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Accountable Communities for Health in the Health Care Reform Landscape

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Intent of the Accountable Community for Health Learning Lab

Building on current efforts for example Community Collaboratives:

1. Give a conceptual model of an Accountable Community for Health and it's 9 core elements
2. Provide a vision for what prevention looks like in the context of an Accountable Community For Health

Markers of Success

- You have honed your vision of what the structure of an ACH looks like in your community and taken steps to put those structures into place

AND/OR

- You have created a vision for what prevention looks like in your ACH, aligning healthcare and prevention, and have taken steps to create a plan for how to support prevention or implemented prevention strategies/activities in your community

It's a journey you did not all start in the same place and
you will not end in the same place over the short period of the learning lab.

What is an Accountable Community For Health

- Coalescing of community organizations and their members to come together around a common vision to ensure the health of a defined population (usually geographically bound).
- They do that by leveraging the resource they have available to them to put in place broad systems that are needed to keep the population healthy and care for those who are sick
- These broad systems and services go beyond what we traditionally think of health care and or public health, focusing on the social determinants that support peoples overall physical, mental, and social wellbeing and on the structures or systems in a community.

Accountability and Governance

Together partners who form an ACH are commit to being:

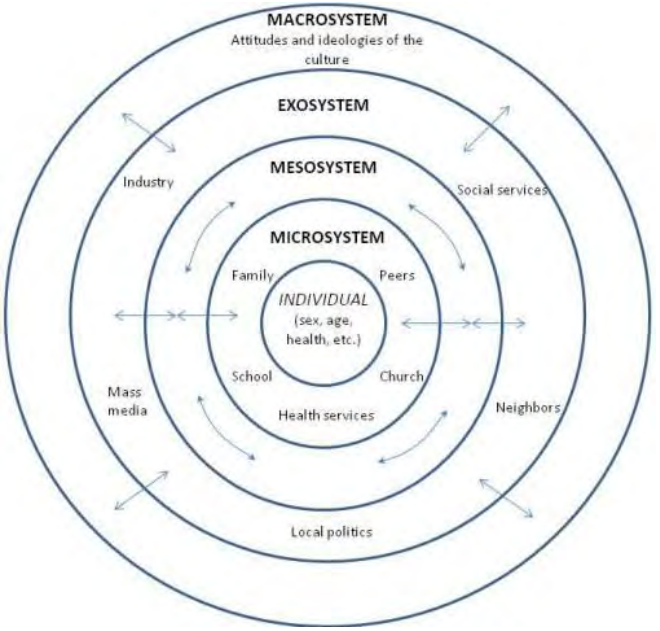
1. Accountable for the population health outcome
2. Responsible for governing the effective and efficient use of resources to achieve a healthy population

It takes a village

- Accountable communities for health need a strong vision, leadership to align resources around the vision and committed people who are willing to work to implement the change at the community (state and local), organization, family, and person levels.

executive leaders and doers

multi-levels of intervention



9 Core Elements

- At the community level it is important that all of the 9 core elements are in place for an ACH
  - Mission
  - Multi-sectoral Partnership
  - Integrator Organization
  - Governance
  - Data and Indicators
  - Strategy and Implementation
  - Community Member Engagement
  - Communications
  - Sustainable Financing

Combination of:

executive functions

work group functions

Functional Team Members

- For the community at large to be successful, functional teams need to come together to work on specific issues which can range from setting the vision to implementing a specific project or change.
- These teams need to be high performing. The Institute of Medicine (now the Academy of Medicine) gives us guidance of the core features of functional teams.
    - Shared goals
    - Clear roles
    - Mutual trust
    - Effective communication
    - Measurable processes and outcomes

Functional Team Members – Personal Values

- Honesty
- Disciple
- Creativity
- Humility
- Curiosity

Communities Not Starting from Scratch

- It's a journey many of us started years ago, build on what you already have

Aligning Health Care Delivery Reform Efforts

- Creation of the Community Collaboratives
  - Brought together dispersed health care reform projects

- Implemented supports to help facilitate success of the collaboratives
  - Local supports (project managers, facilitators, clinical quality consultants)
  - Integrated Community Care Management Learning Collaborative
  - Accountable Communities for Health Learning Lab

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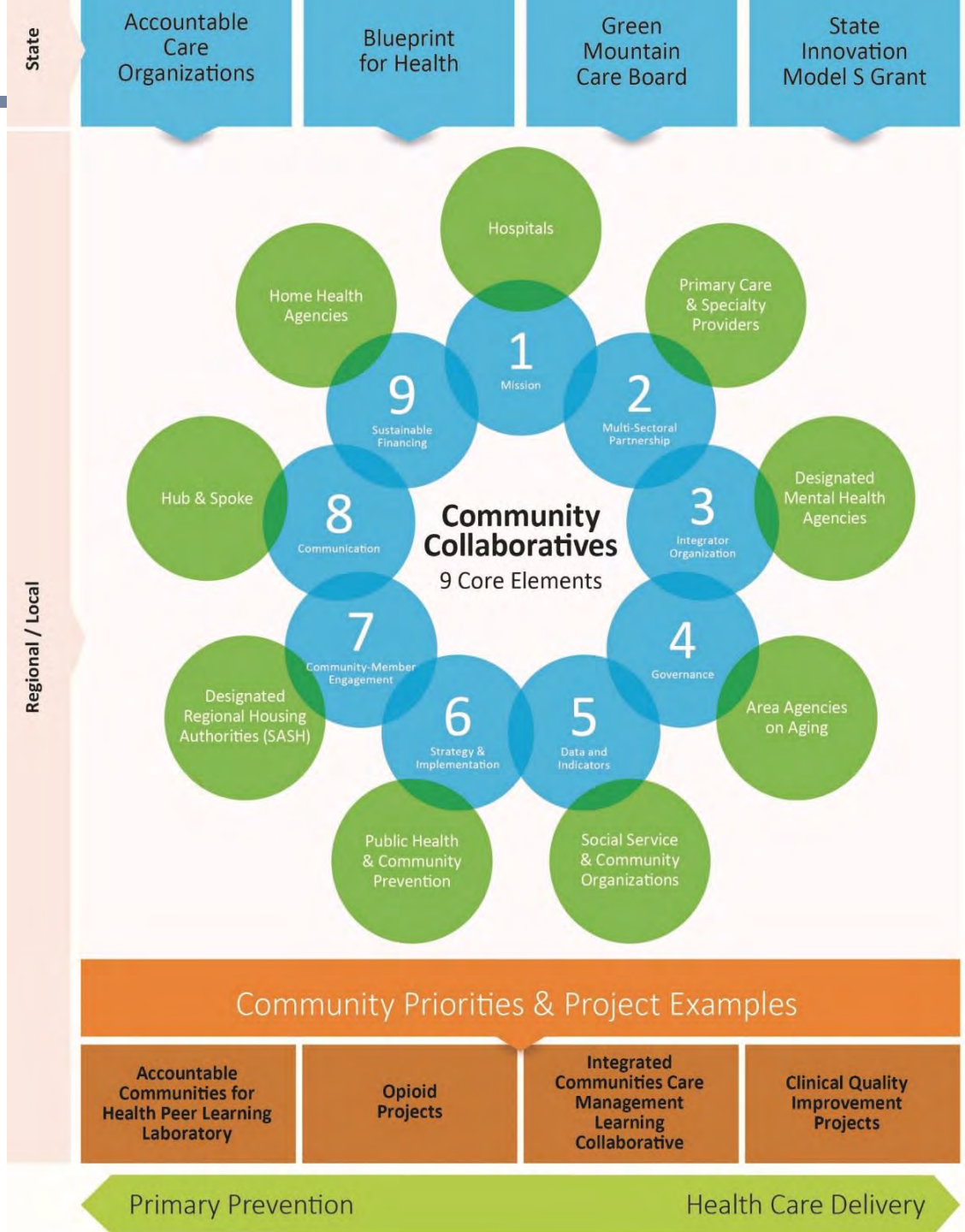
Community Collaboratives and ACH Learning Lab



Measures of Success - Steps

- Within the context of what is already in place in your community (Community Collaborative) you have honed your vision of what the structure of an ACH looks like in your community and taken steps to put those structures into place
  - Assessed whether you had the foundation for the 9 core elements in place and the quality/degree of success of each element
  - Identified which elements you felt could be improved and prioritized which ones you wanted to work first
  - Implemented strategies to improve adoption of those elements
  - Made measurable progress on at least 2 of the 9 elements

Measures of Success

- In the context of what is already happening in your community (community coalitions and prevention groups) you have created a vision for what prevention looks like within your Community Collaborative/ACH, aligning healthcare and prevention, and have taken steps to create a plan for how to support prevention or implemented prevention strategies/activities in your community
  - Assessed current vision to see if it is comprehensive
  - Developed a dashboard of measures that includes the full spectrum
  - Identified existing community coalitions or groups working on primary prevention
  - Selected at least on one primary prevention strategy on which to work
  - Identified a workgroup to work on the primary prevention strategy (don't start from scratch)
  - Developed an A3 or similar project plan
  - Implement a few key action items from the project plan
  - Measured success or learning from action item(s)

It takes time – during the learning lab you will likely only have time to work on 1 or 2 elements ***OR*** 1 prevention project. That is expected – prioritize.

What does that mean for you?

- In this room under this project teams have formed in an effort to head towards the vision of an Accountable Community for Health.
- Yet, in this room there is a lot of variation – some of you are charged by your community to set the vision and direction (senior leadership) others are project based teams whose members have the ability to shift an important sector or your community – public policy, implementation of prevention activities, changes in the way care is provided.
- Regardless of what type of team you are, you have an opportunity to make change.
- You can use this time to learn from others and make a plan.

Where You Are On This Pathway – Set a Course

- Assess who is at the table and identify your locus of control, in other words what do you have the authority to change
- Create a joint vision
- Ensure members of the team are willing and able to invest the their resources to achieve the vision
- Identify how you will determine (measure) that you have been successful and how you will know your work is done
- Identify clear strategies and next steps
- Assign who will do what
- Implement the plan
- Measure the outcomes
- Revisit next steps
- Document your process (A3, PDSA cycle, project charter and plan, …..)

Lead Down and Up

- Remember we have a responsibility to both lead change within our locus of control.

AND

- To lead up and down – to communicate with the leaders and teams who can impact the systems above and below our locus of control:

Individual ↔ Team

Team ↔ Organization

Organization ↔ Community

Community ↔ State

State ↔ Country

Accountability and Data

What you Measure you will Change - To be accountable, we must know the current status of what we are accountable for achieving, where there are opportunities for improvement, and progress as a result of effort made:

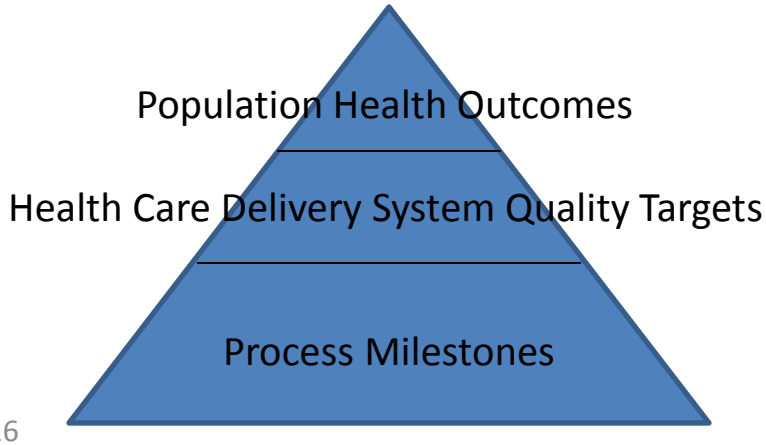
- Set a vision for health that is comprehensive and includes keeping people healthy across the continuum from those who are well, at risk, experiencing illness, or at the end of their life
- Decide how to measure the health of the population (dashboard)
- Don’t start from scratch – most communities have Community Health Needs assessments and many of the community organizations collect their own data, build on these existing efforts
- Regularly revisit progress on those dashboards, using them to help guide how resources should be allocated

All Payer Model Measures – Under Negotiations

Overarching Population Health Goals

1. Improved access to primary care
2. Reduced deaths from suicide and drug overdose
3. Reduced prevalence and morbidity of chronic disease

   (Chronic Obstructive Pulmonary Disorder (COPD), Diabetes, Hypertension)



Outcomes Versus Root Cause

There are outcomes and root causes

- Outcome may be increases in health care utilization or poor educational attainment, likely the root cause is multi-pronged and more closely linked to social determinants of health
- Often quantitative data can tell us the outcome or what, while qualitative data may get us closer to understanding why or the root cause
- Interventions, should be targeted at the root causes
- Monitoring and accountability should be focused on the outcomes

Teams implementing change should be focus on the root causes (processes)

Your Charge for the Day

Use the learning lab to:

- Learn from others
- Set a course for your work back in your communities