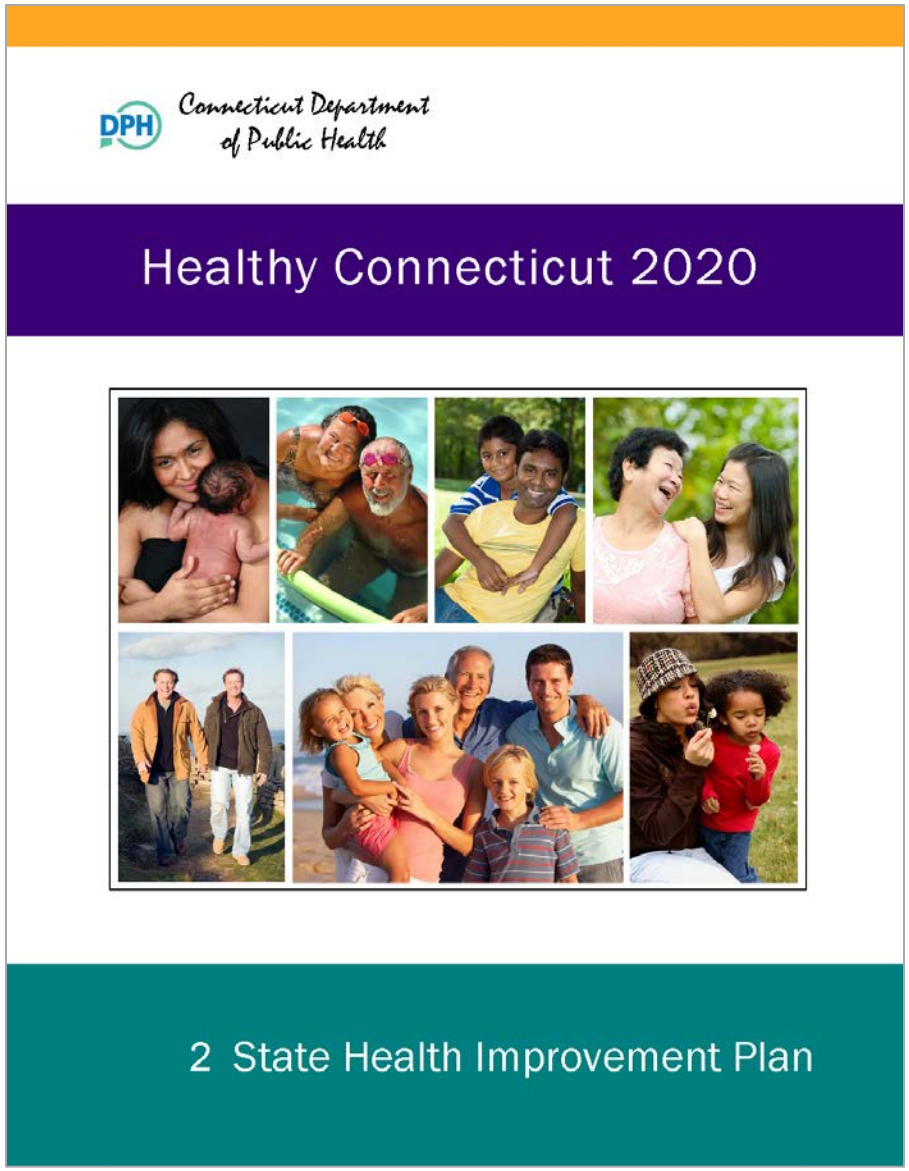

CONNECTICUT
HEALTH IMPROVEMENT PLANNING COALITION

WELCOME!

Healthy Connecticut 2020:

A Call to Action

March 25, 2014

Plan Overview

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Healthy Connecticut 2020
The Connecticut State Health Improvement Plan

CONNECTICUT HEALTH IMPROVEMENT PLANNING COALITION

Connecticut Health Improvement Planning Coalition

Membership
A large advisory body of representatives from diverse local, regional, and statewide organizations and agencies whose policies and activities can affect health. (Up to 400 members)

Charge
Make recommendations for the Plan.
Be community ambassadors for planning initiatives.
Foster connections with key networks and groups for action

Role
- Review Assessment data
- Participate in Work Groups
- Develop goals, objectives, & strategies for the Plan
- Share information
- Participate in implementation activities

Focus Area Work Group Co-Chairs

Membership
Each Focus Area has two Work Group Leaders, from the member organizations of the Coalition

Charge
Coordinate development of goals, objectives, and implementation strategies for the Focus Areas of the Plan

Role
- Lead work groups
- Recruit content experts
- Serve as liaisons
- Act as ambassadors and educators

Advisory Council

Membership
Up to 20 Connecticut leaders from across all sectors--government, non-profits, business & industry, health care, education, community services, and complementary services

Charge
Guide the Connecticut Department of Public Health in the development of a statewide Health Improvement Plan

Role
- Review materials and make recommendations
- Ensure potential effects are considered
- Act as ambassadors
- Contribute to priority setting

Revised 1-29-13

Principles for Planning (1)

- Overall purpose of the Health Improvement Plan:
  To improve the health status of Connecticut residents
- The plan and its related parts will be:
  - **Aligned** with the National Prevention Strategy, Healthy People 2020 objectives, the Centers for Disease Prevention and Control, and with other existing State of Connecticut and DPH Plans
  - **Data-informed** (based on assessment report) and **data-driven** (clear, measurable objectives)
  - **Evidence-based** (using proven strategies)
  - **Systems-change** focused
  - Geared toward **achieving health equity and eliminating health disparities**
  - Integrated with **Healthy Communities** approaches
  - **Accessible** to a broad audience and will **inspire action with personal stories** from the community

Principles for Planning (2)

- Phase 1 Implementation Priorities
  - First 3 years of Plan will be:
    - Based on key selection criteria:
      - Burden
      - Public perception
      - Political will
      - Ability to “move the needle”
    - Focused on prevention

Cross-Cutting Themes for Focus Areas

(*High-Risk, Disadvantaged, Underserved, and Vulnerable Populations*)

- Life Course:
  - Mothers & Infants
  - Children
  - Adolescents and Young People
  - Working-age Adults
  - Older Adults
- Sex and Gender:
  - Male and Female
  - Lesbian, Gay, Bisexual, and Transgender
- Race and Ethnicity:
  - Race (all non-Hispanic):
    - White
    - Black
    - Asian
    - American Indian
  - Hispanic ethnicity (all races)
- Other Specific Populations:
  - People with Disabilities
  - Veterans
  - Homeless Persons
  - Rural Populations
  - Incarcerated Persons

Cross-Cutting Themes for Focus Areas

(*High-Risk, Disadvantaged, Underserved, and Vulnerable Populations*)

DETERMINANTS OF HEALTH THEMES:

- Social & Economic:
  - Income and Poverty
  - Educational Attainment
  - Unemployment
  - Language and Literacy
  - Geography ("The 5 Connecticuts")
  - Access to food (Food Deserts)
  - Housing
  - Public Safety
  - Exposure to Crime & Violence
  - Recreation
  - Transportation
- Overarching Behavioral:
  - Nutrition
  - Weight Status (Overweight, Obesity)
  - Physical Activity
  - Tobacco Use
- STRATEGIC THEMES:
  - Education & Training
  - Communications
  - Policy & Advocacy
  - Data, Surveillance, & Evaluation
  - Partnership & Collaboration
  - Planning & Research
- EMERGENCY PREPAREDNESS
- GENOMICS

Healthy Connecticut 2020 by the Numbers

Focus Area	# Areas of Concentration	Total / Phase 1 Objectives
1: Maternal, Infant, and Child Health	5	13/8
2: Environmental Risk Factors and Health	5	8/4
3: Chronic Disease Prevention and Control	9	30/13
4: Infectious Disease Prevention & Control	10	34/16
5: Injury and Violence Prevention	6	26/11
6: Mental Health, Alcohol, and Substance Abuse	5	8/7
7: Health Systems	8	17/9
TOTAL:	**48**	**136/68**

Maternal, Infant and Child Health

Optimize the health and well-being of women, infants, children and families, with a focus on disparate populations.

Areas of Concentration

- Reproductive and Sexual Health
- Preconception and Pregnancy Care
- Birth Outcomes
- Infant and Child Nutrition
- Child Health and Well-being

Objective Topics for Phase 1 Implementation

- Unplanned pregnancies
- Prenatal care
- Birth outcomes
- Breastfeeding
- Oral health for children
- Developmental screening

Environmental Risk Factors and Health

Enhance public health by decreasing environmental risk factors.

Areas of Concentration

- Lead
- Drinking Water Quality
- Outdoor Air Quality
- Healthy Homes
- Healthy Communities

Objective Topics for Phase 1 Implementation

- Childhood lead poisoning
- Drinking water quality
- Air quality

Chronic Disease Prevention and Control

Reduce the prevalence and burden of chronic disease through sustainable, evidence-based efforts at risk reduction and early intervention.

Areas of Concentration

- Heart Disease and Stroke
- Cancer
- Diabetes and Chronic Kidney Disease
- Asthma and Chronic Respiratory Disease
- Arthritis and Osteoporosis
- Oral Health
- Obesity
- Nutrition and Physical Activity
- Tobacco

Objective Topics for Phase 1 Implementation

- Heart disease and high blood pressure
- Diabetes
- Asthma
- Oral health for children
- Obesity
- Smoking

Infectious Disease Prevention & Control

Prevent, reduce and ultimately eliminate the infectious disease burden in Connecticut.

Areas of Concentration

- Vaccine-preventable Diseases
- Sexually Transmitted Diseases
- HIV
- Tuberculosis
- Hepatitis C
- Vector-borne Diseases
- Foodborne Illness and Infections
- Waterborne Illness and Infections
- Healthcare Associated Infections
- Emergency Preparedness for Emerging Infectious Diseases

Objective Topics for Phase 1 Implementation

- Vaccinations for children, pregnant women, and childcare providers
- Vaccinate adults against seasonal flu
- Vaccinate adolescents for HPV
- Chlamydia and gonorrhea
- HIV/AIDS
- Hepatitis C
- Healthcare associated infections
- Emerging infectious disease

Injury and Violence Prevention

Create an environment in which exposure to injuries is minimized or eliminated.

Areas of Concentration

Unintentional Injury

- Falls
- Poisoning
- Motor Vehicle Crashes

Intentional Injury

- Suicide
- Homicide and Community Violence
- Traumatic Brain Injury
- Child Maltreatment
- Sports Injuries
- Occupational Injuries

Objective Topics for Phase 1 Implementation

- Falls
- Unintentional poisonings
- Motor vehicle crashes
- Seatbelt use
- Motorcycle deaths
- Suicide
- Firearms
- Sexual violence
- Child maltreatment

Mental Health, Alcohol and Substance Abuse

Improve overall health through the lifespan, through access to quality behavioral health services that include screening, early intervention, prevention and treatment.

Areas of Concentration

- Mental Health and Mental Disorders
- Alcohol Abuse
- Substance Abuse
- Autism Spectrum Disorders
- Exposure to Trauma

Objective Topics for Phase 1 Implementation

- Mental health emergency room visits
- Excessive drinking by youths and adults
- Non-medical use of pain relievers
- Illicit drug use
- Screening for autism
- Screening for trauma

Health Systems

Align efforts of health systems stakeholders to achieve sustainable, equitable, and optimal population health.

Areas of Concentration

- Access to Health Services
- Quality of Care and Patient Safety
- Health Literacy, Cultural Competency and Language Services
- Electronic Health Records
- Public Health Infrastructure
- Primary Care and Public Health Workforce
- Financing Systems
- Emergency Preparedness and Response

Objective Topics for Phase 1 Implementation

- Health insurance coverage
- Community-based health services
- Patient-centered medical homes
- Transportation to access health services
- Quality and patient safety standards for health systems
- Adoption of national Culturally and Linguistically Appropriate Services standards by health and social service agencies
- Professional health workforce shortages and diversity
- Funding to align with prevention and population health priorities

Partner Perspectives

- **Phyllis DiFiore**
  Occupant Protection Program Manager
  Connecticut Department of Transportation
- **Lisa Pellegrini**
  First Selectman, Somers, Connecticut
  Connecticut Conference of Municipalities
- **Linda Colangelo**
  Education & Communications Coordinator
  Northeast District Department of Health

DPH Priorities

MODIFIED BASIC PRIORITY RATING SYSTEM

Connecticut Department of Public Health
Public Health Strategic Team

A. SIZE OF PROBLEM
(Number of people directly affected; incidence or prevalence)

B. SERIOUSNESS OF PROBLEM

1.Severity

- **a. Deaths** (Number of deaths)
- **b. Premature Deaths** (Years of potential life lost per 100,000 population)
- **c. Hospitalizations** (Number of inpatient discharges)
- **d. Emergency Department Visits** (Number of ED visits, regardless of whether admitted to hospital or discharged)

2. Economic Cost (Societal or individual)

3. Urgency (Emergent nature, public health/public concern, trend increasing/decreasing/stable)

4. Impact on Others or on Individual's Life Course

5. Health Inequities (Age, sex, race, ethnicity, geography, other specific populations)

C. EFFECTIVENESS OF AVAILABLE INTERVENTIONS
(Includes acceptability to target population)

DEFINED DATA SOURCE (Pre-scored)

NO DEFINED DATA SOURCE (To be scored today)

Chronic Disease Data for Priority Setting

Connecticut Department of Public Health, Public Health Systems Improvement, March, 2014

CHRONIC DISEASE PREVENTION

	A: SIZE OF PROBLEM		B: SERIOUSNESS OF PROBLEM								C: EFFECTIVENESS OF AVAILABLE INTERVENTION(S) (See *Guide to Community Preventive Services* and CDC *Prevention Status Reports*, and other reports on evidence-based interventions)
			Severity					**Urgency** (Public or public health real or perceived concern; need for immediate action to control spread, deaths; increasing trend)	**Impact on Others** (Potential for spreading or affecting others' lives;effect persists throughout life course)	**Health Inequity** (Specify popultation & type of inequity)	
HEALTH PROBLEM OR SUBJECT OF OBJECTIVE	% of Population Affected or Prevalence Rate	No. of Individuals Affected	Deaths (Rate or No.)	Premature Deaths (YPLL)	Hospitalizations (Rate or No.)	Emergency Dept. Visits (Rate or No.)	**Economic Cost** (Specify type)				
Chronic Disease											
Heart Disease and Stroke											
Heart Disease	3.60%	99,255 (adults 18+) Based on 2010 Census pop. of 2,757,082)	7,069 (2010);	697.2 (2010) YPLL analysis, Mortality web page; Varies with geographies; 721.7[c]	37,895 (2011); Males 191 AAHR per 100K; Females 124 AAHR per 100K (2010) SHA; 285.0 per 100K[d]	37,070 (2011); 19.9 per 100K [a]	Total CT hospital charges in 2011 $1,756,089,912[d] Diseases of the heart cost CT $2.5Billion estimated annually in medical costs and product loss (CD cost calculator).	Heart disease deaths and hospitalizations have declined steadily since 2001. Remains one of the leading causes of death in CT, 3rd leading cause of premature death (SHA).	Can result in serious illness, disability, and decreased quality of life.	and AAHR 54% and 64% higher than females (2010) SHA Some unpreventable risks related to heridity, medical history, age, gender, and race. Some underlying social, economic and cultural determinants: stress, education, income and insurance status. [i]Higher	Aspirin for high risk, control of cholesterol and blood pressure, and tobacco use cessation/reduction to 2nd hand smoke. Self-blood pressure monitoring. Systems of care for heart attack (Dr. Dalal). Clinical Descision-Support Systems, Reducing out of pocket costs for CVD prevention services , Team-based care to improve BP control[i] Electronic health records, pharmacists collaborative drug therapy management, patient centered medical homes, stroke systems of care, reduced sodium consumption. h
Stroke	1.70%	46,870 adults 18+	1,326 deaths CVD (2010);	99.7/100,000 (2010) Varies with geographies; 104.1[c]	9,528 (2011); Males 247 AAHR per 100K; Females 200 AAHR per 100K (2010) SHA	9,811 (2011)	For all Cerebrovascular disease in CT hospital charges in 2011, $391,208,611[d]. Hospital costs for stroke were $351M in 2011. Total CT medical costs and productiv. loss for stroke estimated at $863Million annually (CD cost calculator)	Deaths and hospitalization rates have declined since 2001. 4th leading cause of death in CT.	Disability, decreased quality of life.	Deaths, premature death, and hosp differe by race, ethnicity, and gender. Black males higher AAMR. Males AAHR 24% higher than females (2010) SHA. 62% of stroke deaths in females.	Same as above

HEALTH PROBLEM OR SUBJECT OF OBJECTIVE	Focus Area	No. of Persons Affected	Deaths (Rate or No.)	Premature Deaths (YPLL)	Hospital Discharges	ED Visits (Rate or No.)	Mean Severity	2. Economic Cost	3. Urgency	4. Impact on Others	5. Health Inequity	Mean Seriousness	EFFECTIVENES AVAILABLI INTERVENTIO
High Blood Pressure	CD	5	3	1		1	1.7	4	4	4	4	3.5	5
Obesity - Adults	CD	5	0	0	0	0	0.0	5	5	5	4	3.8	4
Asthma	CD	5	0	0	2	4	1.5	4	4	4	5	3.7	4
Cigarette Smoking - Adults	CD	5	0	0	0	0	0.0	5	4	5	4	3.6	4
Heart Disease	CD	4	5	5	5	4	4.8	4	4	4	4	4.2	4
Diabetes	CD	4	4	2	3	4	3.3	5	4	4	4	4.1	4
Stroke	CD	4	5	3	3	3	3.5	4	3.5	4	4	3.8	4
Excessive drinking (>age 12)	MHSA	5	4		0	3	2.3	4	4	5	3	3.7	3
Exposure to Trauma	MHSA	5							4	4.5	4	4.2	2.5
Mental health	MHSA	5	0	0	5	5	2.5	4	4	4	3.5	3.6	3
Cigarette Smoking - Students grades 6-12	CD	4	0	0	0	0	0.0	5	4	5	4	3.6	4
Dental Decay - children up to 3rd grade	CD	4	0	0	0	0	0.0		3	3	4	2.5	5
Rheumatoid/OsteoArthritis	CD	5	0	0	4	1	1.3	4	4	4	4	3.5	3
Obesity - Children 5-12 years old	CD	4	0	0	0	0	0.0	5		4.5	4	3.4	4
Preconception Health	MICH	5	0	0	0	0	0.0			3	4	2.3	4
Motor Vehicle Crashes	INJ	4	3	4	1	4	3.0	4	3	3.5	3	3.3	4

Strategy & Structure for Implementation

- Renewed Coalition and Advisory Council
- DPH roles
- Collaborative process for critical decisions
- Schedule
- Tracking:
  Performance Management IT System (PMIT)

Next Steps

- Synthesize meeting input
- Public comment period
- Webinars on Focus Areas
- Establish Advisory Council
- Additional Coalition members and partners

THANK YOU!

Questions and Additional Comments

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