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CALIFORNIA CONFERENCE OF LOCAL HEALTH OFFICERS

CCLHO News

In the President's Words

The Integration of Primary Care and Public Health by Wilma J. Wooten, M.D., M.P.H.

Recently I was asked to develop a presentation for the National Association of County and City Health Officials (NACCHO) Survive and Thrive Fellowship to train new public health officers about the importance of the integration of primary care and public health. This is a fitting and timely topic! With insurance features of the Affordable Care Act (ACA) now being implemented, many public health jurisdictions (PHJs) are forging new directions and aligning with new, and previously unexpected, partners. Now more than ever before, it will be vital for PHJs to work with new partners, including primary care. The most important reason is to achieve "collective impact." The five principles of Collective Impact include:

- Common Agenda
- Shared Measurement
- Mutually Reinforcing Activities
- Continuous Communication
- Backbone Organization

Achieving these components will require three important actions: Political will and commitment, policy changes, and data integration.

Unless there is political **will and commitment** to deviate from the norm, change is not imminent or likely. **Policy** at all levels (e.g., macro, meso, micro) is required: macrosystems change, such as reporting height and weight for BMI monitoring; mesosystem changes, such as implementing lactation, smoke-free facilities, and procurement policies in organizations, schools, governments, healthcare institutions, and businesses; and microsystem changes, such as commitments by employees, families, churches, schools and peers to change behaviors.

In order to have an efficient health and healthcare system, **data sharing** is essential to adequately monitor the health status of our population at the practice level for physicians (often referred to as population management) and at the PHJ countywide level (referred to as population health). By rowing in the same direction on mutual problems and agreed-upon goals, a change in awareness, education, policies, behavior, and in health outcomes will emanate.

Primary care in the U.S. nods to the community-oriented primary care (COPC) model, which is founded in principles of public health. However, with increasing responsibilities of providers resulting in decreasing time with patients, this model is seldom utilized. However, if the chronic care model (CCM) strategy can be implemented, it will inform, support, and elevate the COPC and contribute further to collective impact. The CCM is a model developed by Edward Wagner that provides a mechanism for health care teams to operate. The model has six dimensions: community resources and policies, health system organization of health care, patient self-management supports, delivery system redesign, decision support, and clinical information system. The model activates patients to interact in a productive way with health care teams. Three components that are particularly critical to this model are adequate decision support, which includes systems that encourage providers to use evidence-based protocols; delivery system redesign, such as using group visits and same-day appointments; and use of clinical information systems, such as disease registries, which allow providers to exchange information and follow patients over time. CCM epitomizes the concept of population management and allows contribution to the collective impact by primary care providers.

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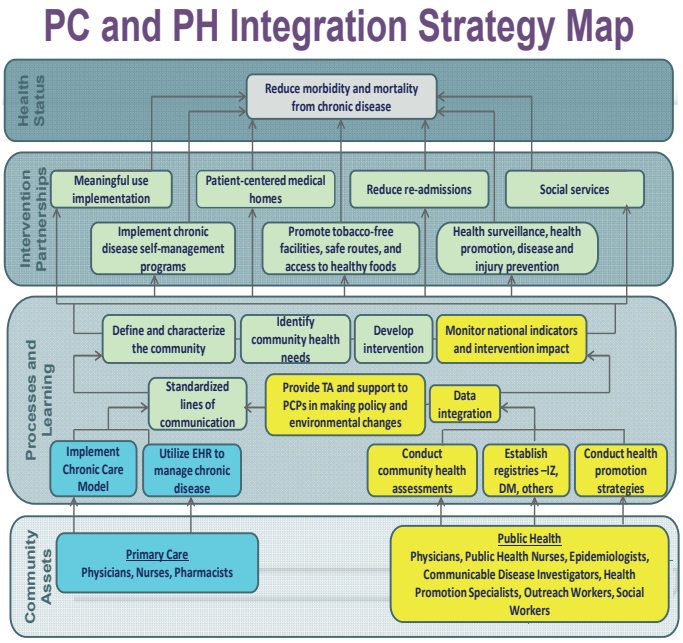
The Integration of Primary Care and Public Health (continued from Page 1)

Another feature of collective impact is the use of the strategic map, a replacement for the old, but familiar, logic model. I refer to the strategic map as the 21st century logic model. The following graphic is my attempt to show how the integration of public care and public health can be effected to decrease mortality (death) and morbidity (illness and disability).



Lastly, I offer you three San Diego County Public Health Services (PHS) programs that are examples of how primary care and public health have shown effective integration in San Diego County. Of note, all three programs also are funded by the Affordable Care Act.

- **Community-based Transitions Program (CCTP)** – Funded by Section 3026 of the Affordable Care Act, this is an Aging and Independence Services (AIS) program to test models for improving care transitions for high risk fee-for-service Medicare patients by using community services to manage patients' transitions effectively. The overall goal of CCTP is to improve transitions of patients from the inpatient hospital setting to home or other care settings by 1) improving **quality of care**, 2) reducing **readmissions** for high risk beneficiaries (target is to reduce readmissions by 20% in two years), and 3) documenting measureable **savings** to the Medicare program. CCTP supports the three-part or "triple" aim of: better health for the population, better care for the patient, and lower cost for all Americans. Beginning January 1, 2013, AIS has partnered with 11 hospitals on 13 campuses to provide innovative care transitions services for up to 21,390 high-risk Medicare patients each year.

- **Community Transformation Grant (CTG)** – Funded by ACA Prevention and Public Health Fund, the CTG grant is a chronic disease prevention award. The grant celebrates 22 interventions, including continuation of 11 from Communities Putting Prevention to Work Grant (CPPW). Of the five strategic directions, the third strategy is related to community and clinical preventive services. The goal for this strategy is to work with primary care providers to increase control of high-blood pressure and high cholesterol. There are two objectives that integrate primary and public health: 1) provide training and technical assistance for providers to control blood pressure and cholesterol levels, and 2) enhance linkages between providers and the San Diego Regional Healthcare Information Exchange for better tracking of high blood pressure and high cholesterol.

- **Home Visitation Program (HVP)** – There are two home visitation programs—the Nurse Family Partnership (NFP) and Maternal Child Health (MCH) Program in the Maternal, Child and Family Health Services (MCFHS) Branch. Since 1999, the HHSA East Region has implemented the Nurse Family Partnership. Over the past 14 years, the program has grown to include 47 nurses across all six HHSA operational regions. Also, MCH enrolls high-risk, first time, or prior mothers. In 2012, the NFP expanded in N. Coastal/N. Inland (highest need areas) through funding from the California Home Visitation Program (CHVP). CHVP funding is from the Affordable Care Act of 2010. The program provides comprehensive, coordinated in-home services to support positive parenting and improve outcomes for families residing in at-risk communities. San Diego County received CHVP funding from April 2011 to June 2013 in the amount of $1.2 million to expand Nurse Family Partnership in the North Coastal and North Inland Regions. For fiscal year 2013-2014, the program will receive $842,022. Since 1999, both NFP and MCH programs have made visits to 2,703 clients.

There are many other opportunities as well, which can be successful if there is will and commitment, the ability to make policy changes, and the ability to share data. Are our respective systems up to the challenge?

Dr. Wooten is the Public Health Officer for San Diego County.

Hearing Voices by Todd Stolp, MD

There is something very comforting about the notion that the self resides between two shoulders, one bearing a tiny angelic image of ourselves encouraging selflessness and benevolence and the other bearing a little devilish self promoting indulgence and malevolence. Some comfort perhaps comes from the limited personal investment intrinsic to multiple choice questions in contrast to writing an essay. Unfortunately, in the public health world it becomes immediately clear that very few of the issues we face are true-false dichotomies. Herein lays one of the main reasons why public health challenges are slow to respond to decision making and intervention.

Consider the issue of access to health care. If the problem simply boiled down to the need for patients to find and pay for a health care provider willing to provide health care to them, the question of "access to healthcare" would be solved by the market like any other commodity. However, healthcare is not a commodity and in today's world, "access to healthcare" is much more than meets the eye. It includes the requirement that the patient retain active membership in a specific insurance company policy in which their selected healthcare provider is a willing participant. The patient must understand the vocabulary of health insurance—such as premiums, deductibles, copayments and co-insurance—and they must have a functional understanding of the importance and benefits of preventive services – including immunization schedules, prenatal care, family planning and routine disease surveillance recommendations—so they can truly "access" those healthcare services. In addition, unlike the decision to shop for a new television, the decision to seek care is often made by our appendices or our tibias and not by our brains.

A great deal of attention is now being focused by public health experts on the "determinants of health," those factors and features of the world around us, including "community design," that limit our life choices and which have enormous impacts upon our health. The opposing argument to the importance of community design in our health is the case for "personal responsibility"—the idea that each individual must be accountable for the decisions they make on behalf of their own health, whether good or bad, given the choices before them. This is the old "bootstraps" principle. Residing between the right and left shoulder in such debates can be deafening. However, the solution almost certainly sits somewhere between the shoulders, with education and community action being at least two of the important mediators in the dispute about the degree to which our neighborhoods and our personal choices are liable for our health.

Which brings us to one of the important light bulbs in the room. Nothing can reveal the shortcomings of arguments from either shoulder as well as facts. For public health experts, this means facts about prospective controlled studies that document the effectiveness or lack of effectiveness of specific healthcare interventions, and facts about the outcomes of various policies on morbidity and mortality in various populations, and facts about social psychology. For members of the public, this means facts about the influence of corporate marketing upon their consumer choices, and facts about the nutritional value or lack of nutritional value of food and beverage products, or facts about the new healthcare and health insurance choices made available through the Affordable Care Act.

No person is as vulnerable to the whims of the world around us as a person suffering from a vacuum of information, and nothing is as willing to fill that vacuum as the arguments of the angels and devils that sit upon every shoulder. Myths that spread with ease through our electronic tethers espouse the risks of immunizations, the threats to our social relationships of

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Hearing Voices (continued from Page 3)

dandruff and the paternalism of the "nanny state" and undermine the ability of the public to make rational decisions on behalf of their own health. Public Health experts represent one of the only sectors of our society with the duty and the resources to counterbalance such forces. We must continue to advocate maintaining and expanding those resources if we are to be effective in meeting our obligations to share facts with the public.

In addition, we must remain humble about our own susceptibility to the voices from our right and left shoulders and use facts to balance our own decision making, recognizing that small victories today lead one step closer to larger victories tomorrow. Avoiding a sanctimonious tenor in our public messages can do wonders to build the public trust and enlist the public in our efforts.

Dr. Stolp is the Public Health Officer for Tuolumne County.

CCLHO Spring 2014 Conference

Save the date for the 2014 CCLHO Spring Semi-annual Conference, which will be held at the Mission Inn in Riverside, on April 16-18, 2014. The conference is sponsored by the California Department of Public Health and CCLHO. More information to come.

The Mission Inn

Detection of the Yellow Fever Mosquito in California by Gil Chavez, M.D., M.P.H.

The yellow fever mosquito, *Aedes aegypti*, has been detected in three California counties in 2013, including Madera (June 7), Fresno (June 20), and San Mateo (August 22). Currently all detected infestations are limited to less than three square miles in each county. The yellow fever mosquito has the potential to transmit several viruses, including dengue, yellow fever, and chikungunya. These viruses are not endemic to California. *Aedes aegypti* is an aggressive day-biting mosquito, has a broad distribution worldwide, and is currently found in the southeastern United States and Arizona. It has not been detected in California since 1979 when one mosquito was found near the San Francisco airport.

Aedes aegypti has adapted to live in close proximity to humans and develops in small containers that can hold water. Female adults lay desiccation-resistant eggs just above the water line, and larvae hatch when flooded. Potential breeding containers include potted plant saucers, bird baths, tires, and buckets, and many backyards provide suitable microhabitat for mosquito development. Additionally, *Aedes aegypti* can be collected from cemeteries located within residential neighborhoods

due to permanent vases and other items that can collect water from rains or sprinklers.

The California Department of Public Health (CDPH) is working closely with affected local vector control agencies and health departments to respond to the infestations. Response activities have included issuance of press releases, development and distribution of public education materials, enhanced mosquito surveillance, and intensive control efforts targeting both immature and adult mosquitoes. The overall objective of these measures is eradication of this invasive species.

Dengue is reportable under Title 17 of the California Code of Regulations and cases must meet both laboratory and clinical criteria to be considered either probable or confirmed cases. From January 2010 through September 2013, 173 human cases of dengue have been reported to CDPH from 32 counties. To date, all dengue cases reported to CDPH have a travel history to an area considered endemic for dengue. Southeast Asia, Latin America, the Caribbean, and India are the most commonly reported travel regions, with India, the Philippines, Thailand, and Mexico being the most frequented countries. Counties with the highest number of imported dengue cases include Santa Clara (25), San Diego (24), Alameda (16), Orange (14), and San Mateo (12).

The risk of local dengue transmission in California is very low. CDPH has enhanced its surveillance for potential dengue cases and is requesting that any suspect dengue case without a travel history to an endemic area in the two weeks prior to symptom onset be reported to CDPH immediately.

For more information regarding dengue, contact Charsey Cole Porse, PhD, MPH, Vector-Borne Disease Section, CDPH, at charsey.porse@cdph.ca.gov.

Dr. Chavez is the Deputy Director of the Center for Infectious Diseases at CDPH.

CCLHO Strategic Plan in Development

The 2013-2018 CCLHO Strategic Plan has been completed. The Plan, developed by the CCLHO Officers, Board Members and affiliates, includes a vision, mission, values, guiding principles, strategic goals, and tracks of work.

Vision:
Healthy People in Health Communities

Mission:
To ensure that the expertise and leadership of California physician health officers strengthen and shape the practice and structure of public health to protect and promote the health and well-being of people and communities.

Values:
Equity, collaboration, professionalism, humility, learning

Guiding Principles:

- Uphold the 10 essential public health services.
- Expand public health practice through leadership and innovation.
- Exemplify agility and flexibility in responding to new opportunities.
- Respect the diversity of partnerships and populations served.
- Focus strategies as far upstream as possible across the full spectrum of prevention.
- Employ evidence-based and scientific principles.
- Demonstrate fiscal responsibility in all activities.

Strategic Goals:

- Provide advice and scientific expertise to CDPH, affiliates, and key stakeholders on public health matters.
- Take a leadership role in the practice of public health and policy development.
- Advance core public health functions in local, state, and federal public health jurisdictions.
- Sustain and further develop CCLHO as an innovative and high-performing organization [CDPH Strategic Goal E].
- Promote and protect health and well-being through focus on targeted outcome for all people in California's diverse communities.

Tracks of Work:

- Value of public health
- Policy and priorities
- Internal and external relationships
- Leadership development
- Core public health functions

The final CCLHO Strategic Plan document will be disseminated at the December CCHLO board meeting.

Passing the Torch

Dr. Muntu Davis has been elected the new president of the CCLHO. Dr. Davis is currently the Director and Public Health Officer for the Alameda County Public Health Department (ACPHD). He is the lead physician on the pandemic influenza response planning.

Prior to working at the ACPHD, he worked with the California Department of Health Services on pandemic influenza planning. His other areas of interest include ways to improve the use of television news, newspapers, and education-entertainment to promote health and health policy changes. He joined the ACPHD in October 2005. Prior to working for the Public Health Department, he practiced medicine in urban and rural primary care and urgent care clinics in Northern and Southern California.

Dr. Davis is board certified in Family Medicine. He received his medical degree from the University of California, Los Angeles and completed a residency in Family Medicine at Presbyterian Intercommunity Hospital in Whittier, California. He completed The California Endowment Scholars in Health Policy Fellowship and received his Master of Public Health from Harvard School of Public Health in Boston, Massachusetts, where he analyzed policies regarding emergency response planning, implementation, evaluation and modification at the county level in California.

Dr. Davis is replacing outgoing president, Dr. Wilma Wooten, the Public Health Officer for San Diego County. A special thanks to Dr. Wooten for all her hard work.

CCLHO *NEWS*

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If you have any questions or comments, note any written errors of discrepancies, or want to add information for the next newsletter, please e-mail: roberta.lawson@cdph.ca.gov.