CalSIM Accountable Communities for Health
Work Group Meeting
Wednesday, September 10, 2014

-- DRAFT NOTES –

Attendees: Marion Standish**;** Barbara Masters; Dana Moore; Beth Malinowski; George Flores; Stephen Shortell; Loel Solomon; Leslie Mikkelsen; Mary Pittman; Alison Fleury; Jeremy Cantor; Keith Nagayma; Marice Ashe; Thomas Huber; Neil Sehgal; Laura Hogan; Caroline Peck; Connie Mitchell

I. Review notes from August meeting

No changes or additional input to the notes.

II. Research update

A. Literature Review Dr. Shortell and his team provided an update on the research they are conducting regarding the evidence base for interventions related to asthma, diabetes and cardiovascular disease. They have reviewed the literature for each condition and have narrowed down most impactful interventions to a list of 40. They are looking at the formal literature as well as the gray literature, which many workgroup members have suggested. Dr. Shortell reported that they are now working on the cross tab view to present settings of the interventions as well as the difficulty implementing. Their next steps are to move to questions such as: What data are needed and what ROI are expected?

In response to a question about methods and what definitions they are using for systems and policy, Dr. Shortell responded that policy is when a civic or governmental body must do something, such as whether a city must make a regulatory change to expand green space for physical activity. Systems refer to community organizations or groups of organizations Also, with regard to how they are assessing the difficulty of implementation, Dr. Shortell indicated that if it was expensive, required specialized training or skills, or required behavioral change by individuals or organizations, it is considered more difficult to implement. Conversely, if the intervention is inexpensive or can rely on resources already in the community, it is considered relatively easy to implement.

Another question was asked about what is considered a clinical-community linkage interventions. For example, if a diabetes workshop is offered by the YMCA but not connected via referral to a clinical program, would that be included? Dr. Shortell responded that that would not be considered a linkage intervention. They are looking for interventions that are implemented with community and clinical strategies in tandem, such as a clinical program with promatores/lay health worker implemented together. In asthma collaboration, there was a clinician-CHW dual stream intervention included. If there is only a clinical or only a community intervention, it was not included here.

The Workgroup then discussed how the literature review will address the layering of interventions. That is, what is known about the power of combining interventions? Dr. Shortell responded that this is still somewhat speculative but it is on the radar screen for their review. Even if there isn't any literature that directly has studied this, they can look at the

potential for an additive value of a combination of interventions. They have also identified four articles, which they will be analyzing, that includes some dose reporting.

With respect to the timeline for interventions, Dr. Shortell responded that most evaluations only follow the period originally funded and don't follow the project long term. They will be making some inquiry to see what has been sustained.

It was also clarified that the results of the literature review is intended to be available for grantees so they will not have to repeat this inquiry as they design and implement their ACHs.

B. Models and governance issues related to the Wellness Fund.

Representatives from ChangeLab Solutions reported that they are conducting a neutral inquiry to look at legal issues and relationship associated with the backbone organization and Wellness Fund. Their approach is to not necessarily look for a single model but rather a presentation of pros/cons of different approaches for communities to consider. For example, could there be a partnership among different entities to divide up the roles? ChangeLab Solutions walked through the four models described in the memo and asked whether Workgroup members know of other models, kinds of organizations/institutions that could serve as a backbone, Wellness Fund or both, as well as any additional fund contributions that should be explored.

The Workgroup discussed whether a for-profit or LLC entity could serve as the Wellness Fund or Backbone? For example, a non profit may have limitations on having physician groups or other for-profits organizations as members. An LLC could serve a non-profit purpose but could provide more flexibility. Is there an analogy to ACOs? Most Pioneer ACOs are not new legal structures, but rather have the same structure as parent entity. Also there are nonprofit ACOs as well as for-profit ones. It's important to know that ACOs required a lot of waivers to allow incentives and payments to be established.

Workgroup members discussed how closely leadership and governance need to be connected to contributing money into the Fund. A concern was raised that if 2-3 entities are making decisions, that may be too limited to attract a broad base of contributions. The Workgroup also discussed potential conflicts that exist. ChangeLab Solutions responded that they are exploring potential conflicts associated with different models.

Workgroup members inquired as whether the Wellness Fund could also be used to obtain funding to conduct drug research or testing; alternatively it was suggested that maybe some new technology could become a source of revenue. Other workgroup members stated that the primary goal of the Wellness Fund should be to support prevention activities because there is so little other resources for these activities.

III. In person meeting

In person meeting is confirmed for November 13 in Sacramento. Next ACH workgroup call is October 8.