



Connecticut State Innovation Model

Population Health Council

Thursday, March 23rd, 2017

3:00 – 5:00 PM

CT Behavioral Health Partnership
500 Enterprise Drive, Rocky Hill, CT
Huntington Room, 4th Floor

Dial in #: 1-800-593-9940/passcode: 9502934

Welcome and Objectives - Council Co-Chairs

- Minutes Approval
- Public Comment
- Ground Rules
 - One person speaking at a time
 - Please wait to be addressed by Facilitator before speaking
 - Identify yourself by name before speaking
 - Mute your phone when not speaking to limit background noise

Meeting Objectives

- Comment on feedback from Capacity Assessment and Listening Sessions
- Discuss Indicators

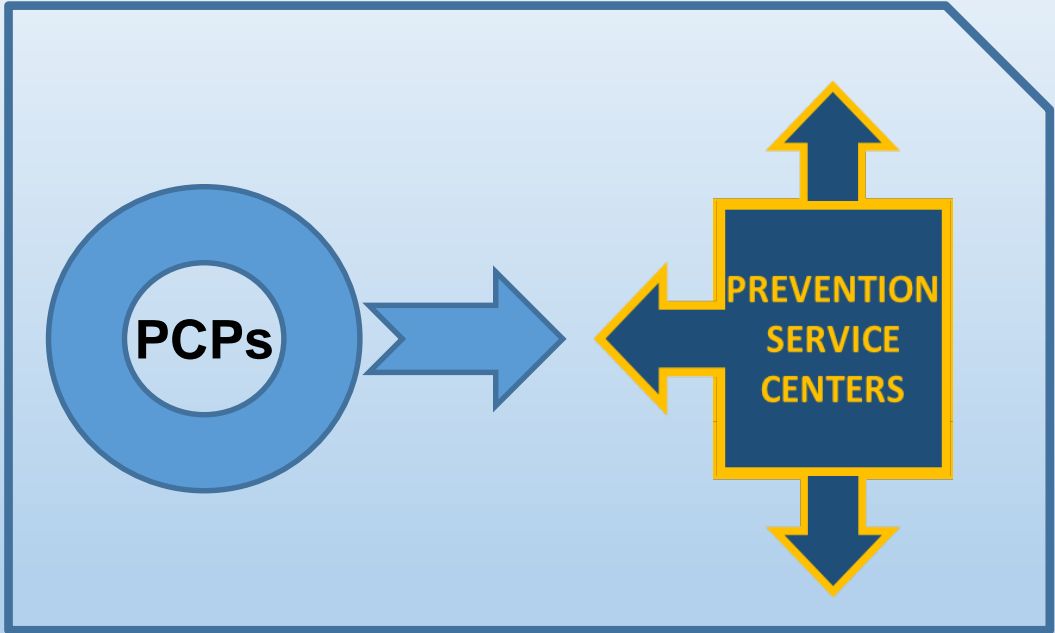
Testing the Population Health Impact of the Connecticut State Innovation Model

Improved Standards of Clinical Care

Community Collaboratives

Attributed Population

SSP/PCPM / PCP+



Improved Community Health Capacity

Community Based Prevention

Total Population

Self Sustaining Financing Model

Engagement of CBOs and Public Health Entities: Updates and Key Findings

1. Listening Sessions
2. Capacity Assessment

Heather Nelson, PhD, MPH, HRiA

Kristin Mikolowsky, MSc, HRiA

Listening Sessions: Goals

1. To ***engage community stakeholders*** and build buy-in for population health efforts
2. To ***discuss challenges and opportunities*** for community-based organizations (CBOs) and public health entities to intersect with the health care system and health care entities
3. To ***test the Prevention Service Center concept*** and its ***assumptions***

Listening Sessions: Methods

- Focus group format, 90-minute sessions, led by facilitator
- Facilitator guide developed with input from PHC, and reviewed by CT DPH & SIM
- Participants represent diverse community service organizations & perspectives
 - identified by CT DPH
 - Informed by capacity assessment
- To date, 2 sessions have been completed in Bridgeport (3/16/17) and New Haven (3/20/17)
 - 15 participants total, representing 14 CBOs and public health entities
- Next session: Middletown (3/27/17)

Listening Sessions: Limitations

- Although a range of perspectives will be included in the sessions, due to the **non-random sample**, the findings are **not generalizable**
- **Small sample size** for today's findings:
 - Listening sessions conducted to date (n = 2)
 - Total participants to date (n = 15 representing 14 community service providers)

Listening Sessions - Key Themes

Current Community Prevention Services

- Participants described a ***range of services*** they currently provide including: health education & screening programs, chronic disease management programs, primary care & other health care services provided in community settings
- Nearly all participants described not just discrete prevention services, but also services related to ***coordination and navigation***

*“[It’s] **coordination**, holding them by their hand, taking them from A to Z and making sure nothing falls through the cracks.”*

Current Relationships with Health Care Entities

- Current relationships range from non-existent to informal partnerships to formal contractual and financial arrangements
- Information sharing is limited
 - 1-way information sharing – typically referrals
 - Varied access to EHRs
 - 2-way information exchange – was limited to case management information
 - HIPPA – a barrier to data sharing

“[We] get referrals from doctors from time-to-time. People walk in the door and say ‘My doctor said I should come [here].’ and we ask ‘What’s it for? Rehab, physical activity?’”

Current Relationships with Health Care Entities

- Some participants reported interest in strengthening collaboration with health care and measuring outcomes
- Challenges include:
 - Lack of awareness of CBO / public health services
 - Lack of willingness to communicate/work with community services
 - Lack of recognition of the value of non-clinical services
 - accountable care context provides a platform for working together

*“I would like us to have a **more formal relationship with hospitals**, rather than it just happens.”*

*“I don’t know if they think we don’t have anything to offer, or **our work isn’t as valuable as theirs is.**”*

Current Relationships with Payers

- A few CBOs and public health entities have contracts with payers
- Participants noted that many of their services are not billable, particularly ***coordination and navigation services***

*“What should a health department be able to offer? **Is it a billable service?**”*

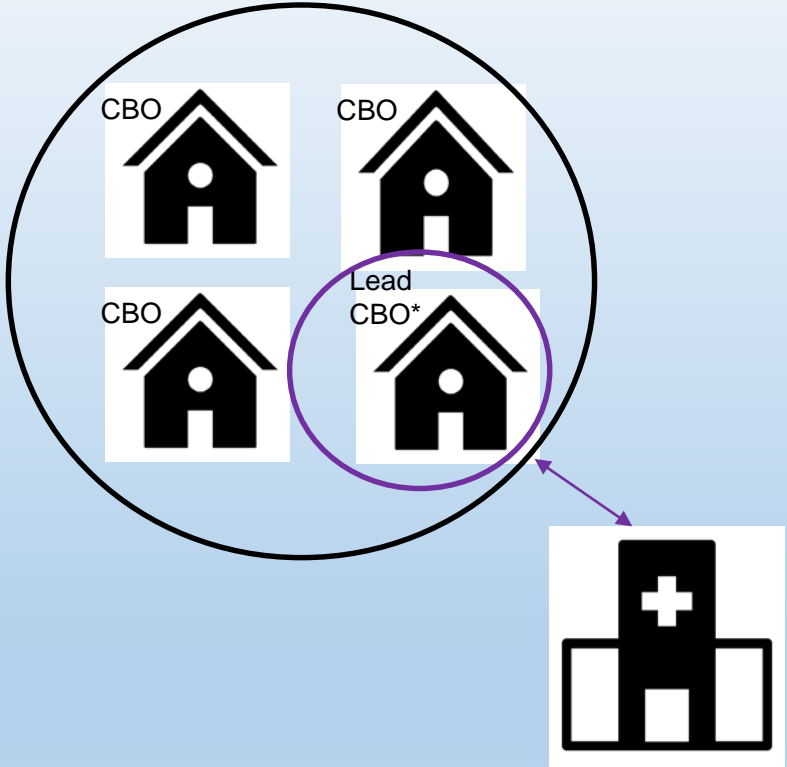
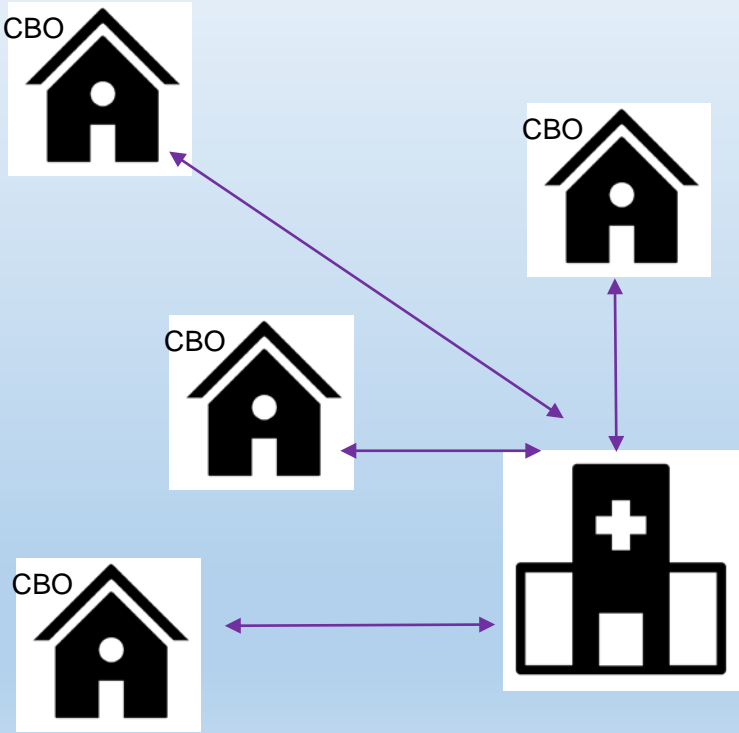
*“[Our] biggest barrier is sustainability and getting paid for... services. [Community health workers] are **soft-money funded.**”*

Current Relationships among CBOs and Public Health Entities

- Some local collaboratives exist:
 - Some focus on community health broadly; others focus on addressing needs of specific populations
 - Health care entities are partners or leaders in these collaboratives
- Sharing information about specific individuals can be challenging
 - Some collaboratives sign Release of Information (ROI) agreements

*“We have layers of meetings... where we talk about people within [the] network to get to most appropriate...solution... This has helped transform the system. Bringing cultures together at the same table in the same way... **We all have ROIs so we can talk about patients.**”*

Feedback on Prevention Service Center Concept



Prevention Service Center: General Feedback on Concept

- Some participants expressed confusion around terminology
 - “Center”
 - CBO/Public Health entity: defined by setting or functionality?

“When you call it a Prevention Service Center... the word ‘Center’... I think of a brick-and-mortar place. I don’t think that’s what you’re doing.”

Prevention Service Center: General Feedback on Concept

- Some participants stressed need to focus on social determinants of health and upstream prevention

*“I worry that it’s framed in a very **medical model** that does not usually work as well.”*

*“We really also need to think about how to do prevention before an emergency... **Triage is important but we also need to think about prevention.**”*

Prevention Service Center Concept: Backbone / Lead Entity

- Most participants agreed that a lead agency or a backbone organization is needed
- Participants noted that different types of organizations could serve as a backbone
 - Importance of considering geographic reach of backbone
- Need for transparency around backbone organization's role and incentives

*“In a system like this, if no one is named as the authority to help push the system along, **it can fall apart.** [We] need someone to wrap their arms around it.”*

*“Does lead group get more of the dollars, and then there's **resentment?** Money's the worry – especially now.”*

Prevention Service Center Concept: Process and Systems

- Clear understanding of scope and expectations for all partners is needed
 - Develop MOUs
- Need to build trust and relationships among new partners

*“The hardest part of this will be to get all the community partners to the table and not just think ‘this is what I want to sell’ but rather ‘**how do I make my community healthier?**’.”*

Prevention Service Center Concept: Process and Systems

- Some participants proposed a “triage” system where backbone would receive referral from health care entity and direct it to most appropriate CBO / public health entity
- Need to consider equitable allocation of referrals

“There’s also a territorial need. If so-and-so gets all the referrals, I could go out of business.”

Prevention Service Center Concept: Accountability & Payment

- Some participants advocated for setting up accountable arrangements
 - Others were hesitant
- Some suggested finding ways to also hold the patient / client accountable

“I think it’s the only way to go. It keeps everyone accountable. Everyone says they can do everything for everyone. Then, when you make a referral at 3pm on Friday – no one’s there! We need shared savings and they need to connect to payment...”

“We’d be reticent if we didn’t have 100% faith in whom we’re getting into bed with.”

Prevention Service Center Concept: Data and IT Systems

- EHRs can be useful for sharing information about patients and clients but have limitations
 - Some participants had no EHR access
 - Some participants had limited access (read-only)
 - Different EHRs are used by different health care entities
- The majority of participants were not providing data to health care entities
 - Currently limited to case management information
- Some participants advocated for tracking data on social indicators, not just health outcomes and cost

*“It’s more than just the health of the patient – **Social Determinants of Health** is 80%. We have to have other indicators out there.”*

Testing of PSC Planning Assumptions

Prevention Service Center Planning Assumptions

1. Individuals may encounter barriers to accessing prevention services offered by CBOs and public health entities
2. Health care providers might not know these services exist or how to facilitate linkages
3. Referral pathways between health care and community organizations are limited or do not currently exist
4. Formal linkages, such as pay-for-performance contracts, can promote the establishment of referral pathways
5. In order to establish referral pathways CBOs may need to augment or develop certain capabilities (for processing referrals, evaluating impact)
6. A regional consortium led by a backbone organization is needed to organize, coordinate, and finance shared strategies and needs.

Q&A

Capacity Assessment

- Completed: Online search to identify CBOs & public health entities in 5 epicenters that provide at least 1 service in the PSC “menu of services”
- Next Steps: Direct follow-up with CBOs and public health entities to gather additional information on:
 - Leadership
 - Operating budgets / funding streams
 - Ability to enter into legal / financial arrangements
 - Ability to track data on outcomes and metrics
 - IT capacity

Discussion on Indicators (Mario Garcia)

Goals:

Informing members of the Council about SIM progress developing a system of regional upstream metrics of total population health.

Compare and value the difference between SIM clinical quality metrics and a set of total population health outcomes indicators.

Discuss benefits and challenges of two different approaches to regional health assessments.

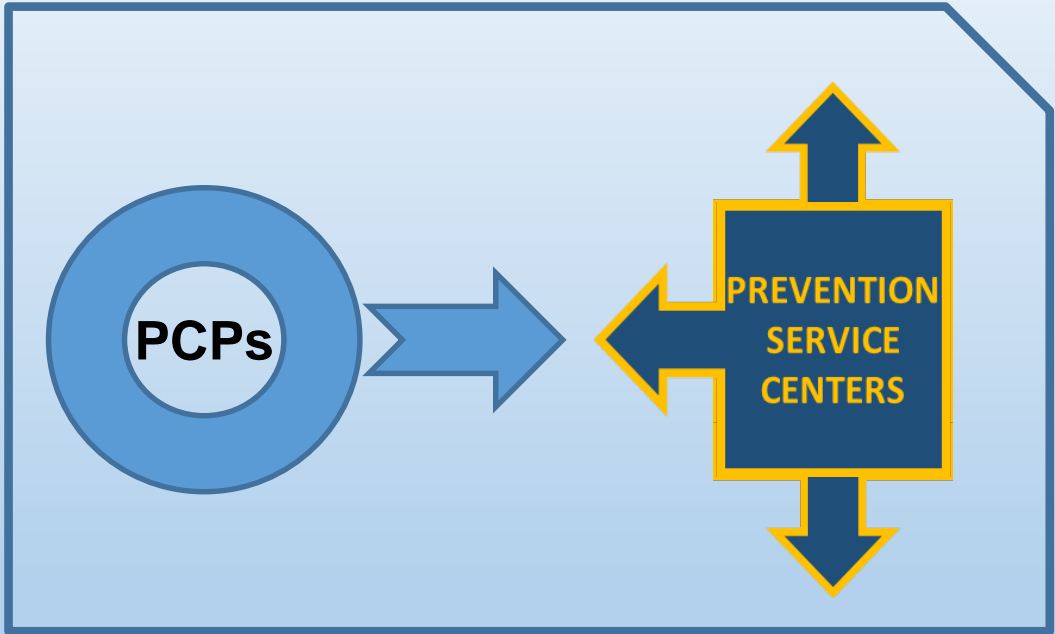
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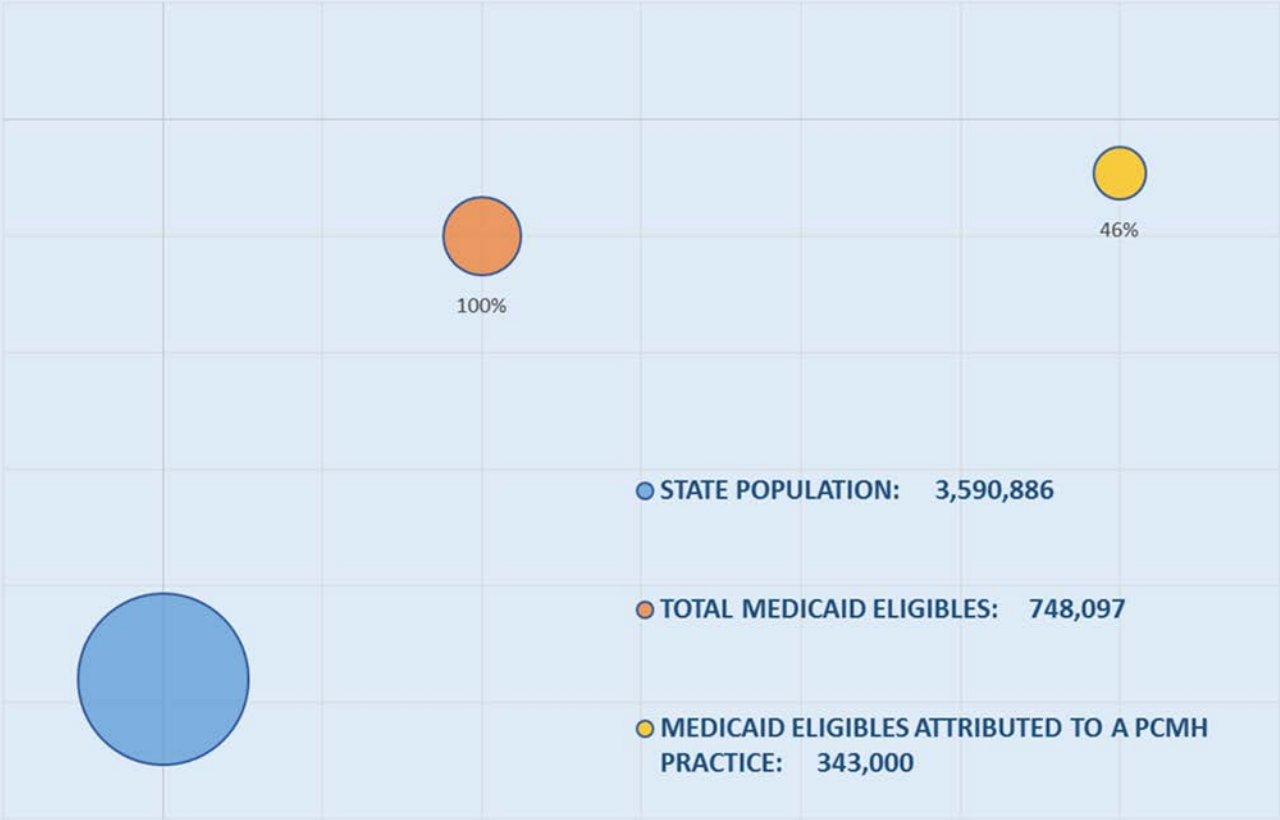
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MEDICAID and PCMH+ Attribution Diagram



QC Provisional Core Measure Set

Consumer Engagement

PCMH/CG - CAHPS care experience measure

Care Coordination

Plan all-cause readmission

Emergency Department Usage per 1000

Annual monitoring for persistent medications

Prevention

Breast cancer screening

Cervical cancer screening

Chlamydia screening in women

Colorectal cancer screening

Adolescent female immunizations HPV

Weight assessment and counseling for nutrition and physical activity for children/adolescents

BMI screening and follow up

Developmental screening in first 3 years of life

Well-child visits in the first 15 months of life

Adolescent well-care visits

Tobacco use screening and cessation intervention

Prenatal Care & Postpartum care

Screening for clinical depression and follow-up plan

Behavioral health screening (Medicaid only)

Acute & Chronic Care

Medication management for people w/ asthma*

Asthma Medication Ratio*

DM: Hemoglobin A1c Poor Control (>9%)

DM: HbA1c Testing**

DM: Diabetes eye exam

DM: Diabetes: medical attention for nephropathy

HTN: Controlling high blood pressure

Use of imaging studies for low back pain

Avoidance of antibiotic treatment in adults with acute bronchitis

Appropriate treatment for children with upper respiratory infection

Behavioral Health

Follow-up for children prescribed ADHD medication

Metabolic Monitoring for Children and Adolescents on Antipsychotics (Medicaid only, custom measure)

Depression Remission at 12 Twelve Months

Child & Adolescent Major Depressive Disorder: Suicide Risk Assessment

Unhealthy Alcohol Use – Screening

CDC Recommended Health Metrics for Community Health Assessments

Health Outcome Metrics		Health Determinant and Correlate Metrics			
Mortality	Morbidity	Health Care (Access & Quality)	Health Behaviors	Demographics & Social Environment	Physical Environment
Mortality - Leading Causes of Death (9)	Obesity (6)	Health Insurance Coverage (6)	Tobacco Use/ Smoking (8)	Age (9)	Air Quality (4)
Infant Mortality (6)	Low Birth-weight (3)	Provider Rates (PCPs, Dentists) (5)	Physical Activity (5)	Sex (6)	Water Quality (3)
Injury-related Mortality (3)	Hospital Utilization (4)	Asthma-Related Hospitalization (4)	Nutrition (4)	Race/Ethnicity (9)	Housing (5)
Motor Vehicle Mortality (3)	Cancer Rates (4)		Unsafe Sex (3)	Income (9)	
Suicide (4)	Motor Vehicle Injury (4)		Alcohol Use (4)	Poverty Level (6)	
Homicide (4)	Overall Health Status (4)		Seatbelt Use (3)	Educational Attainment (6)	
	STDs (chlamydia, gonorrhea, syphilis) (4)		Immunizations and Screenings (5)	Employment Status (6)	
	AIDS (3)			Foreign Born (3)	
	Tuberculosis (4)			Homelessness (3)	
				Language Spoken at Home (3)	
				Marital Status (3)	
				Domestic Violence and Child Abuse (3)	
				Violence and Crime (4)	
				Social Capital/Social Support (4)	

U.S. Centers for Disease Control and Prevention. Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants. Atlanta, GA: Office of Surveillance, Epidemiology, and Laboratory Services, 2013.

BRFSS Regional Population Health Indicators

Health Status

- Good or Better General
- Good Physical
- Good Mental Health
- Healthy Weight
- Health Care Coverage
- At Least One Personal Doctor

Risk Behaviors

- No Leisurely Physical Activity in Past Month
- Current Cigarette Smoking
- Ever Used Hookah
- Excessive Alcohol Consumption in Past Month

Preventive Behaviors

- Routine Check-up in Past Year
- Influenza Vaccination in Past Year
- Ever Had Pneumococcal Vaccination (65 years and older)
- Ever Had Human Immunodeficiency Virus (HIV) Test (18 to 64 years old)

Chronic Conditions

- Current Asthma
- Ever Diagnosed with Arthritis
- Ever Diagnosed with Diabetes
- Ever Diagnosed with Depression
- Ever Diagnosed with Chronic Obstructive Pulmonary Disease (COPD)
- Ever Diagnosed with Cancer
- Ever Diagnosed with Cardiovascular Disease (CVD)

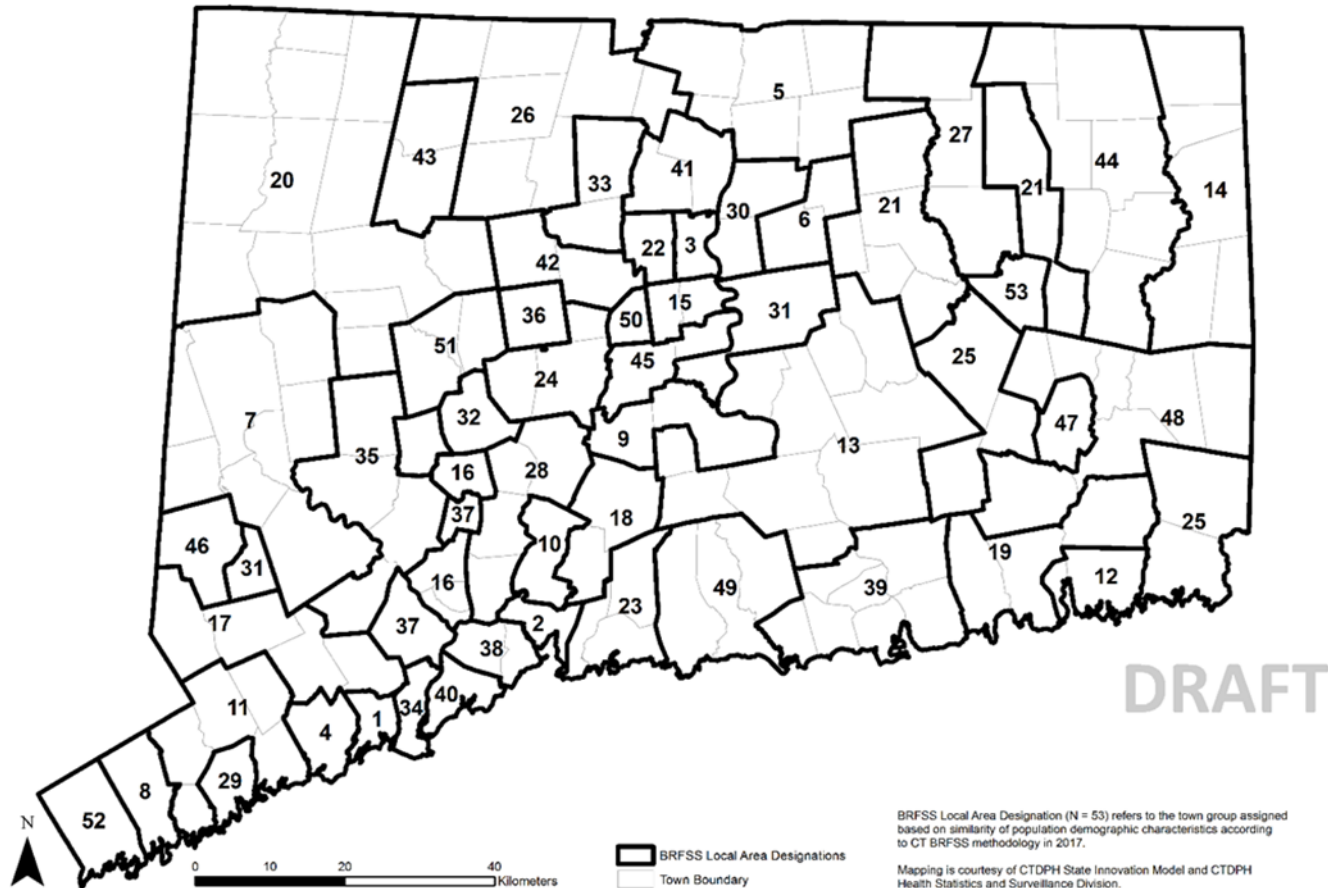
BRFSS Regional Population Health Indicators

Condition	Metric Definition/Description	Data Source	Value of the Measure	Data Regionalization	
				Yes	Maybe
Diabetes	Percent of adults ever told by a provider that they had diabetes, By income	CT BRFSS	Provides an estimate of the percent of adult residents diagnosed with diabetes (both types 1 and 2) to demonstrate the burden of diabetes in the state. Diabetes is a chronic condition of high medical cost, a burden for the healthcare system, and for society.	Aggregated estimate possible	Except for urban areas, the sample size may not be large enough in each income category to display by region.
Diabetes	Percent of adults ever told by a provider that they had diabetes, By race and ethnicity	CT BRFSS	Provides an estimate of the percent of adult residents diagnosed with diabetes (both types 1 and 2) to demonstrate the burden of diabetes in the state. Diabetes is a chronic condition of high medical cost, a burden for the healthcare system, and for society.	Aggregated estimate possible	Except for urban areas, the sample size may not be large enough in each race and ethnicity category to display by region.
Diabetes-Lower Extremity Amputation	Age-adjusted hospital discharge rate of diabetes-related lower extremity amputations per 100,000 population	CHIME	Uncontrolled or poorly managed diabetes may lead to serious complications, such as diabetes-related lower-extremity amputations. Therefore, diabetes-related lower-extremity amputations are a measure of poor diabetes control.	Yes	
Prediabetes	Percent of adults without diabetes who were tested for high blood sugar or diabetes within the past three years	CT BRFSS	Provides an estimate of the percent of adult residents who have been test for prediabetes. Many adults do not know that they have prediabetes. Increasing awareness is important because without intervention, 15% to 30% of people with prediabetes will develop type 2 diabetes within 5 years.	Yes for Urban Areas	For non urban areas the sample size from combined 2011-2015 data may not be large enough for aggregated estimate
Prediabetes	Percent of adults without diabetes who were EVER told by a doctor or other health professional that they have pre-diabetes or borderline diabetes	CT BRFSS	Provides an estimate of the percent of adult residents diagnosed with prediabetes. Many adults do not know that they have prediabetes. Increasing awareness is important because without intervention, 15% to 30% of people with prediabetes will develop type 2 diabetes within 5 years.	Yes for Urban Areas	For non urban areas the sample size from combined 2011-2015 data may not be large enough for aggregated estimate
Obesity	Percent of adults (18+y) who are obese	CT BRFSS	Obesity is a strong risk factor for many chronic condition, including high blood pressure, diabetes, and asthma, as well as for poor quality of life.	Aggregated estimate possible	
Adult Physical Activity	Percent of adults whose aerobic and muscle strengthening exercises meet national guidelines	CT BRFSS		Yes for Urban Areas	For non urban areas the sample size from combined 2011-2015 data may not be large enough for aggregated estimate
Adult Diet & Nutrition	Percent of adults who self-report consumption of fruits and vegetables less than once daily	CT BRFSS		Yes for Urban Areas	For non urban areas the sample size from combined 2011-2015 data may not be large enough for aggregated estimate
Asthma	Rate of asthma ED visits by race and ethnicity	CHIME	Asthma ED visit rate provides an important measure on the status of asthma control of CT residents with asthma.	Yes, town-level data available	
Asthma	Rate of asthma hospitalizations by race and ethnicity	CHIME	Asthma hospitalization rate provides an important measure on the status of asthma control of CT residents with asthma.	Yes, town-level data available	

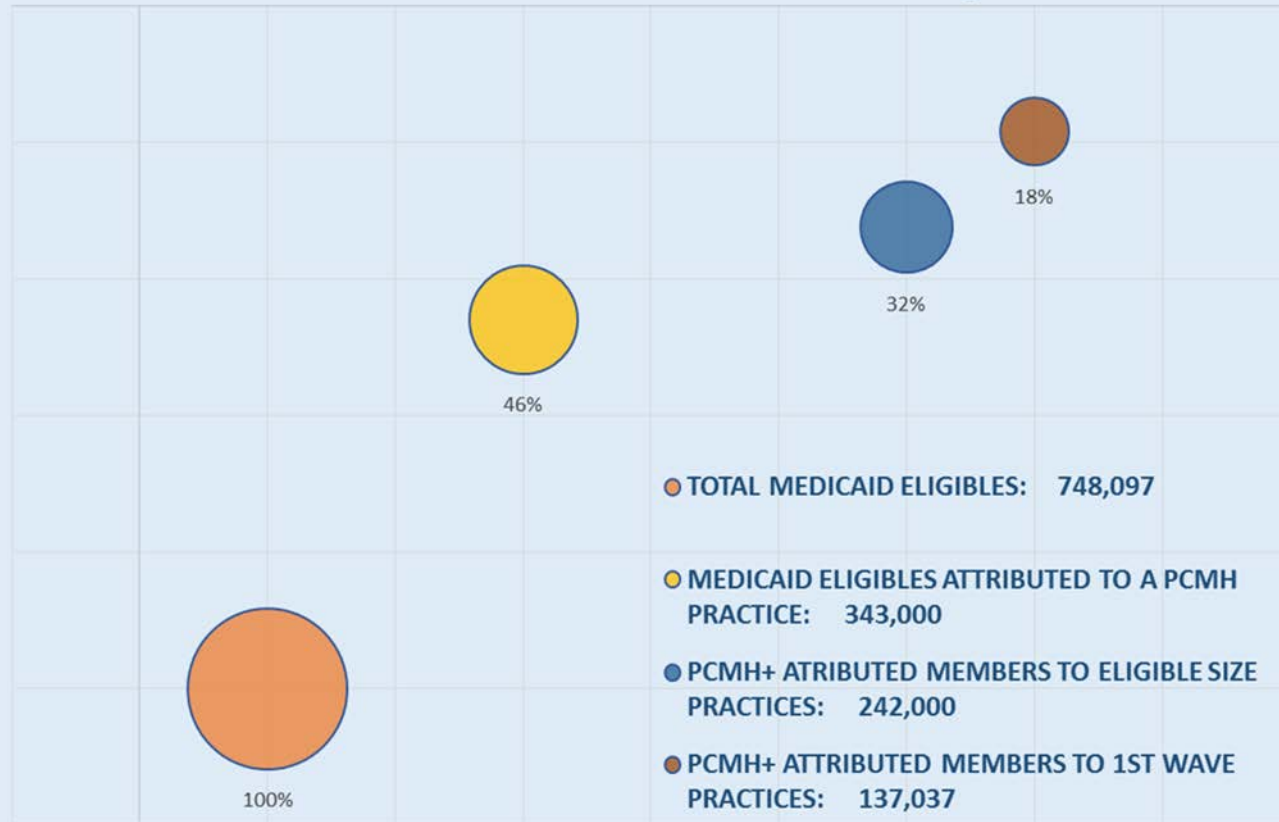
BRFSS Regional Population Health Indicators

Condition	Metric Definition/Description	Data Source	Value of the Measure	Data Regionalization	
				Yes	Maybe
Asthma	Percent of children (0-17 y) and adults (18+y) who were EVER told that they have asthma, By race and ethnicity	CT BRFSS	Provides an estimate of the percent of CT children and adults ever diagnosed with asthma to demonstrate the burden of asthma in the state.	Aggregated estimate only possible for adults in Urban Areas	For non urban areas, the sample size for adults may not be large enough in each race and ethnicity category to display by region.
Asthma	Percent of children (0-17y) and adults (18+y) with CURRENT asthma, By race and ethnicity	CT BRFSS	Provides an estimate of the percent of CT children and adults currently has asthma to demonstrate the burden of asthma in the state.	Aggregated estimate only possible for adults in Urban Areas	For non urban areas, the sample size for adults may not be large enough in each race and ethnicity category to display by region.
Asthma	Rate of asthma ED visits by town for children, adults and total population	CHIME	Asthma ED visit rate provides an important measure on the status of asthma control of CT residents with asthma.	Yes, town-level data available	
Asthma	Rate of asthma hospitalization by town for total population	CHIME	Asthma hospitalization rate provides an important measure on the status of asthma control of CT residents with asthma.	Yes, town-level data available	
Hypertension	Percent of adults ever told by a health care provider that they had high blood pressure	CT BRFSS	High blood pressure increases the risk of heart attack and stroke. High blood pressure costs the nation \$48.6 billion each year. This total includes the cost of health care services, medications to treat high blood pressure, and missed days of work (CDC).	Aggregated estimate possible	
Hypertension	Percent of adults ever told by a provider that they had high cholesterol	CT BRFSS	People with high total cholesterol have approximately twice the risk for heart disease as people with ideal levels. Exercising, eating a healthy diet, and not smoking help prevent high cholesterol and reduce levels.	Aggregated estimate possible	
Depression	Percent of adults (18+y) with a depressive disorder	CT BRFSS		Aggregated estimate possible	For non urban areas the sample size from combined 2011-2015 data may not be large enough for aggregated estimate
Depression	Percent of adults who had at least 14 poor mental health days in the past month, By income	CT BRFSS		Aggregated estimate possible	For non urban areas the sample size from combined 2011-2015 data may not be large enough for aggregated estimate
Readmission	Readmissions for PQI 90 (overall composite)	HIDD	Measures percentage of qualifying hospital admissions that result in unplanned readmissions within 30 days of discharge	Yes - patient zip code, town, county reported in database	
Readmission	Prevention Quality Indicators Overall Composite	HIDD	Composite measure hospitalizations that are potentially avoidable with appropriate ambulatory care	Yes - patient zip code, town, county reported in database	

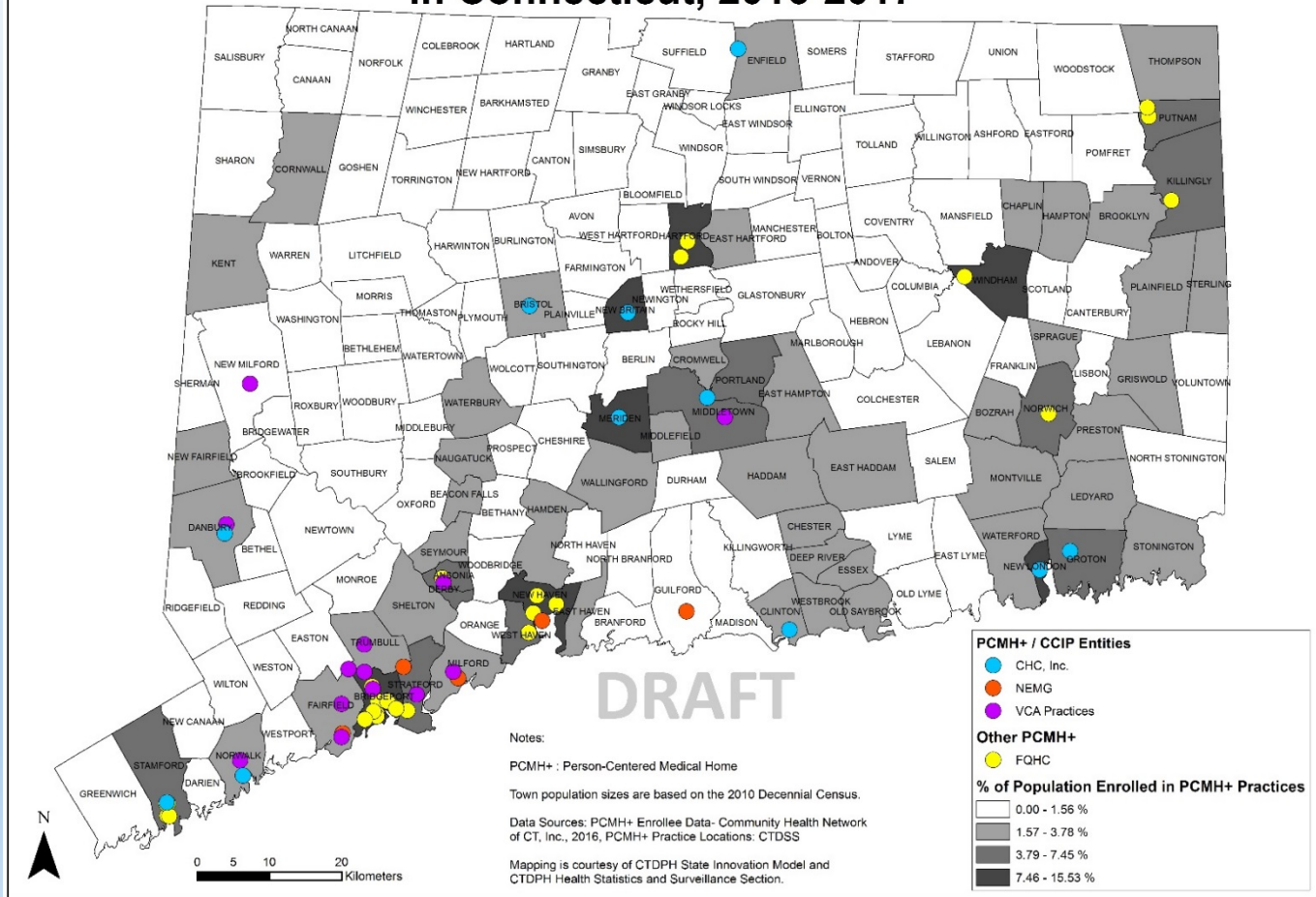
BRFSS Local Area Designations and CT Towns



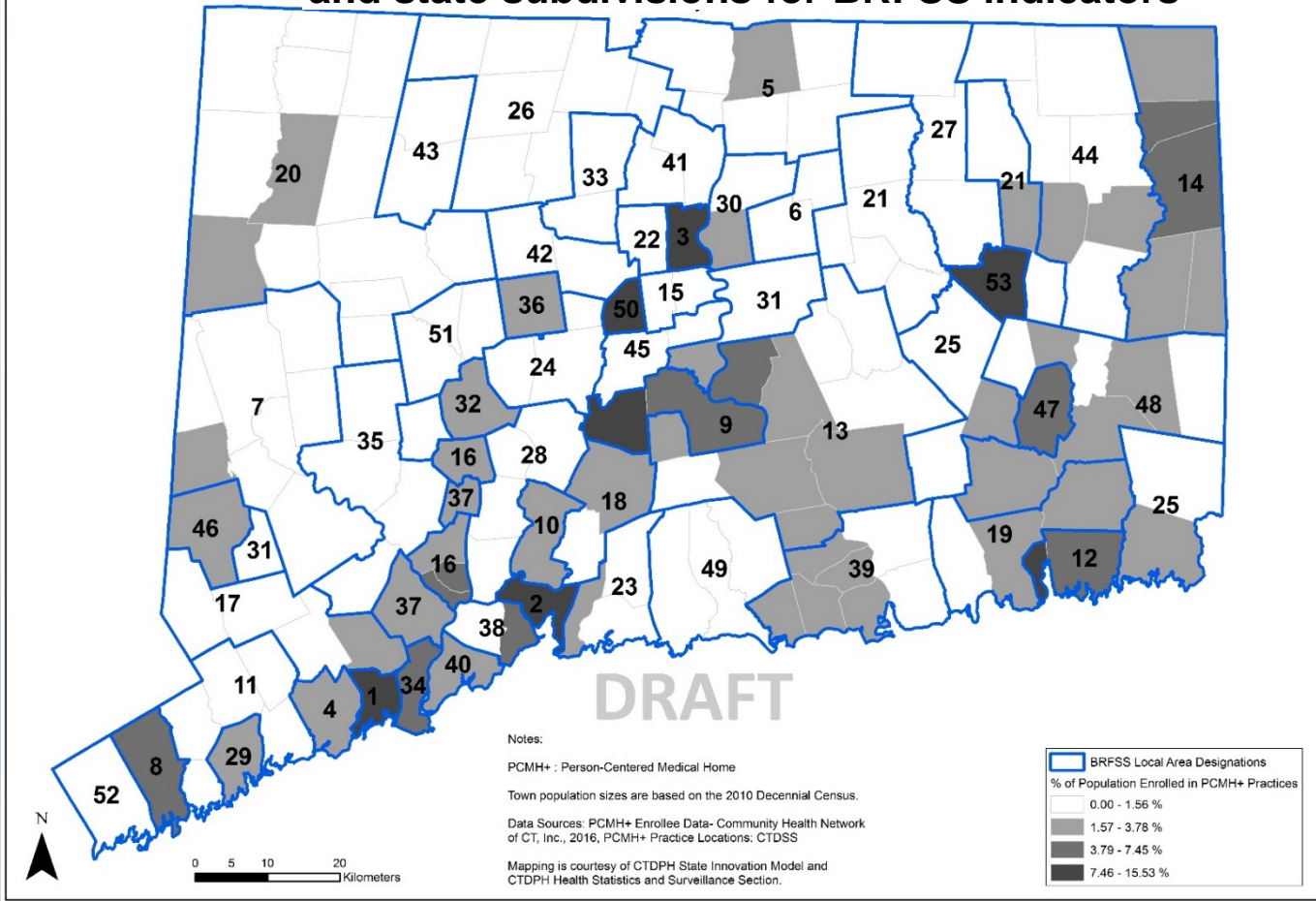
MEDICAID and PCMH+ Attribution Diagram



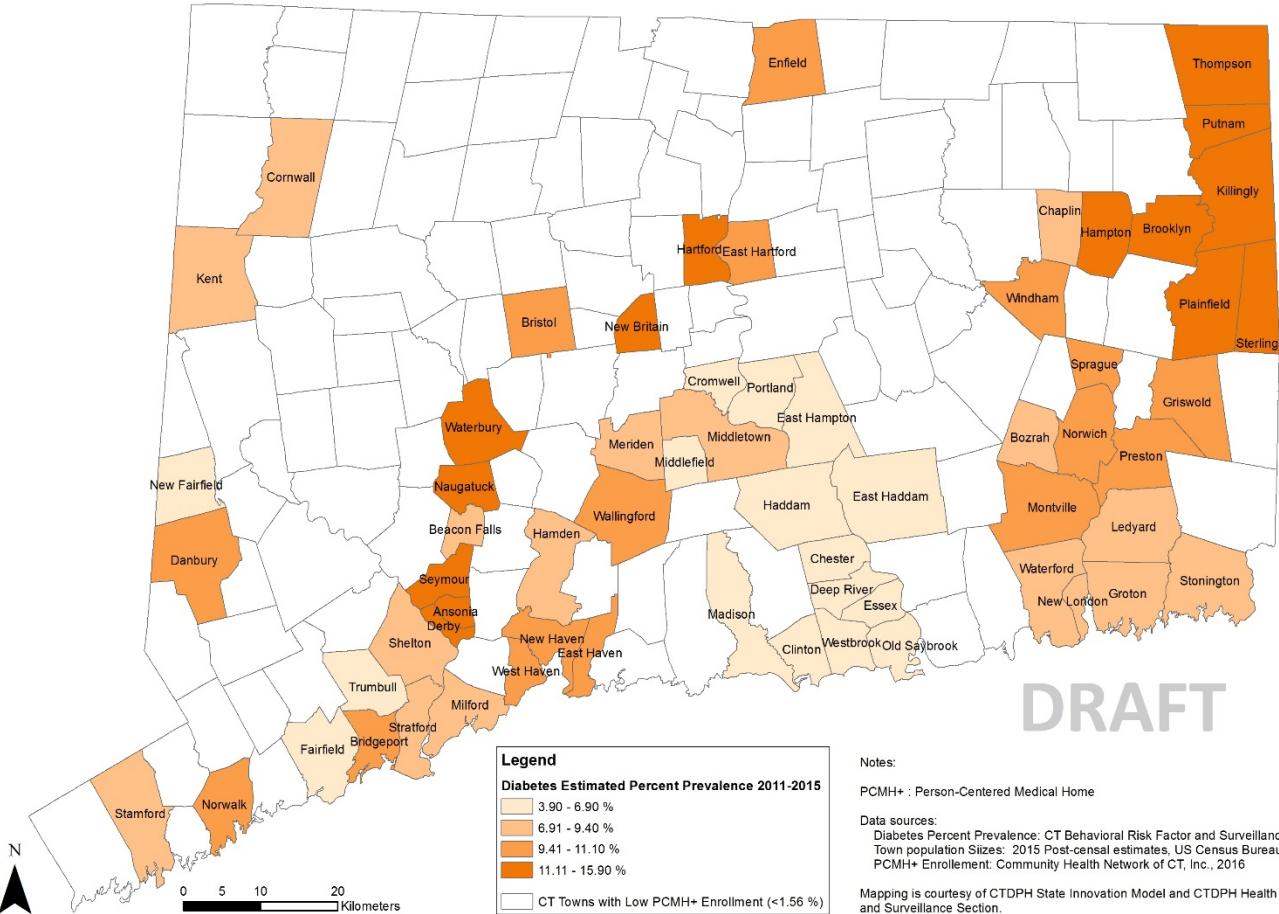
PCMH+ Practices and Population Enrollment by Town in Connecticut, 2016-2017



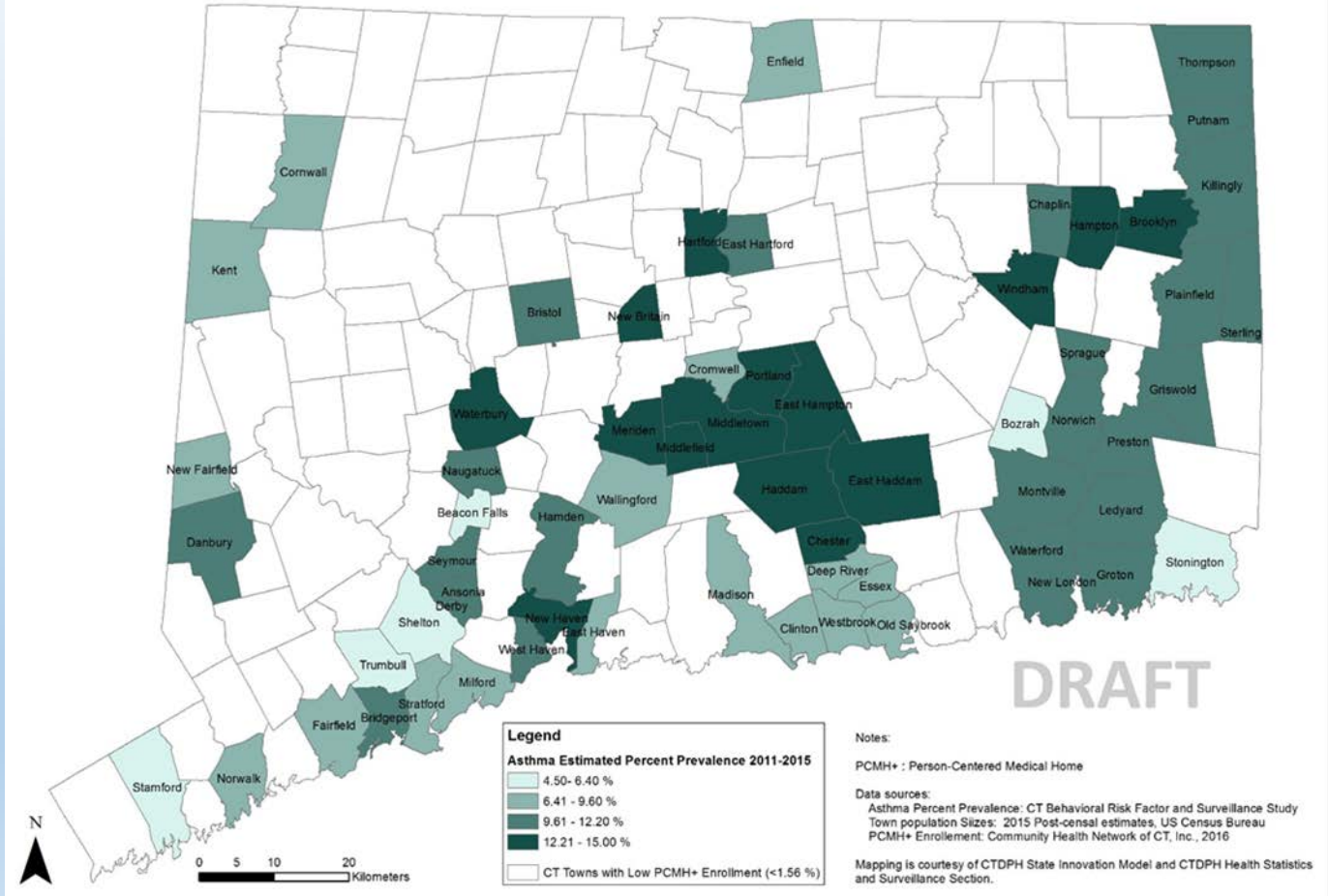
PCMH+ Population Enrollment by Town and state subdivisions for BRFSS indicators



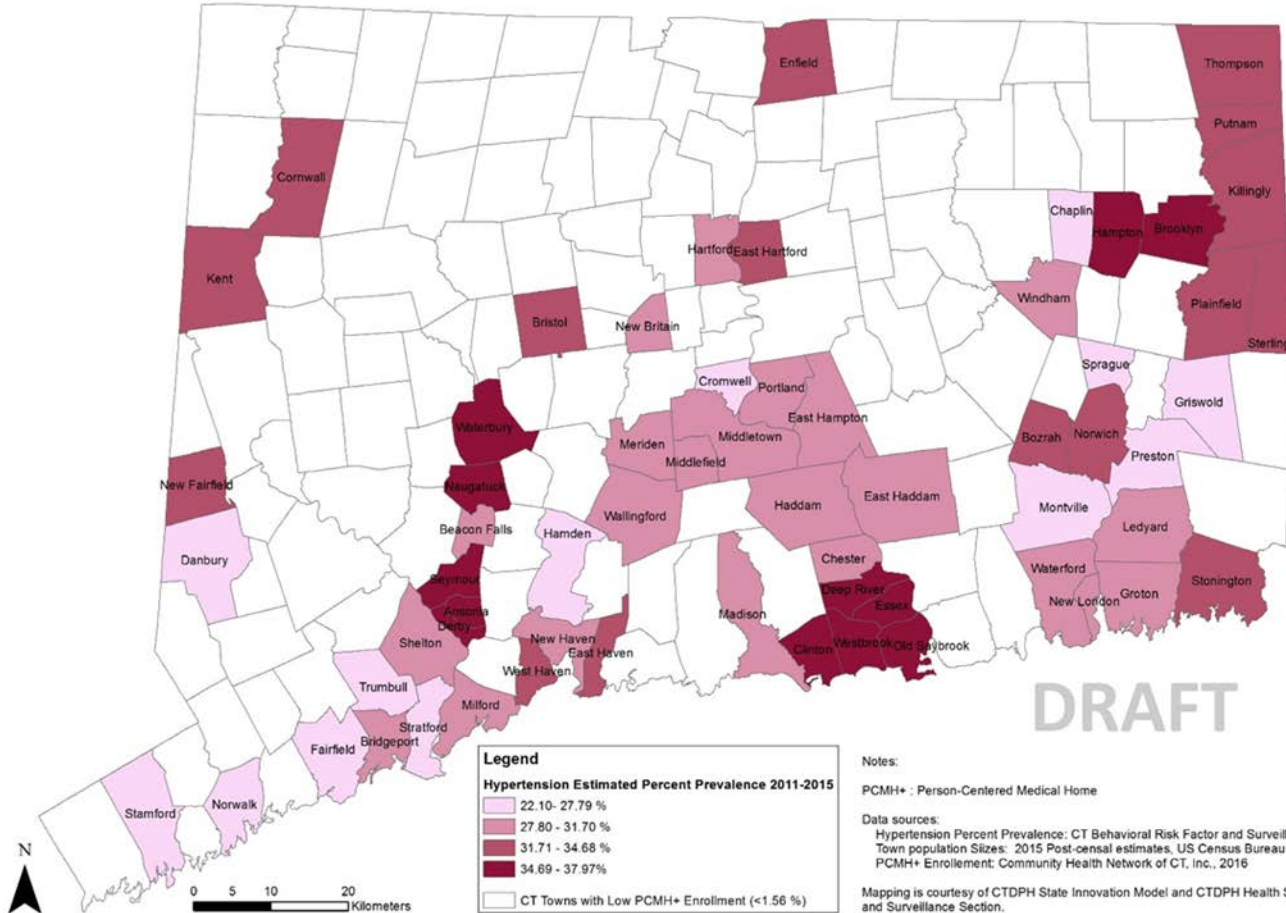
Diabetes Percent Prevalence 2011-2015 in CT Towns with High PCMH+ Enrollment (> 1.55% of the Total Population)



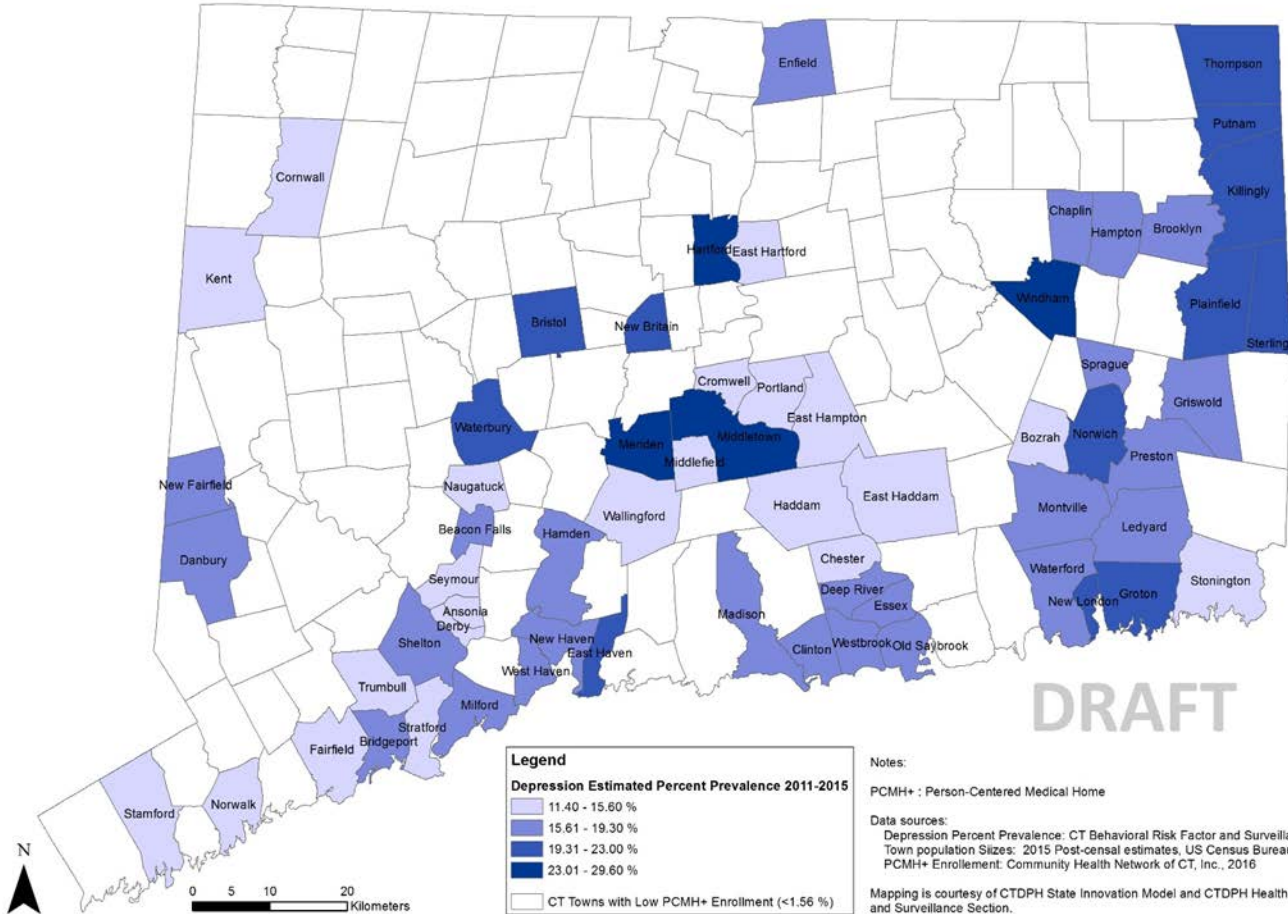
Asthma Percent Prevalence 2011-2015 in CT Towns with High PCMH+ Enrollment (> 1.55% of the Total Population)



Hypertension Percent Prevalence 2011-2015 in CT Towns with High PCMH+ Enrollment (> 1.55% of the Total Population)



Depression Percent Prevalence 2011-2015 in CT Towns with High PCMH+ Enrollment (> 1.55% of the Total Population)



Regional Approaches for Developing Community Health Needs Assessments

Planning Model: HP 2020 Framework, Framework of Social Cognitive, etc.

Surveillance: Mail & online surveys, Focus groups, Phone interviews

Data: Quantitative and qualitative, mixed bag of primary and secondary sources, minimal hospital utilization data.

Consultants: HRiA, Holleran, DataHaven, CRPP & John Snow, Inc.

Collaboration: Local Health District, Federally Qualified Health Center, Health Coalitions

Tools: Hanlon Method, Prioritization Matrix, CHANGE

Community Health Improvement Plan: Critical for developing policies and defining actions to target efforts that promote health

Process Outcomes and Opportunities From Regional Collaborations for CHNAs

- Partners share ownership towards community health improvement.
- Strengthened capacity for data collection and analysis.
- Provided foundations for monitoring and evaluation of interventions.
- Enlightens local decision making for strategic investment.
- Enhances accountability through public reporting.
- Creates opportunities for inter-agency alignment.
- Ensures community engagement and participation.
- Requires priority setting focus.
- Begins improving metrics standardization.

Barriers to Quality Measures of Community Health

- Mistrust of the data, of the people or organizations presenting data or metrics;
- Institutional inertia or resistance or devotion to maintaining the status quo
- Poor accountability or feedback about previously collected data leading to community mistrust
- High-profile validated metrics sets are not always relevant or flexible to meet community needs
- Lack of granularity/local relevance
- Resource limitations
- Technical difficulties with integrating data in different formats
- Competing interests in a multi-sector environment.

Next Steps

- Align available regional metrics with prevention priorities and PSC services.
- Consider regional IT infrastructure and analytical capacity to address issues of accountability.
- Validate methods and data from CHNAs.

Next Meeting (Mario Garcia)

Date and Location

April 27th, 3:00-5:00 p.m.

Connecticut Hospital Association (April, May and June)
110 Barnes Rd., Wallingford