OFFICE OF THE GOVERNOR
STATE OF CONNECTICUT

Governor's Task Force on Housing and Supports for Vulnerable Populations
November 22, 2019, 10:30 am – 12:00 pm
LOB Room 1E
Meeting Minutes

Task Force Members Present*

Office of the Governor	Senior Coordinator for Housing/TOD Lisa Tepper Bates
Court Support Services Division, Connecticut Judicial Branch	Executive Director Gary Roberge
Department of Aging and Disability Services	Commissioner Amy Porter
Department of Correction	William Murphy
Department of Energy and Environmental Protection	Linda Foreman
Department of Labor	Commissioner Kurt Westby
Department of Mental Health and Addiction Services	Kim Karanda and Fred Morton
Department of Public Health	Deputy Commissioner Heather Aaron
Department of Housing	Deputy Commissioner Shante Hanks and Steve DiLella
Department of Social Services	Commissioner Deidre Gifford Director of Health Services Kate McEvoy
Office of Early Childhood	Rosa Rada
Office of Healthcare Strategy	Executive Director Vicki Veltri
Office of Policy and Management	Scott Gaul
Supportive Housing Works	David Rich
Beacon Health Options	Robert Plant
Connecticut Coalition to End Homelessness	Richard Cho
Connecticut Health Network	Sylvia Kelly
Connecticut Hospital Association	Liz Beaudin CT
Housing Finance Authority	Terry Nash

Leadership of participating entities may elect to appoint a designee

Connecticut Nonprofit Alliance	Gian-Carl Casa
Corporation for Supportive Housing	Christi Staples
Mental Health CT	Luis Perez
Partnership for Strong Communities	Kiley Gosselin
United Way of CT	Rick Porth
U.S. Department of Housing and Urban Development	Suzanne Piacentini

Task Force Members Absent

Department of Children and Families	Michael Williams
Department of Developmental Services	Commissioner Jordan Scheff
Department of Economic and Community Development	Commissioner David Lehman
Department of Transportation	Phil Scarrozzo

I. Call to Order – Lisa Tepper Bates called meeting to order at 10:33 AM

II. Approval of Minutes. Correction: include Beacon Health Options as member of taskforce. Approved, with noted correction, unanimously. No members of the public identified themselves to speak.

III. Anchor Institution Model: Experience and Potential in Connection – presentation by Vicki Veltri, Executive Director, CT Office of Health Strategy

OHS fully established in 2018, charged with developing and implementing a comprehensive and cohesive health care vision for CT, including statewide cost containment strategy, promotion of effective health care planning and quality of care, coordinating state's health information technology initiatives, and overseeing multi-payer care delivery and payment reforms.

Anchor Institutions: defined as enterprises that are rooted in their local communities by mission, invested capital, or relationships to customers, employees, and vendors. Place-based entities that control substantial economic, human, intellectual, and institutional resources. Bring crucial and measurable benefits to children, families, and communities. "Anchor Mission:" apply long-term, place-based to benefit households and communities.

Regional Plan Association (RPA) is catalyzing anchor institution strategies in the metro region (NJ, NJ, CT) to affect upstream health factors. Begin with hospital partners as natural anchor institution partners. Emphasis is moving to social, economic, and environmental conditions that affect health outcomes, increase health care costs, and impact well-being.

Anchor Institutions partnership in practice: mission changes at leadership level and throughout institution. Community organization, municipal and state leadership partnership. Local examples: Stamford VITA Health and Wellness District (partnership with Stamford Hospital, City of Stamford, and Charter Oak Communities). Formed local collaborative to meet respective and shared needs and improve health of vulnerable population as identified in community needs assessment. Including mixed income housing, health care services, supportive services, early childhood education, modernization of facilities, land procurement, improved health outcomes and shared cost savings. Southside Institutions Neighborhood Alliance (SINA, a partnership with CT Children's Hospital, Hartford Hospital, and Trinity College). Aimed to work cooperatively with community stakeholders to restore economic vitality and improve the quality of life for the benefit of the people who live work, visit, study, and play in the community. Local examples provide practical example of ways to partner with anchor institutions to improve outcomes for vulnerable households at a community level.

Question raised re: housing as it relates to anchor institution collaboratives. Some examples point to direct investment in housing from anchor institutions. Collaboration can result in outcomes including partnership building, advocacy, policy changes, resource (re)alignment, etc. beyond direct financial investment that mutually benefits all parties. This includes cooperative efforts to end homelessness and housing instability (for example, Community Care Teams efforts that combine in one team hospital staff and homeless service providers). Health Anchor Network should be looked to as model for non-direct financial investment efforts as well. Boston Medical invested $6.5 million in housing, braiding resources and aligning existing funding. Question raised re: having common lens to approach anchor institution lens that includes not only the health outcome piece, but also economic development. State Health Improvement Coalition engaging communities re: equity disparities across state.

IV. Update on Task Force's Frequent Multi-System User Pilot

A. Data Match, Scott Gaul, Chief Data Officer, Office of Policy and Management

The data match for the Multi-System User pilot under the Task Force is primarily aimed to help improve outcomes for targeted households, but the match also serves as an important test case to help CT better understand how to share data across state agencies to provide a more holistic view of the needs of the households our public systems serve. Currently have framework for data match mapped out, conversations scheduled to finalize missing pieces. OPM is conducting a legislatively mandated study regarding barrier to data sharing between state agencies with support from consultant. The report is due in January 2020. A survey has gone out to state agencies to inventory current data sharing efforts. OEC has offered support from Skylight to develop playbook for data sharing.

Thinking about how next phase of data sharing will be done and what barriers need to be resolved to ease the challenges faced thus far. Suggestion to include inventorying of regulatory requirements guiding work and better inform leadership on taskforce to

reduce administrative and legal barriers. State of Washington widely recognized as progressive example of using data sharing that results in dynamic, holistic view of the health of members of the community. In a conversation with Kate McEvoy of DSS, the architect of Washington State's efforts, Dr. Richard Mancuso, emphasized importance of relationships and cultivation of trust to reduce vulnerability of resource competition, etc.

B. Service Coordination for Pilot, Rick Porth, United Way of CT, and Fred Morton, DMHAS

Charged with developing a pilot that will lead to client-centered, asset-based, outcomefocused service delivery for vulnerable households. Subgroup has met to brainstorm parameters and goals and draft process map/design for the service delivery pilot. Working with Dr. Maria O'Connell of Yale Program for Recovery and Community Health to develop a person-centered care tool to understand client priorities and goals as a shared starting point for the multi-disciplinary team. Subgroup will be meeting again prior to next Taskforce Meeting to finalize pilot framework and plan, and to present at January's taskforce meeting. Emphasis on not "case managing" people but partnering with clients to help them manage the system.

1. Person-Centered Care Tool, Leigh Nathan, MD, a psychiatrist affiliated with Yale PRCH

   Defined as care delivered in alignment with client's needs, preferences, and values. Client brings expertise on their needs, preferences, and values, and the healthcare staff bring healthcare expertise, and decisions are made together re: the patient's care. Focus on doctor/practitioner relationship. PRCH PersonCentered Care Research: interviewed individuals and mapped their selfidentified needs, preferences and values to develop a tool that facilitates patients' identification and prioritization of their needs, preferences, and values and communication of them to their practitioner. Tool will have application in service delivery pilot as a shared starting point. Next steps include conducting focus groups to test and refine tool for its use in this pilot. One focus group of families will be convened with the support of the 2Gen Parent Advisory Committee; another focus group of single adults will be convened with the support of the Behavioral Health Partnership client advisory group.

C. Research and Evaluation partners, David Rich, Supportive Housing Works

The Task Force is fortunate to have two key research partners who focus on big data, system utilization, and quality of service delivery ready and willing to engage to support the pilot: Yale School of Public Health and Yale Program for Recovery and Community Health. We are working with both to develop agreed scope of work.

D. Update on Skylight research, Steve DiLella, DOH

Working to identify cross-sector system change to improve outcomes of families with young children. Current phase of research is exploratory, gaining better understanding of how service delivery system works and how families experiencing a housing crisis navigate and engage with the system. Patterns identified include opportunities to better connect families with needed benefits. The research and findings will help to inform development of services for families for the pilot.

V. Next Steps and Discussion, Lisa Tepper Bates and David Rich

A. Next meeting scheduled for January 24, 2019
B. Next meeting will focus on service coordination pilot update – data match and service delivery design for pilot.

VI. Other Business

A. CT Coalition to End Homelessness has announced award of $2.5 million from the Day One Fund, a philanthropic effort of Amazon Founder (Jeff Bezos. The funding will go to support CCEH shelter diversion work with partners across the state. CCEH has drafted strategy to roll out funding and improve performance of system and will be seeking comments and input.

VII. Adjournment – motion to adjourn proposed and seconded, unanimous. Lisa Tepper Bates adjourned the meeting at 11:57 AM.