State of Connecticut
State Innovation Model
Population Health Council
September 22, 2016

Meeting Summary

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

Members Present: Tamim Ahmed, Patricia Baker, Madeline Biondolillo, Lisa Honigfeld, Steven Huleatt, Martha Page, Penny Ross, Carolyn Salsgiver, Susan Walkama, Hyacinth Yennie

Members Participated via Teleconference: Nancy Cowser, Tekisha Dwan Everette, Vincent Tufo

Members Absent: Garth Graham, Kate McEvoy, Hugh Penney, Elizabeth Torres.

Other attendees: Diane Aye, Supriyo Chatterjee, Faina Dookh, Mario Garcia, Geralynn McGee, Lloyd Mueller, Anitha Nair, Mark Schaefer, Rose Swensen, Kristin Sullivan

Call to Order
Co-Chair Susan Walkama 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 Susan Walkama asked for a motion to approve the meeting summary of the July 28, 2016 Population Health Council meeting. The motion was moved by Hyacinth Yennie, second by Martha Page. The meeting summary was approved.

Public Comment: There were no public comments

Meeting Goals: Facilitator Rose Swensen introduced the following meeting goals: To ensure a common understanding of population health within SIM work streams and the health reform environment, to gain updated knowledge about the CT health status, to validate recommended priorities for Prevention Service Centers, and to begin developing approaches to community accountability measures. She followed with a description of the flow and timeline of council meeting topics. She indicated that in October the Council will be presented with data from an environmental scan about prevention initiatives in the state, followed by a discussion in the November meeting about priority issues and root cause analysis, and aiming at having a draft concept of a Prevention Service Centers model by the last meeting of the year.

How do the SIM Work streams, CT SHIP, and Work of Population Health Council interrelate?
Mario Garcia began discussing the rationale for alignment between the State Health Improvement Plan (SHIP) and the State Innovation Model (SIM). This was followed by a description of the current context for health reforms in the State, and how the SHIP (Healthy CT

2020) and SIM play a dominant role among all reform initiatives. He said that the SHIP coalition provides a broad strategic vision for health improvement, which is also supported by a large body of data documented in the State Health Assessment. The SIM project adds specific operational system changes that impact directly the healthcare delivery system and that have the added value of building community health capabilities for population health improvement. The synergy of these two initiatives became clear in the deliberations during the SHIP Coalition Summit which took place on September 8, 2016.

Kristin Sullivan addressed the Council regarding SHIP and said that the program has strategies related to community health and clinical wellness programs. She stated that SIM and SHIP focus on quality data and transparency and informed the Council about a data dashboard which shows the work towards these efforts.

Faina Dookh discussed the alignment of all SIM work streams and the project prioritization process. Ms. Dookh indicated that SIM aims include healthier people, better care, health equity, and reduced cost. SIM funding supports primary and secondary drivers intended to accomplish these aims and track them using multiple measures of impact. CMMI feedback on the latest SIM Operational Plan emphasized prioritization, alignment and creating focus. Ms. Dookh described the draft alignment grid, which elevates five priority areas chosen from the list of measures, and describes how SIM drivers align around them.

Marc Schaefer said that the SIM project has to build new IT solutions. To this end, the SIM project looks at measures that align more closely with defined priority areas. That includes looking at the design of PSC's and HEC's to address gaps and proposed linkages between systems. However, at this point most of the Health Information Technology design work lies ahead of us.

Health Status: Key Indicators for the State

Health status data was presented to validate the SIM selected priorities for Prevention Service Centers planning and to begin exploring a broader scope of priorities for the development of Health Enhancement Communities.

Anitha Nair, SIM/DPH Epidemiologist, presented a high-level overview of the State Health Data Profile to describe the current health status of Connecticut residents. A more comprehensive package of data is available for review on the SIM Population Health website. The presentation covered a variety of topics including disease prevalence, health risk behaviors and social determinants of health. The presentation began emphasizing disparities in racial and ethnic population changes, educational attainment by town, leading causes of death, and geographic hotspots of poverty. This initial discussion on population characteristics was intended to provide context for the interpretation of subsequent population health data. Ms. Nair went on to compare behavioral risk data with other states indicating that Connecticut ranks among the top ten states for preventive health behaviors such as dental visits and cancer screenings. Although the state ranks high regarding several health risks, it still lags behind in rates of asthma and cancer.

The assessment included a description of at-risk adult population subgroups. Specifically, she described populations experiencing health inequities such as the disabled, veterans, sexual minorities and prison inmates. Other at-risk groups are individuals with low household income, no health insurance and groups with less than a high school education. Following, Ms. Nair provided overall summary statistics covering topic areas such as Maternal, Infant and Child Health; Environmental Health; Chronic Disease and their Risk Factors; Mental Health, Alcohol and Substance Abuse; Injury and Violence; and Infectious Diseases. This was followed by a review of the first round of Connecticut Hospital Community Health Needs Assessments, which summarized emerging themes of areas of need utilizing both qualitative and quantitative methods. In addition, abbreviated health cost data was presented with the intent to highlight the limitations for cost data collection at the state level.

Data Report Brief:

- Over time in Connecticut, Hispanics have shown the most growth in overall population numbers; but Asians have shown the most growth as an overall percent of that population.
- Areas (census tracts) with the highest proportion of poverty are concentrated in the largest urban centers but not exclusively. Rural and suburban areas also have pockets of poverty above 10% of their population.
- Connecticut overall has a high educational attainment represented by 90% completion of high school and 62% attendance to college. The highest drop of these percentages is in Hartford (76%/38%) and in Bridgeport (72%/43%).
- Diseases of the heart, malignant neoplasms, accident, chronic respiratory disease and cerebrovascular disease are the five leading causes of death of which all have modifiable risk factors for prevention.
- The percentage of deaths among racial/ethnic minorities was greater than that among non-Hispanic Whites for all age groups under 80 years old.
- Birth rates among Hispanics teens are disproportionally higher compared to other groups. African American women experience substantial disparities in unplanned pregnancies and infant deaths.
- Housing quality and indoor pollutants is a common environmental concern reported to the state local health departments. While outdoor complaints are frequently related to environmental hazards, complains about food and built environment are also common.
- Georeferenced data from the USDA shows scattered locations with no particular pattern across the state that are designated as “food desserts”.
- Obesity, physical inactivity, smoking, poor diet, alcohol, and poor air quality are risk factors for cancer, diabetes, heart disease, stroke and chronic respiratory disease. Modifying at least one risk factor can have a positive impact on most of these conditions.
- Rates of smoking are low (15.4%) compared with other states, but have the potential to be even lower as many adult smokers (63%) regularly attempt to quit.
- Both Hispanic adults and those who have a low education status tend to be at a greater risk for complications from diabetes due to having less than 2 A1C tests.

- Sixty percent of adults are either overweight or obese and only one in five meet physical activity guidelines. While nearly 16% of children between the ages of 5 through 12 are obese and the obesity rate is more than double (36.6%) for children living in low income households.
- One in ten adults and children have asthma, and is more common in women. Three-quarters of the hospitalizations were potentially preventable with timely and effective primary care and medical management. African Americans are 2 to 3 times more likely to die from asthma than any other group.
- One third of CT adults are at risk of coronary heart disease due to high cholesterol. This higher prevalence of high blood pressure puts Connecticut's non-Hispanic African American residents at higher risk for stroke.
- Mental health disorders account for over 1 billion in combined hospitalizations and Emergency Department (ED) visits costs. Adults between the ages of 18 through 44 are the most at-risk age group for hospitalizations and ED visits as a result of mental disorders.
- One in six adults and one in seven high school students report episodes of binge drinking.
- Overdose deaths due to prescription opioids have quadrupled between 2011 and 2013.
- In 2013 unintentional deaths due to accidental poisoning surpassed the historically highest rates due to motor vehicle accidents and falls.
- Suicide is the most common cause of intentional injury death followed by homicide. Suicide occurs four times more frequently among White middle age males, while homicide is more frequent among younger Non-White.
- New HIV cases are reported disproportionally more frequent among black males and females as well as among Hispanic males.
- Healthcare associated infections in CT exceed the national average generating an annual estimate of direct cost between $280 and $450 million.
- Hospital Community Needs Assessments revealed reoccurring themes around older adult health issues, access to care, community infrastructure, asthma, mental health and substance abuse services and obesity.

Overall Health Status Conclusions:

- While our statewide population is aging and growing more diverse, our racial and ethnic minorities are growing younger placing them into a high risk category for risk behaviors like smoking, drinking, practicing unsafe sex, etc.
- Chronic diseases, cancer and accidental injuries top the list of causes of premature death in Connecticut.
- Residents that have lower-income, are ethnic minorities, and specific age groups such as youth, young adults and older adults are more likely than their counterparts to have risk factors for many diseases.
- Limitations on accessing and collecting data on health costs for specific populations in a regional capacity, such as town level data, remain a challenge for planning and policy making.

- At-risk adults, sexually active minorities, veterans, and the prison population also have higher prevalence rates for some risk factors and suffer from many conditions at disproportionate high rates.
- Opportunities exist to address obesity, smoking, and other risk factors for chronic diseases and to prevent accidental and intentional injuries and infectious diseases.

Council Discussion:
Hyacinth Yennie – There is so much social services within these towns, how come we cannot capture these people? How do we fix that?
Susan Walkama – Are we tracking the questions?
Hyacinth Yennie – There are services provided in Hartford but lots of barriers, people do not know how to access these services. What do we need to do more of to address these issues?
Martha Page – Too many people standing in line.
Nancy Cowser – No utilization, correlation, lack of coordination.
Steve Huleatt – Bring in more new people and you can capture New London/Norwich/New Haven/Meriden, where the providers are located.
Hyacinth Yennie – Too much dysfunction, the state needs to do a better job with coordination.
Pat Baker - Any data on diabetes control? Tests do not mean you have control - history of process measure that don't equal health outcomes.
Tamim Ahmed - The health cost per year in CT is 600 million dollars.
Hyacinth Yennie - The cause can be lifestyle and environmental.

Anitha Nair reported the percentages in CT in 2014 of hospitalizations and emergency department visits for mental disorders.

Martha Page - Does the report include all substance issues as well?
Pat Baker - It does not include mental treatment facilities that are not hospitals.
Kristin Sullivan - CT didn't do all that well in comparison with other states in the country, we don't have a priority focus.

Ms. Nair talked about Binge drinking and said that the report states that 1 in 6 adults and 1 in 7 high school students Binge drink in CT.

Frederick Browne - What was the source or metric that was used to measure the Binge drinker?
Anitha Nair replied that the data came from the BRFSS survey.
Hyacinth Yennie - Not clear data if the question is asked over the phone.
Diane Aye - The survey was done nationally and found to be a relatively valid survey since 1988.

Ms. Nair then presented the rate of unintentional prescription opioid overdose deaths per 100,000 CT residents during 2011-2013 and misuse of prescription drugs.

Hyacinth Yennie - Do we have a ratio on who is doing more?
Anitha Nair - More females died from prescription opioids than males died from heroin.

Ms. Nair continued to report that more CT residents die from suicide and homicide than any other injury.

Lisa Honigfeld - Why are suicides not considered under Mental Health?
Frederick Browne - What do you mean by more actionable?
Anitha Nair - Actionable in the sense that through antimicrobial stewardship and infection control practices, we can impact the standard infection ratio.
Tamim Ahmed - Through prevention, we can control these illnesses.
Madeline Biondolillo - Was this from the first or second round of assessments?
Anitha Nair - This information comes from the first round.
Tamim Ahmed - Is there an estimate for obesity? Why doesn't our Population Council work to prevent or lower the level of obesity-- something to target is preventing diabetes which has much more impact.
Hyacinth Yennie – Education comes during the early stages – How do we educate at the early stage to prevent this from happening?

Discussion on Validation of Priorities:

- Data is rich and provides good foundations for the selected priorities.
- Mental health needs to come up more clearly as part of the priorities.
- Depression needs a deeper analysis to address it more comprehensively.
- Information about costs reaffirms the priorities.
- It is important to keep focus on health equities.
- Caution to expand the numbers of priorities due to the intricacies involved in addressing one priority.
- Need to be mindful of mental health issues that co-occur with diabetes, asthma and hypertension.
- Comorbidities will be considered as depression and patients with complex health care needs are also part of the selected SIM priorities.
- Consider the needs of different populations such as Medicaid, commercial, Medicare
- It is necessary to stratify the analysis by racial and ethnical categories.
- It was emphasized that there needs to be better coordination and prevention.
- Health needs assessments usually approach the analysis in two ways: What is the biggest need of the population? And, what is the need that we can impact the most? In some cases behavioral health arises as the most pressing need, but usually drops in the priority list of the needs that can be impacted the most. It was suggested that this results from limiting interventions to case management and lacking population health approaches for mental health.
- Cost analysis for mental health must include not only direct cost but the long term indirect costs such as the impact on the workforce (i.e. absenteeism and lack of productivity). It was compared to multifactorial analysis in education disparities, including the impact of health conditions such as asthma.
- In designing a PSC, which priority areas lend themselves to the PSC scope? Is there a tool (method, activity) that can be implemented with a sustainable financing mechanism? For

example, depression could be considered as one of the key determinants for positive outcomes of diabetes or asthma interventions. That approach would include more effective screening for mental health issues to ensure that depression does not become an impediment for diabetes or asthma control.

- A remark was made that while addressing SIM priorities, there are additional opportunities to leverage the work conducted in the school system, which could also include addressing some of the infrastructural deficiencies to provide support at this level.
- It was noted that health and educational systems are not designed to addressing mental health issues, particularly the need of early intervention for young adults. It is suggested that CHW's interventions can provide clear solutions for early identification of problems and incur on long term savings.
- The discussion highlighted the role of obesity and the relationship with the priorities. It is imperative to consider the implications of obesity, particularly for children and poor communities, while designing solutions for diabetes and hypertension. This was supplemented by another comment about the role of obesity in hypertension, asthma and depression. These co-relations play well into the concept designing PSC interventions that while aiming at priorities they also address comorbidities.
- The discussion also focused on the ability to measure the impact of the interventions including disease prevalence, costs, etc.

Discussion on types of interventions:

- Need to shift to outcome measures as opposed to process. Some of the data is "relatively easy" to obtain for cost analysis but more difficult for large population based analysis. The discussion shifted to the need to identify gaps and design population based solutions.
- Health Information Exchange is a critical vehicle to create long term functionality solutions.
- A comment was made about the sometimes conflicting use of data. In occasions it allows advocating action but not necessarily leads to measure outcomes. Data on health behaviors must strongly suggest the type of intervention but always correlate with the cause of death.
- A question was asked about what is the definition of community measures. Clarification was offered by making a distinction between community-based and clinical prevention. Community measures are intended for prevention interventions that are typically conducted outside of the clinical setting. In addition, communities can be defined by geographical jurisdiction based on either census tracks, zip codes, townships, counties or any other regional subdivision.
- The state is making progress in developing the APCDB which provides more opportunities for process measures than outcome measures. For example, HbA1c testing is likely to be obtained as opposed to Ab1c Poor Control which requires having access to laboratory results data. The aspiration of the database is to obtain information of about 60% of participants with health insurance coverage. That is at least half of the commercial, state employees, Medicare and Medicaid.
- Council members were interested in distinguishing clinical measures and community measures. It was pointed out that the SIM Quality Council spent a number of months developing clinically oriented indicators that will be tied to payments. The population

health council, on the other hand, requires to think about the major indicators of health status or community improvement that can be feasibly obtained and tracked to become the basis to reward accountability over time.

- These comments elicited a discussion about the importance of having clarity about the types of upstream community based interventions that could positively impact on the SIM defined priorities. Comments were made about discussions related to community outcome measures have to be made in context of selected interventions. SIM population based strategies will be guided by the CDC 6|18 strategy, which recommends specific evidence based interventions related to SIM priorities.
- A discussion ensued about whether population outcomes measures (i.e. prevalence of diabetes) or community based program performance measures (weight loss among DPP participants) are more appropriate for population health accountability purposes.
- Members of the Council concurred about the importance of looking at who is doing what and use it as an opportunity to tap into what is already going on in the state. An example is the current collaborative efforts around asthma across the state.
- A few members expressed the desire to do a deeper dive into which prevention efforts make sense.

Co-chair Susan Walkama addressed the members to end the session at this time.

Next Steps:
Co-chair Susan Walkama stated that the next meeting will be held on October 27, 2016 and the agenda will be include a preliminary presentation of an environmental scan of current prevention initiatives in the state.

The meeting adjourned at 5:00 p.m.

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