NOTES
CalSIM Accountable Care Communities (ACC)
Rapid Cycle Work Group
January 28, 2013

Attendees: Allison Fleury, George Flores, Barbara Masters, Connie Mitchell, Mary Pittman, Steve Shortell, Marion Standish, Anne Sunderland
Scribe: Sonia Robinson

I. Overview of Agenda

Work group members welcomed Allison Fleury from Sharp Healthcare to the group. Agenda items for today's meeting include:

1. Review the criteria and goals/outcomes matrix. Provide an opportunity for Allison to comment on what has been developed so far.
2. Brainstorm questions and issues that the group needs to know more about to inform the RFP and to guide the implementation of pilot ACCs. For example:
    a. What are potential governance models of an ACC within the public, nonprofit or health care sectors?
    b. What examples exist for determining shared savings that are most applicable to an ACC and how might they be expanded to capture impacts in the non-healthcare sector?
    c. What are the essential roles and qualities of an integrator/backbone organization?
3. Discuss a potential half-day in person meeting on February 12th to accelerate the progress of the work group and to enable drill down on several issues (e.g., the design of the ACC, the "backbone/integrator" entity, what type of tool kit might be helpful, etc.). The California Endowment in Oakland has offered to host the meeting.

Barbara Masters then asked the work group if there were any questions or comments related to the agenda. Work group members asked for clarity around the timeline for the proposal. California is currently waiting for a funding opportunity announcement for a State Innovation Model Testing Grant from the Centers for Medicare and Medicaid Innovation Center (CMMI); this announcement should be released either this week or next week. The grant proposal will be submitted in April. It is anticipated that CMMI will take several months to review the application and a decision will hopefully be made regarding the Testing Grant by fall. This work group hopes to develop the concept of the ACC pilot and draft the request for proposal (RFP) for an ACC, therefore, when California receives a three-year testing grant it can begin with implementing an ACC.

Work group members also wondered how much time it would take between the state issuing the RFP and the money "hitting the ground." This has yet to be determined.

II. Review of the Criteria and Goals/Outcomes Matrix

This work group has put together draft criteria for ACC applicants as well as a goals/outcomes matrix which is intended to identify the outcomes, structure and financing for an ACC. This process has been challenging because SIM grantees are expected to demonstrate a return on investment (ROI) in three years. The matrix defines goals over the short-, medium-, and long-term, acknowledging that many prevention efforts may take longer than three years to demonstrate an ROI. This matrix is very high-level and the actual pilots would have more types of outcomes and indicators to define success.

The work group has also put together a second document on the criteria for applicants. The goal of these criteria is to set a high bar – there will need to be a high degree of readiness to ensure success in the 2-3 pilot sites. These sites will serve as a proof of concept for better integrating public health with the health care delivery system to achieve higher outcomes.

One work group member commented that they would like to see how patients would be identified as well as what measures would be used to document progress (e.g. hemoglobin levels for diabetic patients). ACC pilots will need to choose one of four chronic conditions to focus on and develop a community-wide intervention plan for that chronic condition.

Another area of concern is how an ACC would cover 75% of the population in a given area. The Akron model managed to cover 80% of the population, including the uninsured. This is what the geography requirement is trying to convey. For a large urban area, there would be many challenges in covering this much of the population, for example, how would data be shared and aggregated? This may be one of the functions of the integrator/backbone function. Work group members discussed the possibility of changing the population requirement to be 75% of the people with a given chronic condition (e.g., diabetes or asthma). The ACC would then focus on secondary interventions within the first three years. An ACC would later expand to cover people who are on the cusp of a diagnosis.

One work group member expressed that improved community conditions (e.g., increasing the number of walking paths) should be a short-term outcome. There was concern that measuring these sorts of community changes are a process measurement rather than an outcomes measurement. Work group members also discussed the challenge of collecting information on the outcome for community interventions (i.e., number of patients engaged in the program who are walking more). Connie Mitchell who oversees the Health in All Policies Task Force and Health Community Indicator project knows of existing modeling that predicts the medium to long-term health impacts of changes in the community. This sort of predictive modeling will allow ACCs to make an association between changes in the community and changes in health status. This will allow communities to say that what they did was intentional and holds promise

for the rest of the state. Connie will forward an article to the group. It would also be useful to have comparative data from the rest of the state.

Another member encouraged the work group to try to use patient reported outcomes (e.g., physical functioning, depression) when possible. It would also be good to reinforce measures around mental health.

III. Brainstorm Research Questions

Work group members then brainstormed research questions which would aid in the design and implementation of ACCs. These include:

- Looking into the Community Transformation Grant (CTG) experience. Counties with CTGs have established relationships with community, clinic and local health departments. Reconnaissance of what these structures look like and what data is being collected would be useful.
- More information on the wellness trust concept.
- What the size and location of a target population has been in prior models and how to determine what this is.
- What sort of curriculum is needed to inform providers on how to implement changes, what investments should be made to change practices.
    - UC Berkeley is currently analyzing national survey data from 170 ACOs around the country. They may be able to assist with these sorts of questions.
- Models for health information exchanges and data sharing.
- Assess what sort of support and technical assistance will be needed to create learning materials and deliver curriculum.
- What tools are most effective in getting patients to respond/increase health literacy.
- How to incorporate community health workers and promotoras, and if there should be standardization and certification.

IV. In-Person Meeting

The February 12th date will not work with many work group member's schedules. Barb will send out a Doodle poll sometime in the next week to see if there is a better date for an in-person meeting in February.