

The Future State



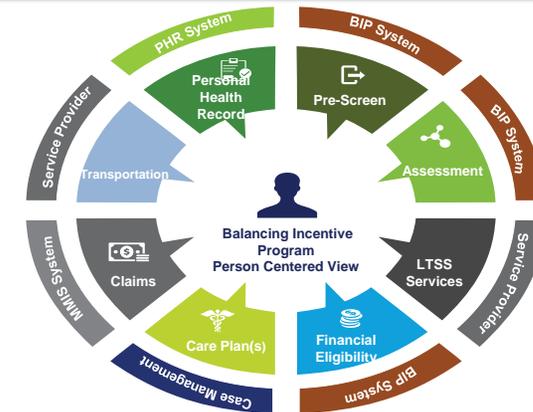
Health neighborhoods composed of PCMH practices, specialties, CHWs and non-medical services and supports



Development of additional value-based payment strategies



Achievement of a person-centered, integrative, rebalanced system of long-term services and supports



CONNECTICUT HEALTHCARE INNOVATION PLAN



Connecticut State Innovation Model

Population Health Council June 30, 2016

Thursday June 30, 2016

3:00 – 5:00 PM

DPH Lab Training/Cafeteria - 395 West Street, Rocky Hill

Agenda

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

Meeting Purpose and Outcomes

- To inform Advisory Council members on first quarter activities/progress and accomplishments.
- To obtain AC feedback on identified challenges and barriers.

Introductory Remarks

Commissioner Raul Pino

- Connecting key national and state priorities to work of the SIM and Population Health Council
- Important areas of alignment and synergy

Welcome and Ice Breaker:

Rose Swensen. Planning Facilitator, HRiA

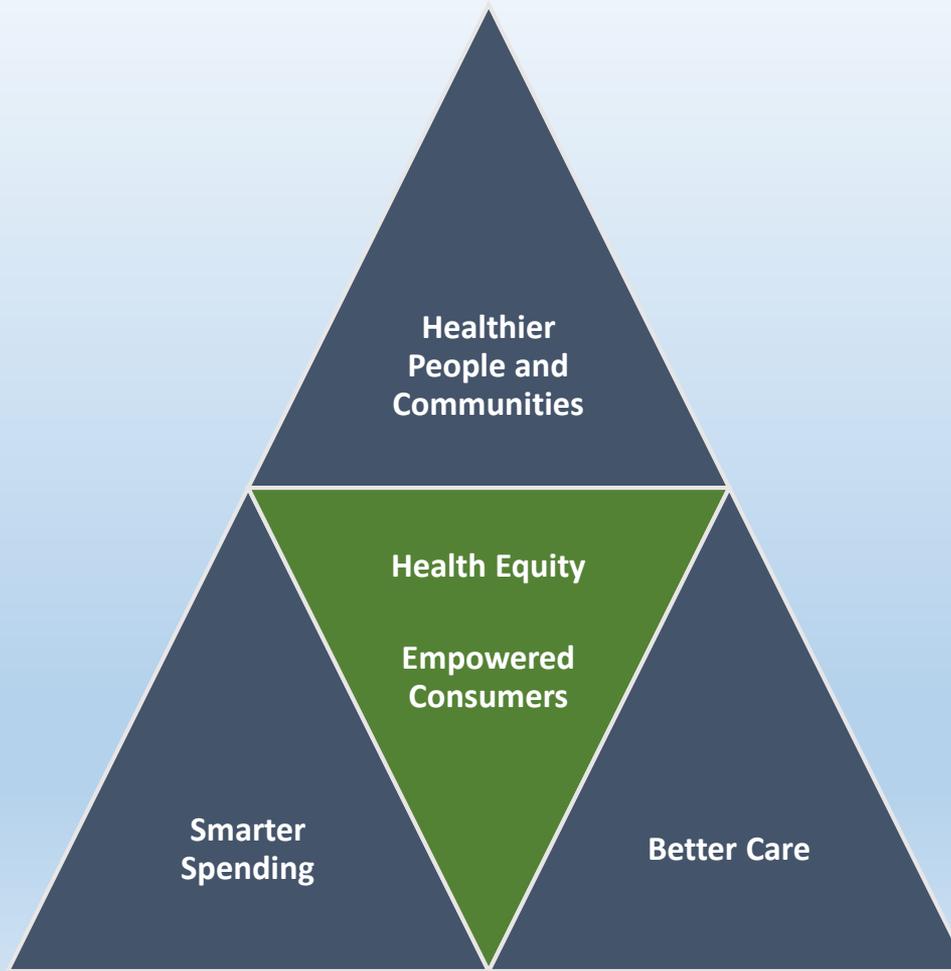
- Introduce yourself: Name, role
- What do you hope to get out of participating on the Population Health Council?
- What do you hope to contribute to the Population Health Council?
- Tell us something about yourself that others would not know

State Innovation Model

Mark Schaefer, Healthcare Innovation Director

- Grant framework
- Overarching goals

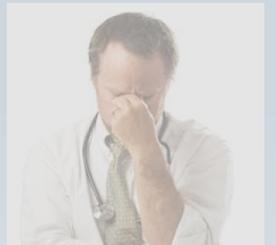
Connecticut State Innovation Model Aims



Connecticut's Current Health System: "As Is"

Fee for Service

- **Limited accountability**
- **Poorly coordinated**
- **Pays for quantity without regard to quality**
- **Uneven quality and health inequities**
- **Limited data infrastructure**
- **Unsustainable growth in costs**



Stages of Transformation

Connecticut's Current Health System: "As is"

Fee for Service 1.0

Limited accountability

Pays for quantity without regard to quality

Lack of transparency

Unnecessary or avoidable care

Limited data infrastructure

Health inequities

Unsustainable growth in costs



Accountable Care 2.0

Accountable for patient population

Rewards

- better healthcare outcomes
- preventive care processes
- lower cost of healthcare

Competition on healthcare outcomes, experience & cost

Coordination of care across the medical neighborhood

Community integration to address social & environmental factors that affect outcomes

Our Vision for the Future: "To Be"

Health Enhancement Communities

3.0

Accountable for all community members

Rewards

- prevention outcomes
- lower cost of healthcare & the cost of poor health

Cooperation to reduce risk and improve health

Shared governance including ACOs, employers, non-profits, schools, health departments and municipalities

Community initiatives to address social-demographic factors that affect health

Population Health Planning – Toward accountable communities

Accountable Care 2.0

Accountable for **patient**
population

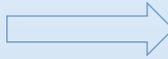
Rewards

- better healthcare outcomes
- preventive care **processes**
- lower cost of healthcare

Competition on healthcare
outcomes, experience & cost

Coordination of care across
the medical neighborhood

Community integration to
address social & environmental
factors that affect **healthcare outcomes**



Health Enhancement Communities 3.0

Accountable for **all**
community members

Rewards

- prevention **outcomes**
- lower cost of healthcare &
the cost of poor health

Cooperation to reduce risk and improve
health

Shared governance including ACOs, employers,
non-profits, schools, health departments and
municipalities

Community initiatives to address social-
demographic factors that affect **health**

www.healthreform.ct.gov

sim@ct.gov



CT SIM Program Management Office



@CT_SIM

Population Health Work Stream:

Mario Garcia, SIM/DPH Population Health Director

- Context of ACA/SHIP
- Products to Deliver (10 mins)
- Q&A (10 mins)

**STATE HEALTHCARE INNOVATION MODEL
POPULATION HEALTH PLANNING**

**HEALTH ENHANCEMENT COMMUNITIES
& COMMUNITY PREVENTION SERVICES**



A PARADIGM SHIFT TO GET TO 3.0



MARIO GARCIA, MD, MSc, MPH

Leadership Mindset

	<u>Fix Problem</u>	<u>Create Solution</u>
Approach	Health reform	System transform
Driver	Cost	Health
Goal	Access to affordable care	Population health / health equity
Emphasis	Disease, treatment, services	Healthstyle, health-in-all places
Measures	Quality, cost, morbidity, burden	Health, value, happiness, empowerment

Julie Gerberding, MD, MPH

Executive Vice President, Merck - Former Director, CDC

ISSUES, CHALLENGES AND SOLUTIONS

CURRENT PARADIGM:

Disease Care vs. Health Protection
Impact on Population Health

SOCIAL DETERMINANTS OF HEALTH:

Community Activation –
Community Integration —

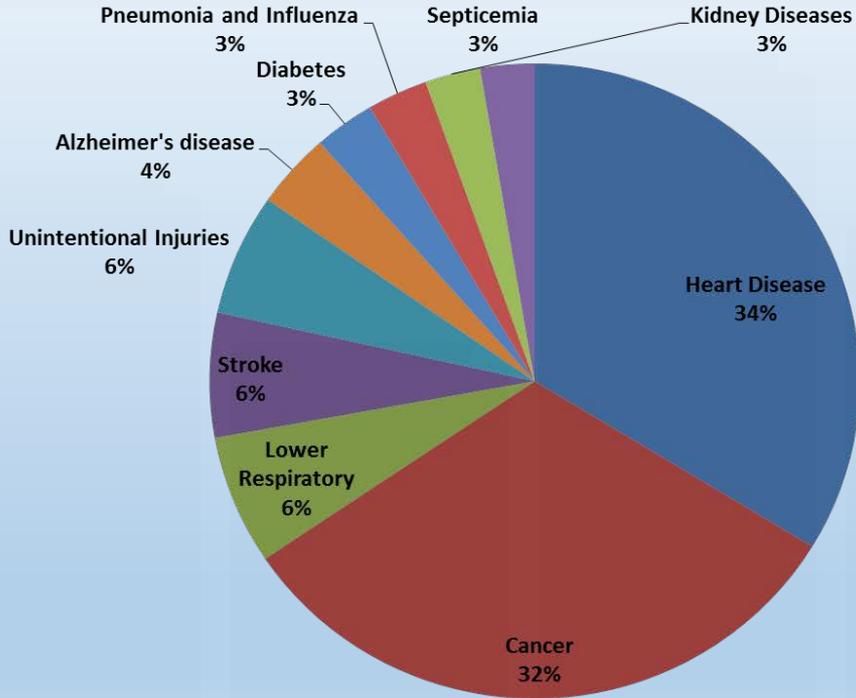
MULTIDIMENSIONAL APPROACH TO PREVENTION:

Clinical Prevention Strategies
Community Health Strategies

HEALTH ENHANCEMENT COMMUNITIES:

Structured Networks, Agenda for Health, Designation Criteria
Transformation Triggers

TOP TEN CAUSES OF DEATH IN CONNECTICUT



Proportional Contribution to Premature Death

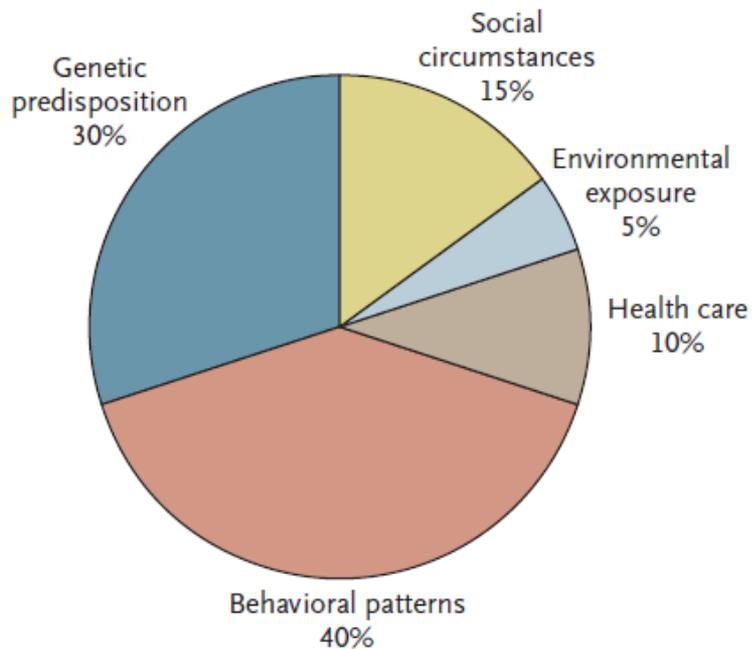
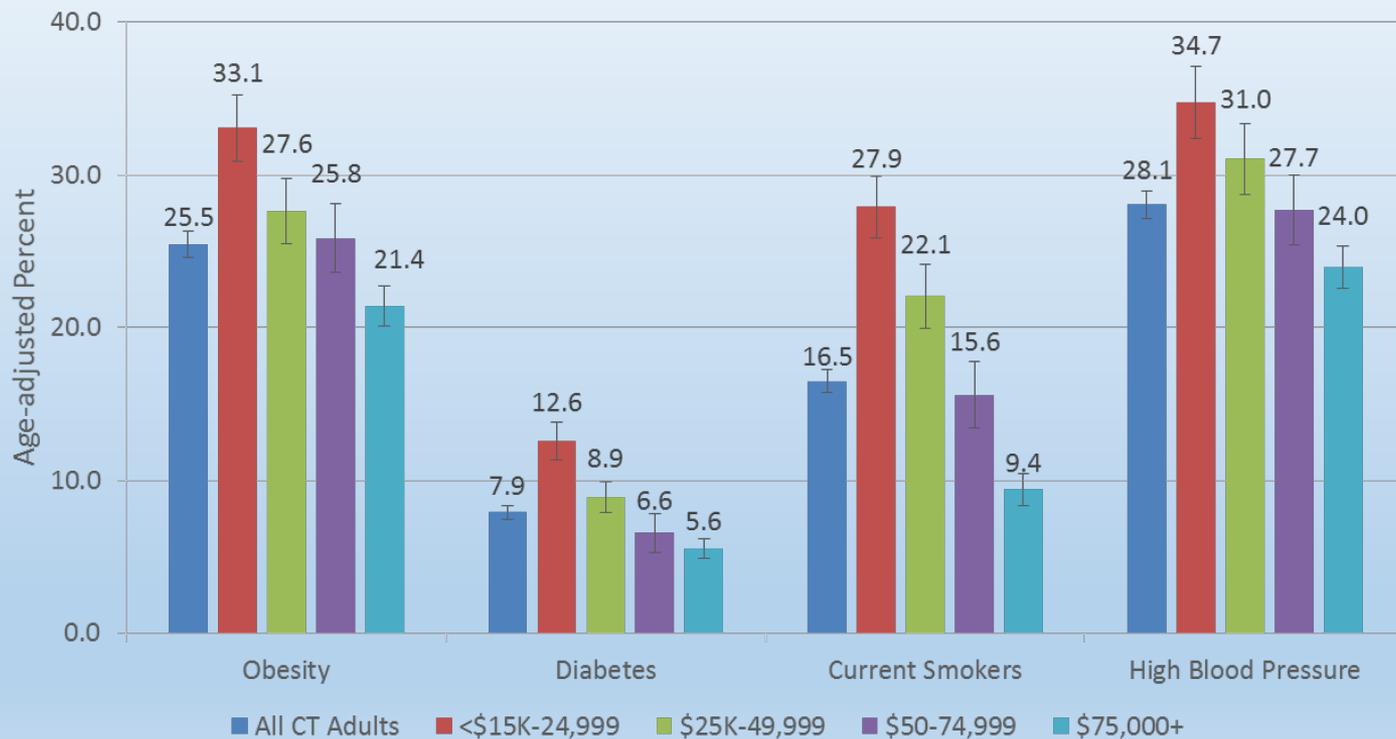


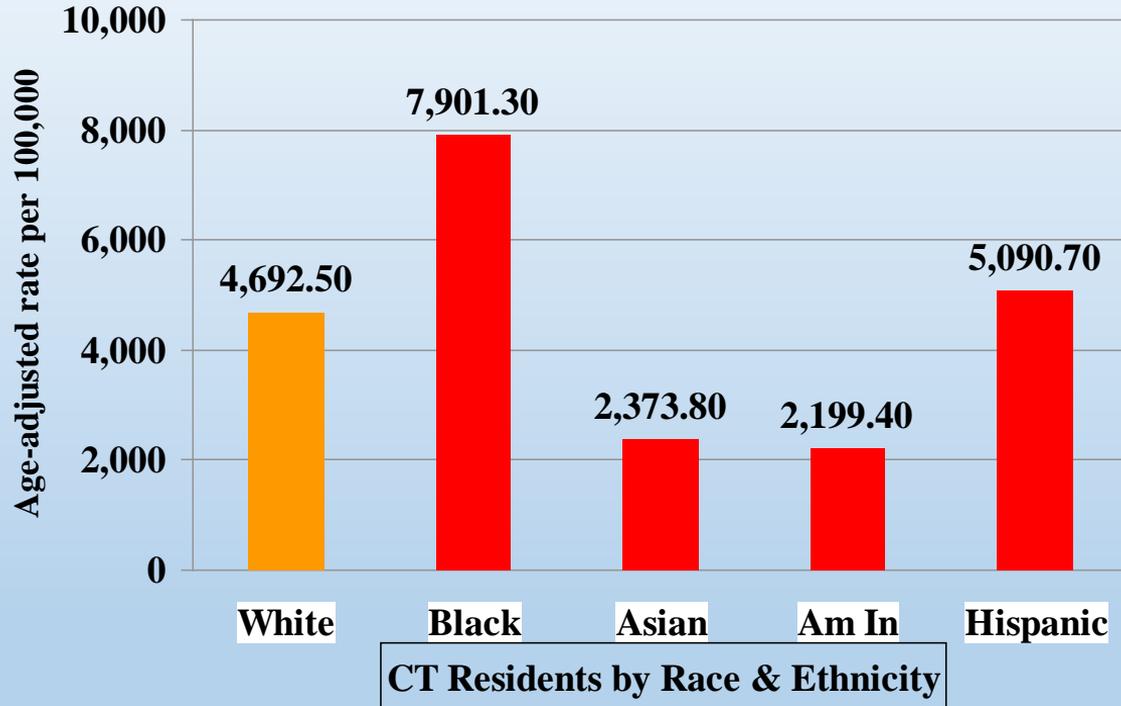
Figure 1. Determinants of Health and Their Contribution to Premature Death.

Adapted from McGinnis et al.¹⁰

RISK FACTORS FOR CHRONIC DISEASE AMONG CT ADULTS BY HOUSEHOLD INCOME 2012-14



PREMATURE DEATH BY RACE AND ETHNICITY



Years of potential life lost (YPLL) represent the number of years lost by each death before a predetermined end point. The YPLL statistic is derived by summing age-specific years of life lost figures over all age groups up to 75 years.

DETERMINANTS OF HEALTH



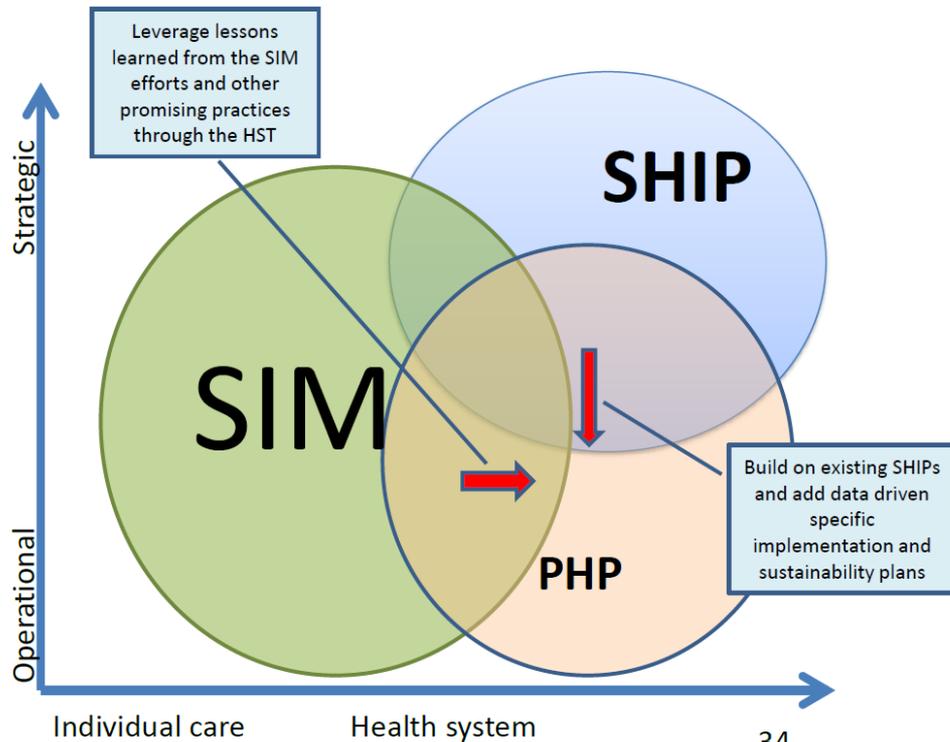
POPULATION HEALTH

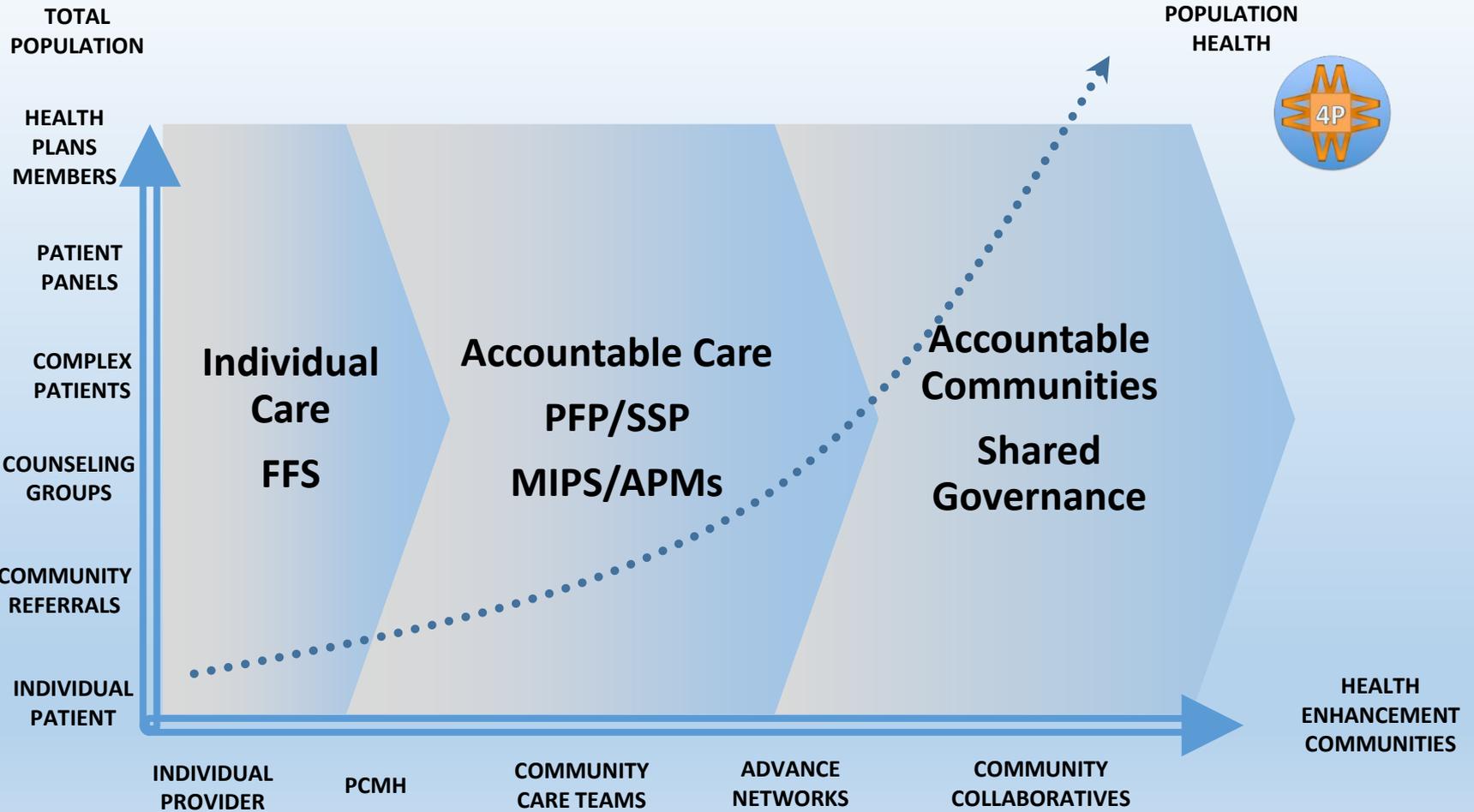
“The health outcomes of a group of individuals, including the distribution of such outcomes within the group...population health outcomes are the product of many determinants of health, including healthcare, public health, genetics, behavior, social factors, and environmental factors.” Kindig D, Stoddart G. What is population health? American Journal of Public Health 2003;93(3):380-383.

Outside Health System Factors

- Food safety
- Neighborhood crime
- Open space
- Disease prevalence
- Income levels
- Unemployment rate
- Age/Sex/Race
- Care seeking behavior
- Food availability
- Housing conditions
- Parks
- Genetic inheritance
- Poverty rate
- Geographic location
- Pharmacy
- Transportation

Scope of Population Health Plan under SIM





HEALTH ENHANCEMENT COMMUNITIES DESIGNATION

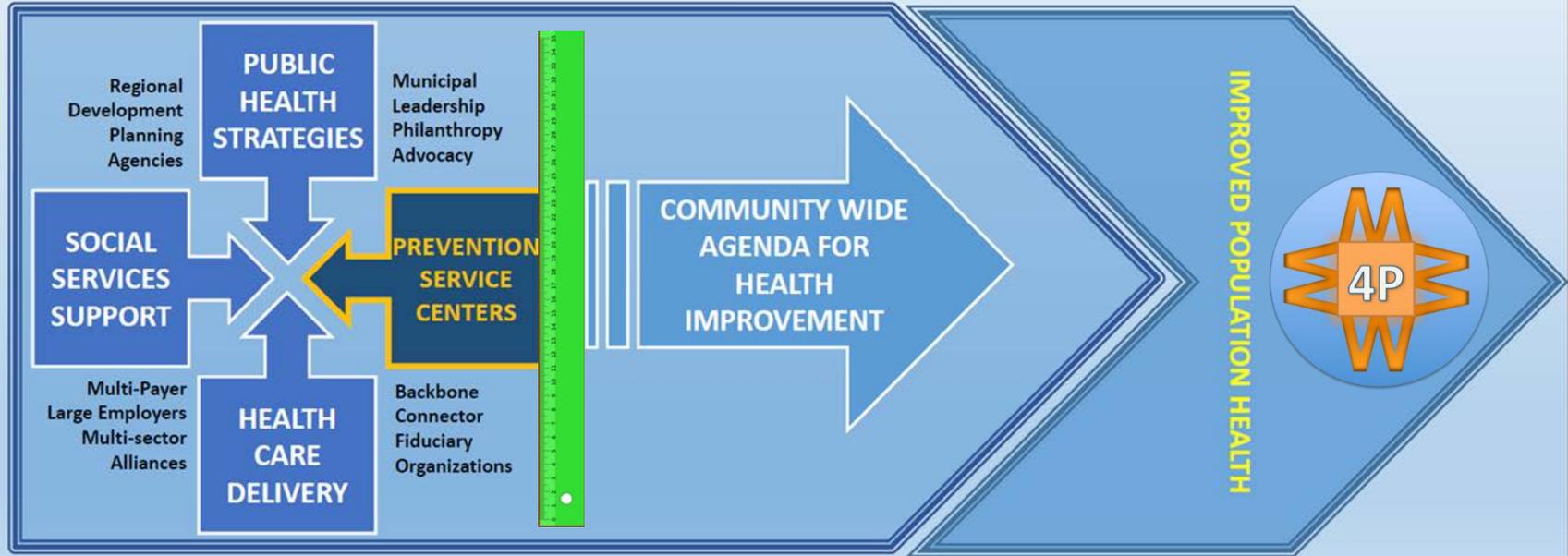


FIGURE 1. California ACH Five Key Domains



Clinical Services

- Services delivered by the healthcare system
- Includes primary and secondary prevention, disease management programs, and coordinated care that is provided by a physician, health team, or other health practitioner associated with a clinical setting



Community and Social Services Programs

- Programs that provide support to patients and community members
- Delivered by governmental agencies, schools, worksites, or community-based organizations
- Frequently target lifestyle and behavioral factors, such as exercise and nutrition habits; also include peer support groups and social networks



Clinical-Community Linkages

- Mechanisms to connect community and social services and programs with the clinical care setting to better facilitate access to and coordination between healthcare, preventive, and supportive services
- Can help form strong bonds between community and healthcare practitioners and, ideally, involves bi-directional feedback systems between the two



Environment

- Social and physical environments that facilitate people being able to make healthy choices
- May include community improvements such as building parks or bike lanes, making farmers markets more available, or transforming corner stores to carry more fruits and vegetables



Public Policy and Systems Change

- Policy, regulatory, and systems changes that affect how the healthcare and other systems operate and influence the overall ability of people to be healthy
- Address environmental issues, school policies, health and social systems coordination, and financing to support prevention-related activities

From a Disease Care System To a System of Health Sustenance

These intervention approaches are briefly described below:

- **Policy improvements** may include “a law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions.”¹⁶
Example: A voluntary school wellness policy that ensures food and beverage offerings meet certain standards.
- **Systems improvements** may include a “change that impacts all elements, including social norms of an organization, institution, or system.”¹⁷
Example: The integration of tobacco screening and referral protocols into a hospital system.
- **Environmental improvements** may include changes to the physical, social, or economic environment.¹⁷
Example: A change to street infrastructure that enhances connectivity and promotes physical activity.



cdc.gov/healthequityguide

Council Operations:

Mario Garcia and Rose Swensen

- Charter for the Council and roles/expectations
- Timeline (Pre-Planning and Planning)
- Process for Pre-Nomination and Selection of Council Chairs and Executive Committee (Criteria, Representation)
- Operating Principles
- Conflict of Interest Letters

Proposed Composition and Criteria for Participation in the Population Health Council

DRAFT

Population Health Council

Composition

- Access Health CT Representative (1)
- Municipal leadership member (1)
- Advance Network (ACO) Representatives (2)
- Health Plan Representatives (1)
- Large and Small Employer (2)
- Consumers/advocates (5)
- Connecticut Hospital Association (1)
- Health Data Analytics expert (1)
- Health Economist (1)
- Federally Qualified Health Centers (1)
- Urban/Rural school district (1)
- Behavioral Health agency (1)
- Local Public Health agency (1)
- Housing Representative (1)

Criteria For Membership

- Direct work experience in the CT public health and healthcare environment
- Knowledge of health related data collection and interpretation
- Experience with outpatient patient care
- Direct experience in regional planning and development organizations.
- Demonstrable experience in community engagement activities related to prevention and health promotion
- Organizational experience in population health management
- Large self-insured organizations/small employers
- Organizational interest in policy advocacy
- Consumers representing philanthropic sector; environmental health interest, homeless advocates, non-profit food systems, disabilities, housing or economic support; advocate against violence, chambers of commerce, racial/ethnic/geographically diverse communities

Support & Technical Assistance Team

- State Agencies: DPH, DSS, SCO, DMHAS, DCF (Ex officio)
- PMO staff (1)
- DPH-SIM Staff (2)
- Contractor Facilitator (HRiA)

- Expertise in public health and healthcare research, policy and evaluation
- Knowledge of CT SIM
- Experienced supporting communications
- Experience facilitating collaborative activities

Charter:

The Population Health Council is a workgroup charged by the Healthcare Innovation Steering Committee with developing a **sustained vision** for improving Population Health in the context of payment, insurance and practice reforms, and community integration and innovation.

The Council **leverages existing state resources** available through the State Innovation Model and builds on the framework established in the State Health Improvement Coalition. The Council uses the State and Community-based Health Assessments, as well as any other Connecticut specific health indicators, as the basis to both advance population health planning and establish a **long term strategy** for public health. This strategy will have a special focus on areas of high burden of disease and on demographic groups impacted by health disparities. The council will focus on addressing root causes of disease and defining priorities based on burden of cost, reducing inequities and improving overall health.

The council will recommend to the SIM Healthcare Innovation Steering Committee **a strategy to maintain a system of population health data, overall health improvement monitoring, and community accountability metrics.**

In addition, the council will assess **community health capabilities** in order to recommend the extension of prevention services outside of clinical settings. The council will, as a result, formulate **a strategy for the establishment of Community Prevention Service Centers.**

Lastly and more importantly, the council will recommend **guiding principles** and a **sustainability strategy** for the designation of **Health Enhancement Communities**, which are structured community-wide collaborations with a multi-sector agenda for health improvement.

SIM Project Timeline



PI Year

- Hire all DPH staff required to establish the Population Health SIM team
- Establish and launch the Population Health Council
- Release a SIM Population Health Status Assessment Report
- Provide data and enabling methods to maintain metrics of Population Health
- While conducting a root cause and barrier analysis, define trends and improvement targets for tobacco use, obesity and diabetes.
- Identify priority areas with highest burden of disease and community capacity to implement prevention initiatives
- Conduct statewide scan to identify entities able to provide evidence-based community-prevention services
- Design Prevention Service Centers, research evidence -based interventions and finalize PSC's service menu

Process for Appointing Co-Chairs and Executive Committee

- Nominated by CT DPH
- Criteria for selecting Co-chairs (2) and Executive Committee (4):
 - Good facilitative leaders
 - Have a strategic perspective with respect to health care reform
 - Ability to listen to and engage multiple points of view in a complex planning environment
 - Unbiased
 - Willingness and capacity to be in this role
 - Co-Chairs: Represent two sectors of Public Health and Clinical/Health care
 - Connection to community and community-based interventions
 - Well respected in peer community
 - Diversity: sectors, demographics (Consumers, Providers, Health Plans, CBO's)

Co-Chairs:

- Susan Walkama (FQHC) – Alternates:
- Steve Huleatt (HD)

Exec Committee: (4)

- Co-Chairs plus
- Garth Graham
- Hyacinth Yennie

Operating Principles

Presence

- Attend meetings
- Prepare and participate between meetings as needed to move issues along

Outlook

- Leave jobs and titles at the door; focus on best interest of CT citizens
- Look for consensus to make recommendations

Action

- Find solutions for proposed questions
- Build ideas and be proponent of change and transformation
- Be vocal and share the importance of our mission

Accountability: Be fully accountable to the public in a transparent process that meets the objectives of Public Act 11-58.

Inclusion: Ensure that there are meaningful opportunities to obtain a broad cross-section of views.

Equity: Recommendations are mindful of the goal of reducing disparities based on race, ethnicity, gender, and sexual orientation.

Impact: Contribute to the improved physical, mental, and oral health of all Connecticut residents:

- The number of individuals and/or constituencies affected
- The depth and/or intensity of the problem
- Reduction of barriers and burdens for those most vulnerable
- The time frame in which change can occur
- The cost effectiveness of health and health care purchasing that promotes value and optimal health outcomes.
- A health insurance marketplace that provides consumers a competitive choice of affordable and quality options.

Leverage: Recommendations must:

- a. Make the best use of past and current knowledge and expertise
- b. Maximize the opportunities provided through initiatives from the public and private sector.
- c. Be informed by data and evidence-based practice/research.

Questions for Feedback

- What does “Population Health” mean to you if anything?
- What information would be most useful to you in going from orientation to planning?

Next Steps

Next meeting date: July 28, 2016 3-5 p.m.

Agenda

- **Conceptual: What Is Community Prevention? (Case Studies)**
- **Operational: Structure, Roles, Decision-making Process for Council**
- **Key Questions for Reflection**
 - **What are the current supports/incentives for Community Prevention models to be successful and sustainable?**
 - **What are the current barriers/issues to overcome to implement Community Prevention models more broadly?**



The **National Prevention Strategy** provides a foundation for all prevention efforts and include four strategic directions necessary to build a prevention-based strategy. **a)** Healthy and Safe Community Environments; **b)** Clinical and Community Preventive Services; **c)** Empowered People, and **d)** Elimination of Health Disparities

Seven priorities provide evidenced-based recommendations that are most likely to reduce the burden of the leading causes of preventable death and major illness. The Priorities are designed to improve health and wellness, including those groups disproportionately affected by: **a)** disease and injury; **b)** Tobacco Free Living; **c)** Preventing Drug Abuse and Excessive Alcohol Use; **d)** Healthy Eating Active Living; **e)** Injury and Violence Free Living; **f)** Reproductive and Sexual Health, and **g)** Mental and Emotional Well-Being.

2 | Journal of Public Health Management and Practice

FIGURE ● Three Buckets of Prevention



The CDC has developed a conceptual population health and prevention framework with 3 categories—“buckets”—of prevention. Each one will be needed to yield the most promising results for a population, regardless of whether the population is defined narrowly, as, for example, the patients in a medical practice, or broadly, as, for example, the residents of a state.

This 3-part framework may be particularly useful as a way of maximizing the likelihood that clinicians, insurers, and public health practitioners attend to traditional office-based as well as innovative clinical approaches and do not neglect the community factors that have an enormous impact on health.



This effort focuses on the patient-oriented approaches—the **first 2 buckets**—which is designed to promote the adoption of evidence-based interventions by health care purchasers and payers to improve health and control costs.

CDC provides these partners with rigorous evidence about six high-burden health conditions and 18 evidence-based interventions to inform their decisions to have the greatest health and cost impact in a relatively short time period.

This initiative aligns evidence-based preventive practices with emerging value-based payment and delivery models.



With bucket 3, the focus shifts from patient to population center approaches. It includes interventions that are no longer oriented to a single patient, or all of the patients within a practice, or even all patients covered by a certain insurer. Rather, the target is an entire population or subpopulation usually identified by a geographic area. Interventions are not necessarily implemented by a clinical provider but out of community consortium as proposed by the **Health Enhancement Community** model.

A portfolio of population based interventions with strong evidence base can lead to improved health and/or cost reduction within a relatively short time. For example, cigarette taxes, smoking ban regulations or laws, and well-designed advertising campaigns have each been shown to have a rapid impact on reduced cigarette use. There is also evidence that community-wide, multifactorial, coordinated efforts to promote healthful eating and increased physical activity have resulted in a decline in the childhood risk for obesity within a few years. Similarly, housing policies that reduce environmental triggers have been shown to reduce active asthma symptoms and health services utilization within a few years.

An optimal strategy is one in which prevention approaches span the 3 buckets—traditional and innovative clinical preventive as well as total population interventions. Each bucket requires its own prioritized interventions and funding sources.