

Attachment 1 - Population Health Work Group Meeting Agenda 7-08-14

VT Health Care Innovation Project Population Health Work Group Meeting Agenda

Date: Tuesday, July 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 that 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	Tracy Dolan	Attachment 1: Agenda	
2	2:40	Approval of minutes	Karen Hein	Attachment 2: Minutes	
3	2:45	Updates Consultant Contract Accountable Communities: RFP Approved Criteria for next round of provider grants – memo sent	Tracy Dolan Heidi Klein	Attachment 3: Draft criteria	
4	2:50	Continuing the Discussion on Financing Population Health Presentations: <i>Are there current efforts in Vermont that are the seeds of a Community Health System as outlined at last meeting? Specifically, what is currently included in Prevention Coalitions, Community Health Teams, and the Blueprint and what additional components are needed?</i> Public Comment	Jenney Samuelson Laural Ruggles Melanie Sheehan	Attachment 4: a. Finance Presentation PP b. Blueprint c. StJ d. MAHHC	
5	3:30	Work Group Plan– Reflections and Refinement <ul style="list-style-type: none"> • <i>Is this the right direction to yield the desired results?</i> • <i>Are these the right levers to influence the project? What might be misdirected or missing?</i> • <i>Thoughts on setting the broader agenda</i> 	Tracy Dolan	Attachment 5: Work Plan Alignment with Operational Plan	
6	3:45	Work Group Process Evaluation	Annie Paumgarten	Attachment 6: Work Group Survey	
7	3:55	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
			•		
			•		
			•		
			•		

Attachment 2 - Population Health Work Group Minutes 6-10-14



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

Date of meeting: Tuesday, June 10, 2014; 2:30 to 4:00 PM, DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT.

Attendees: Tracy Dolan, Karen Hein, Co-Chairs; Heidi Klein, VDH; Georgia Maheras, AoA; Jim Hester, Consultant; Pat Jones, Annie Paumgarten; GMCB; Peter Cobb, VNAs of VT; Mark Burke, Brattleboro Memorial Hospital; Jill Berry Bowen, NMC; Wendy Davis, UVM; Judy Cohen, UVM; Melissa Miles, Bi-State; Chuck Myers, Northeast Family Institute; Laural Ruggles, NVRH; Stephanie Winters, VMS; Jen Woodard, DAIL; Daljit Clark, DVHA; Peter Cobb, VNAs of VT; Joyce Gallimore, CHAC; Nick Nichols, DMH; Sandy Floersheim, Orleans/Esses VNA & Hospice; Julia Shaw, VT Legal Aid; Shawn Skaflestad, AHS; Melanie Sheehan, Mt. Ascutney Hospital; Bradley Wilhelm, DVHA; 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.	
2. Approval of Minutes	Stephanie Winters moved to approve the minutes. Judy Cohen noted the next meeting date was listed incorrectly. Judy seconded the motion and it passed unanimously.	The minutes will be updated and posted to the website.
3. Updates	<p><i>ACO Measures:</i></p> <ul style="list-style-type: none"> The Population Health work group recommended a set of criteria for ensuring population health is considered in the ACO measures to the QPM work group. There had been discussion among QPM work group members about the potential use of the criteria as general principles to inform the project overall and not for evaluating proposed ACO measures. The Population Health Work Group co-chairs submitted a memo to clarify that intention that the criteria be applied to actual measures of actions in a clinical setting (attachment 3). 	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> • Measures listed as MSSP (Medicare Shared Savings Program) are considered likely for adoption because they are already being collected and reported on for other purposes so the data collection is not as burdensome. • Anything that is claims data vs. clinical data is easier to collect. Pat clarified that even if a measure is already being collected, there is still a considerable amount of work being done to collect. • SBIRT- Core-43: there is support for this concept but it is difficult to develop specifications. • Some of the recommended criteria are covered by existing measures and it is acknowledged by the QPM work group that these measures are important. • Additional information to be gathered also means additional time which relates to ease of collection. • Measures currently in place are claims measures. The recommendations from the Population Health are more clinical data collection versus claims. In theory some of the measures may be able to become claims. • Claims data collection still requires work on the provider end; sometimes they refer back to the charts to double check the data. • Need to think about who will be doing the collection in the setting, perhaps a different care provider, not just the clinician. <p><i>Consultant Contract Accountable Communities:</i></p> <ul style="list-style-type: none"> • RFP concept was approved by the Core Team. • DVHA will be writing and releasing it soon. • RFP is for a consultant to identify local exemplars – within VT and elsewhere – of integrated community health systems • Core Team asked that the consultant’s work considers what is already being done and working well in Vermont. 	
<p>4. Criteria for Next Round of Provider Grants</p>	<p>There is \$2.8 million available for the Round Two Provider Grant program. The next grant application will be released in late July. The Core Team has asked for feedback from work groups on criteria that should be considered when reviewing proposals.</p> <p>Tracy reviewed attachment 4- <i>Scoring Criteria for Evaluating Provider Grant Proposals</i>. There are</p>	

Agenda Item	Discussion	Next Steps
	<p>existing criteria already in the application and additional recommendations given to the Core Team will need to relate to the three areas of innovation: payment models; health information; care management to support payment models.</p> <p>The group discussed and the following points were noted:</p> <ul style="list-style-type: none"> • Need to clarify the language around whether an application focuses on a broad population or a specific sub-population (keeping in mind it would be useful to understand trends across the entire population). • In general social determinants need to be emphasized more. • Key shift in thinking moving from patient focus to a geographic population. • Children will not be considered as much if you look at the total population. Need to consider the expanded timeframe so focusing energy on children is a good investment. • The Core Team uses scalability (can a project be applied in another community) as a criteria already. • The Core Team added a project length of 24 months but made few other changes thus far. • Under <i>Focus on broader population and health outcomes</i>- add “short and long term” outcomes, thinking beyond 3 years. Suggested wording: Focus on children and health benefit in the long run. • A Child/Family model to present as an example could be childhood trauma. 	
<p>5. Financing Population Health</p>	<p>Jim Hester presented <i>A Sustainable Financial Model for Improving Population Health</i> (attachment 5a). The focus was on how new payment models could incorporate population health. The presentation outlined key elements and opportunities for a new health care delivery system that utilizes a broad range of financial tools and is grounded in an integrated community level health system.</p> <p>After the presentation a few points were discussed and the group will discuss this topic in more detail at the next meeting:</p> <ul style="list-style-type: none"> • Financing is a vehicle for how you get the money. Example: the Shared Savings model is the financing vehicle and the savings will go back to the community. There are currently no provisions for how the insurers or ACOs should spend the savings. • The Blueprint is looking at innovative ways around pay for performance. A 	

Agenda Item	Discussion	Next Steps
	<p>recommendation was made for them to present to the group to better understand how to build upon this good work.</p> <ul style="list-style-type: none"> • Reference to slide 4: You could have an innovative finance model without the community piece and it is likely to be this way in the beginning. The risk is then that financing is disconnected from community level needs and intervention. • Themes are generally similar based on what came out of the community health needs assessment. 	
<p>6. Work Group Plan – Reflections and Refinement</p>	<p>One goal at the end of this project is to produce a report with Population Health recommendations that talks about future plans based on some of the models that are being tested.</p> <p>Wendy Davis provided feedback on the work plan (attachment 6) including the following:</p> <ul style="list-style-type: none"> • Consider consumer and community • Family system approach- consider Blueprint for kids • More emphasis on social determinants of health- operationalize based on what Jim presented using it as a starting point. <p>This is a draft format and the topic will be reviewed in greater detail at the next meeting.</p>	
<p>7. Public Comment and Next Steps</p>	<p>Next Meeting: Tuesday, July 8th 2:30 – 4:00 pm. ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier.</p>	

Attachment 3 - Draft Scoring Criteria for VHCIP Grant Program

Population Health Integration in VT Health Care Innovation Project
Scoring Criteria for Evaluating Provider Grant Proposals
Draft 6-16-14

The Vermont Health Care Innovation Project (VHCIP) is testing new payment and service delivery models as part of larger health system transformation based on the Triple Aim – reducing cost, improving quality, and improving health. The charge of the Population Health Work Group is to recommend ways the Project could better coordinate population health improvement activities and more directly impact population health¹.

The following proposed criteria align with the population health framework which recognizes the multiple factors that contribute to health outcomes, focuses on primary prevention, and seeks opportunities to impact upstream factors that affect health outcomes. The criteria are intended for use in reviewing the provider grant proposals for testing innovation in payment and care delivery models. Ideally, the criteria would be used for each individual application. Minimally, they would be used as a check to ensure that at least some of the proposals considered for funding meet population health objectives. Could apply to each proposal or to group overall

1. Focus and Funding Towards Primary Prevention and Wellness

The proposal should reflect an explicit understanding of the determinants of health and include efforts aimed at primary prevention², self-care and maintaining wellness rather than solely on identifying and treating disease and illness. The model being tested should show intended investment of savings or budget in prevention and wellness activities and partners.

2. Focus on broader population and health outcomes

The innovation should include efforts to maintain or improve the health of all people – young, old, healthy, sick, etc. The proposal should consider the health outcomes of a group of individuals in a community, ~~including the distribution of such outcomes within the group~~, in order to develop priorities and target action. Specific attention should be given to the maintenance of health and wellness of subpopulations and especially those most vulnerable due to disability, age, income, etc. – and not just those currently the sickest or most costly – in order to consider health benefit over the long term.

[Notes from meeting: Seems contradictory – do we mean everyone or subpopulations?

- Need to clarify choice vs. recommendation regarding which population or subset
- balance across categories
- like to see disparities as a driver

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 Primary prevention is a program of activities directed at improving general well-being while also involving specific protection for selected diseases, such as immunization against measles. Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier. Primary prevention aims to prevent disease from developing in the first place. Secondary prevention aims to detect and treat disease that has not yet become symptomatic. Tertiary prevention is directed at those who already have symptomatic disease, in an attempt to prevent further deterioration, recurrent symptoms and subsequent events.

Population Health Integration in VT Health Care Innovation Project
Scoring Criteria for Evaluating Provider Grant Proposals
Draft 6-16-14

Big shifts:

- consider geographic based population
- focus on children specifically and within the family system
- focus on health benefit over the long run

3. Connects Clinical Service Delivery with Broad Set of Community Partners

The proposed innovation in care delivery should build upon existing infrastructure (Blueprint Medical Homes, Community Health Teams, ACOs and public health programs), connect to a broad range of community based resources, and address the interconnection between physical health, mental health, and substance abuse.

This will drive upstream

4. Scalable

While the innovation must be tested in particular community, potential application to other communities or other scales should be outlined.

Concern that this might be limiting regarding cultural difference – consider template that could be adapted

Already part of the existing criteria – check wording

Attachment 4a - Financial Model Presentation

A Sustainable Financial Model for Improving Population Health

Population Health Workgroup:
June, 2014

Jim Hester



Structure of an CHS

The CHS is made up of

- Backbone organization for governance structure and key functions
- Intervention partners to implement specific short, intermediate, and long term health-related interventions
- Financing partners who engage in specific transactions

Key Functions of a CHS

A community centered entity responsible for improving the health of a defined population in a geographic area by integrating clinical services, public health and community services

- Convene diverse stakeholders and create common vision
- Conduct a community health needs assessment and prioritize needs
- Build and manage portfolio of interventions
- Monitor outcomes and implement rapid cycle improvements
- Support transition to value based payment and global budgets
- Facilitate coordinated network of community based services

CHS: Enhanced Financial Role

- **Oversees the implementation of a balanced portfolio of programs**
- **Uses a diverse set of financing vehicles to make community-wide investments in multiple sectors**
 - **Builds business case for each transaction specific to population and implementation partner: ~ bond issue**
- **Contracts with Intervention partners for short, intermediate, and long term health-related interventions**
- **Measures the "savings" in the health care and non-health sectors and captures a portion of these savings for reinvestment**
- **Supports transition to value based payment**
 - **Potential vehicle for global payments for integrated bundle of medical and social services**

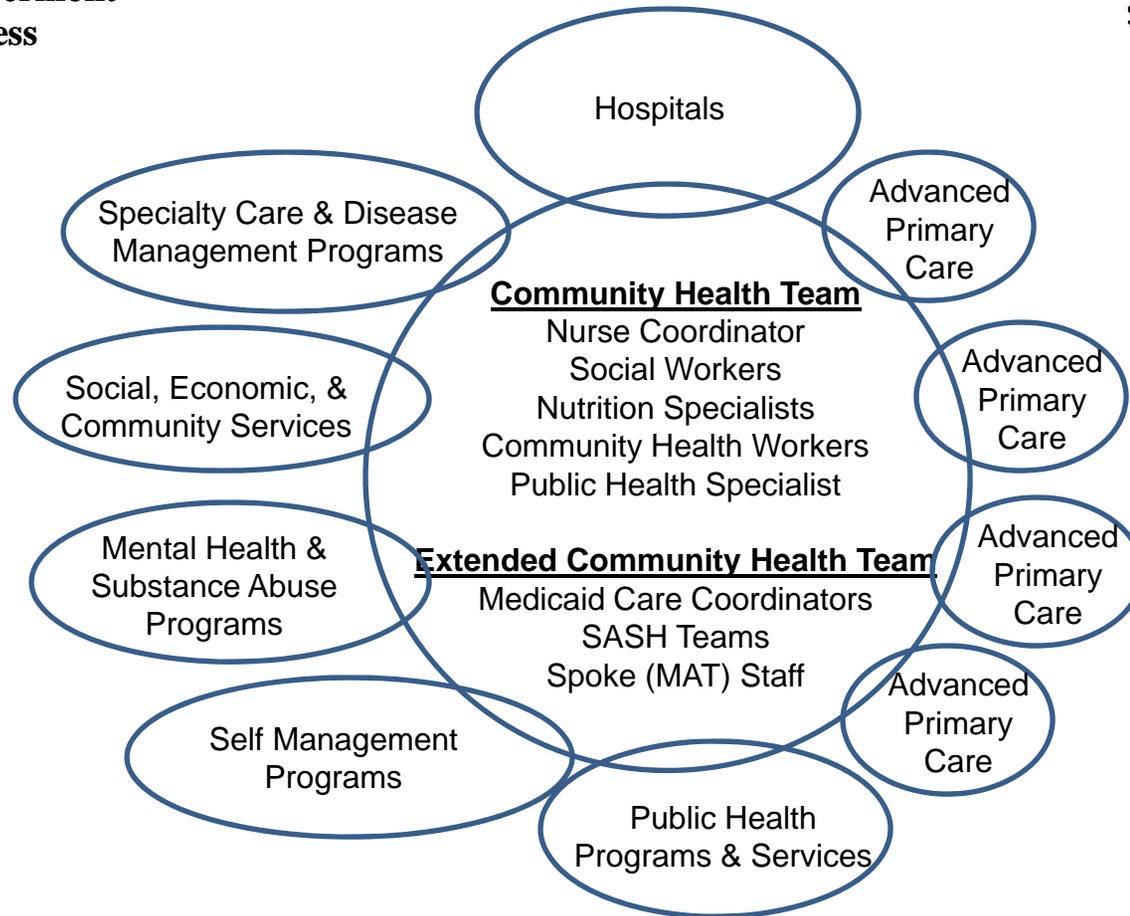
Attachment 4b - Blueprint Presentation

Vermont Blueprint for Health: Community System of Health

Jenney Samuelson & Beth Tanzman
Assistant Directors
Vermont Blueprint for Health
Department of Vermont Health Access
312 Hurricane Lane, Williston, VT 05482
Jenney.Samuelson@state.vt.us

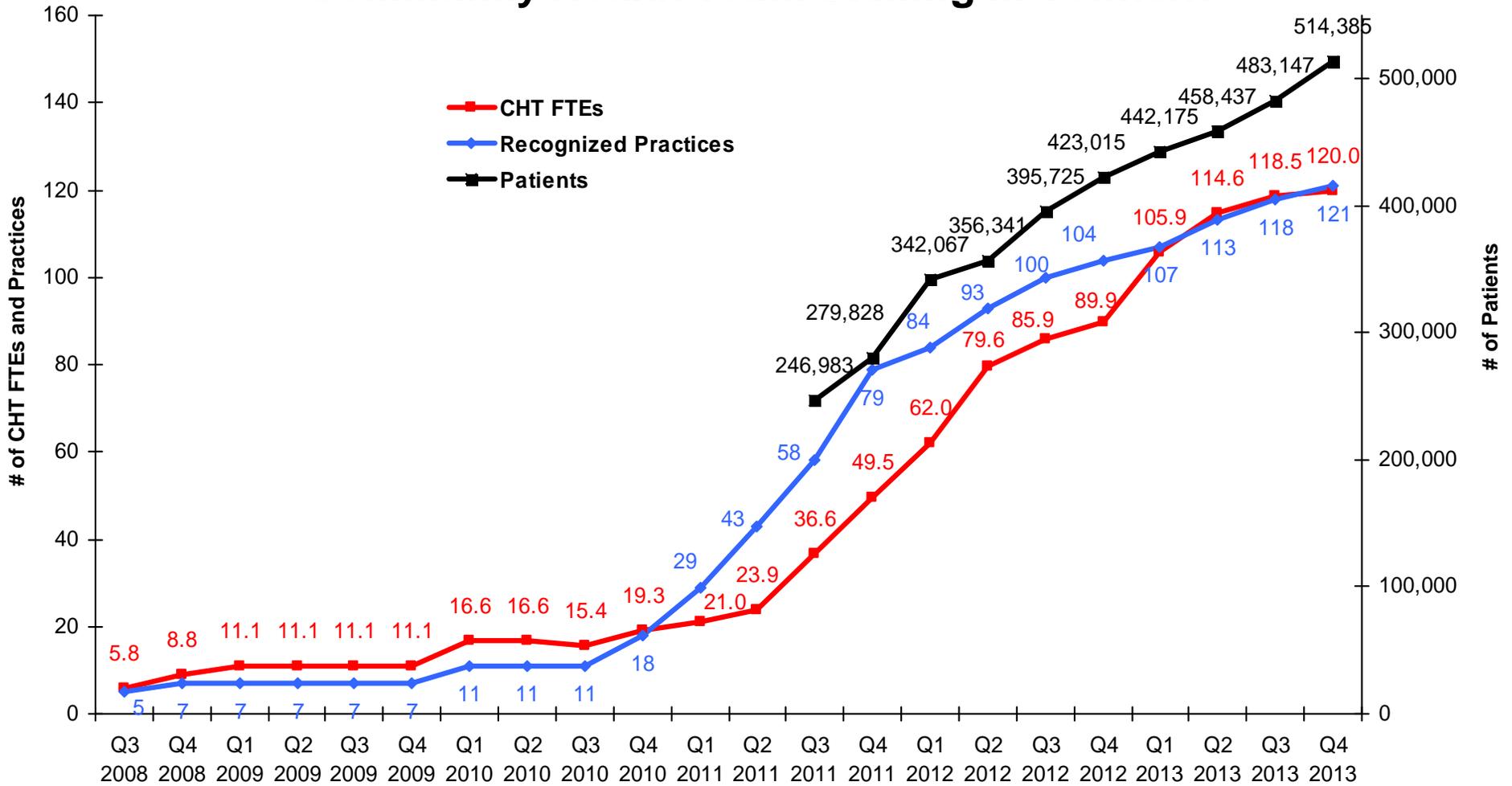
Building A Foundation For The Future

- Advanced Primary Care Practices (PCMHS)
- Community Health Teams
- Community Based Self-management Programs
- Multi-insurer payment reforms
- Health Information Infrastructure
- Evaluation & Reporting Systems
- Learning Health System Activities



All-Insurer Payment Reforms
Local leadership, Practice Facilitators, Workgroups
Local, Regional, Statewide Learning Forums
Health IT Infrastructure
Evaluation & Comparative Reporting

Patient Centered Medical Homes and Community Health Team Staffing in Vermont



*Since joining the Blueprint, three practices have combined to form a new practice, one practice has joined an existing practice, and one practice has closed.

Health Services Network

Key Components	December 2013
PCMHs (scored by UVM)	121
PCPs (unique providers)	629
Patients (per PCMHs)	514,385
CHT FTEs (core staff)	120
SASH provider FTEs (extenders)	46.5
Spoke Staff FTEs (extenders)	30.45

Leadership Network

Program Leaders & Extenders	# People
Program Managers	14
Practice Facilitators	13
Community Health Team Leaders	14
Regional Housing Authority Leaders (SASH)	6
Self Management Regional Coordinators	14

What's Different

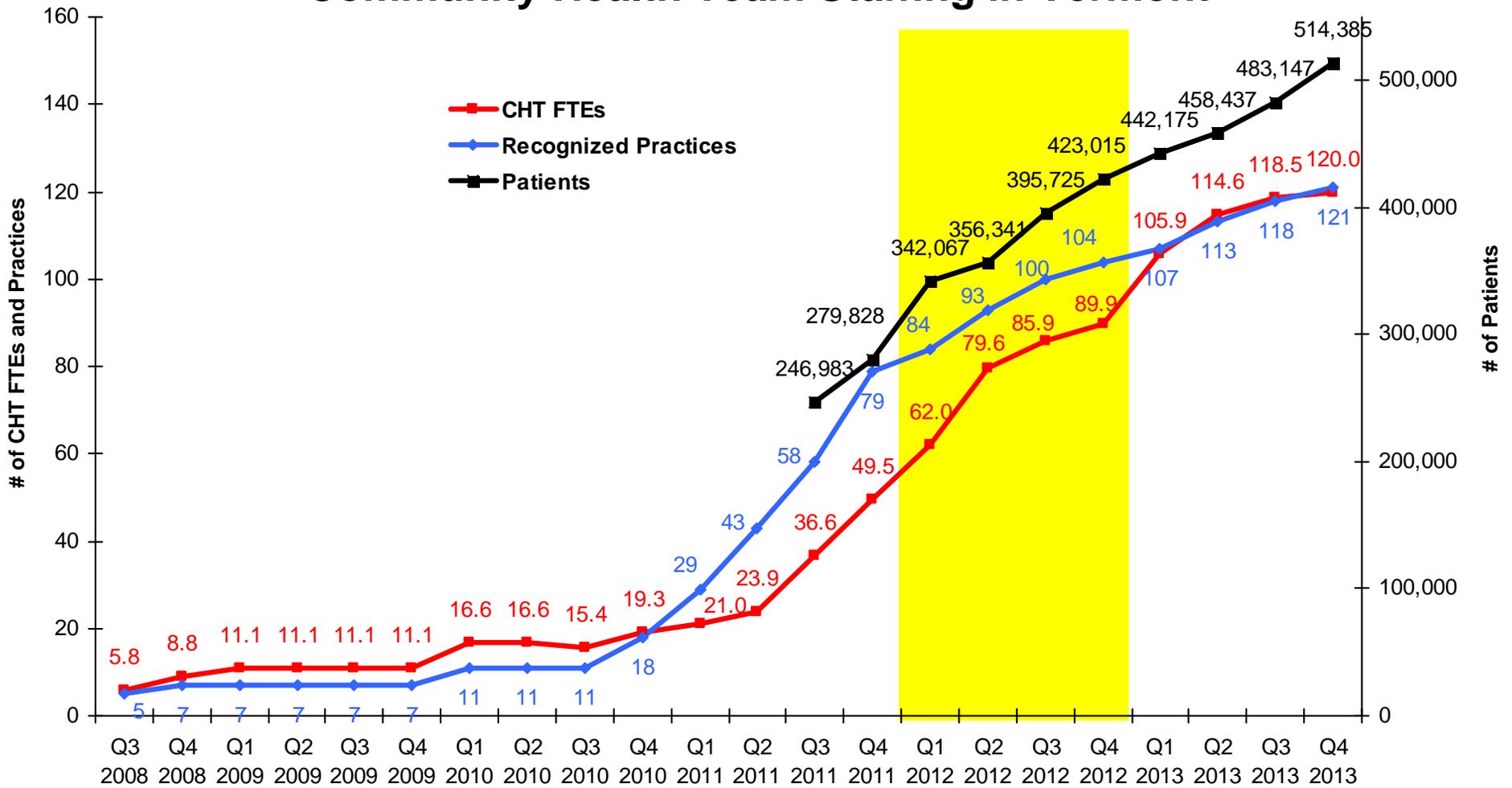
- Systems investments in the leadership network and supports (project management and practice facilitation)
- Population Health Focused Interventions
 - CHT
 - NCQA
 - Self-management Programs
 - SASH

Population Based

Focus on:

- Proactive care across panel in a practice
- Establishing new connections and redesigning delivery of services
- New services provided are not covered by traditional health plans, focus on prevention
- Shift to addressing social determinants (housing, food, transportation, activity)
- Participants Identified for services by patients/client, clinicians, and social service providers

Patient Centered Medical Homes and Community Health Team Staffing in Vermont



*Since joining the Blueprint, three practices have combined to form a new practice, one practice has joined an existing practice, and one practice has closed.

2012 Study Groups

Study Groups	# People	# Practices
Commercial (Ages 1-17 Years)		
Blueprint 2012	30,632	102
Comparison 2012	22,488	49
Commercial (Ages 18-64 Years)		
Blueprint 2012	138,994	105
Comparison 2012	83,171	67
Medicaid (Ages 1-17 Years)		
Blueprint 2012	32,812	94
Comparison 2012	15,333	41
Medicaid (Ages 18-64 Years)		
Blueprint 2012	38,281	105
Comparison 2012	16,159	54

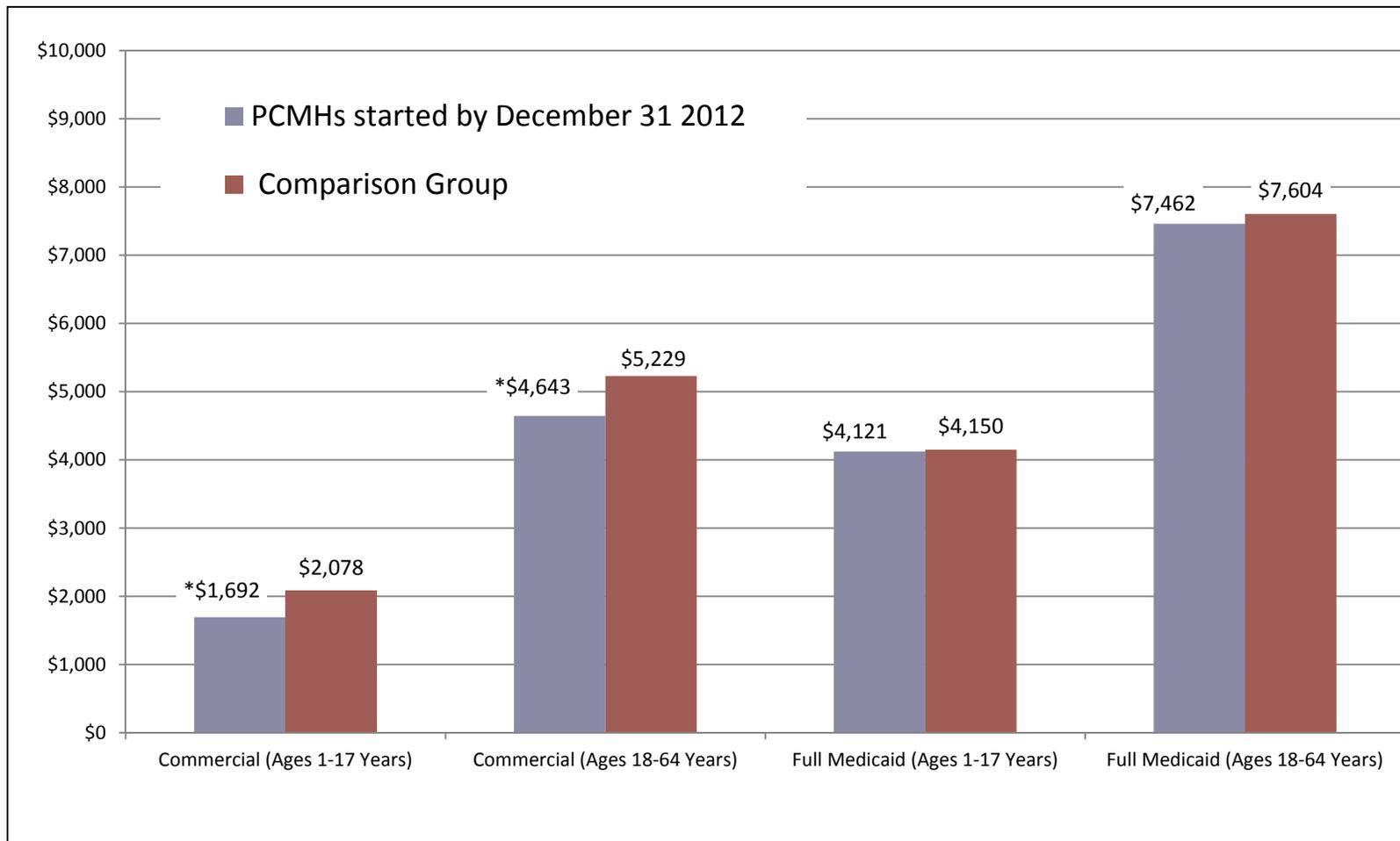
2012 Study Group Characteristics

Age Stratification	Average Age	Male	Healthy CRG*	Acute Illness or Minor Chronic CRG	Chronic CRG	Significant Chronic CRG	Catastrophic or Cancer CRG	Maternity	Blueprint Selected Chronic Conditions
Commercial (Ages 1-17 Years)									
Blueprint PCMHs	9.7	50.4%	80.1%	12.4%	6.6%	0.7%	0.2%	0.4%	11.7%
Comparison Group	9.8	51.8%	80.8%	12.0%	6.2%	0.6%	0.4%	0.3%	10.1%
Commercial (Ages 18-64 Years)									
Blueprint PCMHs	44.2	46.2%	51.5%	22.0%	20.0%	5.9%	0.6%	2.1%	30.4%
Comparison Group	43.3	45.4%	54.4%	21.0%	18.4%	5.3%	1.0%	2.2%	25.7%
Medicaid (Ages 1-17 Years)									
Blueprint PCMHs	8.5	51.1%	72.1%	14.6%	11.5%	1.6%	0.2%	0.7%	24.6%
Comparison Group	8.5	52.8%	72.4%	14.6%	11.1%	1.5%	0.4%	0.7%	21.6%
Medicaid (Ages 18-64 Years)									
Blueprint PCMHs	38.0	42.8%	43.3%	20.2%	26.2%	9.7%	0.7%	4.1%	44.5%
Comparison Group	37.8	42.8%	46.2%	18.8%	25.7%	8.2%	1.2%	4.4%	38.0%

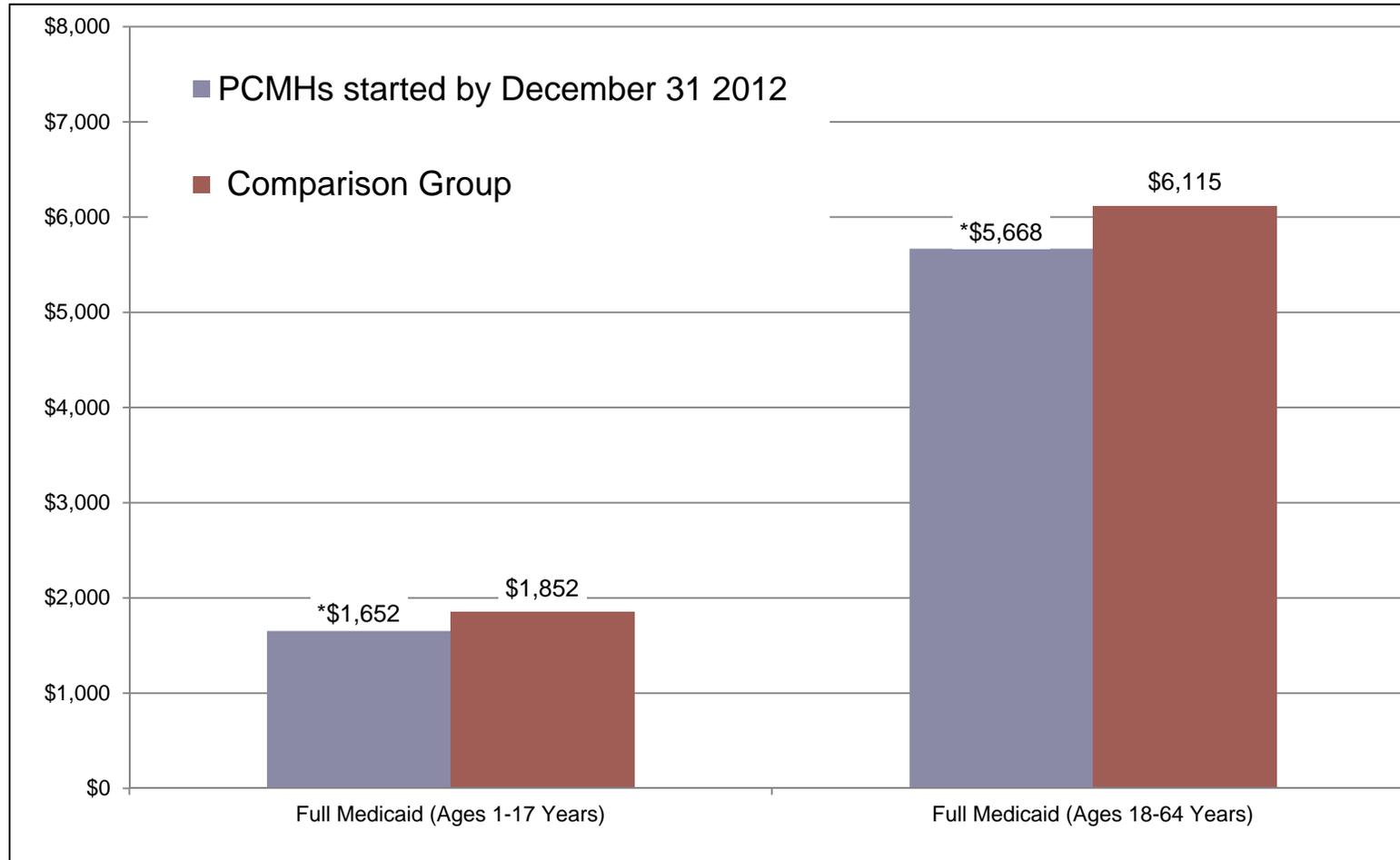
*Clinical Risk Groups (CRGs) are a product of 3M™ Health Information Systems and were applied to the VHCURES claims data to classify each member's health status. For example, members with cancer, diabetes, minor chronic joint pain, or healthy are classified separately for analysis.

**Blueprint Selected Chronic Conditions include: Asthma, Attention Deficit Disorder, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Coronary Artery Disease, Diabetes, Depression, Hypertension

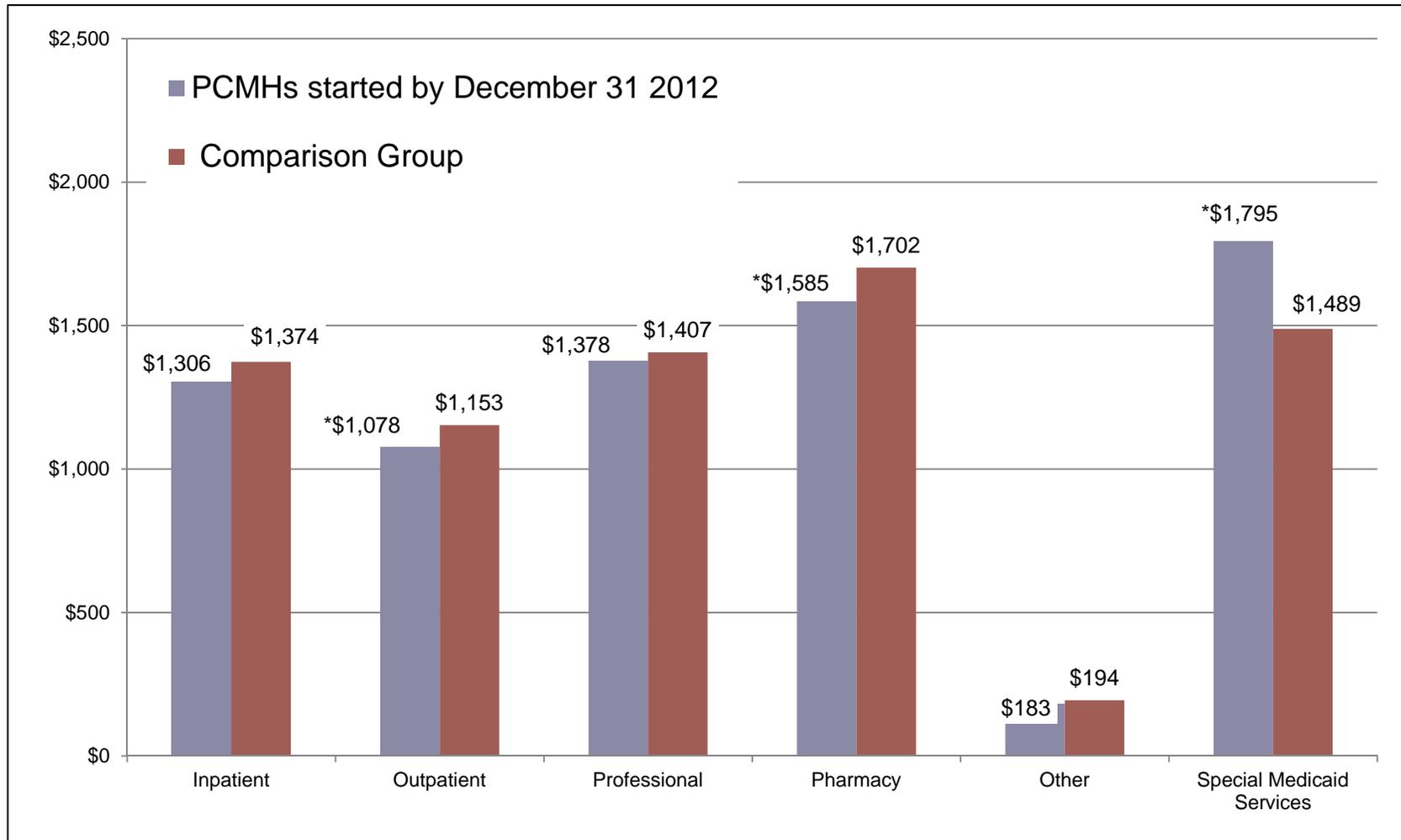
2012 Total Expenditures per Capita



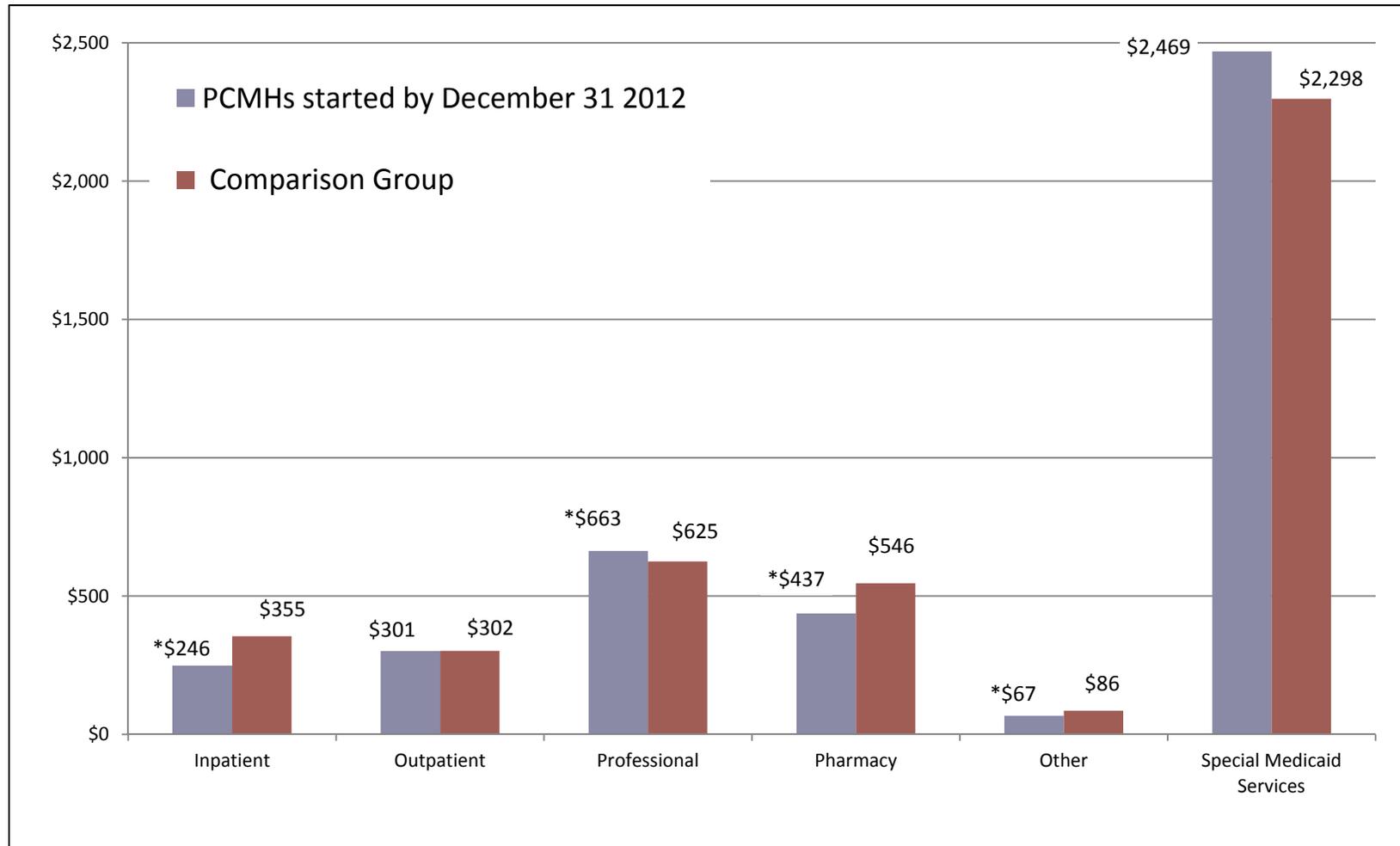
2012 Total Expenditures per Capita (Medicaid minus Special Services)



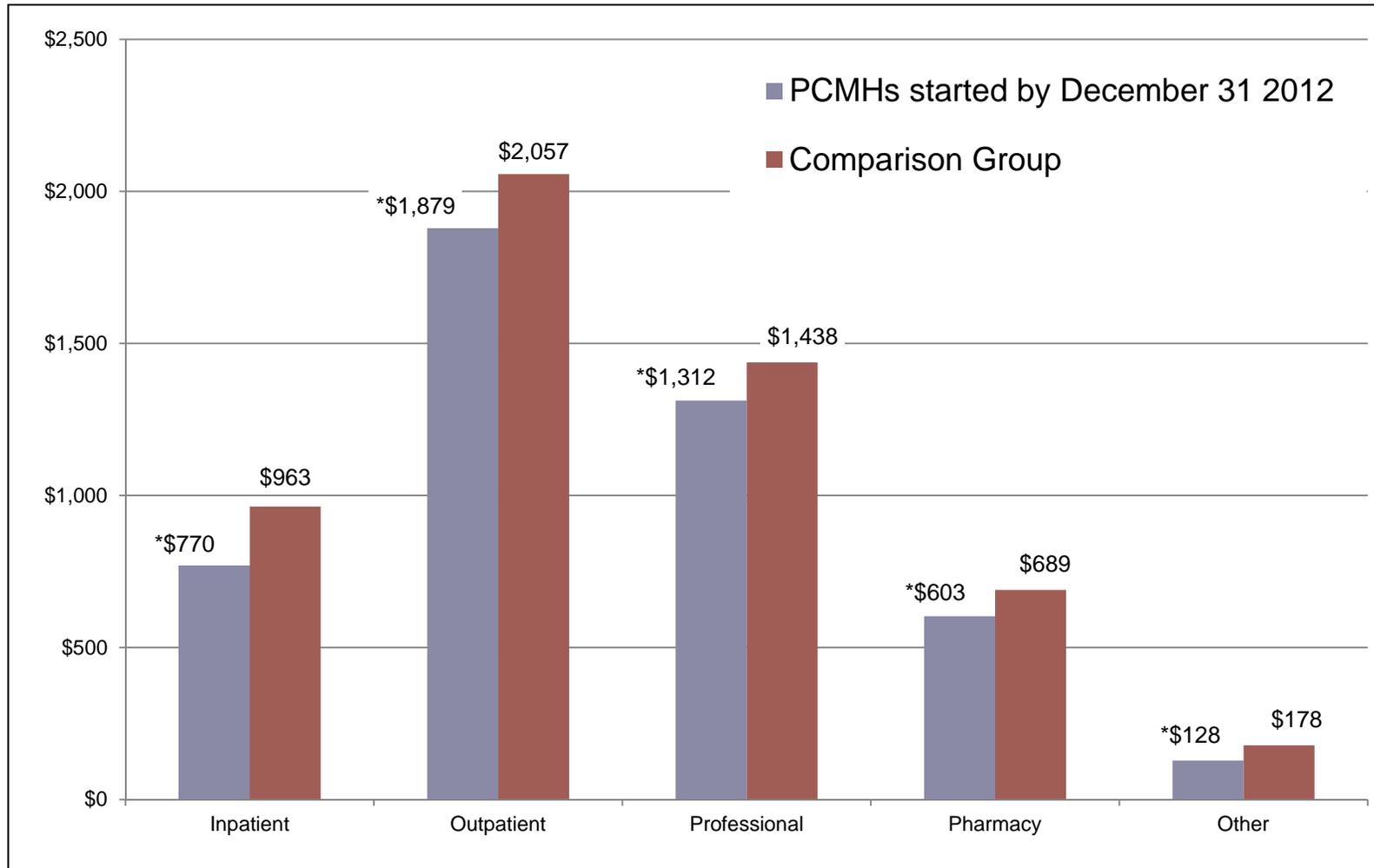
2012 Medicaid Expenditures by Major Category (Ages 18-64)



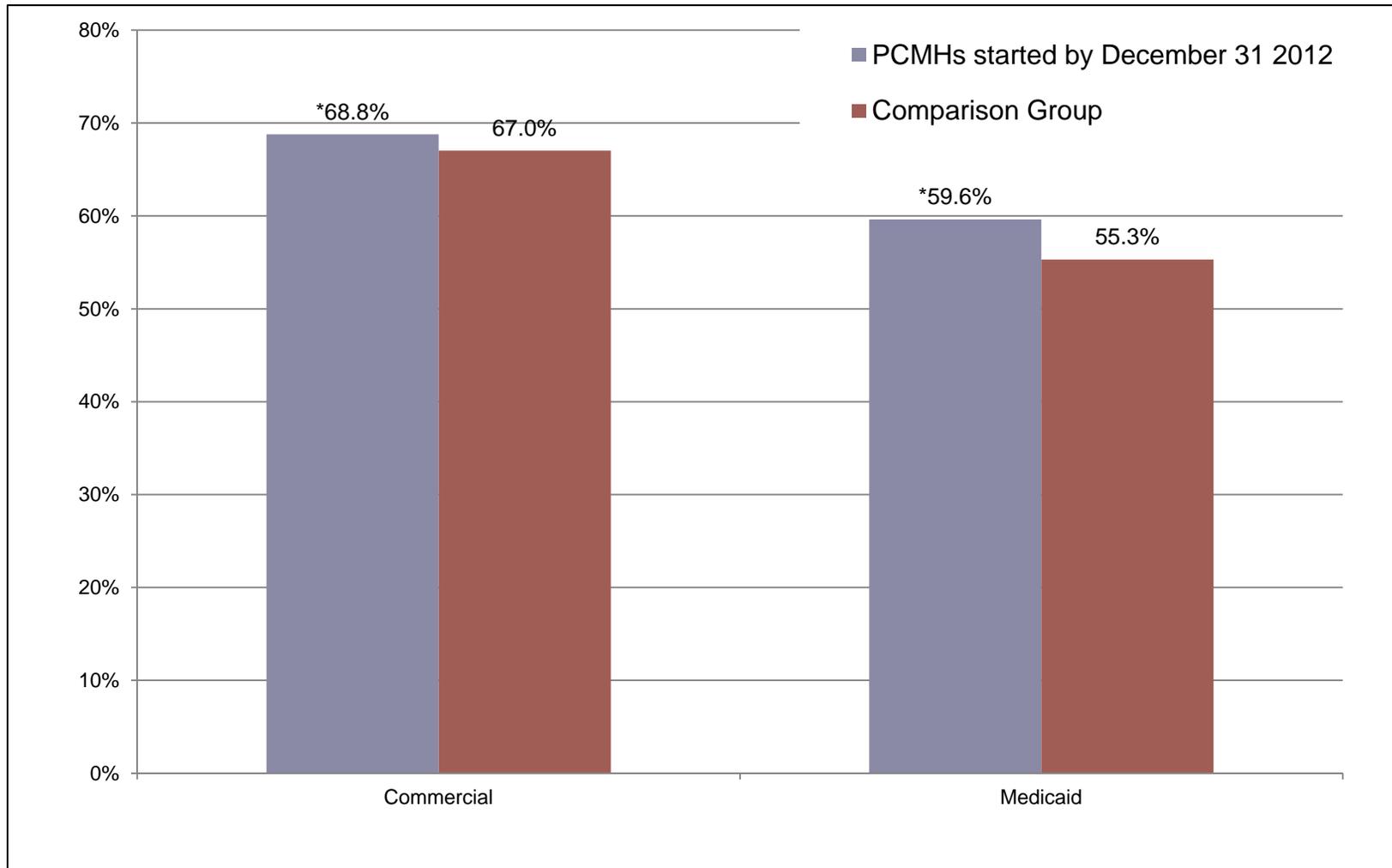
2012 Medicaid Expenditures by Major Category (Ages 1-17)



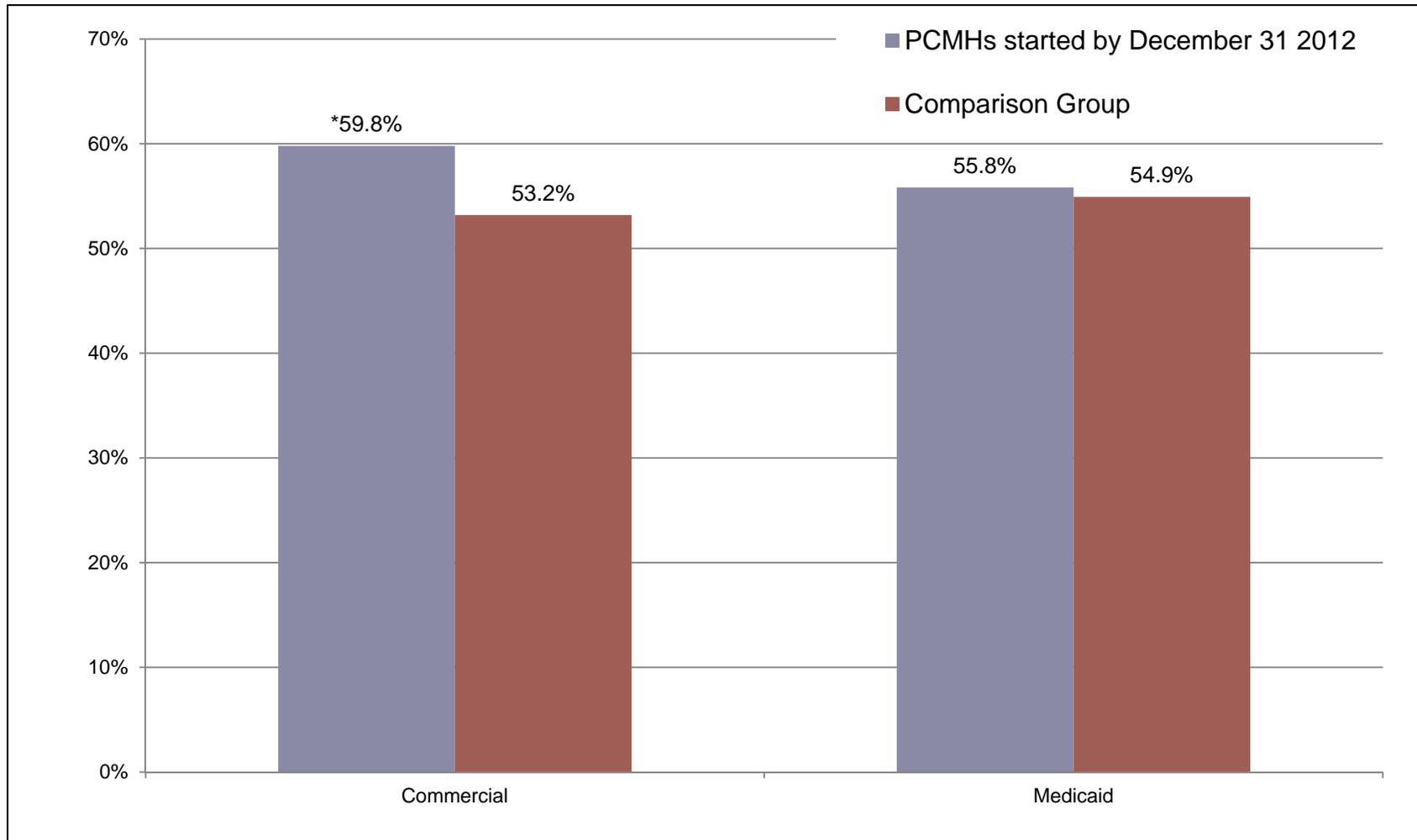
2012 Commercial Expenditures by Major Category (Ages 18-64)



2012 Cervical Cancer Screening (HEDIS)



2012 Adolescent Well-Care Visits (HEDIS)



Savings Compared to Investment in 2012

Study Groups	# People	Amount Saved Per Person in 2012*	Total Saved in 2012	Total Invested in 2012**	2012 Gain/Cost Ratio***
Commercial (Ages 1-17 Years)					
Blueprint 2012	30,632	\$386	\$11,823,952	Commercial \$5,905,166	15.8
Commercial (Ages 18-64 Years)					
Blueprint 2012	138,994	\$586	\$81,450,484		
Medicaid (Ages 1-17 Years) Excluding SMS					
Blueprint 2012	32,812	\$200	\$6,562,400	Medicaid \$2,883,525	8.2 excludes ****SMS
Medicaid (Ages 18-64 Years) Excluding SMS					
Blueprint 2012	38,281	\$447	\$17,111,607		
Medicaid (Ages 1-17 Years) Including SMS					
Blueprint 2012	32,812	\$29	\$951,548	Medicaid \$2,883,525	2.2 includes SMS
Medicaid (Ages 18-64 Years) Including SMS					
Blueprint 2012	38,281	\$142	\$5,435,902		

*Difference in 2012 total expenditures per person for Participants vs. Comparison Group.

**Includes 2012 totals for Patient Centered Medical Home and Community Health Team payments.

***Calculated as Total Saved divided by Total Invested.

****Special Medicaid Services (SMS) include Transportation, Home and community-based services, Case management, Dental, Residential treatment, Day treatment, Mental health facilities, School-based and Department of Education Services

Summary – Vermont Results from 2012

Source: Medicaid and commercial all payers claims

PCMH+CHT patients vs. their respective comparison groups

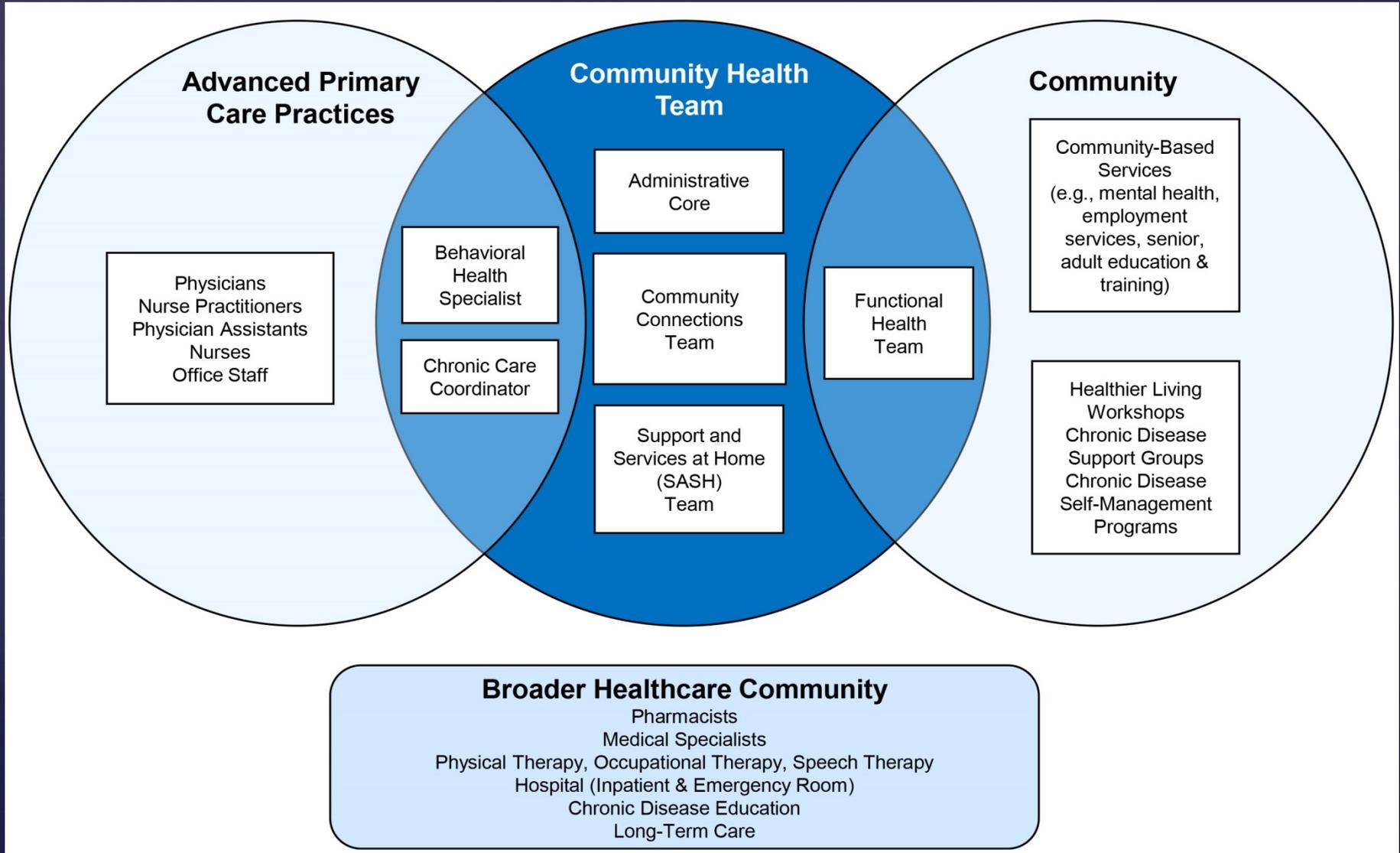
- Improved healthcare patterns
- Reduced medical expenditures per capita
- Linking Medicaid population to non-medical support services
- Similar or higher rates of recommended assessments

Attachment 4c - STJ PH Presentation

{ Vermont Blueprint for Health:
St Johnsbury Community Health Team

Laural Ruggles
Population Health Workgroup
July 2014

St Johnsbury Community Health Team



Fall 2011:

St Johnsbury area Community Health Team chosen by the CDC for a 30 month rigorous evaluation.

Community health workers are members of a community who are chosen by community members or organizations to provide basic health and medical care to their community.

They are seen to play an important role in assisting patients with navigating a complex health care system.

Do you know of a promising intervention for controlling high blood pressure?



Tell us about your promising program or policy!

The Division for Heart Disease and Stroke Prevention at the Centers for Disease Control and Prevention (CDC) is soliciting nominations for innovative programs and policies with the potential to address high blood pressure at the population level. We are interested in policy approaches and system-level strategies in two distinct areas that do the following:

1. **Promote the use of community health workers in chronic disease that results in improved control of high blood pressure.**
- OR
2. **Foster physician adherence to hypertension clinical treatment recommendations issued by the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC).**

A nominated program or policy must:

- Have been implemented for at least 6 months
- Have on-going data collection of measured blood pressure

Key Activities for Participating Programs

1. Nominate a program or policy
2. If selected, participate in a 2 day evaluability assessment site visit to explore program implementation, data collection, and program outcomes
3. Receive on-site technical assistance and follow-up consultation with CDC staff
4. If selected, participate in a comprehensive evaluation

Frequently Asked Questions

1. **What will I need to do?**

If selected, we will work with you to schedule a 2-day site visit to discuss your program with you and your staff. You will also have the opportunity to receive some follow-up consultation with CDC staff by telephone.

2. **How long does the project last?**

The 2-day evaluability assessment site visits will take place in March/April 2011, and an expert panel will make its recommendations for comprehensive evaluation by May 2011.

3. **How will my program benefit?**

If selected, you will receive on-site technical assistance for program improvement and evaluation design. All selected programs also receive a comprehensive written description of your program design and operations. Interventions found to be promising will be featured by CDC or other organizations, and some may be considered for a comprehensive evaluation.

4. **What is the first step in this process?**

Contact Erica Krisel at ICF Macro at ekrisel@icfi.com or (404) 321-3211 to find out how to nominate a program or policy!

Submission deadline is December 31, 2010

National Center for Chronic Disease Prevention and Health Promotion
Division for Heart Disease and Stroke Prevention



Measures

- ▶ Improved Well-being
- ▶ Improved Life Satisfaction
- ▶ Improved Health Status
- ▶ Longer term Population Health Improvement



Improved Well-being

- ▶ **Statistically significant improvements in**
 - ▶ Health insurance
 - ▶ Prescription drugs
 - ▶ Housing
 - ▶ Health education

- ▶ Clients reported being more aware and attentive to their health after receiving services



Improved Life Satisfaction

Quotes from Clients

“It takes a lot off the stress. I had a lot of stress back then...oh, the stress, I was worn out, I had given up.”

“And they give you goals, motivation to improve the quality of your life.”

“My health feels better by seeing them when something comes up...It feels much better and clearer to see them...”



Implications for Public Health Practices

- ▶ St J CHT demonstrates an intervention intended to address issues related to the **social determinants of health** where **patients can effectively manage their health**
- ▶ Design and implementation is rooted in community engagement which resulted in **strengthened relationships between community institutions and enhanced care coordination**
- ▶ Providers support for CHT model cannot be overstated. **Providers reported a number of benefits to their practice.**
- ▶ State legislation that led to **payment reforms was essential** to establishing and sustaining the CHT model.



Key Functions of a Community Health System (Jim's presentation)

- ▶ **A community centered entity responsible for improving the health of a defined population in a geographic area by integrating clinical services, public health and community services.**
- ▶ **Convene diverse stakeholders and create common vision.**
- ▶ Conduct a community health needs assessment and prioritize needs
- ▶ Build and manage portfolio of interventions
- ▶ Monitor outcomes and implement rapid cycle improvements
- ▶ Support transition to value based payment and global budgets
- ▶ Facilitate coordinated network of community based services



Attachment 4d - MAHHC PH Presentation



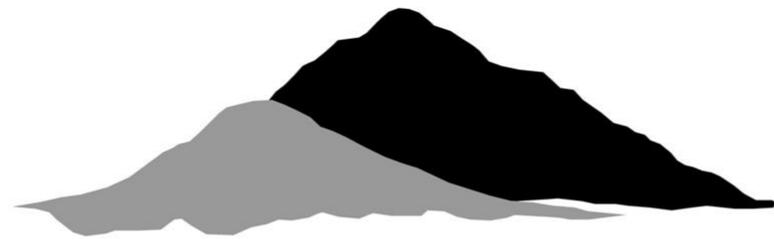
**WINNER OF THE
Foster G. McGaw Prize**
for community service

A prestigious honor
in healthcare

Community Health Outreach



Services & Strategic Plan



MT. ASCUTNEY HOSPITAL
A N D H E A L T H C E N T E R



Mt. Ascutney
Prevention Partnership



Prevention, Education and Promotion
- For Health -



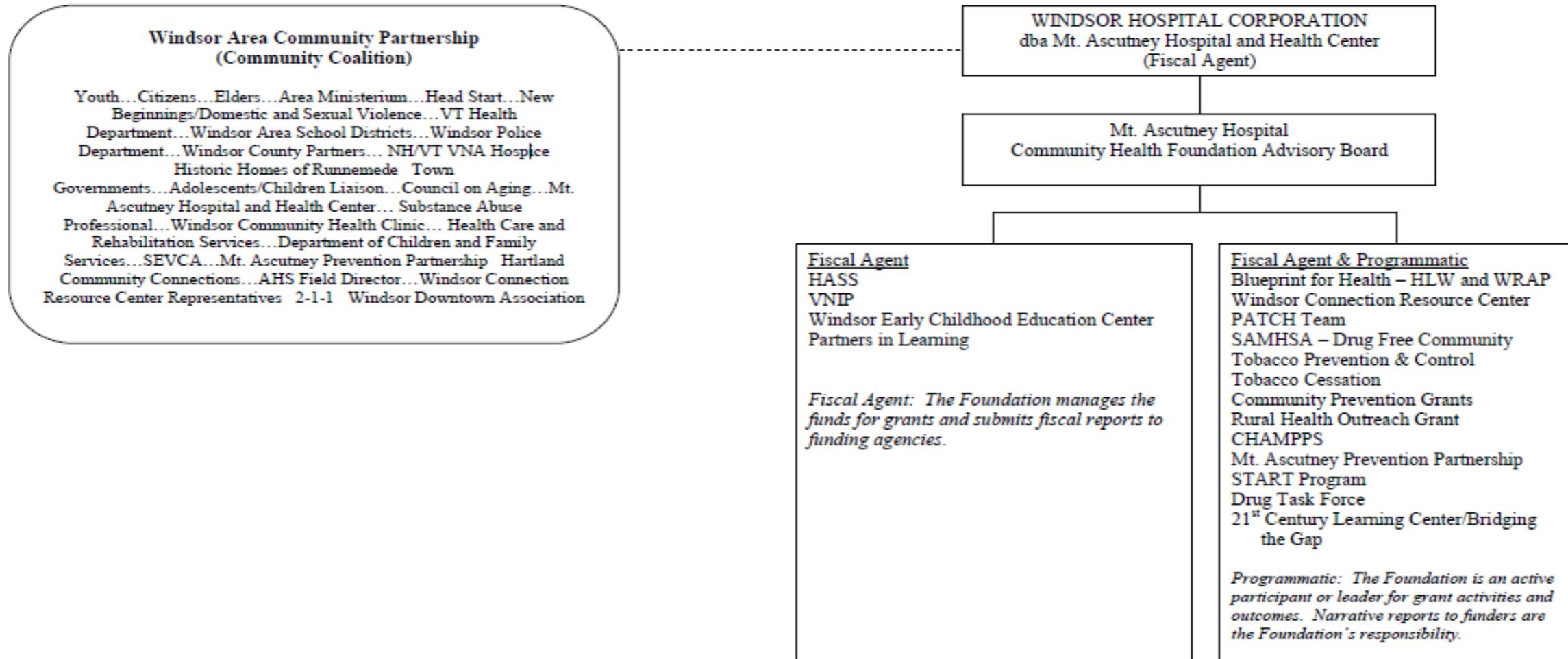
MT. ASCUTNEY HOSPITAL
A N D H E A L T H C E N T E R



WINNER OF THE
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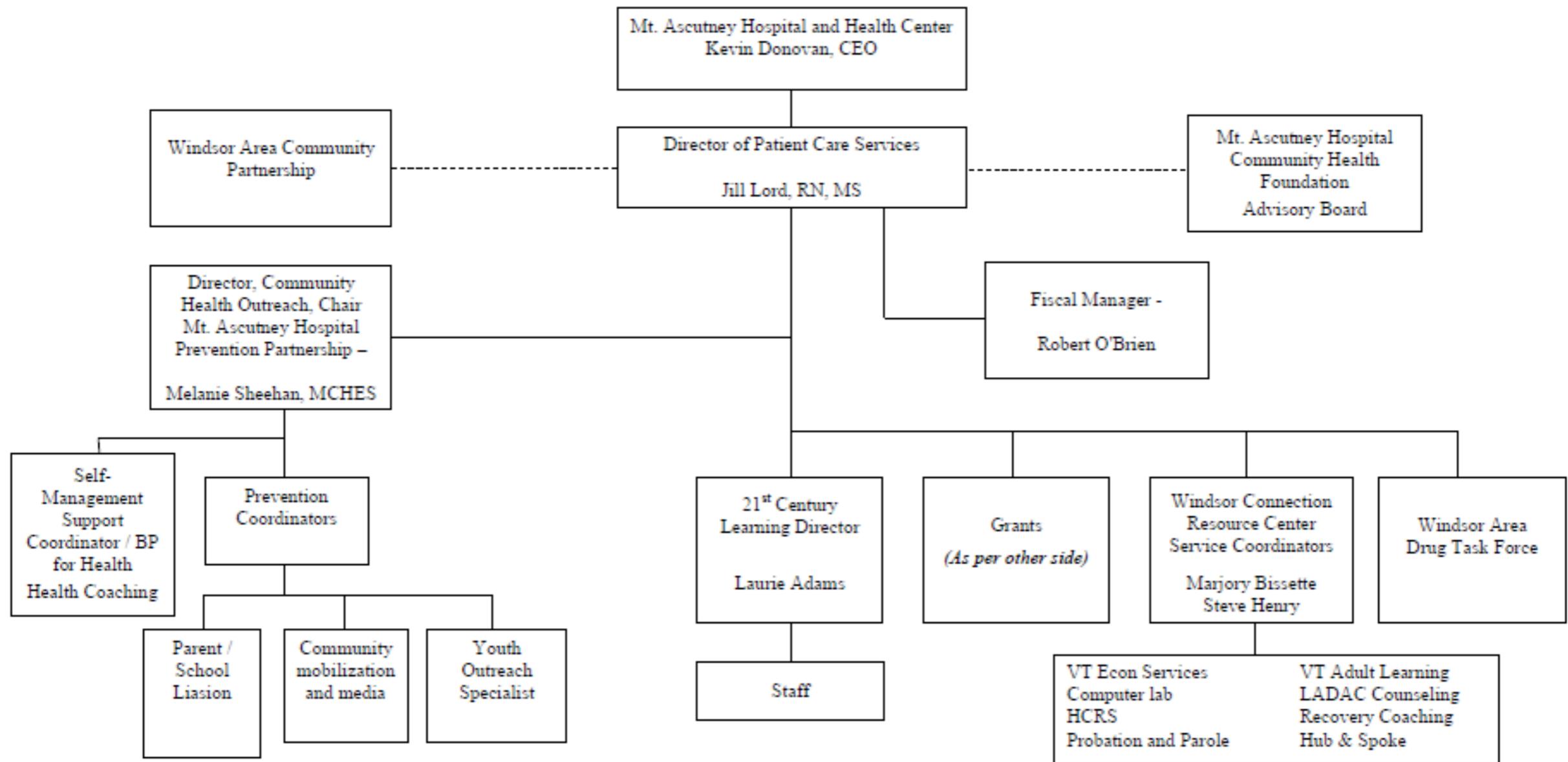
**MT. ASCUTNEY HOSPITAL AND HEALTH CENTER
COMMUNITY HEALTH ORGANIZATIONAL CHART**



Fill/Community Health Foundation/Organizational Chart MAHHC CHO March 2012

* See backside for further detail

**MT. ASCUTNEY HOSPITAL AND HEALTH CENTER
COMMUNITY HEALTH ORGANIZATIONAL CHART**



Community Health Foundation

- Meets monthly; budget oversight and review; program highlights
- Fiscal agent for outside agencies such as Windsor Early Childhood, Partners in Learning, VT Nurses in Partnership, etc.
- Attendees include hospital admin, CFO, Pediatrics, NP, Local School Principal, Community Members, paid staff of PEP

Windsor Area Community Partnership

- ➔ A coalition of Windsor area social service, education, business, community, and government organizations working together to revitalize the community
- ➔ Serves as Advisory Board for all community outreach programs
- ➔ “Mother-Ship” of the Mt. Ascutney Prevention Partnership, or MAPP (paid staff of WACP)

PEP Organizational Vision

- ➔ Full integration with BP Community Health Team
- ➔ Mobilizing communities through education to advocate for policies that improve the communities where MAHHC patients live
- ➔ Implement coordinated, comprehensive strategy for prevention and health promotion
- ➔ Remain dedicated to data collection and continuous quality improvement

Health Education at MAHHC:

1. Tobacco Cessation – Group and In-person coaching; free Nicotine replacement
2. Chronic Disease Self Management Programs: Healthier Living Workshops, Chronic Pain, Wellness Recovery Action Planning (WRAP)
3. Family Support Project – Self Management support for families struggling with child behavior

“To create environments of healthy choice to prevent illness”





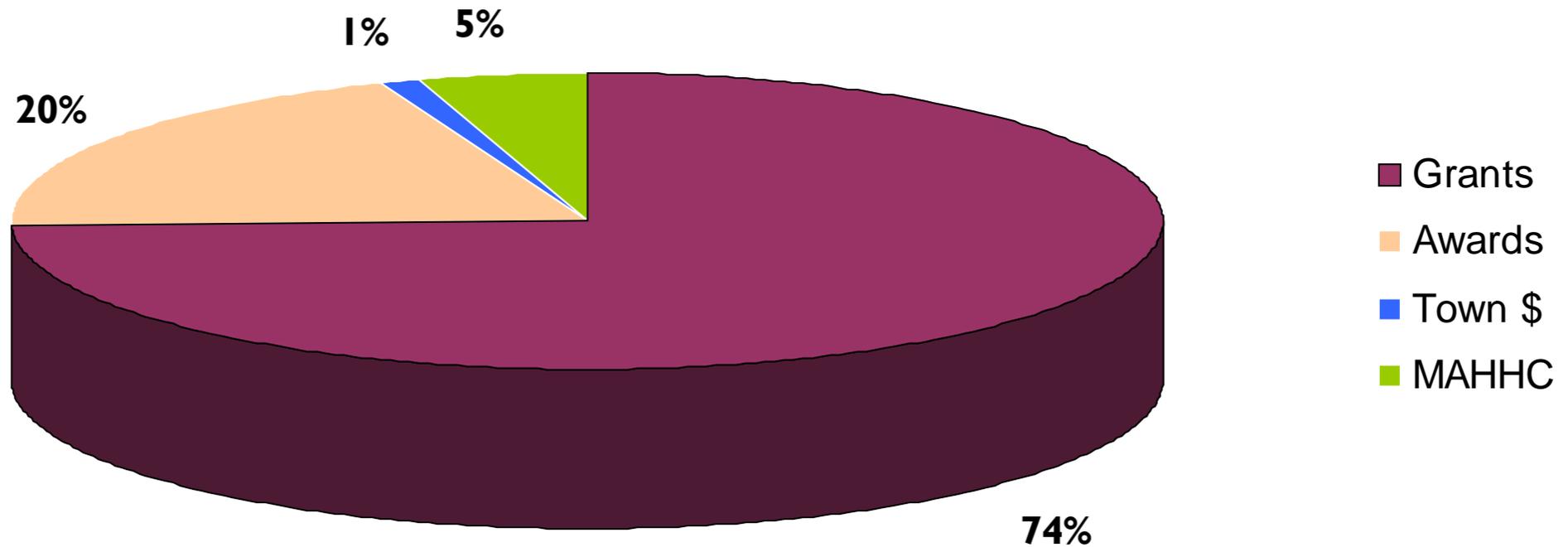
Mt. Ascutney Prevention Partnership (MAPP)

MAPP Mission:

*To pursue opportunities
for health in policies and
practices.*

PEP'S Funding

Funding Sources



PEP's Funding

- ➔ Federal and State Grants
- ➔ Small Allocations from our Four Towns
- ➔ Foster McGaw and other award funds
- ➔ Private Foundation donations
- ➔ Mt. Ascutney Hospital

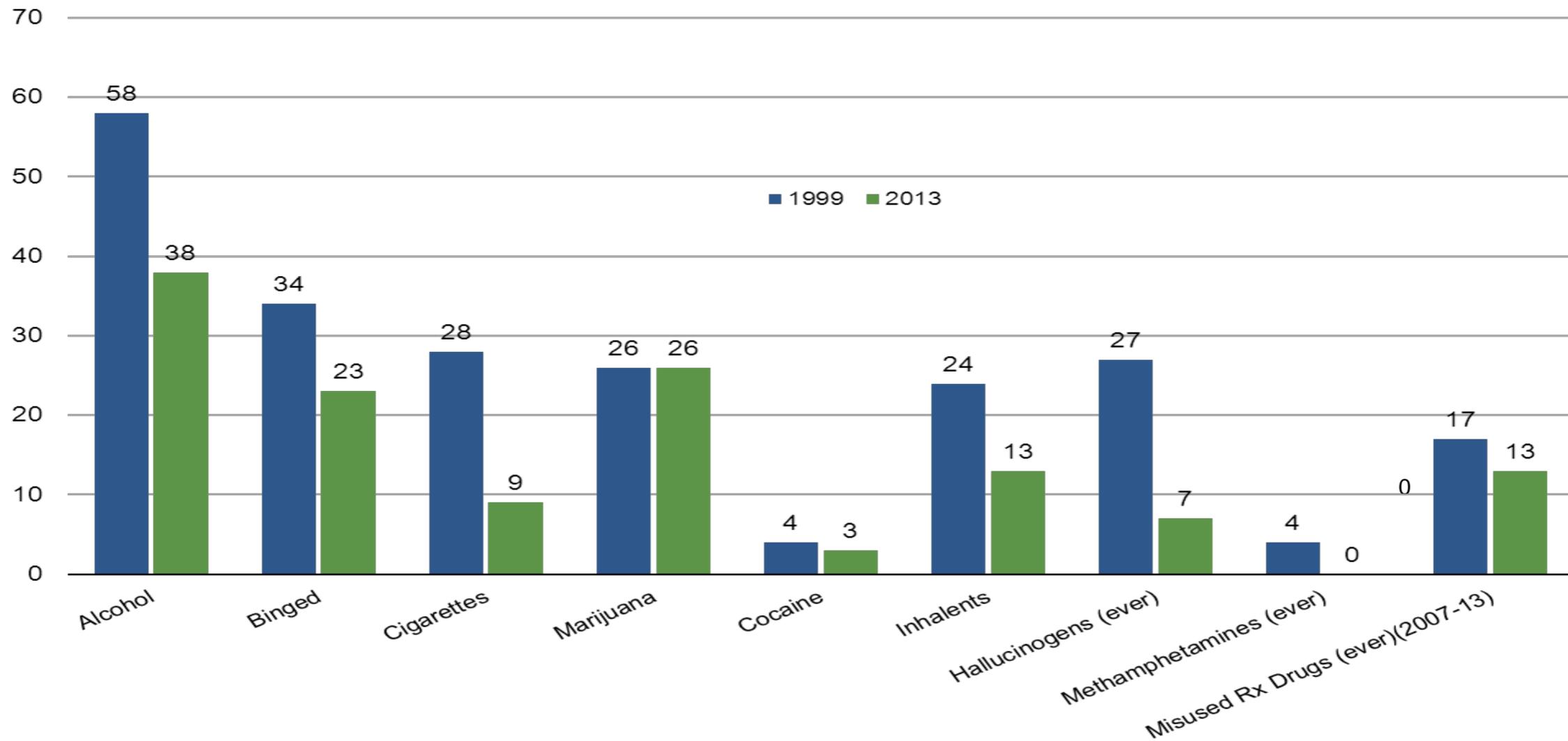
What MAPP Does

- ➔ Leverages community partnerships to create lasting, healthy change
- ➔ Implements grant objectives at grass roots level to mobilize community to action
- ➔ Organizes opportunities to develop Youth leadership and prevention skills
- ➔ Helps to build youth voice and develop assets (assets = ↓ risk taking)



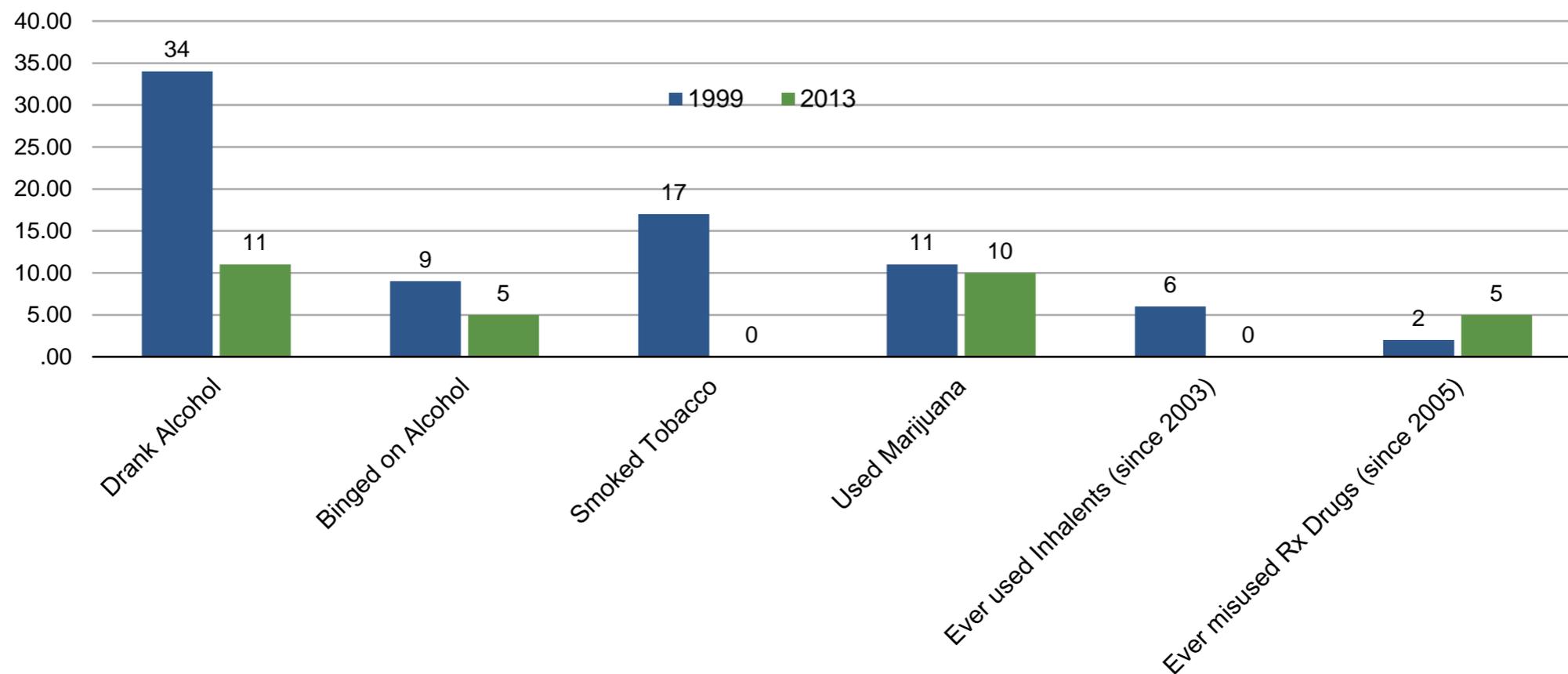
Outcomes

Percent of 12th-graders who, in past 30 days used...



Outcomes

Percent of 8th-grade students who, in past 30 days...



Data from Youth Risk Behavior Survey



Challenges

- ➔ Grant funding is often restricted
- ➔ Success dependent upon vigilance of continued grant seeking
- ➔ Unbalance portfolio of funding
- ➔ Initiatives get started or dropped depending on funding
- ➔ Private / unrestricted funding hard to find

Recommended next steps

- Engage Healthcare Finance professionals in discussion
- Provide more information on alternative finance models (i.e. Wellness Trusts) and where they are working elsewhere
- Explore further how to quantify health or shared “savings” – are they out there?

How to Reach Us

- ➔ Director Melanie Sheehan (802-674-7450)
- ➔ cho@mahhc.org
- ➔ Like us on Facebook:
 - ➔ www.facebook.com/mappvt.org
- ➔ Be sure to visit:
 - ➔ www.mappvt.org

Thank You !



Attachment 5 - Work Plan Alignment with Operational Plan

Population Health Integration in VT Health Care Innovation Project

Alignment with Operational Plan

June 2, 2014

Goals:

- Assure alignment of the Population Health Work Group Charter with VHCIP Areas of Innovation and Operational Plan
- Add specificity to the Population Health Work Group proposed work plan
- Identify enhanced opportunities, not currently specified in VHCIP Operational Plan, which could further improve population health

Three Areas of Innovation Being Tested

- Payment models
- Care models
- Population health plan

Population Health Work Group (From Operational Plan)

This group will examine 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. The group will examine these initiatives and SIM 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 gov't or non-gov't 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

Three Areas of Work According To Population Health Work Group Charter

- 1) Population Health Measures for payment and evaluation of project
- 2) How to pay for population health – financing models
- 3) Exemplars for integrating clinical and population health – delivery system models

Areas of innovation through VHCIP:	Operational Plan	Population Health Work Group approaches	Enhanced Approaches
Payment Models		<ul style="list-style-type: none">• Payment Measures• Modification to the models being	<ul style="list-style-type: none">• Financial Models• Social impact bonds

Population Health Integration in VT Health Care Innovation Project

Alignment with Operational Plan

June 2, 2014

		<ul style="list-style-type: none"> tested Other financial models 	<ul style="list-style-type: none"> Community Development Financial institute Wellness Trust CDC/CMMI Funding RWJ Project Ideas
Bundled (Episodes)		<ul style="list-style-type: none"> Educate PH work group members about model Share population health frameworks with Payment Models Work Group Identify best lever and strategy to include payment for and/or activity related to population health 	
Pay for Performance		<ul style="list-style-type: none"> Educate PH work group members about model Share population health frameworks with Payment Models Work Group Identify best lever and strategy to include payment for and/or activity related to population health 	
Pop. Based Global payments (ACO)		<ul style="list-style-type: none"> Educate PH work group members about model Share population health frameworks with Payment Models Work Group Recommend criteria and measures for payment that will shift funding and practice to actions that will improve population health 	<p>Question to be asked:</p> <p>Who shares in the savings? How can the savings be shared with population health and prevention partners?</p>
Areas of innovation through VHCIP:	Operational Plan	Population Health Work Group approaches	Enhanced Approaches
Delivery System (system of care)	Expansion of scope of delivery models to include PH	<ul style="list-style-type: none"> Share population health frameworks with Care Models Work Group Build upon Blueprint delivery system <ul style="list-style-type: none"> Review BP via Network 	<p>Systems of Care</p> <p>Connect to Community Health Needs Assessment</p>

Population Health Integration in VT Health Care Innovation Project

Alignment with Operational Plan

June 2, 2014

		<p>Analysis for enhancing pop. Health</p> <ul style="list-style-type: none"> ○ How best build on CHT Structure? ○ Look at strengths of “Integrated Health Team” ○ Consider BP for kids? <ul style="list-style-type: none"> ● Review ACO system of care (C. Hindes, OneCare; J. Gallimore, FQHC) ● Identify exemplars of community integration of clinical and population health efforts 	<p>System which includes children – BBF, IFS, etc.</p> <p>Accountable Health Community</p>
Areas of innovation through VHCIP:	Operational Plan	Population Health Work Group approaches	Enhanced Approaches
Pop. Health Plan (CDC/CMMI)	<ol style="list-style-type: none"> 1. Examine current PH efforts in VT & SIM <u>potential impact</u> on health of VT 2. Recommend how the project could <u>help to coordinate</u> health improvement activities + more directly impact population health: <ol style="list-style-type: none"> a. Enhance state initiatives b. Support or enhance Local or regional initiatives c. Expansion of scope of delivery models or preexisting initiatives to include PH 	<p>Share population health frameworks (where money goes; determinants of health outcomes)</p> <p>Create materials that show connection between social determinants, population health and clinical measures</p>	<p>Examine models that connect payment models & system of care for population health improvement</p>

Attachment 6 - Work Group Survey



VHCIP WORKGROUP SURVEY

1. Primary Affiliation (please choose all that apply):

- | | | |
|--|---|---|
| <input type="radio"/> Hospital | <input type="radio"/> State Agency | <input type="radio"/> Consumer |
| <input type="radio"/> Commercial Payer | <input type="radio"/> Specialist Provider | <input type="radio"/> Behavioral Health Organization |
| <input type="radio"/> Community Service Provider | <input type="radio"/> Primary Care Provider | <input type="radio"/> Long-term Services & Supports Org |
| <input type="radio"/> Provider Advocacy Group | <input type="radio"/> Consumer Advocacy | <input type="radio"/> Educational Institution |
| <input type="radio"/> Other: _____ | | |

2. Service Area:

- Statewide
 National
 County or HSA

3. Please rate this VHCIP Workgroup on the following areas:

	Poor	Fair	Excellent		
Balance between member and co-chairs/staff participation	1	2	3	4	5
Communication between meetings	1	2	3	4	5
Co-chairs/staff management of meeting motions/order	1	2	3	4	5
Workgroup Materials: Timeliness of distribution	1	2	3	4	5
Workgroup Materials: Relevance	1	2	3	4	5
Workgroup Materials: Thoroughness	1	2	3	4	5
Communication about the workgroup charter	1	2	3	4	5
Communication about workgroup workplan	1	2	3	4	5
Co-chairs/staff management of diverse perspectives	1	2	3	4	5

4. If you selected 'poor' for any of the above please summarize any suggestions for improvement:

5. Please indicate your level of agreement with the following three statements:

Vermont Health Care Innovation Improvement Project (VHCIP) is providing an effective platform for aligning policy, investments and payment to support a high-performing health system in Vermont.



VHCIP adequately supports activities that integrate population health into the triple aim of improving care, increasing health and reducing cost.



VHCIP adequately incorporates input from stakeholders including payers, providers, advocates and individuals.



WORK GROUP NAME _____