

Vermont Health Care Innovation Project Population Health Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: April 14, 2015; 2:30 PM – 4:00 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome, Roll Call, & Agenda Review	Karen Hein called the meeting to order at 2:33pm. A roll call attendance was taken and a quorum was present. Karen Hein reviewed the meeting agenda.	
2. Approval of Minutes	Penrose Jackson moved to approve the March 10, 2015, minutes by exception. Laural Ruggles seconded. The minutes were approved with two abstentions.	
3. Project Updates: <ul style="list-style-type: none"> • Accountable Communities for Health • Population Health Work Group Work Plan 	<p>Heidi Klein provided updates on our work with the Prevention Institute to investigate Accountable Communities for Health and on the Population Health Work Group Work Plan.</p> <ul style="list-style-type: none"> • <i>Accountable Communities for Health:</i> Tracy and others have presented to other VHCIP Work Groups on this project. Heidi clarified that there is no funding for pilot communities associated with this project; it is a research project. Prevention Institute has shared initial findings from their national review of ACH exemplars, and has also spoken with Vermont communities who might be moving along the path to Accountable Communities for Health. The Prevention Institute will be back in Vermont in June to present their final report. • <i>Population Health Work Group Work Plan (See Attachment 3):</i> Heidi described the process that went into creating this workplan. Work Group leadership identified three major areas of exploration, based on which Heidi drafted a Work Plan for the Population Health Work Group. The Work Group also includes objectives and tasks which overlap with other VHCIP Work Groups and identifies specific endorsements and dependencies to encourage connections. <ul style="list-style-type: none"> ○ Heidi pointed out a few of the objectives this group achieved during the first quarter of 2015 and noted things to come later this spring. 	

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	<p>The group discussed the following:</p> <ul style="list-style-type: none"> Jesse de la Rosa requested additional information on the Integrated Communities Care Management Learning Collaborative. Heidi and Laural Ruggles briefly described the Learning Collaborative, active in three communities; it uses a rapid-cycle quality improvement model to support integrated care management for high-risk patients. Laural also noted that the CCM Work Group voted to expand the learning collaborative to a new group of three communities. That recommendation will go to the Steering Committee later this month. Heidi suggested that this might be an agenda item for a future meeting of this Work Group. 	
<p>4. Paying for Population Health Prevention: Paper Outline</p>	<p>Heidi Klein presented the outline for a paper (Attachment 4) that members of the Work Group leadership team (Heidi Klein and Jim Hester), with support from other project staff (Sarah Kinsler and Mandy Ciecior), are working on.</p> <ul style="list-style-type: none"> This will be the first in a series of papers; all will feed into the Population Health Plan. This paper will describe the payment models Vermont is testing through VHCIP and identify strategic policy levers for embedding population health and prevention in these models. Alicia’s presentation (Item #5 on today’s agenda) will mirror this content. 	
<p>5. Paying for Population Health Prevention 101</p>	<p>Alicia Cooper, Payment Reform Director on the SIM team at DVHA, presented (Attachment 5) on the payment reform landscape in Vermont and SIM’s role in changing payment for population health. (Note: Alicia also staffs the VHCIP Quality and Performance Measurement Work Group.)</p> <ul style="list-style-type: none"> Alicia noted that today’s presentation is the tip of the iceberg – there are nuances and exceptions to every piece of this discussion, but today’s presentation is a high level overview. Vermont has a relatively simple payer landscape: Medicare, Medicaid (and CHIP), and commercial (BCBS, MVP, and Cigna; Blue Cross dominates the market). <ul style="list-style-type: none"> Alicia briefly described each insurer type, including which populations they cover and a general description of covered benefits. Many large employers are self-insured, and contract with commercial insurers for claims administration. Providers can be paid based on a variety of methods, including fee-for-service and other systems like case rate (ex/ DRG), and per-diem; Alicia briefly described each. Alicia provided a high-level diagram of how money flows through the system under each major payer category (Medicare, Medicaid, commercial). <ul style="list-style-type: none"> Different providers are paid using different methods by each payer and sometimes by the same payer; for example, Medicare pays critical access hospitals different from other hospitals. Vermont’s payment reform activities have been underway for nearly a decade; existing and new payment reform activities are supported by VHCIP. In the future, we’re looking ahead to a potential all-payer model currently being discussed with CMS. <ul style="list-style-type: none"> One example is the Blueprint for Health, a program that supports primary care practices based on the medical home model (VHCIP Testing Model: Pay for Performance). 	

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	<ul style="list-style-type: none"> • Value-Based Payment Definition: Any system of paying for health care that emphasizes quality care and cost management; represents a shift from paying for the volume of services delivered to the value of services delivered; movement away from the fee-for-service model. <ul style="list-style-type: none"> ○ Value-based purchasing includes a range of payment models (slide 18); the goal is to shift further along this range toward increased incentives for provider integration and increased provider accountability for quality and costs. • Alicia described the payment models being tested through VHCIP. <p>The group discussed the following:</p> <ul style="list-style-type: none"> • <i>Vermont's ACO programs were planning on moving toward shared risk. Is this still happening?</i> In the Medicaid Shared Savings Program, ACOs have decided not to opt for shared risk. In the Commercial Shared Savings Program, this is a possibility. Medicare recently introduced a new ACO model, the Next Generation ACO Model, which includes increasing shared risk. • <i>What's the difference between capitation and global budgets?</i> Karen Hein responded that a global budget is given to a group to care for a defined population (usually geographic); capitation could be one way to arrive at a global budget, but there are others, for example, using historical budgets. • <i>Are schools or school-based providers integrated into the system anywhere in Vermont? This could be a good opportunity for increased integration and care coordination.</i> Integrated Family Services (IFS) is an approach that identifies families instead of individual children as the target; this might be a good topic to present to this group. The Secretary of Human Services is also having conversations about how IFS can support integration, but Carol Maloney noted that these conversations are somewhat siloed and could be better connected to the Blueprint and regional conversations. • <i>What does provider integration mean, and what provider types are included?</i> Laural Ruggles commented that she's thinking bigger than just medical providers, including human services and social services. Karen Hein noted that there are carrots (incentives) and sticks (penalties) to encourage integration and well managed care. A wide range of partners, including medical and social/human services, will be critical in meeting the quality and cost containment goals. The Blueprint's community health teams (CHTs) might provide some of the building blocks for this. • Loyola University has developed a clinically integrated network (CIN) which includes Loyola's nursing school, and has significant interaction with a local high school that includes embedded primary care and emphasizes mental health and prevention. Vermont's pharmacy school is doing something similar, putting pharmacists in primary care offices. • Shared language is incredibly important for allowing schools, human services, and other allied parts of the system to participate. JoEllen Tarallo-Falk encouraged VHCIP to offer funding to Vermont communities to test bundling of services and provider integration. <p>Heidi asked for feedback on what Work Group members would like to learn next to continue this exploration.</p>	

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	<ul style="list-style-type: none"> • Sue Aranoff suggested more information on how these models are being tested in Vermont; for example, the Nursing Home Bundled Payment Initiative. • Mary Kate Mohlman from the Blueprint suggested a presentation on the payment modifications the Blueprint is considering, which move further up the ladder of value-based payment. • Steve Gordon suggested a presentation on the Blueprint and ACO coordination efforts (Unified Community Collaboratives). (Tracy noted that this Work Group did have a presentation on this a few months ago; Steve suggested we continue to stay up-to-date on this work.) • Shawn Skaflestad suggested a presentation on IFS and how this is being implemented on the ground. • Pennrose Jackson reminded the group that this is the Population Health Work Group; we need to think outside the clinical delivery system. Hospitals are preparing to implement community health needs assessments; these result in funding to improve community health outside the clinical delivery system. • Julie Arel suggested oral health/dental health, which has significant impacts on overall health. Karen Hein noted that pediatric dental coverage is considered an essential health benefit for Qualified Health Plans on the Health Insurance Exchange (Vermont Health Connect). 	
6. Next Steps	Next Meeting: Thursday, May 12, 2015, 2:30 PM – 4:00 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier	