

Strengthening local public health.



Connecticut Association  
of Directors of Health

The Office of the Healthcare Advocate  
Attention: Victoria Veltri, J.D., L.L.M.  
P.O. Box 1543  
Hartford, CT 06144

November 25, 2013

Re: Comments on the Connecticut Healthcare Innovation Plan

Dear Ms. Veltri:

The Connecticut Association of Directors of Health (CADH) is writing to provide comments on Draft 1.1 of the Connecticut Healthcare Innovation Plan. CADH is a nonprofit organization comprised of Connecticut's 74 local health departments and districts. Since its incorporation in 1996, CADH continues to convene, engage, mobilize, and support Connecticut's local health departments and districts to strengthen and assure efficient and effective delivery of public health services. Local health directors are the statutory agents of the Commissioner of Public Health and are critical providers of essential public health services at the local level in Connecticut.

The existing draft of the Connecticut Healthcare Innovation Plan has much strength but also simultaneously raises many concerns about the role of local governmental public health. We outline our specific concerns in the pages that follow, but CADH is predominantly concerned by (1) the notion that providers may potentially subsume some of the traditional, core functions of public health generally and local governmental public health specifically, and (2) the limited references to and inclusion of local governmental public health as key players in transforming the healthcare system in Connecticut, especially in the realm of community health improvement.

We have identified the following as strengths of the proposed Connecticut Healthcare Innovation Plan:

- In describing Connecticut's current health system, public health is included in the list of rich valued services that "provide a strong foundation for advancement." (Page 2)
- One of the three listed primary drivers of transformation is community health improvement, and public health entities are included in the list of players. (Page 3)
- The plan places a high priority on addressing health equity through the social determinants of health. For example: "While the Innovation Plan cannot directly impact the unequal living conditions, life opportunities and distribution of material resources, it can start to resolve the difference in healthcare access, utilization and outcomes. In time, the Innovation Plan can also point to community incentives to address some of the social determinants of health, risk and illness. Moreover, the state aims to enhance the integration between our efforts to transform primary care and improve community health." (Page 22)

We have also identified the following components of the Connecticut Healthcare Innovation Plan as concerning:

- In describing the State Innovation Model design process, the application notes that its core initial team “identified the categories of stakeholders necessary to design the process.” (Page 32) The process failed to identify the importance of local governmental public health officials in this process. The application should note the need for their inclusion going forward, ideally through representation on the State Health Care Innovation Plan Steering Committee, the Health Care Cabinet, or at a minimum, one or more of its established workgroups.
- The plan’s proposed primary care practice transformation raises significant concerns about providers subsuming the traditional governmental public health role in population health. For example, the plan outlines that providers should analyze and interpret the data on the population in their panel or geography. (Page 43) What’s more the plan outlines the following “high-priority changes” for the providers:
  - “Collecting and maintaining accurate and reliable demographic data, including race, ethnicity and other demographic data, to monitor health quality and outcomes to inform service delivery”;
  - “Using population-based data to understand specific risks for one’s own panel, key sub-populations (e.g., race/ethnicity) and individual patients”;
  - “Using risk stratification analyses to identify consumers who are at higher risk to inform and target support efforts”;
  - “Maintaining a disease registry”;
  - “Partnering with certified community-based entities and other social service and support entities to address clinical and support needs when necessary”; and
  - “Aggregating de-identified data with State and payers to facilitate analyses, reporting and intervention” (Page 43).

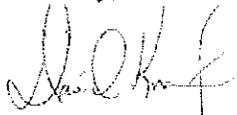
Population health is a core public health function, and rather than prioritizing changes that drive providers toward this role, providers should be urged to leverage the existing expertise of their local governmental public health departments and districts. Ideally, providers looking for specific population trends within their patient population could contract with their local health departments and districts to conduct analyses of their patient population’s data, in the context of broader community trends.

- As part of its approach to community health improvement, the plan proposes “the adoption and designation of a geographically bounded region characterized as having a high level of health improvement opportunities and avoidable health disparities as Health Enhancement Communities (HECs).” (Page 51) As part of its design and process, the proposal states that it will “identify and work with “keen” local health departments (LHD) and non-profit hospitals that conduct community health needs assessments in their regions to find shared priorities and alignments with the Innovation Plan and Health People Connecticut 2020 objectives.” (Page 52) While CADH applauds the recognition of the collaboration between local health departments and non-profit hospitals in conducting community health needs assessments, the use of the word “keen” is troubling. All local health departments need to be included, and the Health Enhancement Communities should build on the geographic boundaries and existing strengths of local public health infrastructure.

- As part of its design and process to create Health Enhancement Communities (HECs), the plan notes that “high quality, reliable local data will be imperative to inform HEC design and administration.” (Page 52) The Health Equity Index is a tool that provides such data and should be noted as such.
- In the plan, the State Department of Public Health proposes the creation of several “Certified Community-Based Practice Support Entities,” also referred to as certified entities for short. (Pages 52) The very name “support entities” runs contrary to the principles embodied in the IOM report that the SIM proposal cites. The IOM speaks to the integration of primary care and public health in the frame of partnership. For example, on the technology side, there is mention in the IOM report of integration of community-level clinical and public health data. In short, local governmental public health departments that are already providing primary preventive public health services should go beyond simple “support” of advanced medical homes. Rather, they should work in partnership, searching for synergies and leveraging the strengths of each partner.
- Asthma Indoor Risk Strategies (AIRS) is mentioned as a program that can be scaled for best practices in health improvement. Specifically, the proposal notes that “AIRS is a statewide regional program currently conducted through local health departments. Current AIRS partners are Northeast District Department of Health, Naugatuck Valley Health District, Milford Health Department, Ledge Light Health District, Central Connecticut Health District and Stratford Health Department. The State is currently encouraging qualified entities operating in vulnerable communities to apply for certification and thus expand the program’s accessibility.” (Page 58) Though CADH applauds the mention of this important work by local public health, the proposal could be strengthened through mention of the funding challenges in sustaining the program. Moreover, the proposal should further mention the importance of building on local public health’s successes, specifically encouraging local health departments in vulnerable communities to certify and expand program accessibility.
- The proposal notes that Connecticut’s Area Health Education Centers network will work together with the Department of Public Health to develop training and a certification process for Community Health Workers (CHWs). In conducting the important work of elevating the role of CHWs through training and certification, CADH likewise wants to ensure that the certification program (1) does not become an impediment for health educators, local public health nurses, and other core local public health professionals conducting their current work, and (2) does not create barriers for health departments and districts becoming certified community-based practice support entities.

We look forward to working in partnership to support revisions to Draft 1.1 of the Connecticut Healthcare Innovation Plan to reflect these concerns. Thank you again for the opportunity to offer these comments.

Sincerely,



David Knauf, CADH President