

Attachment 1 - Population Health  
Work Group Meeting Agenda  
12-09-14

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

Date: Tuesday, December 9, 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>	Tracy Dolan	<b>Attachment 3:</b> N/A	
4	2:45	<b>ACO and Blueprint Collaboration for Unified Community Health Systems</b>	Craig Jones Tom Moore	<b>Attachment 4:</b> Community Oriented Health Systems Transition to Green Mountain Care	
5	3:30	<b>Application to Emerging Ideas for Integrating Population Health</b>  <i>How does this model fit with our prior discussions about integrating population health in health system innovation?</i>  <i>Which elements are included? Which might be missing?</i>	Large Group Discussion	<b>Attachment 5:</b> Population Health in VHCIP	
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 11-18-14



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

**Date of meeting:** Tuesday, November 18, 2:30 to 4:00 PM, ACCD – Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier

Agenda Item	Discussion	Next Steps
<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. Mark Burke seconded the motion and it passed unanimously.	<b>The minutes will be updated and posted to the website.</b>
<b>3. Updates</b>	<p><u>VHCIP Year 2 Retreat:</u> Staff, Work Group Co-Chairs and the VHCIP Core Team members met for a full day retreat to share major accomplishments and biggest challenges from Year One and three items planned for Year Two. It was clear that participants were very interested in our work together and in “population health.” However, it was also clear that other work groups might be defining “population health” more narrowly and not including some of the key principles developed by the PHWG. In follow up, the PHWG co-chairs and staff will seek opportunities to meet staff and chairs from other work groups to discuss potential integration.</p> <p><u>VHCIP Year Two Operational Plan:</u> VHCIP has just submitted its Year Two Operational Plan to the CMMI/CMS. Included in this plan are the following items for the PHWG:</p> <ul style="list-style-type: none"> <li>• Develop inventory of Accountable Care Communities (ACC/AHC)</li> <li>• Release RFP for ACC pilot program</li> <li>• Award ACC pilots, if appropriate</li> <li>• Develop draft population health plan</li> </ul>	<p><b>Update Population Health Work Group Work Plan</b></p> <p><b>Share Population Health Frameworks with other Work Groups</b></p>

	<p>The details of this work will be informed by the outcomes of the research to be conducted by our contractor, the Prevention Institute. It is premature to speculate on the content, timing or funding available for a potential RFP and an ACC pilot program. It was understood at the time of submittal that the work plan may shift significantly.</p> <p><u>Population Health Work Group Work Plan:</u> A draft was distributed to the PHWG. Project staff will be updating this work plan based on the results of the retreat.</p> <p><u>Contract with Prevention Institute (PI):</u> We anticipate actual start up in December for Accountable Health Community work.</p> <p><u>RWJF Grant:</u> The proposal has been approved. The health department will embark on 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><b>4. Examples and Ideas for Integrating Population Health: WA</b></p> <p>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.</p>	<p>To continue our exploration of Accountable Health Communities, we invited Chase Napier, Washington State Health Care Authority and Sue Grinnell, WA Department of Health to share current efforts in WA.</p> <p>The formation of regional Accountable Communities for Health are being proposed as part of health system reform in Washington and the innovations being tested in the SIM grant. In SIM Round 1, 10 Community of Health 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. In addition, 2572 will fund two pilot ACHs, from January 2015 to July 2015, to implement an effective governance and engagement model.</p> <p>The intent is to build upon existing partnerships in self-identified areas for establishing a regional ACH that will coordinate care across sectors (physical, behavioral and chemical dependency), align strategies and connect to Regional Service Areas (RSAs) which are regional hubs for Medicaid purchasing. Ideally, the ACH will help to identify health priorities for a region.</p>	

	<p>However, the ACH is not currently envisioned as a risk bearing entity.</p> <p>The key areas to be tested/developed include:</p> <ul style="list-style-type: none"> <li>• Investment in infrastructure to support ACH</li> <li>• Sustainability beyond initial cost savings in Medicaid; ideally become self-sustaining through the WA Prevention Framework</li> <li>• Governance – balancing the need for broad-based engagement with effective management</li> <li>• Systematic connections between ACH and RSAs beyond shared data and partnerships</li> </ul>	
<p><b>5. Examples and Ideas for Integrating Population Health</b></p>	<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?</i></p> <p>Connection to existing VT policies and new models being tested:</p> <ul style="list-style-type: none"> <li>• Medicaid: Global Commitment already allows use of Medicaid in ways that are currently restricted in WA</li> <li>• Regionalization to further align care management among private and public payers: ACOs and Blueprint practices are seeking a regional approach to engaging stakeholders, sharing data and quality metrics, etc.</li> </ul> <p>Questions for VT to consider:</p> <ul style="list-style-type: none"> <li>• What aspects should be at statewide vs at the regional level? The scale of a WA state region may be the similar to the full state of VT. Do we have an advantage due to scale?</li> <li>• How to set priorities for the use of the savings at a regional level?</li> </ul>	
<p><b>6. Public Comment and Next Steps</b></p>	<p><b>Next Steps</b></p> <ul style="list-style-type: none"> <li>• Identify entry points with other work groups to share population health frameworks</li> <li>• Review PHWG overview and updated work plan</li> <li>• Schedule meeting with PHWG and Prevention Institute</li> </ul> <p><b>Next Meeting:</b> The next meeting will be Tuesday, <b>December 9th</b> 2:30 – 4:00 pm. ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier.</p>	

# VHCIP PH Work Group Member List

Roll Call:

*10 Penrose  
20 Mark G.  
minutes*

Member		Member Alternate				
First Name	Last Name	First Name	Last Name			Organization
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
<del>Teresa</del> Teresa	<del>Joci</del> Joci	<del>Wm</del> Catherine	Hamilton	n/a		Blue Cross Blue Shield of Vermont
Tracy	Dolan	✓	Heidi	✓		AHS - VDH
Joyce	Gallimore					CHAC
Karen	Hein	✓		✓		
Penrose	Jackson	✓		✓		FAHC - Community Care
Pat	Jones					GMCB
Frances	Keeler					AHS - DAIL
Lyne	Limoges					Orleans/Essex VNA and Hospice, Inc.
Ted	Mable	✓		✓		Northwest Counseling and Support Services
Melissa	Miles	Patricia	Launer			Bi-State Primary Care
Nick	Nichols	✓		✓		AHS - DMH
Laural	Ruggles					Northeastern Vermont Regional Hospital
Jenney	Samuelson	✓	Daljit	✓		AHS - DVHA
Julia	Shaw	✓		✓		VLA/Health Care Advocate Project
Melanie	Sheehan					Mt. Ascutney Hospital and Health Center
Miriam	Sheehey	✓	Abe	✓		OneCare Vermont
Shawn	Skaflestad	✓		✓		AHS - Central Office
Chris	Smith					MVP Health Care
JoEllen	Tarallo-Falk	✓	Lori	✓		Center for Health and Learning
Stephanie	Winters					Vermont Medical Society



Attachment 4 - Community  
Oriented Health Systems  
Transition to Green Mountain  
Care

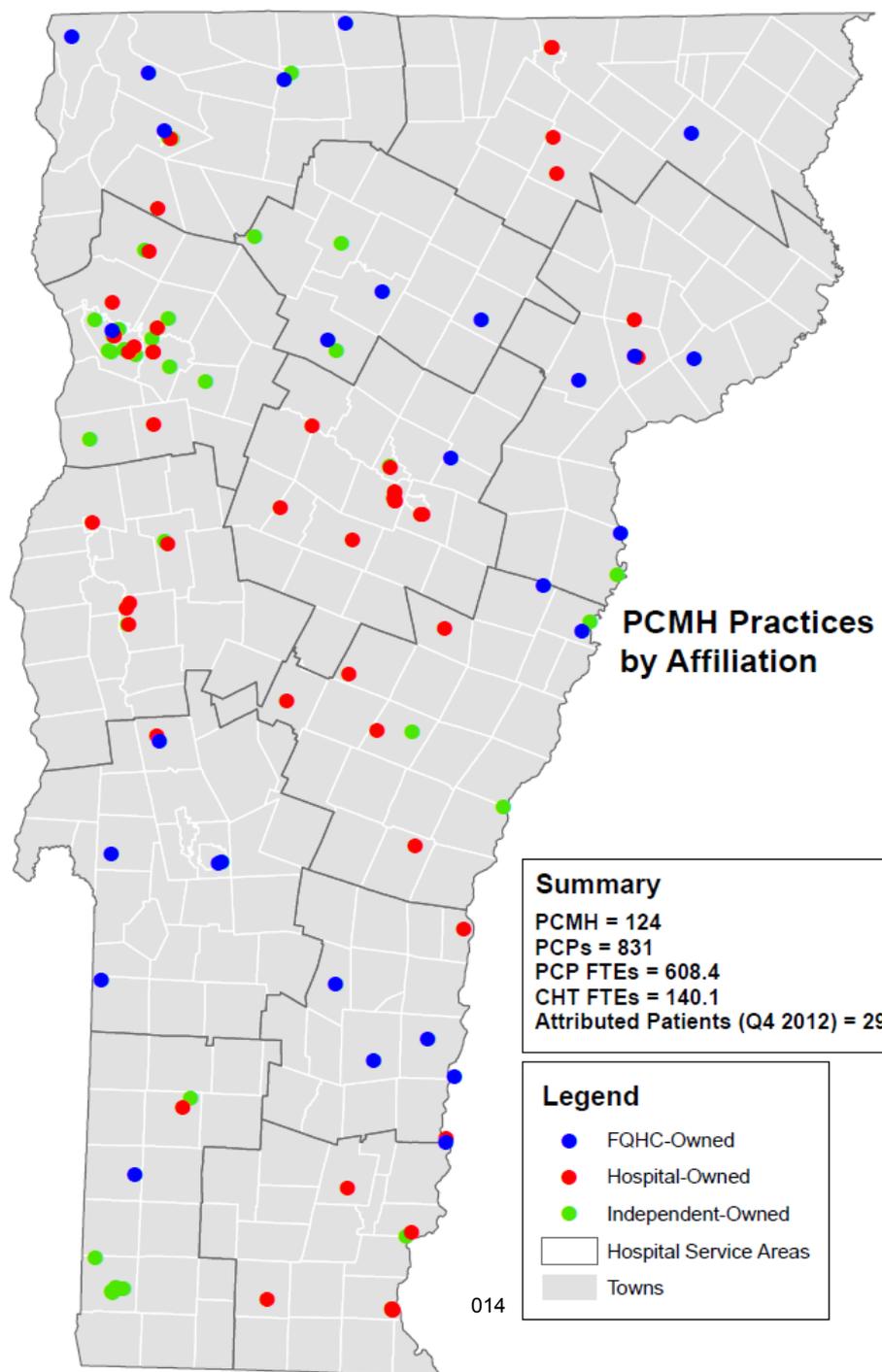
# **Community Oriented Health Systems** *Transition to Green Mountain Care*

## **VHCIP Population Health Work Group Meeting**

### **December 9, 2014**

## Current State of Play

- Statewide foundation of primary care based on NCQA standards
- Statewide infrastructure of team services & evolving community networks
- Statewide infrastructure (transformation, self-management, quality)
- Statewide comparative evaluation & reporting (profiles, trends, variation)
- Three relatively new provider networks (OneCare, CHAC, HealthFirst)
- Opportunity to unify work, strengthen community health system structure



Barre HSA

Full Network

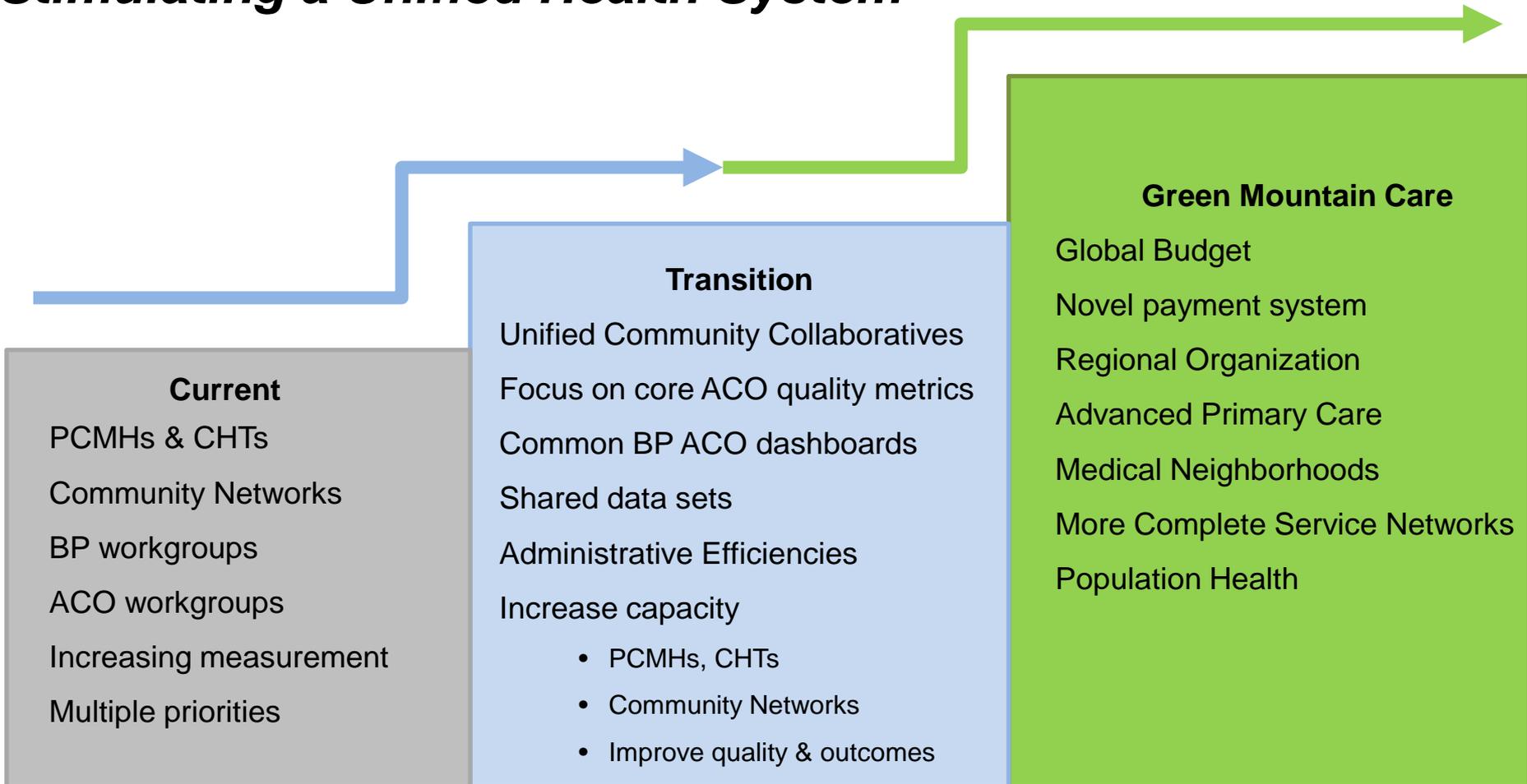
Node color indicates sub-network membership

Node size indicates Betweenness Centrality



# Transition to Green Mountain Care

## *Stimulating a Unified Health System*



# Strategy for the Transition to Green Mountain Care

## Guiding Principles

- Whole population health & prevention
- Community oriented health system
- Primary care has a central coordinating role
- Integration of medical and social services
- Alignment across ACOs and community providers (interests, activity)
- Support interests of individual ACOs
- Capitated payment that drives desired outcomes

# Strategy for the Transition to Green Mountain Care

## Action Steps

- Unified Community Health System Collaboratives
- Unified Performance Reporting & Data Utility
- Administrative simplification and efficiencies
- Implement new service models (e.g. ACE, ECHO)
- Payment Modifications

## Unified Community Collaborative (UCC)

### Structure & Activity

- Leadership Team (~ 7 member team)
  - 1 local clinical lead from each ACO (2 to 3)
  - 1 local representative from VNA, DA, SASH, AAA, Peds
- Convening and support from local BP project manager/admin entity
- Develop charter, invite participants, set local priorities & agenda

## Unified Community Collaborative (UCC)

### Structure & Activity

- Final recommendations rest with leadership team
- Driven by consensus of leadership team and/or vote process as needed
- Solicit structured input of larger group (stakeholders, consumers)
- Larger group meets regularly (e.g. quarterly)
- Convene workgroups to drive planning & implementation
- Workgroups form and meet as needed (e.g. bi-weekly, monthly)

## Unified Community Collaborative (UCC)

### Structure & Activity

- Use measure results and comparative data to guide planning
- Adopt strategies and plans to meet overall goals & local priorities
- Planning & coordination for service models and quality initiatives
  - guide activities for CHT staff and PCMHs
  - guide coordination of services across settings
  - guide strategies to improve priority measures

## Performance Reporting & Data Utility

### Reporting & Comparative Performance

- Profiles for each medical home practice
- Profiles for each Health Service Area
- Whole population results & breakouts (MCAID, MCARE, Commercial)
- Measures - Expenditures, utilization, quality (core ACO for HSAs)
- Improving with input from provider networks

# Payment Modifications

## Need for Modifications

- Current payments have stimulated substantial transformation
- Improved healthcare patterns, linkage to services, local networks
- Reduced expenditures offset investments in PCMHs and CHTs
- Modifications are needed to stimulate continued improvement
- Proposed modifications will support UCCs & quality improvement

# Payment Modifications

## Options

- Adjust insurer portion of CHT costs to reflect market share
- Increase CHT payments
- Increase PCMH payments
- Transition current PCMH payment (composite measures based)
- Plan & test new models (fully capitated + measures based component)

# Attachment 5 - Population Health in VHCIP

# 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>.

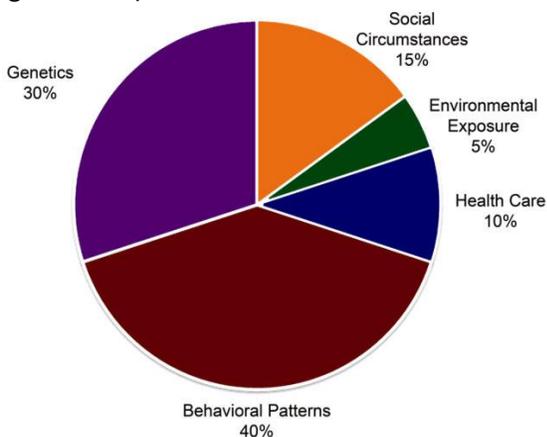
To accomplish the charge of integration of population health and primary prevention within the models being tested in Vermont, the PHWG is committed to several key tasks:

- 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

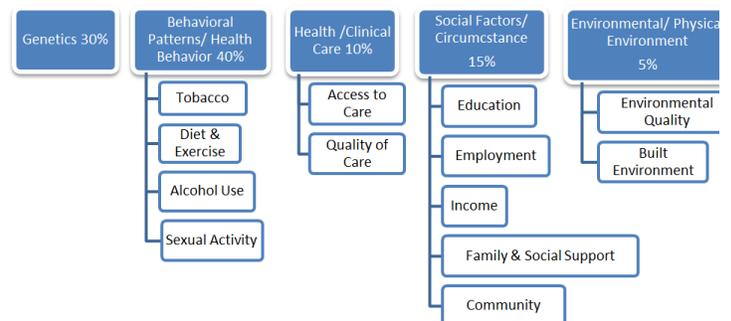
To meet the Triple Aim of moderating cost, improving quality and improving health, increasing access to health care will be insufficient. Access to health care and the quality of medical care account for 10% proportionately to the factors that contribute to premature death (see Figure 1). Therefore, 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>

<sup>1</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>

# Population Health Integration in the Vermont Health Care Innovation Project

## Signs of Successful Integration of Population Health in New Models

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

- 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>i</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>ii</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>iii</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> 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>ii</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>iii</sup> (<http://www.cdc.gov/socialdeterminants/>).