NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

TRIENNIAL REPORT

2004 – 2006

Public Health in New York City

Michael R. Bloomberg, Mayor

Thomas R. Frieden, MD, MPH, Commissioner

Mission...


Our mission
is to protect and
promote the
health of all
New Yorkers.

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Letter from Mayor Bloomberg

Dear Fellow New Yorker:

We live in the greatest city in the world—and we are fortunate to be served by a wonderful Health Department. No public health agency anywhere better combats the leading preventable causes of illness and death.

The Health Department has done this through cutting-edge information technology, reliance on sound data and informed decisions, sharp focus on the city's greatest health problems and commitment to effective program management. This evidence-based approach to improving the health of New Yorkers continues to set the standard for national public health programs. Groundbreaking initiatives have begun to yield big health benefits.

In 2004, the Health Department launched **Take Care New York,** the first-ever comprehensive citywide health policy, targeting health care access, smoking, heart health, HIV, depression, substance abuse, cancer, lead poisoning, domestic violence and maternal-infant health. **Take Care New York** has helped focus the Department's and the city's efforts, and provided a framework to address many of our toughest problems. As a result of tobacco control efforts, 240,000 fewer New Yorkers smoke today than just a few years ago. This will prevent an estimated 80,000 premature deaths in years to come.

The initiatives described in this report do not by any means represent all Health Department activities. Together, however, they begin to tell the story of the many dedicated people working hard every day to protect the health of the more than eight million people who call New York City home.

Sincerely,

Michael R. Bloomberg
Mayor

Letter from Commissioner Frieden

Dear Fellow New Yorker:

Dr. Hermann Biggs, the city's medical officer more than 100 years ago, noted: *"Public health is purchasable. Within natural limitations, a community can determine its own death rate."*

While Dr. Biggs could hardly have predicted some of the challenges we face today—HIV and other emerging infectious diseases, the twin epidemics of obesity and diabetes—his notion that many of our most serious problems are within our own power to solve is as true today as ever. **Take Care New York,** our citywide health policy, is based on this principle. We have identified and are fighting battles that are hard but winnable. And we are succeeding by bringing our best resources to bear—people, commitment, money and technology.

April 2005 marked the 200th anniversary of New York City's Board of Health, the predecessor of the current Department of Health and Mental Hygiene. Today, our Health Department's more than 6,000 staff set the standard for public health. Over the past three years, we've learned more about New Yorkers' health, and done more to prevent and control illness. We achieve this by:

- **Getting the information needed to design, monitor and evaluate programs:** Each year, the Health Department conducts the NYC Community Health Survey, contacting 10,000 New Yorkers by phone to ask targeted health questions. In 2004, we conducted the NYC Health and Nutrition Examination Survey, the nation's first local survey to include both personal interviews and physical examinations. The World Trade Center Heath Registry, the largest post-disaster registry ever in the United States, is already helping us improve health and mental health treatment, and better prepare for future disasters. These and other surveys have led to new or improved programs in areas such as immunization, heart disease prevention and control, diabetes control, depression and anxiety disorders, tobacco control and West Nile virus prevention.

- **Building effective programs:** Our five-point tobacco control program is one effective initiative. Through taxation, smoke-free legislation, hard-hitting educational campaigns, cessation programs and continuous evaluation, the number of smokers declined nearly 20% between 2002 and 2006, with an average decline of more than 5% per year. In addition, enhanced emergency preparedness, improved services for children with developmental delays, prevention and control of infectious diseases, and home visiting services for new mothers are among our many important and effective programs.

- **Coordinating community outreach:** Working with communities, we greatly increased the rate of colonoscopy screening, helped reduce the incidence of childhood lead poisoning, increased the involvement of consumers in the design and evaluation of mental hygiene services, worked to prevent HIV and more.

The hard work, expertise, dedication and creativity of the Health Department's extraordinary staff cannot be described in a single report. They—and our many partners—help New Yorkers live longer and healthier lives.

Sincerely,

Thomas R. Frieden, MD, MPH
Commissioner

Take Care New York: Setting New Goals and Standards

Take Care New York serves as the framework for programs and activities throughout the Department of Health and Mental Hygiene (DOHMH). Launched in March 2004, this groundbreaking, comprehensive health policy sets an agenda for evidence-based intervention against the 10 leading causes of preventable illness and death in our city.

Ten Steps to a Longer, Healthier Life

1. Have a regular doctor or other health care provider
2. Be tobacco-free
3. Keep your heart healthy
4. Know your HIV status
5. Get help for depression
6. Live free of dependence on alcohol and drugs
7. Get checked for cancer
8. Get the immunizations you need
9. Have a safe and healthy home
10. Have a healthy baby

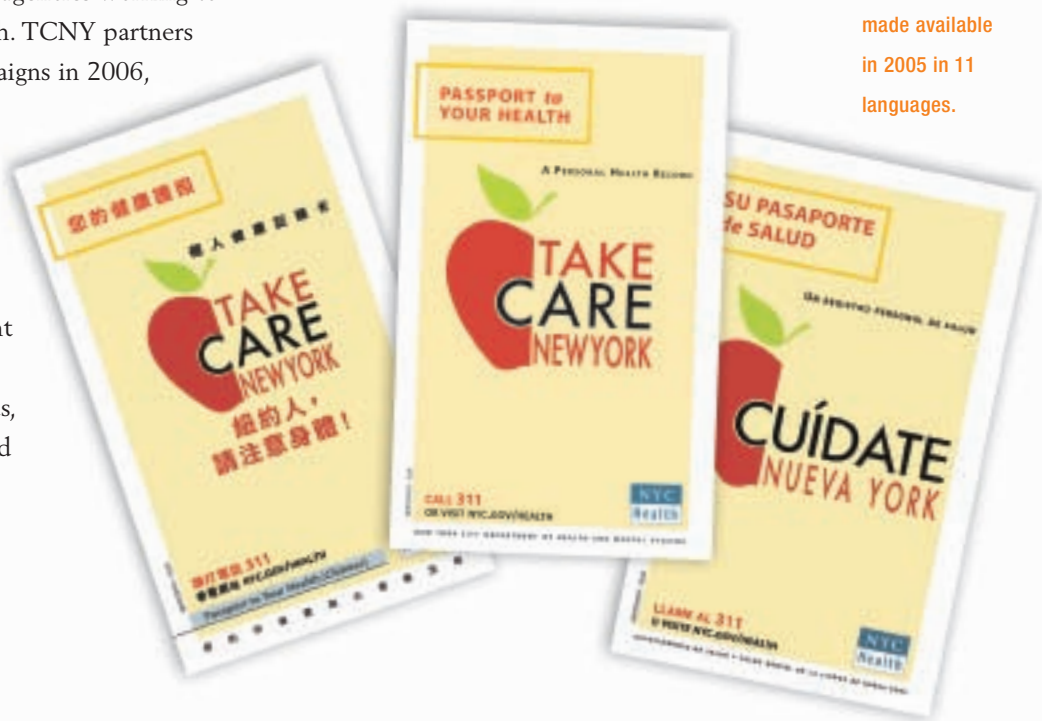
Take Care New York (TCNY) seeks to increase knowledge regarding health, improve medical providers' delivery of services, and encourage policy and environmental changes to improve health. The program sets ambitious but achievable targets for 2008, and gives us a mechanism to assess the current health status of all New Yorkers.

Progress on the City's Health Agenda

TCNY has helped DOHMH, other agencies and the public focus on actions most important to promoting health. The rollout of TCNY and its 10 health goals was publicized through media campaigns and broad distribution of educational materials. In the first three years, DOHMH distributed nearly 3.5 million copies of *Passport to Your Health*, a personal health record designed to encourage New Yorkers to talk to their doctors about preventive health care and track key health indicators. First published in English and Spanish, Passports were made available in nine additional languages in 2005 – Russian, Chinese, Italian, Haitian Creole, Yiddish, Polish, Urdu and Arabic. By 2007, TCNY established a network of more than 270 partner organizations, including hospitals, health clinics, insurers, community-based organizations and other city agencies working to improve New Yorkers' health. TCNY partners participated in several campaigns in 2006, among them initiatives to distribute condoms, increase HIV rapid tests and flu shots, and help New Yorkers quit smoking.

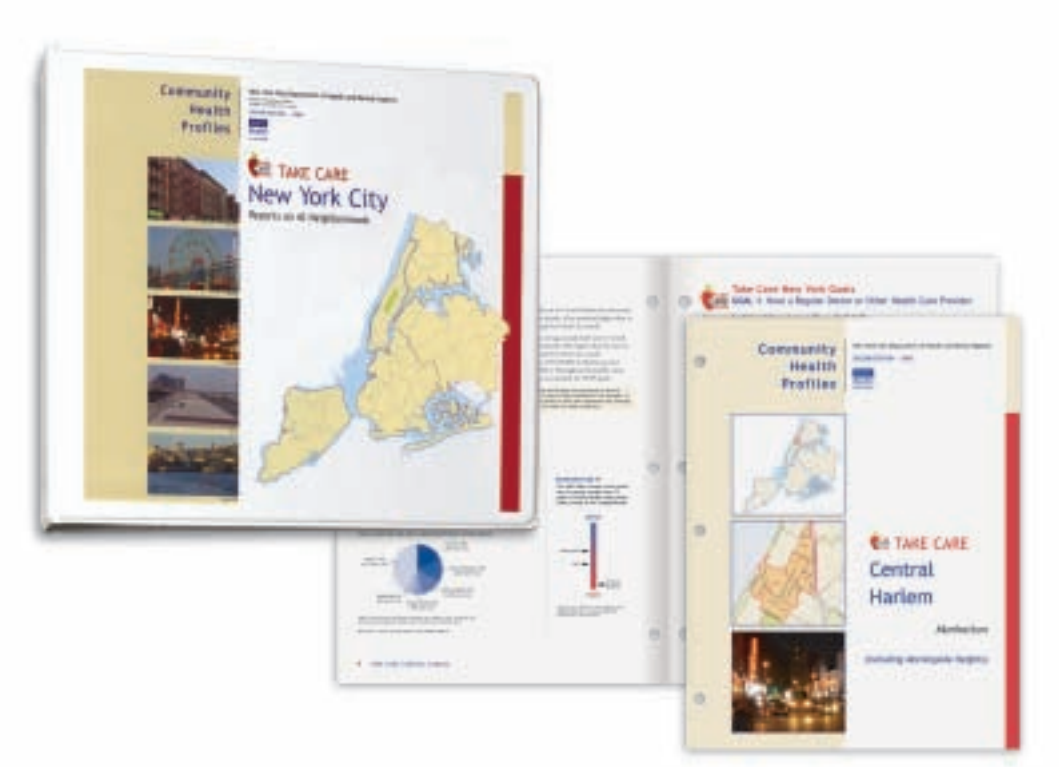
By year-end 2006, significant progress had been made in eight of the 10 priority areas, and two had already reached the 2008 goal:

- **More than 240,000 fewer smokers.** The percentage of New Yorkers who smoke decreased from 21.5% in 2002 to 17.5% in 2006, surpassing the 2008 goal of less than 18%.
- **A 44% increase in colonoscopy screening rates.** The percentage of New Yorkers over age 50 who had received a screening colonoscopy for colorectal cancer within the previous 10 years increased from 42% in 2003 to 60% in 2006, reaching the 2008 goal. The revised target is now that 80% of New Yorkers age 50 and older to be screened by 2011.
- **265,000 more New Yorkers have a regular doctor.** The number of New Yorkers with a regular health care provider increased from 4,470,000 in 2002 to 4,745,000 in 2006 (more than two-thirds of the way to the 2008 goal of 4,850,000).
- **508 fewer deaths from HIV.** The number of New Yorkers who died from HIV/AIDS-related illness fell from 1,713 in 2002 to 1,209 in 2006 (more than two-thirds of the way to the 2008 goal of fewer than 1,000 HIV/AIDS-related deaths).



Passports were made available in 2005 in 11 languages.

In 2006, DOHMH issued Community Health Profiles based on the TCNY framework for each of the city's 42 neighborhoods.



- **More than 100 fewer deaths from alcohol.** The number of New Yorkers who died from alcohol-attributable causes decreased from 1,551 in 2002 to 1,450 in 2005 (two-thirds of the way to the 2008 goal of 1,400 deaths).
- **A 10% reduction in women who die from intimate-partner homicide.** The three-year average rate of women killed by an intimate partner has decreased from 1.0 per 100,000 from 2000-2002 to 0.9 per 100,000 from 2003-2005.
- **Fewer young children newly identified with lead poisoning.** Comparing 2006 to 2002 data, 211 fewer children younger than six years were newly identified with a blood lead level that required environmental investigation and were exposed to an identified lead-based paint violation (more than one-third of the way to the 2008 goal of fewer than 260 children).
- **A 2% decrease in infant deaths.** The infant mortality rate has dropped from 6.0 per 1,000 live births in 2002 to 5.9 per 1,000 live births in 2006 (10% of the way to the 2008 goal of 5.0 per 1,000 live births).

While DOHMH made progress toward many **Take Care New York** goals, there is more to be done. For example, DOHMH must work to:

- **Reduce drug-related deaths.** In 2006, 34 more New Yorkers died from drug-related causes—a total of 939, up from 905 in 2002.
- **Increase breast cancer screening rates.** The percentage of women aged 40 and older who received a mammogram in the past two years declined from 77% in 2002 to 75% in 2006.
- **Increase flu vaccination rates.** Flu immunizations among New Yorkers aged 65 and older fell from 63% in the 2001-2002 flu season to 59% in the 2005-2006 flu season.

In addition, health disparities persist among economic and racial/ethnic groups. Closing these gaps will reduce inequalities and improve New York City's overall health.

Addressing Disparities

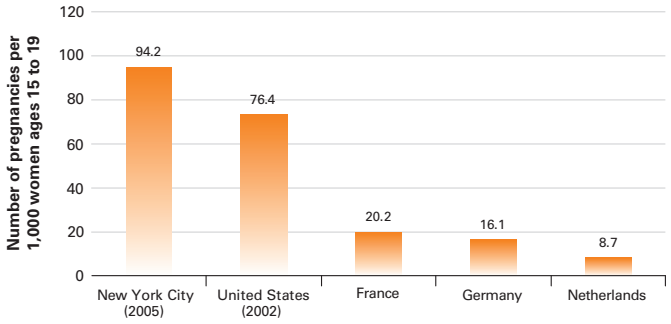
Low-income New Yorkers, and black and Hispanic New Yorkers, are more likely to suffer from a wide variety of health problems. Such health disparities have been highlighted in several DOHMH reports, including Community Health Profiles for each of the city's 42 neighborhoods (published in 2003 and updated to reflect the TCNY framework in 2006), and in the 2004 report, *Health Disparities in New York City*. As part of its response to these unacceptable inequalities in health, DOHMH has established District Public Health Offices (DPHOs) in the city's three most vulnerable communities—East/Central Harlem, South Bronx and North/Central Brooklyn.

In these neighborhoods, residents are more likely than other New Yorkers to have asthma, cancer, HIV/AIDS, diabetes, heart disease and obesity, and more likely to die young. Although only one in six New Yorkers lives in these three areas, one in four premature deaths occurs in these neighborhoods. If the health of residents in these areas matched that of residents in New York's healthiest neighborhoods, nearly 4,000 lives would be saved each year.

DPHOs all have a range of comprehensive programs aimed at reducing disparities, with special focus on asthma management in East and Central Harlem, lead poisoning reduction in Central Brooklyn and teen pregnancy prevention in the South Bronx. In low-income neighborhoods, asthma rates are four times the citywide average. The Managing Asthma in Schools program coordinates asthma management for students by involving school nurses, parents and health care providers (see page 31). Although childhood lead poisoning remains a serious problem (especially for children who are poor and live in deteriorated housing), the number of new cases with blood lead levels of 10 mcg/dL or higher identified in 2006—2,310 among children aged 6 months to 6 years—marks the lowest level ever. This is a 13% decline from 2005 and an 88% decline since 1995, when nearly 20,000 children were newly identified with lead poisoning.

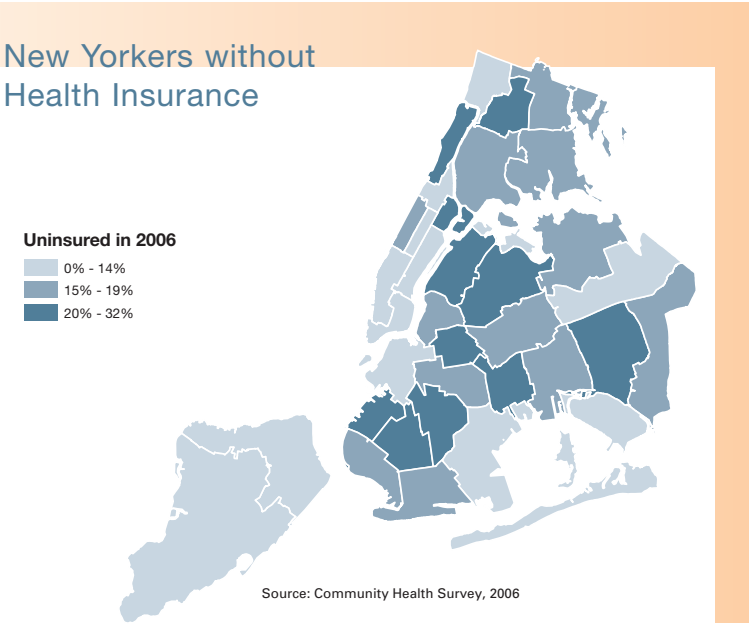
In 2005, the citywide teen pregnancy rate was 94.2 per 1,000 females ages 15 to 19, and there were significant disparities across boroughs, races and ethnic groups. The rates ranged from 63.3 per 1,000 in Staten Island to 125.8 in the Bronx, and from 29.8 per 1,000 for non-Hispanic white teens to 131.5 for non-Hispanic black teens. The Healthy Teens Initiative addresses the need for teen-friendly reproductive health services.

NYC's Teen Pregnancy Rate is Higher than the National Average



The Healthy Teens Initiative addresses the need for teen-friendly reproductive services. Pictured are members from the South Bronx DPHO.

Transforming Public Health: Data and New Technology



The work of DOHMH is grounded in data. Our public health and mental hygiene programs rely on data to:

- **Detect health problems and set priorities.** Epidemiologic data from vital statistics, population-based surveys, surveillance registries of reportable health conditions and other data sources are analyzed to characterize New Yorkers' health problems, identify groups at greatest risk and isolate factors causing the disease or health problem. Data from calls to 311, complaints and community feedback identify the public's top health concerns.
- **Select and evaluate evidence-based programs to address health problems.** DOHMH also uses data to determine whether existing programs are effectively addressing New Yorkers' needs.
- **Manage and monitor programs to ensure efficiency and efficacy, and identify and correct problems promptly.** Programs make use of regular performance data to evaluate their impact on an ongoing basis; this information is also used in executive-level Quarterly Program Review meetings which serve to ensure that all agency programs have the support and oversight needed to be successful.

Assessing the Health of New Yorkers

To better understand the health of New Yorkers, DOHMH routinely conducts representative health surveys that define the scope of health problems and risk behaviors, identify groups at highest risk, and provide direction and evaluation indicators for prevention programs and services.

Community Health Survey

An annual telephone survey of 10,000 adults, representing every neighborhood in New York City, the Community Health Survey (CHS) was initiated in 2002 and has served as one of the pillars of health information for the agency and the public ever since. Random-digit-dialing techniques are used to contact adults from households in each neighborhood. Results are shared with programs throughout the agency and with the public via an interactive website—www.nyc.gov/health/epiquery.

Survey results have revealed important patterns and trends for a wide range of health indicators. By tracking smoking levels in NYC adults, the CHS has identified groups with smoking rates higher than the citywide average. These include the uninsured and underinsured, adults with substance abuse and mental health problems, homeless adults, people who have been incarcerated and residents of Staten Island. DOHMH has been able to use this information to target its education and cessation efforts (see pages 15-16) to reach the greatest number of smokers possible.

NYC Health and Nutrition Examination Survey

Conducted in 2004, the NYC Health and Nutrition Examination Survey (NYC HANES) was the first local survey of its kind in the United States. The survey uses interviews and physical examinations to gather information on important health conditions, including diabetes, obesity, high blood pressure, high cholesterol and depression. It also collects information on awareness and management of these conditions. NYC HANES is modeled on the NHANES, the national survey used by the Centers for Disease Control and Prevention (CDC) to track the nation's health for the past 35 years. NYC HANES was adapted to reflect the uniqueness of our city and to obtain data of local relevance.

NYC HANES was administered by about 90 specially-trained full- and part-time DOHMH employees. They approached 4,026 households in all five boroughs—3,388 households completed eligibility questionnaires and 1,999 individuals participated in the survey. Each participant who completed the survey received a $100 cash payment and approximately $300 worth of medical testing. Survey responses and test results were strictly confidential. Data from the survey have led to activities such as preventing mercury poisoning and better understanding of heart disease, mental illness, HIV, diabetes and much more.

Youth Risk Behavior Survey

DOHMH collaborates with the CDC and the city's Department of Education to administer the Youth Risk Behavior Survey (YRBS). Like NYC HANES, YRBS is based on a protocol developed by the CDC for a national survey. In the spring of 2005, 8,140 students in 87 public high schools completed the survey, a self-administered, anonymous, 99-item questionnaire measuring risk behaviors such as tobacco use, alcohol and drug use, unintentional injury and violence, sexual behaviors, dietary behaviors and physical activity. Analysis from the survey showed that youth smoking had dropped by half, (to 30,000 of 280,000 high school students), since 1997. The survey also identified target populations for tobacco control efforts—one in three white students smoked, compared to one in 10 Hispanic, and one in 15 black students.

Health Measures Assessed in NYC HANES

Physical Exams
- Blood pressure
- Height, weight, arm and waist circumference

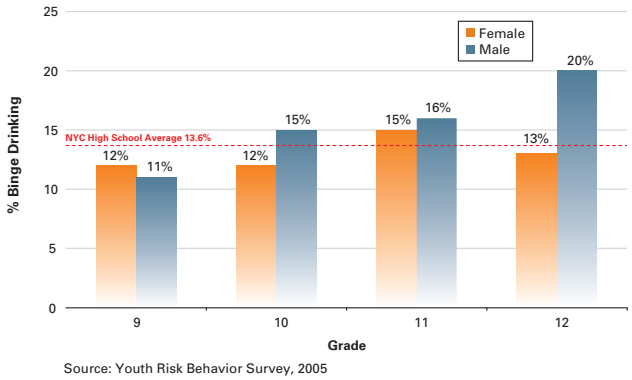
Blood Tests
- Lipid profile
- Diabetes measures (fasting plasma glucose, glycohemoglobin)
- Cotinine (a by-product of tobacco smoke)
- Hepatitis C virus
- Herpes simplex 2 virus
- Mercury, cadmium and lead

Urine Tests
- Exposure to pesticides and metals

In-person Interviews
- Health status
- Nutrition
- Tobacco use
- Alcohol use
- Reproductive health
- Mental health
- Health care access and utilization

Audio Computer-Assisted Self Interview
- Sexual behavior

Binge Drinking Increases with Age among Boys



Source: Youth Risk Behavior Survey, 2005

Snapshot: 311

In 2003, Mayor Bloomberg introduced one-stop shopping for all non-emergency, city-related questions and services. By calling 311, residents can learn about events, get transit updates, find health clinics, report housing problems and much more.

The largest call center of its kind in the nation, 311 consolidated more than 40 separate call centers and hotlines, and 11 pages of government listings in the phone book. By June 2007, more than 50 million people had used the service, which operates 24/7 all year long and provides nearly 180 language translation services.

In addition to helping New Yorkers get the information and services they need, 311 also helps the city and the Health Department learn about New Yorkers. For example, through 311, DOHMH was able to identify more rodent infestations (see page 36) and provide tens of thousands of people with smoking-cessation assistance (see page 14).

Data for Management and Accountability

Since 2005, Quarterly Program Review meetings replaced traditional performance-indicator reporting with a feedback-based management process to sustain and improve performance. Division's key staff meet at regular intervals with the agency's commissioner and chief operating officer to discuss bureau highlights, review performance data and track progress on initiatives. Program performance data include information on workload and outputs, outcomes, quality and efficiency—all related to annual goals for the agency and its divisions. Quarterly Program Review meetings support successful activities, identify and correct performance issues, and focus on priorities as initiatives multiply. Meeting preparation also helps each division review and assess its own activities.

In 2006, the agency started producing monthly reports that include data on selected programs and progress on specific initiatives. These reports facilitate regular communication between agency programs and senior staff.

21st Century Information Technology

From 2004-2006, DOHMH adopted innovative and award-winning information technology applications to improve the quality of clinical care, enhance program operations and customer service, and automate agency business processes. Upgrades and advancements included:

Electronic Health Records and Registries

To improve clinical care, the agency developed the Sexually Transmitted Disease (STD) Electronic Health Record, enabling STD clinics to be entirely paperless. In 2005, the application won the City of New York Excellence in Technology Award for Best In-House Developed Application. The Tuberculosis Prevention and Control program also implemented electronic health records to improve efficiency and accuracy. In 2006, a groundbreaking program, the Primary Care Information (PCIP), was established to support the adoption and use of electronic health records among more than 1,000 primary care providers in New York City's underserved communities (see page 19). The first wave of providers began using this technology in 2007. DOHMH has also developed a hepatitis B registry, started developing a hemoglobin A1C registry to track blood sugar levels in patients with diabetes (see page 23) and conducted follow-up surveys for the World Trade Center Health Registry (see pages 12-13).

Mobile Handheld Technology

Program performance improved with expansion of mobile, handheld computing technology, which enhances operational efficiency and minimizes data entry errors and delays. Restaurant inspections are now completed entirely with handheld computers with portable printers. Day care inspectors now use handhelds developed in 2005 and 2006 to guide and record their 8,000 annual inspections. In 2006, the Day Care Handheld won Mobile Enterprise Magazine's Mobilizer Award for Best Mobile Development. In 2004, the agency completed development of a handheld device that receives data from radiological and chemical monitoring field equipment, and maps that data using Global Positioning System technology. In 2004, the project won the City of New York Excellence in Technology Award for Most Innovative Use of Technology. In 2006, DOHMH completed development of a handheld device for the Newborn Home Visiting Program and started creating one for the Pest Control Program.

The Agency has equipped inspectors with handheld computers.

Laboratory and Disease Reporting

From 2004 to 2006, DOHMH continued developing the Laboratory Information System, which was configured for the agency's tuberculosis, sexually transmitted disease, HIV, microbiology and virology laboratories. Program automation also included the Electronic Clinical Laboratory Reporting System (which enables external laboratories to electronically report test results for reportable diseases to DOHMH and the New York State Department of Health); the Electronic Universal Reporting Form (which allows providers to report all reportable diseases and conditions to DOHMH) and the Public Health Information Network Messaging System (used for disease information transfer between local, state, and federal agencies).

Office of Vital Records

The agency's Office of Vital Records is automating its processes to improve customer service, and, over 12 months in 2006 and 2007, scanned and indexed 14 million birth and death certificates. When complete, the new system will automate record retrieval and ensure that records survive major disasters. In 2006, Vital Records also launched pilot sites for the Electronic Death Registration System, which will use the Internet and biometrics to automate the registration of death certificates. The same system also automates the provision of burial permits to funeral homes.

Internal DOHMH Processes and Resources

Internal agency operations have also improved with the automation of business processes. An internally developed, workflow-based automated hiring approval system provides speedy electronic personnel data collection and hiring approval, improving accountability. Eleven automated processes were added to the agency's extant workflow product, enabling electronic processing of travel arrangements, vendor performance evaluations and requests to initiate contracts and website changes. DOHMH also launched its Geographic Information Systems (GIS) Center of Excellence to provide agency-wide mapping services, training and a GIS data repository.

From 2004-2006, DOHMH also initiated a series of new, cross-agency research projects that required complex matches and linkages between large datasets. In 2005, the Health Department, together with the Department of Homeless Services, released a comprehensive report on the health of homeless adults in NYC, describing mortality rates and prevalence of health conditions such as HIV and tuberculosis. In 2006, DOHMH, with the Departments of Transportation, Police and Parks, released a comprehensive review of 10 years of bicycling fatalities and serious injuries. Both reports detailed a 12-month plan of action in steps that governmental agencies could take to address specific issues, leading to stronger collaborative planning between sister city agencies. In 2006, a third cross-agency project with the Health Department and the Departments of Corrections and Homeless Services was initiated to examine the health of inmates.

Birth records spanning from 1910 to 2006, and death certificates from 1989 to 2006, were scanned and indexed.

Every week, the Office of Vital Records fulfills more than 11,500 requests for birth certificates.

The Primary Care Information Project (PCIP) supports the use of electronic health records by primary care providers.

9/11 Aftermath: Addressing Health, Mental Health and Chemical Dependency in New York City

The WTCHR disseminates information through its website, a quarterly newsletter and a resource guide.

September 11, 2001, continues to affect the physical and mental health of thousands of New Yorkers. DOHMH is working to monitor, evaluate and analyze the health impact of this disaster so that those affected can receive the help they need. In the immediate aftermath of 9/11, the agency released reports about the air quality both in and outside buildings in the area, conducted and published community needs assessments, helped link affected people with health care services; Project Liberty provided crisis counseling and education to nearly 1.5 million people. In 2003, the Health Department established the World Trade Center Health Registry (WTCHR). The agency also helped develop clinical guidelines for 9/11-related health problems and in 2006, participated in the Mayor's interagency WTC Panel, which released an important report, *Addressing the Health Impacts of 9/11,* in February 2007.

World Trade Center Health Registry: Recording and Understanding Health Impacts

More than 71,000 enrollees completed baseline health interviews between September 2003 and November 2004, making the World Trade Center Health Registry (WTCHR) the nation's largest public health registry. Its primary objective is to track the long-term physical and mental health impacts of highly-exposed individuals: rescue, recovery and clean-up workers; volunteers; survivors of collapsed and damaged buildings; passers-by; occupants of nearby buildings; and residents and school children in Lower Manhattan. Participants are asked to complete follow-up health surveys every two to three years; the first follow-up survey was launched in November 2006. Findings from the baseline survey have highlighted the physical and mental health impacts in rescue and recovery

workers, Lower Manhattan residents and survivors of the Twin Towers. For example:

- More than half (57%) of the 8,400 adults evacuated from damaged or collapsed buildings, including the World Trade Center towers, reported new or worsening respiratory symptoms, and nearly all reported witnessing at least one traumatic event.
- 3.6% of the 25,000 rescue and recovery workers and volunteers who worked at the WTC site reported new-onset asthma after responding to the attacks, a rate 12 times that expected for adults during the same time period.
- One in eight (12.4%) had probable post-traumatic stress disorder (PTSD) three years after 9/11; the prevalence of PTSD in the U.S. population is about 4%.

Both asthma and PTSD are potentially lifelong, chronic conditions that can be controlled with appropriate treatment.

The Registry also facilitates in-depth studies by DOHMH and outside researchers. At the time of enrollment, most participants (91%) consented to be contacted by DOHMH and external researchers for 9/11-related studies. Between 2004 and 2006, the WTCHR Review Committee approved three external research projects focused on evacuation practices and post-traumatic stress. Working with Bellevue Hospital and New York University, the WTCHR also launched an in-depth, follow-up study of respiratory health among Lower Manhattan residents and building occupants with persistent respiratory symptoms. And in 2006, the WTCHR began developing methods for assessing cancer and mortality in participants.

The WTCHR also disseminates information through its website, a quarterly newsletter and a comprehensive resource guide for enrollees and others in the community.

In the summer of 2006, in collaboration with colleagues at Mt. Sinai Medical Center, the Fire Department of New York, and others, DOHMH developed updated clinical guidelines for health care providers on treating adults exposed to the disaster.

Mayor's Panel: Addressing the Health Impacts of 9/11

To coordinate and enhance the city's long-term response to the tragedy, in 2006 Mayor Bloomberg convened a panel to provide a comprehensive assessment of WTC-related health issues. In response to the panel's recommendations, the Department appointed a WTC health coordinator to foster and coordinate communication and outreach to all those affected or potentially affected by 9/11-related health issues. DOHMH has launched a comprehensive WTC site (www.nyc.gov/9-11HealthInfo), that offers comprehensive, up-to-date information on 9/11-related health problems and services.

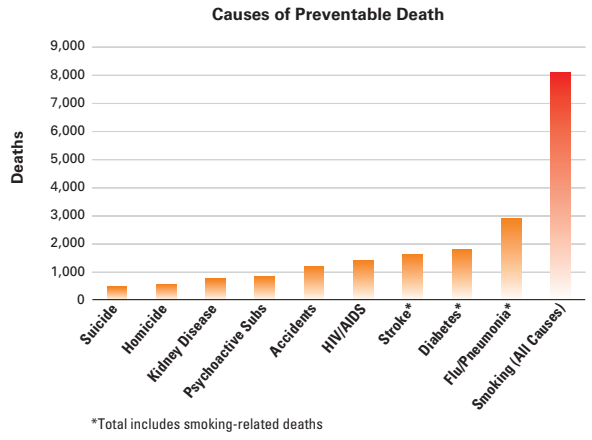
Type of 9/11 Responder	PTSD, 2003-2004
All	12.4%
Unaffiliated volunteer	21.2%
Construction, engineering	17.8%
Firefighter	12.2%
Other government worker	11.8%
EMS	11.6%
Sanitation	10.6%
Volunteer with an organization	7.2%
Police	6.2%

More than 71,000 enrollees completed baseline health interviews between September 2003 and November 2004.

Stopping Smoking: Success with Comprehensive Tobacco Control

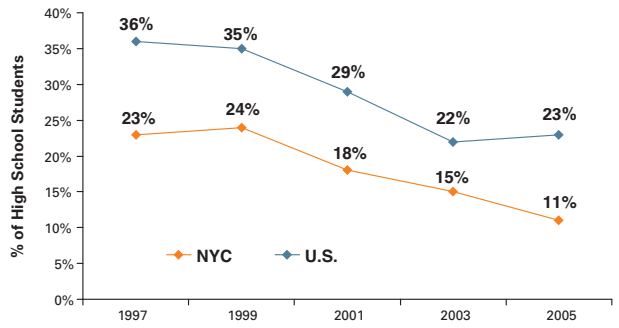
New York City leads the nation in tobacco control. Between 2002 and 2006, the number of smokers declined by 240,000 citywide, preventing an estimated 80,000 early deaths in future years. The smoking rate among New York City women dropped from 20% to 15%, and the rate among men from 23% to 20%. Both of these reductions exceeded national ones, but more than 1 million New Yorkers continue to smoke and smoking remains the leading cause of preventable death in New York City. There is much more work to do.

Smoking is New York City's Leading Cause of Preventable Death



*Total includes smoking-related deaths

Teen Smoking in New York City Fell to Half the National Rate



Source: Youth Risk Behavior Survey

Between 2004 and 2006, the Health Department focused on education, cessation and evaluation activities, the three key areas of its comprehensive five-point plan. The other two areas—taxation and smoke-free workplace legislation—were enacted previously. Further tax increases are needed to keep pace with inflation, and are pending approval by the state legislature.

Taxation and Legislation: Tax Increases and the Smoke–Free Air Act

In 2002, DOHMH raised the cigarette tax from eight cents to $1.50 per pack, effectively increasing the price for a pack of cigarettes to about seven dollars. In 2003, the city's comprehensive smoke-free air law went into effect, prohibiting smoking in almost all indoor workplaces, including restaurants and bars. By 2007, smoking prevalence had dropped from 21.5% to 17.5%. By 2007, the real price of a pack of cigarettes had declined by about 60 cents and the Department has been advocating for another 50-cent increase.

DOHMH ran hard-hitting ads focused on the negative effects of smoking.

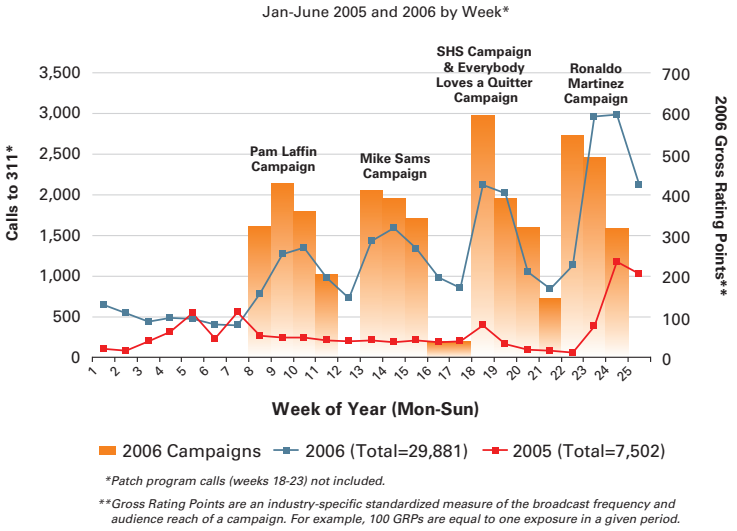
Education: Using Innovative Media to Raise Awareness

The Health Department's educational efforts have focused on the consequences of smoking and the benefits of quitting. In 2004, the agency developed unique media campaigns targeting Chinese and Russian smokers. In 2006, DOHMH ran its largest media campaign to date, featuring hard-hitting ads focused on the negative effects of smoking, including testimonials of sick or dying smokers. Calls to 311 (see page 10) for quit-smoking assistance rose 400% during the campaign's initial run from January to June 2006, and jumped from 7,500 calls to 30,000 calls for the same period in 2005.

In 2004, the agency targeted educational and outreach efforts to Chinese and Russian smokers.

In 2005, DOHMH distributed 45,000 free six-week courses of patches (donated by Pfizer, Inc.) in 36 days.

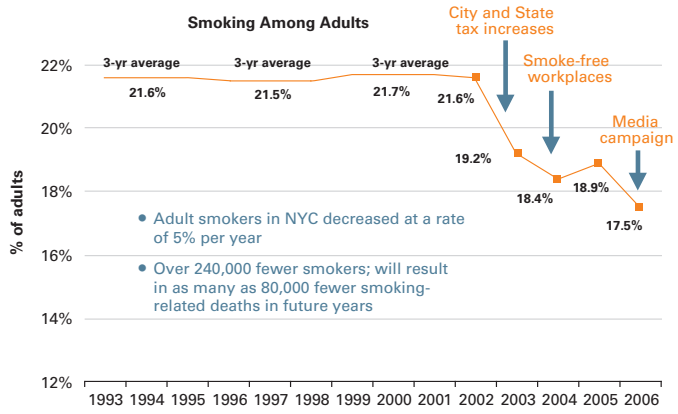
During 2006, DOHMH Media Campaigns Increased Calls to 311 about Smoking Cessation



*Patch program calls (weeks 18-23) not included.

**Gross Rating Points are an industry-specific standardized measure of the broadcast frequency and audience reach of a campaign. For example, 100 GRPs are equal to one exposure in a given period.

New York City Smoking Prevalence among Adults Has Dropped Sharply Since 2002



Cessation: Tools to Help Smokers Quit

Two-thirds of smokers try to quit each year. To support this effort, DOHMH has distributed nearly 240,000 free courses of nicotine replacement therapy to city residents since 2003. In 2005 and 2006, the agency worked with 311 to provide nicotine patches and counseling directly to the public. In 2005, 45,000 free six-week courses of patches donated by Pfizer, Inc. were distributed in 36 days, one of the largest such giveaway programs ever. In 2006, the agency gave away 35,000 free four- and six-week courses of nicotine replacement patches in 34 days.

To enlist more clinicians in helping smokers quit, the Department's Public Health Detailing Program (see page 20) outreach workers distributed smoking-cessation action kits to health care providers and their staffs between 2004 and 2006. The initial rollout included 200 detailing visits in East and Central Harlem, North and Central Brooklyn, and the South Bronx. In 2005, the program was expanded to some 2,300 provider sites citywide, and expansion continued in 2006.

Evaluation: Informing Strategic Directions

DOHMH relies heavily on data from the Community Health Survey (see page 8) and other surveys to inform program planning and track trends in smoking. The agency used these data to chart the effect of laws, educational efforts and cessation programs, and to argue for an additional 50-cent increase in the cigarette tax.

Emergency Preparedness and Response: Systematic Readiness

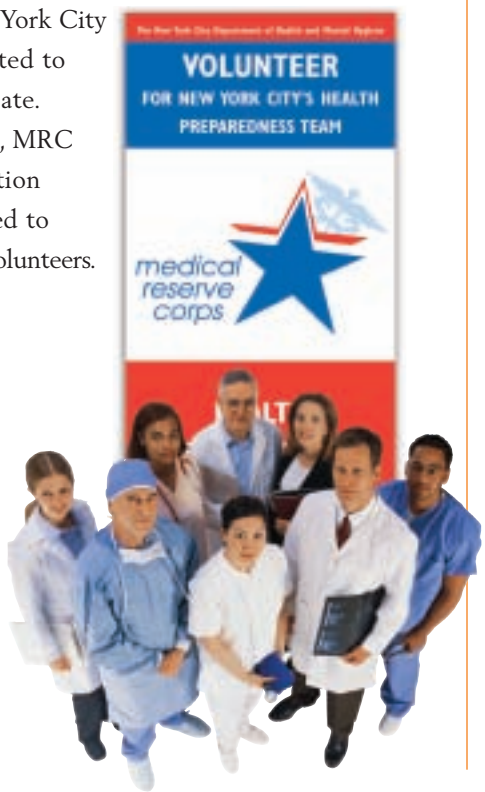
Preparing for public health emergencies, whether manmade or natural, is a critical DOHMH responsibility. The Department has improved the city's state-of-the-art surveillance system and bioterrorism laboratory, and worked with other city, state and national agencies to become a model for emergency preparedness and response. For these efforts, DOHMH received the CDC's highest "green rating" for its Strategic National Stockpile program. The Department also received a near perfect score (97 out of 100) for these activities in its most recent review. In 2004, DOHMH opened its newly renovated bioterrorism detection facility at the Public Health Laboratory. A large amount of the new space was upgraded to Bio-Safety Level 3 (BSL-3), allowing DOHMH to quickly test for a full range of potential biological weapons of mass destruction.

Preparedness

DOHMH continuously studies and sharpens its ability to prepare for and respond to emergencies that may arise from biological, chemical and radiological challenges. An agency-wide working group has developed and is refining the All Hazards Emergency Operations Plan, which specifies roles and responsibilities for key staff in every part of the Department. The working group is currently developing annexes that cover a range of potential hazards, from bioterrorism agents to nuclear radiation.

The Department's 2006 Pandemic Influenza Plan outlines every aspect of response—from surveillance and communication, to testing and delivery of antiviral drugs—in the event of a pandemic flu outbreak. To help the larger business community, in 2006 and 2007, DOHMH gave technical assistance to 270 businesses and corporations citywide and conducted focus groups and needs assessments with small businesses.

Reaching out to the greater city health community, the DOHMH continued to build its volunteer Medical Reserve Corps (MRC) unit. Health care students and health professionals with a valid state license or certification who live or work in New York City are invited to participate. In 2006, MRC registration increased to 5,900 volunteers.



Snapshot: Radiation Preparedness

For 48 years, the Health Department has registered, licensed and inspected the city's research and medical facilities that use radioactive materials and radiation-producing equipment. These activities have focused on health and safety related to radiation exposures. Since 9/11, the Department has recognized that the security of these radioactive materials is essential to prevent radiological terrorist incidents. To promote improved security, DOHMH has enhanced its radioactive securities initiatives by:

- Conducting joint inspections with the New York Police Department to assess and monitor security efforts at hospitals and research facilities;
- Developing a secure web portal where hospitals can submit inventories of radioactive materials;
- Hiring Brookhaven National Laboratories to assess security systems in facilities with radiological materials, develop a best-practices document and construct a self-audit tool to be used by these facilities.

From 2006 to 2007, through its Hospital Emergency Preparedness Program, DOHMH also provided radiation detection equipment to all 59 (of 67 hospitals) in New York City that have emergency departments. Equipment included area monitors, survey meters and personal dosimeters. Radiation dosimeters can be clipped to clothing to measure the cumulative dose of radiation. Dosimeters promote early detection of materials that might enter or escape hospital facilities and provide increased surveillance in the event of a radiation incident. Nearly 500 health care workers were trained as part of this initiative and 72 emergency medical services agencies received 1,655 dosimeters, providing up to two units per vehicle.

Emergency Response

From 2004-2006, DOHMH responded to several emergency situations, using each to enhance its preparedness for future events. Early in the 2004 flu season, a nationwide shortage of the influenza vaccination promoted a skyrocketing demand at city-run health clinics. DOHMH responded with increased patient services through 35 Points of Dispensing (PODs), which are temporary emergency clinics set up to distribute medication or vaccination to large numbers of people. DOHMH also procured and distributed the vaccine to private physicians and practices to ensure that patients seeking routine medical care would receive their flu shots.

Building on this successful response, the DOHMH has continued to develop its flu-vaccination distribution program. In November 2006, the Department conducted one of the largest mass influenza vaccination-distribution campaigns in recent city history. This five-POD operation was intended to test the POD model while providing influenza vaccine to New York City's historically under-vaccinated communities. Nearly 5,100 people received vaccinations citywide in an eight-hour period.

During a 2006 exercise, nearly 5,100 New Yorkers received flu vaccinations during an eight-hour period.

On the eve of the Republican National Convention in August 2004, DOHMH activated its Incident Command System when elevated levels of radiation were detected at an office building in midtown Manhattan. The building was evacuated and the surrounding blocks were closed off to vehicular and most pedestrian traffic. The radiation came from a malfunctioning radiography camera that was being used to take X-ray images of the building's structure. DOHMH worked with other city, state and federal agencies to properly and safely shield, repair and remove the malfunctioning equipment. Agencies also cooperated to determine that there was no immediate or potentially ongoing contamination, and to establish that there were no health risks to people who were in the area.

In February 2006, the Department responded to the nation's first naturally acquired case of inhalational anthrax in 30 years. In this case, anthrax—a Category A bioterrorism agent—was caused by an individual working with animal skins imported from Africa. The patient, a 44-year-old Manhattan man, became ill while performing with his African dance troupe in Pennsylvania, where he was hospitalized and subsequently diagnosed with inhalational anthrax. DOHMH, in collaboration with the CDC and law enforcement agencies, determined that this was not a terrorism event but an incident caused by direct exposure to infected skins imported from Africa that the patient used to make African drums. DOHMH activated its Incident Command System and worked with a number of other agencies, including the CDC, the Federal Bureau of Investigation, the NYC Police Department and the U.S. Environmental Protection Agency to test and clean the man's workshop, apartment and van, and to identify other persons at risk to provide prophylaxis.

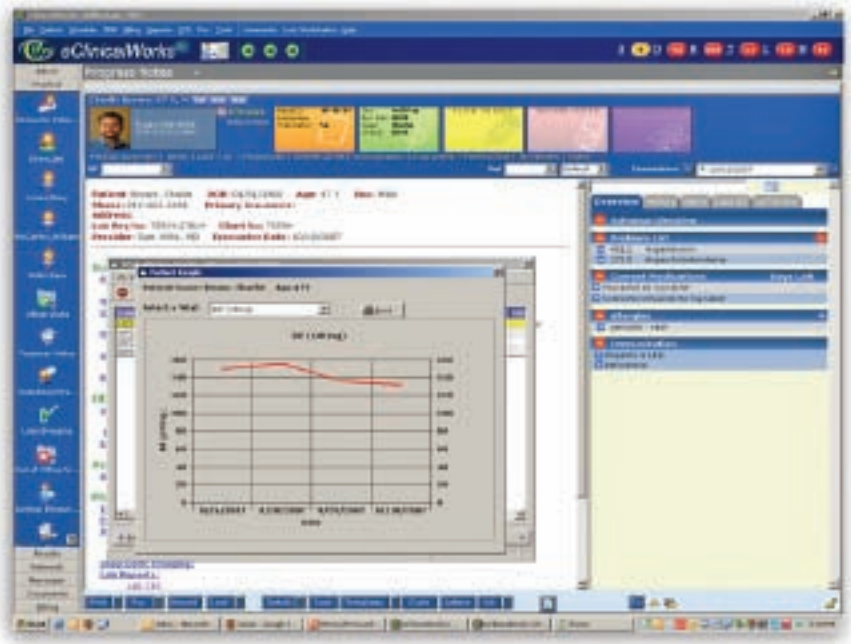
Promoting Quality Health and Mental Hygiene Care

Technology plays a vital role in the Health Department's efforts to inform medical providers, educate patients and support improvements to the health care system.

Primary Care Information Project

The Primary Care Information Project (PCIP) is a groundbreaking project, planned in 2006 and launched in 2007, to promote prevention-oriented electronic health records (EHRs) to primary care providers in the city's underserved communities. The goal is to have EHRs used by more than 1,500 medical providers and in the medical facilities at Rikers Island by 2009. The EHRs will help promote **Take Care New York**'s 10 preventive health measures (see page 4). In 2005, for example, only 33% of adults with private health insurance received a flu vaccination. EHRs have been shown to substantially increase population flu vaccination rates and provide the right information to doctors at the right time, to help them make the right decisions to support patients. EHRs prompt health care providers to follow up with patients about preventive measures such as vaccines and screenings, and to routinely ask patients about high-risk behaviors such as smoking.

EHRs also give health care providers access to statistics on their entire patient panel, so they can better understand the needs of both individual patients and their entire practices. They improve the accuracy and timeliness of information physicians are required to report to the health department on immunizations and reportable diseases. The project was launched with $45 million of city funding and has generated an additional $15 million in private, state and federal contributions to support implementation and evaluation.

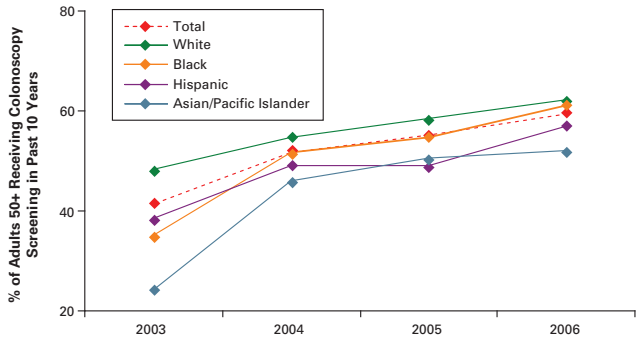


Electronic health records help health care providers understand the needs of individual patients and entire practices.

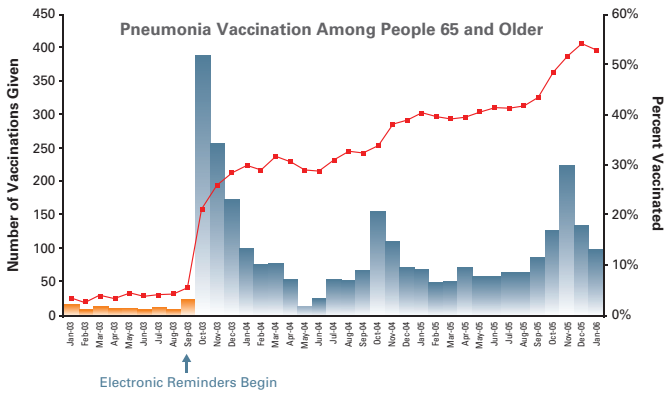
Quality IMPACT for Improving Mental Health Care

In 2004, DOHMH launched Quality IMPACT (Improving Mental Hygiene Programs and Communities Together) to improve outcomes and promote the use of evidence-based practices. Nearly 300 mental health, chemical dependency and mental retardation/developmental disability programs participate. Quality IMPACT has two components: continuous quality improvement (CQI) projects and surveys that assess consumer perceptions of care. In 2004, the Department worked with stakeholders and national experts to identify three priority areas for system-wide quality improvement—detection and treatment of co-occurring behavioral health disorders, cultural competence and engagement and retention of consumers.

Colonoscopy Screening Has Increased, and Racial Gaps Have Narrowed



Electronic Health Record Reminders Can Help Increase Preventive Services



Source: Institute for Urban Family Health

Snapshot: The Fund for Public Health in New York, Inc.

The Fund for Public Health in New York (FPHNY) is a key DOHMH partner organization that provides the financial and strategic support needed for many Department programs. DOHMH helped create FPHNY in 2002 as an independent-yet-affiliated not-for-profit organization to advance public health in New York City. The Fund brings in new funding sources, explores new approaches to public health challenges and improves efficiency in priority public-sector programs.

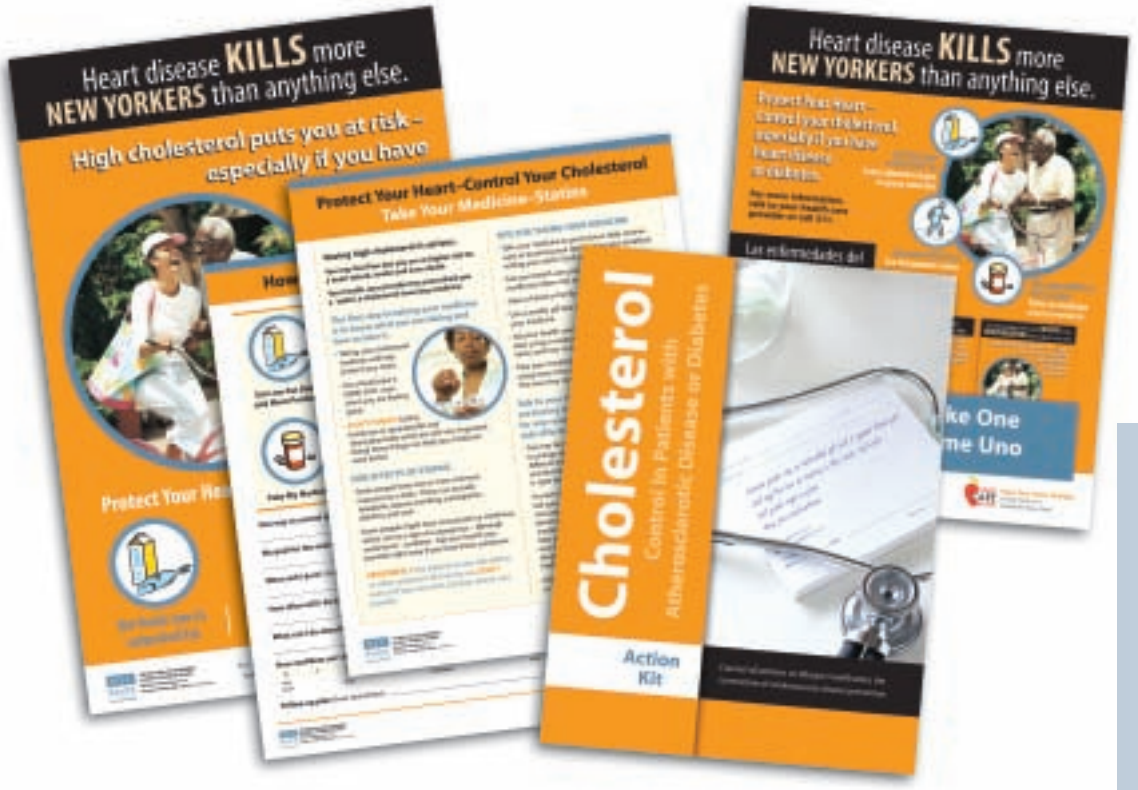
Since its inception, FPHNY has worked with the Department to secure more than $10 million in private grants, forging an alliance with the private grant-making community on shared public health goals. By year-end 2006, FPHNY was administering 40 grant-funded projects, working to conceive and fund new programs, and managing projects in coordination with departmental objectives. FPHNY helped launch and expand the Nurse-Family Partnership (see page 28) and provides administrative support to the Primary Care Information Project (see page 19) and the Hospital Emergency Preparedness Program (see page 17). FPHNY is also home to a range of innovative and promising projects to develop and test new approaches to health promotion and chronic disease prevention.

Colonoscopy Screening

Colorectal cancer kills more nonsmokers than any other cancer. DOHMH estimates that widespread use of colonoscopy to detect polyps and early cancers could result in an 80% reduction in the city's colon cancer deaths, preventing more than 1,000 deaths per year. In 2006, after conducting citywide educational and outreach campaigns and introducing navigation programs that guide patients through the screening process—New York City achieved the 2008 **Take Care New York** goal. Some 60% of eligible New Yorkers had been screened (up from 42% in 2003) and the gap between screening rates of different race/ethnic groups had closed. The agency is now striving to have 80% of eligible New Yorkers screened by 2011.

Detailing: Marketing Public Health to Clinicians and their Staffs

Modeled on the pharmaceutical industry's marketing approach to physicians, the Public Health Detailing Program promotes evidence-based clinical preventive services and tools. DOHMH representatives first make brief, unscheduled visits to health care practices, and then arrange subsequent visits to conduct in-depth two- to three-month educational campaigns on a range of preventable and manageable health topics (see sidebar). Public health detailers distribute "action kits" to inform providers about current best practices for key health conditions. The action kits also include attractive, easy-to-understand patient-education materials such as posters, questionnaires and checklists. By the end of 2006, Public Health Detailing representatives had met with more than 10,250 health care providers and clinical staff at about 2,800 sites.



The Public Health Detailing Program promotes evidence-based preventive services.

Public Health Detailing: Provider Visits

2004	
Colon Cancer Screening	590
Smoking Cessation	494
Asthma	509
Influenza Vaccination	350
2005	
Diabetes	518
Smoking Cessation	8,043
Contraception	621
Emergency Contraception	247*
Influenza Vaccination	129
Hypertension	552
Colon Cancer Screening	592
2006	
Contraception	749
Depression Screening	458
Diabetes	5,752
HIV Testing	392
Cholesterol	383
Influenza	404
TOTAL:	**20,783**

* Visits with pharmacists

Most campaigns were conducted in targeted neighborhoods, though some were implemented citywide – resulting in more visits.

Health Care during Incarceration and after Release

People who are incarcerated in New York City receive a full range of health services. The Department, which took over the contract monitoring for health care at Rikers Island between 2004 and 2006, focused on improving clinical services, particularly for mental health and communicable diseases (especially HIV) and chronic conditions such as hypertension and diabetes.

Through Transitional Health Care Coordination, former inmates and their families now have access to health, mental health and chemical dependency services, as well as public health insurance, information and services in the community. At Rikers Island, the Central Visit Center Health Station offers health information, referrals and screenings to inmates' families. The Correction-Community Linkage Program provides linkages for re-entrants and their families in the communities of greatest need: Central/East Harlem, Central Brooklyn and, in the near future, in the South Bronx. The program targets critical areas of concern for all New Yorkers—care for mental illness, HIV/AIDS prevention and treatment, assistance with chemical dependency and management of chronic diseases such as hypertension, diabetes and asthma.

Addressing Obesity, Diabetes and Cardiovascular Disease

New York City's growing chronic disease burden is a major focus for DOHMH. Using behavioral and demographic data obtained through health surveys (see page 8), the agency develops and implements programs and policies to reduce the burden of obesity, diabetes, cardiovascular disease and hypertension.

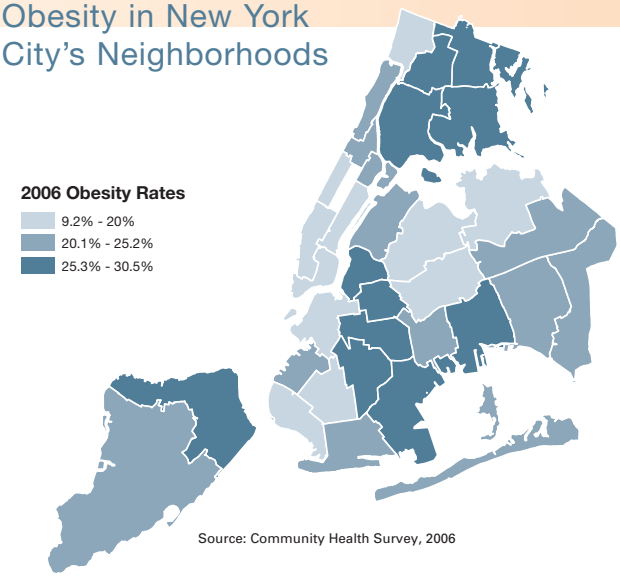
Twin Epidemics: Obesity and Diabetes

The twin epidemics of obesity and diabetes are the only health problems that are getting worse (and getting worse rapidly) in New York City and nationally. About 26% of New York City adults and 24% of our elementary school children are obese. While the problem cuts across all population groups, people of low income are particularly likely to lack exercise and good nutrition, and to be obese. Following the increase in obesity, the number of people with diabetes in the city has more than doubled in 10 years. Approximately 500,000 adult New Yorkers have been diagnosed with the disease and another 200,000 have it but do not yet know it.

In 2002, DOHMH established the Diabetes Prevention and Control Program, and in 2006 the agency launched the nation's first hemoglobin A1C registry.

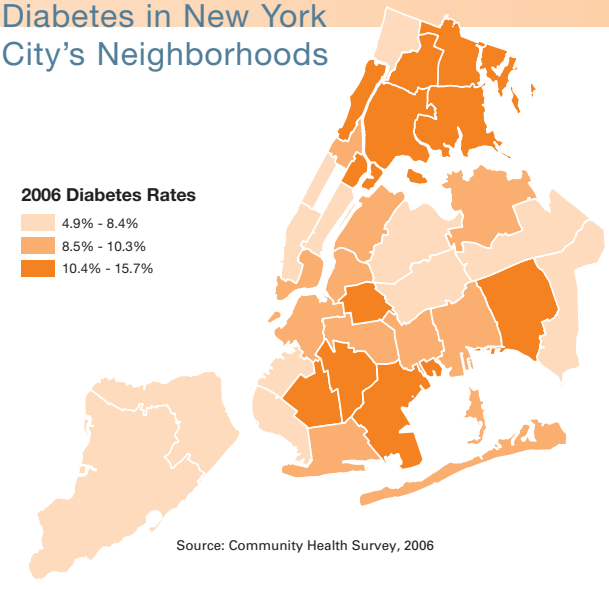
Early in 2006, DOHMH also began a Gestational Diabetes Initiative, using birth certificates to identify new mothers who had developed the condition. Gestational diabetes complicates about 4% of all pregnancies in New York City (about 400 per month) and 11% of pregnancies among South and Central Asian women. As part of this initiative, the Health Department sends multilingual informational packets to women who received a diagnosis of gestational diabetes. Without preventive measures, women with gestational diabetes have about a 50% chance of develop-

Obesity in New York City's Neighborhoods



Source: Community Health Survey, 2006

Diabetes in New York City's Neighborhoods



Source: Community Health Survey, 2006

ing diabetes within 10 years. In 2006, 3,400 women received information packets.

The Diabetes Quality Improvement Collaborative works with practices and hospitals in the city's highest-risk neighborhoods to improve care for people with diabetes.

NYC Hemoglobin A1C Registry: Setting Standards for Diabetes Surveillance and Control

To monitor and help control the city's diabetes epidemic, DOHMH established the first and only population-based hemoglobin A1C registry in the country. Hemoglobin A1C levels are a measure of a patient's blood sugar over two or three months; good control of hemoglobin A1C reduces complications such as heart, eye, kidney and nerve disease.

The registry, which was established through an amendment to the New York City Health Code, took effect in January 2006. It requires clinical laboratories serving New York City to electronically report all hemoglobin A1C results to the Health Department. By collecting information on patient and population blood-sugar levels through this registry, DOHMH can follow trends in glycemic control over time and support providers and their patients in their efforts to control diabetes and its many complications. The registry's tools include quarterly feedback reports sent to medical practices and letters sent on behalf of medical practices to patients with high A1C test results.

A pilot project launched in 2007 focuses on providers serving the South Bronx, which has one of New York City's highest diabetes rates. The project includes more than 1,000 providers who serve more than 50,000 patients. Over the next year, the project will expand to additional providers who serve residents living in other high-risk neighborhoods, such as North and Central Brooklyn and Harlem.

Confronting Obesity and Diabetes: Healthy Eating and Physical Activity

Modest increases in physical activity and decreases in weight can, among many other things, help people with pre-diabetes reduce the risk of developing the disease by as much as 60%. DOHMH works to reduce the prevalence of obesity and diabetes with programs and efforts designed to help people eat better and exercise more.

Calorie Posting

Throughout 2006, DOHMH investigated measures that would give consumers better access to much-needed calorie information in restaurants. Since 1994, the U.S. Food and Drug Administration has required nutrition labeling on packaged foods. Research shows that when calorie information is available, most consumers use it to make informed nutritional choices. Restaurants often obscure important calorie information by placing it on websites, tray liners or food wrappers. Just 100 extra calories per day can add up to 10 additional pounds per year. In December 2006, New York City's Board of Health (see page 24) passed a regulation that would have required certain restaurants to post calorie information prominently on menu boards, where consumers can see it prior to purchase. A restaurant group challenged the legislation in court, and in September 2007, the calorie-labeling initiative

The Health Department works to reduce obesity and diabetes by helping people eat better and exercise more.

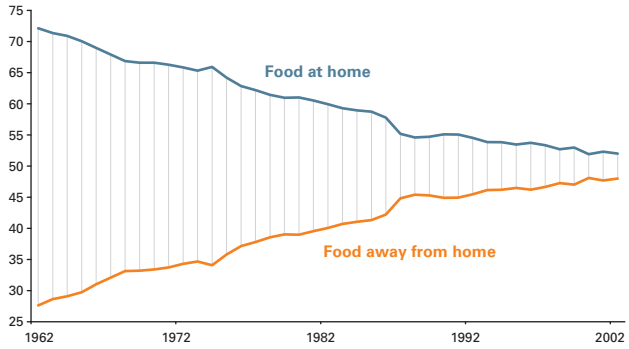
Snapshot: Eliminating Trans Fat in New York City Restaurants

Artificial trans fat increases the risk of heart disease and early death by increasing bad cholesterol and decreasing good cholesterol. The health effects of trans fat are even worse than those of saturated fats. Artificial trans fat is found in vegetable oils and fats that are partially hydrogenated, including many oils, fats and shortenings used for cooking, baking or as spreads, such as margarine. An estimated 33% of calories come from foods prepared outside of the home, indicating that restaurants are an important source of dietary trans fat. Yet, consumers have no practical way of avoiding trans fat intake in these establishments.

Regulation and inspection of restaurants is a core Health Department function. In 2005, DOHMH asked restaurants to voluntarily remove artificial trans fat. But nearly a year later, there was no decrease in the proportion of restaurants using oils that contained artificial trans fat for cooking, frying or baking. Therefore, in 2006, DOHMH proposed a restriction on artificial trans fat use in restaurants. The Board of Health passed the regulation in December 2006 and the first phase—requiring that all restaurants use 0 grams trans fat products for fry oils and as spreads—went into effect on July 1, 2007. As of September 2007, compliance with the first phase stood at 94%. The second phase of the regulation, covering baked goods and all other foods, goes into effect July 1, 2008. Only packaged foods served in the manufacturer's original packaging will be exempt.

As it was with the Smoke-Free Air Act, New York City quickly became a model for the country. Five jurisdictions—from Philadelphia to Seattle—passed regulations to eliminate trans fats and more than 30 others are considering trans fat restrictions. Even the restaurant industry is following suit, with nearly 40 restaurant chains, airline food providers and theme parks such as Disney and Universal Parks implementing similar restrictions.

The Food Environment: Cooking Less, Eating Out More



Sources: Food Consumption (Per Capita) Data System, USDA, Economic Research Service.

Snapshot: General Counsel and the Board of Health

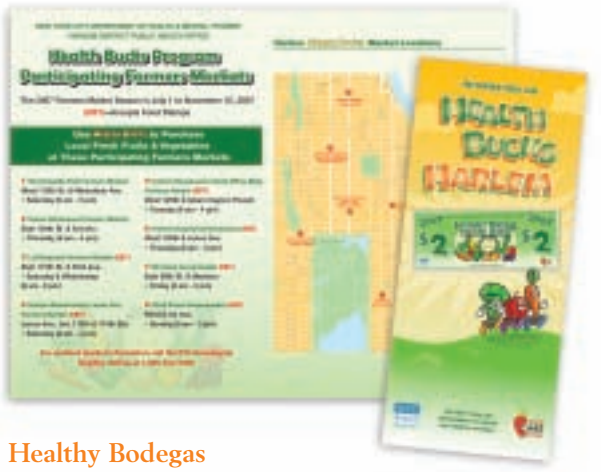
The Office of the General Counsel for Health provides legal advice and assistance to the Health Department as a whole. It is nationally recognized as a leader in public health law. From 2004-2006, the Office advised and helped create a range of DOHMH initiatives, including the trans fat restrictions and proposed calorie labeling laws, the hemoglobin A1C diabetes registry and many of the Department's targeted outreach programs.

For more than two centuries, the New York City's Board of Health has protected the well-being of New Yorkers. The Board held its first meeting in 1805 to combat a yellow fever epidemic in the city. Working with the Mayor, the Board evacuated neighborhoods and started collecting mortality statistics to "furnish data for reflection and calculation." In more recent years, the 11-member Board, which oversees the city's Health Code, has introduced bans on indoor lead paint, enhanced modern tuberculosis control provisions, authorized the hemoglobin A1C registry, strengthened emergency preparation and restricted trans fat use in restaurants.

was overturned. It has since been reintroduced in a form that is more likely to withstand legal challenge.

Shape Up New York

Partnering with the Department of Parks and Recreation, DOHMH offers Shape Up New York, a free family fitness program available at parks, community centers and housing sites citywide. Fitness classes include step aerobics, fitness walking, light weights, stretching and toning exercises. In 2006, some 40,000 people visited the 19 Shape Up New York sites. The Department also promotes physical activity in day cares and schools through Sports, Play and Active Recreation for Kids (SPARK), and NYC FITNESSGRAM (see page 31).



Healthy Bodegas

A DOHMH survey in Central Brooklyn in 2005 showed that only one in three bodegas—which represented more than 80% of the community's food sources—sold healthier foods such as reduced-fat milk and fresh fruits. To increase access to healthier foods, the Department worked with bodegas to launch Moooove to 1% Milk, an initiative aimed at increasing the availability of 1% milk which has fewer calories and fat than whole milk. Bodega owners displayed campaign materials and discounted the lower-fat milk for a month. Sales of 1% milk increased from near zero to 7%-10%. The program added 200 more bodegas, and after two months, 73% of bodegas

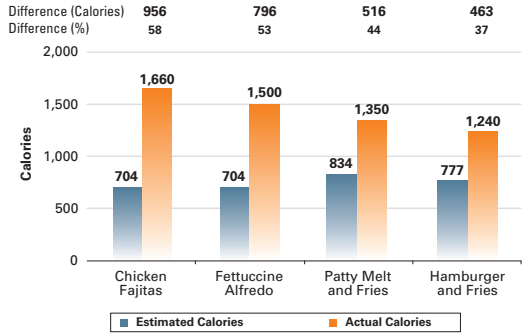
displayed educational materials and 35% reported increases in 1% milk sales. The program is expanding to reach 1,000 bodegas. In 2006, the Department also distributed Health Bucks coupons, each valued at $2, in low-income neighborhoods through its three DPHO offices (see page 7). The program was expanded in 2007.

Cardiovascular Disease and Hypertension

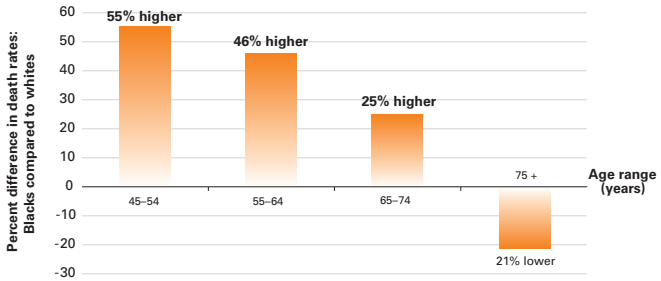
Cardiovascular disease (CVD), a term that includes heart attack and stroke, is responsible for more than 25,000 deaths a year and remains the leading cause of death and preventable death in New York City. Hypertension is a major risk factor for CVD and the leading cause of black/white disparities in in terms of number of years of potential life lost in the United States. One–third of black New Yorkers have hypertension, compared to 21% of whites, and almost one in five New Yorkers with hypertension are unaware of their condition. Even of those who are diagnosed and in treatment, only about two thirds have their blood pressure adequately controlled. One-quarter of adult New Yorkers have high blood cholesterol, another major CVD risk factor, and, as with hypertension, levels of awareness are low (28%). Less than half of all adults with high cholesterol have their condition under control, but the majority (86%) of those in treatment do.

To reduce CVD burden and related disparities, DOHMH works to create sustainable citywide heart-healthy changes in the food environment and enhance CVD risk factor diagnosis, treatment and control through improved care and patient self-management. Heart-healthy changes include the restriction of trans fat use in all NYC restaurants (see Snapshot, page 24).

Most Consumers Underestimate Calorie Content



Black New Yorkers Die of Heart Disease at Higher Rates than Whites



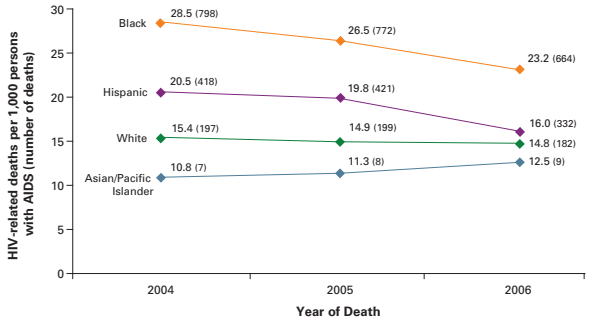
Sources: Bureau of Vital Statistics, NYC DOHMH, 1999-2001; U.S. Census 2000/NYC Department of City Planning

The Health Department has also introduced programs to promote blood pressure control. These include a home blood pressure monitor distribution program in clinical settings, a lay health model blood pressure monitoring program in faith- and community-based organizations, and a pharmacy-based blood pressure monitoring program to be launched in 2007. The Primary Care Information Project (see pages 10 and 19) will also help physicians improve management of their patients with high blood pressure and high blood cholesterol. Improving blood pressure control is an important, continuing priority for the Department.

Confronting Infectious Disease: Awareness, Prevention and Control

Confronting infectious diseases has been a core DOHMH activity since the Department's inception more than 200 years ago.

HIV Takes a Disproportionate Toll on Black New Yorkers



Data Source: HIV Epidemiology and Field Services Program, NYC DOHMH
HIV-related deaths in persons with other/unknown race not shown due to small cell counts.

HIV/AIDS Prevention: Reducing Risk and Removing Barriers to Testing and Care

More than 100,000 New Yorkers—or about 1 in 70—are living with HIV, but many do not know they are infected. HIV is also the health problem with the largest racial disparity: 80% of new AIDS diagnoses and deaths are among blacks and Hispanics. As part of an overall reorganization of prevention, control and surveillance activities from 2004 to 2006, the Department created or expanded initiatives by:

The branded NYC Condom has been a hit since its debut in early 2007. Distribution tops 3 million per month.

Providing Condoms and Clean Syringes

Syringe-exchange programs have been shown to reduce transmission of the HIV and hepatitis C viruses without encouraging substance use. Based on the high prevalence of injection drug use in Queens, locations were opened in Long Island City in 2004—the first new program to open in the city in more than a decade—and in Far Rockaway and Jamaica in 2005. At year-end 2006, 12 syringe-exchange programs were operating at 34 sites in 20 New York City neighborhoods.

Increasing Rapid HIV Testing

In 2006, DOHMH greatly increased opportunities for rapid HIV testing. The Department contracted with 13 medical clinics and community organizations to provide rapid HIV testing: more than 85,000 rapid HIV tests were conducted in DOHMH Sexually Transmitted Disease (STD) clinics, chest clinics and city jails. Rapid testing provides results in less than an hour, compared to the week or two it takes to receive results from standard HIV tests. In 2005, the Department also successfully advocated to change New York State laws to enable nurses to perform HIV testing under a standing order from a physician, making it easier for New Yorkers to determine their status. New York State's HIV laws were written nearly 20 years ago, before the advent of antiretroviral therapy which has increasingly made AIDS a much more manageable disease. Efforts are now underway to remove other barriers to testing and to restructure counseling so providers can tailor services to individual patient needs.

Partner Services and Linkage to Care

Notifying partners of their exposure to HIV is an effective way to identify undiagnosed HIV-infected persons and prevent spread of the infection. New York State law requires providers to discuss partner notification with persons newly diagnosed with HIV infection and report known sex and needle-sharing

partners to the Health Department. In New York City, providers can oversee notifications themselves or request assistance from DOHMH. In 2006, DOHMH established a Field Services Unit, active at eight hospitals in high-prevalence areas, to assist providers and patients with partner services.

Influenza Immunization

Severe disruption in the influenza vaccine supply in 2004-2005 forced the agency to shift its focus from increasing immunization rates to re-distributing vaccine and running targeted vaccination clinics to ensure that high-risk people were vaccinated. Vaccine was distributed widely to long-term care facilities, hospitals, outpatient clinics and private physicians. The Community Health Survey (see page 8) provided data on vaccination rates that permitted the agency to direct the vaccine to areas with the greatest need. The survey showed, for example, that Caribbean and black residents in Central Brooklyn had low vaccination rates, so the Department provided educational materials and resources to medical professionals who service those populations. In this effort, DOHMH collaborated with the Central Brooklyn Flu Steering Committee, a coalition of community leaders interested in health issues. In 2005, nearly 1,000 providers of adult immunizations received the Department's comprehensive *Influenza and Pneumococcal Resource Guide* and in 2006, representatives from the Public Health Detailing campaign (see page 20) visited more than 1,000 sites in high-risk neighborhoods. To increase vaccination rates in hospitals and health centers, DOHMH has promoted standing orders that establish an "opt out" system rather than "opt in" for influenza and pneumonia vaccine administration.

Sexually Transmitted Diseases

The Health Department's 10 STD clinics promoted rapid HIV testing which increased the number of HIV tests from 38,000 in 2004, to 47,000 in 2005 and 55,000 in 2006. The agency produced a waiting room video tailored to the requirements of New York State law to streamline the pre-test counseling process. To accommodate increased patient load, the clinics established an express visit for patients who needed only laboratory tests for STDs. In 2004, an electronic health record was designed for the STD clinics to improve data collection, patient care and efficiency.

In 2005, the Health Department investigated several neonatal herpes cases among babies who had undergone *metzizah bpeh*, an Orthodox Jewish circumcision practice. Also in that year, DOHMH piloted a successful program to screen and treat adolescents for chlamydia infection and gonorrhea in five high schools. This program continues and is being expanded.

Tuberculosis

In 2005, for the first time ever, there were fewer than 1,000 new tuberculosis (TB) cases in the city. Two outbreaks of multi-drug resistant TB cases, primarily in HIV-infected people, prompted an extensive search for additional cases through TB skin testing, chest X-rays and medical evaluation. More than 200 staff and residents at the facilities were exposed. To prevent similar problems elsewhere, the program focused on improving the TB protocols for HIV housing programs. During these years, there was an increase in the number of large-scale contact investigations, and 21,000 people were evaluated for TB exposures in their homes, workplaces, schools and other congregate sites. The TB control program also introduced Quantiferon, a new blood-based TB screening test that promises to help focus preventive services and increase the number of people who complete preventive treatment.

Annual flu vaccination is a vital tool for reducing influenza deaths.

Improving Children's Health

Snapshot: Mayor's Commission for Economic Opportunity

In September 2006, the Mayor's Commission for Economic Opportunity (CEO) issued a comprehensive report that outlined programs that could be created or expanded to help reduce poverty in New York City. The Commission targeted three populations—the working poor, young adults, and young children. Working with leaders from business, labor, government, academia, foundations, and neighborhood and religious organizations, CEO identified programs with proven success records such as apprenticeship, credentialing and on-the-job training programs. CEO also recommended further expansion of the Nurse-Family Partnership to help first-time mothers and their babies, school-based health centers and an innovative conditional cash transfer plan to help families exit from the cycle of poverty.

The health of our children is the health of our future. From 2004 to 2006, the Health Department launched and strengthened key programs to protect and promote children's health. DOHMH has continued to improve maternal and infant health, the city's day care system and the Early Intervention program for children with developmental delays. In 2006, New York City's infant mortality rate—widely regarded as a barometer of a population's general health—also stood at 5.9 infant deaths for every 1,000 births, a number lower than the national rate and a marked decrease since the 1990s, when the rate was in the double digits.

Early Intervention: Families as Partners

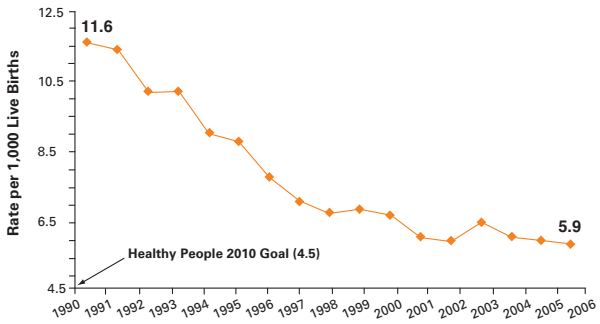
Early childhood is a crucial time for language, social and intellectual development. Each year, the Department's Early Intervention program works with about 37,000 children who have developmental delays and disabilities. Through a network of contracted community-based providers, the program provides speech, occupational, physical and educational therapy, among other services, to children from birth to age three to help them reach their full potential.

A new program model, Families as Partners, is changing the paradigm of care. By increasing family skills and involvement, Families as Partners teaches parents how to work with their children to help their development. In doing so, it extends the impact of services beyond the presence of a therapist and beyond the number of hours a child is involved in Early Intervention sessions. This evidence-based model uses the child's and family's everyday routines as a model for more consistent developmental stimulation for the child. Family involvement is crucial to helping children develop in all areas.

Nurse-Family Partnership

From 2004 to 2006, DOHMH greatly expanded the Nurse-Family Partnership (NFP) which it launched in Jamaica, Queens, in 2003. Through NFP, from the time of a new mother's pregnancy through her child's second birthday, nurses make home visits every one to two weeks to provide guidance on breast feeding, child development, parenting skills, pregnancy planning, preventive health practices and strategies to attain economic self-sufficiency. The program has been proven, in clinical studies, to improve the health and social outcomes of these high-risk children. NFP was expanded to Harlem and Brooklyn in 2004, to the Bronx in 2006, and an additional NFP team serves women and teens in homeless shelters and Rikers Island, and teens in foster care. NFP is expected to serve more than 1,300 families by fall 2007 and more than 2,400 by fall 2008.

Infant Mortality Reached an All-Time Low but is Still Too High



Recognized nationally for its effectiveness and cost savings, NFP was one of the priorities of Mayor Bloomberg's Commission for Economic Opportunity (see Snapshot, page 28) for children younger than five years. By 2011, the program expects to serve more than 4,500 mothers in New York City's highest-need communities. In addition to increased public funding commitments, NFP has received more than $1 million in private support.

Newborn Home Visiting Program

Since 2004, the Newborn Home Visiting Program has provided a one-time visit to mothers of infants who are one month old or younger. The program's public health advisors address home environmental hazards (e.g., peeling, lead-based paint; missing window guards), encourage and instruct women on breastfeeding, provide topic-specific education (e.g., on sudden infant death syndrome and safe sleep practices, bonding and attachment), and make medical and social-services referrals. The program began in Bedford-Stuyvesant, Bushwick, East Harlem, and Central Harlem, and has now expanded to Brownsville and to the six community districts of the South Bronx. The program seeks to narrow the dramatic health disparities between infants born to lower- versus higher-income new mothers. Parents are identified through birth certificates and in-hospital visits. By the end of 2006, nearly 6,000 mothers had been visited.

Assuring Healthy Homes

Although childhood lead poisoning remains a serious problem, the number of new cases identified in 2006 marks the lowest level ever (see page 7), even as health providers expanded testing for one- and two-year-old children citywide. In 2006, an estimated 76% of one-year-olds and 65% of two-year-olds were tested for lead poisoning, compared with 72% and 60%, respectively, in 2005.

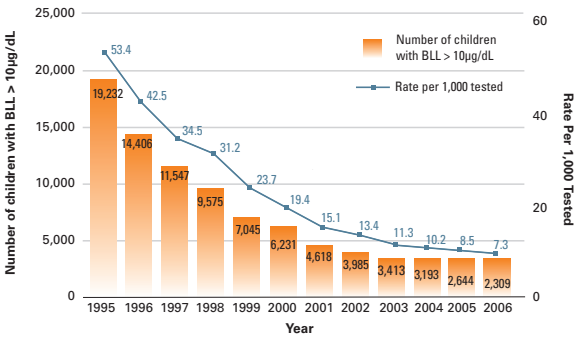
The Families as Partners Program helps parents to work with their children to enhance child development.

The Health Department promotes blood lead testing among health care providers and provides environmental investigation and case coordination services for children with blood-lead levels at or above the Environmental Intervention Blood Lead Level (EIBLL), which has been set at 15 mcg/dL. DOHMH also makes home visits, tests for lead paint, orders building owners to make repairs, and educates families and health-care providers on medical follow-up and exposure reduction.

Through its Healthy Homes Hardware Store Campaign, the Department promotes awareness about household hazards and ways to prevent hazardous conditions in the home. Working with approximately 300 hardware stores citywide, the campaign distributed multi-lingual information on peeling lead-based paint, asthma triggers, poisons, harmful cleaning products and other conditions. The campaign also provided signs to

The Nurse-Family Partnership expects to serve more than 2,400 families by the end of 2008.

Childhood Lead Poisoning Continues to Decline in NYC



* Number and rate (per 1,000 tested) of children, ages six months to less than six years newly identified with blood levels >10µg/dL, by year: NYC, 1995-2006.

inform people that city law prohibits dry scraping and sanding lead paint in homes, schools and daycare centers. All stores that sell or rent paint or paint removal products are required to post the sign.

Day Care Improvement

On August 11, 2004, an infant in a group family day care home in Forest Hills, Queens, died. Following this tragedy, DOHMH issued comprehensive recommendations to improve the oversight, monitoring and inspection of day care programs. Specific goals included:

- Development of clear, detailed written procedures and protocols covering all types of regulated day care facilities and thorough training of inspection staff on these procedures.
- Better information for parents and the public, including online inspection reports.
- Development of a critical incident review and reporting process for major events such as fatalities and development of a quality improvement process.
- Reduction of delays in licensing and license renewals.
- Increased inspection and administrative staff.
- Strengthened tools and controls for recording, tracking and following-up on complaints to ensure proper DOHMH response.

Under new procedures, DOHMH inspects all group and group-family day care facilities annually.

The Department has implemented virtually all of these recommendations, and along with new inspection procedures, DOHMH now inspects all group- and group-family day care facilities annually. In fiscal year 2007, trained staff performed more than 17,688 inspections, a 68% increase over 2005. The average time to respond to imminent hazard complaints has also decreased significantly, from more than six days in 2005 to a half a day in 2007. The number of active day care services with outstanding license renewals has decreased 81%, from 1,539 in 2005 to 298 in 2007.

Also in 2006, the Board of Health (see page 24) approved new requirements to improve physical activity and nutrition in day care facilities and schools. The policies eliminate sugar-sweetened drinks, restrict juice to six ounces per day and require that children two years and older drink only 1% fat milk. They also set minimum physical activity standards of 60 minutes per day for children 12 months and older, and restrict television viewing to one hour per day of educational programs only. The policies are viewed as a model for the rest of the nation.

Caring for the Health and Mental Hygiene of Children and Youths

The Health Department works with school-age children in schools, clinics and DPHOs (see page 7). Jointly with the Department of Education (DOE), DOHMH administers the Office of School Health (OSH) to promote the health of the 1.3 million children enrolled in the city's 1,800 public and private schools. OSH provides health exams and screenings, onsite support in schools of all levels and parent

information for health practices and resources. The office also administers the Managing Asthma in Schools program that helps students use their medications properly and become aware of asthma triggers.

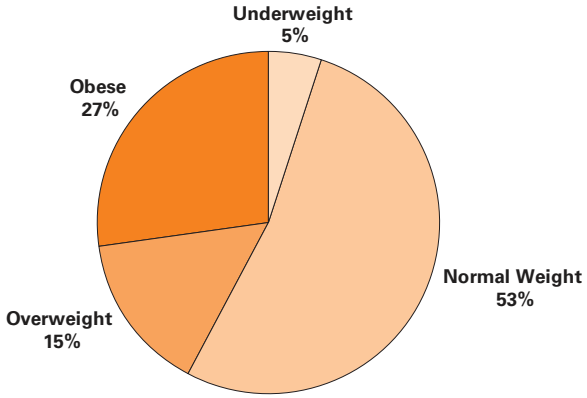
From 2004 to 2005, the Department implemented an electronic school health record to improve its ability to manage students with chronic illnesses. DOHMH also instituted a follow-up program for students who are at risk for amblyopia, (so-called lazy eye), a condition that can result in blindness of one eye unless diagnosed and managed properly. In 2006, the Department's 106-year-old Oral Health Program served about 22,000 school age and pre-school children with preventive dentistry services, including sealants.

In 2005, the Department launched Children's Single Point of Access, a citywide program to improve access to services for youth with serious emotional disturbances. DOHMH expanded school-based mental health services in each borough, and services that target children younger than five years through young adults. DOHMH also expanded the Adolescent Skills program, which offers key services by providing educational and workplace skills to mentally ill youth ages 16 to 23, helping prepare them to live independently. The program now operates in all five boroughs.

Supporting Physical Activity in Schools

To help combat the childhood obesity epidemic in New York City, DOHMH has promoted the evidence-based Sports, Play and Active Recreation for Kids (SPARK) program. Since 2003, the program has trained school teachers, day care staff and school recess aides to develop and run more effective physical activity programs. The SPARK model has been shown to improve children's fitness levels by increasing participation in moderate-to-vigorous physical activity. By December 2006, nearly one-third of New York City's group day care sites (535 centers) had received SPARK training. Sixty percent of school-based pre-kindergarten teachers have also been trained, indicating that some 53,000 kids are now benefiting from SPARK.

Only Half of NYC Children in Head Start Have a Healthy Weight

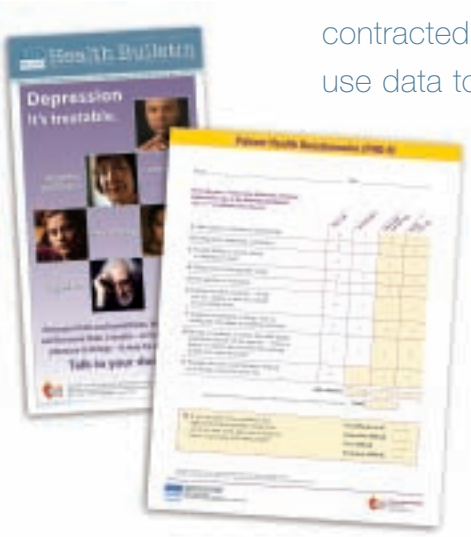


The Department also collaborates with the DOE to sponsor NYC FITNESSGRAM in schools. First piloted 2005, it is now being phased in across all grades citywide. The program assesses key components of fitness such as aerobic endurance, muscular strength and endurance, flexibility and body composition. Parents receive reports that summarize their child's performance and make suggestions for helping children reach the "Healthy Fitness Zone."

Since 2003, the SPARK program has trained school teachers, day care staff and school recess aides.

The Mental Hygiene Spectrum: Mental Illness, Developmental Disabilities and Addiction

Through its Division of Mental Hygiene, DOHMH is responsible for the behavioral and developmental health and well-being of 8 million New Yorkers. More than 450,000 people—those with serious mental illness, mental retardation, developmental disabilities and delays, and chemical dependence—receive assistance from contracted services. Through Quality IMPACT (see page 19), the Department use data to improve outcomes.



The Health Department promotes the use of the PHQ-9 screening tool, which provides a simple, numerical measure of depression.

Ending Addiction

Since the 2004 launch of **Take Care New York** and its goal to help New Yorkers "live free of dependence on drugs and alcohol," DOHMH has promoted the use of buprenorphine, a new treatment for heroin and other opioid addiction. These efforts resulted in a steady increase in buprenorphine prescriptions, from near zero in January 2003 to more than 1,300 in 2007.

In 2005, the Department introduced Screening Brief Intervention and Referral for Treatment (SBIRT) for alcohol and substance use problems at five Health and Hospitals Corporation emergency departments. SBIRT uses brief screenings and interventions to reduce the risk that substance users will become substance abusers. The agency trained more than 300 staff in SBIRT technique and provided funding for patient advocates.

Staff help doctors and nurses assess and provide appropriate education to problem users, and to refer abusers for alcohol or drug treatment. DOHMH is currently exploring ways to expand SBIRT.

Depression: A Widespread Condition with Inadequate Treatment

More than 400,000 (7.5%) of adult New Yorkers are currently affected by depression, and more than one-third (37.6%) receive mental health counseling or prescribed medication. As part of the **Take Care New York** goal to encourage New Yorkers get help for depression, DOHMH promotes awareness and conducts outreach and educational campaigns aimed at high-risk populations and those who are not seeking treatment.

The Department's depression initiative strives to incorporate routine depression screening and management into primary care throughout New York City. DOHMH promotes the use of the PHQ-9 screening tool, which provides a simple, numerical measure of depression that can be monitored and managed. In 2006, the Department expanded depression screening to people in senior centers citywide and in hard-to-serve areas such as the South Bronx, Harlem and Central Brooklyn.

Mental Retardation and Developmental Disabilities

Helping people of all ages with mental retardation and developmental disabilities reach their fullest potential is an important DOHMH goal. The Department operates Early Intervention (see page 28) for children from birth to three years of age, the Adolescent Skills Program for youth (see page 31) and in 2005, launched the Children's Single Point of Access to improve access to services for youth with serious emotional disturbances (see page 31). The Department is also working to improve access to chemical dependency and mental health services for individuals with mental retardation and developmental disabilities.

Housing as a First Step to Recovery

A $1 billion pact between New York City and New York State will finance and develop 9,000 new units of supportive housing in the city. Signed in November 2005, the New York/New York III (NY/NY III) agreement will produce nearly twice the 5,300 units of subsidized, permanent housing with social services generated by the New York/New York I and II agreements combined.

NY/NY III is based on the premise that no person can recover from a serious mental illness or substance-abuse disorder without safe, reliable housing. NY/NY I and NY/NY II produced units solely for single adults with mental illness and some history of homelessness.

NY/NY III is part of United for Solutions Beyond Shelter, a five-year plan issued in June 2004 as part of the administration's initiative to end chronic homelessness. Under the plan, with state, and private partners, 12,000 units of supportive housing will be funded and developed. There will be 9,000 units included in the new agreement and more than 3,000

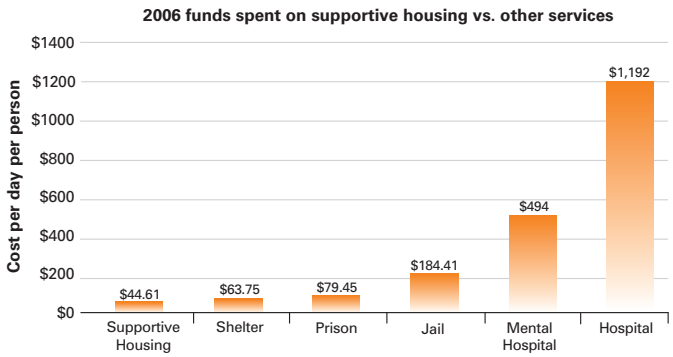
In June of 2004, Mayor Bloomberg announced NY/NY III, New York's largest supportive housing program ever.

additional units, developed by the city's Department of Housing Preservation and Development (HPD), and the state and federal governments. Together, these new units will fulfill Mayor Bloomberg's goal of increasing by more than 50% the 20,000 units of supportive housing that currently exist in the city. DOHMH will contract for approximately 4,000 of the 9,000 units in the NY/NY III agreement.

NY/NY III is available to a broad range of clients, reflecting the chronically homeless population in New York City. NY/NY III includes units for clients with substance

Public and private partners have developed 12,000 units of supportive housing in NYC.

Supportive Housing Reduces the Need for Costly Services



abuse disorders, HIV/AIDS and mental illness. It also serves, for the first time, families with heads of household who are disabled, and young people aging out of foster care and residential treatment. Both congregate and scattered-site housing will be developed. DOHMH also contracts for approximately 2,100 of the 5,300 units in the city created by the first two New York/New York agreements.

In addition to NY/NY III, DOHMH funds services and rental subsidies for more than 3,000 supportive housing units throughout the five boroughs. Approximately 1,300 additional units are in development and scheduled to open over the next five years.

Three Generations of Supportive Housing in New York City

New York/New York I (1990)

3,615 units

Target population:
Single adults with mental illness and some history of homelessness

New York/New York II (1999)

1,500 units

Target population:
Single adults with mental illness and some history of homelessness

New York/New York III (2005)

9,000 units

Target populations:
Chronically homeless, single adults with mental illness from the street and shelters; single adults with mental illness in state psychiatric facilities; young adults with mental illness; chronically homeless families headed by an adult with a mental illness, a substance abuse disorder, a disabling medical condition or HIV/AIDS; homeless adults with substance abuse disorders; chronically homeless individuals with HIV/AIDS; youth aging out of foster care

Housing: A Cost-Effective Solution

Chronically homeless individuals living in shelters and on the street rely heavily on expensive crisis and emergency services such as detoxification, emergency medical care and inpatient care. Supportive housing significantly reduces the need for these services making it a cost-effective alternative to shelters. The previous two NY/NY agreements resulted in cost reductions that came close to paying for the actual cost of housing and services. Placement into supportive housing was associated with a reduction of $16,282 in services used per housing unit per year, as follows:

- 72% resulted from a decline in the use of public health services
- 23% resulted from a decline in shelter use
- 5% resulted from lower rates of incarceration in mentally ill homeless people

The net cost of the average New York/New York supportive housing unit was only $995 per year after deducting these costs. New York/New York III will build on these savings with more targeted assistance to people who have high costs for medical care and other public services.

A substantial portion of New York/New York III's $1 billion development cost and $156 million in annual operating costs (once all 9,000 units are developed) will be shared by the state and city. Various sources, including private equity and tax credits, will provide additional funding. As part of the city's capital commitment, HPD has targeted 25% of its Low Income Housing Tax Credit Allocation to supportive housing. It will dedicate units in city-sponsored new construction to formerly homeless people and operate with an increased capital budget to construct supportive housing.

Sustaining a Healthy Environment

Dining out and enjoying walks in the city's parks and streets are among NYC's many pleasures. The Health Department ensures the health and safety of the city's physical environment by inspecting its food service establishments and monitoring the safety of consumer goods. DOHMH also helps care for the city's stray animals and manages pest populations.

Food Safety

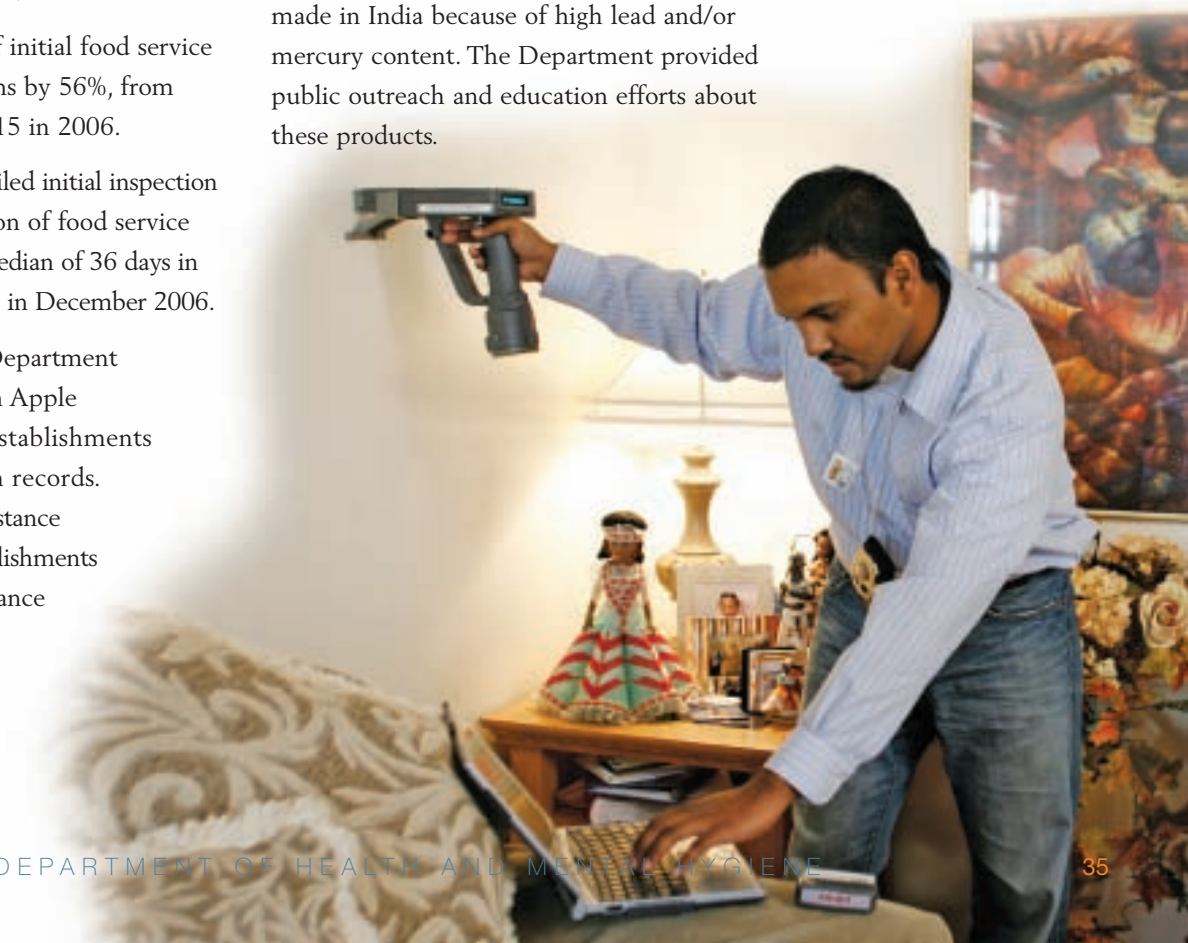
In addition to the new use of handheld devices to facilitate restaurant inspections (see page 10), DOHMH strengthened its inspection procedures and increased the number of inspections performed each year. The Department also maintains a website where the public can view inspection results (www.nyc.gov/html/doh/html/rri/index.shtml). Achievements included:

- An increased percentage of restaurants undergoing an annual inspection, up to 99.9% from 88% in 2002.
- An increased number of initial food service establishment inspections by 56%, from 19,207 in 2002 to 30,015 in 2006.
- Fewer days between a failed initial inspection and the first re-inspection of food service establishments from a median of 36 days in January 2005, to 14 days in December 2006.

In May 2004, the Health Department also established the Golden Apple Award to recognize food establishments with exemplary inspection records. The goal is to provide assistance and incentives to food establishments to implement quality assurance programs.

Consumer Safety

Lead poisoning remains a serious and preventable public health problem. While paint is the primary source of lead poisoning (see pages 7 and 29), non-paint lead sources contribute to exposure among children and adults. In 2005, DOHMH investigated the use and availability of Litargirio, a traditional remedy used in the Dominican Republic as an anti-perspirant and treatment for burns and foot fungus. Because Litargirio can contain high lead levels, the city prohibited its sale. Also in 2005, DOHMH prohibited the sale of certain herbal medicine products made in India because of high lead and/or mercury content. The Department provided public outreach and education efforts about these products.



Department inspectors use specialized equipment to check for lead-based paint, which is the leading cause of children's exposure.

The Health Department investigated and halted the sale of Litargirio, a traditional Dominican remedy that was found to be toxic.

In 2006, DOHMH banned the sale and embargoed more than 7,000 units of herbal remedies from China that were associated with adult lead poisoning cases in the city. In 2007, the Department banned eye cosmetics known as kohl, kajal or surma that were associated with several lead poisoning cases in adults and children. More than 2,000 units of these eye cosmetics have been removed from stores. DOHMH also laid the groundwork for a study that will examine the use of herbal remedies among South Asians, a group with high levels of lead poisoning in children and pregnant women, to better develop effective intervention strategies.

In 2005, several study participants in NYC HANES were found to have very high levels of mercury in their urine, a marker of exposure to metallic mercury and mercury salts. A Department investigation revealed that all the cases were attributable to the use of illegally imported, mercury-containing skin lightening creams. The Department issued a public alert and inspected beauty salons and discount stores in neighborhoods where people reported purchasing the products, removing hundreds of containers of creams that contained dangerous amounts of mercury. Like Litargirio, all the products found to contain high levels of mercury were manufactured in the Dominican Republic.

Pest Control: Fighting Urban Blight

Rodent infestations, possibly exacerbated by warmer winters, remain a serious problem in many communities. Through 311 (see Snapshot, page 10), it became easier for city residents to report rodent infestations, resulting in an increase of 8,700 rodent complaints from 2004

to 2005. The pest control program has also developed an online reporting system that allows managers to monitor complaint response, backlog lists and turnaround time for answering complaints. In 2006, DOHMH focused on prevention and control—rather than just extermination—in problem areas.

In 2005, a rodent initiative in the Bronx and Brooklyn resulted in increased inspections and exterminations. DOHMH is now beginning a pilot rodent control initiative using handheld computers for data collection to improve the efficiency and geographic coordination of the inspection process and program follow up.

The New York City Rodent Control Academy helps pest control inspectors and exterminators effectively manage rodent populations. The academy offers instruction on the biology, behavior and habitat of rodents, contributing factors to infestation, effective ways to evaluate site-specific responses and strategies, and effective communication strategies with the public to achieve lasting change and improvements.

In 2005, New York City adopted Local Law 37, which prohibits the city's use of certain types of pesticides on public property. The law also promotes preventive pest management in place of pesticide-only management. DOHMH has taken the lead in implementing the law, working with many city agencies to reduce the administration of pesticides, improve monitoring and preventive maintenance, and enhance tracking and reporting of pesticide use. In 2007, DOHMH launched an electronic pesticide reporting system that enables agency staff, contractors and private exterminators to track and report their pesticide use.

Animal Programs

Through targeted pet-adoption campaigns, the DOHMH, the NYC Center for Animal Care and Control, and the Mayor's Alliance for NYC's Animals have dramatically decreased the number of dogs and cats euthanized in the city. From 2002 to 2006, adoptions of dogs and cats almost doubled. During that same time period, euthanasia among dogs and cats decreased by more than one third.

Rabies affects the nervous system and is almost always fatal if not treated soon after exposure. There has not been a case of human rabies in New York City in more than 50 years. In 2006 and 2007, DOHMH tracked and targeted an outbreak of animal rabies in Staten Island—35 animals, mostly raccoons, tested positive for rabies. Previously, only one rabid raccoon had been identified from 1998 to 2006. The Department offered free rabies vaccinations for cats in the borough. Four of the animals that tested positive for rabies in 2006 were kittens and about a dozen people had to be given preventive rabies shots because of contact with these kittens.

The Health Department, the Center for Animal Care and Control, and the Mayor's Alliance for NYC's Animals have dramatically decreased the number of dogs and cats euthanized in the city.

A Prescription for Improvement: Health Goals for New York City

From 2004-2006, the Health Department learned more, and did more, to help New Yorkers live longer and healthier lives. But there still is much more to be done. Although we made good progress toward many **Take Care New York** goals (see page 4), gains were slow and slight in some areas, such as reducing HIV deaths and infant mortality. In other areas we moved farther away from our targets—flu vaccinations and breast cancer screenings dropped, and drug-related deaths increased (see pages 5-6).

One of public health's greatest challenges is getting more health value from the health care system. Although DOHMH has created initiatives to help doctors and patients manage hypertension, high cholesterol, depression and diabetes, we have not yet achieved broad enough coverage or success with these initiatives to make a big difference in the health of New Yorkers. Large-scale improvements in the control of high blood pressure and high cholesterol are particularly critical. Cardiovascular disease is the leading cause of early death in New York City and is the greatest source of health disparities (see page 22). We also need to increase the number of people screened and provided with brief intervention for alcohol use, and help more people who are addicted to opiates receive treatment, including buprenorphine (see page 32). We've helped only a fraction of those who could benefit from these interventions.

The Primary Care Information Project (PCIP) is an ambitious attempt to improve the quality of medical care for New Yorkers (see pages 10 and 19). Through the use of prevention-oriented electronic health records (EHRs), PCIP can help shift the health care paradigm from responding to disease to promoting health. EHRs can give doctors the right information, at the right time, to make the right decisions. But in addition to adopting EHRs, providers and insurers must make critical changes. Medical offices need care managers who contact patients for preventive visits and support care of chronic diseases. At the same time, reimbursement should be realigned to reward doctors and clinics for providing the preventive care needed to help patients stay healthy. In this way, we could begin to transform our disease care system into a true health care system.

Despite progress in HIV prevention, testing and care, New York City remains the epidemic's epicenter in the United States, with a case rate that is four times the national average. HIV is the most unequal of all health conditions, killing six times more black than white New Yorkers. Even among HIV-positive people, those who are poor, black or Hispanic die at much higher rates than white people with HIV. And while mother-to-child HIV transmission has been virtually eliminated and new AIDS cases among intravenous drug users are down by about 90%, transmission among young men having sex with men continues and appears to be increasing. We must do more to transform the city from the disease's epicenter to a model of HIV prevention.

Obesity and diabetes continue to increase, undermining many other health gains (see page 22). Creating programs and policies that reduce calorie consumption and increase physical activity are essential. The Department is committed to designing, implementing and rigorously evaluating new interventions.

The early childhood period is critical for health, social and educational outcomes. Initiatives such as the Nurse-Family Partnership and the Newborn Home Visiting program (see pages 28-29) are reaching thousands of children and families, but many more could benefit from these initiatives.

Protecting the environment is also a Health Department priority. We need to work with others to improve air quality and make much greater strides in rodent control (see page 37).

In addition to looking outward to improve the health of New Yorkers, the Department must also look inward to assure that it has the infrastructure—human, operational, financial and physical—to support the development and implementation of its programs. Our administrative systems have improved somewhat in recent years (see pages 10-11), but our continued success depends on our ability to attract and retain talented staff, provide professional work environments, align budgets with program priorities and streamline administrative systems, including contracting and procurement.

We have put in place a strong foundation to support and sustain future growth; we are now poised to achieve even greater results. New Yorkers live longer than ever and, for the first time since World War II, live longer than the average American. Life expectancy in New York City has increased faster than the national average each year since 2001. If we sustain our efforts, generations of New Yorkers will enjoy a healthier city and longer, healthier lives.

The Health Department by the Numbers

Agency-Wide

Indicator	Fiscal Year 2004	2005	2006	Comment
Full-Time Equivalent Employees	5,191	5,205	5,473	Staff has increased in response to DOHMH initiatives that address critical chronic and preventive health care needs. New inspection and enforcement initiatives (e.g., day care) have also led to a growth in staff.
Agency New Hires	N/A	746	936	Increase in 2006 has been spurred by expanding programs.
Final Modified Budget	$1,490,914,894	$1,461,238,961	$1,495,926,818	Increases in spending for school health, correctional health, restaurant inspections, lead poisoning prevention, diabetes, vital records, maternal/ child health programs, and STD and HIV testing have been offset by budget savings in other areas.
Total Expenditures	$1,431,262,156	$1,404,070,830	$1,469,921,830	
City Tax Levy Expenditures	$494,030,593	$495,975,672	$490,136,516	
Revenue From Inter-governmental and Private Grants, Intergovernmental Aid, Fees and Fines	$947,216,177	$936,071,443	$977,649,527	Although a number of one-time grants have not been extended, the Agency has been awarded several federal multi-year grants, including funding from the Department of Homeland Security.
Fines Collected at the Administrative Tribunal, Primarily From Restaurant (86%) and Pest Control (5%) Violations	$22,089,206	$23,591,924	$20,417,627	Fines declined temporarily in 2006 due to a delay in permanently adopting new fine structures for food service establishments and a reduced number of daily hearings for part of that year.
Capital Commitments (in $)				
Mayoral				
Information Technology (IT) Equipment and System Development	$1,164,107	$2,714,836	$7,418,484	
Facilities, Equipment and Outfitting (non-IT)	$9,200,778	$23,263,739	$35,239,936	
Total Mayoral Commitments	**$10,364,885**	**$25,978,575**	**$42,658,420**	
City Council and Borough President Commitments	$9,603,000	$15,730,106	$14,740,144	
Totals by Fiscal Year	$19,967,885	$41,708,681	$57,398,564	
Grand Total			**$119,075,130**	

Administration

Indicator	Fiscal Year 2004	2005	2006	Comment
Calls Received at DOHMH Call Center	177,215	85,359	68,781	Calls to the DOHMH Call Center decreased in 2005 and 2006, following the advent of the 311 system.
Individual Pieces Printed In-House (in millions)	57	51	64	The purchase of new printing equipment enabled the Agency to print more publications in-house.
Contracts	8,397	8,276	8,162	The annual number of contracts has declined as the Agency solicits more multi-year contracts.
Capital Projects (both DOHMH and the Department of Design and Construction)	36	43	57	The Agency has secured funding for capital projects by rigorously documenting the deterioration of facilities.
Supply/Materials Requests Fulfilled by the Distribution Center	2,021	2,125	9,400	Higher demand, and the consolidation of supplies at the Distribution Center, raised the number of requests filled.

Disease Control

Indicator	Fiscal Year 2004	2005	2006	Comment
Medical Reserve Corps Volunteers Enrolled (cumulative, 2004-2006)	2,765	3,195	4,785	Targeted recruitment strategies have attracted thousands of new volunteers.
Primary and Secondary Syphilis Cases	599	646	587	Despite prevention efforts, primary and secondary syphilis cases have been increasing since 1998 (95% are in men; most report having sex with other men). A brief decline in 2006 was not sustained.
Gonorrhea Cases	12,210	10,206	10,221	The number of cases has declined in New York City since 2004, in keeping with a national trend.
DOHMH Sexually Transmitted Disease (STD) Clinic Visits	111,004	107,807	112,155	The demand for clinic services reached an all-time high in 2006.
Confidential HIV Tests Performed at DOHMH STD Clinics	25,094	33,090	42,960	Rapid testing and streamlined pre-test counseling have helped increase the annual number of HIV tests.
HIV-Positive Tests Results from Confidential Testing at DOHMH STD Clinics	376	394	470	The number of positive tests has increased, but the rate has declined as more low-risk people respond to the public health message "Know Your HIV Status" that **Take Care New York** has helped convey.
DOHMH Tuberculosis Clinic Visits	124,695	122,239	123,300	Demand for tuberculosis control clinical services continues to be substantial.
New Cases of Tuberculosis	1,039*	984*	953*	High rates of travel and immigration pose challenges to tuberculosis control. More than two-thirds of tuberculosis cases in New York City are among people born in other countries.
Patients Completing Treatment for Latent Tuberculosis Infection (LTBI)	5,280	4,791	3,722	The number of LTBI patients completing treatment has fallen by 19%. The Agency has bolstered efforts to increase completion.
Tuberculosis Contacts Identified	6,483	7,357*	7,336*	Contact investigation is a core public health function and helps stop the chain of tuberculosis transmission.
Tuberculosis Contacts Tested	5,402*	5,751*	5,656*	
Tuberculosis Contacts Infected	1,409*	1,372*	1,244*	
Exposure Investigations in Congregate Settings	29	23	33	The proportion of tuberculosis patients who expose others at work or other social settings has remained constant or increased.

*Indicates data is by calendar, and not fiscal, year

Disease Control *(continued)*

Indicator	Fiscal Year 2004	2005	2006	Comment
Immunizations (current and historical) Entered Into the City Immunization Registry (CIR)	N/A	N/A	4,139,609	New requirements for the Vaccines for Children Program improved reporting to the CIR; enhancements to the Registry have simplified and expedited the reporting process.
Number of Times Records Were Accessed Online for the City Immunization Registry	127,979	183,980	493,171	Promotional efforts have raised awareness that CIR immunization records can be accessed electronically.
Male Condoms Distributed	4,235,000	3,855,000	17,770,000	Intensive promotion of the NYC Condom, which organizations can order online, helped drive a 300% increase in the number of condoms distributed.
Female Condoms Distributed	22,000	142,000	326,000	Female condoms can reduce HIV transmission and their distribution has been increased, despite relatively high costs.
Agency HIV Tests Completed	25,094	33,090	42,960	Rapid HIV testing and concerted efforts in several settings have increased testing rates substantially.
Citywide HIV Diagnoses	3,576	3,632	3,674	The number of HIV diagnoses has remained constant, likely reflecting ongoing spread of the virus.
HIV Diagnoses in Men Who Have Sex With Men (MSM)	1,260	1,349	1,412	Infections among men who have sex with men continue to occur and are fueling the epidemic in NYC.
HIV Diagnoses in Injection Drug Users	330	246	235	HIV/AIDS among injection drug users has declined by 90% in the past decade.
HIV Diagnoses in Heterosexual Individuals	785	992	732	
HIV Diagnoses in Newborns	16	15	10	Maternal-to-child transmission was reduced by more than 90% after universal HIV testing began.
HIV Diagnoses - Other/Unknown Risk Factors	1,185	1,030	1,285	The Department is working to improve risk factor ascertainment, and to establish more sensible criteria for transmission risk that would still be consistent with CDC standards.
Concurrent HIV-AIDS Diagnoses	1,031	1,008	960	The continued number of concurrent diagnoses reflects a failure to substantially increase early diagnosis of HIV through increased testing programs.
Concurrent HIV/AIDS Diagnoses (%)	28.8%	27.8%	26.1%	
People with HIV Receiving Care Within Three Months of Diagnosis (%)	63.5*	65.8*	66.3*	The Department is working to improve linkage to care among those diagnosed with HIV infection.
New AIDS Diagnosis	4,294*	4,013*	3,823*	Includes people diagnosed concurrently with HIV and AIDS, and those who developed AIDS following an earlier HIV diagnosis.
HIV-Related deaths	1,467*	1,429*	1,218*	HIV-related deaths have fallen mainly among injection drug users, due to a decline in new infections and better care for those already infected.
HIV Contacts Identified Citywide and Referred to DOHMH	751	798	973	Educating physicians about partner notification and notification strategies has resulted in an increase.
Contacts Tested by DOHMH Who Were Positive (%)	16%	13%	28%	In 2006, the Agency strengthened partner notification efforts and doubled the number of people diagnosed through partner notification.
HIV Specimens at Public Health Labs	116,820	90,120	61,560	An increase in rapid HIV testing led to a decrease in lab-based testing.
BioWatch Specimens Tested at Public Health Labs	7,572*	11,671*	12,007*	
Chlamydia Specimens Tested (CT/GC Specimens) at Public Health Labs	62,349*	64, 216*	75,843*	Automation and expanded school screening projects resulted in an increase of 25% over the three-year period.

*Indicates data is by calendar, and not fiscal, year

Epidemiology

Indicator	Fiscal Year 2004	2005	2006	Comment
Information Requests Received at the Public Health Library	4,201	3,661	3,299	Requests for library retrieval declined slightly as electronic access became more convenient.
Books, Articles and Videos Provided by the Public Health Library	N/A	4,944	6,807	Data-driven policy-making has increased the number of resources distributed to DOHMH staff and external partners.
City Health Information Bulletins Published	8	9	10	The number of bulletins for New York City health professionals is growing as the Agency seeks to address priority public health issues.
City Health Information Bulletins Mailed	624,361	742,674	543,148	Bulletins are mailed to all licensed physicians, and to many other health care staff depending on the topic.
Health Research Training Program Students Participating in DOHMH Projects	138	182	143	The HRTP program helps the Department complete important projects and train the next generation of public health professionals.
Visiting Medical Residents/ House Staff Placed at the DOHMH (via the Public Health/Preventive Medicine Residency Program)	N/A	11	13	DOHMH is meeting a growing demand from medical students to fulfill university electives by rotating through the Agency.
Peer-Reviewed Publications Published by DOHMH Staff	23	63	77	Research output has increased sharply as Agency staff collect, analyze and publish more data.
Internal EpiQuery Hits	N/A	2,541	9,742	Redesign of the website has made this interactive, public-health data site easier to access and share, both within the Agency and externally.
External EpiQuery Hits	N/A	1,117	5,409	
Consulting/Assistance Requests to the Bureau of Epidemiology Services	N/A	1	28	An increase in staff has enabled the Bureau to fulfill requests from partner agencies and organizations. Among other activities, the Bureau helps partners develop questionnaires and works with them to ensure sound analysis and data mapping.
Birth and Death Certificate Copies Generated	248,221	256,526	237,825	
Birth Certificate Copies Generated from Online Requests	93,750	100,567	132,781	Efficiency is increasing as more orders for birth certificates are received over the Internet, replacing mail, telephone and fax orders.
Average Response Time for Death Certificate Requests Via Mail (In Days)	9.6	7.4	12.2	Response time increased due to staff shortages.
Average Response Time for Birth Certificate Requests Via Mail (in days)	6.6	4.4	5.2	
People Enrolled in the World Trade Center Health Registry	44,404	71,273	71,270	Enrollment was complete as of November 2004, and attrition has been negligible. Only three enrollees dropped out during the three-year period.

Environmental Health

Indicator	Fiscal Year 2004	2005	2006	Comment
Poison Control Calls	70,036	65,601	64,021	The Poison Control Center is a critical resource for the medical community and the public, and coordinates the Department's 24/7 response.
Number of People Trained in Food Safety	13,429	14,001	14,528	The Department's four-day food safety course is offered in multiple languages, and provides crucial training to reduce the risk of food-borne illness.
Food-borne Illness Complaints	665	1,165	1,009	Implementation of 311 has increased the number of complaints about food-borne illness.

Environmental Health *(continued)*

Indicator	Fiscal Year 2004	2005	2006	Comment
Radiation-Producing Equipment Initial Inspections	1,584	1,506	1,802	Inspections increased in 2006 due to the use of Certified Radiation Equipment Safety Officers to inspect low-risk dental and podiatric X-ray equipment.
Lead Poisoning Prevention Children (six months to six years of age) with Blood Lead Levels > 10 Micrograms/Deciliter	3,318	2,993	2,574	Lead poisoning rates among NYC's children continued to decline steadily due to aggressive prevention efforts.
Newly-Identified Children Requiring Environmental Intervention	578	902	896	The number of children receiving environmental intervention services for lead poisoning rose in 2005, but the actual number of lead-poisoned children did not. Intervention increased because of a reduction in the blood lead level that triggers provision of services.
Dog Bites	4,255	3,985	3,776	Dog bites in NYC continue to decline.
Dogs Licensed	104,633	100,576	104,449	The number of dogs licensed in NYC remains constant and is estimated to be only one-fifth of all dogs in the city.
Dogs and Cats Rescued (Animal Care and Control)	31,568	29,824	29,975	Calls for rescue have decreased since 2004.
Cats and Dogs Adopted, Including Those Placed through New Hope Animal Adoption Network	N/A	17,191	18,226	As the Agency and its partners encourages New Yorkers to adopt pets, cat and dog adoptions have grown. The need for euthanasia has declined accordingly.
Dogs and Cats Euthanized	26,758	21,172	19,782	
Rodent Complaints	17,998	26,637	26,714	The advent of the 311 system in 2004 enhanced the public's ability to file complaints, prompting an increase.
Rodent Inspections (includes Agency-initiated and complaint-driven)	68,100	92,200	74,500	The total number of inspections has fallen as program staff have adopted more efficient methods to identify signs of rodent activity.
Rodent Exterminations	83,900	88,100	53,700	DOHMH has re-focused its strategy to emphasize systematic prevention and rodent control on properties nearby an affected property.
Standing Water Inspections	3,165	3,305	3,464	The Agency increased inspections in an effort to prevent mosquito breeding.
Mosquito Pools Tested	8,772	10,368	7,357	Each year, the Department tests tens of thousands of mosquitos collected from more than 100 sites to track and better control West Nile virus.
Human West Nile Virus Cases	31	5	14	
Active Day Care Service Centers	9,244	9,254	9,271	
Day Care Complaints Received	1,052	1,435	1,508	Day care complaints increased with the implementation of the 311 system and growing public attention to day care safety.
Food Service Establishments Complaints	5,823	7,087	7,144	The advent of 311 made it easier to file complaints about food service establishments.
Food Service Establishments Initial Inspections	25,045	25,819	30,015	Improvements in program efficiency and increases in the number of food service establishments resulted in expanding the number of inspections.
Food Service Establishments Failing Initial Inspection (%)	20.9	16.6	20.2	
Restaurants with Permits Inspected (%)	99.2	99.9	99.9	
Mobile Food Vending Units Initial Inspections	4,914	6,029	8,158	
Day Camp Inspections	1,196	1,312	1,759	The Agency responded to the growing number of new day camps by increasing inspections by almost 50% over 3 years.

Environmental Health *(continued)*

Indicator	Fiscal Year 2004	2005	2006	Comment
Complaints and Referrals for Window Guards	2,995	5,436	4,207	The advent of the 311 system in 2004 made it easier to file complaints about missing window guards.
Window Guard Inspections	17,118	19,089	22,371	Window guard inspections increased 30% between 2004 and 2006.
Preventable Window Falls/ Window Fall Fatalities	2/1	9/2	7/0	Window falls and fatalities remain low due to consistent enforcement of the law requiring window guards in buildings with young children.
Smoking Complaints	3,758	3,364	3,009	Smoking complaints dropped 20% as compliance with the Smoke-Free Air Act increased.

Financial and Strategic Management

Indicator	Fiscal Year 2004	2005	2006	Comment
Early Intervention Services Reimbursed by Medicaid (%)	43	47	51	DOHMH has increased non-city funding for early intervention through Medicaid billing, data matches and challenges to private insurance that deny coverage. Increased Medicaid coverage of children saves the city money and promotes health care for children in need.
Alerts, Advisories and Updates Sent on the Health Alert Network	91	60	58	This number varies according to federal, state and local alerts and advisories.
Registered Users in the Health Alert Network	8,203	12,140	16,542	Content on the HAN increased as the Agency generated more public health alerts and added information on emergency preparedness and response.
New NYCMED Users	11,969	15,794	18,786	NYCMED registrations increased as online content expanded.
Diseases Reported Electronically to the Electronic Clinical Laboratory Reporting System (ECLRS)	77	77	78	
Laboratories Enrolled in the ECLRS	43	64	82	Lab enrollment increased as the Bureau of Informatics and Information Technology conducted outreach to increase laboratory compliance with the ECLRS mandate (effective July 1, 2006).
Test Results Reported Electronically to the ECLRS	261,495	402,729	590,423	The increase is due to increased ECLRS lab enrollment and laboratories submitting additional disease-type reports to ECLRS.
Bureau of Informatics and Information Technology Managed Applications Available to the Public and Agency Partners (Health Care Providers, Laboratories, Others)	5	9	13	Applications include the World Trade Center Registry Online Survey, Condom Order Form, My Health Survey, Flu Locator, Health Alert Network (HAN) and the online Food Protection Course.
Press Releases Issued	90	96	69	The Press Office has reduced the number of releases to maximize impact; output exceeds one release per week.
Articles About NYC DOHMH in Major Print Media	N/A	N/A	881	A single press release can spark hundreds of articles; 881 print articles covering DOHMH appeared in publications with circulation in New York City.
Mass Emails Sent to Website Users Who Request Updates	N/A	50	36	The Department's *Health Bulletin* has been established as a core means of health education and is being sent out both electronically and hard copy.
Mass Email Update Subscriptions to nyc.gov	N/A	128,859	209,788	As the DOHMH website expands and is aggressively promoted, email subscriptions have increased accordingly.
Hits on the Public DOHMH Website	13,901,472	13,286,210	17,341,756	The number of pages viewed increases as content improves. The most popular items include birth certificates, death certificates and restaurant inspection reports.

Financial and Strategic Management *(continued)*

Indicator	Fiscal Year 2004	2005	2006	Comment
Agency Publications Printed	N/A	N/A	6,593,450	The Publications Unit was launched in October 2005. Data are available only for the first six months of 2006.
Foreign-Language Translations	605	327	280	The number of translations is increasing. The apparent decline results from counting multiple translations of one publication as a single translation.

Health Care Access and Improvement

Indicator	Fiscal Year 2004	2005	2006	Comment
Medicaid Managed Care (MMC) Enrollees	1,362,061	1,472,868	1,492,091	Medicaid managed care continues to grow with the addition of new categories of consumers enrolling into MMC plans.
Oral Health: Children Who Received Sealants	N/A	7,767	7,191	The Agency's adoption of a preventive dentistry model increased sealant applications from fiscal year 2004 to fiscal year 2005.
Correctional Health Services				
Primary Care Medical Visits	N/A	822,734	791,110	The Department oversees comprehensive medical care at Rikers Island.
Intake Exams and Sick Call Visits	N/A	89,997	90,399	
Intake and Primary Care Visits for Incarcerated Individuals (primary care medical visits, intake visits, follow-up visits and chronic care visits)	N/A	912,731	881,509	
Mental Health Visits	N/A	215,982	222,409	Initial mental health evaluations and follow-up visits have increased as the Agency seeks to ensure that medical care is provided in correctional facilities.
Detoxifications (opiate)	N/A	15,628	13,972	
Inmates with Chlamydia Treated Prior to Discharge (%)	N/A	N/A	70	A new program screens males under age 35, as well as females, for chlamydia and provides testing in the jails. Because of short stays (<48 hours), nearly one-third of those tested are released to the community before their results are available. Those released prior to treatment are given callback information and sent follow-up letters.
HIV Tests Conducted in City Jails	N/A	17,085	29,074	Testing increased with the implementation of rapid HIV testing upon admission and during incarceration.
Correctional Health Services - Transitional Health Care Coordination (THCC)				
Jail-based Clients Seen for Health Education and/or Discharge Planning	N/A	25,393	55,270	DOHMH increased its focus on post-release care, and more individuals were seen in one-on-one encounters.
Formerly Incarcerated Clients Contacted in the Community	N/A	4,382	15,537	
Visitors Who Received THCC Materials Through Staff Outreach at Correctional Facilities	N/A	50,188	100,669	Health education efforts at Rikers Island Visitor Center were expanded between 2005 and 2006.
Visitors Who Completed Health Needs Assessments and Engaged in Health Promotion Activities at Correctional Facilities	N/A	5,368	10,310	Health education efforts at Rikers Island Visitor Center have consistently resulted in 10% of clients receiving materials and being engaged by staff for additional health promotion activities.

Mental Hygiene

Indicator	Fiscal Year 2004	2005	2006	Comment
Children with Early Intervention Program Service Plans (Cumulative Number of Children with Active IFSPs)	38,455	37,347	36,645	As eligibility for services has been more carefully reviewed in recent years, fewer children have been found to meet eligibility criteria for Early Intervention services.
Children Newly Referred to the Early Intervention Program	23,004	24,784	26,515	More children were identified and referred to Early Intervention because of suspected developmental delays or disabilities.
Individuals Who Filled Buprenorphine Prescriptions (a medication used to treat opiate addiction)	N/A	N/A	2,880	The Department has actively promoted buprenorphine, a new treatment for opiate addiction.
Individuals in the Assisted Outpatient Mental Health Treatment Program	1,196	1,212	1,170	The program remains an important resource for patients and the community.
Units of Supportive Housing Available to Persons with Severe Mental Illness	11,500	12,500	13,900	DOHMH has funded an increasing number of supportive housing units for people with mental illness.
Eligible Mental Hygiene Programs Participating in a Quality Impact Initiative (%)	N/A	N/A	49%	Quality Impact is a quality improvement initiative focusing on key issues in mental hygiene service delivery.
Calls Received for Mental Health Assistance	70,252	66,854	76,573	Calls received on LifeNet (a telephone help line that helps callers LifeNet locate mental health and substance abuse services) have increased since 9/11.
Voluntary Agency Contracts	346	358	358	
Voluntary Agency Programs	735	701	733	
People Served	N/A	N/A	522,660	

Health Promotion and Disease Prevention

Indicator	Fiscal Year 2004	2005	2006	Comment
Citywide Infant Mortality Rate (IMR) (per 1,000 live births)	6.5*	6.1*	6.0*	
Active Clients in the Nurse-Family Partnership	76	83	198	The Nurse-Family Partnership, an evidence-based program for first-time mothers, will serve families in all five boroughs by January 2008.
Clients Graduated from the Nurse-Family Partnership	0	0	11	The first group of clients from the pilot site in East Jamaica, Queens, has graduated from the intensive two-and-a-half year program.
Female Teens (ages 15-19) Who Use Hormonal Birth Control (%)	N/A	8*	N/A	DOHMH is working on many fronts to expand adolescents' access to reproductive health services and increase the use of contraceptives.
Mothers Who Breastfeed Up to Two Months or Longer (%)	64	59	N/A	Breastfeeding initiation exceeds national targets, but exclusive breastfeeding rates are far lower.
Public School Kindergarten Students Undergoing Vision Screening (%)	85	94	94	The Agency has filled staff vacancies and increased the number of screenings to reduce risk of blindness from amblyopia.
Public School First-Grade Students Undergoing Vision Screening (%)	75	95	95	
Students in the Public Schools Who Have Completed Required Immunizations (%)	96	97	97	Immunization rates remain high due to sustained efforts to inform school principals of requirements and monitor compliance.
3rd, 4th and 5th Graders Enrolled in Open Airways Asthma Management Program	N/A	1,973	3,199	Increased buy-in from school staff has improved participation in self-management programs.
Elementary School Students with Provider-Diagnosed Asthma (%)	N/A	5%	7%	The increase in diagnosis reflects Agency efforts to educate parents and school staff about asthma.

*Indicates data is by calendar, and not fiscal, year

Health Promotion and Disease Prevention *(continued)*

Indicator	Fiscal Year 2004	2005	2006	Comment
Individuals Who Are Authorized to, and Who Use, Automated School Health Records (Weekly) (%)	N/A	72	57	Although the percentage was lower in 2006, the number of nurses and other school health staff who are authorized increased citywide.
Students Who Completed FITNESSGRAM Measurements	N/A	9,000	234,208	During the 2006-2007 school year, FITNESSGRAM was implemented in 705 schools (475 elementary, 42 K-8, and 178 middle and high schools), providing students and families detailed feedback on weight and fitness.
Adult Smoking Rate (%)	18.4*	18.9*	17.5*	Following an intensive media campaign from 2005 to 2006, smoking rates declined significantly in men (from 22.5% to 19.9%) and Hispanics (from 20.2% to 17.1%).
Adolescent Smoking Rate (%)	14.8*	11.2*	N/A	The citywide rate of 11.2% is less than half the 2005 national of 23%; NYC's rate has declined as the national rate has remained constant or increased.
Courses of Nicotine Replacement Therapy Distributed	25,000*	75,000*	60,000*	Courses of four to six weeks of nicotine patches are provided through 311 and community and clinical partners, with quit rates as high as 33%, saving thousands of lives.
Calls to 311 for Cessation Services	N/A	21,613*	53,704*	Calls to 311 for assistance to quit smoking more than doubled as a result of a large-scale, hard-hitting, anti-tobacco media campaign launched in 2006.
Citywide Hospitalization Rate for Asthma Among Children Ages 0-14 years (per 1,000 children)	7.3	6.5	5.4	The citywide childhood asthma hospitalization rate is declining, but it remains high in low-income neighborhoods.
Apartments that Received an Integrated Pest Management Intervention	N/A	N/A	401	
Individuals with Asthma Who Benefited from an Integrated Pest Management Intervention	N/A	N/A	796	
Persons 50 Years or Older Who Have Ever Had a Colonoscopy (%)	42	52.2	55.0	Agency efforts to increase awareness about the dangers of colon cancer and promote screening resulted in a slight increase from 2003, and a more than 10% increase since 2004.
In-hospital Colonoscopies	N/A	148,906	141,712	The number of in-hospital colonoscopies has fallen as more colonoscopies are performed in private offices.
Restaurants Not Using Trans Fat for Frying, Baking, Cooking or in Spreads (when product content could be determined) (%)	N/A	50	50	A voluntary campaign to encourage restaurants to switch to trans-fat free alternatives failed.
Health Care Practices Visited by the Public Health Detailing Program in the DPHOs	151	176	214	DOHMH increased the number of detailers in the program, identified new sites in each territory and expanded into new neighborhoods.
Health Care Sites Participating in Clinical Systems Improvement Programs	21	21	23	The number of practices with registries increased, and existing registries expanded, enhancing providers' ability to manage the care of patients with diabetes. Registries are key to improving patient outcomes by enabling doctors to track and improve care of all patients with medical conditions.
Patients Tracked in Registries by Participating Clinical Systems Improvement Program Sites	N/A	7,893	12,166	Registries are key to improving patient outcomes by enabling doctors to track and improve care of all patients with a condition.
Lower Extremity Amputation Hospitalization Rate among Persons With Diabetes (per 100,000)	56	57	54	Diabetes and obesity are epidemic both in New York City and nationally.

*Indicates data is by calendar, and not fiscal, year

Health Promotion and Disease Prevention *(continued)*

Indicator	Fiscal Year 2004	2005	2006	Comment
Daycare and Pre-Kindergarten Sites Trained in SPARK (Sports, Active Play, and Recreation for Kids)	N/A	N/A	285	The agency has expanded NYC's SPARK program beyond DPHO communities to cover other areas with high rates of childhood obesity. The SPARK curriculum is being disseminated in 11 community districts in the Bronx. Brooklyn and Harlem.
Daycare and Pre-K Staff Trained in SPARK (Sports, Active Play, and Recreation for Kids)	N/A	N/A	1,385	Free training of daycare and pre-K staff has been highly effective, with more than 90% of staff still using skills taught four months earlier.
Home Visits by the Newborn Home Visiting Program (Brooklyn and East and Central Harlem District Public Health Offices)	N/A	1,349	2,573	A newborn visiting program for new mothers provides an opportunity to prevent lead poisoning, provide health education and link families to needed health and social services.
Elementary School Children with Asthma Receiving Medication Administration Forms (East and Central Harlem) (%)	N/A	28	39	Increased outreach to families and medical providers helped expand the completion of Medication Administration Forms, which facilitate effective management of asthma.
Medication Administration Forms Returned for Elementary School Children with Asthma (East and Central Harlem)	N/A	171	429	Automated student health records to track and monitor asthma treatment have improved asthma management in schools.
Visits to Shape Up NY Free Fitness Program (Bronx, East and Central Harlem, and Brooklyn District Public Health Offices]	N/A	N/A	42,444	Shape Up programs are held in a variety of venues—the City's parks, NYCHA developments and after-school Beacon programs.
Student Visits to High School Health Resource Rooms Staffed by DPHO Health Advisors (Bronx and Brooklyn District Public Health Offices)	N/A	N/A	5,403	The Department has worked with the Department of Education, and improved promotion and implementation of the condom availability program.
Health Ministry Volunteers Trained as Health Promoters	N/A	176	199	Religious leaders are increasingly used to convey important health education messages to communities.
People Attending Faith-Based Physical Activity Sessions	N/A	N/A	6,224	Physical activity sessions and religious institutions have been popular and well-attended.

*Indicates data is by calendar, and not fiscal, year

Vital Events and Reportable Diseases and Conditions, 1997 to 2006[1]

VITAL EVENTS – (NUMBER/RATE)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Live Births Per 1,000 Population	123,313 (15.8)	124,252 (15.8)	123,739 (15.6)	125,563 (15.7)	124,023 (15.4)	122,937 (15.2)	124,345 (15.3)	124,099 (15.2)	122,725 (15.1)	125,506 (15.6)
Deaths (excluding WTC deaths) Per 1,000 Population	62,506 (8.0)	61,010 (7.8)	62,470 (7.9)	60,839 (7.6)	60,218 (7.5)	59,651 (7.4)	59,213 (7.3)	57,466 (7.0)	57,068 (7.0)	55, 391 (6.9)
WTC Deaths[2] (Final data, reported by 10/31/03)	N/A	N/A	N/A	N/A	2,749	1	N/A	0	N/A	N/A
Infant Mortality Per 1,000 Live Births	881 (7.1)	843 (6.8)	848 (6.9)	839 (6.7)	760 (6.1)	742 (6.0)	807 (6.5)	760 (6.1)	732 (6.0)	740 (5.9)

REPORTABLE DISEASES AND CONDITIONS – NUMBER OF CASES and RATE PER 100,000 POPULATION

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
AIDS[3] Acquired immunodeficiency syndrome	7,409 (92.5)	5,645 (70.5)	5,373 (67.1)	6,382 (79.7)	5,606 (70.0)	4,698 (58.7)	5,316 (66.4)	4,335 (54.1)	4,144 (51.7)	3,686 (46.0)
Amebiasis[3]	846 (10.8)	972 (12.3)	927 (11.7)	858 (10.7)	675 (8.4)	602 (7.5)	550 (6.9)	461 (5.8)	465 (5.8)	547 (6.8)
Anaplasmosis[1,4] (Human granulocytic anaplasmosis)	N/A	N/A	N/A	N/A	9 (0.1)	18 (0.2)	8 (0.1)	30 (0.4)	24 (0.3)	29 (0.4)
Animal Bites[5]	9,730 (124.8)	9,396 (119.4)	9,108 (114.8)	8,523 (106.4)	8,134 (101.6)	8,184 (102.2)	7,141 (89.2)	5,584 (69.7)	5,385 (67.2)	4,938 (61.1)
Anthrax[6]	N/A	N/A	N/A	N/A	7 (0.1)	0	0	0	0	1 *
Babesiosis[1]	7 (0.1)	16 (0.2)	11 (0.1)	10 (0.1)	18 (0.2)	16 (0.2)	25 (0.3)	16 (0.2)	18 (0.2)	38 (0.5)
Botulism	2 *	1 *	1 *	1 *	4 (0.1)	4 *	2 *	0	4 (0.1)	3 *
Brucellosis	0	1 *	0	0	1 *	2 *	3 *	3 *	5 (0.1)	0
Campylobacteriosis	1,044 (13.4)	960 (12.2)	744 (9.4)	870 (10.9)	724 (9.0)	717 (9.0)	733 (9.2)	818 (10.2)	867 (10.8)	960 (12)
Chancroid	142 (1.8)	73 (0.9)	39 (0.5)	26 (0.3)	3 *	2 *	9 (0.1)	4 (0.1)	1 *	4 (0.1)
Chlamydia[7]	27,700 (355.3)	26,129 (332.2)	26,766 (337.2)	26,170 (326.8)	29,649 (370.2)	33,276 (415.5)	34,779 (434.3)	34,189 (426.9)	39,215 (489.7)	41,236 (514.9)
Cholera	1 *	2 *	0	0	1 *	0	0	0	1 *	1 *
Creutzfeld-Jacob Disease[8] Definite	N/A	N/A	N/A	N/A	4 *	0	2 *	1 *	6 (0.1)	2 *
Probable/Possible	N/A	N/A	N/A	N/A	3 *	4 *	3 *	4 *	5 (0.1)	1 *
Cryptosporidiosis	172 (2.2)	208 (2.6)	261 (3.3)	172 (2.2)	122 (1.5)	148 (1.8)	126 (1.6)	138 (1.7)	148 (1.8)	155 (1.9)
Cyclosporiasis	96 (1.2)	26 (0.3)	18 (0.2)	16 (0.2)	20 (0.3)	36 (0.5)	9 (0.1)	10 (0.1)	21 (0.3)	23 (0.3)
Dengue	N/A	N/A	N/A	N/A	2 *	17 (0.2)	14 (0.2)	18 (0.2)	18 (0.2)	46 (0.6)
Ehrlichiosis[1,9] (Human monocytic ehrlichiosis)	1 *	0	1 *	1 *	5 (0.1)	2 *	3 *	18 (0.2)	6 (0.1)	16 (0.2)
Encephalitis[10]	14 (0.2)	15 (0.2)	143 (1.8)	181 (2.3)	173 (2.2)	224 (2.8)	152 (1.9)	185 (2.3)	214 (2.7)	106 (1.4)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
***Escherichia coli* 0157:H7**	20 (0.3)	14 (0.2)	18 (0.2)	23 (0.3)	16 (0.2)	19 (0.2)	9 (0.1)	34 (0.4)	17 (0.2)	35 (0.4)
Giardiasis	1,788 (22.9)	1,961 (24.9)	1,897 (23.9)	1,771 (22.1)	1,530 (19.1)	1,423 (17.8)	1,214 (15.2)	1,088 (13.6)	875 (10.9)	938 (11.7)
Gonorrhea	14,194 (182.1)	12,100 (153.8)	12,207 (153.8)	11,669 (145.7)	12,614 (157.5)	12,811 (160.0)	13,468 (168.2)	10,860 (135.6)	10,596 (132.3)	10,299 (128.6)
HIV[3] *Human Immunodeficiency Virus*	N/A	N/A	N/A	N/A	5,502 (68.7)	4,964 (62.0)	4,450 (55.6)	3,938 (49.2)	3,904 (48.7)	3,585 (44.8)
Hemolytic uremic syndrome[11]	0	0	7 (0.1)	3 *	2 *	3 *	0	7 (0.1)	3 *	6 *
Hepatitis A[12]	923 (11.8)	590 (7.5)	412 (5.2)	550 (6.9)	454 (5.7)	464 (5.8)	449 (5.6)	342 (4.3)	286 (3.6)	122 (1.5)
Hepatitis B[12]	462 (5.9)	424 (5.4)	305 (3.8)	571 (7.1)	666 (8.3)	721 (9.0)	211 (2.6)	163 (2.0)	132 (1.6)	121 (1.5)
Influenza, Pediatric Deaths[13]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	7 (0.1)	4 *
Kawasaki syndrome	10 (0.1)	19 (0.2)	6 (0.1)	4 (0.1)	2 *	35 (0.4)	30 (0.4)	26 (0.3)	21 (0.3)	16 (0.2)
Lead Poisoning Adults aged 18 and older[14]	481	512	611	314	285	248 (4.1)	391 (6.4)	322 (5.3)	273 (4.5)	204 (3.4)
Children *Aged 0-5 years*[15]	1,052 (173.7)	947 (156.3)	775 (127.9)	678 (103.9)	535 (82.0)	520 (79.7)	487 (74.6)	666 (102.1)	751 (115.1)	684 (104.8)
Children *Aged 6-17 years*[15]	97 (9.0)	114 (10.5)	118 (10.9)	137 (10.6)	118 (9.2)	108 (8.4)	100 (7.8)	98 (7.6)	124 (9.6)	116 (9.0)
Children *Aged 0-17 years*[15]	1,149 (68.1)	1,061 (62.9)	893 (52.9)	815 (42.0)	653 (33.7)	628 (32.4)	587 (30.3)	764 (39.4)	875 (45.1)	800 (41.2)
Legionellosis[16]	27 (0.3)	38 (0.5)	42 (0.5)	47 (0.6)	44 (0.5)	67 (0.8)	72 (0.9)	73 (0.9)	119 (1.5)	185 (2.3)
Leprosy (Hansen's disease)	11 (0.1)	9 (0.1)	10 (0.1)	7 (0.1)	15 (0.2)	13 (0.2)	9 (0.1)	10 (0.1)	6 (0.1)	3 *
Leptospirosis	0	0	0	0	3 *	1 *	0	0	3 *	1 *
Listeriosis	44 (0.6)	39 (0.5)	49 (0.6)	50 (0.6)	26 (0.3)	39 (0.5)	25 (0.3)	26 (0.3)	42 (0.5)	36 (0.5)
Lyme disease[17]	196 (2.5)	250 (3.2)	168 (2.1)	214 (2.7)	95 (1.2)	280 (3.5)	224 (2.8)	357 (4.5)	399 (5.0)	307 (3.8)
Lymphogranuloma venereum[18]	19 (0.2)	18 (0.2)	9 (0.1)	0	0	0	10 (0.1)	3 *	31 (0.4)	15 (0.2)
Malaria	307 (3.9)	241 (3.1)	237 (3.0)	229 (2.9)	251 (3.1)	234 (2.9)	208 (2.6)	196 (2.5)	176 (2.2)	172 (2.2)
Measles (rubeola)	13 (0.2)	0	3 *	13 (0.2)	7 (0.1)	6 (0.1)	5 (0.1)	5 (0.1)	6 (0.1)	3 *
Meningitis[10] Aseptic/viral	154 (2.0)	211 (2.7)	303 (3.8)	415 (5.2)	500 (6.3)	536 (6.7)	510 (6.4)	711 (8.9)	487 (6.1)	352 (4.4)
Haemophilus influenzae[19]	44 (0.6)	50 (0.6)	56 (0.7)	65 (0.8)	59 (0.7)	71 (0.9)	70 (0.9)	83 (1.0)	77 (1.0)	89 (1.1)
Meningococcal[20]	56 (0.7)	34 (0.4)	59 (0.7)	46 (0.6)	42 (0.5)	38 (0.5)	45 (0.6)	30 (0.4)	28 (0.4)	58 (0.7)
Other bacterial meningitides[20]	214 (2.7)	181 (2.3)	155 (2.0)	171 (2.1)	91 (1.1)	128 (1.6)	68 (0.8)	108 (1.4)	83 (1.0)	64 (0.8)
Mumps	2 *	154 (2.0)	2 *	6 (0.1)	9 (0.1)	2 *	8 (0.1)	16 (0.2)	15 (0.2)	18 (0.2)
Pertussis	43 (0.6)	12 (0.2)	7 (0.1)	11 (0.1)	6 (0.1)	5 (0.1)	28 (0.3)	61 (0.8)	40 (0.5)	46 (0.6)
Psittacosis	0	0	1 *	0	0	0	0	1 *	0	0
Q Fever	N/A	N/A	N/A	N/A	N/A	1 *	2 *	2 *	1 *	3 *

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Rabies in animals[21]	2	1	10	18	38	28	6	14	28	44
Rickettsialpox[1]	1 *	0	1 *	2 *	15 (0.2)	23 (0.3)	12 (0.1)	17 (0.2)	12 (0.1)	17 (0.2)
Rocky Mountain spotted fever[1]	6 (0.1)	2 *	0	3 *	2 *	10 (0.1)	14 (0.2)	23 (0.3)	7 (0.1)	24 (0.3)
Rubella (German measles)	25 (0.3)	17 (0.2)	6 (0.1)	9 (0.1)	6 (0.1)	1 *	2 *	2 *	1 *	2 *
Rubella syndrome, congenital	2 *	3 *	0	3 *	0	0	1 *	0	0	0
Salmonellosis, nontyphoidal[22]	1,772 (22.7)	1,753 (22.3)	1,508 (19.0)	1,212 (15.1)	1,355 (16.9)	1,435 (17.9)	1,313 (16.4)	1,236 (15.4)	1,196 (14.9)	1,277 (16.0)
Scarlet fever	218 (2.8)	524 (6.7)	310 (3.9)	350 (4.4)	481 (6.0)	882 (11.0)	996 (12.4)	595 (7.4)	812 (10.2)	553 (6.9)
Shigellosis	945 (12.1)	684 (8.7)	366 (4.6)	942 (11.8)	417 (5.2)	517 (6.5)	418 (5.2)	414 (5.2)	415 (5.2)	274 (3.4)
Streptococcus group A invasive	205 (2.6)	142 (1.8)	116 (1.5)	136 (1.7)	168 (2.1)	156 (2.0)	148 (1.9)	126 (1.6)	170 (2.1)	167 (2.1)
Streptococcus group B invasive[23]	N/A	N/A	N/A	N/A	23 (0.2)	27 (0.2)	25 (0.2)	27 (0.2)	36 (0.3)	35 (0.28)
Streptococcus pneumoniae, invasive[24]	N/A	N/A	N/A	N/A	1,017 (12.7)	1,219 (15.2)	981 (12.2)	1,083 (13.5)	1,054 (13.2)	1,147 (14.3)
Streptococcus pneumoniae, invasive penicillin non-susceptible[25]	297 (16.0% of 1,857)	338 (19.8% of 1,709)	290 (23.0% of 1,261)	383 (25.8% of 1,482)	283 (29.5% of 958)	319 (27.2% of 1,160)	250 (28.1% of 888)	292 (28.4% of 1,025)	253 (25.5% of 991)	292 (25.6% of 1,138)
Syphilis Primary and secondary	97 (1.2)	82 (1.0)	130 (1.6)	117 (1.5)	282 (3.5)	434 (5.4)	531 (6.6)	621 (718)	616 (7.7)	578 (7.2)
Early latent (<1 year)	666 (8.5)	644 (8.2)	659 (8.3)	447 (5.6)	548 (6.8)	727 (9.1)	951 (11.9)	681 (8.5)	980 (12.2)	901 (11.3)
Late latent	4,102 (52.6)	3,859 (49.1)	2,893 (36.4)	2,097 (26.2)	2,437 (30.4)	2,278 (28.4)	2,286 (28.5)	2,374 (29.6)	1,587 (19.8)	2,240 (27.9)
Congenital[26]	79 (64.2)	48 (38.6)	49 (39.6)	28 (22.3)	34 (27.4)	26 (21.1)	32 (25.7)	15 (12.1)	5 (*)	14 (0.1)
Tetanus	0	0	0	1 *	1 *	1 *	0	0	0	0
Toxic shock Syndrome	4 (0.1)	0	2 *	3 *	4 (0.1)	1 *	1 *	1 *	2 *	0
Trichinosis	0	0	0	0	1 *	0	0	0	0	0
Tuberculosis[27]	1,730 (22.2)	1,558 (19.8)	1,460 (18.4)	1,332 (16.6)	1,261 (15.7)	1,084 (13.5)	1,140 (14.2)	1,039 (13.0)	984 (12.3)	953 (11.9)
Tularemia	0	1 *	0	0	0	1 *	0	1 *	0	0
Typhoid fever	49 (0.6)	55 (0.7)	49 (0.6)	56 (0.7)	49 (0.6)	46 (0.6)	39 (0.5)	31 (0.4)	33 (0.4)	65 (0.8)
Urethritis[28] non-gonococcal	10,602 (136.0)	11,580 (147.2)	9,236 (116.4)	7,672 (95.8)	8,660 (108.1)	8,588 (107.2)	7,874 (98.3)	7,379 (92.1)	7,368 (92.0)	7,336 (91.6)
Vibrio species, non-cholera	NA	NA	NA	3 (0.1)	4 (0.1)	5 (0.1)	7 (0.1)	0	5 (0.1)	7 (0.1)
Window falls Children aged 16 and younger	23 (1.3)	34 (1.9)	23 (1.3)	15 (0.2)	5 (0.1)	10 (0.5)	6 (0.3)	10 (0.5)	15 (0.8)	8 (0.4)
Yersiniosis	54 (0.7)	27 (0.3)	21 (0.3)	23 (0.8)	14 (0.3)	16 (0.2)	16 (0.2)	8 (0.1)	12 (0.2)	18 (0.2)
West Nile neuroinvasive disease[29]	N/A	N/A	45 (0.6)	14 (0.2)	7 (0.1)	28 (0.4)	31 (0.4)	2 *	11 (0.1)	8 (0.1)
West Nile Fever[30]	N/A	N/A	2 *	0	2 *	1 *	1 *	3 *	3 *	4 *

Values in parentheses ( ) = the rate for each value * Indicates a rate of less than 0.1 N/A = Not applicable (disease was not reportable in that year)

Footnotes

1. Diphtheria, glanders, hantavirus disease, plague, human rabies, smallpox, trachoma and yellow fever were required to be reported during this 10-year time period (1997-2006), but are not listed as no cases were reported during that time period.

   In 2001, the DOHMH began reporting probable (in addition to confirmed) cases of babesiosis, erlichiosis (now known as HGA and HME), rickettsialpox and Rocky Mountain spotted fever (see footnotes 4 and 9). The increase in reports beginning in that year is largely attributable to this change in surveillance method. The probable case definition for each of these diseases varies slightly , but usually requires clinically compatible symptoms plus at least one positive serologic test.

   Recent reporting requirements emphasize increasing public health concern about emerging infectious diseases. Recent additions include: January 1, 1997 - Immunizations administered to children aged 7 years and younger ◆ January 19, 1999 - Exposure to rabies ◆ August 9, 1999 - Vibrio species, non-cholera (including *parahaemolyticus* and *vulnificus*) ◆ June 1, 2000 - HIV (see footnote 3) ◆ August 30, 2000 - Group B streptococcal invasive disease and *Streptococcus pneumoniae* invasive disease (both drug-resistant and drug-sensitive – see footnotes 24 and 25) ◆ July 28, 2001 - Acute arboviral infections, (including dengue), transmissible spongiform encephalopathies (see footnote 8), pesticide poisonings, Q fever, smallpox ◆ November 20, 2001- Glanders, melioidosis, staphylococcal enterotoxin B and viral hemorrhagic fever ◆ January 15, 2006 - Hepatitis D, hepatitis E, other suspected infectious viral hepatitides, influenza caused by novel influenza viral strain with pandemic potential, laboratory-confirmed influenza, influenza-related deaths of children younger than 18 years of age (see footnote 13), monkeypox, severe acute respiratory syndrome (SARS), Shiga toxin-producing *Escherichia coli* (STEC); *Staphylococcus aureus* with reduced susceptibility to vancomycin (SARSV), vaccinia disease ◆ January 15, 2006 - non-A, non-B hepatitis and visceral larval migrans were removed as reportable from the NYC Health Code.

   Data are presented only for diseases required to be reported for an entire year. Diseases newly mandated as reportable during 2006 are not presented in this table. Rates are per 100,000 population unless otherwise noted and are based on population counts from the U.S. Census Bureau. Intercensal population data from 1997 through 1999 are interpolated, using an exponential formula. Rates from 2000 through 2006 were calculated using 2000 population counts. The population of NYC in 1990 was 7,322,564 and in 2000, was 8,008,278.

   Areas shaded in gray indicate years in which diseases were either not yet recognized or not yet required to be reported. Variations in data between this report and previous reports (including other publications of the NYC Department of Health and Mental Hygiene) may be due to several factors, including reporting delays, census data availability, corrections and data-processing refinements (e.g., the removal of duplicate reports).

2. World Trade Center (WTC) deaths data are preliminary, based on certificates filed with the NYC Office of Vital Records through July 18, 2002; three were filed outside of the city for decedents of the WTC disaster on September 11, 2001.

3. New York State mandated AIDS case reporting in 1983 and HIV reporting in June 1, 2000. Currently, providers are required to report all diagnoses of HIV infection, HIV illness in a previously unreported individual (i.e., HIV illness not meeting the AIDS case definition) and AIDS-defining conditions. Laboratories are required to report all positive Western blot test results, all HIV viral load test results (detectable and undetectable), all CD4 test results and all HIV viral nucleotide sequence results. HIV/AIDS data for 1997-2006 are presented by year of diagnosis and reported through March 31, 2007. Case reporting is more than 85% complete 9 months after the date of diagnosis. Therefore, data for 2006 are incomplete. Data on HIV/AIDS cases diagnosed each year continue to be revised as previously diagnosed cases are reported.

4. Human granulocytic anaplasmosis (HGA) was previously known as human granulocytic ehrlichiosis but was renamed based on reclassification of the etiologic agent, *Anaplasma phagocytophilum*. DOHMH is now reporting anaplasmosis separately from human monocytic ehrlichiosis.

5. In 2006, the most frequently reported bites were by dogs (3,498), cats (1,179), and rats and mice (131).

6. In the fall of 2001, five confirmed and two suspected cases of anthrax were identified in NYC residents. One of the confirmed cases was inhalational; all other cases were cutaneous. One additional case of suspected cutaneous anthrax occurred in a non-NYC resident due to an exposure in NYC. The case definitions for anthrax are described in the CDC's *Morbidity and Mortality Weekly Report* (MMWR) (October 19, 2001, 50;889-893).

7. Although men are still tested for chlamydia less frequently than women, there have been large increases in the number of reported cases of male chlamydial infection, likely due to increased male screening. In 2006, among cases where sex was known, 12,945 (341.2 per 100,000) were among males and 28,288 cases (671.3 per 100,000) were among females.

8. The World Health Organization classifies Creuzfeldt-Jakob disease as "definite" when the condition is diagnosed by standard neuropathological techniques and/or immunodiagnostic testing of brain tissue. "Probable" and "possible" cases are diagnosed by progressive dementia with other clinical features and other non-invasive diagnostic procedures.

9. Ehrlichiosis now refers only to human monocytic ehrlichiosis (HME) and is caused by *Ehrlichia chafeensis*. Cases currently classified as human granulocytic anaplasmosis are reported under anaplasmosis and only HME is reported under the heading ehrlichiosis.

10. Increased case-reporting of encephalitis and viral meningitis from 1999 through 2005 is a result of enhanced surveillance for West Nile viral disease and active case management of suspected cases during the adult mosquito season (June–September). In 2006, surveillance for encephalitis and meningitis once again became passive, and reporting decreased somewhat as expected. Cases of aseptic meningitis and encephalitis caused by West Nile virus are counted under West Nile neuroinvasive disease.

11. Active surveillance for hemolytic uremic syndrome among pediatric nephrologists was conducted from 1998 through 2004, which may explain the increase in reported cases beginning in 1999.

12. Surveillance case definitions for viral hepatitis A (HAV) and viral hepatitis B (HBV) have evolved with improvements in laboratory-based diagnostic testing. These case definition changes should be kept in mind when interpreting changes in case counts and rates over time. From 1997 thru July 5, 2005, HAV was defined as IgM antibody-positive to HAV (IgM anti-HAV). Beginning July 5, 2005, the Centers for Disease Control (CDC) and Council of State and Territorial Epidemiologists (CSTE) case definition has been used (an acute illness with 1) discrete onset of symptoms, 2) jaundice or elevated serum aminotransferase levels **and** 3) IgM antibody-positive to HAV **or** an acute illness with a) discrete onset of symptoms and b) jaundice or elevated serum aminotransferase levels in a patient with an epidemiologic link to a patient who meets the previous case definition).

    From 1997 until August, 2003, hepatitis B was defined as IgM HBc-positive. Since August 2003, the CDC/CSTE case definition has been used (IgM anti-HBc-positive **or** HBsAg-positive, if IgM anti-HBc test not obtained; discrete onset of symptoms; and either elevated serum aminotransferase levels or jaundice). Hepatitis C is not listed in this table as both NYC and national data have been unreliable due to the lack of resources necessary to determine whether a laboratory report represents acute, chronic or resolved infection; repeated testing of a person previously reported; or a false-positive test result.

13. The CDC defines an influenza-associated pediatric mortality as a death in any patient younger than 18 years resulting from a clinically compatible illness that was confirmed to be influenza by an appropriate laboratory or rapid diagnostic test. There should be no period of complete recovery between the illness and the death.

14. Adult lead poisoning data include only adult cases newly identified with blood lead levels ≥ 20 mcg/dL. Data reported prior to 2004 include both previously and newly-identified cases. Because of this, a rate has not been calculated for these years. Census data was used to approximate the rates for 2001-2004.

15. The case action definition (environmental intervention blood lead level–EIBLL) of childhood lead poisoning was defined as a blood lead level ≥ 20 mcg/dL from 1993 to June 30, 1999. As of July 1,1999 to August 1, 2004, the EIBLL was defined as either (1) a single venous blood lead level ≥ 20 mcg/dL **or** (2) 2 blood lead levels 15–19 mcg/dL that were drawn at least 3 months apart.

    Since August 2, 2004, the EIBLL has been defined as a blood lead level ≥ 15 mcg/dL; children with blood lead levels in this range receive environmental intervention (assessment, monitoring and enforcement). Effective 1993, New York State law mandates (1) blood lead testing of 1- and 2-year olds and (2) assessment of children between 6 months and 6 years of age, and testing of children at high risk. Since 1994, New York State has also mandated reporting of all blood lead tests. Population rates were computed using data from the U.S. Census.

16. Prior to 1991, suspected cases of legionellosis (those with a single immunofluorescent antibody titer of 1:256) were included in surveillance data. Beginning in 1991, only confirmed cases of legionellosis were included in surveillance data. Confirmed cases include those with (1) culture isolation of legionella species from respiratory secretions, lung tissue, or sterile sites; (2) a 4-fold or more rise in immunofluorescent antibody titers to 128 or higher against Legionella pneumophila serogroup 1; (3) positive direct fluorescent antibody (DFA) testing of respiratory secretions or tissue; or (4) the presence of L. pneumophila serogroup 1 antigen in urine. Beginning January 2006, cases diagnosed solely by positive DFA testing of respiratory secretions or tissue were categorized as suspect rather than confirmed cases.

17. A two-test approach using enzyme immunoassay/antibody followed by Western blot is recommended by CDC for Lyme disease testing. Prior to May 2005, both Lyme antibody tests and Western blots were reportable. After May 2005, the surveillance definition was changed to include only positive Western blots.

18. At the end of 2004, the Health Department's Bureau of Sexually Transmitted Diseases implemented an enhanced surveillance system for lymphogranuloma venereum, facilitating diagnostic testing for this invasive serovar of *Chlamydia trachomatis*. This likely accounts for the number of cases reported since that time.

19. From 1974 to 1981, *Haemophilus influenzae* was reported in the category "other bacterial meningitides." Invasive disease due to H. influenzae comprises several clinical syndromes, including meningitis, bacteremia, epiglottitis and pneumonia.

20. Invasive meningococcal disease includes meningitis, meningococcemia or *Neisseria meningitidis* isolated from other sterile sites. The increase in cases for 2006 reflects a serogroup C outbreak that occurred in Brooklyn.

21. On March 11, 1992, a raccoon found on a Staten Island street corner tested positive for rabies, which had had not been found previously in any NYC animal (other than bats) since 3 dogs were reported to have rabies in 1954. The discovery of this rabid raccoon marked the arrival of the mid-Atlantic raccoon rabies epizootic in the city, prompting the Department of Health to declare all 5 NYC boroughs enzootic for rabies. Additionally, the DOH changed its recommendations to providers regarding the prophylactic management of persons potentially exposed to rabies. Another rabies epizootic began in Staten Island in April, 2006, after an 11-year hiatus. The 44 animal rabies cases confirmed in 2006 comprised 36 raccoons (29 from Staten Island), 2 bats, 2 skunks and 4 cats. There has not been a human case of rabies acquired in NYC since 1944.

22. After 1994, all cases of non-typhoidal salmonellosis are counted together.

23. Invasive Streptococcus group B (*Streptococcus agalactiae*) is an illness that affects newborns whose mothers are asymptomatically colonized. Numbers and rates (per 1000 live births) have been revised for 2001-2005 to reflect only early onset disease (age < 7 days) for which there is preventive treatment.

24. Invasive *Streptococcus pneumoniae*, regardless of penicillin susceptibility, was made reportable in NYC in 2000. City laboratories in acute-care facilities report all cases of S. pneumoniae isolated from normally sterile sites including blood, cerebrospinal fluid, synovial, peritoneal, pleural or thoracic fluid.

25. Penicillin non-susceptible *S. pneumoniae* was made reportable in NYC in 1996. From 1996-2001, numerators of penicillin non-susceptible invasive *S. pneumoniae*, and denominators (reported as aggregate totals by hospital laboratories) of invasive *S. pneumoniae* (irrespective of antibiotic susceptibility) represent blood isolates only. For 2002-2006, numerators and denominators represent isolates from all normally sterile sites for which susceptibility data were available. Penicillin non-susceptibility was defined as penicillin MIC value ≥0.12g/mL or a Kirby-Bauer interpretation of "intermediate or high resistance."

26. The current definition for congenital syphilis includes presumptive diagnoses; none of the cases in 2006 were confirmed.

27. The case definition of tuberculosis (TB) was revised in 1978 to include persons with confirmed TB who were lost to follow-up for more than 12 months and diagnosed with TB for a second time. Prior to 1978, only the initial diagnosis of these cases was counted. Public health law mandates that health care providers report 2 groups of patients to the NYC DOHMH – (1) Suspected and confirmed TB cases with **any** of the following characteristics: (a) a smear from any anatomic site positive for acid-fast bacilli (AFB); (b) a nucleic acid amplification test (e.g., Amplicor, Genprobe)* result suggesting *Mycobacterium tuberculosis* (*M. tb*); (c) a culture positive for *M. tb* ; or (2) individuals prescribed 2 or more anti-tuberculosis medications for treatment of suspected or confirmed active tuberculosis.

    Children younger than 5 years with positive Mantoux tuberculin skin tests must also be reported. Cases of suspected and confirmed tuberculosis should be reported within 24 hours of the time the diagnosis is first suspected. The initial case report should not be delayed pending confirmation by a rapid diagnostic laboratory test. To report cases, use the TB Case Report (TB76) form. Mycobacteriology and pathology laboratories are required to report to the NYC DOHMH any bacteriologic findings which suggest or confirm tuberculosis— AFB-positive smears, cultures positive for *M. tb*, rapid diagnostic results that *M. tb*, results of susceptibility tests performed on *M. tb* cultures, pathology findings consistent with tuberculosis (including the presence of acid-fast bacilli and granulomata). As of January 1, 2001, mycobacteriology and pathology laboratories are required to forward the initial *M. tb* culture or subculture from each new patient to the NYC Bureau of Laboratories within 24 hours of identification.

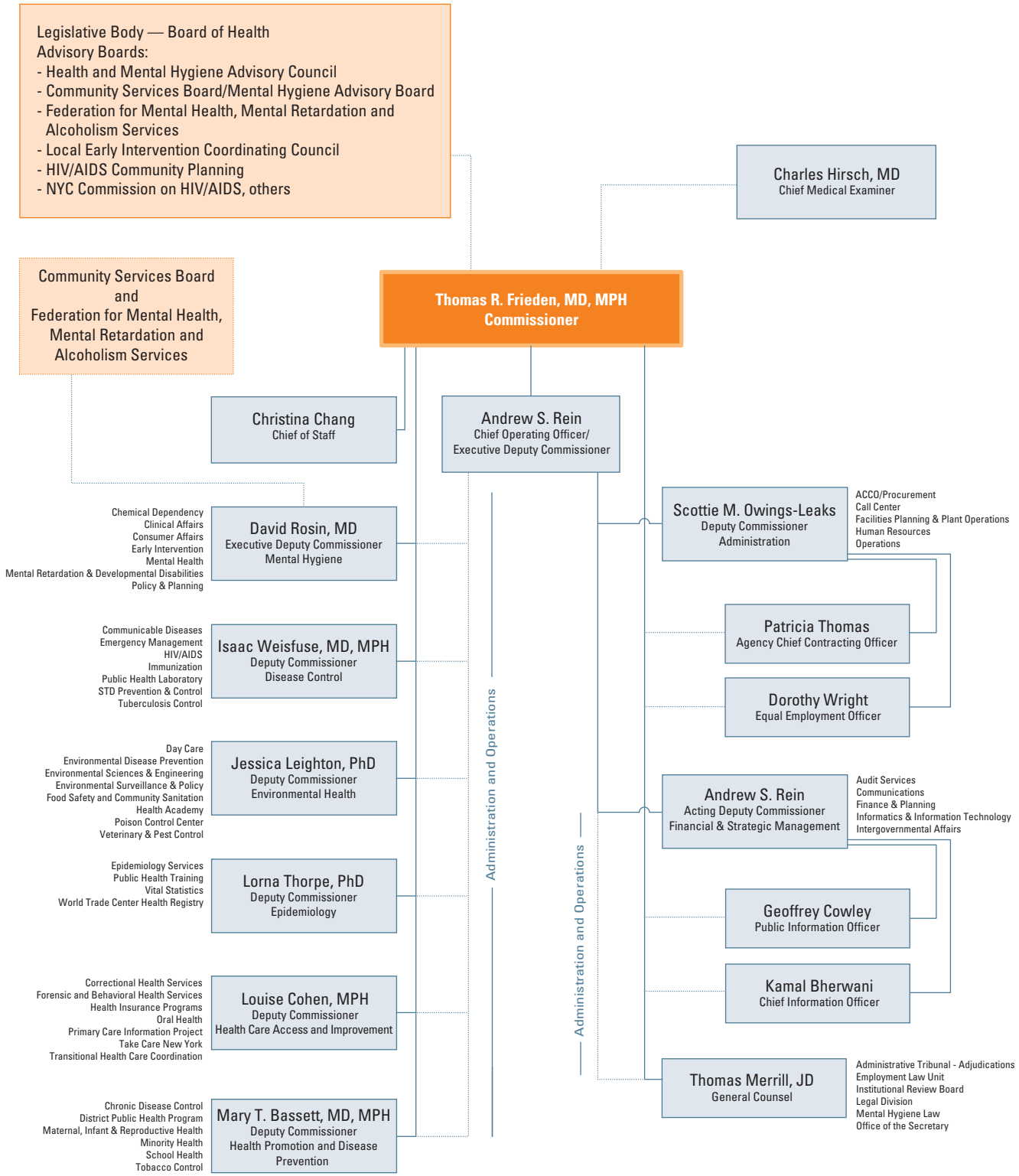
    * Product names are provided for identification purposes only; their use does not imply endorsement by the NYC DOHMH.

28. Non-gonococcal urethritis (NGU) is diagnosed only in men. Historically, a substantial proportion of NGU cases were likely caused by *Chlamydia trachomatis*, but this pathogen was not identified because of limited diagnostic chlamydia testing among men. Since the introduction of newer, non-invasive, chlamydia tests, the number of reported NGU has decreased and the number of chlamydia cases has increased.

29. West Nile neuroinvasive disease (WNND) includes West Nile encephalitis, West Nile aseptic meningitis and acute flaccid paralysis.

30. West Nile fever is defined as laboratory evidence of acute WN virus infection associated with mild to moderate illness but no evidence of central nervous system involvement. For every case of WNND, there are an estimated 140 cases of WN virus infection, among which 20-30 result in WN fever.

DOHMH Organizational Chart



September 17, 2007

Bureau Descriptions

Division of Administrative Services

Works to maintain the agency's human and physical infrastructure.

Bureau of Facilities Planning and Plant Operations
Maintains, repairs and improves facilities owned or leased by the agency.

Bureau of Human Resources
Helps the agency recruit, hire and retain high-quality employees. The Bureau administers staff training and professional development, maintains employee records, ensures compliance with health and safety regulations, and manages labor relations.

Bureau of Operations
Maintains vehicles and facilities, provides security services, acquires space, stores critical documents and manages mail and telecommunications.

The Call Center
Serves as a single point of entry for health care providers and the public. Working closely with 311 and internal programs, the Call Center provides information and referrals, schedules appointments and distributes educational materials.

Office of Equal Employment Opportunity
Works to ensure that the agency does not discriminate against any employee or job applicant. EEO also works to ensure that the agency maintains an environment free of unlawful harassment.

Office of the Agency Chief Contracting Officer
Identifies and retains qualified service vendors. The office oversees the agency's contracting process, provides technical assistance, secures approval of contracts from the city's oversight agencies and procures goods and services.

Division of Disease Control

Identifies, monitors, treats and prevents infectious diseases. The Division also protects the health of New Yorkers by responding to outbreaks and preparing the city for emergency events.

Bureau of Communicable Disease
Tracks reportable diseases and conditions. Prevents disease transmission by educating providers and the public about communicable diseases.

Bureau of Emergency Management
Coordinates planning and response activities to ensure that the agency can respond effectively to public health emergencies. The Bureau promotes preparedness through administration of emergency preparedness grants, and through staff training and drills.

Bureau of HIV/AIDS Prevention and Control
Works to prevent new infections while reducing morbidity and mortality among people living with HIV. The Bureau achieves its mission through surveillance activities, testing and prevention programs such as the citywide condom distribution campaign, and through close partnerships with community organizations.

Bureau of Immunization
Works to prevent vaccine-preventable diseases in all age groups. The Bureau runs five immunization clinics and monitors school vaccination compliance using the Citywide Immunization Registry. It also educates providers about newly developed vaccines and conducts annual influenza vaccination campaigns.

Bureau of Public Health Laboratory
Provides clinical and environmental laboratory testing services to support other programs throughout the agency. The laboratory also monitors beach water quality, helps investigate disease outbreaks and provides diagnostic services that are not widely available through commercial sources.

Bureau of Sexually Transmitted Disease Prevention and Control
Promotes healthy sexual behavior and reduces the impact of sexually transmitted infections in NYC, mainly through its STD clinics. The Bureau's 10 clinics offer all New Yorkers free and confidential HIV testing, as well as screening and treatment for other STDs.

Bureau of Tuberculosis Control
Conducts TB surveillance, investigates outbreaks and monitors patient care to ensure that national standards are upheld. The Bureau also directs screening and case management services at 10 chest centers.

Division of Environmental Health

Prevents and mitigates illness and injury caused by environmental health hazards.

Bureau of Child Care
Regulates group child care services per NYC Health Code Article 47, and enforces health and safety standards in a variety of other care settings, including family day care, group family day care and school-age child care, which are governed by New York State Social Service Law.

Bureau of Environmental Disease Prevention
Works to assess and minimize environmental and occupational health risks in the city. The Bureau includes the Lead Poisoning Prevention Program, the Environmental and Occupational Disease Epidemiology Program, and the Emergency Preparedness Unit.

Bureau of Environmental Sciences and Engineering
Investigates, assesses and mitigates public health threats from hazardous materials, ionizing radiation and food-borne illness. The Bureau also licenses and registers all radioactive materials and radiation equipment in NYC, monitors the quality and safety of drinking water and recreational water, and shares responsibility with other state and city agencies for managing sewage.

Bureau of Environmental Surveillance and Policy
Enhances environmental surveillance efforts, coordinates environmental health policy and increases public awareness of environmental health issues. The Bureau oversees NYC's CDC-funded Environmental Public Health Tracking Program and Network (EPHTN) and responds to public inquiries on environmental issues.

Bureau of Food Safety and Community Sanitation
Regulates, issues permits and inspects food service establishments and mobile vending carts, and educates the public about food-borne illnesses. The Bureau also enforces regulations designed to safeguard children from window falls and day camp hazards, while protecting adults in single-room-occupancy hotels and NYC correctional facilities.

Bureau of Veterinary and Pest Control Services
Protects the public from diseases, hazards and nuisances associated with animals and mosquitoes or other potential disease vectors. Responds to more than 22,000 rodent complaints a year.

Health Academy
Provides safety training and certification for food service workers. Trains Health Department personnel in the principles of food safety and environmental sciences.

Poison Control Center
Provides emergency toxicology services to hospitals, households and individual physicians. The Center also monitors poisoning incidence citywide and conducts community education to prevent poisonings; it receives more than 70,000 calls annually.

Division of Epidemiology

Works to improve public health services in NYC by conducting research and providing critical data to departmental programs and external organization.

Bureau of Epidemiology Services
Collects, analyzes and disseminates data on health trends in the city. The Bureau collects data through multiple surveys and investigative studies, analyzes data with traditional and innovative methodologies, and disseminates information on health and behavioral risk factors through publications, data requests and presentations.

Bureau of Public Health Training
Coordinates training and educational activities to keep NYC's public health and medical communities informed and up-to-date on public health and emergency preparedness issues including prevention, disease control, environmental health, epidemiology, health care access and mental hygiene.

Bureau of Vital Statistics
Registers, processes, certifies and issues, analyzes and reports all births, deaths, and respective certificates, and spontaneous and induced terminations of pregnancy in NYC.

World Trade Center Health Registry
Tracks the health of more than 71,000 of the people most directly exposed to the events of September 11, 2001. Findings allow health professionals to understand the health implications of exposure to the attacks and compare the health of those affected with that of the general population.

Division of Financial and Strategic Management

Provides information, services and analysis to improve and inform priority setting, decision-making and programmatic management throughout the agency.

Bureau of Audit Services
Facilitates prompt and accurate agency response to audits conducted by city, state and federal oversight agencies. The Bureau also conducts internal audits of DOHMH programs and facilitates fiscal audits of vendors providing services for the agency.

Bureau of Communications
Disseminates timely, accurate and responsive health information to the public. The Bureau manages all press relations, creates and provides editorial direction for agency publications, develops and manages media campaigns, provides translation services, manages the agency's Internet and Intranet websites, and assists in community outreach.

Bureau of Finance and Planning
Manages the agency's expense, revenue and capital budgets. The Bureau also manages the agency's grants; administers the agency's Clinical Quality Management activities; provides analyses to assist in policy development, performance improvement and program planning; and oversees new funding and budget-reduction activities.

Bureau of Informatics and Information Technology
Supports 58 IT applications and enterprise systems, and is currently developing 38 new applications that improve program operations. The Bureau also provides centralized network services, including email, Internet and Intranet access, data security and exchange, and client support for the agency's 7,000 staff in 50 locations throughout the city.

Bureau of Intergovernmental Affairs
Coordinates the agency's city, state and federal legislative agenda, and coordinates policy development on related legislative issues. The Bureau also manages all interactions with city, state and federal government agencies, legislative bodies, and elected officials, and drafts testimony for public hearings.

Division of Health Care Access and Improvement

Oversees health services at city correctional facilities and promotes access to high-quality health care services through the Primary Care Information Project, the Oral Health program, Medicaid managed care and other insurance programs.

Bureau of Correctional Health Services
Coordinates medical, dental and mental-health services for inmates in NYC correctional facilities to ensure that high-quality care is always available. The Bureau also monitors intake screenings and follow-up care for chronic conditions.

Bureau of Forensic Behavioral Health Services
Provides discharge planning for mentally ill patients leaving city jails to facilitate access to community-based mental health services. The Bureau also oversees the Medication Grant Program, which covers medication expenses for those with serious mental illness who leave city jails and state prisons.

Bureau of Transitional Health Care Coordination
Coordinates health care for people released to the community from city jails, with a focus on discharge planning for people who are HIV positive.

Bureau of Insurance Programs and Oral Health
Improves health care access by enrolling eligible New Yorkers in publicly-financed health insurance programs. The Bureau also oversees Medicaid managed care organizations providing services for the city and provides dental care in schools and community sites to children who lack access.

Bureau of Primary Care Information Project
Works to improve population health through health information exchange and technology. PCIP actively promotes the adoption of prevention-oriented electronic health records, primarily among providers who care for the city's underserved and vulnerable populations.

Bureau of Take Care New York
Addresses the leading preventable causes of illness and death in 10 priority areas, setting attainable 2008 goals in each. **Take Care New York** is a health policy that is the organizing framework for the DOHMH's efforts to help New Yorkers live longer and healthier lives. The Bureau's approach is to expand existing programs, promote evidence-based interventions, coordinate services, build partnerships and advocate for changes that produce health benefits.

Division of Health Promotion and Disease Prevention

Works to promote health, prevent disease and advance health equity among the people of New York City.

Bureau of Chronic Disease Prevention and Control
Spearheads programs and policy initiatives to reduce the burden of heart disease, stroke, cancer, diabetes and asthma. The Bureau works with physicians to promote best practices, develops programs that promote physical activity and healthy eating, and manages a hemoglobin A1C registry to improve blood-sugar management among people with diabetes. The Bureau helped develop a new regulation to restrict the use of trans fat in restaurants.

Bureau of District Public Health Program
Directs resources, programs and attention to high-need neighborhoods in the South Bronx, East and Central Harlem, and North and Central Brooklyn to reduce health inequalities. The Bureau works to improve the availability of healthy food options and promote physical activity; provides support to new mothers in creating a safe and nurturing environment for newborns; assists schools, families and health care providers in managing childhood asthma; and works to prevent teen pregnancy.

Bureau of Maternal, Infant and Reproductive Health
Works to promote sexual and reproductive health, and prevent teen pregnancies. The Bureau also promotes breast feeding and supports mothers and infants in achieving optimal health. One of the Bureau's key programs is the Nurse-Family Partnership.

Bureau of School Health
Works with the Department of Education to deploy school nurses and promote the health of NYC's 1.3 million school-aged children. Services include case management of chronic health problems such as asthma, preventive health screenings, urgent care, medication administration, and preventive counseling services. The Bureau also coordinates the physical-education and health-education curricula in the public school system.

Bureau of Tobacco Control
Works to reduce tobacco-related deaths and illnesses through five main strategies—taxation, legislation, cessation, public education, and evaluation and monitoring. Recent activities included launching a hard-hitting media campaign focused on the negative effects of smoking and distributing free courses of nicotine replacement therapy to New Yorkers interested in quitting.

Office of Minority Health
Builds partnerships with faith-based organizations to disseminate health information, while providing support for health programs at faith-based organizations.

Division of Mental Hygiene

Works with providers, consumers and families to ensure access to high-quality services, improve the lives of New Yorkers with mental illness and chemical dependency disorders, and help those with mental retardation and developmental delays and disabilities.

Bureau of Chemical Dependency

Contracts with service providers to provide residential, outpatient and hospital-based treatment; detoxification; prevention and education programs. The Bureau monitors programs' productivity, provides technical assistance to service providers and assesses the need for chemical dependency treatment and prevention services throughout the city.

Bureau of Clinical Affairs and Health Integration

Works to increase depression screening in primary care, integrate health improvements into the mental hygiene service system and coordinate care for children and adolescents. The Bureau strives to improve New Yorker's ability to respond to the psychological effects of a disaster and provides clinical consultation and cross-disability coordination.

Bureau of Early Intervention

Supports infants and children with developmental delays in their efforts to realize their full potential. The Bureau works to reduce the likelihood of delays among at-risk children, empower families to meet their child and family's needs and help eligible children secure therapeutic services.

Bureau of Mental Health

Contracts with NYC service providers to offer treatment, rehabilitation and referral services, as well as housing and vocational services, to NYC children and adults. The Bureau oversees more than 700 treatment, rehabilitation, housing, case management, advocacy and assisted outpatient treatment programs.

Bureau of Mental Hygiene Administration

Provides administrative support to the Division of Mental Hygiene by managing information technology, human resources, purchasing, procurement and budget. With the agency's contracting office, the Bureau also manages the contract registration process for mental health, chemical dependency and mental retardation/developmental disabilities services.

Bureau of Mental Hygiene Policy and Planning

Collaborates with other stakeholders to develop quality improvement projects for mental hygiene providers. The Bureau provides analytic support for fiscal and programmatic decisions, coordinates the development of local government plans, develops performance measures and conducts program audits.

Bureau of Mental Retardation/Developmental Disabilities

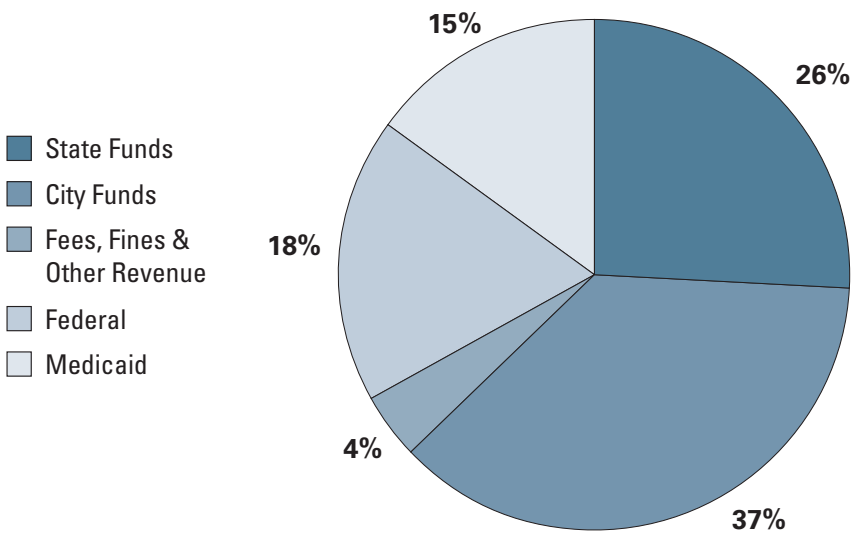
Contracts services for New Yorkers with mental retardation or developmental disabilities such as cerebral palsy, autism, epilepsy and other neurological impairments. The Bureau works with service recipients, families, providers and advocates to identify gaps in service and develop creative solutions.

Office of Consumer Affairs

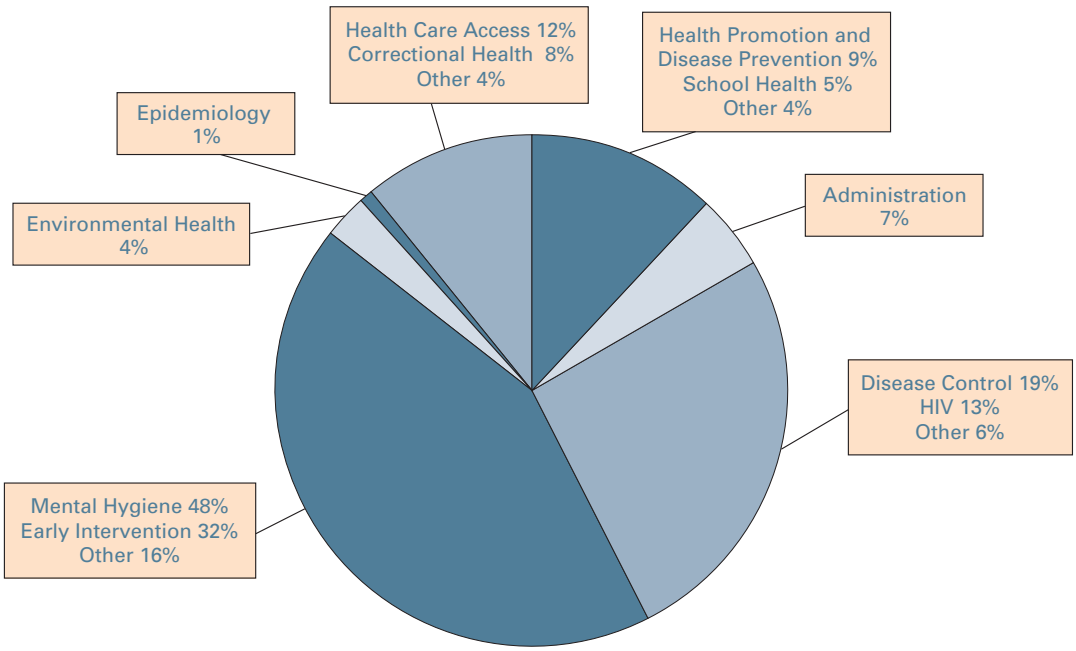
Provides training and consumer information on mental hygiene services and responds to public requests. The office works with the Federation for Mental Health, Mental Retardation, Alcoholism Services and a variety of community-based organizations to promote consumer participation in mental hygiene services.

Fiscal Information

Fiscal Year 2006 Final Budget: Total $1.5 Billion



Distribution of Funds, 2006



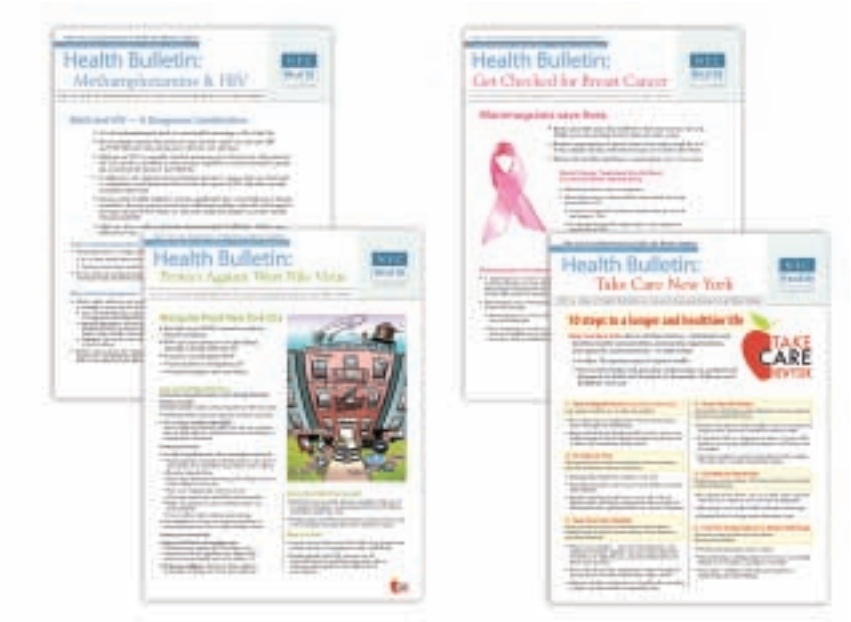
* Includes Commissioner's Office, General Counsel and Divisions of Financial and Strategic Management and Administration

Key Publications

2004

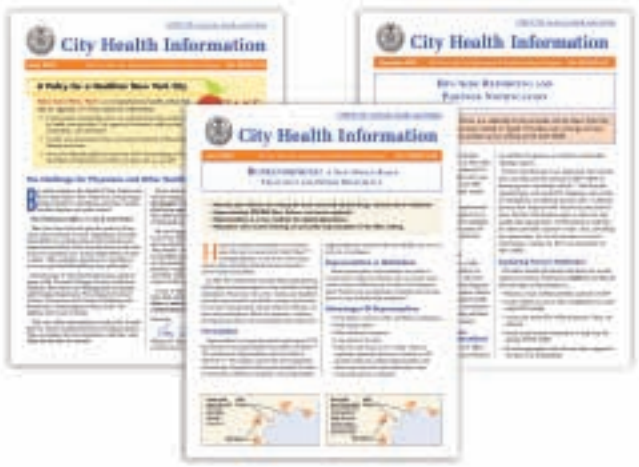
Health Bulletins

- Methamphetamine and HIV
- Take Care New York
- Protect Against West Nile Virus
- Get Checked for Breast Cancer
- Get Checked for Cervical Cancer
- Find a Doctor
- Time to Get a Flu Shot!
- Asthma—What's Your Plan?



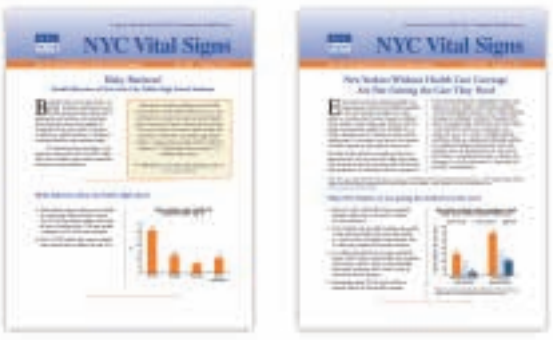
City Health Information (CHI)

- HIV Reporting and Partner Notification
- Influenza: Prevention and Control, 2004-2005
- Buprenorphine: A New Office-Based Treatment for Opioid Dependence
- Take Care New York: A Policy for a Healthier New York City
- School Admission Requirements for the School Year, 2004-2005
- Detecting and Treating Depression in Adults
- Severe Acute Respiratory Syndrome



Vital Signs

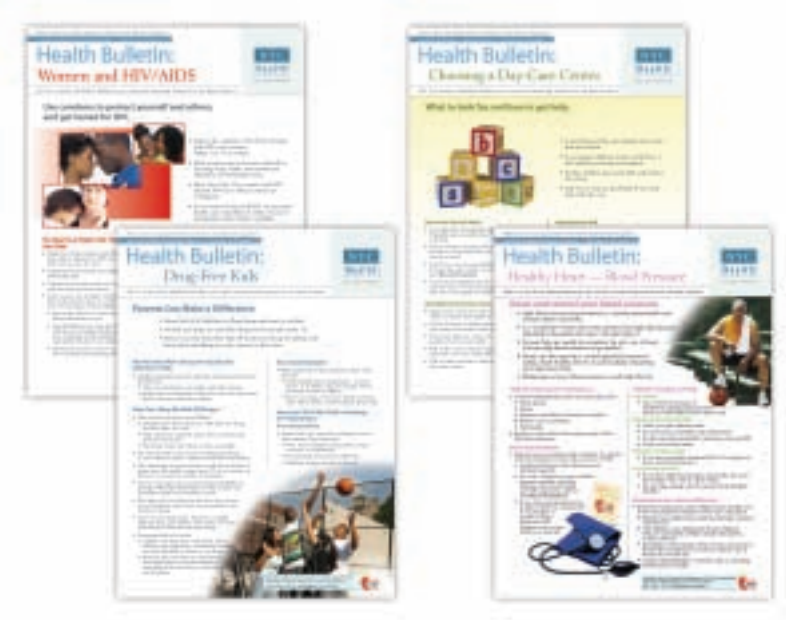
- Risky Business? Health Behaviors of New York City Public High School Students
- New Yorkers without Health Care Coverage: Are They Getting the Care They Need?



2005

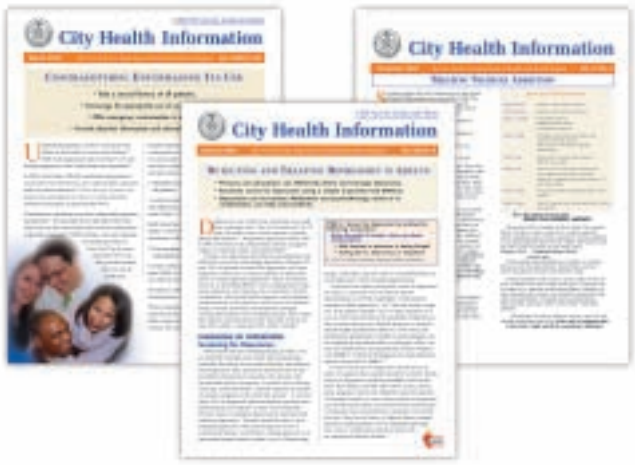
Health Bulletins

- A Smoke-Free Home
- Choosing a Day Care Center
- Drug-Free Kids
- Domestic Violence and Abuse
- Women and HIV/AIDS
- New Medicare Drug Benefit
- Time to Get a Flu Shot!
- Healthy Heart—Blood Pressure
- Back to School
- Healthy Heart—Eat Less Trans Fat



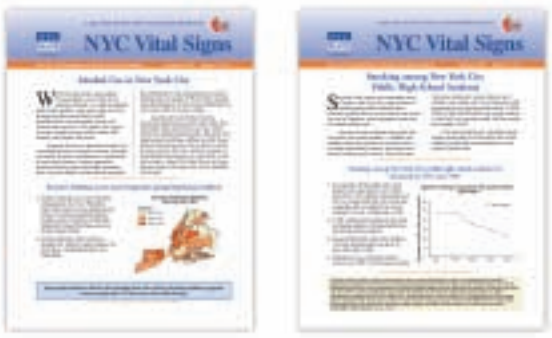
City Health Information (CHI)

- Detecting and Treating Depression in Adults
- Management of Hypertension in Adults
- Influenza: Prevention and Control, 2005-2006
- Treating Nicotine Addiction (including Pocket Guide)
- Diabetes: Prevention and Management
- Contraception: Encouraging Its Use
- Preparing for Bioterrorism



Vital Signs

- Pests Can be Controlled…Safely
- Obesity and Health: Risks and Behaviors
- Alcohol Use in New York City



Key Publications continued

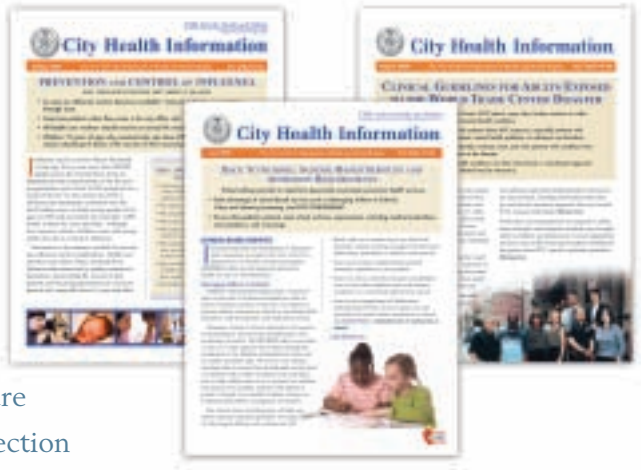
2006

Health Bulletins

- Depression: It's Treatable
- Choose Foods with 0 Grams of Trans Fat
- Diabetes is Epidemic!
- Take Pride and Take Care New York
- Time to Get a Flu Shot!
- Control Your Cholesterol: Keep Your Heart Healthy
- Pap Tests Save Lives—Get Checked for Cervical Cancer!
- Women's Health
- Get Tested for Hepatitis C
- Cut the Salt!
- Get Tested for HIV
- Get Help for Depression

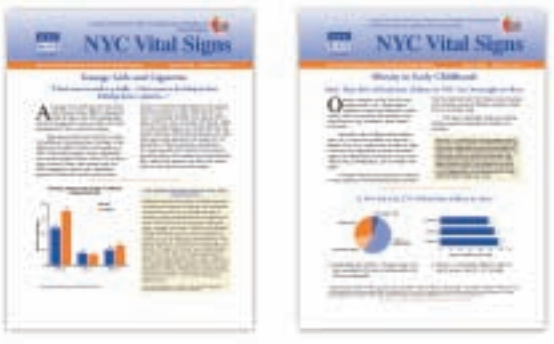
City Health Information (CHI)

- Brief Intervention for Alcohol Problems
- Chlamydia Testing and Treatment
- Influenza: Prevention and Control, 2006-2007
- Lipid Control: Preventing Cardiovascular Events in Patients with Atherosclerotic Disease or Diabetes
- Back to School: Admission Requirements and School-Based Services
- Clinical Guidelines for Adults Exposed to the World Trade Center Disaster
- Making HIV Testing a Routine Part of Medical Care
- Testing and Treatment for Latent Tuberculosis Infection
- Diagnosing and Managing Hepatitis C
- Detecting and Treating Depression in Adults



Vital Signs

- Teenage Girls and Cigarettes
- Cervical Cancer Screening in New York City
- Obesity in Early Childhood
- Smoking among New York City Public High School Students



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2. Be tobacco-free
3. Keep your heart healthy
4. Know your HIV status
5. Get help for depression
6. Live free of dependence on alcohol and drugs
7. Get checked for cancer
8. Get the immunizations you need
9. Have a safe and healthy home
10. Have a healthy baby


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