ACCOUNTABLE COMMUNITIES FOR HEALTH: OPPORTUNITIES AND RECOMMENDATIONS

Prevention Institute

Prevention and equity | Institute at the center of community well-being

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About Prevention Institute

Prevention Institute (PI) is a national nonprofit dedicated to improving community health and equity through effective primary prevention: taking action to build resilience and to prevent problems before they occur. Our work is characterized by a strong commitment to community participation and promotion of equitable health outcomes. To help shape emerging approaches, policies, and practices, PI provides training and tools to communities, policymakers, academics, funders, and coalitions focused on health system transformation, improving healthy eating and activity environments, preventing violence, reducing injury and promoting traffic safety, and supporting mental health.

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EXECUTIVE SUMMARY

INTRODUCTION

The Accountable Community for Health (ACH) model is emerging as a promising vehicle toward reaching the full potential of the Triple Aim—particularly efforts to improve population health. Catalyzed by the Affordable Care Act, the U.S. health system is in the midst of an unprecedented period of transformation. Communities and states across the country are embracing a wave of innovation and experimentation to achieve the Triple Aim of reduced cost, enhanced quality of care, and improved population health. The third aim–improving population health–stands out as a more recent area of focus, and thus opportunity, for healthcare leaders to expand the scope of their work.

This report presents research and analysis conducted by Prevention Institute under contract with the Department of Vermont Health Access to inform the potential development and application of the ACH model within Vermont's healthcare landscape. The work was carried out in close collaboration with the Population Health Work Group and Vermont Health Care Innovation Project leadership.

Prevention and Population Health Improvement

Population health is commonly defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." Further, "population health outcomes are the product of *multiple determinants of health*, including medical care, public health, genetics, behaviors, social factors, and environmental factors." As healthcare leaders embrace the notion of population health, they increasingly recognize that factors outside the healthcare system have a powerful impact on health. The analysis that access and quality of care only accounts for 10% of the factors contributing to health outcomes[1] is now a core principle underlying health system transformation efforts.

Population health is commonly defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." Further, "population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors."

Quality community prevention is aimed at addressing the social, economic, and physical environment that is shaping population health outcomes. It involves a spectrum of comprehensive and synergistic activities that range from increasing individual skills and

[1] Schroeder S. *The Case for More Active Policy Attention to Health Promotion*. New England Journal of Medicine. 2007;357:1221-8. Adapted from: McGinnis JM, et.al. Health Affairs (Millwood.) 2002;21(2):78-93.

knowledge (motivational counseling to quit smoking) to changing organizational practices (establishing a tobacco-free workplace) and policies (tobacco-free parks and public spaces). Another benefit of community prevention is its applicability to improving mental health in addition to physical health. Community prevention serves as a strong complement to clinical care and service referral, decreasing the future patient pool while also helping those already sick or injured recuperate and maintain their health.

The Accountable Community for Health Model

The Vermont Population Health Work Group's working definition of an ACH is:

> "An aspirational model—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. Population health outcomes are understood to be the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, economic circumstances and environmental factors. 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."

An Accountable Community for Health advances previous efforts in community health by engaging healthcare as a central partner in community-wide health improvement. At its core, the ACH is a structure for collaboration that represents a major change in direction in healthcare with tremendous opportunities and challenges.

As emerging, the ACH concept is unique in that it:

1) Brings together major healthcare providers across a geographic area, and requires them to operate as partners rather than competitors;
2) Focuses on the health of all residents in a geographic area rather than just a patient panel;
3) Engages a broad set of partners outside of healthcare to improve overall population health; and
4) 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.

METHODS

Prevention Institute conducted an extensive research process to determine the potential for establishing ACHs in Vermont, working closely with the State of Vermont Population Health Work Group. This process involved identifying five national sites that were engaged in activities that aligned with the concept of an ACH; conducting interviews with core team staff members and affiliated partners that represented different sectors; and producing case studies for each site. The second half of the investigation focused on identifying existing efforts in Vermont that could potentially form the basis of an ACH. Using responses to an online request for information, six Vermont communities were selected for review; findings were summarized in brief profiles. Additional information about the Vermont landscape was provided through meetings with the Population Health Work Group and State of Vermont Health Care Innovation Project and Department of Health staff. Based on these sources, Prevention Institute produced an analysis of core elements of an ACH and recommendations for potential implementation of an ACH initiative.

SYNTHESIS OF FINDINGS

Overarching themes were drawn from the research findings.

Themes from the National Case Studies

- The Accountable Community for Health model is in the developmental stage; no community has all the envisioned elements in place.
- Relatively few U.S. communities are implementing healthcare delivery and payment reforms that include community prevention strategies as a key pillar for improving population health.
- The focus of advocacy and policy change in places engaged in community prevention is most frequently related to food, physical activity, and tobacco.
- The social and economic needs of patients and low-income community residents are broadly recognized and primarily addressed through individual service referrals.
- Ongoing engagement of community residents in planning and implementation processes, beyond the community health needs assessment, is a challenge.
- Emerging ACHs are using a variety of financing mechanisms, including grants, local government general funds, dedicated taxes, or a portion of Medicaid's global budget. Healthcare cost savings is seen as a secondary long-term goal that should not be an impediment to fostering collaborative action that can make a difference in the well-being of the community.

Themes from Vermont Sites

- Vermont's hospital and health system leadership is interested in the ACH model. Notably, in contrast to the national case studies, hospitals are serving as the integrator organization in the majority of Vermont sites.
- Vermont collaboratives are focused on a similar set of priority community health challenges as the national sites, including: chronic disease related to tobacco, food, and activity behaviors; mental health and substance abuse; and poverty.
- Strategies to address health priorities typically involved health education and referrals to community services. All the Vermont collaboratives described at least a few local- and state-level policy goals. Three of the six communities have a more developed approach to promoting a menu of community environmental changes.
- Vermont sites are clearly focused on improving access to non-medical services (ranging from mental health and substance abuse treatment to governmental and non-governmental social and economic support services) and coordinating them with medical services. The Vermont Blueprint for Health Community Health Teams are integral to this service coordination.
- The paradigm differences between partners around the ACH table can influence priority setting. Healthcare and service providers by organizational mandate and professional training may place greater emphasis on improving services to individual clients.

Findings by Core Element

Prevention Institute identified nine core elements of the ACH model:

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.

STATEWIDE RECOMMENDATIONS

Accountable Communities for Health in Vermont

Vermont has many building blocks in place that make the establishment of ACHs a logical next step in advancing health reform efforts. Vermont's working definition of an ACH is notable in that it specifically calls out two important pillars of a system of health:

- Integrated medical care, mental and behavioral and social services.
- Community-wide prevention efforts.

The following recommendations are offered for consideration to advance and nurture local ACH efforts.

A. Foster an overarching statewide approach to support ACH effectiveness

Develop a statewide strategic framework for population health improvement to support local ACHs in setting priorities. The state framework should span service integration and community prevention, and illustrate multiple influences on health. Language that emphasizes health equity should be elevated. The State itself should reflect these priorities in its overall approach to population health by directing funding to communities that have the most impacted community environments, and by supporting and engaging community resident leaders.

Establish a core set of community-level indicators for use by local ACHs to monitor progress in community-wide prevention. Ensure the indicators reflect the contribution of multiple sectors to health. There are Vermont resources to draw on for community indicators, such as: Scorecards developed by Rise VT to promote healthy environments related to food, activity, and tobacco; or the ECOS Scorecard, Chittenden County, which also includes indicators related to community planning, transportation, and economic development.

Emphasize accountability mechanisms that are linked to population health improvement. To achieve Vermont's goals, it may be advantageous to tie accountability more with achievement of process and outcome measures that fall along the pathway to improved population health.

Phase in the formation of ACHs. Vermont's healthcare innovations implemented in the Blueprint Health Service Areas have set the stage for considering ACHs in all 14 places. We recommend beginning with providing funding to localities with greater readiness to test out the ACH elements, then refining the model based on these experiences.

Explore the role of the State Government Department of Health, and other regional offices, in participating in local ACH collaboratives. We recommend further assessment to determine the opportunities and challenges to facilitating this participation, and what it would take to equip staff to effectively participate.

B. Provide guidance to enable regions to effectively establish ACHs

Ensure ACHs balance individual service integration and community prevention efforts. The State should require that localities receiving funding for ACHs engage in a comprehensive set of strategies that span service integration and community prevention work.

Conduct a network analysis of community prevention efforts in each Health Service Area. Building on the Vermont Blueprint analysis of healthcare and community service providers in these regions, we recommend initiating a complementary assessment of community efforts related to prevention with an emphasis on factors such as food systems, tobacco control, housing, transportation, and environmental sustainability.

Encourage ACHs to form around existing regional partnerships and collaborations. Since the most critical element of an ACH is effective partnership in a defined geographic area, it may make sense to consider local variation if partners have a strong history of working together or make a compelling case for varying from the Health Services Area. Further, in order to encourage well-functioning ACH partnerships, we recommend the State not designate a specific type of organization to serve as the integrator.

C. Build capacity and create an environment of ongoing learning

Expand the paradigm of the health system from healthcare to health. ACHs are establishing a new leadership paradigm, in which healthcare is helping to drive community-wide changes for population health improvement. More broadly, effort is needed across the state to elevate the understanding and inclusion of community prevention as part of health system innovation. There is an emerging set of practices for hospitals and community clinics—beyond their role in the ACH *per se*—to use their power as anchor institutions, as employers, as purchasers, and as credible health leaders to support community environmental changes to improve patient outcomes."[2,3,4]

Foster skill development for the emerging cadre of ACH leaders. The State will need to facilitate assessment and delivery of training and technical assistance around the core ACH elements, and foster peer learning. It can also be an opportunity to expand knowledge about core community prevention concepts and practices and their importance for population health improvements—serving to inform and attract state leaders to contribute to building strong local ACHs.

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[2] Serang F, Thompson JP, Howard T. *The Anchor Mission: A Case Study of University Hospitals Vision 2010 Program*. University Hospitals, Cleveland, OH. 2013.
[3] Phillips FB. *Sustaining Community-Hospital Partnerships to Improve Population Health*. Maryland Community Health Resources Commission. 2015.
[4] Cantor J, Cohen L, Mikkelsen L, Pañares R. *Community Centered Health Homes: Bridging the gap between health services and community prevention*. Oakland, CA: Prevention Institute. 2011.

Promote authentic community engagement in all aspects of the ACHs and their work. ACHs in Vermont should be explicitly required to engage community residents, with a particular emphasis on involving individuals and populations whose voices are most commonly missing from the table. Authentic community engagement will support greater success in population health improvement efforts.

Encourage the creation of robust communications platforms for the ACHs. Regional ACH organizations will benefit from State support in developing and disseminating communications materials

D. Explore Sustainable Financing Models for Accountable Communities for Health

Funding is necessary for ACH effectiveness. We recommend building up and aligning ACH funding with existing prevention funding streams as well as exploring ways to create a new funding mechanism. Across the country new ideas and funding models are emerging.

Potential options include:

- Dedicating a portion of a new or existing tax to fund ACH activities.
- Specifying that a portion of a global healthcare payment or a per-patient per-month assessment on payers support the ACH upstream effort.
- Establishing a wellness trust to support the ACHs, funded through one or a blend of the sources described previously under core element nine.

INTRODUCTION

The Accountable Community for Health model is emerging as a promising vehicle toward reaching the full potential of the Triple Aim—particularly efforts to improve population health. The U.S. health system is in the midst of an unprecedented period of transformation catalyzed by the Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA). Communities and states across the country are embracing a wave of innovation and experimentation to achieve the Triple Aim of reduced cost, enhanced quality of care, and improved population health. While the ACA's payment and delivery reform mandates have accelerated progress toward these goals, these elements of the Triple Aim were already under consideration prior to its passage. The third aim–improving population health–however, stands out as a more recent area of focus, and thus opportunity, for healthcare leaders to expand the scope of their work.

This report presents research and analysis conducted by Prevention Institute (PI) under contract with the Department of Vermont Health Access to inform the potential development and application of the Accountable Community for Health model within Vermont's healthcare landscape. The work was carried out in close collaboration with the Population Health Work Group and Vermont Health Care Innovation Project leadership. Findings and recommendations are drawn from national case studies and Vermont-based communities that are implementing healthcare-community partnerships to improve overall population health.

Prevention and Population Health Improvement

Population health is commonly defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group."[5] It is also acknowledged that "population health outcomes are the product of *multiple determinants of health*, including medical care, public health, genetics, behaviors, social factors, and environmental factors."[6] As healthcare leaders embrace the notion of population health, they increasingly recognize that factors outside the healthcare system–particularly conditions in the community environment–have a powerful impact on health. The analysis that access and quality of care only accounts for 10% of the factors contributing to health outcomes[7] is now a core principle underlying health system transformation efforts.

[5] Kindig D, Stoddart G. What Is Population Health? American Journal of Public Health. 2003;93(3):380-383.
[6] Institute Of Medicine. *Roundtable on Population Health Improvement*. Institute Of Medicine website. http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx. Accessed June 30, 2015. Emphasis added.
[7] Schroeder S. *The Case for More Active Policy Attention to Health Promotion*. New England Journal of Medicine. 2007;357:1221-8. Adapted from: McGinnis JM, et.al. Health Affairs (Millwood.) 2002;21(2):78-93.

Guided by this understanding of what shapes health, healthcare is starting to expand its focus to better address the variety of complex non-medical needs that many patients face. For the most part, this expansion beyond the doctor's office takes the form of individual care coordination and referrals to community-based social services (e.g. housing, food, or employment assistance). While these social service referrals are essential—and particularly so for the individual patients who receive them—they are not sufficient to reach the goal of increased *population* health because they do not change the underlying community factors that determine health. These community factors have been well studied and shown to shape the exposures and health behaviors that in turn impact health outcomes.[8] They include such elements as what's sold and how it's promoted in a community (e.g. alcohol, cigarettes, and fast food—or fresh fruit and vegetables); look, feel and safety; the availability of parks and open spaces; and methods of transportation, to name a few. Thus, while an *individual patient* greatly benefits from receiving vouchers for fruits and vegetables from the farmers market, for example, *the entire community* (of patients and non-patients) benefits from efforts to increase community-wide access to healthy affordable foods and opportunities for safe play and activity. Importantly, the same conditions that enable patients to restore their health are equally critical to keeping people healthy in the first place.

> *"No mass disorder afflicting mankind is ever been brought under control or eliminated by attempts at treating the affected individual."*
>
> *- Dr. George W. Albee, Former Professor, University of Vermont*

Fortunately, there is a well-developed approach to effectively address the community factors that shape our health: *community prevention*. Community prevention strategies create lasting changes at the community level by addressing specific policies and practices in the environments and institutions that shape our lives and our health—from schools and workplaces to neighborhoods and government. The focus on community prevention has steadily grown in the past 30 years as the lessons learned from efforts to curb tobacco use, address traffic safety, and increase healthy eating and physical activity have confirmed that community prevention's focus on changes to the social, cultural, and physical environment effectively alters health behaviors and norms and generates positive health outcomes.

Quality community prevention involves a spectrum of comprehensive and synergistic activities that range from increasing individual skills and knowledge (motivational counseling to quit smoking) to changing organizational practices (an employer establishing a tobacco-free workplace) and policies (tobacco-free parks and public spaces). Another benefit of community prevention is its applicability to increasing mental health in addition to physical health. Positive changes to community environments can effectively prevent, and reduce the severity of, some mental health conditions, such as depression and post-traumatic stress disorder, and can delay the onset and support treatment outcomes for those with mental health conditions. Community prevention is by definition a population health-level approach and serves as a strong complement to clinical care and service referral: decreasing the future patient pool by preventing people from getting sick or injured before they reach the waiting room, while also helping those already sick or injured recuperate and maintain their health.

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[8] *THRIVE: Community Tool for Health & Resilience In Vulnerable Environments*. Oakland, CA: Prevention Institute.
[9] Cohen L, Chávez V, Chehimi S. *Prevention is Primary: Strategies for Community Wellbeing*. Oakland, CA: Josey-Bass. 2011.

The Accountable Community for Health Model

The concept of an Accountable Community for Health (ACH) was popularized in the 2012 publication "Healthier by Design: Creating Accountable Care Communities," by Austen BioInnovation Institute in Akron. Since then, a nascent body of literature has developed, including "Achieving Accountability for Health and Health Care" (Institute for Clinical Systems Improvement, 2012); "Accountable Health Communities: Insights from State Health Reform Initiatives" (Dartmouth Institute for Health Policy and Clinical Practice, 2014); and "Accountable Communities for Health, Strategies for Financial Sustainability" (JSI Research and Training Institute, 2015).

The Vermont Population Health Work Group's working definition of an ACH is:

> "An aspirational model—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. Population health outcomes are understood to be the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, economic circumstances and environmental factors. 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."

States including Minnesota and Washington have initiated the development of ACHs and have received federal State Innovation Model (SIM) grants to support their efforts.[10] Minnesota is expanding service delivery and payment models that support collaboration to better coordinate care for all residents.[11] Washington is working to bring together public and private entities to work on shared health goals through ACHs and plan to use their work to inform financing adjustments beginning with Medicaid.[12] California is considering establishment of ACHs that

[10] *Accountable Communities for Health, Strategies for Financial Sustainability*. San Francisco, CA: JSI Research and Training Institute (2015).
[11] Minnesota Office of the Governor et al. *Minnesota Accountable Health Model*. Minnesota. http://mn.gov/health-reform/SIM/. 2015.
[12] Healthier Washington. *Accountable Communities of Health.* Washington State. http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx. 2015.

would include strategies related to clinical care, community programs and referrals, community environments, and policies.[13]

An Accountable Community for Health advances previous efforts in community health by engaging healthcare as a central partner in community-wide health improvement. At its core, the ACH is a structure for collaboration that represents a major change in direction in healthcare with tremendous opportunities and challenges.

As emerging, the ACH concept is unique in that it:

1) Brings together major healthcare providers across a geographic area, and requires them to operate as partners rather than competitors;

2) Focuses on the health of all residents in a geographic area rather than just a patient panel;

3) Engages a broad set of partners outside of healthcare to improve overall population health; and

4) Identifies multiple strands of resources that can be applied to ACH-defined objectives that explore the potential for redirecting savings from healthcare costs to sustain collaborative efforts.

[13] California Healthcare Innovation Plan WorkGroup. *Advancing Community Health Workers to Improve Health Outcomes and Reduce Costs*. State of Californian. Prepared by Barbara Masters. http://www.chhs.ca.gov/PRI/CHW%20Work%20Group%20report%20FINAL.pdf. 2015

METHODS

Prevention Institute (PI), in support of the Population Health Work Group of the Vermont Health Care Innovation Project, began conducting research into the potential for establishing Accountable Communities for Health (ACH) in Vermont in January of 2015. Prevention Institute (PI) developed criteria to employ in a screening process used to identify local sites that were engaged in activities that aligned with the concept of an ACH. These criteria were based upon a review of ACH literature, State Innovation Model program plans, discussions with the Population Health Work Group Planning Group and internal analysis and discussion with Prevention Institute staff. Potential case study sites were also identified by scanning recent publications and conference agendas featuring innovative healthcare–community partnerships to improve population health. Prevention Institute used these criteria to screen potential national sites with the aim of identifying a varied group of four to six that had particular strengths that matched our diverse criteria. Five sites were identified through this screening process: San Diego County, California's Live Well San Diego Initiative; Pueblo County, Colorado's Pueblo Triple Aim Coalition; Bernalillo County, New Mexico's Pathways to a Healthy Bernalillo County initiative; Summit County, Ohio's LiveHealth Summit initiative; and Lane County, Oregon's Trillium Community Health Plan. These are referred to as the national case studies throughout the report.

Once these national sites were identified, the national case study research commenced. This research process involved a series of interviews with core team staff members and affiliated partners that represented different sectors and were engaged in various levels of the work. To help prompt informative discussions, Prevention Institute developed and used an interview guide designed to be synchronized with the criteria from the Final Screening Criteria for National Exemplars. Interviews for the national exemplar research were conducted over the course of several months. All official conversations were recorded and detailed notes were compiled. PI staff relied heavily on notes and recordings to write the case studies for each community.

Simultaneously, Prevention Institute began to expand its focus to investigate the building blocks already in place in Vermont that could potentially be built upon to form an ACH initiative. The first phase of research involved gathering information on existing Vermont communities that exemplified elements of an ACH. PI created an online survey allowing interested parties to submit information detailing the work they were engaged in and describing which elements of an ACH were present in their community initiative. The Vermont Accountable Health Communities Survey was disseminated by the Population Health Working Group in February of 2015 (the survey questions are included in the appendix). Within a week, PI received numerous responses from a diverse range of organizations. Working with the Population Health Planning Group, PI agreed on six communities that exemplified several elements of an ACH, including: Franklin and Gran Isle Counties, Caledonia and Southern Essex Counties, Chittenden County, Windsor County, Upper Connecticut River Valley, and Windham County.

Once the six communities were identified as sites, Prevention Institute staff contacted the lead members from each community and scheduled initial interviews. PI staff gathered information about the work interviewees were engaged in to gauge how close their sites were to developing an ACH. Three PI staff members traveled to Vermont in March 2015 to conduct three-hour interviews with representatives at the Franklin and Gran Isle Counties, Caledonia and Southern Essex Counties, and Chittenden County sites. The three other sites were contacted and interviewed via phone in April 2015. All of the interviews conducted for the purpose of gathering information on the work underway in Vermont were recorded and detailed notes were compiled. PI staff relied heavily on notes and recordings to write brief profiles of each site.

Data collected from Prevention Institute's national scan and the information included in the profiles of the Vermont sites were used by PI to prepare a final report for the Population Health Work Group of the Vermont Health Care Innovation Project in June. This final report included analysis of the promising core elements and considerations for a Vermont ACH initiative and the state of the field locally and nationally, as well as a set of recommendations.

Limitations—One artifact of the integrator role, in both the national and Vermont research, is that it was sometimes difficult to distinguish efforts being carried out specifically under the umbrella of the Accountable Community for Health from other work of the convening organizations. The participation and responses from Vermont sites may also have been influenced by communication from the Population Health Work Group that implied funding support for ACH might be available in the future. The research conducted for the purpose of this report did not include a review of public health and community prevention activities in Vermont.

SYNTHESIS OF FINDINGS

The following section presents the overarching themes drawn from five national Accountable Communities for Health case studies and the lessons learned from six Vermont communities. Based on an analysis of these findings and related research, we describe nine elements that are core to the functioning of an Accountable Community for Health and provide specific community examples.

Themes from the National Case Studies

The national and Vermont study sites were all strong mission-focused collaboratives focused on improving population health. At the same time, our research revealed that the concept of Accountable Communities for Health (ACH) remains in the developmental stage. Our screening criteria reflected thinking in the field about potentially valuable elements of an ACH; communities on the ground are moving towards building out all of these elements. Therefore we determined that even the most advanced sites still qualify as "emerging" ACHs.

Relatively few communities in the country are implementing healthcare delivery and payment reforms that include environmental change strategies as a key pillar for improving population health. In our national scan to identify case studies, it was difficult to find collaboratives engaged in community change efforts. By and large, healthcare–community partnerships (our most basic criteria for an ACH) are taking action to strengthen services to *individuals*. These individual-level services may include community-based case management; mental health and behavioral health services; social and economic support services; and individual or group health education to support healthy behaviors. In selecting potential national case studies, it was challenging to identify sites engaged in community-level policy and organizational practice change to influence the social, physical, and economic environments that are shaping health outcomes of community residents. Our case studies were selected to highlight sites supporting community-wide environmental change efforts.

Food, physical activity, and tobacco are the primary focus of advocacy and policy change efforts. Decades of investments in community prevention to address chronic disease through policy, systems, and environmental changes aimed at addressing tobacco, food, and activity behaviors have had a significant impact. To the extent that collaboratives focus on policy and advocacy, food, activity and tobacco are the most common issues addressed.

Decades of investments in community prevention to address chronic disease through policy, systems, and environmental changes aimed at addressing tobacco, food, and activity behaviors have had a significant impact.

The social and economic needs of patients and low-income community residents are broadly recognized and primarily addressed through individual service referrals. Healthcare increasingly recognizes that social and economic needs—such as housing, transportation, and employment—must be addressed in order to improve the success of patient treatment. In our national case studies, these immediate needs are primarily addressed via individual referrals to

governmental and community based-services, the availability of which varies from community to community. Some collaboratives are beginning to consider how they might also address social and economic determinants from a prevention and systems perspective. In these cases, the identification of a menu of specific policies (e.g. related to economic development and employment, fair wages, or access to affordable housing) and the correct level of engagement for a health-focused collaborative largely remain a work in progress.

Ongoing engagement of community residents is a challenge. While community residents are frequently engaged in the community health needs assessments process, their level of engagement in the development and implementation of solutions appears lower. This results in missed opportunities to fully include the voices and visions of community residents, particularly low-income residents and people of color that typically experience the poorest health outcomes.

Emerging Accountable Communities for Health are using a variety of financing mechanisms. The driving vision of these emerging ACH efforts is a shared mission to improve the health of all community residents; healthcare cost savings is seen as a secondary long-term goal. Capturing and reinvesting healthcare savings is one potential strand being explored for the future. Some site leaders emphasized that requiring short-term (3-5 year) reductions in healthcare costs should not be an impediment to fostering collaborative action that can make a real difference in the well-being of the community.

Collaboration often reflects long-term relationships and a commitment to one's hometown or region.

Themes from Vermont Sites

Our Vermont visits and interviews revealed an impressive set of actions being taken and a highly committed leadership that can serve as potential building blocks for a more formal Accountable Communities for Health effort. Our meetings with collaborative leaders left a strong impression regarding their commitment to improving health and advancing the welfare of community residents. This was particularly poignant in smaller communities where collaboration often reflects long-term relationships and a commitment to one's hometown or region. As a whole, Vermont communities are in the early stages in the ACH development process and many do not yet have a well-defined governance structure. The reflections below do not represent a comprehensive analysis of Vermont efforts, but rather, are based on observations from our site visits and interviews with six communities responding to our request for information.

Vermont's healthcare leadership is interested in the ACH model—Vermont hospitals and health systems have taken particular notice of the ACH concept. Hospital leadership expressed both a passion for their mission of improving health in their community and the sense that given the future direction of healthcare they have to change their mode of operation to be more accountable for improving health and reducing costs. The hospital leaders in the Vermont sites were clear that many factors beyond healthcare have a strong influence on health outcomes. Unlike the national case studies, it is notable that Vermont hospitals frequently serve as the integrator and not merely an Executive Steering committee participant. While we primarily met hospital staff, in a few places, federally qualified health centers and individual medical and dental providers are participating on leadership teams.

Strategic priorities and actions —Vermont collaboratives are focused on a similar set of priority community health challenges as the national sites, including: chronic disease related to tobacco, food, and activity behaviors; mental health and substance abuse; and poverty. A common area of focus is health education and healthy lifestyles (especially tobacco, diet, physical activity, and drug abuse prevention) through one-on-one sessions and community settings such as schools or workplaces. Another focus area is supporting patients outside of healthcare, as described in the Blueprint section below. All the Vermont collaboratives described at least a few local and state level policy goals. Three of the six communities have a more developed approach to promoting a menu of community environmental changes that support health including tobacco policies, healthy worksites and school policies, and promoting health as a central tenet in regional planning.

Paradigm Differences Between Partners Around the Table—An Accountable Community for Health is bringing together organizations with different paradigms. By mandate, and through professional training, healthcare and community service agencies are focused on providing services to individuals in response to pressing health concerns. Community-wide prevention organizations apply an environmental lens to identify community factors that can be improved to prevent illness and injury. In some sites, healthcare and service providers are the primary collaborative members. This can influence the selection of priorities putting greater emphasis on improving services to individual clients.

> Community-wide prevention organizations apply an environmental lens to identify community factors that can be improved to prevent illness and injury

Impact of the Blueprint—Vermont sites are clearly focused on improving access to non-medical services (ranging from mental health and substance abuse treatment to governmental and non-governmental social and economic support services) and coordinating them with medical services. The statewide Vermont Blueprint for Health Community Health Teams (multi-disciplinary care teams offering free services to the local population) is integral to this service coordination. Many sites also referred to Blueprint initiatives such as Support and Services at Home (SASH) and Hub and Spoke as important contributors to their ability to meet the needs of patients. For example, SASH teams are based at subsidized housing sites and feature a wellness-focused nurse and a coordinator per 100 people and focus on assisting high-risk Medicare recipients to have a good quality of life as they age in their homes. The Hub & Spoke program adds a licensed counselor and nurse coordinator for Medicaid beneficiary patients with mental health issues and co-occurring opiate dependency, with treatment in the practice setting or specialty centers.[14]

Consider the role of Unified Community Collaboratives—Blueprint Managers are working with providers and Provider Network Leaderships to establish Unified Community Collaboratives (UCC) in each Health Service Agency, in order to bring together an important range of Blueprint leaders and staff, and healthcare, behavioral health, and support providers to the local leadership table along with Accountable Care Organizations (ACOs). The UCC was mentioned in a few site

[14] *Vermont Blueprint for Health: 2014 Annual Report*. Winooski, VT: Department of Vermont Health Access, p. 10, 2015.

interviews as a potential mechanism for strengthening local collaboration around healthcare, mental health, and human services. We also heard some concerns about the relative power of participating members (acknowledging that hospitals have significant resources beyond those of other partners) that could potentially interfere with genuine collaboration, particularly if decisions coming out of the UCC influence the division of existing or new resources.

Findings by Core Element

Based on analysis from our interviews, Prevention Institute has identified nine core elements of the Accountable Community for Health model. These are presented and discussed below.

Core Elements of an Accountable Community for Health

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**

1. Mission

- ACH mission statements provide an organizing framework for the work that collaborative partners agree to, and serve as the basis for other goals of the ACH.

- Nationally and in Vermont, strong emphasis is placed on improving geographically-based population health; with a robust definition often codified into the mission statements of the collaboratives.

- A defining characteristic of an ACH is that it is concerned with all residents in its area. This must be clearly articulated because it is a paradigm shift from the current orientation

of some of the partner organizations, which primarily or entirely focus only on their patients or clients.

- A strong mission also includes language that references the community determinants of health, safety, and well-being that must be addressed in order to improve population health. For example:
    - "To expand beyond the medical model of health and connect to community to examine social, economic, and behavioral factors."
      - Windham County, Vermont, **Accountable Community**
    - "That Chittenden County becomes a healthy, inclusive and prosperous community."
      - Chittenden County, Vermont, **Environment Community Opportunity Sustainability (ECOS)**

- Health equity is often more of an implicit aim. Virtually all work examined was concerned with the health of low-income residents, yet few organizational missions explicitly highlight equity. Making health equity a part of the mission promotes specific attention to considering the health equity impacts of decisions by the ACH, including priority strategies, investment of resources, and the voices included through the process of planning and implementation.

2. Multi-Sectoral Partnership

- ACHs comprise a structured, cross-sectoral alliance of healthcare and other organizations that impact health in their region.

- ACHs must include the breadth of organizations that are able to help them fulfill their charge of implementing comprehensive efforts to improve the health of the entire population in their defined geographic area.
    - Nationally and in Vermont, hospitals and public health are virtually always included in the collaborative leadership team.
    - Other core healthcare leaders vary greatly by location: medical payers, federally qualified health centers, governmental and non-governmental mental and behavioral health providers.
    - In addition to healthcare, other frequent leadership team members include city and local government, business representatives/Chambers of Commerce, and academic centers.
    - Additional leadership team members come from a range of sectors, including school representatives, media, social and economic support service providers, community resident organizations, advocacy organizations and sectors that can support improvement related to priority community changes—e.g. regional planning commission, transportation, economic development, food systems, parks and recreation.

- Nationally and in Vermont, some leadership team partners primarily come from the service delivery sectors—healthcare, mental health and substance abuse, and social service organizations. Service providers' training, skills, and organizational mandate are focused on providing treatment/resources to individuals in response to a presenting problem. Multi-sector partnerships need to include representatives with skills and experience in analyzing illnesses and injuries from a prevention perspectives, identifying underlying community environmental factors that are shaping health outcomes and designing strategies/recruiting partners to address those community factors.

- Wide-ranging partnerships appear helpful in achieving goals that individual partners would otherwise not accomplish. For example, the Live Well San Diego partnership deliberately includes advocacy organizations, which enable the promotion of local policy change that other partners would not be able to achieve alone.

- Effective multi-sector collaboratives require skillful management. There are challenges, but ultimately opportunities from various sectors in understanding one another's perspective and in identifying common solutions—which requires skillful facilitation. Engagement should be structured to maximize the contribution of each partner.

- While buy-in by all partners is essential, this does not require everyone to participate in every meeting. Some of the best contributions emerge from small groups working together or from one-on-one engagement. For example, service providers may meet to discuss improving systems for cross-agency referrals and follow-up; this can be independent from engagement with food system organizations, which can provide advice on strengthening access to healthy food for low-income residents. Some partners may provide valuable expert advice or help promote ACH efforts without ever coming to a meeting.

- Different ACHs flourish with different leadership. The Integrator may serve as chair of the coalition in some, but in other cases is better working behind the scenes.

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 organization has also been described as a "backbone organization," "quarterback," or "convener." While the exact role of the integrator organization may differ based on the structure of the collaborative, some common roles that were mentioned include:
    - Carrying the vision of the ACH

  - Engaging collaborative members in specific elements of implementation; and fostering accountability for the mission and specific commitments
  - Establishing a collaborative culture that acknowledges and benefits from the different expertise, mandates, and resources of collaborative members; building trust among partners; addressing turf issues
  - Convening and staffing meetings
  - Shepherding the planning, implementation, and improvement efforts of collaborative efforts
  - Recruiting new partners
  - Building responsibility for many of these elements among collaborative members and providing a "trellis" or framework for partners to organically recognize nodes of leadership, build connections, and foster mutually beneficial growth.[15]

- The five collaboratives examined on the national level included a range of organizations fulfilling the integrator role: county health department, county health and human services agency; a university medical school department, a new non-profit established to serve as integrator, and a health plan.

- The Vermont sites stand out from the national landscape because in the majority of places hospital staff are playing the integrator role.

> Trust was described as the most critical attribute of an ACHs coordinating organization.

- Regardless of organizational type, trust was described as the most critical attribute of an ACH's coordinating organization. The other partners in the collaborative must have full faith that the coordinating organization is dedicated to the overarching goals of the partnership and that it deals with all partners fairly. (This point was driven home in virtually all discussions with interviewees across the country and in Vermont, with an emphasis that this trust is built incrementally over time only with great patience and skill).

4. Governance

- ACHs are managed through a governance structure that articulates the roles and responsibilities of the collaborative partners and includes an explicit role for community engagement in the ACHs' work.

- Nationally, collaboratives vary in the level of formality of governance structures. The Pueblo Triple Aim Coalition is guided by the bylaws of the coordinating Triple Aim Corporation, which require participation from the CEOs of its major partners.

[15] Gunderson G. *Trellis*. http://garygunderson.net/2015/04/19/trellis/. 2015.

- A governance structure at minimum articulates the roles and responsibilities of the integrator organization, the steering committee and other collaborative partners, and describes the process for decision making.

- Vermont collaboratives generally have a smaller leadership group that meets regularly to exchange information and to identify opportunities for collaboration as well as a broader set of partners that may be convened on occasion. For the most part, there were no formal MOUs between partnering organizations.

- Decisions about funding to specific organizations that will carry out elements of the strategic priorities should be made by a designated group without conflict of interest
    - Trillium Coordinated Care Organization and Pathways Bernalillo County both make decisions about grants to local organizations to carry out specific priority tasks. They use a governance structure that separates final decisions about priority health improvement activities from decisions about which groups receive the resources.

- Consider requiring organizational CEO participation in the Steering Committee to foster organizational commitment and to ensure Steering Committee members are able to speak with the full authority of their organizations.

5. Data and Indicators

- The ACH benefits from data that informs the community assessment and planning process and helps measure progress in meeting outcome objectives.

- Healthcare providers, mental and behavioral health and community service agencies have a wealth of data about pressing medical and social needs of community residents. With appropriate attention to confidentiality concerns—and with the right technology in place—this data can be used to understand patterns of illness and injury across a community. With Geographic Information System (GIS) mapping analysis, this data can also be used to analyze how these medical conditions relate to the specific community factors. For example, it can be used for comparing the density of healthy food outlets to the density of census tracts where Type II diabetics live, or for mapping home addresses of children visiting the emergency room for asthma in relation to housing code violations. This type of analysis can both reveal strategies to improve health and make the case for their necessity.

- Equally important, qualitative data is needed to highlight potential arenas for community action to improve health. Community residents—especially from disinvested communities—should be engaged in discussions to interpret health data and to develop actions to improve community health. The practitioner wisdom gained by community health workers, front line staff, health and mental health professionals, and community

service providers who spend their days learning about the lives of community members is also a valuable contribution to the data to shape community efforts.

- Data sharing remains an aspirational goal for many of the communities examined. The implementation of electronic medical records and the expansion of technology have raised many hopes about the potential for sharing data about individual patients/clients among service providers and for providing real-time data for community assessment and planning. Data sharing amongst ACH partners at its best is multi-directional, meaning that ACH partner organizations are both receiving data from and providing data to the other members of the collaborative. Many sites noted that their goal is that data from medical providers could be directly accessed in real time.

- The Pueblo Triple Aim Corporation – the integrator of the Pueblo Triple Aim Coalition – acts as the central data hub, receiving and analyzing data from partners. For example, reducing emergency rooms visits is a collective goal of the collaborative, and hospital leaders have agreed to share this information.

- ACH collaboratives track progress in meeting outcome objectives through a set of measures. In addition to health conditions, health behaviors, and demographic data, national and Vermont sites are including measures related to community environments as pivotal conditions for shaping health outcomes. In addition to a broader panel of data, Live Well San Diego employs 10 key indicators that reflect cross-sector contributors to health and wellness, and tracks these on an annual basis.

- In two national sites, funding is connected to performance measures. In Lane County, Oregon, Trillium Health Plan, the Coordinated Care Organization receives incentivized awards if it meets metrics. In Bernalillo County, New Mexico, partner organizations (pathways) receive the majority of their funding by meeting various metrics related to supporting clients along the pathway to improved health. For some community agencies, this was a challenge, as they needed sufficient staff capacity upfront in order to meet the needs of clients.

6. Strategy and Implementation

- An ACH develops a strategic framework and implementation plan to guide the work of the collaborative

- In national sites, most collaboratives are drawing on non-profit hospital partner Community Health Needs Assessments and county public health community assessments to build their strategic plan. While exact alignment can be challenging, some sites described “sitting at each other’s table” during the assessment and Community Health Improvement Plan process to strengthen alignment. In Vermont, priorities identified by

non-profit hospitals during the CHNA and CHIP process help inform the work with their community partners.

- Building on existing assessments, the ACH can help ensure that the process includes a prevention analysis related to community conditions. This analysis begins with the medical conditions of greatest concern and systematically examines risk factors, and the community factors that are shaping those risk factors. For example, Type II Diabetes may be the medical condition of greatest concern. Poor diet, sedentary behavior, and high stress are risk factors making it more difficult to control blood sugar. These risk factors can be traced in part to a lack of full-service grocery stores and places to be physically active in the patient's community, and the presence of family violence in the home. In order to develop an effective community health improvement plan related to diabetes, action is needed to address the multiple levels of influence on behaviors—ranging from family norms to policies and systems. These levels are represented in the Vermont's Prevention Model[16] (reflecting the social-ecological model of health behaviors). A strategic planning framework like the Spectrum of Prevention[17] helps collaboratives select strategies that address these multiple influences.

- For implementation, partners in the collaborative commit to carrying out specific elements of the plan; this may require dedicated resources. The integrator fosters group accountability for these commitments. The Pueblo Triple Aim coalition has partners sign commitments to a work plan. The Community Health Improvement Plan in Lane County, Oregon, (Trillium Coordinated Care Organizations) includes assigned responsibility to specific organizations for specific strategies.

> Authentic community engagement recognizes and harnesses residents' own power in identifying and addressing challenges, while also creating leadership for and buy-in to the work

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 to the work in a manner that acknowledges and builds upon existing community assets and strengths.

- Authentic leadership roles for and community engagement of low-income residents, people of color, and other marginalized groups in health improvement efforts is a key health equity outcome. Authentic community participation should be prioritized throughout: assessment, planning, implementation, and evaluation processes, with a particular emphasis on involving individuals and populations whose voices are most

[16] Vermont Department of Health. *Vermont's Prevention Model*. http://healthvermont.gov/dvsv/model.aspx#model. 2015.
[17] *Spectrum of Prevention*. Oakland, CA: Prevention Institute. http://preventioninstitute.org/component/jlibrary/article/id-105/127.html.

commonly missing from the table. Standard elements of community engagement include: listening to and incorporating community recommendations; creating structures, processes and a welcoming atmosphere to support development of resident leaders and ensure community participation; undertaking proactive outreach to existing community-based groups and representatives; establishing a meaningful baseline standard for involvement and representation of community members; and establishing formal structures and mechanisms, including program evaluation, to ensure effective resident involvement in decision making.

- Formal structures to ensure authentic community participation include but are not limited to: a community advisory council; a leadership development and capacity-building program; mandated community participation in the ACH's leadership structure; robust community involvement in the Community Health Assessment and Community Health Improvement Plan processes; and development of long-term, sustainable infrastructure to support ongoing resident leadership and involvement in the ACH and other community-level prevention initiatives.

8. Communications

- An ACH employs communications platforms to build momentum, increase buy-in amongst partners and the community, and recruit additional partners.

- Communications is a key element of transparency and accountability to the community.

- Communications is critical to help partners within the ACH, members of the community who may be less knowledgeable about the ACH, and other communities seeking models and best practices, to be well informed.

- Communications plays an important role in shifting the frame from health being primarily about *healthcare*, which is after-the-fact, to focusing instead on *in the first place* population health—moving from the portrait to the landscape.

- Collaboratives with effective communications networks are often better able to attract grant funding toward their projects through the increased recognition they receive following the dissemination of their work in attractive, easy-to-understand ways.

- Live Well San Diego in San Diego County, California, has a highly developed communications network that is strengthened by reinforcing its existing frameworks, strong graphics, and easy-to-understand content.

9. Sustainable Financing

- An ACH requires funding, both to support the Integrator organization and to support the implementation of the ACHs work by others.

- Nationally, most coordinating organizations needed approximately 2.5 FTE staff to fully engage in the work. This number will vary by size, involvement, and complexity, but may provide a useful guidepost for funding.

- In addition to new resources, redirecting the resources of ACH partners can be a strategy for implementation. For example, the Parks Department may prioritize a community park and ensure that repairs are done in order to support an overarching physical activity goal of the ACH.

- To the extent possible, focusing on sustainable funding approaches is beneficial. Nationally, the work in Bernalillo County, New Mexico is relatively sustainably funded through a dedicated portion of a mill levy (property tax) going to the collaborative; the levy is approved for 8 years with the possibility of renewal. In Lane County, Oregon, prevention staff and activities are funded through a per-member-per-month set aside of Medicaid global payment dollars, which is perhaps the best example of redirecting current streams of healthcare funding to prevention.

- Neither nationally nor in Vermont is there currently an ideal funding source that can be borrowed to support the ACH. Much work remains in order to develop the sustainable financing models that will support and reward improvements in population health.

- Financial accountability, i.e. effective investment toward reaching goals and consideration of return on investment, is important. The push toward tying financial accountability to the ACH's ability to reach certain benchmarks should be balanced with caution that accountability measures do not disproportionately orient the ACH activities toward short-term service delivery at the expense of comprehensive community prevention strategies that generally have a longer return on investment that can be more difficult to measure.

- An ACH can make use of existing and new funding sources and better align them to advance broad community goals. These include:
    - Philanthropic, community development, community benefits investments
    - Taxes or fees related to production of products with known health risks. (e.g., tobacco, sugary beverages, and alcohol)
    - Taxes on certain population segments (e.g., individuals with annual incomes greater than $1 million) or enterprises
    - Fees charged to health insurers and/or acute care hospitals (e.g., Massachusetts' Wellness Trust Fund)
    - Social impact bonds
    - Legal penalties or settlements
    - Savings generated through prevention efforts that are captured and reinvested

STATEWIDE RECOMMENDATIONS

Accountable Communities for Health in Vermont

Vermont has many building blocks in place that make the establishment of Accountable Communities for Health (ACH) a logical next step in advancing health reform efforts. In a number of places, established hospital – community partnerships already exist with identified priorities to improve the health of residents in a geographic area, and, it appears, there is much trust between partners based on a history of working together. The size of the state is well-suited to establishing core state-level supports that can help locally-determined ACHs to flourish.

Vermont's Accountability Community for Health working definition is notable in that it specifically calls out two important pillars of a system of health:

- Integrated medical care, mental and behavioral and social services.
- Community-wide prevention efforts.

Thus it provides a framework for evolving to a health system that advances both excellent treatment and high-quality prevention, arenas Vermont has made significant progress in achieving. An ACH could be an organizing framework for maximizing synergy among current service enhancement efforts; and for increasing the level of effort devoted to community prevention in the context of the health system.

In the words of the *Vermont 2007 Blueprint for Health Strategic Plan*, "preserving good health and preventing disease is so obviously important that few would disagree that they should be the focus of any health care system; yet prevention is frequently neglected to address the more immediate demand for care…Prevention strategies are more likely to be effective if they are targeted to both the individual and the population as a whole, and are designed to simultaneously reach multiple levels of influence on behaviors."[18]

"Preserving good health and preventing disease is so obviously important that few would disagree that they should be the focus of any health care system; yet prevention is frequently neglected to address the more immediate demand for care…Prevention strategies are more likely to be effective if they are targeted to both the individual and the population as a whole, and are designed to simultaneously reach multiple levels of influence on behaviors."

Vermont is well positioned to serve as a national model for advancing population health through an ACH effort that achieves this Blueprint goal of complementing quality integrated care with population-wide prevention efforts. The following recommendations are offered for

[18] Vermont Department of Health. *Vermont 2007 Blueprint for Health: Strategic Plan, Report to Legislature on Act 191*. 2007.

consideration, along with the core elements in the previous section, to advance and nurture local ACH efforts.

A. Fostering an overarching statewide approach to support ACH effectiveness.

Develop a statewide strategic framework for population health improvement to support local ACHs in setting priorities

The establishment of a state-level strategic framework for population health improvement would help support local ACHs in developing strategy that spans service integration and community-wide prevention. This framework should illustrate the multiple influences on health, and thereby convey the contribution of diverse sectors to population health (e.g. healthcare; mental, public and behavioral health; community services; food systems; planning; transportation; schools; and business).

Building this strategic framework with broad participation from Vermonters can help cultivate widespread understanding of the need for comprehensive approaches that range from building individual skills to changing community environments. The Vermont Prevention Model and the Spectrum of Prevention[19] are two tools for designing a comprehensive approach. Vermont's strategic framework can be supplemented by more detailed menus of strategies such as those included in the Statewide Health Improvement Plan. Rather than each ACH having to 'reinvent the wheel,' local communities can build a tailored strategic plan that draws from a synthesis of evidence-informed strategies related to their priority health concerns.

As part of the framework, we recommend elevating language which emphasizes health equity as a goal and promotes improvement in community conditions for low-income communities and for Vermont's growing population of people of color. The State itself should reflect these priorities in its overall approach to population health including by directing funding to communities that have the most impacted community environments, and by supporting and engaging community resident leaders.

Establish a core set of community-level indicators for use by local ACHs to monitor progress in community-wide prevention

A core set of leading community health indicators can help the State and local ACHs monitor progress in addressing the range of factors in the social, economic, and physical environment that have been prioritized for action in the State strategic framework. By selecting indicators that relate to multiple sectors, they will help foster collective responsibility for achieving improvements in prevention and wellness.

The State of Vermont's Leading Health Indicators[20] report the prevalence of health outcomes and health behaviors. In addition, community health indicators can help direct public attention to specific changes that can be made—in workplaces, schools, and places of worship, as well as local government policies—that represent important actions along the way toward achieving

[19] *Spectrum of Prevention*. Oakland, CA: Prevention Institute. http://preventioninstitute.org/component/jlibrary/article/id-105/127.html.
[20] Vermont Department of Health. *Health Research Data & Records*. http://healthvermont.gov/research/. 2015.

longer-term health improvements. Initially, there may be interest in creating a broad menu from which local communities make selections; ultimately it will be valuable to have a subset of indicators to monitor statewide progress.

There are Vermont resources to draw from for community indicators, such as: Scorecards developed by Rise Vermont to promote healthy environments related to food, activity, and tobacco; or the ECOS Scorecard, used in Chittenden County, which also includes indicators of health-promoting factors related to community planning, transportation, and economic development. Further, community health indicators have been a strong interest across the nation and there are many existing frameworks to draw from (Star index, Seattle King County, San Diego County).

Emphasize accountability mechanisms that are linked to population health improvement
Building on the metrics, the State should explore accountability systems for regional ACHs to incentivize quality collaboration and outcomes. Given that improving population health is the primary mission of local collaboratives, the desire for achieving reductions in healthcare costs should be approached with caution. Due to the national political emphasis on short-term return, accountability measures are frequently focused on achieving a 3-5 year return on investment in healthcare dollars. Such measures, while responsive to some purposes, orient the ACH activities toward short-term easier-to-measure service delivery at the expense of comprehensive community prevention strategies (that may have a longer return on investment and can be more difficult to measure). To achieve Vermont's goals, it may be advantageous to tie accountability more to achievement of process and outcome measures that fall along the pathway to improved population health, but are not explicit health indicators. Examples of such indicators include number of patients successfully placed in stable housing for 12 months, number of residents with access to community food, and number of smoke-free housing options.

Phase in the formation of Accountable Communities for Health
Vermont's healthcare innovations implemented in the Blueprint Health Service Areas have set the stage for considering creating ACHs in all 14 places. We recommend beginning with providing funding to localities with greater readiness to test out the ACH elements, then documenting outcomes. The learnings from these community experiences can be used to refine the model and set realistic outcome expectations before taking it to scale across the state.

The core ACH elements can provide a basis for assessing readiness. Some minimum requirements we would recommend include:

- Integrator organization with demonstrated capacity to engage partners in achieving mutually-determined outcomes
- A multi-sector partnership including at least healthcare, public health, mental health, and 3-5 additional community sectors that reflect a diverse set of community interests; partners with the legal and organizational capacity to advocate for policy change
- A clearly defined leadership structure and decision-making process
- A Steering Committee with responsibility for setting the general direction and strategic priorities
- A formal resolution of commitment by the Boards of Directors of each Steering Committee member

- An existing strategic framework with some identified priorities for action spanning individual services to community environmental change
- Commitments from partners to align some existing efforts and resources towards mutual goals

Explore the role of State Government in participating in local Accountable Communities for Health collaboratives
Vermont Department of Health district office staff members are collaborative members in several of the Vermont sites. Given the multi-sector nature of achieving Accountable Communities for Health outcomes, there may be other State district offices or jurisdictional authorities such as Regional Planning Commissions that could also contribute expertise and resources to support ACH efforts. We recommend further assessment to determine the opportunities and challenges to facilitating this participation, and what it would take to equip staff to effectively participate.

B. Provide guidance to enable regions to effectively establish Accountable Communities for Health

Ensure ACHs balance individual service integration and community prevention efforts
The State should require that localities receiving funding for Accountable Communities for Health engage in a comprehensive set of strategies that span service integration and community prevention work. This comprehensive approach should be specifically illustrated via the Vermont Prevention Model or other selected framework. Several of the profiled Vermont communities already exemplify this breadth of effort. In other HSA regions, healthcare leaders need support in fully building out these comprehensive strategies.

Conduct a network analysis of community prevention efforts in each Health Service Area
The Vermont Blueprint Health Service Areas have each completed a network analysis that helps give a picture of healthcare and other service provider organizations across their regions. We recommend initiating a complementary assessment of community efforts related to prevention; emphasis would be placed on assessing efforts that promote policies and organizational practices for prevention focused on improving community factors such as food systems, tobacco control, housing, transportation, and environmental sustainability. This assessment will help reveal where there are alliances that the ACH can forge to strengthen prevention efforts around mutually shared objectives, as well as areas of the state where the ACH leaders will be the primary drivers of community changes. ACH leaders may need to develop skills in recognizing and articulating the co-benefits to potential partners outside the health or public health sector.

Encourage ACHs to form around existing regional partnerships and collaborations
ACH implementation in Vermont can build upon and leverage existing structures. Based on our research, the partners in each Health Service Area collaborating around service integration may form a natural building block for an ACH. In some places, we also heard about emerging unified community collaboratives (UCCs) that are described as helping to “efficiently scale priority

service models as they are identified"[21]. An ACH by design needs to include an equally robust cross-sector set of partners that engage in community prevention activities. We present several options below to spur discussion about how best to leverage existing efforts, while building a more comprehensive approach to population health improvement.

The existing Blueprint Health Service Areas may be the logical geographic region for an ACH. However, since the most critical element of an ACH is effective partnership in a defined geographic area it may make sense to consider local variation if partners have a strong history or make a compelling case for varying from the HSA. Further, in order to encourage well-functioning ACH partnerships, we recommend the State not designate a specific type of organization to serve as the integrator.

- Option 1: ACHs are established as independent entities that includes a range of healthcare, mental and behavioral health, community support service, and community prevention partners.
- Option 2: The unified community collaborative structure is expanded to include organizations advancing community prevention strategies, as well as Vermont Department of Health District offices, transforming the unified community collaborative into an ACH with a mission to engage in both service integration activities and community prevention. This would require leadership skilled in bridging service delivery and community prevention efforts.
- Option 3: A community-based prevention collaborative serves as a counterpart to the unified community collaborative. The unified community collaborative regularly shares qualitative information about the social and economic needs of patients (including challenges to adopted recommended health behaviors); and quantitative data that can help make the case for community changes. The community prevention collaborative is charged with developing community environmental change strategies to better support patients and the population at large. The ACH is then composed of these two interrelated collaboratives – one focused on service integration and the other community-based. The ACHs coordinating organization serves as the bridge between the two spheres of work.

C. Build capacity and create an environment of ongoing learning

Expand the paradigm of the health system from healthcare to health

An Accountable Community for Health is establishing a new leadership role for healthcare in helping to drive community-wide changes for population health improvement. Our site visits revealed that some innovative hospital leaders are championing this approach; many acknowledge the impact that community environments and social and economic factors have on their patients' health. In order to take the Accountable Community for Health concept to scale, these views need to be institutionalized into a set of practices that go beyond a particular visionary leader. A more extensive cadre of healthcare leaders needs to be equipped with an understanding of quality prevention strategies and the potential roles organizations can play in advancing these strategies. There are an emerging set of practices for hospitals and community

[21] *Vermont Blueprint for Health: 2014 Annual Report*. Winooski, VT: Department of Vermont Health Access. 2015.

clinics—beyond their role in the ACH *per se*—to use their power as anchor institutions, as employers, as purchasers, and as credible health leaders to support community environmental changes to improve patient outcomes.[22,23,24] Further, healthcare, mental health, and community service providers (including nurses, community health workers, and others) bring their understanding of the many challenges faced by their patients and clients, and may need assistance in expanding from a one-person-at-a-time service delivery model to a community-change model. They can share information with clients about how to get involved in community change efforts.

More broadly, effort is needed to elevate across the state the understanding and inclusion of community-wide prevention efforts as part of health system transformation. Knowledge of community prevention approaches and how they are connected to reducing the frequency and severity of medical conditions is not as widespread as it needs to be to best advance population health improvement. There has now been more than a generation of robust and effective community prevention strategies and these approaches must be understood beyond public health and community health practitioners, and applied to current health priorities. A community-prevention analysis that begins with the specific medical conditions of greatest prominence can help illustrate the tools of effective prevention strategy, and support the ACHs in identifying the underlying community determinants and the best practices and strategies to ameliorate them.

Foster skills development for the emerging cadre of ACH leaders

ACH leaders will benefit from training and technical assistance to grow into the role of effectively working together to improve population health. This includes specific attention to the integrator organization, which needs to skillfully staff the ACH, and maintain these functions when there is staff turnover.

As part of an ACH roll out, the State will need to facilitate assessment and delivery of training and technical assistance around the core elements of an ACH. This should include establishing a peer learning network that can maximize exchange among ACH communities. As different ACH members may have different needs, e.g. integrator, healthcare and service providers, community members, non-health sector partners, there will be benefits to specialized training and peer learning.

Further, the ACH rollout can be an opportunity to expand knowledge around the state about core community prevention concepts and practices and their importance for population health improvements. This can be a method for informing and attracting many existing leaders across the state to contribute to building a strong local ACH. For example, people active in tobacco control or maternal child health may already be comfortable with taking action to change organizational practices and public policy and can contribute this expertise to the ACH.

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[22] Serang F, Thompson JP, Howard T. The Anchor Mission: A Case Study of University Hospitals Vision 2010 Program. University Hospitals, Cleveland, OH. 2013.

[23] Phillips FB. Sustaining Community-Hospital Partnerships to Improve Population Health. Maryland Community Health Resources Commission. 2015.

[24] Cantor J, Cohen L, Mikkelsen L, Pañares R. *Community Centered Health Homes: Bridging the gap between health services and community prevention*. Oakland, CA: Prevention Institute. 2011.

Promote authentic community engagement in all aspects of the ACHs and their work
ACHs in Vermont should be explicitly required to engage community residents, with a particular emphasis on involving individuals and populations whose voices are most commonly missing from the table. Authentic community engagement will support greater success in population health improvement efforts. The State should consider engaging a TA provider with this specific expertise to ensure ACHs are well supported in establishing practices to meaningfully engage community residents.

Encourage the creation of robust communications platforms for the ACHs
As described under the ACH core elements, effective communications efforts support the work of the ACH by encouraging stakeholder buy-in, engaging the community, providing transparency and accountability around activities, and sharing its model of success across the state as well as with other potential health innovators. Regional ACH organizations will benefit from State support in developing and disseminating communications materials. Quality communications can also be effective at attracting grant investment to support the work of the ACH and for helping political leaders better understand the ACH contribution to health.

D. Explore Sustainable Financing Models for Accountable Communities for Health

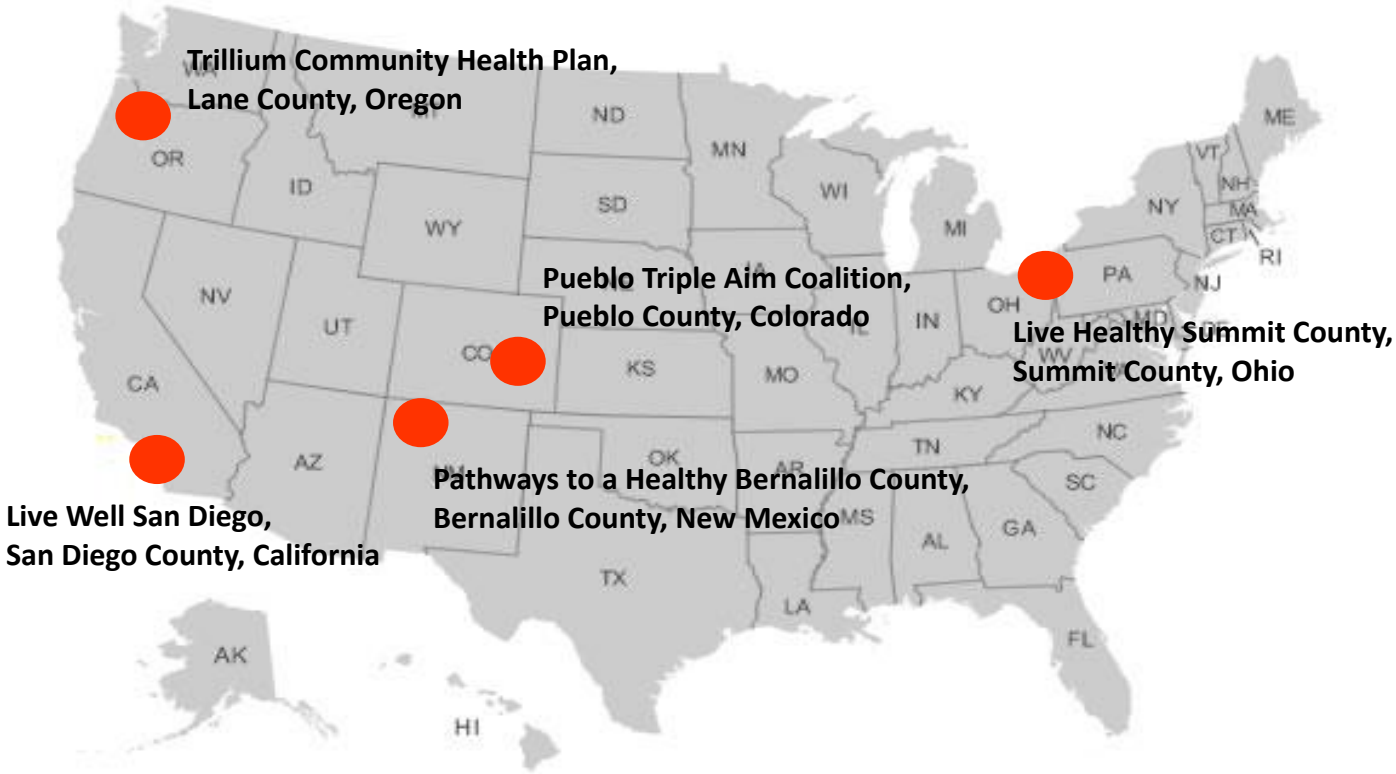
Financial resources are necessary for ACH effectiveness. There are already innovative payment streams (e.g. medical homes, Community Health Teams, SASH, Hub and Spoke) in Vermont to support integration of patient care and to help meet non-medical needs that are essential for healing and health. Discussions to clarify the extent and flexibility of such funding need to be completed.

In addition, dedicated funding is needed to support the ACH integrator organization and to spur comprehensive community prevention efforts carried out by ACH partners and others. Investing in community prevention is the most effective mechanism for significantly reducing future illness and injury across a community. Notably, an effective ACH community prevention effort can help align existing funding streams in support of health and wellness, such as federal transportation dollars, or successful competition for new dollars such as U.S. Farm Bill programs to strengthen food access and local food systems.

We recommend building up and aligning ACH funding with existing prevention funding streams as well as exploring ways to create a new funding mechanism. Across the country new ideas and funding models are emerging. Potential options include:

- Dedicating a portion of a new or existing tax to fund ACH activities.
- Specifying that a portion of a global healthcare payment or a per-patient per-month assessment on payers support the ACH upstream effort.
- Establishing a wellness trust to support the ACHs, funded through one or a blend of the sources described previously under core element nine.

NATIONAL CASE STUDIES



Live Healthy Summit County, Summit County, OH

SNAPSHOT

Name of Initiative	Live Healthy Summit County
Population Served	The entire population of Summit County, Ohio (pop. 541,824).
Leadership Structure	Coordinated by Summit County Public Health, overseen by an Executive Committee, and informed by a soon-to-be-merged Advisory Committee and Wellness Council that represent external organizations and the community.
Partnership Structure	Summit County Public Health coordinates efforts with external partners participating on a voluntary basis.
Number of Staff	Live Healthy Summit County is fairly well-integrated into Summit County Public Health, making it difficult to determine the exact number of staff members involved. It is estimated that nine staff members, including the Assistant Director, are involved in the initiative.
Stated Goal	Live Healthy Summit County seeks to strengthen the local community by promoting healthier lifestyles and reducing chronic diseases and health disparities.
Issues Addressed	(1) Tobacco-free living; (2) Active living and healthy eating; (3) High-impact quality clinical and other preventive services; (4) Social and emotional wellness; and (5) Healthy and safe physical environments.
Scope of Services	From preventative services to policy and built environment change.
Link to other Healthcare Payment or Delivery Reform Efforts	Bidirectional referrals between the medical sector and public health.
Policy Changes	Currently advancing a Health in All Policies platform at the county level.
Funding Sources/ Budget	Funding comes through grant opportunities for different areas of work that the county places under the umbrella of Live Healthy Summit County, as well as general fund dollars dedicated to the public health department.

Key Reported Successes	Project accomplishments include increased Wellness Council membership from 60 to 70 organizations; implementation of software to track health and wellness programs, along with participation from the county's four major health systems; a completed policy scan of the county; and the identification and adoption of key individual and population-wide indicators to evaluate progress. Outcome accomplishments include: adopting smoke-free policies in public housing; changing road structures to calm traffic along school routes; launching a "green cart" program to create business opportunities for vendors to sell fruits and vegetables in food deserts; launching a program in collaboration with two large community health systems to implement enhanced quality of care protocols that support the control of high blood pressure and high cholesterol at 34 sites; and implementing The Million Hearts Project in Summit County - which assists local physician providers in developing a screening tool specific to their practices on assessing psychosocial supports that may be needed by hypertensive clients to maintain compliance in managing their hypertension diagnosis.
Notable Feature	Summit County was the genesis of the Accountable Care Community concept. It has created a structure that involves the three largest regional healthcare systems on its Executive Committee. Additionally, its strategies work along the full spectrum of the socio-ecological model, and it is pursuing a Health in All Policies review for all county policies.

PROFILE

Background

In 2012, the publication of "Healthier by Design: Creating Accountable Care Communities" garnered national attention for its Live Healthy Summit County initiative. This community-level collaborative promotes healthier lifestyles among residents of Summit County, Ohio. The work began in 2008, when the Knight Foundation provided funding to create the Austen BioInnovation Institute in Akron (ABIA) with the support of the local university and hospitals. ABIA's Center for Clinical and Community Health Improvement secured financial commitments from the hospitals to assess county health and document gaps in existing policies, environments, programs, and infrastructure.

In 2011, ABIA's Center for Clinical and Community Health Improvement received a federal Community Transformation Grant (CTG) for capacity building to continue this work. With the support of CTG funds, ABIA organized a coalition of more than 70 community organizations with a range of missions to form the Summit Partners for Accountable Care Community Transformation (Summit PACCT). The coalition was designed to promote healthy lifestyles and

reduce chronic disease prevalence and health disparities. However, sustainable funding for this work proved elusive, and as foundation and federal grant funds receded, stewardship of the project transferred to Summit County Public Health, the current coordinating organization for Live Healthy Summit County.

Population Served
Live Healthy Summit County serves the entire geographic population of Summit County, Ohio. Summit County is currently home to 541,284 residents.

Partnership Structure
Summit County Public Health (SCPH) serves as the coordinating organization for this effort and sponsors all Live Healthy Summit County activities. Approximately nine Summit County Public Health staff members are engaged in the initiative.

Live Healthy Summit County has an Executive Committee composed of executive-level representatives from ten key institutions, three research universities, three health systems, one federally qualified health center, one payer, the Akron city government, and the Summit County government. In addition, an Advisory Committee and a Wellness Committee work to shape overarching strategy, goals, and collaboration. As of May 2015, these two committees are scheduled to merge into one. These committees work on an advisory basis – the collaboration and partnerships involved in Live Well Summit County don't involve a formal governance structure, memoranda of understanding between the various partners, or formal decision-making process.

Notable partners that serve on the various committees include Summit County Public Health, the three major hospitals within Summit County, the Akron Mayor's office, and county government agencies working on social services, housing, and transportation. Other key members of Live Healthy Summit County include substance abuse and mental health providers, the local national park, the United Way, the YMCA, several faith-based organizations, community service providers such as Asian Services in Action, and higher learning institutions such as the University of Akron and Kent State University.

Planning and Implementation
Summit County is moving toward a model of shared community health assessment, but is challenged by legal requirements and timelines. For instance, the Affordable Care Act requires each of the three hospital systems that serve as partners in the collaborative to conduct a community health assessment. Using data provided by sources like SCPH, each hospital conducted its own assessment and wrote an implementation process for the actualization of its plans. After analyzing themes that arose in each of their Community Health Assessments, two priority areas were identified and the three hospitals agreed to pursue a shared effort to address diabetes and prioritize Health in All Policies. As the coordinating organization, SCPH will continue to play a facilitating role throughout the development process of the second Community Health Assessment that the hospitals must produce in 2016.

Live Healthy Summit County strives to improve population health by achieving tobacco-free living, promoting active living and healthy eating, advancing high-impact quality clinical and other preventative services, supporting social and emotional wellness, and fostering healthy and safe physical environments. Through its Million Hearts Project, Live Healthy Summit County is improving the connection between community health resources and healthcare providers by utilizing a referral network to address issues related to social determinants of health.

The initiative also involves partners from a diverse realm of sectors and invites both service providers and higher level policy influencers into the network of members working together to serve the community in a wide range of capacities. At the health department, an organization that serves as a partner in the Live Healthy Summit County initiative, there is a system of care coordination in place to allow staff to call social service providers on their patients' behalf. The collaborative is also involved in educational and training activities. For example, through the Million Hearts Project, training was provided for physicians on how to interact with public health in their communities. As a result of this training, physician offices were able to conduct blood pressure referrals for patients who seemed not to be compliant with their medication regimen or had other social needs. Physician office staff learned how to make referrals to public health. And public health, in turn, learned how to make referrals back to physician offices.

The collaborative also works to change organizational practices as they were involved in getting local employers to introduce worksite wellness practices to their business model. Similarly, SCPH works to influence larger policies and legislation. A Health in All Policies work group was established under the Live Healthy Summit County initiative in an effort to integrate a health framework into all decisions made by county government. This group was able to complete a large community engagement phase of Health in All Policies, host a community event, and send out a survey to collect information about what the community thought would be the most effect policies to include in the Health in All Policies charter. The end goal is to develop a Health in All Policies charter for the county that will garner support from various governing bodies, both public and private.

Funding and Sustainability

Summit County Public Health works with approximately 80 organizations and holds open meetings to encourage community participation. The collaborative activities are funded by leveraging financial resources to support the initiative's priorities. Live Healthy Summit County is funded primarily through grants, which means that the availability of grant-funded opportunities often determines which activities are carried out. Outside of grants, the organization receives funding from the general fund. The overall budget amount ranges from $900,000 to $1,000,000, but the general revenue is about $200,000. SCPH uses grant funding to offset the costs that remain after general revenue funds are spent. At this time, SCPH does not have any healthcare payment innovations in place to support the initiative, nor does it have any mechanisms in place for realized savings to be reinvested back into the effort.

Community Resident Engagement
Live Healthy Summit County encourages community participation, particularly through its Health in All Policies work. The project has contracted with Project Ujima, an organization that specializes in facilitating community engagement and dialogue.

Furthermore, SCPH has identified community engagement as an area for improvement. To this end, it distributed an online survey that received over 600 responses from community members. SCPH has also made plans to involve more community members on its soon-to-be merged Advisory/Wellness Committee. The goal moving forward will be to generate broad input on the community health needs assessment in 2016.

Data Sharing Capability
SCPH has implemented some data sharing practices to enable the distribution of relevant information. For example, it runs the Access to Care Program, which has collected years of data on diabetes and hypertension. Additionally, its Healthy Summit 2020 project tracks key quality of life indicators among Summit County residents over time. Data for Healthy Summit 2020 comes from a wide array of partners, mainly the large levy-funded agencies within the county and other government organizations.

School data is organized by the Summit Education Initiative, which receives data from almost every district (public and private) in the county and analyzes key readiness indicators to track educational progress over time. Furthermore, SCPH tracks data on school readiness and child development. Medicaid HMOs share data with SCPH on children that are behind on child visits. The Maternal Depression Project allows for screening in OB offices, and has established a system to connect at-risk patients with immediate referrals after the screenings are complete.

With all of these data tracking practices in place, SCPH hopes to build an equity database to help improve the quality of health disparity information gathered.

Accountability
Beyond the Healthy Summit 2020 metrics, SCPH does not evaluate Live Healthy Summit County using a single framework. Evaluation measures for the initiative as a whole are closely tied to the Community Transformation Grant, and individual activities within the initiative are evaluated separately. Live Healthy Summit County does not currently have any accountability measures in place tied to financial incentives or disincentives.

Successes and Challenges
Through the Community Transformation Grant experience, ABIA's Center for Clinical and Community Health Improvement improved environmental and policy scans in the community. These improvements laid the foundation for current work. Today, Summit County reports that it can successfully demonstrate a new, emerging governance structure with public health at the hub of the wheel. It has engaged diverse, multi-sectorial community partners who are highly involved in both "upstream" and "downstream" strategies.

Even with this momentum, challenges still exist. Regional adult hospital systems are experiencing significant changes under national health reform, which has, on occasion, impacted their level of engagement. Additionally, Summit County still seeks a long-term financial model that will provide sustainable funding for Live Healthy Summit County.

Lessons Learned for Implementing Accountable Communities for Health

SCPH staff and others involved in the initiative all pointed to the importance of communication to facilitate successful collaboration. James Hardy, Assistant Director of Community Health at SCPH, described this importance, stating:

"It may seem like an over simplification, but communication really is key. It is necessary to have a lead organization whose responsibility includes ensuring communication pathways between activities and stakeholders. In a resource-rich environment like Summit County, funding hasn't been the major challenge, but rather coordination of resources and activities has been the focus of our efforts in recent times. The extent to which you can ensure effective governance structures at the outset the more likely you'll be to steer clear of such issues."

Pueblo Triple Aim Coalition, Pueblo County, CO

SNAPSHOT

Name of Initiative	Pueblo Triple Aim Coalition
Population Served	The entire population of Pueblo County, Colorado (pop. 161,451).
Leadership Structure	The collaboration is coordinated by the Pueblo Triple Aim Corporation, a 501(c)(3) governed by a board of directors that includes CEO-level representation from the various collaborating organizations. These include the health department, local hospital systems and Federally Qualified Health Centers (FQHC) (what does acronym refer to?), Colorado State University Pueblo, and groups like Pueblo United Way, Pueblo Latino Chamber of Commerce, and Pueblo Economic Development Corporation. The CEOs on the board and the organizations they represent are guided by the Pueblo Triple Aim Corporation's bylaws.
Partnership Structure	The Pueblo Triple Aim Coalition serves as a neutral convener bringing county stakeholders to the table. Its board creates the policy and governance decisions for the coalition. The coalition is also supported by the Pueblo Triple Aim Steering Committee, which serves in an advisory capacity and represents more grassroots-level participation. Ad-hoc committees are also formed to work on specific issue areas.
Number of Staff	2.5 Full-time equivalent (FTE)
Stated Goal	To make Pueblo County the healthiest county in Colorado based on county health rankings.
Issues addressed	(1) Obesity; (2) Teen and unintended pregnancy; (3) Tobacco; (4) Emergency department use; and (5) Hospital readmissions.
Scope of Services	The Pueblo Triple Aim Coalition utilizes a spectrum of strategies to implement its plan. The coalition strengthens individual knowledge and skills through activities such as training young parents to talk to high school and college-age youth about parenthood. It also works on policy and systems change, including improving zoning laws to encourage cycling and advocating on behalf of Health in All Policies ordinances to ensure that health impacts are taken into consideration in all major policy decisions.
Link to other Healthcare Payment or Delivery	The Pueblo Triple Aim Coalition works with the regional Medicaid Accountable Care Organization (ACO) on a variety of

Reform Efforts	efforts in care coordination, readmissions, and Emergency Department use.
Policy Changes	The collaborative has yielded new policies on zoning and land use to promote active living.
Funding Sources/ Budget	The Pueblo Triple Aim Coalition is largely supported through philanthropic grant funds. It also works on a contractual basis to help local and state entities perform assessment, planning, and data analysis.
Key Reported Successes	Improved partnership process, reductions in teen pregnancy, and county level policy changes.
Notable Feature	The Pueblo Triple Aim Coalition represents an example of what can be achieved when representatives of hospitals, FQHCs, the public health department, and other key players work together to achieve the Triple Aim and provide a governance structure for a collaborative. The coalition's success depended on its role as a neutral convener, conducting data collection and analysis, and leading all of the collaborative's community activities. Also notable is the specific inclusion of changes to county policy in its work plan.

PROFILE

Background

The convergence of several factors in Pueblo County, Colorado led to the creation of the Pueblo Triple Aim Coalition. Pueblo County had been recognized for some time as a hot spot for collaboration in the health field. In 2010, a number of organizations, including ReThink Health and Kaiser Permanente's new medical offices, began investigating the frameworks of collective. At the same time, the Institute for Healthcare Improvement was seeking local partners to advance the Triple Aim Framework. Finally, the passage of the Affordable Care Act meant that local hospitals would be required to conduct community health needs assessments in addition to those already required of the county health department under state law.

The environment was ripe for collaboration, and several local groups had already achieved some collaborative successes, including the passage of an ordinance prohibiting smoking in enclosed public areas and places of employment – the toughest tobacco regulation in Colorado. It was determined that an independent "neutral convener" should be formed to facilitate the future partnership. The Pueblo Triple Aim Corporation was founded as a 501(c)(3) specifically to serve as the coordinating organization for collaborative efforts intended to improve the health of Pueblo County, and was assigned four tasks: (1) Serve as the neutral convener of coalition work;

(2) Conduct data collection and analysis; (3) Lead all activities in the community directed at achieving the Triple Aim; and (4) Provide a governance structure for the collaborative.

When the Pueblo Triple Aim Coalition was founded, according to County Health Rankings, Pueblo County ranked in the bottom five of all 64 counties in Colorado in behaviors directly impacting health, including nutrition, physical activity, tobacco usage, and sexual activity. The Pueblo Triple Aim Coalition was specifically created to improve these metrics.

Population Served
The Pueblo Triple Aim Coalition seeks to improve the health of the entire population of Pueblo County, Colorado. Its stated aim is "to make Pueblo County the healthiest county in Colorado based on county health rankings." Much of its work is dedicated to improving health equity in the county.

Partnership Structure
Pueblo Triple Aim Corporation is the coordinating organization for the collaborative, and is staffed by 2.5 full-time equivalent employees. Its governing board is comprised of CEO-level representatives from the various collaborating organizations. These include the health department, local hospital systems and FQHCs, Colorado State University Pueblo, and groups like Pueblo United Way, Pueblo Latino Chamber of Commerce, and Pueblo Economic Development Corporation. The CEOs on the board make formal commitments on behalf of their collaborating organizations and are guided by the Pueblo Triple Aim Corporation's bylaws. Of the nine seats on the board, five are specifically reserved for the CEOs of each of the two local hospitals, the county Public Health Director, the CEO of the local federally qualified health center, and the State Director of Kaiser Permanente.

The coalition is also supported in an advisory capacity by the grassroots-based Pueblo Triple Aim Steering Committee. Ad-hoc committees are also formed to work on specific issue areas, which include groups that exist outside of the realm of the Triple Aim effort.

Planning
The Pueblo Triple Aim Coalition's work is largely guided by a Community Health Improvement Plan developed with the participation of all the coalition members—particularly the Pueblo City-County Health Department. This plan began with a health needs assessment conducted by the Pueblo City-County Health Department. Members of the coalition described the assessment process as "highly collaborative," with regards to both the organizations doing the assessing, and overall community involvement. The assessment involved the analysis of 200 indicators and the collection of detailed information on 60 indicators. During the analysis process, community members provided feedback on the data produced and contributed their perspective on the county's health status. A Community Health Assessment Steering Committee was established to engage in a formal weighting process to identify key areas of strength and concern within Pueblo County. This committee was composed of representatives from the Pueblo County hospitals, community-based organizations, and other key stakeholders. At the end of the assessment process, four issues were identified as community priorities: (1) Obesity prevention; (2) Teen and unintended pregnancy prevention; (3) Tobacco prevention; and (4) Improvements in

emergency department use and hospital readmissions. The Pueblo Triple Aim Coalition adopted these as its primary issues.

Following the assessment, the Pueblo City-County Health Department worked with the collaborative to develop a planning process for creating strategies to address the identified community needs. The same collaborative that developed the Community Health Assessment divided into work teams to write a Community Health Improvement Plan. Taking a collective impact approach, work teams directly engaged organizations in the implementation of the plan. The plan detailed goals, objectives, and specific activities committed to by the organizations involved. It was ultimately approved by both the Pueblo Triple Aim Steering Committee and the Pueblo Triple Aim Corporation Board of Directors.

The strategies and objectives outlined in the Community Health Improvement Plan were then ushered in to the implementation phase. The work team members and representatives of different organizations involved united to support a variety of identified issues and signed written commitments to complete specific tasks.

Implementation

The Pueblo Triple Aim Coalition utilized a spectrum of strategies to implement its plan. The coalition strengthens individual knowledge and skills through activities such as training young parents to talk to high school and college-age youth about parenthood, and providing outreach on reproductive health and health services to Spanish-speaking populations. It promotes community education by conducting community outreach campaigns to increase knowledge about healthy choices for reproductive health care and identify gaps where parenting groups are needed. To educate providers, it conducts focus groups with high and low-risk individuals and community members to identify barriers and solutions to accessing medical care and health information, and provides outreach to elected officials, community leaders, and medical providers informing them of those focus group results. The coalition fosters collaborative efforts and network building through its partnership structure. It's also able to maximize resources through its collaboration with Pueblo County agencies and organizations that currently work on Positive Youth Development. To work towards changing organizational practices, the coalition works with school districts to implement policies in accordance with state laws such as comprehensive reproductive and health education in schools. Finally, to influence policy and legislation, the coalition has worked to improve zoning laws to encourage cycling and is working with the Pueblo City Manager to implement a Health in All Policies ordinance to ensure that health impacts are taken into consideration in all major policy decisions.

Funding and Sustainability

Pueblo Triple Aim Corporation's current budget is supported primarily through grant funding offered by the Colorado Health Foundation. The individual organizations in the collaborative it coordinates have a more diverse portfolio of funding sources, and they contribute in-kind staff time to its efforts. Pueblo Triple Aim Coalition also works on a contractual basis to help local and state entities perform assessment, planning, and data analysis, which supplements it's funding. Beginning in June of 2015, in an effort to further diversify its funding, it is entering talks with state and local officials to develop processes to capture savings. They plan on

capturing Medicaid savings from reductions in teen pregnancies and utilizing state tobacco tax revenues tied to decreased smoking in the county.

Community Resident Engagement
Pueblo Triple Aim Corporation and its associated collaborative efforts involve the community in several ways. The collaborative developed a community advisory team that represents populations most affected by obesity. The initial members of this advisory team were recruited by Pueblo City-County Health Department Employees, with ongoing membership recruitment being taken over by the team itself. The members of this team advise the coalition work on an ongoing basis. The collaborative also works to build community resident engagement by hosting Community Engagement Nights to collect community-driven data. Regular meetings are also scheduled to involve community stakeholders and discuss progress, hurdles, and identify new strategies.

Additionally, to build partnerships and expand buy-in, the collaborative hosts meetings with faith-based community organizations, schools, clinics, hospitals, at-risk families and prevention groups. In doing so, they work to build community alliances, strengthen partnerships and identify champions.

Data Sharing Capability
The Pueblo Triple Aim Coalition has established a common measurement tool to ensure that all participating organizations and individuals are tracking their progress in the same way so that data can be accurately compared and contrasted. The coalition uses a management software called ClearPoint to organize and track the activities and objectives of the individuals and organizations participating as well as the community overall. For example, they track both teen pregnancy rates in the county and the progress they are making to reduce those rates. On the community level, they track years of potential life lost (YPLL), uninsured rates, and residents reporting fair or poor health.

Accountability
The Pueblo Triple Aim Coalition measures numerous data points to evaluate itself. There is no formal accountability structure in place with incentives or disincentives. However, In June 2015 it will begin discussions with state and local officials to develop processes to capture savings, potentially serving to increase accountability.

To evaluate progress, the Pueblo Triple Aim Coalition uses multiple teen pregnancy measures, including teen pregnancy rates, the number of teens receiving mentoring from adults, and the number of adults and organizations offering mentoring.

Successes and Challenges
The coalition has achieved multiple successes related to county policy change and community improvement, including: establishing a strong network of community partnerships; engaging leaders in making health a priority; creating a stricter tobacco ordinance; helping organizations come up with their own health assessments based on community data; promoting improved

health education in schools; creating new policies on zoning and land use to promote active living; reducing teen pregnancy; and identifying savings.

Reported challenges include engaging K-12 education, public and private insurance companies, the business community, and faith communities, as well as the need to improve a short-term mentality around change and address the issues of "we don't know what we don't know", and "finding the right place to 'plug in'."

Lessons Learned for Implementing Accountable Communities for Health

To effectively implement Accountable Communities for Health, Pueblo Triple Aim Coalition staff pointed to the importance of having the time and patience needed to build strong partnerships. . Viewing challenges through the lens of each participating organization was described as an important approach to this process. Additionally, Pueblo Triple Aim Corporation Managing Director Matt Guy explained that the best way the state could help implement an Accountable Community for Health is by providing funding for innovation, while allowing the community to set regulations and metrics. Ideally, seed money would be provided to hire two to four FTE core staff members.

Live Well San Diego: San Diego County, CA

SNAPSHOT

Name of Initiative	Live Well San Diego
Population Served	The entire population of San Diego County, California (pop. 3,211,000).
Leadership Structure	In 2010, the San Diego County Board of Supervisors adopted Live Well San Diego as the 10-year plan to improve the well-being of county residents. In 2014, the Board took action to align its $6 billion budget with Live Well San Diego and its long-term vision for the region and for operations of the county. The San Diego County Health and Human Services Agency coordinates the work at both the county and regional level.
Partnership Structure	Live Well San Diego includes more than one hundred partnering entities working across the county. Each partner formally joins the collaborative effort by passing a resolution expressing their commitment to the Live Well San Diego vision and their willingness to share best practices. Partners meet regularly as Community Leadership Teams and as external collaboratives that exist to address specific issue areas.
Number of Staff	At the county-level, nine FTE staff support partnership development, communication, and data. An additional three FTEs support the partnership component of the work in the North County Regions--one of five regions in the county.
Stated Goal	To advance the health, safety and overall well-being of the whole county.
Issues Addressed	(1) Building better health (access to quality care); (2) Increased physical activity, healthy eating, tobacco cessation; (3) Living safely (residents are protected from crime and abuse: neighborhoods are safe to live, work, and play in; communities are resilient to disasters and emergencies); (4) Thriving (built and natural environment; enrichment; prosperity, economy, and education).
Scope of Services	Live Well San Diego addresses issues ranging from individual services and referrals to changes in policy and the built environment.
Link to other Healthcare	Many hospitals and clinics work in various capacities under the

Payment or Delivery Reform Efforts	Live Well San Diego effort. The "Be There San Diego" initiative focuses on more effectively managing hypertension and preventing heart disease and stroke by building better service delivery systems through partnerships with medical groups, hospitals, clinics, and other healthcare providers and improving standard clinical care interventions to more effectively address high blood pressure and high cholesterol. The San Diego Care Transitions Partnership established under Center for Medicare & Medicaid Innovation's Community-Based Care Transitions Program has linked the county and four health systems (13 hospitals) to provide comprehensive hospital and community-based care transition support to medically and socially complex patients. It has also reduced the 30-day all-cause readmission rate and Medicare costs for more than 32,000 fee-for-service beneficiaries since its inception in January 2013.
Policy Changes	The initiative has worked to encourage localities to improve city pedestrian laws, school wellness policies, procurement policies, and other local policies.
Funding Sources/ Budget	Existing County resources from general funds as well as state and federal sources are leveraged to achieve desired results. For example, federal SNAP-Ed nutrition education and obesity prevention funds are used to support improvement in nutrition and physical activity policies and behaviors. These efforts have attracted additional support including CDC's Communities Putting Prevention to Work program, Community Transformation Grants, and Prevention grants, as well as state and philanthropic resources.
Key Reported Successes	Deaths in San Diego attributable to cancer, heart disease and stroke, diabetes, and respiratory conditions have decreased. The partnership's structure has been critical to successfully creating a shared agenda and establishing commitment to a common goal.
Notable Features	Highly coordinated government collaboration; successful integration of health with safety and standard of living; and robust communications systems.

PROFILE

Background

Live Well San Diego continues San Diego County's strong history of fostering partnerships that stretch back to its Communities Putting Prevention to Work and Community Transformation Grants, as well as many other earlier successful efforts. In 2010, the San Diego County Board of

Supervisors officially adopted Live Well San Diego as the county's 10-year plan to advance the health, safety, and overall well-being of its residents.

San Diego County has a population of over three million people and a geographic area approximately the size of Connecticut. To best serve this large and diverse area, the county Health and Human Services Agency is divided into five Regional Planning Areas (there are technically six areas, but – for the purposes of Live Well San Diego – the North Coastal and North Inland regions are generally treated as one region, known as the North County Regions). As the initiative launched in 2010, these service regions began involving themselves in comprehensive community planning processes. These processes produced Community Health Needs Assessments, which in turn informed the Live Well San Diego Community Health Improvement Plans - both of which operate on a regional level.

Live Well San Diego first involved county Health and Human Services Agency staff at all levels in the "Building Better Health" component—eventually expanding to the other four branches of county government, with the additions of "Living Safely" component in 2012 and "Thriving" component in 2014. Community partners first joined in 2013 and now number more than one hundred. Health and Human Services' Agency has provided the critical coordinating role, developing partnerships with agencies, organizations, and businesses across the county.

Population Served
Live Well San Diego aims to improve the health of the entire geographic population of San Diego County, California - the home to 3,211,000 residents. This profile focuses on the North County Regions – with a population of approximately one million - to highlight the regional work taking place in the county.

Partnership Structure
San Diego County Health and Human Services Agency serves as the coordinating organization for Live Well San Diego on both the county and regional level. The Agency serves as an "internal" coordinating organization that provides a wealth of services beyond its facilitating role, including public health, behavioral health, aging and independent services, children's services, and others. The Agency sponsors the "Building Better Health" agenda; the County's Public Safety Group sponsors the "Living Safely" agenda; and the Land Use and Environment and Community Services Groups co-sponsor the "Thriving" agenda.

The list of partner organizations outside of county government now numbers more than one hundred, including hospitals and clinics, school districts, the military, social service organizations, community-based organizations, the business community, and faith-based organizations.

Much of the partnership collaboration occurs on a regional level. In the North County Regions, partners convene at monthly Community Leadership Team meetings. The Community Leadership Team includes key representatives from throughout the North County Regions, where the stakeholders use the regional Community Health Improvement Plan as a guiding document to identify ways to collaboratively move forward to achieve regional common goals.

Data provided by the county helps inform this work by allowing the teams to identify priority areas for intervention and track their progress. In addition to the Community Leadership Team meetings, existing workgroups and coalitions within the region address specific issues (e.g., preventing violence). These efforts are also considered part of Live Well San Diego.

No formal governance structure or memoranda of understanding bind the various partners in the collaborative. However, organizations that wish to join Live Well San Diego as recognized partners must pass resolutions by their governing boards expressing their commitment to the Live Well San Diego vision and willingness to share best practices. This is required to ensure organizational buy-in amongst partners, rather than potentially relying upon a single champion to maintain the collaboration.

Planning

Live Well San Diego's guiding strategic framework is a pyramid model outlining "ten indicators that measure progress in achieving the vision for healthy, safe, and thriving communities; five areas of influence that capture overall well-being; four strategies that encompass a comprehensive approach; three components to be rolled out over the long-term initiative; and one vision of a healthy, safe, and thriving San Diego County."[25]

This strategic framework is reflected in San Diego County's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), both of which were conducted through extensive regional and county processes. San Diego County developed CHA and CHIP through a community health improvement planning model called Mobilizing for Action through Planning and Partnerships (MAPP), a model adapted from the National Association of County and City Health Officials and the Centers for Disease Control and Prevention. Because of the size and diversity of the county, each region participates in its own CHA and CHIP processes. Health and Human Services Agency Community Health Statistics staff provides data on demographics, community health indicators, and additional countywide and regional health data to the five regional Community Leadership Teams throughout the development stages. Final documents are produced by the Health and Human Services Agency, which weaves the regional CHAs and CHIPs into complete, county-wide documents.

In the North County Regions, CHIP was developed through quarterly community forums over a two-year period that brought community partners together to discuss priority health issues. Surveys and assessments were also used to inform this process. North County Community Leadership Team members used the MAPP planning model in bimonthly meetings to help determine priority areas. Under the Building Better Health component of Live Well San Diego, three priority areas were selected: (1) Physical Activity; (2) Nutrition; and (3) Behavioral Health. Success in each priority area is linked to objectives and performance measures, some of which relate to policy, systems, and environmental change and others to individual behaviors. For example, in the Physical Activity priority area, one of the objectives is to "increase the number of community stakeholders that adopted Live Well San Diego to utilize joint use policies by December 2018," using "number of schools with joint use agreements" as the performance

[25] *Vision Pyramid*. San Diego, CA: Live Well San Diego. 2015.

measure. In the Behavioral Health priority area, one of the objectives is to "increase the percentage of residents who needed a mental health service and who sought out a service by 1% by December 2018," using data from the California Health Interview Survey as the performance measure.

Implementation

Live Well San Diego has three key components and four basic strategies that guide efforts to achieve its vision of a healthy, safe, and thriving county. The "Building Better Health" component includes the development of better service delivery systems through strong partnerships with hospitals, clinics, and other healthcare providers. As an example, Be There San Diego – an initiative of local medical groups, hospitals, health plans, Naval Medical Center San Diego, community clinics, the local medical society, and the county – has a shared goal to make San Diego the nation's first heart attack and stroke-free zone. The collaboration has established regional standards of care and treatment protocols for more effectively managing hypertension, and preventing heart disease and stroke. In addition it has designed technology-supported tools to assist physicians in managing the health of their whole practice population and helping patients manage their own health outcomes.

In the North County Regions, Palomar Hospital has a community liaison that sits on the Community Leadership Team and works to address community health issues through such efforts as diabetes screenings at schools and health education programming for students and families.

Live Well San Diego works to provide county residents with individual knowledge and skills to support healthy behaviors. For example, the 5-2-0 messaging campaign aims to increase knowledge about childhood obesity prevention by recommending that children eat five servings of fruits and vegetables daily, get two hours of exercise per week, view only one hour of non-instructional screen time daily, and consume zero sugary beverages daily. The message is disseminated through schools, community fairs, brochures, and posters. Live Well San Diego also works to educate providers of medical and other services on prevention. For example, over 600 county employees received violence prevention training through the Risk Awareness, Violence Prevention and Crisis Response Training.

Changing organizational practices is another area where Live Well San Diego is active. In North County Regions, the partnership works closely with school districts to update their wellness policies to better support health, as well as creating specific organizational policies to support safe routes to schools. Live Well San Diego also promotes policy change. In North County Regions, members of the Community Leadership Team, partner organizations, and local resident leaders have worked with cities to improve pedestrian safety laws to encourage active transportation. For example, this collaborative work in one North County city resulted in an agreement by city staff to update their crosswalk policies, which date back to the mid-1970s, as well as create new sidewalks at a critical intersection near two local schools.

Funding and Sustainability

Live Well San Diego is primarily funded by leveraging and optimizing existing resources, county general funds, state, and federal support. Because Live Well San Diego has been so successfully integrated into the overall mission of the county, it provides a basis for coordinating efforts that serve the same clients, working with community partners, and attracting new funding sources from government and foundations. The Affordable Care Act has been a major source of such resources, including CDC's Community Transformation Grants and Prevention grants, the CMMI award, the San Diego Care Transition Partnership, and increased Medicaid funding for community outreach efforts designed to enroll the newly eligible childless adult population. Health and Human Services Agency's role as the coordinating organization is funded through its annual county budget.

Community Resident Engagement

The Community Health Assessment and Community Health Improvement Plan that guide Live Well San Diego were both developed with broad community participation through the Mobilizing for Action through Planning and Partnerships (MAPP). In the North County Regions, the collaborative work that takes place in the Community Leadership Team meetings is informed by community partners, which are largely organizations that aim to represent residents.

Data Sharing Capability

At the county-level, the Community Health Statistics Unit and the Office of Business Intelligence are responsible for gathering, analyzing, managing, and improving data. The Community Health Statistics Units provides health statistics that describe health behaviors, diseases, and injuries for specific populations and health trends. In addition to providing such data, it also compares it to national targets and links it to other available local, state and national statistics. The Office of Business Intelligence provides information, risk analysis, and predictive analytics to support Live Well San Diego, identifying opportunities for service integration through the use of data reporting and business process analysis. The Office also employs tools such as integrated dashboards, data visualization, data mining, and predictive analytics.

These data are provided from the county to the regions to support regional planning and implementation of activities.

Evaluation

Live Well San Diego relies upon a shared measurement system to collectively focus its activities and track the progress of its collaborative effort. With input from local, state, and national experts, Health and Human Services Agency developed the Live Well San Diego Indicator Framework to highlight the top ten indicators and allow for progress assessments. The framework encompasses the range of factors that impact how individuals live and recognizes the influence of social and environmental factors on overall health and well-being. By drawing a link between living condition and overall health, the Live Well San Diego Indicator Framework includes measures for assessing health outcomes as well as those that address social determinants of health.

Live Well San Diego's top ten indicators and associated measures are:

INDICATOR	***MEASURE***
HEALTH - Enjoying good health and expecting to live a full life	
Life Expectancy	Measure of length of life expected at birth and describes overall health status
Quality of Life	Percent of population that is sufficiently healthy to be able to live independently
KNOWLEDGE - Learning throughout the lifespan	
Education: High School Diploma or Equivalent	Percent of population with at least a High School Diploma or equivalent
STANDARD OF LIVING - Having enough resources for a quality life	
Unemployment Rate	Percent of the total labor force that is unemployed
Income: Spending Less Than 1/3 of Income on Housing	Percent of population spending less than 1/3 of household income on housing
COMMUNITY - Living in a clean and safe neighborhood	
Security: Crime Rate	Number of crimes per 100,000 people
Physical Environment: Air Quality	Percent of days that air quality was rated as unhealthy
Built Environment: Distance To Park	Percent of population living within a half mile of a park
SOCIAL - Helping each other to live well	
Vulnerable Populations: Food Insecurity	Percent of population with income of 200 percent of poverty or less, who have experienced food insecurity
Community Involvement: Volunteerism	Percent of population who volunteer

Successes and Challenges
The sheer size and magnitude of Live Well San Diego poses a significant challenge to this effort. Despite the obstacles faced by a program that serves a diverse county of more than three million, the leadership of Live Well San Diego takes great pride in the momentum that has been created, in which partners are recruiting other partners, the goals and vision are embraced, and organizations strive to be part of Live Well San Diego.

Another challenge was that, in the early stages of Live Well San Diego, the work advanced quicker than the processes and infrastructure could keep pace with. Additionally, the ability to sustain meaningful regional engagement of the partners as they come on, and in the long-term, is viewed as another challenge.

Lessons Learned for Implementing Accountable Communities for Health
Keep it simple. From messaging to measurement, "potent simplicity" is the rule. In reaching across political jurisdictions, disciplines, programs and geographic and cultural lines, it is necessary to communicate the issues, proposed solutions, measurements and engagement opportunities very clearly and simply.

Keep it local. In a large, diverse region like San Diego County (which has a population of 3.2 million filled with complex societal dynamics, 18 incorporated cities, 18 tribal organizations and 43 school districts), information, engagement and action must occur at the sub-regional level in order to be effective and sustained. A one-size-fits-all approach to community health improvement does not always work.

Keep it real. Large population wellness initiatives require goal and resource alignment, changing the business culture to be more data-driven and evidence-based and addressing workforce wellness concurrent with population health—"walking the talk." Initially, progress is slow and steady, but it accelerates with time.

Trillium Community Health Plan, Lane County, OR

SNAPSHOT

Name of Initiative	Trillium Community Health Plan
Location	Trillium serves the approximately 92,000 Medicaid beneficiaries in Lane County, Oregon, constituting 26% of the total population. In addition, specific collaborative prevention activities they have engaged in target the broader population of Lane County, Oregon (pop. 356,212).
Leadership Structure	Trillium is governed by a board of 22 directors that includes senior Trillium employees, representatives from hospitals, primary care and specialty care physicians, county government, the County Public Health Department, and others, as well as representatives from its Community Advisory Council and its Rural Community Advisory Council. As a Coordinated Care Organization, Trillium is ultimately accountable to the Oregon Health Authority.
Partnership Structure	Trillium partners with its Community Advisory Council, its Rural Community Advisory Council, Lane County Public Health, and several other workgroups to invest in population health improvement efforts.
Number of Staff	As the county Medicaid provider, Trillium has a number of employees providing the services of a medical payer. In addition, Trillium funds three prevention employees at Lane County Public Health through a $1.33 per-member per-month set-aside, as well as an additional FTE to interface with schools.
Stated Goal	Trillium Community Health Plan is dedicated to transforming healthcare for Lane County's Medicaid beneficiaries into a system that makes substantial and sustainable advancement toward achieving the Triple Aim.
Issues Addressed	(1) Medicaid services; (2) Healthcare and behavioral health integration; (3) Health equity; (4) Tobacco, obesity, substance abuse and behavioral health; (5) Access to health care.
Scope of Services	As a payer, Trillium covers a range of medical services including doctor visits, prescriptions, medical equipment, hospital stays, dental care, mental health services, tobacco cessation, substance abuse treatment, vision, home healthcare, and transportation to healthcare appointments. In addition, Trillium's community partnerships have brought tobacco prevention programs into

	schools, created interventions for pregnant mothers who smoke, and engaged in a range of other population health-focused activities.
Link to other Healthcare Payment or Delivery Reform Efforts	Trillium is closely linked to healthcare payment and delivery reform efforts in Oregon that relate to (1) Improving care coordination; (2) Implementing alternative payment methods; (3) Integrating physical, behavioral, and oral health; (4) Increased efficiency through administrative simplification; (5) Improving care through the use of flexible services ; and (6) Spreading effective innovations and best practices.
Policy Changes	With the support and backing of Lane County Public Health, the Community Advisory Council, and the Rural Community Advisory Council, Trillium endorsed a tobacco prevention policy that recently took effect in Lane County. While Lane County Public Health has embraced a policy, systems, and environmental approach to public health, Trillium has played a less central role in these efforts to date.
Funding Sources/ Budget	As a Coordinated Care Organization, Trillium receives a capitated per-member per-month budget from Oregon's Medicaid program. Trillium has approximately 92,000 members as of April 2015. In addition, Trillium is eligible to receive incentivized funds from Oregon's CCO Performance and Quality Pool for achieving key quality benchmarks. The CCO's collaborative prevention activities are funded through a $1.33 per-member per-month set aside Trillium provides from its global budget; those funds go to staffing and program support for Lane County Public Health and provides dollars for evidence-based strategies.
Key Reported Successes	Trillium has successfully met key statewide quality metrics for service delivery, created a smoking cessation incentive program for pregnant women, trained 200 teachers in an evidence-based tobacco prevention program for seven-year-olds, integrated behavioral health providers and medical providers in eight different clinics in the county, and supported the successful passage of a county cigarette regulation ordinance.
Notable Feature	Trillium serves as an example of successful integration between physical and behavioral health services. It is also notable that Trillium and Lane County have created a structure to invest Medicaid dollars in prevention activities that extend significantly beyond the scope of normally billable services (e.g., tobacco prevention programs in county schools).

PROFILE

Background

Oregon Health Plan, the state's Medicaid program, underwent significant reform in 2012. Under a waiver from the federal government, Oregon embarked upon a program that allowed the state greater flexibility in how it spends its Medicaid dollars, with the provision that it must meet quality metrics while growing at a rate 2% slower than the rest of the United States. The state began implementing its new program through Coordinated Care Organizations (CCOs). CCOs are local managed care entities, selected through a competitive process, that receive capitated budgets from the state to provide Medicaid beneficiaries with integrated physical, behavioral, and dental care.

In the summer of 2012, Lane County launched its local CCO – the Trillium Community Health Plan. Trillium took on the portfolios of Lane Individual Practice Association, the local Medicaid managed care plan, and LaneCare, the division of the county Department of Health and Human Services responsible for behavioral health services. It was also the recipient of Transformation Award funds from the state government – a one-time award that allowed them to launch the Shared Care Plan, which focuses on care coordination and quality, patient activation, and health information exchange work.

Lane County was also the site of an innovation in integration between service delivery and public health that has its roots in a collaboration between Lane County Public Health and United Way's 100% Access Coalition. The Lane County Public Health administrator and the CEO of Trillium sat on the 100% Access Coalition Steering Committee and worked together to foster a community-wide initiative to increase the uninsured population's access to healthcare. When Trillium launched as a CCO, there was already a collaborative relationship between the two organizations. In conversations between the leadership at Trillium and the County regarding what each party might bring to the table, it was decided that in addition to staff work that would be conducted under an administrative service agreement there needed to be a financial investment in prevention. A per-member per-month set aside was identified as the appropriate funding mechanism. In consultation with Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration, $1.33 per-member per- month was determined to be a suitable amount to underwrite staffing, support prevention programing for the Lane County Public Health Department, and develop evidence-based strategies. This financial collaboration between the CCO and the county public health department is unique in the state of Oregon.

Population Served

Trillium's primary population is the approximately 92,000 low-income Medicaid beneficiaries in Lane County - comprising about one quarter of the county's population. Trillium has also partnered with Lane County Public Health to engage in prevention activities that benefit the county's broader population.

Lane County contains the small cities of Eugene, Springfield, and Cottage Grove, and is otherwise quite rural.

Partnership Structure

Trillium originated from an initial partnership between Lane Individual Practice Association, the previous Medicaid managed care plan, and LaneCare, the division of the county Department of Health and Human Services that was responsible for behavioral health services. During the merging process that founded Trillium as a CCO, internal planning teams from each organization met regularly to integrate their systems and ensure that Trillium would have a unified approach to both physical healthcare and behavioral and mental health.

Trillium is governed by a board of 22 directors that includes its senior employees, representatives from hospitals, primary care and specialty care physicians, county government, Lane County Public Health, and others, as well as representatives from its Community Advisory Council and its Rural Community Advisory Council. As a CCO, Trillium is ultimately accountable to the Oregon Health Authority.

Under the CCO charter with the state, Trillium is also required to have a Community Advisory Council (CAC) consisting of a board of its consumers and Lane County community members. Once priorities have been identified using the Community Health Assessment and Community Health Improvement Plan as resources, the CAC is charged with engaging Trillium members and the community as a whole to advise and make recommendations to its Board on the strategic direction of the organization and ensure it remains responsive to consumer and community health needs and achieves the Triple Aim. The Prevention Work Group serves as a subcommittee of the CAC and works with county public health experts on developing evidence-based prevention strategies and proposes strategies for investing funds. This package of proposals goes through a series of committees including the Community Advisory Council, the Clinical Advisory Panel, the Rural Advisory Committee, which more specifically represents the county's rural interests, and the Finance Committee, which determines reasonable return on investment, for feedback and approval. Two CAC members serve as representatives on the Trillium Board, fulfilling a state requirement of the CCO. The Trillium Board of Directors is responsible for granting final approval of proposed strategies.

Examples of prevention programs that have been approved by this advising body in the past include a cash incentive smoking cessation program for pregnant women, a school-based tobacco prevention program for seven-year-olds, and a plan for Trillium membership cards to provide children with access to public pools.

In addition to engaging in a robust collaborative decision-making process through its internal partnerships, Trillium also works in a grant-making capacity to develop partnerships and increase coordination throughout Lane County. For example, through the Trillium Integration Incubator Project, eight county clinics were funded to promote service integration by bringing physical health providers and behavioral health providers to the same location.

Planning and Implementation

Trillium was required to submit a Transformation Plan to the Oregon Health Authority as part of its certification process for becoming a CCO. The Transformation Plan outlined initiatives that it planned to roll out to fulfill state requirements. These are shown below.

Oregon Health Authority Initiatives for Transformation

1) Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions.

2) Continuing implementation and development of Patient-Centered Primary Care Home.

3) Implementing consistent alternative payment methodologies that align payment with health outcomes.

4) Preparing a strategy for developing a Community Health Assessment and adopting an annual Community Health Improvement Plan.

5) Developing electronic health records, health information exchange, and meaningful use.

6) Assuring communications, outreach, member engagement, and services are tailored to cultural, health literacy, and linguistic needs.

7) Assuring provider network and staff ability to meet cultural diverse needs of community.

8) Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

Trillium engaged in Community Health Assessment (CHA) and Community Health Needs Assessment (CHIP) processes in a collaborative that included Lane County Public Health, the United Way of Lane County, and PeaceHealth, a non-profit hospital system with several medical centers in Lane County. The CHA looked across a range of data, both clinical and environmental, to assess the health of the county and identify strengths and challenges. After this process was complete, the collaborative then developed a CHIP that articulated a series of

strategies to address the health challenges faced by Lane County. The collaborative identified five key areas of intervention:

1) Advance and Improve Health Equity
2) Prevent and Reduce Tobacco Use
3) Slow the Increase of Obesity
4) Prevent and Reduce Substance Abuse and Mental Illness
5) Improve Access to Health Care

Along with improvement strategies, CHIP details performance measures, target benchmarks, and "responsible parties" for achieving its objectives. Trillium was among the group of organizations responsible for addressing the prevention and reduction of tobacco use – a key health priority. Trillium helped craft a strategy to increase the number of environments where smoking is prohibited, including more city and community campuses and parks and recreational spaces, as well as expanding the number of physical and mental health support centers and worksites. This anti-smoking plan includes improvement strategies and specified target dates for outlined goals. Trillium was also listed as a responsible party for preventing and reducing substance abuse and mental illness. The implementation strategies for this priority area focus on supporting the adoption and implementation of mental health-friendly workplace environments as a means to encourage mental health and reduce substance abuse. Additionally the team was responsible for strategizing ways to implement policies that work to restrict access to lethal means of self-harm and reduce the availability of alcohol and other drugs in local retail and social markets. Lastly, Trillium and the other organizations represented in CHIP worked with healthcare and social service providers to improve support for providers as they adopt evidence-based and trauma-informed screening assessments and referral policies to improve services for mental health and substance abuse patients.

Funding and Sustainability

As a CCO, Trillium receives a capitated per-member per-month budget from Oregon's Medicaid program, 36% of which comes from the state and 64% of which comes from the federal government. In 2015, that budget is approximately $400 per-member per-month. It has approximately 92,000 members as of April 2015. In addition, Trillium is eligible to receive incentivized funds from Oregon's CCO Performance and Quality Pool for achieving key quality benchmarks – equaling approximately $5 million dollars in 2013. CCO collaborative prevention activities are funded through a $1.33 per-member per-month set aside that Trillium provides from its global budget; those funds are dedicated to providing program support and staffing three positions at Lane County Public Health, and provide dollars for the development of evidence-based strategies.

The sustainability of these funds largely depends upon Trillium's ability to control costs while meeting quality measures, as well as the state's continued agreement with the federal government to allow the CCO model.

Community Resident Engagement

The CAC and the Rural Community Advisory Council serve as the primary vehicles for

Trillium's engagement with the community. Each of these councils – which have representatives on the Trillium Board – is designed to represent community residents and Trillium members. The CHA and CHIP processes are also designed to involve the community.

Data Sharing Capability

Trillium has in place a fairly well-adopted electronic medical record system. In its Transformation Plan, it reports that "approximately 90% of providers already have an EMR that meets meaningful use criteria. The small number of providers who do not use an EMR are not likely to convert as many plan to retire in the near future."[26]

Trillium is pursuing a robust Health Information Exchange (HIE) that will mobilize relevant healthcare information between users to offer more effective patient-centered care. This "smart HIE" will enable all healthcare-related providers in Lane County to have timely access to relevant, actionable information about Trillium members for coordination and delivery of integrated patient-centered care. It will also serve to assist members in self-managing their care through electronic connections with their care teams and provide healthcare data that is presented in an easily understood format.

Accountability

The state evaluates Trillium's success according to 17 measures. These range from clinical (controlling high blood pressure) to screening tests (colorectal cancer screening) to administrative (Patient-Centered Primary Care Home enrollment). Trillium is provided with financial incentives when it meets key benchmarks. It was awarded approximately $5 million – equaling the largest award for the state's 16 CCOs – for successfully reaching benchmarks related to diabetes, depression, and Patient-Centered Primary Care Homes in 2013.

The CHIP also has evaluation measures built into it, such as "increase the number of cities in Lane County that adopt and implement tobacco-free campus policies"[27] from a baseline of zero and ensure that "all school districts in Lane County are on track to meet minimum PE requirements"[28] according to state data.

Successes and Challenges

The cross-sectoral work between Trillium and Lane County Public Health is reported to have been both "challenging" and "transformational." Though combining these differing cultures was described as an initial obstacle, public health staff report that they have learned to think in more concrete financial terms about issues such as hospital readmissions, while Trillium staff are becoming more familiar with the public health approach.

One Trillium representative attributed some of their success to relationships. She noted that "[h]aving a strong relationship between Trillium and the County has helped move us through some of the difficult spots. Leadership from the very top was determined to figure things out and do things together and this made a difference. Our relationship with Public Health is very

[26] *Trillium Community Health Plan*. Lane County, OR: Trillium Community Health Plan CCO. 2012.
[27] *Lane County Community Health Assessment: Spring 2013*. Lane County, OR. P. 20. 2013.
[28] *Lane County Community Health Assessment: Spring 2013*. Lane County, OR. P. 32. 2013.

different. In other communities [establishing a relationship with Public Health] is more of an afterthought and that makes it hard to shift things once everything is set."

Another representative noted a challenge being that "[t]here are always providers that are skeptical." When it comes to adopting a long- term view and making investments that do not produce short-term returns on investment, it might take a leap of faith for people to buy-in.

Lessons Learned for Implementing Accountable Communities for Health
Staff involved in the collaboration between Trillium and Lane County Public Health offered the following advice:

"Be very clear on your processes, and make sure that the entities involved are clear on the process and comfortable with it."

"Understand the different perspectives. Public health and insurance companies have very different views. You need to understand each other to move the agenda forward."

One Trillium representative explained that "it helps to have a physical advocate." Trillium benefitted from having a majority physician board and a history of being physician owned. The providers were described as being very involved in the governance of Trillium. For example, there was a Public Health Officer, a fellow physician who was there to translate how primary prevention works and why it was important. In our discussions, Trillium representatives emphasized the importance of continuing to remind physicians to think about what health conditions they see in their offices and help them to better understand how the collaborative might reduce such issues.

A Trillium representative recommended structuring policy so that it requires public health to have a strong voice from the beginning in thinking about how the collaborative can get to the Triple Aim. She noted that it is difficult structuring anything within the CCO framework because each CCO has a lot of latitude in how they accomplish the Triple Aim and therefore, there are some CCOs that have almost an adversarial relationship with Public Health and this was very unfortunate.

Pathways to a Healthy Bernalillo County, Bernalillo County, NM

SNAPSHOT

Name of Initiative	Pathways to a Healthy Bernalillo County
Population Served	The entire population of Bernalillo County, New Mexico (pop. 674,221) with a broad focus on low income, uninsured adults, serving between 350-400 residents at any point in time.
Leadership Structure	The Office for Community Health of the University of New Mexico Health Sciences Center staffs Pathways to a Healthy Bernalillo County, the "Hub" of the effort. The Program Manager is an employee of UNM Health Services Center, and oversees all programmatic aspects of Pathways and reports to the CEO of UNM Hospital, UNMH Board of Trustees, and Pathways Community Advisory Group. The Program Manager is supervised by the Director of the Office of Community Health Worker Initiatives, which is under the Office of Community Health in the Health Sciences Center. The Hub provides technical support and coordinates standing monthly meetings or training for the navigators, assists the partner organizations, and evaluates the program. Navigators are employees of their respective organizations, who are contracted by the program.
Partnership Structure	The collaborative is coordinated by the central hub that contracts with various partner organizations, selected through a competitive RFP process, to provide services known as "pathways" to the clients.
Number of Staff	The Hub is allocated a 1.0 FTE, staffed by a full-time Program Manager, and 0.2 FTE in administrative support. The "pathways" organizations have their own, separate staffing, and employ community health workers, called navigators, to carry out HUB activities.
Stated Goal	Through a comprehensive participatory planning process, the community participants identified the four primary goals of the program as: (1) People in Bernalillo County will self-report better health; (2) People in Bernalillo County will have a healthcare home; (3) Health and social service networks in Bernalillo County will be strengthened and user-friendly; (4) Advocacy and collaboration will lead to improved health systems.
Issues Addressed	(1) Access to healthcare; (2) Housing; (3) Education; (4) Social isolation; (5) Systemic barriers inhibiting access to all of the above.

Scope of Services	Medical care, behavioral health, employment, social services, establishing health homes.
Link to other healthcare payment or delivery reform efforts	HUB Pathways leverages Community Health Navigators (CHNs) to identify and connect vulnerable County residents to community-based and social service resources based on their individual unmet need(s). The HUB Model is "service-oriented", in that a bulk of the effort is in identifying and connecting clients to participating pathways resources, and establishing a healthcare home. In addition to working with individual clients, standing monthly community meetings with all navigators and 5-10 additional interested community partners provide a platform for Community Health Navigators and other community collaborators to offer social service administrators feedback on service access barriers that clients face. Meetings are organized by the Program Manager, but each agenda is decided upon in the prior meeting with input from the navigators. This feedback, in turn, has motivated improved processes and policies to make services more efficient and accessible (e.g. utilizing client I.D. cards).
Policy Changes	Because Pathways to a Healthy Bernalillo County is a service organization, policy change is not a big part of its work. That said, political and organizational leaders are often brought to monthly meetings so that navigators may share their thoughts on systemic barriers. Navigators have been able to bring up repeated barriers to organizational leaders in order to change ineffective practices.
Funding Sources/Budget	Funded through a county mill levy tax. Slightly less than 1% of the tax, approximately $800,000 each year, is dedicated to funding Pathways to a Healthy Bernalillo County. The tax is renewed every eight years (next cycle starts in 2017). The "pathways" partner organizations are guaranteed 30% of their funding from the Hub to cover administrative costs; the other 70% is based upon the incentive structure paid to the partner organizations for successfully achieving outcomes for the clients served.
Key Reported Successes	76% of Pathways clients report better health at the time they complete their participation in the program. 20% of participants (630 individuals) have established a healthcare home. Strengthened processes and procedures related to services provided through community-based and social service (e.g. County) networks. Distributed and shared the quality assurance manual developed by the program with interested individuals from across the

	country.
Notable Feature	Pathways to a Healthy Bernalillo County uses a dedicated, tax-based funding structure, which promotes sustainability. It is also significant that the majority of the "pathways" funding is spent on payment incentives to community partners and is dependent upon its ability to successfully achieve specific outcomes.

PROFILE

Background

In December 2005 the University of New Mexico (UNM) Health Sciences Center, at the request of the Governor, held a statewide summit to discuss its public mission and address concerns about the costs of uncompensated care for indigent residents. The Health Sciences Center leadership, including UNM Hospital, was receiving increasing pressure from Community Coalition for Healthcare Access (CCHA)to be more transparent and accountable for the more than $80 million (at the time) that it received each year through the County mill levy fund. CCHA consists of leaders from non-profits, frontline community members, and health workers. CCHA combined efforts with the All Indian Pueblo Council (AIPC), who had been challenging the hospital for not fulfilling its agreement in the 1952 Treaty. After the summit, County stakeholders and the public taxpayers wanted to detail a strategy for fostering financial accountability. The County Commission convinced the UNM Hospital (UNMH) to commit a small portion (~1%) of the mill-levy tax to support a program that would "improve access for the underserved of the County in collaboration with community resources." No less than $800,000 per year for an eight-year period (duration of mill-levy funding) was committed for this newly created Pathways Program.

Early in the program's tenure, office leaders became aware of the Pathways Model developed by Dr. Mark Redding and Dr. Sarah Redding. They were attracted to its emphasis on leveraging community health workers (CHNs) and its ability to track each client's needs and progress to accurately access appropriate "pathways" services offered through participating health and social service agencies and community-based organizations. Program leaders felt that a similar approach could help at-risk county residents, including those with limited English proficiency, Native Americans living on and off reservations, returning citizens, immigrants, and other at-risk populations.

Following a community workshop by Dr. Redding in October 2007, a workgroup was formed to define the program's mission and to explore the Pathways Model for use in Bernalillo County. The work group included representatives from community-based social service organizations, the New Mexico Department of Health, the University of New Mexico Health Sciences Center, the University of New Mexico Hospital, the Bernalillo County Community Health Council, community advocates, and others. Additional planning took place at a "kickoff" community meeting in September 2008 and at five half-day planning meetings with community-based organizations. In November 2008, passage of a mill-levy bond issue ensured that funding would

be available through 2017. The workgroup then developed specific community outcomes as programmatic goals.

Population Served
While the overarching mission of Pathways to a Healthy Bernalillo County is to improve the health of the entire county, the program focuses on low-income, uninsured adults with risk factors that include multiple or complex unmet needs, or who self-report the following: fair to poor health, unemployed, unstable employment, feeling unhealthy, at least one ED visit during the previous year, homelessness and not receiving services, and averaging fewer than two full meals per day.

The target population also includes individuals parenting young children; urban off-reservation Native Americans not connected to community resources; formerly incarcerated people experiencing difficulty obtaining employment and stable housing, among other needs; and undocumented immigrants or residents with limited-English proficiency.

Clients are identified and referred through a variety of sources, including friends and family members (who referred nearly 30 percent of clients in the program's first 4 years), community health navigators, and interagency referrals.

The program's goals and priorities were jointly set by community representatives and HUB staff, and include:

(1) People in Bernalillo County will self-report better health;
(2) People in Bernalillo County will have a healthcare home;
(3) Health and social service networks in Bernalillo County will be strengthened and user-friendly;
(4) Advocacy and collaboration will lead to improved health systems.

Partnership Structure
1.2 FTE staff in the Hub provide technical support and coordinate standing monthly meetings or training for the navigators, assist the partner organizations, and evaluate the program.

The Office for Community Health organizes an RFP process to identify the community organizations that house the community health navigators. Selected organizations are referred to as community partners- each of which has a minimum of one (1.0 FTE) community health worker engaged in the pathways program. The Pathways Community Advisory Group, comprised of non-UNM community representatives (i.e. Bernalillo County, NM Dept. of Health, Albuquerque Area Indian Health Board, Presbyterian Healthcare Services, private consultants, New Mexico Health Connections, the NM Community Health Workers Association, etc.) meets quarterly and serves the Hub in an advisory capacity, develops and reviews Request for Proposals, advocates on systems issues, and serves as a "sounding board" for the Hub. Funding for Pathways is written into Memorandum of Understandings (MOU) between the Bernalillo County Commission and the UNMH and the Hub's office and the UNMH.

Planning and Implementation
Twenty community health workers, called navigators, are employed by community partner organizations to assess the immediate needs of the person referred, determine whether the individual would be an appropriate candidate for Pathways participation (i.e., has multiple needs), and conduct an approximate 45-minute risk score assessment. The navigators obtain written consent from the individual prior to collecting any information, including the risk score instrument, and for individuals deemed eligible, the navigator obtains consent before enrolling them in the program.

The navigator works to build the client's trust in the system of care, coordinates the services provided by participating community agencies, reports any system barriers encountered, and documents all activities in the program's database.

Funding and Sustainability
Pathways to a Healthy Bernalillo County is funded through a county mill levy tax. Slightly less than 1% of the tax, approximately $800,000 each year, is dedicated to funding Pathways to a Healthy Bernalillo County. The tax is renewed every eight years (next cycle starts in 2017). The "pathways" partner organizations are guaranteed 30% of their funding from the Hub to cover administrative costs; the other 70% is based upon the incentive structure paid to the partner organizations for successfully achieving outcomes for the clients served.

The pathways are paid through financial incentives, and payments are based on milestones. The partner organizations receive incentive-based payments at three stages:

a) After the initial risk assessment/enrollment in the program;
b) After confirmation that the client has received some level of necessary services; and
c) After verification that pathways have been completed.

Each partner organization can be reimbursed for up to three completed pathways per individual, with the total payment limited to $1,550 per client[29]. Incentive payments are weighted based on the average time it takes clients to complete a pathway. Examples of outcomes associated with a completed pathway include[30]:

- Behavioral health: The client has appropriate health coverage or a financial assistance program in place to establish a behavioral healthcare home and has seen a behavioral health specialist a minimum of three times. The client reports that he or she is no longer experiencing the negative symptoms that previously interfered with his or her quality of life.
- Employment: The client has found consistent source(s) of steady income and is gainfully employed over a period of three months.
- Food security: The client has achieved food security, including access to at least two hot meals per day during the last three months.

[29] The program is based on a capitated-plus payment structure per referred client.
[30] To Note: Partners are incentivized based on both process outcomes AND "health/care outcomes" (e.g. clinical quality, community health). Outcomes are NOT based on cost or healthcare cost proxies (e.g. readmission rates)

- Healthcare home: The navigator confirms that the client has seen a provider a minimum of two times, has established a comfortable relationship with the provider (CAHPS survey), has confidence in asking questions (CTM survey), is treated respectfully (CAHPS survey), has received whole-person care, and understands the follow-up treatment plan (CTM survey), if applicable.

Community Resident Engagement
Pathways interfaces with the community largely through its navigators, who are closely connected to grassroots efforts themselves. Additionally, community members are welcome to attend monthly meetings with navigators, and most community members attending meetings are "grass tops," meaning paraprofessional employees who work directly with communities. There has been outreach to grassroots organizers, but the program has faced challenges in getting additional community involvement at meetings.

Data Sharing Capability
A database maintained by the hub allows navigators to avoid duplication of services, confirm that care pathways have been completed, and collect data for reporting purposes.[31]

Accountability
Pathways is held accountable for its work through its pay structure, where it receives incentivized payments based on its ability to achieve milestones. Incentive payments for each pathway are weighted differently, and depend on the amount of time and effort that is required to complete each. The average time period that a CHN works with its clients and completes three pathways is eight to nine months, but in some cases, particularly with the housing pathway, it can be well over a year. This structure initially created a potential for CHNs to favor, and actively enroll, clients in certain "low hanging fruit" pathways, while avoiding those that were harder to complete (e.g. have more administrative hurdles). For example, one outcome measure of the housing pathway - "client has stable housing for greater than three months" - is required to be completed by clients before CHNs can receive a final incentive payment. However, many clients do not have State-issued I.D's, which is a requirement to apply for public housing. State-issued I.D.'s can take up to 6 months to process, while public housing wait lists can be one year or more. Thus, the 18-month timeframe was often too short to successfully complete the housing pathway.

Aligning evaluation measures (especially those tied to incentive-based payments) with administrative timelines, processes and procedures will promote "buy-in" (among CHNs) and ensure that outcomes-based incentive rewards are achievable.

[31] Integrator maintains internal database with updates from CHNs. Thus, no data "sharing" activities between partners occurs. Instead, HUB reports out to partners and community based on outcomes reported to the Hub.

Successes and Challenges

The most recent long-term evaluation of Pathways to a Healthy Bernalillo County measured outcomes from 2009-2013. Key data held up by the HUB include the following successes:

- 2,129 individuals participated in the program during the four-year reporting period.
- 3,058 separate pathways were successfully completed.
- 92% of participants assessed during exit interviews reported being either "completely satisfied," "mostly satisfied," or "satisfied" with the help that they received.
- 86% reported that what they did with the navigator on specific pathways will continue to help them.
- 84% have been able to help others with information and resources/services that they had learned about from participation in Pathways.
- 76% reported having a better understanding of how to access health and social services as a result of their participation in Pathways.
- 70% reported that their overall health has either "greatly improved" or "improved" since they began participating in the program.
- 68% of participants remained active in the follow-up program, a figure the Hub prides itself on given the transient nature of the population served.

One challenge faced by Pathways to a Healthy Bernalillo County has been the evaluation of long-term outcomes. This struggle has occurred both due to the lack of funding put towards program evaluation (when the focus is on putting funding back into the community), as well as challenges in contacting participants to conduct a six month follow-up when many of them have relocated and/or changed their contact information. An exit interview has now been instituted asking participants to update their contact information and to provide feedback regarding their experiences, but data supporting the long-term efficacy of the program has not yet been collected.

An additional challenge posed by the Pathways model is that its reach – both in terms of how many participants it is able to enroll and how many services it is able to provide – is limited by its funding constraints.

The Bernalillo County program experienced an unexpectedly high turnover rate among its navigators during the first two years, primarily because navigators found better paying positions elsewhere. In response, program leaders have taken steps to improve retention rates, including:

- Developing a training program for new navigators, such as a two-day nationally certified training on mental health and first aid

- Requiring that Pathway organizations must pay their navigators no less than $14 an hour

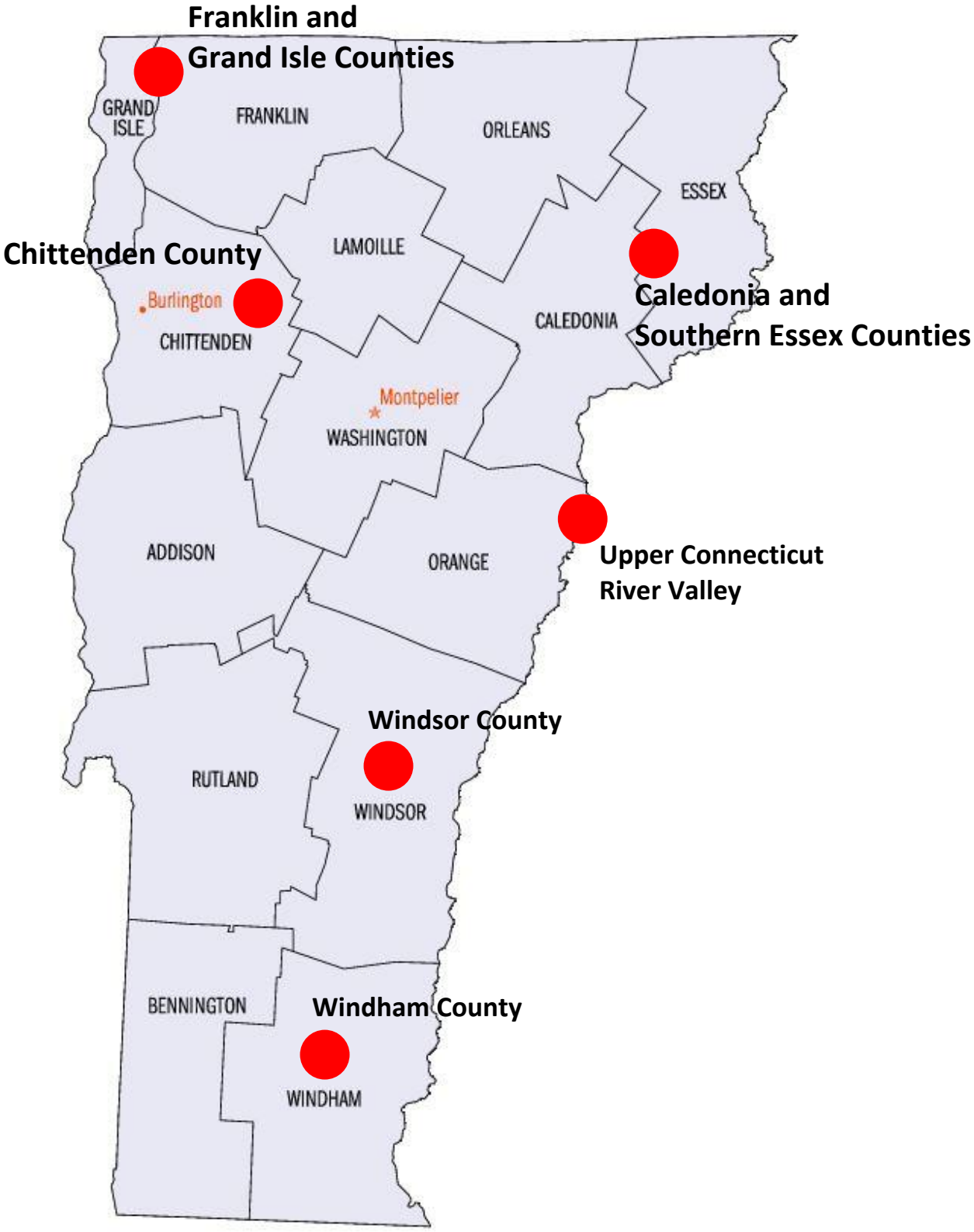
- Holding standing monthly navigator meetings to address topics of interest, learn about additional community resources, provide mini-workshops, and allow the navigators to mingle, network, and support one another

- Fostering more active program managers, serving to better inform the navigators about opportunities for continuing education and to actively encourage employers to support these efforts

- Developing training materials through a contracted consultant to service coordination and advocacy skills, community knowledge, and assessment as part of the statewide efforts to establish a voluntary Community Health Worker Certification Program

Lessons Learned from Implementing Accountable Communities for Health
Ongoing support from the community can be maintained by hosting an annual Report-to-the-Community, providing leadership opportunities for the Navigators, working with a community advisory board, and issuing annual public reports.

VERMONT COMMUNITY SNAPSHOTS



Rise VT, Franklin and Grand Isle Counties

SNAPSHOT

Name of Initiative	Rise VT
Population Served	Rise VT currently serves the population of Franklin and Grand Isle Counties (pop. 55,000). The initiative has discussed scaling up to include other parts of the state.
Leadership Structure	Rise VT is an initiative of Northwestern Medical Center and the Vermont Department of Health St. Albans District Office that operates semi-independently from the hospital. Dorey Demers, the Rise VT Coordinator, oversees all staff and the implementation of work. The Committee on Healthy Lifestyles, representing key local stakeholders, informs the strategic direction of the work and serves as an oversight committee. The committee is co-chaired by the CEO of Northwestern Medical Center and the District Director of the Vermont Department of Health Saint Albans District Office, with representation from medical and dental providers, businesses, media, local and state elected officials, public schools, and community members. Subcommittees work on operations; community engagement; and planning and vision.
Partnership	Rise VT works to bring individuals, schools, businesses, and other organizations on as partners in its movement, and convenes these groups monthly to discuss community goals.
Number of Staff	As of June, 2015, Rise VT is staffed by one full-time Coordinator, one full-time Health Coach, and 1.5 FTE Health Advocates supported by Northwest Medical Center. There are plans to expand the FTE employment levels for the Health Coaches and Health Advocates. Additionally, the local public health office provides in-kind support of a 0.25 FTE Public Health Nurse and 0.1 FTE commitment from the District Director of Public Health.
Stated Goal	Rise VT envisions a region that supports and embraces healthy lifestyles.
Issues Addressed	(1) Physical Activity; (2) Healthy Eating; (3); (4) Smoking (5) Reduce Healthcare Costs
Scope of Strategies	Preventative health, smoking cessation, organizational practice change, and policy advocacy.

Link to Other Healthcare Payment or Delivery Reform Efforts	Rise VT is supporting legislation to ensure that every hospital service has a plan to incorporate wellness into their medical home model.
Policy Changes	Rise VT and Northwestern Medical Center and the Vermont Department of Health has worked on state legislation surrounding anti-marketing campaigns, a sugary beverage tax, employer breastfeeding policies, tobacco policy, and the broader incorporation of wellness into the medical home model in businesses, schools and municipalities in their hospital service area.
Funding Sources/ Budget	Rise VT is funded through a $400,000 over-two-years award from the state SIM grant, matched by a $200,000 per year contribution from Northwest Medical Center, giving it an operating budget of $400,000 per year. It also receives in-kind donations of staff time from the Department of Public Health.
Key Reported Successes	Rise VT is a new initiative transitioning from the planning phase to implementation phase, so many of their reported successes are in their early stages. Rise VT is using branding as an opportunity to attract business to Franklin and Grand Isle county and build the industrial sector. They are advertising their area as a healthy place to live with access to healthy activities. Rise VT staff works collaboratively with surrounding schools to help implement wellness initiatives in their school population. The collaborative was successful in getting one school to stop food fundraising programs that served pizza for lunch. The RiseVT data subcommittee is developing a data dashboard which includes long, medium and short term indicators and will be shared to broaden the understanding of their efforts and progress. This Data Dashboard has both behavioral individual metrics such as fruit and vegetable consumption, as well as larger policy systems and environmental change metrics such as expanding resources for walking and biking. They are also creating a portal to track and share individual participation, behavior change, and health improvement for individuals in the broader community. With the permission of the participants, this information can be shared with their primary care provider and aggregate data can be shared with other entities like the Blueprint for Health Community Health Teams.

	Additionally, Rise VT has created scorecards to assess different entities, municipalities, businesses, schools, and families/individuals on how they are promoting healthy lifestyles. The scorecard is derived from best practices recommended by the CDC Community Guide.

St. Johnsbury Collective Impact, Caledonia and Southern Essex Counties

SNAPSHOT

Name of Initiative	St. Johnsbury Collective Impact
Population Served	The St Johnsbury Collective Impact region covers populations residing in Caledonia and Southern Essex Counties, Vermont (primary service population: 30,000 people). This region is a state-designated health service area, and part of Vermont's Northeast Kingdom which is comprised of three of the poorest counties in Vermont.
Leadership Structure	St. Johnsbury Collective Impact (informally known as the "A Team", and functioning informally as an "accountable health community") is made up of a core team of organization leaders focused on common health needs, determinants, and outcomes in the Northeastern Vermont Regional Hospital service area. There is no formal governance structure.
Partnership	St. Johnsbury Collective Impact consists of three lead agencies: Northeastern Vermont Regional Hospital, Northern Counties Health Care, Inc., and Northeast Kingdom Human Services. Additional organizations who are members of this collective impact include the Northeastern Vermont Area Council on Aging, the Vermont Foodbank, Northeast Kingdom Community Action, Rural Edge (housing and SASH), Vermont Agency of Human Services (Continuum of Care), DART 2.0 community based drug abuse resistance team, OneCareVT ACO, CHAC ACO, and the Vermont Department of Health. Representatives of the business community join on an ad hoc basis. One member of the public also joins the meetings on a regular basis. This collective impact leadership group meets once a month for formal meetings facilitated by the CEO of the hospital.
Number of Staff	There are no dedicated staff members exclusively supporting the work of St. Johnsbury Collective Impact. Paul Bengtson, the CEO of Northeastern Vermont Regional Hospital, facilitates monthly meetings with representatives from partnering organizations, referred to as the A-Team.
Stated Goal	To work collaboratively to collectively assess the health needs of the population, prioritize identified needs, design methods to address those needs, and implement work that will produce sustainable improvements.

Issues Addressed	(1) Causes of depression; (2) Poverty; (3) Affordable housing; (4) Food insecurity; (5) Wellness of aging populations; (6) Job opportunity; and (7) Community determinants of health.
Scope of Strategies	Service integration and policy advocacy.
Link to other Healthcare Payment or Delivery Reform Ffforts	Referrals to programs such as human services, elder care partnerships, and mental health services. The links are coordinated through a formal Community Connections division supported by the hospital and the Vermont Blueprint for Health.
Policy Changes	St. Johnsbury Collective Impact has participated in legislative involvement by testifying on behalf of policy change, influencing drug abuse policy and practice in the state of Vermont.
Funding Sources/ Budget	St. Johnsbury Collective Impact currently depends on in-kind contributions of staff time. The work of the partnership is facilitated using existing resources and grants, including resources for Community Health Teams, Vermont's Demonstration Grant to Integrate Care for Dual Eligible Individuals, and Aging and Disabilities Resource Center Grant. It has recently been awarded a major grant by the Arnold Foundation.
Key Reported Successes	St. Johnsbury Collective Impact has achieved policy success in its early adoption of the NCQA Patient-Centered Medical Home Program. They have also achieved many successes working to improve the region's County Health Rankings scores. It has developed an expansive network and referral system within the region, and is able to accomplish a great deal of community care through its partnerships. Examples include working to provide continuity of addiction treatment for populations coming out of correctional facilities, finding stable housing for homeless families, assuring health coverage for people not insured and not connected to primary care medical homes, and more.

Environment Community Opportunity Sustainability, Chittenden County

SNAPSHOT

Name of Initiative	Environment Community Opportunity Sustainability (ECOS)
Population Served	ECOS aims to serve the entire population of Chittenden County.
Leadership Structure	ECOS leadership is provided by the ECOS Leadership Team. The Chittenden County Regional Planning Commission provides backbone support for ECOS as a whole, while the United Way, UVM Medical Center and Burlington District Department of Health office share collaborative leadership roles for the social community portion of the plan, which includes health, among others issues.
Partnership	ECOS's collaborative partnership is primarily directed by the ECOS Leadership Team, which includes Chittenden County Regional Planning Commission, the City of Burlington, Greater Burlington Industrial Corporation, Lake Champlain Regional Chamber of Commerce, United Way of Chittenden County, University of Vermont, University of Vermont Medical Center, and the Vermont Department of Health. The ECOS Partnership developed a Steering Committee Agreement to guide their collective work. During the development of the ECOS Plan, sixty-five organizations, including municipalities and relevant state and regional agencies participated. ECOS Partners are currently updated on the work via email.
Stated Goal	That Chittenden County becomes a healthy, inclusive and prosperous community.
Issues Addressed	ECOS works across four broad issue areas: (1) Natural systems; (2) Social community (which includes both health and safety); (3) Economic; and (4) Built environment. More specific to health, ECOS addresses: (1) Basic needs; (2) Tobacco use; (3) Obesity; (4) Substance abuse; (5) Emergency preparedness; (6) Caregiving; and (7) Social Connectedness. The ECOS Social Community section and Health Strategy connects to the Regional Clinical Performance Committee (RCPC). The RCPC will develop strategies that will develop community and clinical-based goals and activities which, working together in the context of population health improvement, will address ACO quality measures, clinical priorities (e.g., congestive

	heart failure) and complex/rising risk populations. Additionally, connections will be made to help clinicians understand how the built and natural environments connect to population health improvement such as locating housing in walkable areas, building more sidewalks and creation paths and providing access to transportation.
Scope of Strategies	ECOS partners are dedicated to implementing the ECOS Plan. ECOS divided its work into eight strategies: (1) Economy; (2) Smart growth; (3) Water quality; (4) Working lands and local food; (5) Health; (6) Education; (7) Finance and governance; and (8) Equity. Early action funded projects have included providing fresh produce and transportation to those in need.
Policy Changes	The ECOS Health Strategy calls for policy changes that including tobacco policy and policies that increase access to active transportation, active recreation, and healthy foods and decrease access and exposure to tobacco and alcohol.
Funding Sources/ Budget	ECOS was created in 2011 after Chittenden County received a $1 million federal grant from the U.S. Department of Housing and Urban Development through the Sustainable Communities Regional Planning Grant Program - which supports sustainable and more livable communities. Those funds expired in 2014, but the ECOS implementation work continues through activities of the participating agencies and organizations.
Key Reported Successes	ECOS has developed a scorecard to track its work progress and identify areas in need of intervention. Neighbor Rights initiative - a partnership between the United Way and the transit agency - has expanded capacity to transport seniors by bringing in additional volunteer drivers and integrating them into the overall transportation system. ECOS is also tracking sustainable, healthy community design growth patterns. The data indicates that developers and municipalities are exceeding the objective of locating more than 80% of new housing in areas planned for growth. These areas are places where there are sidewalks, services, transportation and other infrastructure to maintain the county's natural landscape and to provide housing in areas where residents can access food, transportation and other services more easily.

Windsor HSA Accountable Care Community for Health, Windsor County

SNAPSHOT

Name of Initiative	Windsor Health Service Area Accountable Care Community for Health
Population Served	The entire population of Windsor County, VT (pop. 56,670).
Leadership Structure	Mt. Ascutney Hospital and Health Center serves as the coordinating organization for the Windsor HSA Accountable Community for Health.
Partnership	The Windsor HSA Accountable Care Community for Health is comprised of a number of organizations and collaboratives, including Mt. Ascutney Hospital and Health Center, Windsor Area Community Partnership, Windsor Connection Resource Center, the Mt. Ascutney Prevention Partnership, the Windsor Area Drug Task Force, and PATCH Community Services Concept. Organizations working with these collaboratives include Vermont Adult Learning, Vocational Rehabilitation Services, Department of Corrections, hospice, alcohol and drug treatment services, mental health organizations, schools, and child/parenting services.
Number of Staff	There are two full-time Mt. Ascutney Hospital and Health Center staff working on the Windsor HSA Accountable Care Community for Health project. Overall, the project integrates a large number of organizations and community partnerships, making it difficult to determine an exact number of staff.
Stated Goal	To connect agencies, community leaders, and constituencies through a coalition that represents adults, youth, and elders in the Windsor area to promote the health and well-being of the community.
Issues Addressed	(1) Substance abuse; (2) Tobacco cessation; (3) Smoke-free parks; (4) Elevated challenges for low income populations; (5) Oral health; (6) Obesity; and (7) Nutrition.
Scope of Strategies	The collaborative members support a range of strategies. These include improving access to health insurance and dental care; improving school environments including student perceptions of safety and safe routes to school; advocacy in support of state and local tobacco policy; and connecting residence to social and economic support services.

Link to other Healthcare Payment or Delivery Reform Efforts	Referrals to multiple community resources including substance abuse rehabilitation, social service agencies, and mental health.
Policy Changes	The Windsor HSA Accountable Care Community for Health has influenced state and local tobacco policy.
Funding Sources/Budget	The Windsor HSA Accountable Care Community for Health depends on in-kind services of the Mt. Ascutney Hospital and Health Center. Funding is accessed through state and federal grants, including the Blueprint for Health grant, as well as insurance companies and local support.
Key Reported Successes	The Windsor HSA Accountable Care Community for Health has been a leader in regional prevention efforts, and established one of the first patient-centered medical homes in the state. It was able to quickly create medication return boxes located in the police department, which have since been replicated in multiple locations in the region. The Windsor HSA Accountable Care Community for Health has conducted intensive Community Needs Assessments in order to examine the regional metrics of health over time, and has used them to further develop program goals and objectives. It uses consistent, existing metrics in order to evaluate itself and measure its progress over time. For its Community Health Needs Assessment, it has developed a three-tier approach, involving community dialogues and focus groups, widely distributed survey administration, and information analysis. Metrics include social and economic factors related to health such as lack of jobs and access to transportation, as well as local healthcare needs such as access to dental care and improved emphasis on restorative practices. This information is then used to discuss priorities and plans for implementation. It has used its expansive partnership to unite a staff that has the capacity to best implement its work and serve the community.

ReThink Health Upper Connecticut River Valley, Upper Connecticut River Valley

SNAPSHOT

Name of Effort	ReThink Health Upper Connecticut River Valley (UCRV)
Population Served	Approximately 180,000 in 69 towns of the Upper Connecticut River Valley of New Hampshire and Vermont.
Leadership Structure	ReThink Health UCRV intends to be a 501(c)(3) led by Executive Director Steven P. Voigt, with The Dartmouth Institute currently serving as fiscal sponsor. It's overseen by a steering committee of regional leaders in business, social services, health care and health.
Partnership	ReThink Health UCRV engages with a variety of partners in different aspects of its work. In Claremont, New Hampshire, it partners with a Claremont leadership group to assess community assets, needs, and priorities.
Number of Staff	0.5 FTE Executive Director, 5 FTE employees.
Stated Goal	To catalyze, connect, and support collaborative work and learning to achieve measurable and sustainable improvements in health and healthcare.
Issues Addressed	Healthcare access, healthy lifestyles, education, employment, aging with dignity, and better community engagement.
Scope of Strategies	Supporting health improvement plans with a data hub, community engagement and community wellness trust.
Link to other Healthcare Payment or Delivery Reform Efforts	ReThink Health UCRV is exploring more sustainable investment models that include community benefit funds, ACO shared savings and employer contributions.
Policy Changes	ReThink Health UCRV does not work on policy change at this time.
Funding Sources/ Budget	ReThink Health UCRV is primarily grant funded, and will be exploring more sustainable investment models that include

	community benefits and employer contributions.
Key Reported Successes	ReThink Health UCRV successfully completed its Claremont Health Survey, which assessed community assets, needs, and priorities. The priorities identified include civic engagement, leadership, health and wellness, employment, and education. ReThink Health is supporting the formation of a leadership team to address these issues. ReThink Health is working with seniors across the region to systematically identify what is needed to support seniors to age with dignity. This project will bring a more scientific approach to analyzing their stories to inform aging in place projects. Several employers in the region have made financial investments to support ReThink Health based on a contribution per employee. The collaborative, in partnership with The Dartmouth Institute, has received a grant to investigate models of sustainable financing including employer contributions, community benefit contributions, and shared savings from ACOs. It's also exploring the establishment of a Wellness Trust to serve as the mechanism for consolidating and disseminating resources generated.

Accountable Community, Windham County

SNAPSHOT

Name of Initiative	Accountable Community
Population Served	Windham County, Vermont (pop. 44,513)
Leadership Structure	The Accountable Community is currently in the development stage and a formal governance structure has yet to be established. There is an overarching Accountable Care Organization Steering Committee currently housed in the Brattleboro Memorial Hospital structure. The steering committee involves representatives from the business development sector, Chief Medical Officer, Chief Financial Officer, the Blueprint team, the ACO One Care, a Physician Chair and a medical director from the hospital. The Accountable Community has also established a RCPC Leadership Team. The RCPC group is chaired by Dr. Denise Paasche of Brattleboro Memorial Hospital and co-chaired by Wendy Cornwell, the Project Manager of VT Blueprint for Health.
Partnership	Partners involved in the collaboration include: Blueprint Clinical Planning Group, Blueprint Project Manager, Community Health Team, Grace Cottage Hospital, Brattleboro Retreat and Brattleboro Memorial Hospital. The collaboration began with the Blueprint Clinical Planning Group, which represents a large group of community stakeholders. This planning group was formed to provide guidance about the composition of the staff on the community health team. As time progressed, the planning group became a forum for sharing information between organizations.
Number of Staff	The Accountable Community is currently in the planning stages and has no dedicated staff.
Stated Goal	To expand beyond the medical model of health and connect to community to examine social, economic, and behavioral factors.
Issues Addressed	Potential issues include (1) Alcoholism; (2) Mental health; (3) Obesity; and (4) Dental health. Work groups have been organized under the RCPC to focus on improving hospice utilization and quality of life at the end of life. The RCPC is scheduled to participate in Vermont's Integrated Communities Care Management Learning Collaborative and plans on developing the outgrowth of this project into another RCPC workgroup that will focus on mental health care.

Scope of Strategies	These are yet to be determined.
Link to other Healthcare Payment or Delivery Reform Efforts	Referrals to programs such as social services, hospice, and mental health services.
Policy Changes	None at this time.
Funding Sources/ Budget	The initiative is funded by Brattleboro Memorial Hospital.
Key Reported Successes	The planning process for this effort has leveraged its Community Health Needs Assessment process to support its work. It will use this information to create individual implementation plans for each hospital based on their unique areas of strength. By using this approach, the collaborative hopes to pool its resources. It will be required to have an implementation plan complete within the first four months of 2016.

APPENDICES

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ACCOUNTABLE COMMUNITY FOR HEALTH NATIONAL CASE STUDIES SCREENING CRITERIA

Prevention Institute developed the following criteria to employ in the screening process for national case studies to inform Vermont's work on Accountable Health Communities (AHCs). These criteria were developed based upon the *Accountable Health Community Program* Request For Proposals issued by the Department of Vermont Health Access in July, 2014, the discussion on AHCs held by the Population Health Work Group on September 9, 2014, subsequent conversation with the Population Health Planning Group on December 9, 2014, the paper *Healthier by Design: Creating Accountable Care Communities*, describing similar work conducted in Summit County, Ohio, a review of State Innovation Model program plans being developed in other states, and internal analysis and discussion.

The criteria are broken down into Principle Screening Criteria that Prevention Institute views as definitional to the concept of an AHC, as well as Secondary Screening Criteria that Prevention Institute views as desirable to the implementation of a robust and sustainable AHC model in Vermont. Potential sites will be screened for both sets of criteria, with an aim to identify a varied group of four to six sites that have strengths amongst the diverse criteria.

Definition

- An Accountable Health Community (AHC) is accountable for the health and well-being of the entire population in its defined geographic area, including reducing disparities in the distribution of health.

Principle Screening Criteria

- **Partnership Structure**
  - Structured, integrated partnership of health care delivery systems, social service agencies, public health departments, government, and community organizations.

- **Integrator Function**
  - Facilitated by an internal or external integrator that coordinates the capacities of the partners within the AHC.

- **Multiple Levels of Intervention**
  - Implements a comprehensive set of strategies across its defined geographic area to improve the social, physical, and economic conditions driving health outcomes. These strategies span the Spectrum of Prevention, from individual services and education to organizational practices and policy change.[32]

- **Shared Strategies for Population Health Improvement**
  - Engages all partners in a process for assessing, planning, and implementing health improvement approaches.

[32] *Spectrum of Prevention*. Oakland, CA: Prevention Institute. http://preventioninstitute.org/component/jlibrary/article/id-105/127.html.

Secondary Screening Criteria

- **Community Resident Engagement**
  - Prioritizes authentic community participation throughout assessment, planning, and implementation processes.

- **Data Sharing Capability**
  - Includes the exchange of health and community data useful for assessing and developing strategies to improve population health.

- **Multilevel Evaluation Metrics**
  - Uses measures of quality and performance at multiple levels of change to ensure accountability in system design and implementation for improved population health.

- **Sustainability and Reach**
  - Fosters sustainable and generalizable delivery and funding models that support and reward improvements in population health.

- **Portfolio of Strategies**
  - Includes a diverse portfolio of short-, medium-, and longer-term strategies to positively impact health and reduce health care costs.

ACCOUNTABLE COMMUNITY FOR HEALTH NATIONAL CASE STUDIES INTERVIEW GUIDE

ACH National Case Studies Interview Guide

The following interview guide was developed to synchronize with the criteria from the *Final Screening Criteria for National Exemplars* previously discussed with the Vermont Population Health Planning Committee. Depending on the interview site and the roles and responsibility of the interviewee, questions were adjusted to direct the conversation. Bullet points indicate questions to be asked; sub-bullets indicate further questioning prompts if the specified material was not addressed.

Background

- What's the history of your organization and this effort? How did it come about?
    - Was there a roll-out of your effort (i.e., did you start smaller and expand)?
    - What role does improving health equity (reducing health disparities) play in this work?
- What is your role within the effort?
- What population does this effort target (e.g., a geographic population, Medicaid-eligible adults, high utilizers, etc.)?

Partnership Structure/ Integrator Function

- Who/which organizations are a part of this collaborative effort?
    - More specifically, are there representatives from:
        - Health care delivery systems?
        - Social service agencies?
        - Public health departments?
        - Other government agencies?
        - Community organizations?
- What is the structure of this collaboration?
    - Are there formal Memoranda of Understanding (MOU) or governance agreements between these parties?
    - Is there an integrator/backbone organization that coordinates the collaboration?
    - How is this integrator funded?
    - Does the integrator exist solely as an integrator, or does it also have additional functions within the community?
- How was the structure of this collaboration developed?
- How would you describe the functioning of the collaborative
    - What is working well?
    - What is challenging?

Shared Strategies for Population Health Improvement

- How does your effort assess community needs?

- What is your effort's planning process for developing strategies to address those needs?
    - Ask for copy of written plan if available.
- What is your effort's implementation process for actualizing those plans?
- Do your strategies include short-, medium-, and longer-term strategies to positively impact health and reduce health care costs?
- Would you describe these assessment, planning, and implementation processes to be shared amongst all stakeholders, or do they rest more with a particular organization?

Multiple Levels of Intervention/Portfolio of Strategies

- Is there a central health concern or set of concerns that you were founded to address?
- As a collaborative effort, what are the core activities you are doing together?
    - Prompts:
        - Referring to medical providers?
        - Providing social services (e.g., case management, employment support, medical-legal partnerships, etc.)?
        - Referring to social services?
        - Strengthening individual knowledge and skills?
        - Promoting community education?
        - Educating providers?
        - Changing organizational practices?
        - Influencing policy and legislation?
        - Other important activities that did not fit the above criteria?
- Would you describe the focus of your effort as providing quality services to individuals, changing the overall community environment to better support health, or both?
    - Examples, if not already detailed.

Community Resident Engagement

- Does this effort involve community participation throughout the assessment, planning, and implementation processes?
    - If so, how?

Data Sharing Capability

- Does your effort have data sharing practices in place?
    - If so:
        - What types of data are collected, and for what purpose?
        - How are data collected and stored (e.g., data warehouse with specific fields/indicators; full access to electronic data; etc.)?
        - How are data used by each partner?
        - How "integrated" are electronic systems?
        - Who "owns" shared data and who is the steward of the data?
        - Do you have health e-learning resources, social networking, or health literacy tools?
        - Were your E-health and tele-health capable of wide use of remote monitoring and tele -health and e-health management?

Multilevel Evaluation Metrics

- What are your greatest successes?
- What are your greatest challenges?
- What evaluation measures are you using?
    - Quality and performance measures?
    - Evaluates multiple levels of change?
    - Process for reviewing measures and modifying implantation strategies?

Funding and Sustainability

- How are the collaborative's activities funded?
- Has the integrator/collaborative had success in leveraging funding sources to support the collaborative's priorities?
- Are there health care payment innovations in place that support this effort?
- Is there a formal ACO structure present?
- Is there any mechanism in place for savings realized through this effort to be cycled back into the effort?
- How would you characterize the sustainability of your funding sources?

Close

- Is there anything additional you'd that you'd like to add?
- Are there documents or reports about this work that you can refer us to?
- Is there anyone else within your effort that you think we might want to speak with?

VERMONT ACCOUNTABLE HEALTH COMMUNITIES SURVEY

Background Sent to the Vermont Population Health Work Group

Prevention Institute is supporting the Population Health Work Group of the Vermont Health Care Innovation Project in conducting research into the potential for Accountable Communities for Health in Vermont. One element of the research process is to gather information on existing building blocks of this work already underway in Vermont. The working definition of Accountable Communities for Health is:

> *Accountable Communities 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 is not limited to a defined group of patients. Population health outcomes are understood to be the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, economic circumstances, and environmental factors. 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.*

We are seeking information from collaborations, clinical settings, and community initiatives that meet some of the ACH Criteria listed below. If you would like to participate, please submit some key information about your work through this short form.

Please note that there is no funding opportunity connected with this survey; your assistance will be for research purposes only. We will be selecting several sites within Vermont for follow-up interviews to inform profiles that may be included in our final report.

Your assistance in this effort is greatly appreciated. Please feel free to share this email with your networks to more fully engage all interested parties.

<u>ACH Characteristics</u>

- **Partnership**
  - Structured, integrated partnership of health care delivery systems, social service agencies, public health departments, government, and community organizations.

- **Integrator Function**
  - Facilitated by an internal or external integrator that coordinates the roles and capacities of the partners within the AHC according to its governance structure.

- **Multiple Levels of Intervention**
  - Implements a comprehensive set of strategies across its defined geographic area to improve the social, physical, and economic conditions driving health outcomes. These strategies span the Spectrum of Prevention, from individual services and education to

organizational practices and policy change.

- **Shared Strategies for Population Health Improvement**
  - Engages all partners in a process for assessing, planning, and implementing health improvement approaches.

- **Community Resident Engagement**
  - Prioritizes authentic community participation throughout assessment, planning, and implementation processes.

- **Data Sharing Capability**
  - Includes the exchange of health and community data useful for assessing and developing strategies to improve population health.

- **Multilevel Evaluation Metrics**
  - Uses measures of quality and performance at multiple levels of change to ensure accountability in system design and implementation for improved population health. Integrates learnings into adjustments through an iterative cycle of continuous improvement.

- **Sustainability and Reach**
  - Fosters sustainable and generalizable delivery and financing models that support and reward improvements in population health.

- **Portfolio of Strategies**
  - Includes a diverse portfolio of short-, medium-, and longer-term strategies to positively impact health and reduce health care costs.

Vermont Accountable Health Communities Survey Form

Name of Community Initiative:

Contact Name:

Contact Title:

Contact Email:

Contact Phone Number:

Please briefly describe your community initiative:

Which elements of an Accountable Community for Health are present in your community initiative?
Check all that apply:

- ☐ PARTNERSHIP: Structured, integrated partnership of health care delivery systems, social service agencies, public health departments, government, and community organizations.

- ☐ INTEGRATOR FUNCTION: Facilitated by an internal or external integrator that coordinates the roles and capacities of the partners within the AHC according to its governance structure.

- ☐ MULTIPLE LEVELS OF INTERVENTION: Implements a comprehensive set of strategies across its defined geographic area to improve the social, physical, and economic conditions driving health outcomes. These strategies span the Spectrum of Prevention, from individual services and education to organizational practices and policy change.

- ☐ SHARED STRATEGIES FOR POPULATION HEALTH IMPROVEMENT: Engages all partners in a process for assessing, planning, and implementing health improvement approaches.

- ☐ COMMUNITY RESIDENT ENGAGEMENT: Prioritizes authentic community participation throughout assessment, planning, and implementation processes.

- ☐ DATA SHARING CAPABILITY: Includes the exchange of health and community data useful for assessing and developing strategies to improve population health.

- ☐ MULTILEVEL EVALUATION METRICS: Uses measures of quality and performance at multiple levels of change to ensure accountability in system design and implementation for improved population health. Integrates learnings into adjustments through an iterative cycle of continuous improvement.

- ☐ SUSTAINABILITY AND REACH: Fosters sustainable and generalizable delivery and financing models that support and reward improvements in population health.

- ☐ PORTFOLIO OF STRATEGIES: Includes a diverse portfolio of short-, medium-, and longer-term strategies to positively impact health and reduce health care costs.

List the partners collaborating on this initiative and describe the partnership structure in place:

What shared strategies have you identified for improving the health of residents in your community:

Describe your community's capacity to share data to make informed decisions and evaluate strategies to improve population health:

In what way could your initiative help to inform research into Accountable Communities for Health in Vermont:

LIST OF INTERVIEWEES

Accountable Community, Windham County, Vermont

- Mark Burke, MD, FACC, Cardiovascular Services Medical Director, Population Health and Accountable Care, Brattleboro Memorial Hospital
- Wendy Cornwell, RN, Director of Community Health Initiatives/Blueprint Project, Brattleboro Memorial Hospital

Environment Community Opportunity Sustainability (ECOS), Chittenden County, Vermont

- Charlie Baker, BS, Executive Director, Chittenden County Regional Planning Commission
- Amy Carmola, PhD, Director of Community Impact, United Way of Chittenden County
- Julie Cole, MPA, Community Benefits Coordinator, Community Health Improvement Department, University of Vermont Medical Center
- Heather Danis, MPS, RD, Health Services District Director, Burlington District Office, Vermont Department of Health
- Pam Farnham, RN, Manager of Community Health Team, University of Vermont Medical Center
- Penrose Jackson, BA, Director Community Health Improvement, University of Vermont Medical Center
- Vicki Loner MHCDS, RN.C, Vice President, Clinical and Network Operations, OneCare Vermont / University of Vermont Health Network
- Melanie Needle, MSGIS, Senior Planner, Chittenden County Regional Planning Commission
- Beth Hallock Stekel, RN, CCM, Manager Community Outreach, Community Health Improvement, University of Vermont Medical Center

Live Healthy Summit, Summit County, Ohio

- Norman Christopher, MD, Noah Miller Chair, Department of Pediatrics, Akron Children's Hospital
- James Hardy, MPH, Assist Director, Community Health, Health Equity and Social Determinants Unit, Summit County Public Health
- Jeff Krauss, BMS, Public Health Coordinator, Summit County Public Health
- Gene Nixon, RS, MPA, Health Commissioner, Summit County Public Health
- Donna Skoda, MA, Deputy Health Commissioner for Planning, Summit County Public Health

Live Well San Diego, San Diego County, CA

- Dale Fleming, BS, Director, Office of Strategy and Innovation, County of San Diego Health and Human Services Agency
- Julianne Howell, MPP, PhD, Senior Health Policy Advisor, County of San Diego Health and Human Services Agency
- Chuck Matthews, MS, MBA, Deputy Director, Health and Human Services Agency, North Coastal and North Inland Administration
- Leslie Upledger Ray, PhD, MPH, MPPA , MA, Senior Epidemiologist, Community Health Statistics at Emergency Medical Services, County of San Diego
- Carey Riccitelli, MPH, Community Health Promotion Manager, Health and Human Services Agency, North Coastal and North Inland Administration
- Wilma Wooten MD, MPH, Public Health Officer, Health and Human Services Agency, Public Health Services

Trillium Community Health Plan, Lane County, Oregon

- Chris DeMars, MPH, Director of Systems Innovation, Oregon Health Authority Transformation Center
- Leah Edelman, Community Health Analyst, Lane County Public Health

- Debi Farr, Director of Government and Public Health Affairs, Trillium Community Health Plan
- Jeffrey Fritsche, BBA, Finance Director, Oregon Health Authority
- Karen Gaffney, MS, Assistant Director, Lane County Health and Human Services
- Megan Lee Gomeza, MSW, Project Manager, Lifeways Inc.; Coordinator, Malheur Community Advisory Council, Eastern Oregon Coordinated Care Organization
- Ellen Larsen, RN, Director, Hood River County Health Department
- Jennifer Webster, MPH, CHES, Community Health Analyst, Lane County Public Health

Pathways to a Healthy Bernalillo County, Bernalillo County, New Mexico

- Claudia Benavidez, Program Director, Peanut Butter & Jelly Pre-School Family Services Inc.; Community Health Navigator, Pathways to a Healthy Bernalillo County
- Daryl T. Smith, MPH, Pathways Program Manager, Pathways to a Healthy Bernalillo County

Pueblo Triple Aim Corporation/Coalition, Pueblo County, Colorado

- Shylo Dennison, MPH, Public Health Planner, Pueblo City-County Health Department
- Matt Guy, MPA, Managing Director, Pueblo Triple Aim Corporation
- Donald Moore, MHA, CMPE, Chief Executive Officer, Pueblo Community Health Center, Inc.

ReThink Health, Upper Connecticut River Valley, New Hampshire/ Vermont

- Margaret Brown, MPH, Senior Project Coordinator, ReThink Health Upper Connecticut River Valley
- Alice Stewart, MA, Associate Director, ReThink Health Upper Connecticut River Valley
- Steve Voigt, MBA, Executive Director, ReThink Health Upper Connecticut River Valley

RiseVT, Franklin and Grand Isle Counties, Vermont

- Judy Ashley, MS, St. Albans District Director, Vermont Department of Health
- Jonathan Billings, BA, Vice President of Planning and Community Relations, Northwestern Medical Center
- Jill Berry Bowen, MS, MSN, MBA, Chief Executive Officer, Northwestern Medical Center
- Dorey Demers, RN, Rise VT Coordinator, Northwestern Medical Center
- Elisabeth Fontaine, MD, OBGYN and Medical Director Lifestyle Medicine, Northwestern Medical Center
- Briana Haenke, RN, BSN, Public Health Nurse, Vermont Department of Health
- Katharine Laddison, BA, Community Relations Specialist, Northwestern Medical Center
- Emerson Lynn, BA, Editor and Co-Publisher, St. Albans Messenger and Milton Independent; Owner/Publisher, The Colchester Sun and The Essex Reporter
- Patricia Rainville, Board Member, Franklin-Grand Isle United Way Board
- Suzanne Tremblay, BS, Supervisor of Lifestyle Medicine, Northwestern Medical Center

St. Johnsbury Collective Impact, Caledonia and Southern Essex Counties, Vermont

- Paul R. Bengtson, MA, MBA, FACHE, Chief Executive Officer, Northeastern Vermont Regional Hospital
- Doug Bouchard, MSW, Executive Director of Northeast Kingdom Human Services
- Patrick Flood, CEO, Northern Counties Health Care
- Merry Porter, RN, Danville Health Center
- Laural Ruggles, BS, MPH, MBA, Vice President of Marketing and Community Health Improvement, Northeastern Vermont Regional Hospital
- Lisa Viles, Executive Director, Area Agency for Aging for Northeastern Vermont

Washington State Health Care Authority

- Kayla Down, MPH, Community Transformation Specialist, Washington State Health Care Authority
- Sue Grinnell, MPH, Special Assistant, Health Transformation and Innovation, Washington State Department of Health
- Lena Nachand, MPH, Community Transformation Specialist, Washington State Health Care Authority
- Chase Napier, BA, Community Transformation Manager, Washington State Health Care Authority

Windsor Health Service Area Accountable Care Community for Health, Windsor County, Vermont

- Jill Lord, RN, MS, Chief Nursing Officer and Director of Patient Care Services, Mt. Ascutney Hospital
- Melanie Sheehan, MCHES, TTS, Director of Community Health Outreach and Chair of Mt. Ascutney Prevention Partnership, Mt. Ascutney Hospital