

# Attachment 1 - Population Health Work Group Meeting Agenda 11-18-14

# *VT Health Care Innovation Project Population Health Work Group Meeting Agenda*

Date: Tuesday, November 18, 2014 Time: 2:30-4:00 pm  
 Location ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier  
 Call-In Number: 1-877-273-4202; Passcode: 420-323-867

**All Participants: Please ensure that you sign in on the attendance sheet the will be circularized at the beginning of the meeting, Thank you.**

<b>AGENDA</b>					
<b>Item #</b>	<b>Time</b>	<b>Topic</b>	<b>Presenter</b>	<b>Relevant Attachments</b>	<b>Action #</b>
1	2:30	<b>Welcome, roll call and agenda review</b>	Karen Hein	<b>Attachment 1:</b> Agenda	
2	2:35	<b>Approval of minutes</b>	Tracy Dolan	<b>Attachment 2:</b> Minutes	
3	2:40	<b>Updates</b> VHCIP Year 2 Retreat and Operational Plan Population Health Work Group Work Plan	Tracy Dolan	<b>Attachments:</b> <b>3a:</b> PHWG Plan <b>3b:</b> PHWG Overview <b>3c:</b> PH in VHCIP overview	
4	2:45	<b>Examples and Ideas for Integrating Population Health: WA</b> A proposed community-based model to leverage local strengths through Accountable Community of Health to amplify the impact of the other proposed Healthier Washington models.	Chase Napier	<b>Attachments:</b> <b>4a:</b> WA ACH intent and goals <b>4b:</b> WA ACH set up and outcomes <b>4c:</b> Seattle ACH	
5	3:35	<b>Application to VT</b> How does this model fit with our prior discussions for building upon existing seeds of a community health system that links clinical care and community systems in VT?	Large Group Discussion		
6	3:55	<b>Next Steps</b> <i>What information do work group members need in order to continue our work together?</i>	Karen Hein		

OPEN ACTION ITEM LOG					
Date Added	Action Number	Assigned to:	Action /Status	Due Date	Date Closed
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			•		
			•		
			•		



# Attachment 2 - Population Health Work Group Minutes 10-14-14



**VT Health Care Innovation Project  
Population Health Work Group Meeting Minutes**

**Date of meeting:** Tuesday, October 14, 2014; 2:30 to 4:00 PM, ACCD – Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier

<b>Agenda Item</b>	<b>Discussion</b>	<b>Next Steps</b>
<b>1. Welcome, roll call and agenda review</b>	Tracy Dolan called the meeting to order at 2:33 pm.	
<b>2. Approval of Minutes</b>	Penrose Jackson moved to approve the minutes. Laural Ruggles seconded the motion and it passed unanimously.	<b>The minutes will be updated and posted to the website.</b>
<b>3. Updates</b>	<p>Contract with Prevention Institute (PI): We are still awaiting final sign off from our federal partners before the work will begin on the Accountable Health Community work</p> <p>RWJF Grant: A proposal has been submitted by the health department to support two projects: 1) review of the multiple governmental dashboards for inclusion of indicators of health and well-being; and 2) expansion of the Health Care Expenditure Analysis (focused on health care goods and services) to a Health Expenditure Analysis which would include spending throughout government on health and well-being.</p> <p>Escape Velocity: Karen Hein and Jim Hester attended this high energy invitation only gathering to help accelerate health reform. Jim was one of the core organizers and presenters. He will share additional materials from that meeting shortly</p>	

Agenda Item	Discussion	Next Steps
	<p>ACO Measures to GMCB: The Core Team voted on Oct. 8 to accept 9 of the 11 QPM measure change recommendations; the two that were not accepted were moving pediatric weight assessment and counseling from Reporting to Payment, and moving Avoidable ED use from Monitoring and Evaluation to Reporting. The Green Mountain Care Board has received the Core Team recommendations and will vote on Oct 23 between 11 am and noon. They will take any new written comments until COB on Oct 20.</p>	
<p><b>4. Totally Accountable Care Organization: New models Considered in Medicaid</b></p>	<p>Georgia Meharas provided an overview of the current Medicaid Shared Savings ACO Program in Vermont. An ACO is a network of health care providers, such as doctors, hospitals, home health agencies and mental health providers, who have committed to work together to improve health outcomes at lower costs for a defined group of patients. Currently, reimbursement mechanisms for services by ACO providers have not changed, but the ACO and its providers benefit from “shared savings” arrangements with payers.</p> <p>In a shared savings program, the ACO provider network agrees to be tracked on total costs and quality of care for the patients it serves, in exchange for the opportunity to share in any savings achieved through better care management. Provider participants in ACOs essentially have agreed that quality can be improved and health care costs can be reduced, and they will work together toward that goal.</p> <p>Currently, ACOs in VT cover physical and behavioral health. The State is taking a very careful approach to integrating long-term services and supports and specialized disabilities services in shared savings programs. Discussions are also underway on how to bridge health care and human services delivery in a positive way.</p> <p>VT has been participating in a Learning Collaborative convened by the Center for Health Care Strategies (CHCS) to address this very issue. Rob Houston provided an overview of a Totally Accountable Health Community (TACO) – an aspirational model developed through a recent learning collaborative. TACOs would integrate health and social services and pay for them through a global payment mechanism. Specifically, this model includes the following features:</p> <ul style="list-style-type: none"> <li>• Integration of physical and behavioral services, LTSS, social services and public health</li> <li>• Fully accountable to a geographic area</li> <li>• Involve all payers</li> </ul>	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> <li>• Financed through global capitation ties to a broad set of health outcomes.</li> </ul> <p>“There is a long and winding road to TACOs” which will be based on incremental steps.</p>	
<b>5. Examples and Ideas for Integrating Population Health</b>	<p><i>How does this model fit with our prior discussions for building upon existing seeds of a community health system that links clinical care and community systems? What else would we want to be considered to fully integrate population health?</i></p> <p>In place:</p> <ul style="list-style-type: none"> <li>• Currently VT ACOs include physical health and behavioral health only. One of the first steps is to consider pharmacy costs.</li> <li>• We have the structure in VT to build upon between the ACOs and the Community Collaborative Programs; we are missing funding streams for the latter.</li> </ul> <p>Connection to PHWG frameworks:</p> <ul style="list-style-type: none"> <li>• Moves definition of “population health” from panel of patients in a practice or the population attributed in a health plan to the whole population living in a particular community.</li> <li>• The model seems to focus primarily on care coordination. How do we include primary prevention?</li> <li>• How are social determinants of health included? <ul style="list-style-type: none"> <li>○ Quantifying and paying for activities related to SDOH may be difficult</li> <li>○ Before jumping to social determinants of health, we have a lot of evidence on practices to improve health by addressing risk and protective factors and behaviors.</li> </ul> </li> <li>• Global payment in the future, theoretically, will provide the incentive/reward to pay for the preventive services.</li> <li>• How does the TACO model relate to our work related Accountable Health Communities? Many of the features are similar; these features should be included in our search for models.</li> </ul> <p>Connection to other parts of VHCIP:</p> <ul style="list-style-type: none"> <li>• Payment models work group is now talking about behavioral health and LTSS</li> </ul>	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> <li>• Care Models work group is discussing a regional approach to Blueprint for Health and ACOs through its learning collaborative.</li> <li>• PHWG still needs to discuss whether we support this aspirational model.</li> </ul>	
<b>6. Public Comment and Next Steps</b>	<p><b>Next Steps</b></p> <p><i>What information do work group members need in order to continue our work together?</i> Jim Hester has compiled a list of “Essential References” on the following topics:</p> <ul style="list-style-type: none"> <li>• What is Population Health and why is it important?</li> <li>• Determinants of Health and Examples of Upstream Interventions</li> <li>• Community Financing Vehicles</li> <li>• Health System</li> </ul> <p><b>Next Meeting:</b> Due to the Veteran’s Day, the next meeting will be Tuesday, <b>November 18th</b> 2:30 – 4:00 pm. ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier.</p>	<p><b>Post “Essential Resources” on the PHWG web page</b></p>

## VHCIP PHWG Attendance List 10-14-14

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	Staff/Consultant
X	Interested Party

First Name	Last Name	Title	Organization	Population Health
April	Allen	Director of Policy and Planning	AHS - DCF	M
Julie	Arel	Director of Health Promotion and Ch	VDH	X
Lori	Augustyniak		Center for Health and Learning	MA
Ena	Backus		GMCB	X
Susan	Barrett	Executive Director	GMCB	X
Abe	Berman		OneCare Vermont	MA
Bob	Bick	Director of Mental Health and Substa	HowardCenter for Mental Health	X
Mary Lou	Bolt		Rutland Regional Medical Center	X
Jill Berry	Bowen	CEO	Northwestern Medical Center	M
Mark	Burke		Brattleboro Memorial Hopsital	M
Donna	Burkett	Medical Director	Planned Parenthood of Northern New En	M
Dr. Dee	Burroughs-Biron	Health Services Director	Vermont Department of Corrections	M
Jan	Carney		University of Vermont	X
Amanda	Ciecior	Health Policy Analyst	AHS - DVHA	S
Barbara	Cimaglio	Deputy Commissioner	AHS - VDH	X
Daljit	Clark	Director for Clinical Operations	AHS - DVHA	MA
Peter	Cobb	Executive Director	VNAs of Vermont	M
Judy	Cohen	Professor, Department of Nursing	University of Vermont	M
Amy	Coonradt	Health Policy Analyst	AHS - DVHA	X
Janet	Corrigan		Dartmouth-Hitchcock	X
Brian	Costello			X
Mark	Craig			X
Wendy	Davis		University of Vermont	X
Jesse	de la Rosa		Consumer Representative	M
Geera	Demers		Blue Cross Blue Shield of Vermont	M
Trey	Dobson	Medical Director	Dartmouth-Hitchcock	X
Tracy	Dolan	Deputy Commissioner	AHS - VDH	C/M
Kevin	Donovan	CEO	Mt. Ascutney Hospital and Health Center	X

Trudee	Ettlinger			Vermont Department of Corrections	MA
Sandy	Floersheim		✓	Orleans/Essex VNA and Hospice, Inc.	M
Joyce	Gallimore			Director, Community Health Payment Bi-State Primary Care/CHAC	M
Lucie	Garand			Senior Government Relations Special Downs Rachlin Martin PLLC	X
Christine	Geiler			Grant Manager & Stakeholder Coord GMCB	S
Don	Grabowski			The Health Center	X
Wendy	Grant			Blue Cross Blue Shield of Vermont	A
Thomas	Hall			Consumer Representative	X
Bryan	Hallett			GMCB	X
Catherine	Hamilton			Blue Cross Blue Shield of Vermont	MA
Carolynn	Hatin	✓		AHS - Central Office - IFS	X
Karen	Hein	✓	✓		C/M
Jim	Hester	✓		Consultant	X
Churchill	Hindes			COO OneCare Vermont	X
Penrose	Jackson			FAHC - Community Care	M
Pat	Jones		✓	GMCB	MA
Frances	Keeler	✓	✓	Director AHS - DAIL	M
Heidi	Klein	✓		AHS - VDH	MA/S
Norma	LaBounty			OneCare Vermont	A
Kelly	Lange			Director of Provider Contracting Blue Cross Blue Shield of Vermont	X
Patricia	Launer			Clinical Quality Improvement Facilita Bi-State Primary Care	MA
Mark	Levine			University of Vermont	X
Nicole	Lukas			Cancer & Cardiovascular Disease Pre AHS - VDH	X
Ted	Mable			Executive Director Northwest Counseling and Support Service	M
Georgia	Maheras	✓		AOA	S
David	Martini			AOA - DFR	M
Mike	Maslack				X
Jill	McKenzie				X
Kimberly	McNeil			Payment Reform Policy Intern AHS - DVHA	X
Melissa	Miles	✓		Project Manager Bi-State Primary Care	M
Chuck	Myers		✓	Executive Director Northeast Family Institute	X
Nick	Nichols	✓		Planning/Development/Policy Directo AHS - DMH	M
Annie	Paumgarten	✓		Eveluation Director GMCB	X
Luann	Poirer			Administrative Services Manager I AHS - DVHA	X
Laural	Ruggles			Marketing/Development Director Northeastern Vermont Regional Hospital	M
Jenney	Samuelson	✓		Assistant Director of Blueprint for He AHS - DVHA - Blueprint	M
Ken	Schatz			AHS - DCF	X

seashre@msn.com	seashre@msn.com			House Health Committee	X
Deborah	Shannon		Chief of Change	Shannon Resources, LLC	X
Julia	Shaw	✓		VLA/Health Care Advocate Project	M
Melanie	Sheehan	✓		Mt. Ascutney Hospital and Health Center	M
Miriam	Sheehey	✓	✓	Clinical Improvement and Compliance OneCare Vermont	M
Shawn	Skaflestad	✓		Quality Improvement Manager AHS - Central Office	M
Mary	Skovira			Executive Staff Assistant AHS - VDH	A
Chris	Smith			MVP Health Care	M
Kayian	Sobel			The Council of State Governments	X
Kara	Suter		Reimbursement Director	AHS - DVHA	X
JoEllen	Tarallo-Falk	✓		Center for Health and Learning	M
Nathaniel	Waite			VDH	X
Anya	Wallack		Chair	SIM Core Team Chair	X
Marlys	Waller			Vermont Council of Developmental and N	X
Kendall	West	✓			X
Bradley	Wilhelm		Senior Policy Advisor	AHS - DVHA	X
Stephanie	Winters	✓	✓	Vermont Medical Society	M
Mary	Woodruff		✓		X
Cecelia	Wu		Healthcare Project Director	AHS - DVHA	X
Joelle	Judge				

# VHCIP PHWG Roll Calls 10-14-14

29

10 Penrose  
120 Jesse  
Minutes

C	Chair
M	Member
MA	Member Alternate

Member		Member Alternate		Organization
First Name	Last Name	First Name	Last Name	
April	Allen			AHS - DCF
Jill Berry	Bowen ✓			Northwestern Medical Center
Mark	Burke			Brattleboro Memorial Hospital
Donna	Burkett			Planned Parenthood of Northern New England
Dr. Dee	Burroughs-Biron	Trudee	Ettlinger	Vermont Department of Corrections
Peter	Cobb			VNAs of Vermont
Judy	Cohen			University of Vermont
Jesse	de la Rosa ✓			Consumer Representative
Geera	Demers	Catherine	Hamilton	Blue Cross Blue Shield of Vermont
Tracy	Dolan ✓	Heidi	Klein ✓	AHS - VDH
Sandy	Floersheim ✓			Orleans/Essex VNA and Hospice, Inc.
Joyce	Gallimore			Bi-State Primary Care/CHAC
Karen	Hein ✓			
Penrose	Jackson ✓			FAHC - Community Care
Frances	Keeler ✓			AHS - DAIL
Ted	Mable			Northwest Counseling and Support Services
<del>David</del>	<del>Martini</del>			AOA - DFR
Melissa	Miles ✓	Patricia	Launer ✓	Bi-State Primary Care
Nick	Nichols ✓			AHS - DMH
Laural	Ruggles ✓			Northeastern Vermont Regional Hospital
Jenney	Samuelson ✓	Daljit	Clark ✓	AHS - DVHA
Julia	Shaw ✓			VLA/Health Care Advocate Project
Melanie	Sheehan			Mt. Ascutney Hospital and Health Center
Miriam	Sheehey ✓	Abe	Berman ✓	OneCare Vermont
Shawn	Skaflestad ✓			AHS - Central Office
Chris	Smith			MVP Health Care

JoEllen	Tarallo-Falk ✓	Lori	Augustyniak ✓	Center for Health and Learning
Stephanie	Winters ✓		✓	Vermont Medical Society
		Pat	Jones	GMCB

# Attachment 3a - PHWG Plan

Planned Year Two Activities	Vermont's Year Two Metrics	Planned Activities
<b>Advanced analytics</b>		
Define analyses payment reform models	Redefine analyses as necessary. Minimum 3 analyses each year.	Vermont has designed multiple analyses for the Commercial and Medicaid ACO Shared Savings Programs. Analyses include: attribution reports; summary statistics for attributed populations; calculation of performance measures; calculation of shared savings; and analysis of the difference between core and non-core costs. Draft models of reports have been developed, and initial reports have been shared with participating ACOs. The VMSSP and commercial SSP staff are working together to align analyses for both programs.
Consult with payment models and DLSS WGs on definition of analyses	Number of analyses performed (goal = 3)	Proposed analyses include sub-group analyses of populations with DLSS needs.
Episode of care (EOC) data analyses	Procure contractors to support	Vermont will procure a contractor for analytics associated with EOC plans described in Ops plan.
Episode of care (EOC) data analyses	Analyses performed on EOCs (goal = 3)	Contractor will perform analyses of EOCs.
Consult with payment models and DLSS WGs on ACO SSP financial model design	Number of meetings held with Payment Models and DLSS WGs (goal = 2)	Continued discussions with these two work groups in 2015.
Produce quarterly and year-end reports for ACO program participants and payers	Annual reports for Year 1 will be completed in 2015. Quarterly reports in year two. Goal = 5 reports	These reports will be generated by the ACO SSP Analytics Contractor (Lewin). Vermont has established criteria and timelines for quarterly and annual reports and plans to work closely with the Analytics Contractor to ensure accurate compliance with report requirements.

Design ACO Performance Measure Dashboards	Produce Dashboard reports (goal = 3)	Dashboards will be designed by Analytics Contractor with input from ACOs, payers, and QPM Work Group
Review ACO Performance Measure Reports and Dashboards with ACOs and with Quality and Performance Measures Work Group	Incorporate Quarterly agenda items in meetings relating to review of reports and dashboards (goal = 2 meetings)	Quarterly ACO Performance Measure Reports and Dashboards from the Analytics Contractor will be shared with ACOs and QPM Work Group, and discussed at QPM Work Group meetings.
<b>Evaluation</b>		
Develop evaluation plan	Evaluation plan developed	The contractor will work in close collaboration with the Evaluation Director and present a design plan for the self-evaluation.
Obtain stakeholder input in self-evaluation plan	Meetings with work groups (goal = 4)	The draft self-evaluation plan will be shared with the project's work groups in Q1 2015.
Consult with the Quality and Performance Measures Work Group	Number of meetings held with Quality and Performance Measures Work Group on evaluation (goal = 2)	Engage the QPM Work Group during 2015 to discuss the evaluation plan and early results.
Input baseline data	Baseline data identified	This will be identified with the Contractor in late 2014 and early 2015.
Planning and Stakeholder Engagement Assessment	Number of reports on stakeholder engagement (goal = 2)	Planning and stakeholder engagement assessment will begin in Y2
Qualitative studies	Number of studies conducted (goal = 2)	The evaluation plan calls for 4 qualitative studies, two of which will be conducted in Year 2
Implementation	Number of reports on	Implementation monitoring will

Monitoring	Implementation Monitoring (goal = 2)	begin in Year 2
Trend Monitoring	Number of reports on Trends (goal = 2)	Interrupted Time Series Analysis will begin in Year 2. Reports will include a data strategy plan and an analytic plan.
<b>Initiative Support</b>		
Develop interagency and inter-project communications plan	Interagency and inter- project communications plan developed	The plan will be developed once the contractor is selected.
Implement plan	Complete three activities outlined in the plan	The plan will be implemented once the contractor is selected.
<b>State staff training and development</b>		
Identify training opportunities for VHCIP staff	Formal identification of training opportunities for VHCIP staff	
<b>Model Testing</b>		
Develop ACO SSP model standards	Review and revise standards, as necessary.	Provide updates to commercial and Medicaid SSP standards as applicable.
Ensure compliance with ACO SSP performance measures and other standards	Periodic reporting by ACOs participating in ACO SSPs	Ensure all standards are incorporated into payer contracts. Utilize the ACO SSP Analytics Contractors (Lewin) for reporting and monitoring. Incorporates the oversight role of the GMCB and DVHA.
Execute amendments to Medicaid ACO SSP contracts	Annual updates to Medicaid ACO contracts(2)	Amend the existing Medicaid ACO SSP contracts.
Execute amendments to commercial ACO SSP agreements	Annual updates to commercial agreements (goal = 2)	Amend the existing commercial ACO SSP agreements.
Develop Medicaid value- based purchasing plan	Medicaid value-based purchasing plan developed	A contractor has been hired to support the state in performing this activity. The plan will be finalized in 2015, with input from the Payment Models Work Group.
Implement the Medicaid value-based purchasing plan	Implement the plan	

Launch learning collaboratives for providers	Implement learning collaboratives (goal = 3 communities)	Roll-out a learning collaborative to convene clusters of providers (e.g., hospital, home health, primary care, community services) in 3 communities to identify best practices, plan interventions, share data and identify improvement opportunities for integrated care management was approved by the Core Team. The first in-person learning session will be held in January 2015. Subsequent learning sessions will be held throughout 2015.
Launch learning collaboratives for providers	Implement learning collaboratives (goal = engage 300 providers)	Roll-out a learning collaborative to convene clusters of providers (e.g., hospital, home health, primary care, community services) in three communities to identify best practices, plan interventions, share data and identify improvement opportunities for integrated care management was approved by the Core Team. The first in-person learning session will be held in January 2015. Subsequent learning sessions will be held throughout 2015.
Collect reports and shared learnings from sub-grant program	Collect quarterly reports from sub-grantees and disseminate lessons learned (goal = 4)	Collect quarterly reports from the sub-grantees, of which there are 14, and distill lessons learned for sharing across the project.
Continue technical assistance program for providers implementing payment reforms	Number of provider organizations served by technical assistance program (goal = 14)	Technical Assistance is part of Vermont's Sub-Grant Program. The Sub-Grant Program released its first round of awards and awarded technical assistance to these awardees. Technical Assistance will be provided to fourteen awardees and dozens of providers.
Number of providers participating in one or more testing models	Maintain and increase participation if possible (goal = 2000 providers)	Continue to encourage participation in models.

Number of Blueprint practice providers participating in one or more testing models	Maintain and increase participation if possible (goal = 160 primary care practices)	<ul style="list-style-type: none"> <li>• Continue to encourage participation in models.</li> </ul>
Begin to develop unified data reporting between ACOs and the Blueprint for Health	Develop unified data reporting (goal = 3 communities)	Work with ACOs and Blueprint analytics team to develop uniform reporting structure.
Develop Unified Care Delivery System Systems	Begin to develop unified care delivery systems (goal = 3 communities)	Continue integration of ACO and Blueprint clinical teams.
<b>Technology and Infrastructure</b>		
Provide input to update of state HIT plan	Solicit substantive input on at least two drafts from stakeholders including the HIE/HIT Work Group.	Work with stakeholders to revise the current HIT Plan.
Revise state HIT Plan	Updated state HIT plan	Work with stakeholders to revise the current HIT Plan.
Expand provider connection to HIE infrastructure: Connectivity	Increase the number of new interfaces built between provider organizations and the HIE	Continue to work with VITL to develop new interfaces to the HIE.
Expand provider connection to HIE infrastructure: Connectivity	Use the information provided in the two SIM-funded gap analyses	Use the gap analyses to identify priorities in interface development.
Expand provider connection to HIE infrastructure: Availability and Interoperability	Expansion of VITLAccess	Work with VITL to expand VITLAccess beyond pilot sites

Expand provider connection to HIE infrastructure: Availability and Interoperability	Launch and expand Event Notification System (ENS)	Work with VITL to pilot test and then expand the ENS.
Expand provider connection to HIE infrastructure: Availability and Interoperability	Improve data quality	Continue work with providers, ACOs and VITL to improve clinical data quality.
Expand provider connection to HIE infrastructure: Availability and Interoperability	Development of the Uniform Transfer Protocol	Complete design of the uniform transfer protocols.
Expand provider connection to HIE infrastructure: Availability and Interoperability	Development of Gateways between the HIE and each ACO's chosen analytics platform	Continue work with ACOs and VITL to develop analytics gateways.
Conduct Gap Analysis and develop Remediation Plan for collection of ACO clinical data-based performance measures	Presentation of remediation plan to HIE/HIT Work Group for review and action	Gap analysis has been conducted and will be presented to QPM Work Group and others in Q4 2014. Remediation Plan will be developed and presented in Q1 2015.
Develop a plan for data repository & reporting systems	Complete data system inventory	Work with contractor to develop data inventory.
Develop a plan for data repository & reporting systems	Develop proposal and solicit stakeholder input on proposal	Continue developing proposal, including financing mechanism, for data repository.
Develop a plan for data repository & reporting systems	Finalize proposal	The proposal will include data governance and management as core components.
Consent Policy Updates	Provide input into any modifications to the HIE consent policy as appropriate	The HIT/HIE Work Group will develop these criteria.
42 CFR Part 2 data	Provide input into any	Continue to develop plans for data

integration	proposed processes developed by the State	integration.
Develop criteria for telemedicine sub-grants	Criteria developed	Vermont will work with a contractor to develop these criteria in early 2015.
Release RFP for telemedicine sub-grants	RFP released	Release this RFP in early summer 2015.
Award telemedicine sub-grants	Award sub-grants (goal = 1)	Make awards in early autumn 2015.
<b>Population Health</b>		
Develop inventory of Accountable Care Communities (ACC/AHC)	Inventory developed	Work with contractor to identify exemplars and qualities inherent in ACCs/AHCs
Release RFP for ACC pilot program	RFP released	Develop RFP for pilot program.
Award ACC pilots, if appropriate	Awards made	If appropriate, award ACC pilot contracts
Develop draft population health plan	Draft plan developed	Work with stakeholders to develop population health plan

# Attachment 3b - PHWG Overview

## *VT Health Care Innovation Project Population Health Work Group Work Plan*

<b>Objectives</b>	<b>Supporting Activities</b>	<b>Target Date</b>	<b>Responsible Parties</b>	<b>Status of Activity</b>	<b>Measures of Success</b>
Develop shared understanding of factors contributing to population health outcomes	<p>Define “population health”</p> <p>Share potential frameworks for identifying the major contributors to population health</p> <p>Create materials that show connection between social determinants, population health and clinical measures</p>			Completed	<p>Definition adopted</p> <p>Socio-ecological framework adopted</p> <p>Pop Health 101 materials shared with all work groups</p>
<b>Measures</b> Develop consensus on population health measures	<p>Collect existing sets of “population health” measures currently used in VT, CDC and/or by CMMI, for example:</p> <ul style="list-style-type: none"> <li>• Healthy VT 2020</li> <li>• VT State Health Improvement Plan</li> <li>• GMCB dashboard</li> <li>• ACO Measures for VHCIP</li> <li>• CMMI</li> </ul>			<p>Initial identification of set completed</p> <p>On-going collection of data</p>	
	Review current process for selecting ACO (Medicare) measures and preliminary set for expanded ACO (Medicaid and commercial insurers) in 2014		Pat Jones	Completed	
	Recommend appropriate set of measures for ACOs for Years Two and Three		Work Group	Completed	<ul style="list-style-type: none"> <li>• Criteria for selection of measures adopted</li> <li>• Measures recommended</li> <li>• Measures adopted/approved</li> </ul>
	Ensure on-going dialogue with members of the Quality and Performance Measures Work Group	On-going	Heidi Klein is a voting member	On-going	
	Identify, help select and support integration of population health measures for other models being tested (bundled payments, P4P, and other delivery system reforms)				
	Explore other areas where population health measures could be used in tracking results (e.g. dashboard and CHNA Community Health Needs Assessment) priority setting, implementation strategies and outcomes;				

***VT Health Care Innovation Project  
Population Health Work Group Work Plan***

<b>Objectives</b>	<b>Supporting Activities</b>	<b>Target Date</b>	<b>Responsible Parties</b>	<b>Status of Activity</b>	<b>Measures of Success</b>
<b>Payment Models</b>	<ul style="list-style-type: none"> <li>Review of current payment models</li> <li>Share population health frameworks with Payment Models Work Group</li> </ul>		Richard Slusky Co-chairs		
Bundled Payment/Episodes of Care	<ul style="list-style-type: none"> <li>Review model being tested</li> <li>Analyze strengths and limitations in integration of population health</li> <li>Identify best lever and strategy to include payment for and/or activity related to population health</li> </ul>		Kara Suter?		
Pay for Performance (P4P)	<ul style="list-style-type: none"> <li>Review model being tested</li> <li>Analyze strengths and limitations in integration of population health</li> <li>Identify best lever and strategy to include payment for and/or activity related to population health</li> </ul>		Kara Suter	Not expending to expand beyond Blueprint	
Shared Savings/ACOs	<ul style="list-style-type: none"> <li>Review model being tested</li> <li>Recommend criteria and measures for payment that will shift funding and practice to actions that will improve population health</li> <li>Identify how the savings can be shared with population health and prevention partners</li> <li>Analyze strengths and limitations in integration of population health</li> </ul>		Kara Suter?	Georgia provided a quick overview at the Oct meeting on TACOs	
<b>Financing Options</b> paying for prevention	Identify promising new financing vehicles that promote financial investment in population health interventions		Jim Hester		
	Financial Options <ul style="list-style-type: none"> <li>Social impact bonds</li> <li>Community Development Financial institute</li> <li>Wellness Trust</li> </ul>		Jim Hester		
	Provide recommendations to other VHCIP committees to consider link with payment models being tested in VT				

***VT Health Care Innovation Project  
Population Health Work Group Work Plan***

<b>Objectives</b>	<b>Supporting Activities</b>	<b>Target Date</b>	<b>Responsible Parties</b>	<b>Status of Activity</b>	<b>Measures of Success</b>
<b>Care Models</b> Identify opportunities for expansion of delivery models to include population health and broad range of community prevention partners	Examine current population health improvement efforts in VT administered through the Department of Health, Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs and other provider and payer entities.	July 2014	Blueprint NVRH Mt. Ascutney	Initial presentation at July 2014 meeting	Matrix of existing care models and features for improving population health
	Share population health frameworks with Care Models Work Group		Co-Chairs		Identification of opportunities in time and content to include population health in innovations tested
	Explore options to build upon Blueprint delivery system <ul style="list-style-type: none"> <li>• Network Analysis for enhancing pop. health</li> <li>• How best build on CHT Structure?</li> <li>• Look at strengths of “Integrated Health Team”</li> <li>• Consider a whole family approach</li> </ul>				Identification of opportunities in time and content to include population health in innovations tested
	Review ACO system of care		C. Hinds, OneCare; J. Gallimore, FQHC		Identification of opportunities in time and content to include population health in innovations tested
	Review other systems of care as they are identified and/or proposed throughout the project				
	Review other innovations for systems of care for population health – other SIM states, IOM Population Health, etc.		Consultant		

***VT Health Care Innovation Project  
Population Health Work Group Work Plan***

<b>Objectives</b>	<b>Supporting Activities</b>	<b>Target Date</b>	<b>Responsible Parties</b>	<b>Status of Activity</b>	<b>Measures of Success</b>
Examine <b>models that connect payment models &amp; system of care</b> for population health improvement	Review theoretical models of community health systems to improve population health <ul style="list-style-type: none"> <li>Consider Neal Halfon's 3.0 framework</li> <li>Review IOM Roundtable on Population Health and CHCS white papers</li> </ul>		Jim Hester		
	Look at examples <u>outside Vermont</u> for promising practices of the integration of integration of clinical care, mental and behavioral health, and primary prevention		Prevention Institute		
	Identify <u>Vermont exemplars</u> : community integration of clinical care, mental and behavioral health, and primary prevention		Prevention Institute		
	Share models of integration to improve population health outcomes with communities interested in testing out change		Prevention Institute		
	Share the work with other VHCIP committees to consider link with payment and care models being tested in VT		Co-chairs		
Develop <b>Population Health Plan (CDC/CMMI)</b>	Develop outline to inform work plan for the Population Health Work Group		Heidi Klein	Review of outline by Pop Health Work Group scheduled Aug 2014 mtg.	
	Develop work plan to ensure collection of information, exploration of topics, etc. Collect and organize materials		Heidi Klein		



# Attachment 3c - PH in VHCIP overview

# Population Health Integration in the Vermont Health Care Innovation Project

The Vermont Health Care Innovation Project (the Project) is testing new payment and service delivery models as part of larger health system transformation to deliver Triple Aims outcomes of better care, lower costs and improved health. The charge of the Population Health Work Group (PHWG) is to recommend ways the Project could better coordinate population health improvement activities and more explicitly improve population health<sup>1</sup>.

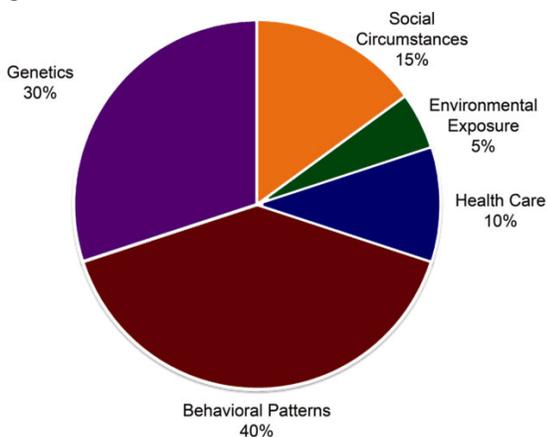
To accomplish the charge of integration of population health and primary prevention within the models being tested in Vermont, the PHWG is committed to several key tasks:

- Develop consensus on a robust set of population health measures to be used in tracking the outcomes of the Project and to be incorporated in the new payment models.
- Offer recommendations on how to pay for population health and prevention through modifications to proposed health reform payment mechanisms.
- Identify promising new financing vehicles that promote financial investment in population health interventions.
- Identify opportunities to enhance current initiatives and health delivery system models (e.g. the Vermont Blueprint for Health and Accountable Care Organizations) to improve population health by better integration of clinical services, public health programs and community based services at the practice and community levels. One model to be explored is an Accountable Health Community.
- Develop the “Plan for Integrating Population Health and Prevention in VT Health Care Innovation.”

## Frameworks to Guide Population Health

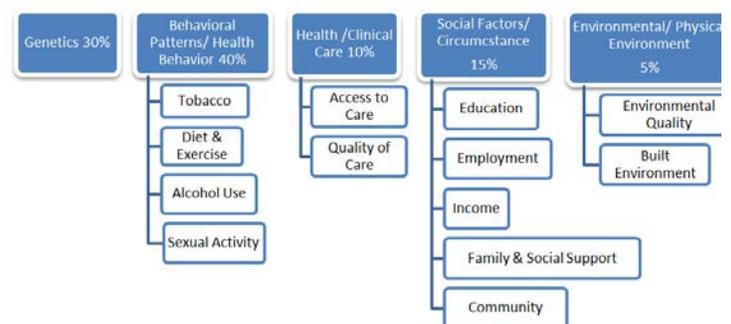
To meet the Triple Aim of moderating cost, improving quality and improving health, increasing access to health care will be insufficient. Access to health care and the quality of medical care account for 10% proportionately to the factors that contribute to premature death (see Figure 1). Therefore, we must seek opportunities to address the multiple factors affecting health outcomes (see Figure 2).

Figure 1: Proportional Contribution to Premature Death



Source: Schroeder, Steven. N Engl J Med 2007;357:1221-8  
Adapted from: McGinnis JM, et.al. *The Case for More Active Policy Attention to Health Promotion*. Health Aff (Millwood) 2002;21(2):78-93.

Figure 2: Factors Affecting Health Outcomes



County Health Rankings adapted to include genetics and McGinnis weighting of factors  
<http://www.countyhealthrankings.org/our-approach>

## Health in New Models

Focus on the Whole Population in an area, not just attributed patients

# Population Health Integration in the Vermont Health Care Innovation Project

- Use data on health trends and burden of illness to identify priorities and target evidence-based actions that have proven successful in preventing diseases and changing health outcomes.
- Expand efforts to maintain or improve the health of all people – young, old, healthy, sick, etc. Focus specific attention on the health and wellness of subpopulations most vulnerable in the future due to disability, age, income and other factors.

## Focus on Prevention, Wellness and Well-Being by Patient, Physician and System

- Focus on primary prevention<sup>ii</sup> and actions taken to maintain wellness rather than solely on identifying and treating disease and illness.
- Utilize proven evidence-based prevention strategies to address risk and protective factors<sup>iii</sup> and personal health behaviors such as tobacco use, diet and exercise, alcohol use, sexual activity, as well as other health and mental health conditions that are known to contribute to health outcomes.

## Address the Multiple Contributors to Health Outcomes

- Support integrated approaches that recognize the interconnection between physical health, mental health and substance abuse.
- Identify the social determinants of health<sup>iv</sup> and circumstances in which people are born, live, work, and age (e.g. education, employment, income, family support, community, the built and natural environment).

## Create Accountability for Health

- Use measures of quality and performance at multiple levels of change to ensure accountability in system design and implementation for improved population health.
- Build upon existing infrastructure (Blueprint Medical Homes, Community Health Teams, Accountable Care Organizations and public health programs) to connect community resources for health in a geographic area.
- Include partners and resources able to influence the determinants of health and the circumstances in which people live, work and play.

## Create Sustainable Funding Models Which Support and Reward Improvements in Population Health including Primary Prevention and Wellness

- Incentivize payers and health systems to invest in community-wide prevention efforts and to encourage delivery of physical health, mental health and substance use prevention services
- Direct savings, incentives and investments to efforts aimed at primary prevention and wellness including efforts that address the social determinants of health (e.g. housing, transportation, education).
- Develop budgets that explicitly demonstrate spending and/or investments in prevention and wellness.

Identify long and short term multi-sector impacts and capture a portion of those benefits for reinvestment

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<sup>i</sup> Population Health is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart, 2003)... While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors. **Institute Of Medicine, Roundtable on Population Health Improvement** <http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx>

<sup>ii</sup> Primary prevention aims to prevent disease from developing in the first place. Secondary prevention aims to detect and treat disease that has not yet become symptomatic. Tertiary prevention is directed at those who already have symptomatic disease, to prevent further deterioration, recurrent symptoms and subsequent events. Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier.

<sup>iii</sup> [http://www.who.int/hiv/pub/me/en/me\\_prev\\_ch4.pdf](http://www.who.int/hiv/pub/me/en/me_prev_ch4.pdf)

<sup>iv</sup> (<http://www.cdc.gov/socialdeterminants/>).

# Attachment 4a - WA ACH intent and goals



## The Proposed Role of Accountable Communities of Health in Washington State

Accountable Communities of Health (ACHs) are a precondition to achieving better health, better care and lower costs under the Healthier Washington initiative.

### 1. ACHs are designed to implement the following proposed strategies:

- **Build upon existing community-based health improvement coalitions, leveraging and enhancing the relationships, commitments, and initiatives already in place** to ensure a diverse, multi-sector approach to health and health care. The precise organizational and governance structure will not be dictated at the state level. ACHs will utilize a “collective impact” model to guide development.
- **Strengthen community linkages between the local health care delivery system, public health, and others who influence a community’s physical and social environments**, better informing and coordinating the priorities of each and placing a greater emphasis on social determinants of health and population health improvement.
- **Formally connect health innovation and transformation efforts at the state and local level**, allowing each to focus on its strengths, and leverage shared resources.
- **Coordinate and connect at the regional and local level** the delivery of the range of health care services and community and social supports contributing to individual and community well-being.
- **Be a resource that managed care organizations draw upon to meet the state’s new expectations as it transitions medical assistance programs** more rapidly from payment for particular health care services to payment for improved outcomes.
- **Evaluate and elevate health innovations happening at the local level and facilitate the sharing of information about successes and failures statewide**, enabling replication of success and avoidance of failures.

### 2. Utilizing the functions introduced above, ACHs will accomplish the following goals:

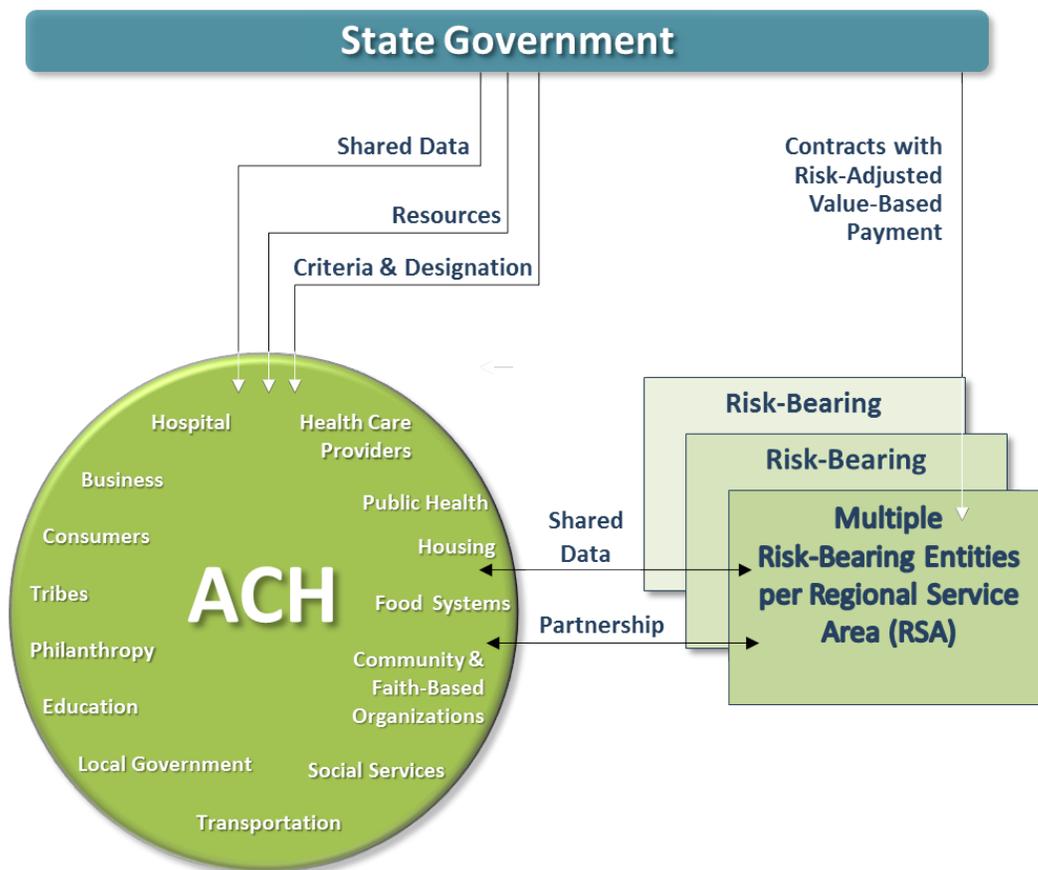
- Leverage the unique strengths of the region by providing a strong and organized local voice **to tailor and adapt state health care purchasing, delivery system reform and other health improvement activities within a region** so programs are responsive to the unique strengths and needs of the region.
- **Implement regional strategies and interventions set forth in the Plan for Improving Population Health.** Engage and mobilize its multi-sector members in implementation.
- **Accelerate the integration of physical and behavioral health care at the financing and delivery system level, starting with Medicaid**, and inform the reinvestment of shared savings to support the community.
- **Invest in promising and evidence-based practices and evaluating the results, scaling and spreading effective models, and capturing savings for reinvestment and sustainability** through statewide learning collaboratives and testing innovative financing mechanisms.
- **Address community health needs with the use of innovative data.** ACHs will be armed with health mapping capabilities that will leverage improved statewide data analytics and integration.
- **Partner with the state in successful achievement of quantitative and qualitative measures targets set as bars of success**, specifically those tied to population health improvement and scaling efforts statewide.
- Amplify the role and responsibility of multiple sectors in health improvement to **further address the social determinants of health.**



### 3. What is the relationship between ACHs and Risk-Bearing Entities?

As indicated in the illustration below, the relationship between ACHs and risk-bearing entities is as follows:

- **The geographic area of an ACH will align with Regional Service Areas (RSA) for Medicaid purchasing** and it is likely there will only be one ACH per RSA.
- Whether an RSA decides to be an early adopter (integrated purchasing in 2016) or a transition region (integrated purchasing by 2020), **the ACH will be actively engaged in health improvement initiatives within the RSA and work in partnership with the risk bearing entity.**
- **ACHs will inform the state’s purchasing of Medicaid in their region**, including strategies for incentivizing health plans based on regional needs and priorities.
- **As ACHs progress they are expected to partner with HCA and with risk-bearing entities to improve health delivery systems.** ACH influence will increase as the partnership with risk-bearing entities matures.



# Attachment 4b - WA ACH set up and outcomes



## Accountable Community of Health Setup and Desired Outcomes

Work to establish ACHs has already begun and will continue independent of CMMI grant funding for this proposal, although at a less accelerated and limited basis if grant funding is not awarded.

1. Washington is finalizing an ACH development continuum to guide ACH development, resulting in advanced, fully functioning ACHs statewide by the end of 2018.
2. Guided by the State Health Care Innovation Plan (funded by SIM Round 1), 10 Community of Health (COH) planning grants were authorized and funded by the State Legislature through E2SHB 2572. These grants provide a six-month planning period for communities to plan for governance and multi-sector engagement strategies, with the grant period ending December 31, 2014.
3. In addition, 2572 will fund two pilot ACHs to further demonstrate and lead the implementation of an effective governance and engagement model, which is essential for statewide ACH implementation to be successful. These pilot grants will begin January 2015 and end by July 2015.

These state-funded grants jumpstart Washington’s ACH initiative, but SIM Round 2 funding will provide the necessary support for communities to respond to and build on the state-funded COH planning process and Pilot ACH designations. There is a significant gap between current levels of development and the envisioned ACH development continuum that will result in fully functioning ACHs by the end of 2018. While ACHs will be established statewide by 2016, communities will be at different levels on the continuum, with varying strengths and needs. Washington has established four key phases under the statewide ACH initiative:

1. Strategic Planning – Development of the State Health Care Innovation Plan and exploration of the role and potential of community health collaboratives in driving transformation.
2. Community Engagement – Implementation of the state-funded COH planning grants.
3. Community Empowerment – Implementation of ACH design grants (funded by SIM Round 2) and two state-funded pilot grants.
4. Community Empowerment and Accountability – Designation of ACHs statewide and implementation of accountability measures to align with capacity and funding levels.

The following table outlines the phases in more detail, including the feedback mechanisms that demonstrate the state’s responsiveness to lessons learned in each phase:

	Phase, Intent and Funding	Outcomes and Deliverables
2013 - Q2 of 2014	<b>Phase 1, Strategic Planning (SIM Round 1):</b> <ul style="list-style-type: none"> <li>• Development of the five-year State Health Care Innovation Plan.</li> <li>• Emphasizes the role of communities and multi-sector engagement in population health and health system transformation.</li> </ul>	<ul style="list-style-type: none"> <li>• The Innovation Plan sets the framework for the Triple Aim in Washington, including the purpose of the ACH initiative.</li> <li>• Informed the development of Community of Health (COH) grants to prepare communities for the ACH initiative.</li> </ul>



Q3 - Q4 of 2014	<p><b>Phase 2, Community Engagement (State Funding):</b></p> <ul style="list-style-type: none"> <li>COH grants (E2SHB 2572) call for 10 communities to develop Community Health Plans to describe how communities will align, amplify and evolve existing priorities and efforts to develop multi-sector shared priorities and approaches to achieving the Triple Aim.</li> <li>Leveraging and building on existing infrastructure and strengths within the community.</li> </ul>	<ul style="list-style-type: none"> <li>Community Health Plans provide a roadmap for communities regarding regional strengths, challenges, health priorities, and future strategies.</li> <li>COH planning prepares communities for design funding to implement a regional ACH proposal.</li> <li>The COH planning process has already informed the development of the ACH progression of capacity and funding model. For example, Washington is responding to lessons learned through the COH planning process by elevating the significance of a robust governance and engagement structure, specifically within the several multi-county regions.</li> </ul>
Q1-Q3 of 2015	<p><b>Phase 3, Community Empowerment / Implementation (SIM Round 2 and State Funding):</b></p> <ul style="list-style-type: none"> <li>Design grants will build on the Community of Health planning process to allow communities to adapt to the newly established Regional Service Areas and to prepare for ACH designation.</li> <li>Design grants are not limited to one entity within a Regional Service Area as the goal is for communities to collaborate on the design of a future ACH model for the region. Emphasis on governance structure, multi-sector engagement and sustainability.</li> <li>Two pilot grants are intended to provide startup to test two ACH models, but pilot designation does not constitute official ACH designation and does not necessarily preclude design funding.</li> <li>Pilot designations will be based on highly functioning governance models, engagement strategies, and organizational capacity and sustainability.</li> </ul>	<ul style="list-style-type: none"> <li>Design grantees will respond to the Community Health Plans delivered through the COH planning grants and align the plans with other community health plans within the newly established Regional Service Areas.</li> <li>Respond to lessons learned (i.e., the development of a more robust tribal engagement strategy, including dedicated support).</li> <li>Respond to the initial demonstrations and learning opportunities provided by the pilots.</li> <li>The two pilots will be responsible for demonstrating the effective utilization of ACH governance and engagement as part of an ACH startup.</li> </ul>
Q3, 2015 - after grant duration	<p><b>Phase 4, Community Empowerment and Accountability (SIM Round 2):</b></p> <ul style="list-style-type: none"> <li>ACH designations represent a continuum of progression and accountability.</li> <li>ACH designation criteria will be informed by the COH planning process and the existing promising practices as informed by the pilot designation process.</li> <li>ACH designation indicates a level of readiness for increased accountability to lead regional health improvement efforts.</li> <li>Funding will be provided for infrastructure (with sustainability planning), innovation and accountability incentives.</li> <li>ACHs will be at disparate levels of development and funding will be provided based on need and established expectations/accountability.</li> </ul>	<ul style="list-style-type: none"> <li>Serve as an advisor/partner in Medicaid procurement based on regional needs and perspectives.</li> <li>Develop a regional health assessment and Regional Health Improvement Plan.</li> <li>Implement the Plan for Improving Population Health at the community level.</li> <li>Act as a forum for harmonizing payment models, performance measures and investments</li> <li>Facilitate health coordination and workforce development.</li> <li>Facilitate Practice Transformation Support Hub community liaisons.</li> <li>Use innovative data analytics to address community health needs.</li> <li>Assist with the development of performance measures, metrics, and expectations to assure the ACHs are functioning effectively, reducing waste and duplication, and adding value.</li> </ul>



# Attachment 4c - Seattle ACH

## Accountable Community of Health (ACH) Planning – For the King County Region

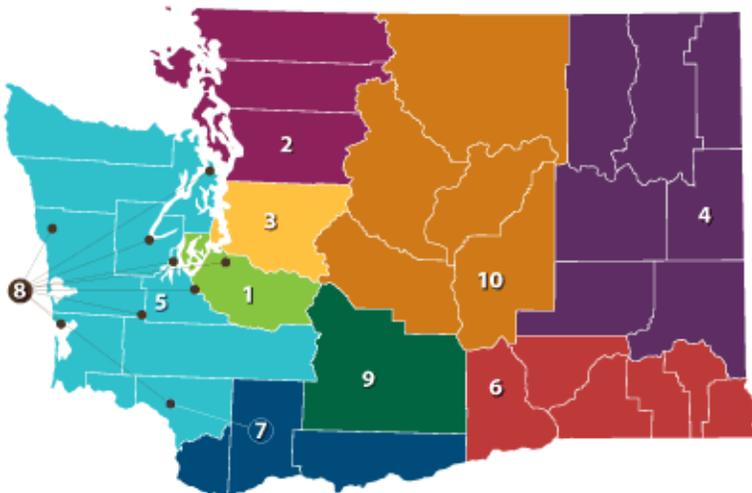
The Washington State Health Care Authority has awarded King County a \$49,898 planning grant for the July – December 2014 period for Accountable Community of Health (ACH) planning.

The planning phase is designed to align, amplify, and evolve existing priorities and efforts to develop multi-sector shared priorities and approaches to achieve the triple aim of better health, better care, and lower costs. In addition, the planning phase is designed to inform the ACH designation process and support the King County’s region’s preparation for eventual designation as an ACH.

- Washington’s [State Health Care Innovation Plan](#) calls for leveraging innovation and collaboration already occurring in local communities by bringing public and private entities together to work on shared goals that can produce the triple aim of better health, better care, and lower costs.
- From July – December 2014, a series of planning activities involving community stakeholders and the state will help inform the design of an ACH approach that works for the diverse King County region. This background document provides general information and how to get involved.

### Who are the Planning Grantees Across the State?

Ten entities - covering the entire state – were awarded planning grants:



1. [Pierce County Health Innovation Partnership](#): Serving Pierce County
2. [North Sound Accountable Community of Health](#): Serving Whatcom, Skagit, Island, San Juan and Snohomish counties
3. [King County](#): Serving King County.
4. [Better Health Together](#): Serving Spokane, Stevens, Pend Oreille, Ferry, Lincoln, Whitman and Adams counties
5. [CHOICE Regional Health Network](#): Serving Clallam, Cowlitz, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, Thurston and Wahkiakum counties
6. [Benton-Franklin Community Health Alliance](#): Serving Benton, Franklin, Walla Walla, Columbia, Garfield and Asotin counties
7. [Southwest Washington Regional Health Alliance](#): Serving Clark, Klickitat and Skamania counties and the Cowlitz Indian tribe
8. [South Puget Intertribal Planning Agency](#): Serving the Confederated Tribes of the Chehalis Reservation, Nisqually Indian Tribe, Skokomish Tribal Nation, Shoalwater Bay Indian Tribe, Squaxin Island Tribe and the Quinault, Cowlitz, Puyallup and Port Gamble S'Klallam tribes
9. [Yakima County Accountable Community of Health](#): Serving Yakima County
10. [North Central Health Partnership](#): Serving Okanogan, Douglas, Chelan, Grant

The Health Care Authority will be working with the grantees, individually and together, to help us stay coordinated and learn from each other. You can learn more at the State Health Care Innovation Plan's Community of Health

website: [http://www.hca.wa.gov/shcip/Pages/communities\\_of\\_health.aspx](http://www.hca.wa.gov/shcip/Pages/communities_of_health.aspx)

### **How will planning be approached in the King County region?**

As described in the ACH application, the King County region has a portfolio of cross-sector health improvement initiatives already underway or in formation, such as those connected to the King County Health and Human Services Transformation Plan and others. The planning phase will help advance and evolve these efforts towards a common set of community-developed goals and priorities in light of the new ACH initiative and opportunity.

We envision working together to clarify and affirm a set of high priority issues that stakeholders most want to work on (or are working on) – a shared agenda reflecting current areas where momentum is high. From that, work together to arrive at the next phase of mutually agreeable

infrastructure, roles, and governance arrangements that will help these cross-sector efforts be as successful as possible in improving outcomes and lowering costs.

Because this work involves looking for ways to better align certain aspects of local work and priorities with those of the state, it will entail close partnership with state staff and consultants. We'll learn more about the state's vision for ACHs, including how local needs and interests will inform the state's strategies and efforts. The Health Care Authority has hired a dedicated staff lead, Chase Napier, to work with the ACH grantees. They are also using the consulting firm Strategies 360 to assist with opportunities for grantees to convene as part of the envisioned learning network.

Keep in mind this is a new initiative, and part of the purpose of the planning phase is to help *inform* the designation criteria and process that the state will eventually use. No one yet knows what an ACH in the King County region will look like or how it will evolve over time – that is something we look forward to thinking about together.

### **What are the deliverables under this grant?**

At the end of the planning period, a “Community Health Plan” for the King County region will be submitted to the State. The final report will address such issues as:

- Engagement of stakeholders in Community of Health planning
- Partnering with the State to identify opportunities for alignment
- Identification of shared community health and health care priorities that align with the State Health Care Innovation Plan and related transformation efforts.
- Articulation of potential roles in driving transformation, such as roles related to:
  - Region-wide community health needs assessments and plans
  - Engagement with HCA in Apple Health (Medicaid) purchasing
  - Innovative use of data (such as GIS mapping)
  - Facilitating shared workforce
  - Practice transformation support
- Plan for a governance structure, shared measurement mechanisms, a communication framework, and sustainability.

Important dates:

October 15, 2014 – Interim narrative progress report and financial status report

December 31, 2014 – Final narrative report (called Community Health Plan)

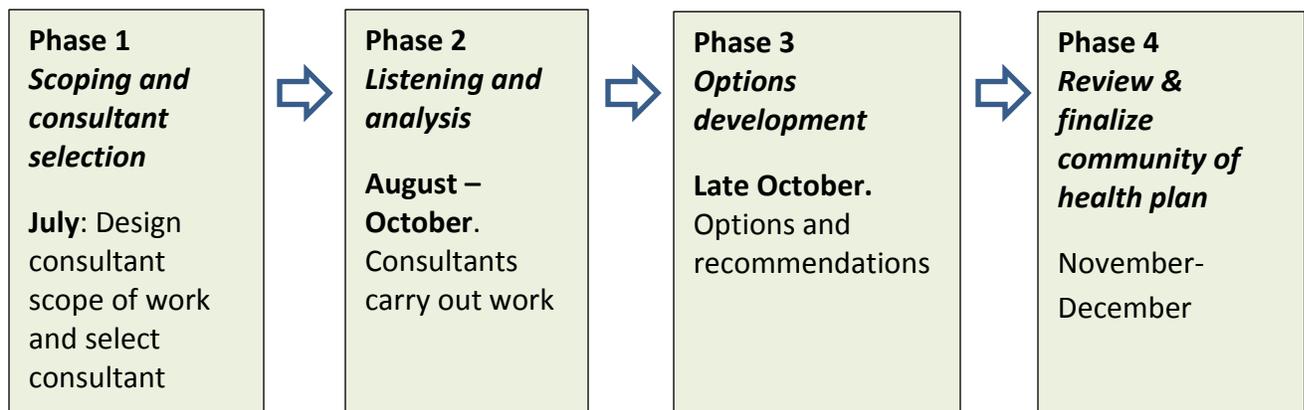
January 31, 2015 – Final financial report

**What happens after the planning phase? Will resources be available?**

In a bill that passed the state legislature in 2014, ESSHB 2572, funding was authorized for start-up of two Community of Health pilots. HCA has indicated they plan to go through a process later this year to select the two pilots. In addition, the state is applying to the Centers for Medicare and Medicaid Innovation (CMMI) for a State Innovation Model (SIM) Round 2 testing grant, and as part of that will be asking for resources to further support ACH development.

**What are the phases of work from July – December 2014?**

ACH planning for King County will fall into four broad phases:



During this same timeframe, activities designed to move the King County Health and Human Services Transformation Plan forward will continue concurrently, as planned, as will other health improvement initiatives (see below).

The ACH planning will therefore unfold as an iterative process, both shaping and being shaped by the initiatives already in motion that pertain to achieving better health, better care, and lower costs in King County. Some of those initiatives (not an exhaustive list) include:

Initiative	Status/structure
King County Health and Human Services Transformation Plan	Advising Partners Group <ul style="list-style-type: none"> <li>This group was established for an interim period to advise on start-up of the Transformation Plan implementation. It is scheduled to revisit its purpose and</li> </ul>

	<p>configuration in the latter part of 2014.</p> <p>Design Team – Adults with complex needs</p> <ul style="list-style-type: none"> <li>• This cross-sector group will be formed in summer 2014 to develop an improvement plan/agenda for high risk adults</li> </ul> <p>Design Team – <i>Communities of Opportunity (see below)</i></p>
Communities of Opportunity	<p>Communities of Opportunity is a public-private partnership being jointly designed and launched by the Seattle Foundation and King County with community partners. A Design Team is currently in place.</p> <p>COO is focused on a <i>broad set</i> of equity issues (including but not limited to health.) The COO frame encompasses economic, social, health, and racial equity goals.</p> <p>Future governance of COO will come under discussion in latter part of 2014.</p>
Medicare-Medicaid Dual Eligibles financial alignment demonstration	<p>Project governance group not yet formed due to project delay, but expected in fall 2014.</p>
Exploration of early adopter of behavioral health/physical health integration (Apple Health)	<p>Specific processes and community engagement TBD.</p>
King County Hospitals for a Healthier Community	<p>Collaborative of 12 hospitals and hospital systems in King County working on a joint Community Health Needs Assessment (CHNA), supported through PHSKC.</p>
Area Agency on Aging / Seattle Aging & Disability Services	<p>The AAA plans, coordinates, and advocates for a comprehensive service delivery system for older adults, family caregivers, and people with disabilities in King County.</p> <p>Areas related to ACH include community convenings on care transitions, (focus is on reducing avoidable hospital readmissions); and participating in integrated care models (key partner in duals demonstration), among others.</p>
Community Transformation Grant /	<p>Multi-disciplinary partnership involving Seattle Children’s, Public Health, and the Healthy King County Coalition; focused on</p>

chronic disease prevention	community prevention activities primarily in South King County and south Seattle.
Housing-Health Partnership group	Cross-sector planning group meeting in 2014/2015, led by Mercy Housing, exploring development of pilots in 3 areas of the state, including King County, related to the housing / health intersection for purpose of achieving triple aim. Pacific Hospital PDA has funded several housing-based community health worker projects in Seattle and south county that will inform this effort.
Vulnerable Population Strategic Initiative Steering Group (Emergency Medical Services system)	Collaboration of EMS, fire districts, community-based agencies, and University of Washington

**What roles will consultant(s) perform?**

King County will engage consultant(s)/organizations, funded by the ACH planning grant resources, to carry out the following activities:

1. **Conduct landscape review and crosswalk – for identification of areas of shared priority interest.** Develop a crosswalk of priorities, objectives, structures, and measurement activities related to achievement of triple aim in King County. Extract common threads – where are the areas of high, shared interest? Where are there areas where interests are *not* shared, or dynamics that need to be factored in to avoid working at cross purposes?
2. **Assess potential roles.** Analyze current roles, capacities, and stakeholder perspectives on these roles to better support health transformation in King County:
  - Community health needs assessment activities in King County
  - Voice in Apple Health (Medicaid) procurement
  - Convener roles for cross-sector health improvement collaboration
  - Data analysis, evaluation, measurement of cost savings/offsets across sectors
  - HIT/HIE to support work across sectors
  - Workforce shifts – including use of community health worker/peers
  - Practice transformation support roles
  - Governance structure to support health transformation work

3. **Exploration of engagement and inclusion strategies.** The inclusion of underrepresented populations, geographies and consumers is a high priority both in (1) how the July – December COH planning phase is carried out; and (2) what gets recommended in the Community Health Plan as ongoing elements or activities designed to proactively drive health equity in King County. A qualified organization/consultant(s) will be identified to lead activities in this area, with expertise in community engagement.
4. **Development of options and recommendations.** A *discussion draft* and presentation will be developed by the consultant team to share with various community groups to present and discuss what they have learned, and gather feedback. At this time, the existing Advising Partners Group of Health and Human Services Transformation Plan will serve as the main steering group/sounding board for the development of the Community Health Plan, but is not the place where discussions will occur.

### How can interested parties be involved and stay updated?

- Sign up for the Transformation Plan stakeholder e-mail distribution list by writing to: [HHSTransformation@kingcounty.gov](mailto:HHSTransformation@kingcounty.gov)
- Visit the King County ACH website page for updates and resources: <http://www.kingcounty.gov/exec/HHSTransformation/ach.aspx>
- Contact project staff Janna Wilson [janna.wilson@kingcounty.gov](mailto:janna.wilson@kingcounty.gov) (206) 263-8281, with Public Health-Seattle & King County, if you have questions or would like to discuss opportunities for involvement.