Vermont Health Care Innovation Project
Population Health Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: August 18, 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	Tracy Dolan called the meeting to order at 2:32pm. **Introduction:** The focus for the meeting is to discuss what to do for next steps around Accountable Communities for Health. (ACHs) The Prevention Institute was hired to conduct national research, identify current activities in Vermont that include components of ACH, and recommendation what Vermont can do to bring forward an ACH model. The Population Health work group will divide into smaller discussion groups during today's meeting to consider some key questions, discuss the Prevention Institute recommendations and identify options for next steps. A roll call attendance was taken and a quorum was present. **Agenda Review:** Heidi Klein reviewed the meeting agenda. Today's meeting will focus on the report from the Prevention Institute and the strategic questions posed by the Center for Health Care Strategies. Heidi referenced the memo in the materials that bring forward the questions to consider as we think about how to bring an ACH model in Vermont.	

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	The small groups will review the strategic questions and then break out to discuss the following questions: What strikes you about the Prevention Institute report? Which recommendations do you think are most critical? Which questions from the CHCS are the most critical for consideration if we want to move forward in the development and support of Accountable Communities for Health? The PI is not recommending a pilot test. An alternative would be to support a number of communities that are interested in exploring how to move towards an ACH through technical assistance and a peer learning collaborative. What would need to be in place to support this effort?	
2. Approval of Minutes	Sue Aranoff moved to approve the May 12, 2015, minutes by exception. Teresa Voci seconded. The minutes were approved with one abstention.	
3. Accountable Communities for Health	**Prevention Institute: Accountable Communities for Health Presentation** Leslie Mikkelson and Will Harr presented by phone to review the highlights of the report on Accountable Communities for Health. The group discussed the following: Reviewed Executive summary Reviewed Core recommendations Q&A **Overarching themes for Accountable Communities for Health report:** • Across the country Accountable Communities for Health are being seen as partnerships between organizations to improve the health across a community (a geographic community) • The definition we are using is the right definition – especially given recognition of factors outside of medical care in affecting health • The key aspects of Vermont model are: 1) Population = all people in a geographic area; 2) scope = integration of health care with mental and behavioral health and social services and connecting these with community wide prevention activities • There is a lot of interest in this topic – in Vermont and across the country • Themes from the Vermont sites o Strong partnerships with hospitals (versus over the rest of the country where this is not widely	

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	seen) o Already strong partnerships between health organizations and other kinds of organizations (mental health, etc…) that are poised and ready to help the population o Every site expressed interest in doing community-based policy work on the community-based determinants of health. (walkability, health eating, worksite wellness) o Recognition that poverty is the underlying issue and how it can be addressed to help economic development in the community. **Core Elements of an Accountable Community for Health (page 10):** • 9 core elements o Mission o Multi-sectoral partnership o Integrator organization o governance o data and indicators o strategy and implementation o community member engagement o communication o sustainable financing • Recommendations by Prevention Institute o See page 124 of the full materials packet o We already have AHC in VT; some formal some less so o Two clusters of concerns = chronic disease, substance abuse o Vermont should build on efforts where there were already strong partnerships in communities. o There is a VT prevention model – and could we move from that toward something like the San Diego model where the community selected certain health conditions to establish their framework. o We know that there is other work going on in VT in service area integration and health improvement and we can work to integrate them to ensure there's a balance between the patient specific efforts and community wide prevention to improve health. (E.g. increasing physical activity; tobacco use reduction; traffic hazard reductions…) o The state should develop a common set of indicators and have communities select from this list; as opposed to each community developing its own set of indicators… o Re: data sharing systems – building toward an integrated data system is key but should not hold up the other work o Creating a learning environment; building a network analysis statewide to review the service areas and activities. Surveying communities to see what kinds of work is going on in certain areas (such as local food distribution…)	

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	o There is no one type of organization that *should* be the integrator – this can be done by the hospitals but not necessarily. Consideration should be given to other partners who are actively engaged in the community and are trusted entities. o Sharing lessons between the public health approach (VT Prevention model) and other people in health care (direct service providers) – sharing knowledge about what the model can bring to the table and expand the paradigm from individual health care to community based health care and support services. o Explore sustainable financing. There is work underway already – in kind contributions; hospital funding, etc… Lane County CO model was using dedicated funding for community care. Find a way to calculate a dedicated funding stream for prevention. **Questions and Answers** o Laural Ruggles – excellent report. Excellent start o Sue Aranoff – There was a reference to community benefit hospital funding in VT? Was that Brattleboro? Specifically the report was referencing the hospital contribution in St. Albans o In MA – hospitals are asked to earmark 5% of their overall budget for community health activities.	
4. Report from Small Groups	**Group One Breakout Session Report-out** Tracy Dolan lea this break out group • Which recommendations struck us? Helpful to highlight the information; hospitals play a big role in VT; strike a balance between the individual and community prevention work. Not a statewide infrastructure to invest in prevention. • Might be a call for legislature to help develop a statewide approach – around funding, responsibility to lead that work, etc… • Even where we are progressing, no one has dedicated time to work on this topic (evidenced by meetings that start at 7:30 AM!) • Pilot –too early to talk about that now. More important to build up the overarching statewide approach. o Clinical o Clinical community o Broader community – this is where we need to focus our attention • Next step, provide technical assistance to those communities who are already working on this. Recognize that communities are in different places of development of ACH depending on the make-up of the community and the participants. Provide technical assistance to help them where they are stuck now. **Group Two Breakout Session Report-out** Sarah Kinsler lead this break out group	

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	• Foundation of alignment across communities with strengths to come out of measures and core themes and goals
	• Blueprint, CHT, ACOs
	• League of cities and towns
	• Data infrastructure – beyond health claims data – also looking at community health data re: quality of life
	• Something that all communities would be able to participate in
	• Funding and financing – public money; hospital community benefit monies.
	• Are hospitals the right place to be the integrator? Or, should a community organization with community leaders be better placed?
	• Missing from the report:
	  o Health equity
	  o Mental health
	  o Age specific populations kids seniors and families
	  o How do our current reforms fit into to this?
	
	Group Three Breakout Session Report-out
	Heidi Klein lead this group on the phone
	
	• Pat Jones – Noted that she supports the recommendation from the Prevention Institute to "Encourage ACHs to form around existing regional partnerships and collaborations." In that same vein, she also suggested that the recommendation to "Develop a statewide strategic framework for population health improvement to support local ACHs in setting priorities" could mean setting statewide priorities/goals and letting regional collaborations choose from them. She used San Diego County as an example of that approach.
	• Joyce Gallimore – Suggested that it would be important to provide guidance to effectively establish an ACH – much progress has been made with the ACOs and providers in VT. There always needs to be a strong voice to continue the work of moving forward to keep coming back to the fundamentals of creating a system that's inclusive and is built around community care and integrating care.
	• Patty Launer – building the capacity to create an on-going learning environment. We have the backbone of that from the Learning Collaboratives and it's got good support from outside the health care community and expanding the partnerships.
	• Maura Graff – How would these be different than the Learning Collaboratives that are already going on.
	  o It seems the existing learning collaboratives are looking at impacting a specific population of patients to address the highest spenders and highest needs patients through interventions.
	  o We're looking across care to build upon partnerships among service providers across the continuum of care; we're focusing on the bottom of the impact pyramid to impact things like the fundamental social determinants of health.	

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	o Also, while the Learning Collaboratives are for care management and care integration, it's also to test out some of the interventions that are collaborations between care providers and will ultimately lead to a population wide approach once they are tested and proven. It seems that this initiative would be to bring forward prevention strategies as well. • Steve Voigt – mirrors his project Re-Think Health of the Upper Valley and what strikes him the most is the need to bring forward sustainable financial models. Peter Cobb echoed that because if we can't do that, then we can't carry it forward. What's next: • Patty Launer - Should they serve a specific geographic area – yes. They have to work within their own community. • Joellen – Need well thought-out criteria to be an integrator; also things like rural demographics, or more suburban? Or use North/South? • Also, where there is a well thought out guidance document, to keep the groups together and sharing their common experiences. • Also, sharing of resources can galvanize people toward a common goal. • Chris Smith – on the measures piece – setting them and how to calculate them and where do they go – should drive where the project goes. Sometimes measures feel very distant, there has to be a local community based element in order for these to feel relevant to those participating. • Joyce – we've seen a lot of angst over selecting measures and how they can help to move the process forward; it's important to get them out there so that you can celebrate successes early and assess change sooner. • Miriam – the regional teams that are meeting now are reviewing measures that are given to them by CMS and other programs like meaningful use. There are a lot of measures. And…their time is already so limited that over-measuring is a hindrance. How can we finance a group that works together so well so that they can move the dial in their region? • Joellen – public health planning model that's clear to everyone and that lays out the process clearly, especially the plan for implementation so that everyone is moving on along the same framework will help address Joyce's concern. • Miriam - The Health department has some already existing population health measures – those should be utilized. • Pat – to the extent that measures can be aligned with measures that are already in use would add to the power of the measurement activity. Next – Patty – use the work that's already being done – or at least build on those. To avoid burn-out in the providers Miriam – agree!	

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	Overarching themes: • Build on existing efforts – ACOs, BP, UCCs, City councils • Focus on broader community (of the three CMMI tiers: 1) clinical, 2) clinical community; 3) community) • Develop strategic framework but give local enough freedom • ACH pilot too early; focus on statewide approach first • Develop a common set of community measures from which AHC can choose based on their situation • Allow each "community" to determine appropriate integrator • Provide technical assistance to communities wanting to go the next step; recognize that communities will be at different levels Why are we doing this: • To keep the momentum going – both for the remainder of the SIM as well as beyond the life of the SIM grant. • Jim pointed out that CMMI intends to release a funding opportunity in this area (Accountable Communities for Health) potentially by the end of this calendar year.	
4. Next Steps	**Next Meeting:** Tuesday, September 15, 2015, 2:30 PM – 4:00 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier	