CONNECTICUT Office of Health Strategy

Connecticut Department of Public Health

SIM connecticut state innovation model

Health Enhancement Community Initiative

Population Health Council Meeting

March 28, 2019

SIM connecticut state innovation model

Meeting Objective

Resolve key design questions to enable the production of:

- Final Response to Comments and
- Final HEC Framework documents

Review provisional timeline and update financing strategy

Agenda

1. Review of the public comments
   a. Actions from disposition document
   b. Key Design Adjustments:
      i. HEC Structure: Governance & Community Input
      ii. Health Disparities and Main HEC Goals
      iii. Scale and Timing of HEC Initiative
      iv. Centralized Support System
      v. Other ad hoc issues
   c. Timeline for Response to Comment and HEC Framework approval
2. Update on the strategy for near-term and long term HEC financing

Public Comments Disposition

1. Prepare a compendium of public comments (previously distributed)
2. Prepare a draft *response to comment* with proposed:
   a. Clarifications
   b. Adjustments to framework/model design
   c. Considerations for future planning
3. Review selected design questions with PHC (today)
4. PHC review and approval of final response to comment
5. PHC review and approval of final HEC Framework documents

Key Design Adjustment: HEC Structure

What We Need to Solve:

- Clarity about how community members will be meaningfully involved in the HEC structure, including:
  - In making decisions
  - In the governance body
  - Through other options
    - Some community members expressed that they did not want the only option for participating to be sitting on a governance body.
    - Having more than one option would enable community members to be part of making decisions and also lead and/or work on issues that matter most to them through the vehicle of their choice.

Key Design Adjustment: HEC Structure

What We Need to Solve:

- A better description of a believable and workable way for HECs to be structured and function that…
  - Isn't about creating three siloes.
  - Can manage power issues.
  - Can truly involve community members in the ways they choose to be involved.
  - Can get things done.

For Discussion Purposes Only

HEC Structure

Backbone Organization/ HEC Director and Staff: Managing the HEC and Coordinating Across Community Groups, Governance Body, and Partners

Community Groups: Leading Interventions They Select

Governance Body: Overseeing HEC with Community Member and Partner Representation

Key Design Adjustment: Health Disparities and Goals

What We Need to Solve:

- Elevate the focus on health disparities and health equity within the HEC Initiative and framework

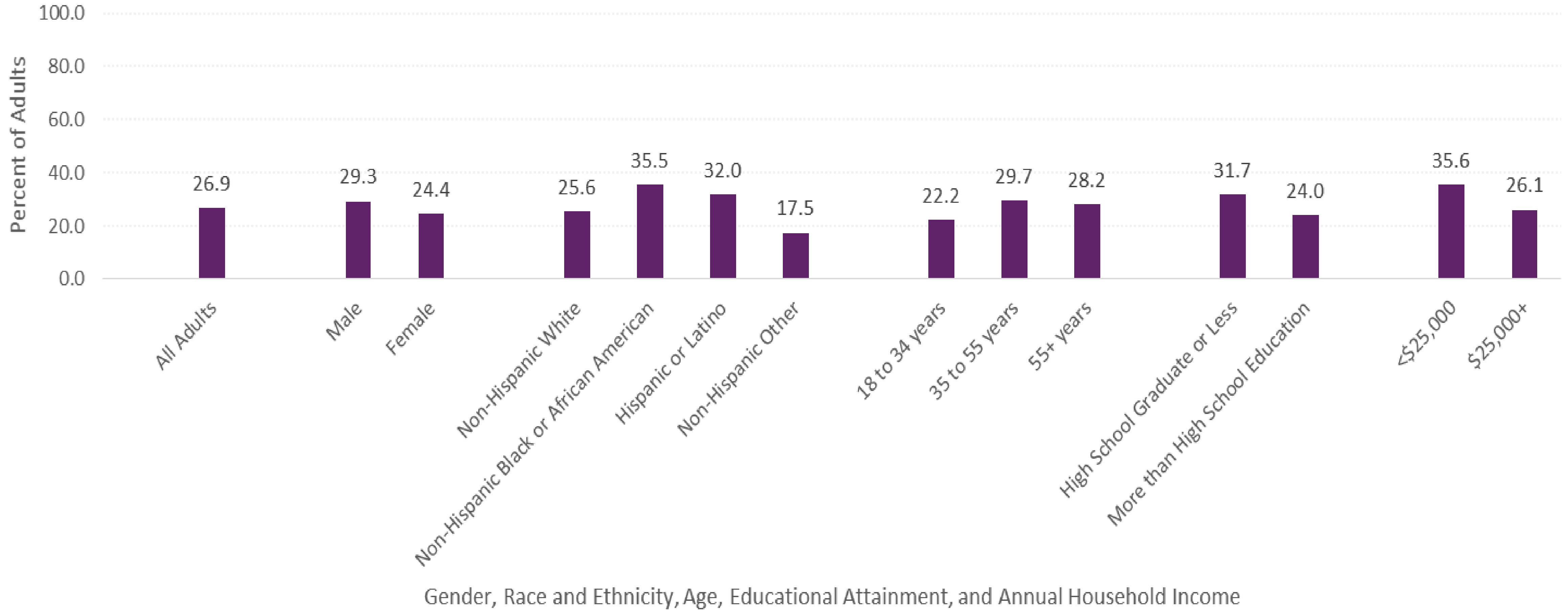
What We Know:

- Addressing racial and ethnic health disparities and improving health equity are essential to achieving HEC outcomes
  - There will be specific measures in the final measures list that specifically address health disparities and health equity
  - Today we'll discuss other options

Disparities in Health Outcomes by County and Race/Ethnicity

	Healthiest County	Least Healthy County	American Indian/ American Native	Asian/Pacific Islander	Black	Hispanic	White
Premature Death (years lost/100,000)	4,200	6,400	3,800	2,200	7,600	5,000	5,300
Poor or Fair Health (%)	11%	13%	17%	5%	20%	29%	10%
Poor Physical Health Days (avg)	2.9	3.3	N/A	2.1	3.9	4.7	3.1
Poor Mental Health Days (avg)	3.2	4.0	N/A	2.5	3.6	4.5	3.8
Low Birthweight	7%	7%	10%	8%	12%	8%	7%

Source: http://www.countyhealthrankings.org/explore-health-rankings/reports/state-reports/2018/connecticut



Data source: CT BRFSS 2017

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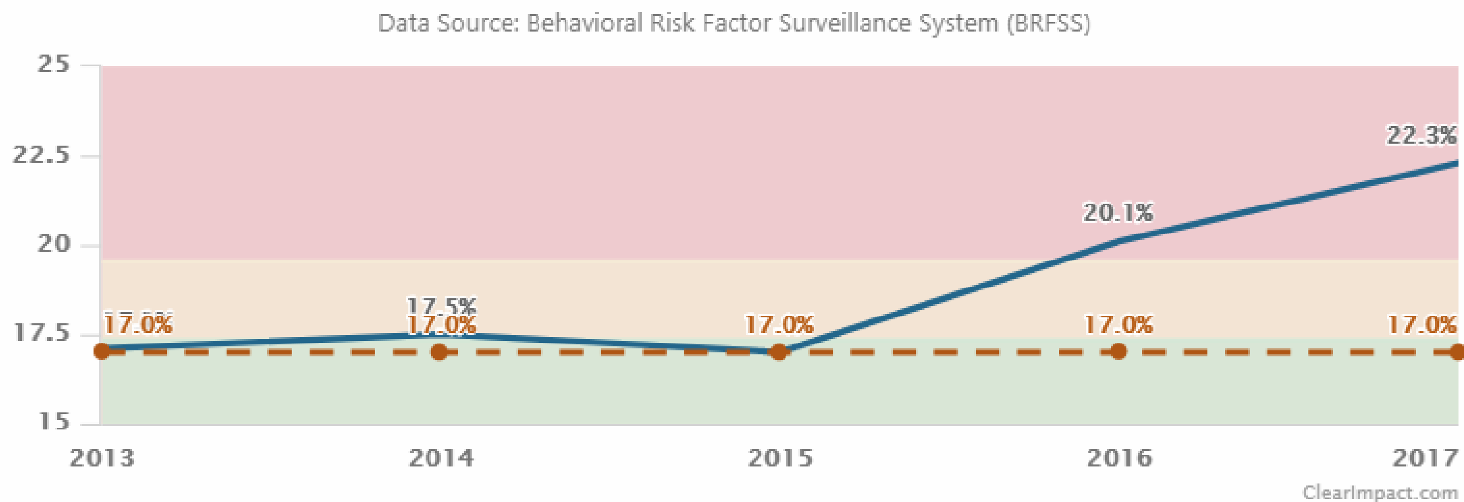
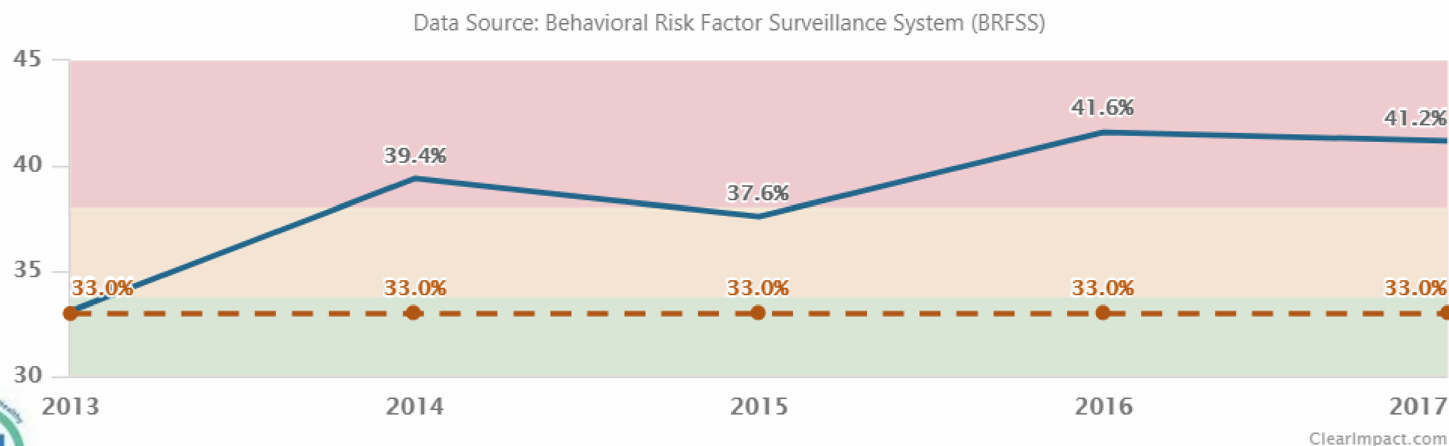
Obesity Percent of children (5-12y) in Connecticut who are obese. (HCT2020)



2017	22.3%	17.0%	↗	2	30% ↗
2017	22.3%	17.0%	↗	2	30% ↑
2016	20.1%	17.0%	↗	1	18% ↑
2015	17.0%	17.0%	↘	1	-1% ↓
2014	17.5%	17.0%	↗	1	2% ↑
2013	17.1%	17.0%	→	0	0% →

Obesity Percent of Connecticut children (5-12y) with a household income of <$25,000 who are obese.



2017	41.2%	33.0%	↘	1
2017	41.2%	33.0%	↘	1
2016	41.6%	33.0%	↗	1
2015	37.6%	33.0%	↘	1
2014	39.4%	33.0%	↗	1
2013	33.1%	33.0%	→	0

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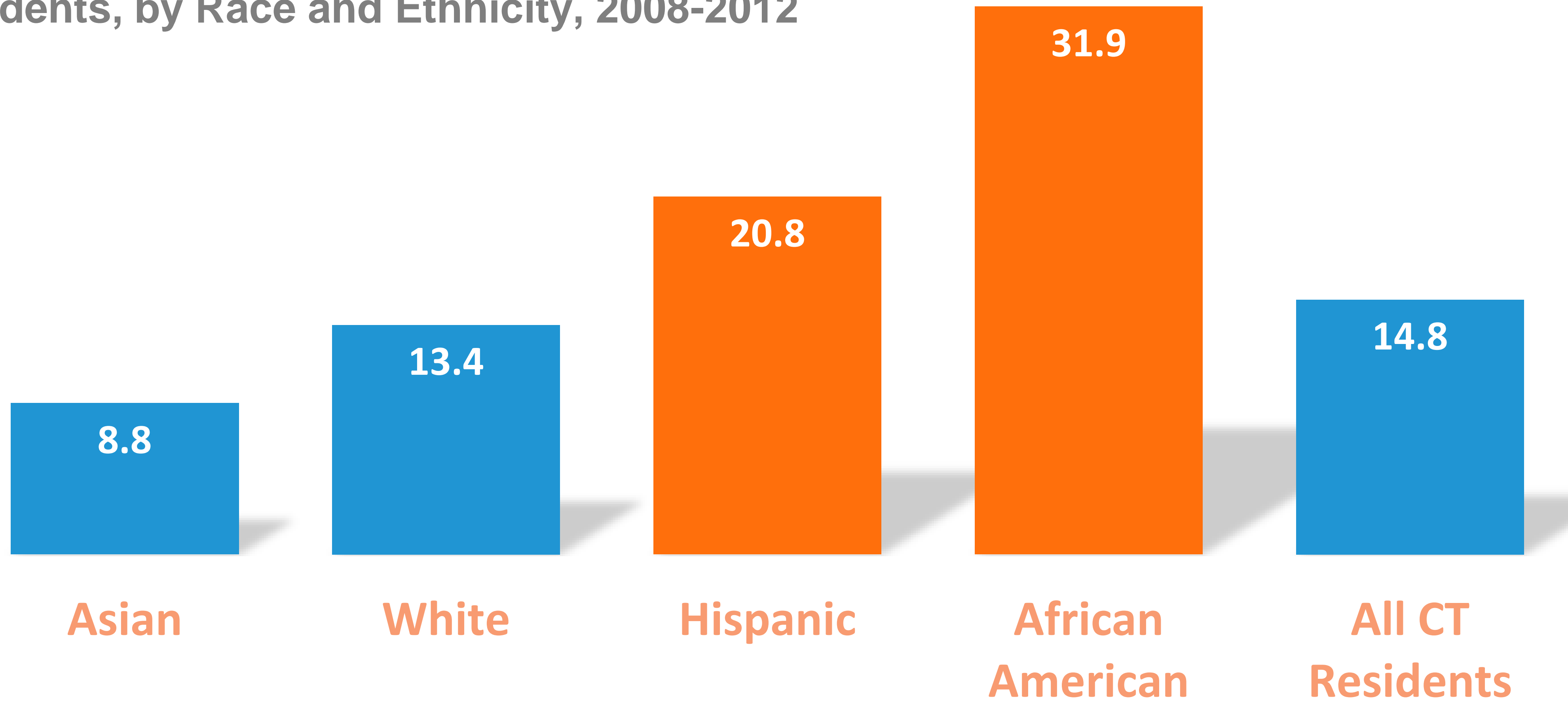
Health Disparities in Connecticut

Age-adjusted Deaths for Diabetes (per 100,000), Connecticut Residents, by Race and Ethnicity, 2008-2012



Data Source: CT DPH, Vital Records Mortality Files, 2008-2012 data.

Adverse Childhood Experiences: Percent of adults, ages 18 and over, with four or more adverse childhood events, by demographic characteristics, Connecticut, 2017

0 5 10 15 20 25 30

Total Population 13.0818

18-34 20.762

35-54 14.4695

55 and over 7.6538

Male 11.3431

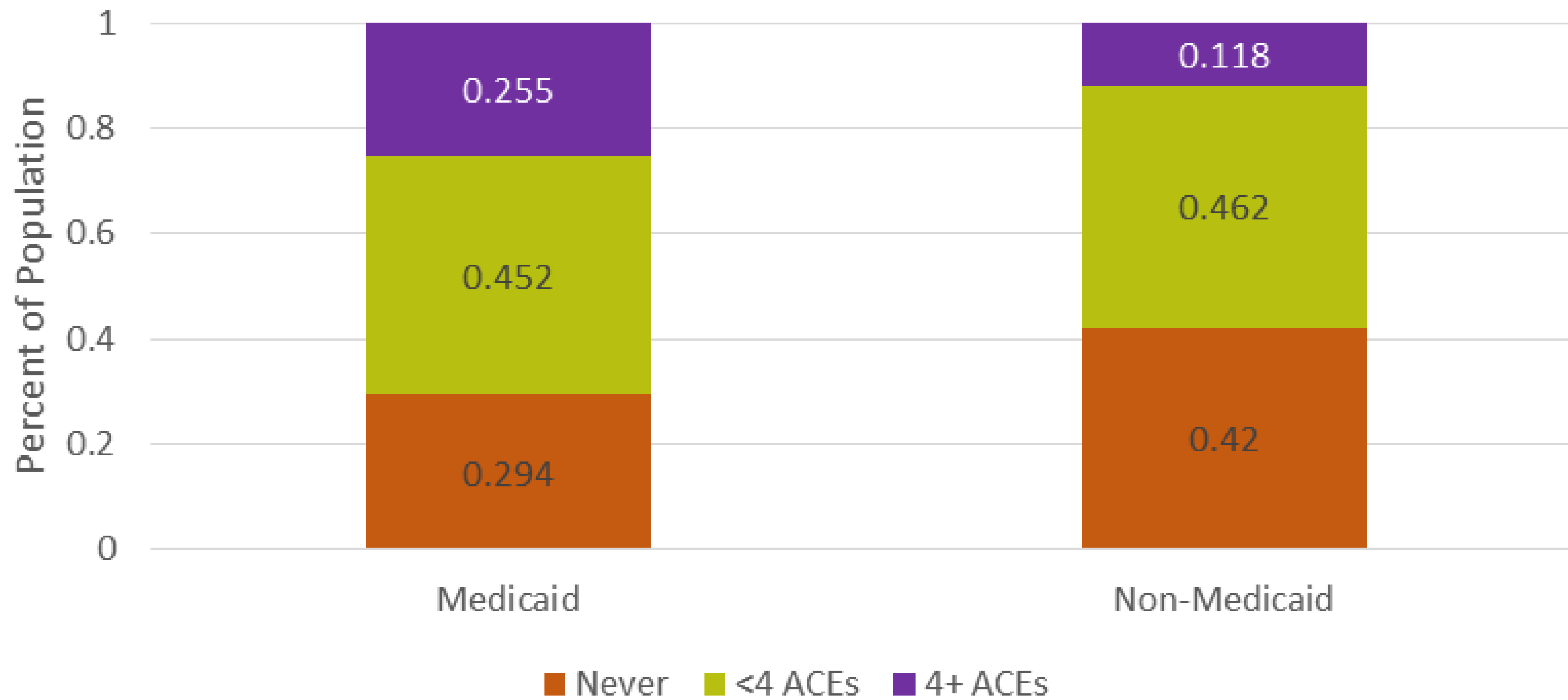
Female 14.6601

Non-Hispanic White 11.8521

Non-Hispanic Black 14.227

Hispanic or Latino 18.3405

Data source: CT BRFSS 2017



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Keeping Connecticut Healthy
Connecticut Department of Public Health

Health Disparities and Goals Options to Discuss

- Create subgoals under goals 1 and 2 for health disparities and health equity
- Create another "top line" goal(s) specifically for health disparities and health equity
- Replace goal 1 with a health disparities and health equity goal
- Other option?

Current "Top Line" Goals

1. Make Connecticut the healthiest state in the country.
2. Make Connecticut the best state for children to grow up.
3. Slow the growth of Connecticut's health care spending.

Key Design Adjustment: Scale and Timing of HEC Initiative

What We Heard in Some Public Comments:

- Concern about the broad scale and timing of initiative.

Considerations:

- Requires a paradigm shift:
  - Different than a typical grant-funded initiative
  - Goal is to create the market conditions that enable HECs to pilot new interventions or scale multiple existing evidence-based strategies that will significantly move the needle on community health, health equity, and prevention in their geographies

Key Design Adjustment: Scale and Timing of HEC Initiative

Considerations:

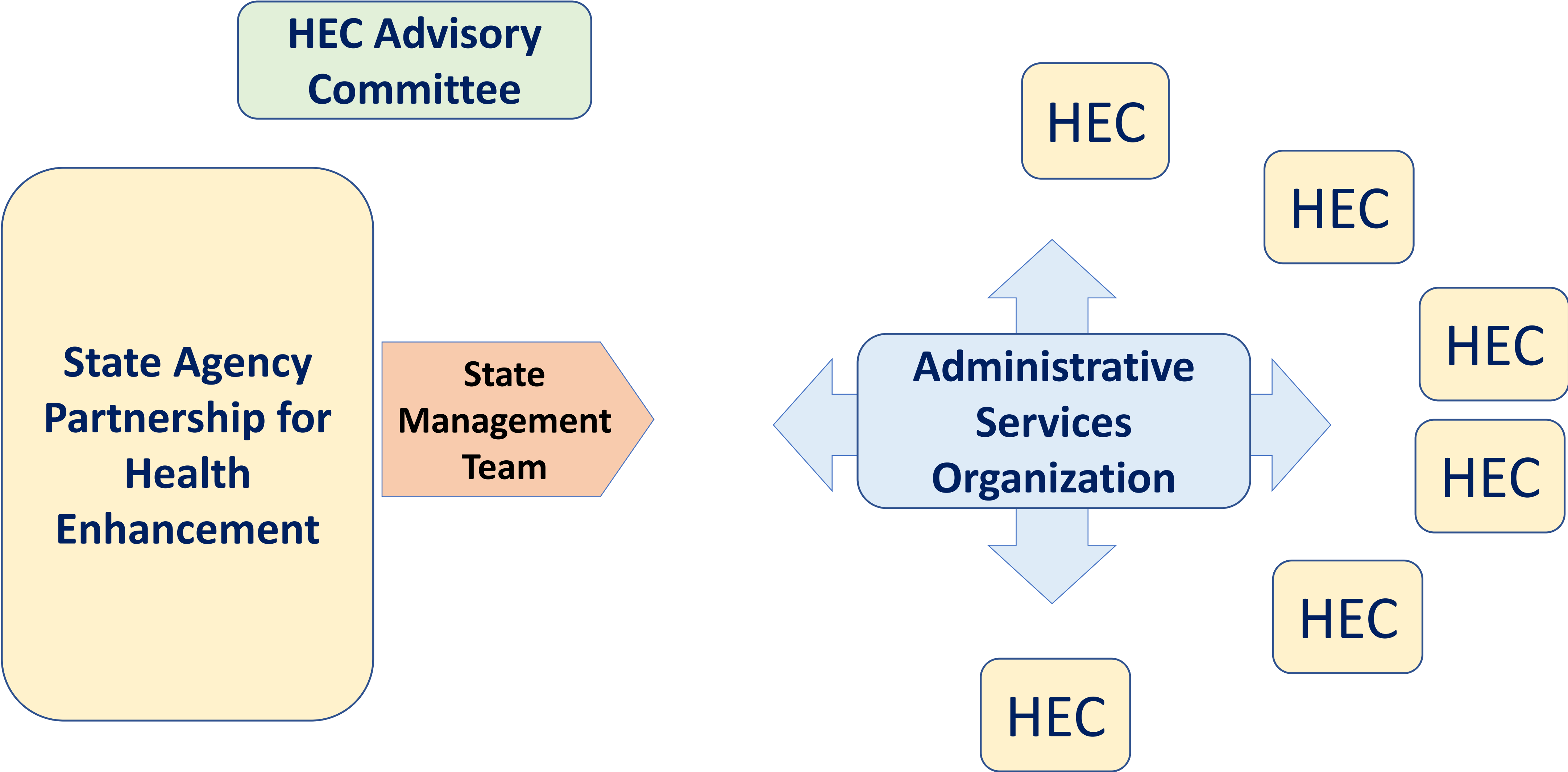
- Must be start-up funds to support the formation and implementation of HECs. We also agree that the multi-payer demonstration negotiations have to be sufficiently advanced to initiate the next design phase
- Long-term financing arrangement with CMS will require that we propose to do these things on a large scale.

Key Design Adjustment: Scale and Timing of HEC Initiative

Considerations:

- Not all HECs will be ready to do this at the same time.
  - Anticipate two tracks for implementation—with HECs most ready to implement starting first and other HECs participating in the second track after they have demonstrated a sufficient level of readiness.
- Having initial pilot of the HECs not in current framework
  - Some questions about the pros and cons of piloting first

Key Design Adjustment: Centralized Support System



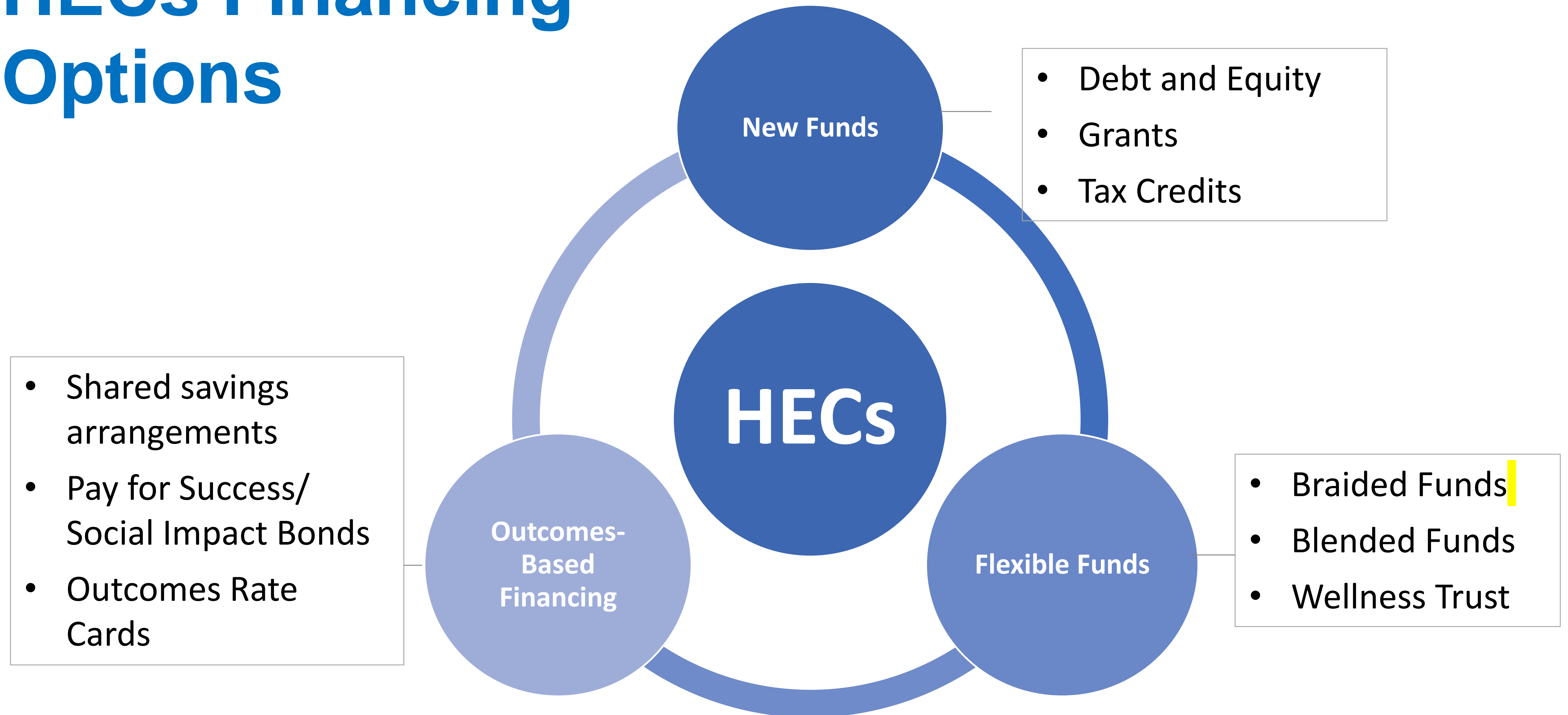
HEC Framework and Strategy Approval

Step		Timeframe
Milestone:	PHC receives 1st draft HEC Report *(complete)*	**Monday October 22**
	PHC webinars and in-person meeting (November 1) to provide verbal feedback, and opportunity to provide written feedback *(complete)*	**October 23 – November 1**
	HISC meeting to provide input on key topics *(complete)*	**Thursday November 15**
Milestone:	PHC receives 2nd draft: HEC Framework + Technical Report *(complete)*	**Friday November 23**
Milestone:	PHC meeting to determine whether to advance the HEC Framework and Technical Report to the HISC	**Thursday November 29**
	Send the HEC Framework and Technical Report to the HISC	**December 6**
Milestone:	HISC review and approval for public comment	**December 14**
Milestone:	Public Comment period	**January – February**
	PHC reviews select comments and draft public comment response	**March**
Milestone:	Approve to send to HISC	**April or May**
Milestone:	HISC review and approval	**May or June**

Proposed HEC Financing Approach

- Monetizing prevention is at the core of the HEC Initiative
- Will require a mix of:
  - **Near-term**, upfront funding in the first 5 years of implementation
  - Sustainable **long-term** sources of funds beyond 5 years
  - Assumption that near-term financing options will serve as a bridge to longer-term financing
  - Long-term financing will rely upon ongoing collaboration with health care purchasers such as Medicare, Medicaid, and potentially other payers.
- Pursuing multiple strategies
  - Multi-payer demonstration
  - Social finance options

HECs Financing Options



*Examples of each type of funding source (New Funds, Flexible Funds, Outcomes-Based Financing) are included in the Appendix.

Near-Term Fundraising Approach: Overview

- Identifying needs for funds and financing in the framework
- Developing a provisional budget
- Mapping potential sources and timeframes to needs
- Potentially adjusting the framework
  - Including timeframes for the next phases of work based on key funding and financing key dependencies (e.g., securing start-up funds, sufficient advancement of the multi-payer demonstration)
- Pursuing multiple options for funding sources and mechanisms from 2019-2022

Opportunity for Partnership with Medicare

Medicare Multi-Payer Demonstration

- PCM offers Connecticut the opportunity to partner with Medicare to develop a customized demonstration that drives primary care transformation and reduces costs
  - Medicare would be asked to invest an **estimated at $50 to $100 million a year** to transform primary care in return for CT's commitment to Medicare and all-payer financial targets
  - A demonstration gives the state **an opportunity to negotiate different terms for Connecticut** that better reflect our goals for patient care, readiness of providers and protections for consumers.

- HEC offers Connecticut the opportunity to partner with Medicare to support an innovative community-driven model that can encourage investments in community health by monetizing prevention efforts
  - Medicare would be asked to agree to a health risk benchmark and to provide a financial return on investment (estimated at **more than $1 billion over ten years**) if CT beats the benchmark
- As a *condition of participation*, Medicare will require participation of Medicaid and a significant portion of the commercially-insured population