

**Pomperaug Health District**

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*Serving public health needs of Southbury, Woodbury, Oxford since 1986*

**To: Victoria Veltrie J.D., L.L.M., Office of Health Care Advocate**

**From: Neal Lustig, MPH, Director of Health, Pomperaug Health District**

**RE: Review of Connecticut Healthcare Innovation Plan (SIM) draft 1.1  
November 1, 2013**

As a Local Health Director (LHD) representing the Pomperaug Health District and very much involved in clinical preventive service delivery, I read with great interest the Connecticut Health Care Innovation Plan draft. The report echoes many of the initiatives, especially in "Prevention", that the regional health district I supervise in Western Connecticut, have been working towards in the last few years. My comments will be provided in two stages, the first being an overview of the draft with particular attention to Disease Prevention and Local Health Departments. The second stage will be recommendations to the various work-groups and occasionally criticisms of the draft. These comments are meant to assist the workgroup in understanding the existence of a professional administrative structure, presently in place, working to improve "public health" in Connecticut.

**State Innovative Model Review**

It is illustrative to review parts of the proposal in relation to above along with understanding the wide variety of new terms and administrative structures, many of them new to me, to be created under this proposal.

**Triple Aim**

- A. Better Health, eliminating disparities.
- B. Improved healthcare quality and experience, and
- C. Lower health care costs.

**Primary Drivers**

- A. Primary Care practice transformation
- B. Community Health Improvement the efforts of community organizations, healthcare providers, employers, consumers and public health entities.
- C. Consumer empowerment.

*Question:* Connecticut has 74 local health departments (LHD) of various sizes, types and capacities. Are LHD's among the key "public health entities" mentioned above? The administrative structure exists, has been around for many years, already has the statutory responsibility in prevention areas among others, and the workgroup task force should consider acknowledging that.

#### **Page 6- Community Health Improvement**

- A. Establishing health enhancement communities (HECs) to ...improve public health.
- B. Strengthening community-bases health services and linkages to primary health care by establishing "certified community-based practice support entities" (CCBPSE).

*Question:* Are the HECs and Certified Community Entities mentioned above to include the existing LHD infrastructure or be a brand new creation in Community Health Improvement? An existing workforce of health educators and public health nurses already exists in Connecticut. It is my recommendation that the SIM workforce specifically include this dedicated existing "entity. It is difficult to understand why we would create a new "public health" related support entity when one already exists. This would essentially create a duplicative community health support system; i.e. a "**shadow local health department.**"

#### **Page 10- Health Workforce Development**

Noted that the creation of a new class of employee is to be created, "community health worker" (CHW).

*Question:* Why is a new class of worker being created when we already have a class titled "public health worker?" Is the intention to replace existing public health worker with community health workers? My recommendation might be to combine the two or recognize the two in some fashion.

#### **Page 16- Community Health Improvement**

Key comments on HECs and community based certified entities provide opportunities to integrate IOM best practices in primary care and public health. Local Health Departments provide an excellent resource vehicle to provide and support that integration.

Page 21- It is possible that the Barrier to Access issues may recede as more Medicaid recipients get fully integrated Health Insurance under the Affordable Care Act.

### **Page 33- SIM Design Process**

As a local health director, I wonder where the Local Health Department infrastructure fits in the workgroup model shown on page. 33. I am in support of giving Local Health Departments (LHD's) a separate category under the Health Care Cabinet umbrella. LHD's are a governmental entity comprised of professionals dedicated to improving "public health". LHD's staff comprised of health educators, public health nurses, and administrators working at the local level, and have experience in delivering "prevention programs" to the community. This is in addition to a "population health" oversight role.

### **Page 50-56- Community Health Improvement**

This section of the SIM is a critical component of "prevention" and support strategies for this improved health care model. The coordination between clinical practice and "community services" is crucial to its effectiveness as a prevention and disease reduction tool.

The establishment of Health Enhancement Communities (HECs) and Certified Community-based Support entities are excellent ideas in the creation of community prevention goals. As stated earlier, the existing Local Health Department infrastructure, with its connections into communities, is an excellent vehicle to pursue this option. Local Health Departments, with their epidemiologic knowledge and skills are in a unique position from both a top-down level and in many cases of field staff level also.

I support the State Department of Public Health (DPH) proposal to create these entities and assume that the DPH will look towards its own LHD system to support the effort. Many LHDs are presently planning or conducting to carry out a core set of evidence-based community interventions. These LHDs maintain a unique understanding of their local knowledge to deliver appropriate services.

Local Health Departments may, in many instances, have existing Public Health Workers (PHW) that can easily be converted to Community Health Workers (CHW). That will help to speed the process along of transformation.

### **Ideas on Best Practices**

The above referenced coordination of clinical practice and disease modification could be applied in numerous areas of health but examples are provided below. My health district is trained and experienced in many of the below referenced initiatives in evidenced based prevention based programs. These could serve as models for CT statewide initiatives.

- Diabetes Prevention Program (DPP)
- Diabetes Chronic Disease Self-Management
- Chronic Disease Self Management
- Blood Pressure (Hypertension) Control
- Matter of Balance Fall Prevention
- Asthma Home Assessment Program
- Community Vaccination Programs

These are excellent examples of “**programs**” that can and should be provided by Community Based Organizations including Local Health Departments (LHDs) and/or through the aforementioned “certified community based practice support entities”.

All of the above can be coordinated through clinical providers, are evidence based, and will reduce the community health burden and cost. The authors of the draft SIM report do not delve into how these types of excellent evidenced based community/population health program will be **paid for**. There is ongoing work at various health departments in CT on billing methodologies through Medicare, Medicaid and private insurance reimbursement for community type prevention. Some billing codes exist in CMS Structure for certain diseases reduction efforts, while new ones (codes) will have to be created for additional initiatives. The existence of billing codes for a particular lesion treatment is just part of the reimbursement issue. Developing the capacity to deliver these initiatives, and be reimbursed, for the certified community based support entities is a far greater challenge. Billing for reimbursement for evidenced based programs, like the ones mentioned above, requires an organized information technology capacity that few community based organizations possess. The Pomperaug Health District has become adept at billing for seasonal flu vaccination and has just received a “grant” to further explore those billing options in chronic disease self-management programs.

#### **Page 109- Integrate Primary Care and Population Health**

As a local health director who directs community prevention and intervention health programs, I am concerned with the wording of the following passage in this section. *“Certifying community- based Practices Support Entities (certified entities). This will standardize services offered by community organizations and make services more transparent and accessible to primary care. Because this is a new state function , the state may need to expand the mandate of current state organizations or establish a new entity.”* There is already a system in place to integrate primary care and population health. While it is apparent that the system can and should be improved upon, the core local health/state health infrastructure remains intact. These existing systems should be utilized and developed whenever possible.

**Page 122- Suggest the phrase “Local Health Department” –“LHD” be added to the glossary.**

#### **Summary -**

The goal of the State Innovative Model is to use various methods to improve the health of CT citizens, improve access, and control health care costs. All of these are very worthy objectives and key objectives of the Affordable Care Act now rolling out throughout the United States. As mentioned throughout this commentary the role of **Local Health Departments and Districts** should be expanded to fill some of the “community and population health based” roles under the State Innovative Model. As a Local Health Director working to improve community and personal health I look forward to assisting any way possible in the Implementation Phase of the State Innovative Model.