



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

**Pending Work Group Approval**

**Date of meeting:** Tuesday, March 10, 2015; 2:30 – 4:00 pm, ACCD – Calvin Coolidge Conference Room, 1 National Life Drive

Agenda Item	Discussion	Next Steps
<b>1. Welcome, roll call agenda review</b>	The work group welcomed members of Prevention Institute (PI) to Vermont! Leslie Mikkelsen, Will Haar, Victoria Nichols, Kalahn Taylor-Clark and Lisa Dulsky-Watkins attended the meeting to give an overview of the work that will be done under the contract to support the Population Health Work Group (PHWG)’s exploration of Accountable Communities for Health. The PI has been asked to conduct national research to learn about efforts to create community-wide accountability for the improvement of health outcomes. Additionally, PI will be researching efforts here in VT that appear to be aimed in this direction.	
<b>2. Approval of minutes</b>	A motion to accept the February minutes was made by Susan Aranoff and seconded by Peter Cobb. A roll call vote approved the minutes with two abstentions.	
<b>3. Project Updates</b>	<ul style="list-style-type: none"> <li>• Orientation for new members</li> </ul> <p>An orientation packet has been created for the PHWG – for use in both orienting new members to this group, as well as to provide to other work groups to help share purpose and goals across the project. The packet includes definitions and the overall population health framework, among other things. It will also help other SIM states as they are reaching out to us. VT appears to be at the forefront of some of the thinking behind population health and other SIM states are asking for help as they begin their planning work.</p> <ul style="list-style-type: none"> <li>• Actions in other work groups</li> </ul> <p>As the Year 2 workplans are finalized, we will review other work group plans and reach out to them, as the PHWG is meant to provide the ‘population health lens’ through which to view the work across the project. We may ask for presentations from other groups and may present to them.</p>	
<b>4. Accountable Communities for</b>	We are lucky and thrilled to have such a powerful and innovative group working with us. Prevention Institute staff members presented from the slides that are included in the published meeting materials – also <a href="#">linked here</a> .	

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<p><b>Health</b></p>	<p>Please note there are some references to particular slides in the notes below.</p> <p>Leslie Mikkelson, Will Haar and Kalahn Taylor-Clark presented an overview of the work done thus far – including summaries of the initial round of interviews at the sites across the country who have already begun to work with the Accountable Community for Health (ACH) model</p> <p>Following are notes that accompany the slides in the materials linked above.</p> <p><b>Research process used by Prevention Institute:</b></p> <p><u>Phase I</u>  Review the field to identify national exemplars of the ACH theme  Conduct interviews with multiple stakeholders  Present preliminary findings  Produce case studies</p> <p><u>Phase II</u>  Survey the field to identify VT examples of the same (ACH work)  Identify several VT sites to conduct site visits  Conduct visits  Produce case studies</p> <p><u>Deliverables</u>  Produce preliminary reports  Produce final report</p> <ul style="list-style-type: none"> <li>• Results of national investigation</li> <li>• Results from the VT survey</li> <li>• Update on VT site visits</li> </ul> <p>VT Research  PI also received information from a number of communities about their efforts. In order to take a deeper dive on a few different approaches, PI Identified three sites with which to begin in the Vermont exploration:</p> <ul style="list-style-type: none"> <li>• Franklin and Grand Isle Counties</li> <li>• St. Johnsbury</li> <li>• Burlington</li> </ul>	

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	<p>ACH – Accountable Community for Health  How do we, systemically integrate medical care with community wide prevention and wellness efforts? How do we create sustainable payment models and financing mechanisms to support this integrated approach?</p> <p>National Exemplars: (see slides for details)</p> <p><b>Oregon – Coordinated Care Organizations (CCO)</b>  Medicaid population (90% is receiving services via the CCO!) It’s comprised of multiple payers, dental care, mental health providers and many others. 16 regions within the state; each have their own CCO. See slide 13 within the PI presentation.</p> <p>The idea is more to use the ‘carrot’ of rewards, versus the ‘stick’ for penalties related to participation in the CCO. The funding source is used to fund activities like smoking cessation programs (For example, one CCO carves out \$1.33PMPM to fund these activities) as well as several positions to help coordinate population based health programs. Outcomes are measured on a statewide basis, i.e. hospitalizations, ED visits, enrollment in patient-centered primary care homes. The CCO has the requirement to create a community health improvement plan. The advisory committees are comprised of consumer representatives (at least a majority) and other community stakeholders. At this time, the CCOs are funded via Medicaid dollars; the potential expansion to the broader population will be explored in subsequent interviews and research.</p> <p><b>OH – Live Health Summit County OH (~550,000 people)</b>  Initially begun when 7 healthcare partners collaborated to create a white paper. Perhaps the first “Accountable Care Community” example. The initiative was initially supported by a bio-technology company committed to the health of its employees and interested in economic development. Austen Biomedical served as original integrator/backbone/quarterback for 80+ collaborative partners with the intent to create connections, obtain savings and ultimately reinvest savings</p> <p>The company has since pulled out of the initiative and the county health department is the ‘quarterback’ as it has responsibility for the health of the population. 8 core staff people support the initiative. Executive committee (hospital, university, Federally Qualified Health Center) he initiative has a ‘Health in all Policies’ approach to incorporate into the local governmental structure. The funding source is approximately 80% grant and 20% general fund contributions.</p> <p><b>Bernalillo County – NM – Pathways to Healthy Bernalillo County</b>  Hub Pathways Model – this model starts with a dedicated staff person/entity/navigator to coordinate and act as fiscal agent to support coordination and referral to a range of services needed to support high risk individuals (e.g. transportation. Focus is on at-risk people in the community, identified not only within clinical settings but also via social service and community based organizations. They are then referred to the hub, where a community health worker follows the client through the process. This is county funded, currently</p>	

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	<p>\$800,000/year, over a 7 year period; 10% to hub/integrator 2.5 FTE. with 90% of funds to the community services; There is an incentive structure set up – how many pathways might a consumer follow – this decision is made jointly with the individual and the community health worker. There are currently 21 pathways available to consumers/clients within a service based model.</p> <p><b>CO – Pueblo Triple Aim Coalition (PTAC)</b>  Began as a tobacco-free initiative. Started as a 501c3 organization – goal is to make Pueblo County the healthiest county in CO. They are a Re-Think Health program with the Triple Aim, Collective Impact and ReThink Health as their three goals.  They encompass high level community support, with high-level participation from hospital executive organizations. Currently, this is entirely grant funded. They have the strongest tobacco-free policy in CO and have documented Medicaid savings through reductions in teen pregnancy.</p> <p><b>CA – LiveWell San Diego</b>  This was initiated 5 years ago and is county based. The overall vision is the health and well-being of their population using the pyramid approach documented on slide 27 in the presentation. They focus on 4 strategic approaches:</p> <ul style="list-style-type: none"> <li>• Building a better service delivery system</li> <li>• Supporting positive choices</li> <li>• Pursuing policy and environmental changes</li> <li>• Improving the culture within</li> </ul> <p>The backbone of the program is the San Diego County Health and Human Services Agency with 5 regional leadership teams (approximately 600,000 people per region). This initiative produces a great deal of information and literature; the language is consistent across the program/county; very well coordinated system of communication. They have leveraged existing positions and funding streams to create and support this program. This program has a very thorough measurement program. See slide 30 in the presentation for the measures highlighted. The indicators exemplify the cross-responsibility of the health outcomes between the government and the community partners</p>	
<p><b>5. Next steps</b></p>	<p>The next meeting is:  Tuesday, April 14, 2015  2:30 pm – 4:00 pm</p> <p>ACCD - Calvin Coolidge Conference Room</p>	

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	1 National Life Drive, Montpelier  Call-In Number: 1-877-273-4202 Conference ID: 420-323-867	