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# Combined Meeting of The Blueprint Executive Committee and Blueprint Expansion, Design and Evaluation Committee

## November 18, 2015

***Attendees:*** J. Batra; B. Bick; P. Cobb; T. Dolan; R. Gibson; P. Farnham; A. French; C. Fulton; M. Hazard; L. Hendry; J. Hester; P. Jackson; C. Jones; J. Le; T. Mable; L. McLaren; T. Moore; S. Ridzon; J. Samuelson; J. Wallace; J. Zirena

***By phone:*** J. Anderson-Swayze; P. Biron; W. Cornwell; S. Eagle; E. Emard; K. Hein; E. McKenna; S. Narkewicz; L. Ruggles; M. Young

The meeting opened at 8:30 a.m.

I. Opening Remarks and Context: Craig Jones, MD.

- The agenda and PowerPoint slide deck were distributed prior to the meeting.
- The purpose of the meeting will give the group both a sense of activities and developments happening around the state. The three (3) accountable care organizations (ACOs) and the Blueprint have been working together on creating a community collaborative structure.

II. Status of Community Collaboratives

- Slide #5, *Evolution of Community Collaboratives* shows how the communities have evolved to where the Blueprint, the ACOs, and community health and human service providers are working together on quality improvement projects and shared measures. C. Jones mentioned the Blueprint has restructured our Health Service Area (HSA) grants for 2016 to include Project Managers and QI Facilitators supporting ACO initiatives and the work of the integrated community collaboratives.
- J. Samuelson gave a quick overall status update before Lesley Hendry (St. Albans Blueprint Project Manager) reported out on St. Albans' efforts, which include:
  - Priorities including ER utilization, food insecurity, and housing.
  - Sub groups and work groups were also created.
  - Solutions are community-based.

    - The communities are in different levels of maturity. In some communities, they are still working on the framework.

- L. Hendry reported St. Albans has a lot of teams that are participating in their learning collaborative sessions. The teams are both practice-based and from community organizations. At each meeting, each entity chooses one or two measures they want to focus on. The teams have been able to come back to the meetings and demonstrate what specifically they did.
- J. Batra responded this sounds great and questioned how this is different from VCCI. J. Samuelson responded VCCI is a short-term intervention, whereas this effort identifies a lead care coordinator who can work with the person on a long-term basis. It is creating a shared action plan across the agencies with the person in the room. B. Tanzman also responded these initiatives are payer agnostic, including dual eligible, and VCCI will only serve Medicaid-only beneficiaries.
- B. Bick questioned if the economic benefits of these initiatives have been examined. C. Jones responded that the costs of the other providers and other people involved will need to be a new consideration for calculating ROI of these efforts. The Hub & Spoke and SASH teams have been studied fairly significantly in terms of costs and savings, both by Medicare and Medicaid. This new approach has not been developed yet, and it's too soon.
- T. Mable questioned how the savings are identified? C. Jones mentioned we have seen reductions in acute care. So far, each of the evaluations demonstrates cost savings for initiatives that we take on targeted populations. T. Moore responded that OneCare is starting to do longitude tracking of ED visits and admissions.
- A. Ramsey questioned when this will evolve into a process where the clinicians will know at the beginning of the day which patients they will be seeing who are high utilizers and need extra attention. T. Moore responded an event notification system called Patient Ping is being developed. The clinician's iPhone will ping whenever their top utilizing 10 patients are admitted to the hospital or have an ER visit.
- W. Cornwell responded that we are in a transitional period in health care. We have never worked together (medical and community partners) on the population health of a community before. It's hard work and a tremendous effort, but the time and effort will be worth pursuing.

III. Accountable Communities for Health

- Tracy Dolan, Deputy Commissioner of VDH and Co-Chair of the Population Health Workgroup (VHCIP), presented the *Accountable Communities for Health Research* report from the Prevention Institute. The report is based on the population health initiative that originated out of SIM that both she and VDH are helping to drive. The goal of the report is to find out if any of the selected communities in Vermont had some of the elements of the Accountable Communities for Health.
- The report shows Vermont is the right size for innovation. The Vermont Blueprint for Health was seen as a great building block in Vermont.
- T. Dolan mentioned an RFP will go out for a group to help with phase 2.
- K. Hein stated if want to improve health, we can't do it without fully integrating the communities. We have to come together, the sooner the better.

- L. Ruggles mentioned with J. Hester's connection, St. Johnsbury will be attending a round table at the Federal Reserve Bank in Boston to discuss community development and how to fund Accountable Health Communities.
- E. Emard questioned how these initiatives align with the Community Health Needs assessments. T. Dolan reported the report found the priorities in Vermont align with each other.
- J. Hester mentioned CMMI is supposed to be announcing a funding opportunity for Accountable Health Communities.

IV. Program Planning for 2017

- C. Jones mentioned at the next meeting we will start with *Issues to Consider for 2017* (slide #28). This is a very important discussion and transition and will also be a creative process. We will be engaging over the next few months.

With no further time, the meeting adjourned at 10:00 am.

# Executive Committee
# Planning & Evaluation Committee

November 18, 2015

# Agenda

1. Opening Comments
2. Status of Community Collaboratives
3. Accountable Communities for Health
4. Program Planning for 2017

# Community Oriented Population Health

# Current State of Play

- Statewide foundation of primary care based on NCQA standards
- Community Health Teams providing supportive services to population
- Team extenders supporting key populations (SASH, Hub & Spoke)
- Maturing health information & data systems, comparative reporting
- Integration with ACOs & formal community collaborative structure
- Growing emphasis on coordination, accountability, & population health
- Planning underway for a single accountable health system

# Evolution of Community Collaboratives

| Activities | Structure | Financial |
|---|---|---|
| Information sharing & learning within separate initiatives | BP workgroups. Separate ACO workgroups | CHT funds and BP grants to administrative entity. Agreements with administrative entity clarify roles of BP PMs and PFs. |
| Information sharing & learning across organizations & programs | Integrated service area collaborative meeting | CHT funds and BP grants to administrative entity. Agreements with administrative entity clarify roles of BP PMs and PFs. |
| Consensus based planning of coordination & quality initiatives. Initiatives supported by PMs, PFs, CHT leads, and ACO quality leads | Integrated service area collaborative meeting & workgroups | CHT funds and BP grants to administrative entity. Agreements with administrative entity clarify roles of BP PMs and PFs. |
| Strategic initiatives to meet accountable health system and population health priorities. Initiatives supported by PMs, PFs, CHT leads, and ACO quality leads | Integrated service area collaborative with workgroups and formal decision making leadership team | CHT funds and BP grants to administrative entity. Agreements with administrative entity clarify roles of BP PMs and PFs. |

# Accountable Communities for Health Research


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Lisa Dulsky Watkins, MD
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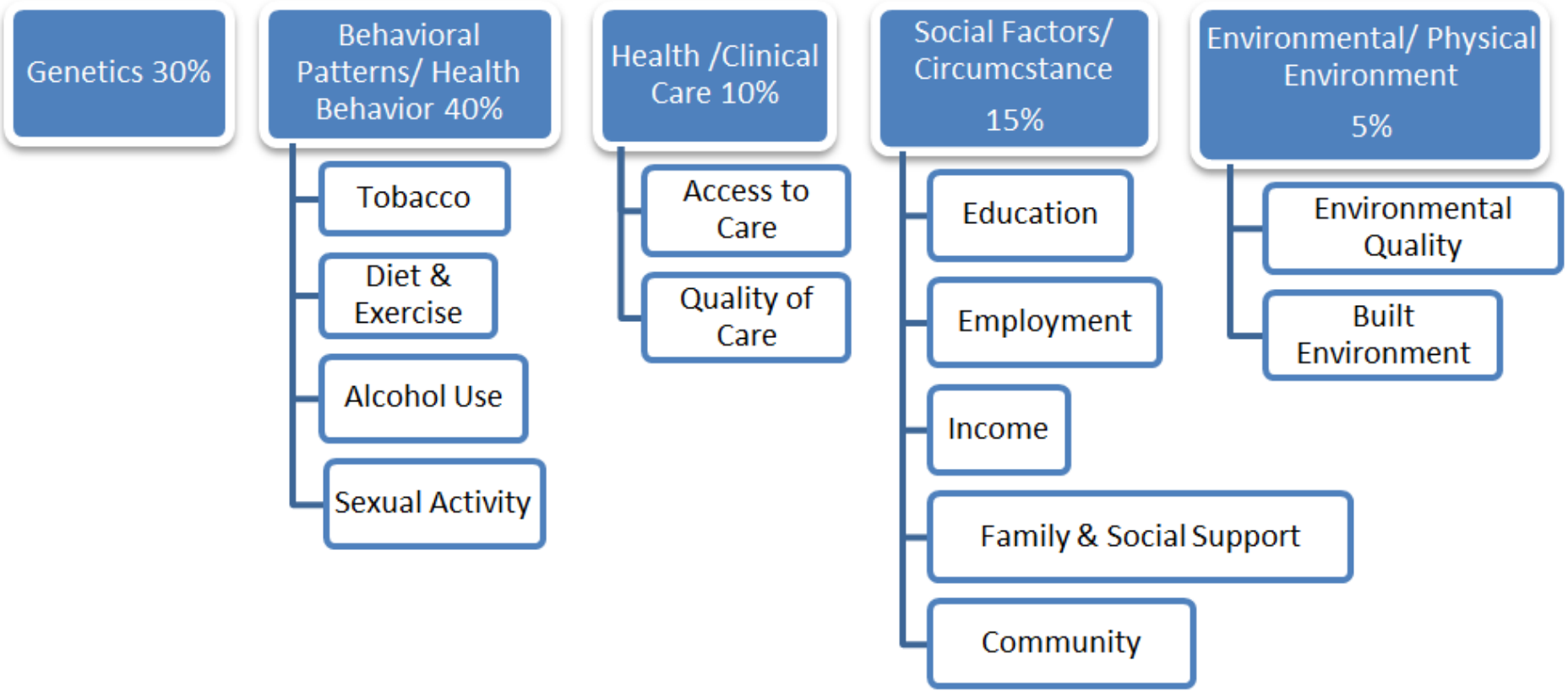
Kalahn Taylor-Clark, PhD, MPH
*Senior Advisor,* Center for Health Policy Research & Ethics

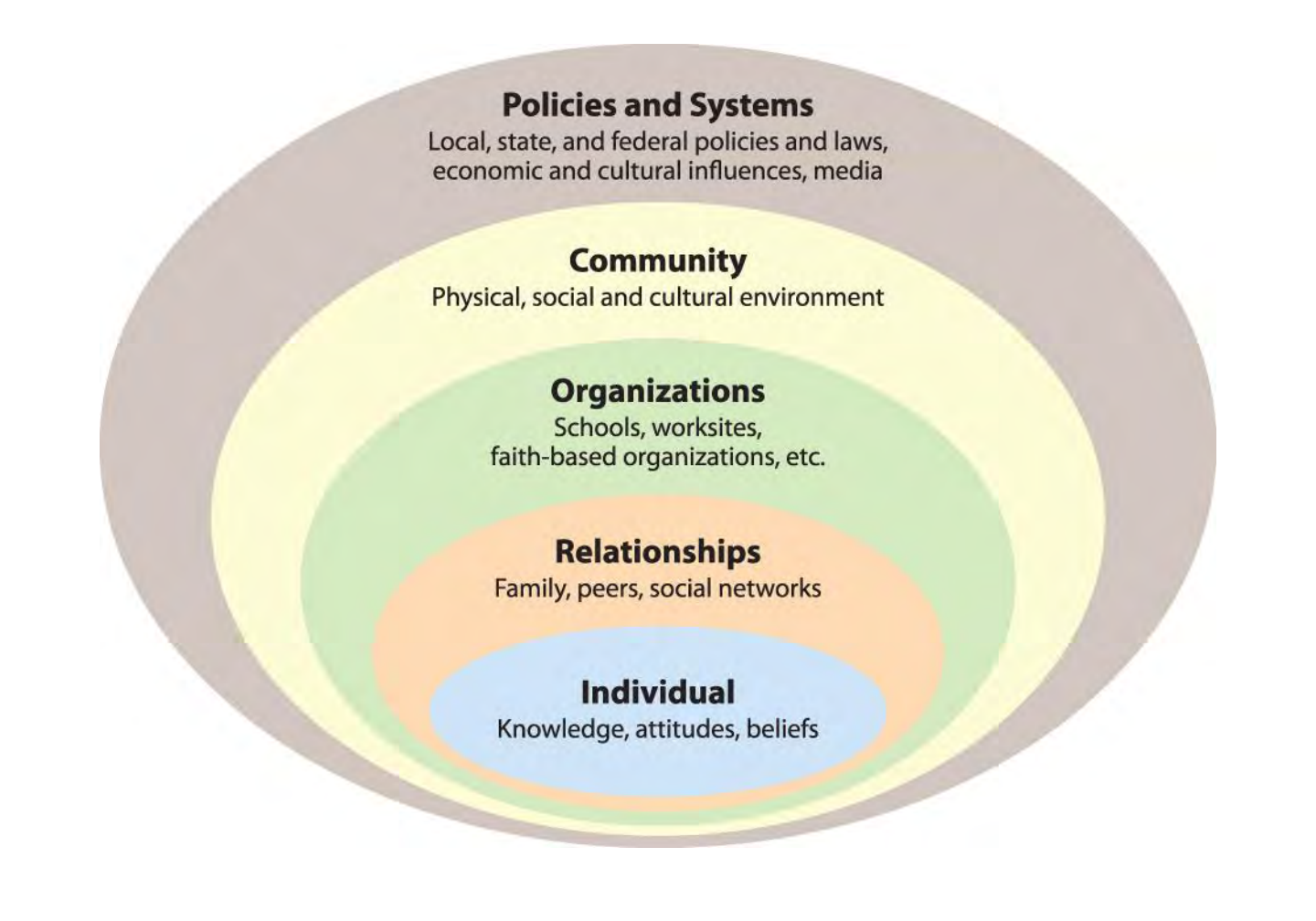

Prevention Institute
Prevention and equity | at the center of community well-being

# Factors Affecting Health Outcomes




Source: Schroeder, Steven. N Engl J Med 2007;357:1221-8
Adapted from: McGinnis JM, et.al. *The Case for More Active Policy Attention to Health Promotion.* Health Aff (Millwood) 2002;21(2):78-93.

# Vermont Prevention Model



# Accountable Communities for Health (ACH) Definition

An ACH works across the entire population of its defined geographic area to support the integration of:

- Medical Care
- Mental and Behavioral Health Services
- Social and Community Services
- Community-Wide Prevention Efforts

# Elements of Accountable Communities for Health

- Integrator
- Partnership
- Assessment, Planning, and Comprehensive Strategies
- Data, Metrics, and Accountability
- Community Resident Engagement
- Funding and Sustainability

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# National Sites

- Live Healthy, Summit County, Ohio
- Pueblo Triple Aim Coalition, Colorado
- Trillium Community Health Plan, Oregon
- Live Well San Diego, California
- Pathways to a Healthy Bernalillo County, New Mexico

# Integrator

- *ACH facilitated by an internal or external integrator that coordinates the roles and capacities of the partners within the ACH according to its governance structure*
  - San Diego/Summit (California/Ohio): HHSA/public health is integrator
  - Lane County (Oregon): Health plan is integrator
  - Bernalillo/Pueblo (Colorado): External integrators
  - No significant difference observed between internal and external integrators

# Partnership

- *Structured, integrated partnership of healthcare delivery systems, social service agencies, public health departments, government, and community organizations*
  - *Hospitals and public health always included (except Bernalillo)*
  - *Pueblo: Signed commitments to a work plan*
  - *Pueblo: External integrator's board requires CEO level participation from partners*

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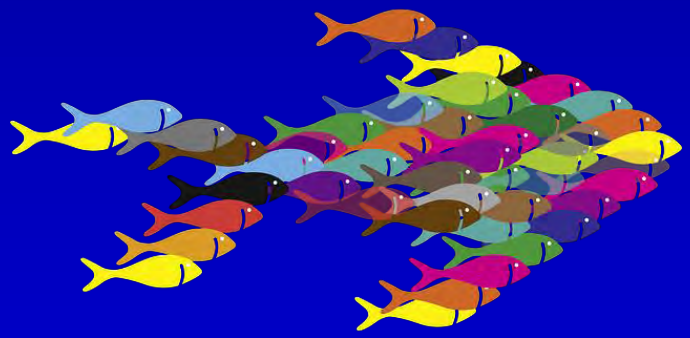
# Assessment, Planning, and Comprehensive Strategies

- Engages all partners in a process for assessing and planning health improvement approaches, as well as implementing a comprehensive set of strategies that span the Spectrum of Prevention



**Spectrum of Prevention**

- Influencing Policy and Legislation
- Changing Organizational Practices
- Fostering Coalitions and Networks
- Educating Providers
- Promoting Community Education
- Strengthening Individual Knowledge and Skills

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# Data, Metrics, and Accountability

- *The exchange of health and community data useful for assessing and developing strategies to improve population health.*

- San Diego: Data central to planning, evaluation, and communications. Public annual reports on progress.

- Pueblo: Hospitals share proprietary data with other sectors to measure success

- Lane: Health plan receives incentivized awards if it meets metrics

# Community Resident Engagement

- Prioritizes authentic community participation throughout assessment, planning, implementation, and evaluation processes
- Lane: Community Advisory Council has representation on executive board
- Overall, community participation is far more likely to involve “grass tops” than grassroots.

# Funding and Sustainability

- Fosters sustainable and generalizable delivery and financing models that support and reward improvements in population health
  - Bernalillo: Set-aside portion of mill levy funds integrator
  - Pueblo: Grant funded, contract work
  - Lane: Global Medicaid payments, set-aside for prevention
  - San Diego/Summit : County general funds, grants

# Vermont Sites

- Franklin and Grand Isle Counties
- Northeast Kingdom
- Chittenden County
- Windsor County
- Upper Connecticut River Valley
- Windham County

# Integrators

- Franklin and Grand Isle Counties: Northwestern Medical Center
- Northeast Kingdom: Northeastern Vermont Regional Hospital
- Chittenden County: Regional Planning Commission
- Windsor: Mt. Ascutney Hospital and Health Center
- Upper Connecticut River Valley: ReThink Health UCRV
- Brattleboro: Brattleboro Memorial Hospital (planning)

# Priorities

- Healthy lifestyles
- Access to mental, behavioral, social, and economic services
- Substance abuse treatment
- Poverty – housing, economic development, jobs
- Aging in Place

# Partners

- Hospitals, FQHCs
- Public Health districts
- Social Services, AAA, other service providers
- Regional Planning
- Business community, media

# Strategies

- Individual and group health education
- Service referrals – working with CHTs
- Model organizational practices to promote healthy lifestyles
- Regional plans, local tobacco policies, state sugar sweetened beverages tax

# Funding

- In-kind staff contributions
- Monetary contribution by hospital
- Grants

# Building Blocks in Vermont

- Communities organizing around ACH concepts
- The right size for innovation
- Communities taking action to create healthy environments
- Vermont Blueprint for Health
- Hospital system leadership

# Recommendations

- Foster an overarching statewide approach to support ACH effectiveness
  - Provide guidance to enable regions to effectively establish ACHs
  - Build capacity and create an environment of ongoing learning - RFP
  - Explore sustainable financing models for ACHs
- Build on existing community structures and relationships

# Ensuring a Strong Role for Community Prevention in the ACH

- Make the co-benefits for multi-sector partnership explicit
- Promulgate a comprehensive framework for population health
- Establish a set of core community level metrics for use by communities
- Cultivate leadership

# Planning to Support an Accountable Health System

# Issues to Consider for 2017

- Payment for PCMHs
- Payment for support services (CHT, SASH, Hub & Spoke, other)
- Support for transformation network (PMs, PFs, CHT leaders)
- Support for self management network (HLWs, DPP, Tobacco, WRAP)
- Data quality, aggregation, management, and linkage
- Comparative analytics, reporting, and learning forums
- Program positioning

# Questions & Discussion