State of Connecticut
State Innovation Model
Population Health Council
October 27th, 2016

Meeting Summary

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

Members Present: Tamim Ahmed, Patricia Baker, Lisa Honigfeld, Steven Huleatt, Martha Page, Susan Walkama, Hyacinth Yennie, Nancy Cowser, Tekisha Dwan Everette

Members Participated via Teleconference: Garth Graham, Kate McEvoy, Carolyn Salsgiver, Penny Ross

Members Absent: Madeline Biondolillo, Hugh Penney, Elizabeth Torres, Vincent Tufo, Federick Browne.

Other attendees: Faina Dookh, Mario Garcia, Lloyd Mueller, Anitha Nair, Mark Schaefer, Kristin Sullivan, Heather Nelson, Kristin Mikolowski.

Call to Order
Co-Chair Steve Huleatt called the meeting to order at 3:00 p.m. It was determined a quorum was present.

Review and approval of Meeting Summary: Co-Chair Steve Huleatt asked for a motion to approve the meeting summary of the September 22nd, 2016 Population Health Council meeting. The meeting summary was approved.

Public Comment: There were no public comments

MEETING PURPOSE, OUTCOMES AND TIMELINE

The chairs, Steve Huleatt and Susan Walkama, indicated that the meeting was convened to present preliminary findings from an environmental scan being conducted by Health Resources in Action and learn about the state's capacity for delivering prevention services and other aspects of community-based prevention in Connecticut. In this context, key questions designed to inform the structure and content of a draft Prevention Service Center model were presented to Council members for deliberation.

Mario Garcia, SIM Population Health Director, made a brief review of the council meetings' timeline. The first two meetings were dedicated to agree on the overarching goals of the Council, teambuilding, nominating chairs and to discuss operating principles. As introduction to the planning

process, the council discussed prevention concepts based on case studies from in and outside the state. Subsequently, the council engaged on conversation about alignment goals between the State Health Improvement Plan (SHIP) and the State Innovation Plan (SIM). In the last meeting, ~~the~~ DPH presented an update of the State Health Assessment Data and discussed the extent that the assessment validates the proposed prevention models. The upcoming meetings are designed to discuss specific approaches of the Prevention Service Center (PSC) model.

ENVIRONMENTAL SCAN

Heather Nelson and Kristin Mikolowski, SIM consultants from Health Resources in Action (HRiA), presented preliminary findings of an environmental scan. This is the first report of a two-phase project. The first part is intended to identify key elements of community health integration models and current clinical-community linkages in Connecticut. The second part of the scan will address clarifying question and research gaps while taking a deeper dive on issues of organizational capacity and financing options for community based prevention. HRiA used sources publically available and conducted interviews with national leaders in community accountability initiatives. In Connecticut, HRiA interviewed several leaders in prevention related services.

Ms. Nelson discussed basic approaches to building Accountable Health Communities, such as the importance of identifying current health-related needs of specific populations to be served. She highlighted the responsibility of including community input into the process. She also reported that expert advice recommends securing a multi-sectorial partnership under a solid governance structure. Ms. Nelson presented recommendations about shared vision and goals, prioritizing focus areas and relying on evidence based interventions. She illustrated several funding mechanisms and data evaluation possibilities to support Accountable Health Communities. Finally, she pointed out the importance of Community Health Workers to bridge gaps between health systems and communities.

Ms. Mikolowsky proceeded to discuss progress towards community and clinical integration. She highlighted the lack of coordination and the fact that existing efforts primarily target children and low income families. Ms. Mikolowsky mapped out a number of programs in CT that are located in the poorest areas of the state. In addressing the challenges around clinical and community linkages, she also discussed the need for a centralized convener and questioned what would make entities that would otherwise compete to collaborate. Another frequent challenge is that healthcare providers are not reimbursed for preventive and educational services. Regarding the operation of prevention services, coordination is lacking even for programs sharing similar goals. In addition to the uneven distribution of resources across the state, sharing data and information across institutions is difficult.

Ms. Mikolowsky shared recommendations compiled from telephone interviews with leaders familiar with prevention efforts. It was recommended to identify strong backbone organizations such as hospitals or local health departments. It was also recommended to emphasize on coordination of existing services and initiatives. Other recommendations included incentivizing prevention and multisector work while tapping on payment reforms, sharing data electronically, expanding home

visits and CHW's programs, working with non-health sectors such as education and collaborating at multiple levels such as service delivery, training and shared learning, advocacy and policy change.

Q&A SESSION

Pat Baker said that while speaking about funding it would be important to point out specific experiences such as the recently approved 1115 waiver in the state of Washington and other states using DSRIP money. She suggested to look at the successful elements of other state experiences such as Vermont or Oregon.
HRiA responded that in the next phase of the environmental scan, they expect to look at successful case components relative to the proposed solutions in CT.
Jenna Lupi from PMO asked whether in the interviews there were any mention about other models beside shared savings.
HRiA mostly focused on potential advantages of share savings arrangements as they were the primary interest of those interviewees from Connecticut. Discussion were mostly about value-based and performance metrics.
Faina Dook from PMO indicated that one of the challenges is how to capture savings from reductions in cost and allocate accountability to the different sectors involved. Then she asked whether any of the interviews addressed accountability and the reduction in cost savings allocation.
HRiA answered that in spite of addressing these questions, interviewees did not get into the detail of payment systems. They talked to about thirty people whose make up was implementers, managers and others without financial expertise. In the next phase, it is planed that HRiA will explore different financing models and how to implement them.
Martha Page wondered why people would follow the lead of a backbone organization. She indicated that the hardest thing is to bring many stakeholders together and agree on common objectives. Compromise among various stakeholders requires to trade off important objectives in order to seek collective impact. She touched on the concept of the backbone organization being more of a facilitator and not unilateral in its' function. Ms. Page inquired how much the scan shows clarity about the role of a backbone organization as part of a collective impact organization.
HRiA acknowledged that perceptions of lead organizations vary from using the term "backbone" just as a buzzword to recognizing their role as facilitators and convener agencies. There is a desire of having an organization that keeps people accountable and on task, while there is also hesitance that this type of agency may become a unilateral decision maker.
Tamim Ahmed asked whether the task is to target specific sets of populations with specific conditions such as diabetes. He pointed out that health plans have had VBID programs and disease management programs in place for some time. He also asked whether the target is privately insured populations, publicly insured or even the uninsured.
HRiA suggested that target populations may vary, but they are mostly vulnerable and harder to reach individuals with worse outcomes and living conditions. It is not only rightly justified but it also offers the opportunity to show impact if starting in a place where people are not faring well. In the context of integrating public health and health care, it also make sense to start from a place where public health focuses its interventions to address health disparities.
Kate McEvoy expressed interest in expanding the meeting's discussions about opportunities under value based payment and best practice experiences in other states. Ms. McEvoy is also interested in

any upcoming opportunity to offer additional information on the shared savings initiative that Medicaid is prepared to launch and how it presents itself as an opportunity for being a model of prevention. She went on to discuss the 1115 integration authority as an alternative path for the state. Of note, there is local distrust about the elasticity of this authority because its potential misuse. Ms. McEvoy would like to have the opportunity to extend this discussion and amplify about the unique self-insured structure of the Medicaid program in Connecticut.
Pat Baker asked whether Connecticut can use the state plan amendment to access Delivery System Reform (DSRP) funding.
Kate McEvoy responded that it is not possible. DSRP is a specific application out of the 1115 waiver process whereas the state elects to accept a cap amount of federal match for a five year period to obtain additional money upfront to capitalize investments and get the flexibility of a research and demonstration waiver. However, there are integration opportunities across disciplines in the state plan amendment to support services that can impact social determinants of health (SDOH). For example the CMS liberation about tenancy sustain support for individuals which is coverable under the state plan. Important to capitalize on this opportunities like NY state that have been able to generate an immense amount of capital.

VISION OF PREVENTION SERVICE CENTERS

Mario Garcia provided a vision of the purpose and key elements for the development of a PSC model. He began making a distinction between the overall model development and the planning of a prevention service centers pilot. The PSC final model is intended to bring about a systems' change by transforming how prevention services are delivered and by designing a model of prevention that is embedded in the healthcare financial system. That includes creating functional links between PCP/ANs and CBOs, establishing guidelines for interagency contractual arrangements and shifting resources from acute care to prevention care. All this is expected to result in enabling mechanisms for integration, coordination and accountability of prevention services delivery among CBOs and PCPs. To this end, implementing a pilot as part of the planning process will provide a proof of concept and begin to enlist CBOs primed for accountable networking. A demonstration will test the minimum required IT and performance measurement capacity. The tested model will aid in building a business case for investments in prevention.

The purpose of the PSCs will be to provide broad, coordinated access to community-based preventions services to reduce individuals' health risks associated with diabetes, hypertension, uncontrolled asthma and other high burden conditions. To this end, the PSC model will offer an integrated set of strategies that are aligned with the long-term vision above. The strategies will add value and innovation to a geographically defined population and will configure a cost structure that allows returns on investments. The SIM approach to test this model will be to establish prevention service centers/consortiums in two or three regions throughout the state with responsibility for providing evidence-informed, culturally and linguistically appropriate community prevention services. Potential implementers are any healthcare or human service agency, private non-profit, or local health department acting as lead entity. A lead entity will provide services directly and/or by administering sub-contractual relationships with consortium partners that provide community-based prevention services.

The planning of a PSC "straw man" model will be framed around five elements/components: a) type of prevention services and how they meet SIM and other public health priorities, b) community health measurements which include both health outcomes and performance metrics, c) long term financial sustainability and PSC pilot funding options, d) Infrastructure proposals regarding consortia or single agency models, and lastly, e) types of ownership whether the PSC should be private, public or mixed.

KEY QUESTIONS AND DIALOGUE

The following three main questions were submitted to prompt the dialogue among Council members:

- Given what the Council learned from the data presentation and current capacity from the environmental scan what should be the focus of the PSC model?
- Given what the Council learned from other experiences out of the state, what do we want the key functions of the PSC model to be?
- What potential structures would maximize operations of the PSC model and why?

Steve Huleatt noted that Mark Schaefer's comments in the previous meeting encouraged council members to think about new approaches. Mr. Huleatt is fearful that thinking exclusively about menu of services would lead to PSCs to become only a place for treatment and case management as opposed to a place for health where healthy people go to stay healthy. That poses the question as to how to measure health and not only illness of recovery outcomes. Mr. Huleatt encouraged members of the council not to get caught up in what is already known, but to expand the imagination.

Pat Baker suggested that the term "centers" seem to frame the concept on a single entity as opposed to looking at a more expanded consortium or network of agencies or programs. Ms. Baker went on to emphasize that the focus of the PSC must take into account that the SIM project has obligations around specific outcomes/priorities and therefore the project requires alignment with all work streams.

Tekisha Everette expressed concerns about building a process exclusively focused around asthma, diabetes and hypertension. Her perception looks beyond addressing these diseases directly to focus on the social and environmental conditions that may impact them. She suggested that the conversation should focus on creating a body that addresses upstream factors and that it is not pigeon-holed on specific diseases but also applicable to other interventions. There is some significance to being able to scale what we design to other priorities.

Hyacinth Yennie indicated that because the effort is around prevention, it is important to look at what is happening with and around the individual. That includes recognizing the mental, family and environmental conditions that contribute to these diseases.

Hayley Skinner mentioned that ProHealth Physicians has already committed to various shared savings arrangements for several years and focuses on critical populations like diabetes and asthma. Their experience has shown that lack of access, patient engagement and behavioral health concerns prevent providers from making a greater impact at the point of care. PSCs could serve as a place

where people want to go to learn about health and engage with behavioral health services organizations.
Lisa Honigfeld expressed concerned about the process being tagged to a diagnosis, which would require going back and addressing childhood, pregnancy and other innumerable issues.
Nancy Cowser inquired about the prospect of issuing an RFP. She thinks that there is benefit from targeting specific conditions if the approach is to pilot the model and serve as a test of impact. An RFP could require participants to offer a minimum of services, and also ask for what other things could they provide to impact specific conditions. If places are chosen by other means, there might be less of an opportunity for creativity and innovation.
Pat Baker recommended that perhaps a logic model will be useful to describe how this will affect health outcomes. Define the conditions that have to be in place that, in fact, will impact population health and should include the measurement of impact on health outcomes.
Tamim Ahmed said that the long-term issue is lifestyle management and a critical distinction should be made between control and prevention. Many things are already being done at the clinical level to control these conditions, but more has to be done to impact lifestyle changes and patient education. Therefore, the approach has to use this two-prong strategy.
Steve Huleatt raised the question of whether this is a clinical or a community based approach. Council members need to figure that out to prevent the conversation to go on in circles. The innovation is more likely to come from community interventions, which also raises issues of governance.
Lloyd Mueller commented on a past pre-natal study that resulted in dismal outcomes due to participants struggling with issues that stemmed from lack of transportation and availability of child-care.
Hyacinth Yennie insisted that the discussion also needs to be addressed at the grassroots level. She cautioned that policy making should involve the people who will be directly impacted by it.
Tekisha Everette pointed out that the community-clinical question is foundational. She suggested that this is a community-based effort to address clinical issues in ways that physicians can't do it. She illustrated the issue by discussing how individuals can be labeled non-compliant when compliance is actually not always an option for all patients given the conditions in which they live in their communities. This effort must focus on the interventions that address those conditions to make patients able to turn from "non-compliant" to "in-control".
Kate McEvoy was encouraged by the suggestions to move further upstream, particularly when they refer to interventions in the home environment. She supported the caution expressed by others to binding the planning by diagnosis.
Mario Garcia recalled that based on the CDC three buckets model of prevention, PSCs will address innovative clinical interventions conducted in the community which fit the second bucket in the model. Related upstream interventions that address social determinants of health are intended to be at the center of the larger model of Health Enhancement Communities.
Mark Schaefer commented about how valuable is to distinguish between what can be realistically achieved through a PSC model as first phase and what might have to be built into the Health Enhancement Community (HEC) as a second phase of evolution. Equally important to debate the benefit of ideas such as being prescriptive vs allowing innovation or how far upstream the model must go. Against those ideas there are serious challenges regarding financial models of sustainability or budget availability to test the model. Mark encouraged the council to think about interventions

that have sufficient value that someone would want to finance. He also mentioned that there is a need to face practical realities in terms of whether there is a market in the context of current reforms or whether the market needs to be created. If a market for services is going to be created and the interventions are more upstream, the longer the return of investment can take to demonstrate (which can be in the magnitude of several years). Mark feels that is instructive to think about what needs to be built in, even if the question about how and when it can be built remains.
Lisa Honigfeld believes that this planning constitutes a great opportunity to build on what is in existence and whether funding is immediately available should not preclude the advancement of this initiative.
Steve Huleatt reminded the Council that public health typically works with limited resources but many initiatives work as a brush fire catching the attention of the public and political leadership. PSCs could have a similar effect once the model is "branded" if there is a coalition behind it.
Susan Walkama remarked that the focus must be kept in addressing disparities and that the voice of consumers need to be brought into the process.

Next Steps:

It was proposed that a survey should be sent out to follow up on the questions that were not sufficiently addressed in the meeting.
Co-chair Susan Walkama proposed November 17th for the next meeting.
The meeting adjourned at 5:00 p.m.

Note: The November meeting date has been rescheduled due to several council member conflicts and will be on Thursday- December 1, 2016 at the usual time of 3-5pm.