CalSIM Accountable Care Community Work Group
Wednesday, April 9, 2014
Conference Call

-- NOTES --

Attendees: Jeremy Cantor, Prevention Institute; Ron Chapman, CDPH; Allison Fleury, Sharp Healthcare; George Flores, TCE; Liz Gibboney, Partnership Health Plan; Laura Hogan, Consultant; Laura Jones, Santa Clara Health and Hospital System; Beth Malinowski, California Primary Care Association; Barbara Masters, CalSIM; Mary Pittman, Public Health Institute; Steve Ramsland, Redwood Community Health Care; Loel Solomon, Kaiser Permanente; Marion Standish, The California Endowment; Anne Sunderland, Public Health Institute; Jessica Tomlinson, Public Health Institute
Scribe: Sonia Robinson

I. Background and Meeting Overview:

Barbara Masters noted that she had sent many materials out for this meeting. The expectation is not that work group members would have read all the materials, rather that they would have them in case they are interested.

Today the goal is for the work group to see if there are any questions from the last meeting, review and prioritize research/information gathering questions, and discuss what kind of data could be gathered and shared in an ACC. Laura Hogan is conducting preliminary research on this last topic and will share some of her findings. Afterwards, the work group will review Massachusetts' recent Wellness Trust grants to nine collaboratives. Lastly, if work group members are receiving questions from stakeholders about this process, please refer them to Barbara Masters.

II. Questions

Work group members wondered if there has been any update from CMMI. There has not, but CalSIM has been reassured that the testing grant is coming out. Work group members also wanted to ensure "cross-pollination" with other work groups – this will be done as appropriate. There were no comments on the notes.

III. Review priority research topics and workplan

Six priority research questions were identified during the last meeting:

1. **Data Sharing:** What kinds of data can an ACC be reasonably expected to collect or share among partners to advance the goals of an ACC, how can population and aggregate health system data be linked, and what are potential mechanisms for sharing such data?
2. **Other SIM models:** What are other states' models or proposed models that are similar to the CA ACC? How have they approached key issues, such as the cost of implementation, the boundaries and optimal size of an ACC, focus on a particular disease or condition, the integrator function, financing, etc.
3. **Literature Review and analysis regarding evidence base and ROI:** Where is there the strongest evidence linking particular interventions with ROI? Is there sufficient evidence

to include all three potential conditions in the Innovation Plan – and linking both population health and health care interventions to ROI?

4. **Nexus between secondary and primary prevention:** What secondary prevention interventions, which are necessary to achieve a three-year ROI, can help advance/lead to primary prevention? How should ACC's be structured to achieve both?
5. **Financing templates/models:** What are potential payment reforms/financing mechanisms that an ACC could consider, particularly as they relate to shared savings?
6. **Governance models and structures for a Community Prevention and Wellness Fund:** What are governance options for a Wellness Trust and what are the legal and policy issues associated with a Wellness Trust receiving funding from various sources, such as a portion of federal and/or state grants, a portion of a hospital's community benefits, etc.

Work group members suggested asking other states about their nexus between secondary and primary prevention as well as their backbone organizations. Work Group members also requested that other states present to this work group on their ACC model. It was suggested that the ACC work group research what sort of technical capacity needs to be in place for a successful e-referral system. Jeremy Cantor and Loel Solomon will be assisting in researching #4, the nexus between secondary and primary prevention. Barbara Masters noted that the "Wellness Trust" was changed to a "Wellness Fund."

IV. Data needs and sharing update

Laura began talking to a few people about data sharing at the local level. She asked what data was being collected, how to establish baselines, what surveillance data existed, and how data was being shared. When folks began to discuss data sharing, they jumped to thinking that it might not be reasonable to assume that it is possible to get all payers, commercial and public, into an agreement like the ACC. Lots of people began discussing registries, which are largely provider or chronic condition specific – sometimes registries may be payer specific. Registries are constructed to meet needs of a single provider or research question; they are not designed to think about improving the population's health. Some things are already in place, for example, the Integrated Healthcare Association (IHA) is able to calculate total cost of care for commercial payers. IHA works with managed care plans to figure out pay for performance models. IHA is able to share scrubbed, aggregated data. However, this is typically not done in local geographies.

One question that came out of these conversations is: Do we envision that calculating an ROI will require financial information about the program, clinical information, community (built environment, etc.) data and population data? Work group members stated that as much data as possible is needed on all levels, especially in terms of data which addresses health disparities. All of these data sources will need to be triangulated. Work group members agreed that aggregating clinical data to approximate outcomes would be a good start, although one work group member questioned the difference between population and clinical data. These terms will need to be defined further. Work group members acknowledged that complete information for some indicators may be hard to obtain, and asked if there was a process for identifying potential proxy indicators. Work group members also discussed that it will be important not to be too prescriptive when deciding data needs. One work group member cautioned against trying to

collect too many different indicators, instead, the ACC should focus on those indicators necessary to calculate an ROI.

The work group then engaged in a discussion around what data was necessary to produce an ROI. One work group member argued that, although important to the ACC's mission, it is questionable whether CMMI will support tracking indicators such as number of parks in a neighborhood. Although CMMI may not see the importance of this, the work group thought it was important to push the prevention agenda a bit further. It may be important to bring a health economist on board to look at this.

Laura Hogan had asked stakeholders how many indicators they believed were reasonable – stakeholders indicated that about seven to ten indicators would be ideal. Laura asked for feedback from the health care representatives in the group. One work group member emphasized that it is important to use what is already being collected, rather than adding new measures. Another work group member gave an example of a Pioneer ACO which needs to track 33 quality measures. Managing this sort of data burden is challenging – the specs for these measures are not consistent with other nationally reported data. One advantage, however, is that these measures are uniform across all the Pioneer ACOs. It is not recommended that communities define what measures they are interested in. One work group member recommended that communities build on state level data or infrastructure that already exists.

To summarize, the work group has agreed that it will be necessary to address transparency and consistency across all of the four parameters. The four parameters will need to be defined further. All payers should participate. It is ideal to narrow the data requirements as much as possible and still attend to ROI and primary prevention. It is important to look at both total cost of care and quality of care to be able to calculate value. Also, each county will have a different payer make up; the complexity of the health care system will vary in each community. This should be taking into account as well.

V. Massachusetts Prevention and Wellness Trust Fund grants

Massachusetts has funded nine collaboratives for four years with their Wellness Trust. They are granting a total of $42 million over four years. In the first year, they are granting $250,000 per collaborative and then, in years following, the amounts range from $700,000 to $2M per collaborative per year. Massachusetts specified that collaboratives needed to be in a clearly defined geography with no fewer than 30,000 people and no more than 120,000 people. They also asked collaboratives to focus on two of four priority conditions, including pediatric asthma, hypertension, tobacco, and falls among older adults. Obesity, diabetes, substance abuse, oral health and mental health were included as secondary conditions. Massachusetts required that collaboratives formed partnerships with community organizations, local health departments, public health, etc., and required that each collaborative conduct a project which addressed clinical, community and "linkage" (both clinical and community) interventions.

It may be worth discussing the following with Massachusetts:

- How they arrived at this population size,
- How they chose the priority conditions and what they are measuring,
- How they are calculating ROI,

- How they define an “anchor” institution, and
- How they define “linkage” interventions

Barbara Masters will pursue a conversation with them, and see if someone might be able to join a subsequent workgroup call.

VI. Responding to Inquiries

If any colleagues are asking about the ACC, please refer them to Barbara Masters on an ongoing basis.

VII. Next call and schedule. All calls at 2 pm

The next call is on May 7.

Future calls will be on the following dates:

- June 11
- July 9
- August 13
- September 10
- October 8