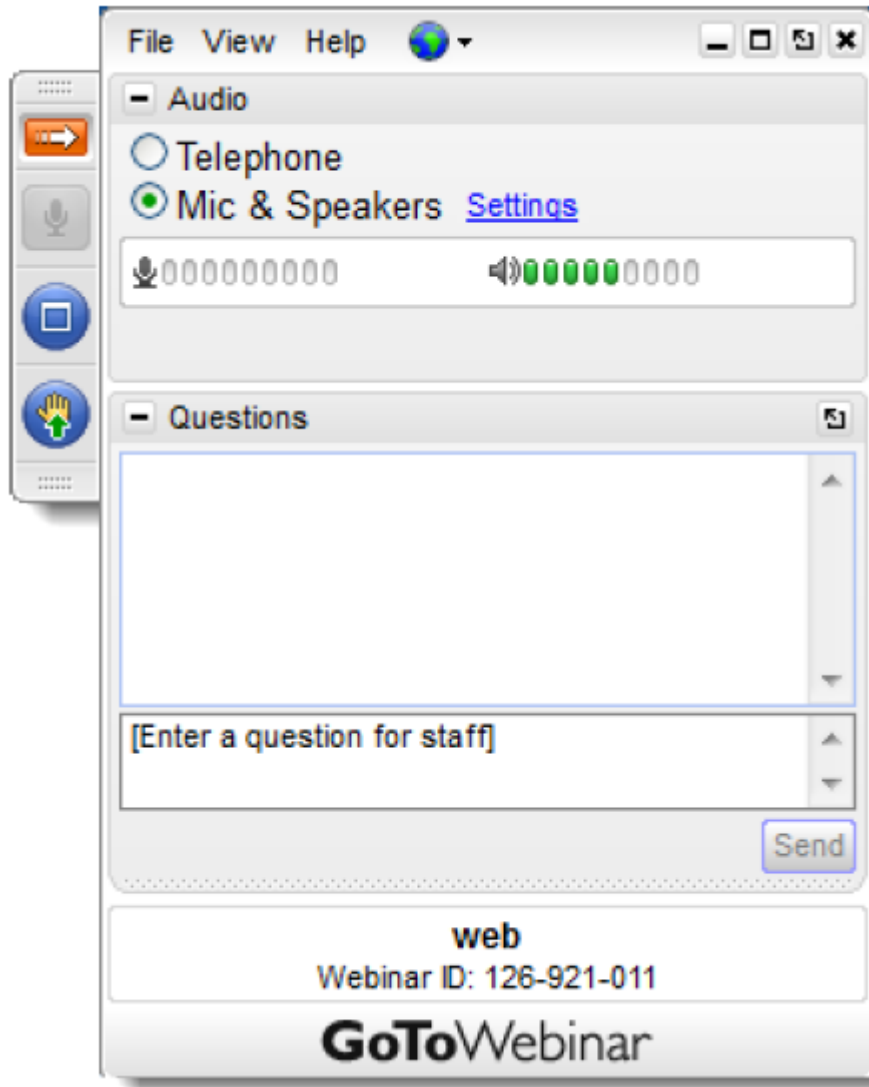


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# ACCOUNTABLE COMMUNITIES FOR HEALTH

Peer Learning Laboratory 2016

# Before we get started...



- By default, webinar audio is through your computer speakers.
- If you prefer to call-in via telephone, click “Telephone” in the Audio pane of your control panel for dial-in information.

# Before we get started...

- **We've reserved time for Q&A at the end of this event.** Submit questions via Questions pane in webinar control panel, or use the “raise your hand” function and we'll unmute your line so you can ask your question out loud.
- **This webinar is being recorded.** Slides and recording will be posted to the VHCIP website following the event: <http://healthcareinnovation.vermont.gov/>
- **Please complete our brief evaluation survey** at the end of the event. We value your feedback!

# Agenda

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- Defining Health and Population Health
- Accountable Communities for Health (ACH) Model
- Overview of ACH Peer Learning Lab Opportunity
- Q&A

# Population Health Defined

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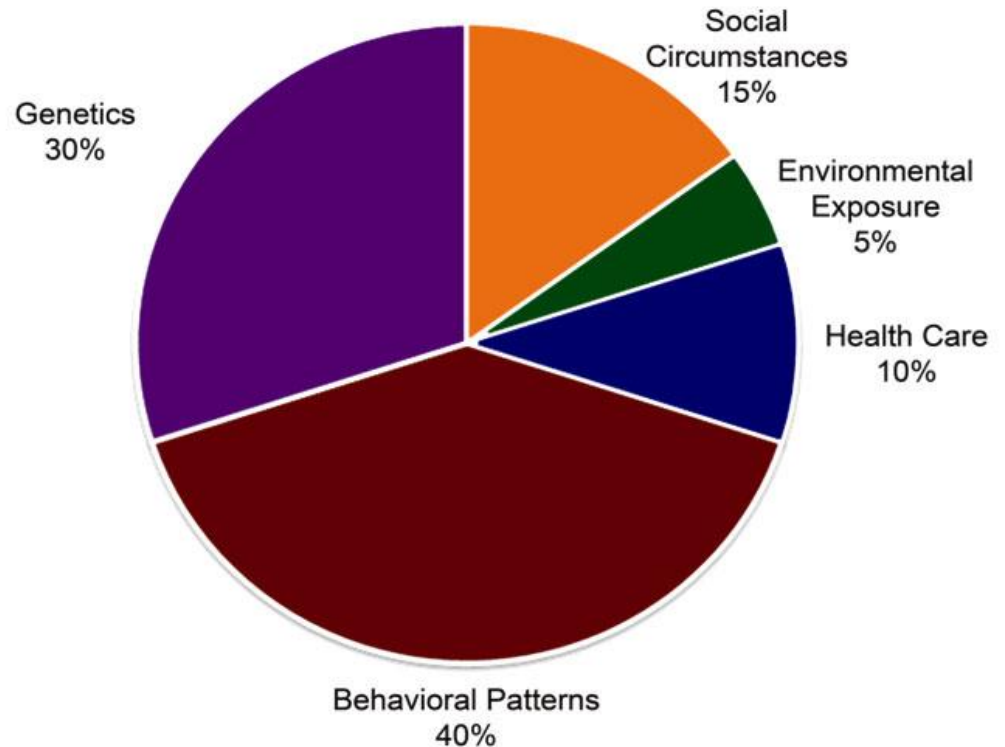
The health outcomes (morbidity, mortality, and quality of life) of a group of individuals, including the distribution of such outcomes within the group.

Health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors.

# Determinants of Health

## Factors influencing Health Status

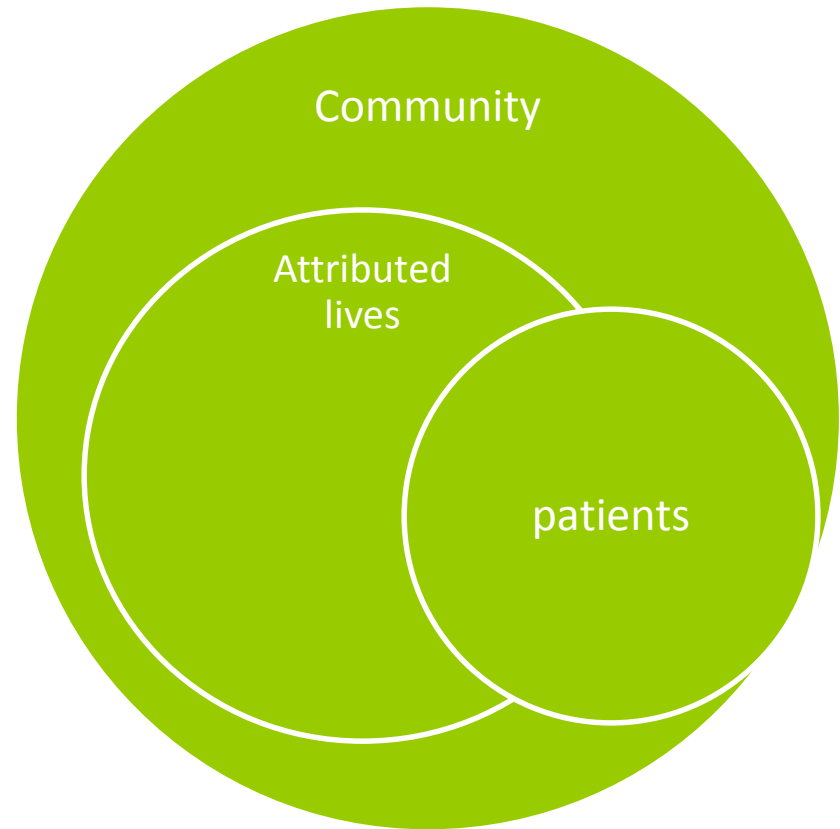
Health outcomes are the product of multiple determinants of health, including medical care, genetics, behaviors, social factors, and environmental factors.



Source: N Engl J Med 2007;357:1221-8.

# What is Population Health?

- Health Care Providers
  - Managing the health outcomes of the patients in their practice
- Health Insurers/Payers
  - Managing the clinical outcomes of enrolled patients and attributed lives
- Community
  - Improving the health of everyone who lives in a geographic area



# What is an Accountable Community for Health?

- Accountable for the health and well-being of the **entire population in a defined geographic area.**
- Supports the **integration** of high-quality medical care, mental and behavioral health services, and social services with community-wide prevention activities.
- Engages a **broad set of partners outside of healthcare** to improve overall population health.
- Identifies multiple strands of resources that can be applied to ACH-defined objectives that **explore the potential for redirecting savings from healthcare costs** in order to sustain collaborative efforts.



# Core Elements of the ACH Model

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 Funding

# Population Health Strategies

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- **Traditional Clinical Approaches** focus on individual health improvement for patients who use their provider-based services
- **Innovative Patient Centered Care and/or Community Linkages** include community services for individual patients
- **Community-wide** strategies focus on improving health of the overall population or subpopulations

# 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 <b>integrated care for target individuals</b>		Focus at <b>regional level on collaborative quality improvement across systems</b>		Focus on planning for <b>community-wide systems and strategies to improve population health outcomes across a geographic area</b>
Support for <b>design and implementation of cross-organization, team-based care</b>		Support for <b>design and implementation of cross-organization, team-based care and coordination of services</b>		Support for high-level <b>convening, planning, and community level environmental and policy changes to address social determinants</b>
Working with <b>organizational leadership and front-line care managers</b> from health and social service organizations		Working with <b>organizational leadership</b> from health and social service organizations		Working with <b>organizational leadership</b> 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

# ACH Peer Learning Lab

- **Goal:** Explore the ACH concept with interested communities to support them in building Accountable Communities for Health from the ground up.
- **Communities will:**
  - Learn with and from one another and from national innovators;
  - Identify the practical steps and developmental stages in creating an Accountable Community for Health; and
  - Inform the development of necessary state-level policy and guidance to support regional efforts.

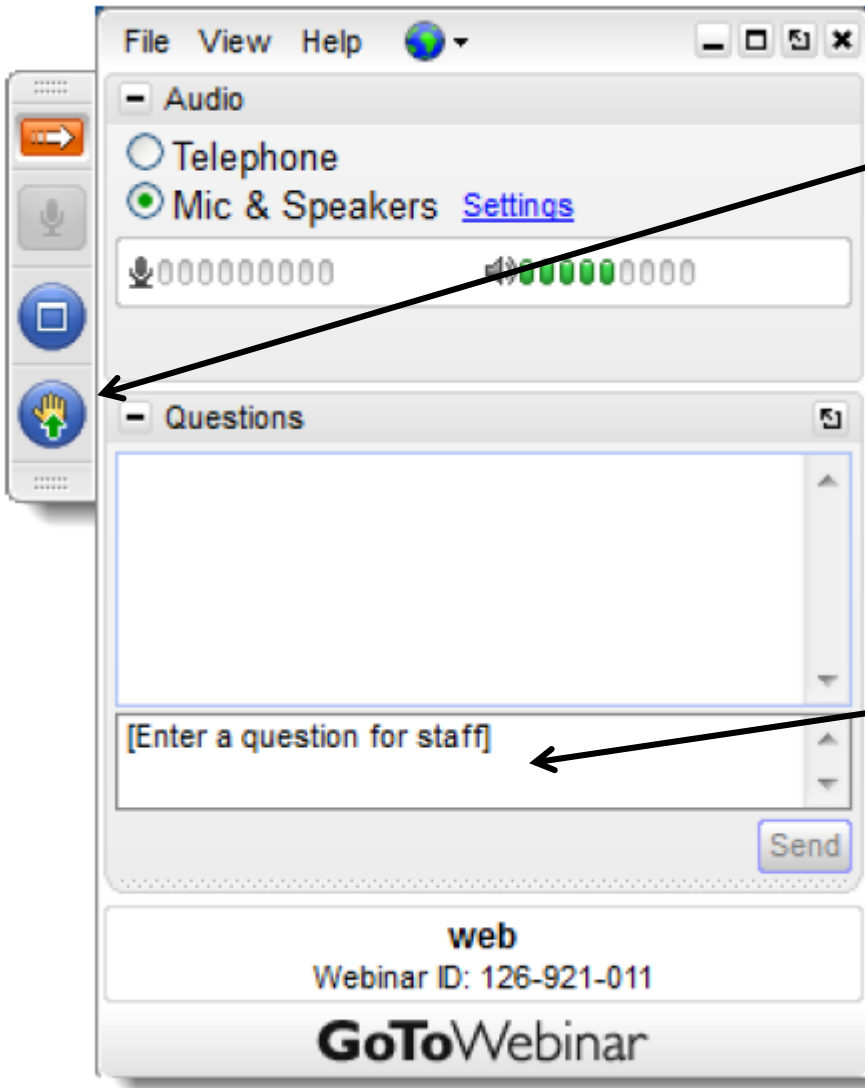
# ACH Peer Learning Lab

- 12-months of peer and individual learning activities and technical assistance
- Combination of full-day in-person learning sessions; webinars to reinforce concepts and discuss progress and challenges; and as-needed technical assistance to support ongoing community-level work.
  - **Learning sessions** and **webinars** would engage state leaders and national experts as faculty.
  - **Technical assistance** will help communities dig deeper into concepts of particular interest and learn from national examples.

# Comparison of 2016 Opportunities

VHCIP Accountable Communities for Health (ACH) Peer Learning Lab	CMS Accountable Health Communities (AHC) Cooperative Agreement
Peer learning opportunity; with technical assistance and no funding	Competitive funding opportunity; Cooperative agreement
Eligibility: One team per geographic region	Eligibility: screening 75,000 community-dwelling Medicare and Medicaid beneficiaries per year.
1-year learning lab to continue to develop Vermont ACH model and build community capacity	5-year test of CMS AHC model to determine whether identifying health-related social needs has a positive impact on cost, quality, and outcomes;
Focus on linking existing efforts to integrate medical care, mental and behavioral health services, and social services with community-wide prevention activities – bridging individual and community-level interventions	Focus on supporting individual beneficiaries' access to services (all tracks), with some community-level alignment (Track 3 only); very limited focus on public health and prevention activities
Payer agnostic	Targets community-dwelling Medicare and Medicaid beneficiaries only, with particular focus on high-risk beneficiaries

# QUESTIONS?



- Use the “raise your hand” function and we’ll unmute your line so you can ask your question out loud

OR

- Type questions into the Questions pane