State of Connecticut

State Innovation Model
Population Health Council

Meeting Summary
December 20, 2016

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

Members Present: Elizabeth Beaudin, Steven Huleatt, Penny Ross, Carolyn Salsgiver, Hyacinth Yennie, Tamim Ahmed, Martha Page

Members Participated via Teleconference: Garth Graham, Elizabeth Torres, Vincent Tufo, Frederick Browne

Members Absent: Patricia Baker, Tekisha Dwan Everette, Lisa Honigfeld, Hayley Skinner, Susan Walkama, Kate McEvoy, Hugh Penney, Nancy Cowser (resigned).

Other Attendees: Joan Ascheim, Supriyo Chatterjee, Mehul Dalal, Faina Dookh, Mario Garcia, Sandy Gill, Anitha Nair, Stephanie Poulin, Mark Schaefer, Kristin Sullivan, Rose Swensen.

Call to Order: Co-Chair Steven 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 Steven Huleatt asked for a motion to approve the meeting summary of the December 1st, 2016 Population Health Council meeting. The motion was approved.

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

Meeting Goals: Co-Chair Steven Huleatt introduced the meeting objectives to finalize criteria for scoring the current list of prevention service options and apply criteria to each of the prevention service options.

Purpose of the meeting: HRiA consultant, Rose Swensen, stated that the meeting discussion was intended to create a provisional menu of prevention services that might be provided by PSCs and that could be further validated and prioritized through listening sessions with ACOs, consumers and community based organizations (CBOs).

Ms. Swensen proceeded to revisit the "buckets of prevention" concept outlined by the CDC and previously discussed in Council meetings. Once again, it was clarified that services proposed for the Prevention Service Centers will fall into the second bucket definition where typical clinical prevention interventions are delivered outside of clinical settings. In contrast, population or community wide prevention initiatives that aim at policy and systems change fall within the third bucket definition. These are approaches intended for the design of Health Enhancement Communities concept.

To further highlight this point, Ms. Swensen talked about the Health Impact Pyramid concept proposed by Dr. Frieden, CDC Director. This concept states that interventions that address socioeconomic factors and change the context in which individuals make decisions, bring the largest impact on health status. On the other hand, interventions that focus mostly on clinical interventions and health education bring the smallest impact on health. She highlighted that although the PSC model is less likely to impact the bottom of the pyramid, the SIM plan considers the HEC model as the opportunity to address issues of context and health policy that bring broader impact.

Lyn Salsgiver asked whether solutions that incorporate the use of Community Health Workers still are within the second bucket definition, which was responded in the affirmative.

Garth Graham asked for further clarification about the role of PSC and policy development.

Mario Garcia explained that the PSC design is intended to help individuals with clinical conditions with more operational solutions to reach them in the community. The HEC model will further these effort by mobilizing agencies to change policies on the same areas of interest but with broader environmental impact. For example, a PSC provider will offer nutritional counseling to individuals or group of students, while the HEC in that community will work with the school district to improve the nutritional standards in the school cafeteria.

Martha Page remarked that the connections between PSC and HEC should not be lost and the plan should avoid to draw a hard line between the delivery of services and the need to advance health policy and systems change.

Rose Swensen clarified that for the sake of planning these are separate concepts but that they are not intended to preclude each other. In fact, PSCs are understood as repositories of the experience were policy discussion will be drawn from.

Review of Key Inclusion Criteria: Ms. Swensen went over the list of inclusion criteria, which had been reviewed per the recommendation of the Council members on the 1st of December meeting. The language was simplified and the number of criterion reduced from seven to five.

a. Population Health Priority: Services address population health priorities identified by state or regional assessments
b. Evidence-based: Extent to which there is an evidence-based protocol for the service
c. Helps Providers Earn Shared Savings: Services provide investment opportunities for providers because they can earn points on quality scorecards or generate healthcare cost savings
d. Aligned with SIM: Services align with the SIM priorities and/or CDC 6|18 strategy
e. Bucket 2: Preventive services bridging clinical and community-based services

Garth Graham asked what the time period is for the regional assessments mentioned in the first criteria.

Mario Garcia answered that the most current and reliable source of regional data is obtained from the Hospital Community Needs Assessments, which currently are at the end of the second three-year cycle. In addition, the SIM/DPH team is looking to adjust state-wide data by developing town level estimations of population and increasing the sample size of the BRFSS survey. These methods will be available in the near future.

Tamim Ahmed inquired about the criteria for evidence based protocols. He asked whether NQF or NCQA type of standards will be required.

Mario Garcia indicated that although the question of evidence was meaningfully discussed in the previous meeting, not all answers have been fully elucidated. In principle, the criteria seeks to exclude initiatives that do not have a net effect or that are potentially harmful or wasteful. There is a need to further discuss the strength of the available evidence and how to consider that in the selection process.

Scoring Exercise: Rose Swensen explained that the purpose of the exercise was to finalize the proposed criteria and apply it to a pre-selected list of prevention service options. The adoption of the final criteria and scoring method will help to evaluate any new proposed prevention services. Following this introduction, staff from the DPH Chronic Disease Program section briefed members of the Council on each the ten pre-selected services. This was followed by each council member making an assessment about the extent (high, medium or low) to which services meet each of the five criteria.

Throughout the discussion about services the following issues were highlighted.

- Some programs are based on scientific rigorous research (RCTs) and others are an assembly of various components, with more or less evidence-based themselves, which may simply originate from quality improvement initiatives.
- How to better assess the strength of the evidence of prevention initiatives remains an unresolved issue, particularly when the initiative is built around multiple components.
- Impact on the score card or ROI should be program specific with limited room for inferences.
- Tracking data of patients served across systems for each program is central for performance evaluation

Mario Garcia made reference to the previous meeting discussion about the ability of PSC's to impact social determinants of health (SDOH). He briefly presented two examples of Community Based Organizations in California that specialize in providing social services support for the elderly and mentally ill. These agencies are engaged in a learning collaborative to improve their business acumen for the purpose of contractually engage healthcare providers seeking their services to enhance prevention efforts. Commercial payers, Medicare and Health Systems are all participating in supporting community based interventions that look at upstream solutions. The questions was raised about the extent that the PSCs design should include social services support in it menu of services.

Lynn Salsgiver remarked that these types of services must be included even if they are not meant to address all the social determinants of health comprehensibly. Martha Page concurred with the need to address the social needs to succeed implementing clinical prevention. Hyacinth Yennie strongly supported this approach and indicated that prevention will not realistically work without these services in place.

Next Steps:

A ranking of services will be prepared and presented in the next meeting. The planning process will move to a phase of direct stakeholder engagement to test the assumption regarding feasibility of the PSC model.

Co-Chair Steven Huleatt adjourned the meeting at 5:04 p.m.

Attachment: Results of the Scoring Exercise