LEAD PUBLIC HEALTH
An Informational Forum

February 7, 2014

Summary

On February 7, 2014, an informational forum for public health, state and local elected officials, stakeholders and partners, was held at the Legislative Office Building at the Connecticut State Capital in Hartford, Connecticut. The forum was part of the Aspen Institute's Excellence in State Public Health Law Program. This one-year program with Aspen supports policymakers and agencies to more effectively address public health issues by strengthening public health law collaborations among state officials and state-level policy-makers, and increasing leaders' effectiveness on public health issues in their respective states, including working across party lines and government agencies and branches.

The overarching goal of the forum was to include legislators, municipal leaders, public health officials, academia and other partners and stakeholders in discussions about public health and the current public health system in Connecticut, and to create a demand for efficient and effective public health services across the state. Three public health experts shared their expertise and observations: Maryann Cherniak Lexius, health director in the town of Manchester, Connecticut; Patrick Libbey, former executive director of the National Association of County and City Health Officials and currently co-chair of the Center for Sharing Public Health Services; and Carmen Hooker Odom, former Massachusetts legislator, secretary of Health and Human Services in North Carolina from 2001-2007, and past president of the Milbank Memorial Fund.

This paper begins with a summary of the speakers' presentations: a snapshot of the current public health system in Connecticut; core public health services and capabilities, what other states do to achieve them and how Connecticut can too; and some ways to achieve efficient and effective public health services. Highlights from the moderated discussion with the panel and the audience are followed by suggested next steps in the journey to realize a fully functioning public health system for Connecticut.

The current public health system in Connecticut

Maryann Cherniak Lexius, Director of Health for Manchester Health Department, provided a summary of state and local public health in Connecticut. While not commenting on the effectiveness of the system, it was acknowledged was that there is room for improvement.

At the state level, the Connecticut Department of Public Health (DPH) is at the center of a comprehensive network of public health services, and is a partner to local health departments for which it provides coordination and a link to federal initiatives, training and certification, technical assistance and consultation,

and specialty services such as risk assessment that are not available at the local level. Connecticut General Statute 19a-2a – establishes broad powers for the Commissioner of the DPH, including prevention and suppression of disease, administration of all state public health laws and regulations, and oversight of local directors of public health departments.

At the local level there are 74 total local health departments or districts (LHD): 21 are health districts; 29 are full-time departments; and 24 are part-time departments. In total 116 towns have consolidated to form health districts. Despite the "part-time" designation for some departments, all local health departments have full-time staff. Ninety-six percent of Connecticut residents are served by full-time districts or health departments. Within this structure, governance varies: municipal health departments are directly funded by town or city budget, overseen by an elected official (e.g. CEO, Mayor); and health districts are overseen by a board comprised of appointees from member towns. Health district boards are responsible for promulgating regulations, overseeing finances, and general governance of the district. Municipalities must serve over 50,000 individuals to be eligible for per capita funding from the state and districts comprised of three or more municipalities are eligible for per capita funding regardless of population served.

Among LHD, there are differences based upon community needs and reflected in services offered. Nevertheless, public health works best as an integrated practice, when public health problems are addressed through a multifaceted approach. Hoarding was used as an example where public health officials, law enforcement, social services, housing and other officials come together to more efficiently address an issue.

Public health duties are both uniform and situated in unique context depending upon community needs and state and local roles. The DPH and LHD for example collaborate on regulatory enforcement (e.g. lead poisoning prevention), through some community health programs (e.g. community transformation grants), on emergency preparedness, and during monthly calls and semi-annual meetings.

While differences exist between and among state and local governmental public health entities, it is important to acknowledge that the public health infrastructure is interconnected and that collaborations are necessary. The challenge is to balance local discretion with achieving a minimum standard of public health services for all Connecticut residents. Results-based accountability and accreditation were two examples of standardized metrics mentioned at the forum that could be used to realize a minimum standard.

Core public health services and capabilities, how some states achieve them, and how Connecticut can too

Patrick Libbey brought to the discussion national expertise in the area of core public health services and capabilities, and shared public health resources across jurisdictions. Before getting into individual state efforts

to revise their vision of public health, he discussed seminal public health reports from the Institute of Medicine (IOM) that spurred national, state and local action in public health. The IOM reports articulated the three core functions, ten essential services and foundational capabilities of public health. By 2011, national accreditation standards, reflecting the IOM reports' recommendations, defined ways in which state and local health departments could measure and operationalize core functions, essential services and foundational capabilities through the accreditation process.

The accreditation process, however, requires time, resources, and support from elected officials and leaders. Because elected officials were not part of conceptualizing foundational capabilities and core functions, they have a different understanding of what public health is and can be. Elected officials often view public health as a number of discrete programs and services, and therefore may not envision an integrated and fully functioning public health system. For instance, without foundational capabilities (e.g., administrative functions, information technology, legal services) it is not possible to build a robust public health system. Emphasizing both public health services and the foundational capacity to provide those services is necessary to create a fully functioning public health system. But the way forward to creating a fully functioning public health system is far from clear and is not uniform across the country.

States like Ohio, Kansas, Washington, Colorado and Oregon are engaging in specific efforts to create a fully functioning public health system. Ohio has defined a minimum package of local public health services, while emphasizing the importance of foundational capabilities. In that state, local health departments will be required to be accredited by 2018. Kansas, over a period of two years, has developed a common understanding of the value of a robust public health system and connected it to accreditation as a means to hold departments accountable. Unlike Ohio, Kansas has not analyzed foundational capabilities comprehensively.

Washington State, while not requiring accreditation, developed performance standards for governmental public health, both state and local. Colorado established a set of core public health services with performance standards that are overseen by a state board of health, and Oregon has developed strong commitment to community care organizations, a unique approach to Affordable Care Act implementation which has significant implications for the way government is involved in public health.

The need for efficient and effective public health services and how they might be achieved

Carmen Hooker Odom provided a unique perspective as a former Massachusetts legislator and secretary of Health and Human Services in North Carolina. She began by acknowledging the many significant public health

achievements, and that too frequently the medical rather than the public health model is relied upon to improve health. This reliance leads to inefficient use of resources and a missed opportunity to truly improve population health outcomes. There are examples to draw upon, however, in which resources have been used to successfully implement change that creates a better public health system. North Carolina is one of those examples.

North Carolina has a legacy of recognizing the legitimate and significant role of local public health while acknowledging the importance of core public health functions. Like Connecticut, LHD vary in size (from ~5,000 to >1,000,000), and many departments have merged into larger entities. A generally positive relationship exists between local and state public health officials, as evidenced by some successful local/state and public/private public health collaborations: the Incubator Collaborative, housed within the UNC School of Public Health, comprised of teams of local health departments that work together voluntarily to address pressing issues of public health; Area Health Education Centers Public Health Quality Center, a partnership between area health education centers and local health departments to work on quality issues; and North Carolina Department of Public Health and North Carolina Hospital Association Partnership Automated State Hospital Emergency Surveillance System which transmits real time visit data from all state hospital emergency departments to local public health division to provide notice of unusual clinical information; and "Community Care of North Carolina" in which LHD are included in a community health program which provides services to the Medicaid population.

In addition to these collaborations, North Carolina also has passed legislation requiring all LHD become accredited. The impetus for this grew out of the Robert Wood Johnson Foundation Turning Point initiative in which states were asked to assess what needed to change to make public health more effective. A state senator who had been involved in Turning Point proposed legislation requiring all LHD become accredited and when LHD balked, he instead proposed legislation to regionalize local health. The accreditation mandate became law in 2005 and now in 2014, several LHD are working on becoming re-accredited.

Moderated discussion with panel and audience

The discussion was mostly very positive, with offers of support and collaboration from the Connecticut Public Health Association and others to continue this work that emphasizes public health capacity. What is it that every resident of Connecticut should expect from their local health department, and what should every municipal leader support? Part of the challenge in this regard is the variation in municipal leaders' understanding of and support for public health, both of which are critical to creating an efficient and effective

public health system. Building on municipal leaders' support and acknowledging successes in the area of public health are important first steps.

How then to build a momentum for public health? Participants suggested that collaborations, relentless communication, messaging and marketing were all necessary to creating demand for public health. Commissioner Mullen noted that it is also necessary to align values among leaders so that public health receives the support necessary to create an effective and efficient public health system that will serve all of Connecticut's residents with a core set of public health services. Creating demand for public health is a first step in the journey to creating a fully-functioning public health system and assuring that the system has the capacity to serve all Connecticut residents with a core set of public health services. Lessons from other states provide a good foundation upon which Connecticut can build.

For instance all 85 LHD in North Carolina are now accredited. The law that was passed mandating accreditation was the result of effective and charismatic leadership, some funding and support for LHD to become accredited, and a focus on capacity rather than regionalization. As Carmen Hooker Odom pointed out, accreditation is a public declaration that these basic public health services are available to each and every resident, regardless of where they live in the state.

Accreditation is also an opportunity to improve the delivery of public health services, as Mr. Libbey noted, and to highlight all public health efforts, not just those being done well. One health director agreed that accreditation would not be a struggle in her jurisdiction as much as an opportunity to showcase the work that is being done already. Another health director agreed that accreditation is a worthy goal.

As Connecticut works to create a fully functioning public health system, it will be important to involve multiple partners and to keep in mind that change may be incremental. Regardless, time and a sustained effort are necessary. A new vision for public health will require frequent and sustained communications, time to plan and to act, and dedicated time and resources.

Conclusions

The key goal of the Lead Public Health Informational forum was to bring together partners and stakeholders in public health to share expert knowledge and invite suggestions for a discussion about how to create a more efficient and effective public health system in the state of Connecticut. While differences exist among individual LHDs because of the unique communities they serve, collaboration and interconnectedness across the public health system are necessary. The challenges are to balance the local needs with a minimum and

uniform standard of public health services for all residents, and to recognize differences in perception and support of public health by municipal leaders.

As a first step it would be important to acknowledge and support the successes of the municipal leaders in their respective areas. To sustain the momentum, continued communication, collaborations among departments and marketing of public health will be essential to creating a demand for public health services. Lessons from the success of similar initiatives of other states as highlighted by the guest speakers can serve as a learning tool and a good foundation upon which Connecticut can build.

As Connecticut works towards creating a more efficient and effective public health system, it will be important to keep in mind that change will be require time and will be incremental, and will require bringing together multiple partners, aligning interests and values, and ensuring support for public health. Sustained efforts and continuous communication will be a key to successfully realizing a fully functioning public health system for Connecticut.

Next steps

Participants indicated that they would like to be involved with and contribute to the Lead Public Health goal to market and build demand for, public health. Suggestions to accomplish this include:

1. organizing a Google chat with public health, municipal and academic partners during public health week;
2. conducting bi-monthly community engagement sessions with partners and stakeholders;
3. hosting informational forums for stakeholders and the public;
4. marketing public health, foundational capabilities and the ten essential services;
5. partnering with academia to disseminate the public health message; and
6. sharing knowledge from public health experts within and outside of Connecticut about the accreditation process.