

Attachment 1 - Population Health
Work Group Agenda 4-08-14

VT Health Care Innovation Project Population Health Work Group Meeting Agenda

Date: Tuesday, April 8, 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.

AGENDA					
Item #	Time	Topic	Presenter	Relevant Attachments	Action #
1	2:30	Welcome, roll call and agenda review Goal: Refine recommendations for measures of population health Obj: Report on ACO "pending" measure process Obj: Identify other statewide, community and clinical measures Obj: Share example of use of measures in a non-clinical context	Tracy Dolan	Attachment 1: Agenda	
2	2:40	Approval of minutes	Karen Hein	Attachment 2a: Minutes Attachment 2b: Criteria Attachment 2c: Tally	
3	2:45	Share Criteria and Recommendations Submitted to Measures Work Group on Pending Measures	Tracy Dolan Heidi Klein	Attachment 3: Memo	
4	3:00	From Measures to Action -- So what? Why do measures matter?	Tracy Dolan	Attachment 4:	
5	3:10	Working Backwards: Population Health to Community to Clinical Measures sets <i>Given the criteria we have identified, which measures would the group recommend for inclusion in Year 2 or 3 for the ACOs?</i>	Heidi Klein	Attachment 5: Population Health to Clinical Measures	
6	3:45	Consultant Contract: Accountable Communities	Karen Hein	Attachment 6: Proposed Scope of Work	
7	3:55	Public Comment and Next Steps Plans underway for a process evaluation <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 2a - Population Health Work Group Minutes 3-11-14



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

Date of meeting: March 11, 2014 - 2:30pm to 4pm; at ACCD Calvin Coolidge Conference Room 6th Floor, 1 National Life Drive - Montpelier.

Call in: 877-273-4202 Passcode 9883496

Attendees: Karen Hein, Co-Chair; Georgia Maheras, AoA; Jill Berry-Bowen, Northwest Medical Center; Mark Burke, Brattleboro Memorial Hospital; Judy Cohen, UVM; Jim Hester; Laural Ruggles, Northeastern Vermont Regional Hospital; Jesse de la Rosa, VT Wellness Educator; Penrose Jackson, VT Public Health Assn; Melanie Sheehan, Mt. Ascutney; Ted Mable, Northwest Counseling and Support Services; JoEllen Tarallo-Faulk, Center for Health and Learning; Melissa Miles, Bi-State; Wendy Davis, UVM; Geera Demers, Blue Cross Blue Shield; Heidi Klein, VDH; Pat Jones, Christine Geiler, GMCB; Catherine Hamilton, BCBS; Julia Shaw, VT Legal Aid; Mary Woodard, DAIL; Charlie Smith; Frances Keeler, DAIL; Alicia Cooper, DVHA; Nicole Lukas, VDH ; Marlys Waller, VT Council of Developmental and Mental Health Services; Donna Burkett, PPNNE; George Sales, Project Management Team.

Agenda Item	Discussion	Next Steps
1 Welcome, introductions, Agenda review	Karen called the meeting to order at 2:30pm and briefly reviewed the agenda.	
2 Approval of Minutes	Karen briefly reviewed the February 11th minutes. Heidi noted that Melanie Sheehan’s comment from the previous meeting was not accurately reflected in the minutes. Noted that, given recent national trends to legalize marijuana as a source of state (and possible healthcare reform) funding, workgroup representatives might consider if this aligns with the principals of health promotion and be willing to speak in opposition to this funding model. Judy Cohen moved to accept minutes as amended for Melanie comment; 2 nd by Jill Berry-Bowen. Passed unanimously.	

Agenda Item	Discussion	Next Steps
<p>3 Review and adopt criteria for recommendations</p>	<p>Heidi Klein gave an overview of proposed objectives of the Vermont ACO measures work group and the criteria that workgroup used for selecting measures. The group discussed what additional criteria are important in recommending population health measures for ACO payment, reporting or measuring and evaluation.</p> <p>Through discussion, work group members recommended the following criteria:</p> <ul style="list-style-type: none"> • focused on the broader population and health outcomes’ prioritizing wellness by patients, physicians and system; • Including risk and protective factors; • Expanding to social determinants; • Longer timeframes; and • characteristics of the measures—clear, simple and evidence supported. <p>A full summary of the discussion is will be included in the April meeting materials.</p> <p>Discussion followed, including:</p> <ul style="list-style-type: none"> • The ACO criteria are not currently tied to health outcomes. The criteria can be connected to other layers of influence and be complementary to ACOs measures. • There is a need for clear definitions of community and population. • Should physician engagement be considered as part of this work? • What is the difference, if any, between risk and protective factors” and “social determinants”? • Community engagement is essential in identifying measures. • The more complex the harder it may be to have others accept and use, be cautious regarding layers of complexity. • Consider a lifespan approach – prenatal through elderly; keeping it young helps to focus on prevention. • It is hard to use the medical based list to choose when so much of what we discussed and brainstorm come from non-clinical factors. • Select measures that can be impacted at all levels of the social-ecological model and measures that hold promise for including the greatest number of stakeholders and partners. 	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> • What data exists and does it provide what is needed? 	
4 Review measure sets and begin to identify initial set of population health measures to recommend for ACO	Heidi Klein presented the CMS Population Health measures and the ACO pending measures and asked the work group to review the pending ACOs measures with the criteria they just developed in mind. The work group reviewed the attachments presented and took some polls to gage the interest and importance of each of the pending measures to the work group. The tally is attached.	
5 Public Comment, Next Steps	Public comment: None Next meeting: April 8,2014 2:30pm-4:00pm at ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier	

Attachment 2b - Criteria for
Population Health Measures
Discussion Notes 3-11-2014

Criteria for Recommending Population Health Measures

What criteria are important in recommending population health measures for ACO payment, reporting or measuring and evaluation?

(Broader) Population and health outcome focused¹

- Beyond covered lives and “most expensive first” – Recognize population demographics; priority to aging population and other ages
- Considers geographic community not just patient population

Focus on wellness by patient, physician and system

- Patient engagement; patient has some responsibility to focus on wellness
- Health literacy of patient to focus on wellness
- Patient experience – self management, perception, PCMH CHAPS
- Physician engagement²
- Cultural competency of physician
- Care coordination and care management

Risk and protective factors need to be included³

- Include mental health indicators – e.g. depression screen
- Include measures of substance use and misuse – regulated and unregulated
- Weave in adverse childhood health events
- Environmental factors – e.g. air, water, walk to school

Expand to social determinants

- Transportation, housing, education, poverty
- Consider social health status – GMCB working on this
- “Community” , school and family engagement

Expanded Timeframe

- Limit to 3-5 years or longer for expected changes? 20 year better
- Develop a balanced portfolio of measures — some short term and others longer

Characteristics of the measures

- Simple
- Clear
- Measureable
- Evidence based or “evidence supported”

¹ Tie to definition of population health – patterns, distributions, etc.

² One participant questioned whether physician engagement should be part of this work group

³ Need to define the difference (if any) between “risk and protective factors” and “social determinants”

Criteria for Recommending Population Health Measures

Other discussion:

- ACO criteria currently not tied to health outcomes – this is important
- Need definition community – geographic or community services or actual people? Risk environment?
- Recognize need for community engagement in knowing what is best for their community
- Layers of complexity – be cautious! The more complex the harder it will be to have others accept and use
- Be clear about what population – not just attributed but also include community/HSA
- Revisit the CMS/CDC measures
- Find one upstream/determinant of health
- Consider a lifespan approach – prenatal through elderly; keeping it young helps to focus on prevention
- It is hard to use the medical based list to choose when so much of what we discussed and brainstorms come from non-clinical factors.
- Select measures that can be impacted at all levels of the social-ecological model and measures that hold promise for including the greatest number of stakeholders and partners.

Additional Use:

- Continuous monitoring of patterns of risk to evaluate and targeting
- Can be connected to other layers of influence and need not be directed at ACOs; complementary to ACOs measures

Criteria for Recommending Population Health Measures

CMS Criteria for Population Health Measures

- High population burden, societal costs
- Amenable to interventions with potential improvement in health, quality of care and decreased costs within the next three to five years
- Data for the measure are available for major segments of the population at the state and/or sub-state level.

Additional Potential Criteria for Measures for ACO Measures

- Ease of collection
- Reflects a driver of health outcomes – if changed it will lead to both to cost saving and health improvement
- Focus is on upstream determinants of health and/or preventive contributors to positive health outcomes
- Opportunity to link data on attributed and geographic populations

Other Ideas to Consider

- Measures subjective component of patients' self-reported impact on quality of life and ability to cope with illness
- Accountability for geographic population within a community instead of attributed population
- Measures that do not need to be measured at the ACO level (at the statewide or county or HSA level) that could be considered for addition to the Monitoring and Evaluation measures list
- Measures of the health of the system to improve health overall beyond clinically related measures

Attachment 2c - ACO
Pending Measures 12-2013
with Priorities

VT Measure ID	MSSP Measure ID	Number of Votes	MEASURE	Measure Domain	National Recognized /Endorsed	Aligns with CMS/HHS Requirements, Programs Measure Sets	Aligns with State Requirements, Programs or Measure Sets	Linked to Payment, Monitoring, or Program Evaluation (ACO Year 1)	VT Medicaid SSP	VT Commercial SSP	Medicare SSP	Can we measure	Data Source	Is it a health dept priority? (SHIP/HV2020)
Core-9		13	Depression Screening by 18 Years of Age	Children/Adolescents	NQF #1515		Healthy Vermonters 2020 (thoguh no data source available)	Pending	x			No-though it is a HV2020 goal there is no baseline data and there has not been a data source identified for future measurement	***	HV2020 goal
Core-3	MSSP-29	2	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)	Chronic Conditions: Cardiovascular	NQF #0075, NCQA		Duals Demonstration, Healthy Vermonters 2020	Pending	x	x	x	No- while we can measure some information related to stroke we do not measure for this clinical test	***	No
Core-30		11	Cervical Cancer Screening	Preventive Health: Screening	NQF #0032, HEDIS measure	Meaningful Use, Adult Core	Blueprint Recommendation, Healthy Vermonters 2020	Pending	x	x		Yes-We have been measuring this for several years and we can adjust our estimates to match how the guidelines have changed over the past several years	BRFSS	HV2020 goal among women age 21 and older
Core-31	MSSP-30	0	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Chronic Conditions: Cardiovascular	NQF #0068, NCQA	Meaningful Use	Duals Demonstration, Healthy Vermonters 2020	Pending	x	x	x	No- while we can measure some information related to stroke we do not measure this level of detail	***	No
Core-32		4	Proportion not Admitted to Hospice (cancer patients)	End-of-Life Care	NQF #0215			Pending	x	x		No	***	No
Core-33		1	Elective Delivery before 39 Weeks	Pregnant Women	NQF #0469			Pending	x	x		Maybe- this could be collected by looking at birth certificate data. Though the data we obtain and classify as elective may be more robust than GMCB expected for this measure	Vital Records	No
Core-34		11	Prenatal and Postpartem Care Timeliness	Pregnant Women	NQF #1517	Child Core		Pending	x	x		Maybe- there is a measure of adequate prenatal care that we can obtain on the birth certificate. However, I am not sure this will align with the NQF measure. I am not sure what postpartem care timeliness means or how we could measure this.	Adequate prenatal care, and time entered prenatal care are collected on the brith certificate	No
Core-35	MSSP-14	14	Influenza Immunization	Preventive Health: Immunizations	NQF #0041, AMA-PCPI	Meaningful Use, Adult Core	Duals Demonstration, Healthy Vermonters 2020	Pending	x	x	x	Yes-we can measure this. We can measure this as self reported data or we can try to use to use the immunization registry. I would recommend the BRFSS self report since immunizations can be administered at various locations (including work based wellness clinics, drug/grocery stores, dr office, etc.)	BRFSS (Immunization registry is also possible but may not be best choice at this point)	HV2020 goal among adults ≥65 years
Core-36	MSSP-17	16	Tobacco Use Assessment and Tobacco Cessation Intervention	Preventive Health: Tobacco	NQF #0028, AMA-PCPI	Meaningful Use	Duals Demonstration, Healthy Vermonters 2020	Pending	x	x	x	Yes- we can measure information about smoking prevalence, quit attempts, cessation methods, and other information about smoking perceptions	BRFSS or the ATS	There are HV202 goals related to smoking prevalence in adults and adolescents as well as quit attempts in adults, these are also mentioned in the SHIP
Core-37		13	Care Transition-Transition Record Transmittal to Health Care Professional	Care Coordination/ Patient Safety	NQF #0648	Adult Core, Home Health Core	Duals Demonstration	Pending	x	x		No	***	No

Core-38	MSSP-32-33	2	Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL-C	Chronic Conditions: Cardiovascular	NQF #0074 CMS (composite) / AMA-PCPI (individual component)		Duals Demonstration	Pending	x	x	x	No	***	No
Core-39	MSSP-28	5	Hypertension (HTN): Controlling High Blood Pressure	At Risk Population: Hypertension	NQF #0018, NCQA HEDIS measure	Meaningful Use, Adult Core, Home Health Core	Duals Demonstration, Healthy Vermonters 2020	Pending	x	x	x	maybe- we can measure some prevalence information related to hypertension and high blood pressure but it may not be specific enough to match this measure	BRFSS	HV2020 measure of % adults with HTN
Core-40	MSSP-21	14	Screening for High Blood Pressure and Follow-Up Plan Documented	At Risk Population: Hypertension	CMS	Meaningful Use	Duals Demonstration	Pending	x	x	x	yes to the screening of high blood pressure, but 'no' to the documentation of a follow-up plan by a provider	High blood pressure screening information collected on BRFSS	No
Core-41		16	How's Your Health? **	Patient Engagement				Pending	x	x		yes-we do measure self reported response to general health status	BRFSS	No, but I am also not clear what this is
Core-42		10	Patient Activation Measure	Patient Engagement			Blueprint Recommendation	Pending	x	x		maybe- I think this is a composite of a few different components and we may collect information on the various components	BRFSS	No, but I am also not clear what this is
Core-43		4	Frequency of Ongoing Prenatal Care	Effectiveness of Care	NQF # 1391, HEDIS Measure	Child Core	Healthy Vermonters 2020	Pending	x	x		Maybe...what does this mean? Number of prenatal visits-that the number of prenatal visits in each trimester is on the birth certificate	Vital Records??	No
Core-44		16	Percentage of Patients with Self-Management Plans	Care Coordination/ Patient Safety	NCQA			Pending	x	x		yes we measure the presence of an asthma action plan	BRFSS/ACBS	HV2020 measure for both adults and children
Core-45		16	Screening, Brief Intervention, and Referral to Treatment	Mental Health/ Substance Abuse	AHRQ Measure		VT SBIRT Grant	Pending	x	x		yes we have measured this for alcohol in 2011	BRFSS	No
Core-46		9	Trauma Screen Measure	Children/Adolescents				Pending	x	x		no	***	No
Core-47	MSSP-13	4	Falls: Screening for Future Fall Risk	Elderly	NQF #0101	Meaningful Use	Duals Demonstration	Pending	x	x	x	maybe- we have been measuring self reported falls and injuries due to falls, but I am not sure what the components to future fall risk means or how it is measured	BRFSS	Fall related deaths are the only fall related HV2020 measure
Core-48	MSSP-15	8	Pneumococcal Vaccination for Patients 65 Years and Older	Elderly	NQF #0043	Meaningful Use	Duals Demonstration	Pending	x	x	x	yes, we measure this in BRFSS and it may also be collected with the immunization registry. However, we face some of the same issues stated with flu vaccines, immunization may miss some vaccines depending on where they were delivered	BRFSS (possibly IMR)	HV2020 measure
Core-49		6	Use of High-Risk Medications in the Elderly	Elderly	NQF #0022, HEDIS Measure	Meaningful Use	Duals Demonstration	Pending	x			No	***	No
Core-50		4	Persistent Indicators of Dementia without a Diagnosis	Elderly				Pending	x			maybe- in 2013 we did the alzheimers module (also have some information in 2012 on alz./dementia)	BRFSS	No

Priority = Pop Health

Second priority

Attachment 3 - Population Health Memo for Measures Work Group

Date: March 21, 2014

To: Measures and Accountability Working Group, VHCIP

From: Population Health Working Group, VHCIP

Re: Recommendations for ACO measures

The Population Health Working Group is comprised of a variety of members interested in improving health of Vermont's population and who represent a broad range of stakeholders including insurers, healthcare, academia, state government, and community organizations. One of our tasks is to recommend measures for Vermont that move the varied health innovations in the state toward a system that supports and accounts for population health.¹

The Population Health Working Group would like to recommend that some of the pending measures that are most consistent with prevention and population health improvement be included in the next set of ACO measures. In addition, we expect to continue to explore in the longer term other options for developing a shared accountability for improving the health of the population which may include measures that demonstrate more 'upstream' factors for a broader set of stakeholders or geographic regions.

Our Working Group determined that the following criteria were important in recommending population health measures for ACO payment, reporting or measuring and evaluation:

(Broader) Population and health outcome focused

- Beyond covered lives and "most expensive first" – Recognize population demographics; priority to aging population and other ages
- Considers geographic community not just patient population
- Consistent with the State Health Improvement Plan

Focus on wellness by patient, physician and system

- Patient engagement; patient has some responsibility to focus on wellness
- Health literacy of patient to focus on wellness
- Patient experience – self management, perception, PCMH CHAPS
- Physician engagement²
- Cultural competency of physician
- Care coordination and care management

¹ 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. **Working Definition of Population Health, Institute Of Medicine, Roundtable on Population Health Improvement** <http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx>

² One participant questioned whether physician engagement should be part of this work group

Risk and protective factors need to be included³

- Include mental health indicators – e.g. depression screen
- Include measures of substance use and misuse – regulated and unregulated
- Weave in prevention of adverse childhood health events
- Environmental factors – e.g. air, water, walk to school

Expand to social determinants⁴

- Transportation, housing, education, poverty
- Consider social health status – GMCB working on this
- “Community” , school and family engagement

Expanded Timeframe

- Do not limit to 3-5 years; Need longer for expected changes; 20 year better
- Develop a balanced portfolio of measures — some short term and others longer

Characteristics of the measures

- Simple
- Clear
- Measureable
- Evidence based or “evidence supported”

Priority Measures

The following pending measures were selected as our first priority to be moved into payment or reporting status:

Core-40	MSSP-21	Screening for High Blood Pressure and Follow-Up Plan Documented
Core-36	MSSP-17	Tobacco Use Assessment and Tobacco Cessation Intervention
Core-44		Percentage of Patients with Self-Management Plans
Core-34		Prenatal and Postpartem Care Timeliness

³ **Risk factors** are conditions or variables associated with a lower likelihood of positive outcomes and a higher likelihood of negative or socially undesirable outcomes. **Protective factors** have the reverse effect: they enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences from exposure to risk.

⁴ **The social determinants of health** are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics <http://www.cdc.gov/socialdeterminants/>

There were also measures selected as our second priority:

Core-9		Depression Screening by 18 Years of Age
Core-30		Cervical Cancer Screening
Core-35	MSSP-14	Influenza Immunization
Core-39	MSSP-28	Hypertension (HTN): Controlling High Blood Pressure
Core-45		Screening, Brief Intervention, and Referral to Treatment

This current list of pending measures is not comprehensive; the universe of possible measures looking at upstream determinants is wider and deeper than this particular list. We would like to work with you on a process to identify, vet and include additional measures for other parts of our health system that can be used to address population health as we go forward.

Thanks for the opportunity to contribute to this discussion. We would be glad to engage in more exploration of how measurement can play a role in incentivizing change in the system to improve the health of the population.

Attachment 5 - Population Health to Clinical Measures

Healthy Vermonters 2020

Healthy Vermonters 2020 Indicator	Corollary Measures in a Clinical Setting	Corollary Measures in a Community Setting	Notes
ACCESS TO HEALTH SERVICES			
% of Vermonters with health insurance			
% of adults with health insurance			
% of children with health insurance			
Number of practicing Primary Care Providers – Medical Doctors (MD and DO)			
Number of practicing Primary Care Providers – Physician Assistant			
Number of practicing Primary Care Providers – Nurse Practitioner			
% persons with insurance coverage for clinical preventative services			
% of adults with a usual primary care provider			
% of all Vermonters with a specific source of ongoing care			
% who cannot obtain care or delay care (including medical care, dental care, or prescriptions)			
ARTHRITIS & OSTEOPOROSIS			
% of adults with diagnosed arthritis who have activity limitations			
% of adults with diagnosed arthritis who receive physical activity counseling			
% of adults with diagnosed arthritis who receive arthritis education			
% of adults age 50 and older with osteoporosis			
CANCER			
Overall cancer death rate per 100,000			
% of cancer survivors always or usually getting emotional support			
% of cancer survivors who report excellent or good general health			
% of women receiving cervical cancer screening			
% of adults receiving colorectal cancer screening	NQF – 0034		
% of women receiving breast cancer screening			
% of men discussing PSA screening for prostate cancer with their health care provider			
CHILDHOOD SCREENING			
% of infants screened for Autism Spectrum Disorder and other developmental delays before 24 months			
% children with Autism Spectrum Disorder diagnosis with first evaluation by 36 months			
% of newborns screened for hearing loss by 1 month age			
% of newborns not passing screening, who have an audiologic evaluation by 3 months			
% of infants with hearing loss who receive intervention services by 6 months age			
DIABETES & CHRONIC KIDNEY DISEASE			
Rate of new cases of end-stage renal disease (ESRD) per million population			

Healthy Vermonters 2020

Healthy Vermonters 2020 Indicator	Corollary Measures in a Clinical Setting	Corollary Measures in a Community Setting	Notes
% of adults with diagnosed diabetes with A1C < 7%	NQF 0279 Optimal Diabetes Care The percentage of patients 18-75 with a diagnosis of diabetes, who have optimally managed modifiable risk factors (A1c<8.0%, LDL<100 mg/dL, blood pressure<140/90 mm Hg, tobacco non-use and daily aspirin usage for patients with diagnosis of IVD) with the intent of preventing or reducing future complications associated with poorly managed diabetes.		
% of adults with diagnosed diabetes with A1C < 7%	NQF 0056 Foot Exam Percentage of Adults (aged 18 years or older) with Diabetes Receiving a Foot Exam in the Last Year		
% of adults with diagnosed diabetes with A1C < 7%	NQF 0055 Percentage of Adults (aged 18 years or older) with Diabetes Receiving a Dilated Eye Exam in the Last Year		
% of adults with diagnosed diabetes with controlled blood pressure			
% of adults with diagnosed diabetes who had an annual dilated eye exam			
% of adults with diagnosed diabetes who had diabetes education			
ENVIRONMENTAL HEALTH & FOOD SAFETY			
% of persons served by public water supplies that meet Safe Drinking Water Act standards			
% of children with elevated blood lead levels			
Elevated blood lead level rate per 100,000 employed adults			
% of homes with high radon levels (4pCi/L) with mitigation system			
% of schools with an indoor air quality management system			
% of inspections that find critical food safety violations			
FAMILY PLANNING			
% of pregnancies that are planned			
% of adolescents in grades 9-12 who used contraception at most recent intercourse			
% of female adolescents who receive education on STDs			
% of male adolescents who receive education on STDs			
HEART DISEASE & STROKE			
Coronary heart disease death rate per 100,000			
Stroke death rate per 100,000			
% of adults with hypertension	NQF 0018 HTN: Controlling High Blood Pressure Percentage of patients > 18 years of age with a diagnosis of hypertension in the first six months of the measurement year or any time prior with last BP < 140/90 mm Hg		
% of children and adolescents with hypertension			

Healthy Vermonters 2020

Healthy Vermonters 2020 Indicator	Corollary Measures in a Clinical Setting	Corollary Measures in a Community Setting	Notes
<p>NQF 0074 Lipid Control Percentage of patients aged 18 years and older with a diagnosis of CAD seen within a 12 month period who have a LDL-C result <100 mg/dL OR patients who have a LDL-C result >=100 mg/dL and have a documented plan of care to achieve LDL-C <100mg/dL, including at a minimum the prescription of a statin</p>			
<p>% of adults with cholesterol check in past 5 years</p>			
<p>HIV & STD</p>			
Number of new HIV diagnoses among all persons	NQF 1999		
% of adults age 18-64 tested for HIV in past 12 months			
% of adolescents ever tested for HIV			
% condom use among sexually active adult females			
% condom use among sexually active adult males			
% condom use among sexually active adolescent females in grades 9-12			
% condom use among sexually active adolescent males in grades 9-12			
% of females age 15-24 with Chlamydia infections			
<p>IMMUNIZATION & INFECTIOUS DISEASE</p>			
<p>% of children age 19-35 months receiving recommended vaccines (4:3:1:4:3:1:4)</p>			
% of kindergarteners with 2 or more MMR doses	NQF 0038		
% of adolescents age 13-17 with at least 1 Tdap booster			
<p>% of adults age 65 and older who receive annual flu shot</p>			
% of adults age 65 and older who ever had pneumococcal vaccine	NQF 0041		
% of identified active TB case contacts with newly-diagnosed LTBI who started and then completed treatment			
Infection ratio for central-line associated bloodstream infections			
<p>INJURY & VIOLENCE PREVENTION</p>			
Nonfatal motor vehicle crash-related injury rate per 100,000			
Fall-related death rate per 100,000 adults age 65 and older			
ED visits for self-harm rate per 100,000			
<p>MATERNAL & INFANT HEALTH</p>			
Sudden, Unexpected death rate for Infants (per 1,000 live births)			
% of pregnant women who abstain from alcohol			
% of pregnant women who abstain from smoking cigarettes			
% of pregnant women who abstain from illicit drug use			
% women delivering a live birth who discussed preconception health prior to pregnancy			
% of women delivering a live birth who had a healthy weight prior to pregnancy			
% of infants breastfed exclusively for six months	% referred for breast feeding class prior to delivery/% referred to lactation consultant	% attending breast feeding classes in local community	
<p>MENTAL HEALTH</p>			
<p>Rate of Suicide per 100,000 Vermonters</p>			
<p>% of adolescents in grades 9-12 with a suicide attempt that requires medical attention</p>			

Healthy Vermonters 2020

Healthy Vermonters 2020 Indicator	Corollary Measures in a Clinical Setting	Corollary Measures in a Community Setting	Notes
% of adults age 19 and older PCP visits that include depression screening			
% of adolescent PCP visits that include depression screening			
NUTRITION & WEIGHT STATUS			
% of adults age 20 and older who are obese	Adult Weight Screening and Follow-Up. Percentage of patients aged 18 years and older with a calculated BMI documented in the medical record AND if the most recent BMI is outside the parameters, a follow up plan is documented		
% of children age 2-5 (in WIC) who are obese	Body Mass Index (BMI) 2 through 18 Years of Age Percentage children, 2 through 18 years of age, whose weight is classified based on BMI percentile for age and gender		
% of adolescents in grades 9-12 who are obese	Body Mass Index (BMI) 2 through 18 Years of Age	not applicable	
% of households with food insecurity			
% of adults eating the daily recommended servings of fruit			
% of adolescents in grades 9-12 eating the daily recommended servings of fruit			
% of adults eating the daily recommended servings of vegetables			
% of adolescents in grades 9-12 eating the daily recommended servings of vegetables			
OLDER ADULTS			
% of older adults who use the Welcome to Medicare Benefit			
% of males age 65 and older who are up to date on a core set of clinical preventive services			
% of females age 65 and older who are up to date on a core set of clinical preventive services			
ORAL HEALTH			
% of children age 6-9 with dental caries			
% of adults age 45-64 with tooth extraction			
% of children age 6-9 using dental system yearly			
% of children in grades K- 12 using dental system yearly			
% of adults using dental system yearly			
% of the population with optimally fluoridated water			
PHYSICAL ACTIVITY			
% of adults with no leisure time physical activity			
% of adults meeting physical activity guidelines			
% of adolescents in grades 9-12 meeting physical activity guidelines			
% of children age 2-5 with no more than 2 hours of television, videos, or video games			
% of children age 2-5 with no more than 2 hours of computer use			
% of adolescents in grades 9-12 with no more than 2 hours of screen time			
RESPIRATORY DISEASES			
Asthma hospitalization rate per 10,000 children less than age 5			
Asthma hospitalization rate per 10,000 persons age 5-64			
Asthma hospitalization rate per 10,000 adults age 65 and older			
% of adult non-smokers exposed to secondhand smoke			
% of adults who have a written asthma management plan from a health care provider			

Healthy Vermonters 2020

Healthy Vermonters 2020 Indicator	Corollary Measures in a Clinical Setting	Corollary Measures in a Community Setting	Notes
% of children who have a written asthma management plan from a health care provider			
% of adults with asthma advised to change things in home, school, or work environments			
% of children with asthma advised to change things in home, school, or work environments			
SCHOOL AGE HEALTH			
% of kindergarteners ready for school in all five domains of healthy development			
% of middle schools that require newly hired staff who teach health education to be licensed or endorsed by the State			
% of students age 10-17 who have had a wellness exam in past 12 months			
% of students absent due to illness or injury			
SUBSTANCE ABUSE			
% of persons age 12 and older who need and do not receive alcohol treatment			
% of adolescents in grades 9-12 who used marijuana in the past 30 days			
% of adolescents age 12-17 binge drinking in the past 30 days			
TOBACCO USE			
% of adults smoking cigarettes			
% of adolescents in grades 9-12 smoking cigarettes			
% of adult smokers who attempted to quit in the last year	A) Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period, B) Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period		
# of statewide laws on smoke-free indoor air to prohibit smoking in public places			
PUBLIC HEALTH PREPAREDNESS			
Time necessary to issue official information regarding a public health emergency			
Time necessary to activate personnel for a public health emergency			
Time to produce after-action reports and improvement plans following an emergency			
Proportion of crisis and emergency risk messages intended to protect the public's health that demonstrate the use of best practices			

Attachment 6 - Proposed Scope of Work

Vermont Health Care Innovation Project
Population Health Work Group
Statement of Work
Draft 3/31/14

I. Background

The Population Health Workgroup (PHWG) is one of seven workgroups created to assist in the implementation of the CMS award to Vermont of a State Innovation Model implementation grant (the Vermont Health Care Innovation Project <http://healthcareinnovation.vermont.gov/>). One of the three tasks specified in the charter of the PHWG is:

Identifying and disseminating current initiatives in Vermont and nationally where clinical and population health are coming together. Identifying opportunities to enhance new health delivery system models, such as the Blueprint for Health and Accountable Care Organizations (ACOs), to improve population health by better integration of clinical services, public health programs and community based services at both the practice and the community levels.

The workgroup has recognized that improving population health requires a coordinated strategy at multiple levels including the provider practice, state, and national; however, the community level is increasingly recognized as an critical locus of efforts. A number of conceptual models have identified the need to have an integrator function at the community level to mesh clinical care, public health programs and community based initiatives in a coherent strategy to meet the community's needs. This is the common denominator among several similar concepts such as Accountable Health Communities, community integrators, community quarterbacks for community development, the 'backbone organization' of the collective impact movement and the Community Health System.

For the purposes of this RFP, we will use the term an Accountable Health Community (AHC).

An AHC would be accountable for the health of the population in a geographic area, including reducing disparities in the distribution of health. Its major functions when fully developed could include:

- convening a broad set of key stakeholders such as governmental public health agencies, communities, the health care delivery system, employers and businesses, and the education sector.
- reconciling diverse perspectives and defining a shared vision and goals
- assessing the needs of the community, identifying gaps and potential interventions and prioritizing actions to achieve shared goals
- managing a diverse portfolio of interventions and allocating resources

- creating the information systems and capability to assess performance and implement rapid cycle changes

Vermont is interested in exploring the development and potential application of a model that is appropriate within the context of the innovations currently underway through VHCIP and other health system reforms.

One significant area to explore is the necessary infrastructure to support these functions, generally, and specifically options in Vermont given our existing and newly emerging models for health care delivery and health system reform.

For example, what would be the appropriate infrastructure in a community served by an ACO? The AHC model must be attentive to the capabilities of the ACO's, Enhanced Medical Homes, and other resources and entities in a region in order to engage potential partners and not duplicate their functions.

No complete model of an AHC exists.

The task in the workgroup charter is intended to lay the groundwork for the potential development of a Phase II pilot program which would create one or more tests of the AHC concept in Vermont.

After the completion of Phase I, this scope of work, the PHWG will consider contracting with a vendor that could provide technical assistance in completing a pilot program in the subsequent 12 months.

II. Deliverables

The vendor will be a resource for the PHWG leadership team in completing the task. In general, it will participate in the planning and conducting workgroup meetings and in identifying interdependencies with other tasks of the workgroup and coordinating work with other workgroups.

The vendor will be responsible for the following deliverables:

1. Develop required materials including

- a. Communications: a clear written description of the plan for carrying out the scope of work and ppt presentation for key stakeholders
- b. Description of the key characteristics of an AHC based on a synthesis of the literature and building on the products of the IOM Roundtable on Population Health.
- c. A tool based on the characteristics identified which can be used for both identify potential models in action both outside and within Vermont

2. Identify exemplars outside of Vermont

- a. Conduct a scan of potential exemplars from the literature, IOM roundtable agendas, and pools such as the IHI Triple Aims collaborative, Aligning Forces for Quality, CMMI SIMs states, etc.
- b. Use the assessment tool from #1 to recommend 4-6 sites for in depth reviews
- c. Conduct telephonic reviews and write up case studies
- d. Synthesize key gaps and developmental needs and issues in developing a model for an AHC in VT
- e. Prepare report on finding based on case studies

3. Apply national scan to Vermont

- a. Analyze how the identified functions and configurations of the AHC model could interface with the current major delivery system reforms in Vermont (Blueprint for Health and ACO's) and identify major synergies and potential issues
- b. Note issues related to Vermont's size and scale, governmental structures, community infrastructure, etc.

4. Identify opportunities in Vermont

- a. Develop and disseminate a Request for Information from Vermont communities and providers interested in exploring the AHC concept
- b. Select 2-4 sites for in-depth discussion about current structures and functions as well as opportunities and changes needed to adopt an AHC model for population health improvement.
- c. Report on readiness in VT communities to create new systems or infrastructure to provide the functions of an AHC.

5. Developing a draft proposal for a pilot

- a. Develop a proposal for Phase II: development of 1-3 pilot AHC's in Vermont including potential sites, resource needs and objectives of the pilot.
- b. Identify potential funding sources/sponsors for the pilot including the possibility of seed grants from the PHWG
- c. Identify potential strategic relationships with other states, foundations and federal agencies in developing a pilot
- d. Share the work with other VHCIP committees to consider link with innovations and payment models being tested in VT

III. Scope and timeline

Phase I will be completed by 12/31/14 and should not exceed \$70,000