**Pomperaug District Department of Health**
77 Main Street North • Playhouse Corner • Suite 205 • Southbury, CT 06488
(203) 264-9616 • Woodbury (203) 266-4785 • Oxford (203) 888-2543 x3005
Fax: (203) 262-1960 • Website: www.pddh.org

May 10, 2016

To: Steering Committee – Connecticut State Innovative Model

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

RE: The role of Connecticut Local Health Departments in Designated Prevention Service Centers and Health Enhancement Communities.

My name is Neal Lustig and I appreciate your time in understanding the role of a Local Health Department in providing programs in health promotion and disease remediation.

The Pomperaug Health District has been conducting evidence based health promotion and disease remediation programs for the past four years. These six to eight week programs, utilizing behavior modification techniques, are key components in our long-term efforts in health promotion. The programs are directed by Health District employees, community health workers and volunteers. We are presently focused on Diabetes Self-Management and Matter of Balance Fall Prevention. Health District staff is certified and, in the case of Diabetes, we are operating under the auspices of the Western Connecticut Area Agency on Aging and the Connecticut Department of Aging. Our major focus of interventions in the delivery of these excellent evidence based programs is in aiding our senior populations to stay at home and properly manage their health issues.

The District, with the assistance of the Connecticut Community Foundation, has now promoted these "prevention" programs in a wide swath of Connecticut from Cheshire all the way to New Milford. Additionally, the District provides health programming in childhood and adult vaccinations, travel immunizations, and blood pressure control. For your information, there are numerous Health Departments and Districts providing "prevention services" in many areas of Connecticut. We work proactively with local private medical providers and hospitals. The Health Departments clearly have a strong role in provision of services and coordination of "health improvement" through community integration, and thru leadership in the development of Designated Prevention Service Centers and Health Enhancement Communities.

Thank you for your time and consideration with this matter and I have attached materials for your review.

Pomperaug District Department of Health Invites You



# Community Preventive Services: Best Practices Workshop

## May 11, 2015

**8:30 AM – 12:30 PM**

Registration & Light Breakfast 8:00 – 8:30 AM

at the Jewish Federation of Western CT, 444 Main Street North, Southbury 06488

**Speakers:**

**Paula Van Ness, President & CEO, Connecticut Community Foundation**
**Santina Galbo, Health Educator, Fairfield Health Department**
**Debbye Rosen, Vaccine Coordinator, West Hartford-Bloomfield Health District**
**Cindy Kozak, Diabetes Prevention & Control Program, CT Dept. of Public Health**
**Dr. Sheila Molony, Director of Quality Improvement, Connecticut Community Care, Inc.**
**Loryn Ray, Director of Senior Services, Town of Woodbury**
**and other Public Health Professionals**

**Topics Include:**

**Diabetes Prevention Program • Matter of Balance Fall Prevention**
**Diabetes Self-Management Program • Chronic Disease Self-Management Program**
**Medicare Billing for Diabetes Programs • Community Vaccination**

A light breakfast will be served.

**RSVP by May 4: 203-264-9616, ext. 0 or Lreinheimer@earthlink.net**

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"The workshop helped me understand that I'm not alone".
Live Well participant

Join a FREE 2 ½ hour Live Well workshop, held each week for six weeks.

Learn from trained volunteers and professional leaders with health conditions themselves on how to better manage your chronic health condition.

Set your own goals and make a step-by-step plan to improve your health – and your life.

Participants who attend at least 5 sessions will receive a gift card and/or a book, a $40 value.

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Live Well

"It's Your Life...Live it Well"

Live Well Workshops are evidence-based Self-Management Programs developed by Stanford University.

Supported by: The Western CT Area Agency on Aging, CT Department on Aging, and CT Department of Public Health. Funding through the CT Community Foundation and CDC in cooperation with the National Association of County and City Health Officials.

## *Spring 2015 Schedule*

***Chronic Disease Self-Management***
*For Arthritis & Fibromyalgia & others*
*Every Thursday, March 19 – April 23*
*1:30 – 4:00 PM*
*at the Woodbury Senior Center*

***Diabetes Self Management***
*Every Wednesday, April 15 – May 20*
*5:30 – 8:00 PM*
*at the Pomperaug District Dept. of Health*

***Diabetes Self Management***
*Every Wednesday, May 20 – June 24*
*1:30 – 4:00 PM*
*at the Jewish Federation, Southbury*

***Diabetes Self Management***
*Every Wednesday, June 10 – July 15*
*5:30 – 8:00 PM*
*at Southbury Parks & Recreation*

***Registration Required: 203-264-9616***

# Live Well Workshops

For People with Diabetes • Heart Disease • Cancer • Stroke • Asthma • Arthritis • Fibromyalgia • Chronic Pain • Depression • Anxiety • Osteoporosis • Any Chronic Health Condition

**Pomperaug District Department of Health**
Southbury, Woodbury, and Oxford, CT

# DO YOU HAVE concerns about falling?

## A MATTER OF BALANCE

MANAGING CONCERNS ABOUT FALLS

**Many older adults experience concerns about falling and restrict their activities. A MATTER OF BALANCE is an award-winning program designed to manage falls and increase activity levels.**

### This program emphasizes practical strategies to manage falls.

**YOU WILL LEARN TO:**

- view falls as controllable
- set goals for increasing activity
- make changes to reduce fall risks at home
- exercise to increase strength and balance

**WHO SHOULD ATTEND?**

- anyone concerned about falls
- anyone interested in improving balance, flexibility and strength
- anyone who has fallen in the past
- anyone who has restricted activities because of falling concerns

Presented by the
**Pomperaug Health District**

**Mondays, March 9 – April 27**
**10:00 AM – 12:00 PM**
**at the Woodbury Senior Center**

**Pre-registration is required:**
**203-264-9616, Ext. 0**

**Wednesdays, March 25 – May 13**
**2:00 PM – 4:00 PM**
**at the Southbury Senior Center**

**Pre-registration is required:**
**203-262-0651**

Classes are held once a week for 8 weeks for 2 hours each.

There is no cost for this program!

**The program is open to anyone over 60 years old who is ambulatory and can problem-solve.**

**This program is provided at no cost to you with funding from the Connecticut Community Foundation.**

**Pomperaug District Department of Health**
**Serving the Western Connecticut towns of Southbury, Woodbury, Oxford since 1986**
**Providing a full range of Environmental Sanitation and Disease Prevention Health Programs**

Take Control

Feel Better

Re-Energize

Live

Enjoy

Live Well

"It's Your Life...Live it Well"

# Learn How to Self-Manage Your Diabetes

## Attend a FREE Live Well Workshop and learn skills to understand and take control of your Diabetes

Learn about what to eat, foot care, blood sugar, sick day guidelines, tips for dealing with stress, how to set small and achievable goals and more.

**Join a FREE 6-week Live Well Workshop**

**Thursdays, June 9 – July 14**

**1:00-3:30pm**

**Waterbury Health Department**

1 Jefferson Square, (185 South Main Street), Lower Level, Waterbury
to sign up call Cindy Vitone at 203-573-6679

**RAFFLE**

**All participants who attend 4 sessions will be entered to a PRIZE**

**Sponsored by the Western CT. Area Agency on Aging & State of CT. Dept. of Public Health & State of CT Dept. on Aging**

**This workshop supported by funds from the Centers for Disease Control and Prevention, Office for State, Tribal, Local and Territorial Support, under grant 1305**

An evidence based self-management Stanford Workshop developed at Stanford University

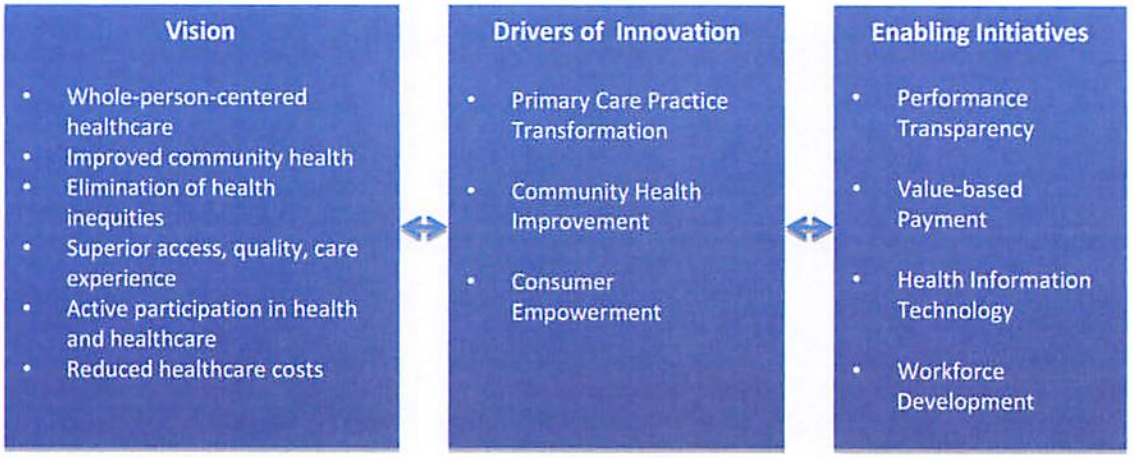
# CONNECTICUT HEALTHCARE **INNOVATION PLAN**

SUBMITTED
**DECEMBER 30, 2013**

- The advancement of our vision requires a commitment to measuring the impact of transformation initiatives on health, access, quality, equity, and costs, and further, by establishing a mechanism for oversight and mid-course corrections.

## OUR STATE INNOVATION MODEL AT-A-GLANCE

**Exhibit 2**




## PRIMARY DRIVERS OF INNOVATION

In order to achieve the goals we have set forth and our vision for improved health and healthcare, three drivers of transformation are necessary:

- **Primary care practice transformation**: An Advanced Medical Home model will allow practices to manage effectively the total needs of a population of patients.
- **Community health improvement**: Designated Prevention Service Centers ("Prevention Service Centers") and Health Enhancement Communities (HECs) will coordinate the efforts of community organizations, healthcare providers, employers, consumers and local public health entities.
- **Consumer empowerment:** Mechanisms for consumer input and feedback, incentives for positive care experience, and enhanced information will enable consumers to manage their own health and make informed choices regarding their care.

### Primary Care Practice Transformation

A cornerstone of our Innovation Plan is supporting the transformation of primary care to the Advanced Medical Home (AMH), a care delivery model comprising five core elements:

- **Whole-person-centered care:** Care that addresses the full array of medical, social, behavioral health, oral health, cultural, environmental, and socioeconomic factors that contribute to a consumer's ongoing health.
- **Enhanced access:**[2] an array of improvements in access including expanded provider hours and same-day appointments; e-consult access to specialists; non-visit methods for access the primary care team; clear, easily accessible information; and care that is convenient, timely, and linguistically and culturally appropriate.
- **Population Health Management**: use of population-based data to understand practice sub-populations (e.g., race/ethnicity), panel and individual patient risk, and to inform care coordination and continuous quality improvement, and to determine which AMHs are impacting health disparities, for which conditions and for which populations.
- **Team-based coordinated care:**[3] multi-disciplinary teams offering integrated care from primary care providers, specialists, and other health professionals. An essential element in what makes this work is the combination of behavioral healthcare with medical care, whether through co-location, referral linkages, or as part of a virtual team.
- **Evidence-informed clinical decision making:** Applying clinical evidence to healthcare decisions using electronic health record (EHR) decision support, shared decision making tools, and provider quality and cost data at the point-of-care to enable consumer directed care decisions.

Practices are in very different stages in terms of their ability to meet the advanced standards for becoming an Advanced Medical Home, so we designed the Glide Path program, which provides technical assistance and other support to facilitate the practice transformation process. When practices demonstrate readiness to coordinate care, payers (insurance companies, self-funded employers, Medicaid, Medicare) will begin to finance care coordination services and other advanced primary care activities. In time, providers will take responsibility for a broader array of quality and performance metrics, including offering a better care experience for their patients.

## Community Health Improvement

While primary care transformation is essential, we recognize that effective prevention cannot be achieved by the care delivery system or by public health agencies acting alone. A major part of our transformation strategy is to foster collaboration among the full range of healthcare providers, employers, schools, community-based organizations, and public agencies to collectively work to improve the health of populations within their community. Our approach to community health improvement comprises two elements:

[2] Paulus RA, et al. Health Affairs 2008; Reforming the healthcare delivery system, Geisinger report , 2009

[3] ACA Sec. 3502: Establishing Community Health teams to support the Patient Centered Medical Homes.

- **Designated Prevention Service Centers (DPSCs)** to strengthen community-based health services and linkages to primary healthcare.
- **Health Enhancement Communities (HECs)** to target resources and facilitate coordination and collaboration among multiple sectors to improve public health and reduce avoidable health disparities in areas with the highest disease burden, poorest indicators of socioeconomic status, and pervasive and persistent health disparities.

### Consumer Empowerment

The delivery of whole-person-centered care requires a transformation in how payers and providers respect and enable consumers to be active participants in the management of their health. A person's values and preferences and the freedom to make informed decisions must be placed at the center of any efforts to achieve our vision.

Primary care practices will equip consumers with culturally and linguistically appropriate information, resources, and opportunities for them to play an active role in managing their health. As part of our plan for consumer empowerment, we include a three-pronged strategy detailed in the Innovation Plan:

- **Enhanced consumer information and tools** to enable health, wellness, and illness self-management, including shared decision making with providers.
- **Consumer input and advocacy** via decision-making roles in the SIM governance structure and through consumer care experience surveys that will directly affect provider payment.
- **Consumer incentives** to encourage healthy lifestyles and effective illness self-management through the promotion of value-based insurance designs (VBID) and employer incentive programs.

## ENABLING INITIATIVES

Connecticut will enable our broad transformation through performance, cost and price transparency, value-based payment, health information technology, and workforce development. These initiatives, described in detail in the Innovation Plan, are highlighted here because of their role in achieving our vision.

### Performance Transparency

Diverse groups of stakeholders have emphasized that increased transparency of quality, cost and price is a fundamental prerequisite to improving our health system. Transparency is essential for shaping our new care delivery and payment models, for informing consumer choice of health plans and providers, for guiding providers' own performance improvement efforts, and for identifying disparities in health and health outcomes. We will achieve this level of transparency with the following levers and focus areas:

To achieve the Triple Aim for everyone, the state has committed to eliminating persistent barriers to health equity and will leverage current investments in this area as more fully described in the "Foundational Strengths and Initiatives" section.

During the design process we solicited advice through the formation of a health equity group to ensure inclusion of health equity's crosscutting influences on primary care practice transformation, community health improvement, consumer empowerment, performance transparency, value-based payment, workforce development, health information technology, and governance. Furthermore, our evaluation plan will examine our success in reducing health equity gaps in health and health care quality.

Our Innovation Plan is committed to promoting health equity through the elimination of health disparities in every aspect of the model. Although the promotion of health equity is a distinguishing feature of our plan, it is viewed not as a separate and distinct initiative, but rather inherent to all elements of the plan.

### Equity and Access Council

Our value based payment reforms emphasize achievement of quality and care experience targets, while also recognizing the need for methods to guard against underservice. Through the establishment of an Equity and Access Council, Connecticut intends to be a national leader in the identification and deployment of advanced analytic methods that offer special protections for consumers as we migrate to value-based payment and to prevent providers from benefiting from unwarranted denials of care.

### Consumer Empowerment

Consumer empowerment is one of the primary means of achieving our goals. It encompasses distinct initiatives and is also embedded throughout the plan as a means to achieving our goals. Consumer experience must matter to a much greater degree than it does today. For this reason, Connecticut intends to be among the first states to measure care experience statewide at the practice level and to factor care experience performance into our payment methods across all public and private payers. We will promote the widespread adoption of value-based insurance designs as a powerful means for rewarding healthy behavior. In addition, consumers will be represented in all of the key committees, councils and tasks forces that shape our SIM reforms over the next five years.

### Designated Prevention Service Centers and Health Enhancement Communities

Community health improvement is a key component of our model—realizing that the goal of community health is in the value of our diverse communities. The states proposed Health Enhancement Communities (HECs) and Designated Prevention Service Centers (DPSCs) are innovative opportunities to foster an alignment among our Advance Medical Home providers

and a diverse array of community participants. The proposed innovation will establish a structure that allows a bi-directional flow of information from providers to community based organizations and local health departments allowing for the planning and deployment of strategic investments in community health.

### Connecticut Service Track for Healthcare Workforce Development

Connecticut will build upon its current program for community-based interprofessional education, UConn's Urban Service Track (UST), established to serve disadvantaged populations in urban settings through team-based care, cultural and linguistic appropriateness, and population health. The envisioned Connecticut Service Track (CST) extends beyond urban communities to include Connecticut's more rural counties—effectively covering all of Connecticut.

The CST program, as more fully described in the "Foundational Strengths and Initiatives" section, reaches across health professions schools, including nursing and allied health professions schools and additional community providers, increasing the number of participating schools, occupations, and community service locations.

## MANAGING THE TRANSFORMATION

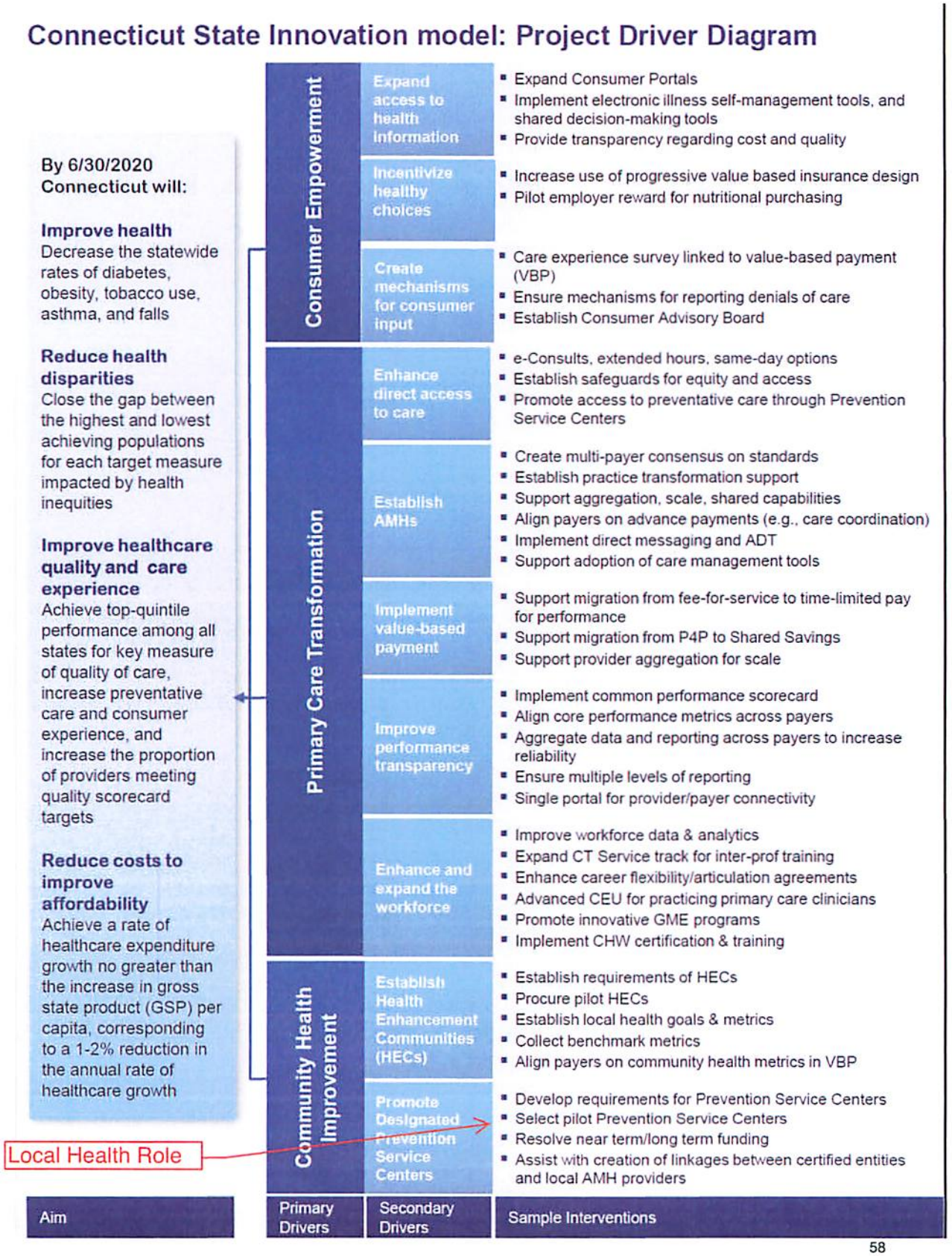
### Governance Structure

The Lieutenant Governor will provide overall leadership for the Innovation Plan implementation. She will establish a Healthcare Innovation Steering Committee, a successor to the existing Steering Committee, with additional consumer, consumer and health equity advocate and provider representation. A Project Management Office will also be established to lead detailed design and implementation, oversee evaluation efforts, engage with stakeholders, manage vendors, and communicate progress to the public, state government, and CMMI. The Project Management Office will sit within Connecticut's Office of the Healthcare Advocate. The Steering Committee and Project Management Office will seek ongoing input and guidance from Connecticut's Healthcare Cabinet and Consumer Advisory Board.

Five specialized task forces and councils are envisioned focusing on provider transformation standards, support, and technical assistance; coordination of the various health information technology projects; quality, care experience, and health equity metrics and performance targets; methods for safeguarding equity, access, and appropriate levels of service; and workforce initiatives. Consumer membership in the task forces and councils will be facilitated through the statutorily created Consumer Advisory Board throughout the detailed design, pre-implementation and implementation phases of this initiative.

This structure is expected to be in place by February 2014.

**EXHIBIT 16: Driver Diagram**



# 3. Community Health Improvement

Health is impacted by the communities in which people live. Connecticut's geography reflects a need for targeted innovations. For instance, 40% of black and 30% of Hispanic residents reside in just three large cities or Manufacturing Centers.[58] Health outcomes, such as rates of ED Non-urgent visits and percent of ED non-admits, correlate with the "Five Connecticuts:" wealthy, suburban, rural, urban periphery, and urban core.[59] Community resources can be better leveraged, engaged, and coalesced to work towards a common vision of improved health that addresses the unique needs of their community.

Connecticut has a rich array of community-based organizations and local governmental and non-governmental health and human service agencies with a deep and unique understanding of the communities they serve. These entities administer community-based programs that share a common objective with clinical practices – preventing illness or injury, managing chronic illness and improving the health of consumers. Unfortunately, these programs face multiple obstacles in achieving this goal. Few systems, structures and incentives exist that would help foster collaboration and coordination between clinical practice and community services. Furthermore, it is unclear how prevalent are evidence-based community health programs in regions with vulnerable and high-risk populations. Current data suggests that the need for such programs far outstrips their availability. Finally, many community-based services rely on grant funding, leaving even the highest quality services vulnerable to funding cycles and thus unsustainable.

The SIM initiative offers a unique opportunity to design a focused and coordinated approach to improving community health and reducing avoidable health disparities not easily addressed by the healthcare sector alone. A community health improvement approach is critical to the successful achievement of the state's aim of improving the health and healthcare quality of Connecticut's residents, eliminating health disparities, and improving care experience. The State is proposing two community health improvement strategies. These strategies will support our efforts to advance primary care and empower consumers, while incorporating these reforms into an overarching strategy to improve the health of vulnerable communities.

- **Designated Prevention Service Centers**: Local centers of evidence based primary and secondary prevention services intended to serve as cost-effective resource to AMH providers, helping them to achieve their illness prevention and management goals.
- **Health Enhancement Communities (HECs):** Enterprising communities organized to facilitate coordination and collaboration among multiple sectors to improve public health and reduce avoidable health disparities.

[58] Community Health Data Scan: Preliminary Results (2013)

[59] Ibid.

## 3.1 DESIGNATED PREVENTION SERVICE CENTERS

Connecticut proposes the creation of Prevention Service Centers that have been designated by the Program Management Office as meeting criteria for the provision of evidence-informed, culturally and linguistically appropriate prevention services. Prevention Service Centers may be new or existing local organizations, providers (e.g., FQHCs), non-profits or local health departments. Prevention Service Centers will initially focus on environmental quality issues in homes and promoting positive health behavior. Their primary purpose is to provide a single source of evidence-based, preventive services to local primary care practices that might otherwise lack the resources and infrastructure to provide these services.

Prevention Service Centers will foster alignment and collaboration between primary care providers, community-based services and State health agencies. They will supplement AMH and community interventions as the literature has shown that a single intervention often does not reduce an overall medical or behavioral burden or sustain preventive health behavior.[60] Their workforce will include the emerging community of certified community health workers envision as part of our healthcare workforce development strategy.

Prevention Service Centers also provide a special opportunity to implement the Institute of Medicine's (IOM) best practices in integrating primary care and public health.[61] The IOM recognizes that the degree of integration may vary and consequently offers several best practices to help primary care and public health providers decide on which community-based programs/activities to integrate.

### Selection of Initial Evidence-Based Services

The identification of an initial service package was based in part on our Innovation Plan goals and also the target conditions for which AMH providers and HECs will be held accountable. We also considered the importance of linking clinical practices with population health strategies that are already established in Connecticut. With this in mind, the Department of Public Health, Department of Aging, Department of Social Service, stakeholders from the SIM Care Delivery workgroup and the SIM Steering Committee prioritized three community prevention programs that Prevention Service Centers will focus on during the SIM implementation phase. These evidence-based community-based programs are already being implemented in some regions in Connecticut and include:

- Diabetes Prevention Program (DPP)
- Asthma Home Environmental Assessment Programs

[60] A Report on Recommendations of the Task Force on Community Preventive Services: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5410a1.htm Accessed October 2, 2013.

[61] IOM Report 2012: http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx

- Falls Prevention Program

These programs were selected in part because of the recent comprehensive State Health Assessment[62] conducted by DPH. This assessment identified and ranked the leading causes of hospitalization in the state (e.g., diabetes, asthma, injuries). These conditions also correlate with the leading causes of healthcare costs in Connecticut and are target conditions of the Innovation Plan. All three programs are basic elements of the Center for Disease Control's (CDC's) framework.[63] The state also selected these programs because there is strong evidence of their effectiveness and return on investment (ROI) with respect to disease prevention and health promotion. The State also assessed the programs' ability to serve individuals or groups and to address or reduce health disparities. Finally, this framework aligns with the State's emerging CDC-supported Coordinated Chronic Disease Plan, which identifies priorities and measures for diabetes, asthma and injury prevention. The rational for selecting each target condition and service is discussed in greater detail later in this section.

### Proposed Prevention Service Center Criteria

The proposed criteria for Prevention Service Centers will help assure that high quality, coordinated services are available to clients. Satisfying these criteria will earn an entity the "designated" status and listing in a portal accessible by primary care providers and consumers. The criteria will require at minimum that Prevention Service Centers be responsible for the delivery of a core set of evidence-based community interventions. They will be expected to meet the following requirements:

- Enter into formal understanding or agreement with primary care practices and share accountability for quality and outcomes
- Have a unique understanding of the community and population served and be able to deliver high quality, culturally and linguistically appropriate services
- Meet specified standards pertaining to the type, quality, scope and reach of services
- Have IT-enabled integrated communication protocols, including bi-directional referrals with collaborating primary care and other relevant providers and health agencies
- Include community health workers in the provision of services

[62] Lisa Wolff ScD-Connecticut State health Assessment: http://www.ct.gov/dph/lib/dph/state_health_planning/sha-ship/coalition_kickoff/ct_sha_prelim_rev020413.pdf Accessed August 19, 2013

[63] Chronic Disease Prevention and Health Promotion Domain: http://www.astphnd.org/resource_files/477/477_resource_file3.pdf

## Relationship of Designated Prevention Service Centers and State Health Agencies

The state is working to break down silos in its workforce by encouraging state and local health agencies to collaborate in their data collection, programs and community investments. State and local health agencies played a major role in the SIM planning phase and will do so again in the Prevention Service Center's establishment and specific evidenced-based population health program selections.

## Quality Assurance and Reporting requirements

Prevention Service Centers will deliver a "minimum package" of services of evidence-based interventions that have high potential to improve health outcomes, reduce health disparity and medical costs. During the implementation phase, the Program Management Office will lead a transparent planning process by engaging key state agency, community and provider groups to develop detailed standards and the process for designation. DPH and other involved state agencies will also provide technical assistance and best practices to organizations that are voluntarily seeking designation or have achieved designation.

## Subcontracting by Prevention Service Centers

As primary care practices become AMHs, the state expects the demand for Prevention Service Center services to grow. The state will meet this demand by allowing Prevention Service Centers to enter into subcontract arrangement with local partners in order to ensure an adequate supply of preventive services.

## Strategy to engage community resources

The Project Management Office will begin the process of educating and engaging providers, community based organizations (CBO), consumers and other stakeholders on the benefits of integrating AMHs and community resources during the detailed design phase. During the first 18 months of SIM implementation, the Project Management Office will:

- Initiate a state wide campaign to educate providers and AMHs, who are critical partners to a successful integration on the benefits of collaboration
- Begin a state wide scan using the Community Transformation Grant to identify existing infrastructure and community based entities that may be appropriate for the initial pilot implementation
- Propose legislation to speed up the CHW certification process to ensure that identified entities from the scan have a sufficient number of CHWs to meet the designation criteria
- Propose a platform that brings prospective Prevention Service Centers and primary care practices to the table to determine and agree to partnership terms that are fair to all parties

- Sets up and maintain a list of Prevention Service Centers that is accessible to AMHs, Prevention Service Centers, State health agencies and consumers.

## Prevention Service Centers and Health Equity

Prevention Service Centers will help address health equity through a targeted approach. The Project Management Office will give priority to placement of Prevention Service Centers in areas where health equity gaps are substantial and that may also be recognized as a Health Professional Shortage Areas (HPSA).

## Financing Designated Prevention Service Centers

The State is currently evaluating several financial options to ensure that our Prevention Service Center model is financially sustainable. During the initial pilot phase, the state will explore the possibility of secure start-up funding from Connecticut's health foundations or allocating a portion of the test grant funds. Beyond an initial one or two year start-up phase, the State anticipated that primary care providers will purchase such services as needed to achieve their quality objectives (e.g., reducing hospitalization rates for asthma). We do not intend to establish an exclusive market for Prevention Service Centers within any geographic area. Accordingly, the viability of a Prevention Service Center in the long run will depend on the value of the services that they provide to their primary care practice clients.

## Rationale for the Proposed Prevention Service Center Programs

### Diabetes Prevention Program (DPP)

Connecticut acknowledges that its population is getting older and becoming increasingly overweight and sedentary. An estimated 8.3% or 25.8 million people have diabetes in the United States compared to 163,000 people or 8.5% percent in Connecticut.[64] If this situation is ignored in Connecticut, diabetes may lead to disability, blindness, increased healthcare costs and increased mortality. To address this public health issue, Connecticut will use the SIM to leverage the State's existing, evidence-based Diabetes Prevention Program (DPP). DPP increases referrals to, use of, and/or reimbursement for CDC recognized lifestyle change programs for the prevention of type 2 diabetes. Type 2 diabetes accounts for about 90 to 95% of all adult cases. Its treatment protocol focuses on weight control, exercise, diet and medication.

[64] The Connecticut Diabetes Prevention and Control Plan 2007-2012: http://www.ct.gov/dph/lib/dph/aids_and_chronic/chronic_disease/pdf/dpcp_plan_8_10_07.pdf Accessed August 19, 2013

The DPP may help delay patients' becoming type 2 diabetics by 58%[65]. and can reduce costs.[66] DPH and its partners are committed to supporting and broadening the impact of DPP. DPH will continue to promote the CDC-recognized DPPs statewide, encouraging healthcare systems to refer eligible participants to them. It will also convene established Connecticut DPP sites two to four times a year to share best practices and lessons learned in implementation, recruitment and retention. DPH and its partners such as the Department of Social Services (DSS), the SIM planning team and the Office of the State Comptroller will continue discussions to ensure that DPP will be a covered benefit for publicly employed or publicly insured beneficiaries. The current targeted populations are the employed or those receiving services from the 14 DPP-trained institutions (i.e., hospitals, local health). However, through the Prevention Service Center, SIM is potentially looking at policy changes that allow DPP to impact a larger population.

Literature shows that the burden of diabetes disproportionately affects the less educated, racial minorities and those regions with fewer resources. (See Current Connecticut Environment – Section 2)Connecticut is determined to eliminate diabetes-related health disparities. It can start to accomplish this by collaborating with Community Health Centers and other community-based organizations that deal with disparate populations. Prevention Service Centers can improve the DPP's outcomes by using Health Information Technology (HIT) to connect closely to the AMHs and incorporate additional evidence-based services into the DPP. Recruitment and retention of multi-lingual leaders and community health workers will be a priority in order to better serve the Hispanic population and other vulnerable populations. Connecticut intends to address this diabetes related disparity by reducing the percent of low-income (<25k) adults with diabetes from 14.3% to 12.0% by 2020.[67]

**Asthma Home Environmental Assessment Programs**

Patients diagnosed with asthma may be exposed to several environmental allergens that may trigger or exacerbate their conditions, especially in their homes. Some of these individuals may be poor, urban residents who lack health insurance and hence depend on emergency departments for their medical care. Just as importantly, individuals may not receive adequate education on how to detect and avoid some of their asthma triggers.

Asthma is an important issue for Connecticut's residents and a significant healthcare cost. As described in Section 2, Hispanics and Non-Hispanic blacks had a high rate of asthma emergency

65 Linda M Delahanty, MS, RD, David M Nathan, MD- Implications of the Diabetes Prevention Program (DPP) and Look AHEAD Clinical Trials for Lifestyle Interventions: J Am Diet Assoc. 2008 April; 108(4 Suppl 1): S66–S72. doi:10.1016/j.jada.2008.01.026

66 Robert E. Ratner, MD, FACE- AN UPDATE ON THE DIABETES PREVENTION PROGRAM: Endocr Pract. 2006 ; 12(Suppl 1): 20–24.

67 Live healthy Connecticut : Connecticut's Coordinated Chronic Disease Prevention Plan. DPH, Hartford CT (DRAFT)

department visit in Connecticut. According to a recently published study, 9.2% of adults and 11.3% of children living in Connecticut have asthma.[68] In 2009, Connecticut spent over $112 million for acute care management of asthma as a primary diagnosis. It also spent $80.3 million on hospitalization charges and $32.6 million on asthma-related emergency department (ED) visit charges in 2009.

The U.S Environmental Protection Agency encourages individuals and communities to participate in decisions about proposed activities that will affect their environment and health. To make this possible, the DPH administers and local health departments carry out asthma home visit and environmental assessment known as "Putting on AIRS". The program has already produced results, decreasing the number of asthma-related emergency department visits, visits to healthcare providers and missed days of school/work due to asthma.[69]

Asthma Indoor Risk Strategies (AIRS) is a free, in-home asthma education and environmental home assessment program provided by a certified asthma educator and an environmental specialist. It improves patient/family asthma recognition and self-management skills through education and interactive interventions that identify and decrease exposure to asthma triggers in the home. It also teaches patients how to properly use their medication devices to administer prescribed asthma medications.

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 will encourage qualified entities operating in vulnerable communities to join in the SIM efforts of expanding the AIRS program's accessibility. Successful implementation and collaboration between providers and Prevention Service Centers in this effort will be monitored and evaluated in an ongoing basis. The state proposes that a reduction of emergency department visit among Hispanic Connecticut residents for which asthma is the primary diagnosis from 170.5 per 10,000 to 162 per 10,000 by 2020.[70]

[68] The Burden of Asthma in Connecticut – 2012 Surveillance Report: http://www.ct.gov/dph/lib/dph/hems/asthma/pdf/3_fast_facts_about_asthma_in_ct_2012.pdf

[69] KIMBERLY H. NGUYEN, M.S., M.P.H. et al- Quality-of-Life and Cost–Benefit Analysis of a Home Environmental Assessment Program in Connecticut: Journal of Asthma, Early Online, 1–9, 2010: http://www.ct.gov/dph/lib/dph/hems/asthma/pdf/kims_final_published_airs_in_ct.pdf Accessed August 20, 2013

[70] Live healthy Connecticut : Connecticut's Coordinated Chronic Disease Prevention Plan. DPH, Hartford CT (DRAFT)

## Falls Prevention Program

Injuries to the musculoskeletal system are one of the leading causes of hospitalization among the over 64 year age group in Connecticut.[71] The fact that the chances of falling and being seriously injured increases with age is well documented. Available data in the state shows that Non-Hispanic whites have the highest fall death rate (6.1/100,000), followed by non-Hispanic blacks (2.3/100,000) and Hispanics (1.2/100,000).[72] Data from 2009 show that Falls ranks highest in the number of unintentional injury death in Connecticut. One estimate shows that Connecticut spends $119 million more every year on home or nursing home long-term care for older adults who sustain a fall-related injury. [73]This is also a national trend, with the United States spending $28 billion annually on fall victim treatment. If the rate of falls is not urgently addressed, the direct and indirect treatment costs in the United States will be an estimated $54.9 billion annually in 2020.[74]

The Connecticut State Legislature tried to address this issue as it examined the State's shifting demographics. As part of this effort, the Department of Aging helped fund the Yale University's Connecticut Collaboration for Fall Prevention (CCFP). This program works with community-based sites, faith based organizations, home care agencies, outpatient rehabilitation centers, senior centers, assisted living facilities, hospitals and providers. The program uses a standard curriculum and protocol with a "train the trainer" approach; this makes it easy for the partner organization to maintain the program and keep working with consumers. The primary risk factors that providers look for are such things as vision problems, balance impairments, postural hypotension, use of four or more medications and home hazards.

Some additional action steps that may help in the reduction of hospitalizations and deaths due to falls include;

- Facilitating connections between clinical providers and community providers on ways to implement fall risk assessment as a routine part of healthcare visits and other services for older adults
- Identifying barriers to implementation of effective fall prevention interventions and strategies to address those barriers

71 Lisa Wolff ScD-Connecticut State health Assessment: http://www.ct.gov/dph/lib/dph/state_health_planning/sha-ship/coalition_kickoff/ct_sha_prelim_rev020413.pdf Accessed August 26, 2013

72 Connecticut Injury Prevention and Control Plan, 2008-2012.

73 2006 analysis prepared for the Long Term Care Planning Committee regarding the costs of falls among older adults in Connecticut

74 Englander F, Hodson TJ, Terregrossa RA. Economic dimensions of slip and fall injuries. Journal of Forensic Science 1996; 41(5):733–46.trial. The Gerontologist 1994; 34(1):16–23. *Connecticut Injury Prevention and Control Plan-2008-2012: State of Connecticut Department of Public Health*

While some factors that increase the risk of falls such as age and previous falls cannot be changed, Connecticut's evidence-based falls prevention program is determined to address and reduce the changeable risk factors. The state proposes that by 2020, it will reduce hospitalizations due to falls to no more than 245.0 per 100, 000 population.[75]

### Interventions that may be considered in the future

As community-based services become more integrated with primary care, we envision stronger, more innovative and more cost-effective Prevention Service Centers. Projected cost savings and the innovative quality health experience will be due in part to the solid foundation provided by the SIM, but also from the effect of more AMHs participating in the achievement of our shared health goals. The areas that will be considered for enhancement of the basic package are obesity (promoting nutrition and exercise), tobacco cessation, and hypertension.

## 3.2 HEALTH ENHANCEMENT COMMUNITIES

It is well understood that all pathways to better health do not travel through the health care system. Differences in healthcare explain only a portion of the disparities in health outcomes that are observed in Connecticut. Neighborhoods with more limited financial resources tend to have less access to resources that promote good health, such as safe neighborhoods, high quality foods, and well-paying jobs. To prevent avoidable illness and improve care for the sick, Connecticut must address the community health factors that impact residents in their homes, schools, worksites and neighborhoods. Our Innovation Plan acknowledges this critical truth, and has included the goal of improving community health in its overarching vision statement. To this end, our Innovation Plan makes a prioritized investment and commitment to expanding access to community prevention services that can improve health at the individual and population level.

### Prevention and Public Health Leadership in Connecticut

#### Department of Public Health

In Connecticut, community health efforts are championed by the Department of Public Health (DPH) in collaboration with its sister agencies and numerous community based organizations. DPH efforts have included participation in numerous CDC initiatives, with highlights including:

- Community Transformation Grants (CTGs): DPH received a planning award to build capacity to support healthy lifestyles, targeting tobacco-free living, active living and healthy eating, quality clinical and other preventive services, healthy and safe physical environments, and social and emotional wellness.

[75] Connecticut Injury Prevention and Control Plan-2008-2012: State of Connecticut Department of Public Health