Attachment 1 - Population Health Work Group Meeting Agenda 1-13-15

VT Health Care Innovation Project
Population Health Work Group Meeting Agenda

Date: Tuesday, January 13, 2015 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: **420-323-867**

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	2:35	**Approval of minutes**	Tracy Dolan	**Attachment 2:** Minutes	
3	2:40	**Updates** Work Group Membership	Tracy Dolan		
4	2:45	**The VHCIP Population Health Plan**	Heidi Klein	**Attachment 4:** Table of Contents	
5	2:55	**Paying for Prevention Contract**	Karen Hein	**Attachment 5:** Scope of work for Jim Hester	
6	3:00	**Research to Identify Emerging Accountable Health Communities**	Prevention Institute	**Attachment 6a:** Excerpts from AHC RFP **Attachment 6b:** Experience of Prevention Institute Team	
7	3:55	**Next Steps** *What information do work group members need in order to continue our work together?*	Karen Hein		

OPEN ACTION ITEM LOG					
Date Added	**Action Number**	**Assigned to:**	**Action /Status**	**Due Date**	**Date Closed**
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			•		
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Attachment 2 - Population Health Work Group Minutes 12-09-14

Vermont Health Care Innovation Project

VT Health Care Innovation Project
Population Health Work Group Meeting Minutes

Date of meeting: Tuesday, December 9, 2:30 to 4:00 PM, ACCD – Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier

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	Teresa Voce 1st; Jenney Samuelson 2nd	**The minutes will be updated and posted to the website.**
3. Updates		
4. ACO and Blueprint Collaboration for Unified Community Health Systems	Craig Jones, Blueprint for Health, and Todd Moore, One Care Vermont, shared their intention for connecting Blueprint practices and ACOs to create Unified Community Health Systems to improve the quality and effectiveness of health services in their community. This effort is based on provider feedback and GMCB encouragement to address the question: How can BP and ACOs work together to develop a population health management model? The primary rationale is that the ACO shared savings program concept builds on patient-centered medical homes with substantial overlap of the people and organizations who are participating in Blueprint and ACO activities.	

	In 2015-2016, in each Health Service Area, payers, Blueprint and ACO leadership would work together to merge their workgroups, and collaborate with stakeholders to form a single unified health system initiative. The collaborative would include medical and non-medical providers, a shared governance structure with local leadership, focus on improving the results of core ACO quality measures, support the introduction and extension of new service models, and provide guidance for medical home and community health team operations. Some of the specific characteristics of a Unified Community Health System Collaborative mentioned include:
	
	• governance structure to formalize preventive infrastructure and activities
	• based at HSA level (14 total) "natural" existing groupings
	• focus at community level with shared measures, administration
	• leadership team that include clinical providers from each of the ACO, BP and VNA, DA, SASH, AAA, Peds →
	  o governance structure
	  o balance influence to include LTSS and peds
	  o sets local priorities not focused on individual patients
	  o develop its own charter
	• beyond NCQA medical home as the only mechanism for incentive	

5. Examples and Ideas for Integrating Population Health	*How does this model fit with our prior discussions for building upon existing seeds of a community health system that links clinical care and community systems?* Q: Where do hospital community health needs assessments fit in this model? A: Should be considered by HSA Leadership Team Q: How does this fit with ACO care model and mgmt.? A: The collaborative should ground teams in quality measures and then determine if care coordination is necessary. Q: Where is prevention and how are upstream factors included? A: In St. J already trying a unified approach – started because wanted to figure out how to address poverty; ACOs still medical; need to be more than an ACO measure driven and need to expand; the team looking beyond that Q: Who is part of the leadership structure? It sounded like medical providers only	

	Q: What you measures counts – will these regional entities be thinking about an expanded set of measures; consider how best to link with CHNA data points, BRFSS measures (fruit and veg), county health rankings Q: Need to think about strategies for incorporating social determinants Q: Consider payment based on measurement at HSA level rather than solely within primary care medical home Q: How will the proposed unified health system integrate assurance of physical safety necessary for health and ACES approach? A: Local governance structure is intended to have to local data, priorities and become forum for figuring it out at within the HSA Q: How would schools be included? What about their health-related work? Thinking about connections with providers, social services, and justice – share ecological model A: BP so far has not included schools; collaborative can determine if this is important in that HSA; sets framework for community to determine Q: Leadership for UCC – is it intended to look like St J; what is different in the communities that have moved forward? A: St. J using the collective impact model or approach A: Governance = moving from collaboration to shared decision-making A: Who sits on the leadership team will determine which broader models to include; need to be more than traditional medical care; do not need to be limited to ACO just a starting place Q: How will payment model influenced?	
6. Public Comment and Next Steps	**Next Steps** • Send Blueprint HSA profiles to work group • Next meeting: quick update on work with the Prevention Institute; current financing of population health **Next Meeting:** The next meeting will be Tuesday, **January 13** 2:30 – 4:00 pm. ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier.	

VHCIP PH Work Group Participant List

Attendance: **12/8/2014**

Kim McClellan
Chuck Myers
Mary Lou Bolt
William Hart

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	Staff/Consultant
X	Interested Party

First Name	Last Name		Organization	Population Health
April	Allen		AHS - DCF	M
Susan	Aranoff		AHS-DAIL	X
Julie	Arel		VDH	X
Lori	Augustyniak		Center for Health and Learning	MA
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
Abe	Berman		OneCare Vermont	MA
Bob	Bick		HowardCenter for Mental Health	X

Craig Jones here
Sarah Kinsler here

Mary Lou	Bolt	phone	Rutland Regional Medical Center	X
Jill Berry	Bowen	Phone	Northwestern Medical Center	M
Mark	Burke	phone	Brattleboro Memorial Hopsital	M
Donna	Burkett		Planned Parenthood of Northern New England	M
Dr. Dee	Burroughs-Biron		Vermont Department of Corrections	M
Jan	Carney		University of Vermont	X
Amanda	Ciecior		AHS - DVHA	S
Barbara	Cimaglio		AHS - VDH	X
Daljit	Clark		AHS - DVHA	MA
Peter	Cobb	here	VNAs of Vermont	M
Judy	Cohen		University of Vermont	M
Amy	Coonradt		AHS - DVHA	X
Janet	Corrigan		Dartmouth-Hitchcock	X
Brian	Costello	phone		X
Mark	Craig			X
Wendy	Davis		University of Vermont	X
Jesse	de la Rosa	phone	Consumer Representative	M
Trey	Dobson		Dartmouth-Hitchcock	X

Tracy	Dolan	here	AHS - VDH	C/M
Kevin	Donovan		Mt. Ascutney Hospital and Health Center	X
Lisa	Dulsky Watkins			X
Trudee	Ettlinger		Vermont Department of Corrections	MA
Joyce	Gallimore		Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler	phone	GMCB	S
Steve	Gordon		Brattleboro Memorial Hopsital	X
Don	Grabowski		The Health Center	X
Wendy	Grant		Blue Cross Blue Shield of Vermont	A
Thomas	Hall		Consumer Representative	X
Bryan	Hallett		GMCB	X
Catherine	Hamilton		Blue Cross Blue Shield of Vermont	X
Carolynn	Hatin		AHS - Central Office - IFS	X
Karen	Hein	here		C/M
Jim	Hester ✓	here	Consultant	X
Churchill	Hindes		OneCare Vermont	X
Penrose	Jackson	phone	FAHC - Community Care	M
Cathy	Henry	here		

Pat	Jones		GMCB	M
Joelle	Judge ✓	here	UMASS	S
~~Frances~~	~~Keeler~~		~~AHS - DAIL~~	~~M~~
Heidi	Klein	here	AHS - VDH	MA/S
Norma	LaBounty		OneCare Vermont	A
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Patricia	Launer		Bi-State Primary Care	MA
Mark	Levine	here	University of Vermont	X
Lyne	Limoges		Orleans/Essex VNA and Hospice, Inc.	M
Nicole	Lukas		AHS - VDH	X
Ted	Mable	phone	Northwest Counseling and Support Services	M
Georgia	Maheras	here	AOA	S
Mike	Maslack			X
Jill	McKenzie			X
Melissa	Miles ✓		Bi-State Primary Care	M
Chuck	Myers	phone	Northeast Family Institute	X
Nick	Nichols		AHS - DMH	M
Annie	Paumgarten		GMCB	X

Luann	Poirer		AHS - DVHA	X
Carley	Riley			X
Brita	Roy			X
Laural	Ruggles ✓	here	Northeastern Vermont Regional Hospital	M
Jenney	Samuelson ✓	here	AHS - DVHA - Blueprint	M
Ken	Schatz		AHS - DCF	X
seashre@msn.com	seashre@msn.com		House Health Committee	X
Julia	Shaw	phone	VLA/Health Care Advocate Project	M
Melanie	Sheehan		Mt. Ascutney Hospital and Health Center	M
Miriam	Sheehey	phone	OneCare Vermont	M
Shawn	Skaflestad	phone	AHS - Central Office	M
Mary	Skovira		AHS - VDH	A
Chris	Smith	phone	MVP Health Care	M
Kaylan	Sobel		The Council of State Governments	X
Kara	Suter		AHS - DVHA	X
JoEllen	Tarallo-Falk	phone	Center for Health and Learning	M
Teresa	Voci	phone	Blue Cross Blue Shield of Vermont	M
Nathaniel	Waite		VDH	X

Anya	Wallack		SIM Core Team Chair	X
Marlys	Waller		Vermont Council of Developmental and Mental Health Services	X
Kendall	West			X
Bradley	Wilhelm		AHS - DVHA	X
Stephanie	Winters	phone	Vermont Medical Society	M
Mary	Woodruff			X
Cecelia	Wu		AHS - DVHA	X
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Todd Moore phone

VHCIP PH Work Group Member List

Roll Call: 12/8/2014

Passed
2° Jenney
1° Teresa Voci

Member		Member Alternate		Minutes		
First Name	Last Name	First Name	Last Name			Organization
April	Allen					AHS - DCF
Jill Berry	Bowen	(joined by phone)		No vote		Northwestern Medical Center
Mark	Burke					Brattleboro Memorial Hopsital
Donna	Burkett					Planned Parenthood of Northern New England
Dr. Dee	Burroughs-Biron	Trudee	Ettlinger			Vermont Department of Corrections
Peter	Cobb			✓		VNAs of Vermont
Judy	Cohen					University of Vermont
Jesse	de la Rosa					Consumer Representative
Teresa	Voci			✓		Blue Cross Blue Shield of Vermont
Tracy	Dolan	Heidi	Klein	✓		AHS - VDH
Joyce	Gallimore					CHAC
Karen	Hein			✓		
Penrose	Jackson			✓		FAHC - Community Care
Pat	Jones					GMCB
Susan ~~Frances~~	Aranoff ~~Keeler~~					AHS - DAIL
Lyne	Limoges					Orleans/Essex VNA and Hospice, Inc.
Ted	Mable			✓		Northwest Counseling and Support Services

~~Ted~~ Anoak Myers

Melissa	Miles	Patricia	Launer			Bi-State Primary Care
Nick	Nichols					AHS - DMH
Laural	Ruggles					Northeastern Vermont Regional Hospital
Jenney	Samuelson	Daljit	Clark			AHS - DVHA
Julia	Shaw					VLA/Health Care Advocate Project
Melanie	Sheehan					Mt. Ascutney Hospital and Health Center
Miriam	Sheehey	Abe	Berman			OneCare Vermont
Shawn	Skaflestad					AHS - Central Office
Chris	Smith					MVP Health Care
JoEllen	Tarallo-Falk	Lori	Augustyniak			Center for Health and Learning
Stephanie	Winters					Vermont Medical Society
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Attachment 4 - Table of Contents

Population Health Improvement Plan

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2. VT Policy Landscape ..... Error! Bookmark not defined.
C. Basic Overview of Current System ..... Error! Bookmark not defined.
1. Flow of funding and payment for population health ..... Error! Bookmark not defined.
2. Current linkages between clinical and community health systems for population health improvement ..... Error! Bookmark not defined.
D. Goals – How We Measure Success (1-2 pages) ..... Error! Bookmark not defined.
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2. Pay for Performance ..... Error! Bookmark not defined.
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2. Care Models Care Management Learning Collaborative ..... Error! Bookmark not defined.
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2. Seeds of Change in Vermont ..... Error! Bookmark not defined.
3. Pilot Projects: Adapting models to creating change in the VT context ..... Error! Bookmark not defined.

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B. Strategies ..... **Error! Bookmark not defined.**

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2. Using Best Practices Evidence Based Action for Health Improvement ..... **Error! Bookmark not defined.**

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Attachment 6a - Excerpts from AHC RFP

Excerpts from the Accountable Health Communities RFP

Purpose: to explore the development and potential application of a model that is appropriate within the context of the innovations currently underway through VHCIP and other health system reforms… The intent of this RFP is to engage a vendor who can:

1. Research promising community level innovations in payment and service delivery in others parts of the country to coordinate health improvement activities and more directly impact population health;
2. Identify key features to consider in developing recommendations for VT;
3. Determine which features are present in the innovations currently underway through VHCIP and other health system reforms and what expansion in the scope of delivery models would be recommended; and
4. Identify initiatives in Vermont that have some of the features necessary to improve population health by better integration of clinical services, public health programs and community based services at both the practice and the community levels.

Deliverables The vendor will be a resource for the PHWG leadership team in completing the task. The vendor will be responsible for the following deliverables:

1. Development of required materials including:

    - Description of the key characteristics of an AHC based on a synthesis of the literature and building on the products of the IOM Roundtable on Population Health.
    - Both a screening tool and an assessment tool based on (a), which can be used for both external sites in 1.4.2 and Vermont sites in 1.4.3 below.

2. Identifying exemplars outside of Vermont:

    - Conduct a scan of potential exemplars from the literature, IOM Roundtable agendas, IHI Triple Aim Collaborative, Aligning Forces for Quality, CMMI SIM States, etc.
    - recommend 4-6 sites for in-depth reviews in Vermont.
    - Conduct telephone reviews and write up case studies.
    - Synthesize key gaps and developmental needs and issues in building an AHC.

3. Identifying potential AHC sites in Vermont:

    - Assess how the current major delivery system reforms in Vermont (Blueprint for Health and ACOs) would interface with and AHC and identify major synergies and potential issues.
    - Develop and disseminate a Request for Information from Vermont communities and providers including a communication program for key stakeholders explaining the AHC concept.
    - Use the screening tool to select 2-4 sites for assessment.
    - Assessment Vermont sites, compare Vermont's status of development to the national assessment (as identified in 2(d) above).

4. Potential for a pilot:
    - Identify potential external funding sources/sponsors for a pilot.
    - Identify potential strategic relationships with other states, foundations and federal agencies in developing a pilot.

Attachment 6b - Experience of Prevention Institute Team

Experience of Prevention Institute Team

As submitted in response to the
STATE OF VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS
Request For Proposals: ***Accountable Health Community Program***

221 Oak Street Oakland, CA 94607 510.444.7738 fax 510.663.1280 www.preventioninstitute.org

Experience of Prevention Institute Team

Prevention Institute, in partnership with Dr. Lisa Dulsky Watkins of Granite Shore Consulting, is pleased to submit this proposal to support the Department of Vermont Health Access in the development of the Accountable Health Community Program. This project is well-aligned with Prevention Institute's skills, expertise, and organizational mission. A national non-profit, for nearly two decades Prevention Institute has served as a focal point for quality primary prevention practice – promoting comprehensive approaches and building from the learnings of multiple topics and fields. We focus on strategies that address the community determinants of health, as they are key drivers of patterns of illness and injury across communities, and on furthering policies, organizational practices, and collaborative efforts that prevent illness and injury and foster health and social equity. Importantly, community prevention strategies not only prevent illness and injury in the first place, these same strategies are critical to maintaining and restoring health. As our nation implements the Affordable Care Act with a vision of achieving a system that promotes health, not just treats sickness, Prevention Institute has applied its community prevention know-how to emphasize prevention as a core strategy for achieving the Triple Aim: improved health, improved healthcare, and lower health costs. Since the passage of the ACA, we have been deeply engaged in the research, analysis, and dissemination of promising practices and policies to integrate clinical care and community-level prevention efforts to improve population health by addressing the upstream determinants of health. This has included specific examinations of the Accountable Care Community established in Akron, Ohio and subsequent models that have a strong potential to establish community-wide infrastructure that effectively integrates clinical care, community services, and community prevention strategies, resulting in improved health and reduced disparities across a geographic area.

For this proposal, Prevention Institute is partnering with Granite Shore Consulting, a limited liability corporation based in Ferrisburgh, VT. Sole proprietor Lisa Dulsky Watkins, MD brings 30 years of experience in healthcare delivery and policy in Vermont to the rapidly changing national health reform landscape. Dr. Dulsky Watkins has a deep familiarity with Vermont's geography and the unique characteristics of its 14 Health Service Areas. She was the Chief of Operations at the Vermont Blueprint for Health from 2008 to 2013, where she was a liaison to Vermont's health system community (medical providers, hospitals, allied health professionals, key public and private sector stakeholders, and community members) as the comprehensive reform program was implemented throughout the state. She was a pivotal figure in shepherding the intense community-based processes, fostering collaborative relationships between existing (and often siloed or competing) organizations at the local level. The strengthening of this infrastructure allowed it to be used in subsequent reforms such as Accountable Care Organizations and population health improvement efforts.

Prevention Institute and Granite Shore Consulting bring a wealth of experience applying the skills and methodologies required to successfully execute this proposal, including expertise conducting broad scans for innovative practices, developing comprehensive interview guides, conducting qualitative interviews, analyzing implications for policy and practice, employing innovative best practices to facilitate decision-making amongst groups of diverse stakeholders, synthesizing case studies, and communicating findings to diverse audiences. We have extensive experience extracting and synthesizing information and qualitative data from a diverse pool of

stakeholders including government employees, local advocates, business interests, faith communities, public health departments, healthcare systems, and payers. Our collective experience emphasizes the synthesis of research and practice, developing prevention tools and frameworks, managing and implementing healthcare payment and delivery policy changes, conducting trainings, and providing technical assistance.

Prevention Institute, the primary bidder, pioneered the concept of the Community-Centered Health Home (CCHH), a core set of practices for healthcare institutions to partner with communities in addressing upstream determinants of population health. The Community-Centered Health Home is both a method and a metaphor for integrating quality individual patient care with impactful community-level strategies to advance health and well-being at a community level. Over the last three years, we have conducted further research, analysis, and education activities focused on various facets of establishing a community-centered health system across a geographic area. Very little of our work is stand-alone. We work closely in consultation with government, foundations, and community-based organizations nationwide to develop strategy and build the capacity of community and government leaders to implement effective population health strategies. We are skilled in helping leaders navigate the complexity of the multi-sector partnerships required to support health, and in providing strategies for engaging community residents in drivers of priorities and implementation strategies. Our work spans local, state, national, and international domains.

We believe our combined knowledge of the Vermont healthcare system, Vermont Blueprint, and our interest and commitment to prevention and the Accountable Health Community model – along with our skills and expertise carrying out the specified scope activities – makes us ideal candidates for this project and we are most excited by this opportunity. Vermont is an innovative leader in health system reform and prevention nationally, and is at the very forefront of innovative efforts to integrate accountable clinical care delivery with community prevention. We welcome the opportunity to work collaboratively with the State of Vermont Department of Health Access and the Population Health Work Group to develop an AHC program specifically tailored to Vermont.

Similar Contracting Experience in Previous Five Years

Over the past five years, Prevention Institute and Granite Shore Consulting have successfully executed numerous contracts providing services in line with those called for in this RFP:

Prevention Institute Experience

Project: Engaging Community Health Centers in Community Prevention
Funder: Tides Foundation Center for Care Innovation
Description: Prevention Institute conducted extensive research and synthesis to prepare a document titled “Community Centered Health Homes: Bridging the Gap between Health Services and Community Prevention.” This paper launched the term “community-centered health homes” to refer to systematic actions by community health centers, in partnership, to change the community environments that are influencing the patterns of illness and injury among their patients. We researched this report by engaging in a nationwide screening process to identify

community health centers doing innovative work integrating clinical service delivery with community prevention and related population health efforts. We conducted in-depth interviews with key stakeholders at these healthcare sites to collect primary qualitative data, used interview findings to model patterns of implementation, and synthesized these findings into a core set of practices detailing the steps necessary for a community health center to become a community-centered health home. Building on these interviews, we wrote and disseminated case studies to ensure the framework's broad utility as a practical resource. This work was released at an event with Dr. Howard K. Koh, then Assistant Secretary for Health for the U.S. Department of Health and Human Services, in the Prevention Institute's offices. The paper presents an up-to-date model for the successful integration of clinical service delivery and community prevention in order to reduce *preventable* demand for resources and services and improve health, safety, and equity outcomes.
Targeted outcomes: Preparation of a document to inform healthcare, particularly community clinics, on how to engage more effectively in population health and address determinants most critical to the medical conditions treated in their setting
Number of years: 1
Geographic areas served: California and national

Project: Convergence Partnership
Funder: Tides Foundation Convergence Partnership
Description: Prevention Institute, in collaboration with another non-profit organization, staffs the Convergence Partnership, a collaboration of eight major national funders and healthcare institutions who share a common vision for fostering healthy people in healthy places. CDC serves as technical advisor. Convergence Partnership promotes equity, policy and practices that create healthy conditions, and multi-sector partnerships to fulfill its vision. Convergence seeks to influence philanthropy and government practice through direct investments, dissemination of best practices, and cultivation of a community of practice among its 80 member network of local and regional philanthropies. As staff, PI plans and facilitates meetings, strategy sessions, and trainings; prepares advice memos on behalf of the partnership for government and community leaders; develops and prepares resource documents; analyzes opportunities for strategic investment through qualitative research with key stakeholders nationwide; vets potential grantees and their proposals; presents proposals to partners for discussion and review; and monitors grantee progress. The successful execution of this work relies heavily upon on-the-ground discussions with leaders and stakeholders in local initiatives and interviews with state and national advocates and government officials working to improve community environments and promote equity through community engagement and community improvements. An example of a major document Prevention Institute helped prepared is "Promising Strategies," an overview of community level strategies to support healthy eating and activity living drawn from interviews with over 200 advocates, researchers, and practitioners from around the country. An example of a recent advice memo is a letter responding to a Senate Finance Committee request regarding improving health system data collection where we described the importance of including data on community determinants and of segmentation of data collection by race and ethnicity. Additionally, PI provides technical assistance and strategic advice to Regional Convergence Partnerships in states across the US, generally state-level partnerships of funders in a similar model, providing advice on partnership structure and investment strategies to advance healthy people and healthy places agenda in their state.

Targeted outcomes: Influence philanthropic and government systems to invest in community change to improve access to quality services and systems, achieve greater equity, and cultivate diverse leadership in low-income communities and communities of color.
Number of years: 2
Geographic areas served: National

Project: Technical Assistance and Training support for CDC Chronic Disease Prevention grantees
Funder: ICF Macro (via contract from Centers for Disease Control and Prevention)
Description: Prevention Institute served as member of the core technical assistance team for the federal Communities Putting Prevention to Work initiative, a national initiative to foster local level policy, systems, and environmental changes to reduce smoking and improve healthy eating and physical activity habits. CPPW was the precursor to the Community Transformation Grant program established in the Affordable Care Act, and Prevention Institute has continued in a technical assistance and training role for the CTG program. Our work includes keynote presentations, skill building sessions around topics such as coalition building, local policy development, making the case, and strategies for healthy food and activity environments. We provide tailored technical assistance to grantee sites to support implementation of their action plans. Through this work, we have also produced documents that serve as tools for community-level environmental change efforts. Our largest undertaking was supporting CDC in the production of A *Practitioner's Guide for Advancing Health Equity*, which provides detailed advice on ensuring policy, systems and environmental change efforts enhance health equity and do not widen disparities. Prevention Institute managed an internal team of over 20 staff (tapping all of our content experts) to conduct literature reviews and interviews with local practitioners. We distilled our findings into recommendations for ensuring CDC-promoted strategies, such as improving school food or improving walkability, are equity focused. We worked collaboratively with CDC staff to organized panels of expert reviewers and to support CDC in production of the final documents. This work had enabled us to contribute to strengthening a health equity approach in the prevention field and equally to familiarize ourselves with the successes, models, and challenges in communities and states across the country.
Targeted outcome: Provide training and TA for local CDC grantees across the United States
Number of years: 3
Geographic areas served: local and state CTG sites around the country

Project: Enhancing Prevention in Health Reform
Funder: Primary funding from the Kresge Foundation, enhanced by The California Endowment core support, Convergence Partnership, and the Robert Wood Johnson Foundation 21st Century contract
Description: The PI Health Reform team promotes promising practices and policies for transforming the health system to advance community health and prevention in health reform. We conduct research, produce briefs and policy memos, and conduct outreach to policymaker, health care, public health, and philanthropic audiences to provide practical examples of methods for stronger health care – community prevention integration to improve population health. This section describes selected efforts relevant to the Vermont AHC program.

The team has devoted significant resources and capacity toward carefully monitoring and researching the development and implementation of innovative practices that integrate clinical care and community prevention. As the next generation of work after our Community Centered Health Homes brief (highlighted above), PI published a series of profiles in the Forbes blog on "Healthcare Innovators" – systems and institutions that are at the vanguard of moving healthcare upstream toward prevention, including in-depth discussions with the (now former) director of the nation's first Accountable Care Community in Akron, Ohio. This work has honed Prevention Institute's capacity to conduct nationwide scans of innovative practices, conduct high-quality interviews, and synthesize the collected qualitative data into contextualized models for how health systems move toward becoming accountable and community-centered.

Through our synthesis of innovative health care practices and our knowledge of community prevention strategy, we have produced a series of memos relating to opportunities to enhance prevention by impacting the social, economic, and physical environments in communities as a key pillar of improving population health. We have produced a series of memos specifically aimed at influencing greater inclusion of community-level prevention language in Center for Medicaid Medicare Innovation Requests for Proposals, and in supporting states applying for State Healthcare Innovation Models grants and localities applying for health care innovation grants to incorporate strong health care – community prevention integration strategies. Our emphasis is the opportunities to leverage improved health outcomes by better aligning health care, public health, and community-based efforts. Selected products include: *The Intersection of Health Services and Community Environments: Eight Profiles of State-Driven Initiatives to Advance Population Health*, and *Recommendations for CDC FOA Applicants: Advancing Linkages between Healthcare and Community Prevention*.

The Health Reform team disseminates its work through presentation, the PI list serve, and print and electronic media. For example, a recent web forum on CDC funding opportunities for prevention and healthcare, co-produced by Prevention Institute, reached over 700 participants. A component of the Prevention Institute presentation was on enhancing partnerships between healthcare and community health, and the vast majority of participants found the forum very valuable and more than 50% of the participants said they would benefit from further information on community health/healthcare partnerships. The team has well-established relationships with a variety of local, state, and federal health policy officials. Their perspectives on the opportunities and barriers to strengthen community prevention in the health system have informed our work. We regularly communicate with officials at the Center for Medicare Medicaid Innovation, Centers for Disease Control and Prevention focused on state level health reform, the Office of Management and Budget, and congressional staff working on health reform.

The health reform team is also examining payment mechanisms. The brief *How Can We Pay for a Healthy Population? Innovative New Ways to Redirect Funds to Community Prevention* was intended to catalyze further national discussion of funding options. It provides detailed examples of the ways that four different healthcare funding models – Accountable Care Communities, Community Benefits, Health Impact Bonds, and Wellness Trusts – can help bridge the divide between clinical care and community prevention, and advance a comprehensive health agenda across the population with particular focus on underserved communities. Preparation of the document required literature reviews, extensive research interviews, and information synthesis.

More recently PI's executive director Larry Cohen researched and wrote a report in co-authorship with Anthony Iton titled "Closing the Loop," to be published shortly by the Institute of Medicine Roundtable on Population Health. It emphasizes the importance of ensuring that fees and taxes, philanthropic and community benefits investments, and revenue from reduced healthcare expenditures are captured and reinvested in prevention efforts as a way to "close the loop" between the investment in prevention and the revenues and savings that are the fruit of that investment.
Targeted outcomes: Comprehensive qualitative research and analysis into healthcare organizational practices to support community prevention, practices that advance healthcare/community prevention integration, equity-focused community determinants for assessment, community data integration into the healthcare system, payment mechanisms for supporting upstream efforts, opportunities for strengthening population health measures in healthcare delivery, and payment reform.
Number of years: 1
Geographic areas served: National

Granite Shore Consulting Experience

Granite Shore Consulting Principal Lisa Dulsky Watkins has also successfully executed projects and is under contract to provide services similar to those called for in the RFP in the last five years. These include:

Contract: Policy Advocate and Manager, Milbank Memorial Fund Multi-State Collaborative
Funder: The Milbank Memorial Fund
Description: The Milbank Memorial Fund Multi-State Collaborative (MC) is a voluntary group composed of representatives of state-based primary care initiatives. With support from the Fund since 2009, the MC has provided an active forum for its members. Dr. Dulsky Watkins is one of the founding members of the Collaborative.
Targeted outcomes: Share data, participate in collaborative learning, and advocate for improved collaboration between the states and the federal government on primary care transformation.
Number of years: 1 in current capacity, 6 representing Vermont
Geographic areas served: As of April 2014, there are 17 states and markets engaged in multi-payer primary care transformation

Project: Associate Director and Chief of Operations, Vermont Blueprint for Health
Funder: Department of Vermont Health Access
Description: The State of Vermont has demonstrated an intensive commitment to comprehensive health reform that includes the following components: universal coverage, a novel delivery system built on a foundation of medical homes and community health teams, a focus on prevention across the continuum of public health and healthcare delivery, a statewide health information exchange, and a robust evaluation infrastructure to support ongoing improvement with quality and cost effectiveness as guiding principles. As Associate Director and Chief of Operations, Lisa Dulsky Watkins carried out key responsibilities associated with the development and implementation of the Blueprint including:

1. Provided leadership, developed partnerships and fostered collaboration to accomplish key healthcare reform goals of the Blueprint and the Department of Vermont Health Access (DVHA). The magnitude of the change needed to accomplish these goals demanded strong leadership, excellent communication skills, in-depth knowledge of healthcare and of Vermont's healthcare system, and the support of a diverse group of individual and organizational stakeholders.
2. Planned, developed and supervised implementation of statewide changes in the practices of physicians, other healthcare providers, health insurers, and other components of the health system, in order to improve healthcare for Vermonters.
3. Lead State Healthcare initiatives and testified on emerging policy issues at the state and federal level. Directed systematic implementation of statewide of payment reforms, which required significant data collection effort and coordination between insurers (including Medicare), Blueprint project managers and participating primary care practices. Supervised the incorporation of mental health and substance abuse treatment components into the Blueprint framework. Managed the Blueprint budget ($5 million annually) and key contracts regarding scoring of primary care practice adherence to advanced primary care practice standards; qualitative (Patient and provider experience) and quantitative (clinical outcomes) evaluation of the Blueprint; and implemented a clinical registry and health information technology in participating practices and community health teams.
4. Established strong working relationships with DVHA staff and with staff at sister State agencies, such as the Vermont Department of Health, the Vermont Department of Aging and Independent Living, the Vermont Agency of Human Services, the Green Mountain Care Board, the State Innovation Model implementation team, State legislators and Committee staff, and the Governor's Office of Healthcare Reform.

Targeted outcomes: Integrating a system of healthcare for patients, improving the health of the overall population, and improving control over healthcare costs by promoting health maintenance, prevention, and care coordination and management.
Number of years: 6
Geographic areas served: State of Vermont

Project: Public Health Physician, Vermont Blueprint for Health
Funder: Vermont Department of Health
Description: Implementation of Wagner's Chronic Care Model[1] in competitively selected Vermont Health Service Areas, including engagement of providers, community organizations, local public health officials and other stakeholders. Extensive negotiations with third party payers, primary care providers, and other stakeholders led to the design, implementation and evaluation currently underway.
Targeted outcomes: Design, implementation and early evaluation of the pilot phase of the Vermont Blueprint for Health.
Number of years: 2
Geographic areas served: 3 of 14 Health Service Areas in pilot phase serving a general patient population of ~50,000

[1] Wagner E.H. 1998. Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness? *Effective Clinical Practice* 1(1):2–4.

Prevention Institute Team Bios

Leslie Mikkelsen, MPH, RD, *Managing Director*, Prevention Institute – <u>Project Lead</u>
As Managing Director at Prevention Institute, Ms. Mikkelsen serves on the senior management team, supporting organizational operations and development to advance the practice of primary prevention. Leslie directs the Health Reform program, which focuses on promoting community-level prevention in the implementation of the Affordable Care Act. Leslie manages the development of model practices for healthcare-community prevention and promotes policies and payment mechanisms to support these practices. Leslie's team is currently leading efforts to implement funding initiatives for community and rural health centers to adopt Community-Centered Health Homes practices, a model developed by Prevention Institute.

Leslie oversees national training and technical assistance on community approaches to chronic disease prevention, including the CDC's CPPW and CTG initiatives. She leads research into payment mechanisms to support community prevention, including Wellness Trusts and other pooled funding mechanisms as well as Accountable Communities for Health models, and produces publications describing these models. She serves as a technical assistance provider for a variety of foundation and community prevention collaborations at the state and local level. Leslie is on the Advisory Committee for implementation of the Accountable Community for Health and Wellness Trust Initiative of the California State Innovation Models. Leslie provides extensive support to the Convergence Partnership—a consortium of national funders—with strategy development and implementation to promote their vision of *Healthy People, Healthy Places*. She co-founded and served as Project Director for the *Strategic Alliance for Healthy Food and Activity Envir*onments, a California coalition that has successfully advanced a multi-faceted environmental change agenda influencing state legislation, incorporated into the Governor's California Obesity Prevention plan. She develops programmatic work related to promoting environmental and policy approaches to improving eating and physical activity habits, with emphasis on addressing inequities. Leslie is responsible for overseeing qualitative research and literature reviews, and organizing convenings with researchers and practitioners to help inform policy and practice.

Leslie has been with Prevention Institute since 1999. She previously worked for the Alameda County Community Food Bank in Oakland, California and Food For Survival Food Bank in New York, New York. She is a graduate of the University of California, Berkeley where she earned her Master of Public Health; Bachelor of Science, Nutrition and Food Science; and Bachelor of Arts, Political Science.

William L. Haar, MPH, MSW, *Program Coordinator*, Prevention Institute
William works on the Health System Transformation Team, where he studies and shares emerging innovative health care practices that integrate community prevention with clinical service delivery. Will's work also includes projects related to healthy eating and active living, including ENACT Day, a yearly advocacy event organized by a diverse coalition of health and social justice organizations that brings community residents and local organizations together to support policies that create environments where healthy eating and physical activity are available to all Californians. Before becoming a program coordinator, Will spent two years working part-time on the communications team at Prevention Institute while completing his graduate studies. Previously, Will conducted evaluation projects for the Sarah Samuel Center for Public Health Research & Evaluation. He has also worked with Health for Oakland's People & Environment (HOPE) Collaborative, East Oakland Community Playdate, and La Clínica de La Raza. Will has several years' experience working internationally in China and Poland. He received his Masters of Public Health and his Masters of Social Welfare from UC Berkeley and his bachelor's degree from Thomas Edison State College of New Jersey. His academic research focused primarily on nutrition policy, particularly related to sugar-sweetened beverages and breastfeeding.

Lisa Dulsky Watkins, MD, Principal, Granite Shore Consulting, LLC
Granite Shore Consulting offers a wide range of services to bring innovation from theory to reality. Working closely with government organizations, non-profits, foundations, clinical practices and health systems, GSC provides the strategy, technical assistance, advocacy and communication tools essential for a rapidly transforming healthcare landscape. GSC Principal Lisa Dulsky Watkins has 25 years of experience in the fields of health care delivery, policy development and reform implementation.

Lisa Dulsky Watkins, MD is a former primary care pediatrician in Vermont, where she completed her internship and residency at the University of Vermont College of Medicine. She received her MD from the Perelman School of Medicine at the University of Pennsylvania and her BS from the City College of New York. She is the former Associate Director of the Vermont Blueprint for Health at the Department of Vermont Health Access, and one of the founding members of the Milbank Memorial Fund Multi-State Collaborative.

At the Vermont Blueprint for Health, where she served from 2008 to 2013, Dr. Dulsky Watkins was Chief of Operations, acting as liaison to Vermont's health system community (medical providers, hospitals, allied health professionals, key public and private sector stakeholders, and community members) and directed the comprehensive reform program implementation throughout the state. Prior to that, she was a researcher at the Vermont Program for Quality in Health Care, Inc.

Dr. Dulsky Watkins serves on a number of committees and advisory groups, including as a Cabinet Member of the Advocacy and Public Policy Center of the Patient-Centered Primary Care Collaborative. In her current role as Director of the Milbank Memorial Fund Multi-State Collaborative, she acts as an advocate for new and continued support for health system and payment innovation at the state and federal levels.

Kalahn Taylor-Clark, PhD, MPH, *Senior Advisor*, Center for Health Policy, Research and Ethics

Kalahn Taylor-Clark, PhD, MPH most recently served as the Director of Health Policy at the National Partnership for Women and Families (NP). Her primary responsibilities were in providing strategic policy support on a range of activities related to delivery system reform, including payment reform, quality measurement, reduction of health disparities, consumer engagement, and promotion of patient-centered care delivery and the effective use of health information technology (HIT). Prior to joining NP, Dr. Taylor-Clark led the Patient-Centeredness and Health Equity Portfolio in the Engelberg Center for Health Care Reform at the Brookings Institution, which sought to inform regional, state, and national practices for advancing priorities for patient-generated measurement in new delivery and payment reform models; incorporate consumer perspectives into strategic planning of new delivery reforms; focus on social determinants and population health in health care reform models; and identify innovative ways to collect and report data to measure and address health care disparities.

Dr. Taylor-Clark was a W.K. Kellogg Health Scholar at Harvard University from 2006-2008 where her areas of research included public health communication in politically and socially marginalized populations and minority voting on health care issues. In 2005-2007, she was a lecturer at Tufts University, teaching classes titled “Women and Health” and “The Politics of Health Disparities.” Before teaching at Tufts, Dr. Taylor-Clark held a position as a researcher at the Harvard School of Public Health’s Project on Biological Security and the Public, where she focused on risk communication in communities of color during public health emergencies.