State of Connecticut

State Innovation Model
Population Health Council

Meeting Summary
September 27, 2018

Meeting Location: Connecticut Hospital Association, 110 Barnes Road, Wallingford, CT

Members Present: Pat Baker, Elizabeth Beaudin, Frederick Browne, Rick Brush, Jeanette Weldon, Steve Huleatt (Co-Chair): **Members Participated via Teleconference**: Penney Hugh, Lyn Salsgiver

Members Absent: Susan Walkama (Co-Chair), Garth Graham, Craig Glover, Tekisha D. Everette, Martha Page, Hayley Skinner, Elizabeth Torres, Hyacinth Yennie

Other Attendees: DPH: Mario Garcia, Amy Smart, Trish Torruella; Kristin Sullivan, Laurie Ann Wagner; SIM PMO: Mark Schaefer; HMA: Deb Zahn, LLHD Reference Community: Megan Brown, Russell Melmed, Laurel Holmes; Norwalk RC: Deanna D'Amore, Theresa Argondezzi; Hartford RC: Liany Arroyo

Call to Order: Co-Chair Steve Huleatt called the meeting to order at 3:00 pm.

Public Comments: There were no public comments.

Co-Chair Steve Huleatt made a motion to approve the July 26, 2018 Population Health Council meeting summary. The meeting summary was approved by the Council.

Health Management Associates (HMA) opened by introducing the four Reference Communities (RC) in attendance who were invited to speak about their HEC design input. Each RC had an opportunity to present on their individual collaborative background and experience participating in the HEC planning process. Specific topics reviewed by each RC were key HEC partnerships, community engagement, and HEC opportunities and challenges that were discovered throughout the process.

The Greater Waterbury Health Partnership (GWHP) presented first on their background, stating that they conceptualize the HEC model as a "Super GWHP." Several key partnerships were listed and their community engagement involved survey/focus groups along with key informant interviews. Opportunities involve local alignment with state and federal goals, and a transition to value based reimbursement. Challenges addressed sufficient capital and timeline to develop the HEC infrastructure and expertise.

Member comments/questions:

- Two very distinct hospital systems are sitting around the table for Waterbury—how do you see that as being good or challenging?

    - The hospitals have gone through a lot of change too so as a coalition they have tried to move things along as quickly as possible. They are both at the table, both CEOs are very engaged and willing to put up funding—they have for the past 5 years to support collaborative efforts. There are challenges, but they are being addressed openly.
- I applaud CEOs sitting at the table.
- Please expand a bit more because I feel this is an important question—it can be hard to align with hospitals and how do your challenges relate to other collaboratives?
    - There are definitive challenges for others working with multiple hospitals. Waterbury has an interesting size city to have two hospital so the market share is interesting. In larger cities there's more to go around.
- The community based organization structure—what's the conversation about getting to the neighborhood level provider and engaging them at that level. Have you had discussions or made plans around that?
    - One of the networks participating in this effort is Bridge to Success and they have 90 organizations and families working with us. This is a group that has been involved and their input is just as valued so the atmosphere is very strong. Another organization works with Latina mothers and we'll have conversations on how they would like to see childhood obesity addressed or access to healthy foods.

New London's Health Improvement Collaborative of Southeaster CT presented their background and collaborative structure. Their full collaborative has been involved in HEC planning through quarterly meetings and deep dive sessions. They have also been working with community partners for special HEC engagement. Top two opportunities identified include an incentive to formalize work that has been already occurring in the collaborative over the last two years and the potential to fund important interventions that can impact health in the long-term. Challenges are concerns about funding infrastructure and long-term funding through Medicare or the uncertainty surrounding that.

Member comments/questions:

- Question for the LLHD epidemiologist on the challenges around getting data and tracking priorities and success.
    - These are challenges that have been around forever. Delays are a common problem so it is very difficult to measure progress for funders. Interpreting the data that is available can be difficult because of the specific data jargon and talking the same language with multiple partners and organizations that are used to looking at data in different contexts. We're frequently speaking two different languages. When it comes to doing our next Community Health Needs Assessment, we're talking about restructuring it and leading with SDOH that lead to those health outcomes—this is in an attempt to speak that same language.
- Do the four action teams lead to your focus or is the focus already developed?
    - The action teams were formed prior to the HEC activity and the two health priorities recently identified. Fortunately, the design teams focus on topics directly relating to HEC priorities of child well-being and preventing obesity. We are concerned about how the HEC priorities could disrupt our current efforts and

we'll have to decide as a group how to handle that. When there is direct alignment, we won't have an issue, but sustainable funding to move forward with these initiatives will be imperative.

- How does this align with your Community Health Needs Assessment?
    - During our Deep Dive sessions there were certain aspects that directly align with our efforts and we were happy to see them, such as diabetes prevention, it fits very neatly—there's an evidence-based strategy that would work well.

The Greater Norwalk Community Health Improvement Initiative presented their background showing their origin with their 2016 CHA/CHIP process and three priority areas identified. Key partnerships and community engagement were reviewed and included group discussions and a community survey. The collaborative have identified opportunities to scale up through the HEC initiative, increasing data capabilities, additional community engagement and sustainability. Challenges are around governance and structure around municipalities, along with maintaining long-term engagement. Overall, community feedback has been enthusiastic and root causes are being addressed.

Member comments/questions:

- Recently the CDC came out with small area estimates of census tracts in CT—how do you think about health equity in Norwalk?
    - I haven't had a chance to check those life expectancy estimates in Norwalk. We think a lot about health equity. We are discussing SDOH and root causes more and more. This focus alters the conversation completely and this project offers a lot of opportunity to address those issues across the board.
- You mentioned an opportunity for sustainability—what ideas have you come up with looking toward the future.
    - Looking at the collective impact agency in Norwalk—they were able to figure out sustainable funding as an organization and it was at that point that their work really went off the ground. We have funding from multiple sources, but having the mechanics and logistics for sustainable funding will make that change. We really see it as the future of public health.

The North Hartford Triple Aim Collaborative developed a bit differently than other collaboratives who were a product of the CHNA/CHIP processes. The collaborative has been engaged with several key partners and involved community engagement activities such as HEC Deep Dive sessions, webinars, and community surveys. Opportunities identified look at funding, new partnerships and innovation. Challenges listed were grouping disparate populations with different needs, creating new entity to manage funding, addressing disparities, and health equity.

Member comments/questions:

- This particular area of Hartford is quite small and there are complicated dynamics and groups—I'm curious about those dynamics coming into creating a new entity and you have a unique confluence of these types of groups.
    - It's been helpful that the leader for the promise zone sits on the collaborative. People on the ground want to see action now. This can cause some tension and we're trying to be flexible and make it happen as best as we can. The

collaborative has been together for one year now and we're starting to work together with St. Francis to collaborate on the CHNA/CHIP process.

Following the RC presentations, HMA covered community member engagement as it relates to HEC planning and the final report. Details and timeline for planned and ongoing stakeholder engagement was offered.

Questions/comments from the Council:

- How "community member" is defined and requested a clear definition be included in the strategy design.
- Seeing the geographic are covered by the RC (i.e. breadth), what is the way to capture a really diverse group of individuals based on race, socioeconomic status, etc. so you don't just end up with a bunch of organizations.
- It's not about bringing the community to the table of the HEC, it's about bringing the HEC to the table of the community. For example, how do we set up the table in the NRZ? Making it part of the community.
- I would caution about setting up the table because if we don't bring anything, it's almost better not even trying to set up with the community. The community doesn't need another "catch and release."
- We can't go into the community and do the same thing that's always been done, asking the same questions about priorities, etc. over and over. We need to do something meaningful and involve the community to the extent that they feel something is being done.
- It also requires people (HEC leadership) to be flexible. For instance, ACES if very much about trauma and sometimes we get stuck by the definition instead of looking at child health and not working on assumptions or our favorite programs and interventions.
- It's community accomplishment that we're trying to achieve. Accountability is the system behind it, but we're trying to accomplish something in each community and showcase that success.

HMA revisited the HEC definition since the provisional definition was presented to the PHC months earlier.

Questions/comments from the Council:

- My assumption was that we would be starting with existing collaboratives in CT. I'm seeing the word "new" in the definition. Does that mean it's an evolution or the creation of something new?
- I think multi-sector may be worth defining. It can mean different things in different places throughout CT, which can cause problems or confusion because you may assume something else.

The HEC health focus areas were revisited and feedback solicited on HEC prevention priorities under each area. There is an open question about the age range of 0-5 for the HEC child well-being goal. Lisa Hunningfield was contacted by HMA for her expertise and her feedback was that the younger 0-5 gives the greatest opportunity for impact.

Questions/comments from the Council:

- I would have said 0-8 because you have an opportunity to reach children, but we've also found that those early school grades is another great opportunity for making a difference.
- When you were looking at studies, were you looking at home visitation programs?
- My understanding is that ACES happens to kids of all ages. They are also things that happen to the family—parents and children. Is the age range in terms of measurement or intervention?

HEC geography proposed elements and processes were reviewed by HMA and feedback solicited.

Questions/comments from the Council:

- I would support that it should be 100,000 or greater since meaningful data is in rates rather than percentages. This could also be a challenge in the rural areas in CT.
- The space between municipalities can be vast. Even in an attempt to bring communities together—navigating those divisions can be nearly impossible.
- In terms of being accountable to payers rather than constituents, you could have two different accountable structures.

Due to time, additional design team and/or PHC webinars were proposed to cover the remaining agenda items.

Next Meeting Date: November 1, 2018

Meeting adjourned at 5:00 pm.