCRA Initiatives in subsequent State Budgets c3ontinued the programs. The purpose of dsthese programs is to improve the health of New York's rural communities by providing support for rural providers to improve access to care, enhance coordination of services, increase the efficiency of service delivery, and introduce needed community services through the formation of rural health networks.

Issues: Recent changes in the health care marketplace have created new challenges for rural health care providers of health care services. Rural areas must focus special attention on their capacity to provide health services that serve their residents within a new and expanding managed care system.

Population Served: Residents of rural counties and towns.

Performance Measures: Quarterly progress reports are compared with approved work plans to determine compliance. All contractors are working to achieve approved plans.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL - Rural Health Care Access Development Grants

Mandate: Section 2958 of the Public Health Law

Mandated Funding Level: None

Brief Description/History/Background: The Rural Health Care Access Development Program (RHCADP) authorizes funds to assist rural hospitals with the unique costs incurred by rural facilities to provide hospital services in remote or sparsely populated areas. Funds are provided to rural hospitals to improve operational efficiencies, reduce duplication of services and develop affiliations with community based providers.

This program was initially funded under the New York State Health Care Reform Act of 1996 (HCRA I) with an annual appropriation of $10 million. HCRA 2000 and the HCRA Initiatives in subsequent State Budgets continued the program.

Issues: Recent changes in the health care marketplace have caused rural hospitals to examine their health care delivery systems and their role as a provider of health care services. Rural hospitals must focus special attention on their capacity to provide health services that serve their residents within a new and changing health care system to ensure that they can respond to community need.

Population Served: NYS rural hospitals and the patients they serve

Performance Measures: 50 Rural Hospitals receive funds through this program and meet program objectives as follows:
28 Rural Hospitals use funds to expand MIS (Information Systems) capabilities.
31 Rural Hospitals use funds to improve cost efficiencies.
7 Rural Hospitals use funds to expand essential health care and related services to meet the needs of the rural community through increase capacity of primary care.
8 Rural Hospitals use funds to develop finance and resources plan for long-term support/self-sufficiency.
2 Rural Hospitals use funds to begin procedures for participation in the swing-bed program.
6 Rural Hospitals use funds to plan and implement integration of services with other hospitals and/or community-based providers.
5 Rural Hospitals use funds to plan and implement activities that result in pooling/sharing resources with other hospitals and community-based providers.

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11 Rural Hospitals use funds to plan and implement activities that result in quality improvement.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL - Rural Health Network Development Program Grants

Mandate: Section 2952 of the Public Health Law

Mandated Funding Level: None

Brief Description/History/Background: The Rural Health Network Development Program (RHNDP) provides funds to develop rural health network agreements among rural health care providers that result in the merger or integration and coordination of health care services. These agreements will promote more effective health care delivery through the coordination, development, planning, implementation, and operation of rural health networks. This programs was initially funded under the New York State Health Care Reform Act of 1996 (HCRA I) with an annual appropriation of $7 million. HCRA 2000 and the HCRA Initiatives in subsequent State Budgets continued the program. The purpose of the program is to improve the health of New York's rural communities by providing support for rural providers to improve access to care, enhance coordination of services, increase the efficiency of service delivery, and introduce needed community services through the formation of rural health networks

Issues: As rural health care providers seek stability and financial viability, and consumer access to essential health care services has become more fragile, the need for cooperative and collaborative efforts among rural providers becomes increasingly important.

Population Served: Residents of all rural counties and towns.

Performance Measures: Quarterly progress reports are compared with approved work plans to determine compliance. All contractors are working to achieve approved plans.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL - Area Health Education Center (AHEC)

Mandate: Section 2807-m(7) of the Public Health Law

Mandated Funding Level: None

Brief Description/History/Background: The Health Care Reform Act of 2000 established funding for the New York State Area Health Education Center program (AHEC) to expand community-based training of healthcare professionals enabling the New York State AHEC program to receive matching funds from the federal government of approximately $3.1 million per year for this program. The purpose of the Area Health Education Center program is to improve the supply and distribution of health care professionals through community based training of health trainees in underserved areas; recruit students to health careers from under-represented populations; increase retention and enhance practice in underserved communities; promote disease prevention and healthy life styles, and economic development through health.

Issues: Consumer access to quality health care services is impeded by the shortage of physicians and other health care professionals, particularly in many rural and inner-city areas, and is a problem of increasing significance.

Population Served: Statewide

Performance Measures: Number of training sites, students trained. Medical student training placements in underserved areas: 2849
Nurse and other health professional training placements: 1970

Medical education program attendance: 3914

These range from 1 to 6 hour courses with topics such as Psychiatry 10; Oral health during Pregnancy and Managed Care Basics.

Middle School/High School program attendance: 16851

These MS/HS range from 1 hour in-school classroom programs to 30 hour MASH Camps and 60 hour shadowing programs.

Department of Health – Office of Health Systems Management
PROGRAM INFORMATION SHEET

Program: ATL - Commissioner's Emergency Assistance Program

Mandate: Chapter 58 of the Laws of 2007

Mandated Funding Level: None

Brief Description/History/Background: This program, originally supported by the Commissioner's HCRA Priority Pool, is intended to provide funding (grants) to health facilities facing an emergency that threatens or potentially undermines patient safety. For example, the failure to meet payroll could lead to patient care staff refusing to show for work or vendors refusing to deliver critical supplies or services (heat, water, etc.)

Though any facility is eligible, it is primarily used for nursing homes and clinics. Hospitals have access to the DASNY Restructuring Pool. Over the past year, 2 clinics and one nursing home have been awarded a total of $1M from the fund.

Issues: None

Population Served: Health facilities and the employers and patients of the affected facilities.

Performance Measures: No specific measures-goal of the grants is to transition facility away from the immediate crisis.

Attachment B

Agency Programs/Activities: Inventory and Key Data
Executive Direction and Administration

Page	Relation to Core Mission (H/M/L)	Program/Activity	Spending Category (SO, ATL, CAP)	3/31/09 FTEs (All Funds)	General Fund Disbursements ($000s)				State Special Revenue Funds Disbursements ($000s)				Capital Projects Funds Disbursements ($000s)			
					2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected
		EXECUTIVE DIRECTION														
		Division of Legal Affairs														
1	H	DLA	SO	121	$4,541	$5,363	$5,600	$5,600	$8,065	$7,280	$8,877	$8,877	$0	$0	$0	$0
		OGEA														
3	H	Governmental Affairs	SO	1	$193	$226	$225	$225	$0	$0	$0	$0				
4	H	Council Operations	SO	1	$100	$113	$113	$113	$0	$0	$0	$0				
5	H	External Affairs	SO	1	$202	$234	$235	$235	$0	$0	$0	$0				
		OGEA Subtotal		3	$495	$573	$573	$573	$0	$0	$0	$0	$0	$0	$0	$0
		OHITT														
6	H	Health Information Technology Transformation	SO	8		$195	$800	$800	$0	$0	$0	$0	$0	$0	$0	$0
		Public Affairs Group (PAG)														
7	H	Press Office (Office of the Director)	SO	6	$213	$269	$280	$280	$152	$126	$130	$130				
9	H	Health Media Marketing	SO	6.5	$230	$234	$235	$235	$0	$0	$0	$0				
11	H	Communications Production Services	SO	4	$190	$214	$215	$215	$80	$183	$190	$190				
12	H	Public Web Site Administration	SO	0	$98	$132	$125	$125	$166	$104	$145	$145				
14	H	Print Shop	SO	8	$410	$327	$635	$350	$434	$0	$0	$0				
		PAG Subtotal		24.5	$1,141	$1,176	$1,490	$1,205	$832	$413	$465	$465	$0	$0	$0	$0
		EXECUTIVE DIRECTION TOTAL		156.5	$6,177	$7,307	$8,463	$8,178	$8,897	$7,693	$9,342	$9,342	$0	$0	$0	$0
		ADMINISTRATION														
		Fiscal Management Group														
15	H	Audit	SO	12	$266	$305	$300	$300	$465	$476	$475	$475				
16	H	Accounts Management	SO	51	$189	$1,653	$1,450	$1,450	$1,160	$1,148	$1,200	$1,200				
17	H	Budget Management	SO	27	$629	$646	$628	$628	$2,823	$3,823	$3,800	$3,800				
18	H	Fiscal Systems Support	SO	6	$394	$387	$390	$390	$0	$0	$0	$0				

Page	Relation to Core Mission (H/M/L)	Program/Activity	Spending Category (SO, ATL, CAP)	3/31/09 FTEs (All Funds)	General Fund Disbursements ($000s)				State Special Revenue Funds Disbursements ($000s)				Capital Projects Funds Disbursements ($000s)			
					2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected
19	H	Medicaid Financial Management	SO	10	$504	$567	$600	$600	$0	$0	$0	$0				
		FMG Subtotal		106	$1,982	$3,558	$3,368	$3,368	$4,448	$5,447	$5,475	$5,475	$0	$0	$0	$0
		HR&O														
20	H	Personnel Management	SO	31	$471	$651	$700	$700	$520	$648	$650	$650				
21	H	Employee Relations	SO	5.5	$306	$362	$365	$365	$121	$111	$115	$115				
22	H	Affirmative Action	SO	1	$143	$150	$150	$150	$0	$0	$0	$0				
23	H	Staff Development	SO	4	$361	$369	$370	$370	$154	$170	$175	$175				
24	H	Occupational Health and Safety	SO	2	$120	$136	$138	$138	$0	$0	$0	$0				
25	M	DOH Wellness Program	SO	1	$116	$130	$135	$135	$0	$0	$0	$0				
		HR & O Subtotal		44.5	$1,517	$1,798	$1,858	$1,858	$795	$929	$940	$940	$0	$0	$0	$0
		Information Systems & Health Statistics Group														
26	H	Vital Records	SO	37	$247	$503	$500	$500	$2,676	$2,803	$2,810	$2,810				
28	H	SPARCS Administration and Supervision	SO	17	$237	$413	$400	$400	$1,850	$2,264	$2,300	$2,300				
29	H	Healthcom Services	SO	27	$730	$1,370	$1,300	$1,300	$267	$889	$1,000	$1,000				
30	H	Computer Systems Development	SO	45	$3,390	$3,366	$3,350	$3,350	$2,901	$2,855	$2,900	$2,900				
31	H	Healthcom Network Systems Management	SO	59	$3,080	$2,375	$2,500	$2,500	$1,555	$1,735	$1,700	$1,700				
		ISHSG Subtotal		185	$7,684	$8,027	$8,050	$8,050	$9,249	$10,546	$10,710	$10,710	$0	$0	$0	$0
		Operations Management Group														
32	H	Office Support Services	SO	35	$18,571	$20,340	$21,000	$21,000	$998	$207	$177	$177				
33	H	Internal Controls Management	SO	4	$338	$311	$383	$383	$67	$59	$63	$63				
34	H	Telecommunication Services	SO	4	$391	$531	$540	$540	$0	$0	$0	$0				
		OMG Subtotal		43	$19,300	$21,182	$21,923	$21,923	$1,065	$266	$240	$240	$0	$0	$0	$0
		ADMINISTRATION TOTAL	SO	378.5	$30,483	$34,565	$35,199	$35,199	$15,557	$17,188	$17,365	$17,365	$0	$0	$0	$0
		EXECUTIVE DIRECTION & ADMIN TOTAL		516	$36,660	$41,872	$43,662	$43,377	$24,454	$24,881	$26,707	$26,707	$0	$0	$0	$0

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Legal Affairs

Mandate: None

Brief Description/History/Background:

Legal Affairs (DLA) provides legal support and counsel for the daily operations of the program divisions with the Department, including:

- Reviewing program activities for compliance with all laws and regulations
- Drafting and reviewing legislation and regulations
- Reviewing contracts and memoranda of understanding
- Reviewing applications for licensure for health care entities
- Serving as legal advisor to the Public Health Council, the State Hospital Review and Planning Council, and many other councils

DLA attorneys also:

- Represent the Department in adjudicatory proceedings to enforce the PHL and regulations against hospitals, nursing homes, diagnostic and treatment centers, adult homes, laboratories, emergency medical services, and all other regulated entities
- Prosecute charges of abuse or neglect of nursing home residents
- Provide liaison with the Attorney General in litigation arising out of all Department operations and programs
- Prosecute physicians, physician assistants and specialist assistants charged with professional misconduct, including practicing with negligence and incompetence, fraudulently or while impaired by drugs, alcohol or mental disability
- Perform the functions of Administrative Law Judges in the Department's adjudicatory proceedings, including hearings concerning professional medical conduct, patient abuse or neglect,

nursing home discharge appeals, adult home and nursing home operating violations, WIC vendor disqualifications, Medicaid rate audits, Medicaid fraud and abuse, violations of the state sanitary code, and the establishment and construction of hospitals

Issues: None

Population Served: Legal Affairs supports the functions of all programs within DOH.

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Governmental Affairs

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Provide overall strategy on legislative matters and interaction with the Legislature, Governor's Office and the public. Develop and coordinate the Department's state and federal legislative agendas. Lobby elected officials and other stakeholders to advance the Department's agenda. Serve as the primary spokesperson for the Department's position on legislation. Serve as the primary source of legislative information and track legislation affecting the Department. Identify legislation of concern and proactively negotiate appropriate changes or other actions. Promptly respond to legislative inquiries regarding constituent issues. Develop the Department's position on legislation before the Governor for Executive action.

Issues: None

Population Served: Governor's office, local/state/federal legislators and their staff, advocates, lobbyists, the public and DOH staff.

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Council Operations

Mandate: PHL Section 224 (Executive Secretary to the Public Health Council Duties)

Mandated Funding Level: None

Brief Description/History/Background: Track all DOH Councils, including reporting requirements. Identify DOH council vacancies. Coordinate development of DOH candidates. Process vetting to identify candidates. Serve as liaison with Governor's Appointments Office. Provide staff for Public Health Council (PHC) duties. Provide Implementation assistance to program council staff. Oversee 14th Floor Reception area.

Issues: None

Population Served: Governor's Office, DOH Program Liaisons, Health Industry (on PHC matters), Hospital Physicians and Residents (on PHC matters), Public Health Council Members, Public Health Council Staff and the general public.

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: External Affairs

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: External Affairs manages executive correspondence (all mail coming to Commissioner and Executive Deputy Commissioner); answers and directs Commissioner's and general DOH phone calls; monitors and responds to web site inquiries; coordinates and responds to constituent issues; coordinates Commissioner and department-wide events; and manages special projects for the Office of Governmental Affairs and External Affairs, Commissioner and Executive Deputy Commissioner offices.

Issues: None

Population Served: Public on behalf of Commissioner's office; various constituents including advocacy groups, legislators, health service providers; liaison with Governor's Correspondence Office; liaison with DOH staff regarding correspondence and phone calls; DOH executive staff

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Health Information Technology Transformation

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background:

- Health Information Technology Transformation (OHITT) is charged with coordinating health information technology (IT) programs and policies across the public and private health care sectors while accelerating efforts to bring information tools to the delivery of health care.

- OHITT is currently managing approximately $392M in state, federal, and private health IT funds.

- Activities are focused on interoperable health information exchange – the secure flow of personal health information to follow the patient – and quality measurement and reporting tools – the valid collection of clinical data to measure results or outcomes to improve quality and population health.

Issues: None

Population Served: All New Yorkers receiving health care

Performance Measures: Compliance with existing federal health IT standards, policies and requirements. Participate in the ongoing development of and compliance with federal and state standards, policies and requirements.

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PROGRAM INFORMATION SHEET

Program: Press Office (Office of the Director)

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The Press Office is responsible for the following functions:

- Acts as the official voice of DOH for media through the development of news releases, print and broadcast interviews, video news releases, Internet and Intranet postings, and media outreach activities. Requires coordination with high-level staff throughout DOH.
- Provides interviews and research at the request of reporters and implements new outreach programs.
- Approves all material before posting on the DOH Web site and reviewing Executive Deputy Commissioner Clearance Forms before they are sent to the Executive Deputy Commissioner.
- Uses in-house staff to gather and distribute daily news articles of interest to DOH staff and management.
- Arranges public events for the Commissioner to alert the public about current and pending public health issues (e.g., West Nile virus, disease outbreaks, and environmental disasters and emergencies) and to announce health news to the media or increase awareness of a DOH program. The Press Office acts as the advance team and liaison to local officials appearing with Dr. Daines at events.
- Writes speeches and statements for the Commissioner and his deputy commissioners on health-related news topics. For the 2007-08 fiscal year, we wrote about 150 speeches.
- Advises and collaborates on news issues with the Governor's Press Office, other agency public affairs staffs, Governor's health program staff, and DOH program staff.
- Advises local health departments on media issues and drafts press statements for their use.
- Advises programs on media and promotional campaigns.
- Supervises operations of DOH public Web site.
- Posts new items to Lotus News and all public meeting notices to the Web site.
- Coordinates DOH responses to the Governor's Proclamations Office, which requests DOH input on all public requests for proclamations related to health care.

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- Performs other duties and assignments as assigned by the Commissioner or Executive Deputy Commissioner.

Issues: None

Population Served: Externally, PAG serves the journalists of New York and beyond. Internally, PAG is a service program that enhances the effectiveness of program initiatives and tries to serve all program and service units.

Performance Measures: None

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PROGRAM INFORMATION SHEET

Program: Health Media Marketing

Mandate: Specific statutory mandates throughout Public Health Law require the Department to produce the following publications:

- Breast Cancer: A Woman's Guide to Diagnosis and
- Breast Screening Saves Lives
- Prostate Cancer: What All Men should Know
- Hysterectomy
- Early Help Makes a Difference
- The Early Intervention Program: A Parent's Guide
- Shaken Baby Syndrome video and brochure
- Choking poster demonstrating the Heimlich maneuver
- Children's Camps in New York State
- Non-Hospital DNR Order
- Your Rights as a Hospital Patient
- Your Rights as a Nursing Home Resident
- You Now Have a Choice
- You Have 60 Days to Choose a Health Plan
- Now You Can Choose a Health Plan
- You Have 90 Days to Choose a Health Plan

Mandated Funding Level: None

Brief Description/History/Background: HHM is responsible for the following functions:

- Works with programs to develop messages and materials to motivate people to make positive changes in their health behaviors. Most materials are brochures, direct mail, promotional items, outreach materials, public service announcements, and multimedia campaigns of print ads, video news releases, radio spots, TV ads and Internet flash ads that lead users to our Web site and other materials at the click of a mouse.
- Develops campaigns to fit program budgets and reach target audiences. This requires consultation with our media buyers.

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- Provides focus-group testing of materials with the target audience and makes adaptations as needed. Studies marketing publications for latest trends in advertising media possibilities and health care messaging.
- Provides translations of DOH materials as requested, working with an outside translation service.
- Works with programs on multiyear strategies to get our messages out, including ad campaigns as well as press releases and events.
- Orders promotional items.
- Prepares scripts for the Commissioner to appear in certain industry-related videos, e.g., Wadsworth Labs' video for nurses on compliance with newborn screening requirements.
- Owns the DOH display booth used during events on the Concourse and can provide staffing for it on occasion.
- Works with the Press Office's Bureau of Communication Production Services when outside bids are needed for printing.
- Prepares purchase orders and contract amendments as needed for media campaigns and works with the Office of the State Comptroller for approval.
- HHM provides scripts and supervises production of video news releases, a new area for the Press Office, but one that will grow in importance. We have three videos available for download on our web site now: How to Catch a Bat, Recognize the Signs of Stroke, and MRSA in Sports Settings.

Issues: None

Population Served: Public health and science programs within DOH.

Performance Measures: None

Attachment C

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Communication Production Services (CPS)

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: CPS is responsible for these functions:

- Develops artistic and graphic elements of promotional materials, reports, ad campaigns and posters. Staff is experienced in a dozen software programs for electronic art display.
- Advises PAG Director on cost-effective use of printing sources, so that we print in-house as much as possible and limit outside contracting.
- Assists PAG Director in advising programs on report formats and presentation, including the use of color, paper stock, quantity to be printed, fonts and other typography, etc.
- Works with programs to design agency reports.
- Works with programs to develop new artwork/slogans “on spec.”
- Helps scientists and other staff prepare attractive presentation materials for conferences and other public meetings.
- Prepares posters for Commissioner’s press conferences and other events.
- Supervises DOH’s presence at the New York State Fair. Responsible for construction of site displays, recruits volunteers to staff the fair, works with programs to determine best materials to display to educate fairgoers on public and personal health issues, and coordinates activities when Commissioner visits the Fair.
- Supervises the Print Shop.

Issues: None

Population Served: DOH program and science staff.

Performance Measures: None

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Program: Public Web Site Administration

Mandate: From the 2008 legislative session:

- Chapter 193 of the Laws of 2008 "Expands the disclosure requirements of regulatory agendas which are to be published in the state register." Specific mandates are: Agencies shall publish the regulatory agendas on their respective websites whenever feasible; The agency shall inform the public that it maintains an updated regulatory agenda on its website and shall list the address of its website;
- Chapter 223 of the Laws of 2008 adds new requirements relating to the provision of public agency records. Specific mandates are: In determining the actual cost of reproducing a record, an agency may include only an amount equal to the hourly salary attributed to the lowest paid agency employee who has the necessary skill required to prepare a copy of the requested record; the actual cost of the storage devices or media provided to the person making the request in complying with such request; the actual cost to the agency of engaging an outside professional service to prepare a copy of a record, but only when an agency's information technology equipment is inadequate to prepare a copy, if such service is used to prepare the copy; An agency shall provide records on the medium requested by a person, if the agency can reasonably make such copy or have such copy made by engaging an outside professional service; and . When an agency has the ability to retrieve or extract a record or data maintained in a computer storage system with reasonable effort, it shall be required to do so.

Mandated Funding Level: None

Brief Description/History/Background: PWSA is responsible for the following functions:

- Quality control of www.nyhealth.gov and its thousands of individual program pages. PWSA is responsible for the presentation of materials, timely postings, and checking for updates from programs.
- Implements OFT mandates for accessibility of the DOH site to visually impaired people. Coordinates with OFT on all mandates for state sites.
- Provides technical assistance to programs for major innovations to the DOH site.
- Advises PAG Director on issues relating to the quality of information on the site and ensures that HPN and HIN updates are sent immediately to PAG as

breaking news.
- Stays alert to major changes at other health web sites, particularly the CDC, DOHMH and Web MD to alert PAG to replicate innovations.

Issues: None

Population Served: Public at large and DOH staff.

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Print Shop

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: The Print Shop is part of Communications Production Services, but provides a distinct service: to prepare and execute printing for all DOH mass reproduction materials, including reports, mailings to stakeholders, brochures, posters, ads, etc. The Print Shop prints about 30 million sheets a year and serves all programs. Our goal is to ensure that the Print Shop is used at full capacity every day and that outside printing is minimized.

Issues: None

Population Served: Internal DOH staff, health care providers, general public.

Performance Measures: None

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PROGRAM INFORMATION SHEET

Program: Audit

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background:

- Conducts desk and field audits of programs and contracts to ensure funding was appropriately expended and accounted for, in accordance with applicable laws, regulations, policies and contract terms;
- Conducts field audits of selected laboratories to verify required fees were remitted, as well as special or investigative audits, as required;
- Administers DOH's external audit function, acting as the liaison with outside audit entities including OSC, the federal DHHS, the single state auditor and others, ensuring a timely and aptly response to auditors' information requests and in issuing comments on audit reports;
- Operates as an Audit Clearinghouse to identify the recipients of grant funding who are required to file third-party independent auditor reports, ensuring the required audit reports are timely and compliant with applicable accounting and auditing standards. This involves issuing management decisions relative to audit findings, tracking and follow-up on grantees' non-compliance and enforcing associated penalties including initiating actions to suspend current grant payments and in certain circumstances to recoup prior payments;
- Provides guidance to DOH staff, grantees and independent auditors regarding grantees' compliance with applicable administrative requirements, including accounting and cost principles and audit requirements.

Issues: None

Population Served: The Audit Unit supports DOH's programs as they administer grant contracts with local governmental and not-for-profit human services organizations providing health-related services to New York State residents.

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Accounts Management

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background:

- Oversees DOH's contracting, purchasing, accounting and grant awards activities to ensure they are carried out within applicable laws, regulations and accounting standards;
- Develops and maintains cost allocation plans that enable DOH to claim hundreds of millions of dollars in federal reimbursement.;
- Collects, deposits and accounts for over $6 billion in annual revenue;
- Maintains employees' time records and processes the Department's payroll;
- Prepares fiscal reports required by the federal government and OSC, and duns for receivables due from assessed fines and penalties;
- Encumbers contracts in DOH and OSC electronic systems, while maintaining and updating internal systems that reduce the Department's late-payment charges;
- Processes payments to vendors and contractors;
- Issues travel payments to employees;
- Reconciles credit card transactions;
- Processes legislative initiatives.

Issues: None

Population Served: Supports DOH programs in their contracting, purchasing, procurement card transactions, internal controls, accounting activities and other business transactions. It supports management in developing fiscal policy, improving fiscal reporting, and improving programs' cost effectiveness. It advises program staff throughout their contracting and granting processes, as they prepare RFPs and RFAs, as well as all other documents, which require OSC approval. It also serves program staff as a liaison with OSC, OGS and DED and maintains the Department's vendor file, bidders' list and MWBE list.

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Budget Management

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background:

- Budgets funds and evaluates program fiscal proposals;
- Oversees expenditure controls and manages related fiscal functions for all appropriated funds in DOH;
- Compiles the department's budget request in accordance with DOB's Budget Policy and Reporting Manual and ensures that all DOB requests for financial information, such as the status of expenditures and contracts, are processed in an accurate, timely, and responsive manner;
- Provides analyses and comments on the fiscal implications of bills and legislation;
- Develops cash projections of program and operations spending and estimates the number of staff, operational activities and program activities that can be supported by the Department;
- Guides management in developing fiscal policy and improving programs' cost effectiveness;
- Provides fiscal advice, guidance, and service to program staff in support of DOH's core goals and objectives;
- Serves as DOH's primary fiscal liaison with DOB, the Legislature's fiscal committees as well as county fiscal offices and federal human services and control agencies.

Issues: None

Population Served: Supports all DOH programs advising them on budgeting and related fiscal matters.

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Fiscal Systems Support

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background:

- Develops, maintains, and operates the fiscal systems environment for the Department's financial and management operations;
- Provides systems to FMG's bureaus to track, expedite, and administer DOH's budgeting, contracting, purchasing, accounting, payroll, and federal reporting;
- Supports Medicaid budgeting with data for the development and monitoring of the MA budget, as well as for the analysis of pending state and federal regulations and laws;
- Provides analytical support regarding the state's Medicaid cap on the local share and conducts the annual reconciliation of the capped local share relating to what counties and New York City would have paid under the previous funding methodology.

Issues: None

Population Served: Department financial operations.

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Medicaid Financial Management

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Function is carried out through the following:

- Calculates funding for the weekly Medicaid cycle and ensures all federal, state, and county shares are on deposit prior to check release;
- Administers an extensive Medicaid accounts receivable system for provider debts;
- Compiles financial data and submits required federal expenditure reports for the Medicaid and SCHIP programs;
- Reconciles all Medicaid and SCHIP grant awards and maintains federal cash plans for all open grant years;
- Calculates special state reimbursement for certain claims;
- Assists Medicaid providers that are experiencing cash flow difficulties and responds to provider questions concerning payment issues;
- Processes reimbursement to nursing homes for nurse aide training and testing costs;
- Administers the Medicaid escrow accounts;
- Records and reimburses Medicaid claims from other state agencies.

Issues: None

Population Served: Supports the state's Medicaid program within DOH, other state agencies, and the local social services districts.

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Personnel Management

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Personnel Management is responsible for:

- Classifying and reclassifying positions and titles to meet program organizational needs;
- Civil Service examination planning and development;
- Recruiting, hiring, promoting and retaining a well-qualified workforce;
- Workforce and succession planning.

These activities are necessary to ensure Department compliance with NYS Civil Service Law, NYS Human Rights Law, NYS Public Officers Law, Retirement and Social Security Law, State Finance Law, the Americans with Disabilities Act, the Family Medical and Leave Act, and federal EEO laws.

Issues: The program is challenged by an aging workforce and the impending retirement of large numbers of staff with the subsequent loss of the knowledge and expertise. Current and anticipated fiscal constraints in New York State will likely make the recruitment, hiring, appointment, and promotion of qualified personnel resources more difficult.

Population Served: Managers and employees of the Department, as well as interested job-seekers and prospective employees. Other interested parties include the Governor's Appointments Office and the Civil Service Commission.

Performance Measures: None

Attachment C

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Employee Relations

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Employee Relations

- Conducts ongoing department level discussions and negotiations with representatives of employee organizations;
- Administers the negotiated agreements, grievance and disciplinary procedures;
- Provides guidance and assistance to managers and supervisors with respect to handling a variety of workplace problems;
- Oversees the employee relations activities in the Department's health care facilities (Helen Hayes Hospital and the NYS Veterans' Homes at Oxford, St. Albans, Batavia, and Montrose);
- Provides technical assistance, advice and support to management at the Department's numerous (over 20) field locations;
- Conducts disciplinary investigations and prepares reports of findings and recommendations in these matters;
- Represents the Department in arbitrations and other review proceedings, and serves as Step 2 reviewers in the grievance process;
- Responds to questions on workplace issues including telecommuting, compressed work schedules, performance evaluations, counseling employees, payment of unemployment insurance, fitness for duty, impairment at the workplace, and time and attendance issues.

These activities are necessary to ensure Department compliance with the Public Employees Fair Employment Act ("Taylor Law") and NYS Civil Service Law.

Issues: None

Population Served: DOH employees, supervisors, and managers. Other interested parties include NYS labor unions, GOER and Department of Civil Service.

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Affirmative Action

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: State agencies have been required to provide equal employment opportunity to qualified individuals regardless of their race, national origin, religion, gender, age, sexual orientation, disability, etc., since the 1970s.

Affirmative Action:

- Fosters diversity in the workforce;
- Participates in outreach recruitment;
- Ensures accommodation for employees and job applicants with disabilities;
- Investigates internal complaints of discrimination and sexual harassment;
- Investigates external complaints filed with the Division of Human Rights or the Equal Employment Opportunity Commission (EEOC);
- Represents management at hearings at Human Rights and the EEOC and work to achieve settlements where appropriate;
- Serves as the Reasonable Accommodation Coordinator for the Department.

These activities are necessary to comply with the NYS Human Rights Law, the Americans With Disabilities Act and Title VII of Civil Rights Act of 1964

Issues: The Department is developing an aggressive strategy to attract a workforce that reflects the population diversity of New York State.

Population Served: Department of Health employees, supervisors and managers.

Performance Measures: None

Attachment C

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Staff Development

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Staff Development provides training to Department managers and employees to most effectively and efficiently meet organizational and individual needs.

- Coordinates and implements the Department's human resource and core competency training programs, including mandated training such as Preventing Sexual Harassment;
- Works with managers, providing consultation and support, to meet identified development and training needs;
- Represents DOH and works with the Governor's Office of Employee Relations to insure that the Department's needs are represented through access to GOER training and financial resources, including train-the-trainer programs, statewide interagency training initiatives, union-negotiated and management/confidential training programs, and tuition support and training grant programs.

These activities are necessary to comply with NYS Civil Service Law, Title VII of the Civil Rights Act, and NYS Labor Law Article 2, Section 27-b on Workplace Violence

Issues: None

Population Served: DOH, and temporary employees; supervisors and managers. Other interested parties include GOER and labor unions.

Performance Measures: None

Department of Health – Executive Direction and Administration
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Program: Occupational Health & Safety

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background:

- Provides employees with a work environment that minimizes health risks and safety hazards;
- Works to reduce lost time associated with work-related accidents, injuries, and illnesses by identifying and reducing exposure to potential risks and hazards, and by developing control measures to minimize hazards;
- Ensures employee access to personal protective equipment, ergonomically correct furniture, and immunizations;
- Provides training to ensure that employees understand the need for safe work practices and how procedures should be carried out to minimize risk, and evaluates the effectiveness of control measures and training;
- Develops policies and procedures on occupational health and safety, inspects DOH worksites to determine compliance, conducts medical monitoring, and investigates reports of accidents and occupational injuries while recommending corrective action to minimize recurrence.

These activities are necessary to comply with the Public Employees Fair Employment Act ("Taylor Law") and NYS Labor Law Article 2, Section 27-b on Workplace Violence

Issues: None

Population Served: DOH and temporary contract employees, supervisors, and managers. Other interested parties include NYS labor unions and OGS.

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Wellness

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Since 1995, the Wellness Program (WellNYS) has provided workplace wellness programs to all DOH/HRI and temporary contract employees. It is now a statewide interagency program in which DOH plays the lead role. Programs offered include America on the Move (AOM), Healthy Holidays, and Take the Stairs in the spring, fall and winter, respectively. Ongoing initiatives include Walking on Wednesdays, brown bag lunch and learn sessions, Weight Watchers at the Empire State Plaza, and daily FITnet messages. In the spring, the WellNYS program forms a team for the GHI Workforce Challenge in Albany. In 2007, a pilot project called WellNYS Everyday opened on the Concourse for all NYS employees, offering Physical Activity Challenge, Go the Extra Half Mile, Weigh-in on Wednesdays, WellNYS Everyday Olympic Experience, Weight Watchers, and a variety of lunch and learn wellness programs. A circuit of wellness stations is offered to demonstrate weight and diabetes self checks, meditation/stress reduction, grip strength, and information on the NYS Smokers Quitline. The Director works directly with the Statewide Employee Assistance Program (EAP) to promote health and wellness programs to employees of other NYS agencies.

Issues: None

Population Served: DOH and temporary employees, supervisors, and managers. Employees from other NYS agencies. Other interested parties include GOER, NYS employee unions, and the Employee Assistance Program.

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Vital Records

Mandate: Public Health Law Article 41, Domestic Relations Law Articles 1, 2 & 3, Federal Intelligence Reform and Terrorism Prevention Act of 2004, Section 1711, and the REAL ID Act of 2005

Mandated Funding Level: None

Brief Description/History/Background: The Vital Records function is comprised of three main functions:

- Registration Services - responsible for filing birth, death, marriage, dissolution of marriage, spontaneous fetal death and induced fetal death certificates. Data reported on the certificates is edited and coded, and the certificates are numbered and digitized in order to make the data and certificate copies available. Advises 1,500 local registrars and 1,000 town and city clerks of the legal filing and copy issuance requirements for birth, death and fetal death registration and marriage license issuance, through telephone consultation, field visits and audits, and presentations at local and statewide meetings. Manages the local officials' form and certificate distribution program and the in-house and local security and fraud prevention program.
- Customer Request Services – responsible for issuing copies of birth, death and other certificates to qualified members of the public who require them for employment, insurance claims, and driver license applications. Files and copies are also made available to researchers, epidemiologists, and fraud prevention programs, such as the Medicaid Inspector General's Office.
- Adoption Registry – provides non-identifying information to adoptees about their birth parents and matches adoptees with their birth parents and biological siblings. The Registry also files birth parent consents at the time of adoption permitting adoptees to obtain identifying information when they reach the age of eighteen.

Vital Records must also ensure compliance with the Intelligence Reform and Terrorism Prevention Act of 2004. This Federal legislation requires states to standardize vital records documents, comply with minimum safety paper and physical plant security standards, verify applicant identity, match birth and death certificates, and verify vital records information for federal and state DMV (Real ID) offices.

Issues: None

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Population Served: The general public, epidemiologists; public health researchers.

Performance Measures: None

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PROGRAM INFORMATION SHEET

Program: SPARCS Administration and Supervision

Mandate: Public Health Law Article 28, Section 2816 (SPARCS)
State Finance Law Article 16, Section 97-X (SPARCS Fees)

Mandated Funding Level: None

Brief Description/History/Background: PHL establishes the Statewide Planning and Research Cooperative System (SPARCS) to collect, monitor, maintain and disseminate information on patients treated and services provided at Article 28 health care providers. SPARCS summarizes patient characteristics, diagnostic, treatment, financial and outcome information associated with each discharge/visit for inpatient, emergency department, ambulatory surgery center and clinic. The system is a core source of information on health care utilization, cost, quality and access. SPARCS data is essential to numerous DOH programs, including Medicaid reimbursement, and a myriad of health care system stakeholders nationwide. SFL Article 16 provides the Department with the authority to assess and collect annual fees from Article 28 hospitals to help fund the system.

Issues: Article 28 was expanded in 2006 to include data reporting from all outpatient clinic services provided in the state and the Department is in the process of implementing this expansion. The addition of this class of health care provider will increase the information flow volume by a factor of fifteen.

Population Served: State and national policy makers, DOH programs, health care providers and their associations, purchasers and consumers.

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Healthcom Services

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background:

- Provides centralized information technology security services;
- Operates the Help Desk for computer users;
- Provides targeted PC/LAN support;
- Supports the LAN/WAN segment of the HEALTHCOM network, which connects all departmental mainframes, file servers, PCs and office LANs. This infrastructure was implemented to connect the central department offices and offices across the state to allow staff access to the email, public access, and Health Commerce System;
- Responsible for data protection and interoperability, which includes the development of tools and resources to support encryption of sensitive information stored on personal computing devices or transmitted in e-mail; developing and maintaining a comprehensive and well-defined classification system to assess or describe the sensitivity of data.

HSB Central Security provides account management including identity management service, network vulnerability scanning and reporting, network monitoring for security purposes, anti-virus, centralized active directory management, firewall and log management, application security scanning, tools and assistance, security awareness training and compliance with NYS Cyber Security Policy P03-002 and HIPAA security.

Issues: None

Population Served: Approximately 8,000 DOH users and more than 60,000 Health Commerce System users and partners.

Performance Measures: Availability of security systems. Compliance with P03-002 and HIPAA for security systems. Security awareness completion percentages are kept.

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Computer Systems Development

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: This function:

- Provides systems analysis and computer application development and support services to Department programs;
- Administers agency databases;
- Assists program managers with technology decisions such as hardware and software purchases, outsourcing, data analysis and management;
- Works with program area IT groups to facilitate end user computing;
- Supports and promotes project management practices throughout the Department, working in conjunction with the Project Management Office;
- Provides enterprise content management services.

Issues: None

Population Served: DOH program areas, health care providers and their associations, external regulated health entities, and the general public.

Performance Measures: Critical databases and applications are available according to business requirements.

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Healthcom Network Systems Management

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: HNSM provides infrastructure design, management, operations, and informatics support enabling the provision, capture, exchange and analysis of health information and data both within DOH and with external information exchange partners; informs policy decisions and supports implementation of the Department's program mission; facilitates effective response to emergent health events and extends program initiatives to assure the health of the general public.

All programs rely on HNSM's functions and the systems that support not only day-to-day operations but also response activities during a health event. External regulated health entities (local health departments, hospitals, clinical labs, long term care, etc.) are also dependent on HNSM's support of the Health Commerce System (HCS).

HNSM supports the management and operation of systems such as the Healthcom network, Health Alert Network, the DOH public website and the infrastructure supporting back-up, recovery and availability of these systems. In turn, these activities collectively support DOH e-mail, office automation, internet access, inter office communications and information exchange, data access, analysis and visualization.

HNSM informatics assist grant funding initiatives; participate in the ICS response to health events; support public health situational awareness through analysis and visualization; and support adoption and implementation of federal interoperability standards required for health information exchange.

Issues: None

Population Served: DOH health program areas, external regulated health entities, and the general public.

Performance Measures: Ensure that core infrastructure systems and functions are available 24/7, reliable, responsive in real-time, backed up in real-time and recoverable offsite.

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Office Support Services

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background:

- Responsible for the provision and management of central services to the Department; i.e. mail and supply functions, equipment inventory management and control, employee identification control, administrative policy and procedure development, records management, and similar services.
- Acts as manager for all DOH office space (both state-owned and leased sites) with OGS and multiple control agencies; and for monitoring all construction and space modification projects for approximately 30 leases and one-million square feet of state-owned space.

Issues: None

Population Served: All Department of Health staff

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Internal Control Management

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background: Ensures that the requirements of the Internal Control Act, are met:

- Develops and maintains Department policies and procedures to conform with the State's Internal Control Act;
- Administers the annual internal control review process for all DOH assessable functions;
- Analyzes DOH program compliance with internal control standards;
- Recommends agency compliance certification.

Issues: None

Population Served: All Department of Health organizational units

Performance Measures: None

Department of Health – Executive Direction and Administration
PROGRAM INFORMATION SHEET

Program: Telecommunication Services

Mandate: None

Mandated Funding Level: None

Brief Description/History/Background:

- Responsible for managing voice services and connectivity for data services for all Department of Health locations;
- Ensures the availability, access, continuity, adequacy, and maintenance of telecommunication services throughout the Department, including all landline and cell services, toll-free services, and teleconferencing;
- Acts as the Point of Contact for federal programs regarding Wireless Priority Services and the Governmental Emergency Telecommunications Services in anticipation of providing telecommunication services in emergency situations or catastrophic events.

Issues: None

Population Served: All Department of Health staff

Performance Measures: None

Attachment B

Agency Programs/Activities: Inventory and Key Data
Office of Health Facilities Mangement

Page	Relation to Core Mission (H/M/L)	Program/Activity	Spending Category (SO, ATL, CAP)	3/31/09 FTEs (All Funds)	General Fund Disbursements ($000s)				State Special Revenue Funds Disbursements ($000s)				Capital Projects Funds Disbursements ($000s)			
					2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected
1	H	**Health Facilities Management/Helen Hayes Hospital**	SO	610	$0	$0	$0	$0	$57,834	$57,034	$66,444	$66,444	$0	$0	$0	$0
													$0	$0	$0	$0
		Health Facilities Management/ State Veterans' Homes at:											$0	$0	$0	$0
2	H		SO	290	$0	$0	$0	$0	$20,294	$19,571	$35,295	$35,295	$0	$0	$0	$0
	H	**NYC (St. Albans)**	SO	308	$0	$0	$0	$0	$18,940	$20,129	$24,874	$24,874	$0	$0	$0	$0
	H	**Oxford**	SO	164	$0	$0	$0	$0	$9,812	$10,733	$12,135	$12,135	$0	$0	$0	$0
	H	**WNY (Batavia)**	SO	300	$0	$0	$0	$0	$22,181	$23,041	$24,697	$24,697	$0	$0	$0	$0
		Montrose	SO	1062	$0	$0	$0	$0	$71,227	$73,474	$97,001	$97,001	$0	$0	$0	$0
		State Veterans' Homes, Total														
		Health Facilities Management, Total	SO	1672	$0	$0	$0	$0	$129,061	$130,508	$163,445	$163,445	$ 2,742	$ 7,308	$ 6,500	$ 5,500
		HCRA Prior Year, RPCI							$93,000	$93,000	$91,100	$91,100	$0	$0	$0	$0
			SO													
		Grand Total	ALL	1672	$0	$0	$0	$0	$222,061	$223,508	$254,545	$254,545	$2,742	$7,308	$6,500	$5,500

Attachment C

Department of Health – Health Facilities Management
PROGRAM INFORMATION SHEET

Program: Health Facilities Management – Helen Hayes Hospital

Mandate: Helen Hayes Hospital is operated under authority of Article 26 of the Public Health Law. The Hospital is also certified to operate pursuant to Article 28 of the Public Health Law Article 28 and applicable state and federal regulations.

Mandated Funding Level: Federal regulations for rehabilitation hospitals mandate certain primary diagnostic codes to determine funding eligibility; this rule requires that 60% of all admissions meet this criterion to maintain eligibility.

Brief Description/History/Background: Helen Hayes Hospital was founded in 1900 by the State of New York and is believed to be the first freestanding state-operated physical rehabilitation hospital in the United States. The Hospital focuses on medical, therapeutic and nursing care to restore mobility, independence and functioning to individuals facing disability, injuries and chronic illness. Hospital services include 155 inpatient beds, a comprehensive day hospital program and an active outpatient program. Innovative centers include the Prosthetic Orthotic Center, which constructs advanced prosthetic and orthotic devices; and the Center for Rehabilitation Technology, which provides the latest seating and mobility aids, as well as augmentative communication aids. A 25-bed sub acute skilled nursing unit was recently opened.

Issues: The Hospital faces workforce challenges, including recruiting and retaining of qualified clinical, technical and support staff. The Hospital is also challenged by federal reimbursement constraints and the need to support and update the hospital infrastructure.

Population Served: The Hospital regularly attracts from a wide geographic and diverse area. Multi-disciplinary treatment teams care for patients with traumatic brain and spinal cord injuries, strokes, cardiopulmonary and orthopedic disorders as well as other neurological conditions including multiple sclerosis. The Hospital also participates in several federally-funded research grants many of which incorporate patient treatment and outcomes, such as the osteoporosis research project.

Performance Measures: The Hospital is required to have annual independent audits completed by a certified public accounting firm and is surveyed regularly by the Joint Commission on Accreditation of Health Care Organizations and the NYS Department of Health.

Attachment C

Department of Health – Health Facilities Management
PROGRAM INFORMATION SHEET

Program: Health Facilities Management – NYS Veterans' Homes

Mandate: The NYS Veterans' Homes are operated under authority of Article 26-A of the Public Health Law (PHL). The Homes are certified to operate as residential health care facilities pursuant to Article 28 of the PHL and applicable state and federal regulations. Additionally, the facilities are recognized as "State homes" under the federal State Veterans Homes Program pursuant to Title 38, U.S.C. 8131-8137.

Mandated Funding Level: A minimum veteran occupancy level of 75% is mandated in order to maintain standing in the federal program.

Brief Description/History/Background: The Department of Health operates the four skilled nursing homes, which have a total of 870 beds and provide skilled services for veterans and their qualified dependents:

- The NYS Veterans' Home at Oxford, which originally opened in 1897, began operating in the current 242-bed facility in 1979. There is currently a sixty million dollar building program underway to rebuild the facility. It is expected to be completed in 2008. (Chenango County)

- The NYS Veterans' Home at St. Albans is a 250-bed facility that opened and began operations in 1993. (Queens County)

- The NYS Veterans' Home at Batavia is a 126-bed facility that opened and began operations in 1995. (Genesee County)

- The NYS Veterans' Home in Montrose is a 252-bed facility that opened and began operations in 2001. (Westchester County)

Issues: The homes in Oxford, Batavia and St. Albans are, or will soon, undergo facility modernization projects to address infrastructure issues. Additionally, the facilities face workforce challenges, including recruiting and retaining a qualified clinical staff.

Population Served: To be eligible for admission to the Homes, the applicant must have been: (1) a New York State resident at the time of entry into active duty or for one year prior to application for admission; (2) had an honorable discharge from the armed services; and (3) had at least 30 days of service. Parents and spouses may also be eligible depending on certain criteria.

Performance Measures: The Homes are required to have annual quality surveys by the Department of Health and the Department of Veterans Affairs. Additionally, they are required to have annual independent audits completed by a certified public accounting firm.