VT Health Care Innovation Project
Population Health Work Group Meeting Agenda

Date: Tuesday July 19, 2016 Time: 2:30-4:00 pm
EXE - 4th Floor Conf Room, Pavilion Building, 109 State Street, 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**		**Attachment 1:** Agenda	
2	2:35	**Approval of Minutes**		**Attachment 2:** Minutes	
3	2:40	**Project Updates**	Georgia Maheras / Sarah Kinsler		
4	2:50	**Status of All Payer Waiver and Pop Health** • Implications and application to population health objectives	Michael Costa/Ena Backus		
5	3:00	**Population Health Plan** Filling in the Pop Health Plan: *What do we believe must change in our health systems in order to improve population health outcomes?*	Heidi Klein	**Attachment 5:** Pop Health Plan Concepts	
6	3:45	**Open Comments and Next Steps**			

OPEN ACTION ITEM LOG					
Date Added	**Action Number**	**Assigned to:**	**Action /Status**	**Due Date**	**Date Closed**
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			•		
			•		
			•		

Attachment 2: Minutes

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	

Agenda Item	Discussion	Next Steps
	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	

Agenda Item	Discussion	Next Steps
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	

Agenda Item	Discussion	Next Steps
	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**	

Agenda Item	Discussion	Next Steps
	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.	

VHCIP Population Health Work Group Member List

April 13, 2016

Member		Member Alternate			
First Name	Last Name	First Name	Last Name	Minutes	Organization
Susan	Aranoff				AHS - DAIL
Jill Berry	Bowen				Northwestern Medical Center
Mark	Burke	Dr. Kat	McGraw ✓		Brattleboro Memorial Hopsital
Donna	Burkett	Maura	Graff ✓		Planned Parenthood of Northern New England
Daljit	Clark	MaryKate	Mohlman		AHS - DVHA
		Jenney	Samuelson ✓		
Peter	Cobb				VNAs of Vermont
Judy	Cohen				University of Vermont
Jesse	de la Rosa				Consumer Representative
Tracy	Dolan ✓	Heidi	Klein ✓		AHS - VDH
Joyce	Gallimore	Kendall	West ✓		CHAC
	✓	Melissa	Mike		
Dale	Hackett				Consumer Representative
Karen	Hein ✓				Dartmouth Medical School
Kathleen	Hentcy	Charlie	Biss		AHS - DMH
		Jay	Barra ✓		
Penrose	Jackson				UVM Medical Center
Pat	Jones				GMCB
Lyne	Limoges				Orleans/Essex VNA and Hospice, Inc.
Ted	Mable	Kimberly	McClellan		DA - Northwest Counseling and Support Services
Melissa	Miles ✓	Patricia	Launer		Bi-State Primary Care

4/13/16

Joshua	Plavin ✓				Blue Cross Blue Shield of Vermont
Laural	Ruggles ✓				Northeastern Vermont Regional Hospital
Julia	Shaw				VLA/Health Care Advocate Project
Melanie	Sheehan				Mt. Ascutney Hospital and Health Center
Miriam	Sheehey				OneCare Vermont
Shawn	Skaflestad ✓	Sarah	Clark		AHS - Central Office
Chris	Smith				MVP Health Care
JoEllen	Tarallo-Falk	Lori	Augustyniak		Center for Health and Learning
Karen	Vastine				AHS - DCF
Teresa	Voci				Blue Cross Blue Shield of Vermont
Stephanie	Winters				Vermont Medical Society
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Kim Fitzgerald ✓ — SASH

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	Meeting Name:	VHCIP PH Work Group Meeting	
	Date of Meeting:	April 13, 2016	
	First Name	Last Name	
1	Susan	Aranoff	
2	Julie	Arel	
3	Lori	Augustyniak	
4	Ena	Backus	
5	Susan	Barrett	
6	Bob	Bick	
7	Charlie	Biss	
8	Mary Lou	Bolt	
9	Jill Berry	Bowen	
10	Mark	Burke	
11	Donna	Burkett	
12	Jan	Carney	
13	Barbara	Cimaglio	
14	Daljit	Clark	
15	Sarah	Clark	
16	Peter	Cobb	
17	Judy	Cohen	
18	Amy	Coonradt	
19	Alicia	Cooper	
20	Janet	Corrigan	
21	Brian	Costello	
22	Mark	Craig	
23	Jesse	de la Rosa	
24	Trey	Dobson	

Ken Remy - GMCB Intern

25	Tracy	Dolan	here
26	Kevin	Donovan	
27	Lisa	Dulsky Watkins	
28	Suratha	Elango	
29	~~Gabe~~	~~Epstein~~	
30	Kim	Fitzgerald	phone
31	Erin	Flynn	
32	Joyce	Gallimore	
33	Lucie	Garand	
34	Christine	Geiler	
35	Steve	Gordon	
36	Don	Grabowski	
37	Maura	Graff	phone
38	Wendy	Grant	
39	Dale	Hackett	here
40	Thomas	Hall	
41	Catherine	Hamilton	
42	Carolynn	Hatin	
43	Karen	Hein	here
44	Kathleen	Hentcy	
45	Jim	Hester	here
46	Penrose	Jackson	
47	Pat	Jones	
48	Joelle	Judge	here
49	Sarah	Kinsler	here
50	Heidi	Klein	here
51	Norma	LaBounty	

52	Andrew	Laing	
53	Kelly	Lange	
54	Patricia	Launer	
55	Mark	Levine	
56	Lyne	Limoges	
57	Nicole	Lukas	
58	Ted	Mable	
59	Carole	Magoffin	
60	Georgia	Maheras	here
61	Carol	Maloney	
62	Melissa	Miles	here
63	MaryKate	Mohlman	
64	Chuck	Myers	
65	Annie	Paumgarten	
66	Joshua	Plavin	Phone
67	Luann	Poirer	
68	Sarah	Relk	
69	Brita	Roy	
70	Laural	Ruggles	phone
71	Jenney	Samuelson	
72	seashre@msn.com	seashre@msn.com	
73	Julia	Shaw	
74	Melanie	Sheehan	
75	Miriam	Sheehey	
76	Shawn	Skafelstad	Phone
77	Chris	Smith	
78	Angela	Smith-Dieng	

79	Holly	Stone	here
80	JoEllen	Tarallo-Falk	
81	Karen	Vastine	
82	Teresa	Voci	
83	Nathaniel	Waite	
84	Marlys	Waller	
85	Kendall	West	here
86	James	Westrich	
87	Stephanie	Winters	
88	David	Yacovone	

Attachment 5: Pop Health Plan Concepts

Population Health Plan

Basic definitions and frameworks to inform health care innovation and reform strategies

January 2015

Vermont Health Care Innovation Project

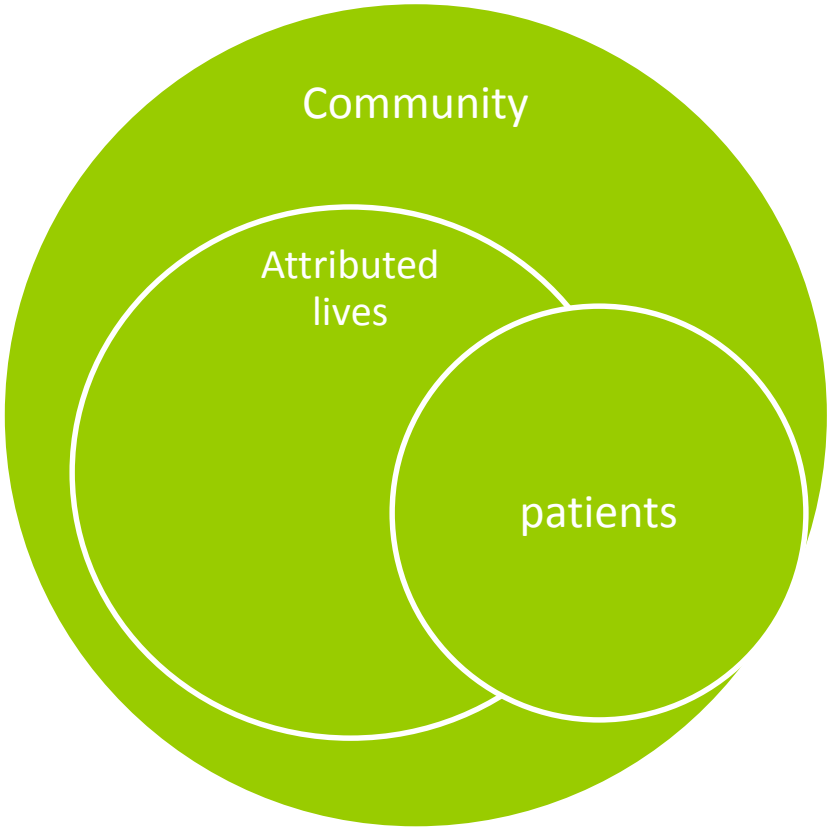
What is Health?

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

- SOURCE: Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

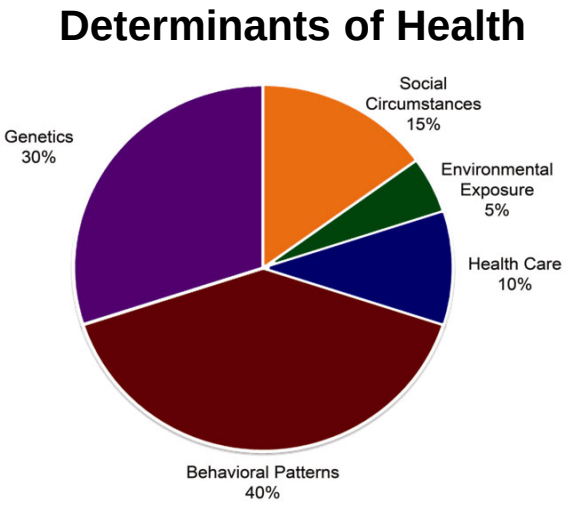
What is Population Health?

- Health Care Providers
  - Managing the health outcomes of the patients in their practice
- Health Insurers/Payers
  - Managing the clinical outcomes of enrolled patients and attributed lives
- Community
  - People who live in a geographic area



Population Health Defined

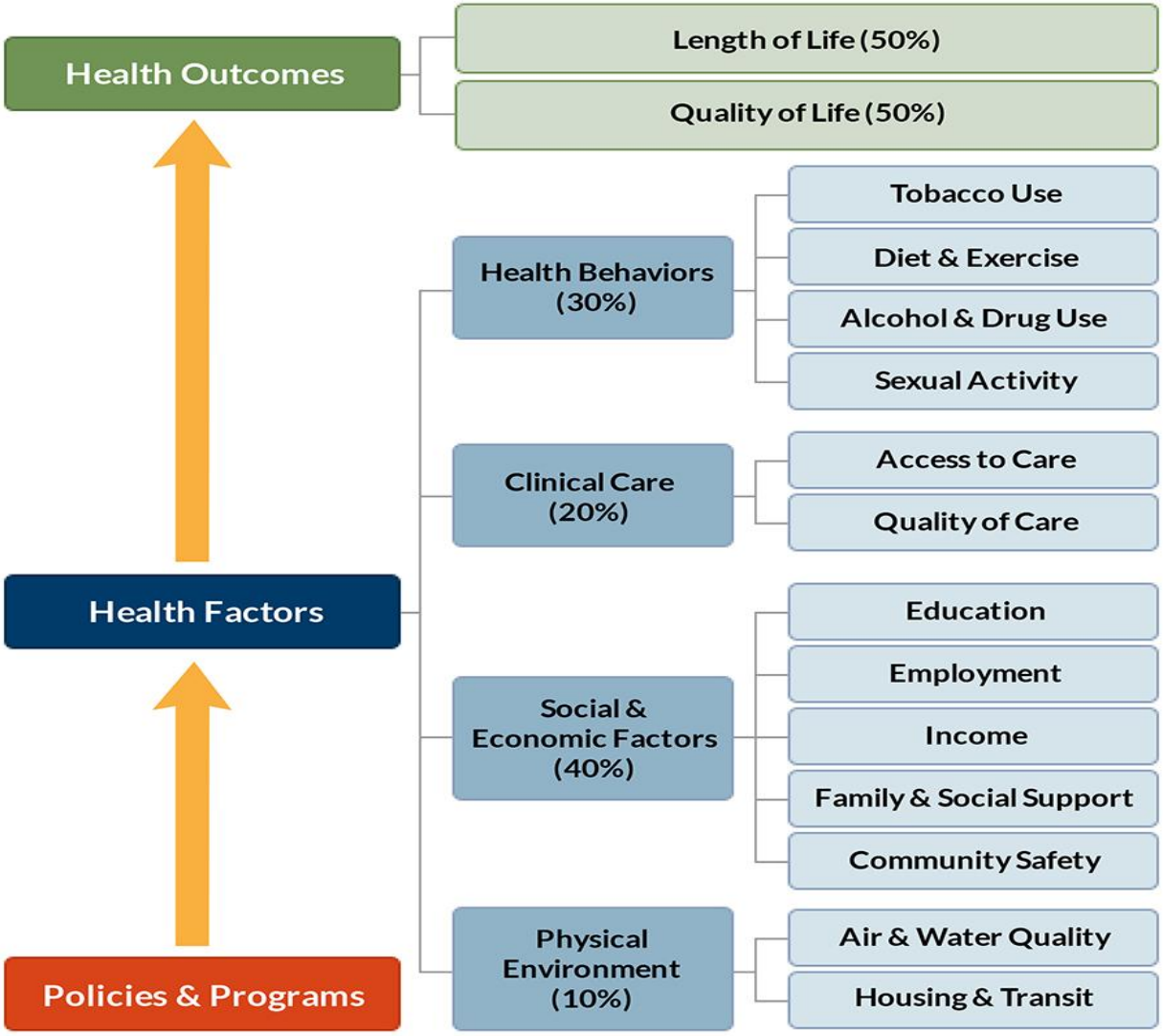
The health outcomes (morbidity mortality, quality of life) of a group of individuals, including the distribution of such outcomes within the group.



Health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors.

Institute of Medicine, Roundtable on Population Health Improvement

Improving Health Outcomes



Core Principles

Use data on health trends and burden of illness to identify priorities

Focus on identified state priorities given burden of illness, known preventable diseases and evidence-based actions that have proven successful in changing health outcomes.

Focus on broader population and health outcomes

Consider the health outcomes of a group of individuals, ***including the distribution of such outcomes within the group***, in order to develop priorities and target action.

Focus on prevention and wellness by patient, physician and system

Focus on actions taken to maintain wellness rather than solely on identifying and treating disease and illness.

Focus upstream to include risk and protective factors

Risk factors: lower likelihood of positive outcomes and a higher likelihood of negative or socially undesirable outcomes.
Protective factors: enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences from exposure to risk.

Link to social determinants and environmental factors

The circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics

Expand Timeframe

Changes to population health will require a longer time frame than the duration of this project. Balance potential for short term impact (within 3-5 years) and other which require a longer time frame (5-20 years).

Population Health Strategies

- **Traditional Clinical Approaches** focus on individual health improvement for patients who use their provider-based services
- **Innovative Patient Centered Care and/or Community Linkages** include community services for individual patients
- **Community-wide** strategies focus on improving health of the overall population or subpopulations

VERMONT
DEPARTMENT OF HEALTH

Strategies to Improve Developmental Screening Rates

The following table highlights evidence-based strategies and best practices to improve developmental screening rates in clinical and community settings.

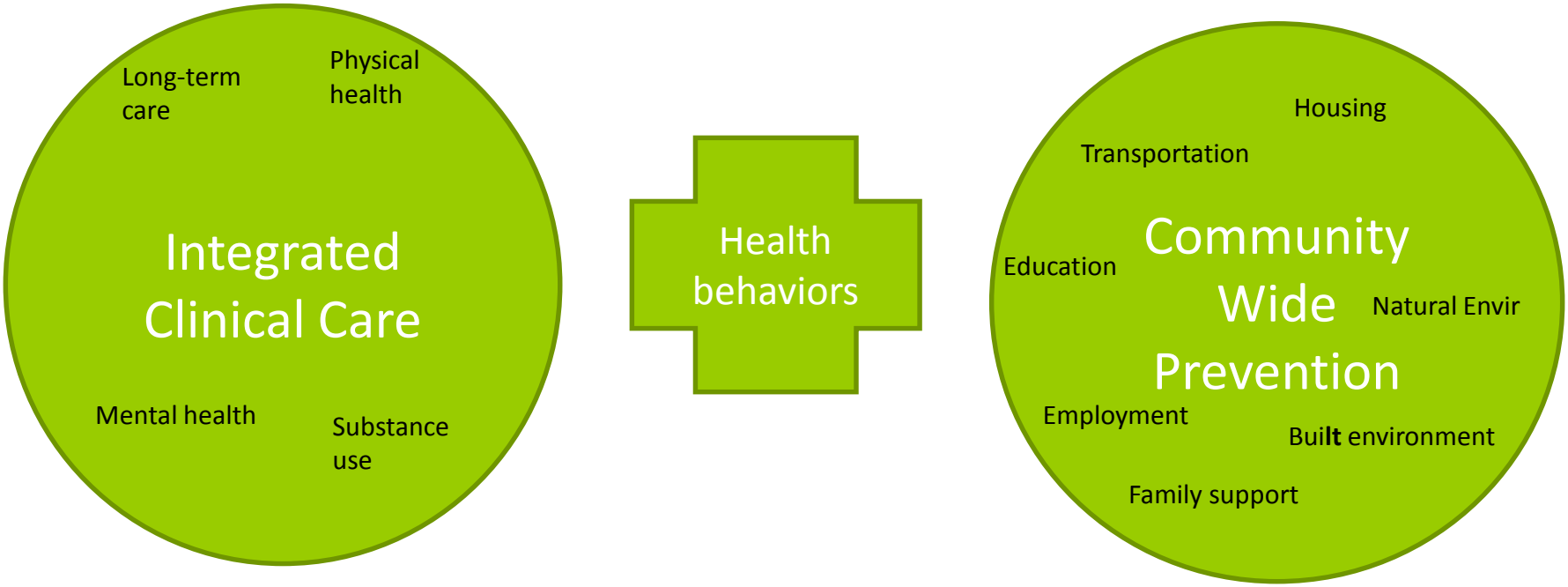
ACO Measure: Core-8 (NCQA HEDIS): Developmental Screening in the First Three Years of Life
The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life, that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Strategies
Patient education & tools • Adopt *Bright Futures* (i.e. pre-visit questionnaires, documentation, education handouts) • Educate families on developmental milestones • Establish a multidisciplinary team within your practice to implement universal developmental screening **Validated screening tool and protocol** • Review and identify a primary structured, validated developmental screening tool • Implement structured developmental screening using a validated tool at the 9, 18 and 30 month well visits • Implement developmental screening at other visits **Training and roles** • Ensure practitioners and staff are trained on accurate administration of screening tool • Identify and assign roles/responsibilities across the practice	**Parent/Family resources** • Increase parental education on early child development • Provide parents/caregivers with 2-1-1-phone number and encourage outreach to *Help Me Grow* (HMG) • Provide informational materials customized for specific audiences to increase knowledge of HMG resources • Provide information on community-based resources and education in support of early childhood development (e.g. parenting classes, library services) **Partnership building/referral resources** • Promote educational resources and materials with providers and partners (e.g. *Bright Futures*, Learn the Signs Act Early) • Outreach to community stakeholders (e.g. early care and education providers, CIS, schools) • Identify appropriate referral resources and capacity	**Help Me Grow** • Enhance utilization of *Help Me Grow* (HMG) by providers, families, and community resources • Collect feedback from HMG community stakeholders and families to improve service delivery **Quality improvement** • Integrate QI activities in support of universal developmental screening (i.e. medical home, early care and education, Unified Community Collaboratives) • Connect providers (medical home and early care and education) to VCHIP-supported quality improvement activities • Spread VCHIP's early care and education learning collaboratives by adding new regions each year **Improvements to the system of care** • Strengthen referral and evaluation systems at the community-level • Build relationships to improve communication and collaboration around referrals • Conduct a community-level gap analysis and needs assessment to identify levers to enhance the system of care

VT Accountable Community for Health

Integrated Regional Health System

Systematic Clinical - Community Linkages



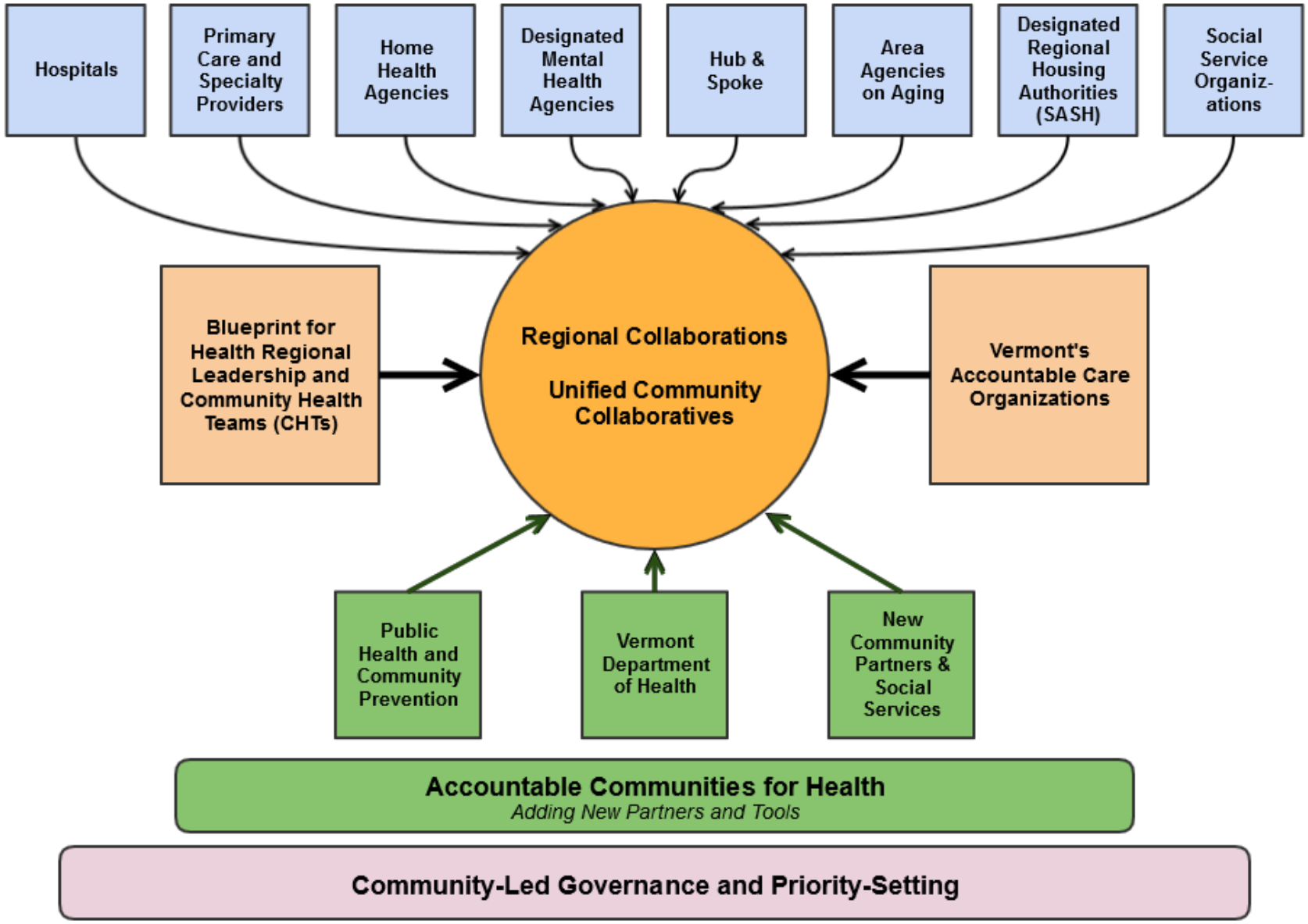
What is an Accountable Community for Health?

Accountable for the health and well-being of the entire population in its defined geographic area

Supports the integration of high-quality medical care, mental and behavioral health services, and social services for those in need of care

Supports community-wide prevention efforts to reduce disparities in the distribution of health and wellness.

Vermont: Regional Integration



Core Elements of Vermont's ACH Model

1. Mission
2. Multi-Sectoral Partnership
3. Integrator Organization
4. Governance
5. Data and Indicators
6. Strategy and Implementation
7. Community Member Engagement
8. Communications
9. Sustainable Funding

Additional Policy Levers

- **Community Health Needs Assessment**
- **Health resource allocation plan and Unified health budget**
- **Global budgeting**
- **Health in All Policies**