Vermont Health Care Innovation Project
Population Health Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: April 13, 2016; 2:30 PM – 4:00 PM; EXE 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome, Roll Call, & Approval of Minutes **Agenda Review**	**Welcome** Tracy Dolan called the meeting to order at 2:40pm. **Roll Call and Approval of minutes** A roll call attendance was taken and a quorum was not present. **Agenda Review** Tracy Dolan then reviewed the agenda with the group, including an update VHCIP project activities to date, the Population Health Plan RFP, Accountable Communities for Health initiative and a new CMMI funding opportunity.	
2. Update: • VHCIP Operational Plan and Year 3 Budget • Population Health Plan RFP • Accountable Communities for Health: Phase II • CMMI new AHC funds	**Update:** VHCIP Operational Plan and Year 3 Budget The Year 3 Operational Plan is being developed for submission to CMMI by May 1, 2016. Key components include aspects of population health planning that is occurring as part of the overall SIM work. We will also be drawing some attention to the linkages from our work to related initiatives going on across the state. **Update:** Population Health Plan RFP Bids were received last week and an apparent awardee has been identified. This required element was not originally included in the scope of the Round 1 SIM projects but was added later when CMMI recognized its value. **Update:** Accountable Communities for Health: Phase II Heidi Klein and Sarah Kinsler added more information around the Peer Learning Laboratory and its intent to help inform the work in this area in hopes of moving the accountable communities for health model forward. A vendor	

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	has been selected to help develop curriculum and a learning environment to share ideas. Ten (10) regional teams have been selected. Each of the teams includes a wide variety of organizations and participants, and each team is in a different place in terms of readiness to adopt this model. One of our goals is to make the products of this initiative available so that we can share the experiences with those communities who are not quite ready to participate now, but who might be later on. Dale commented that his experience at the Blueprint Annual Meeting included a presentation about the model being used in Britain, where clinical and primary care is outside the model they showcased. Tracy commented that we found, as part of the work done by the Prevention Institute, that hospitals in Vermont appear to be ready to serve key partners for communities as they pursue the accountable community for health model. We however, are not going to dictate how the pilot communities should be organized. This is part of the learning. All of the materials for this will be posted on the VHCIP website, and as materials develop they will be posted as well. Heidi noted that Bennington showed a strong interest and was ready to move forward quickly, so their team kickoff meeting has been scheduled for April 14, 2016 and they will be engaging in a conversation around the 9 core elements of an accountable community for health and explore their readiness according to each one. Melissa Miles asked about the overlap between this work and the community care groups (UCCs, as they are known.) Heidi noted that there is connection. The intent is to build upon the foundation of the UCCS with this complementary effort to connect the work of the UCCs to integrated care for individuals with community-wide prevention that serves the whole community. See attached chart that show building blocks from PCMH to UCC to ACH. **Conflict of Interest Policy** – if you have not submitted these to Joelle Judge, please do so. Thank you! (Joelle.Judge@partner.vermont.gov) **Update**: CMMI new AHC funds CMMI is seeking applications related to Accountable Health Communities. This "AHC" shares some common features with VT's efforts. The application requires that the State Medicaid Agency support their application. Jenney Samuelson commented that DVHA has indicated that they may not currently have the bandwidth to support an application for this endeavor. Jenney noted that their group also came to the conclusion that it would likely cost the state more to coordinate the effort than would be granted by CMMI, so they have chosen not to pursue this opportunity at this time.	
3. Status of All Payer Waiver and	**Status of All Payer Waiver and Pop Health** Implications and application to population health objectives	

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Pop Health
• Implications and application to population health objectives
	Michael Costa, Deputy Director of Health Care Reform presented. He noted that his job functions at the intersection of Health Care, Budget and Tax Policy issues. He is co-coordinator of the All Payer Model project, with Ena Backus, Deputy Director of the Green Mountain Care Board. Their work is focused on building a legal, policy and regulatory framework that people will want to join in. The group discussed the implications of the All-Payer Model for population health objectives.
	
	Quality: (One of 18 objectives)
	
	Michael stated that he views the establishment of quality goals for the All-Payer model to be a series of relationships. If one envisions a pyramid of relationships, then the relationship between the federal government and the State is at the top; next is the relationship between the ACO and the GMCB; relationship between the providers and the ACOs; and next the payers and the ACO.
	
	Relationship between the federal government and the State:
	• Quality is important to the federal government
	  o Make it real for Vermonters using Population Health goals, based on ambitious targets and build on our state health improvement plan
	    ▪ Primary care – increase access
	    ▪ Chronic disease – reduce the prevalence
	    ▪ Substance abuse - address the epidemic
	  o Next – what kinds of things inform this work to create benchmarks for these measures?
	• Things to watch – what type of resources can we devote to it over time; how do we get to the top of the pyramid; and integrate these more fully with the work we already do at the Department of Health.
	
	Karen Hein referenced the CDC health impact pyramid (where the bigger impacts are at the bottom of the health pyramid in the social determinants of health). She opined that we need to focus on the impacts upstream and look more toward the social determinants of health which will drive our ability to meet these goals. Michael responded by asking what our ultimate goal is – are we building consensus or finding new funding models? The hope is that if we make smarter investments in certain areas, we then free up more dollars to make better investments in the kinds of interventions that will impact further down.
	
	Jim Hester noted that the 32 objectives are tied to the funding mechanisms, and is that kind of analysis being done for the APM? Michael responded that quality is tied to payment as part of the ACO model Next Gen. Yes, the relationships may be different where the GMCB does the regulation versus CMS, but the goal is to keep paying for quality as we currently do as part of the MSSP.
	
	Tracy Dolan asked about the targets and whether there is any discussion around bonus payment for reaching	

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	targets. We could build accountability into Medicare's PMPM to the ACO for these big population health goals – which would be very far ahead of any other state in the country. Rather than framing as adding risk in terms of withholding funds, could we offer a bonus for reaching these goals? . Michael noted that there is likely not more money being added to the system, but that there is a different way to break up the pie that already exists. Michael noted that there is a great deal of balancing going on in these early negotiations and these kinds of measures and adding risk represent moves that are of interest to CMMI, but that they are likely to be part of discussions much further down the road. How can the population health work group help? The Board will end up being the public forum for support and concerns. Josh Plavin surmised that the commercial payers will also be tied to quality via the GMCB. It is estimated that there are a couple of open issues but that it could be estimated 4-8 weeks before the public forums with the GMCB. Dale Hackett noted that the addiction issue is so large, we need investments now in those areas and for those areas where there is no short term. Are you going to cannibalize investments in some other areas when we invest in these larger pop health goals? Michael noted that the team is keenly aware of this issue and is aiming to prevent that. Jim Hester noted that APM presents an opportunity for the ACH communities to work on via the learning lab Heidi noted that one of the important planning pieces of the ACH Lab initiative is to ensure alignment with on-going state-wide initiatives.	
4. Auerbach's 3 Buckets and the ACO "Change Packets" • Presentation: Framework and initial packets developed • Discussion: Feedback on content and opportunities for use	**Auerbach's 3 Buckets and the ACO "Change Packets"** • Presentation: Framework and initial packets developed • Discussion: Feedback on content and opportunities for use **Auerbach Framework:** The best outcomes are achieved when all partners in the health system are working towards the same goals using the best practices in three different domains to incorporate prevention activities and improve population health outcomes: **Traditional Clinical Approaches** This category includes increasing the use of prevention and screening activities routinely conducted by clinical providers. Examples include: annual influenza vaccination, use of aspirin for those at increased risk of a cardiovascular event, screening for tobacco use, screening for substance abuse, and screening for domestic or other violence. **Innovative Patient-Centered Care and/or Community Linkages**	

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	This category includes innovative, evidence-based strategies offered within the community that are not typically leveraged by health care systems under fee for service payment models. Examples include: community-based preventative services, health education to promote health literacy and patient self-management, and routine use of community health workers. **Community-Wide Strategies** This category includes specific system-wide action steps demonstrating an organization's investment in total population health. Examples include: funding for worksite wellness, immunizations for children and adults, smoking-cessation groups, substance abuse prevention and treatment programs and chronic disease self-management groups in the larger community, passing legislation that addresses public health issues (i.e., smoking bans in bars and restaurants), providing healthier food options at state-operated venues and public schools. The Health Department has adopted the Auerbach approach to recommending evidence based actions for prevention in each of the three domains. Health department staff are working with clinical care experts and ACO clinical guidance committees to develop **"change packets"** for each of the ACO measures. These change packets are intended to demonstrate the connections between the ACO measures and the work that is occurring in PCMH, on the ground in the UCCs and in the emerging ACHs. Heidi asked the group to review these tools to see if there are any changes or updates that could be made to make them more useful to a larger audience. Melissa Miles asked if they will be tested within the ACH pilots. Certainly, this will be brought as one of the potential tools to be used to address the need for a coordinated strategy. Tracy pointed out that there is a nice multiplication affect that some of these interventions have far more impact further upstream than just on the item that the measure is focused on. CHAC's clinical committee would be interested in reviewing them, as well as OneCare Vermont. Josh Plavin noted that adding some references might be helpful when vetting these with clinical groups. Jim Hester suggested sharing this with the UCCs as they are a perfect forum for this work; Maura Graff noted that it would be helpful to share this with the ACHs when it becomes final.	
5. Open Comments and Next Steps	**Open Comments and Next Steps** Karen noted that the APM negotiations are ongoing and the go and no-go decision appears to be this summer; the Legislature may ultimately pass some bills that could have implications to Population health; Sustainability Planning is also ramping up and the conversations will be on-going with the various VHCIP work groups and leadership.	
6. Next Meeting and Next Steps	**Next Meeting and Next Steps** The next meeting is Tuesday, July 12, 2016 2:30 pm – 4:00 pm EXE - 4th Floor Conf Room, Pavilion Building; 109 State Street, Montpelier Please note that it is necessary for ALL visitors to have proper photo id as identification when signing in at the Kiosk Desk on the 1st floor.	