Moving Toward Public Health Equity in Connecticut

Presented by the
Governor's Council for
Local Public Health Regionalization

Submitted to Governor Rell and the General Assembly
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Prepared by the Department of Public Health

I. Introduction

On May 12, 2009, Governor M. Jodi Rell signed Executive Order No. 26, creating the Governor's Council for Local Public Health Regionalization (Appendix A). The Council was charged to advise the Governor and provide recommendations for defining the local public health infrastructure with the goal of public health regionalization. Members of the Council included representatives from local public health (Directors of Health and Boards of Health), municipalities, and State agencies (Department of Public Health and Office of Policy and Management). A list of members is provided in Appendix B.

Council members met nine times July through December 2009. Meetings were two hours in length and included time to receive public comment. Three to seven members of the public attended each meeting, many of whom provided written and verbal comments to the Council.

Council members reviewed the current public health infrastructure and analyzed information from a number of sources, including efforts in other states to enhance the quality and equity of public health services. Much of this information has been included in the Appendices for reference.

This report represents the Council's recommendations to the Governor and General Assembly. It includes a description of the current public health system in the State, an analysis of data collected, and governing principles to guide future changes to the system.

II. Current Public Health System

A. Infrastructure

The Department of Public Health is mandated by the Connecticut legislature as the lead agency for statewide health planning activities. Responsibility for overall protection of the public's health rests with the Commissioner of Public Health. Directors of Local Health are assigned agents of the Commissioner. Connecticut General Statute, Title 19, Chapter 368a, Section 19a-2a provides the scope and authority, and describes the powers and duties of the Commissioner regarding local health departments and districts (Appendix C). The Department oversees and coordinates a complex network of public health services providing advocacy, training, certification, technical assistance and specialty services to the local level.

There are currently 80 local health departments and districts in the state[1]. Of these, 32 are full-time municipal health departments, 20 are full-time health districts (health departments that serve multiple towns), and 28 are part-time health departments. Full-time departments/districts provide services to 93% of the State's residents.

[1] See Appendix D for map of Connecticut's Local Health Departments and Districts as of July 2009.

- The full-time municipal health departments serve a population ranging from 14,100 to 136,695 representing 48% of the population (see Table 1 in Appendix H).
- Each full-time health district represents two to nineteen municipalities, and serves a population ranging from 28,737 to 162,733. Health departments of the tribal nations are located within the geographic confines of two districts. In total, the districts provide services to 45% of the population.
- The remaining 28 departments are considered part-time because the Director of Health and oftentimes the additional staff are employed less than 35 hours/week. Part-time departments serve a combined total population of 225,000 (or 7% of the State's residents).

Local health districts provide an example of successful regionalization in Connecticut (see Appendix E). Among the key elements in current health district statutes that make regionalization of public health services work include:

- Participation by towns in a health district is voluntary;
- Communities are allowed to cluster in ways that meet their needs and local relationships;
- Historical relationships between and among towns that join the district are acknowledged and respected; and
- Health districts recognize the existing legal authority of local town health departments (town ordinances, codes, etc.) and accommodate this in their planning and functions. Sometimes legal authority remains with the town; other times it is transferred to the district by mutual consent.

A key to the voluntary formation, and subsequent function, of these districts is their governing boards of health made up of representatives appointed to three-year terms by the member towns. In this way the town's needs and perspective is maintained and provided.

Local health departments are further organized into 41 Mass Dispensing Areas for purposes of distributing medications or vaccine to the public during a public health emergency. These areas serve 1 to 3 multiples of 50,000 residents and each having at least one point of dispensing. One full-time local health department is the planning and operational lead for each Area.

In addition, the Department of Emergency Management and Homeland Security organized the State into 5 planning and operational regions. State and local public health operate within this regional structure for purposes of all-hazards emergency preparedness planning.

B. Public Health Functions and Services

1. State Mandated Services

State and local public health have a broad scope of regulations and mandated services that must be delivered. Connecticut General Statues govern the scope of mandated services in conjunction with local ordinances and health district regulations. Public Health Code 19a-76-2 outlines the basic services and options for the provision of local health department services (Appendix F). The provision may include providing services directly, contracting with another health department or community agency, or coordinating with other community or regional resources for services. State mandated public health services include:

(1) Public Health Statistics
(2) Health Education
(3) Nutritional Services
(4) Maternal and Child Health
(5) Disease Control
(6) Environmental Services
(7) Community Nursing Services
(8) Emergency Medical Services

In addition, local health departments/districts have legal authority to levy fines and penalties for public health code violations, grant and rescind license permits (such as for food services establishments and septic systems); and carry out activities to improve the health of people in their jurisdictions.

While the Department of Public Health monitors the provision of services by local health departments and districts, Connecticut does not apply a uniform, comprehensive measure of performance for State and local public health.

2. National Performance Standards

On the national front, the Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994. This steering committee included representatives from US Public Health Service agencies and other major public health organizations. The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems (see Appendix G for Essential Services and examples of performance standards).

The National Public Health Performance Standards Program (NPHPSP) is a collaborative effort to enhance the Nation's public health systems. Seven national public health organizations have partnered to develop national performance standards for State, governance and local public health systems.

The mission and goals of the NPHPSP are to improve the quality of public health practice and the performance of public health systems by:

1. Providing performance standards for public health systems,

2. Improving quality and accountability of public health practice,
3. Conducting systematic collection and analysis of performance data, and
4. Developing a science-base for public health practice improvement.

The NPHPSP is a collaborative effort of national partners representing the organizations and individuals that will use the performance standards:

- Centers for Disease Control and Prevention, Office of the Chief of Public Health Practice (CDC/OCPHP),
- American Public Health Association (APHA),
- Association of State and Territorial Health Officials (ASTHO),
- National Association of County and City Health Officials (NACCHO),
- National Association of Local Boards of Health (NALBOH),
- National Network of Public Health Institutes (NNPHI), and
- Public Health Foundation (PHF).

C. Financial Support for Public Health

As part of the State Fiscal Year 2008 Annual Report completed by the Local Health Administration Branch of the State Department of Public Health, local health departments and districts submitted information regarding the sources of funding for their operations. Along with the total amount of revenues received in fiscal year 2007-08, departments and districts were also asked to provide the amounts received in the following categories: Federal Funds; State Funds; Local Funds and Health Department Revenues (see Appendix H).

One caution with respect to information is that it is self-reported and is not standardized across all departments and districts. One example is that district revenues are likely to cover all the costs of the districts, including employee benefits and other overhead costs, while this is not the case for many full- and part-time municipal departments. Nonetheless, the revenue information reported should give a good sense of how local health departments and districts are funded.

Generally, it is small to mid-size suburban communities and larger urbanized communities that operate their own health departments with a full-time director. As a group, indicated in Table 1, municipal departments get over half of their revenues from municipal appropriations and departmental fees and charges. Many municipal departments received significant amounts of categorical grants from the State and Federal Governments to fund particular services or programs. These included programs related to AIDS prevention and treatment, immunizations, childhood lead poisoning and prevention, preventive health programs, STD prevention and other programs. When these categorical grants are excluded, revenues are more comparable to the full-time districts.

In terms of local funding, the average amount for health districts was $10.67 per capita. This is only slightly higher than the $9.90 average for the part-time departments as a whole, despite districts overall revenues being $5.00 more per capita than municipal departments with part-time directors. As mentioned, district budgets are likely more inclusive than most of the budgets for the full-time municipal departments because certain costs, such as employee benefits, may be handled as an administrative cost of the municipality.

Almost all of the revenues for municipal health departments having part-time directors are comprised of local municipal appropriations or local charges and fees. There are no reported Federal Funds for these departments, with the State Funds appearing to only involve the State $.49 per capita grant provided to eligible departments. Among the 25 towns providing revenue information, more than one-half reported total revenues of less than $3.50 per capita, which means that a small or modest amount of resources are provided for local health department activities. Meanwhile, nine towns had per capita revenues of $10 or more.

Table 1: Average Per Capita Funding to Local Public Health, SFY 2008[2]

Type of Local Health Department	State Per Capita[3]	Local Per Capita[4]	Federal Per Capita[5]	Total Per Capita
Municipal Departments	$10.02	$25.55	$11.24	$46.81
Municipal Departments Adjusted[6]	$3.89	$14.05	$0.16	$18.11
Health Districts	$3.92	$10.67	$0.62	$15.21
Part-Time Departments	$0.29	$9.90	$0.00	$10.19

[2] State Fiscal Year 2008 Annual Report completed by the Local Health Administration Branch of the Department of Public Health.

[3] State Funds involve grant funds, some of which are categorical to fund specific services, while others, like the State per capita grant provided to eligible departments and districts, are for general use in funding district and department operations and services.

[4] Local funds generally are appropriations from municipal general funds and tax dollars (including payments from member municipalities in the case of health districts). Also included are local department revenues typically involving charges and fees to individuals and entities for a service or permit. One example would be a fee related to restaurant license issued by a local health department or district.

[5] Federal Funds largely involve grant funds of a categorical nature categorical to fund specific services.

[6] Adjusted figures exclude Danbury, East Hartford, Fairfield, Hartford, Meriden, New Haven, Norwalk, Stamford and Waterbury. Note: Hartford's revenues reflect some non-public health activities (e.g., Parks and Recreation); Hartford and New Haven provide some AIDS-related services to other municipalities in their regions.

Connecticut is ranked 33rd in the country for State funding of public health[7] and funding has not kept pace with inflation or changing demands. Over the last 12 years State per capita funding averaged $1.09 for full-time municipal health departments, $0.48 for certain part-time municipal departments, and $1.95 for larger health districts (see Table 2 below). Cuts implemented during the 2009 legislative session resulted in a reduction to health districts and an elimination of funding for all part-time departments, districts serving less than 3 municipalities, and full-time municipal departments serving a population less than 50,000.

Table 2: State Per Capita Funding for Local Health Departments/Districts

State Fiscal Year	Full-time Municipal Health Department	District – Populations less than 5,000	District – Populations more than 5,000	Part-time Municipal Health Department
SFY 1998	$0.52	$1.78	$1.52	None
SFY 1999	$1.02	$2.09	$1.79	$0.53
SFY 2000	$1.02	$2.09	$1.79	$0.53
SFY 2001	$1.13	$2.32	$1.99	$0.59
SFY 2002	$1.13	$2.32	$1.99	$0.59
SFY 2003	$0.94	$1.94	$1.66	$0.59
SFY 2004	$0.94	$1.94	$1.66	$0.49
SFY 2005	$0.94	$1.94	$1.66	$0.49
SFY 2006	$0.94	$1.94	$1.66	$0.49
SFY 2007	$0.94	$1.94	$1.66	$0.49
SFY 2008	$1.18	$2.43	$2.08	$0.49
SFY 2009	$1.18	$2.43	$2.08	$0.49
SFY 2010	$1.18	$1.85	$1.85	Not Eligible
Average	$1.09	$2.25	$1.95	$0.48

D. Connecticut's Public Health Workforce

According to the National Association of County and City Health Officials (NACCHO) Profile of Local Health Departments (2005) approximately 20 percent of the local public health workforce will be eligible for retirement in 2010. In the next few years, Connecticut may experience loss of many local health directors who are at or near retirement age. This means local health departments face a potential loss of leadership as workers just developing the skills they need to be effective replace experienced workers who are able to shoulder the increased demands.

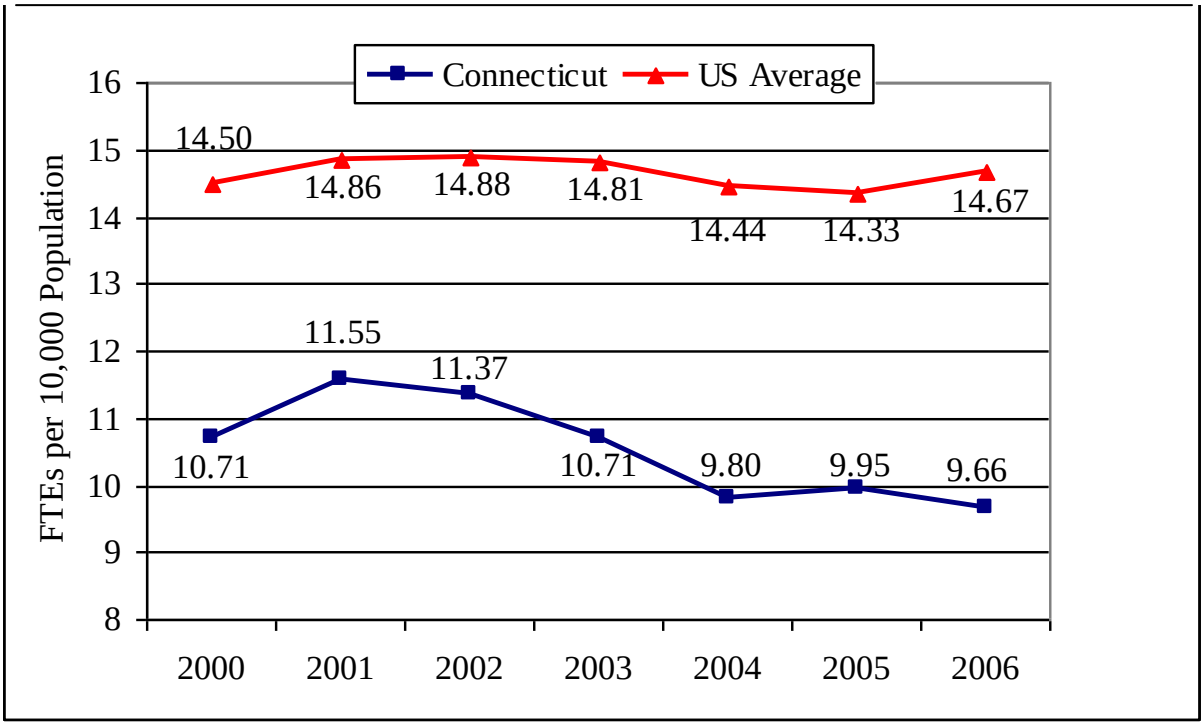
The workforce decline is due to several factors, including an insufficient number of workers in highly skilled occupational categories, aging of the workforce resulting in loss of talent through retirement, inadequate replacements in the pipeline, insufficiently prepared workers, and new skills and expectations as a result of 9/11 and other emerging public health issues.[8] Areas encountering shortages include

[7] Trust for America's Health, State Health Data, 2009.
[8] Miner and Richter, Public Health Reports, 2008 Supp. 2; Gebbie and Turnock, Health Affairs, July/August 2006.

public health nurses and physicians, epidemiologists, laboratory scientists and technicians, planners and public health leaders.[9]

Figure 1 below compares Connecticut to the nation for the number of public health workers per 10,000 population. Connecticut's workforce is less than the national average and has witnessed a continued decline since 2003. Connecticut is ranked in the bottom third of states based on its ratio of workers to population.

Figure 1: State and Local Health Full-Time Equivalents Per 10,000 Population



E. Assessments of Connecticut's Public Health System

1. Center for Public Health Policy, University of Connecticut

"Compared to other states, Connecticut places a particularly low priority on prevention. State per capita spending on population health interventions (including prevention of epidemics, protection against environmental hazards, injury prevention, promotion of disease control, encouragement of health lifestyles, disaster preparation, disaster response and health infrastructure) ranks 44th in the country." (Center for Public Health and Health Policy at the University of Connecticut, June 2008)

[9] ASTHO Survey, 2007; Institute of Medicine Report Brief, June 2007.

2. University of Washington and Public Health Foundation

Connecticut's State Public Health performance management profile (2002), where 94% (n=47) of states participated in a national survey comparing and contrasting characteristics noted that Connecticut was[10]:

- One of 21 or 45% of the states with a decentralized structure (i.e., local public health services are provided through agencies that are organized and operated by units of local government).
- One of 11 or 5% of the states with an estimated proportion of less than 25% of public health budgets for most local public health agencies that are provided or administered by the state health agency.
- One of 20 or 43% of the state health agencies with performance management efforts for categorical programs only (e.g., Maternal and Child Health [MCH], STD/HIV, nutrition).

3. Legislative Program Review and Investigation Committee

In December 2004, the Legislative Program Review and Investigation Committee (LPRIC) completed an analysis and submitted recommendations related to "Preparedness for Public Health Emergencies". The study assessed the status of public health preparedness planning and capacity building at that time. The report concluded that municipalities employing a part-time Director of Health did not have the capacity to respond to public health emergencies[11].

To address this finding of the report, the Department of Public Health developed the "Transition Program" in March 2005. This program provided funds to municipalities with part-time health departments to increase public health services and emergency response capabilities by joining an existing health district, or by forming a new health district with other municipalities. Nineteen of the 47 municipalities with part-time local health services have expanded to full-time operations as a result of the Transition Program (2009).

4. State Public Health System Performance Assessment

In June 2008, Connecticut became the 24th state in the nation to participate in the National Public Health Performance Standards Program (NPHPSP) program. To address growing concerns about an eroding public health infrastructure as well as the need to improve the quality of services and efficient use of resources[12], state and local health departments around the nation have embraced the development

[10] *Turning Point Performance Management Collaborative Survey on Performance Management Practices in States* (2002, February). University of Washington and the Public Health Foundation.
[11] *Legislative Program Review and Investigations Committee Preparedness for Public Health Emergencies Report (*2004). Full report available at http://www.cga.ct.gov/2004/pridata/Studies/Public_Health_Prep_Final_Report.htm
[12] Institute of Medicine (1988*). The Future of Public Health* and (2003a) *The Future of Public's Health in the Twenty-first Century*

and use of national public health performance standards.

One of the key findings that emerged from Connecticut's assessment was the current "system" continues to be "fragmented, with public health activities largely taking place in categorical silos"[13]. Further, Connecticut's overall score for activity levels in each of the Essential Public Health Service areas was 46 out of 100, representing a moderate level of activity. Table 3 below lists the consolidated score for each of the ten service areas. The range of scores is from a high of 68 for Diagnose and Investigate to a low of 35 for Evaluate Effectiveness.

Table 3: Summary of Performance Scores by Essential Public Health Service

Essential Public Health Services		Score
1	Monitor Health Status to Identify Community Health Problems	49
2	Diagnose and Investigate Health Problems and Health Hazards	68
3	Inform, Educate, and Empower People about Health Issues	46
4	Mobilize Community Partnerships to Identify and Solve Health Problems	38
5	Develop Policies and Plans that Support Individual and Community Health Efforts	51
6	Enforce Laws and Regulations that Protect Health and Ensure Safety	44
7	Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	37
8	Assure a Competent Public and Personal Health Care Workforce	55
9	Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	35
10	Research for New Insights and Innovative Solutions to Health Problems	37
Overall Performance Score		**46**

5. Local Health Self-Assessments[14]

Six Connecticut local health departments/districts completed self-assessments based on the Operational Definition of a Functional Local Health Department. Two medium-sized districts, two large-sized districts, one small-sized district, and one small full-time municipal department completed the self-assessments in 2007 and 2008. All participants scored high in functions #6, *enforce public health laws and regulations*, and #2, *protect people from health problems and hazards*. All health departments scored over 60% on function #3, *give people information they need to make healthy choices*, and 5 scored over 60% on #8, *maintain a competent public health workforce*. Four out of six participants scored lower than 60% on #1, *monitor health status and understand health issues facing the community* and on

[13] Traugh, K. (2008, October). *From Silos to Systems Assessing Connecticut's State Public Health System*. National Public Health Performance State Assessment. (p. 10).
[14] *Explanation of Self-Assessment Data*, courtesy of Connecticut Association of Directors of Health.

#4, *engage the community to identify and solve health problems*. Five of the six scored lower than 60% on #10, *contribute to and apply the evidence base of public health*. Function #5, *develop health policies and plans*, was a weaker area for five of the six participants.

6. Trust for America's Health (TFAH)[15]

Researchers found that if the country reduced type 2 diabetes and high blood pressure rates by 5 percent the country could save more than $5 billion in health care costs; reducing heart disease, kidney disease, and stroke prevalence by 5 percent could raise savings to $19 billion; and 2.5 percent reductions in the prevalence of some forms of cancer, chronic obstructive pulmonary disease and arthritis savings could increase to more than $21 billion. TFAH concluded that an investment of $10 per person per year in proven community-based disease prevention programs could yield net savings of more than $2.8 billion annually in health care costs in one to 2 years, more than $16 billion annually within 5 years, and nearly $18 billion annually in 10 to 20 years (in 2004 dollars). The country could recoup nearly $1 over and above the cost of the program for every $1 invested in the first one to 2 years of these programs, a return on investment (ROI) of 0.96. Projected savings in Connecticut are presented in Table 4.

Table 4: Costs and Savings to Connecticut Based on Investment of $10/Person

Connecticut			
Total Annual Intervention Costs (at $10 per person): $34,940,000			
Connecticut Return on Investment of $10 Per Person			
	1-2 Years	**5 Years**	**10-20 Years**
Total State Savings	$79,100,000	$266,400,000	$292,500,000
State Net Savings (Net savings = Total savings minus intervention costs)	$44,100,000	$231,500,000	$257,600,000
ROI for State	1.26:1	6.63:1	7.37:1
* *In 2004 dollars*			
Indicative Estimates of State-level Savings by Payer: Proportion of Net Savings for an Investment of $10 Per Person			
	1-2 Years	**5 Years**	**10-20 Years**
Medicare Net Savings (proportion of net savings)	$11,900,000	$62,500,000	$69,500,000
Medicaid Net Savings (federal share) (proportion of net savings)	$2,140,000	$11,200,000	$12,400,000
Medicaid Net Savings (state share) (proportion of net savings)	$2,140,000	$11,200,000	$12,400,000
Private Payer and Out of Pocket Net Savings (proportion of net savings)	$27,900,000	$146,500,000	$163,000,000
* *In 2004 dollars* * *Source: TFAH calculations from preliminary Urban Institute estimates, based on national parameters applied to state spending data.*			

[15] Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities, Trust for America's Health, February 2009; A Compendium of Proven Community-Based Prevention Programs, The New York Academy of Medicine, September 2009.

III. Findings

1. Overall, Connecticut's local health departments/districts are made up of highly dedicated professionals struggling to provide quality public health services to their communities with very limited resources.
2. Connecticut's local public health departments/districts vary significantly with respect to geographic area covered, population served, overall budget, number of staff, staffing expertise, overall capability, and programs and services provided.
3. Lack of a commonly recognized identity, scarce resources, structural and organizational challenges and workforce issues make it difficult for local health departments/districts in Connecticut to provide the public health protections that Connecticut residents deserve.
4. The current State and local public health system is fractured and services have to be pieced together to reach underserved areas.
5. Part-time health departments lack the resources to provide a full array of public health services, which sometimes results in costs being shifted to other public health entities.
6. Municipalities provide the majority of financial support to local public health. However, the amount of municipal support and the fees charged for public health services vary widely across the State.
7. Joining a district may be more cost effective, but not necessarily less expensive for municipalities that want to enhance or expand their public health services. For other municipalities, joining a district may be a cost effective way of providing their current or higher level of service.
8. Connecticut's financial contribution for local public health ranks well below the national average.
9. Recent legislation eliminated State per capita funding for health districts serving fewer than three municipalities or serving a population of less than 50,000. Per capita funding was reduced for all other districts. This decrease in funding is likely to reduce the incentive for new districts to form and for existing districts to take on additional municipalities. Recent legislation also eliminated State per capita funding for all part-time health departments and full-time municipal departments serving a population less than 50,000. In 2008, 98% of State residents lived in areas that received State per capita support for public health services. Under recent legislation, only 78% of State residents live in areas receiving State per capita support, a decrease of 20%.
10. Lack of consistency and stability in State per capita funding makes delivery of public health services difficult, regardless of whether services are being provided by a municipal department or health district.
11. Qualifications for Directors of Health are different between districts and full-time municipal health departments.

12. State mandates are broad and in the absence of performance measures, there is no State or local accountability for the provision of public health services and they are not uniformly available to residents across the state. The statutorily mandated functions are antiquated and do not align with the services of contemporary public health practice and nationally recognized standards.
13. It is likely Connecticut will face a public health workforce shortage in the near future. Without adequate training and qualified staff replacements in the pipeline, the quality of public health services provided will suffer regardless of infrastructure changes.

IV. Recommendations

A. Governing Principles

The following principles were agreed upon by Council members early on in the process and have served as a guide in developing recommendations.

- All residents of the State of Connecticut will receive equal access to basic, comprehensive and competent public health services.
- The nationally recognized Ten Essential Public Health Services will be the standard by which State and local public health services are measured.
- The structure for State funding of public health will be designed to promote equity, performance and an economy of scale.
- Investment in disease prevention and health promotion through State funding can offer a return on investment, potential savings related to health care costs, and improved health outcomes for State residents.

B. Suggested Changes

1. By February 1, 2010, the Commissioner of Public Health will create a Local Public Health Council (the Council) for the purpose of designing a more equitable and effective means of delivering public health services, eliminating cost shifting between municipalities, and meeting nationally recognized performance standards.
    a. Members of the Council will be appointed by the Commissioner and will include the following representatives: local Directors of Health, Connecticut Association of Directors of Health, Boards of Health, State Department of Public Health, Office of Policy and Management, Connecticut Conference of Municipalities, Connecticut Council of Small Towns, and other appropriate stakeholders.
    b. By September 1, 2010, the Council will recommend to the Governor, Commissioner of Public Health, and legislative committees of cognizance the core local public health services, the standards by which such services

will be measured, and the review process for determining whether local health departments and districts have met these standards. The Council will give consideration to nationally recognized standards, such as those being developed by the Public Health Accreditation Board. The Council will also recommend accountability measures for local health departments/districts not meeting performance standards, including remedial actions.

c. By September 1, 2010, the Council will recommend a tiered State per capita grant structure that would promote equity, performance and an economy of scale (regionalism, larger districts) for implementation by July 2011. The first tier would consist of a base grant for all full-time departments and districts, regardless of population size. The base grant would be greater for health districts than for full-time municipal departments to encourage the continued formation of districts. The second tier would be a higher per capita grant for those full-time departments and districts that can demonstrate the ability to provide the 10 essential services in accordance with performance standards recommended by the Council. The State Department of Public Health would maintain oversight of the grant administration process.

d. By September 1, 2011, the Council will demonstrate the viability of and recommend a strategy for continuing the transition of local public health to larger districts. The goal will be to reduce the number of health departments and districts by 2014.

e. By July 1, 2014, in order to receive State per capita funding, every municipal health department must join a health district that has been designated as meeting the performance standards. Any municipal health department may opt out from joining a health district by demonstrating they are able to meet the performance standards on their own. A municipal health department may also form a new health district and will have two years to demonstrate that they can meet the performance standards.

f. On or after July 1, 2014, the base grant (first tier) and higher per capita grant linked to performance measures (second tier) will be combined into one grant. The combined grant would be allocated to those full-time health departments and districts that meet the established performance standards.

2. Health departments and districts may chose to enter into written Mutual Aid Agreements with surrounding health departments/districts or other public health providers that would provide resources and services as a method of achieving the established performance standards.

3. Part-time health departments that meet the established performance standards will be eligible for State per capita funding. By September 1, 2011, the Council will recommend a funding structure for part-time health departments that by 2014 meet the standards. Some members of this Council question whether part-time health departments will be able to effectively or efficiently meet the established performance standards.

4. Modify Connecticut General Statutes 19a-200 for Municipal Health Departments as follows:

   … “such director of health shall either

   - be a licensed physician, or
   - hold a graduate degree in public health from an accredited school, college or institution.

   Existing Directors of Health would be grandfathered in their current positions. An existing Director of Health who would be moving to another health department or district would need to meet the new requirements.

5. Modify Connecticut General Statutes 19a-244 for Health Districts as follows:

   … “The director of health shall either

   - be a licensed physician and hold a degree in public health from an accredited school, college or institution, or
   - hold a graduate degree in public health from an accredited school, college or institution.

   Existing Directors of Health would be grandfathered in their current positions. An existing Director of Health who would be moving to another health department or district would need to meet the new requirements.