Attachment 1 - Population Health Work Group Meeting Agenda 5-13-14

VT Health Care Innovation Project
Population Health Work Group Meeting Agenda

Date: Tuesday, May 13, 2014 Time: 2:30-4:00 pm
DVHA Large Conference Room, 312 Hurricane Lane, Williston
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: Explore Northwest Medical Innovation Proposal	Tracy Dolan	**Attachment 1:** Agenda	
2	2:40	**Approval of minutes**	Karen Hein	**Attachment 2:** Minutes	
3	2:45	**Report on Measures Work Group on Criteria and Pending Measures** Presentation Public comment	Heidi Klein	**Attachment 3:** Proposed Measures Review	
4	3:00	**Northwest Medical Presentation and Discussion**	Jill Berry Bowen	**Attachment 4:** RISE VT Presentation Link to VHCIP Grant Program Application: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/VHCIP.GP_.Application.1.16.14.Final_.pdf	
5	3:45	**Work Group Work Plan and Charter: Update**	Tracy Dolan		
6	3:50	**Next Steps** *What information do work group members need in order to continue our work together?*	Karen Hein		

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

Attachment 2 - Population Health Work Group Minutes 4-08-14

VT Health Care Innovation Project
Population Health Work Group Meeting Minutes

Date of meeting: Tuesday, April 8, 2014; 2:30 to 4:30 PM, Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT

Call in: 877-273-4202, Passcode: 9883496

Attendees: Tracy Dolan, Karen Hein, Co-Chairs; Heidi Klein, VDH; Georgia Maheras, AoA; Mark Burke, Brattleboro Memorial Hospital; Judy Cohen, Wendy Davis, UVM; Ted Mable, NW Counseling & Support; Laural Ruggles, NVRH; Geera Demers, BCBS; Jesse de la Rosa, VWED; Penrose Jackson, FAHC; Melissa Miles, Bi-State; Julia Shaw, Lila Richardson, VT Legal Aid; Wendy Davis, UVM; Nick Nichols, DMH; Stephanie Winters, VMS; JoEllen Tarallo Falk, Center for Health & Learning; Chris Smith, MVP; Miriam Sheehey, OneCare; Dee Burroughs-Biron, DOC; Jessica Mendizabal, Nelson LaMothe, Project Management Team.

Agenda Item	Discussion	Next Steps
1 Welcome, roll call and agenda review	Tracy Dolan called the meeting to order at 2:33 pm. She reviewed the agenda noting the overall goals and adding that the 4th objective will be to review the provider grant proposals that were referred to this work group by the Core Team.	
2 Approval of minutes	Karen Hein asked for a motion to approve the minutes. Laural Ruggles moved to approve the minutes and Stephanie Winters seconded. The motion passed unanimously. Georgia Maheras gave an overview of the VHCIP Grant Program: the Core Team received 33 applications and $3.4 million is intended to be awarded in two rounds of funding. They received applications totaling over $17 million in requests. The Governor announced awards to nine entities. More information will be posted to the website soon and all contracts will be made available. Proposals were placed into three categories: proposals awarded; those that did not meet criteria;	

Agenda Item	Discussion	Next Steps
	those that had some merit and were referred to work groups (though they are considered denied for grant funding purposes). A second grant round is scheduled for the June/July timeframe. Organizations that have been referred to work groups are allowed to modify and re-submit their applications in the second round. Work groups are asked to review the proposals and discuss the ideas. Work groups are not, at this point, expected to take any action on the referred applications until guidance from the Core Team provided. Two proposals from Northwestern Medical Center have been recommended to the Population Health work group, and they have been asked to present at the next meeting. The work group needs to decide if they want to encourage NWMC to submit to the second round of grant funding, and discuss ways to strengthen proposal to meet the application criteria. Georgia noted the approved funding under the SIM grant is meant to support three specific payment models so if there is a request for a different model of reimbursement we can't fund it through this grant. Karen noted that we would like to see more population health topics reflected in the SIM work and this work group will begin to work closely with other work groups to strengthen Population Health ideas.	
3 Share Criteria and Recommendations Submitted to Measures Work Group on Pending Measures	Heidi updated the work group on the actions taken since the last meeting to develop recommendations for population health measures. She referenced the Criteria for Population Health Measures Discussion Notes 3-11-2014 (attachment 2b) and the votes from the last meeting and included the tally sheet (attachment 2c). These were reviewed by the subcommittee and were the basis for the memo sent to Quality and Performance Measures work group (attachment 3). She noted that the co-chairs reviewed the recommendations of the work group, reviewed the existing ACO reporting measures and the State Health Improvement Plan, in order to develop the two sets of priority measures. Heidi shared the official recommendations from the Population Health work group at the March QPM meeting. No decisions have been made but the response from QPM was positive and it seemed that there is some overlap with DLTSS and mental health. There is no further action for the Population Health work group at this point. There will be other opportunities to promote measures. Dee Burroughs-Biron agreed with the recommendations and stated these are aligned with what	

Agenda Item	Discussion	Next Steps
	the Department of corrections is already using. Penrose Jackson recommended sharing this information with the Workforce work group so those who are not in clinical positions can support it as well. Tracy explained that she and Karen Hein presented to the Care Models and Case Management work group on some of Vermont's demographics including a future projection to help plan for health care needs. In addition to the aging of the adult population there is also a decline in birth rates.	
4 From Measures to Action -- So what? Why do measures matter?	This time was used to discuss the VHCIP grants determination for round one and the referral back to the Population Health work group.	
5 Working Backwards: Population Health to Community to Clinical Measures sets	Heidi noted that the group will begin to focus on the broader factors that contribute to health overall, and not only what is represented in the ACOs, where the most sick and costly are documented. Heidi referenced attachment 5, the Healthy Vermonters 2020 measures. Measures highlighted in yellow are already in the State Health Improvement Plan (SHIP) and those in Mauve are required by CMS for the State to track. For the Healthy Vermonters measures, 95% are generated from the surveys (such as the behavioral risk factor survey), counterpart agencies, and claims data. There are some measures currently without a data source which is being improved upon. Measures where there is overlap: weight status, nutrition, and tobacco use (which this work group has recommended to QPM). Within the SHIP: immunization, mental health, physical activity and substance Abuse. CMS: colorectal screening, diabetes, hypertension, cholesterol. Using criteria from attachment 2b, the group was asked to consider how the measures can be documented in a clinical or community setting. For example: with diabetes the NQF measure happens in a clinical setting, but what are the contributing factors in a community setting? The	

Agenda Item	Discussion	Next Steps
	work group divided into small groups to discuss the health areas and identify corollary measures in a clinical, community and population-wide setting. The intent was to see if there might be additional clinical measures to track through the ACOs. The community measures and population-wide measures will inform other parts of our efforts. The groups were instructed to focus on measures that are already being collected, the type of measure, and how it is collected. They discussed how collection would differ in a community and clinical setting. The breakout groups reviewed the following areas: Nutrition/Weight Status, Diabetes, Hypertension and Substance Abuse and Mental Health. Substance Abuse- Core 45: Screening and brief intervention listed under the clinical setting measure, including questions about developmental task, how are they expressing their creative selves, and barriers to do that. In a community setting: substance outlet density; access to treatment; access to cultural activities and recreational activities. Think about how you would describe an asset rich community. Nutrition and Weight Status- Community setting: measure employers that have wellness plans and assessments; fruit and vegetable consumption; community farmers markets; CSAs; foods being served in schools and institutions; price of healthy food relative to unhealthy food; and physical activity. Clinical measures: standard obesity, blood pressure, physical activity, food insecurity: use standardized tools to measure. Mental Health: Assess suicide risk and discuss warning signs in a standard depression screen (2 already exist): practices for self-care; impact of sexuality and gender; impact verbal or physical violence; what coping skills they use; asking about safety; home safety and support; access to resources and community groups; warning signs when they are critical; asking about suicide and thoughts. Special need to create a private space to conduct the screening. Diabetes- NQF0279 in a clinical setting, Hypertension- NQF018 Community for both: nutrition and physical activity; food literacy and nutritional counseling for everyone; affordable gym classes, employee wellness; changes in school physical activity; and safe sidewalks.	**Note takers for this activity should send their notes to Heidi and she will work on next steps.**

Agenda Item	Discussion	Next Steps
6 Consultant Contract: Accountable Communities	Karen referenced attachment 6, the proposed Scope of Work for the Population Health work group and the ability to use funding to assist with the third goal of identifying exemplars that represent Accountable Healthcare Communities (AHCs). There is no complete model of an AHC in Vermont and the group is proposing to identify the opportunity within VT to develop an AHC pilot program. There is $70,000 remaining in the work group's budget this year and a portion of it would be spent on this goal. The proposal will be sent to the Steering Committee and then the Core Team. The work group has $100,000 to spend each year to advance the Population Health agenda. Year 1 SIM grant funding needs to be spent by Sept. 30, 2014. Penrose Jackson moved to recommend the proposal, which was seconded by Peter Cobb. Georgia noted that if there is a delay in committing these funds it will not hold up the funding for activities for next year. Accepting the modification, the motion passed unanimously.	
7 Public Comment and Next Steps	Next Meeting: May 13th 2:30 – 4:00 pm. ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier. In the coming weeks the group will be asked to complete a survey via Survey Monkey to help assess what is going well and what can be improved.	

Attachment 3 - Proposed Measures Review

VT Quality and Performance Measures Work Group
Review of 2014 Pending Measures for 2015 Reporting Status
April 26, 2014

The measures listed below are those that were proposed for adoption for 2015 reporting by the Population Health Work Group, the Howard Center and Vermont Legal Aid during the Quality and Performance Measures Work Group's March 24, 2014 meeting. With the possible exception of measure Core-45, the measures make use of data residing in clinical records, thus requiring rate generation through individual record review or automated electronic data extract.

#	Measure Name	Considerations for Review
Core-8	*Developmental Screening in the First Three Years of Life (currently in Medicaid measure set; proposed for commercial measure set)*	• NQF #1448 • HEDIS and CHIPRA • CMS has analyzed data from five states (AL, IL, NC, OR, TN that reported the measure for FFY12 consistently using prescribed specifications. (CMS reports that 12 states reported in FFY13 and 18 stated intent to do so in FFY14.) • Best practice (IL): 77%, 81%, 65% in Years 1-3; five-state median: 33%, 40%, 28% • Medicaid is able to use claims data, but provider coding for commercial payers is not reliable, so the commercial measure would require data from clinical records.

Core-30	Cervical Cancer Screening	• NQF #0032
		• HEDIS benchmark available (for HEDIS 2015, no benchmark for 2014).
		• Change in HEDIS specifications for 2014:
		  o Added steps to allow for two appropriate screening methods of cervical cancer screening: cervical cytology performed every three years in women 21–64 years of age and cervical cytology/HPV co-testing performed every five years in women 30–64 years of age.
		  o Removed coding tables and replaced all coding table references with value set references.
		  o Added the hybrid reporting method for commercial plans.
		• Historical Performance HEDIS 2013 (MCO w/o PPO)
		  o BCBSVT: 76%; CIGNA: 76%; TVHP: 74%
		  o National 90th percentile: 82%; **Regional 90th percentile: 85%**
		  o National Average: 76%; Regional Average: 79%
		• Historical Performance HEDIS 2013 (PPO)
		  o BCBSVT: 72%; CIGNA: 71%; MVP: 71%
		  o National 90th percentile: 78%; **Regional 90th percentile: 82%**
		  o National Average: 74%; Regional Average: 78%

#	Measure Name	Considerations for Review
Core-34	Prenatal and Postpartum Care	• NQF #1517 • HEDIS benchmark available • Timeliness of Prenatal Care Historical Performance HEDIS 2013 (MCO w/o PPO) o BCBSVT: 95%; CIGNA: 75%; TVHP: 93% o National 90th percentile: 97%; **Regional 90th percentile: 98%** o National Average: 90%; Regional Average: 90% • Timeliness of Prenatal Care Historical Performance HEDIS 2013 (PPO) o BCBSVT: 94%; CIGNA: 74%; MVP: 95% o National 90th percentile: 96%; **Regional 90th percentile: 96%** o National Average: 81%; Regional Average: 82% • Postpartum Care Historical Performance (MCO w/o PPO) o BCBSVT: 86%; CIGNA: 50%; TVHP: 83% o National 90th percentile: 91%; **Regional 90th percentile: 93%** o National Average: 80%; Regional Average: 84% • Postpartum Care Historical Performance (PPO) o BCBSVT: 83%; CIGNA: N/A; MVP: 84% o National 90th percentile: 86%; **Regional 90thpercentile: 90%** o National Average: 70%; Regional Average: 70%
Core-35/ MSSP-14	Influenza Immunization	• NQF #0041 • MSSP • No national benchmark available. • Need to consider how to capture immunizations that were given outside of the PCP's office (e.g., in pharmacies, at public health events, etc.)
Core-36/ MSSP-17	Tobacco Use Assessment and Tobacco Cessation Intervention	• NQF #0028 • MSSP measure • No national benchmark available, but measure in use in other states and HRSA and CDC publish benchmarks, so benchmarking feasible.

#	Measure Name	Considerations for Review
Core-39/ MSSP-28	Hypertension (HTN): Controlling High Blood Pressure	• NQF #0018 • MSSP measure • Changes to national guideline: In December 2013, the eighth Joint National Committee (JNC 8) released updated guidance for treatment of hypertension. The new guidelines: o Set the BP treatment goal for patients 60 and older to <150/90 mm Hg. o Keep the BP treatment goal for patients 18–59 at <140/90 mm Hg. • Proposed big changes to HEDIS specifications in 2015: The proposed measure aligns with the JNC 8 guidelines. The measure will be based on one sample for a total rate reflecting age related BP thresholds. The total rate will be used for reporting and comparison across organizations. • HEDIS benchmark currently available but with measure likely to change, there is a possibility that there won't be a benchmark for 2015. • Historical Performance HEDIS 2013 (MCO w/o PPO) o BCBSVT: 70%; CIGNA: 67%; TVHP: 62% o National 90th percentile: 75%; **Regional 90th percentile: 78%** o National Average: 63%; Regional Average: 68% • Historical Performance HEDIS 2013 (PPO) o BCBSVT: 61%; CIGNA PPO: 62%; MVP PPO: 67% o National 90th percentile: 65%; **Regional 90th percentile: 78%** o National Average: 57%; Regional Average: 63%
Core-40/ MSSP-21	Screening for High Blood Pressure and Follow-up Plan Documented	• Not NQF-endorsed • MSSP measure • No national benchmark available
Core-44	*Percentage of Patients with Self-Management Plans*	• Need to develop measure specifications based on the NCQA standard • Not NQF-endorsed • No national benchmark available
Core-45	*Screening, Brief Intervention, and Referral to Treatment*	• Need to develop measure specifications or a claims-based measure. If the latter, could possibly involve provider adoption of new codes. • Not NQF-endorsed • No national benchmark available, but in use by Oregon Medicaid

Attachment 4 - RISE VT Presentation

RISE VT

Embracing Healthy Lifestyles

A collaborative approach
to creating, expanding, and accelerating
improved health in our community.

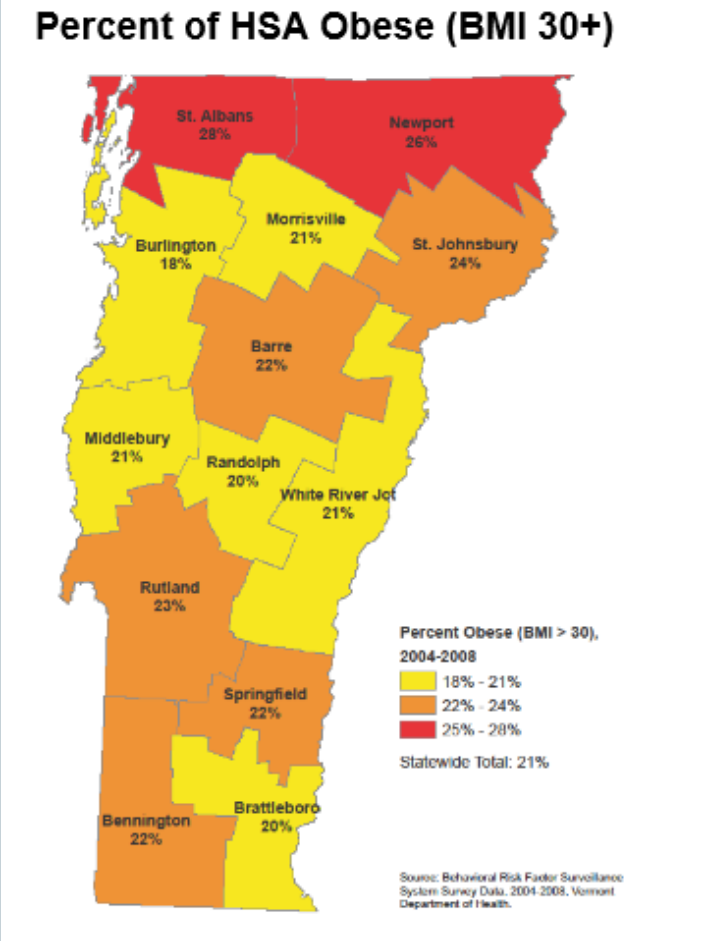
Overview Presentation
May, 2014

Facing Poor Health Indicators

- Franklin County has some of the poorest health indicators in Vermont, lagging behind in indicators which include:
  - Obesity,
  - Physical activity,
  - Healthy eating.

- Grand Isle County appears to score somewhat better but the small population makes it difficult to accurately assess, as slight changes result in large percentage shifts.

The Data Is Clear: We Lag Behind



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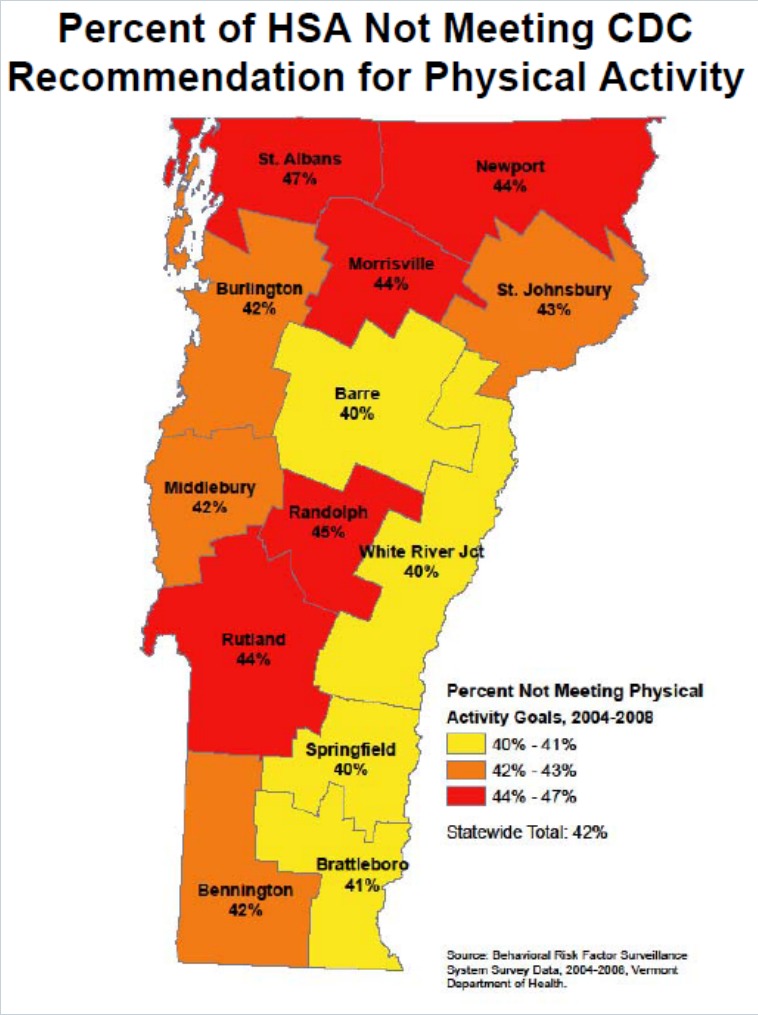
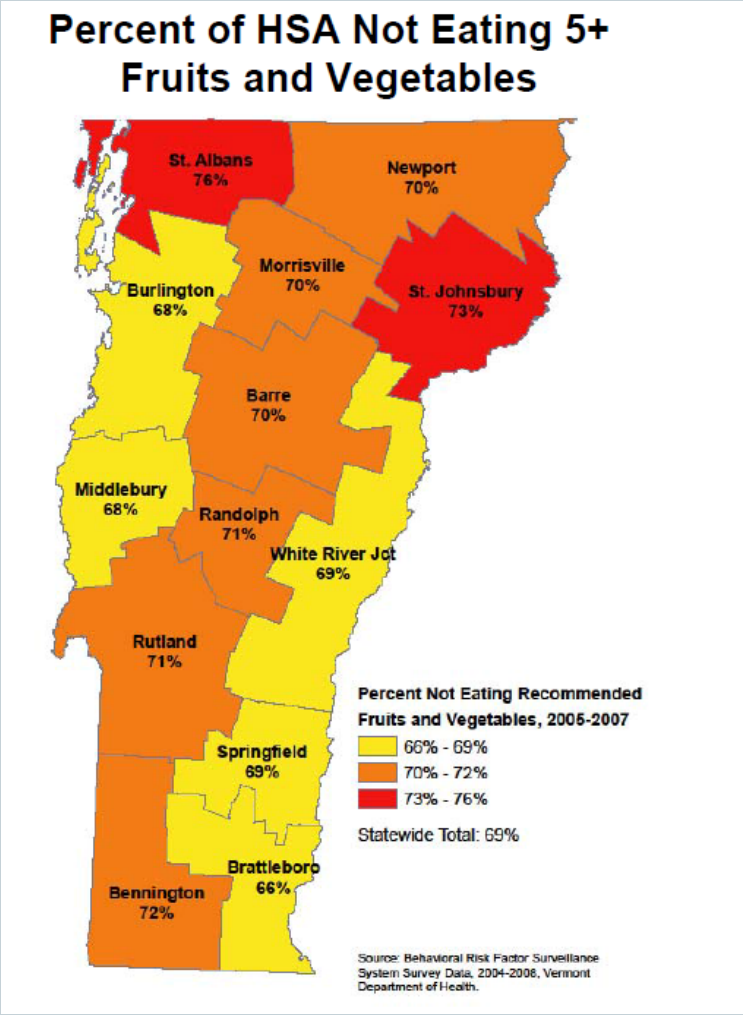
RISE VT Embracing Healthy Lifestyles

The Data Is Clear: We Lag Behind



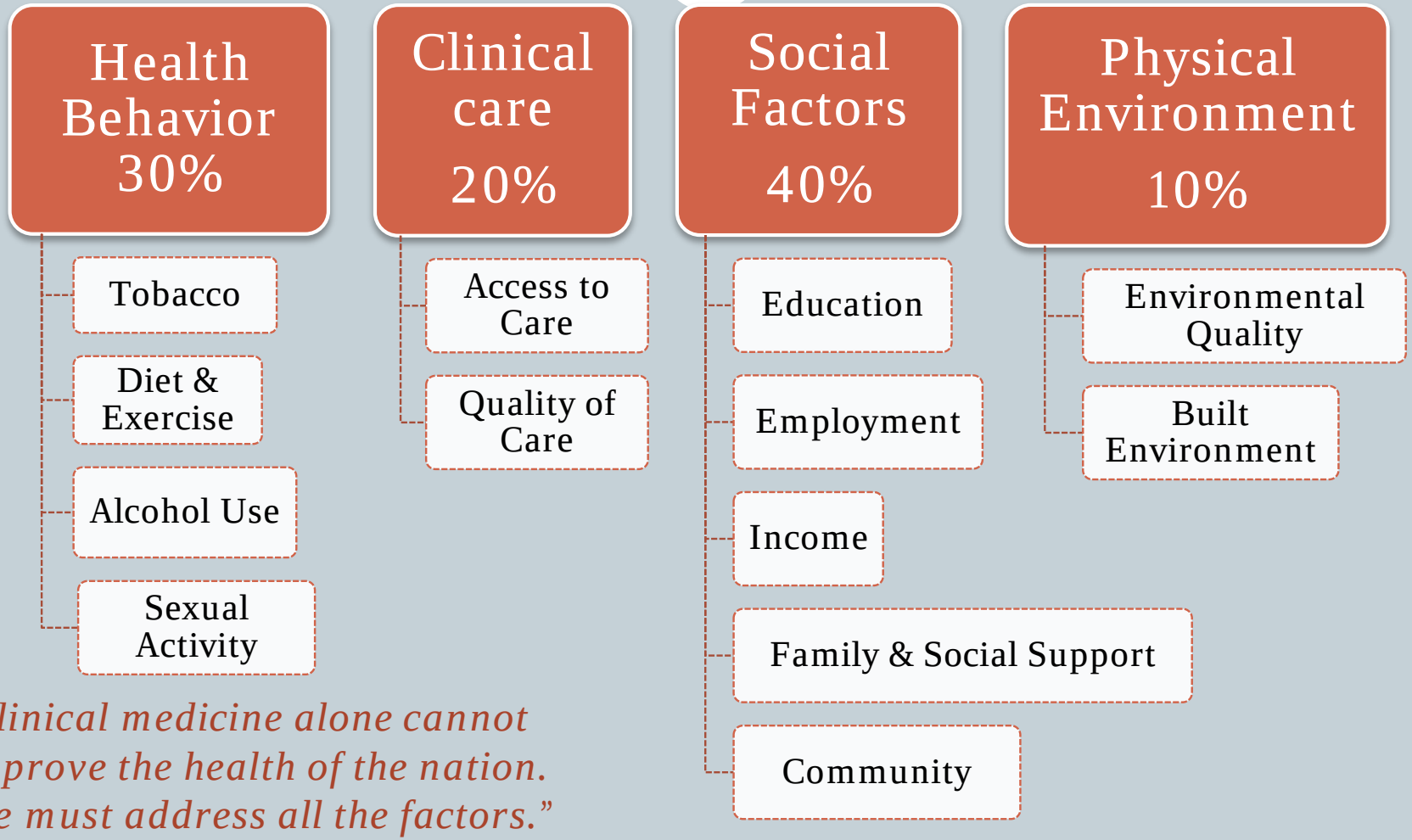


The Ramifications of Our Poor Health

- Our behaviors are literally killing us through heightened rates of cardiovascular disease and other chronic conditions.

- Our heightened rates of significant medical problems result in increased costs within the healthcare system which could have been prevented.

Factors Affecting Health Outcomes



"Clinical medicine alone cannot improve the health of the nation. We must address all the factors."

Source: U. of Wisc. Population Health Institute, 2012

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Coming Together For Change

- The Community Committee on Healthy Lifestyles is our new collaborative approach to improving the health of our community, building upon what is working and adding what is needed. It includes representatives of:

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NOTCH

NMC Northwestern Medical Center

Franklin-Grand Isle United Way fgiunitedway.org

LIVE UNITED United Way

St. Albans Messenger Vermont's Oldest Evening Newspaper

Northwestern Counseling & Support Services

Peoples Trust Company

FWSU Franklin West Supervisory Union

Franklin County Regional Chamber of Commerce

dickinson&branon dental care

Saint Albans Vermont

And additional community partners.

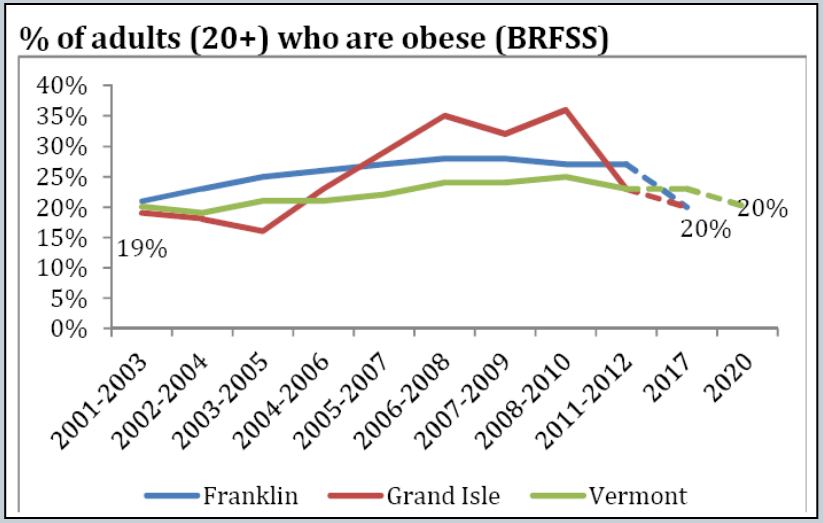
Duke's Fitness Center

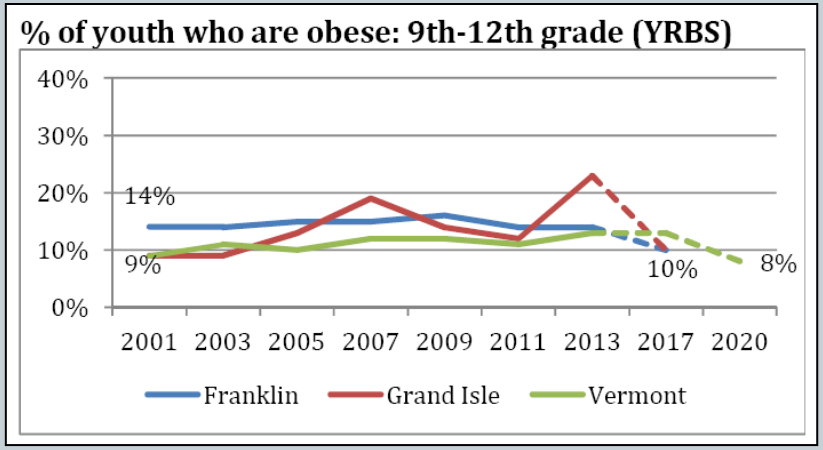
RISE VT Embracing Healthy Lifestyles

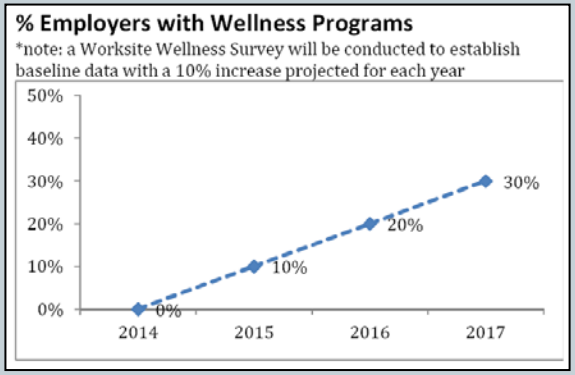
Focusing Our Efforts

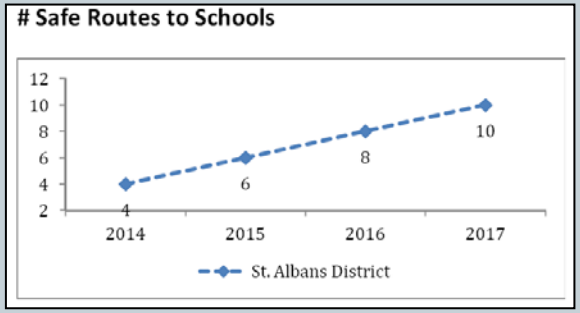
- The Committee used Results Based Accountability (RBA), data, and evidence-based practice to identify key outcomes:
  - Increase the overall health of residents by decreasing the percentage of overweight and obese individuals;
  - Expand resources for biking and walking;
  - Increase the number of employers offering a wellness program in which greater than 50% of the employees participate.
- The Committee has done research on evidence-based best practices to guide our strategy.

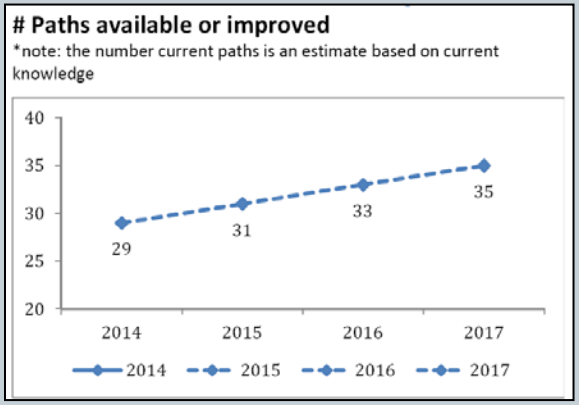
Targeting Specific Measurable Results











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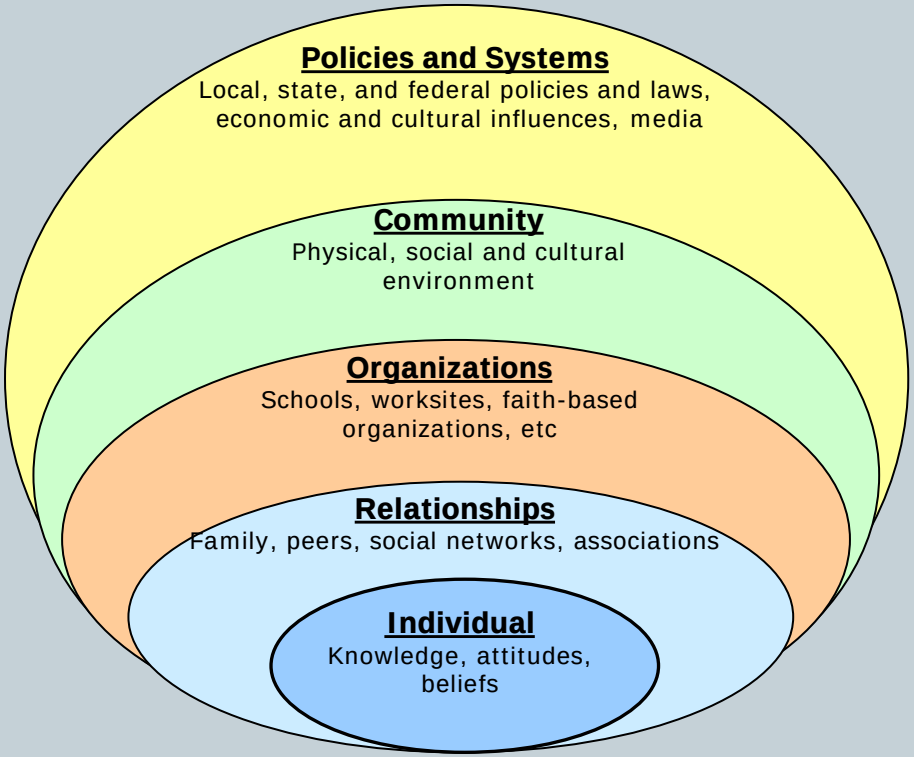
An Integrated, Best-Practice Approach

There are many factors in play that influence individual and population health.

- **Individual:** Factors that influence behavior such as knowledge, attitudes and beliefs
- **Relationships:** Influence of personal relationships and interactions
- **Organizations:** Norms, standards and policies in institutions or establishments where people interact such as schools, worksites, faith based organizations, social clubs and organizations for youth and adults
- **Community:** The physical, social, and cultural environments where people live, work, and play
- **Policies and Systems:** Local, state and federal policies; laws; economic influences; media messages and national trends that regulate or influence behavior

Vermont's Prevention Model



Adapted from: McElroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. Health Education Quarterly 15:351-377, 1988.

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RISE VT Embracing Healthy Lifestyles

An Energizing Brand

- The Committee has established "RISE VT: Embracing Healthy Lifestyles" as the brand for this exciting initiative – an energizing approach that creates a platform for local and Statewide success.

Details In Development

- Finalizing initial program components and creation of a cohesive plan for implementation;
- Establishing Levels of membership built on defined criteria, including measurable results, so an individual, group, event, or business can become part of the initiative at a base level and then advance through as their involvement expands;
- Co-branding with existing healthy initiatives to recognize great work being done and build collective strength;

Details In Development

- Integrating with community partners such as Primary Care, the Chamber of Commerce, schools, and others to leverage broad participation;

- Expanding the impact of prevention efforts through health advocates embedded in the community and a focus on policy changes and infrastructure development;

- Expanding the reach of NMC's proven Healthy Ü employee wellness program and Better Ü personal wellness program;

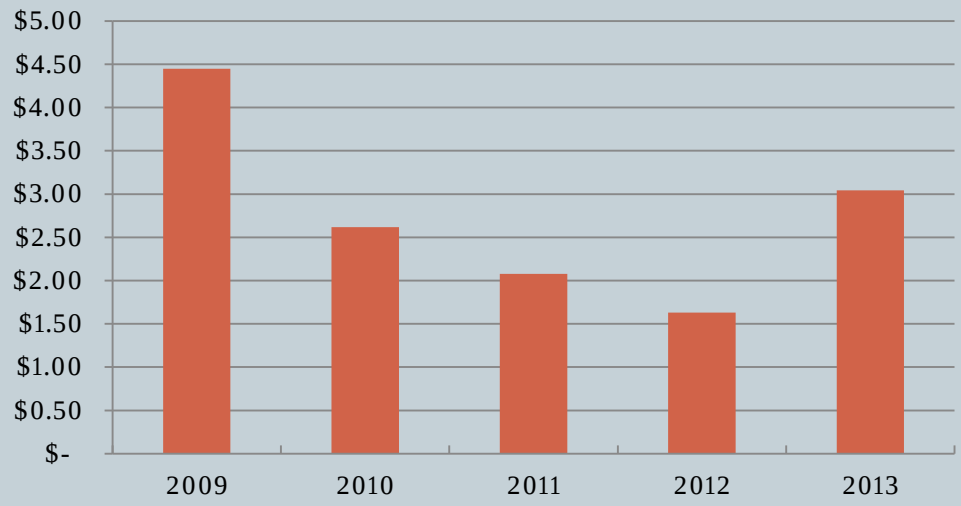
Details In Development

- Establishing a wellness portal so participants can have a health risk appraisal, track results, access education, share support, and hear about new opportunities;
- Seeking funding and expanded coordination to finish development, launch the program, and achieve sustainability;
- Documenting our path to assist in facilitating replication.

Building On Proven Success

- NMC's Healthy Ü employee wellness program has demonstrated a measurable and significant return on investment of $3 saved for every $1 invested.

Healthy U Return on Investment:
Savings Per Invested Dollar in Healthcare Claims
2009 - 2013
(not including hospital-absorbed staffing costs to implement)



**Calculated using annual health claims per covered life and annual Healthy U budget, compared to pre Healthy U health claims mean from 2004-2007.*

RISE VT
Embracing Healthy Lifestyles

Next Steps

- May 12: Presentation to NMC Incorporators.
- May 13: Presentation to the Green Mountain Care Board's "Population Health Workgroup" in follow-up to the referral of our unfunded grant application from the payment reform focused SIM grant process;
- June 4: Presentation to the NMC Board of Directors as part of hospital budget discussions;
- August (TBD): Presentation to the Green Mountain Care Board as part of NMC budget presentation;
- Ongoing: Continued work by the Committee to develop, refine, and implement this important initiative.