CONNECTICUT
HEALTH IMPROVEMENT COALITION
Partners Integrating Efforts and Improving Population Health

Healthy Connecticut 2020

State Health Improvement Plan

Infectious Disease ACTION Team Meeting AGENDA & NOTES

Date: July 22, 2015
Time: 10am-12pm
Location or Conference Call Number: Room 1112 395 West Street, Rocky Hill (860-920-6687)
Conference Call Access Code: N/A

Attendees *(Please list all who participated)*: Matthew Bizzarro (YNHCH), Marianne Buchelli (DPH), Matthew Cartter (DPH), Dale Cunningham (AFT/CT), Carol Dietz (Qualidigm), Nancy Dupont (UCONN Health), Lynne Garner (Donaghue Foundation), Sandy Gill (DPH), Delores Greenlee (CSHHC), June Holmes (YNHH), Kathy Kudish (DPH), Victoria Liquori (DPH), Kristin Magnussen (Ledge Light HD), Richard Melchreit (DPH), Linda Niccolai (Yale School of Public Health), Elaine O'Keefe (Yale School of Public Health), Jon Olson (DPH), Ramon Rodriguez-Santana (DPH), Josh Rozovsky (HGLHC), Vincent Sacco (DPH), and Carol Steinke (Hartford HHS)

Agenda Items	Time	Discussion	ACTION Items and person responsible
Introductions		• Booklets of meeting materials (agenda and action analysis grids) were distributed and introductions were made	• **Infection disease ACTION team**
Review Ground Rules		• The group was reminded of the Ground Rules: ➢ Start and end on time ➢ Please come prepared to each meeting ➢ Be respectful to other members (be concise in your comments, avoid interrupting each other, and allow everyone to participate) ➢ Stay focused • It was noted that the group has been exemplary in following the rules and being collegial	• **Infectious disease ACTION team**

Discuss Feedback from Constituents		• Many of our HIV objectives align with the work of the CHAIR Task Force (Connecticut HIV/AIDS Identification and Referral Task Force). It was discussed at their last meeting. They may be a good potential partner.	• **Infectious disease ACTION team**
Discuss Action Tables (See: SHIP Actions document)		• Began discussion with Immunization Actions • Table 1 Action: Expand access to ACIP recommended vaccines for children by increasing coverage in the Connecticut Vaccine Program (CVP) for: flu, HPV, rotavirus, and hepatitis A (via budget option) o Vaccines for CVP are purchased off the federal contract o Flu vaccine cost is renegotiated every year. Price varies by year. o Insured: get vaccine via MD order o CVP: doctors are required to use the vaccines ordered by the government o By passing possible budget options, more children would receive vaccinations through CVP which would drive down costs and potentially increase the number of people vaccinated o Vaccine uptake is a potential problem for providers because reimbursement is slow. We should try to make the reimbursement process quicker to improve uptake and make the vaccine more available o Administration fee: providers are eligible to receive a set reimbursement outside of the CVP, which is negotiated between providers and insurance companies o Budget option process: Budget option goes into the DPH budget (through commissioner), to the Office of Policy and Management (OPM), and into the Governor's budget where it is approved or rejected o Local Health Departments are not able to bill Medicaid and are not being reimbursed for vaccinations. LHD are losing money by paying for vaccines, which they can no longer afford due to budget cuts. There is a model for setting up billing to make reimbursement available to LHD. Federal funds were made available to do so (funding to create model was a one time funding source) and it was successful. LHD would have to follow that model, but it is time consuming and requires a lot of work. o Connecticut Chapter of American Academy of Pediatrics and Family Physicians could aid in advocating for these potential budget options. They support CT becoming a universal vaccination state, but there is some controversy surrounding CVP. Vaccines Advisory Committee is also another potential partner.	• **Infectious disease ACTION team**

		○ Most insurance companies don't pay for titers, so some clients end up receiving the same vaccinations multiple times. Ties into age expansion in the registry and making them more accessible • Table 2 Action: Enable EHR to report directly to the registry, which would expand the registry across the lifespan, including adolescents and HPV (HER-IIS interoperability) ○ Potential Partners-vendors (All Scripts, Yale, CCMC) ○ Immunization personnel are funded through the federal grant ($800,000+ just to cover those staff members who currently work with the registry, the rest depends on other grants and funding) ○ Meaningful Use 3, federal requirement ○ Could require providers to order vaccines through the registry and enter information into the registry. They have to enter data up to a certain age, but the law does not require electronic entering, so they tend to send paper and it must be entered by DPH staff. (Potential action: submit bill to require providers to order through the registry and enter info, but DPH employees don't believe that this could be accomplished in the next year, a system needs to be set up to allow ordering through the registry, it requires federal funding) ○ DPH was approved for Meaningful Use Phase 2, but not funded to expand EHR and ordering through the registry. ○ Manual data entery at DPH (the current system in use) is overwhelming at DPH and the registry is not where it should be ○ HEMA: lobby EHR providers to make the integration easier, ○ Comment Meaningful Use, open API (makes it easier for EHR to integrate without having to show them how CIRTS work and provide extensive IT support ○ DPH has requested tech assistance from CDC to provide recommendations if we should move to a different vendor than the one we are currently using, this may not be a good option to tackle for the next year or two • Process Reminder: It was brought to the group's attention that the purpose of the Action Team is not to create actions for the DPH, it is supposed to be a more collaborative effort. The team responded by saying that the group has always viewed the process as a collaborative effort, but some of these actions are DPH-centric. Even though these actions involve collaborating with partners, the Action Agenda needs to reflect that to be effective and successful.	

		• Table 5 Action: Expand patient eligibility for free HPV vaccine available through CVP.
		  o Discussed in Table 1: Expand access to ACIP recommended vaccines for children by increasing coverage in the Connecticut Vaccine Program (CVP) for: flu, HPV, rotavirus, and hepatitis A (via budget options
		• Skipped to HIV Actions
		• Table 6 Action: Establish routine testing initiatives throughout the state at healthcare facilities, modeled after YNHH's program.
		  o YNHH is eager to train peers
		  o Resources DPH funded $90,000 (curriculum, buy in, fund coordinator)
		  o ETI (Expanding Testing Initiative) program: CDC funded, 8 in CT
		  o Disseminate YNHH's protocol to other sites
		  ➢ Begin by expanding within YNHH and YNHH affiliates
		  ➢ Then beyond Yale
		  ➢ FQCHC (federally qualified community health centers)
		  ➢ PP (Planned Parenthood)
		  ➢ DOC (Department of Corrections)
		  ➢ Private MDs (more difficult target)
		  o Disparities: routine testing has identified many MSMs of color
		  o Program needs champions: CHAIR, YNHH are willing
		• Establish partner referral services throughout the state at healthcare facilities, modeled after YNHH's program.
		  o Routine testing program coordinator introduces patients to partner services. This will eventually be integrated into the routine testing program
		  o Disease Intervention Specialists (DIS): providers need to be made more aware of this valuable resource, especially private MDs
		  o Materials/resources for all providers to promote DIS
		  o DIS present to providers at Continuing Medical Education (CME)
		  o Potential Action: Make more providers aware of DIS and partner services, CHAIR can revisit materials and resources and work on getting them out into the community and distributed by DIS
		• Table 7 Action: Establish Pre-Exposure Prophylaxis (PrEP) programs in conjunction with risk reduction and adherence to counseling throughout the state at healthcare facilities. Modeled after YNHH's program.
		  o Risk reduction counseling is the clinical part	

		○ Partners: CHAIR, CIRA ○ HHD-PrEP-collaborative counsel/provider ○ Address provider attitude barriers (assess and educate) • Table 8 Action: Expand PrEP awareness in CT using social media and other CDC PrEP social marketing campaigns, like bus ads. ○ Targets population • The other actions were not reviewed at the meeting directly, but were mostly covered by the discussion at this meeting except for Table 10 Action: "Coordinate data collection, identify data needs, and evaluate approaches for identifying people who are unaware of their status and link them and their patient level data with community viral load."—CHAIR	
Next Steps		• Evaluate Meeting ○ It was helpful to have subject matter experts in the room • Review Next Steps ○ An Action Agenda outline will be sent out based on this discussion ○ Vote on which actions should be tracked on the 2016 Action Agenda ○ Assemble the Action Agenda draft • Homework ○ Discuss with constituents ○ Give feedback on the Action Agenda outline • Next Meeting Date/Time: TBD	**Infectious disease ACTION team**