CONNECTICUT
HEALTH IMPROVEMENT COALITION
Partners Integrating Efforts and Improving Population Health

Healthy Connecticut 2020

State Health Improvement Plan

Health Systems ACTION Team Meeting
NOTES

Date: **November 17, 2017**
Time: **1:00 PM – 3:00 PM**
Location: **CT Hospital Association, 110 Barnes Rd, Wallingford, CT 06492**

Meeting Purpose and Outcome

- Recap the Health Systems reform discussion from our last meeting
- Identify the item/issue/topic for the Action Team to work on in 2018

Agenda Items	Time		Discussion
1. Welcome & Introductions	1:00	15	
2. Health Systems Reform Discussion Recap & Closure	1:15	20	See attached slides.

3. Identify the item/issue/topic for the HS Action Team to work on in 2018	1:55	55	***Brainstorm***
			• White Paper – data needed, EHR's, EPIC
			• HS Policy Agenda (need to be careful)
			  - Look at root causes for HER's, Data, Pressure for systems to have common formats
			• VT model
			  - To look at other strategies in SHIP
			  - Shows various groups/players/people who are working on an initiative (e.g. oral health)
			• VT model → SIM Clinical Quality Measures
			• Become the Design Group for a SDOH News Case or PH reporting (e.g., *learn more about what is happening with immunizations)
			• Current developments in Public Health recording and SDOH
			• Be subject matter experts to provide info on various Health Systems topics
			• Look at models for the new Office of Health Strategy (do they want/need our help?

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4. Next Steps	2:50	10	• Consider options • Pick top 2 or 3, or, rank in order (rate against criteria) • We should look at: - Level of interest and willingness to engage - Prioritizing - Short-term and long-term outcomes – IMPACT - Identify groups where others are involved, and ask if what we are thinking would be helpful
5. Adjourn	3:00		

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State Health Improvement Plan

Health Systems Action Team

Friday, November 17, 2017

1:00-3:00 PM

CT Hospital Association, 110 Barnes Rd, Wallingford, CT 06492

Welcome and Introductions

Meeting Purpose and Outcomes

- Recap the Health Systems reform discussion from our last meeting
- Reconfirm the role of the Health Systems Action Team
- Identify the item/issue/topic for the Action Team to work on in 2018

Health Systems Reform Discussion Recap & Closure

Overview of Discussion from our Last Meeting

- Around the table
  - What is going on in Health Systems reform?
  - What has changed since the SHIP was developed?
  - What do we need to know as the HS Action Team?
- Summary of the Issues
- Next Steps

Health Systems Landscape in Connecticut – A Summary of the Issues

- Affordability Issues
- Affordable Care Act (ACA)
- Health Information Issues
- Funding Issues
- Quality of Care
- Operational Issues
- Workforce
- Other

Health Systems Landscape in Connecticut – A Summary of the Issues

- **Affordability Issues**
  - For consumers (cost sharing/deductibles)
  - For providers (consolidation/prices/ROI)
  - For payers (market stability, exchange, federal match/subsidies)
- **Affordable Care Act (ACA)**
  - Impact of preserving ACA without improvement
  - Feasible reforms of the ACA
  - Impact of ACA repeal
  - Impact of ACA possible replacements
  - Accreditation systems (health care, public health, communities)
- **Health Information Issues**
  - Health equity data collection and analysis
  - Health Information Exchange (registries, HMR's APCDB, etc.)
- **Funding Issues**
  - Potential system changes through Federal and State budgets
  - Stability of the ACA individual state individual mandate
  - Budget costs across public and not for profit agencies
  - Support for SHIP Coalition and action groups
  - Support for state health equity initiatives
  - Positioning the SHIP Coalition to support public health transformation.
  - Threats to Medicaid Husky B
  - Payment Reforms models currently being tested
  - Seeking sustainable financial solutions for community coalitions and other resources.

Health Systems Landscape in Connecticut – A Summary of the Issues

- **Operational Issues**
  - Development of integration models of clinical care and public health
  - Emphasis on coordinated care and integration across community agencies
  - Incorporating SDOH interventions that add value beyond referrals to social services
- **Workforce**
  - Advancing policies about Community Health Workers (CHWs)
  - Workforce fluctuations
  - Promotion of community based practice
- **Quality of Care**
  - Emphasis on home and community based services
  - Attention to Person Centered Care
  - Focusing on value of services rather than just volume
  - Moving towards population and community health care
  - Aiming at community accountability for health outcomes
  - Integration of community based providers for prevention services
  - Integration of health equity strategies into regular care delivery
  - Emphasis on linking a continuum of care
  - Support standards developed for school-based medical homes.

Health Systems Landscape in Connecticut – A Summary of the Issues

- **Other**
  - Promoting the value of prevention across community sectors
  - Available out-of-state input regarding integration models
  - Priorities on Children and Adolescents
  - Progression through the three phases of public health and healthcare systems transformation
  - Impact of health reforms on most vulnerable populations
  - Impact of state reform initiatives (SIM, PTN, PCMH+, APCDB, ACOs, HC Cabinet, etc.)
  - Impact of CHNAs on health priorities and SDOH interventions
  - Assessment of broad impact of health systems reforms on health equity

The Role of the Health Systems Action Team

Overview of Discussion from our Last Meeting

- What role does the Health Systems Action Team play?
  - How does what we have learned today inform the content of our 2018 Action Agenda and the way we would like to position this team to be successful?
- Reconfirm the three-fold function of the Health Systems Action Team moving into 2018
- Discuss members' roles and responsibilities

New Role of the SHIP Health Systems Action Team

We discussed a three-fold approach for the role of this Action Team, which participants were in agreement on:

1. Continue to share health systems information, learnings and happenings at each meeting (short agenda item – around the table) and via email between meetings. This is an important part of the role of this group and is a benefit to members.
2. Pick one item/issue/topic (either currently part of the SHIP, or something new) to work on as a team; something to sink our teeth into.
3. Continue to capture and monitor progress of health systems efforts, activities and initiatives that others are doing across the State as part of the Action Plan and progress reporting.

Discussion Points on Role of the Health Systems Action Team

- Find points of leverage and drive systems change.
- Endorse a policy agenda that drives health systems change.
- Focus on a clear agenda with only a few policy options.
- Keep the attention on threats and opportunities related to the ACA.
- Instigate transformations and influence policy decision making.
- Distinguish the SHIP HS Action Team from other councils charged with policy development of statewide health systems.
- Incorporate in the HS Action Agenda representation from other councils and adjust objectives and strategies to drive change.
- Break silos among statewide entities to move forward and drive change.
- Work only on issues supported by robust data and which impact other areas of the SHIP.

Discussion Points on Role of the Health Systems Action Team

- Provide leadership and advocacy around integration of community based prevention and clinical care.
- Seek consensus on necessary elements of quality outcomes.
- Recommend a policy agenda supported by the SHIP coalition.
- Evaluate the need and feasibility for standardization of CHNA's.
- Ensure that the population health agenda is moving in the right direction and that changes are happening.
- Place attention on the entire Health System and beyond the Health Care System alone.
- Emphasize only high level overview of changes of the health system.
- Recommend approaches for equity measurement.
- Regularly assess the operational viability of the action team and the overall SHIP coalition.

Identify the Item/Issue/Topic for the HS Action Team to Work On in 2018

Identify the Item/Issue/Topic for the HS Action Team to work on in 2018

- Agree Upon Criteria
- Gather ideas for items/issues/topics to work on
- Group Discussion
- Make selection(s)
- Team members' roles and responsibilities

Draft Criteria for Selecting an Item/Issue/Topic for the Health Systems Action Team to Work on

- Is there a potential for cross-cutting impact? (impact multiple objectives/focus areas)
- What is reasonable to take on for the coming year?
- Where can we have an easy or quick success to ensure positive momentum?
- Is anyone else already working on this?
  - Align with other initiatives, or
  - Select something where we can make progress where others have not been able to
- Do we already have data or have the ability to start collecting data?
- Do we believe we can move the needle to show progress?
- Do members of the Action Team feel a connection? Will people be engaged?
- What needs to happen first in terms of timing?
- Other?

Gather Ideas for Items/Issues/Topics to Work On

- Individual Brainstorm
- Group Brainstorm
- Group Discussion on Brainstormed Items/Issues/Topics

Select Item/Issue/Topic to Work On

- Make Selection(s)
- Team Members' Roles and Responsibilities

Next Steps/Next Meeting Date

- Next Meeting Date/Time:
  - _____
- Provide an update at the Advisory Council Meeting on Nov 30th
- Develop the 2018 Action Agenda for identified objectives and strategies

The 2018 Action Agenda

- Review the Health Systems Objectives & Strategies identified for the 2018 Action Agenda at the August meeting, and identify strategies that need to be revised/refined or added given the discussion on Health Systems reform.

- As we develop the Action Agenda for these, keep in mind:
  - Wherever possible, make strategies more ACTIONABLE and think about how we will MEASURE our accomplishments. Members of the HS Action Team need to be able to connect to the Action Agenda.
  - Do we have the team members needed to successfully implement the Action Agenda for each strategy? Who is missing? How do we engage/reengage them?

Thank You!

VERMONT
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Improving Population Health Outcomes
Prevention Change Packages

EXECUTIVE SUMMARY

The *Change Packages* were originally created as part of Vermont's health system innovation work to reduce cost, to ensure quality of care, and to improve health outcomes. Increasingly, health care system partners are being pressed to shift from practices that focus on care for individuals to practices, systems, and structures that focus on the improvement of population health.

To be successful, this shift will require greater understanding of the determinants of health outcomes beyond health care: behaviors; social and economic factors; and the physical environment, and consideration of new ways of practicing that recognize the influence of these determinants.

How to Use The Prevention Change Packages

The *Change Packages* are intended to provide users with suggested evidence-based and best practices to address the social determinants of health and increase prevention. The *Change Packages* provide practical guidance and examples of strategies by which practitioners in different parts of the healthcare system can work in ways that recognize the influence of factors that determine health outcomes as well as the social determinants of health such as education, poverty, race and gender.

The primary audience for these *Change Packages* are members of Accountable Communities for Health and Regional Teams composed of ACO, Blueprint, health department and community partners working together to improve population health. The secondary audiences include organizations or other entities responsible for developing guidance and practice standards (e.g. state administrators, insurers).

The *Change Packages* are organized by health topic and the measures of accountability for Vermont's Accountable Care Organizations (ACOs) as these are an essential component in Vermont's health care system reforms supported by the Vermont Health Care Innovation Project (VHCIP). **(See Appendix X).** The Change Packages recommend action across all partners in the health system, working toward the same goals, using best practices in three different domains to incorporate prevention activities and improve population health outcomes.

The *Change Packages* use the *Prevention Framework* developed by the Centers for Medicaid and Medicare Innovation and the Centers for Disease Control and Prevention[1]. The Framework outlines three domains of action:

> Traditional Clinical Approaches include increasing the use of prevention and screening activities routinely conducted by clinical providers. Examples include: annual influenza vaccination, use of aspirin for those at increased risk of a cardiovascular event, screening for tobacco use, screening for substance abuse, and screening for domestic or other violence.
>
> Innovative Patient-Centered Care and/or Community Linkages include innovative, evidence-based strategies offered within the community that are not typically leveraged by health care systems under fee for service payment models. Examples include: community-based preventative services, health education to promote health literacy and patient self-management. In Vermont, this also includes actions to integrate care (physical, mental health, substance use) and connect individuals to necessary social services.

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[1] Three Buckets of Prevention, J Auerbach, J Public Health Management Practice, 2016, 00(00), 1–4 Copyright C _ 2016 Wolters Kluwer Health, Inc. All rights reserved.

Community-Wide Strategies include specific system-wide action steps demonstrating an investment in total population health. Examples include: funding for worksite wellness, passing legislation that addresses public health issues (i.e., smoking bans in bars and restaurants), providing healthier food options at state-operated venues and public schools.

As Community Collaboratives and Accountable Communities for Health evolve, partners can use the Change Packages to identify actions in each of the three domains that can be carried out by appropriate partners, working simultaneously to improve population health in their own domain of influence.

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Clinical & Community Strategies to Improve Adolescent Well-Care Visits

The following table highlights evidence-based strategies to improve adolescent well-care visit rates in clinical and community settings.

ACO Measure: Core-2 (NCQA HEDIS): Adolescent Well-Care Visit (AWCV)
The percentage of attributed individuals 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
Increase insurance access • Promote use of Vermont Health Connect resources including website, phone number, and local navigators, brokers, and certified application counselors • Assist adolescents and families to understand insurance benefits and address perceived barriers to care (e.g., AWCV frequency, EOB descriptions, etc.) Adopt current *Bright Futures* guidelines for health supervision • Adopt *Bright Futures* core tools (i.e. pre-visit questionnaires, documentation, education handouts) • Educate families and adolescents on annual AWCV recommendation (including guidelines outlined in the periodicity schedule) and the benefits of these visits • Adopt evidence-based screening tools • Ensure all practice staff are aware of annual recommendations (including systems for scheduling and reminder-recall) Provide adolescent-centered and informed care Ensure the physical space is welcoming and age-appropriate for adolescents • Provide training and tools to ensure all practitioners are adolescent-friendly	Use mobile devices, e-mail, and social networking sites to promote prevention education and services; new media vehicles offer low-cost avenues to develop and distribute tailored health care messages • Use social networking to reach adolescents and caregivers • Use texting to reach adolescents and caregivers Develop partnerships with key community stakeholders • Work with school-based and community health centers • Work with partners to explore alternate funding sources • Partner with Title V (maternal and child health) agencies • Engage key community stakeholders • Pediatric and Family practice providers can establish relationships to assist with transition of care from adolescence into young adulthood • Partner with the Health Department/ Office of Local Health designees and leadership • Review local *Youth Risk Behavior Survey* data to understand current risk behaviors. • Partner with School Nurses to ensure all students are receiving AWCVs, and improve	Office of Local Health designees, Agency of Human Services departments, ACOs, and healthcare quality improvement focused organizations should make state-adopted periodicity schedules well known to all clinical and community providers (*Bright Futures* is Vermont's EPSDT periodicity schedule) Providers and community partners (such as the Office of Local Health, schools, designated agencies, etc.) should educate families and adolescents on annual AWCV recommendation (including guidelines outlined in the periodicity schedule) and the benefits of these visits Providers and community partners should encourage their local schools to ask that sports physicals be completed during, or within a reasonable timeframe (as determined by the provider) of a recent AWCV Athletic directors and coaches can remind parents and caregivers that sports physicals should not replace recommended AWCVs

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
• Use or create adolescent-friendly materials; test materials with adolescents • Consider strategies to ensure continuity of provider care • Communicate the confidential nature of visits and EOB/billing to adolescents and parents/caregivers, and ensure private consultation time with patients • Expand or tailor office hours to fit adolescent lives (i.e. school, sports, and work) • Hold specific slots for AWCVs • Consider ways to evaluate satisfaction with care, privacy and confidentiality Improve quality of adolescent care • Ensure providers are well-trained to understand adolescent needs • Ensure providers and office staff adopt the *Bright Futures* guidelines • Adopt the use of a strengths-based approach as described in *Bright Futures* Leverage missed opportunities to increase well-care visits • Maximize other patient encounter opportunities to schedule AWCVs (e.g. episodic, acute care, sports physicals, sexual health services, immunizations) Inform caregivers on the importance of AWCVs	communication between schools and provider offices • Partner with supervisory union or school district's Whole School, Whole Community, Whole Child wellness teams	

Resources

Bright Futures Guidelines: brightfutures.aap.org/Pages/default.aspx
Paving the Road to Good Health Strategies for Increasing Medicaid Adolescent Well-Care Visits
medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Paving-the-Road-to-Good-Health.pdf
National Adolescent and Young Adult Health Information Center: http://nahic.ucsf.edu/

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Clinical & Community Strategies to Improve Adult Type 2 Diabetes Control

The following table highlights evidence-based strategies to reduce poor A1C control in clinical and community settings.

ACO Measure: Core-17: Diabetes Mellitus: Hemoglobin A1C Poor Control >9%

A1C testing is recommended quarterly for adults who do not meet treatment goals. Performance measures apply to adults 18 – 75 years of age. Patients with an A1C greater than 9 percent should be offered multicomponent interventions to improve blood glucose control.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
Implement a standardized diabetes treatment protocol using evidence-based clinical practice recommendations–Diabetes Care Clinical Practice Recommendations[i]: • Diabetes self-management education/support (DSME/S) • Medical nutrition therapy (MNT) • Education on physical activity • Guidance on routine immunizations • Psychosocial care is a critical component of diabetes management Tobacco Cessation: See Clinical & Community Strategies to Reduce Tobacco Use.Use motivational interviewing techniques to discuss behavior change goals and action plans For patients with A1C greater than 9 percent, offer multicomponent behavioral interventions to include the following: • Achieving a realistic body weight • Improving nutrition and increasing physical activity • Achieving blood pressure control • Scoring diabetes distress and reducing it • Treating depression	Use Motivational Interviewing: (http://motivationalinterviewing.org/) Train providers in these techniques to best assist patients. Provide referrals to self-management programs: (http://myhealthyvt.org/) • Healthier Living Workshop – Diabetes for problem solving and action planning; healthy eating; exercise; monitoring blood sugar; managing stress; using good foot care; and handling sick days Use of Diabetes Self-Management Education (DSME) Programs provided by Certified Diabetes Educators in all local health service areas • http://myhealthyvt.org/ Use of Registered Dietitians who provide medical nutrition therapy (MNT) available through the local Vermont Blueprint for Health Community Health Teams (CHTs) and ambulatory services at all Vermont Hospitals (http://blueprintforhealth.vermont.gov/) • See Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up. • See Clinical & Community Strategies to Reduce Tobacco Use.	Community-based YMCA's Diabetes Prevention Program to reduce diabetes risk See Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up. Policy and Regulatory Approaches • Advocate lowering of sugar content in processed foods and beverages • Use new Nutrition Facts labels starting in July 2018 to note "added sugars" • Promote population level oral health by supporting community water fluoridation

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
• Establishing realistic priorities for lifestyle improvement • Adjusting diabetes medications • Adjusting plans for self-monitoring of blood glucose For self-management support: • Encourage use of patient portals • Community-based programs and services • Consumer support group Provide patients with information and resources available in the local health service areas and statewide including: • Learning to Live Well with Diabetes (http://www.healthvermont.gov/sites/default/files/documents/2016/12/HPDP_Diabetes_Learning%20to%20Live%20Well%20with%20Diabetes.pdf) • Single Page Guide For Diabetes Care (http://www.healthvermont.gov/sites/default/files/documents/2016/12/HPDP_Diabetes_guide_for_diabetes_care.pdf) • DASH Eating Plan (http://www.healthvermont.gov/sites/default/files/documents/2016/12/HPDP-Diabetes_dash%20eating%20plan.pdf) • A1C...what's Your Number? (http://www.healthvermont.gov/sites/default/files/documents/2016/12/HPDP_Diabetes_A1C_whats_your_number.pdf)	Oral Health Having diabetes increases a person's risk for having oral disease; untreated oral disease makes it more difficult to control A1C levels.[ii] Integrate messages about the importance of oral health to overall health using the Qualis Guide for Implementing Oral Health Integration and refer patients to a local source for dental care as you would make a referral to any other specialist.	

Additional Resources:

Centers for Disease Control and Prevention, Diabetes: http://www.cdc.gov/diabetes/home/
NIH Diabetes Health Sense: http://ndep.nih.gov/resources/diabetes-healthsense/
American Diabetes Association: http://www.diabetes.org/
Vermont Department of Health Diabetes Prevention and Control: http://www.healthvermont.gov/prevent/diabetes/diabetes.aspx
Vermont Department of Health: 3-4-50: http://healthvermont.gov/prevent/3-4-50/index.aspx