



Connecticut State Innovation Model Population Health Council

Thursday, October 27, 2016

3:00 – 5:00 PM

500 Enterprise Drive, Rocky Hill, CT
Rocky Hill, CT

Dial in #: 877-916-8051/passcode: 5399866

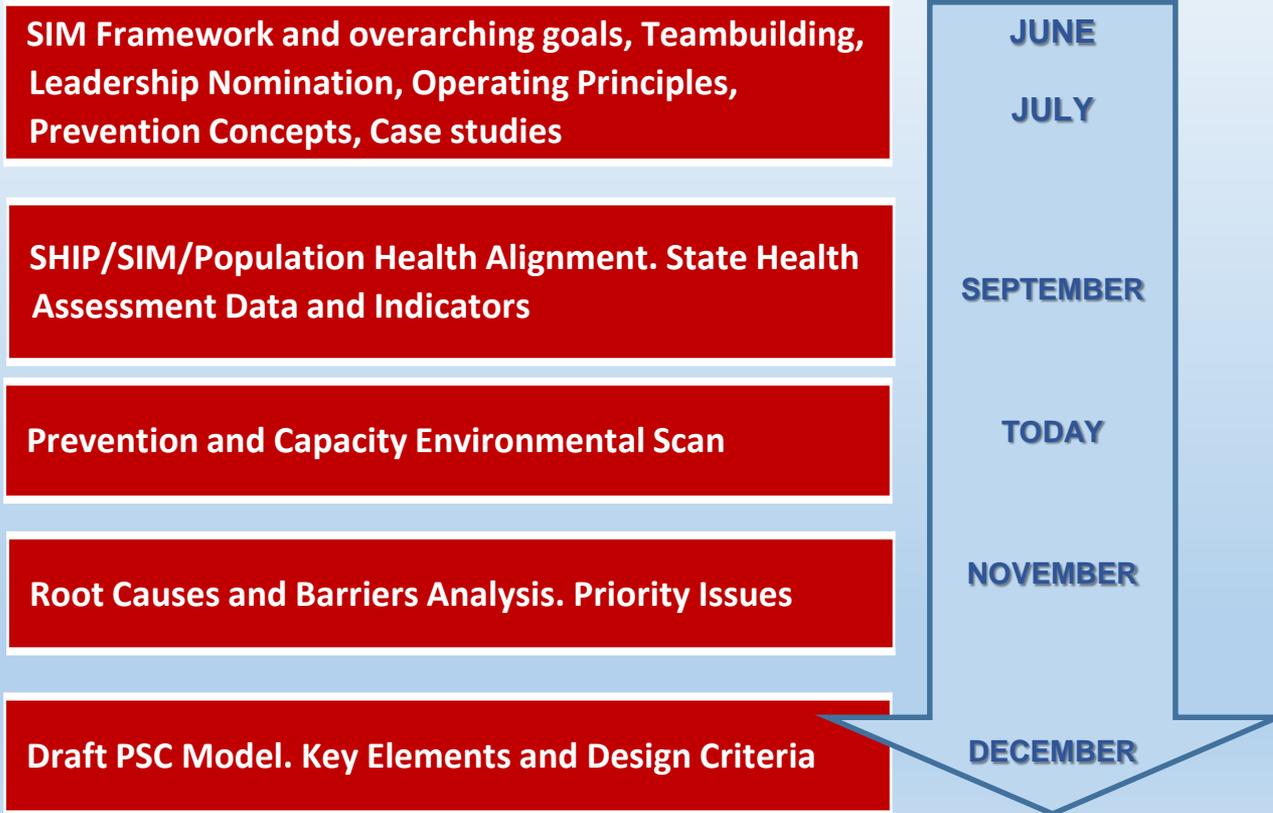
Welcome: Co-Chairs Susan Walkama, Steve Huleatt

- Minutes Approval
- Public Comment
- Welcome New Members To Table

Meeting Purpose and Outcomes

- Present findings from the Environmental Scan to learn about State capacity for prevention and aspects of community-based prevention models in practice
- Discuss key questions to inform the structure and content of the Prevention Service Center model for Connecticut

POPULATION HEALTH COUNCIL MEETINGS



Environmental Scan

Heather Nelson, PhD, MPH, HRiA

Kristin Mikolowsky, MSc, HRiA

Goals & Objectives

Today's Results: Phase I

- **Preliminary review and synthesis** of:
 1. Community health integration models & Accountable Communities for Health implemented ***nationally***
 2. Current evidence-based community prevention services ***in Connecticut***
- **Focused on** services related to ***tobacco use****, ***asthma, hypertension, obesity, diabetes, and depression***

*National only

Phase II

- Identification of clarifying questions and areas of gaps
- **Deeper dive** into specific areas, based on feedback from the Population Health Council

Methods

Environmental Scan:

- **Nationally-focused** search on community health integration models (CHIM) and accountable health models
- **Connecticut-focused** search on local community initiatives, community-based networks, and community-based prevention services
- Resources and publications suggested by interviewees also incorporated

Key Informant Interviewees:

- **National interviews**
 - 9 phone interviews conducted with 13 leaders in CHIM & Accountable Communities for Health (ACH)
- **Connecticut interviews**
 - 11 phone interviews conducted with 16 CT leaders in prevention-related services and networks
- Interviews were conducted using semi-structured interview guides to examine:
 - Types, structures, successes, challenges, and lessons learned related to community-based networks and community-based prevention services in CT
 - Innovations, key successes, and challenges in community health integration models & Accountable Communities for Health across the U.S.

Limitations

➤ Scope of Scan

- Findings are based on initial broad scan and interviewee recommendations, and do not represent a complete inventory of all prevention programs in CT / ACHs nationally
- Phase II will be used for a “deeper dive”

➤ Interviewee Perspectives

- Non-random and small samples – may not be representative of all points of view

Key Elements for Clinical- Community Integration and Accountable Health

1. Needs Assessment and Community Engagement

“It’s always good in addition to data to have a mechanism for community involvement and identification of community issues that may not have been fully captured by data.”

“The local/regional approach is why we have 9 Accountable Communities of Health in the state... [It’s] driven out of a local context.”

“There has to be community representation. Different geographic locations have unique needs and challenges.”

- As a first step, define the population that will be served and identify current health-related needs as well as resources
 - Leverage existing community health needs assessments and community health improvement plans
- Enter the process understanding that the initiative is not the first to enter the community
- The initiative needs to be responsible to the needs and demands of the community
- Engage the community throughout the process: Inception, prioritization and planning process, implementation, evaluation

2. Governance and Leadership Structure

“There should be some organizational structure that is headed by a backbone organization. Public health is an organization that plays a strong role as convener, purveyor of data, and takes an independent role that’s not linked to a particular model.”

“Agreements are absolutely necessary. The Governance should spell out the vision for the overall effort. [It] should include not just the intention, but the intended outcome of the project, the players, roles, responsibilities, methods of accountability. Who’s supposed to be doing what and how they’re linked together. If there’s resource-sharing, what are those agreements?”

- Identify a neutral, strong backbone organization to integrate and move efforts forward
 - Examples: health departments (CA); hospitals (VT); 501(c)(3) (CO); planning commission (VT)
- Develop a common language and framework
- Clarify the decision-making processes

- Agreements are a critical component of sustaining a large, complex and multi-faceted ACH
- Agreements should be transparent and include the mission; sectors represented; roles of backbone organization, Steering Committee, and other partners; conflict(s) of interest; structure; decision-making processes; policies around conflict

3. Multi-sector Partnerships

“In general, it’s good to have representatives from multiple sectors – public health, insurance, health care delivery, community agencies, and other sectors where their policies have an impact on health. That could be education, transportation, job training, public safety, it would vary depending [the] health issues [the are prioritized]. It’s also good to have representatives that are representing the general or key population.”

- Convene partners across sectors that impact health:
 - Health care
 - Public health
 - Insurance
 - Housing
 - Education
 - Transportation
 - Community-based organizations
 - Etc.

4. Shared Vision, Mission, and Goals

“Be realistic, be clear about what can be done and what the tasks are... Be ambitious, but tend to under-promise and over-deliver.”

“[There needs to be] something big and broad that is unifying enough that everyone can coalesce around. The tension is that the way work happens and moves is when the work takes focus. The fear is that the focus alienates someone around the table. Can we find something that everyone finds meaning and purpose in?”

- Develop a shared understanding of why the initiative is convening
- Be clear about the goals and objectives
- Avoid unrealistic expectations
- Under-promise and over-deliver

5. Focus Area(s) and Portfolio of Strategies

“My own view is that the greatest likelihood of impact is when there’s agreement across a spectrum of participants to all focus on a small number of issues – as few as 1 or maybe 2...”

“How do those [population health] pieces support and reinforce what’s happening in clinical level? And how does policy happening at the payer level or [health insurance companies] ... [influence and support] community-clinical [integration]?”

- Identify and prioritize focus area(s) or target condition(s)
 - The prioritization process to identify focus areas should be data-driven
- Identify key lever points and low hanging fruit
- Address the social determinants of health, which will move the lever on multiple health outcomes
- Identify opportunities for synergies across sectors, initiatives, services
- Develop an **evidence-based** Portfolio of Strategies*, spanning the following levels:
 - Clinical
 - Social Services and Community Resources
 - Clinical-Community Linkages
 - Policy, Systems, and Environment

*JSI Research & Training Institute, Inc. Accountable Communities for Health: Strategies for Financial Sustainability. May 2015. Accessed 10/21/16 at:

http://www.jsi.com/JSIInternet/Inc/Common/download_pub.cfm?id=15660&lid=3

6. Funding Mechanisms

“Unlike accountable care models with a defined population and payer, the community piece gets confused. Where does the funding come to drive that work? That is harder to nail down.”

“We are trying to... work with our partners [to determine how we] can create a system to show that the partners need to work together and behind that specifically tracking how the money works and connects to the outcomes.”

- Funding for ACH initiatives remains a challenge
- Funding is needed for services and also for infrastructure
- Potential funding approaches and sources include:
 - Grants (foundation or government), especially for early phases
 - Raising revenue – for example, establish local or state tax (e.g. on soda); use % of insurance premiums; require nonprofit hospitals to allocate portion of community benefits spending
 - Blended or braided financing – pooling funding from different sectors
 - Medicaid waivers to pay for nontraditional programs
 - Incentives for providers / hospitals – invest in ACH to prevent hospitalization / readmission; invest in ACH to meet benchmarks like HEDIS measures

JSI Research & Training Institute, Inc. Accountable Communities for Health: Strategies for Financial Sustainability. May 2015. Accessed 10/21/16 at: http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15660&lid=3

The Commonwealth Fund. A State Policy Framework for Integrating Health and Social Services. July 2014. Accessed 10/21/16 at: http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jul/1757_mcginnis_state_policy_framework_ib.pdf

7. Data and Evaluation

“We use process measures, like the number of partnerships, number of people reached at a community event. It gets difficult to measure when you talk about long-term population base.”

“[There is a disconnect] in the amount of resources that are available for the evaluation versus how much you’d actually want in the real world.”

- Evaluation is important for measuring outcomes, but there are limited resources available to support and sustain comprehensive evaluation
 - Measure processes, outcomes, changes in policies and procedures
 - Connect the investments with the outcomes
- Current evaluation tools: Surveillance data, indicators from program participants
- There are challenges in accessing cost analysis data
- Need to build trust & agreements to share evaluation-related data across health care institutions
- Align measures where possible to reduce reporting burdens

8. Importance of Community Health Workers

“You need full-time staff, a navigator or community health worker. You need to have someone who can implement the patient plans and state funding to do the work. You need the one-on-one relationships. It needs to be someone the patient trusts and it’s a long-term behavior change.”

- A population health approach requires addressing the social determinants of health
- Need to connect residents with social and health care resources
- Community health workers are best positioned to bridge gaps between systems and communities, addressing a range of determinants of health
- Existing funding for community health worker (CHW) model is limited
- Vision for CHW model is not yet determined: is it a medical model or a population health model?

Community-Based Prevention Services and Networks in CT

Current Connecticut Community-Based Prevention Initiatives

- Several initiatives and networks are working to provide community-based prevention-related services, but current services are not coordinated
- Health issues commonly addressed: asthma, obesity, diabetes and mental health
- Limited discussion of networks / programs addressing hypertension
- Populations served: children, low-income families
- Vulnerable populations: undocumented immigrants, linguistic minorities, communities navigating transportation barriers

“Our first step is to figure out who’s working on [the issue] and pull them together. The people who work on asthma here don’t know the ones who work over there.”

“[In the area of] substance abuse, [there are] 13 regional action councils... They all have resources and strengths... but one area of the state may be very well-funded and another is not... There is no mechanism for sharing resources, [such as]... materials for dissemination, innovation happening in some places but not others...”

We’ve done some events around the state and we forget about rural health. We don’t think of CT as rural, but you go to the Northeast and the Northwest, they have nothing.”

MAP TO BE INSERTED HERE

Moving Current Connecticut Initiatives Towards ACH

- Enhance coordination across initiatives
- Strengthen communication across health care institutions (patient information & evaluation data)
- Increase the intensity of home visiting resources
- Identify a neutral convener to advance and sustain initiatives

“I think a lot of people come in talking about these different things – whether state agencies, any organization or foundation. The left hand doesn’t know what the right hand is doing and it takes a lot to get that information.”

“Where I struggle though is who governs it? Who’s in charge? Somebody needs to be in charge.”

Funding: “The Million Dollar Question”

- Existing funding (e.g., grants, health payment systems) supports downstream interventions, not preventive care
- Need to reform payment structures to incentivize preventive services
- Funding needs to support preventive, wrap-around services; coordination of services; data sharing and comprehensive evaluation

“You either need a grant or you need to be able to bill for services, like at a health center. In Connecticut, we’re struggling with figuring out how to pay for the community health worker service.”

“The funding should not be to start new programs. It should be to hire [connectors].”

“While there’s lots of enthusiasm at the community level, without the financial support it’s hard to get things that are sustainable.”

Connecticut's Vision for the Future

- Advance current initiatives in a coordinated, community-based approach
- Address social determinants of health
- Focus resources on opportunities that can achieve the greatest improvements
- Potential populations of focus: Health disparities, low-income communities

“Stop looking at diseases and start looking at people.”

“Even a small difference in some of the toughest communities would make a huge difference in the data. We should be explicit about where to apply the resources and make the changes in those communities.”

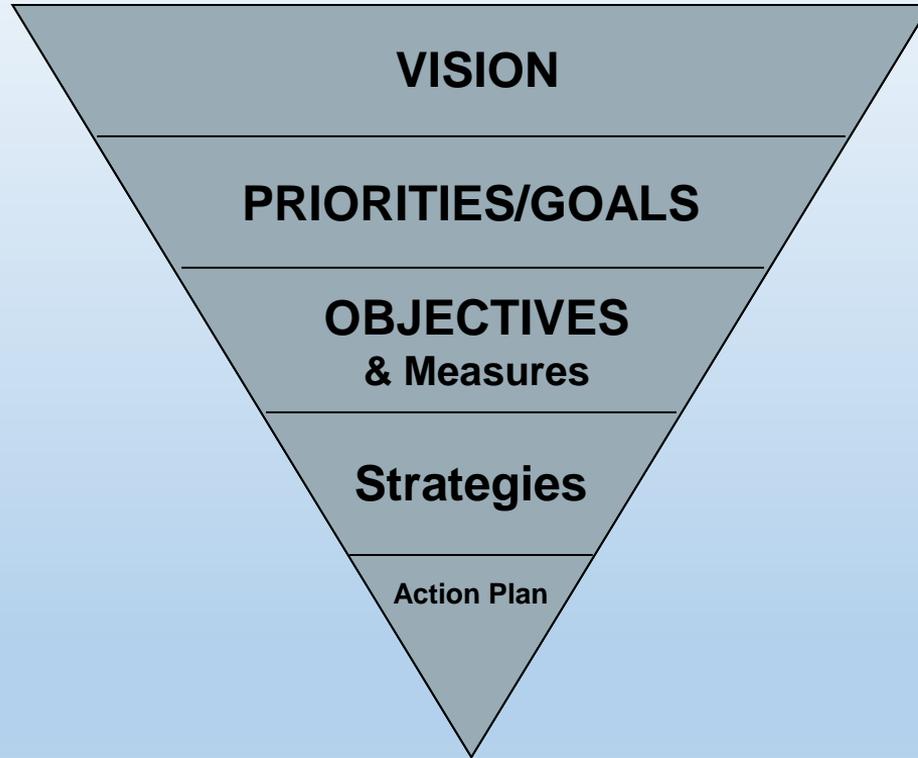
“One would like it to be integrated – ‘Hey, why aren’t you all talking to each other?’”

Questions

15 min



From Context to Planning



A VISION OF PREVENTION SERVICE CENTERS

PSC's MODEL : A SYSTEMS CHANGE DESIGN

- ❑ Transform how prevention services are delivered
- ❑ Design a community integrated model of prevention that is embedded in the overall health system
- ❑ Build a business case for prevention
- ❑ Design functional links between PCP/AN's and CBO's
- ❑ Define Value Based Payment impact of prevention
- ❑ Establish guidelines for COB's interagency contractual arrangements
- ❑ Trigger a shift in resources from acute care to prevention care
- ❑ Develop enabling mechanisms for integration, coordination and accountability of prevention service delivery among CBO's and PCP's

PSC's PILOT : DEMONSTRATION OF A BUSINESS CASE

- ❑ Proof of concept
- ❑ Enlist CBO's primed for accountable networking
- ❑ Ensure or enable essential IT and performance metrics capacity
- ❑ Design a mechanism to monitor health outcomes
- ❑ Provide evidence of value-based cost savings
- ❑ Structure a sustainable strategy for community based prevention

PREVENTION SERVICE CENTERS

PURPOSE

- ❑ To provide broad, coordinated access to community-based prevention services to reduce individuals' health risks associated with diabetes, hypertension, uncontrolled asthma and other high burden conditions.

APPROACH

- ❑ Establish prevention service consortiums in two or three regions throughout the state with responsibility for providing evidence-informed, culturally and linguistically appropriate community prevention services.

ELIGIBILITY

- ❑ Any healthcare or human service agency, private non-profit, local health department acting as lead entity. A lead entity will provide services directly and/or by administering sub-contractual relationships with consortium partners that provide community-based prevention services.

PREVENTION SERVICE CENTERS MODEL COMPONENTS

MENU OF SERVICES

(SIM / PH Priorities)

COMMUNITY HEALTH MEASURES

(Outcomes / Performance Indicators)

FINANCIAL SUSTAINABILITY

(PSC Pilot / PSC Model)

INFRASTRUCTURE

(Agency / Consortium)

OWNERSHIP / GOVERNANCE

(Private / Public / Mixed)

Key Questions and Feedback: Dialogue 45 min

1. Given what learned from the data presentation and current capacity from the environmental scan, should the PSC model focus on:
 - a. SIM priorities such as diabetes, asthma, and hypertension only?
 - b. Accommodate expanded services (e.g., childhood obesity and mental health) from the onset?
 - c. Have a scalable design to address additional priorities in the future?

Key Questions and Feedback: Dialogue 45 min

2. Given what we have learned from other models, what do we want the key functions of the CT PSC model to be?
 - a. Coordination of, referral to, and delivery of appropriate care/prevention services
 - b. Prevention quality control
 - c. Measures - Data monitoring and evaluation (handled by PSC or at the state level)
 - d. Contracting and billing / Financial management
 - e. Geographic reach/capacity in regards to areas of need

Key Questions and Feedback: Dialogue 45 min

3. What potential structures would maximize operations of the CT PSC model and why?

a. Which of the following organizational structure would be most effective for the PSC? Why?

- single entity
- partnership group
- regional lead agency
- consortium of several regional programs

b. Which sector(s) should hold ownership, fiduciary role and governance of PSC's?

- healthcare
- public health
- human services
- private non-profit
- municipal government

Next Steps

Next Meeting Dates

November _____, 2016, 3:00-5:00 p.m.

December _____, 2016, 3:00-5:00 p.m.