Population Health Planning Advisory Group
November 17, 2015
Meeting Notes

TOPIC	DISCUSSION
Welcome Amy Rohling McGee Greg Moody	Dir. Greg Moody (Office of Health Transformation) reviewed the process for the meetings and for soliciting feedback from the population health advisory and infrastructure groups. He noted that the process is not meant to get complete agreement, but rather get a sense of where there may be general consensus. Amy Rohling McGee (HPIO) reviewed the objectives for the meeting. Materials from this and prior meetings are available here: Population Health page
Population health planning infrastructure framework Reem Aly Amy Bush Stevens	Amy Bush Stevens and Reem Aly (HPIO) reviewed the population health planning infrastructure framework recommendations as well as the recommended timeline for implementation of these recommendations. Both documents are available here under Meeting 4 materials. Rohling McGee discussed how feedback from Advisory Group and Infrastructure Subgroup meetings was integrated into the framework recommendations. Beth Bickford (AOHC) said she is not sure that the timeline recommended reflects what was discussed at the November 10 infrastructure subgroup meeting. Rohling McGee noted that in addition to feedback received from the Infrastructure Subgroup, HPIO thought about how to overcome the challenges that were discussed. Aly explained that the timeline provides flexibility on when assessments and plans are conducted, but ensures state and local-level alignment in the years covered by the plans. Aly also enumerated that a benefit of this recommendation is the ability for the state and communities to track outcomes and evaluate progress at consistent intervals of time. Group members noted concern with the term “subsidy” in the Funding section of the framework (3a), which is often used to refer to the state’s current funding stream for LHDs. The language in this section of the document has been revised to clarify that the recommendation is referring to additional rather than current state funding. Aly noted that following discussion in the Infrastructure meeting,

	the community benefit reporting section was expanded to include the "cash and in-kind donations" category as well as the community health improvement services (CHI) category reflected on Part I of the Schedule H form. Marie Curry (Community Legal Aid Services) asked if will there be a recommendation around the specific amount of community benefit encouraged for these two categories. Dir. Moody said that in the final report HPIO will provide possible scenarios for setting the community benefit amount for these two categories. The state will then circle back to stakeholders when issuing guidance. Dir. Moody emphasized that transparency is the most important next step. Aly reviewed the recommendation around Schedule H reporting and clarified that government hospitals required to comply with the IRS community health needs assessment requirements would also need to submit equivalent information to the state. Sarah Durfee (OPERS) asked if the information from Schedule H would be easily accessible to the public. Aly said that the specifics of how Schedule H information is reported by the hospitals and made available to the public could be addressed through the guidance/specific requirements, and that item 4b in the framework document could be updated to include "state provides online repository of Schedule H and equivalent information" (revised version posted here). Jim Misak (MetroHealth) noted disappointment that several recommendations are "guidance," and said there will have been a missed opportunity by not requiring more. Aly responded that more requirements could be phased in, allowing time to evaluate where requirements might be needed and where guidance was working. Cathy Levine (UHCAN Ohio) asked how long it would take to move more towards requirements. Dir. Moody responded that if the state had a great SHIP with specific priorities right now, he'd make the case for more requirements. If there is legislative will to go further with requirements, then that could be pursued. Robert Falcone (Ohio Hospital Association) asked if research is included in the community benefit recommendations. Dir. Moody said that it is included in the transparency section, as everything in Schedule H will be reported. He noted that tools can be developed to highlight how hospitals are investing their

	community benefit dollars. Every hospital can make its case for why they may be investing more than other hospitals in research/education. Aly added that the recommendations around transparency are key to ensuring that this information is available to public. Dir. Moody noted that even though this process is concluding, this group may find that they are meeting again in the spring around SHA/SHIP planning. Rather than starting over, the state can use this group as a starting point. He said the goal is to firm up guidance by June 2016, and he would love to find a legislative vehicle and have something enacted by June as well.
PCMH model design update and "focus group" on preliminary PCMH quality metrics Greg Moody Chiara Leprai Sophie Clarke	Dir. Moody explained that in the process of reallocating state resources into primary care, the question is: "What do we want to buy?" He noted the need for improved quality and lower total cost of care. He also stated that the primary care model design has changed a lot based upon input from this group and other focus groups. He also noted that they are keeping in mind the question of "How do you encourage "unsophisticated" practices to transform while also rewarding those that have already transformed?" In the PCMH model design document, red font indicates important elements that were added along the way. In the care delivery model, three payment streams are available to everyone: practice transformation, new clinical activities; and outcome-based payment. Dir. Moody stated that there should be additional payment for new clinical activities and outcomes (meeting objectives and reducing total cost of care). There should be a way to support practices that need resources to get started, but also reward those that are already achieving results. Chiara Leprai and Sophie Clarke (McKinsey & Company) reviewed clinical quality measures tied to the PCMH model (see handout, also attached to pre-meeting email). They noted that all of the top ten population health priorities are addressed in the quality measures, with the exception of substance abuse. Leprai and Clarke indicated that they have not yet been able to find a good clinical measure for substance abuse. Leprai then asked for feedback from the group on two questions: • Do you feel that at a high level this strawman addresses population health priorities? • Are there any measures that we should replace?

	Levine said that regarding infant mortality, women should be screened for intent to get pregnant, since ideally prenatal care starts before pregnancy. Group members mentioned that injury prevention measures were missing, for example guns or seat belts. Levine mentioned that the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) could be a relevant measure related to substance abuse. Hubert Wirtz (The Ohio Council of Behavioral Health and Family Services Providers) noted that this measure should be available through claims data. Aly also mentioned specific measures for alcohol use (PQRS 173, PQRS 305 and NQF 0004). Dr. Mary Applegate (Ohio Department of Medicaid) asserted that they have not been able to find a substance abuse measure with which payers have experience. Durfee said she would challenge the team to be more outcomes-oriented in their approach to the measures, noting that most of these are process measures. She recommended looking at Catalyst for Payment Reform's recently recommended quality measures. For example, CPR has a recommended measure related to optimal diabetes care. Clarke noted that the big challenge is that they are using claims-based measures that tend to be more process based. Durfee suggeseted that eventually these measures should not be limited to claims data. Clarke said that in focus groups providers raised similar concerns about the need to move to measures that were not solely claims-based. Dr. Ted Wymyslo (Ohio Association of Community Health Centers) noted the need to start somewhere, but desire to move toward outcomes over time. Terry Allan (Cuyahoga County Board of Health) suggested looking at Healthy People 2020 for measures. He also asked if they will be tracking demographic measures like income and race. Leprai said that over the long term, they would look at outcomes and evaluate based on income and race. Wally Burden (Pike County General Health District) asked why

	adults rather than adolescents where targeted on some measures, particularly tobacco. Dr. Applegate noted that screening for tobacco use should be part of the adolescent well-care visit. Reina Sims (Ohio Commission on Minority Health) said cultural competency needs to be interwoven more throughout the design. Curry asked if there will be additional measures related to other domains, noting that she was specifically concerned about cultural competency measures. She noted that she would like to have a better idea of what measures will be used to capture disparities and social determinants of health. Dr. Wymyslo noted the need to universally ask people the same questions. He asked what agreement exists on what should be capturing in terms of demographics. Applegate proposed that the model call out health equity as a separate component in the care delivery model to ensure that it is addressed. Dr. Greg Weaver (Senders Pediatrics) expressed concern about using the adolescent and child well-care visits as proxies for other measures (e.g. tobacco use). Weaver noted that primary care would have more engagement if age cut-offs were adjusted; there is no handoff or continuity when patients reach 18. Rohling McGee agreed with Burden's earlier comment about including a measure related to adolescent tobacco use. Given the fact that Ohio performs poorly on several tobacco-related metrics and that tobacco use results in many negative health outcomes, she argued that adding an additional tobacco-related measure is warranted. She also stated that the selected metric (NQF 0028) is focused on screening and cessation (defined as 3 minutes or less of counseling and/or pharmacology). She said that she doubts that screening and 3 minutes or less of counseling has much impact, but that the group should not to let perfect be enemy of the good. Kate Keller (Interact for Health) and Levine asked about including dental concerns. Dr. Applegate responded that primary care providers' did not have direct ability to influence dental care. Jodi Mitchell (Health Action Council) noted that purchasers can

	influence the payers. J.D. Whitlock (Mercy Health) said he strongly disagrees with anyone who says that this is a step backwards. He noted that it is great that payers and providers are on board, and reiterated that the group should not let perfect be enemy of the good. Applegate said the way payment is structured today is completely disconnected from population health. She wants to leverage training opportunities to strengthen this connection. Curry said she is glad to see progress and to hear that this is iterative. She would like the model to envision what Phase 2 might look like. She noted that an Adverse Childhood Experiences (ACE) tool would be a good addition because it captures a lot of good information and ways that medical providers can intervene. Wymyslo suggested documenting these ideas and concerns in a "parking lot" for consideration during the next iteration of quality measure development. He said there seems to be a lot of consensus about concerns, but also agreement that a first step is necessary. Stevens said that while she appreciates the limitations of claims data and existing clinical measures, there is no metric related to the *prevention* of type 2 diabetes. She noted that the adult BMI metric is simply documentation of BMI without follow-up or referral, and that the diabetes metric addresses A1c management for those who already have diabetes. Stevens suggested further consideration of NQF 0421 (BMI documentation with follow-up), and future consideration of a metric related to screening for pre-diabetes, which is now recommended by USPSTF, once a nationally-recognized metric for this is developed. Leprai said they never explicitly discussed that. Clarke noted that providers and payers voiced concern that the BMI measure is just "box checking," and they could take another look at that. Dr. Applegate said they want the metrics to not be too prescriptive so as to allow innovation between the provider and the payer. She noted that there is a lot of duplication in care management. Dir. Moody referred the group to the top of page three of the handout, saying that the capability and activity measures will capture this. He said that it is surprising how many primary care

	practices do not do the things that are listed on the proposed clinical quality measures. Misak suggested that maybe there should be a core set of metrics with some additional optional metrics depending on the type of practice (such as the infant mortality measures). He added that he thinks that colonoscopy should be included rather than breast cancer screening, especially given the large disparities in colon cancer. Dr. Applegate responded that colonoscopy was originally included, but was taken out because the ten-year frequency was too complex to capture with payer data. Robyn Taylor (ODH Office of Health Equity) suggested that housing, employment, education, and poverty should be added. Applegate asked, "what can primary care providers (PCPs) do to influence these measures?" Taylor suggested that PCPs can be included in local planning processes. Whitlock asked, "what would you add as a measure?" Dr. Applegate indicated that demographics would be accounted for through risk adjustment of the patient population. Roni Christopher (Mercy Health) noted that payers should be measured on cultural competency. She also said that hand offs/hand backs should be captured, and suggested tracking how referrals are working in phase 2. She noted the importance of being purposeful in these documents to spell out the hypotheses: What do we expect will happen when these metrics are tracked? Will what we're measuring result in what we want to achieve? She noted that if it is assumed that things like tobacco screening and injury prevention will be addressed in the well-child/adolescent visits, then that needs to be explicitly stated in the model because well visits vary widely by provider and this cannot be assumed. Dr. Applegate noted that the transition from youth to adulthood may be a weakness in the model, but this is a place to start. There was further discussion in the group around how and what types of demographic and socio-economic data providers in the PCMH model should be required to collect. Curry asked if demographic data was consistently being collected through uniform patient registries. Dr. Applegate clarified that the PCMH model does not include requirements for providers to capture specific demographic or socio-economic data in their register/EMR.

	Dir. Moody said that currently providers are paid to not care about social determinants of health and there is a need to re-orient that. He noted that he has a greater appreciation for the complexity of this based upon today's conversation. He stated that ideally holding the total cost of care down will incentivize providers to reach out to others to address social determinants. He also noted that some of the things that people said were missing are elsewhere in the model. This will be clearer to the group once all of the measures are provided. Krista Wasowski (Medina County Health Department) asked if they have looked at how to support PCPs in parts of the state where there are not a lot of resources to refer to for behavior change and other services. Moody said that at least we can start increasing capability on the primary care side while others work on the social determinants side. For example, as more people become covered by Medicaid and other insurance, local mental health boards can free up some of their local levy dollars to address housing and employment supports. Todd Baker (OSMA) noted concern about the timing for how this all fits together. He asked what the thought process is for how long we expect it will take before we see results. Dir. Moody said this is a reason that sometimes these things don't happen, because it is hard to motivate for a future benefit. This administration won't get credit for the value that accrues from this work. He said this is why they have built in immediate financial return for providers, in the hopes that this will impact population health. Levine thinks that we need to set higher expectations if we want to see results. Durfee noted that OPERS implemented PCMH years ago, and it has been impactful. She said many PCMH's are NCQA accredited, and we do not want to see them go backwards. She asked if there is a way for those who have gone ahead to bring others along. Dir. Moody said a lot of NCQA accredited practices are not using EHRs to their fullest potential to get to results. He agrees that the high functioning practices could help others. Durfee said she

	would be interested to hear carrier perspective in terms of differentiating levels of transformation. Dir. Moody said that they are open to further feedback on the PCMH model. Input can be sent to Dir. Moody (greg.moody@governor.ohio.gov) and Monica Juenger (monica.juenger@governor.ohio.gov). He said they will be able to share all of the detail/measures in the PCMH model, ideally by the end of the year. He also noted that the Office of Health Transformation will convene state agency leaders to plan for the next SHA/SHIP. Information from the PCMH presentation is preliminary. Documents will be made available on the Office of Health Transformation (OHT) website as they are finalized.
Next steps for connecting population health and PCMH Amy Bush Stevens Reem Aly Amy Rohling McGee	Stevens discussed the next steps for connecting population health to PCMH design, including the upstream "glide path" framework and HPIO's plan to update the Guide to evidence-based prevention. Aly discussed HPIO's interest in building out tools and technical assistance to support state and community-level health planning processes. She also discussed the next iteration of the Health Value Dashboard to be released in 2017 and HPIO's plans to track the impact of policy and programs implemented in Ohio on population health outcomes and healthcare costs in the state (see slides here).
Closing remarks	McGee wrapped up the meeting by reviewing Ohio's health challenges and hope for the work completed as part of this project. She thanked the group for its contributions throughout the process. HPIO will complete a final report on the project by the end of the year, which will be shared with the group. The Office of Health Transformation will make the PCMH model design deliverables available on their website as soon as they are completed.

Attendance

ADVISORY GROUP MEMBERS			Mtg #1	Mtg #2	Mtg #3	Mtg #4
Allan	Terry	Cuyahoga County Board of Health	y	n	call-in	y
Aly	Reem	HPIO	y	y	y	y
Applegate	Mary	Ohio Department of Medicaid	n	y	y	y
Baker	Todd	OSMA	y	y, M. Hueckel	y	y
Beck	Andrew	Cincinnati Children's Hospital	call-in	y	y	call-in
Bickford	Beth	Association of Ohio Health Commissioners	y	y	y	y
Bollig Dorn	Sarah	HPIO	y	y	y	y
Cannon	Jessie	Nationwide Children's Hospital	n	y	y	y
Curry	Marie	Community Legal Aid Services	y	y	n	y
Durfee	Sarah	Ohio Public Employees Retirement System	y	y	y	y
Falcone	Robert	Ohio Hospital Association	y	y	y	y
Goon	Anne	Henry County Health Department	y	call-in	y	y
Gullett	Heidi	Health Improvement Partnership-Cuyahoga	y	call-in	call-in	call-in
Himes	Lance	Ohio Department of Health	y	n	y	y
Hodges	Richard	Ohio Department of Health	y	y	y	n
Hoyt	Karin	Ohio Department of Medicaid	n	y	y	y
James	Tamara	AARP Ohio	y	n	y	n
Juenger	Monica	Governor's Office of Health Transformation	y	y	y	y
Keller	Kate	Interact for Health	y	y	y	y
Kilinc	Afet	Aetna Better Health of Ohio	y	y	y	n
Levine	Cathy	UHCAN Ohio	-	-	y	y
Long	Teresa	Columbus Public Health	y	y	call-in	n
Michener	Melissa	CareSource	n	y	n	n
Misak	Jim	MetroHealth	y	y	y	y
Mitchell	Jodi	Health Action Council	-	y	y	y
Moody	Greg	Governor's Office of Health Transformation	y	y	y	y
Motter	Miranda	Ohio Association of Health Plans	n	y	y	n
Robinson	Brandi	Ohio Department of Health	y	y	y	y
Rohling McGee	Amy	HPIO	y	y	y	y
Sims	Reina	Ohio Commission on Minority Health	y	y	n	y
Spicer	Ann	Ohio Academy of Family Physicians	n	n	y	y
Stevens	Amy	HPIO	y	y	y	y
Taylor	Robyn	ODH Office of Health Equity	y	n	y	y
Thackeray	Jonathan	Ohio Department of Medicaid	y	y	y	y
Tobias	Barb	Health Collaborative, UC	y	y	n	y
Waldron	Rich	MMO	y	y, N. Martin	y, D. Pirc	y
Wapner	Andrew	Ohio Department of Health	y	y	y	n
Wasowski	Krista	Medina County Health Department	y	y	y	y
Weaver	Greg	Senders Pediatrics	y	y	call-in	y

Whitlock	J.D.	Mercy Health	call-in	y	y	y
Wills	Jon	Ohio Osteopathic Association	y	y	y	y
Wirtz	Hubert	The Ohio Council of Behavioral Health & Family Services Providers	y	y, T. Lampl	n	y
Wymyslo	Ted	Ohio Assoc. of Community Health Centers	n	y	y	y
INFRASTRUCTURE SUBGROUP ATTENDEES			**Mtg #1**	**Mtg #2**	**Mtg #3**	**Mtg #4**
Adams	Jim	Canton City Health District	-	call-in	-	y
Burden	Wally	Pike County General Health District	-	-	-	y
Cranciun	Kirsten	The Center for Health Affairs	-	call-in	call-in	y
Deangelo	Aly	Ohio Hospital Association	y	y	y	y
Everett	Ryan	Ohio Hospital Association	-	call-in	-	y
Gartland	Heidi	University Hospitals	-	call-in	-	call-in
Hamilton	Corey	Zanesville-Muskingum County Health Dept.	-	y	-	call-in
Ingram	Tim	Hamilton County Public Health	-	y	-	-
Klingler	Jeff	Central Ohio Hospital Council	-	y	-	-
Larson	Marty	Greater Dayton Areas Hospital Association	-	call-in	-	-
Moore	Deanna	The Center for Health Affairs	-	call-in	-	-
Ruma	Jan	Hospital Council of Northwest Ohio	-	call-in	call-in	-
Schultz	Jessica	Mercy St. Vincent	-	call-in	-	-
Thompson	Terri	ProMedica Health Systems	-	call-in	-	-
Ward	Britney	Hospital Council of Northwest Ohio	-	-	call-in	call-in
OTHER ATTENDEES			**Mtg #1**	**Mtg #2**	**Mtg #3**	**Mtg #4**
Akah	Hailey	HPIO	y	-	-	-
Akerman	Susan	Joint Medicaid Oversight Committee	-	-	y	-
Baker	Carrie	Ohio Children's Hospital Association	-	y	y	-
Clarke	Sophie	McKinsey	-	-	-	y
Christopher	Roni	Mercy Health	-	-	-	y
Dye	James	American Cancer Society	-	-	y	-
Hollingshead	Larry	Board of Countryside YMCA, Atrium Medical Center, Premier Health System & Premier Health Group	-	-	y	-
Hutzler	Kyle	McKinsey	y	-	-	-
Kincaid	Sarah	Nationwide Children's Hospital	-	-	y	y
Kumar	Adi	McKinsey	-	call-in	y	-
Leprai	Chiara	McKinsey	-	-	-	y
Peterson	Sarah	Rep. Barbara Sear's office	-	-	y	y
Saladonis	Melissa	Cincinnati Children's Hospital Medical Center	-	-	y	y
Vath	Kyle	Mercy Health	-	y	-	-
Winn	Bryony	McKinsey	y	-	-	-
Wiselogel	Nick	HPIO	y	-	y	y
Wright	Celia	HPIO	y	y	y	y