CalSIM Accountable Communities for Health
Work Group Meeting
Wednesday, August 13, 2014

-- NOTES –

Attendees: Barbara Masters; Dana Moore; Laura Jones; Beth Malinowski; George Flores; Liz Gibboney; Stephen Shortell; Thomas Huber; Laura Hogan; Leslie Mikkelsen; Mary Pittman; Pat Powers; Caroline Peck; Connie Mitchell
Scribe: Jennifer Bernstein

I. Research Update

The Berkeley team described a matrix, based on the matrix developed by the Workgroup, they will be using for a literature review of the evidence supporting California Accountable Communities for Health (ACH). They are reviewing evidence for diabetes, asthma, and cardiovascular disease. Although they are focusing primarily on adults, some seminal interventions around pediatrics will likely be captured. The setting of intervention will be captured as clinical, community wide, a combination of community and clinical linkages, or at the policy/systems/environment level. The evidence will be categorized in terms of its strength and how widely it has been distributed. The team will also try to see whether the literature says about the uptake and dissemination of intervention across populations, and whether it limited to a single organization or a single area of a community. In terms of the time frame, the team will be making an assessment of the outcome change or cost as being short (1 to 3 years), medium (4-7 years), or long (8-10 years). The review is particularly focused will include not only single interventions, but also two or more, such as is being discussed as part of a portfolio of interventions. The team believes that evidence favors multiple reinforcing interventions or portfolio approaches. Information about metrics will also be collected, including clinical and patient experience outcomes, although the latter may be scarce. ROI will be also examined, as well as data needed to generate the indicators of success. Some additional criteria will include ease of implementation, impact, and ease of scalability. The interventions reviewed will be given an overall grade.

In response to a question about the overarching goal of this literature review, it was stated that the results will allow the work group and the state to assess what types of interventions are most likely to produce the desired results and will inform decisions about how prescriptive or flexible the RFP should be. For example, Massachusetts was explicit in requiring applicant communities' to only include interventions that have a strong evidence base and which interventions that met criteria. The CalSIM work group also wants to be able to help potential sites know what evidence exists as each site shapes its application and set of interventions. The literature review will also be helpful for evaluating and tracking progress and outcomes over time.

Workgroup members noted that the work done around healthy food, activities, and environments has been primarily about children, but some of it can apply to adults as well. It was suggested that the literature review doesn't overlook a decade of work

because it focused primarily on children. Other workgroup members suggested studies that have found strong evidence nurse-family partnerships as well as any studies related to trauma-informed interventions related to Adverse Childhood Experiences (ACES).

The review is also going to include "grey literature" in order to capture evaluations and other analyses that may not have been reported through a peer reviewed journal or may still be in progress.

In addition to the PubMed search, the team is looking at CDC, NIH, AHRQ, IHI, Kaiser, and bigger organizations around chronic care management. Already 1261 articles for diabetes, 355 for asthma, 848 for cardiovascular disease have been uncovered for the past ten years. After the initial screen, the good candidate articles will be filtered through the matrix to be completed in the next couple of weeks. The team will also be talking to a list of key experts. By the end of this month, there should be an outline of findings. By the end of next month, there should be a graph of findings from the PubMed search and grey literature. Work group members should send any additional information about evidence- based interventions to the Berkeley team for review.

It was stated that the main purposes of this project, which will ultimately be developed in an easy to read guide, is to help the sites develop portfolios of intervention so that they may have the benefit of knowing what the literature says, and to make sure they have knowledge about where there might be a complementarity of intervention. The group agrees that there is no one single intervention that can get to the kinds of outcomes of cost and quality and population health goals in the short terms and put the community on the path to getting medium and long term outcomes as well - having this sort of data in one place will be very helpful for communities in designing their strategies.

In response to a question, it was noted that the SIM testing application will be made available in the Fall. One of the challenges is that each initiative and building block is at a developmental stage and are being fleshed out in parallel. Once a grant is awarded, it will be possible to clarify the potential synergies across initiatives and building blocks.

II. Webinar and Information Gathering Form

There has been a lot of interest in the ACH, and Barbara suggested that it would be a good time to share early deliberations of the workgroup with the broader community. This will help inform people of what we are doing, clear up any misperceptions, and solicit additional thoughts or ideas. It will also enable potential communities to learn more about the concept of an ACH so they can begin to think about whether or not they would be a good candidate for the project. If and when the SIM grant is awarded, the state hopes to move quickly to develop an RFP and solicit applications in order to select pilots to give them the maximum amount of time to plan and implement its activities.

The state is looking to host a webinar at the end of September and to send out a notice after Labor Day through the CalSIM process and through work group members'

networks. In order to inform the workgroup about the potential level of readiness of communities, a short information gathering form has been developed to gather information what is happening around the state. It should be relatively short to make it easy for communities to fill out. The intent is that it would be sent out in conjunction with webinar.

Workgroup members shared feedback and suggestions about the information gathering form:

- Include a paragraph describing the ACH.
- There might be a need for a bit of definition/guidance on what is meant by "formal" - what is the distinction in terms of how to respond? (#7 on the form) *NOTE: this will be changed in the revised form*
- There is not a clear indication about sharing governance, about allocating funds. Are they collaboratively funding any prevention or community efforts outside of clinical interventions? This is the additional step that makes the ACH unique: extending beyond clinical settings.
  NOTE: this form is to assess current activities not a potential ACH.
- It was suggested that the form should explicitly ask about the health component of the initiative; for example, the form might ask "Does this program target diabetes, obesity, etc…?"
- The form should include the name and age of the project; for example, when it was accomplished - 20 years ago, or is it more current?

It was pointed out that people will not be asked about what they *could* do as part of an ACH, but rather about what is already in existence that might be a good foundation for becoming an ACH. Members are encouraged to send more thoughts to Barbara Masters.

It was also suggested that the webinar actually paint a picture of how an ACH might operate using a condition/intervention/community that could work as an example for people to follow ~ in other words a model example. Another issue that ought to be conveyed in the webinar is the message that we expect there to be full cooperation for an active community learning around this. Progress should be shared in real time so that other communities can benefit - not just the few communities that get funded. That's key to sustainability and replicability.

There is a goal of making a final report by the end of the year, which means there are only one or do remaining working sessions. The group discussed whether there are any key topics that need to be covered.

- It was suggested that some time is spent on the topic of payment reforms next week.
- Elements in the application for the other programs such as Health Homes, or Community Health Workers. When the application narrative becomes available some time should be spent analyzing it for leverage points.
- There could be some discussion about the role of community assessment planning and community engagement as part of the vision for sustainable ACH.

- Looking at the program design and portfolios of intervention, community and social service programs deserve more fleshing out.
- Connectivity to the workforce as well as the data and the information systems will be necessary to get a good sense of how it all hangs together.
- Elements of behavioral health should be included.
- Making health equity explicit may be important as we talk about the model. It was fundamental in the original LGHC. This group should be able to demonstrate within the health issues being addressed that the disparities have narrowed, stayed the same, or gotten worse.
- Part of the challenge in a multi payer initiative is that the model will need to encompass payers and providers in that community that expand beyond safety net. There needs to be a guard against only wealthier folks being better off.

III. Conclusion

Another work group call is scheduled for next month, and it was suggested that in-person meeting should be held in November to review the draft report. Workgroup members agreed. Barbara indicated that a Doodle will be sent out to find the best dates for workgroup members.