Michael V. O'Brien
City Manager

CITY OF WORCESTER

Attachment for Item #

January 12, 2010

TO THE WORCESTER CITY COUNCIL

COUNCILORS:

I am pleased to share with your Honorable Body the final recommendations of the Task Force on Public Health.

In June 2009, I convened a task force of community health partners co-chaired by John O'Brien, President and CEO of UMass Memorial Health Care, and Dennis Irish, Vice President of Vanguard Health System, and charged them with researching and developing a focused mission for our Division of Public Health that is based on national best-practices and is reflective of a sustainable financial model. The task force has completed its work and has made the following recommendations:

- **Reconstitute the Board of Health**
- **Reorganize administration of the Division of Public Health**
- **Utilize data in identifying community health priorities**
- **Formalize a cooperative working relationship with existing community health services (community health centers, working groups, etc)**

I support these recommendations and I have been intimately involved in discussions with its members. I must, however, balance these recommendations within the context of the current financial circumstances we find ourselves in today. I believe that this report clearly outlines guiding principles from which we, as a community, can and should continue to design and improve the function of public health within city government. However, many of the long-term strategies outlined will require ongoing discussion, new systems and policies, and the necessary capacity to achieve the desired goals.

The following is my proposed implementation plan:

<u>Reconstitute the Board of Health</u>
The Board of Health is presently a four member board with the Commissioner of Public Health serving as a fifth, ex-officio member functioning as the Chair of the Board and voting only in the instance of a tie. While State law provides Boards of Health the authority to promulgate regulations, the City has historically implemented a special act that vests this regulatory authority in the Commissioner of Public Health, with the Board itself serving an advisory role. The Task Force recommends returning public health regulatory authority from the Commissioner to the Board of Health as a whole, and

reconstituting the Board as a five-member board with the Commissioner serving as a sixth non-voting but active participant. The recommendation also increases the terms of the voting members from three years to four. The appointing authority for the members of the Board of Health would remain the City Manager. Upon endorsement of this plan by the City Council, I will submit a reorganization of the Board of Health as part of the FY 2011 budget process.

I will make appointments to the re-constituted Board of Health with the expectation that the membership will make decisions as to priorities based on data and statistics (as is outlined on page 3 of this memo). It will also be my expectation that the Board of Health and the Commissioner will engage and apprise the community as to their work, will be transparent in their decisions, and will make a strong case to the community when identifying public health priorities.

Reorganize administration of the Division of Public Health

The table of organization of the Division of Public Health presently includes a Director of Public Health and a part-time Commissioner of Public Health. The Task Force recommends that the Commissioner of Public Health be transitioned to a full-time position. The position would serve as chief advisor to the City Manager on public health matters, and would be charged with overseeing data collection and analysis, advising the Board in the establishing of community health priorities, responding to public health threats, and fulfilling all statutory requirements and compliance with regulations and ordinances. While we will aggressively seek out a candidate with a Doctor of Medicine degree, the Task Force has recommended the establishing a Medical Director position in the event the Commissioner is not a physician. The Task Force also recommends that the City maintain the position of Director of Public Health, who would be responsible for maintaining the day-to-day operations of the department.

As is stated under separate cover, Dr. Leonard Morse, Commissioner of Public Health, has informed me of his decision to retire effective September 1, 2010. He has also informed me of his support of the recommendation for a full-time Commissioner and I will rely on his guidance as we as we craft a full-time Commissioner job description, recruit potential candidates, and ultimately fill this position. I intend to re-craft the Commissioner position to full-time as part of the FY 2011 budget process. Dr. Morse has offered to stay on board in his current capacity through this transition.

The Task Force report includes a long-term recommendation that the public health inspectional functions presently within the Department of Inspectional Services be re-aligned under the stewardship of a full-time Commissioner of Public Health. While I intend to pursue the hiring of a full-time Commissioner of Public Health as part of the FY 2011 budget, it is also my intention that the Department of Inspectional Services remain as presently constituted through at least through Fiscal Year 2011 while we continue our efforts to stabilize neighborhoods impacted by foreclosure. I am evaluating this proposed re-alignment as well as other ways to improve coordination of public health-related functions in all City divisions/departments, and will be forwarding a recommendation to achieve this as part of the FY 2011 budget recommendation.

I am currently exploring the regionalization of the full-time position of Commissioner of Public Health. I have had conversations with other communities regarding the potential sharing of policy and medical expertise in the form of this position, and we believe that this relationship could be fruitful for both parties. I am grateful to the University of Massachusetts Medical School for their willingness to consider a faculty appointment for

the City's Commissioner of Public Health. We believe that this appointment would be attractive to highly-qualified candidates. I anticipate financial and other support from regional foundations, which will minimize impact of this position on the City's budget.

Utilize data in identifying community health priorities

While we have sustained the core public health services of infectious disease surveillance, tuberculosis case management, death certificates, and burial certificates, we also know that there are a myriad of public health needs that surpass our core capabilities. The Task Force has recommended that the City, through its Board of Health and Division of Public Health, utilize data to prioritize the initiatives and programs we implement. In support of this "data-driven decisions" approach, I am pleased to inform your Honorable Body that the University of Massachusetts Medical School has committed to conducting the first of anticipated regular community-wide public health needs assessments on behalf of the City. The data compiled by the Medical School will then be submitted to the Commissioner of Public Health and the Board of Health. Using this data, we will identify priorities and develop a strategic approach to meeting our most critical public health needs. The City will also continue dialogue with appropriate community partners – including the Commonwealth's Department of Public Health, the Medical School, hospitals, and community health organizations – to establish local systems in coordination with the aforementioned groups to monitor data on a day-to-day / ongoing basis.

Formalize a cooperative working relationship with existing community health services (community health centers, working groups, etc)

There are dozens of community health service providers in our community whose mission it is to address the health needs of specific groups (medical, cultural, geographical, economic) and of the community as a whole. Given this unusually rich mix of hospitals, health centers, college and universities, we must rely on data and systems to maximize our collective efforts. While the City already works alongside these organizations, we intend to strengthen the public health system to better coordinate all of these resources. This could include: the City convening cooperative workgroups to address key public health issues; the City conveying grant funds (state and otherwise) to our partners to address issues on behalf of the City; and/or the City endorsing privately-funded efforts as complementary to meeting our core needs.

As you already know, the University of Massachusetts Medical School stepped up last summer and our City public health nurses have supervised, and worked alongside, 24 graduate student nurses twice per week this past fall as we vaccinated residents against the H1N1 influenza. This relationship will be long-term and the City and the Medical School are currently developing a work plan for implementation post-H1N1. Additionally, UMass Memorial Health Care CEO John O'Brien has committed the assistance of UMass' Disaster Management Program to ensure preparedness and connectivity throughout the community as we combat the H1N1 influenza. Our emergency response to H1N1 has also been supported by the American Red Cross and the Worcester District Medical Society, and has operated in conjunction with the Worcester Public Schools.

The Task Force also recommended a community advisory and advocacy group be established to support the implementation of this plan. The expectation of the Task Force is that, much like a "Friends of the Library" or "Friends of the Senior Center", this non-profit group will advocate for financial and other resources in support of improving

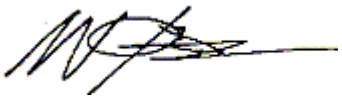
community health in Worcester. I will be vetting the establishing of this organization with key community stakeholders.

I wish to extend my gratitude to the Task Force for their countless hours of work and thorough research and for putting forth a comprehensive document from which we can build a 21st century public health model. I am grateful to John O'Brien and Dennis Irish for their leadership and for service as co-chairs, and to all of the members of the task force who worked so diligently to produce this report. I am also grateful to UMass Memorial Health Care, and Chancellor Michael Collins and the University of Massachusetts Medical School, for their commitment of staff assistance to support the Task Force in the formulation of this report.

Moving forward, I am grateful to the Medical School for their offer to consider a faculty position for the City's full-time Commissioner of Public Health, and for the City's continued access to graduate student nurses. I must also re-state my gratitude to John O'Brien and UMass Memorial Health Care for their continued support of core public health operations, in the form of an annual contribution to the City in the amount of $145,000. Finally, I wish to express my sincere appreciation to Dr. Leonard Morse for his leadership during this process, and to Derek Brindisi, Director of Public Health, for his active participation in the work of the Task Force and for his continued stewardship of the Division of Public Health during this transition.

I respectfully request that the attached report be referred to the Standing Committee on Public Health and Human Services for further discussion and deliberation.

Respectfully submitted,



Michael V. O'Brien
City Manager

City of Worcester
Task Force on Public Health

Recommendations to the City Manager

November 30, 2009

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Task Force Membership List

Co-Chairpersons

Dennis Irish	Vice President, Marketing, Government and Community Relations, Vanguard Health Systems New England & Chicago Market
John O'Brien	President and CEO, UMass Memorial Health Care

Executive Committee

Michael F. Collins, MD, FACP	Senior Vice President for the Health Sciences, University of Massachusetts and Chancellor, UMass Medical School
Dennis Irish	Vice President, Marketing, Government and Community Relations, Vanguard Health Systems New England & Chicago Market
Leonard Morse, MD	Commissioner of Public Health, City of Worcester
John O'Brien	President and CEO, UMass Memorial Health Care
John Smithhisler	President and CEO, Saint Vincent Hospital
Carlton Watson, MSW	President and CEO, Henry Lee Willis Community Center
Jan Yost, EdD	President and CEO, The Health Foundation of Central Massachusetts

Task Force

Frances Anthes, MSW	President and CEO, Family Health Center
Abigail Averbach, MS	Director, Commonwealth Medicine Office of Massachusetts Client Relations, UMass Medical School; Member, Worcester Board of Health
Patricia Bruchmann, MS, RN	Chief, Public Health Nursing, Division of Public Health, City of Worcester
Suzanne Cashman, ScD	Professor and Director of Community Health, Department of Family Medicine and Community Health, UMass Medical School
Dawn Clark, PhD	Chair, Commission on Disabilities, City of Worcester
Michael F. Collins, MD, FACP	Senior Vice President for the Health Sciences, University of Massachusetts, and Chancellor, UMass Medical School
Octavio Diaz, MD, MPH	Chief Medical Officer, Saint Vincent Hospital
Sheilah Dooley, RN, BSN, MS	Executive Director, Pernet Family Health Service
Jack Dutzar, MD	President and CEO, Fallon Clinic
Erik Garcia, MD	Director, Homeless Outreach and Advocacy Project, Community Healthlink
Karen Green, BSN, MA	President and CEO, VNA Care Network and Hospice

David Hillis, FACHE, FACATA	President and CEO, AdCare Hospital
Michael Hirsh, MD	Division Chief of Pediatric Surgery and Trauma, UMass Memorial Health Care
Dennis Irish	Vice President, Marketing, Government and Community Relations, Vanguard Health Systems New England & Chicago Market
Catarina Kiefe, PhD, MD	Chair, Department of Quantitative Health Sciences, UMass Medical School
Robin Klar, DNSc, RN	Assistant Professor of Nursing, Graduate School of Nursing, University of Massachusetts Worcester
Dale Magee, MD, MS	Assistant Professor of Clinical OB-GYN, UMass Medical School
Antonia (Toni) G. McGuire, RN, MPH	President and CEO, Great Brook Valley Health Center
Charles F. Monahan, Jr.	President, Massachusetts College of Pharmacy and Health Sciences
(Represented by Deborah O'Malley, JD)	Executive Director, Massachusetts College of Pharmacy and Health Sciences
Leonard Morse, MD	Commissioner of Public Health, City of Worcester
John O'Brien	President and CEO, UMass Memorial Health Care
William O'Connell, MA, LCSW	Regional Director, Massachusetts Department of Public Health
Michele Pugnaire, MD	Senior Associate Dean for Education Affairs, UMass Medical School
Laurie Ross, PhD	Professor, Clark University
Clara Savage, EdD	Director, Common Pathways
John Smithhisler	President and CEO, Saint Vincent Hospital
Steven Ward, MPH, REHS/RS	Director of Public Health, Town of Watertown
Carlton Watson, MSW	President and CEO, Henry Lee Willis Community Center
Jan Yost, EdD	President and CEO, The Health Foundation of Central Massachusetts

Acknowledgements

This report to the City Manager was made possible by the efforts of many individuals and organizations.

In particular, Leonard Morse, MD, the Commissioner of Public Health; Derek Brindisi, the Director of Public Health; and Patricia Bruchmann, RN, Chief, Public Health Nursing, provided invaluable contributions too numerous to list. Their deep knowledge of and expertise in public health is matched by their idealism and passion. We wish to thank them for their tireless work and support over the past five months and for their selfless service to our community every day.

The work of the Task Force was accomplished with the generous support of the UMass Medical School Office of Program Development and Enterprise Project Management Office. We thank Pamela MacLeod, Senior Program Development Associate for her leadership; project managers Todd Chapman, Sharon Pigeon, and Susan Hartshorn for their diligent efforts in coordinating, facilitating, and supporting the work of the Task Force; and Catherine Sampson for her administrative support.

Finally, we would like to thank staff from UMass Memorial Health Care who worked with the Task Force and all of the subcommittees. Their work and dedication allowed the Task Force to complete its work in a thoughtful and timely manner. In particular, we want to thank Katherine Shocas, Cheryl Lapriore, and Gary Lapidas.

Executive Summary

The Task Force on Public Health was convened by Worcester City Manager Michael V. O'Brien in June 2009 to redefine the mission, vision, capabilities, and services of a vital and focused Division of Public Health (DPH). From late June through November 2009, the Task Force, comprised of two chairpersons, a five-member executive committee, and a committee of twenty-two individuals, met in Executive Committee, Subcommittee, and full Task Force meetings. Task Force members reviewed national standards, conducted online scans, examined research studies, studied other cities' approaches, met at length with the Worcester DPH Commissioner, DPH Director, and other City staff, and consulted with state and national public health experts.

The Task Force recommendations to the City Manager are presented in the spirit of a strategic framework to guide future decision-making. This document is the first step in the City's planning and implementation process. The work ahead for the City will involve determining priorities and feasibility, turning priorities into phased action plans, determining budgets and funding sources, and creating and executing an implementation plan.

This report includes proposed new mission and vision statements; four strategic goals, each with a brief summary of findings and recommended priorities; a new Board of Health governance model; and a new organizational structure.

Proposed New Mission Statement

The mission of the Department of Public Health, in collaboration with community and government partners, is to improve and protect the health and safety of those who live, work, visit, and study in Worcester.

Proposed New Vision Statement

To lead an efficient, effective and equitable public health system that serves as a national model and enables all who live, work, visit, and study in Worcester to be healthy and safe.

Four Strategic Goals

1. Improve Organizational Effectiveness: Design a new Department of Public Health and strengthen its governance and leadership in order to provide efficient, effective, and equitable public health prevention, protection, and health promotion services; advance knowledge of public health practices and transfer that knowledge into innovative and responsive community and public health approaches; and build, in an incremental process, a model public health system that achieves accreditation from the Public Health Accreditation Board by 2015.

2. Mobilize a Coordinated Community Approach: Lead a connected and effective local public health system by establishing new and strengthening existing collaborative partnerships and creating strategic alliances.

3. Make Data-Driven and Evidence-Based Decisions: Build the capacity and capability to measure, monitor, and report health status and health risk; to identify health priorities; and to evaluate effectiveness.

4. Build a Road to Sustainability: Expand all sources of funding and pursue regionalization through shared services and cooperative agreements with area towns.

The recommended new organizational structure includes a stronger Board of Health and elevates the current Division of Public Health to a department level. DPH will have depth in senior management and staff in order to set policy and priorities; lead the development of internal capabilities in data collection, analysis, and community engagement; convene and lead the larger network of organizations and services that comprise the entire public health system in Worcester; and pursue multiple funding approaches. The recommended structure groups all City public health-related functions under one department.

The Task Force envisions the Worcester DPH as a model for an effective urban public health practice that achieves accreditation from the Public Health Accreditation Board.

Finally, the Task Force recommends two key strategies to support and strengthen public health services. Pursuing regionalization – shared services and cooperative arrangements with area towns - should improve effectiveness, maximize resources, expand capacity, and reduce duplication. Partnering with local health care organizations, colleges and universities, community-based agencies and other local groups will give technical and financial assistance to DPH, and will improve the City's ability to offer key public health services to the community.

Introduction

Public health programs have made significant progress since the 19th century. Great strides have been made in combating traditional infectious diseases with the advent of vaccinations, antibiotics, sanitation, and treatment. However, the emergence of viruses such as HIV, West Nile, and H1N1, and drug-resistant tuberculosis and Staphylococcus aureus infections reminds us that the threats from new and old microorganisms are still with us. The speed and reach of global travel and the international food trade now make possible the spread of disease worldwide in a matter of hours or days. Though often taken for granted, efforts to keep our water potable, improve sanitation, and ensure safe food likely contribute more to our good health and longevity than medical care. Daily scientific breakthroughs are teaching us about the contributory impact of individual behavior, genetics, and environmental factors on the current major public health problems - chronic diseases, cancer, injuries, and substance abuse. Health disparities illustrate the powerful health effects of the economic and social conditions under which people live. In the past decade alone, the national tragedies of September 11 and Katrina transformed local public health departments' responsibilities to include responding to and preparing for bioterrorism and natural disasters. These are today's and tomorrow's public health challenges, and they form a backdrop for the Task Force recommendations.

The Task Force offers these recommendations as a way to build, in a phased approach, the capacity and capability of the Worcester DPH to address these challenges. The Task Force recommends an organizational structure that:

- strengthens the Board of Health;
- has talent, skill, and depth in senior management and staff to set policy and priorities and to lead the development of internal capabilities in data collection and analysis and community engagement;
- can convene and lead the larger network of organizations and services that comprise the entire public health system in Worcester;
- can pursue multiple funding approaches;
- groups all City health-related functions under one department; and
- becomes a model for an effective urban public health practice that achieves accreditation from the Public Health Accreditation Board.

One key theme that runs through several of the goals is the elimination of traditional lines and boundaries in the delivery of public health services. The Task Force envisions that DPH can play a more significant role in bridging the traditional organizational "silos" of community partners to better meet Worcester's public health needs; and that DPH can cross municipal borders and pursue shared services with area towns.

As a result of fiscal and time constraints, the Task Force did not conduct a community health assessment. In our opinion, that comprehensive review is a top priority for completion in 2010, and DPH should collaborate with community partners such as Common Pathways in order to build upon assessment work being done. Completion of this comprehensive assessment will enable DPH to better define priorities and work within City government and with the larger community to meet Worcester's public health needs.

This report includes:

- The City Manager's charge to the Task Force
- Brief history and description of the Worcester DPH
- The Task Force methodology
- Framework for Task Force recommendations
- New mission and vision statements for DPH, with guiding principles
- Four goals, each with a brief summary of the findings of the Task Force and recommended priorities
- A recommendation roadmap with timeframes and sequencing of major tasks
- A table of organization that describes the relationships and functions of DPH

Also included are the following resources developed by the Task Force for the City's future use:

- Community partner survey results
- Selected data resources and sample indicators for community health assessment
- Sample health status report
- Comparable communities for further study

DPH is currently a division within the City organizational structure. The Task Force recommends elevating DPH to a departmental level. Therefore, this document refers to DPH as a division in its current state, and as a department in its future state.

City Manager's Charge to the Task Force

The worsening recession of 2009 resulted in deep cuts in local aid and lower local revenue. This led to budget and staff cuts in towns and cities across the Commonwealth including in the City of Worcester in May 2009. The City's Division of Public Health was affected by the cuts and experienced a number of staff layoffs, the termination of some services, and the transfer of others to several City divisions.

Worcester City Manager Michael V. O'Brien treated this fiscal crisis as an opportunity to take a fresh look at public health services in Worcester. In June 2009, Mr. O'Brien convened the Task Force on Public Health. (See Appendix A)

The Task Force was comprised of Co-Chairpersons John G. O'Brien, President and CEO of UMass Memorial Health Care and Dennis Irish, Vice President, Vanguard Health Systems, a five-member executive committee, and a committee of twenty-two individuals with expertise in medicine, research, education, public health, public health nursing, biostatistics, community indicators, non-profit health clinics, pharmacy, substance abuse, youth issues, health disparities, and ADA/disability.

The Task Force's charge was to redefine the mission, vision, and services of a vital and focused Division of Public Health, including:

- reviewing DPH's current and past mission, services, and funding;
- analyzing national best practices;
- recommending an updated mission and vision statement, and a strategic plan;
- considering data and measurement tools to assess effectiveness;
- recommending a new table of organization;
- reviewing the responsibilities of the Board of Health;
- reviewing ways to leverage and integrate the public health and wellness work already being done in the community; and
- identifying budgets, baseline City funding, new funding sources, and partners to take on portions of the mission and operations.

Brief History and Description of the Worcester Division of Public Health

Founded in 1878, the Worcester Division of Public Health is one of the oldest local public health departments in the nation. Over the past 131 years, DPH has continually evolved to meet the pressing health care issues of the day, and has often been at the forefront of public health practice. For example, in 1885, Worcester established the nation's first public health laboratory, reflecting the latest scientific thinking about the source and prevention of disease. In 1972, DPH developed the state's second lead detection and prevention program. Ten years later, it began providing HIV testing, education, and counseling.

Today, the Division of Public Health is comprised of a part-time commissioner and eight staff: a director; a nurse supervisor of communicable disease; two public health nurses; a coordinator of regional public health preparedness, a coordinator of healthcare emergency preparedness; a project administrator; and an administrative assistant.

Established by City ordinance, the current Worcester Board of Health is a four-member body appointed by the City Manager, and serves to advise the Commissioner.

The current functions of DPH include: infectious disease surveillance and reporting; tuberculosis and other communicable disease case management; death certificate review and issuance of burial permits; community immunizations; safe needle sharps disposal ("Operation Yellow Box"); regional and local emergency health preparedness; health promotion (new "Mass in Motion" state initiative); and substance abuse prevention programs (opioid use, underage drinking, and tobacco). DPH staff actively participates in numerous statewide, regional, and local committees, workgroups, task forces, and coalitions that address health disparities, substance abuse, infant mortality, HIV/AIDS, rDNA, chronic disease, and numerous other community health initiatives, e.g., CPR/AED for Worcester Public School students. The Commissioner and Director collaborate with several area colleges and academic health science programs to teach the next generation of public health practitioners.

Additional public health functions required by state statute, local ordinance, and regulation are currently provided by other City departments and divisions. These functions include: emergency medical response; enforcement of housing codes and lead inspections; food protection inspections; air and water quality sampling; other hazard inspections; tanning, body art (tattoo), and camp inspections; and animal control.

Task Force Methodology

The Task Force on Public Health was convened in June 2009, met numerous times as a body over the next few months, and prepared its final report of recommendations in November 2009. (See Appendix B)

Much of the work of the Task Force was conducted by members serving on four subcommittees chaired by Executive Committee members: Mission and Structure; Best Practices; Measures and Metrics; and Community Resources. Additional community members and public health experts served on the subcommittees. (See Appendix C)

While working with their subcommittees, Task Force members reviewed national standards; performed online scans; examined research studies; studied other cities' approaches; met at length with the Worcester DPH Commissioner, DPH Director, and other City staff; and consulted with public health experts and Massachusetts DPH staff. National Association of County and City Health Officials (NACCHO) staff provided the subcommittees with guidance, reports, and a national perspective.

Subcommittees produced several documents. The Community Resources subcommittee summarized a survey it conducted of local health and human service providers on their areas of expertise and their interest in working with DPH. (See Appendix D) The Measures and Metrics subcommittee compiled an extensive list of data resources and as a demonstration, prepared a report on several measures of the health status of Worcester residents using the Massachusetts Community Health Information Profile (MassCHIP) database. (See Appendices E and F) The Best Practices subcommittee compiled a list of comparable cities for further study. (See Appendix G)

Due to the very short time frame, the subcommittees worked simultaneously over several months to develop recommendations on their focus areas. After the Task Force reviewed and commented on each subcommittee's recommendations separately, the full set of recommendations were viewed and vetted as a whole by a Future State Workgroup. The Future State Workgroup was comprised of the chairs and vice chairs of the four subcommittees. The Future State Workgroup examined all the subcommittees' findings and recommendations and reviewed comments received from the full Task Force. After identifying the common threads and key themes of the subcommittees' findings, the Future State Workgroup drafted a set of strategic goals, each with its own integrated set of priorities and recommendations. All recommendations were then further vetted, refined, and approved by the full Task Force.

Framework for Task Force Recommendations

The recommendations presented here are the culmination of this intensive and condensed five month committee process. The goals and priorities recommended by the Task Force map a route towards realizing the City Manager's vision of a vital and focused Division of Public Health as a national model that can carry out its mission to protect and preserve the health of those who live, work, visit, and study in Worcester.

It is the opinion of the Task Force that the City's optimal public health capacity and capability can best be achieved by combining traditional public health services with new approaches and collaborations. Implementing some of these recommendations will require restructuring City services as well as finding new funding sources.

The Task Force recognizes that public health is one of many competing priorities for the City to balance, and notes that even as the Task Force is winding down its work, the most recent revenue forecast for Massachusetts cities remains uncertain. As the City of Worcester may again experience even more fiscal constraints in the coming months and years, the Task Force recognizes that the City must make funding and restructuring decisions about public health within those real financial limitations.

Therefore, the Task Force makes these recommendations to the City Manager in the spirit of a strategic framework to guide future decision-making. This document is the first step in the City's planning and implementation process. The work ahead for the City will involve determining priorities and feasibility, turning priorities into phased action plans, determining budgets and funding sources, and then creating and executing an implementation plan. (See Appendix H)

This will, of necessity, be an incremental approach. These recommendations describe an idealized state and provide a solid foundation upon which government and community interests can work together.

Task Force Recommendations

This report includes proposed new mission and vision statements; guiding principles; four strategic goals, each with a brief summary of findings and recommended priorities; a new Board of Health governance model; and a new organizational structure.

Proposed New Mission Statement

The mission of the Department of Public Health, in collaboration with community and government partners, is to improve and protect the health and safety of those who live, work, visit, and study in Worcester.

Proposed New Vision Statement

To lead an efficient, effective, and equitable public health system that serves as a national model and enables all who live, work, visit, and study in Worcester to be healthy and safe.

Guiding Principles for the Department of Public Health

1. Fulfill all statutory responsibilities, enforce laws, and assure compliance with regulations that protect the public's health and ensure safety.

2. Adopt and integrate the Institute of Medicine's three core public health functions of assessment, policy development, and assurance and the Ten Essentials of Public Health[1] as the framework for a systems approach to carrying out public health's core functions. The Ten Essentials of Public Health are:

    1) *Monitor health status to identify and solve community health problems (e.g., community health profile, vital statistics, and health status).*
    2) *Diagnose and investigate health problems and health hazards in the community (e.g., epidemiologic surveillance systems, laboratory support).*
    3) *Inform, educate, and empower people about health issues (e.g., health promotion and social marketing).*
    4) *Mobilize community partnerships and action to identify and solve health problems (e.g., convening and facilitating community groups to promote health).*
    5) *Develop policies and plans that support individual and community health efforts (e.g., leadership development and health system planning).*
    6) *Enforce laws and regulations that protect health and ensure safety (e.g., enforcement of sanitary codes to ensure safety of environment).*
    7) *Link people to needed personal health services and assure the provision of health care when otherwise unavailable (e.g., services that increase access to health care).*
    8) *Assure competent public and personal health care workforce (e.g., education and training for all public health care providers).*
    9) *Evaluate effectiveness, accessibility, and quality of personal and population-based health services (e.g., continuous evaluation of public health programs).*
    10) *Research for new insights and innovative solutions to health problems (e.g., links with academic institutions and capacity for epidemiologic and economic analyses).*

[1] A consensus list developed by federal health agencies in partnership with major national public health organizations, adopted: Fall 1994 by the Public Health Functions Steering Committee.

3. Recognize that Worcester's public health system should strive to include individuals, community agencies, health care providers, academia, employers and business, faith organizations, the media, *and* government, all working together.

4. Provide leadership to foster collaboration and coordination among the many partners in Worcester's public health system.

5. Promote health equity and the elimination of health disparities by using health assessments to influence policy, advocacy, programs, and assessments.

6. Engage and include the Worcester community in assessing public health needs and resources, setting priorities, planning interventions, and evaluating effectiveness and progress.

7. Base public health policy, practice, priorities, and evaluation on evidence and science; use a population-based approach to determine public health needs and effectiveness of interventions.

Strategic Goals

The Task Force set out four major focus areas as strategic goals. This report does not list in detail all the objectives, tactics, and activities the Department of Public Health might undertake to achieve the goals; rather, it lays out the major priorities and a general direction for the City Manager to consider. The strategic goals are:

1. Improve Organizational Effectiveness

2. Mobilize a Coordinated Community Approach

3. Make Data-Driven and Evidence-Based Decisions

4. Build a Road to Sustainability

Strategic Goal 1 - Improve Organizational Effectiveness

Design a new Department of Public Health (See Appendix I) and strengthen its governance and leadership in order to:

- provide efficient, effective, and equitable public health prevention, protection, and health promotion services;
- advance knowledge of public health practices and transfer that knowledge into innovative and responsive community and public health approaches; and
- build, in an incremental process, a model public health system that achieves accreditation by 2015.

Rationale for Priorities

1. In the current governance, the four-member Worcester Board of Health is advisory only; the commissioner has the sole authority to promulgate regulation. Per City ordinance, the Commissioner of Public Health serves, ex-officio, as the chair of the Board of Health but is not a member of the board and votes only when the board is equally divided. There is no standard public health governance model in the state or the nation. Governance changes can be made at the recommendation of the City Manager and with enactment by the City Council.

2. The Worcester DPH Commissioner position is part time and is currently required to be a physician or hold a master of public health degree. There is no requirement in state law for these credentials; for example, the current Massachusetts DPH Commissioner holds neither degree.

3. In the City's organizational structure, DPH is a division, and currently there is no public health representation on the City Manager's cabinet.

4. The assignment of inspectional services, animal control, and some public health emergency preparedness functions to several different departments in recent years may lead to fragmentation of the public health responsibilities of the City. Bringing these public health functions back under DPH control should provide more public health oversight, enhance communication and cross-functional management, and reduce the risk of adverse public health events.

5. Core and essential functions of public health nursing should be maintained and supported and include triage, referral, and communicable disease prevention, surveillance, investigations, and case management. Given the limited City resources, other traditional public health activities that have historically been provided by nursing may be accomplished in other settings by partnering with community clinicians.

6. There is a need to build a robust health informatics system, including using advanced information technology, and developing data collection, analysis, and reporting capability.

7. Health communication expertise is needed to inform and educate the public. Needed communication services include timely and understandable health education and information;

health promotion; risk communication; and communication of community health status, policy, and program information.

8. More public health resources should be focused on chronic disease and injury prevention, the leading causes of death.

9. The organizational infrastructure, staffing, and processes should support the strategic goals and recommendations of the Task Force.

10. A national accreditation program for public health departments is anticipated to be launched in 2011 by the Public Health Accreditation Board. Achieving accreditation standards will increase quality and improve performance, and may someday be required for certain funding.

Priorities

The following priorities associated with **Improving Organizational Effectiveness** (Strategic Goal 1) are described below.

- Strengthen public health governance
- Reorganize and strengthen public health leadership
- Integrate traditional public health services
- Build capacity to manage new public health functions
- Conduct internal assessment of strengths, determine adequacy of infrastructure, and identify areas for improvement
- Pursue the highest quality of public health performance

1. Strengthen Public Health Governance

a) Change the source of authority for enacting public health regulations from the Commissioner back to the Board of Health.
b) Continue the Board of Health's advisory role to the Commissioner and the City Manager on direction, policy, programs, and evaluation. The Board of Health should adhere to the guiding principles recommended in this report.
c) Expand the number of Board of Health members from the current four members to five members, all to be appointed by the City Manager. Members should reflect the diversity of the community and should possess public health, emergency preparedness, medical, dental, and other relevant expertise and knowledge.
d) Stagger the terms of members, and change the term length from the current three years to four years, with a limit of two consecutive terms.
e) Change the chairperson from the Commissioner to a Board of Health member, to be elected annually by the Board of Health members.
f) Change the Commissioner's role with the Board of Health to be a non-voting but active participant. The Commissioner should work closely and collaboratively with the Board,

should help set agendas, and should actively participate with and attend all Board of Health meetings.

g) Structure the authority of the Board of Health and Commissioner to ensure that the Commissioner can make necessary decisions when the Board of Health cannot convene.
h) Continue the current practice of open Board of Health meetings.

2. Reorganize and Strengthen Public Health Leadership

a) Expand the position of Commissioner to full time, with the Commissioner to be appointed by the City Manager. The City Manager should seek the advice of the Board of Health with this appointment.
b) Elevate the Division of Public Health to a department within the City's organizational structure, and include the Commissioner on the City Manager's cabinet.
c) Revise the Commissioner position by expanding the credentials to a Doctor of Medicine (MD) or other educational degree with demonstrated ability to lead and manage a public health department.
d) Create and staff a Medical Director position if the Commissioner is not a physician.
e) Although the Commissioner would continue to report to the City Manager as his chief advisor on public health matters, revise the Commissioner's position to formally lead the Department of Public Health.
f) Revise the Director position to report directly to the Commissioner and to oversee all the day-to-day public health operations.

3. Integrate Traditional Public Health Services

a) After the Commissioner position is filled and the necessary department structure is in place, transfer inspectional environmental health, public health preparedness, and animal control staff back to DPH in order to group all City health-related functions under one department.
b) Focus the public health nursing role on triage, referral, and disease prevention, surveillance, investigations, and management.
c) Maintain the public health nurse supervisor position.

4. Build Capacity to Manage New Public Health Functions

a) Create new positions and/or partnerships for data surveillance and population data gathering, analysis, and reporting.
b) Create new positions and/or partnerships for health education and other health communication, chronic disease management, and injury prevention.
c) Integrate community partnership management into DPH, as appropriate.

5. Conduct Internal Assessments of Strengths, Determine Adequacy of Infrastructure, and Identify Areas for Improvement

a) Institutionalize internal review, including conducting self assessments using National Association of County and City Health Officials (NACCHO) tools for governance and for local health departments, and evaluating operational efficiency, client satisfaction, and compliance with all regulations and mandates.
b) Build and implement an ongoing methodology for analyzing and improving the organization's structure, staffing levels, staff training, and processes.

6. Pursue the Highest Quality of Public Health Performance

a) Institutionalize the practice of studying comparable local health departments to learn new models of infrastructure, services, and partnerships.
b) Build upon the work of the Task Force and select comparable communities that, at a minimum, include the presence of a medical school, are located at similar latitude, and are of the approximate population size of the Greater Worcester area (up to 500,000). (See Appendix G)
c) Pursue Public Health Accreditation Board accreditation by 2015.

Strategic Goal 2 - Mobilize a Coordinated Community Approach

Lead a connected and effective local public health system by establishing new and strengthening existing collaborative partnerships and creating strategic alliances.

Rationale for Priorities

1. Due to reduction in tax revenue and severe cuts in state aid and local revenue declines, the City of Worcester is limited in its resources to develop and expand public health infrastructure, implement programs, and hire staff over the next few years.

2. In both good and bad economic climates, municipal health departments alone, including the City of Worcester's, cannot and should not be responsible for providing all the services and functions described in the Ten Essentials of Public Health.

3. Worcester has all the major components of public health system infrastructure already in place, with an unusually rich mix of hospitals, health centers, home health services, physician and dental practices, medical and dental societies, behavioral health services, colleges and universities, community-based organizations, community coalitions, faith organizations, businesses, and employers. The area's academic health sciences include the state's medical school, a veterinary school, a pharmacy school, undergraduate and graduate nursing programs, including a community-public health nursing program, a graduate public health program, undergraduate and graduate biomedical and community health programs, and many allied health, dental, and other health programs. However, this large public health system is not coordinated across organizational lines.

4. Many key stakeholder health and community based organizations surveyed by the Task Force are eager to explore partnerships with DPH. This may include providing staff or financial support and technical assistance to DPH, as well as offering key public health services to the community.

5. There is a need for more formal and consistent two-way communication between the Massachusetts DPH and the City DPH to improve coordination for common efforts.

Priorities

The following priorities associated with **Mobilizing a Coordinated Community Approach** (Strategic Goal 2) are described below:

- Leverage the public health system
- Develop and increase community and government partnerships
- Build the future public health workforce

1. Leverage the Public Health System

a) Act as a convener and monitor of the public health system in Worcester, and create and provide the necessary links and bridges among community and government partners.

b) Focus DPH resources on policy-making, education, and communication as part of strengthening the larger public health system.
c) Improve routine and ongoing communication channels with the multiple departments and divisions of the Massachusetts DPH that provide essential services to residents and to Worcester's DPH.

2. Develop and Increase Community and Government Partnerships

a) Institute a formal and comprehensive community partnership survey at least every five years, beginning in 2010, to determine agencies willing and capable of providing clinical and environmental services required by statute or beneficial to the health of the community. (See Appendix D)
b) Recruit, seek out, and contract with partners where appropriate; manage and monitor partnerships.
c) Insure proper organizational accountability and oversights are built into all collaborative agreements.

3. Build the Future Public Health Workforce

a) Strengthen and expand existing collaborations with the area's many academic health science programs.
b) Continue existing and develop new public health learning opportunities for area students in academic health science programs, including internships, field education, service learning, clerkships, practica, research, and volunteer opportunities.

Strategic Goal 3 - Make Data-Driven and Evidence-Based Decisions

Build the capacity and capability to measure, monitor, and report health status and health risk, to identify health priorities, and to evaluate effectiveness.

Rationale for Priorities

1. Worcester is in need of a surveillance system for 24/7 reporting of health problems, hazards, and threats. This is a core function of a local public health system.

2. Data should be used to set measurable organizational and community health goals.

3. DPH has some capability in accessing and using population-based data, but needs to implement systemic and comprehensive data collection, analysis, and reporting.

4. DPH's health planning and evaluation activities using data and evidence-based practices is often grant-driven and so is limited to specific health issues, due to the categorical nature of most grant funding.

5. There is a need to better identify and address Worcester's socioeconomic, racial, ethnic, gender, and other health disparities.

6. Periodic and systemic community health assessments have not been conducted in the City of Worcester.

7. In the future, full deployment of health information technology and electronic medical records in various clinical settings will include networks for electronic health information exchange (HIE) between individuals and providers of care. To fulfill the goal of protecting the public's health, health care providers and public health departments need the capability to exchange pertinent health information about individuals and communities.

Priorities

The following priorities associated with **Making Data-Driven and Evidence-Based Decisions** (Strategic Goal 3) are described below:

- Develop and maintain a 24/7 surveillance system for receiving reports regarding health problems, threats, and hazards

- Collect and maintain reliable, valid, and comparable population health data

- Use insights from the community to inform needs assessment, planning, and evaluation

- Develop ability to analyze and report on the health status of the community

- Use quantitative and qualitative data to inform needs assessment, set priorities, respond to public health threats, and continually evaluate effectiveness

- Utilize advanced information technology

1. Develop and Maintain a 24/7 Surveillance System for Receiving Reports Regarding Health Problems, Threats, and Hazards

a) Continue the work DPH has already started to review and finalize the list of data sources for acute incident reports.
b) Establish protocols, reporting processes, methods for updates, and ongoing communication standards with clinical, community, and other public health system providers who will report surveillance information.
c) Build and maintain connections with Massachusetts DPH and with Common Pathways - the state's Community Health Network Area (CHNA) for the Worcester area - to align surveillance collection and responses.
d) Collaborate with area health information exchange initiatives that monitor acute surveillance items.
e) Continually evaluate and improve the surveillance system to ensure quality and adherence to protocols.

2. Collect and Maintain Reliable, Valid, and Comparable Population Health Data

a) Develop a system for collecting and updating primary and secondary data on population health status and public health issues from multiple sources.
b) Maintain and expand the inventory of free and low cost data resources.
c) Develop competency in Massachusetts Community Health Information Profile (MassCHIP) and other publicly available, free or low cost data sources.
d) Use advanced methods and techniques to collect, interpret, and report health status, such as geographical data analysis.
e) Establish and foster relationships with "owners" of key data sources (local, state, national, including the area's CHNA) and the community to provide more up-to-date information than available in MassCHIP, where needed.
f) Collaborate with area health information exchange initiatives that monitor community health status indicators (e.g. obesity, hypertension, smoking, etc.).

3. Use Insights from the Community to Inform Needs Assessment, Planning, and Evaluation

a) Identify, develop, and implement qualitative methods such as focus groups, interviews, and community forums for gathering information from the community.
b) Work with community stakeholders to identify other sources to inform specific public health policy.

4. Develop Ability to Collect, Analyze, and Report on the Health Status of the Community

a) Establish competence and capacity for analyzing surveillance data, population health status data, and information on evidence-based practices.
b) Evaluate the type of capacity/competence needed to conduct these tasks on an ongoing basis.
c) Collaborate with partners such as Common Pathways to access existing data repositories and reports to support evidence-based decision making for public health priorities.

5. Use Quantitative and Qualitative Data to Inform Needs Assessment, Set Priorities, Respond to Public Health Threats, and Continually Evaluate Effectiveness

a) Conduct a comprehensive community health status survey not less than every five years.
b) Design and develop the first community health status survey in 2010.
c) Analyze all available data to identify baseline health status, health problems, health disparities, and service and data gaps.
d) Collect and report data geographically.
e) Identify critical stakeholders/audience for each type of information.
f) Develop and implement a plan for disseminating information to stakeholders.
g) Through training and other initiatives, develop processes for engaging stakeholders in the use of data for local public health planning.

6. Utilize Advanced Information Technology

a) Assess current and future technology needs and available solutions.
b) Develop a plan to implement an IT system and apply technology in a manner that effectively and consistently meets the needs of the DPH.

Strategic Goal 4 - Build a Road to Sustainability

Expand all sources of funding and pursue regionalization through shared services and cooperative agreements with area towns.

Rationale for Priorities

1. The City's environmental service component is currently in deficit relative to revenue from inspection and licensing fees. Most fees are set locally and can be raised to cover costs; the revenue can be retained in City departments through enterprise accounts.

2. Numerous models exist around the nation for innovative public health department partnerships and strategic alliances with medical schools, hospitals, health systems, and other community organizations. These relationships support and/or provide technical assistance, staffing, and funding to support core services, data collection, analytics, reporting, and more.

3. The Patrick administration is actively promoting regionalization of municipal services as a strategy to stretch scarce dollars, reduce redundancy, broaden capabilities and capacity, and eliminate duplication of services and costs among the 351 cities and towns of Massachusetts.

4. The Massachusetts DPH public health regionalization initiative is encouraging shared services and cooperative arrangements among area towns as a means of improving community health while also reducing costs.

5. Research indicates that the strongest predictor of public health system performance is based on the size of the population serviced. Population size was positively associated with public health system performance for the most essential services for systems serving up to 500,000 residents. Larger public health systems have efficiencies of scale and are better staffed, resulting in better performance and enhanced ability to address community health needs.

6. Nationally, local health departments have a mix of funds to support their operations: On average, 44% are from local government appropriations; 30% from state government; 19% from fees; and 3% from direct federal funding. A large proportion of public health government funding is categorical and is distributed through grants.

Priorities

The following priorities associated with **Building a Road to Sustainability** (Strategic Goal 4) are described below.

- Pursue all fee revenue opportunities to better cover program costs

- Pursue private funding and partnerships to support key services

- Pursue regionalization to improve effectiveness, maximize resources, and reduce duplication

- Pursue grant and other opportunities to support key services

1. Pursue All Fee Revenue Opportunities to Better Cover Program Costs

a) Review, revise, and increase, where appropriate, inspectional and permit fees as permitted by law.
b) Retain inspectional and permit fees in DPH to cover those basic service costs: redeploy saved tax levy dollars to support new functions.
c) Investigate creative ways to increase revenue while supporting and enhancing the public health mission.

2. Pursue Private Funding and Partnerships to Support Key Services

a) Identify, set priorities, and conduct key activities associated with pursuing partnership and private funding opportunities.
b) Initiate discussions with potential partner agencies, health care providers, etc., that may have the capacity to provide either direct funding or in-kind funding for public health activities.
c) Pursue and formalize UMass Medical School's offer to provide assistance with data surveillance, population data, the first health status indicator report, and other foundational data initiatives.
d) Identify potential partner agencies willing to provide/contract for the provision of direct public health services to residents of Worcester.
e) Partner with local academic health science programs to support and supplement public health services as well as to build the future public health workforce.

3. Pursue Regionalization to Improve Effectiveness, Maximize Resources, and Reduce Duplication

a) Explore shared services and cooperative arrangements with area towns.
b) Work with the Massachusetts DPH to explore regionalization opportunities.

4. Pursue Grant and Other Opportunities to Support Key Services

a) Building on the current success of DPH in obtaining grants, conduct key activities associated with pursuing additional grant funding.
b) Pursue grant funding that aligns with the identified priorities of the DPH.
c) Consider funding information technology through capital bonds.

Appendices

A. City Manager's Letter to Task Force Members, June 23, 2009
B. Timeline of Tasks and Meetings
C. Task Force Subcommittees, Future State Workgroup, and Planning Workgroup Members
D. Community Partner Survey Results
E. Selected Data Resources and Sample Indicators for Community Health Assessment
F. Sample Health Status Report
G. Comparable Communities for Further Study
H. Recommendation Roadmap and Proposed Sequencing of Tasks
I. Proposed Table of Organization for Department of Public Health

Appendix A:

City Manager's Letter

to Task Force Members

June 23, 2009

Michael V. O'Brien
City Manager

CITY OF WORCESTER

June 23, 2009

Dear

Thank you for your willingness to serve on the Task Force on Public Health. We are pleased to invite you to our first meeting, to be held on **Tuesday, June 30, 2009 at 8:00 am in the Levi Lincoln Chamber at Worcester City Hall.**

The membership of the Task Force is comprised of two co-chairpersons, an executive committee of five members, and committee membership of twenty-two. The entire Task Force consists of individuals/ professionals from our community with in-depth knowledge, expertise and experience in the fields of medicine, research, education, public health, public health nursing, nursing, biostatistics, biometrics, community indicators, not-for-profit health clinics, pharmacy, substance-abuse care, youth issues, health disparities and ADA/ disabilities focus.

The Task Force's charge is to define the mission and services of a revitalized and refocused Public Health Division. This effort will include, but not be limited to, the following:

I. A substantive review and analysis of the City's Public Health Division mission, services and funding sources over the last decade, to include all use of biometrics and biostatics that defined the highest public health priorities, what resources were then focused to address these identified challenges and what were the outcomes (measurements).
II. A substantive review and analysis of national best practices, current – up to date status, given the broader economic challenges facing every community in the Nation.
III. Determination and recommendation of an updated mission statement, strategic plan and operations that will be focused and consistent with our statutory responsibilities and the greatest public health needs in our community as determined by key indicators (biometrics and biostatistics). This mission statement, strategic plan and operations must be developed with particular care regarding the statutory oversight and reporting responsibilities over hospitals, clinics, health care agencies and others by the City's Public Health Division. It must provide for the clear fire-walls and systems to preserve, protect and enhance these responsibilities.
IV. Per III, an analysis and a recommendation as to the systems and the measurement tools that should be instituted and maintained to track and monitor all City public health efforts and provide the necessary feedback to determine effectiveness and success and to ensure accountability.
V. A complete analysis and recommendation as to the table of organization of the City's Public Health Division, to include number of positions, titles with job descriptions,

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responsibilities and potential pay grades. This table of organization will relate directly to mission statement, strategic plan and operations as defined in III and IV. This would also include the evaluation the current mission, configuration and responsibilities of the Board of Health, with acknowledgement and adherence to state law.

VI. A complete analysis, matrix and recommendation as to systems to ensure that the mission, strategic plan and operations of the City's Public Health Division are leveraging and integrating all the complementary public health and wellness work already conducted in our community. This work is being done day in and day out by our network of hospitals, physicians, community health providers, public schools, colleges and universities, emergency preparedness teams and social service agencies. Accordingly, the relationship with these agencies must be better defined, our efforts must truly be integrated and our progress measured (biometrics) on the highest public health priorities as defined by data (biostatics).

VII. An analysis and a recommendation of proposed, realistic annual budgets that identify and address the issues and scopes as presented in II-VI, identify the partners that could potentially take on portions of this mission statement, strategic plan and operations, as overseen, tracked and monitored by the Public Health Division, identify real funding sources and build sustainability and adaptability into the "ramp up" of our Public Health Division (short term/ long term). This recommendation must also include what the City's baseline funding commitment should be.

Our collective goal is to develop draft recommendations through the months of June – September 2009 and for those recommendations to be completed by September 30, 2009. Please be advised this ad-hoc Task Force is advisory to the City Manager, seeking out the very best in our community to assist in the shaping of public health policy and operations. The Task Force has been asked to host public hearings during this process at the appropriate junctures as determined by the chairpersons.

Enclosed please find the agenda for the June 30th meeting as well as the following background materials for your review:

City Manager's Task Force on Public Health

1) Report to the City Council of June 9, 2009. Details the creation of the Task Force on Public Health and the charge from the City Manager.

2) Task Force on Public Health Membership List.

3) Roles of the Task Force on Public Health Chairpersons, Executive Committee, and Committee (draft).

City of Worcester Division of Public Health Information

4) 2010 Budget for the Division of Public Health, 2010 Budget Impact Statement for the Division of Public Health, and 2009 Budget for the Division of Public Health

5) Division of Public Health 2008 Summary Report. Describes the functions and services of the DPH and includes recent data and statistics.

6) Division of Public Health Organization Chart. Effective 7/1/09.

7) Summary List of Public Health Statutes and Regulations. Defines the City of Worcester division responsible for each regulated function or service.

8) Summary of Division of Public Heath Functions and Services. Depicts services and functions before and after the budget reductions enacted in May 2009.

National Public Health Standards

9) Essential Public Health Services List. A national consensus recommendation of the ten essential public health services for all communities.

10) Operational Definition of a Functional Local Health Department: A publication of the National Association of County and City Health Officials (NACCHO). Defines the roles and responsibilities of a local governmental public health department, framed upon the ten essential public health services.

11) Local Public Health System Performance Assessment Instrument: A publication of the National Public Health Performance Standards Program (NPHPSP). Describes the activities that should be provided by the entire public health system, defined as all the combined resources of public, private, and voluntary entities in any community. We include it here as an educational document that illuminates the many dimensions of a public health system.

It is our hope that working together, we can adopt a community-developed and endorsed plan to revitalize our City's Public Health Division into a national model of focus, prioritization, achievement, accountability, and sustainability to continue their dedicated work protecting and preserving the health of our citizens. Again, thank you for your willingness to serve, and we look forward to seeing you on **Tuesday, June 30, 2009 at 8:00 am at Worcester City Hall**.

Sincerely,

Michael V. O'Brien
City Manager
City of Worcester

John G. O'Brien
President and CEO
UMass Memorial Health Care
Task Force Co-Chair

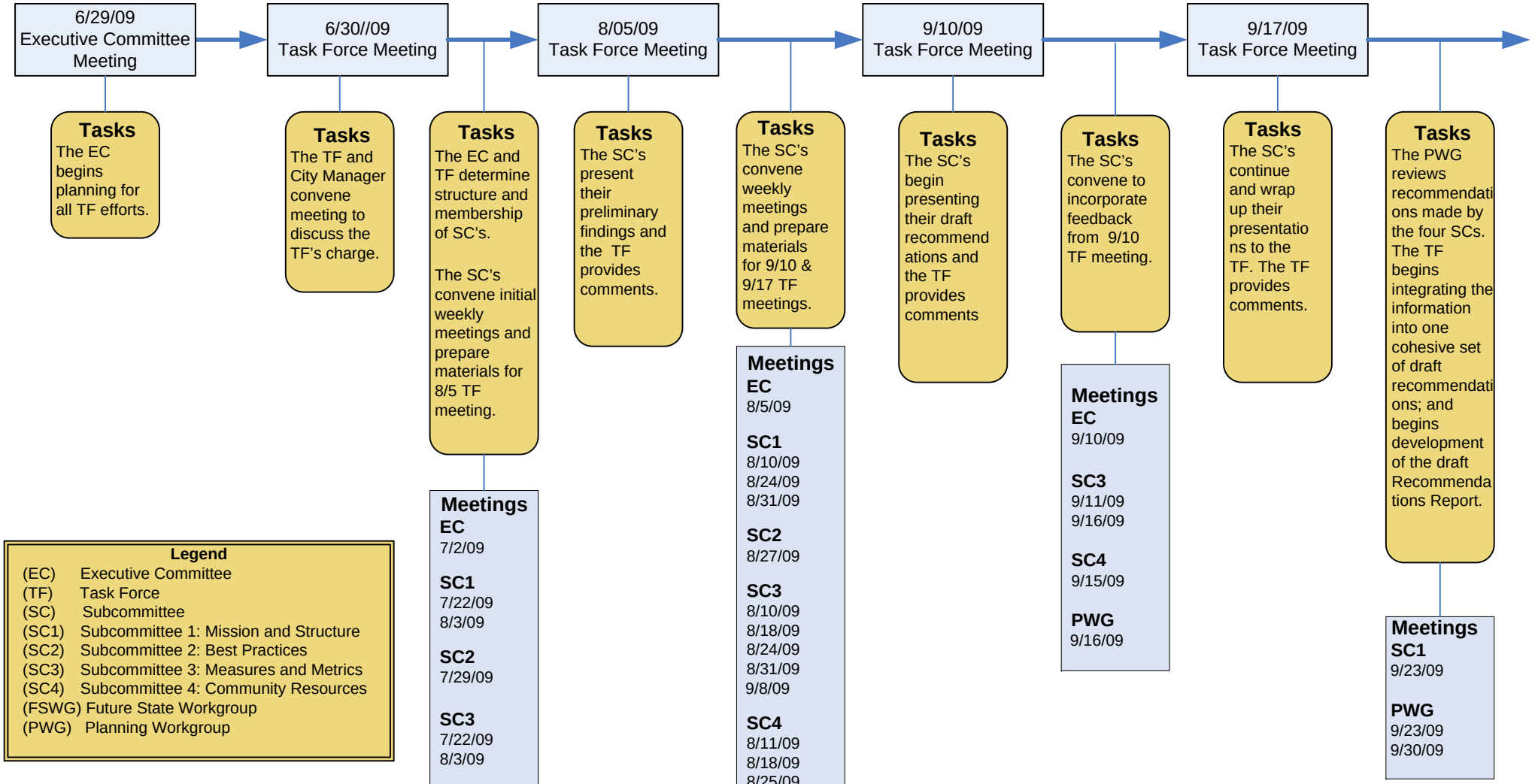
Dennis L. Irish
Vice President
Vanguard Health System
Task Force Co-Chair

Appendix B:

Timeline of Tasks and Meetings

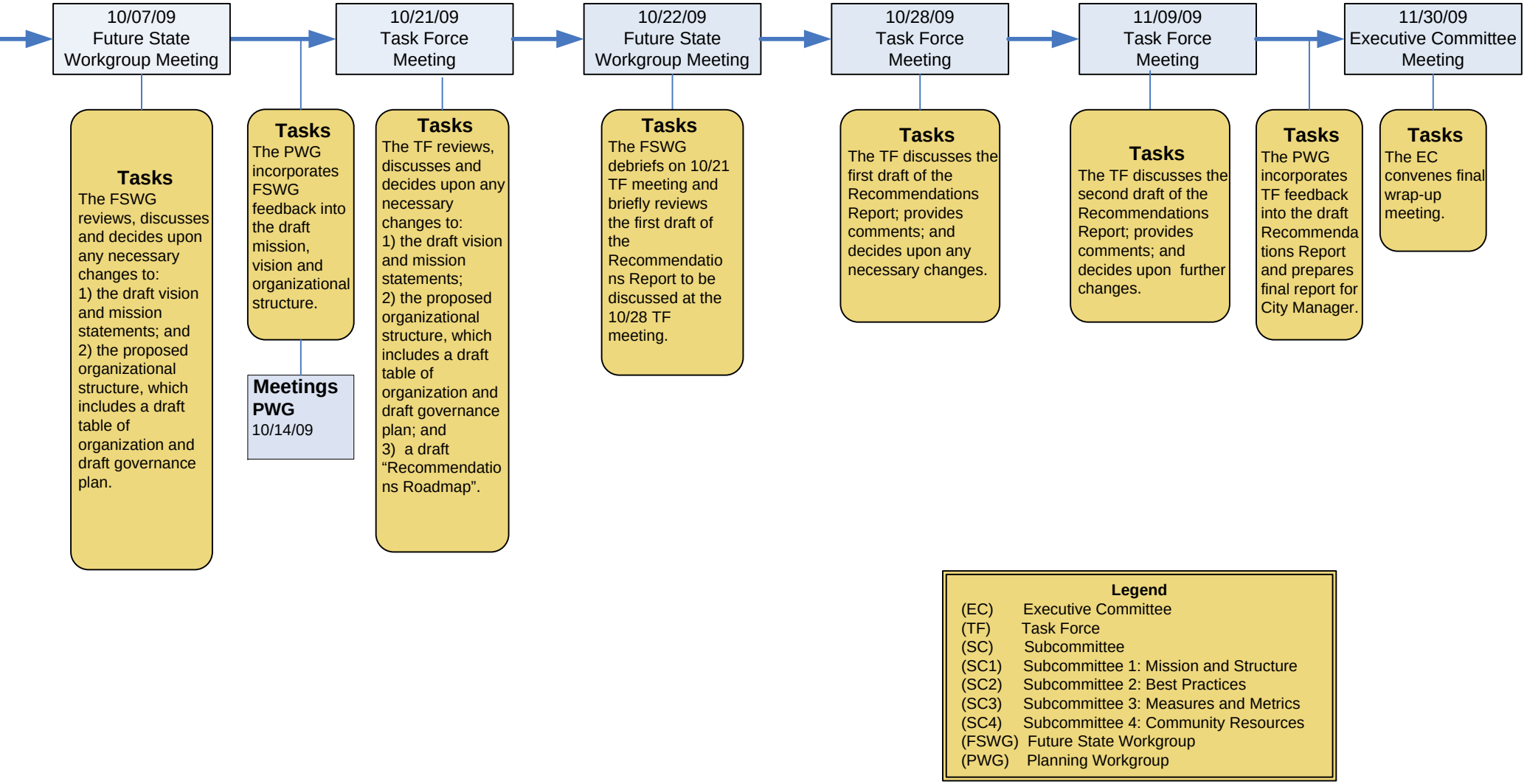
Task Force on Public Health

Timeline of Tasks and Meetings – (Part 1 of 2)



Task Force on Public Health

Timeline of Tasks and Meetings – (Part 2 of 2)



Legend

(EC)	Executive Committee
(TF)	Task Force
(SC)	Subcommittee
(SC1)	Subcommittee 1: Mission and Structure
(SC2)	Subcommittee 2: Best Practices
(SC3)	Subcommittee 3: Measures and Metrics
(SC4)	Subcommittee 4: Community Resources
(FSWG)	Future State Workgroup
(PWG)	Planning Workgroup

Appendix C:

Task Force Subcommittees, Future State Workgroup, and Planning Workgroup Members

Task Force Subcommittees, Future State Workgroup, and Planning Workgroup Members

Subcommittee 1: Mission and Structure

Chair: John Smithhisler	President and CEO, Saint Vincent Hospital
Vice Chair: Steven Ward, MPH, REHS/RS	Director of Public Health, Town of Watertown
Project Manager: Todd Chapman, JD	Senior Program Development Associate, UMass Medical School
Derek Brindisi, MPA, RS	Director, Division of Public Health, City of Worcester
Patricia Bruchmann, MS, RN	Chief, Public Health Nursing, Division of Public Health, City of Worcester
Dawn Clark, PhD	Chair, Commission on Disabilities, City of Worcester
Heidi Deutsch	Program Manager, National Association of County and City Health Officials
Jack Dutzar, MD	President and CEO, Fallon Clinic
Patty Ellis	Vice President, Quality and Patient Safety, Saint Vincent Hospital
Anthony Esposito, MD	Chief of Medicine and Hospital Epidemiologist, Saint Vincent Hospital
Antonia (Toni) G. McGuire, RN, MPH	President and CEO, Great Brook Valley Health Center
Cathy O'Connor	Director, Office of Healthy Communities, Massachusetts Department of Public Health
Susan Olszta	Executive Assistant to the President, Saint Vincent Hospital
Michele Pugnaire, MD	Senior Associate Dean for Education Affairs, UMass Medical School
Katherine Shocas	Director of Special Projects, UMass Memorial Health Care
Amanda Wilson	Director of Housing and Health Inspections, Department of Inspectional Services, City of Worcester

Subcommittee 2: Best Practices

Chair: Jan Yost, EdD	President and CEO, The Health Foundation of Central Massachusetts
Vice Chair: Suzanne Cashman, ScD	Professor and Director of Community Health, Department of Family Medicine and Community Health, UMass Medical School
Project Manager: Todd Chapman, JD	Senior Program Development Associate, UMass Medical School
William Bartosch, PhD	School of Public Health and Health Sciences, University of Massachusetts Amherst
Derek Brindisi, MPA, RS	Director, Division of Public Health, City of Worcester
Stephanie Chalupka, EdD, RN, PHNCNS-BC	Professor and Coordinator, Master of Science in Community/Public Health Nursing Program, Worcester State College
Heidi Deutsch	Program Manager, National Association of County and City Health Officials
Octavio Diaz, MD, MPH	Chief Medical Officer, Saint Vincent Hospital
Sheilah Dooley, RN, BSN, MS	Executive Director, Pernet Family Health Service
Robin Klar, DNSc, RN	Assistant Professor of Nursing, Graduate School of Nursing, University of Massachusetts Worcester
Antonia (Toni) G. McGuire, RN, MPH	President and CEO, Great Brook Valley Health Center
Clara Savage, EdD	Director, Common Pathways
Geoff Wilkinson	Senior Policy Advisor, Massachusetts Department of Public Health

Subcommittee #3 – Measures and Metrics

Chair: Michael F. Collins, MD, FACP	Senior Vice President for the Health Sciences, University of Massachusetts, and Chancellor, UMass Medical School
Vice Chair: Abigail Averbach, MS	Director, Commonwealth Medicine Office of Massachusetts Client Relations, UMass Medical School; Member, Worcester Board of Health
Project Manager: Sharon Pigeon, MSW	Senior Project Director, UMass Medical School
Derek Brindisi, MPA, RS	Director, Division of Public Health, City of Worcester
Saul Franklin, MS	MassCHIP Director, Massachusetts Department of Public Health
Larry Garber, MD	Medical Director, Informatics, Ambulatory Multi-Specialty Medical Group, Fallon Clinic
Erik Garcia, MD	Director, Homeless Outreach and Advocacy Project, Community Healthlink
Catarina Kiefe, PhD, MD	Chair, Department of Quantitative Health Sciences, UMass Medical School
James Leary	Associate Vice Chancellor for Community Affairs, UMass Medical School
Cheryl Lapriore	Chief of Staff, UMass Memorial Health Care
Dale Magee, MD, MS	Assistant Professor of Clinical OB-GYN, UMass Medical School
Jenelle Angela Quill	Intern, UMass Memorial Medical Center
Susan Shepherd, RN, BSN, MPH	3rd yr PhD Nursing, Graduate School of Nursing, University of Massachusetts Worcester

Subcommittee #4 – Community Resources

Chair: Carlson Watson, MSW	President and CEO, Henry Lee Willis Community Center
Vice Chair: Leonard Morse, MD	Commissioner of Public Health, City of Worcester
Project Manager: Susan Hartshorn	Project Manager, Office of Program Development, UMass Medical School
Fran Anthes, MSW	President and CEO, Family Health Center
Derek Brindisi, MPA, RS	Director, Division of Public Health, City of Worcester
Maritza Cruz	Community Consultant
Karen Green, BSN, MA	President and CEO, VNA Care Network and Hospice
Lois Green	Trustee of the Hoche-Scofield Foundation
David Hillis, FACHE, FACATA	President and CEO, AdCare Hospital
Michael Hirsh, MD	Division Chief of Pediatric Surgery and Trauma, UMass Memorial Health Care
Sara Kanevsky	Greater Worcester Organizer, Massachusetts Public Health Association
Gary Lapidas	Senior Vice President, UMass Memorial Health Care
Charles F. Monahan, Jr.	President, Massachusetts College of Pharmacy and Health Sciences
(Represented by Deborah O'Malley, JD)	Executive Director, Massachusetts College of Pharmacy and Health Sciences
William O'Connell, MA, LCSW	Regional Director, Massachusetts Department of Public Health
Laurie Ross, PhD	Professor, Clark University

Future State Workgroup

Co-Chair: Dennis Irish	Vice President, Marketing, Government and Community Relations, Vanguard Health Systems New England & Chicago Market
Co-Chair: John O'Brien	President and CEO, UMass Memorial Health Care
Project Manager: Pamela MacLeod	Senior Program Development Associate, UMass Medical School
Abigail Averbach, MS	Vice Chair, Measures and Metrics Subcommittee
Suzanne Cashman, ScD	Vice Chair, Best Practices Subcommittee
Michael Collins, MD, FACP	Chair, Measures and Metrics Subcommittee
Leonard Morse, MD	Vice Chair, Community Resources Subcommittee
John Smithhisler	Chair, Mission and Structure Subcommittee
Steven Ward, MPH, REHS/RS	Vice Chair, Mission and Structure Subcommittee
Carlton Watson, MSW	Chair, Community Resources Subcommittee
Jan Yost, EdD	Chair, Best Practices Subcommittee

Planning Workgroup

Project Manager: Pamela MacLeod	Senior Program Development Associate, UMass Medical School
Derek Brindisi, MPA, RS	Director, Division of Public Health, City of Worcester
Todd Chapman, JD	Senior Program Development Associate, UMass Medical School
Louise Eichman	Executive Director, Office of Program Development, UMass Medical School
Michael Gilleberto	Director of Operations, City of Worcester
Susan Hartshorn	Project Manager, Office of Program Development, UMass Medical School
Gary Lapidas	Senior Vice President, UMass Memorial Health Care
Cheryl Lapriore	Chief of Staff, UMass Memorial Health Care
Sharon Pigeon, MSW	Senior Project Director, Office of Program Development, UMass Medical School
Katherine Shocas	Director of Special Projects, UMass Memorial Health Care

Appendix D:

Community Partner

Survey Results

Appendix D: Informal Community Partnership Survey Results
August 2009

	Communicable Disease	Chronic Disease	Environmental Health	Substance Abuse Prevention	Public Health Preparedness	Injury Prevention	Education Promotion	Maternal Child Health	Administrative	Known Gaps	Current DPH Partnering	Desire to Partner	Data
AdCare Hospital, David Hillis;				Provide inpatient and outpatient substance abuse treatment and education and prevention programs			Substance abuse education and prevention programs				Opioid Overdose Prevention coalition Regulatory Reporting	**Yes**	
Center for Living & Working, Inc.; Mike Kennedy; mkennedy@Center LW.org					Emergency Preparedness information & referral					Slow response times in many service areas due to the job cuts the whole city has endured		**Yes**	
Central MA AHEC, Joanne Calista							Provides career focused college supported education for community health professionals including medical interpreters and Community Health Workers					**Yes**	
Central MA Center for Health Communities; E. Vicente Sanabria; VSanabria@luk.org									Provide technical assistance in the areas of program planning, evaluation, community and school assessments, cultural competency, sustainability, science-based program design, leadership development, coalition development, capacity building, strategic planning, social justice and addressing the social determinants of health	Lack of community resident participation in many of the "tables" struggling to address the issues that impact residents most - particularly the immigrant population. The issues are the ones integral to the social determinants of health equity	Worcester Cares and the Partnership for Health Disparities	**Yes**	
Child Development Head Start Program-Worcester Public Schools; Rosemarie Condito-Franchi							Preschool program for at risk children and families; social service support and referrals, family involvement activities; adult education programs, ABE, GED and ESOL on site; health services and screenings, special needs services and nutritional services that includes breakfast, lunch and snacks daily and oral health.				Smoking cessation programs and other health related activities that impact the well being of children and families in Worcester	**Yes**	
Community Healthlink, Inc., Leah Bradley; lbradley@communityhealthlink.org	TB testing to all clients in inpatient and residential programs	Medical clinic for homeless adults; includes managing diabetes, HIV, hepatitis C and additions. Provides disease management in DMG residential programs.		Comprehensive continuum of programs that address the needs of persons with addiction disorders. Part of this treatment is to prevent future use for the individuals and provide prevention education to family members.			Through counseling in the various treatment programs			Undocumented individuals and those who continue to be uninsured or under insured tend not to receive the preventive care or disease management care needed.	CHL is currently an active participant in the WDPPH's grant to reduce the number of Opioid fatalities in Worcester.	**Yes**	
Community Women's Care (UMMHC), Cathy Violette; Cathy.Violette@umassmemorial.org		High risk pregnancy care for women w/ Diabetes, Cardiac disease		Collaborative management of substance abuse in pregnancy				Low & high risk pregnancy care; adolescent pregnancy care; Worc Infant Mortality Task Force				**Yes**	

August 2009

	Communicable Disease	Chronic Disease	Environmental Health	Substance Abuse Prevention	Public Health Preparedness	Injury Prevention	Education Promotion	Maternal Child Health	Administrative	Known Gaps	Current DPH Partnering	Desire to Partner	Data
Fallon Clinic, Jack Dutzare, MD jack.dutzar@fallonclinic.org	Screening and testing	Specialty programs focused on diabetes, COPD, and HIV using electronic registries		Through peds and adult medicine visits	H1N1 preparations	Anticipatory guidance (esp peds)	Nutrition section; health promotion activities	Practitioner visits		Pediatric behavioral health; Counseling and assistance to patients who need help accessing publicly subsidized health care services; Transportation, especially for seniors	Potentially	**Yes**	Data not organized by municipality or population
Family Advocates of Central MA, Valerie Zolezzi-Wyndham			FACM is a medical-legal partnership formed by UMMS and Legal Assistance Corp of Central MA to provide legal assistance to low-income families including bad apartment conditions such as mold or insects which both cause and aggravate asthma and other breathing problems.				Provides trainings to medical providers and certain group of people about its program and the availability of free legal services.			Would like to see improved integration of services provided by different Worcester agencies.		Eager to partner with DPH around initiatives aimed at fighting health disparities and chronic illness	
Family Health Center of Worcester, Inc; Fran Anthes	Testing and treatment	Care Coordination program	Lead testing	Treatment programs	Yes	Yes	Yes	Yes			Emergency Prep; Yellow Boxes; TB Clinic; Common Pathways; Mass in Motion; City Mgr's HIV Task Force	**Yes**	Patient data; Census, MDPH, and other assessment data
Girls Inc. of Worcester, Anne Sadick		Fighting obesity through the Fit Girls/Sporting Chance programs		Friendly PEERsuasion programs substance abuse prevention program		Girls Promoting Safety program					Smoking cessation programs and other health related activities that impact the well being of children and families in Worcester	**Yes**	
Great Brook Valley Health Center, Toni McGuire; toni_mcguire@GREATBROOK.ORG	Extensive HIV/AIDS counseling & testing	Full primary care, family practice model		Grant funded youth programs		As part of primary care visits	Four school based health centers	Healthy Start Program; promote early entry to prenatal care; engage in community based education; Worcester Infant Mortality Task Force; education to providers		Disconnect between state DPH and local service delivery. Need more engagement around local emergency prep; local response to outbreaks, local response to environmental emergency; we could use a local resource that provided us with data to better meet the needs of this community		**Yes**	GEO mapping
Guild of St. Agnes, Sharon Woodbury, swood16@aol.com							Second largest childcare facility in MA with over 1200 children. Would like to be more involved with educating their teacher population and providing mental health resources for their clients.					Definitely would like to enter some form of partnership with WDPH	

August 2009

	Communicable Disease	Chronic Disease	Environmental Health	Substance Abuse Prevention	Public Health Preparedness	Injury Prevention	Education Promotion	Maternal Child Health	Administrative	Known Gaps	Current DPH Partnering	Desire to Partner	Data
HOPE Coalition, Laurie Ross			Working with the City to change the signage ordinance around alcohol and tobacco. Working to limit the number of tobacco permits issued in the City	Underage drinking prevention social marketing campaign aimed at middle school aged youth.							Signage ordinance and underage drinking prevention social marketing campaign aimed at middle school aged youth	**Yes**	
MA DPH-BSAS, Ray Kosincki ray.kosincki@state.ma.us				Prevention, intervention, treatment							BSAS currently funds two PH grants		
MCPHS Pharmacy Outreach Program; Mary Sullivan						Medication safety presentation given at senior centers and community outlets, focused on preventing medication errors. Targeted presentations on medication related fall prevention.	Operates MassMedLink to Health, a toll free info line with recorded educational information on specific disease states and treatments (English and Spanish)			Medication reconciliation upon discharge from the hospital is a universal medication related issue affecting all residents.		**Yes**	
MCPHS, Health Services, Edith Claros							As part of educational opportunities in the Nursing program students are required to participate in community based patient care. These opportunities include participation in free clinics, flu shot clinics, health fairs and blood pressure and asthma screenings.					**Yes**	
MCPHS School of Pharmacy, Michael Malloy							Faculty and students provide brown bag lunch programs, health fairs and other informational sessions when students are on their clinical rotations. Some student groups also sponsor some of these events.					**Yes**	
Rape Crisis Center of Central MA, Kim Dawkins							Sexual Assault Your Education (SAYE) program; Rape Prevention Education (RPE) to community and educational facilities.					**Yes**	
Regional Center for Poison Control and Prevention, Colleen Longfellow; colleen.longfellow@childrens.harvard.edu						Assistance and expertise in the medical diagnosis, management and prevention of poisonings	Poison prevention education and outreach; would be very interested in collaborating to do outreach around injury prevention, poison prevention and medication safety					**Yes**	

August 2009

	Communicable Disease	Chronic Disease	Environmental Health	Substance Abuse Prevention	Public Health Preparedness	Injury Prevention	Education Promotion	Maternal Child Health	Administrative	Known Gaps	Current DPH Partnering	Desire to Partner	Data
The Willis Center; Keesha LaTulippe							Provides advocacy for multiple health issues, many that include community education with both services recipients (primarily focused on behavior change both individually and organized) and with service providers (primarily focused on increasing access to marginalized populations and community engagement)			Access to existing services for the poor and especially people of color. Insufficient cultural proficiency.	Currently partnering on the Worcester Partnership for Racial and Ethnic Health Disparities and the Worcester Opioid Overdose Prevention Coalition.	**Yes**	
UMMHC, Gary Lapidas; gary.lapidas@umassmemorial.org	As part of hospital and physician services	As part of hospital and physician services		As part of hospital and physician services	As part of hospital and physician services	Community based and grant funded		As part of hospital and physician services				**Yes**	Medical record data; could share blinded data within HIPPA regulations
UMMS, Suzanne Cashman; suzanne.cashman@umassmed.edu	Through med school and residency training programs	Through med school and residency training programs		Through med school and residency training programs	Through med school and residency training programs	Through med school and residency training programs	Through med school and residency training programs	Through med school and residency training programs				**Yes**	Students collect data in conjunction with research and service projects
VNA Care Network, Janet Bovaird	Immunization for elders; flu clinics; home hospice care	Home hospice care		Tobacco cessation programs			Cultural diversity education	Home health services				**Yes**	
Willis Center, **Substance Recovery Services,** Jesse Mellor				Services for substance abuse treatment > 18 yrs			HIV/AIDS education; TB & hepatitis education					**Yes**	
												Yes	

Appendix E:

Selected Data Resources and

Sample Indicators for

Community Health Assessment

Appendix E: Selected Data Resources and Sample Indicators for Community Health Assessment

Sample Health Status Reports

1. **MassCHIP** (MA Department of Public Health) Public access, interactive website with standard reports at the state, community and regional level http://masschip.state.ma.us/

2. **Health of Boston** (City of Boston, MA) www.bphc.org/hob

3. **Worcester Indicators Report 2008** (Compiled by Common Pathways) http://www.commonpathways.org/CMS/images/8-05-08Common%20Pathways%20rerevised%20Indicators.pdf

4. **Healthy Brookline Health Status Indicators Brookline Department of Public Health** http://www.brooklinema.gov/index.php?option=com_docman&task=cat_view&gid=315&Itemid=463

Data Resources (Local, State)

5. **Publications and statistics from Massachusetts Department of Public Health** http://www.mass.gov/dph/pubstats.htm

6. **Profile of Drug Indicators in Massachusetts** (Types of offenses, treatment admissions, arrest data, etc.) http://www.whitehousedrugpolicy.gov/statelocal/ma/ma.pdf

7. **Massachusetts Department of Education** School and District Profile (enrollment, expenditures, test results, dropout rate, post graduation plans) http://profiles.doe.mass.edu/

8. **Massachusetts Department of Employment and Training** http://massstats.detma.org/websaras/index.asp

9. **Massachusetts Geographic Information System (map tool)** http://www.mass.gov/mgis/

10. **Central Massachusetts Regional Planning Commission** http://www.cmrpc.org/

11. **Worcester Regional Research Bureau** http://www.wrrb.org/

12. **New York Guidance on Community Health Assessment**
    http://www.nyhealth.gov/statistics/chac/nysguidance.htm

13. **Access to Resources for Community Health** Links to a multitude of health data and health information websites arranged by topic http://www2.massgeneral.org/library/arch/arch.asp

14. **Commonwealth Communities** Community profiles, public school information, legislators, municipal finance, etc.
    http://www.mass.gov/portal/index.jsp?pageID=mg2terminal&L=3&L0=Home&L1=State%20Government&L2=Local%20Government&sid=massgov2&b=terminalcontent&f=cc_landing&csid=massgov2

15. **Massachusetts Institute for Social and Economic Research (MISER)**
    http://www.umass.edu/miser/population/index.html

16. **Division of Health Care Finance & Policy**
    http://www.mass.gov/?pageID=eohhs2subtopic&L=5&L0=Home&L1=Researcher&L2=Physical+Health+and+Treatment&L3=Health+Care+Delivery+System&L4=DHCFP+Data+Resources&sid=Eeohhs2

National Data Resources:

17. **CDC National Youth Risk Behavior Survey Data**
    www.cdc.gov/healthyyouth/yrbs/index.htm

18. **Community Health Status Indicator Project web site**
    http://communityhealth.hhs.gov/HomePage.aspx

19. **NACCHO Mobilizing for Action through Planning and Partnerships**
    http://www.naccho.org/topics/infrastructure/MAPP/index.cfm

20. **FedStats for Worcester:** http://www.fedstats.gov/qf/states/25/2582000.html

21. **DataPlace** http://www.dataplace.org

22. **Census 2000 Demographic Profiles** http://censtats.census.gov/pub/Profiles.shtml

23. **Child Trends Data Bank (Child, Family and Community characteristics)**
    http://www.childtrendsdatabank.org

24. Youth Risk Behavior Surveillance System (YRBSS)
http://www.cdc.gov/HealthyYouth/yrbs/index.htm

25. National Center for Health Statistics/CDC - http://www.cdc.gov/nchs/index.htm

26. State Health Facts (Kaiser Permanente) - http://statehealthfacts.org/

27. Faststats (CDC) - http://www.cdc.gov/nchs/FASTATS/default.htm

28. Healthy People 2010/2020 http://www.bphc.org/about/research/hob/Pages/Home.aspx

Other Resources

29. UMass Medical School library, Public Health Resources - http://nnlm.gov/ner/publichealth/

30. NACCHO self-assessment for local boards of health and local health departments and the Operational Definition of a Functional Local Health Department - www.naccho.org

31. Public Health Informatics Institute web site - Business Process Analysis - www.phii.org

32. Suggested Contacts from Local and County Health Departments

- Syracuse Health Department, Part of Onondaga County Health Department, Commissioner Cynthia Morrow, 315-435-3252
- City of Newton Director of Health and Human Services, David Naparstek (dnaparstek@newtonma.gov)
- Town of Brookline Director of Health, Alan Balsam (617) 730-2300
- Town of Watertown Director of Health, Steven Ward (617) 972-6446

33. Public Health Foundation http://www.phf.org/about/links.htm

34. National Public Health Performance Standards Program (NPHPSP) http://www.nphpsp-results.org/ContentPage.aspx?Page=Welcome and http://www.cdc.gov/od/ocphp/nphpsp/

35. From Silos to Systems http://www.phf.org/pmqi/silossystems.pdf

36. Public Health Accreditation Board http://www.exploringaccreditation.org/

37. Proposed Local Standards and Measures
http://www.exploringaccreditation.org/assets/documents/PHABLocalJuly2009-finaleditforbeta.pdf

38. Biosense http://www.cdc.gov/biosense/publichealth.htm#biosense

39. Epi INFO http://www.cdc.gov/epiinfo/

40. Best Strategies Evaluated for Building Ties Between Public Health Schools and Public Health Departments http://www.rwjf.org/reports/grr/050889.htm

41. Preparing for the Flu: A Communication Toolkit for Institutions of Higher Education http://www.flu.gov/plan/school/higheredtoolkit.html

Sample List of Community Health Status Indicators

Indicator
Health status
Perinatal and Child Health
Mortality
Infectious Disease and Other Reportable Conditions
Injury and Violence
Chronic Disease (Cancer, Diabetes, etc.)
Substance Abuse
Hospital Discharges
Health Risk Behaviors
Mental Health
Disability and Functional Status
Access to Health Care
Health Care Coverage
Health Care Expenditures
Emergency Preparedness
Environmental Health
Occupational Health
Determinants of Health
Demographics
Socioeconomics
Education
Housing
Community Assets
Potential Focal Areas:
Adolescent Health
Racial and Ethnic Disparities
Disability
Senior Health
Program Evaluation Data (Process and Outcomes)
Tobacco Control
Opioid Overdose and Underage Drinking Prevention
Immunization
Infant Mortality Reduction Task Force
Racial and Ethnic Disparities
Mass in Motion
Metropolitan Medical Response System (transferred to Dept of Emergency Comm.)
Health and Wellness Screening (program has been discontinued until further notice)
Inspectional services: Body Art, Food Protection, Water Quality, Lead Poisoning, Housing, Air Quality, Animal Control

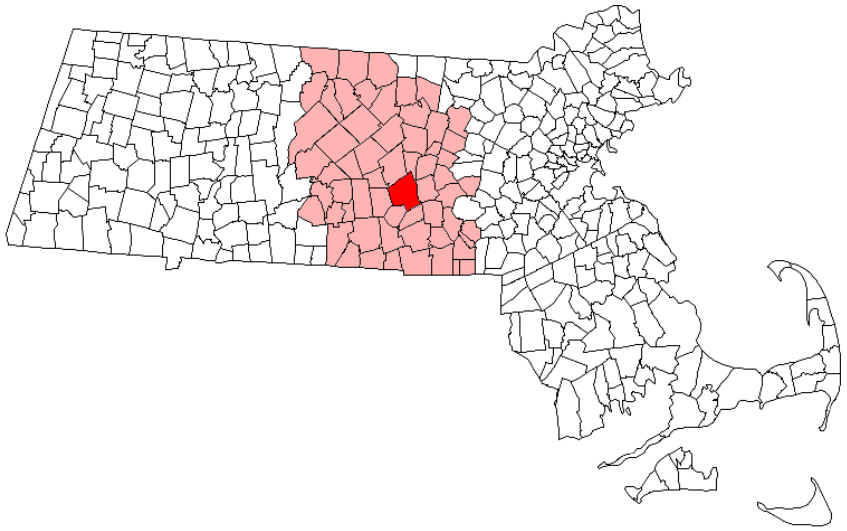
Appendix F:

Sample Health Status Report

WORCESTER HEALTH STATUS REPORT

Worcester Massachusetts 2009

For demonstration purposes only. Data not verified.



Worcester Public Health – Measures and Metrics

Please refer to MassCHIP for Data and to the CHSI Data Sources, Definitions, and Notes for additional sources, methods, and calculations.

Report replicated using Community Health Status Indictors.

DEMOGRAPHIC INFORMATION

WORCESTER, MA

Population size[1]	175,454
Population density (people per square mile)[1]	4,597
Population living below 100% of poverty level	17.9%
Population living below 200% of poverty level	36.2%
Age distribution	
Ages 18-34	35.9%
Ages 35-44	21.2%
Ages 45-54	16.2%
Ages 55-64	10.5%
Ages 65+	16.1%
Race/Ethnicity[1]	
White	77.1%
Black	6.9%
American Indian/Alaskan Native	0.5%
Asian	4.9%
Native Hawaiian/other Pacific Islander	0.1%
Hispanic/Latino origin	15.1%

[1]U.S. Census Bureau

PUBLIC HEALTH IN WORCESTER

VISION
Healthy People in Healthy Communities

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

PUBLIC HEALTH

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

ESSENTIAL PUBLIC HEALTH SERVICES

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

Source: Public Health Functions Steering Committee, Fall 1994.

LEADING CAUSES OF DEATH

WORCESTER, MA

Area 3 year count

	White	Black	Asian/PI	Hispanic
Ages 15-24				
Motor Vehicle Injuries	6	1	1	3
Cancer	1	0	0	2
Homicide	3	3	0	6
Suicide	1	0	0	1
Ages 25-44				
Motor Vehicle Injuries	7	1	0	2
Cancer	17	1	1	5
Heart Disease	19	5	1	1
Suicide	19	1	0	4
HIV/AIDS	3	0	0	11
Homicide	NA	NA	NA	NA
Ages 45-64				
Cancer	220	13	4	24
Heart Disease	145	13	0	12
Diabetes Mellitus	22	2	0	0
Liver Disease	29	1	1	5
Stroke	8	1	0	2
Ages 65+				
Cancer	784	12	4	16
Heart Disease	969	21	5	26
Diabetes Mellitus	83	1	0	9
Stroke	219	8	4	10
Pneumonia/Influenza	172	3	0	4
COPD	220	3	0	0

VULNERABLE POPULATIONS

WORCESTER, MA

Vulnerable populations may face unique health risks and barriers to care, requiring enhanced and targeted strategies for outreach and case management.

Vulnerable Populations Include People Who:

Have no high school diploma	25,387
Are unemployed	4,958
With disability, help needed	305
With disability, no help needed	305
Heavy drinking (within last month)	1,267

ENVIRONMENTAL HEALTH

WORCESTER, MA

INFECTIOUS DISEASES

Cases	Reported	Expected
E. coli	NA	NA
Salmonella	NA	NA
Shigella	NA	NA

TOXIC CHEMICALS RELEASED ANNUALLY[2]: (Worcester County) 399,594 pounds

NATIONAL AIR QUALITY STANDARD MET BY CITY[3]

Carbon Monoxide	Nitrogen Dioxide	Sulfur Dioxide	Ozone	Particulate Matter	Lead
Yes	Yes	Yes	Yes	Yes	Yes

[2]EPA. Toxic Release Inventory (TRI) Explorer Report, 2007.
[3]EPA. AIRSDATA, 2006.

CONFIDENCE INTERVALS

SUMMARY MEASURES OF HEALTH

	Value	95% Confidence Interval
ALL CAUSES OF DEATH	824.5	(801.7 – 847.3)
FAIR OR POOR HEALTH	15.8%	(14.3 – 17.2%)
15+ DAYS OF POOR PHYSICAL HEALTH IN THE PAST 30 DAYS	11.1%	(9.8 -12.4)
15+ DAYS OF POOR MENTAL HEALTH IN THE PAST 30 DAYS	12%	(10.5-13.5)

ADULT PREVENTIVE SERVICES USE (%)

	Value	95% Confidence Interval
Pap Smears (18+)	83.5%	(80.6 – 86.45)
Mammography (18+)	66.4%	(63.5 – 69.4)
Sigmoidoscopy (45+)	41.3%	(32.7 – 49.9)
Pneumonia vaccine (65+)	71.2%	NA
Flu vaccine (65+)	72.2%	(68.5 – 75.9)
HIV testing (18+)	47%	(44.6 49.4)

RISK FACTORS FOR PREMATURE DEATH

	Value	95% Confidence Interval
Not meeting moderate activity exercise recommendations	54.9%	NA
Obesity	22.9%	(21.2 – 24.6)
High Blood Pressure	25.2%	(22.8 – 27.6)
Smoker	23.4%	(21.6 – 25.1)
Diabetes	19.3%	(16.1 – 23.5)
Binge Drinking	18.4%	(16.7 – 20.2)

MEASURES OF BIRTH AND DEATH

Worcester, MA

Birth Measures	Area Count	Area Percent	State Percent
Low Birth Weight (less than 2500 grams)	232	9.1	7.9
Very Low Birth Wt. (less than 1500 g)	NA	NA	NA
Prematurity (less than 37 weeks gestation)	228	8.9	9.0
Births to Women under 18	93	3.6	2.0
Births to Women over 40	NA	NA	NA
Births to Unmarried Women	NA	NA	NA
No prenatal care in first trimester	531	20.8	18.0

Infant Mortality	Area Count	Area IM Rate	State IM Rate
Infant Mortality	21	8.2	4.9
White non-Hispanic	8	5.3	3.9
Black non-Hispanic	4	NA	10.2
Hispanic	9	NA	7.5
Neonatal Infant Mortality (<28 days)	14	5.5	3.4
Post-neonatal Infant Mortality (28-364 days)	7	2.7	1.5

*Area and State Infant Mortality Rates are expressed per 1,000 live births.

Injury Indicators	Area Count	Area Crude Rate	State Crude Rate
Motor vehicle related injury deaths	12	6.7	6.8
Suicide	16	8.9	7.8
Homicide	6	3.3	2.8

Chronic Disease Indicators	Area Count	Area Age-adjusted Rate	State Age-adjusted Rate
Total deaths (all causes)	1,710	823.2	699.7
Total cancer deaths	356	185.3	178.9
Lung cancer deaths	102	56.6	50.8
Breast cancer deaths	25	21.5	20.1
Cardiovascular disease deaths	515	237.8	214.4

*Age-adjusted rates are expressed per 100,000 persons.

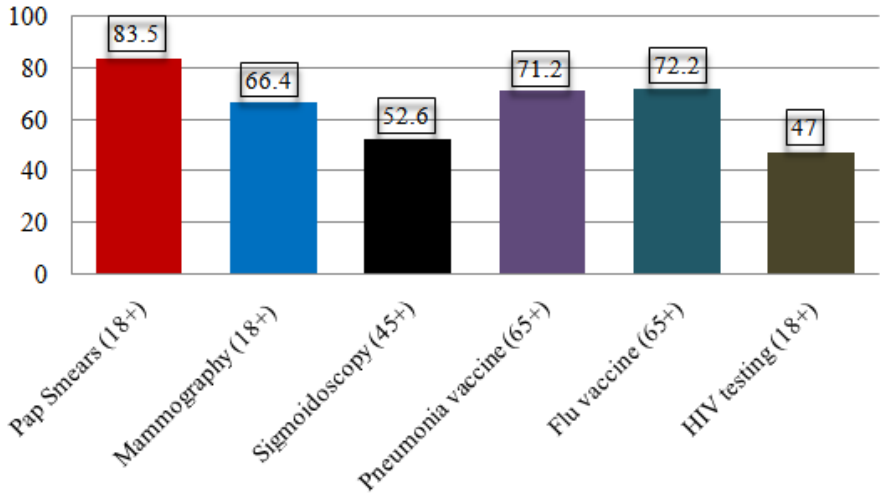
PREVENTIVE SERVICES USE

WORCESTER, MA

INFECTIOUS DISEASE CASES

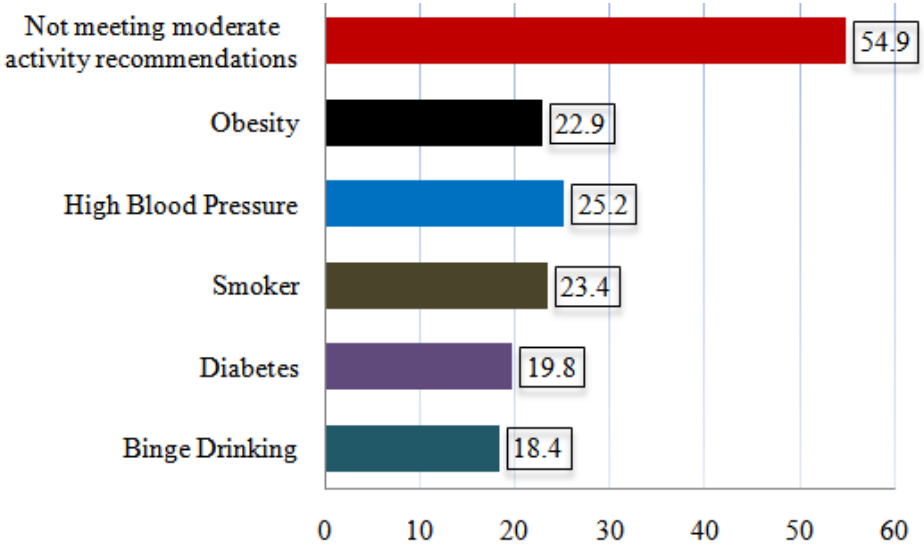
	Area Count
Newly Diagnosed HIV cases	45
Persons with HIV/AIDS	910
AIDS and HIV-related deaths	14
Tuberculosis	6
Pertussis	12
Hepatitis-B	28
Syphilis	6
Gonorrhea	84
Chlamydia	682

ADULT PREVENTIVE SERVICES USE (%)



RISK FACTORS FOR PREMATURE DEATH

WORCESTER, MA



ACCESS TO CARE

Personal Health Care Provider (18+)	85.6%
Could not see a Doctor due to cost (18+)	11.4%
No Health Insurance (18+)	10%
Medicaid:	
Age 65+	10.45%
Disabled recipients	24.03%
Family recipients	62.95%

WORCESTER HEALTH STATUS REPORT
WORCESTER, MA 2009

I. **OVERVIEW**:
- a. MassCHIP was developed by the Massachusetts Department of Public Health to assist communities and professionals in health planning. MassCHIP provides access to 36 health status, health outcome, program utilization, and demographic data sets, from which you can generate two types of reports, Instant Topics and Custom Reports. Depending on the data source, you can view an entire range of selectors including geography, year, age, race and ethnicity, gender, or income.

II. **MASSCHIP TRAINING**
- a. ***Massachusetts Department of Public Health***
  - i. 250 Washington Street 6th Floor
    Boston, MA 02108
  - ii. ***Saul Franklin***
    1. Saul.Franklin@state.ma.us
    2. (617) 624-5512
  - iii. ***Jamie Wilkins***
    1. Jamie.Wilkins@state.ma.us
    2. (617) 624-5693
- b. 1 hour training provided and roughly 30 hours to complete the entire report.

III. **INSTANT TOPICS**
- a. Predefined reports which use MassCHIP's most current data to supply information on a variety of topic areas for specific geographies.
- b. http://www.mass.gov/?pageID=eohhs2subtopic&L=5&L0=Home&L1=Researcher&L2=Community+Health+and+Safety&L3=MassCHIP&L4=Instant+Topics&sid=Eeohhs2
  - i. ***Health Status Indicators***
    1. **Demographic Information (page 2)**
       - a. Population living below 100% of poverty level
       - b. Population living below 200% of poverty level
    2. **Measures of Birth and Death (page 7)**
       - a. Birth Measures
         - i. Low Birth Weight (less than 2500 grams)
         - ii. No prenatal care in first trimester
       - b. Infant Mortality
         - i. Infant Mortality: White non-Hispanic, black non-Hispanic, Hispanic
       - c. Injury Indicators - all
       - d. Chronic Disease Indicators - all
    3. **Preventive Services use (page 8)**
       - a. Infectious Disease Cases - all

  - ii. ***Behavioral Risk Factor Surveillance System – Chronic Illness***
    1. **Confidence Intervals (page 6)**
       - a. Risk Factors for Premature Death
         - i. High Blood Pressure

For demonstration purposes only. Data not verified.

iii. ***Behavioral Risk Factor Surveillance System – General Health Status***
   1. **Demographic Information (page 2)**
      a. Age distribution – all
   2. **Confidence Intervals (page 6)**
      a. Summary Measures of Health
         i. Fair or poor health
         ii. 15+ days of poor physical health in the past 30 days
         iii. 15+ days of poor mental health in the past 30 days

iv. ***Behavioral Risk Factor Surveillance System – Health Care Access***
   1. **Access to Care (page 9)**
      a. Personal Health Care Provider (18+)
      b. Could not see a Doctor due to cost (18+)
      c. No Health Insurance (18+)

v. ***Behavioral Risk Factor Surveillance System – Health Screening***
   1. **Confidence Intervals (page 6)**
      i. Adult Preventive Services Use (%)
         1. Pap Smears (18+)
         2. Mammography (18+)
         3. Sigmoidoscopy (45+)
         4. Flu vaccine (65+)
         5. HIV testing (18+)

vi. ***Behavioral Risk Factor Surveillance System – Risk Factors and Health Behaviors***
   1. **Confidence Intervals (page 6)**
      a. Risk Factors for Premature Death
         i. Obesity
         ii. Smoker
         iii. Binge Drinking

vii. ***Census 2000, 1990 Socio-Demographic Trends***
   1. **Vulnerable Populations (page 5)**
      a. Have no high school diploma

viii. ***Mortality Standard Report***
   1. **Confidence Intervals (page 6)**
      a. Summary Measures of Health
         i. All causes of death
      b. Risk factors for Premature Death
         i. Diabetes

ix. ***Perinatal Reports***
   1. **Measures of Birth and Death (page 7)**
      a. Birth Measures
         i. Prematurity (less than 37 weeks gestation)

For demonstration purposes only. Data not verified.

ii. Births to Women under 18

b. Infant Mortality
   i. Neonatal infant Mortality (<28 days)
   ii. Post-neonatal Mortality (28-364 days)

x. ***Race/Hispanic Ethnicity Report – Mortality***
   1. **Leading Causes of Death (page 4)**

IV. CUSTOM REPORTS (QUERIES)

a. User-defined reports which can be created by downloading the MassCHIP Client and choosing the data set and selectors of interest.

i. ***Download MassCHIP:***
   1. Go to: http://masschip.state.ma.us
   2. Click on download MassCHIP, then Download and Installation Instructions
   3. Download MassCHIP using the link given under How to Install MassChip
   4. Run FULLSETUPEX.EXE
   5. Follow the instructions given during the Setup program.
   6. Program should post to the desktop.

ii. ***Sending created queries to other users***
   1. Through email create an attachment
   2. Click on My Computer
   3. Click on (C:)
   4. Click on Program Files
   5. Open the MassCHIP folder
   6. Find the document **mchipusr** and click open
   7. Add the attachment
   8. Send the email to designated personnel

iii. ***Accessing created queries***
   1. Open the email with the mchipusr file
   2. Click on Download
   3. Click Save
   4. Go to My Computer
   5. Click on (C:)
   6. Click on Program Files
   7. Open the MassCHIP folder
   8. Click save in order for **mchipusr** to post in folder
   9. It will then ask if you would like to replace the mchipusr file
   10. Click yes: if you are building upon previous queries (*Please note*: If you already have MassCHIP installed on your computer and have built your own queries this method will replace your personal file. If you need to access other queries send the mchipusr file as outlined above to yourself in order to save your files.)

iv. ***Username:***
   1. MassChip

v. ***Password:***
   1. password

b. ***Created Queries***

i. **Vulnerable Populations (page 5)**
   1. Are unemployed
   2. With disability, help needed
   3. With disability, no help needed
   4. Heavy drinking (within past month)

ii. **Confidence Intervals (6)**
   1. Adult Preventive Services Use (%)
      a. Pneumonia vaccine (65+)
   2. Risk Factors for Premature Death
      a. Not meeting moderate physical activity

iii. **Access to Care (page 9)**
   1. Medicaid – all

V. **OTHER DATA SOURCES**

a. ***U.S. Census Bureau Quick facts for Worcester, Massachusetts***
   i. http://quickfacts.census.gov/qfd/states/25/2582000.html
      1. **Demographic Information (page 2)**
         a. Population size
         b. Population density (people per square mile)
         c. Race/Ethnicity - all

b. ***U.S. Environmental Protection Agency***
   i. **Environmental Health (page 5)**
      1. Toxic chemicals released annually
         a. http://www.epa.gov/cgi-bin/broker?view=COCH&trilib=TRIQ1&sort=_VIEW_&sort_fmt=1&state=25&county=25027&chemical=All+chemicals&industry=ALL&year=2007&tab_rpt=1&fld=RELLBY&fld=TSFDSP&_service=oiaa&_program=xp_tri.sasmacr.tristart.macro
      2. National air quality standards met by city
         a. AIRSDATA, 2006.

Appendix G:

Comparable Communities

for Further Study

Appendix G: Comparable Communities for Further Study

The Task Force compiled this list of Local and County Health Departments that have been identified as comparable communities to Worcester. They are being suggested because at a minimum, each community includes the presence of a medical school, are located at similar latitude, and are of the approximate population size of the Greater Worcester area (up to 500,000).

These communities can be used as comparable references for further study as the City seeks to rebuild and expand its public health infrastructure.

City:

New Haven, CT	http://www.cityofnewhaven.com/Health/
St. Louis, MO	http://stlouis.missouri.org/citygov/health/

City/County:

Rockford/Winnebago County, IL	http://www.ci.rockford.il.us/socialServices/index.cfm?id=646
Albany County, NY	http://www.albanycounty.com/health/
Rochester/Monroe County, NY	http://www.monroecounty.gov/health-index.php
Syracuse/Onondaga County, NY	http://www.ongov.net/Health/
Genesee County (Flint), MI	http://www.gchd.us/
Madison & Dane County, WI	http://www.publichealthmdc.com/

Appendix H:

Recommendation Roadmap and

Proposed Sequencing of Tasks

Proposed Recommendation Roadmap

June – September 2009	September – November 2009	FY 2010 – FY 2012+
Organizational Assessment	**Strategy Formulation**	**Execution**
Task Force separates into four subcommittees organized to develop recommendations in support of a specific subcommittee charge: Mission/ Structure, Best Practices, Measures/Metrics and Community Resources	Task Force reviews and vets the findings and recommendations of the subcommittees; identifies key themes; and develops an integrated set of strategic goals, priorities and recommendations	City Manager appoints Implementation Team that, in partnership with community advisory group, creates "roadmap" to implement Task Force recommendations with respect to priorities, fiscal and process feasibility, and a goal toward achieving accreditation

What is our current position in Public Health?

Review current/past mission, services and funding
Analyze best practices (NACCHO)
Recommend updates to mission, vision, values
Consider data and measurement tools to assess effectiveness
Review organizational structure
Review BOH responsibilities
Identify community partners

What Forces will influence our Future?

Public Health Trends
Impact Analysis
Strategic Imperatives
Fiscal Challenges

Strategic Imperatives

How will we define success for Public Health?

Creation of new mission, vision and guiding principles
Improve the health status of the community through the achievement of four strategic goals:
Improve Organizational Effectiveness
Mobilize a Coordinated Community Approach
Make Data-Driven and Evidence-Based Decisions
Build a Road to Sustainability

What is our desired Future State for Public Health?

Decision Framework

How will we get there?

Vision Goals. Objectives & Tactics

Vision/Plan 2010 2012+

Determine Investment Requirements such as:
- Leadership and Staff
- Data and Technology
- Services Delivery

Partnerships
Other Relationships

What is the Execution Roadmap?

Action Plans
- 5 Year Plan
- 1 Year Operations Plan

Critical Success Factors
Monitoring & Execution Structures and Systems
Change Management Strategy
Feedback Mechanism
On-going Planning

Execution Strategy

Organizational Plans Strategic Plan (2015) 5 Year Plan 1 Year Operations Plan

Courtesy of: Edward Hindin, Hindin Healthcare Advisors, LLC

Ongoing Monitoring and Planning

Proposed Recommendation Roadmap

City Manager appoints Implementation Team that, in partnership with community advisory group, creates "roadmap" to implement Task Force recommendations with respect to priorities, fiscal and process feasibility, and a goal toward achieving accreditation

Execution - Proposed Sequencing of Tasks

Year 1

- **Transition BOH to New Model**
  - Discuss new BOH model/responsibilities
  - Complete terms of existing BOH members
  - Create new role descriptions for BOH members and BOH function
  - Transition BOH to new model
- **Develop Function and Recruiting Plan for Commissioner Position**
  - Create function/role for commissioner
  - Create recruiting plan for commissioner
  - Add commissioner to City Manager Cabinet
- **Develop Function and Recruiting Plan for Medical Director**
  - Create function/role for medical director, if commissioner not MD
  - Create recruiting plan for medical director
- **Hire Data Analyst or Partner for Data Analyst Skill Set**
  - Create function/role for data analyst
  - Create recruiting plan or devise partnership plan for data analyst
  - Hire data analyst or partner for data analyst skill set
- **Identify and Engage Partnerships, Funding Sources, and Create Partnership Management Function**
- **Create Management of Data Collection and Analysis in Partnership with UMass Medical School**

Proposed Recommendation Roadmap

City Manager appoints Implementation Team that, in partnership with community advisory group, creates "roadmap" to implement Task Force recommendations with respect to priorities, fiscal and process feasibility, and a goal toward achieving accreditation

Execution - Proposed Sequencing of Tasks

Year 2

- **Develop Data Support Funtion**
  - Create function/role for data support function/role
  - Create recruiting plan or devise partnership plan for data support function/role
  - Put data support function/role into place
- **Develop & Implement Chronic Disease Function**
  - Create function/role for chronic disease
  - Create recruiting plan or devise partnership plan for chronic disease function/role
  - Put chronic disease function/role into place
- **Develop & Implement Injury Prevention Function**
  - Create function/role for injury prevention
  - Create recruiting plan or devise partnership plan for injury prevention function/role
  - Put injury prevention function/role into place

Proposed Recommendation Roadmap

City Manager appoints Implementation Team that, in partnership with community advisory group, creates "roadmap" to implement Task Force recommendations with respect to priorities, fiscal and process feasibility, and a goal toward achieving accreditation

Execution - Proposed Sequencing of Tasks

Years 3+

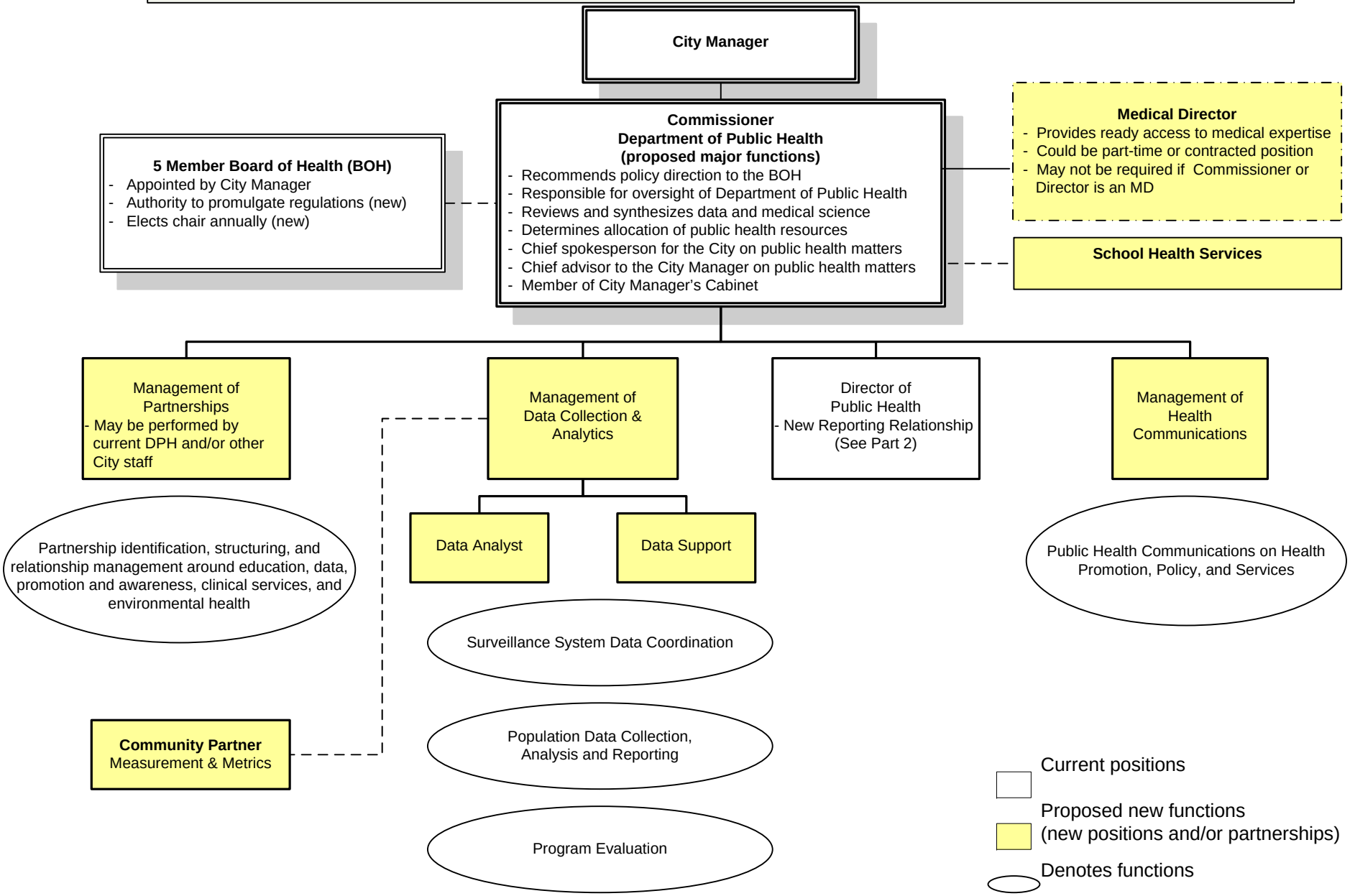
- **Create Surveillance System Data Coordination, Population Data Collection, Analysis and Reporting and Program Evaluation**
- **Migrate Health and Housing Inspection Processes into Public Health Department in Phased, Fiscally Feasible Manner**

Appendix I:

Proposed Table of Organization

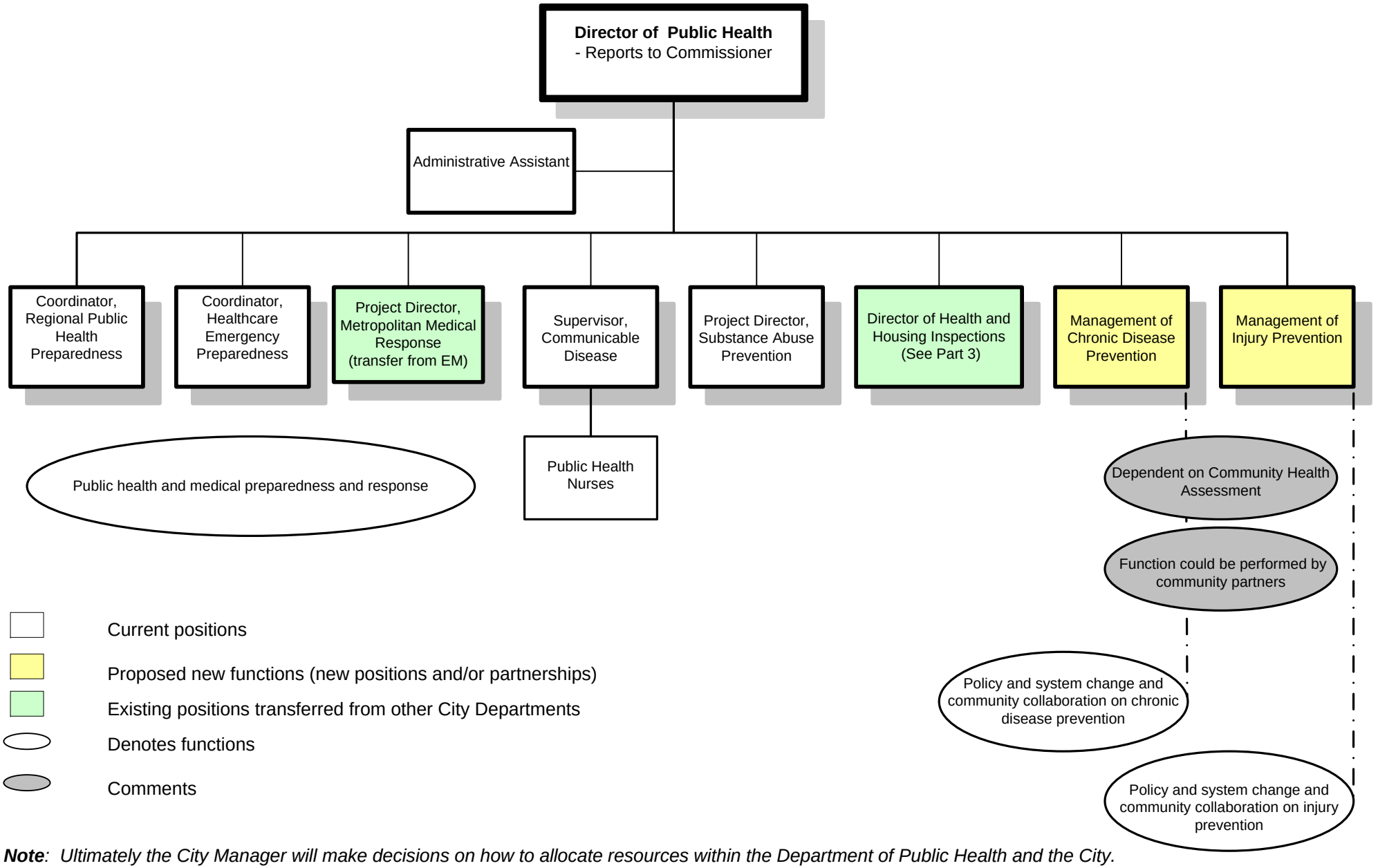
for Department of Public Health

Proposed Table of Organization for the Department of Public Health (Part 1 of 3)



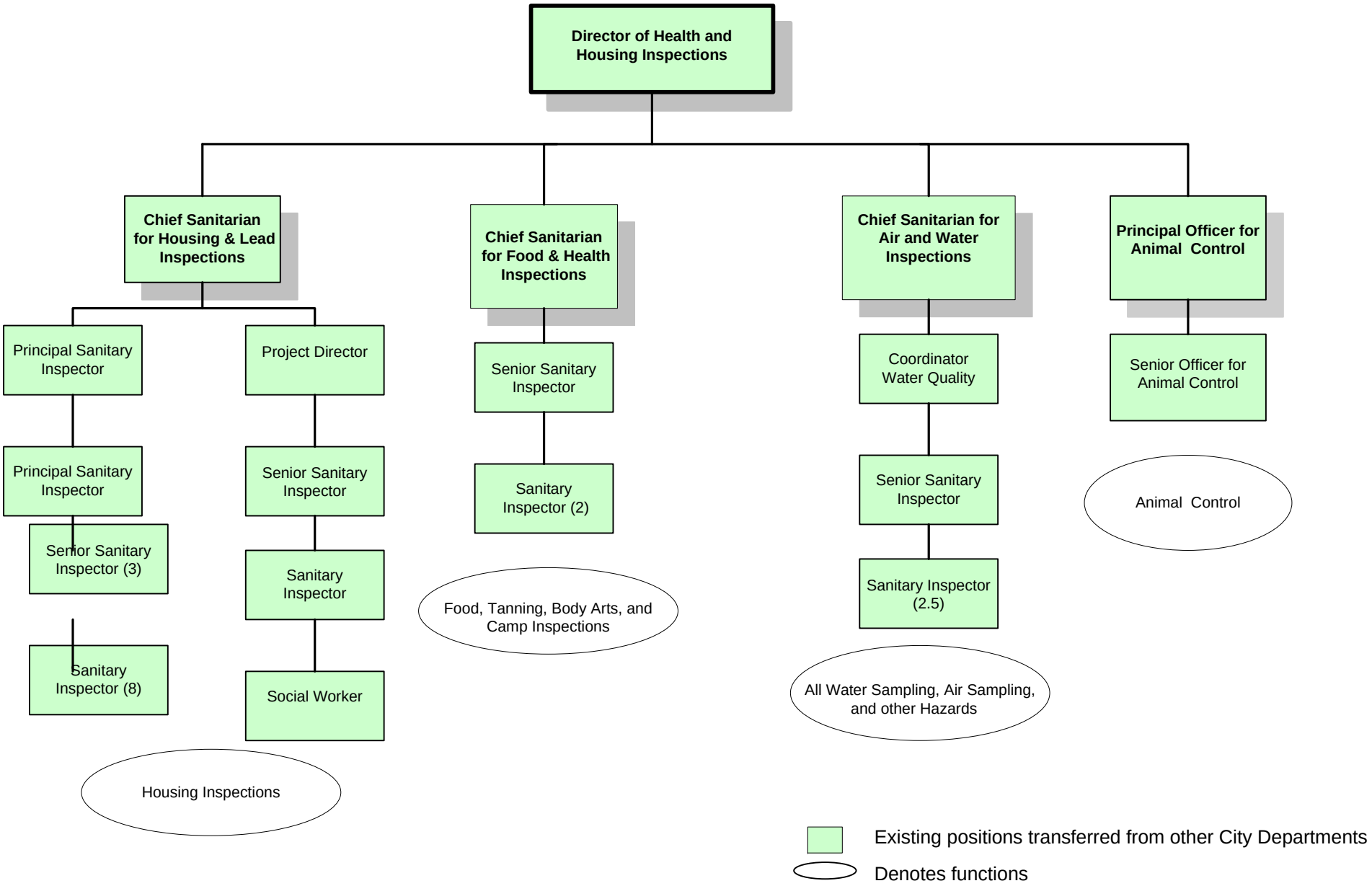
***Note**: Ultimately the City Manager will make decisions on how to allocate resources within the Department of Public Health and the City.*

Proposed Table of Organization for the Department of Public Health (Part 2 of 3)



***Note**: Ultimately the City Manager will make decisions on how to allocate resources within the Department of Public Health and the City.*

Proposed Table of Organization for the Department of Public Health (Part 3 of 3)



***Note**: Ultimately the City Manager will make decisions on how to allocate resources within the Department of Public Health and the City.*