

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

Date: Tuesday, February 11, 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: 9883496

**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, introduction, agenda review</b> <ul style="list-style-type: none"> <li>• Provide a framework for understanding the continuum of measures from the clinical to the non-health social determinant of health</li> <li>• Discuss potential uses of measures in the VHCIP project</li> <li>• Begin to explore intersection between measures and financing mechanisms</li> </ul>	Tracy Dolan Karen Hein	<b>Attachment 1:</b> Agenda	
2	2:40	Approval of minutes	Tracy Dolan Karen Hein	<b>Attachment 2:</b> Minutes	
3	2:45	<b>A Framework for Population Health Measures</b> <ul style="list-style-type: none"> <li>• Presentation— Diabetes: Our Case Example (10 min.)</li> <li>• Discussion – Options for Using Population Health /Multiple-Determinants Data               <ol style="list-style-type: none"> <li>1. <i>What are some of the ways that you use measures in your work?</i></li> <li>2. <i>What are some of the ways population health measures could be used in the context of this project?</i></li> </ol> </li> </ul>	Heidi Klein	<b>Attachment 3a:</b> Diabetes measures – ACO to determinants of health  <b>Attachment 3b:</b> VT Prevention Model and Frieden's Pyramid	
4	3:20	<b>Framework for an integrated Community Health System:</b> Presentation on idea of integrator, “balanced portfolio” and capturing savings (10)	Jim Hester	<b>Attachment 4a:</b> How Do We Pay For A Healthy Population  <b>Attachment 4b:</b> Developing Policy Frameworks for Integrated Health Delivery Systems: A Practical Guide for States	

5	3:45	<b>Contractual Support for Population Health Work Group</b>	Karen Hein	<b>Attachment 5:</b> Contract for Population Health Technical Services provided by Jim Hester	
6	3:50	<b>Public Comment and Next Steps</b>  <i>What information do work group members need in order to continue our work together?</i>	Tracy Dolan		

**OPEN ACTION ITEM LOG**

<b>Date Added</b>	<b>Action Number</b>	<b>Assigned to:</b>	<b>Action /Status</b>	<b>Due Date</b>	<b>Date Closed</b>
			<ul style="list-style-type: none"><li>• .</li></ul>		
			<ul style="list-style-type: none"><li>•</li></ul>		
			<ul style="list-style-type: none"><li>•</li></ul>		
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## ***VT Health Care Innovation Project Population Health Meeting Minutes***

**Date of meeting: Jan 14, 2014 2:30pm to 4pm: Location: ACCD Calvin Coolidge Conf Rm 6<sup>th</sup> Fl; 1 National Life Drive, Montpelier; Call in 877-273-4202 Passcode 9883496**

**Attendees: Karen Hein and Tracy Dolan, Co-Chairs; Anya Rader Wallack, SIM Core Team Chair; Jill Berry-Bowen, NW Medical Center; Mark Burke, Brattleboro Memorial; Donna Burkett, Planned Parenthood of Northern NE; Mark Levine, Wendy Davis, and Judy Cohen, UVM; Ted Mable and Kim McLellan, NW Counseling and Support; Melissa Miles, Bi-State; Chuck Myers, Northeast Family Institute; Laural Ruggles, NE VT Regional Hospital; Stephanie Winters, VT Medical Society; Deborah Shannon, Good Neighbor Health; Melanie Sheehan, MAHHC; Catherine Hamilton, Blue Cross of VT; Marlys Waller, VT Council; Kim McLellan, NW Counseling and Support Services; Julia Shaw, VT Legal Aid; Melanie Sheehan; Dennis Childs; Chuck Meyers; Jim Hester; Vicki Sayarth; Abe Berman, One Care; Mary Lou Bolt, RRMCC; ; Nick Nichols, DMH; Jenney Samuelson, Heidi Klein, Mary Woodruff, and Daljit Clark, AHS; Pat Jones and Annie Paumgarten, GMCB; Nelson LaMothe and George Sales, Project Management Team.**

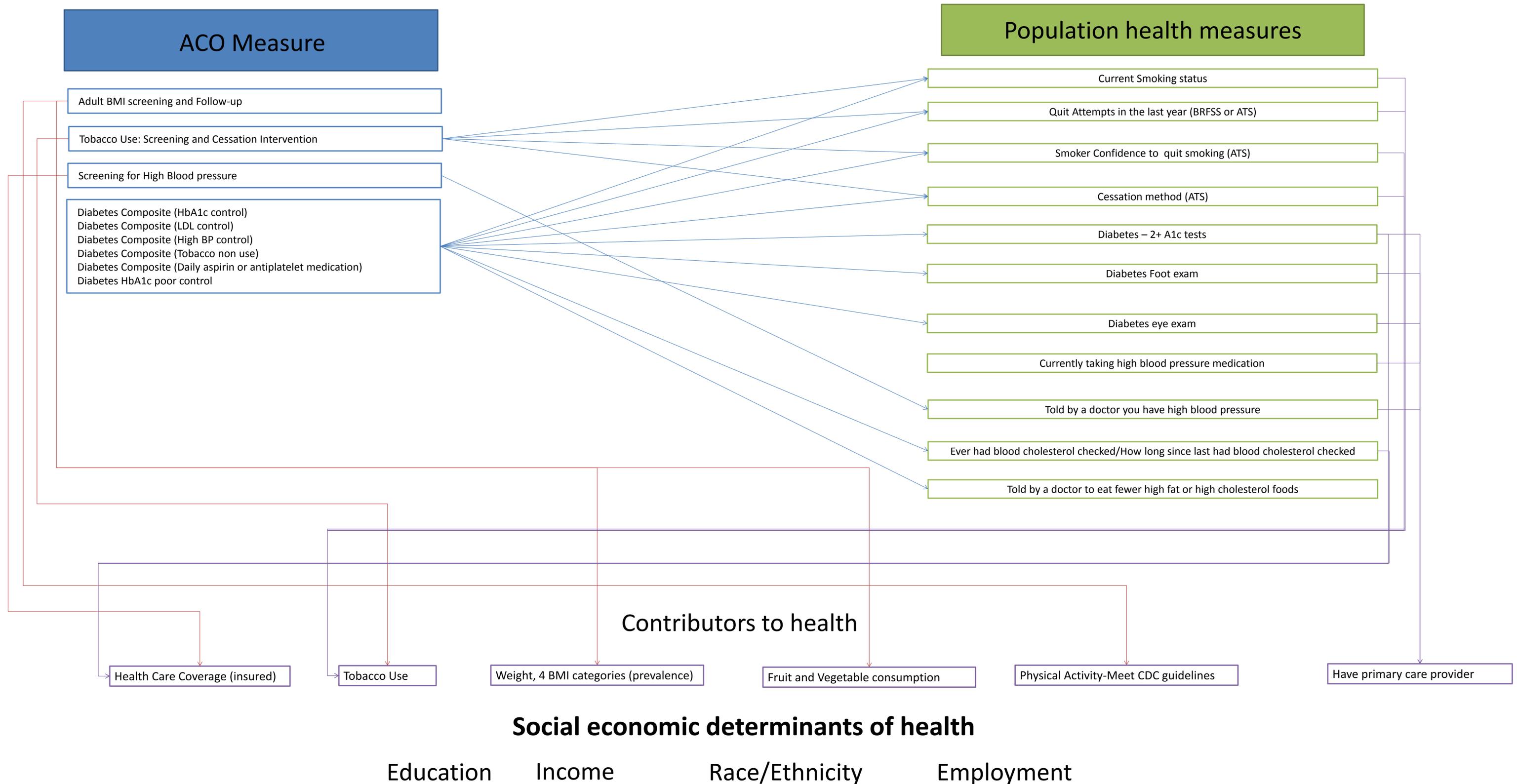
<b>Agenda Item</b>	<b>Discussion</b>	<b>Next Steps</b>
<b>1 Welcome &amp; Introductions</b>	Meeting brought to order by Karen Hein at 2:31pm:	
<b>2 Business: approval of minutes; members vs. interested parties; Conflict of interest policy</b>	Jill Bowen moved to approve Dec 10, 214 Minutes; Laural Ruggles 2 <sup>nd</sup> ; Motion passed; none opposed, no Abstentions.  Karen Hein reminded participants to read and sign the COI acknowledgement, and return today to the Project Management Team. Please identify on the Acknowledgement whether you are a Member or Interested Party.	
<b>3 Agenda Review and Meeting Goals</b>	Tracy Dolan recapped today's agenda. We will explore how we pay for Population Health, the measures of performance, and how Population Health will integrate with "medical health".	
<b>4 CMS/CDC Population Health Measures</b>	Tracy and Heidi Klein discussed the measures selected based on 3 criteria: high population burden and high societal cost; health issues amenable to intervention w/in 3-5 years; and, the data for these measures must be available for major segments of the population. Most of the selected	

Agenda Item	Discussion	Next Steps
	measures are already reported on BRFSS.	
<b>5 ACO Measures Presentation</b>	<p>Pat Jones presented on ACO Measures:</p> <ul style="list-style-type: none"> <li>• What is ACO – composed of providers who have agreed to be accountable for cost and quality of care for a defined population (excluding Dual eligible), and work together to coordinate care for patients.</li> <li>• The Shared savings Program (SSP) comprise payment reform initiatives developed by health care payers.</li> <li>• The three ACO’s : <ul style="list-style-type: none"> <li>○ Accountable Care Coalition of Green Mountains (ACCGM) is Commercial payer centric;</li> <li>○ One Care Vermont is Commercial and Medicaid payer centric;</li> <li>○ Community Health Accountable Care (CHAC) is also Commercial and Medicaid payer centric</li> </ul> </li> <li>• Measures selected are very important because it is not just about reducing costs, but also improving the delivery of quality care.</li> <li>• The objectives of the measures are to evaluate performance of the ACO’s while also avoiding administratively burdensome data generation.</li> <li>• The former ACO Work Group’s process for selecting Measures included a review of more than 200 quality measures, which tried to cover all the domains. The Medical Society and 1 ACO’s suggested there were too many measures, and the ACO Work Group narrowed the field. In December 2013, a Core set of Measures and a Monitoring and Evaluation Measure Set were recommended and approved.</li> <li>• The Core Set: the 3 ACOs collect and report and contribute to the calculation of shared savings; Monitoring and Evaluation Measure Set.</li> <li>• Selected Performance Measures affect payment of savings to the 3 ACO’s use a gate and ladder approach. <ul style="list-style-type: none"> <li>○ If an ACO does not achieve at least 35% of the maximum available points across all payment measures, it is not eligible for any shared savings (“gate”).</li> <li>○ The commercial SSP ladder allows ACO’s to earn 75% of the potential savings for</li> </ul> </li> </ul>	

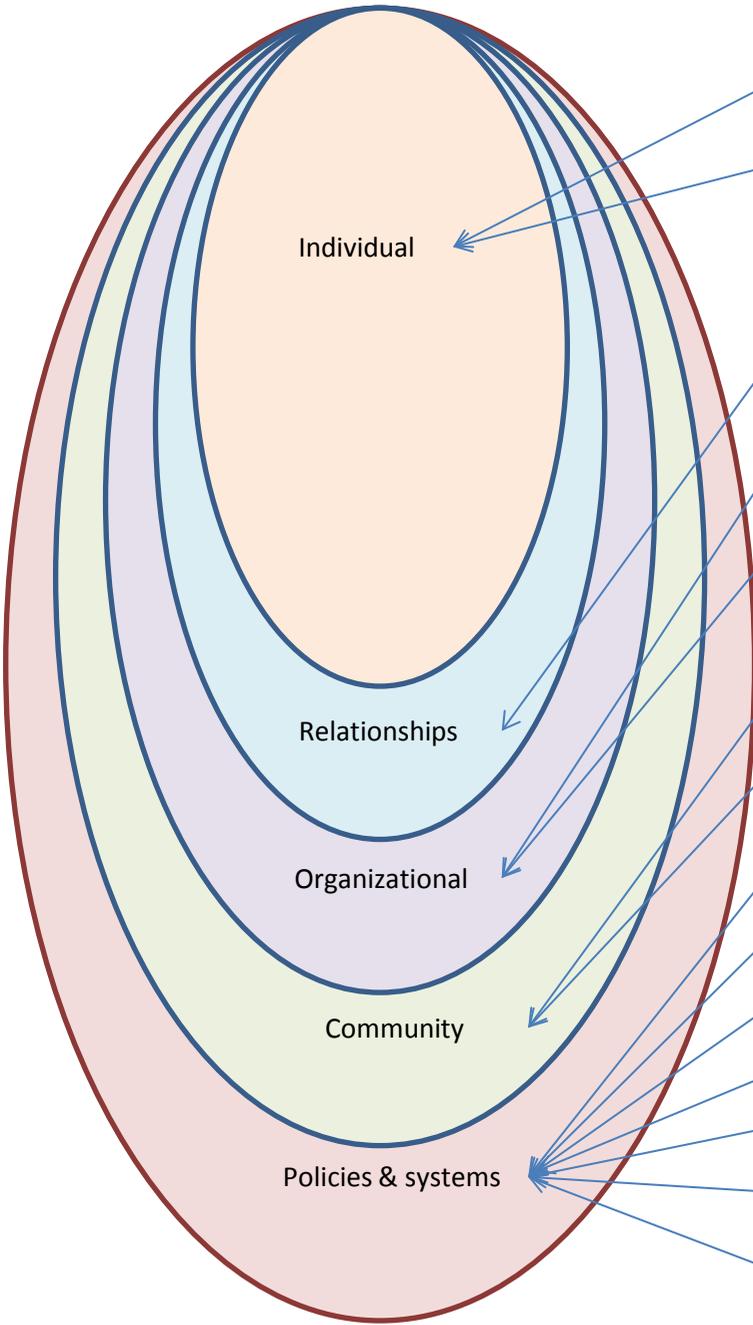
Agenda Item	Discussion	Next Steps
	<p>achieving 35% of the available points; 85% of potential savings for achieving 45% of available points; and 95% of potential saving for achieving 55% of available points.</p> <ul style="list-style-type: none"> <li>• Consideration given to adding Measures in Year #2 and #3 has been discussed with some stakeholders expressing concerns about the added administrative burden. A procedure to add measures requires approval by the Steering Committee and Core Team.</li> <li>• A question was raised about how to deal with measurement when the Medicaid population is constantly churning/changing. Pat Jones responded that Attribution to ACO's is calculated on a monthly basis to specifically adapt for the changing population.</li> <li>• Jill Berry Bowen asked how patients are incented to engage in "wellness" and expects that it should be quite interesting for providers.</li> <li>• Catherine Hamilton asked how the meaningfulness of measures will be communicated to consumers. Pat responded that the two proposed measures are: How's your health? and, Patient activation measure.</li> <li>• Tracy Dolan summarized the challenge as: using measure to determine where to invest, to obtain the best ROI; clearly improving Population Health offers a significant savings, adding that the GMCB is assembling a dashboard of social well-being of Vermonters.</li> <li>• Anya Rader Wallack added that a committee in Massachusetts focused on improving Population Health has endorsed John Watson's Population measure: "how much control do you have over your health" for survey.</li> </ul>	
<p><b>6 Discussion – Options for Using Population Health/Multiple Determinants Data</b></p>	<p>Karen Hein led off the discussion asking: How can we impact what happens outside the clinical setting?</p> <ul style="list-style-type: none"> <li>• Because it's what happens at home that is critically important to health outcomes = diet, exercise, tobacco, alcohol, etc. Identifying quality of life indicators for Vermonters is very important. The Population Health WG is the group to drive the determination of measures that have an impact.</li> <li>• Many population measures fall outside of the clinical setting and are often community oriented, e.g. availability of public transportation, bike-ability, walk-ability,</li> <li>• it would be very effective to use measures to drive local investment, create partnerships, informing public policy about the implicit ROI of community investments, and activate consumers to improve their health outside of the clinical setting.</li> </ul>	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> <li>• Responsibilities and burdens fall on many stakeholders if looking at contributors.</li> </ul> <p>Additional discussion included the following:</p> <ul style="list-style-type: none"> <li>• What are the best measures to track for improving health outcomes?</li> <li>• Really want to talk about the drivers of the outcomes (not proxies)</li> <li>• Quality of life – what are real QOL indicators; it is not satisfaction with care</li> <li>• Recent Health Affairs article on which measures actually have any impact will be shared with the group for discussion and to assist with setting criteria</li> <li>• Concerns expressed that CMS is looking at only 3-5 years out; this is a time limited grant but we can identify additional frameworks and policy making beyond grant to set a course for the future and inform policy.</li> <li>• Consider how the proposed measures will be used? Payment vs. accountability vs. process improvement vs. direct investment? Could we invest in community coalition work; Many prevention approaches are not clinical but affect health and we need to quantify in the community – and look at community interventions</li> <li>• Use community needs assessments to identify opportunities for investment <ul style="list-style-type: none"> <li>○ How to push money?</li> </ul> </li> <li>• Consider Community Care Model instead of ACO</li> </ul> <p>The Care Models Work Group is interested in hearing from Population Health on these topics.</p> <p>Summary statement: Need to focus on a dual track – 1) this 4 year opportunity to impact ACO and new models; and 2) broader agenda and framework for longer term impact on the drivers of health outcomes</p>	
<b>7 Next Steps, Wrap Up</b>	<p>Karen asked participants to please review the Grant Application included in meeting materials; funds are intended to support providers.</p> <p>Net meeting scheduled for: Tuesday Feb 11, 2014; <b>ACCD Calvin Coolidge Conf Rm 6<sup>th</sup> Fl; 1 National Life Drive, Montpelier.</b></p>	

# Diabetes Management



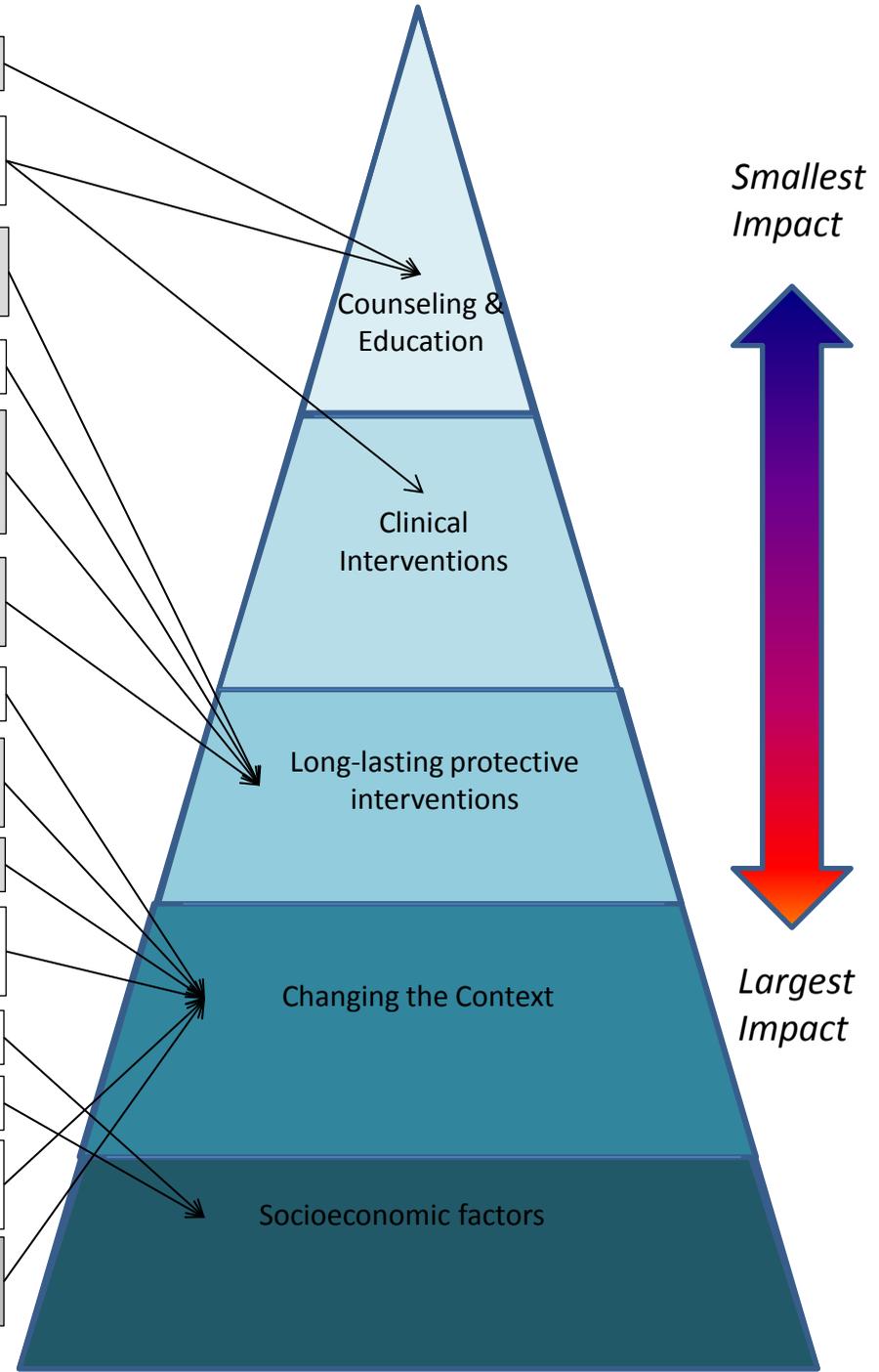
### Social Behavioral Model



### Factors related to Diabetes control

- Good nutrition and physical activity behaviors (BRFSS)
- Adherence to medical regimens, and general self-care regarding stress, self-monitoring blood glucose, keeping medical appointments, etc.
- Seeking/using informal support from family, peers, and social networks; opportunities to build self efficacy (BRFSS)
- Public places with standards affecting health and hygiene
- Using self-management support services, evidence-based community resources to gain knowledge, skills, and build self-efficacy (tobacco cessation, chronic disease mgmt seminars, etc.) (BRFSS/ATS)
- Using the built environment safe resources for physical activity and community resources to support self-management. (BRFSS)
- Access to affordable healthy food
- Understandable nutrition/menu labeling to make well informed decisions about food (BRFSS)
- Smoke-free housing and public places (ATS)
- Enforcement of traffic, zoning laws in order to maintain built environment
- Opportunities for employment and reliable transportation
- Regulations about eligibility impacting access to primary care
- Worksite regulations regarding sick time and break time to promote better overall health
- Health insurance coverage and regulation for affordable co-pays for medications and supplies (BRFSS)

### Freiden's Pyramid



# HOW CAN WE PAY FOR A HEALTHY POPULATION?

## Innovative New Ways to Redirect Funds to Community Prevention

THIS DOCUMENT WAS PREPARED BY PREVENTION INSTITUTE WITH PRIMARY FUNDING FROM THE KRESGE FOUNDATION AND ADDITIONAL SUPPORT FROM THE CALIFORNIA ENDOWMENT AND THE ROBERT WOOD JOHNSON FOUNDATION.

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Prevention Institute is a non-profit, national center dedicated to improving community health and wellbeing by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur. The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since its founding in 1997, the organization has focused on injury and violence prevention, traffic safety, health disparities, nutrition and physical activity, and youth development. This and other Prevention Institute documents are available at no cost on our website.

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# HOW CAN WE PAY FOR A HEALTHY POPULATION?

## Innovative New Ways to Redirect Funds to Community Prevention

### INTRODUCTION

The US health system, the most expensive in the world, has long been hampered by a fundamental paradox: resources are systematically allocated in ways that neither maximize health nor control costs. Seven of ten deaths among Americans are caused by often preventable conditions including heart disease, stroke, diabetes, injuries and some kinds of cancer.<sup>2,3</sup> These conditions account for roughly three-fourths of the national healthcare bill.<sup>4</sup> Yet one of the historic shortcomings of the U.S. healthcare system is that there are few incentives for insurers or providers to invest in prevention. In a fee-for-service model that pays doctors to treat sick patients, there's no financial inducement to try to keep people well and few sources of funds to pay for the things that would address the social and environmental conditions that shape people's health in the first place.

While the main goal of the Affordable Care Act (ACA) is to increase access to healthcare, it also recognizes that broad improvement in health outcomes requires shifting the focus of the US healthcare system from the delivery of services to individuals toward prevention-oriented strategies that can improve the health of populations. With encouragement and funding from the ACA and foundations, community health planners, advocates and health-systems executives are now engaged in innovating and developing new concepts and models of healthcare delivery that can improve outcomes and reduce costs.

As new ideas for health reform emerge, a growing literature is examining new ways to broaden health care delivery to incorporate expanded use of clinical preventive services and prevention education efforts aimed at improving the health of large numbers of people, not just individuals. What's missing from most of these "pay for population health" approaches is a clear focus on community prevention—efforts aimed at improving the social, physical, and economic environments of communities and reducing health inequities. This reflects a potentially important missed opportunity

to better align clinical and non-clinical activity, to provide clinicians and clinical institutions support in addressing chronic illness, and to apply the most effective strategies for improving health, safety, and equity.<sup>5,6</sup>

A case in point: When staff at Asian Health Services in Oakland became aware of high rates of automobile injury and fatality among pedestrians in the Chinatown neighborhood, they realized that the only way to reduce the number of injuries to community members was to engage with community leaders, local officials and city planners to instigate changes in the physical environment. At the urging of the community, the city modified the timing of traffic lights, improved signage, and created "scramble" intersections that allow pedestrians to cross an intersection in every direction, including diagonally. Here's the catch: although the

#### THE COMMUNITY-CENTERED HEALTH HOME

Better integration of clinical service and community prevention is increasingly being seen as an integral component of a reformed and efficient health system. In 2011, Prevention Institute described a comprehensive approach for health institutions to systematically engage in community prevention in our report *Community-Centered Health Homes*.<sup>1</sup> The report lays out a three step process of *Inquiry, Analysis, and Action* to identify the social and environmental conditions causing the greatest impact on health outcomes in communities, develop strategies to address those conditions, and then implement those strategies to ultimately improve health outcomes at a population level. Identifying and elevating promising approaches for leveraging health care funds to pay for community prevention is a key step in creating a health system that encourages community-centered health activities.

agency's staff was able to document reduced rates of injury and fatality, there was no way to use healthcare dollars to fund the traffic-safety work and no way to capture the savings to invest in further prevention.

In this brief, we lay out four promising approaches for sustainably generating resources to pay for community prevention within and outside the health care system. The approaches profiled below are not intended to be a comprehensive overview of all potential pay-for-population health initiatives that could support community prevention. Rather they represent those that stood out based on a broad scan of the academic and grey literature and popular media, as well as discussions with key informants in the field. Our intent is not to recommend any specific approach but rather to catalyze further discussion and analysis. Each of the four approaches profiled here has the potential to sustainably generate funding for community prevention and is either being put into practice or is in the process of being piloted by health systems and/or local and state governments.

## Wellness Trusts

A Wellness Trust, at its most basic level, is a funding pool raised and set aside specifically to support prevention and wellness interventions to improve health outcomes of targeted populations. While funds to support the Trust can come from many sources, one key option is to levy a small tax on insurers and hospitals. This can help address a key obstacle: the reluctance of any one insurer to invest in a strategy that might improve the health of the entire population, thereby dispersing the potential financial benefit beyond the pool of its insured members (who may also switch coverage before benefits are realized). Requiring all insurers to pay into the Trust may address this reluctance. Public policy advocates including the Brookings Institution have called for the establishment of wellness trusts.<sup>7</sup>

The Massachusetts Legislature recently passed a health-cost control bill that creates a \$60-million Prevention and Wellness Trust to support prevention efforts over the next four years<sup>8</sup> –the first state-based prevention fund in the nation. The money for the Trust will be raised by a tax on insurers and an assessment on larger hospitals. Beginning in the summer of 2013, the Massachusetts Department of Public Health will distribute the funds, in consultation with a new Wellness and Prevention Advisory Board, to local communities, regional planning agencies and healthcare providers. These groups would use grants from the Trust to carry out community-based prevention initiatives that reduce rates of costly preventable health conditions, lessen health disparities, and increase healthy behaviors.<sup>9</sup> All grant recipients must partner with a local health department. Ten percent of the money will also be

used to provide tax credits to employers that set up workplace wellness programs. The bill also requires health insurers to provide premium discounts to small businesses that launch workplace wellness programs.

A 20-member commission will be established to evaluate the effectiveness of the prevention initiatives started through the Prevention and Wellness Trust and to measure the impact on healthcare costs. An outside organization will be hired to conduct the evaluation and results must be posted on the state's website by June 30, 2015. The bill was introduced and moved through the state legislature by a broad-based coalition of organizations, led by the Massachusetts Public Health Association.

While taxing insurers guarantees a sustainable source of revenue, other options exist for establishing wellness trusts, including pooling private foundation resources or redirecting existing government funding. For instance, the North Carolina Health and Wellness Trust Fund was created with funding received by the state through the Tobacco Master Settlement Agreement.<sup>10</sup>

## Social Impact Bonds/Health Impact Bonds

Health impact bonds (HIBs) provide a market-based approach to pay for “evidence-based interventions that reduce health care costs by improving social, environmental and economic conditions essential to health.”<sup>11</sup> The basic idea involves raising capital from private investors to invest in prevention

interventions, capturing the healthcare cost-savings that result from the interventions, and then returning a portion of those savings to the investors as profit. It is based on the broader concepts of social impact investing and social impact bonds that have garnered significant attention in the academic and popular press lately.<sup>12,13</sup> For example, a social impact bond now being tested in the United Kingdom has raised \$8 million to invest in measures that would reduce the recidivism of 3,000 prisoners in Petersborough Prison.<sup>14</sup> The goal is a 7.5 percent reduction in six years. If successful, the UK government will save a substantial amount of money and return some to investors, beginning in 2013. New York City is also initiating a social impact bond to reduce recidivism among juveniles in the justice system.

Health impact bonds provide a financial instrument for making investments to improve health outcomes within a community. In a recent brief, the initiator of the first health impact bond to be tested in the US identified five components needed to create a successful investment opportunity:

- “Target outcomes must be clearly defined and achievable;
- The proposed intervention should reflect best practices;
- Measuring outcomes must be independently validated;
- A clearly defined “savings” or return value should be established; and
- Public agencies, nonprofits, investors and community stakeholders must all be willing to work together.”<sup>15</sup>

An investment firm may assist community stakeholders by issuing the health impact bonds and offering to investors and social entrepreneurs. With capital raised from the bond sales, the community stakeholders would implement the prevention intervention. If the intervention generates savings, a portion of those savings would be returned to investors and any additional savings could be used to identify or seed new prevention-oriented investment opportunities.

The first-ever health impact bond is now being set up in Fresno, California, with the aim of reducing

the incidence and severity of asthma, a condition that disproportionately affects low-income people and communities of color due to poor environmental conditions in communities and homes. Fresno is the second-most impoverished and the second-most polluted city in the U.S.<sup>16,17</sup> Over 17 percent of Fresno residents have asthma, more than twice the national average.<sup>18</sup> Every day in Fresno, 20 asthma sufferers go to the emergency department and three are hospitalized.

Researchers at the University Of California Berkeley School of Public Health, working with a health impact investing firm called Collective Health, studied the potential for reducing healthcare costs by investing in home-based remediation of environmental conditions in the homes of Fresno residents with severe asthma who are frequent users of emergency and hospital treatment. They found that the intervention would generate net savings of over \$4.5 million and a return on investment of \$1.69 for every dollar spent on the intervention.<sup>19</sup>

Health impact bonds are also being envisioned to fund interventions that would reduce hospital admissions for acute conditions such as asthma, traffic injuries, or environmental poisonings, in which a reduction in health care costs and return on investment might be easily identified and attributed to the intervention. Such interventions aim to prevent or reduce the severity of conditions experienced by individuals—as with the Fresno effort to change conditions in people’s homes. A next step in developing this approach will be to find ways to use the bonds to fund community-based interventions intended to reduce illness and injury for populations. For example, could the Fresno effort also yield returns by funding broader community prevention strategies such as enforcement of housing codes related to asthma triggers, establishing smoke-free housing policies, or reducing local sources of pollution?<sup>20,21</sup> Health impact bonds might also be used to invest in community improvements with the potential to result in identifiable healthcare savings. Examples might include upgrading pedestrian and bicycle infrastructure to decrease traffic-related injuries and deaths and to prevent chronic conditions such as diabetes.<sup>22,23</sup>

## Community Benefits from Non-Profit Hospitals

The “community benefit” requirements imposed on nonprofit hospitals and health plans may represent a significant and sustainable source of funds for community-prevention initiatives. Legislation passed in 1994 requires these hospitals “to provide community benefits in the public interest” as a condition of their tax-exempt status. This is a substantial resource estimated at around \$13 billion annually nationwide.<sup>24</sup> The bulk of community benefit funds have historically gone to cover the costs of charity care given to people who are unable to pay for treatment. However, IRS has recently begun asking hospitals to track “Community Building” expenditures, defined as support for physical improvement and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy, and workforce development.<sup>25</sup> As of 2012, “community building” activities are now allowed to be counted as “community benefit” expenditures, opening up the potential for significant new investments in community prevention.<sup>26</sup>

As part of the move toward expanding “community building” activities with their community benefit dollars, new ACA regulations require each tax-exempt hospital to do a “Community Health Needs Assessment” every three years. This assessment must include input from the community served by the hospital and from those with expertise in public health. Hospitals must adopt an implementation strategy that addresses the community health needs identified by the assessment.<sup>27</sup> Also, most analysts believe the ACA will reduce the number of uninsured people and thus the burden of uncompensated treatment on hospitals, freeing up community benefit dollars formerly dedicated to “charity care” to be used for “community building” and community prevention initiatives.

Many hospital systems are already engaging in this type of activity. In 2008, Nationwide Children’s Hospital in downtown Columbus launched and invested community-benefit funds into

the Healthy Neighborhoods, Healthy Families (HNHF) collaboration, a partnership with the city and community-based organizations to address affordable housing, healthy food access, education, safe and accessible neighborhoods, and workforce and economic development.<sup>28</sup> Under the auspices of HNHF, the hospital invested over \$3 million in affordable housing and \$6 million in local women- and minority-owned business, while the city of Columbus invested \$15 million in pedestrian and bicycle infrastructure improvements on unsafe streets in downtown Columbus.<sup>29</sup>

### COMMUNITY PREVENTION REDUCES THE BURDEN ON THE HEALTH CARE SYSTEM

Community prevention interventions improve health and safety outcomes for all members of the population and as a result can reduce both long- and short-term demand for clinical services. For example, improving air quality in a neighborhood reduces the chance that those who are healthy will need medical care for conditions such as respiratory illnesses and COPD, helps those with conditions such as asthma manage their illness, and also has benefits in terms of encouraging physical activity and reducing climate impacts.

The Cincinnati Children’s Hospital Medical Center has used community-benefit dollars to fund a Community Health Initiative (CHI), which partners with community-based organizations to address asthma, accidental injuries, poor nutrition, and other preventable illnesses and injuries in their community.<sup>30</sup> CHI uses geographic information systems (GIS) technology to identify “hotspots,” or communities with the highest incidence of preventable health conditions, and to develop strategies to address those conditions. For instance, by mapping the homes of re-admitted asthma patients, they identified clusters of patients living in substandard housing units owned by the same landlord. CHI then partnered with a local legal aid association to help tenants compel the landlord to make necessary housing improvements.

## Accountable Care Organizations

In an effort to shift the focus from individual patient care to population health management, the Affordable Care Act promotes the establishment of accountable care organizations (ACOs). An ACO, at its most fundamental level, is a group of coordinated health care providers (i.e. a hospital and all of its affiliated primary care and specialist providers) that work in concert to coordinate a continuum of care for a designated population of patients. The ACO model seeks to improve health outcomes and reduce total costs of care for a specified population of patients by tying reimbursements to quality metrics that demonstrate improved outcome, rather than quantity metrics based on units of services provided.

If an ACO is able to achieve reductions in the total cost of care for a designated population of patients, a portion of those savings could potentially be set aside to invest in community-prevention initiatives aimed at improving community environments. These initiatives could further lower costs by reducing the need for health care services over time.

The potential of ACOs is being demonstrated by a collaborative of health providers, local government agencies, and community-based organizations in Akron, Ohio, led by the Austen BioInnovation Institute (ABIA), which is developing the nation's first "Accountable Care Community" (ACC).<sup>31</sup> According to ABIA, "An ACC encompasses not only medical care delivery systems, but the public health system, community stakeholders at the grassroots level, and community organizations whose work often encompasses the entire spectrum of the determinants of health."<sup>32</sup> The ACC reflects a broad vision of how an ACO can focus on health promotion and disease prevention as well as access to quality services.

The primary distinguishing factor between an ACO and an ACC is that while an ACO may only be responsible for the health outcomes of its own population of patients (i.e. members of a single insurance plan that covers only a small percentage of the residents within a community), an ACC is responsible for the health outcomes of the entire population of a defined geographic region or community, in this case Summit County, Ohio.

Participating health providers cover 85 percent of the county's half-million residents as well as a substantial population in surrounding counties that will also benefit from the ACC's activity. The Akron ACC integrates medical and public health models, making use of teams that include doctors, pharmacists, nurses, social workers, mental health professionals, and nutritionists. It is fostering collaboration between health providers, public health officials, other local government agencies, and community-based organizations and is developing new health information tools while also engaging in policy analysis and advocacy work needed to promote wellness.

*"An ACC encompasses not only medical care delivery systems, but the public health system, community stakeholders at the grassroots level, and community organizations whose work often encompasses the entire spectrum of the determinants of health."*

The ACC has already gained recognition for its work addressing community environments in Akron. One example: Members of the ACC identified an underserved Akron neighborhood that has no public transportation access to a national park located just outside the city, Cuyahoga Valley National Park, and the recreational and physical activity opportunities it provides. The ACC worked with the local public transit agency to establish a new bus line connecting the community to the park. The ACC is also partnering with the metropolitan housing authority and the city planning department to improve local housing and pedestrian and bicyclist infrastructure. In addition, it has established partnerships with local employers of all sizes to set up worksite wellness initiatives.

While the initial development phase of the Akron ACC is being funded through grants, including a Community Transformation Grant from the Center for Disease Control and Prevention (CDC), and community benefit funds from local hospital systems, leaders of the Akron effort believe they have developed a model that will be financially

self-sustaining in the long term. They project that health care costs will be lowered by 10 percent as a result of the new programs and interventions. These savings will be captured through cost-avoidance and cost-recovery financial models, which quantify the dollars saved through reductions in health care utilization by Summit County residents, and will be shared with the ACC by participating health systems, providers, and payers through negotiated agreements with each entity. The portion of the savings that gets returned to the ACC is projected to cover all of the collaborative's operating costs and provide additional funds for future investment in the community. The Innovation Institute has developed "impact equations" that will demonstrate the overall costs and benefits of the ACC implementation and calculate the savings achieved. This work should enable the model to be replicated elsewhere if it succeeds.

## The Potential for Replicating and Scaling Up Promising Approaches

Because each of the efforts described here is in the early stages of testing and implementation, it will be important to monitor their progress and viability to determine whether they are useful models for funding community prevention work elsewhere. The Massachusetts Wellness Trust, the Ohio hospital community benefit efforts, the Fresno Health Impact Bond, and the Akron Accountable Care Community

*Mounting evidence indicates that interventions and policy changes that promote community prevention constitute the most cost-effective strategies for improving health outcomes at a population level.*

all include robust evaluation components that will measure the effectiveness and success of each. These approaches for generating consistent, sustainable sources of revenue for community prevention should help inform the broader debate of how best to allocate healthcare resources to achieve the best possible outcomes for the least possible cost. To save money and lives, it is essential not only to develop dedicated streams of funding that can pay

for prevention but also to consider how existing funding streams are utilized to maximize health, safety, and equity. For example, California recently adopted a Health in All Policies approach, directing 19 government agencies to work collaboratively to advance health and equity goals in all decision-making and funding.

With the implementation of the Affordable Care Act, the expansion of insurance coverage, and the mandate to control health care costs, it is vital to ask big questions about the types of activities and efforts that should be incentivized in the US health system. Mounting evidence indicates that interventions and policy changes that promote community prevention constitute the most cost-effective strategies for improving health outcomes at a population level.<sup>33,34</sup> This brief is intended to spark interest and advance research in a new wave of groundbreaking approaches that are aimed at improving health outcomes and controlling healthcare costs. We hope the pioneering efforts described here will catalyze more innovation and become beacons that others can develop and refine.

## Acknowledgements

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## *Developing Policy Frameworks for Integrated Health Delivery Systems: A Practical Guide for States*

By Maia Crawford, Tricia McGinnis, Deborah Brown, and Stephen A. Somers

### **Introduction**

The federal government's State Innovation Models (SIM) initiative has re-ignited interest in broad care delivery and payment reforms that seek to improve clinical care and address the social determinants of health through an integrated approach. Grounded in the recognition that health is determined by a variety of interrelated factors, states are looking to connect services from different sectors in a coordinated manner to help providers and communities achieve the Triple Aim of better health, improved care, and reduced cost of care.

#### **Key Takeaways**

- There is increasing acknowledgement that non-clinical factors like social and physical environments impact health, and care delivery reforms should address these determinants to improve health outcomes
- A unique window of opportunity is open for states to integrate public health, social services, and care delivery
- Three core components of an integrated service program are: an integrator agent, aligned payment and financing, and quality measurement and data sharing capacity
- A phased approach to service integration—in which states develop, pilot and scale new initiatives over time—may be the key to successful program development

The medically-oriented health care system and overburdened managers of publicly financed care programs may question the feasibility of seeking to change how the U.S. conducts its “health care business.” Nevertheless, there is now a window of opportunity, and a potential business case, for coordinating the delivery of public health, social services, and clinical care.

States are seeking innovative solutions to improve quality and rein in costs, particularly for high cost “super utilizers” and patients with behavior-related chronic conditions like diabetes and obesity. To succeed at providing high-quality, cost-effective care for these populations, providers must be able to easily link patients to health-relevant services. States

can play an important role in supporting on-the-ground integration by leveraging funding and policies to promote more effective linkages between service sectors.

The Commonwealth Fund asked the Center for Health Care Strategies (CHCS) to develop a practical policy approach that states can use to move beyond one-off integration efforts and create a health system that continuously incentivizes and fosters integration across a continuum of services and populations. This brief presents a framework to guide state policy decisions in developing a realistic strategy to support community- and provider-level integration. The framework will help states develop a practical short- and long-term implementation plan that incorporates the infrastructure requirements, incentives, and decision-making authority needed to support integrated systems. This paper reflects insights gleaned from state officials and health policy experts through interviews and group discussions (See Exhibit 1 on page 2).

### **Background and Current Context**

The vision for an integrated approach to address the factors that drive health has emerged over several years. David Kindig published *Purchasing Population Health* more than 15 years ago, articulating the need to tie health funding to its impact on health outcomes. More recently, he

has argued for creating a ‘pay-for-population health performance system’ that “goes beyond medical care to include financial incentives for the equally essential nonmedical care determinants of population health.”<sup>1</sup> Such a health system encompasses the following premises:

- 1) Social factors are important determinants of health, so focusing exclusively on health care interventions is not enough to ensure health;
- 2) Planning, financing, and delivery of social, public health, and health care services currently occur in silos, with the vast majority of expenditures going toward medical care; and
- 3) An approach is needed at the state, community, and care delivery levels to coordinate services and promote seamless integration for the population.

The underlying goal is to bolster the effectiveness of patient-centered care delivery by simultaneously addressing the many underlying factors that influence health, including: social supports; housing; economic opportunities; education; public health services; and the environment. Neal Halfon has labeled this future state “Health System 3.0” – as compared to Health System 1.0 that focuses on treating acute care and infectious disease and Health System 2.0, focused on treating chronic conditions and prolonging disability-free life.<sup>2</sup>

The current policy environment appears more favorable to service integration for a number of reasons. First, policymakers are demonstrating newfound interest in strategies that promote the Triple Aim and address the social determinants of health. Payment reform efforts like accountable care organizations (ACOs) and shared savings programs are emerging and advancing financial incentive schemes that can align well with integration efforts. Second, millions of low-income individuals – many with chronic physical, behavioral, and social challenges – will gain health coverage under the ACA’s Medicaid expansion and are primed to benefit from an integrated, coordinated, and prevention-focused health system. Finally, the provider community is supportive of such approaches: the majority of primary care providers believe that unmet social needs directly lead to worse health for their patients, but feel that they do not have sufficient time or staff support to address those needs.<sup>3</sup>

#### EXHIBIT 1: Individuals Interviewed for Discussion Paper

- John Auerbach, Northeastern University
- Tammy Vehige Calise and Amanda Ryder, John Snow, Inc.
- Jeremy Cantor and Sana Chehimi, Prevention Institute (CA)
- Susan Castellano and Glenace Edwall, Minnesota Department of Human Services
- Debbie Chang, Nemours
- Jennifer DeCubellis, Hennepin Health
- Carrie Fitzgerald, First Focus
- Tracy Garland, National Interprofessional Initiative on Oral Health
- Karen Hein, Green Mountain Care Board, State of Vermont
- Jim Hester, State of Vermont
- Rhonda Hill, Arkansas Center for Health Improvement
- David Kindig, University of Wisconsin
- Thomas Land, Massachusetts Department of Public Health
- Laura Landy, Fannie E. Rippel Foundation
- Carol Lewis, Carolina Advanced Health
- MaryAnne Lindeblad, Washington State Health Care Authority
- David Mancuso, Washington State Department of Social and Health Services
- Karen Matsuoka, Maryland Department of Health and Mental Hygiene
- Sharon Moffat and Monica Valdes Lupi, Association of State and Territorial Health Officials
- Judy Monroe and Paula Staley, CDC
- Bill Roper, UNC Health Care System at the University of North Carolina, Chapel Hill
- Stephen Shortell, UC Berkeley School of Public Health
- Winston Wong, Kaiser Permanente

<sup>1</sup> D. Kindig. “A Pay-for-Population Health Performance System.” *The Journal of the American Medical Association* 296.21 (2006): 2611-2613.

<sup>2</sup> N. Halfon. “Transforming the Child Health System: Moving from Child Health 2.0 to 3.0.” Aspen Institute’s Children’s Forum presentation, July 23, 2012. Available at: <http://www.aspeninstitute.org/sites/default/files/content/docs/psi/TransformingtheChildHealthSystem-HalfonNeal.pdf>

New coordination efforts can build on the many existing programs that successfully integrate clinical care with other types of services. These programs often seek to achieve one of three main goals: (1) reducing the incidence and severity of chronic health conditions; (2) advancing prevention and health promotion efforts; and/or (3) addressing the health-related needs of specific high-need populations. Examples of successful efforts include:

- **Hennepin Health:** This [integrated, patient-centered demonstration program](#) serves high-risk and high-need adults who are eligible for Medicaid in Hennepin County, Minnesota. It integrates health care, public health, community partners, behavioral health and social services to improve health outcomes and reduce costs. The program is financed by a prospective payment for all services provided under the Medicaid program, with blending of additional county-based social services funds into care plans for needy beneficiaries.<sup>4</sup>
- **Vermont's Support and Services at Home (SASH):** [SASH combines supportive housing with critical medical and nursing services](#) to help Medicare beneficiaries age in place. It offers an initial assessment by a health team, an individualized care plan, onsite nursing and care coordination, and supportive community activities. This Medicare-funded program has reduced hospital admissions and readmissions and improved beneficiaries' health outcomes.<sup>5</sup>
- **Maryland's Health Enterprise Zones (HEZs):** Within Maryland, five geographic areas with high rates of health disparities were competitively selected to become HEZs and receive funding to test innovative, multi-sector programs to reduce disparities, improve health care access and outcomes, and reduce costs (leading to an expected long-term return-on-investment). Examples of HEZ initiatives include establishing a "health care transportation route" to address barriers to accessing care in rural areas; forming a patient-centered medical home (PCMH) in a senior housing complex; and promoting the use of healthy food retailers and exercise facilities.<sup>6</sup>

## The Conceptual Framework

For the purposes of this project, CHCS is adopting the following definitions:

- **Public health** is defined, per the World Health Organization, as "all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole."<sup>7</sup>
- **Population health** is defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." These populations are often geographic regions, such as nations or communities, but they can also be other groups, such as employees, ethnic groups, and people with disabilities.<sup>8</sup>

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<sup>3</sup> Robert Wood Johnson Foundation. "Health Care's Blind Side: The Overlooked Connection between Social Needs and Health." (2011).

<sup>4</sup> For more information, visit: <http://www.hennepin.us/healthcare>

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<sup>6</sup> For more information, visit: <http://dhmh.maryland.gov/healthenterprisezones/SitePages/Home.aspx>

<sup>7</sup> World Health Organization. "Public Health." Available at: <http://www.who.int/trade/glossary/story076/en/>

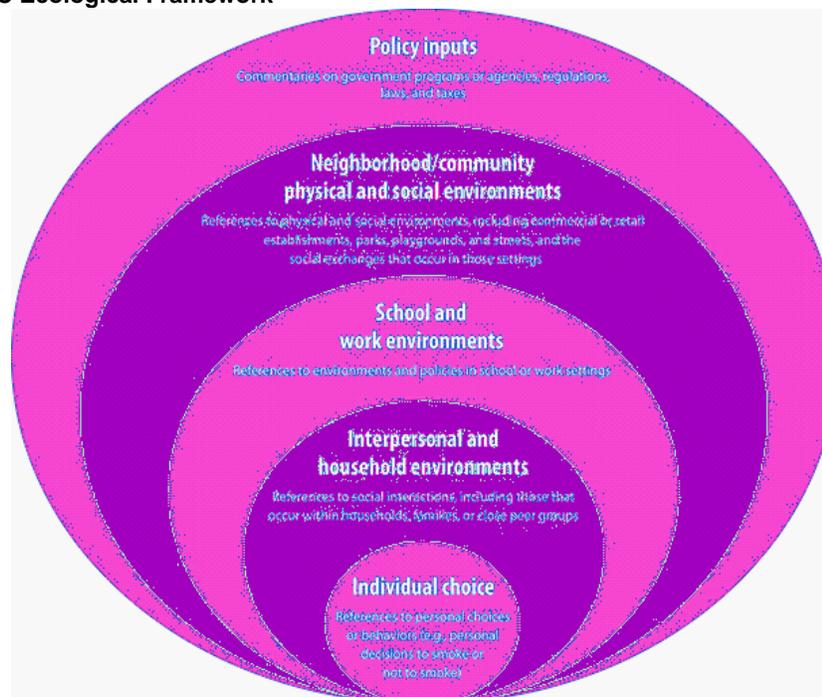
<sup>8</sup> D. Kindig and G. Stoddart. "What is population health?." *American Journal of Public Health* 93.3 (2003): 380-383.

- **Social services** are non-health programs or activities that address individual and community needs or provide socio-economic supports. Such programs include housing, education, childcare, jobs, transportation, and the environment.
- **Integration** is the linking, coordinating, or connecting of public health, social services, and health care programs and activities at state, local, and patient levels to achieve population health gains and cost reductions.

Current policy frameworks tend to take an “either/or” approach when defining a delivery model’s focus, treating different focus areas as separate from, or in opposition to, one another. They may focus on either improving health or health care, or on targeting either the entire population or a high-needs population (e.g., super utilizers). To succeed in improving health, a more useful framework may be one that reconciles these competing priorities within a complementary approach. Fully integrated models therefore would address both targeted and broad populations. Ideally, populations will be defined expansively, beyond attributed patients, in order to produce widespread and wide-ranging results and to achieve the economies of scale necessary for financial sustainability and effectiveness.

A set of policymakers in Vermont have adopted an ecological framework developed by Sallis et al.<sup>9</sup> to demonstrate how individual and population health is affected by inputs beyond clinical care (see Exhibit 2 for a similar model from the Centers for Disease Control and Prevention). This framework suggests improving health requires an integrated, multidisciplinary approach that targets individuals, social environments, physical environments, and policy inputs.

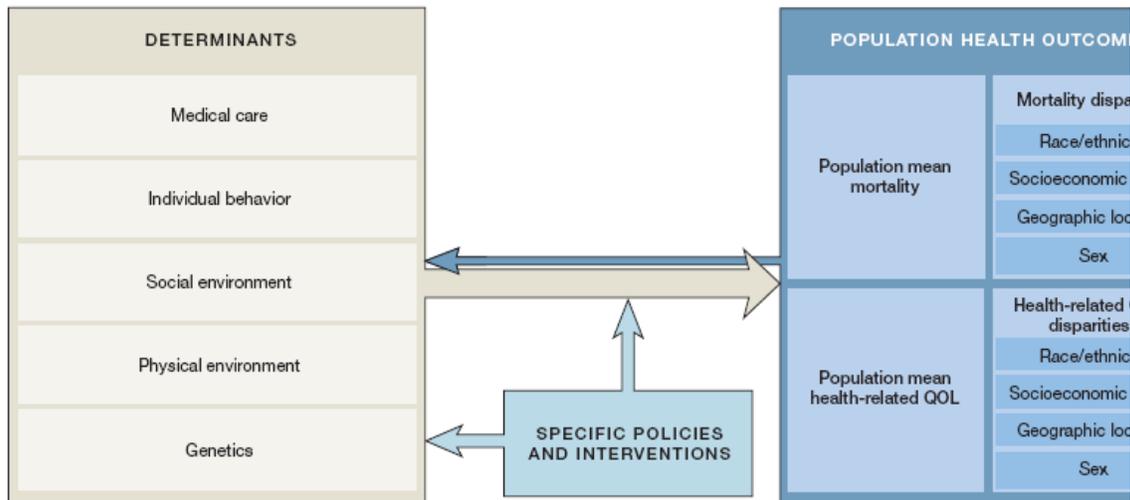
EXHIBIT 2: CDC Ecological Framework



<sup>9</sup> J. Sallis, et al. "An Ecological Approach to Creating Active Living Communities." *Annual Review of Public Health*, 27 (2006): 297-322.

Similarly, Kindig and colleagues<sup>10</sup> have outlined a population health framework (see Exhibit 3) that identifies five interrelated determinants that affect health outcomes: (1) the physical environment; (2) the social environment; (3) health services; (4) biology and genetics; and (5) individual behavior. It suggests that policies and interventions simultaneously addressing these determinants will improve population health outcomes. Notably, this framework was adopted by the *Healthy People 2020* campaign to communicate its national health objectives.

EXHIBIT 3: David Kindig et al. Population Health Framework



There are a core set of commitments that are critical to the successful development and implementation of integrated models of health:

- *Demonstrating a shared commitment to the integrated vision.* Public sector leadership must be committed to a wide-ranging view of patient health drivers and establishing an environment in which stakeholders and agencies can work together to develop health improvement goals and programs.
- *Increasing community accountability for population health outcomes.* Building on the concept of ACOs (accountable for clinical outcomes within an assigned population), states may consider community-wide models that promote shared accountability for the health of all community members (such as [Akron, Ohio's Accountable Care Community](#) model).<sup>11</sup>
- *Generating sufficient resources using funding methodologies that foster accountability for outcomes.* Just as states are pursuing payment reform to appropriately align incentives at the care delivery level, they must also properly align financial incentives to integrate programs and ensure long-term viability.
- *Generating and using population health data to assess, plan, and evaluate/incentivize performance.* Tracking population health status and resource utilization is essential for guiding effective integrated health initiatives.

<sup>10</sup> D. Kindig, A. Yukiko, and B. Booske. "A Population Health Framework for Setting National and State Health Goals." *Journal of the American Medical Association* 299.17 (2008): 2081-2083.

<sup>11</sup> For more information, visit: <http://www.abiakron.org/1accountable-care-community>

## Essential Program Components

For integrated approaches to ultimately be effective, providers and their care team must be able to easily link patients to health-relevant services and play a role in community-level planning activities. States also have an important role to play both in promoting new care models and establishing state- and community-level decision-making entities that can support on-the-ground integration. For state leaders committed to integrated models of health, it may be useful to approach planning efforts by focusing on three core components of an integrated service delivery model:

1. Coordinated service delivery mechanisms (integrators);
2. Supportive infrastructure such as quality measurement and data sharing; and
3. Aligned financing and payment methodologies.

In the long run, states will want to develop these core components – each elaborated on in more detail below – across three key stakeholder levels, as illustrated in Exhibit 4. While the primary focus of this paper is the state and community levels, the table also addresses patient/provider level considerations.

EXHIBIT 4: Examples of Multi-Level Integration Components

LEVEL	COORDINATION MECHANISMS	SUPPORTIVE INFRASTRUCTURE	FINANCING AND PAYMENT
STATE	Integrator and other formalized interagency arrangements	Integrated health care, public health, social services, and claims database/ analysis	Braided or blended agency financing, Wellness Trusts
COMMUNITY	Accountable community organizations, community care teams	Integrated community-level population health/quality report cards	Community-wide global services payment; community benefit funds
PATIENT/ PROVIDER	Accountable Care Organizations, Medicaid health homes	E-referrals, integrated patient-level data sharing	Global capitation, shared savings, care management PMPM

### 1. Coordinated Service Delivery Mechanisms

States are well positioned to identify or develop the mechanisms/entities that assume accountability for implementing a fully integrated health system, particularly at the state and community levels. In developing a strategic plan, states may need to evaluate whether a top-down or a bottom-up approach will be most effective in creating such entities.

#### *State Level*

Silos exist between and within state government departments and service agencies, often reinforced by divergent cultures, incentives, and “turf battles” to protect authority and funding. Some states have considered reorganizing existing agency structures or authorizing new programs or entities to facilitate state-level integration.

One approach to overcome such barriers is to designate an “integrator:” an entity that serves a coordinating role across various public agencies and oversees the many moving parts of an integrated delivery model. Integrator examples range from governmental or quasi-governmental agencies to community-based non-profits and coalitions. Maryland’s Office of Health Reform serves as an integrator, as it is charged with facilitating inter-agency collaboration on state health care programs. California, meanwhile, created a Health in All Policies Taskforce to bring together 19 state agencies and departments to develop a broad set of recommendations for improving residents’ health.

### *Community Level*

Given that an integration strategy must be attuned and targeted to local needs, integrators are important at the community level as well. In *Purchasing Population Health*, Kindig introduced the concept of a health outcomes trust, a local entity that receives financial incentives to coordinate resources and policies across the different public and private organizations working to address medical care, public health, education, income, and individual behaviors.<sup>12</sup> The Prevention Institute proposes a model called “Community-Centered Health Homes,” in which community health centers and other health care institutions take an active role in improving surrounding communities. Improvement projects could include building walking and biking paths, improving community food production, and minimizing environmental hazards.<sup>13</sup> Other current examples of community-level integration efforts include:

- The Oregon Health Authority (OHA) is implementing *Coordinated Care Organizations* (CCOs) to assume responsibility for the cost, access, and quality of physical, behavioral, and oral health services. CCOs also have the option of including alternative, non-medical services that improve health.
- The *Camden Coalition of Health Care Providers* (NJ), as part of its community-based ACO, regularly engages with representatives from local public health, housing, and transportation to facilitate coordination at both the patient and the community level to better serve high-need patients in Camden.
- Maryland has created Local Health Improvement Coalitions to monitor community and population health, identify and respond to hot spots of health needs, and create local plans for health improvement. These coalitions engage a diverse range of stakeholders, including individuals working in housing, education, corrections, and business.

Given that state-level policies must align with and support community efforts, creating linkages between the state and community-based entities is an important consideration. In Oregon, “Innovator Agents” serve as a single point of contact between local CCOs and the OHA. Integrator agents provide data and feedback from the state to CCOs and offer OHA ideas from CCOs for health improvement strategies and care innovations. “Igniter” projects, which bring local entities together for the first time to collaborate on a specific common project, can often spark sustainable partnerships among county-based departments, local civic organizations, providers, and the state. ReThink Health, an initiative of the Fannie E. Rippel Foundation,

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<sup>12</sup> D. Kindig. *Purchasing population health: paying for results*. University of Michigan Press (1997).

<sup>13</sup> J. Cantor, et al. “Community-Centered Health Homes: Bridging the gap between health services and community prevention.” The Prevention Institute (2011).

focuses specifically on how to forge meaningful linkages across stakeholder groups to create a shared vision to redesign local health systems.<sup>14</sup>

#### *Patient/Provider Level*

States are beginning to weave social service integration approaches into existing provider-level efforts (e.g., PCMHs and Medicaid health homes) in ways that remove barriers and avoid new burdens for providers. For example, Maryland is creating Community Integrated Medical Homes, building on the state's existing multi-payer PCMH infrastructure to integrate primary care with community health resources. New York is using its health homes initiative to partner with a supportive housing organization and with other community-based organizations to link patients with needed services. In Vermont, PCMH patients are supported by Community Health Teams – made up of nurses, social workers, dietitians, and health educators – that connect patients to community services, including long-term care and housing.

States are also supporting on-the-ground integration through bi-directional electronic referrals between providers and social service organizations. Massachusetts' new e-referral system will connect up to nine community health centers with community resources such as tobacco quitlines, YMCAs, local senior centers, and visiting nurse services.

## **2. Integration Infrastructure: Measurement and Data Sharing**

Important precursors to an integrated delivery system include: (1) a robust set of data/analytics to track individual and population-level health outcomes and costs; and (2) a mechanism to share data, link different service delivery systems, and establish evidence-based processes to assess and improve programs.

In determining what data to collect, an integrated system needs to identify which metrics will support the achievement of manageable quality and accountability goals. There is no one population health indicator and no overriding consensus about the best measures to use (though mortality and health-related quality of life are two examples). What's more, many determinants of health, such as education, the environment, and pollution, may take years, decades, or even generations to fully influence population health. The Institute of Medicine recently published recommendations for creating population health measures, noting that any outcomes being measured should reflect a highly preventable burden that is actionable at the appropriate level for intervention. The measures themselves should be timely, usable for assessing various populations, understandable, methodologically rigorous, and widely accepted.<sup>15</sup>

Although states are still in the early stages of effectively measuring population health outcomes, some are beginning to collect and analyze health data from sources outside clinical settings. For example, Connecticut created the [Health Equity Index](#), a community-level electronic tool that measures the social, political, economic, and environmental conditions that affect health and their correlations with specific health outcomes.<sup>16</sup> [Santa Cruz County, California is tracking "health-related quality of life"](#) among residents, an indicator of self-perceived physical and

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<sup>14</sup> For more information, visit: <http://rippelfoundation.org/rethink-health/>

<sup>15</sup> Committee on Quality Measures for the Healthy People Leading Health Indicators; Board on Population Health and Health Practice. "Toward Quality Measures for Population Health and the Leading Health Indicators." Institute of Medicine (2013).

<sup>16</sup> For more information, visit: <https://www.sdo.org/>

mental health.<sup>17</sup> Maryland's [State Health Improvement Process tracks outcomes on 39 different health measures](#), including measures related to healthy social environments (such as children entering kindergarten ready to learn) and safe physical environments (such as access to healthy foods and unhealthy air days).<sup>18</sup>

Upfront technology investments are needed from states to support integration efforts, accurately measure program impact, and inform future investment decisions. This includes not just building an integrated data system, but also establishing the IT supports, training and facilitation necessary to efficiently implement it. Laying the groundwork for an integrated data infrastructure will not only support existing initiatives but will also catalyze new efforts that may only be possible once different sectors can share information. Ideally, such systems would both facilitate cross-agency data sharing at the state-level and enable providers and community organizations to input and access information at the individual and population level. Because data measurement, health analytics, and information technology (IT) are ever-evolving fields, infrastructure investments should allow for flexibility and growth.

One prominent example of a state-level data sharing system is PRISM, an integrated decision-support tool developed by Washington State to support care management interventions for high-risk, chronically ill Medicaid patients. PRISM integrates health, behavioral health, long-term care, and emergency department data, as well as data from social service programs (such as Temporary Assistance for Needy Families and low-income housing programs), and creates unified risk and service experience scores. PRISM can also identify consumers most in need of comprehensive care coordination.

### **3. Financing and Payment Methodologies**

An integrated, community-based service model requires both sustainable financing sources and payment models with incentives to encourage ongoing integration at each stakeholder level.

#### *Financing*

The appropriate financing formula for interested states will depend on a host of factors related to existing structures and future goals. Available funding streams and sources will also likely shift over time as integration initiatives progress from a pilot phase to a scale-up phase to a fully operational program. Incremental funding steps are included in the Framework for Phasing Integration Over Time (Exhibit 5).

The state agency running the integration program can apply for local, state, and federal grant funding or use appropriated state and federal categorical funding during the initiative's early phases. Maryland's Department of Health and Mental Hygiene and Community Health Resources Commission, for instance, secured \$4 million in funding in the state's FY2013 budget to pilot Health Enterprise Zones by projecting an expected long-term return on investment (ROI).

During the piloting phase, states could consider using social impact bonds for funding. Under this model, a state contracts with a private-sector entity to run small-scale programs to improve

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<sup>17</sup> For more information, visit: <http://www.santacruzhealth.org/phealth/CountyHealthReport/2012/pdfs/24-HRQoL%20chapter.pdf>

<sup>18</sup> For more information, visit: <http://dhmh.maryland.gov/ship/SitePages/measures.aspx>

health outcomes and lower costs. The state would pay private investors only if the pilot program achieves pre-determined performance targets, such as improving health outcomes or indicators (like asthma-related ED visits or smoking rates) or producing a positive ROI. The state could then choose to scale up any programs deemed successful. Another option to consider is using trust funds to finance integrated population health programs. Massachusetts recently established a first-in-the-nation [Prevention & Wellness Trust Fund](#) to pay for evidence-based community prevention activities. The Fund is paid for by an assessment on insurers and some hospitals, and allocates \$60 million over four years for these programs.<sup>19</sup>

Within the child health policy and workforce sectors, states and local governments often turn to blended or braided financing to fund the delivery of integrated services across multiple agencies. Blended funding involves commingling funds from a variety of sources into one "pot" to draw down service dollars as needed for a range of services. Braided funding uses multiple funding streams to pay for all of the services needed by a given population, with careful accounting of how every dollar from each stream is spent. Some state officials in Vermont are discussing the idea of creating a "unified health budget" to classify and pay for the many different services and programs affecting population health under one central authority.

To raise revenue for integrated efforts, states could decide to allocate a small share of insurance premiums to fund integrated service models. Vermont provides an example: the state currently collects 0.2% on all health insurance claims to fund The Vermont Health IT Fund, which supports health information technology and exchange. Another option is to use an explicit portion of the funding non-profit hospitals are required to allocate toward "community benefits." In 2012, U.S. hospitals spent at least \$104 billion on community benefits, but only five percent of these payments went toward community health improvements (the majority was spent on unreimbursed charity care or making up for low Medicaid reimbursements).<sup>20</sup> States could encourage or require hospitals to redirect some of these community benefit resources toward evidence-based population health improvement programs.

Finally, given that state Medicaid agencies are likely to reap financial savings if integrated programs result in improved health outcomes, states may examine ways to funnel such savings back into program financing and fund services beyond traditional Medicaid medical services. At minimum, states may need to apply for a waiver to purchase non-clinical services for Medicaid enrollees. Oregon, for example, was [granted a waiver](#) to use Medicaid dollars to pay for non-traditional health care workers and an array of "flexible" services within their CCOs.<sup>21</sup> If these waivers lead to overall cost reductions, there may be an opportunity for states to reinvest these savings to support ongoing funding of non-clinical care.

### *Payment*

States can leverage advanced payment methodologies at both the community and provider levels to address clinical and social determinants of health. Community and provider-level payment methods should complement one another and create a set of fully aligned incentives.

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<sup>19</sup> Massachusetts Public Health Association. "Fact Sheet: The Massachusetts Prevention & Wellness Trust Fund." (2012). Available at: <http://mphaweb.org/documents/PrevandWellnessTrustFund-MPHAFactSheetupdatedOct12.pdf>

<sup>20</sup> G. Young, et al. "Provision of Community Benefits by Tax-Exempt US Hospitals." *New England Journal of Medicine* 368.16 (2013): 1519-1527.

<sup>21</sup> For more information, visit: <http://www.oregon.gov/oha/OHPB/Documents/special-terms-conditions-accountability-plan.pdf>

One option is to use “capitation” rates to purchase population health services at the community or provider level. For example, states could reallocate a portion of social services and public health funding and include a population health payment in Medicaid managed care capitation rates. Medicaid health plans would use that funding to purchase social and public health services from county-run programs, based on the needs of the community and working with the community-level integrator. This could promote better provider-county collaboration around health-related resource investments, and would enable health plans to offer members a new range of services.

Alternatively, such capitation payments could be made directly to a fully integrated multi-payer entity, such as a community-based medical home or accountable community organization, with responsibility for planning and delivering these services. The entity would purchase health and non-health services identified as necessary for patients/clients; this arrangement would promote further relationship-building and information sharing between medical and non-clinical service providers.

States can also bundle payments to cover a set of clinical and social services specific to a population. Payers can draw on lessons from the Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT), which is a benefit package for children that can be an effective vehicle for identifying social determinants of health and directing resources to address those needs. There are also opportunities for states to think creatively about how to modify current payment models to support integration. For example, while Medicare generally reimburses only for clinical services, certain Pioneer ACOs are using Medicare dollars to create population health appraisal tools.<sup>22</sup>

States may consider community-level budgeting/shared savings approaches as well. For example, community health budgets could include a blend of public health, Medicaid, and social services; within those budgets, a population-level shared savings model could distribute accrued savings to all relevant entities that contribute to population health improvements.

### **Strategic Planning and Program Design**

With the three core program components in mind, states can develop a strategic plan for systems-level integration. To lay a foundation for inter-agency collaboration and successful program design, engaging a wide range of policy, provider, and community stakeholders in this planning process will be important. Five key program planning steps include:

**Step 1: Identify goals.** The first step is to identify goals to achieve under an integrated health program. The Triple Aim framework paired with a State Health Improvement Plan can be useful in establishing measureable goals. States may want to consider different goals for different patient populations across a spectrum of complexity (e.g., healthy adults, adults with chronic illness, adults with complex behavioral and health needs, etc).

**Step 2: Identify gaps.** The next step is to determine what gaps exist to prevent the state from meeting these goals, both in terms of the availability of needed public health and social services

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<sup>22</sup> Conversation with Jim Hester, Consultant to the State of Vermont, and MaryAnne Lindeblad, Medicaid Director, Washington State, September 17, 2013.

and the ability of providers and patients to easily connect with such services. City and county governments, and community and consumer organizations can be particularly helpful in identifying areas where specific population needs are not being met—either because programs do not exist or because there is not sufficient capacity to meet patient needs. Some communities may be “resource rich” but ineffective in linking patients and providers to those resources. It will also be important to identify existing investments that may be unnecessary and whose funding can be reallocated to critical investment areas. States can partner with non-profit hospitals in gathering information about community-level health needs, as non-profit hospitals are now federally mandated to conduct community health needs assessments (CHNAs).

**Step 3: Prioritize opportunities for integration.** States could use findings from their gap analysis or health needs assessment to develop a state or community health improvement plan. States can prioritize which of the gaps they wish to address based on: (a) opportunities for improvement with a positive ROI (e.g. high-need geographic areas or patient populations); and (b) existing infrastructure strengths. Identifying areas with the greatest needs and the biggest bang for the buck over the short term can help states build the business case necessary for continued investment. Many experts have suggested using an “asset-based” approach to prioritizing integration opportunities, which considers a particular community’s unique strengths, resources, and leverage points when deciding which types of interventions to pursue. States may also benefit from identifying how existing integrated programs and approaches, such as those in maternal and child health, can be extended for other patient populations. Finally, states may consider pursuing a variety of interventions to ensure a “balanced portfolio” of evidence-based interventions with both short-term and long-term ROI, broad and specific population targets, and a range of different partnering service sectors and organizations.<sup>23</sup>

**Step 4: Establish an implementation roadmap.** Developing an implementation roadmap can guide near- and long-term planning activities and highlight policy considerations. A stepwise roadmap would include a developmental stage to pilot new ideas (Phase 1), a scaling stage (Phase 2), and a fully operational stage (Phase 3), allowing the state to first test promising approaches on a small scale and invest in evidence-based interventions that show promising results. There are multiple pathways states can pursue; for example, interventions could be both “bottom up” (originating at the local or county level) or “top down” (overseen by state-level authorities). Once states and local communities agree upon a coherent development strategy, they should begin to operationalize their integration plan, which will include establishing new coordinating mechanisms or integrator agencies, data tracking and sharing infrastructures, and payment schemes. See Exhibit 5 below for a sample roadmap.

States can draw upon a variety of additional inputs to inform their strategic integration plans, including:

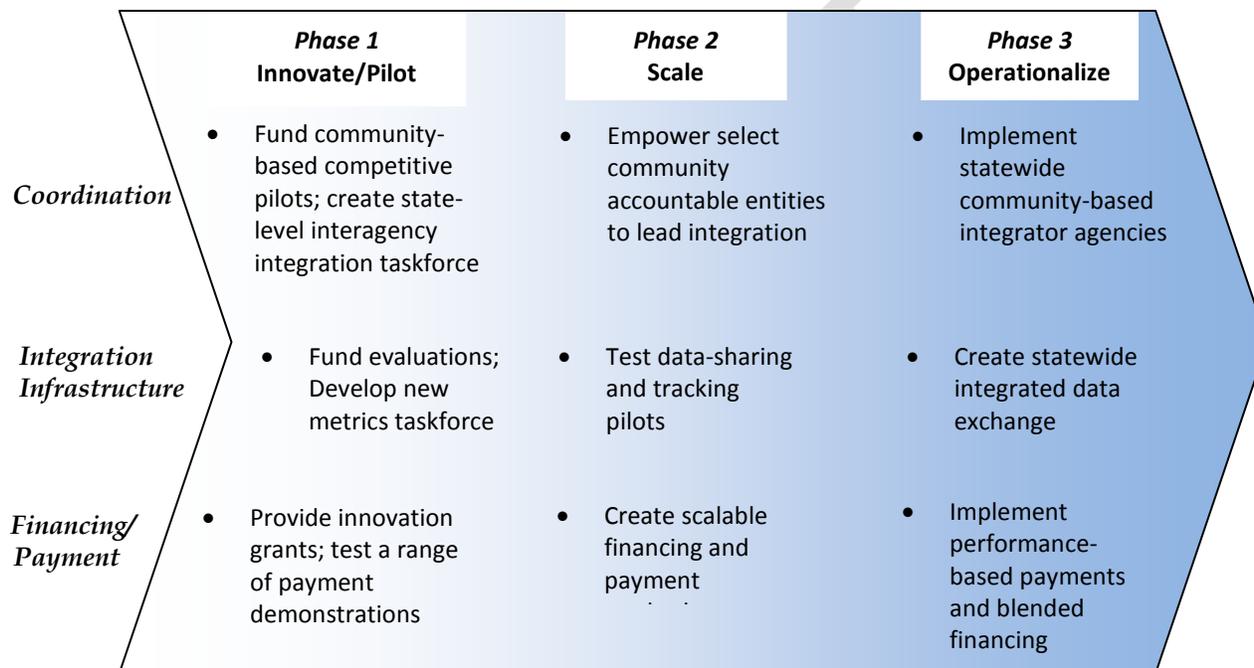
- Existing State Health Improvement Plans;
- State/community-wide assessments of the impact of social service, public health, and clinical interventions, including health and health care outcomes;
- The Kaiser Family Foundation’s State Health Facts data;
- Financial analysis of ROI for state-wide/community integration interventions;

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<sup>23</sup> Phone conversation with Jim Hester, Consultant to State of Vermont, September 13, 2013.

- The National Prevention Strategy and Healthy People 2020 goals;
- IOM’s Community Health Development Process; and
- Proposals for and assessments of payment and delivery reform initiatives, including SIM, CMS Health Care Innovation Awards, CMS State Demonstrations to Integrate Care for Dual Eligible Individuals, and the Robert Wood Johnson Foundation’s Roadmaps to Health Community Grants.

EXHIBIT 5: Roadmap for Phasing Integration Over Time: Potential State Activities



**Step 5: Create a Measurement Strategy.** Needless to say, measuring the impact of the integrated strategy against state goals will be critical for evaluating overall effectiveness, promoting continuous quality improvement, and ensuring sustainability. A robust measurement strategy will include not only key metrics that closely link intervention outcomes and goals, but also promote accountability at the state, community, and provider levels. Making the business case for integration will also be a key goal of this strategy. The business case should contain the intervention’s expected or realized ROI, as well as information on how integration might lead to improvements at the organizational level (such as higher employee satisfaction and productivity) and environmental/social level (such as fewer missed school and work days). Although few tools exist to quantify the financial and social returns associated with better service integration, states can begin to think about how to identify, assess, and measure these results.<sup>24</sup>

### Barriers

There are a number of barriers that make integrating public health, social services, and the health care delivery system difficult. Funding for health improvement initiatives is often siloed

<sup>24</sup> Health Systems Learning Group. “Health Systems Learning Group Monograph.” (2013).

and disaggregated: a state's public health department, Medicaid program, and social service agencies often have different federal and state funding streams and different requirements for how to use resources. Furthermore, state and county-level departments can be more interested in protecting their limited funding allotments than in working collaboratively with others to achieve common goals. As a result, cross-agency collaboration is very challenging in many states. Another barrier is the fact that integrating service streams is a new frontier for many states. Limited experience and a lack of understanding regarding what an integrated health system will actually look like make it difficult not only to establish concrete development plans, but to sell this vision to potential funders and other collaborators. Finally, many state officials may be "burnt out" on new health reform initiatives, having devoted substantial resources to ACA implementation over the past four years.

## **Conclusion**

There is growing consensus around the need to broaden our vision of high-quality health care to encompass more than traditional clinical services. At its broadest, the vision includes public health, housing, long-term care, socio-economic status, and the environment in which people live. New models and programs are emerging across the country to link these historically separate sectors. At the state level, barriers exist for incorporating community-based resources and services into health care delivery networks, yet states have a number of policy, financing, and regulatory opportunities available—many outlined in this paper—to facilitate the creation of integrated delivery systems. The time is ripe for states to work in concert with the federal government, local organizations, and health care professionals to establish integrated delivery systems that best meet individuals' complex circumstances and needs.

## Appendix: Resource Library

E. Bradley, et al. "Health and social services expenditures: associations with health outcomes." *BMJ quality & safety*, 20.10 (2011): 826-831.

T. Casper and D. Kindig. "Are Community-Level Financial Data Adequate to Assess Population Health Investments?" *Preventing Chronic Disease*, (2012). 9:120066. Available at: [http://www.cdc.gov/pcd/issues/2012/pdf/12\\_0066.pdf](http://www.cdc.gov/pcd/issues/2012/pdf/12_0066.pdf)

Community Preventive Services Task Force. "Annual Report to Congress and to Agencies Related to the Work of the Task Force." (2013). Available at: <http://thecommunityguide.org/annualreport/2013-congress-report-full.pdf>

Health Systems Learning Group. "Health Systems Learning Group Monograph." (2013). Available at: <http://www.methodisthealth.org/dotAsset/0aa7ab05-12f0-4773-acfa-c30e8bb741d0.pdf>

D. Kindig, G. Isham and K. Siemering. "The Business Role in Improving Health: Beyond Social Responsibility." Institute of Medicine, (2013).

D. Kindig, P. Peppard, and B. Booske. "How healthy could a state be?" *Public health reports*, 125.2 (2010): 160.

D. McCarthy and A. Cohen. "The Cincinnati Children's Hospital Medical Center's Asthma Improvement Collaborative: Enhancing Quality and Coordination of Care." The Commonwealth Fund, (2013). Pub. 1660, Vol. 7.

To: Population Health Work Group  
Fr: Georgia Maheras  
Re: Contract for Population Health Technical Services provided by Jim Hester  
Date: February 4, 2014

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This request is to continue an existing contract with Jim Hester to provide support to the population health workgroup related to the SIM Grant/VHCIP. This contract would be funded by the SIM/VHCIP funds allocated to the Population Health Work Group for work group support.

### *Background*

The SIM grant requires the State of Vermont work towards improving overall population health.

The Population Health Work Group examines current population health improvement efforts administered through the Department of Health, the Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs and other provider and payer entities. This work group will examine these initiatives and SIM/VHCIP initiatives for their potential impact on the health of Vermonters and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including:

- Enhancement of State initiatives administered through the Department of Health
- Support for or enhancement of local or regional initiatives led by governmental or non-governmental organizations, including employer-based efforts
- Expansion of the scope of delivery models within the scope of SIM or pre-existing state initiatives to include population health

In 2013, the VHCIP determined the need for assistance with the development of the population health workgroup described in the SIM Operational Plan. Jim Hester as uniquely positioned to perform this work.

### *Vendor Qualifications*

Mr. Hester has recently completed two and a half years assisting in the start up of the Center for Medicare and Medicaid Innovation at CMS. He is familiar with both the population health work at the federal level and the work in Vermont. At the federal level, he was the Acting Director responsible for the initial work on the Pioneer ACO shared saving model, the Comprehensive Primary Care Initiative Model and the Bundled Payment models. Significantly, he served as the Acting Director of the Population Health Models Group overseeing the development of enhanced measures and strengthening the population health component of

the payment models. He has a strong set of working relationships with public and private partners, especially CMS and CDC. His Vermont experience includes serving as director of the Health Care Reform Commission for the state legislature for four years, the Blueprint Executive Committee since its inception and the VITL board for three years.

### *Scope of Work*

The specific tasks for this contract would be:

- assist the co-chairs of the workgroup in developing the initial approach, work plan, and resource needs for the workgroup
- assist in developing agendas for the workgroup once it is formed.
- through ongoing work with CDC, IOM and others, identify models and resources in other states and communities that could inform the design of sustainable financing models for improving population health.
- assist in identifying the population health measures and measurement systems required to support the population health financing system.
- help formulate an approach to creating Vermont pilots of Accountable Health Communities by drawing on expertise in models being tested in other states

### *Recommendation:*

Approve a sole source contract with Jim Hester for an amount not to exceed \$28,000 for a twelve month engagement. This price is competitive in relation to the other contracts held by the State for support for workgroups and other technical areas.