State of Connecticut

State Innovation Model
Population Health Council

Meeting Summary
April 26, 2018

Meeting Location: Beacon Health Options (Behavioral Health) 500 Enterprise Drive, Rocky Hill

Members Present: Pat Baker, Elizabeth Beaudin, Rick Brush, Steve Huleatt (Co-Chair), Hayley Skinner, Susan Walkama (Co-Chair), Jeanette Weldon; **Members Participated via Teleconference**: Tekisha D. Everette, Craig Glover, Lisa Honigfeld, Kate McEvoy, Carolyn Salsgiver

Members Absent: Frederick Browne, Garth Graham, Martha Page, Hugh Penney, Elizabeth Torres, Hyacinth Yennie

Other Attendees: DPH: Mario Garcia, Amy Smart, Trish Torruella, Kristin Sullivan; SIM PMO: Faina Doohk, Mark Schaefer; HMA: Cathy Homkey, Deb Zahn; DPH: Raul Pino (via teleconference)

Call to Order: Co-Chair Steve Huleatt called the meeting to order at 3:05 pm; a quorum was present.

Public Comments: There were no public comments.

Co-Chair Steve Huleatt made a motion to approve the March 29, 2018 Population Health Council meeting summary, second by Rick Brush. Tekisha Everette and Jeanette Weldon abstained. The meeting summary was approved.

PHC Interviews: Cathy Homkey (HMA) discussed the presentation for today. The initial items is the PHC interviews and we will provide overview of the interviews which are 75% complete, reviewing and validating the process for selecting interventions for financial modeling and looking for the Council to share input on the HEC strategy development process and what is critical for success. Our introduction slide is an approach emphasizing a multidirectional flow of information and input to support decision making.

PHC Process: Cathy Homkey stated that PHC Process need more discussion and interaction from Council members, more vision setting driven by PHC members, state-provided data to form basis of PHC recommendations, emphasized the need to focus on children's issue as well as adults, a group composed well to include a wide array of stakeholders, perhaps consider more representation from consumer groups and regular discussion on SIM updates and how pieces fit together.

Ms. Homkey listed the potential attributes of successful health enhancement communities (HECs) and the feedback received was to meet patients where they are in the community, that a sustainable payment model with state, federal, private payer and private business participation is needed, the need to address current fragmentation in the system, the need to focus on measures that truly impact improved outcomes, and infrastructure support for organizations that leads to a glide path of self-sustainability.

Ms. Homkey discussed the High Priority Public Health Challenges with health equity; must find a way to focus on areas in greatest need that fall through the cracks, early intervention and children's health issues, behavioral health, diabetes, heart disease and root causes and indicated that this input has been received from the Council and is being used. She also discussed the critical elements of HEC implementation such as use of and financing for community health workers, strong governance structured in the community, commitment from state and local leaders, clear and attainable outcome goals, assist communities in attracting investment to address social determinants of health, data that is culturally sensitive and easily understood, to employ interventions representing proven strategies and are based in evidence, and accountability for measures that the community can control and impact.

Cathy Homkey asked the Council if there was anything that was not contemplated or quickly reflected or any questions or comments?

Lyn Salsgiver – Disparities between household of the lower income vs higher household income and how education should be a key factor we need to consider.

To Secure Sustainable Financing. Deb Zahn (HMA) indicated this was the most important slide in the presentation because it is a critical element of where we need to end up with health enhancement communities to end with some sustainable financing. What we have to essentially arrive at is Interventions where savings can accrue to at least 1 of these sources of sustainable financing. We are going to look at an economic benefit broadly but also at an economic benefit that produces cash in hand that can be used to support the health enhancement communities. The buckets that we are looking at is having interventions where there is savings that accrue to Medicare, to Other Health Care Payers, Health Care sector or to other non-health sectors. In order to get sustainable financing in-hand there has to be some savings that accrue in one of these categories.

Deb illustrated the end point of the HEC planning by discussing the issue of sustainable financing. This elicited the following comments:

Rick Brush pointed out that sustainability can be considered beyond savings tied to payer contracts to include other forms of revenue such taxes or productivity increases.

Steve Huleatt and Lisa Honigfeld advised to prepare a response regarding timelines for ROI. It is anticipated that stakeholders in HEC will inquire about this question.

Deb suggested that answer lies on selecting interventions that can provide a satisfactory time window to anticipate realistic health and financial impacts.

Hayley Skinner remarked on the need to develop methods of data collection and analysis that could clearly demonstrate the cause-effect relationship between selected interventions and any observed outcomes. This is particularly important to separate out the role of multiple initiatives (confounders) among large attributed populations that may overlap among providers.

Following this discussion, Deb introduced an infographic about the process for selecting interventions. She highlighted the need to look at interventions with outcomes that payers are willing to invest on. Baseline knowledge for selection of interventions is being gathered by levering information collected from multiple state sources including an earlier SIM environmental scan, regional community health needs assessments and the state health improvement plan.

Next, Deb examined the main topic areas being addressed by both the State Innovation Model and the State Health Improvement Plan to frame the state and community health problems. In addition, Deb introduced the priority areas for intervention that have been selected by four HEC reference communities. The next step in the selection process is to narrow down to the initial high priority conditions based on the following criteria: previously identified in other planning process, outcomes can be measured, some evidence of return on investment, relate to both children and adults.

Lisa Honigfeld warned that information presented so far seem to look only at clinical interventions. She recommended to focus on more and mostly upstream approaches.

Pat Baker remarked that interventions could be more or less upstream.

Jeanette Weldon acknowledged that an intervention that is too far up stream may have limitations to attribute the effects to the intervention.

Deb clarified that the HECs will certainly focus on upstream approaches while examining root causes. She illustrated the multiple causes of obesity and discussed how a comprehensive examination of root causes would allow a selection that is both upstream and not too far reaching that to obtain measurable outcomes. She concluded that the goal is to look for the "sweet spot".

Steve Huleatt supported the "sweet spot" rationale and recommended that activities directed to address uncontrolled conditions could meet that definition.

Pat Baker suggested that selection criteria need to be appropriate to what is in the area of influence to set the upstream level and not to set the project to failure.

Mark Schaefer brought up the innovations on genomic medicine and the opportunity it raises to consider for long term prevention.

Pat Baker cautioned against focusing on rare diseases and urged for an emphasis on prevalent conditions impacted by race and ethnic disparities.

Kristin Sullivan pointed out that all topic areas proposed by the State health Improvement Plan have been thoroughly vetted and warned against duplicating efforts.

Lynn Salsgiver also suggested that findings and priorities listed in the Community Health Needs Assessments are supported by reliable sources of data and therefore they should be considered as being already validated.

Deb continued discussion the process by indicating that all objective topics will be narrowed down to targeted objectives. The goal is to frame the objectives and the interventions so payers and providers can perceive their value and the attainability to show success. After considering and mapping the overall root causes of identified priorities, the project will use a second set of criteria for intervention selection such as: a) existing statewide and community interventions; b) there is ROI that accrues to available sustainable financing options; c) successfully addressed in other similar place-based initiatives.

Additional criteria includes whether there are authorities that can be activated to advance the interventions and their potential for scalability and transferability.

Jeanette Weldon recommended to make a decision about whether all or partial criteria would be required.

Deb suggested that in developing the criteria it should be designated as a must and/or preferred.

Steve Huleatt strongly recommended to engage the participation of municipal governments to the extent that they self-insured large local populations.

Rick Brush inquired about whether the Medicaid program would be involved in the modeling of financial solutions for their population.

Deb clarified that although the financial modeling will not initially include Medicaid, the concept includes a multi-payer solution.

Pat Baker warned about the unintended consequences of beginning the modeling with Medicare data.

Mark Schaefer replied that analytical plan considers beginning with a basic methodology that could be extended to use with other data set from multiple payers.

Susan Walkama recommended to expand the multisector approach to include faith based organizations.

On the same note, Lyn Salsgiver reiterated the need to include local administrators and local officials.

Mario Garcia: A factor that you would like to consider in the selection of a condition whether you are targeting risks factors that are behavioral or monumental.

Deb replied the first is to get to a more management list of conditions.

Reference Community Engagement Process: Deb Zahn shared that HMA will work hand-in-hand with Reference Communities to develop recommendations and listed the steps that will be taken toward the engagement process.

Reference Community Engagement Timeline: Deb Zahn referenced the timeline table with the planned items and target dates.

Cathy
Next Meeting Date: June 28, 2018 from 3:00 pm – 5:00 p.m.

Meeting adjourned at 5:00 p.m.