State of Connecticut

State Innovation Model
Population Health Council

Meeting Summary
September 22, 2016

Meeting Location: CT Behavioral Health, 500 Enterprise Drive, Rocky Hill, CT

Members Present: Tamim Ahmed, Patricia Baker, Madeline Biondolillo, Lisa Honigfeld, Steven Huleatt, Martha Page, Penny Ross, Carolyn Salsgiver, Susan Walkama, Hyacinth Yennie

Members Participated via Teleconference: Nancy Cowser, Tekisha Dwan Everette

Members Absent: Garth Graham, Kate McEvoy, Hugh Penney, Elizabeth Torres, Vincent Tufo,

Other attendees: Diane Aye, Supriyo Chatterjee, Faina Dookh, Mario Garcia, Geralynn McGee, Lloyd Mueller, Anitha Nair, Mark Schaefer, Rose Swensen, Kristin Sullivan (there was another women who did not sign in—do not know her name)

Call to Order: Co-Chair Susan Walkama called the meeting to order at 3:05 p.m. It was determined a quorum was present.

Meeting Goals: Co-Chair Susan Walkama introduced the meeting goals: The Population Health Council met to ensure a common understanding of population health within SIM work streams and the health reform environment, to gain updated knowledge about the CT health status, validate recommended priorities for Prevention Service Centers, and begin to develop approaches to community accountability measures.

Review and approval of Meeting Summary: Co-Chair Susan Walkama asked for a motion to approve the meeting summary of the July 28, 2016 Population Health Council meeting. The motion was moved by Hyacinth Yennie, second by Martha Page. The meeting summary was approved.

Public Comment: There were no public comments at this time.

Alignment: How do the SIM Work streams, CT SHIP and Work of Population Health Council interrelate?

Mario Garcia discussed the alignment map for SHIP and SIM and the flow of meeting topics and time-line. He indicated that in October the Council will hear more data from participants and

from the state, that in November the discussion will be about priority issues; and that by the end of December, the Council will be discussing a Model.

Dr. Garcia discussed the State Health Reform Context and indicated that DPH's State Health Improvement Plan and Healthy CT 2020 plays an important role in the health initiatives by providing updated information on the initiatives and other efforts going on throughout the state. He said that SIM's role is to intercept and coordinate with what is going on in the different states in creating these initiatives and policies to address more individuals. He went on to discuss that SHIP's contribution to these initiatives is to provide strategic data. He mentioned the participation and input of many different organizations in the SHIP Coalition Summit which took place on September 8, 2016.

Kristin Sullivan addressed the Council regarding SIM and said that the program has strategies related to community health and clinical wellness programs. She stated that SIM and SHIP focus on quality data and transparency and informed the Council of the existence of the data dashboard which show the work towards these efforts.

Faina Dookh presented the State Innovation Model's (SIM) alignment and prioritization strategy. Ms. Dookh indicated that SIM aims include healthier people, better care, health equity, and reduced cost. These aims are tracked by a dozen or so measures. SIM funding invests in primary and secondary drivers that will impact these aims and measures. CMMI feedback on SIM's latest Operational Plan emphasized prioritization, alignment and creating focus. Ms. Dookh described the draft alignment grid, which elevates five priority areas chosen from the list of measures, and lists how SIM drivers align around achieving them.

Marc Schaefer said that some of the initiatives designed and launched already set the target populations which we measure to implement and that the measures that align closely with these areas are looked at first.

Health Status: Key Indicators for the State

Anitha Nair presented the Connecticut State Innovation Model State Health Profile, Preliminary Findings report. She began by introducing the many things that affect our health, the population in Connecticut (CT) and its growth in the racial and ethnic minority population from 1980-2015, the poverty level in CT by Census tract and the percentage of population by educational attainment in CT's largest towns from 2014, CT's leading causes of death and the percentage of all deaths by age and race/ethnicity from 2013 and CT's specific populations by group.

The report indicates that CT ranked better than most top 10 states in preventive health behaviors; CT ranked better than most states with fewer health risks such as strokes, cardiovascular disease, obesity and cigarette smoking; and CT ranked worse than most states with more special equipment use, asthma and cancer. CT's At-Risk adult populations include

Hispanic/Latino ethnicity, non-Hispanic Black/African American; disabled, low household income (up to $35,000/yr.), no health insurance and have a high school degree or less.

Ms. Nair presented the maternal infant child health racial and ethnic disparities in CT from 2013; the percentage of non-Hispanic White teen births, unplanned pregnancy and infant death rate. The report showed the community environmental quality concerns such as indoor environment and outdoor environment. The report also shows that CT has many 'food deserts" and that 280,000 people live in food deserts.

Hyacinth Yennie – There is so much social services within these towns, how come we cannot capture those people? How do we fix that?
Susan Walkama – Are we tracking these questions?
Hyacinth Yennie – There are services provided in Hartford but lots of barriers, people do not know how to access these services. What we need to do more of to address these issues?
Martha Page – Too many people standing in line.
Nancy Cowser – No utilization, correlation, lack of coordination.
Steve Huleatt – Bring in more new people and you can capture New London/Norwich/New Haven/Meriden, where the providers are located.
Hyacith Yennie – Too much dysfunctional, the state needs to do a better job with coordination.
Supriyo Chatterjee (public comment) - This economic problem is much bigger and can be addressed.

Ms. Nair continued to report the chronic diseases and their risk factors. Smoking is the largest health risk factor. The report shows the percentage of adults (2012-14) with diabetes who had at least 2 AIC tests performed. Obesity, physical activity and nutrition is another high risk factor among CT population; asthma (1 in 10 adults and children have asthma); high blood pressure and cholesterol (non-Hispanic African American adults are more than likely to have high blood pressure and over 1/3 of the population have high cholesterol; and are therefore, at risk for heart disease). Heart disease, diabetes and asthma can be controlled.

Pat Baker - Any data on control? Test does not mean you have control - history of process measure that don't equal health outcomes.
Tamim Ahmed - The health cost per year in CT is 600 million dollars.
Hyacinth Yennie - The cause can be lifestyle and environmental.

Ms. Nair reported the percentages in CT in 2014 of hospitalizations and emergency department visits for mental disorders.

Martha Page - Does the report include all substance issues as well?
Pat Baker - It does not include mental treatment facilities that are not hospitals.
Kristin Sullivan - CT didn't do all that well in comparison with other states in the country, we don't have a priority focus.

Ms. Nair talked about Binge drinking and said that the report states that 1 in 6 adults and 1 in 7 high school students Binge drink in CT.

Frederick Browne - What was the source or metric that was used to measure the binge drinker?
Ms. Nair replied that the data came from the BRFSS survey. In 2011, they were then able to base the data on telephone call inquiries.
Hyacinth Yennie - Not a clear data if the question is asked over the phone.
Diane Aye - The survey was done nationally and found to be a relatively valid survey since 1988.

Ms. Nair then presented the rate of unintentional prescription opioid overdose deaths per 100,000 CT residents during 2011-2013 and misuse of prescription drugs.

Hyacinth Yennie - Do we have a ratio on who is doing more?
Anitha Nair - More females died from prescription opioids than males died from heroin.

Ms. Nair continued to report that more CT residents die from suicide and homicide than any other injury.

Lisa Honigfield - Why are suicides not considered under Mental Health?
Frederick Browne - What do you mean by more actionable?
Anitha Nair - Actionable in the sense that through antimicrobial stewardship and infection control practices, we can impact the standard infection ratio.
Tamim Ahmed - Through prevention, we can control these illnesses.
Madeline Biondolillo - Was this from the first or second round of assessments?
Anitha Nair - This information comes from the first round.
Tamim Ahmed - Is there an estimate for obesity? Why doesn't our Population Council work to prevent or lower the level of obesity-- something to target is preventing pre-diabetic which has much more impact.
Hyacinth Yennie – Education comes during the early stages – How do we educate at the early stage to prevent this from happening?

Co-Chair Susan Walkama addressed the Council to remain on track since timing poses a challenge in terms of managing the agenda.

Key Questions and Feedback: Dialogue

Ms. Rose Swensen asked the Council members to provide key questions/comments on health assessment validation, what prevention interventions should be measured at the community level to track progress and other priorities that should be considered.

Following are the questions/comments from the Population Health Council members:

- Yes

- What about mental health priority? (see depression S/M)
- Asthma, diabetes, cost drivers affirm
- Look at co-occurring issues with mental health (depression, anxiety) few pop based approaches for behavioral health so ability to impact is more
- Affirms focus on health equity
- Focus needs by priority and population demographics
- Better coordination of services for prevention
- This is bigger than health (need to start with kids (schools)
- Include in child health wellness screenings (early intervention for young adults who are developing serious mental illness)
- Can get at obesity through diabetes, hypertension, asthma and depression
- *Place for PCS – Food Deserts
- *BP } easy to tie cost } create a visual tool to show sources of data and identify gaps (task SIM with this)(for HIX)
- A/C control over timeframe
- Reported annually at med groups
- Data unclear (tracking diseases and major risk factors like tobacco)
- All Payer Claims double measures at community level will include
- MEDIS metrics (1/2 commercial, 100% Medicaid)
- What are major indicators of health status/outcomes we should be tracking?
- Indicators
  At community levels not ready to test for diabetes, can be ready to control
- *Need to define intervention first, then must include youth/child intervention
- Metrics to assess whether they work, use evidence-based intervention, include economic costs and ROI
- Don't lose systems measures (i.e., ER use)
- Look at who is doing what in state and tag on

Next Steps:

Co-Chair Susan Walkama asked about the possibility of having the meeting materials sent to the Council members ahead of time to review prior to the meeting in order to have time for discussion. She indicated that the next Population Health Council meeting is scheduled for October 27, 2016.

Kristin Sullivan stated that the unit is striving to have the meeting materials sent to the Council members for review prior to the meetings.

Co-Chair Susan Walkama adjourned the meeting at 5:04 p.m.