State of Connecticut

State Innovation Model
Population Health Council

Meeting Summary
July 28, 2016

Meeting Location: Northend Senior Center, 80 Coventry Street, Hartford, CT 06112

Members Present: Lisa Honigfeld, Carolyn Salsgiver, Martha Page, Patricia Baker, Penny Ross, Steven Huleatt, Susan Walkama, Tekisha Dawn Everette, Vincent Tufo, Garth Graham, Hugh Penney, Hyacinth Yennie

Members Participated via Teleconference: Madeline Biondolillo, Frederick Browne, Elizabeth Torres, Tamim Ahmed, Hayley Skinner

Members Absent: Nancy Cowser, Kate McEvoy

Other attendees: Kristin Sullivan, Mario Garcia, Joan Ascheim, Rose Swensen, Kelly Vaughan, Susan Walker, Faina Dookh, Geralynn McGee, Fran Dantos, Anitha Nair

Call to Order
Co-Chair Steven Huleatt called the meeting to order at 3:07 p.m. It was determined a quorum was present.

Review and approval of Meeting Summary
Co-Chair Steven Huleatt asked for a motion to approve the minutes of the June 30, 2016 Population Health Council meeting, moved by Hyacinth Yennie, second by Pat Baker. The meeting summary was approved.

Public Comment: There were no public comments

Meeting purpose:

The Population Health Council met to discuss key aspects related to innovative community based prevention and how it relates to the State Innovation Plan. The meeting began with a presentation about current concepts of community prevention. The goal of the presentation was to begin drafting elements of a Connecticut designed model of Prevention Service Centers as proposed in the State Innovation Plan.

Prevention Concepts:

In the introduction, Dr. Garcia discussed current issues, challenges and solutions that the SIM project needs to address. He said that it is important for council members to recognize there exists a systemic divide between health care (disease care) and public health (health protection). This is important for designing strategies that bridge such division allowing patient interventions that are synergistic between clinical and prevention activities. Then, Dr. Garcia discussed how *community activation* and *community integration* are two distinct efforts that need to occur concurrently when implementing population health initiatives and linking clinical and community settings. Community activation generally refers to the direct involvement of community leaders and other individual members in promoting participation in and sustainability of community based interventions for prevention. Community integration describes whether functional networks of health and human services agencies effectively operate health promotion and disease prevention programs. Dr. Garcia went on to point out that although prevention interventions are generally characterized as primary, secondary and tertiary, they are actually multidimensional. Clinical and community-wide prevention are two dimensions of primary prevention, which will be the focus of population health planning.

Clinical preventive services are typically screenings, counseling services, and preventive medications. The U.S. Preventive Services Task Force (USPSTF) issues recommendations on evidence-based clinical prevention interventions. Members of the USPSTF are from the fields of preventive medicine and primary care, including internal medicine, family medicine, pediatrics, behavioral health, obstetrics and gynecology, and nursing. Their recommendations apply only to people who have no signs or symptoms of a specific disease or condition under evaluation, and their recommendations address only services offered in the primary care setting or services referred by a primary care clinician. In contrast, the CDC Guide to *Community Preventive Services* urges public health partners and their constituencies to adopt community prevention recommendations and include them in their strategies and programs outside of the clinical setting. Interventions for community-based prevention are systematically reviewed by development teams and CDC staff. These teams include topic area experts, a task force member, a liaison, an economist, and one or more research fellows. With the assistance of consultants, the review group develops a logic model, conducts data collection and analysis, and submit recommendations.

The *three buckets of prevention model* better explains the clinical and community spectrum. This model is an effort to characterize differences and potential synergies between clinical and community based primary prevention. In the first bucket there are things like flu vaccines, colonoscopies and screenings for tobacco and obesity, which are examples of traditional clinical prevention. Typically these interventions are conducted in a clinical setting and make part of a reimbursement system that is based on evidence of efficacy, health improvement and cost-effectiveness. Insures may provide financial incentives; and along with providers, structure a system of monitoring compliance and quality assurance. Public health practitioners may participate developing stronger evidence and advancing social marketing strategies. A second bucket of prevention refers to innovative clinical prevention interventions that are conducted

outside of the clinical setting and may work in a relatively short time. Although they are patient-focused and of clinical nature, payers historically do not reimburse them. Home based approaches, educational counseling and community-based behavioral change programs are good examples. The utilization of community health workers in some of these interventions provides an opportunity for innovations. The CDC 6-18 initiative was introduced to implement these type of innovative approaches and accelerate putting evidence into action. Adopting the 6-18 initiative will put emphasis on areas such as diabetes, asthma and hypertension where community and evidence based strategies are clearly recognized. Lastly, grouped in the third bucket are community-wide prevention interventions designed to impact the total population. Regulations, tax disincentives, social marketing and housing policies are examples of this dimension of prevention. The goal is to target entire population groups within geographic boundaries and with an expectation of longer term outcomes. Although the evidence is not always strong the correlation of results is persuasive enough. Although there are not reimbursement models fully tested, these interventions can be very attractive to payers and providers in large markets. Although providers are unfamiliar with these solutions, public health practitioners have experience promoting pilots and grant funded activities that may represent opportunities for value based designs.

Following this discussion, Dr. Garcia briefly reviewed once again the SIM Health Enhancement Community model. This time with the purpose to focus on the proposed Prevention Service Center concept within the model. The next steps in the Council deliberations will focus on the development of such model of prevention to articulate it with other reforms introduced by the SIM project.

The next section of the meeting introduced members of the council to illustrative examples of community based primary prevention from in state and outside of the state.

Case studies:

a. Camden

A video presentation of a Medicaid ACO from Camden, New Jersey illustrated community-based approaches to address social determinants of health of patients with complex healthcare needs and high utilization of the emergency department. This example emphasizes on how the provision of mental health and primary care as we know it is obsolete. It suggests that no medical intervention will ever succeed if key determinants such as stable housing are not solved first. The case demonstrated how utilization data and proper segmentation of target populations can aid in locating and in following high cost and high utilizer patients. Electronic medical records connectivity among providers proved key in setting targets and implementing care management plans. The case also described various incentive mechanisms that extend beyond providers to patients and community members to secure follow-up and appropriate referrals.

b. YMCA - DPPs

Ms. Kelly Vaughan presented the experience of the YMCA in CT of delivering a group-based lifestyle intervention program for the prevention of Diabetes. The YMCA partnered with multiple agencies, including health systems, health departments, advocate associations and the CDC and CMMI to conduct this program across many communities nationwide. As a national network, the YMCA is uniquely positioned to deliver this program as it is deeply embedded in rural, suburban and urban communities. The program has demonstrated that if all program goals are met, there is a meaningful risk reduction of developing diabetes type-2. Program data is based on individual patient biometric data collection which is kept in locally managed databases. Weight loss and reduced number of participants transitioning to diabetes type-2 are key evaluation indicators.

Following, Ms. Vaughan said that sustaining DPPs and enhancing their success is critical to create greater awareness about pre-diabetes through media campaigns, and to increase screening and education by medical providers. Although DPPs are not regularly reimbursed by insurers and most participants self-pay, these barriers will begin to fade as a new Medicare rule will allow payments as of January 2018.

c. CHDI – Children Developmental Delays

Ms. Lisa Honigfeld presented a case study by the Child Health and Development Institute (CHDI) for the prevention of developmental delays in children. The program is based on universal surveillance and screening associated with a system of referrals to early intervention services. The program metrics rely heavily on billing and surveillance data from early childhood programs such as Head Start, the providers' quality improvement programs and 211 Infoline for childhood referrals.

CHID ensures engagement of coordinated services by community and partners through its pediatric practice training program, the training of the staff of the Office of Early Childhood (Head Start, Home visiting programs), referrals by United Way 211 Child Development Infoline and Help Me Grow connecting children and families to follow-up services.

The program takes advantage of Medicaid and insurance payments for screening in primary care child health settings. Screening for early detection of developmental delays also uses state and federal funding from the Office of Early Childhood. In addition, PCMH practices have access to per member/per month rewards.

The implementation of these prevention programs has impacted both policy and delivery systems. Screenings have been introduced as a quality measure for PCMH's in both SIM and MQISSP and specific documentation of screening outcomes is required. Operationally, the program also promotes 211 Infoline as a single point of entry for follow-ups and offers alternatives such as Help Me Grow for children who do not qualify for Birth-to-Three programs. About two hundred practices (almost twice the number from 2009) reported over 46,000 developmental screenings in 2015.

CHID recommended considering future challenges such as tracking services and improving information sharing across various systems. More importantly, programs need to have the means to evaluate long-term savings related to outcomes across other sectors such as education.

Questions and Answers Session:

Q: Hyacinth Yennie – Why is the DPP not in the public schools?
A: Kelly Vaughn – DPP is offered to participants between the ages of 18 and older and so school-aged kids are not eligible. However, one of the goals is that the parents bring home to their children the information/education.
Q: Martha Page – Does the YMCA Program track low income population?
A: Kelly Vaughn – 11% currently
Q: Patricia Baker – Do you have data by race/ethnicity?
A: Kelly Vaughn - Yes
Q: Tekisha Everette – Is the data 50% of Connecticut population or 50% of people at risk?
A: Kelly Vaughn – "Rough estimate is 65% or 1/3 of population are pre-diabetic." Type 2 Diabetes is preventable.
Q: Tekisha Everette - Is the program building awareness of DPP?
A: Kelly Vaughn - Yes, the YMCA and its partners and also through the doctor's office. No medical provider I work with lets a patient go without making sure they have a written prescription with the information which refers that patient to our program. There is a good chance that the person will not call me until they hear about the program a few times.

Key Questions and Feedback: Dialogue

Ms. Rose Swensen asked the Council members to provide key questions/comments on ideas for fostering synergies, compatibilities among sectors, strategies for bridging differences and implications for our plan.

***Discussion*:**
Patricia Baker - Is the SIM focus big or specific to community prevention for affecting outcomes.
Co-chair Susan Walkama - How do we not only collaborate with programs, how do we include them in the financing models.
Penny Ross - School based centers to become PCMH, for example with reporting Asthma to DPH.
Carolyn Salsgiver - Collaboration with partnerships.
Co-chair Hyacinth Yennie - Not enough prevention information gets to the people, lack of time the doctor spends with the patient and no relationship is built between family and care providers.
Patricia Baker - Moving towards outcomes - controlling diabetes.

Hugh Penney - Need a strong enough, adequate primary care base. Doing a Pub Med search to review the structures.
Lisa Honigfeld - Extend primary care home to the community.
Co-chair Hyacinth Yennie - How to encourage more value based information - Consistency with providers.
Susan Walkama - How to develop/sustain financing model for large health systems.
Patricia Baker - How to capture the community with data.
Garth Graham - Connecting the variety of population, 3 or 4 towns are not captured in the program, population not connected is the biggest barrier, what's the target population.
Co-chair Hyacinth Yennie - Language barriers - it is important for us to get more information out to the public - providing services and information for people to get better educated - get the information to the schools which will then get to the parents.
Co-chair Steve Huleatt - Barriers to data - there is no communication between sets/groups collecting data - implication is to measure success of program implementation – it's going to cost money - data has to be in a meaningful way to tell a story and how do we put in the data to find the right questions.
Patricia Baker – How do you build on screening to deal with intervention - We screen the population for diabetes and 80% were pre-diabetic - then we can start building the interventions.
Hyacinth Yennie - Implications if population does not have the right information.
Martha Page - Dealing with population life circumstance disease, not always possible to change their environment. Broaden the connection with programs.
Rose Swensen - Broaden our definition of disease when defining solutions, are you taking about social determinants?
Marth Page - Group of diabetics and pre-diabetic, when you ask them about their concept of health, their perception of health is how much support do I have, certainly social determinants.
Susan Walkama - Community Outreach to understand resources - very under developed system - finding ways to communicate with different ethnic groups and races.
Kelly Vaughn - Native to our program is to address those issues, to help solve problems for different people and their circumstance.

Summary:

Following the three case studies, the Council members were urged to discuss ideas for fostering synergies and compatibilities among sectors, strategies to bridging differences and potential implications for the population health plan.

An open dialogue ensued among the Council members to address key questions for reflection on factors for success and challenges conducting community oriented prevention programs. The remarks focused on current supports of sustainable models for prevention and on possible solutions to overcome barriers for implementing prevention models more broadly.

a. Supports

Council members discussed the importance of school-based health centers and their role as an extension of the primary care network. This solution highlights the need to outreach to community settings and partnering with other sectors. School-based health clinics are critical in following up patients with chronic diseases who require basic supportive interventions which prevent overutilization of the health care system (typically the emergency department). Other examples of support systems are mostly implemented through grants and advocacy organizations and are linked to specific conditions such as asthma, led prevention and diabetes. Prevention has taken a front row in the last few years due to a flurry of activity by hospitals to reach out to community coalitions to develop community needs assessment plans. On occasions, these affiliations have become very strong, particularly in the process of conducting health assessments; but to a lesser degree, in the process of implementing improvement plans.

b. Barriers

Council members discussed barriers for a systematic approach to prevention from their various perspectives. The issue of appropriate reimbursement for evidence-based interventions emerged first. It was pointed out that reimbursements are asymmetric in addition to not being standardized by type of preventive interventions. That is the case of FQCHC's that receive only a portion of reimbursements made to PCMH's. The need for more emphasis on prevention in community health centers was also mentioned. In response, a Council member remarked about the limitations of provider-time for prevention. The issue of information was highlighted, particularly about the need to ensure that families are sufficiently informed. This elicited a discussion about weaknesses of data collection at the primary care level, which is especially deficient when it relates to social determinants that could potentially be addressed. This makes data analysis and appropriate referrals difficult to interpret and coordinate. The discussion emphasized that issues of data sharing are related not only to poor infrastructure but also to the absence of good health analytics. As a result, data is not actionable and opportunities to develop case narratives are missing. In cases where electronic health records are available, data collection is not always designed to capture the activities of community prevention or process for sharing among providers. Prevention is also limited by poor incentives to practice family medicine and by cultural and language barriers in an ever changing demographics.

c. Implications/Solutions

It was strongly suggested that community prevention interventions should be made part of the PCMH care model. That includes "structural" interventions for community prevention that research has proven to work. The discussion also included the need to incorporate evidence based prevention strategies in any new financial model/payment system. Council members advocated for the school systems to become part of the solutions for community-based prevention as a way to achieve universal screening in many interventions directed to children.

The council highlighted the importance of having a consistent source of data at the primary prevention level through the use of HIE/EMR. The sharing of information and impact measures would strengthen trust among community agencies. Finally, the discussion focused on the role of community health workers as agents of change in their own communities.

Co-chair Steve Huleatt addressed the members to end the session at this time.

Next Steps: Co-chair Susan Walkama stated that the next meeting will be held on September 22, 2016 and the agenda will be to continue discussion on data and to look at structural operational issues.

Co-chair Steve Huleatt adjourned the meeting at 5:00 p.m.