Connecticut State Innovation Model

Population Health Council

Thursday, October 27, 2016

3:00 – 5:00 PM

500 Enterprise Drive, Rocky Hill, CT

Rocky Hill, CT

Dial in #: 877-916-8051/passcode: 5399866

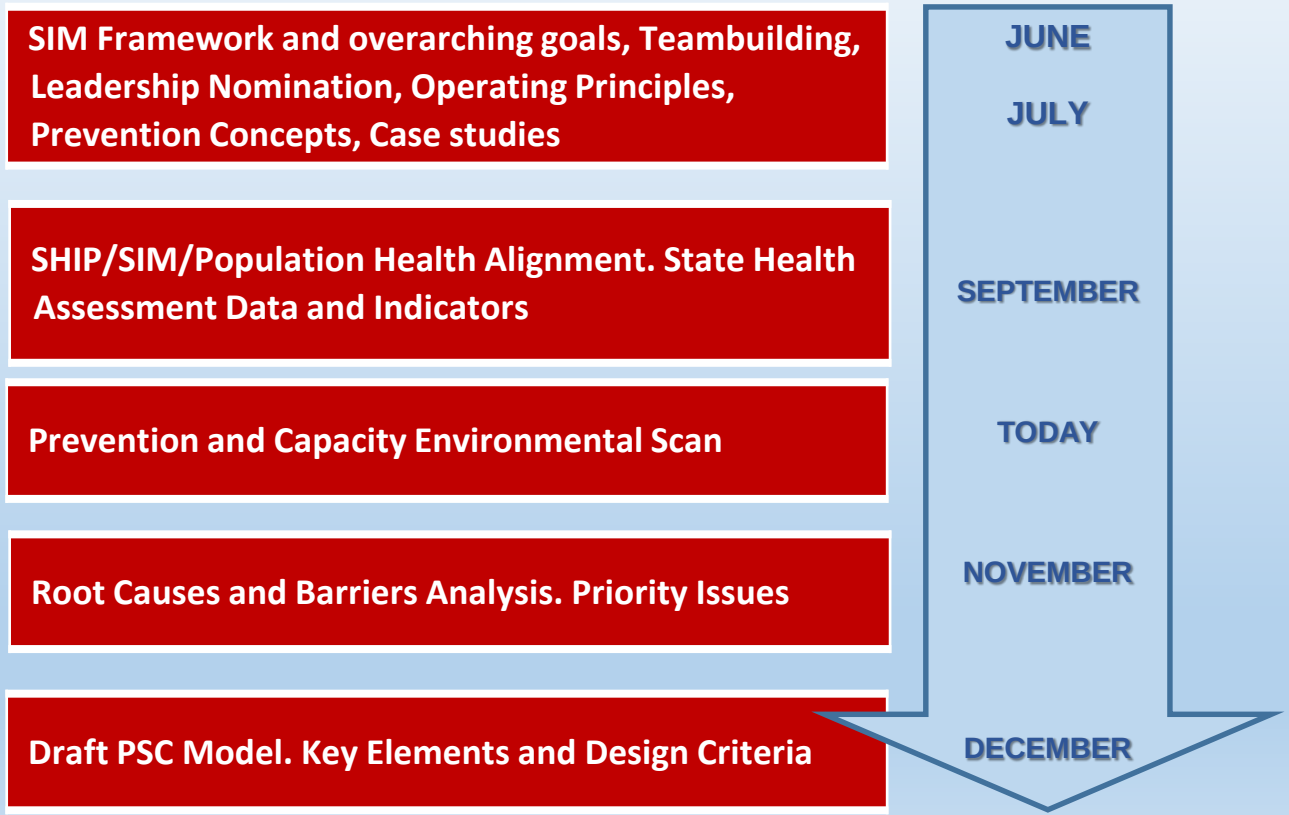
Welcome: Co-Chairs
Susan Walkama, Steve Huleatt

- Minutes Approval
- Public Comment
- Welcome New Members To Table

Meeting Purpose and Outcomes

- Present findings from the Environmental Scan to learn about State capacity for prevention and aspects of community-based prevention models in practice
- Discuss key questions to inform the structure and content of the Prevention Service Center model for Connecticut

POPULATION HEALTH COUNCIL MEETINGS



Environmental Scan

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Goals

Phase I

- **Identify**:
  1. Key elements of community health integration models
  2. Current clinical-community linkages ***in Connecticut***

Services related to:
- asthma
- depression
- diabetes
- hypertension
- obesity
- tobacco use

Phase II

- **Identify** clarifying questions and gaps
- **Take a deeper dive** into specific areas, based on feedback from the Population Health Council

Methods

Environmental Scan

- **Nationally-focused** search on community health integration models (CHIM) and accountable communities for health (ACH) models
- **Connecticut-focused** search on local community-based networks and community-based prevention services
- Sources – publically available – articles, papers, website content and resources suggested by interviewees
- Sources recorded in a matrix and catalogued by 13 criteria (e.g. governance structure, financing, workforce, etc.)
- 78 sources reviewed

Methods

Key Informant Interviews

- **National interviews –** phone interviews with 13 leaders in community health integration
- **Connecticut interviews –** phone interviews with 16 CT leaders in prevention-related services and networks
- Interviews were conducted using **semi-structured interview guides** to examine:
  - Innovations, elements for success and challenges in community health integration models & Accountable Communities for Health across the U.S.
  - Types, structures, successes, challenges, and lessons learned related to community-based networks and community-based prevention services in CT

Limitations

- Scope of Phase I scan
  - Findings are based on initial broad scan and do not represent a complete inventory of all prevention programs in CT / ACHs nationally
  - Information on community context and clinical-community linkages is limited

- Interviewee Perspectives
  - Non-random and small samples – does not represent all points of view

Key Elements for Clinical-Community Integration & Accountable Communities for Health

Approach

- There is no “one size fits all” model
- Allow for regional and local differences

“Our first step is already to figure out who’s working on it, and pull them together…explain the goal… [and determine] how do we work together, [and] develop standard processes and protocols.”

“The local/regional approach is why we have 9 Accountable Communities of Health in the state… [It’s] driven out of a local context.”

1. Needs Assessment & Community Engagement

- You are not designing with a clean slate

- Define the **population** that will be served
- Identify current **health-related needs**
- Identify **community assets** and **resources**
  - Leverage existing community health needs assessments and community health improvement plans

- The initiative needs to be responsible to the needs and demands of the community
- Engage the community throughout the process: assessment, prioritization and planning process, implementation, evaluation

"It's always good in addition to data to have a mechanism for community involvement and identification of community issues that may not have been fully captured by data."

"There has to be community representation. Different geographic locations have unique needs and challenges."

2. Multi-sector Partnerships

- Convene partners across sectors that impact health:
  - Health care
  - Public health
  - Insurance
  - Housing
  - Education
  - Transportation
  - Community-based organizations

"In general, it's good to have representatives from multiple sectors – public health, insurance, health care delivery, community agencies, and other sectors where their policies have an impact on health. That could be education, transportation, job training, public safety, it would vary depending on [the] health issues [the priorities]. It's also good to have representatives that are representing the general or key population."

3. Governance and Leadership Structure

- Identify a neutral, strong **backbone organization** to coordinate, integrate and move efforts forward
  - Examples: health departments (CA); hospitals (VT); 501(c)(3) (CO); planning commission (VT)
- Governance structure may separate decision-making about health improvement activities and funding
  - Examples: Trillium Coordinated Care Organization, Pathways Bernalilllo county
- Develop **agreements** that are transparent and include the mission; sectors represented; roles of backbone organization, steering committee, and other partners; conflict(s) of interest; structure; decision-making processes; policies around conflict

"There should be some organizational structure that is headed by a backbone organization. Public health is an organization that plays a strong role as convener, purveyor of data, and takes an independent role that's not linked to a particular model."

"Agreements are absolutely necessary. The Governance should spell out the vision for the overall effort. [It] should include not just the intention, but the intended outcome of the project, the players, roles, responsibilities, methods of accountability. Who's supposed to be doing what and how they're linked together. If there's resource-sharing, what are those agreements?"

4. Shared Vision, Mission and Goals

- Develop a **common language**
- Develop a **shared understanding** of why the initiative is convening
- Be **clear** about the **goals** and **objectives**
- **Avoid unrealistic expectations**
- Under-promise and over-deliver

"Be realistic, be clear about what can be done and what the tasks are... Be ambitious, but tend to under-promise and over-deliver."

"[There needs to be] something big and broad that is unifying enough that everyone can coalesce around. The tension is that the way work happens and moves is when the work takes focus. The fear is that the focus alienates someone around the table. Can we find something that everyone finds meaning and purpose in?"

5. Focus Area(s) and Portfolio of Strategies

- Identify and **prioritize focus area(s)** based on **data**
- Identify **low hanging fruit**
- Address **the social determinants of health**, which will move the lever on multiple health outcomes
- Identify opportunities for **synergies** across sectors, initiatives, services

- Develop an **evidence-based** Portfolio of Strategies*, spanning the following levels:
  - Clinical
  - Social Services and Community Resources
  - Clinical-Community Linkages
  - Policy, Systems, and Environment

"My own view is that the greatest likelihood of impact is when there's agreement across a spectrum of participants to all focus on a small number of issues – as few as 1 or maybe 2…"

"How do those [population health] pieces support and reinforce what's happening in clinical level? And how does policy happening at the payer level or [health insurance companies] … [influence and support] community-clinical [integration]?"

*JSI Research & Training Institute, Inc. Accountable Communities for Health: Strategies for Financial Sustainability. May 2015. Accessed 10/21/16 at: http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15660&lid=3

6. Funding Mechanisms

- Funding for ACH initiatives remains a challenge
- Funding is needed for **services** and also for **infrastructure**
- Potential funding approaches and sources include:
  - **Grants** (foundation or government), especially for planning
  - **Raising revenue** – for example, establish local or state tax (e.g. on soda); use % of insurance premiums; require nonprofit hospitals to allocate portion of community benefits spending
  - **Blended or braided financing** – pooling funding from different sectors
  - **Medicaid waivers** to pay for nontraditional programs
  - **Incentives for providers / hospitals** – invest in ACH to prevent hospitalization / readmission; invest in ACH to meet benchmarks like HEDIS measures

"Unlike accountable care models with a defined population and payer, the community piece gets confused. Where does the funding come to drive that work? That is harder to nail down."

"We are trying to… work with our partners [to determine how we] can create a system to show that the partners need to work together and behind that specifically tracking how the money works and connects to the outcomes."

JSI Research & Training Institute, Inc. Accountable Communities for Health: Strategies for Financial Sustainability. May 2015. Accessed 10/21/16 at: http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15660&lid=3

The Commonwealth Fund. A State Policy Framework for Integrating Health and Social Services. July 2014. Accessed 10/21/16 at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1757_mcginnis_state_policy_framework_ib.pdf

7. Data and Evaluation

- Evaluation should occur on multiple levels:
  - **Process** – value in qualitative data
  - **Outcomes** – health, policy, etc.
  - **Connect investments with the outcomes**
- Limited resources available to support and sustain comprehensive evaluation
- Challenges in accessing data to conduct cost analysis
- Data sharing is vital for evaluation
- Need to build trust and data sharing agreements share
- Align measures where possible to reduce reporting burdens

"We use process measures, like the number of partnerships, number of people reached at a community event. It gets difficult to measure when you talk about long-term population base."

"[There is a disconnect] in the amount of resources that are available for the evaluation versus how much you'd actually want in the real world."

8. Importance of Community Health Workers

- A population health approach requires addressing the social determinants of health
- CHWs are best positioned to bridge gaps between systems and communities, addressing a range of social determinants
- CHW models can be medical models or population health models
- Existing funding for community health worker (CHW) model is limited

"You need full-time staff, a navigator or community health worker. You need to have someone who can implement the patient plans and state funding to do the work. You need the one-on-one relationships. It needs to be someone the patient trusts and it's a long-term behavior change."

Connecticut: Clinical-Community Integration

SIM connecticut state innovation model

DPH Connecticut Department of Public Health

Approach

- **Key informant interviews:** 11 phone interviews with 16 Connecticut leaders
  - Government, health care, policy research, non-profits

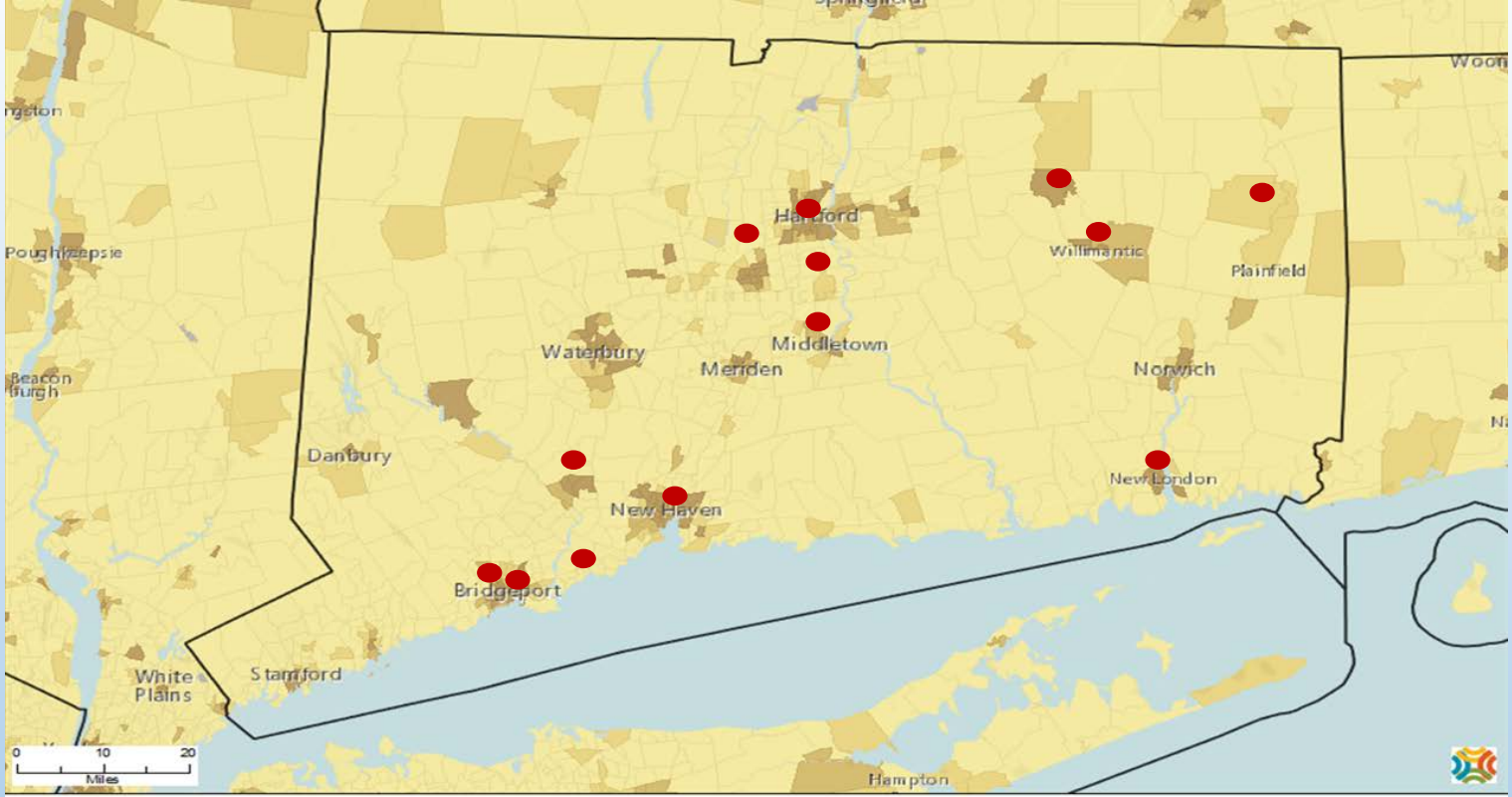
- **Environmental scan:** Connecticut-focused search on local clinical-community linkages and accountable health models
  - Information on community context and clinical-community integration is limited via online publications and resources

Progress Towards Community-Clinical Integration

- Several initiatives and networks are working to provide community-based prevention services that are linked to clinical care
  - ➢ However, current services are not coordinated
- Health issues commonly addressed: asthma, obesity, and diabetes
  - ➢ Services to address hypertension were discussed less frequently
- Efforts are underway to develop a shared savings initiative
- Existing services primarily target children and low-income families

"We approach this [asthma initiative] by thinking, 'Who's already working in this space and how can we work with them?' We're not replicating things that already exist."

Map of Poverty & Clinical-Community Linkages in CT*



Map Legend

Population Below the Poverty Level, Percent by Tract, ACS 2010-14

- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed

Community Commons, 8/15/2016

*Locations are approximate.
● indicates presence of service(s); NOTE: multiple services provided in some locations (e.g., Hartford)

SIM connecticut state innovation model

DPH Connecticut Department of Public Health

Programs and Initiatives Included in Map

*Programs serve multiple communities / geographies

Program Name	Location / Headquarters*	Focus
Putting on Airs Asthma Prevention Program	6 regional health departments / districts	Asthma
Little AIR / AIR Middlesex	Middletown	Asthma
CT Children's Healthy Homes Program	Hartford	Lead / Healthy Homes
Suicide Prevention Info-line	Hartford	Depression / suicide
Diabetes Care Management Program	Middletown	Diabetes
YMCA Diabetes Prevention Program	New Haven ex on map	Diabetes
Know Your Numbers (Healthy CT)	Bridgeport & New Haven	Hypertension
CT WISEWOMAN	Hartford	Various
Fit for Kids	Middletown	Obesity
Farmer Markets Nutrition Education	Farmington	Obesity
Husky Smart Shopping	Farmington	Obesity
Get Healthy Walk 'n Talks	Bridgeport	Obesity
Smoking Intervention Program	Middletown	Tobacco Cessation
CT Screening, Brief Intervention, and Referral to Treatment	Hartford	Substance abuse
CT AHEC / UCONN Migrant Farm Worker Clinics	Farmington	Medical & dental screenings
GOT Care! Geriatric Outreach and Training with Care	Storrs	Multiple chronic conditions (elderly)
Help Me Grow/ home visiting program	Hartford	Early Childhood
Child Health and Development Institute of CT, Inc.	Farmington	Early Childhood
South Park Inn – medical clinic	Hartford	Homeless services (co-located)
Covenant Soup Kitchen – medical clinic	Willimantic	Homeless services (co-located)
School-Based Health Centers, Community Health Center, Inc.	Middletown	Medical, Behavioral, Dental treatment

Challenges Around Clinical-Community Linkages in Connecticut

- Structure: A centralized convener must be identified, and may depend on local context
- Partnerships: May require entities that would otherwise compete to collaborate
- Funding: Many of the existing initiatives depend on grant funding
  - Health care providers need to bill for services, and many preventive and educational services are not covered

"Where I struggle though is who governs it? Who's in charge? Somebody needs to be in charge."

"You either need a grant or you need to be able to bill for services, like at a health center. In Connecticut, we're struggling with figuring out how to pay for the community health worker service."

Challenges Around Clinical-Community Linkages in Connecticut

- Strategies and Operations:
  - Coordination across existing initiatives is lacking, even for programs that target the same disease
  - Resources and innovation are currently distributed unevenly across the state
  - Sharing health data across institutions is challenging

- Certain populations – for example, in rural areas and those who are undocumented – are particularly vulnerable

"[In the area of] substance abuse, [there are] 13 regional action councils… They all have resources and strengths… but one area of the state may be very well-funded and another is not… There is no mechanism for sharing resources, [such as]… materials for dissemination, innovation happening in some places but not others…"

Recommendations & Connecticut's Vision for the Future

- Identify **strong backbone organization(s)**
  - ➢Hospitals and health departments
- **Coordinate existing** services and initiatives
- Reform **payment structures** to incentivize preventive services and multi-sector work
  - ➢Value-based payments
  - ➢Shared savings incentives
- **Share data** electronically
  - ➢To deliver care and to measure outcomes

"I would love to be able to see regional centers for chronic disease management."

"Why not leverage [for example the] asthma model? [We] don't necessarily need to create new things."

Recommendations & Connecticut's Vision for the Future

- **Expand home visiting** / CHW models and programs
  - ➢Discussed in almost every interview
- Work with non-health sectors
  - ➢**Education** (school systems) and **Housing** mentioned most often
- Collaborate on **multiple levels**
  - ➢Service delivery, training and shared learning, advocacy and policy change
- Address **social determinants of health**
  - ➢Programs / services should be provided a minimal or no cost

"I've been so impressed by… these home visiting programs… we in primary care can never do what a person in the home with a family can do – it needs to be linked with primary care but not based here."

Questions

15 min

From Context to Planning

A VISION OF PREVENTION SERVICE CENTERS

PSC's MODEL : A SYSTEMS CHANGE DESIGN

- Transform how prevention services are delivered
- Design a community integrated model of prevention that is embedded in the overall health system
- Build a business case for prevention
- Design functional links between PCP/AN's and CBO's
- Define Value Based Payment impact of prevention
- Establish guidelines for COB's interagency contractual arrangements
- Trigger a shift in resources from acute care to prevention care
- Develop enabling mechanisms for integration, coordination and accountability of prevention service delivery among CBO's and PCP's

PSC's PILOT : DEMOSTRATION OF A BUSINESS CASE

- Proof of concept
- Enlist CBO's primed for accountable networking
- Ensure or enable essential IT and performance metrics capacity
- Design a mechanism to monitor health outcomes
- Provide evidence of value-based cost savings
- Structure a sustainable strategy for community based prevention

PREVENTION SERVICE CENTERS

PURPOSE

- 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.

APPROACH

- Establish prevention service consortiums in two or three regions throughout the state with responsibility for providing evidence-informed, culturally and linguistically appropriate community prevention services.

ELEGIBILITY

- Any healthcare or human service agency, private non-profit, 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.

PREVENTION SERVICE CENTERS MODEL COMPONENTS

MENU OF SERVICES
(SIM / PH Priorities)

COMMUNITY HEALTH MEASURES
(Outcomes / Performance Indicators)

FINANCIAL SUSTAINABILITY
(PSC Pilot / PSC Model)

INFRASTRUCTURE
(Agency / Consortium)

OWNERSHIP / GOVERNANCE
(Private / Public / Mixed)

Key Questions and Feedback: Dialogue 45 min

1. Given what learned from the data presentation and current capacity from the environmental scan, should the PSC model focus on:
   a. SIM priorities such as diabetes, asthma, and hypertension only?
   b. Accommodate expanded services (e.g., childhood obesity and mental health) from the onset?
   c. Have a scalable design to address additional priorities in the future?

Key Questions and Feedback: Dialogue 45 min

2. Given what we have learned from other models, what do we want the key functions of the CT PSC model to be?
   a. Coordination of, referral to, and delivery of appropriate care/prevention services
   b. Prevention quality control
   c. Measures - Data monitoring and evaluation (handled by PSC or at the state level)
   d. Contracting and billing / Financial management
   e. Geographic reach/capacity in regards to areas of need

Key Questions and Feedback: Dialogue 45 min

3. What potential structures would maximize operations of the CT PSC model and why?
   a. Which of the following organizational structure would be most effective for the PSC? Why?
      - single entity
      - partnership group
      - regional lead agency
      - consortium of several regional programs
   b. Which sector(s) should hold ownership, fiduciary role and governance of PSC's?
      - healthcare
      - public health
      - human services
      - private non-profit
      - municipal government

Next Steps

Next Meeting Dates

November _____, 2016, 3:00-5:00 p.m.

December _____, 2016, 3:00-5:00 p.m.

Agenda Topics

- x