VT Health Care Innovation Project
Population Health Work Group Meeting Agenda

Date: Tuesday September 15, 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**	Tracy Dolan	**Attachment 1:** Agenda	
2	2:35	**Approval of Minutes**	Karen Hein	**Attachment 2:** Minutes	
3	2:40	**Project Changes and Work Group Continuity** • Measures • Paying for Prevention/Financing • Accountable Community for Health • Population Health Plan	Georgia Tracy	**Attachment 3:** Work Group Charter	
4	3:00	**Discuss Recommendations for Next Steps – small group discussions** If we proceed, what would need to be built into the planned next steps to ensure success? What tools, resources and decisions are needed to support regional efforts? What would we still need to develop? What would be the right frequency for convening peer communities? Do the regions have capacity to consider alignment with community wide prevention strategies when they are already investing heavily in quality improvement efforts and integration of services for individuals through changes in care management?	Heidi Klein	**Attachment 4a:** Nine Core Elements **Attachment 4b:** Proposal for Next Steps for Accountable Communities for Health	
5	3:40	**Report From Small Groups**	Tracy Dolan		
6	3:55	**Wrap Up**	Karen Hein		

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

Date of meeting: August 18, 2015; 2:30 PM – 4:00 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier

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

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

Agenda Item	Discussion	Next Steps
	◦ Already strong partnerships between health organizations and other kinds of organizations (mental health, etc…) that are poised and ready to help the population ◦ Every site expressed interest in doing community-based policy work on the community-based determinants of health. (walkability, health eating, worksite wellness) ◦ Recognition that poverty is the underlying issue and how it can be addressed to help economic development in the community. **Core Elements of an Accountable Community for Health (page 10):** • 9 core elements ◦ Mission ◦ Multi-sectoral partnership ◦ Integrator organization ◦ governance ◦ data and indicators ◦ strategy and implementation ◦ community member engagement ◦ communication ◦ sustainable financing • Recommendations by Prevention Institute ◦ See page 124 of the full materials packet ◦ We already have AHC in VT; some formal some less so ◦ Two clusters of concerns = chronic disease, substance abuse ◦ Vermont should build on efforts where there were already strong partnerships in communities. ◦ There is a VT prevention model – and could we move from that toward something like the San Diego model where the community selected certain health conditions to establish their framework. ◦ We know that there is other work going on in VT in service area integration and health improvement and we can work to integrate them to ensure there's a balance between the patient specific efforts and community wide prevention to improve health. (E.g. increasing physical activity; tobacco use reduction; traffic hazard reductions…) ◦ The state should develop a common set of indicators and have communities select from this list; as opposed to each community developing its own set of indicators… ◦ Re: data sharing systems – building toward an integrated data system is key but should not hold up the other work ◦ Creating a learning environment; building a network analysis statewide to review the service areas and activities. Surveying communities to see what kinds of work is going on in certain areas (such as local food distribution…) ◦ There is no one type of organization that *should* be the integrator – this can be done by the	

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

Agenda Item	Discussion	Next Steps

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

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

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

VHCIP Population Health Work Group Member List

Roll Call: 8/18/2015

Sue Aranoff 1°
Theresa Voci 2°
Motion to approve by exception
- Approved with one abstention.

Member		Member Alternate		Minutes		
First Name	**Last Name**	**First Name**	**Last Name**			**Organization**
Susan	Aranoff ✓					AHS - DAIL
Jill Berry	Bowen ✓					Northwestern Medical Center
Mark	Burke ✓					Brattleboro Memorial Hopsital
Donna	Burkett	Maura	Graff ✓			Planned Parenthood of Northern New England
Dr. Dee	Burroughs-Biron	Trudee	Ettlinger			AHS - DOC
Daljit	Clark	Jenney	Samuelson			AHS - DVHA
Peter	Cobb ✓					VNAs of Vermont
Judy	Cohen ✓					University of Vermont
Jesse	de la Rosa ✓					Consumer Representative
Tracy	Dolan ✓	Heidi	Klein	A		AHS - VDH
Joyce	Gallimore ✓	Kendall	West			CHAC
Karen	Hein ✓					Dartmouth Medical School
Kathleen	Hentcy ✓	Charlie	Biss			AHS - DMH
Penrose	Jackson					UVM Medical Center
Pat	Jones ✓					GMCB
Patricia	Launer ✓					Bi-State Primary Care
Lyne	Limoges					Orleans/Essex VNA and Hospice, Inc.
Ted	Mable	Kimberly	McClellan			DA - Northwest Counseling and Support Services
Carol	Maloney					AHS - Central Office
Melissa	Miles					Bi-State Primary Care
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 ✓					AHS - Central Office
Chris	Smith ✓					MVP Health Care
JoEllen	Tarallo-Falk ✓	Lori	Augustyniak			Center for Health and Learning
Karen	Vastine					AHS - DCF
Teresa	Voci ✓	LaRae	Francis			Blue Cross Blue Shield of Vermont
Stephanie	Winters					Vermont Medical Society
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Maura Graff - PPNNE
Kim Fitzgerald - Cathedral Square

VHCIP Population Health Work Group Participant List

Attendance: 8/18/2015

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

First Name	Last Name		Organization	Population Health
Susan	Aranoff	here	AHS - DAIL	S/M
Julie	Arel		VDH	X
Lori	Augustyniak		Center for Health and Learning	MA
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
Bob	Bick		DA - HowardCenter for Mental Health	X
Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DMH	X/MA
Mary Lou	Bolt		Rutland Regional Medical Center	X
Jill Berry	Bowen	here	Northwestern Medical Center	M
Mark	Burke	phone	Brattleboro Memorial Hopsital	M
Donna	Burkett		Planned Parenthood of Northern New England	M
Dr. Dee	Burroughs-Biron		AHS - DOC	M
Jan	Carney		University of Vermont	X
Amanda	Ciecior		AHS - DVHA	S
Barbara	Cimaglio		AHS - VDH	X

Daljit	Clark		AHS - DVHA	MA
Peter	Cobb	phone	VNAs of Vermont	M
Judy	Cohen	phone	University of Vermont	M
Amy	Coonradt		AHS - DVHA	S
Alicia	Cooper		AHS - DVHA	S
Janet	Corrigan		Dartmouth-Hitchcock	X
Brian	Costello			X
Mark	Craig			X
Wendy	Davis		University of Vermont	X
Jesse	de la Rosa	here	Consumer Representative	M
Micah	Demers		Blue Cross Blue Shield of Vermont	X
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
Suratha	Elango		RWJF - Clinical Scholar	X
Gabe	Epstein	here	AHS - DAIL	S
Trudee	Ettlinger		AHS - DOC	MA
Kim	Fitzgerald	here	Cathedral Square	X
Erin	Flynn		AHS - DVHA	S
LaRae	Francis		Blue Cross Blue Shield of Vermont	MA
Joyce	Gallimore	phone	Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Steve	Gordon		Brattleboro Memorial Hopsital	X
Don	Grabowski		The Health Center	X
Maura	Graff	phone	Planned Parenthood of Northern New England	X
Wendy	Grant		Blue Cross Blue Shield of Vermont	A
Dale	Hackett		Consumer Representative	X
Thomas	Hall		Consumer Representative	X
Bryan	Hallett		GMCB	S
Catherine	Hamilton		Blue Cross Blue Shield of Vermont	X
Carolynn	Hatin		AHS - Central Office - IFS	S
Karen	Hein	here		C/M

Kathleen	Hentcy	here	AHS - DMH	M
Jim	Hester	here	SOV Consultant	S
Penrose	Jackson		UVM Medical Center	M
Pat	Jones	phone	GMCB	S/M
Joelle	Judge	here	UMASS	S
Sarah	Kinsler	here	AHS - DVHA	S
Heidi	Klein	here	AHS - VDH	S/MA
Norma	LaBounty		OneCare Vermont	A
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Patricia	Launer	phone	Bi-State Primary Care	MA
Mark	Levine		University of Vermont	X
Lyne	Limoges		Orleans/Essex VNA and Hospice, Inc.	M
Nicole	Lukas		AHS - VDH	X
Ted	Mable		DA - Northwest Counseling and Support Services	M
Carole	Magoffin		AHS - DVHA	S
Georgia	Maheras		AOA	S
Carol	Maloney		AHS	X
Mike	Maslack			X
Jill	McKenzie			X
Melissa	Miles		Bi-State Primary Care	M
MaryKate	Mohlman	here	AHS - DVHA - Blueprint	X
Chuck	Myers		Northeast Family Institute	X
Annie	Paumgarten		GMCB	S
Luann	Poirer		AHS - DVHA	S
Carley	Riley			X
Brita	Roy			X
Laural	Ruggles	here	Northeastern Vermont Regional Hospital	M
Jenney	Samuelson		AHS - DVHA - Blueprint	M
seashre@msn.con	seashre@msn.com		House Health Committee	X
Julia	Shaw	here	VLA/Health Care Advocate Project	M
Melanie	Sheehan		Mt. Ascutney Hospital and Health Center	M
Miriam	Sheehey	phone	OneCare Vermont	M
Shawn	Skaflestad	here	AHS - Central Office	M
Chris	Smith	phone	MVP Health Care	M
Kaylan	Sobel		The Council of State Governments	X

JoEllen	Tarallo-Falk	phone	Center for Health and Learning	M
Karen	Vastine		AHS-DCF	
Teresa	Voci	here	Blue Cross Blue Shield of Vermont	M
Nathaniel	Waite		VDH	X
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Kendall	West	here	Bi-State	X
James	Westrich		AHS - DVHA	S
Stephanie	Winters		Vermont Medical Society	M
Mary	Woodruff			X
Cecelia	Wu		AHS - DVHA	S
McKenna	Lee		OneCare Vermont	
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Attachment 3: Work Group Charter

Vermont Health Care Innovation Project
Population Health [1] Work Group Charter

EXECUTIVE SUMMARY

This group will examine current population health improvement efforts administered through the Department of Health, the Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs and other provider and payer entities. The group will examine these initiatives and SIM initiatives for their potential impact on the health of Vermonters and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including:

- Enhancement of State initiatives administered through the Department of Health
- Support for or enhancement of local or regional initiatives led by governmental or non-governmental organizations, including employer-based efforts
- Expansion of the scope of delivery models within the scope of SIM or pre-existing state initiatives to include population health

PURPOSE/PROJECT DESCRIPTION

The Population Health Working Group will leverage the opportunities available through the Vermont Health Care Innovation Project to enhance population health improvement efforts in Vermont and to achieve the health priorities in the State Health Improvement Plan.

Scope of Work

The Group will be a resource for the other working groups and advise them on ways that their work can incorporate population health principles and contribute toward improving the population health of Vermonters. It will be proactive in identifying opportunities to create both the infrastructure to support improvements in population health and sustainable approaches to rewarding improvements. The Group will review products from the other working groups, participate in formative discussions with them, and develop recommendations for refinements to models, measures, and other elements that contribute to improved population health outcomes.

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[1] **Working Definition of Population Health, Institute Of Medicine, Roundtable on Population Health Improvement**
http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx

Realizing that there is not uniform agreement on the definition of population health, the IOM Roundtable will use the following definition to guide its initial conversations.

Population Health is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart, 2003). While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors.

For additional details about defining population health, see the *Working Definition* here.
Kindig, D., and G. Stoddart. 2003. What is population health? *American Journal of Public Health* 93(3):380-383.

Work Group Objectives/Success Criteria

The work group will concentrate on three major areas of work:

- Consensus on population health measures to be used in tracking the outcomes of the Vermont Health Care Innovation Project (formerly known as SIM) and to be incorporated in the new payment models.
  - Collect existing sets of "population health" measures currently used by VT, CDC or CMMI
  - Compare and align with ACO measures identified for Year One of the Project
  - Recommend appropriate set for use in the Innovation Project

- How to pay for population health through modifications to proposed health reform payment mechanisms, and identification of promising new financing vehicles that promote financial investment in population health interventions.

  - Describe options from which others can chose to test out in the payment experiments
  - Build upon materials developed by
  - review and learn from others that are trying new approaches

- Identifying and disseminating current initiatives in Vermont and nationally where clinical and population health are coming together. Identifying opportunities to enhance new health delivery system models, such as the Blueprint for Health and Accountable Care Organizations (ACOs), 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.

  - Define characteristics of interest
  - Identify current community efforts that appear promising (e.g. intersection between Blueprint, Fit and Healthy Coalition, VDH)
  - Link these communities to experiments currently being conducted through the Innovation Project

PROJECT JUSTIFICATION

In order to meet the triple aim of reducing cost, improving quality, and improving health, we must address the non-clinical social, economic and behavioral determinants of health and incorporate primary prevention efforts that address total population health.
Core project components should align and provide consistent incentives and operational models for health care providers, including Population health improvement activities that address underlying factors affecting population health:

RISKS

The Population Health Work Group was created after primary structure of the Project was determined. The Population Health Workgroup must recognize the framework and constraints of bringing a complementary framework to a project primarily focused on payment incentives for medical care.

The role of this Work Group is largely advisory so it will seek to strategically cross-pollinate ideas through the co-chairs, work group members and staff.

DELIVERABLES

The deliverables from this work group will include:

1. A set of population health measures
2. A suite of options for paying for prevention
3. Examples and options for integrating clinical, public health and community activities to improve population health

SUMMARY MILESTONES

This section provides an estimated schedule of all high-level project milestones. This is only an estimate and will change as the tasks and milestones and their associated requirements are more clearly defined in the work plan and as the project moves forward.

MEMBERSHIP REQUIREMENTS

Work Group members are expected to consistently participate in monthly meetings, ideally in person. Occasional work will be needed between meetings.

PARTICIPANT LIST ()

RESOURCES AVAILABLE FOR STAFFING AND CONSULTATION

Work Group Chairs:

Tracy Dolan, tracy.dolan@state.vt.us

Karen Hein, Karen.hein@state.vt.us

Work Group Staff: Heidi Klein, Heidi.klein@state.vt.us, 802-863-7494

DRAFT

WORK GROUP PROCESSES:

1. The Work Group will regularly meet on the second Tuesday of each month.
2. The Work Group Co-Chairs plan and distribute the meeting agenda through project staff.
3. Related materials are to be sent to Work Group members, staff, and interested parties prior to the meeting date/time.
4. Work Group members, staff, and interested parties are encouraged to call in advance of the meeting if they have any questions related to the meeting materials that were received.
5. Minutes will be recorded at each meeting by Project Management Staff.
6. The Work Group Co-Chairs will preside at the meeting.
7. Progress on the Work Group's work will be reported as the Monthly Status Report.
8. The Work Group's Status Reports and Recommendations are directed to the Steering Committee.

AUTHORIZATION

____ **Date:** ___________________________

Project Sponsor/Title

DRAFT

Attachment 4a: Nine Core Elements

NINE CORE ELEMENTS OF AN ACCOUNTABLE COMMUNITY FOR HEALTH

1. Mission – An effective ACH mission statement provides an organizing framework for the work. A strong mission defines the work as pertaining to the entire geographic population of the ACH's region; articulates the ACH's role addressing the social, economic, and physical environmental factors that shape health; and makes health equity an explicit aim.

2. Multi-Sectoral Partnership – An ACH comprises a structured, cross-sectoral alliance of healthcare, public health, and other organizations that impact health in its region. Partners include the breadth of organizations that are able to help it fulfill its charge of implementing comprehensive efforts to improve the health of the entire population in its defined geographic area.

3. Integrator Organization – To maximize the effectiveness of the multi-sectoral partnership, it is essential for the ACH to have an integrator organization. The integrator helps carry the vision of the ACH; build trust among collaborative partners; convene meetings; recruit new partners; shepherd the planning, implementation, and improvement efforts of collaborative work; and build responsibility for many of these elements among collaborative members

4. Governance – An ACH is managed through a governance structure that describes the process for decision making and articulates the roles and responsibilities of the integrator organization, the steering committee, and other collaborative partners.

5. Data and Indicators – An ACH employs health data, sociodemographic data, and data on community conditions related to health (such as affordable housing, food access, or walkability) to inform community assessment and planning, and to measure progress over time. It encourages data sharing by partners to inform these activities. Equally important, an ACH seeks out the perspectives of residents, health and human service providers, and other partners to augment and interpret quantitative data.

6. Strategy and Implementation – An ACH is guided by an overarching strategic framework and implementation plan that reflects its cross-sector approach to health improvement and the commitment by its partners to support implementation. The process for developing this framework includes a prevention analysis that identifies community conditions that are shaping illnesses and injuries across the community. The implementation plan includes specific commitments from healthcare, local government, business, and non-profit partners to carry out elements of the plan

7. Community Member Engagement – Authentic community engagement is a well-recognized best practice in the field of community health that requires commitment from the highest levels, designated staff, and commensurate resources to ensure effective integration into ACH processes and systems. Authentic community engagement recognizes and harnesses residents' own power in identifying and addressing challenges, while also creating leadership for and buy-in of the work in a manner that acknowledges and builds upon existing community assets and strengths.

8. Communications – An ACH employs communications platforms to build momentum, increase buy-in amongst its partners, recruit new members, and attract grant investment to support its work, and share successes and challenges with others. Communications is also a key tool for framing solutions in terms of community environments and comprehensive strategies.

9. Sustainable Financing – An ACH requires resources to support both its integrator function and ACH implementation work by others. An ACH makes use of existing and new funding sources and better aligns them to advance broad community goals.

Attachment 4b: Proposal for Next Steps for Accountable Communities for Health

Vision Align and mutually reinforce evidence based strategies in a geographic area to improve specific health outcomes

> **Accountable Community for Health:** "An aspirational model—accountable for the health and well-being of the entire population in its defined geographic area and not limited to a defined group of patients. Population health outcomes are understood to be the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, economic circumstances and environmental factors. An ACH supports the integration of high-quality medical care, mental and behavioral health services, and social services (governmental and non-governmental) for those in need of care. It also supports community-wide prevention efforts across its defined geographic area to reduce disparities in the distribution of health and wellness."

Goals Regional goals will be developed based on data regarding existing population health status and opportunities for improvement.

The Vermont State Health Improvement Plan identifies 3 statewide goals, with corresponding measures and evidence-based strategies for meeting those goals**.** The three goals were chosen based on data reflecting the health status of Vermonters and an interest in choosing priorities that are strategic. As a result, the focus of Vermont's plan is on conditions that are preventable and when improvements are made, will have a positive impact on multiple health outcomes in the future

Goal 1: Reduce the prevalence of chronic disease
Goal 2: Reduce the prevalence of individuals with or at risk of substance abuse or mental illness
Goal 3: Improve childhood immunization rates

Additionally, hospitals carryout community health needs assessments for their hospital service areas. Through this process hospitals engage the communities they serve and learn more about the most pressing health care concerns and needs. Based on community health data provided by the state health department and others, combined with the feedback that the hospitals gather, each hospital develops an implementation strategy to address prioritized community health needs.

In combination, the statewide and hospital service area goals provide a foundation for determining regional goals for population heath improvement.

Scope Given the impact of factors beyond the medical office on health outcomes, this effort will seek to establish alignment among programs/strategies related to integrated care and services for individuals and community-wide prevention efforts to improve health outcomes.

As emerging, the ACH concept:

- Engages a broad set of partners outside of healthcare to improve overall population health;
- Brings together major medical care, mental and behavioral and social services, across a geographic area, and requires them to operate as partners rather than competitors while also connecting systems set up to integrate/coordinate services for individuals with community-wide prevention efforts;
- Focuses on the health of all residents in a geographic area rather than just a patient panel; and
- Identifies multiple strands of resources that can be applied to ACH-defined objectives that explore the potential for redirecting savings from healthcare costs in order to sustain collaborative efforts

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Structure

An Accountable Community for Health would have the following nine core elements: mission; multi-sectoral partnership; integrator organization; governance, data and indicators; strategy and implementation; community member engagement; communications; and sustainable financing.

A regional integrator will pull together regional partners to consider how best to ensure that the nine core elements are in place. The regional integrator will be identified by regional leaders best positioned to build on the excellent foundation for the integration of services for individuals establish via Hospital/BP/ACO collaboration and other cross-disciplinary collaborations aimed at population health improvement in the regions. Options include: hospital, UCC, Health Department District Office, Community Collaborative, Foundations.

Next Steps: Building Accountable Communities from the Ground Up

We have developed a conceptual framework for Accountable Communities for Health in VT based on research and interviews. Now we need to flesh out the model based on the real world practical experiences and questions of those who would be the leaders within an Accountable Community for Health. We will convene on-the-ground innovators to inform the next set of decisions.

Establish Statewide Framework

- Bring the State Health Improvement Plan (SHIP) to VHCIP, GMCB, AHS and stakeholders
- Share PHWG frameworks for Population Health Improvement
- Highlight the shared accountability across sectors for health outcomes

Produce Guidance to Regions

- Goals and Indicators
    - State Health Improvement Plan (SHIP)
    - Hospital Community Health Needs Assessment (CHNA)
- Evidence based strategies

Build capacity and learning – PHWG will hire TA/Facilitator to Convene

- Who: Integrator and team leads from established Regions – UCC and/or Community Wide Health/Prevention Structure
- How: monthly facilitated peer learning labs to share evidence based strategies and best practices across the continuum of health and to identify information or decisions needed
- How: technical assistance based on research of other communities nationwide seeking similar outcomes or exploring similar ACHs

Explore Financing Opportunities

- Research paper on potential: dedicating a portion of a new or existing tax to fund ACH activities; specifying that a portion of a global healthcare payment or a per-patient per-month assessment on payers support the ACH upstream effort; establishing a wellness trust to support the ACHs, funded through one or a blend of the sources)
- Local options for funding for AHCs will be part of this exploration together

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Key Issues to Consider

If we proceed, what would need to be built into the planned next steps to ensure success?

What tools, resources and decisions are needed to support regional efforts? What would we still need to develop? What would be the right frequency for convening peer communities?

Do the regions have capacity to consider alignment with community wide prevention strategies when they are already investing heavily in quality improvement efforts and integration of services for individuals through changes in care management?

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Prevention Institute Recommendations

A. Foster an overarching statewide approach to support ACH effectiveness

Develop a statewide strategic framework for population health improvement to support local ACHs in setting priorities.

Establish a core set of community-level indicators for use by local ACHs to monitor progress in community-wide prevention.

Emphasize accountability mechanisms that are linked to population health improvement.

Phase in the formation of ACHs.

Explore the role of the State Government Department of Health, and other regional offices, in participating in local ACH collaboratives.

B. Provide guidance to enable regions to effectively establish ACHs

Ensure ACHs balance individual service integration and community prevention efforts

Conduct a network analysis of community prevention efforts in each Health Service Area

Encourage ACHs to form around existing regional partnerships and collaborations. *PI recommends the State not designate a specific type of organization to serve as the integrator.*

C. Build capacity and create an environment of ongoing learning

Expand the paradigm of the health system from healthcare to health.

Foster skill development for the emerging cadre of ACH leaders. *Consider establishing and supporting a peer learning collaborative for communities ready to start.*

Promote authentic community engagement in all aspects of the ACHs and their work.

Encourage the creation of robust communications platforms for the ACHs.

D. Explore Sustainable Financing Models for Accountable Communities for Health

Potential options include:

- Dedicating a portion of a new or existing tax to fund ACH activities.
- Specifying that a portion of a global healthcare payment or a per-patient per-month assessment on payers support the ACH upstream effort.
- Establishing a wellness trust to support the ACHs, funded through one or a blend of the sources described previously under core element nine.