Vermont Health Care Innovation Project

Accountable Communities for Health Peer Learning Lab

Invitation to Participate

The Vermont Health Care Innovation Project (VHCIP) is pleased to announce this special opportunity for Vermont communities to participate in a 12-month Peer Learning Lab to explore the development of the Accountable Communities for Health model.

An **Accountable Community for Health (ACH)** is accountable for the health and well-being of the entire population in its defined geographic area. An ACH supports the integration of high-quality medical care, mental and behavioral health services, and social services (governmental and non-governmental). It also supports community-wide prevention efforts across its defined geographic area to reduce disparities in the distribution of health and wellness.

In Vermont, we are building upon the strong foundation established through years of innovation in our health systems, including the Blueprint for Health patient-centered medical home program, our three Accountable Care Organizations, and the Unified Community Collaboratives (UCCs)/Regional Clinical Performance Committees (RCPCs) that are working to create regional governance and quality improvement infrastructure throughout the state. The Accountable Community for Health model seeks to align existing work related to integrated care and services for individuals with community-wide prevention efforts to improve population health outcomes.

The Peer Learning Lab is intended to engage regional and State leaders in exploring the implementation of the recommendations from research undertaken by the Prevention Institute on creating and supporting ACHs in Vermont. This report identified nine core elements of ACHs:

1. Mission
2. Multi-Sectoral Partnership
3. Integrator Organization
4. Governance
5. Data and Indicators
6. Strategy and Implementation
7. Community Member Engagement
8. Communications
9. Sustainable Financing

Details on these core elements can be found in the Prevention Institute's July 2015 report, Accountable Communities for Health: Opportunities and Recommendations.

Scope

The overall goals of the Peer Learning Lab are to:

1. Identify practical steps at the regional and state levels to support Vermont communities in progressing towards an Accountable Community for Health;
2. Identify necessary supports for development of nine core elements of ACHs in Vermont regions;
3. Determine what can be done independently at the regional level (e.g. without statewide intervention or support); and
4. Inform the development of state-level policy change and/or resources to support regional efforts.

Peer Learning Lab Description

The Peer Learning Lab will launch in February 2016 and will bring together leaders from emerging Accountable Communities for Health across Vermont to learn with and from one another through structured face-to-face dialogues over the course of a year. Participants will also have an opportunity to learn from national innovators and industry leaders. Participation in the Learning Lab will include a combination of: full-day in-person learning sessions; webinars to reinforce concepts and discuss progress and challenges; and local facilitation to support ongoing community-level work.

Participants are expected to benefit in the following ways:

- Gain skills and explore options for developing the nine core elements of an ACH;
- Gain knowledge of innovations and strategies used by other communities in Vermont and across the country to create ACHs and improve population health;
- Strengthen community partnerships between clinical settings, social services, and public health;
- Form connections within and between emerging ACHs; and
- Inform future innovations and policy changes at the state level.

Expected Commitment

Participating communities will be expected to:

- Maintain a leadership team which includes at least four leaders with decision-making authority within their organizations. Each participating community should include a diverse set of community leaders who have a history of successfully working with one another in a collaborative manner. Suggested participants include leaders from existing Unified Community Collaboratives (including ACOs, Blueprint for Health representatives, hospital, and other service providers) along with partners in community-wide prevention (district health department, community prevention coalition/partnership). VHCIP welcomes participation from **one leadership team from each of the 14 health service areas**; leadership teams should include a critical mass of key stakeholders from each region.
- Complete a survey about existing activities and outstanding needs prior to the kick-off meeting;
- Participate in 4 to 6 day-long in-person "learning labs";
- Participate in group and individual technical assistance activities, including in-person meetings, webcasts, conference calls, and consultation with experts;
- Report on successes, challenges, and barriers, and provide suggestions for improvements;
- Complete a survey update at the end of the Peer Learning Lab to report on progress; and
- Review collaborative reports and products, as requested.

TO PARTICIPATE: Complete the ACH Learning Lab Application Form and send to Heidi Klein (Heidi.Klein@vermont.gov) by **February 5, 2016**.

The form requires a list of leadership team members who have committed to participating and a brief description (maximum one page) of progress toward developing the nine core elements identified above. It is expected that participating teams will have some but not all of the core elements in place or in progress.

For more information, please attend an informational webinar on January 28th from 10-10:30am. Register here.

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Nine Core Elements of an Accountable Community for Health

1. Mission – An effective ACH mission statement provides an organizing framework for the work. A strong mission defines the work as pertaining to the entire geographic population of the ACH's region; articulates the ACH's role addressing the social, economic, and physical environmental factors that shape health; and makes health equity an explicit aim.

2. Multi-Sectoral Partnership – An ACH comprises a structured, cross-sectoral alliance of healthcare, public health, and other organizations that impact health in its region. Partners include the breadth of organizations that are able to help it fulfill its charge of implementing comprehensive efforts to improve the health of the entire population in its defined geographic area.

3. Integrator Organization – To maximize the effectiveness of the multi-sectoral partnership, it is essential for the ACH to have an integrator organization. The integrator helps carry the vision of the ACH; build trust among collaborative partners; convene meetings; recruit new partners; shepherd the planning, implementation, and improvement efforts of collaborative work; and build responsibility for many of these elements among collaborative members.

4. Governance – An ACH is managed through a governance structure that describes the process for decision making and articulates the roles and responsibilities of the integrator organization, the steering committee, and other collaborative partners.

5. Data and Indicators – An ACH employs health data, sociodemographic data, and data on community conditions related to health (such as affordable housing, food access, or walkability) to inform community assessment and planning, and to measure progress over time. It encourages data sharing by partners to inform these activities. Equally important, an ACH seeks out the perspectives of residents, health and human service providers, and other partners to augment and interpret quantitative data.

6. Strategy and Implementation – An ACH is guided by an overarching strategic framework and implementation plan that reflects its cross-sector approach to health improvement and the commitment by its partners to support implementation. The process for developing this framework includes a prevention analysis that identifies community conditions that are shaping illnesses and injuries across the community. The implementation plan includes specific commitments from healthcare, local government, business, and non-profit partners to carry out elements of the plan.

7. Community Member Engagement – Authentic community engagement is a well-recognized best practice in the field of community health that requires commitment from the highest levels, designated staff, and commensurate resources to ensure effective integration into ACH processes and systems. Authentic community engagement recognizes and harnesses residents' own power in identifying and addressing challenges, while also creating leadership for and buy-in of the work in a manner that acknowledges and builds upon existing community assets and strengths.

8. Communications – An ACH employs communications platforms to build momentum, increase buy-in amongst its partners, recruit new members, and attract grant investment to support its work, and share successes and challenges with others. Communications is also a key tool for framing solutions in terms of community environments and comprehensive strategies.

9. Sustainable Financing – An ACH requires resources to support both its integrator function and ACH implementation work by others. An ACH makes use of existing and new funding sources and better aligns them to advance broad community goals.

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Key Definitions

Health

Health is defined by the Constitution of the World Health Organization as:

> *Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*
>
> SOURCE: Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

Population Health

The definition of population health varies depending upon the perspective of a given group. For a medical provider, "population" may be either the "panel of patients" (all patients who use the provider, regardless of whether they see other providers more frequently) or "attributed lives", which refers only to those patients who receive most of their care from that provider. For a health insurer or payer, the definition of "population" is "covered lives" (health plan beneficiaries). For the community, the "population" includes everyone who lives in a defined geographic area.

For the purposes of this project, the Population Health Work Group of VHCIP has adopted the following definition of Population Health based on Kindig and Stoddart (2003) and referenced by CMS for the SIM initiative:

> *Population Health is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart). While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors.*
>
> SOURCE: Institute Of Medicine, Roundtable on Population Health Improvement
> http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx

Accountable Community for Health (ACH)

The Accountable Community for Health (ACH) is an aspirational model where the ACH is accountable for the health and well-being of the entire population in its defined geographic area and not limited to a defined group of patients. An ACH supports the integration of high quality medical care, mental and behavioral health services, and social services (governmental and non-governmental) for those in need of care. It also supports community-wide prevention efforts across its defined geographic area to reduce disparities in the distribution of health and wellness. Examples of community-wide prevention efforts include: changes to local planning and zoning to increase access to physical activity and healthy foods; zoning to prohibit sales of alcohol and tobacco products near schools; social and traditional media campaigns; expansion of affordable housing.

Building Blocks to Support Population Health Improvement

Integrated Care Management	+	Unified Community Collaboratives	+	Accountable Communities for Health
How do we enhance team-based care for high risk individuals?		How do we improve the quality of care, integrate services, and improve health outcomes?		How do we connect integrated services for individuals with community-wide prevention strategies?
Focus on **integrated care for target individuals**		Focus at **regional level on collaborative quality improvement across systems**		Focus on planning for **community-wide systems and strategies to improve population health outcomes across a geographic area**
Support for **design and implementation of cross-organization, team-based care**		Support for **design and implementation of cross-organization, team-based care and coordination of services**		Support for high-level **convening, planning, and community level environmental and policy changes to address social determinants**
Working with **organizational leadership and front-line care managers** from health and social service organizations		Working with **organizational leadership** from health and social service organizations		Working with **organizational leadership** from health and social service organizations, and community prevention partners
Supported by Integrated Communities Care Management Learning Collaborative		Supported by Blueprint and ACO facilitation and technical assistance		Supported by Accountable Communities for Health Peer Learning Lab

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