**DRAFT**

Governor's Council for Local Public Health Regionalization

Minutes for meeting, September 2, 2009

Public Comment

Eloise Hazelwood:
Read a letter from Karen Weiss, sanitarian from Stonington. The letter will be sent out to membership. Please see attached.

Bill Blitz:
Health districts have a track record of managing multiple health efforts to protect the public's health. There are inequities in the amount of public health and other resources in the state that need to be addressed. Connecticut does not adequately fund public health, which is highlighted by the number of public health staff available for the population served. He added that, a county structure might have helped address the problem. He requests that the Council identify basic public health services that would be available to all Connecticut residents to make public health more equitable.

John Marriot, Wallingford:
Wallingford has had private wells that encountered 2 instances of contamination. His concern was that if Wallingford joins a regional health district they might not get immediate attention and response as they did with *E. coli* in their wells.

Rick Matheny:
Responded to Karen Weiss's letter "If you've seen one health department you've seen one health department." The negative comments about one health district were about one health district she'd worked for. These comments do not reflect all 20 health districts in the state.

Jennifer:
The benefits of public health must be included in the Council's discussion and actions.

Essential Services Presentation

Jennifer Kertanis presented the ten essential services of public health. Differences between these services and the eight mandated services in State Statute were discussed. Not all essential services are currently being provided and service provision varies. At the next meeting, the group will identify a basic set of essential services that should be provided by all health departments.

Discussion:
There was a discussion of the 10 Essential Services and the question was asked if one service was more important than another or if they could be prioritized. Karen Spargo noted that in order to offer effective public health programs the services need to be

integrated (e.g., for a food service program to be successful it should include inspections, code enforcement, education and investigations of foodborne illnesses.

Public Health Accreditation Presentation

Rick Matheny presented an update on the status of a national accreditation program for local public health departments and districts. He noted that are 4 workgroups and Connecticut is represented on three: the Standards Committee by Tim Callhan, the Incentive Group by Baker Salisbury, and the Assessment Group (that process is completed) by Rick. The fourth workgroup on, Equivalency does not have CT representation.

Rick thinks accreditation will come sooner than later in US but that we need to have an agreed upon set of standards in order to, "grade ourselves and look at ourselves in a public health context."

He also commented that the NACCHO annual report is very helpful and that the council should read it.

Eloise:
We have minimum standards now in CT. Should we be moving towards national standards and 10 essential services when we already have 8 core services in CT?

Comments by Baker, Jennifer, Rick, Pamela all noted that the 8 core functions in the CT Public Health Code are not really standards as all that is required is for local health to ensure the services are being provided. They are not the 10 essential services of public health.

Speaker Carolyn Wysocki
Carolyn advocates for local boards of health as governing boards but advisory boards can be helpful and use the NALBOH instruments. (Include presentation.)

Eloise:
Boards of health statistics do not relate to municipality as the structure of advocacy, policy, etc is really up to CEO.

Karen B:
There are statutes that reflect the relationship for municipalities and local health.

Presentation on Public Health Preparedness

Mary Pettigrew gave a presentation about public health preparedness funding and the transition to preparedness planning regions. Preparedness planning has moved from individual health departments to 10 BT regions to the 5 DEMHS regions in the last 4 years. A map of the 41 mass dispensing areas was distributed.

Jennifer:
The MDA map is an example how the public health system in CT is a mix of arbitrary lines.

Pamela:
Overlaying local health district maps and other emergency preparedness maps create a black map.

Rick and Donna:
They have met with Congressman Murphy and the CT delegation to get future funding.

Donna:
Are other RPOs involved in Public Health like the HEVCO region is?

Willie:
The RPO in the CT River area is taking an active role in playing in large-scale drills.

Rick:
The Farmington Valley Area has a subcommittee of the COGs to address regional issues.

Discussion
Bob:
Some part time directors do a great job but he speculated that others must not have the capacity at the small town level. He added that we've gone from nearly 100 health departments to 80 and we should not be afraid of regionalization as tax payers of small towns. The benefit of being more efficient for small towns like Glastonbury may provide more public health services of the citizens. Notes Glastonbury is doing a good job.

Ralph:
Small towns like his with a part time director work for him but we do need a workable matrix so we are not crossing random areas that do not have common concerns surrounding public health. He is not in favor of county government but advocates for the RPOs to get involved.

Rick:

Comparing costs is difficult as the municipalities have the cost hidden throughout their budgets whereas districts include rent, overhead, financial costs up front.

Carolyn:
She suggested inviting Mass to go over their new 5 guiding principles of how to move forward on regionalization.

Bob:
Mass modeled their program after CT's approach of a transition program to move small towns into larger districts.

Pamela:
She concurred that she has assisted Mass.

Baker:
Te group should help establish minimum level of services. There's been 15 years of work at the federal level with local partners being a part of the process all along. It would be foolish of us not to utilize the established systems and embrace the 10 essential services of public health for CT's benchmark.

Bob:
Can we quantify the costs of a district?
Pamela will put together summary information on salaries and other costs.

Baker will present on an ideal department in CT next meeting.

Agenda items for next meeting:

- Discussion of the components of an ideal health department.
- Basic/minimal level of services on a statewide basis, using 10 essential services as a guide.
- Discussion of how to attain equal access to services.
- Review of local health cost data.
- Report assignments.

## A COMMENTARY ON LOCAL PUBLIC HEALTH INFRASTRUCTURE

I am a sanitarian who started a public health career in a one-town health department, then worked in a multi-town health district and returned to the one-town setting. I provided full-time services in all locations. I entered the field in 1992 with no pre-conceived

notion about local public health infrastructure and today in 2009 I have an opinion to offer based on my years of working experience in the different type settings.
My first year in the public health field was in a small town where I was impressed by the sense of community and could provide quick, efficient service as I was only moments away from all locations in the town. After a year I changed jobs for a lesser commute to work and increased benefits. I was now in a new health district comprised of only one town at the onset. I stayed there almost 12 years, watching the district grow to three towns and noting the pros and cons of serving a larger population and geographic area. I voluntarily left the district for the one-town option that became available. After leaving the district, I continued to be aware of district sentiment as the entity grew to five towns large.
There are those who believe regionalization automatically means less costs and more services to the taxpaying public. I strongly disagree and feel the multi-town approach is not the way to go, for the public and the sanitarian alike. Bigger is not better. The following are my findings when comparing one-town to multi-town entities:

1. District staffing needs are greater with a larger territory and population, requiring more support personnel to accommodate the increased demands and resulting in a more elaborate staff hierarchy.

2. In a one-town setting the Director of Health is available on an as-needed basis, commanding a lesser salary than a District director who is mainly a full-time administrator involved in non-mandated activities. The one-town setting already provides an administrator (community CEO) and a personnel department available to health staff.

3. In the one-town setting the Director of Health was a practicing physician well-versed in diseases, diagnosis, treatment and prevention, whereas District directors functioned more as administrators. The physician Director of Health could serve as Medical Advisor, saving consultant fees.

4. The District office is a separate physical site, paying rent, utilities, housekeeping, property maintenance, etc., whereas, a health department housed in a Town Hall does not incur all these additional costs. Appliances and resources are shared in the Town Hall, saving dollars.

5. A larger territory means more time spent driving and more associated expenses.

6. Fees to the public are higher in the District and attached to more services. There are also more monetary penalties.

7. Health-related records for district member towns are not all kept in one location.

8. Physical sanitarian presence in District member towns actually decreased after joining. District expansion was not associated with a commensurate increase in sanitarian staffing. This decrease in service was not reflected by a decrease in resident tax bills.

9. Non-mandated grant programs took precedence over mandated activities, with the sanitarian performing special interest activities at the expense of general public health duties. Grant programs duplicated services and information already available to the public.

10. District sanitarians have to familiarize themselves and keep updated with the individual policies, procedures and personnel of each member town rather than just one town. Health does not operate in a vacuum but interacts with other town department and agencies.

Most importantly, service suffered with the larger entity due to more burdened sanitarians and more populace to handle. The personal touch was gone as people became just a number and were oftentimes lost in the shuffle and forgotten. I personally fielded complaints during and after my employ at the District and still do. Some residents could no longer do all their business at their local Town Hall as before but had to travel out of town for the health piece of their project. Health was pulled out of the equation to stand alone yet it is an integral part of the workings of a municipality. The stand alone health entity did not foster the same close working relationship achieved in the Town Hall setting. A lack of personal feeling accompanied by intimidation by a large organization was expressed to me as well. The true satisfaction of providing public health service lies not just with the perfunctory performance of one's duties but with the interaction and meeting of the minds of the individuals receiving the service. This is what community is all about and the local health department is one part of its fabric that needs to be preserved.

Respectfully submitted,

Karen Weiss
Registered Sanitarian