CalSIM Accountable Care Communities
Work Group Meeting
Wednesday, June 11, 2014

-- NOTES --

Attendees: Marice Ashe, Jeremy Cantor, Laura Hogan, Beth Malinowski, Barbara Masters, Leslie Mikkelsen, Mary Pittman, Pat Powers, Steve Shortell, Loel Solomon, Marion Standish, Heidi Burbage

I. CMMI State Innovation Model Round Two FOA

California is thrilled to have the funding opportunity announcement (FOA) in hand. The grants will be between $20-100 million based on population size and the complexity of proposal. Funding will be available over a four year period, starting January 2015. Awards are expected to be made in October 2014. Before awards are made, there will be a review process with state representatives and select stakeholders.

The proposal is due on July 21st and will be written around the California Health Care Innovation Plan. The California Health and Human Services Agency will host a stakeholder webinar on the proposal some time after July 1st.

A new addition to the FOA is a requirement for a population health improvement plan to promote greater collaboration and integration between public health and health care. California will build off of the work set forth by The California Wellness Plan and Let's Get Healthy California, paying particular attention to specific interventions related to tobacco, obesity, and diabetes as requested by the FOA.

CMMI would like to see that the financial analysis and savings estimates are certified by an actuary. This will be challenging as many of the initiatives are experimental. The initial financial analysis did not include savings estimates for ACCs because the initiative has not yet been clearly defined and because it will be piloted in three communities, not statewide.

Secretary Dooley requested letters of support from organizations participating in the work groups. If any there are any specific questions about the letters of support, which are due July 3, Pat, Barb, or Sonia will be happy to address them.

II. Wellness and Prevention Fund

The concept of an ACC pilot program contains two elements: an ACC and a Wellness Trust. Although initially referred to as a Wellness "Trust", the work group subsequently recommended calling this a Wellness "Fund", since a Trust is often used to describe a protected fund with a dedicated revenue source, such as the Social Security Trust Fund or the Massachusetts Prevention and Wellness Trust Fund. There are a number of governance and structural issues associated with a Wellness Fund to be developed:

1) What are governance options for a pooled wellness fund to support and sustain the ACC and prevention activities over the long term (e.g., community foundation, nonprofit, health care entity, etc.)?
2) What should the fiduciary and governance standards and practices of a Wellness Fund look like?
3) What are the legal and policy issues associated with such a fund receiving resources from various sources, such as a portion of federal and/or state grants, a portion of a hospital's community benefits, etc.?

ChangeLab Solutions is being asked to conduct research on these issues and joined the call to solicit preliminary input to guide its research, including feedback on the governance and structural issues, as well as what core questions the group would like to know about wellness funds. Several topics were mentioned:

- Workgroup members discussed the role of the Backbone/Integrator entity and whether it needs to serve both as the fiscal agent and as the governance structure for the ACC. The governance function would make decisions on where the money goes while the fiscal agent would manage the funds. Work group members agreed that it would be valuable to look at the pros and cons of having one entity serve as both the fiscal agent and the governance structure. For example, if there are two separate entities then there are transaction and coordination costs, and that allows an opportunity for a different interpretation of the money flow. Mary Pittman will share some examples in the literature with Marice.
- Work group members also discussed the core competencies of a fiscal agent. Examples included the ability to manage funds across multiple funders and time periods.
- It had been discussed previously that an organization should have visible and robust community-level input. The work group should spend some time defining community representation as there are many different models, for example, community representatives could be involved in the decision-making process or they could serve as the fiscal agent, managing pooled funds. While the Backbone/Integrator entity should have experience working with government and non-government organizations and negotiating contracts, the role of community members would be to offer advice regarding practice or strategies.

This research will have to be done by late fall so that in January 2015 the state can "hit the ground running" in the first planning year of the testing grant.

III. Comprehensive Portfolio

Barbara Masters set up a matrix to reflect a comprehensive portfolio of interventions. The matrix was shared with work group members prior to the meeting to solicit feedback. Beth Malinowski sent the matrix to CPCA members and will be receiving feedback later this week.

The left hand side of the matrix covers five different dimensions of interventions:

1) Clinical: This domain primarily covers secondary interventions such as disease management. The care team also resides in the clinical realm.
2) Community: Examples of this domain are community programs and social services, such as the YMCA and workplace wellness campaigns.

3) Linkage between community and clinical domains: This dimension is present in the CMMI FOA. Examples of interventions in this area are CHWs, different types of referral systems, and e-referrals.
4) Public Policy: Legal and regulatory changes such as smoke free environments, etc.
5) Systems and environments: These are more upstream interventions necessary to promote population-wide healthy behaviors (e.g., walking and bike trails).

Work group members had several comments on the proposed matrix:

- Should the linkage area be a way to connect the clinical and community pieces or be its own domain?
- Organizational practice change is not represented on the matrix and should be.
- Policy changes often drive changes in systems and environments.
- Partnership network development could be called out.
- The indirect or social network also affects an individual's health.
- Some interventions are interrelated and include multiple domains.
- The clinical setting should also include primary prevention (e.g., prenatal care, dietician appointments).
- Add an additional column which specifies if an intervention is short, medium or long term, what the ROI is, and the degree of certainty regarding the success of the intervention.
- Identification of the complementarity between the different levels of intervention – how might they interact to form a whole strategy
- The matrix does not identify patient populations.

One way to test this matrix is to think about if the matrix covers the range of interventions needed for a sample population. For example, if you think about the pre-diabetic population in a given area, how would the various strategies help keep that population from becoming diabetic? What is the pathway to help people stay well?

Barb will update the matrix once she has received feedback from the clinics and the health centers early next week.

IV. Name: Accountable Care Communities versus California Accountable Communities for Health

Barbara observed that other states, and potentially CMS, are moving towards having the name "Accountable Communities for Health" or something related. Overall, work group members liked this name and agreed to change the name of the ACC initiative to California Accountable Communities for Health.

V. Conclusion

Barb will send out notes from her call with Minnesota regarding their implementation of Accountable Community for Health ~ their approach is very different from Massachusetts.