State of Connecticut

State Innovation Model
Population Health Council

Meeting Summary
March 23, 2017

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

Members Present: Patricia Baker, Elizabeth Beaudin, Steven Huleatt, Martha Page, Susan Walkama, Hyacinth Yennie

Members Participated via Teleconference/Webinar: Elizabeth Beaudin, Tekisha Dwan Everette, Craig Glover, Lisa Honigfeld, Carolyn Salsgiver, Hayley Skinner, Vincent Tufo
Members Absent: Tamim Ahmed, Frederick Browne, Nancy Cowser, Garth Graham, Kate McEvoy, Hugh Penney, Penny Ross, Elizabeth Torres

Other Attendees: Faina Dookh. Mario Garcia, Sandy Gill, Kristin Mikolowsky, Heather Nelson, Mark Schaefer, Carol Stone, Kristin Sullivan, Rose Swensen, Supriyo Chatterjee

Call to Order: Co-Chair Susan Walkama called the meeting to order at 3:05 p.m.; a quorum was present.

Review and Approval of Meeting Summary: Co-Chair Susan Walkama asked for a motion to approve the meeting summary of the February 23, 2017 Population Health Council meeting. Martha Page made a motion to approve the meeting summary. The meeting summary was approved.

Public Comment: Supriyo Chatterjee wanted to share a published report about what is happening in the Midwest relative to the opioid epidemic which seem to be a lot worse in that area based on new analysis.

Meeting Objectives: Rose Swensen – We will be discussing preliminary findings from the environmental scan and focus groups and their potential implications for the demonstration model. We will also be discussing the feedback from the capacity assessment and the listening sessions. HRiA staff presentation will refer to the engagement of CBOs and public health entities.

Listening Sessions: Goals – Heather Nelson indicated that the goals of the listening sessions are (1) to engage community stakeholders and build buy-in for population health effort; (2) to discuss challenges and opportunities from community-based organizations (CBOs) and public health entities to intersect with the health care system and health care entities-- what are they experiencing, what is going well for them; and (3) to test the prevention service center concept and its assumptions-- to get feedback on all this work being done and assumption feedback.

Listening Sessions: Methods – Ms. Nelson indicated that the focus group format were 90 minutes sessions, led by a facilitator and using the Facilitator guide developed with input from PHC, and reviewed by CT DPH and SIM. The participants represent diverse community service organizations and perspectives identified by CT DPH and informed by capacity assessment. To date, 2 sessions have been completed in Bridgeport (3/16/17 and New Haven (3/20/17). The aim of these focus groups is to have diverse input. She indicated that her group is working on the capacity assessment and will refer to that as they continue to do more focus groups. There was a total of 15 participants per group, representing 14 CBOs and public health entities. The next session will be in Middletown on March 27, 2017.

Listening Sessions: Limitations - Although a range of perspectives will be included in the sessions to the non-random sample, the findings are not generalizable. Small sample for today's findings include the 2 listening sessions conducted to date with a total participants to date of 15, representing 14 community service providers.

Listening Sessions – Key Themes – Current Community Prevention Services - Heather Nelson explained that the participants were asked to speak about their current experiences and to tell us what the concept is. Participants described a range of services they currently provide including health education and screening programs, chronic disease management programs, primary care and 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: "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. One of the organizations had a relationship with an entity who provided the funding to get patients to these medical services.

Information sharing is limited to 1-way sharing, typically as referrals. Varied access to EHRs, 2-way information exchange is limited to case management information and HIPPA, a barrier to data sharing.

Some participants reported interest in strengthening collaboration with health care and measuring outcomes but that there are challenges which 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.

Current Relationships with Payers - A few CBOs and public health entities have contracts with payers. A few had contracts with Medicaid but the majority did not have a relationship with payers. Participants noted that many of their services are not billable, particularly coordination and navigation services. They indicated their biggest barrier is sustainability and getting paid for services.

Current Relationships among CBOs and Public Health Entities - Some local collaborative exist, some focus on community health broadly, others focus on addressing needs of specific populations like the homeless population. Health care entities are partners or leaders in these collaboratives.

Sharing information about specific individuals can be challenging. Members sign release of Information (ROI) agreements. One specific example is, "We have layers of meetings…where we talk about people within the network to get to the 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 and General Feedback on Concept: Kristin Mikolowsky, HRiA, presented a graphic. Some participants expressed confusion around the following terminology: "Center" – when we are developing more of a network.
They asked us to define CBO/Public Health entity by setting or functionality.

Ms. Mikolowsky explained some participants stressed the need to focus on social determinants of health and upstream prevention. How to manage a disease; social determinants of health and prevention; how do we prevent people from getting sick?

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. Discussed were notions such as the importance of considering the geographic reach of backbone; should backbone have relationship and coverage of the whole region and the need for transparency around backbone organization's role and incentives.

Dr. Mark Schaefer stated this is an enormous amount of information. I am struck by the parallel union of the CBOs engaged. There seems to be universal challenges in the community and the lack of standardization around methods and of privileged information even before you talk about demonstrated value. There is an opportunity to prescribe some solution to develop a community consensus protocol on how to work together.

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. They stressed the need for upstream solutions and considering the importance of how referrals are allocated.

Accountability & Payment - Some participants advocated for setting up accountable arrangements, while others were hesitant. However, most indicated the only way to go is an accountable arrangement. Some suggested finding ways to also hold the patients/clients responsible.

Data and IT Systems – Electronic Health Record (EHRs) can be useful for sharing information about patients and clients, but they have their limitations. Issues such as: some participants had no EHR access, some participants had limited access (read-only), and different EHRs are used by different health care entities, to name a few. The majority of participants were not providing data to health care entities, and are currently limited to case management information. Participants advocated for tracking data on social indicators, not just health outcomes and cost. Also, tracking of social determinants of health has proved challenging due to the variation in indicators and their lack of uniformity across systems.

Prevention Service Center Planning Assumptions offered by participants:

1. Individuals may encounter barriers to accessing prevention services offered by CBOs and public health entities – more coordination and navigation.
2. Health care providers might not know these services exist or how to facilitate linkages – they have been around for a long time but certainly do not know everything that is out there.
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 – a desire to develop more formal relationships.
5. In order to establish referral pathways CBOs may need to augment or develop certain capabilities (for processing referrals, evaluating impact, etc.)
6. A regional consortium led by a backbone organization is needed to organize, coordinate, and finance shared strategies and needs.

Q & A Session:

- Hyacinth Yennie – How can the Population Health Council guide them or bring them together to communicate and help do a better job? How can they not have data? Are they looking for accountability? Make sure there is data that supports this notion.
- Heather Nelson – They want to work with health care centers. What was interesting is in bringing these concepts, people are very appreciative to get this information and the data piece was very specific; no one was offering information on what they keep track of.
- Susan Walkama – What is our take away out of our listening sessions? With engagement being a high priority, what is the take away, what is going to happen in the community?
- Heather Nelson – What is happening currently and how are folks responding to these sessions. All this information will be posted online and on the website as it was given to participants.

Q & A (this information is from Rose Swensen's notes)

- How can PSC help CBOs do a better job providing services

- How can PSC help build capacity regarding data sharing.
- If engagement is high priority, link input to the next steps and communicate back to participants.
- PSC and HC has challenge similar to CBO and HC collaboration.
- Lack of standardization and systemization about things that are "good" to opportunity to prescribe near-term solutions.
- Define prevention and capacity (wide range and diverse)
- Categorize participants for Council—types of organizations/themes by type
- Thrilled to see social determinants, coordination and navigation elements and triage concept to services.
- United Way 211 might be a resource (using)
- Positive remarks regarding current state or innovation? Hard to tell.
- Hold patient accountable—making client full partner in prevention.

Capacity Assessment: Kristin Mikolowsky updated the Council on the next steps. Online search to identify CBOs & public health entities in 5 epicenters that provide at least 1 service from the PSC menu of services. The next steps is to 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 and IT capacity.

Discussion on Indicators: Dr. Mario Garcia gave a brief update on the progress of the goals and presented various charts.

He stated that ultimately we need all this information and input from the focus groups to find out about the landscape of diverse programs and types of organizations that are out there. Once you start talking about prevention, this is very broad, the diversity of services and diversity of size and capacity of these organizations are important considerations for planning.

Comments:

- Lisa Honigfeld stated she enjoyed the presentation and if at some point these focus group participants can be categorized so we can have a sense of who participates in these sessions. It would be helpful to categorize the types of organizations; we can learn quite a bit about some services out there but that are not getting into the network.
- Carolyn Salsgiver indicated this is the social determinant side of health. I love the coordination and navigation that was talked about and love the triage concept to create a center with a list and whether they are taking advantage of these services.
- Tekisha Everette said the information was very helpful and is interested in seeing a list of the types of organizations that responded.

- Liz Beaudin inquired about the United Way, what level of resources or services they have around the state.
- Kristin Sullivan replied that we are utilizing that organization in our discussions.
- Steve Huleatt said he hopes they are positive about these ideas, something they are truly interested to make innovative change.
- Heather Nelson indicated there is a willingness but the organizations need to hear or know more, the general sense was to have the discussion.
- Hyacinth Yennie asked what is out there and how we can be helpful to make it better.
- Martha Page said there should be a way to hold the patient accountable, once you are diagnosed with something. How you get people to take responsibility for their health care.
- Hyacinth Yennie said that when you go to the providers, you are being rushed, there is no time to build a relationship.

Next Steps: Mario Garcia indicated the next steps are to align available regional metrics with prevention priorities and PSC services; consider regional IT infrastructure and analytical capacity to address issues of accountability; and validate methods and data from CHNA's.

Data and Metrics: (Information from Rose Swensen's notes)

- CHNAs part of IRS tax code – not repeated under Trump Care
- Build on demographics of data sets, track social determinant factors (educational attainment) and health equity
- BRFSS limitation – available by county, but not by town. DPH has been collecting information by town and zip-code level.
- Look into DataHaven data (includes social determinant information) – need HIC approval.

Faina Dookh provided an update regarding the status of the Community & Clinical Integration Program and Community Health Collaborative. The vendor Qualidigm will begin conducting an environmental scan in the three selected regions of Bridgeport, New Haven, and Middletown to assess whether there are any existing related collaborative already in place. If there are none, Qualidigm will convene a multi-sector collaborative. If one already exists, they will support this collaborative to meet CCIP goals.

Next Meeting: The next council meeting will be held on April 27, 2017 from 3:00 pm – 5:00 pm at the Connecticut Hospital Association, 110 Barnes Road, Wallingford. The agenda topic for the next meeting will be to continue to bring additional feedback from the focus groups.

The meeting was adjourned at 5:00 p.m.