

Attachment 1 - Population Health
Work Group Meeting Agenda 8-12-14

VT Health Care Innovation Project Population Health Work Group Meeting Agenda

Date: Tuesday, August 12, 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	Karen Hein	Attachment 1: Agenda	
2	2:40	Approval of minutes	Tracy Dolan	Attachment 2: Minutes	
3	2:45	Updates Consultant Contract Accountable Communities Next round of provider grants Quality and Performance Measures Voting	Tracy Dolan Pat Jones	Attachment 3: SSP Measures report	
4	3:00	Draft Pop Health Plan Outline and Work Group Plan <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>	Heidi Klein	Attachment 4a: Population Health Plan Attachment 4b: Work Plan	
5	3:40	Work Group Process Evaluation Results	Annie Paumgarten	Attachment5: Work Group Survey Results	
6	3:55	Next Steps <i>What information do work group members need in order to continue our work together?</i>	Karen Hein		

OPEN ACTION ITEM LOG

Date Added	Action Number	Assigned to:	Action /Status	Due Date	Date Closed
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Attachment 2 - Population Health Work Group Minutes 7-08-14



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

Date of meeting: Tuesday, July 8th, 2014; 2:30 to 4:00 PM, ACCD – Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier

Attendees: Tracy Dolan, VDH, Co-Chair; April Allen, DCF; Bob Bick, HowardCenter; Donna Burkett, HowardCenter; Amanda Ciecior, VHIP(DVHA); Daljit Clark, DVHA; Peter Cobb, VNAs of VT; Brian Costello; Geera Demers, BCBS; Christine Geiler, GMCB; Caroline Hatin, DCF; Penrose Jackson, FAHC; Pat Jones, GMCB; Heidi Klein, VDH; Nelson Lamothe, UMASS; Ted Mable, NCSSInc; Jill Mckenzie; Michael Moss, NVRH; Nick Nichols, DMH; Annie Paumgarten, GMCB; Laural Ruggles, NVRH; Jenney Samuelson, Blueprint(DVHA); Julia Shaw, VLA; Miriam Sheehey, OCVT; Chris Smith, MVP; Sharon Winn, BSPC; Stephanie Winters, VMS; Jennifer Woodard, DAIL.

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	Penrose Jackson moved to approve the minutes. Peter Cobb seconded the motion and it passed unanimously.	The minutes will be updated and posted to the website.
3. Updates	Tracy Dolan described the work done at the last meeting in regards to the upcoming RFP <ul style="list-style-type: none"> ○ That RFP is going out this week <ul style="list-style-type: none"> ▪ 4-6 months of work Pat Jones gave an update on measures work <ul style="list-style-type: none"> ○ We're in measure development season year 2 for ACOs <ul style="list-style-type: none"> ▪ 12 measures were added to the reporting set 	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> ▪ 8 measures were proposed to be promoted to the payment measure set ▪ 1 measure was added to the commercial set from the Medicaid set ▪ 1 measure was eliminated due to questions of treatment efficacy/safety ○ QPM is meeting this month to decide whether or not to propose further measures. <p>Tracy Dolan discussed the measures and updates the group on the work done and thought processes behind measure decisions</p> <ul style="list-style-type: none"> ○ She also discussed the relationship between social determinants of health and the measures being used by ACOs ○ Pat Jones added that the QPM work group decided to add two criteria suggested by this work group to the list of those used to determine measures ○ There is a question on the phone about whether the data would be available in real-time <ul style="list-style-type: none"> ▪ Tracy explained that in general, the data is usually about a year old <p>Update provided on the timeline for the next round of provider grants</p> <ul style="list-style-type: none"> ○ The steering committee received PHWG’s input on what the criteria should be for those determinations <p>Tracy gave an overview of Jim Hester’s presentation from the last meeting</p>	
<p>4. Continuing the Discussion on Financing Population Health</p>	<p>Jenney Samuelson from Blueprint presented on “Building a Foundation for the Future”</p> <ul style="list-style-type: none"> • She presented the view from 30,000 feet <ul style="list-style-type: none"> ○ Discussed the work that the Blueprint does and how payment reforms interact with that work ○ Discussed how Vermont’s intervention is different from facially similar interventions going on in other states <ul style="list-style-type: none"> ▪ And the blueprint’s pop-health focused interventions <ul style="list-style-type: none"> • Medical and non-medical <ul style="list-style-type: none"> ○ Including services not typically included by traditional insurance plans ○ Summarized Vermont results from 2012 report 	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> • She then segued to the next presenters by asking, “What does this look like on the ground?” <p>Laurel Ruggles of Northeastern Vermont Regional Hospital presented on Community Health Teams</p> <ul style="list-style-type: none"> ○ Discussed how APCPs, CHTs, and the community-based organizations interact ○ Discussed the findings from the CDC evaluation of the St J area CHT <ul style="list-style-type: none"> ▪ It 30-month evaluation ▪ Presented quotes from clients of the CHT ▪ Went over the implications for public health practices ○ Summarized the key functions of a community health system <ul style="list-style-type: none"> ▪ Talked about the importance of not strategically planning in silos <p>Melanie Sheehan from Mt. Ascutney hospital presents discussed what her hospital is doing in the community</p> <ul style="list-style-type: none"> ○ Went over MA’s services and strategic plan ○ Discussed how they are addressing the cultures of MA’s community environment <ul style="list-style-type: none"> ▪ Working with the planning and zoning commissions ○ Talked about the organizational vision ○ Discussed the prevention partnership’s mission <ul style="list-style-type: none"> ▪ And the funding sources ○ Talked about the operations of the prevention partnership ○ Presented and discussed outcomes and challenges ○ Talked about healthcare finance integration into the prevention partnership’s work for the future <p>Discussion ensued in regards to the three presentations that just occurred</p> <ul style="list-style-type: none"> ○ Peter Cobb voiced his concern that blueprint is not appropriately recognizing the importance of home health providers <ul style="list-style-type: none"> ▪ He stated that of the 20,000 most vulnerable population of Vermonters, home health likely serves most of them ○ Discussion focused on how the PHWGs work can influence payment and delivery system reforms 	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> ▪ And how the three presentations related to that focus ○ Bob Bick asked about where Blueprint’s data comes from <ul style="list-style-type: none"> ▪ Jenney Samuelson discussed ways the blueprint is improving their data going forward ○ Peter Cobb asked about the causal factors behind the discussed savings ○ Tracy Dolan requested that the group discuss where it thinks the money for community health intervention should come from and where it should sit <ul style="list-style-type: none"> ▪ Jenney Samuelson stressed the importance of community-wide accountability <ul style="list-style-type: none"> • April Allen iterated the importance of health information in the work that she does ○ Discussion went back to talking about the key functions of a community health system <ul style="list-style-type: none"> ▪ Question: what is the financing system for something bigger? 	
5. Work Group Plan – Reflection and Refinement - tabled	<p>General Questions</p> <ul style="list-style-type: none"> • Is this the right direction to yield the desired results? • Are these the right levers to influence the project? What might be misdirected or missing? • Thoughts on setting the broader agenda? 	
6. Work Group Process Evaluation	<p>Annie Paumgarten presented on the two major evaluations of VHIP</p> <ul style="list-style-type: none"> • One is external via CMMI/RTI <ul style="list-style-type: none"> ○ Second is internal to help the state improve throughout the grant period • This survey is a first step towards the goal of continuous improvement • Stakeholders requested to participate in the survey <ul style="list-style-type: none"> ○ Comments regarding the survey should be directed to Annie 	
7. Public Comment and Next Steps	<p>Next Meeting: Tuesday, August 12th 2:30 – 4:00 pm. ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier.</p>	

Attachment 3 - SSP Measures Report

Vermont ACO Shared Savings Program Quality Measures: Recommendations for Year 2 Measures from the VHCIP Quality and Performance Measures Work Group

Population Health Work Group

August 12, 2014

Measure Use Terminology: Core

Payment

- Performance on these measures will be considered when calculating shared savings.

Reporting

- ACOs will be required to report on these measures. Performance on these measures will be not be considered when calculating shared savings.

Pending

- Measures that are included in the core measure set but are not presently required to be reported. Pending measures are considered of importance to the ACO model, but are not required for initial reporting for one of the following reasons: target population not presently included, lack of availability of clinical or other required data, lack of sufficient baseline data, lack of clear or widely accepted specifications, or overly burdensome to collect. These may be considered for inclusion in future years.

Measure Use Terminology: Monitoring & Evaluation

Monitoring

- These are measures that would provide benefit from tracking and reporting. They will have no bearing on shared savings; nonetheless, they are important to collect to inform programmatic evaluation and other activities. These measures will be reported at the plan or state-level. Data for these measures will be obtained from sources other than the ACO (e.g., health plans, state).

Utilization & Cost

- These measures reflect utilization and cost metrics to be monitored on a regular basis for each ACO. Data for these measures may be obtained from sources other than the ACO.

QPM WG Year 2 Measure Review Process

- **Goals were to adhere to transparent process and obtain ongoing input from WG members and other interested parties**
- **March-June**
 - Interested parties and other VHCIP Work Groups presented Year 2 measure changes for consideration
 - WG reviewed and finalized criteria to be used in evaluating overall measure set and payment measures
 - WG reviewed and discussed proposed measure changes
- **June-July**
 - Co-Chairs/Staff/Consultant scored each recommended measure against approved criteria on 0-1-2 point scale and developed proposals for Year 2 measure changes for the WG's consideration
 - WG reviewed and discussed proposals
- **July**
 - WG voted on measures during July 29th meeting

QPM Criteria for Evaluating All Measures

- ✓ Valid and reliable
- ✓ Representative of array of services provided and beneficiaries served by ACOs
- ✓ Uninfluenced by differences in patient case mix or appropriately adjusted for such differences
- ✓ Not prone to effects of random variation (measure type and denominator size)
- ✓ Consistent with state's objectives and goals for improved health systems performance
- ✓ Not administratively burdensome
- ✓ Aligned with national and state measure sets and federal and state initiatives whenever possible
- ✓ Includes a mix of measure types
- ✓ Has a relevant benchmark whenever possible
- ✓ Focused on outcomes
- ✓ Focused on prevention, wellness and/or risk and protective factors
- ✓ Limited in number and including measures necessary to achieve state's goals (e.g., opportunity for improvement)
- ✓ Population-based

QPM Criteria for Evaluating Payment Measures

- ✓ Presents an opportunity for improvement
- ✓ Representative of the array of services provided and beneficiaries served
- ✓ Relevant benchmark available
- ✓ Focused on outcomes
- ✓ Focused on prevention and wellness
- ✓ Focused on risk and protective factors
- ✓ Selected from the Commercial or Medicaid Core Measure Set

Summary of Year 2 Recommended Changes

- QPM Work Group voted to:
 - Re-classify **9 existing** measures
 - 3 to Payment
 - 5 to Reporting
 - 1 to M&E
 - Add **2 new** measures
 - 1 to Reporting (Patient Experience Survey)
 - 1 to M&E

Recommended Year 2 Payment Measures

– Claims Data

Commercial &
Medicaid

- All-Cause Readmission
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)*
- **Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite** (10-5 vote of QPM WG; move from Reporting)

Medicaid-Only

- Developmental Screening in the First Three Years of Life

**Medicare Shared Savings Program measure*

Recommended Year 2 Payment Measures

– Clinical Data

Commercial
& Medicaid

- **Diabetes Care: HbA1c Poor Control (>9.0%)*** *(10-5 vote of QPM WG; move from Reporting)*
- **Pediatric Weight Assessment and Counseling** *(10-5 vote of QPM WG; move from Reporting)*

**Medicare Shared Savings Program measure*

Recommended Year 2 Reporting Measures – Claims Data

Commercial
& Medicaid

- Ambulatory Care-Sensitive Conditions Admissions: COPD*
- ~~Breast Cancer Screening*~~
- ~~Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: Composite~~
- Appropriate Testing for Children with Pharyngitis
- **Avoidable ED Visits** *(9-6 vote of QPM WG; move from M&E)*

Commercial-
Only

- **Developmental Screening in the First Three Years of Life** *(10-4 vote of QPM WG; already in Y1 Payment Measure Set for Medicaid SSP)*

**Medicare Shared Savings Program measure*

Recommended Year 2 Reporting Measures – Clinical Data

Commercial &
Medicaid

- Adult BMI Screening and Follow-Up*
- Screening for Clinical Depression and Follow-Up Plan*
- Colorectal Cancer Screening*
- Diabetes Composite
 - *HbA1c control**
 - *LDL control**
 - *High blood pressure control**
 - *Tobacco non-use**
 - *Daily aspirin or anti-platelet medication**
- ~~Diabetes HbA1c Poor Control*~~
- Childhood Immunization Status
- ~~Pediatric Weight Assessment and Counseling~~
- **Cervical Cancer Screening** (*Unanimous vote of QPM WG, move from Pending*)
- **Tobacco Use: Screening & Cessation Intervention*** (*Unanimous vote of QPM WG, move from Pending*)

**Medicare Shared Savings Program measure*

Recommended Year 2 Reporting Measures

– Patient Experience Survey Data

Commercial
& Medicaid

- Access to Care
- Communication
- Shared Decision-Making
- Self-Management Support
- Comprehensiveness
- Office Staff
- Information
- Coordination of Care
- Specialist Care
- **Provider Knowledge of DLSS Services and Help from Case Manager/Service Coordinator**
(11-3 vote of QPM WG; NEW)

Recommended Year 2 Monitoring & Evaluation Measures

PLAN-LEVEL MONITORING

- Appropriate Medications for People with Asthma
- Comprehensive Diabetes Care: Eye Exams for Diabetics
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Follow-up Care for Children Prescribed ADHD Medication
- Antidepressant Medication Management
- **Breast Cancer Screening** (*Unanimous vote of QPM WG; moved from Reporting*)

STATE-LEVEL MONITORING

- Family Evaluation of Hospice Care Survey
- School Completion Rate
- Unemployment Rate
- **LTSS Rebalancing** (*Medicaid-only; state and county level; unanimous vote of QPM WG; NEW*)
- **SBIRT** (*for pilot sites; unanimous vote of QPM WG; move from Pending*)

UTILIZATION & COST

- Total Cost of Care
 - Resource Utilization Index
 - Ambulatory surgery/1000
 - Average # of prescriptions PMPM
 - Avoidable ED visits- NYU algorithm
 - Ambulatory Care (ED rate only)
 - ED Utilization for Ambulatory Care-Sensitive Conditions
 - Generic dispensing rate
 - High-end imaging/1000
 - Inpatient Utilization - General Hospital/Acute Care
 - Primary care visits/1000
 - SNF Days/1000
 - Specialty visits/1000
- Annual Dental Visit

Recommended Year 2 Pending Measures

- Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)*
 - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic*
 - Influenza Immunization*
 - ~~Tobacco Use Assessment and Tobacco Cessation Intervention*~~
 - Coronary Artery Disease (CAD) Composite*
 - Hypertension (HTN): Controlling High Blood Pressure*
 - Screening for High Blood Pressure and Follow-up Plan*
 - ~~Cervical Cancer Screening~~
 - Care Transition-Transition Record Transmittal to Health Care Professional
 - Percentage of Patients with Self-Management Plans
- How's Your Health?
 - Patient Activation Measure
 - Elective delivery before 39 weeks
 - Prenatal and Postpartum Care
 - Frequency of Ongoing Prenatal Care
 - ~~Screening, Brief Intervention, and Referral to Treatment~~
 - Trauma Screen Measure
 - Falls: Screening for Future Fall Risk*
 - Pneumococcal Vaccination for Patients 65 Years and Older*
 - Use of High Risk Medications in the Elderly
 - Persistent Indicators of Dementia without a Diagnosis
 - Proportion not admitted to hospice (cancer patients)

**Medicare Shared Savings Program measure*

Other Proposed Measures

- QPM Co-Chairs/Staff/Consultant recommended considering these measures for promotion
- QPM work group members voted to retain Year 1 status

Year 1 Measure Category	Year 2 Suggested Measure Category	Measure	QPM Vote
Pending	Reporting	Prenatal and Postpartum Care (Clinical Data)	5 in favor of promotion 9 opposed to promotion
Pending	Reporting	Influenza Immunization (Clinical Data)	7 in favor of promotion 7 opposed to promotion

Other Proposed Measures

- QPM Co-Chairs/Staff/Consultant DID NOT recommend considering this measure for promotion
- Work group members requested additional consideration for use as Reporting in Year 2
- QPM work group members voted to retain Year 1 status

Year 1 Measure Category	Year 2 Suggested Measure Category	Measure	QPM Vote
Pending	Pending	Screening for High Blood Pressure and Follow-Up Plan Documented (Clinical Data)	2 in favor of promotion to Reporting 11 opposed to promotion

Other Proposed Measures

- QPM Co-Chairs/Staff/Consultant DID NOT recommend considering these measures for promotion
- QPM work group members chose not to vote on these measures

Year 1 Measure Category	Year 2 Suggested Measure Category	Measure
Reporting	Reporting	Optimal Diabetes Care (D5 – Composite)
Reporting	Reporting	Rate of Hospitalization for ACSCs (COPD/Asthma in Older Adults)
Reporting	Reporting	Screening for Clinical Depression & Follow-Up
Reporting	Reporting	Adult BMI Assessment
Pending	Pending	Controlling High Blood Pressure
Pending	Pending	Care Transition Record Transmitted to Health Care Professional
Pending	Pending	Transition Record with Specified Elements Received by Discharged Patients
Pending	Pending	Percentage of Patients with Self-Management Plans

Attachment 4a - Population Health Plan

Goals – How We Measure Success

1. Focus On Broader Population And Health Outcomes

The innovation includes efforts to maintain or improve the health of all people – young, old, healthy, sick, etc. The health status and trends in the community are considered in order to develop priorities and target action. Specific attention is given to the maintenance of health and wellness of subpopulations and especially those most vulnerable in the future due to disability, age, income, etc.

2. Sustainable Funding Towards Primary Prevention and Wellness

Savings, incentives and investments are directed at the determinants of health and efforts aimed at primary prevention¹, self-care and maintaining wellness (rather than solely on identifying and treating disease and illness). Budgets explicitly demonstrate spending and/or investments in prevention and wellness activities and partners.

3. Expanded Health Focus through Integrated Clinical Service Delivery with Broad Set of Community Partners

The innovation in care delivery builds upon existing infrastructure (Blueprint Medical Homes, Community Health Teams, Accountable Care Organizations, and public health programs), connects a broad range of community based resources, and addresses the interrelationships among physical health, mental health, and substance abuse.

4. Measures that Matter

The innovation includes accountability in the system design and its implementation for improved population health through the use of measures of quality and performance at the multiple levels of change necessary.

Theory of Change (See Jim’s presentation for ideas + mismatch)

- Focus on the people – person in context (work, play, learn and live) – center of the model should be the people (not the payment or delivery system)
- Recommendations: how to influence the context

Background

Expectations of the project

Process of Population Health Workgroup

Recommendations aligned with:

¹ 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 Frameworks
 - Socio-ecological model
 - County health rankings
 - Frieden Pyramid
 - Disparities
 - Determinants of health
 - Evaluating population health programs
 - Population Health measures

- State Planning Efforts
 - Act 49
 - State Health Improvement Plan
 - Healthy Vermonters 2020
 - Results-based accountability framework; Well-being of Vermonters

- Existing resources and tools on high priority population health topics, measures and strategies

- Best practices and evidence based actions for health improvement
 - Clinical guide to preventive services
 - Community guide

- Existing reform efforts and innovation models
 - Global budgeting and population health budgeting

Analysis

Current system

- Flow of funding and payment for population health
- Linkages between clinical and community health systems for individual and population health improvement
- State-specific inventory of ongoing population health efforts that could be effectively leveraged by SIM to advance the population health aim.
- Current practices and new opportunities to leverage Medicaid and other payers

Current thinking and research on Incorporating Pop Health into Health Care Reform

- HCR 1.0 – 3.0
- National thought leaders (e.g. IOM)
- Experimentations in financing, integration, community-level work

Payment Model Reforms Tested (Shared Savings, Pay for Performance)

- What is it and how do we measure success
- Strengths
- Limitations
- Potential additions to incorporate population health
 - Payment Measures
 - Modification to the models being tested
 - Other financial models
 - Scenarios of investments

Delivery Model Reforms Tested (Blueprint – CHT and expanded team, ACO)

- Strengths
- Limitations
- Expansion of scope of delivery models to include PH
 - Identify exemplars of community integration of clinical and population health efforts
 - Options for including children
 - Approaches that integrate physical health, mental health and substance abuse
 - Measures of success

Other Innovations Explored to Improve population health (Accountable Health Communities)

- Strengths
- Limitations
- Adapting/creating In the VT context

Other innovations outside of VHCIP in VT

- global budgeting

Recommendations: Ensuring Success

Widening the Lens

- Payment Model → Financial Model
- Health Care Delivery Model → Population Health System
- Health In All Policies

Creating a Population Health System: Models that connect payment models and system of care for population health improvement

- Integrating clinical payment and delivery models

- Publicly funded
 - Privately funded
- Financing population health and prevention
- Support or enhance existing local or regional initiatives
- Broader innovations needed/recommended

State Policy and Planning

- **Policy levers to advance population health:** Effectively leveraging existing policy levers to advance population health as part of the triple-aim objectives. The examples may include the Community Health Needs Assessment (CHNA), the new Medicaid regulation around non-traditional healthcare providers, etc.
- Leveraging Medicaid and other payers – how to use
- Community Health Needs Assessment
- Health resource allocation plan
- Unified health budget

Technical Assistance to be Offered through CDC/CMMI

Behavioral health/Mental health: Coordination with and support of efforts to improve health and quality of care for population with behavioral health needs.

Public health and community capacity building: foster collaboration and better support SIM objectives through public health, community services and healthcare collaborations.

Financing and payment models for population health strategies: and prevention efforts through non-traditional funding methods such as trust funds, community bonds, etc.

Provider Engagement into population health TA activities, when topic is appropriate for those audiences.

Policy levers to advance population health: Effectively leveraging existing policy levers to advance population health as part of the triple-aim objectives. The examples may include the Community Health Needs Assessment (CHNA), the new Medicaid regulation around non-traditional healthcare providers, etc.

Aging: strategies for fall prevention, self-management, referrals to community-based services, etc. to better support the SIM models with a focus on aging population, such as Long Term Support and Services (LTSS) and Patient Centered Medical Home (PCMH).

Health Information Technology investments in support of population health: ensure that HIT and infrastructure resources are allocated appropriately across traditional HC and community settings in support of new delivery models.

Topical Areas

- a. Diabetes
- b. Tobacco
- c. Obesity
- d. Disparities
- e. Determinants of health
- f. Evaluating population health programs
- g. Population Health measures

Attachment 4b - Work Plan

***VT Health Care Innovation Project
Population Health Work Group Work Plan***

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
Develop shared understanding of factors contributing to population health outcomes	Define “population health” Share potential frameworks for identifying the major contributors to population health Create materials that show connection between social determinants, population health and clinical measures			Completed	Definition adopted Socio-ecological framework adopted Pop Health 101 materials shared with all work groups
Measures Develop consensus on population health measures	Collect existing sets of “population health” measures currently used in VT, CDC and/or by CMMI, for example: <ul style="list-style-type: none"> • Healthy VT 2020 • VT State Health Improvement Plan • GMCB dashboard • ACO Measures for VHCIP • CMMI 			Initial identification of set completed On-going collection of data	
	Review current process for selecting ACO (Medicare) measures and preliminary set for expanded ACO (Medicaid and commercial insurers) in 2014		Pat Jones	Completed	
	Recommend appropriate set of measures for ACOs for Years Two and Three		Work Group	Completed	<ul style="list-style-type: none"> • Criteria for selection of measures adopted • Measures recommended • Measures adopted/approved
	Ensure on-going dialogue with members of the Quality and Performance Measures Work Group	On-going	Heidi Klein is a voting member	On-going	
	Identify, help select and support integration of population health measures for other models being tested (bundled payments, P4P, and other delivery system reforms)				
	Explore other areas where population health measures could be used in tracking results (e.g. dashboard and CHNA Community Health Needs Assessment) priority setting, implementation strategies and outcomes;				

***VT Health Care Innovation Project
Population Health Work Group Work Plan***

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
Payment Models	<ul style="list-style-type: none"> • Review of current payment models • Share population health frameworks with Payment Models Work Group 		Richard Slusky? Co-chairs		
Bundled Payment/Episodes of Care	<ul style="list-style-type: none"> • Review model being tested • Analyze strengths and limitations in integration of population health • Identify best lever and strategy to include payment for and/or activity related to population health 		Kara Suter?		
Pay for Performance (P4P)	<ul style="list-style-type: none"> • Review model being tested • Analyze strengths and limitations in integration of population health • Identify best lever and strategy to include payment for and/or activity related to population health 		Kara Suter?		
Shared Savings/ACOs	<ul style="list-style-type: none"> • Review model being tested • Recommend criteria and measures for payment that will shift funding and practice to actions that will improve population health • Identify how the savings can be shared with population health and prevention partners • Analyze strengths and limitations in integration of population health 		Kara Suter?		
Financing Options paying for prevention	Identify promising new financing vehicles that promote financial investment in population health interventions		Jim Hester		
	Financial Options <ul style="list-style-type: none"> • Social impact bonds • Community Development Financial institute • Wellness Trust 		Jim Hester		
	Provide recommendations to other VHCIP committees to consider link with payment models being tested in VT				

***VT Health Care Innovation Project
Population Health Work Group Work Plan***

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
Care Models Identify opportunities for expansion of delivery models to include population health and broad range of community prevention partners	Examine current population health improvement efforts in VT administered through the Department of Health, Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs and other provider and payer entities.	July 2014	Blueprint NVRH Mt. Ascutney	Initial presentation at July 2014 meeting	Matrix of existing care models and features for improving population health
	Share population health frameworks with Care Models Work Group		Co-Chairs		Identification of opportunities in time and content to include population health in innovations tested
	Explore options to build upon Blueprint delivery system <ul style="list-style-type: none"> • Network Analysis for enhancing pop. health • How best build on CHT Structure? • Look at strengths of “Integrated Health Team” • Consider a whole family approach 				Identification of opportunities in time and content to include population health in innovations tested
	Review ACO system of care		C. Hindes, OneCare; J. Gallimore, FQHC		Identification of opportunities in time and content to include population health in innovations tested
	Review other systems of care as they are identified and/or proposed throughout the project				
	Review other innovations for systems of care for population health – other SIM states, IOM Population Health, etc.		Consultant		

***VT Health Care Innovation Project
Population Health Work Group Work Plan***

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
Examine models that connect payment models & system of care for population health improvement	Review theoretical models of community health systems to improve population health <ul style="list-style-type: none"> Consider Neal Halfon’s framework of health care reform 3.0 Review IOM Roundtable on Population Health and CHCS white papers 		Jim Hester		
	Look at examples <u>outside Vermont</u> for promising practices of the integration of integration of clinical care, mental and behavioral health, and primary prevention		Contractor		
	Identify <u>Vermont exemplars</u> : community integration of clinical care, mental and behavioral health, and primary prevention				
	Share models of integration to improve population health outcomes with communities interested in testing out change				
	Share the work with other VHCIP committees to consider link with payment and care models being tested in VT				
Develop Population Health Plan (CDC/CMMI)	Develop outline to inform work plan for the Population Health Work Group		Heidi Klein	Review of outline by Pop Health Work Group scheduled Aug 2014 mtg.	
	Develop work plan to ensure collection of information, exploration of topics, etc. Collect and organize materials		Heidi Klein		

Attachment 5 - Work Group Survey Results



POPULATION HEALTH WORKGROUP SUMMARY OF SURVEY RESULTS

WORKGROUP PARTICIPANTS RANKED WORKGROUP PROCESSES

23 Responses
(29 Members)



Primary Affiliation (all that apply):

	Percent	Count
Hospital	33.3%	7
Community Service Provider	28.6%	6
Educational Institution	19.0%	4
State Agency	14.3%	3
Commercial Payer	9.5%	2
Specialist Provider	9.5%	2
Consumer Advocacy	9.5%	2
Provider Advocacy Group	4.8%	1
Primary Care Provider	4.8%	1
Consumer	4.8%	1
Behavioral Health Org	4.8%	1
LTSS Org	0.0%	0
Other: ACO, Blueprint, Prevention Council		3

Respondent Suggestions for Improvement: More communication between meetings; Periodic break-out sessions so that everyone has a voice; Small group work between meetings on focused topics, this will facilitate more “diverse perspectives and participation.”; More clarity on charter and work plan; Clearly indicating what votes will take place in the agenda and materials; All workgroup materials one full week in advance of the meetings; Involve more patients and consumers in the workgroup process; Continue to focus on the well-being of Vermonters (PH Workgroup is doing this best in VHCIP); VHCIP Workgroup has a bureaucratic atmosphere; Do more to foster relationships via outreach; Team-building (locally, and integrating with VHCIP) is a formula for advancing a stronger foundation for Population Health; Delegates at the table could do more to support PH Workgroup Leadership in seeing more social determinates be addressed; Objectives outcomes need to be developed; Poor audio quality on the phone.

Respondent Perceptions of VHCIP

