State of Connecticut

State Innovation Model
Population Health Council

Meeting Summary
January 26, 2017

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

Members Present: Patricia Baker, Elizabeth Beaudin, Frederick Browne, Craig Glover, Lisa Honigfeld, Steven Huleatt, Martha Page, Susan Walkama, Hyacinth Yennie, Hayley Skinner

Members/Other Attendees Participated via Teleconference: Yvonne Addo, Janet Brancifort, Garth Graham, Penny Ross, Carolyn Salsgiver, Tamim Ahmed

Members Absent: Nancy Cowser, Tekisha Dwan Everette, Hugh Penney, Elizabeth Torres, Vincent Tufo,

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

Call to Order: Co-Chair Steven Huleatt called the meeting to order at 3:06 p.m. It was determined a quorum was present.

Mr. Craig Glover, CEO of the Norwalk Community Health Center was welcomed as a new member of the council.

Meeting Objectives: Summarize results from the December meeting; Provide context for today~~'s~~ and for February's meeting~~s~~ regarding stakeholder engagement and feedback; Present and comment on criteria for community selection; Select epicenters from maps and next steps for demarcation of boundaries; Identify potential and key questions for stakeholder engagement

Review and approval of Meeting Summary: Co-Chair Susan Walkama asked for a motion to approve the meeting summary of the December 20, 2016 Population Health Council meeting. The motion was moved by

Hyacinth, seconded by Steve Huleatt. The meeting summary was approved.

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

Conflict of Interest Disclosure: Co-chair Steven Huleatt reminded council members of their signed consent to disclose any conflict of interest that may arise through the council's deliberations and decision making.

Review of December Meeting Outcomes and Next Steps

Rose Swensen from HRiA described the methodology for weighting the services selection criteria. A point system assigned services to either high, medium or low matching the chosen criteria. A provisional menu of services/programs were selected for the PSC model and will serve as reference for testing planning assumptions as we go onto next phase of work.
Lisa Honigfeld commented on the menu of services as being too "skimpy" for the purpose of engaging stakeholders and noted the lack of emphasis on pediatric care or behavioral health.
Martha Page suggested making a clear distinction between programs and services to avoid being too narrow. Services are more commonly understood as direct interventions for individuals within the context of one or several programs and most often related to support immediate social needs.
Pat Baker highlighted the need to describe services/programs within every particular context setting as an essential step toward integration.
Martha Page inquired about the importance of defining ways to assess measurable outcomes.
Rose Swensen briefly reviewed the PSC model planning process which in its early phase helped to understand the current state of prevention services. As a result, services were selected and an analysis was conducted about enablers and barriers for implementation of the menu of services. Methods for community health accountability are in development and further analysis about financial sustainability and governance is underway. The planning effort will enter a phase of field work during the next three months. A series of focus groups and stake holder engagement activities will occur in pre-selected areas of SIM program activity.

SIM Context: PSCs, PCMH+ & CCIP:

For the purpose of providing context for the selection of regions, Mario Garcia explained the relationship between the Prevention Service Centers and the Community Health Collaboratives launched under the SIM CCI

Initiative. He indicated that an important goal of the SIM test grant is to examine the impact on regional health outcomes of an improved model of delivering prevention services and operating in alignment with increased standards of patient care and community outreach.
Mario Garcia commented on the need to gain better understanding of financial vehicles that may sustain this new type of community integration structure. The SIM project will retain expertise to assist in making such assessment and make recommendations on PSCs sustainability strategies. The project will explore how community based organizations can tap into new payment models for care delivery that have been introduced by the health reform. In addition, the model would have to explore alternative multisector funds and other innovative strategies that may include hospital community benefits, social impact funds, wellness funds and community development financial entities.
Faina Dookh added context by providing a short description of the Person Centered Medical Home (PCMH+) program launched by the DSS in January. This is a shared savings program offered to primary care practitioners who agreed to be accountable to a set of performance standards. The program seeks to improve quality and reduction of costs, which would allow providers to retain part of the savings. In coordination with Medicaid, the SIM program offers technical assistance to PCMH+ providers who also agreed to join the Clinical and Community Integration program (CCIP). The program offers transformation awards to Advanced Networks and FQHCs to help them achieve CCIP standards and address the social determinants of health of its attributed population. The New England Medical Group, the Community Health Center Inc., and the Value Care Alliance are three entities selected to participate in the program. CCIP providers are expected to meet a three set of standards around comprehensive care management, health equity and behavioral health integration.
Establishing Community Health Collaboratives are also a requirement of CCIP. They are intended to promote coordination between clinical and community organizations. Their goal is to bring together multi-sector organizations to coordinate their protocols. The selection of Community Health Collaboratives and Prevention Service Centers sites creates an opportunity for SIM alignment.
Pat Baker suggested that CCIP participation should be part of the criteria for prevention.
Mark Schaefer clarified that the objective was to maximize the efforts of the two initiatives and ensure that selected communities and primary care networks are implementing them concurrently, which will allow building

more effective linkages.

Selection Criteria

Mario Garcia introduced selection criteria for Prevention Service Centers demonstrations. He indicated that the selection process would be conducted in two steps. An initial pre-selection of epicenters, which would help to launch the Community Health Collaboratives. These epicenters would be mostly defined by two criteria: first, an area with meaningful presence of accountable PCMH+ providers and second, a high proportion of resident population attributed to participating PCMH+ providers.
Mario Garcia presented a map of the distribution of healthcare entities (hospitals and FQHCs) in CT. The data also illustrated the overlaps of the hospitals primary care service areas. He also shared a map with town level data, provided by the Community Health Network of CT, about the distribution of the population attributed to PCMH+ providers in the state. These data illustrates the high density of Medicaid patients in the urban centers of Bridgeport, New Haven, Hartford, Middletown and New London areas.
A second step in the final selection of PSCs regions would require the definition of specific boundaries for town-aggregates. The criteria for defining regions include having a measurable burden of disease by prioritized conditions, and clear indicators of health disparities, health risks and other determinants of poor health. DPH is working on outlining PSC regions based on the availability of a suitable sample drawn from the statewide BRFFS survey. Other criteria include ongoing prevention initiatives in the area related to the PSC menu of services and regional capacity represented by presence of potential implementer Community Based Organizations (CBOs).
Fred Browne pointed out that a few locations of the Value Care Alliance on the map seemed incorrect.
Lynn Salsgiver comment that OHCA uses 75% to define hospitals primary service areas, however if the 80% was used all towns in the state be covered.
Hayley Skinner suggested considering areas that (at this time) are not covered by PCMH+ providers but might be areas in great need. Providers in these areas will likely enroll in PCMH+ in the future. She also added that many providers are already committed to improving quality of care and participating in shared savings arrangements.
Fred Browne suggested that having demonstration sites serving as controls can add benefit to the assessment of impact. He asked whether PSCs and CCIP Community Health Collaboratives in the same area would be

redundant, while placing them in different areas would provide comparative results.
Mark Schaeffer responded that the SIM test concept is aimed at assessing maximum alignment between quality initiatives, new payment arrangements and prevention care. Therefore, the selection relies mostly in community capacity for implementation. The test grant does have a case control design and it is geared instead to observe prospective changes in health outcomes and costs. This approach is still challenged by the fact that, with current financial arrangements, reductions in disease prevalence are still not part of the incentives for better coordination.
Lynn Salsgiver commented that areas where providers are already working together and having working partnerships in place should be considered.
Pat Baker remarked that the state of readiness in terms of capacity, infrastructure and participation in CCIP seems an important addition to the criteria.

Stakeholder Engagement

Mario Garcia discussed the next step of the SIM Population Health planning process. The project will retain Health Resources in Action to facilitate a series of focus groups for the purpose of validating planning assumptions. They will conduct inquiries with CBOs affiliated to regional systems implementing the DSS Person Centered Medical Homes (+) and the SIM Community and Clinical Integration Program (CCIP). The goal is to summarize and discuss with stakeholders challenges and opportunities of CBOs to effectively intersect with the healthcare system market. In addition, the consultant will conduct a second round of the environmental scan. This is intended to conduct a fact-finding analysis of all CBOs affiliated to networks implementing selected prevention service initiatives. The goal of this environmental scan is to profile all participating agencies in the selected networks regarding their type of operation, fiduciary capacity, span of service, IT infrastructure or dependencies, sustainability strategy and adaptation to healthcare reform payment system. From this effort, SIM can recommend minimum operational standards to launch a PSC demonstration.
Steven Huleatt asked whether CBOs would be selected or invited to participate in the focus groups. He suggested to diversify the audience and types of agencies participating in the listening sessions to enrich the discussion.
Pat Baker highlighted the need to ensure that communities of color are represented along with advocacy and community based organizations.
Susan Walkama cautioned that small agencies might perceive that their

services are demanded without resources brought to the table.
Mark Schaeffer commented that Bridgeport has four accountable care organizations and a high density of population served by PCMH+ providers. In addition, Bridgeport has reached a state of readiness through its Primary Care Action group and enhance inter-sector coordination. He also mentioned that in Hartford there are two entities—Charter Oak and CHC Inc., participating in PCMH+ and a fair amount of patient enrollment. Although neither the major of the hospitals have a major role in CPMH+, there are community innovations through Community Solutions.
Middletown has a long history of collaboration, particularly around issues of behavioral health. In addition, Middlesex hospital—a member of the Value Care Alliance—and the CHC,Inc. are primary providers enrolled in CCIP. The city of New Haven has three of the biggest Medicaid providers, Fair Haven Community Health Center, Hill Community Health Center and the Northeast Medical Group.
Lynn Salsgiver commented that the New Haven partnership has been very active and worked collaboratively to develop community health needs assessments.
Mark Schaeffer finally mentioned that CHC, Inc. has part of its footprint in the area. He is also aware of a large emerging collaborative. In contrast, the two large providers in Waterbury—St. Mary's and Waterbury hospitals—did not commit to participate in PCMH+ or CCIP.
Steven Huleatt asked whether New Britain should be considered as an epicenter. However additional data about providers and CBOs is required. He also discussed the difficulty of engaging multiple towns for coordination around issues of social determinants of health.
A discussion ensued about the ability to measure population health indicators at different levels of regional subdivisions. This was put in the context of local analysis at the zip code level that providers might have the technical ability to conduct among their patient panels.
Rose Swensen indicated that the discussion on stakeholder engagement will continue in the next meeting and plans for the fieldwork will be shared with the council members.

The next Population Health Council meeting is scheduled for February 23, 2017.

Co-Chair Steve Huleatt adjourned the meeting at 5:03 p.m.