

Attachment 4B: Work Plan Guidance

Revised 2011

Notes:

- 1. There are no changes to the data collection instrument.**
- 2. Changes are summarized in Attachment 4C: Work Plan Guidance Updates**
- 3. The expiration date will be updated upon receipt of OMB approval**
- 4. The burden estimate has been updated from 25 hours to 20 hours**

**Guidance Document for
Completing Your States/Territories/Tribes PHHS Block Grant
Work Plan**

Updated 2011

Documentation Contact:
Tracy Perkins
PHHS Block Grant Public Health Analyst
CDC/DACH/SAEQoL
Ph: 770-488-5312
Email: tlp6@cdc.gov

***Special thanks to Connecticut Department of Public Health
Krista Veneziano, Lead Poisoning Program and Julianne Konopka,
Section Chief, Health Information Systems and Reporting Planning Branch***

Public reporting burden for this collection of information is estimated to average 20 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collected information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, NE, MS D-74, Atlanta, Georgia 30333: ATTN: PRA (0920-0106).

Table of Contents

This document provides a. *Page Limit*, 1. *Definition*, 2. *Example*, 3. *Discussion*, and 4. *BG-MIS* related to the various information items that make up the PHHS Block Grant work plan and references where the information is entered in the software. **It is recommended that you use this document in conjunction with the Example work plan.** The pages of the document have been numbered, however, page numbers may be altered due to printer compatibility's.

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A. Work Plan Main Menu Tab

The “Before you begin box” on the work plan contains links to individual sections the work plan guidance, the entire guidance document, and a function that automatically counts the number of pages in the current work plan. The system will perform the page count as of the time that you click the link. The count will increase as you add pages and decrease when pages are deleted.

To select a work plan you can either click the [work plan list](#) link in the left hand window or select the Work Plan List tab from the top row of tabs. also click the work plan tab.

Page Limits:

Below is a list of recommended page limits. Limits are based on the amount of funding. Work plans (work plans) that exceed the recommended page limits will be flagged as ‘page limit exceeded’, and grantees will be reduce the number of pages.

Up to \$1m in PHHS Block Grant funding:	= up to 40 pages
\$1m+ to 3.99m funding:	= up to 65 pages
\$4m + funding:	= up to 75 pages

B. Work Plan Cover Page & Executive Summary

General System Navigation: The left hand tree displays the various sections of the work plan. Clicking the section causes the tree to expand, displaying the individual items in the section that make up the work plan. For example when Cover Page is clicked, the Executive Summary and FTE nodes appear in the tree. To view or edit the information, click the Edit/View buttons in the right hand window.

A list of ‘Other things that you can do.....’ appears at the bottom on the right hand window. This list allows you to perform functions needed to complete your work plan such as printing items, or adding and deleting items.

Work Plan Cover Page

1. Definition: The Cover Page of the Block Grant work plan identifies items such as the Title of your States Block Grant Work Plan, date and time of creation, Version (Original or Revision), Work Plan Fiscal Year, your state’s governor, your state health officer’s name, and the name of the Block Grant Coordinator, an Executive Summary, a prioritization check-box that helps you to stay in compliance with the legislative requirement that the advisory committee prioritize use of funds, and the % of the Block Grant coordinators time that is paid for with Block Grant funds.

See Discussion for more clarification.

2. Example: *(Please Refer to Cover Page in the Example Work Plan)*
This is an Example work plan Submitted by Connecticut

Original for Fiscal Year 2007
Submitted by: Connecticut

12/07/2006 ---- 09:26AM

Governor: Honorable M Jodi Rell
State Health Officer: J Robert Galvin, M.D., M.P.H.
Block Grant Coordinator: Julianne Konopka
CDC Work Pan: 2007CTB01PRVS-01R
Created on: 12/07/2007
Work Plan Prepared for Submission: Yes

3. Discussion: Some of the information on the Cover Page, such as the name of your states governor, is inputted by you, the grantee. Other items, such as the date and time of creation, CDC work plan ID, Version number, and “stamp” indicating that the work plan was Prepared for Transmission to CDC, are automatically generated by the BG-MIS software.

The date that follows the “Submitted by”: Our State item refers to the date that the work plan that you are viewing is printed on. For example, the Example work plan was printed on, December 07, 2006 at 9:26 AM. The “Created on” date, indicates the date that the work plan was **initially created**. The created on date does not change as the work plan undergoes edits. Both created on and printed on dates are automatically generated by the BG-MIS.

4. BG-MIS Button: Cover Page

Executive Summary:

Page length = 1 Page

1. Definition: This summary section allows State Block Grantees to provide readers, such as Advisory Committee members, with information about numerous topics related to the Block Grant work plan including:

- History
- Rationale for using Block Grant dollars for the purposes identified in the work plan
- Funding assumptions
- Advisory Committee recommendations

2. Example:

This is Connecticut's work plan for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Fiscal Year 2007. The PHHSBG is administered by the United States Department of Health and Human Services through its administrative agency, the Centers for Disease Control and Prevention (CDC). The Connecticut Department of Public Health (DPH) is designated as the principal state agency for the allocation and administration of the PHHSBG within the State of Connecticut.

Funding Assumptions

The FFY 2007 work plan is based on the assumption that Block Grant funding will be at least equal to the FFY 2006 grant award. Any changes in funding are consistent with, and in full compliance with applicable state and federal law. Implementation of Connecticut's FFY 2007 prevention programs that are funded by the PHHSBG will be contingent upon receipt of level funding for FFY 2007.

Connecticut's final 2006 PHHSBG award was \$1,338,994, which reflects the \$348,099 reduction in Connecticut's FFY 2006 Basic Award.

Proposed Allocation for FY2007

PHHS Block Grant dollars are allocated to those health areas that have no other source of state or federal funds or wherein combined state and federal funds are insufficient to address the

extent of death or disability that result from the health problem. FY2007 funding priorities are as follows:

Program	Health Objective	Funds
Cancer Prevention	3-1	\$101,781
Childhood Lead Poisoning	8-11	\$156,278
Emergency Medical Services	1-11	\$178,886
Heart Disease & Stroke Prevention	12-1	\$402,901
Intimate Partner & Violent Prevention	15-34	\$ 76,920
Local Health Departments	7-10	\$143,075
Rape Crisis	15-35	\$ 83,396
Youth Violence Suicide Prevention	15-32	\$ 215,764

There are changes in the proposed FFY2007 budget, which address the annual increases in salary due to contractual pay scales and related fringe charges for the budgeted positions (8.5 FTE). The reduction of the Basic Award by \$348,099 will be covered by the balance forward of federal funds from the previous year, the elimination of the Surveillance and Evaluation program (including 1.0 FTE Epidemiologist position), the elimination of the Preventive Block Grant Coordinator position and the reduction in the Emergency Medical Services Program. Funding for the five Regional EMS councils is eliminated in FFY 2006 and one internal DPH staff position has been removed from this program. The budgeted 1.0 FTE in the Cancer program will be filled in FFY 2006

**** Note: The example work plan includes information only for National Health Objective 8-11 Blood Poisoning

Funding Priorities:

Identify in order of priority the rationale that was used by the legislative mandated Block Grant Advisory Committee to fund Health Objectives: 3, 2, 1.

Attach a copy of the Advisory Committee Members and their affiliation as required by legislative mandate.

Amount of Block Grant coordinator's time paid for with BG Funds. 35%

3. Discussion: None.

4. BG-MIS: Cover Page

C. Statutory Information

Statutory Information:

1. Definition: The Statutory Information section of the Block Grant Work Plan is mandatory. It identifies the dates that the Public Hearing and Advisory Committee meetings were held. It also indicates to CDC whether or not hard copies of the Certification Form and the Certification and Assurances Form signed by the Chief Executive Officer were sent to CDC. See 3. Discussion for further clarification.

2. Example: (Please see the Statutory Information page of the Example work plan).

3. Discussion: At transmission time, BG-MIS verifies whether or not these items have been completed (attached) and provides the user with a Pass/Fail status. Since the information is required by CDC as a condition of funding the Block Grant work plan, it should be completed in the Statutory section of the BG-MIS before transmitting your work plan. In the event that you receive a Fail status, this indicates that not all of the items have been completed. CDC will ask you to complete these items.

4. BG-MIS: Statutory Information

D. Budget Section

Budget Section Cover Page:

Begins with a cover page for the budget section which includes a Budget Detail page and Summary of Funds Available for Allocation page.

Budget Detail:

1. Definition: The Budget Detail and Summary of Funds Available for Allocation page are automatically generated by the BG-MIS based on the information entered into the various tabbed pages within the BG-MIS Budget Section. These two pages are snap shot summary information.

2. Example: Please see the Budget Detail page of the Example work plan.

3. Discussion: Note that the amount of funds available to allocate to HO's is the total award less administrative costs and direct assistance. (Direct assistance is only applicable if a state uses PHHS block grant funds to pay for a federal employee assigned to the state. See BG Nuts and Bolts within the "Important Information" button for further clarification).

4. BG-MIS: Budget

Summary of Allocations by Program and Healthy People 2010 Objective:

1. Definition: The Summary of Expenditures by Program and Healthy People 2010 Objective page provides a dollar breakdown of each Program by the amount allocated to the HO's that are associated with the Program. It displays a sub-total for each Program, and a Grand Total that represents the Total Amount of Dollars for all Programs/HO's. The information on this page is a compilation of information that is entered in both the Budget and Program/HO sections of the BG-MIS.

2. Example: Please see the Summary of Expenditures by Program and Healthy People 2010 Objective page in the Example work plan.

3. Discussion: None.

4. BG-MIS: Budget and Program/HO.

E. Program Information Including Health Objectives

Program Section Cover Page:

The Program Information Section begins with a cover page identifying the Program/HO section which includes State Program Title, State Program Strategy, National Health Objective, State Health Objective, Description of Health Problem, Target population, Disparate population, 10 Essential Services, Desired Impact Objectives, Annual Activity Objectives, and Profile.

State Program Title:

1. Definition: All programs described in the work plan must be identified by a Program Title that is descriptive of the State Health Department Program.

2. Example: Connecticut Lead Poisoning Prevention Control Program (LPPCP)

3. Discussion: Work plan information is tied to a Program title. Programs can be associated with one or more HO's from one or more Healthy People 2010 Chapters.

4. BG-MIS: Program/HO

State Program Strategy:

Page Limit: 1 page

1. Definition: The State Program Strategy includes the following items of information.

- Program Goal
- Program Priorities --- Whenever possible tie this text to the Essential Services that are chosen for the Health Objectives that are funded by this program. In the example below note that policy and planning would apply to “insure the passage of proposed legislation” followed by monitoring health status and diagnosing and investigating.
- **Primary** strategic partners (primary strategic partners within health department and/or with agencies and organizations outside of the state health department).
- Role of PHHSBG funds relative to other sources of funding
- Evaluation Strategy
- FTE's (Include the Title, and % of time that Block Grant funds are used for activities associated with State, Local and/or Other Activities. A written description of FTE's is optional. The legislation requires however that the number of FTE's be identified).

2. Example

Goal: The Connecticut Lead Poisoning Prevention Control Program (LPPCP) is committed to reducing and eliminating lead poisoning in children less than six years of age living in Connecticut by 2010.

To decrease the effects of lead poisoning in children, children at risk need to be identified at an early age with screening and interventions initiated in a timely manner. Subsequently, the most important strategic imperative is to insure the passage of proposed legislation in Connecticut that calls for mandatory universal screening of all children one and two-years old and any child under the age of 6 years who has not been previously screened is passed in FY2007-2008. This legislation also includes:

- Mandatory insurance coverage for blood lead screening and risk assessments conducted by primary care providers as stipulated in the legislation
 - Authorization of DPH to stipulate the method of lead data reporting by labs
- Secondarily, the program will focus on improving health status monitoring by increasing the number of laboratories that electronically report blood lead analysis data to the state agency and will strengthen investigation efforts by increasing the annual number of local health department field audits.

The Department of Public Health’s overall strategy includes compliance with statewide screening recommendations that call for screening of children to occur at 12 months of age and again at 24 months of age (consistent with federal requirements for children receiving Medicaid assistance). In addition to screening, health care providers are asked to utilize an initial risk assessment, anticipatory guidance, and parental health education. It is important to note that a significant percentage of the Connecticut children who have elevated blood lead results are Medicaid recipients. With this fact in mind, the Connecticut DPH is currently working with the Department of Social Services (DSS) to match Medicaid data with blood lead screening data so that Medicaid children who have not been screened can be identified and screened.

Primary Strategic Partnerships: The Department of Public Health (DPH) has fostered a number of collaborative relationships and strategic partnerships both internally and externally.

Internal:

- DPH Laboratory

Eternal:

- Medical community

- CT Refugee Health Coordinator
- Environmental Public Health Tracking Program
- DPH Asthma program
- DPH Legal Office

- Federal Agencies – HUD, EPA, HHS
- Hartford and Yale New Haven Regional Lead Treatment Centers
- Lead Elimination Plan - Implementation Planning Committees

Role of PHHS BG Funds: Block grant dollars support efforts to improve the diagnosis and investigation of lead poisoning in children. The dollars pay for operating expenses, providing approximately 10% of the funds in the area of laboratory support and program personnel costs, as well as lead surveillance activities for several local health departments.

Evaluation Methodology: Surveillance data from the Childhood Lead Poisoning Prevention Program Surveillance System (CLPPSS) will be used to evaluate progress toward the overall program goal of eliminating childhood lead poisoning. The Data Management Unit (DMU) staff will produce a surveillance report and compile data that will be used to monitor progress. In particular, the statewide prevalence of elevated blood lead levels 10 g/dL in children less than six years of age will be tracked and trends will be evaluated.

FTE's associated with this Program: Lab Technician
 Block Grant Funded State Activities: 10%
 Block Grant Funded Local Activities: 90%
 Total: 100%

3. Discussion: PHHS Block Grant dollars generally fund a portion of a public health program rather than an entire program. The Program Strategy gives a brief description of the overall program goal and identifies key strategic partners. It differentiates how PHHSBG funds are used within the program. For example, PHHSBG dollars; fund activities that are not funded by CDC categorical programs (for example Health Promotion Education activities), are used to increase program reach to specific geographic areas or at risk populations, or are used to increase resources needed to effectively accomplish activities funded by categorical dollars. The program strategy identifies a method for evaluation methodology.

4. BG-MIS: Program/HO

Objectives Overview:

There are 3 levels of objectives in the PHHS Block Grant program, 1. National Objective (selected from HP2010) 2. State Health Objectives, 3. Impact Objectives. While it is difficult to attribute changes in health status to completion of Impact Objectives and the related Activities, they often constitute the best evidence that the core functions of public health as described in Public Health's 10 Essential Services are being carried out. Impact Objectives are tied to Essential Services.

- Write Objectives using the SMART Objectives principles, Specific, Measurable, Achievable, Relevant, and Time Based. Suggested Web links to SMART Objectives appear below.

References for writing SMART Objectives:

- <http://www.wgrange.com/news/smart.html>
- <http://www.cdc.gov/nccdphp/dnpa/physical/handbook/appendix4.htm>
- <http://www.dph.sf.ca.us/CHPP/CAM/3-ToolBox/Skill-BasedActivities/WritingSMARTObjs.pdf>

- Provide baseline information for State Health Objectives and Impact Objectives. Baselines apply both to health objectives that measure change in health status as well as health objectives that establish infrastructure or focus on health education. For example, if you plan to provide training to local health departments, the baseline would be the number of trainings that you provided, for example in the last period, compared to the number of trainings that you intend to provide in the next period. It is possible to increase the number of trainings, decrease the number of trainings, or maintain the number of trainings from a prior year.

HP2010 National Health Objectives:

Page Limit: The National Health Objective is selected from a pre-defined list of HP 2010 Titles and cannot be changed by the user.

1. Definition: National Health Objectives (HO's), used as the basis for the PHHS Block Grant work plan, are derived from the National Healthy People 2010 Health Objectives document. HP2010 objectives are considered long term and strategic in the planning process. Grantees should choose a National Objective from the pull down menu within the BG-MIS. Not all HP2010 Objectives are available for use in the PHHS Block Grant. In addition to the drop down list in the BG-MIS, the CDC accepted list can be printed by selecting the Important Information button in the BG-MIS and selecting List of Available National Health Objectives. See 'Discussion' below for further information.

All Programs, 10 Essential Services, Desired Impact and Annual Activity objectives, and Dollars are tied to one or more HO's.

2. Example:

8-11 Blood lead

Title: Eliminate elevated blood levels in children

Baseline: 4.4 percent of children aged 1 to 5 years had blood lead levels exceeding 10 ug/dL during 1991-94.

3. Discussion: Within the BG-MIS there is a pull down menu of available National HP 2010 Health Objectives (HO's) to select from. Also, a hard copy of the List of Available National Health Objectives can be printed from "Important Information" button within the BG-MIS. The BG-MIS includes some, but not all of the HO's in the actual National Healthy People 2010 document. The reason is that the National Healthy People 2010 document includes Health Objectives that are specific to a health problem(s); others that are activities related to the health problem(s); and others that are services or issues oriented. To see a complete listing of all the objectives, you will need to refer to the official National Healthy People 2010 document.

HP 2010 website: <http://www.healthypeople.gov/>

Chapters which are health problem(s) specific, such as chapters 2, 3, 4, 5, 9, 10, 12, 13, 24, 25, and 28, will have one or more health objective(s) that correspond to a specific health problem. For example: Chapter 5 - Diabetes has 17 health objectives which correspond to reducing Diabetes. If a state is using PHHS block grant funds to reduce Diabetes, then select HO 5-5 Diabetes Deaths. The rationale is to provide a broader Program scope versus having to select every health objective in the 2010 document that supports that particular health problem or program.

Chapters which are not health problem(s) specific, such as chapters 1, 6, 7, 8, 11, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 26, and 27 have a greater number of available health objectives to choose. Some health objectives have been consolidated together when similarities existed.

The Health Objectives selected for the BG-MIS were chosen to allow for flexibility in the use of funds while maintaining, where possible, a Programmatic scope. The grantee planning process should **Prioritize and identify the best possible selection of Health Objectives that reflect where PHHS Block Grant funds are targeted to be spent.**

Specific HO's: (The following HO's have been identified to maintain consistency)

Emergency Medical Services use HO 1-11

Community Water Fluoridation use HO 21-9

Rodent Control use HO 8-31 (Rodent control is not found in HP2010, so a HO number was created)

Sex Offense Set-Aside (old version of Grant Work plan and Reporting System was HSO 7.7) use HO 15-35

Rape Prevention Education (old version of software listed as HO's 93 and 93.1) are no longer applicable and are funded as a separate grant from the National Center for Injury Prevention and Control.

4. BG-MIS: Program/HO.

State Health Objective(s):

Page Limit: ¼ to ½ page

1. Definition: The State Health Objective should mirror the National Health Objective.

HP2010 objectives are considered long term and strategic in the planning process.

The baseline data should reflect the status of the health problem within your state.

Identify how change will be tracked. For example, will change be measured by data derived from standard surveys such as BRFSS or YRBS, data from the Medicare Medicaid database, Vital Statistics data, Hospital Discharge data, others?

2. Example:

Between 01/2000 and 12/2010, decrease the number of children less than six years of age with blood lead levels $\geq 10\mu\text{g/dL}$ to less than 1.8%, and those with levels of $\geq 20\mu\text{g/dL}$ to 0.4% or less.

Baseline: 2.2% of children tested with blood lead levels of $10\mu\text{g/dL}$ and 0.4% of children tested with blood lead levels of $20\mu\text{g/dL}$. Based on 67,688 children tested and recorded in 2004. (Data for 2005 is not available at this time.)

Data source: Connecticut LPPCP Comprehensive Lead Surveillance System (Data for 2004 is not available at this time.)

The State Health Objective includes the following items of information:

When:

Begin Date: 01/2000

End Date: 12/2010

What is the measure of change:

decrease

What is being measured:

the number of children less than six years of age with blood lead levels $\geq 10\mu\text{g/dL}$ to less than

2.2%, and those with levels of $\geq 20\mu\text{g/dL}$ to 0.4% or less.

Baseline and change over baseline:

2.2% of children tested with blood lead levels of $10\mu\text{g/dL}$ and 0.4% of children tested with blood lead levels of $20\mu\text{g/dL}$. Based on 67,480 children tested and recorded in 2003. (Data for 2004 is not available at this time.)

Data Source --- How will changes to baseline be tracked:

Connecticut LPPCP Comprehensive Lead Surveillance System

3. Discussion: In the new BG-MIS the objective is automatically “written” based on the separate items of information that are entered into the BG-MIS system. The user click’s a Display button enabling the software to combine the fields to create a SMART Objective.

Discrete Field: Unlike GARS (Grant Work plan and Reporting System) that allowed the user to enter multiple State Health Objectives for a single National Health Objective, the web-based BG-MIS will only allow ONE State Health Objective for each National Health Objective.

CDC recognizes that not all National Health Objectives include all components of SMART Objectives. Include those components in your Block Grant work plan that reflect the National Objective.

4, BG-MIS: Program/HO

Health Problem Description including Target and Disparate Text:

Page limit: 1 page

1. Definition

Health Burden A description of the scope and magnitude of the problem as it applies to the state using current or trend data such as morbidity/mortality, incidence/prevalence by race, ethnicity, age, gender for the health problem related to the state and jurisdictions or regions. Include similar data on risk /contributing factors; disproportionately burdened groups; and other data that contributes to the picture of the health problem. The health problem includes the following:

1. Textual Description of Target and Disparate
2. Prevalence - the measure of a condition in a population at a given point in time. Prevalence data provide an indication of the extent of a condition and may have implications to the provision of services needed in a community.
3. Incidence - the number of new occurrences of a condition (or disease) in a population over a period of time.
4. Distribution – the distribution of the problem within the population.
5. Data sources

Note: Include textual description of the population in the health problem field.

Cost Burden Cost – The estimated dollar amount that the health problem is costing the state. Can also include subjective cost such as reduced quality of life.

Possible Sources of Cost Data:

State Burden document that was developed for CDC categorical programs such as CVH or Diabetes,

Insurance company data or other state sources

2. Example:

Health Burden: Childhood lead poisoning is one of the most common pediatric public health problems in Connecticut. The primary focus of the LPPCP is on minority children between 1 and 2-years of age. Children in this age group are at highest risk for lead poisoning for various reasons including common toddler behavior (i.e., crawling on floors and putting things in their mouths). This age group is also recognized as the most critical for lead level screening. Analysis of Connecticut data reveals that Black and Hispanic children in urban areas represent the population at highest risk as evidenced by the highest percentages of elevated blood lead levels within the State. In calendar year 2004, 1,472 children under six had blood lead levels of greater than or equal to 10µg/dL. Of those 1,472 children, 977 were new cases of elevated blood lead.

The target population includes all Connecticut children **under the age of six**, regardless of their race or socio-economic background. This definition of the target population recognizes that lead poisoning can affect any child who is exposed to lead-based paint or dust. However, low-income, minority children living in urban settings are at highest risk for lead poisoning because of the high lead levels found in the older (Disparate), urban housing stock and the condition of some of that housing. Children are particularly susceptible to the adverse effects of lead poisoning due to their developing neurological systems. They need to be screened and, if they demonstrate an elevated blood lead level, followed-up by their medical provider with appropriate intervention. All children 3-6 years of age, who have not been previously tested, must also be screened.

Two major sources of lead exposure remain a significant health threat for children: (1) deteriorated lead-based paint in older housing, and (2) urban dust and soil that has been contaminated by the previous use of leaded gasoline and the deterioration of exterior lead-based paint on dwellings. Housing built prior to 1978 and particularly those units built prior to 1950 pose the greatest risk of exposure for children since housing of this age is most likely to contain lead-based paint. Paint manufactured before 1950 contained a higher percentage of lead than paints produced in subsequent years.

Age of housing stock continues to be a major risk factor. The high proportion of rental housing in the major urban areas coupled with the fact that Connecticut has an extremely high proportion of housing stock built before 1950 ranks Connecticut among the top 15 states with the highest levels of at-risk housing. (According to the 2000 US Census, 35% of Connecticut's housing stock was built before 1950).

Cost Burden: (Not a required field)

Medical Costs

- Blood lead levels of 10-19 µg/dL require medical intervention and follow-up costing about \$56 perchild¹.
- High levels of lead (20 µg/dL or above) require a full physical with blood tests and follow-up, costing approximately \$466 per child.
- Blood lead levels in excess of 45 µg/dL require treatment including chelation that alone costs a minimum of \$275 per course.

A thorough analysis of cost burden and potential savings has been completed and can be found in the Cost Burden Document: Lead Screening in Connecticut

2. Discussion: Use state specific data to describe the health problem.

Population Descriptions within Health Problem: A Target Population is defined as the population for which the intervention is planned. (A Dictionary of Epidemiology IEA)

Populations for Infrastructure vs. Non-Infrastructure Health Objectives: The population demographics for Healthy People 2010 Objectives that relate to Public Health Infrastructure (Chapter 23) generally differ significantly from the population demographics for HP2010 chapters that relate to health problems. Subsequently, a special set of population demographics has been created for HP 2010 objectives. The two topics are discussed separately below.

Significance of Population to the Reader: The Population description is critical in helping the reader to understand how grantees utilize PHHSBG funds to benefit individuals in their states, tribes, and territories. While standard demographic data items are needed to insure that a minimum amount of demographic data is available that can be used for nationwide trending, in many instances, the most descriptive information is written information that describes the population in terms of:

- behavioral,
- lifestyle,
- psychological, or,
- social attributes.

In some instances the population is made up of

- individuals that have been diagnosed with a particular disease, or,
- that are part of a high-risk population such as individuals with high blood pressure or a previous family history of breast cancer.

In still other instances, the population is defined as specific counties within the state.

A. Elements of Population Description for Health Objectives (non-infrastructure)

Note that some of the items below are captured textually, and others in check-boxes. Examples are provided for several health problems.

Basic Elements:

1. Number – The Number seldom represents the entire state population. For example, funds for fall related injuries are generally, though not always, directed to older individuals, for example, >65 years. US or State Census data can be used to identify individuals in this age range. If a number of counties within a state are targeted, US Census data numbers can be combined for individual counties.

4. **BG-MIS:** Program/HO

Population: Target and Disparate

Page Limit: Static boxes are checked for Disparate and Target populations. Include textual description of Target and Disparate in the Health Problem Section.

Number in populations, Check boxes and identification by County or indication that it population is statewide

1. Definition Target:

- Number
- Gender
- Geography – When possible, use the US Census Bureaus classifications for defining rural vs. urban populations. The following website provides helpful information.
Census 2000 Urban and Rural Classification
http://www.census.gov/geo/www/ua/ua_2k.html
**Use your state guidelines if they exist.

2. Example: Target Population:

Target Population: Childhood Lead Poisoning
Number: 270,187
Age: 1-3 years
Geography: Urban

Source: US 2000 Census Data
(Check-Box Information -- Automatically Summarized by BG-MIS)

3. Discussion: None

4. BG-MIS: Program/HO. Health Problem

OMB Minimum Standard Checkbox Disparate:

1. Definition: Based on the population being targeted, identify any sub-populations that bear a disproportionate burden from the health problem. In some instances, the Disparate Population will be identical to the Target Population.

1. Definition:

Basic Elements -- Check Boxes:

- Race/Ethnicity –The options for race/ethnicity reflect OMB minimum requirements for combined Race/Ethnicity reporting. Select “Other” when none of the items in the list identify the population served, or when the populations served includes additional items not included in the list. In the second instance, you would check “Other” in addition to the items in the list.
- Age – States vary widely in the age ranges that are used to define populations. Subsequently, an attempt was made to identify ranges that are consistent with ranges for CDC’s National Center for Chronic Disease Prevention and Health Promotion. This will insure that the data that is submitted by your state can be used center (and hopefully) CDC wide. Choose the range that most closely approximates the population age range(s) served. Use US and/or state census data.
- Gender
- Income – “Poverty thresholds are the statistical version of the poverty measure and are issued by the Census Bureau. They are used for calculating the number of persons in poverty in the United States or in states and regions.” Refer to:
How the Census Bureau Measures Poverty
<http://www.census.gov/hhes/poverty/povdef.html>

**Many states develop their own thresholds for poverty/low income. Use your states’ definition if it exists. Otherwise, use US Census data.
- Geography – When possible, use the US Census Bureaus classifications for defining rural vs. urban populations. The following website provides helpful information.
Census 2000 Urban and Rural Classification
http://www.census.gov/geo/www/ua/ua_2k.html

**Use your state guidelines if they exist.

2. Example:

Number: 88094

(Check-Box Information -- Automatically Summarized by BG-MIS)

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, Native Hawaiian/Other Pacific Islander, White, Other

Age: 1-3 years

Gender: Female and Male

Geography: Urban

Primarily Low Income: Yes

Source: US 2000 Census Data

3. Discussion: None

4. BG-MIS: Program/HO. Health Problem.

Infrastructure Demographics Chapter 23 – Infrastructure Health Objectives:

As of FY2004, PHHS Block Grantees allocated more dollars to Infrastructure Health Objectives than to any other Healthy People 2010 area. The typical descriptions of target and disparate populations do not adequately identify how states are using these funds. Subsequently, a separate set of demographic items has been created in an attempt to demonstrate how states are building capacity to carry out public health services.

Please complete the textual information and check the boxes that apply.

- Example Target & Disparate Population Infrastructure Health Objective

Number: 2,232,169 (This number represents the state's population count).

State and Local Health Departments

Boards, Coalitions, Task Forces, Community Planners, Policy Makers

Disease Surveillance (High Risk)

Community Based Organizations

Health Care Systems

Research and Educational Institutions

Business and Merchants

Safety Organizations

Other

Evidence Bases Guidelines and Best Practices

1. Definition: Evidence Based Guidelines/Best Practices

- As of FY2007, the PHHS Block Grant will begin to capture information about the public health science that is the bases of interventions that are carried out with Block Grant dollars.

2. Example: Evidence based guidelines for the LPPCP's intervention guidance includes: CDC documents 1) *Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials*, November 1997 and 2) *Managing Elevated Blood Lead Levels Among Young Children: Recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention*, March 2002, the Connecticut Department of Public Health Lead Poisoning Prevention and Control Regulations

3. Discussion

List of Evidence Based Guidelines and Best Practices

Evidence Based Guidelines ---- United States

CDC Recommends: The Prevention Guidelines System (Centers for Disease Control and Prevention)

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

Guide to Community Preventive Services (Task Force on Community Preventive Services)

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Best Practices (Experienced -Based)

Best Practice Initiative (U.S. Department of Health and Human Services)

Model Practices Database (National Association of County and City Health Officials)

Promising Practices Network (RAND Corporation)

4. **BG-MIS:** Program/HO. Evidence Based Guidelines.

F. Essential Services, Impact Objectives and Activities

Essential Services:

Page Limit: The Essential Service is selected from a drop down list.

1. Definition: The 10 Essential Public Health Services are comparable with those proposed by the Institute of Medicine in its 1988 report, The Future of Public Health (i.e. assessment, health policy development, and assurance of quality health services). The analysis of the core functions are part of the refocusing and strengthening of public health under the reformed health care system.

The 10 Essential Services and definitions are listed below. Each Essential Service specifies various activities that are carried out to address a health problem. More than one Essential Service may be chosen. The Activities should be unique to the nature of the Essential Service.

Essential Service 1 - Monitor health status - (this service area comprises the collection, analysis, and integration of information systems to accurately assess the health status of the populations. Examples: BRFSS, health assessment tools, surveillance, health profiles, integration of public and private data systems.)

Essential Service 2 - Diagnose and Investigate -(this service area comprises epidemiological and laboratory identification of disease outbreaks, screening and testing services, client interviewing and following, investigations for disease transmission)

Essential Service 3 - Inform and Educate -(this service area comprises social marketing and media campaigns, pamphlets, providing health information to providers, communities, worksites, patients, and culturally and linguistically appropriate materials)

Essential Service 4 - Mobilize partnerships-(this service area comprises convening and facilitating coalitions, participation on workgroups, development of partnerships to improve human and material resources targeted to health status improvement)

Essential Service 5 - Develop policies and plans -(this service area comprises health improvement plans, strategic planning, development of consistent policy and procedures regarding prevention and treatment services, development of codes, regulations and legislation to guide the practice of public health)

Essential Service 6 - Enforce laws and regulations- (this service area comprises enforcement of codes and regulations regarding sanitary codes, clean air standards, quality assurance of laboratory standards)

Essential Service 7 - Link people to services -(this service area comprises activities to support a coordinated system of clinical care services)

Essential Service 8 - Assure competent workforce-(this service area comprises education and training for personnel, licensure of professionals, continuing education and development programs, and conferences)

Essential Service 9 - Evaluate health programs-(this service area comprises ongoing evaluation activities using the data collected in Intervention area 1 (monitoring health status) to assess program effectiveness and guide resource allocations and intervention strategies)

Essential Service 10 - Research - (this service area comprises continuous linkage with appropriate institutions of higher learning and research and an internal capacity to mount timely epidemiologic and economic analyses and conduct needed health services research)

2. Example:

Essential Service 1 - Monitor health status
Essential Service 3 - Inform and Educate
Essential Service 8 - Assure competent workforce

3. Discussion: CDC uses the 10 Essential Services framework to enhance the capability to better identify and describe the value and uses of block grant dollars. The goal is to be able to categorize and identify according to the 10 Essential Services what activities are funded using block grant dollars. CDC will use the 10 Essential Services to produce national profiles of how the block grant dollars are supporting either one or numerous Essential Services within National Programs. (For Example: if 30 States put block grant dollars into HO 12-1 Coronary Heart Disease and the dollars are used in Essential Service 1-Monitor Health Status to produce community health assessment plans. CDC can portray that the Block grant supports efforts to determine the health status of the populations in 50% of grantees).

4.BG-MIS: ES -- 10 Essential Services

Impact Objectives:

Page Limit: The Impact Objective should be concise, reflecting the data elements identified in the Definition section below. Include at least one, but no more than 5 Impact Objectives for each Essential Service.

Note: The Impact Objective is entered by SMART (Specific, Measurable, Achievable, Realist, Time Based) component. Click the Preview SMART Objectives button to create the objective.

- 1. Definition:** Impact objectives identify what you expect to happen as a result of the activities that are carried out. Impact Objectives (and Activities) are entered under the selected Essential Services. They are completed within a 2 to 3 year timeframe and are considered strategic for planning purposes.
- 2. Example:**

Impact Objective: Increase Electronic Monitoring

Between 10/2006 and 09/2007, the LPPCP will increase the number of laboratories that electronically report blood lead analysis results to DPH from a baseline of 9 laboratories (53%) to 12 laboratories (71%).

Title: Increase Electronic Monitoring

(Time bound)

Begin Date: 10/2006

End Date: 09/2007

Who will do the work? (Specific) the LPPCP

What will be accomplished and to what extent does this represent change over the baseline?

increase the number of laboratories that electronically report blood lead analysis results to DPH from a baseline of

Baseline: of 9 laboratories (53%) to 12 laboratories (71%).

Note: The baseline does not need to represent health status. It can be the estimated number of trainings that were held in FY2006 versus the number that are projected for FY2007. Or, the estimated number of health promotion programs that will be carried out versus the number that are currently carried out. The increase or decrease over a baseline is one of the determinants of Achievable and Realistic.

Example:

VERBS: A cross section of work plans were reviewed to identify verbs that could be used in the “to-be-developed” BG-MIS automated tool. Use a verb from this list when describing what will be accomplished in the Measurable/Achievable/Realistic portion of your objective

1. Increase
2. Decrease
3. Maintain
4. Update
5. Develop
6. Collect
7. Implement
8. Establish
9. Evaluate
10. Publish

Discussion: Due to major inconsistencies in grantee work plan information the PHHS Block Grant program has decided to use a structured format in the new BG-MIS system for writing Impact Objectives. Attempts have been made to make the tool for writing SMART objectives as flexible as possible while establishing consistency in writing objectives from grantee to grantee.

Annual Activities:

Page Length: The page length should not exceed ½ page for 1 set of 3 to 5 activities.

1. Definition: Activities are short term and are carried out in order to obtain the desired Impact. In accordance with the PHHS Block Grant legislation, Activities are 1 year in length and are considered tactical. Activities include a begin and an end date, and a count. They do not need to include a baseline or a data source.

2. Example:

Annual Activity 1: Between 10/2006 and 09/2007, Identify 3 laboratories that will submit data electronically through assessment of the number of hard copy blood lead lab results submitted by private and commercial laboratories.

Annual Activity 2: Between September 1 2006 and October 1 2007 Meet with the 3 laboratory directors to identify technical barriers to electronic submission, develop strategies to overcome identified barriers, and identify dates to begin electronic reporting.

Annual Activity 3: Between 10/2006 and 09/2007 DPH will provide the laboratory Information Technology personnel with the criteria for electronic submission for the laboratories that are interested in electronic submission of blood lead data.

WORK PLAN REVIEW

The CDC Project Officer will review the following Work Plan sections:

- 1. Page Limits
- 2. Cover Page
- 3. Statutory Information
- 4. Budget
- 5. Programs/HO's

Each section will be identified as:

- Approved
- Approved with Recommendations
- Not Approved
- Not Reviewed

Work plans that receive a rating of Not Approved for any one of the 5 sections will be electronically marked with a status of Not Approved. The deficient items must be corrected and the plan re-submitted.

Items with the status of Approved with Recommendations do not require a work plan re-write.

A work plan is approved when all 5 of the areas reviewed receive a rating of Approved or Approved with Recommendations.