

**State of Connecticut
State Innovation Model
Population Health Council**

Meeting Summary
December 1, 2016

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

Members Present: Patricia Baker, Elizabeth Beaudin, Tekisha Dwan Everette, Lisa Honigfeld, Steven Huleatt, Penny Ross, Carolyn Salsgiver, Hayley Skinner, Susan Walkama, Hyacinth Yennie

Members Participated via Teleconference: Frederick Browne, Nancy Cowser, Martha Page

Members Absent: Tamim Ahmed, Garth Graham, Kate McEvoy, Hugh Penney, Elizabeth Torres, Vincent Tufo,

Other Attendees: Joan Ascheim, Supriyo Chatterjee, Mehul Dalal, Faina Dookh, Mario Garcia, Sandy Gill, Jenna Lupi, Anitha Nair, Stephanie Poulin, Mark Schaefer, Kristin Sullivan, Rose Swensen, Janet Brancifort, Evan Vantos

Call to Order: Co-Chair Susan Walkama called the meeting to order at 3:04 p.m. It was determined a quorum was present.

Meeting Goals: Co-Chair Susan Walkama introduced the meeting goals: a) Provide an update on the planning process and rationale for services data gathered to date; b) Validate criteria for inclusion of prevention services in the model; c) Determine Prevention services that are best ‘test cases’ for the model.

Review and approval of Meeting Summary: Co-Chair Susan Walkama asked for a motion to approve the meeting summary of the October 27, 2016 Population Health Council meeting. The motion was moved by Hyacinth Yennie, seconded by Pat Baker. The meeting summary was approved.

Public Comment: There were no public comments at this time.

PSC’S Strawman Model Planning Process:

Rose Swensen explained that the Prevention Service Centers (PSCs) are formalized collaborations among one or more community-based organizations and health care providers with the purpose of providing, and/or coordinating the provision of evidence-based clinical prevention services that enhance health outcomes and are typically delivered outside of the clinical setting. She indicated that the planning process of PSCs requires an analysis of the current state of prevention services delivery followed by a design of implementation strategies.

This includes the planning of a variety of services included in the model such as: accountability measures; mechanisms of financial accountability; and definitions of governance and organizational structure.

Mario Garcia described the broad framework of the planning process. He indicated that the first phase of planning is focusing on the current state of prevention services delivery. The planning team is looking at the current status of the pre-selected services in detail, including documentation of their capacity, the evidence of their effectiveness, and cost-benefit. This analysis also includes the identification of appropriate accountability measures of program performance and health outcomes. Next steps in the planning process consist of analyzing enablers and barriers for implementation in order to propose appropriate implementation strategies.

Organization and Governance of Prevention Service Centers:

Joan Ascheim introduced preliminary concepts about organization and governance options for Prevention Service Centers. She indicated that currently there is not a functioning Prevention Service Centers-like model in Connecticut. However, prevention services such as diabetes self-management or medication management programs do exist in various settings. These initiatives are typically uncoordinated and lacking appropriate referral mechanisms. Sustainability is uncertain due to the varied types of funding outcomes. In addition, ability to consistently track processes and outcomes is limited.

Ms. Ascheim presented a possible organizational structure with a lead organization and formalized relationships among partners of prevention services. It was proposed that the lead organization be accountable for services and outcomes and provide financial management. Further it was proposed that there be an advisory council comprised of participating partners and community representatives.

Hyacinth Yennie recommended that the proposed organization must guarantee accountability for quality services and outcomes.

Following, Ms. Ascheim listed a set of proposed functions for PSCs. These include the provision of evidence-based prevention services directly or in coordination with partner organizations, promoting and marketing services to payers, maintaining accountability for services and outcomes, maintaining formal agreements, collecting and analyzing client and program metrics, pursuing diverse funding, and participating in an evaluation and learning collaborative.

Lyn Salsgiver inquired about whether the PSCs will be designed to serve all age-groups and anyone who walks in. Ms. Ascheim indicated that the target population will likely be defined by the type of services provided.

Martha Page commented that all age-groups and particularly children should be a target for prevention programs.

Pat Baker expressed concern about the proposed organizational model. She believes that naming a lead entity would create competing power structures as opposed to building on community assets to forge a collaborative relationship among partners. Ms. Baker cautioned about possible failure if the organizational structure does not create a “continuum” of community agencies. She is not opposed to have a fiscal agency with fiduciary roles and handling administrative tasks, but highlights the importance of cross agency governance that includes healthcare system agencies. Ms. Baker insisted that coordination is essential and that accountability should be shared to prevent agencies walking out.

Lisa Honigfeld commented that DPH has experience leading collaborative efforts and coordinating with the healthcare sector.

Mark Schaeffer invited members to think about who would be accountable for ensuring that the full set of services which are available, are being delivered at a certain level of fidelity. The planning assumptions do not include the availability of large grants, but instead, services could expectedly be paid for by healthcare system participants.

Susan Walkama indicated that the governance mechanism needs to be broader and more formal than just an advisory council.

Steven Huleatt pointed out that a vision where services are just provided outside of the clinical setting and marketed to providers does not represent a change from what some agencies are currently doing. Offering services and doing referrals alone does not match the vision. Neither does it amount to a systemic change.

Faina Dook clarified that the intention behind the idea of marketing the prevention services of the PSCs is to try to address the sustainability issue.

Pat Baker responded that there is an ambivalence in the proposal. On one side, she hears about an entity implementing a full set of services with capacity to contract out if they can't deliver, but there is also a notion of an entire community of stakeholders, including the healthcare system, that engage to share all available resources. She thinks that if the healthcare participants are at the table, there should not be a need to market to them. It becomes a problem of creating linkages and keeping the participants engaged.

Tekisha Everette pointed out that PSCs will need to be reimbursable entities, and therefore, they must exist right now with capacity to claim payments.

Mark Schaeffer is pessimistic that services will be billable in the current environment. It is unlikely that traditional payers would build entirely new coding systems. However, he has observed that non-traditional payers such as hospitals and nursing homes are purchasing technologies and services that help them to do better job in an increasing accountable

environment. It is plausible that payment for PSCs services could flow from FQHCs and healthcare organizations.

Lisa Honigfeld thinks that many regional services are already seeing patients that are not connected to medical homes and therefore making those connections should be part of the functions of the PSCs.

Lyn Salsgiver said that communities programs are working in silos, and therefore, an assessment of what is already available are found as best practices. She cautioned about relying on providers because funds are being cut and Medicaid is paying only thirty cents of every a dollar. She suggested going after grants and state or federal funds to pull resources together.

Hyacinth Yennie noted that pulling resources has a risk of turf tensions and that cooperation has to be encouraged.

Pat Baker said that there is a gap between what is needed and what is available. She suggested that the job of PSC networks is to make those gap assessments. In addition, she expressed concern that focusing on services and metrics will take the attention away from the emphasis on population health outcomes.

Inclusion Criteria and Pre-selected Services:

Rose Swensen introduced key criteria for selection and inclusion of prevention services in the PSC model. She indicated that it was incumbent of the council to also validate the criteria regarding its applicability to pre-selected services or potential future services to be considered. Dr. Mehul Dalal, DPH Chronic Disease Director, was in attendance to provide Council members with subject matter expertise regarding prevention services.

Ms. Swensen explained the scoring and voting exercise using a paper sheet and a “clicker” device linked to the power point presentation. Next, she listed seven proposed criteria.

Tekisha Everette needed clarity about the definition of community health needs and whether it is restricted to certain age groups.

Pat Baker thought that there were too many criteria. Ideally no more than five criteria. She suggested rejecting the last criteria regarding the role of a lead agency.

Hyacinth Yennie supported the idea and recommended to limit the number of criteria by not ~~to~~ spreading too thin and being more effective.

Lisa Honigfeld requested clarity about SIM priorities and inquired whether all payers use the public payer score card to measure quality and reimburse cost.

Faina Dook indicated that SIM has elevated the issues related to asthma, diabetes, hypertension, depression and individual with complex health care needs in response to a CMMI request to focus the intervention for cross coordination between work streams. The priority areas are listed in a handout with a SIM alignment grid. She also indicated that quality measures are used by the Medicaid PCMH+ program, Medicare Shared Savings Program and commercial payer score cards. She offered to send an updated list of quality measures.

Pat Baker asked whether the criteria may become too exclusionary. She asked what to do if there is a great need but the evidence of interventions is not strong.

Steven Huleatt asked how the final score will be used and what will be the implications of the scoring exercise.

Mario Garcia responded that in some cases evidence might not be strong, but every other criteria might be supportive of inclusion. Therefore, the practical use of the tool is to exclude services that largely do not meet any of the criteria. Those services included may meet the criteria ranging from high to low. He also clarified that the exercise was mostly designed to evaluate the process (Beta). Mario Garcia also explained that the pre-selected services are existing interventions addressing the priority areas, and that a detailed analysis of services are being conducted to understand enabler and barrier factors impacting the ability to provide prevention in the state.

A discussion ensued about whether instead of services the discussion should focus on policies related to environmental interventions and/or systems change. Rose Swensen clarified that the Population Health Plan considers two parts: The Prevention Service Centers and the Health Enhancement Communities model. The latter being more intended to effect change at the level of policies. Mario Garcia confirmed that statement and added that planning for Health Enhancement Community is a longer term goal while the current focus on PSCs is intended as a shorter term goal and a building block for a Health Enhancement Community designation.

Dr. Mehul Dalal proceeded to illustrate to council members about three types of diabetes programs (handouts were also made available with detailed description). Dr. Mehul addressed most of the following questions:

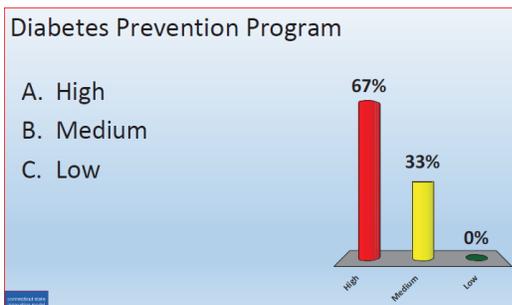
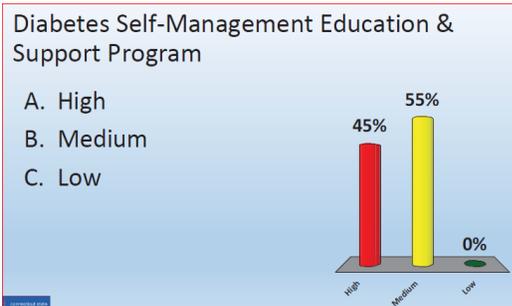
Who funds the programs and what happens when funds run out?

How these programs emphasize the role of schools?

Are programs reimbursed?

What age-groups are participating?

After each one of them, participants scored and voted for each one of the services.



Key Final Comments:

It is important to clarify what is meant by community and what population is addressed (i.e. what age group does community pertain to).

Too many criteria. It should be narrowed to four or five.

It was suggested to eliminate the last criterion in the list.

There is an inherent bias/tension between evidence base and innovation- how strict do we need to be? Is a promising practice ok? Do we need to give some criterion extra credit over other?

Third criteria is hard to understand and participants lack baseline understanding regarding aspects surrounding payment reforms.

There is a need to revisit the concept of what is meant by “clinical in nature” and to simplify the definition of the buckets of prevention concept.

Scalability and replicability of services are issues

that pose challenges for implementation.

Other non-clinical support services need to be considered as part of the interventions in the PSC.

Ensure that the functionality of the PSCs is clear in terms of either delivering services or ensuring that services are available through various mechanisms.

Providers and consumers must have the opportunity to comment on the plan to design the PSC’s.

Next Steps:

The criteria will be adjusted to reflect Council member input. The next Population Health Council meeting is scheduled for December 20, 2016 and will continue scoring prevention services.

Co-Chair Susan Walkama adjourned the meeting at 5:04 p.m.