

Advancing State Innovation Model Goals through Accountable Communities for Health

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IN BRIEF

Across the country, multi-stakeholder groups are using a new model to achieve the goals of a community-focused Triple Aim — improved care, reduced health care costs, and enhanced population health. These new Accountable Communities for Health (ACH) are bringing together partners from health, social service, and other sectors to improve population health and clinical-community linkages within a geographic area. Several State Innovation Models (SIM) states are testing ACH models to advance their goals and address the full range of clinical and non-clinical factors that influence health.

This brief reviews state efforts to develop and test ACH models within the federal SIM initiative, including an examination of how ACHs are connected with broader population health and delivery system reform plans. It profiles key elements of ACHs in pioneering states and examines models in **California, Michigan, Minnesota, and Washington**. It also looks at additional SIM states — **Delaware, Iowa, and Virginia** — that are pursuing regional ACH-like alliances.

The Affordable Care Act (ACA) ushered in a new focus on health care delivery, centered on providing integrated, patient-centered, and value-driven care to achieve the goals of the Triple Aim — improve care, reduce health care costs, and improve population health.¹ Responding to the ACA's challenge, states are creating Accountable Communities for Health (ACH) that integrate entities from a broad range of sectors — health care, behavioral health, public health, social services, and community-based supports — to address the medical and non-medical factors that influence health, particularly the social determinants of health. ACHs provide care for individuals through partnerships that extend beyond doctor's offices, integrating medical and non-medical services to achieve greater health equity among all residents. This emerging model can be used to leverage public health activities to address the community-level factors shaping population health, including social, economic, and environmental determinants.²

This brief reviews state efforts to develop and test ACH models within the federal State Innovation Models (SIM) initiative, including an examination of how ACHs are connected with broader population health and delivery system and payment reform plans.³ It profiles key elements of ACHs in pioneering states and provides an in-depth review of models in California, Michigan, Minnesota, and Washington. Finally, it also looks at additional SIM states — Delaware, Iowa, and Virginia — that have developed regional ACH-like alliances and describes how states are integrating ACHs into SIM plans.

Background on State Innovation Models

The SIM initiative, made possible through the Center for Medicare and Medicaid Innovation (CMMI), provides select states with financial and technical support to advance new service delivery models and multi-payer health care payment reforms. The underlying goal of state SIM efforts is to improve health system performance, increase quality of care, improve patient experience, and decrease health care costs. Among other requirements, state awardees must develop a population health plan that addresses health disparities, determinants of health, mental health, and substance abuse and integrates community health

and prevention into their delivery system and payment models.⁴ Several states are testing ACH models as a way to advance SIM goals and address the full range of clinical and non-clinical factors that influence health. These states are exploring how ACH models will operate within broader delivery system and payment reform efforts, including patient-centered medical homes (PCMH), behavioral health integration models, accountable care organizations (ACOs), value-based reimbursement, care coordination efforts, community health teams, efforts to target high-need, high-risk populations, and Medicaid waiver demonstrations.

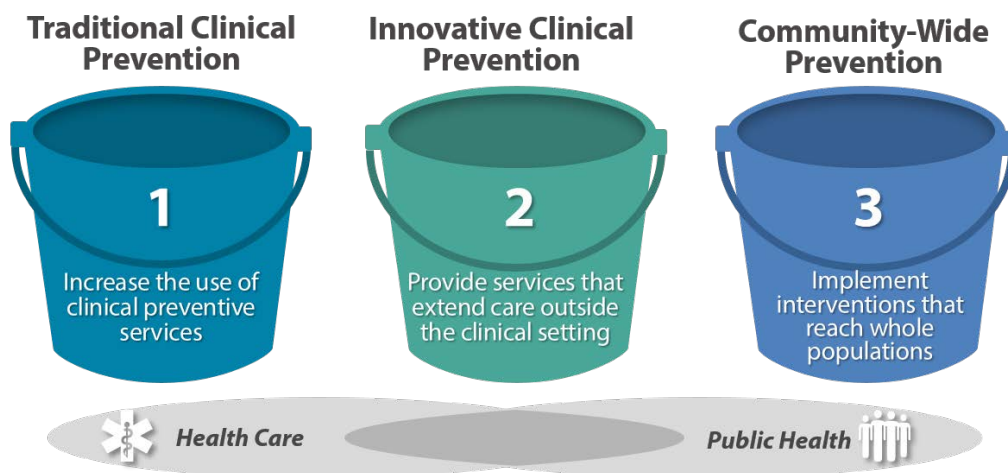
The Role of Accountable Communities for Health in State Innovation Models

The idea of multi-stakeholder groups working together toward attaining a community-focused Triple Aim is not new. In 2012, Magnan and colleagues from the Minnesota Department of Health proposed the development of voluntary regional organizations called accountable health communities to work with health system stakeholders in reviewing local data on health, experience, and quality of care in order to develop strategies to meet the Triple Aim.⁵

Since then, the ACH concept has become more firmly rooted in communities across the US. ACHs, variably referred to as *accountable health communities*, *accountable care communities*, or *community health innovation regions*, are generally defined as a coalition of partners from health, social service, and other sectors working together to improve population health and clinical-community linkages within a geographic area. For this paper, the term ACH is used to refer to all models. The ACH model facilitates cross-sector collaboration to address the full range of factors that influence health, including access to medical care, public health, genetics, behaviors, social factors, economic circumstances, and environmental factors.

The CDC's "Three Buckets of Prevention" framework is useful for understanding the role that ACHs play in population health improvement (see Exhibit 1).⁶ ACHs focus primarily on bucket 2 and 3: innovative prevention initiatives that extend care outside the clinical setting and total population or community-wide prevention interventions.⁷ In contrast, traditional delivery transformation and payment reform efforts, such as ACOs or PCMHs, focus primarily on buckets 1 and 2. State seeking to establish a comprehensive population health improvement approach can thus structure ACHs to complement more traditional delivery system and payment reforms.

Exhibit 1: The 3 Buckets of Prevention



SOURCE: J. Auerbach. The Three Buckets of Prevention. *Journal of Public Health Management Practice* (2016).

States are testing a variety of strategies to integrate ACHs into SIM efforts. For example, some state SIM programs require ACHs to partner with a managed care organization (MCO) or ACO and others are integrating ACHs into broader delivery system reform efforts. In Minnesota, for example, ACHs must partner with an ACO, and under SIM the state is testing whether health outcomes and costs are improved when ACOs align with Community Care Teams and ACHs to support integration of health care with non-medical services.¹⁰

Washington's ACHs cover geographic regions that together encompass the entire state, representing a total population and multi-payer approach. The ACH regions align directly with the state's Medicaid purchasing boundaries, which will help foster the necessary linkages and supportive environments to address the needs of the whole person, including a shift toward fully integrated and value-based purchasing, starting with Medicaid. Additionally, through its Section 1115 Medicaid demonstration waiver application, Washington State is proposing a Delivery System Reform Incentive Payment program (DSRIP) that will link delivery system transformation activities to measureable outcomes, coordinated and directed by the ACHs across the state. The ACHs will be expected to act as primary point for accountability for the state and will convene providers to coordinate health transformation activities, implement interventions, connect clinical and community-based organizations, and track regional health improvement tied to payment.

Centers for Medicare & Medicaid Services: Accountable Health Community Model

In support of the Triple Aim goals and growing evidence that linking high-cost beneficiaries to social services can improve health outcomes and reduce costs, the Centers for Medicare & Medicaid Services (CMS) recently announced a five-year, \$157 million Accountable Health Communities (AHC) model that will test whether addressing health-related social needs among dually eligible Medicare and Medicaid beneficiaries who live in the community can reduce health care costs and utilization.⁸ The AHC model encourages enhanced community-clinical linkages in developing and implementing approaches to solving unmet social needs, such as food insecurity and housing instability. Through the AHC program, communities throughout the country will launch a variety of transformation efforts testing different payment methods. The ultimate goal of CMS' five-year test is to "accelerate the development of a scalable delivery model for addressing upstream determinants of health for Medicare and Medicaid beneficiaries."⁹

Core ACH Design Elements

While each state has approached the development of ACHs within SIM efforts slightly differently, researchers generally agree on the basic design elements of an ACH.^{11,12,13} Below are seven core elements that CHCS has identified across models, recognizing that the incorporation of all elements takes time:

1. Geography;
2. Mission and vision;
3. Governance;
4. Multi-sector partnerships;
5. Priority focus areas;
6. Data and measurement; and
7. Financing and sustainability.

Following is a discussion of key considerations within each of these core elements and examples from SIM states (see Exhibit 2 for select ACH features in a sample of SIM states):

1. Geography

ACHs aim to increase clinical-community linkages and improve population health typically within a specific geographic area. The geographic boundaries of communities often dictate the numbers of ACHs in a state, sometimes resulting in variable coverage. For example, the nine ACHs in Washington State cover all counties within the state. By contrast, the initiatives in California, Minnesota, Michigan, and Iowa cover only certain regions, and in some cases, the ACHs have overlapping geographic boundaries. Beyond defining an ACH by the community, county, or region served, ACHs may also serve a specific population, including high-risk beneficiaries or those with specific chronic conditions. The Total Care Collaborative ACH

in Minnesota, for example, focuses on increasing person-centered care for people with serious mental illness living with chemical dependency issues and co-occurring chronic diseases.¹⁴

2. Mission and Vision

An effective mission statement provides an organizing framework for the ACH. It may define the ACH's geographic region, the ACH's role in addressing the full range of determinants that shape health, and in some cases, may make health equity an explicit aim.¹⁶ Having a shared vision among stakeholders can help ensure a clear understanding of the purpose and expectations of the ACH, as well as collective accountability for achieving its goals.

3. Governance

ACHs have diverse governance structures that are driven by state requirements and guidance as well as the needs of the communities in which they operate. The leadership organization — sometimes referred to as the backbone, integrator, or quarterback organization — plays an essential coordinating role. States have selected a number of different types of lead agencies, such as public health departments, health systems, community based organizations, county health boards, and social service agencies. Key functions can include, but are not limited to: (1) guiding development of a common vision, goals, and strategy; (2) ensuring community engagement; (3) facilitating agreements across partner organizations; (4) serving as a coordinator and convener; (5) managing the ACH budget and mobilizing funding; (6) overseeing data collection, analysis, and evaluation; and (7) ensuring transparency of goals, activities, and outcomes.

4. Multi-Sector Partnerships

A range of multi-sector partners is necessary to help an ACH fulfill its mission. While health care providers are important ACH participants uniquely positioned to reach the target population within the community, public health and community and social services organizations, are also critical partners. All ACHs are required to be multi-sectoral, although some states are more prescriptive about certain required ACH partners, such as ACOs, public health, schools, criminal justice, food banks, housing and transportation agencies, and businesses. ACHs need to strike a balance between broad involvement in governance, to ensure that regional interests are being appropriately represented, and effective decision making, so that coalitions are functional.

5. Priority Focus Areas

ACHs typically have the flexibility to select the health conditions and populations on which to focus. This enables ACHs to prioritize the needs of certain sub-populations while simultaneously aligning their efforts with overall population health goals.

California, for example, has outlined five core domains — clinical, community, clinical-community linkages, policy and systems change, and environment — to help ACHs focus on a common set of goals, but gives them the flexibility to design a broad range of interventions.¹⁷ In contrast, Michigan's Community Health Innovation Regions (CHIRs) must focus on high emergency department (ED) utilizers in the first year of operation, but can expand to additional target populations in subsequent years, specifically individuals with multiple chronic conditions or healthy mothers and babies. Similarly, the Iowa ACH-type coalitions, called Community Care Coalitions (C3s), must pursue care coordination interventions that address the state's SIM population health focus areas — tobacco, obesity, and/or diabetes — as well as the social determinants of health. Several states are also offering technical assistance to ACH entities: Minnesota and Michigan are using outside vendors to help develop ACH organizational capacity and facilitate learning communities or collaboratives.

King County Accountable Community of Health

Below is the vision statement from the King County Accountable Community of Health in Washington State:

"By 2020, the people of King County will experience significant gains in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities."¹⁵

6. Data and Measurement

Data sharing, particularly at the local-level, is an essential component to identify community-wide needs, inform ACH activities, and monitor the impact of population-based health efforts. Collecting, aggregating, and sharing health, social services, and financial data from disparate clinical and non-clinical services and programs, as well as community and population-level data, across a variety of providers and organizations is thus an important goal for ACHs. Complexities surrounding data selection and/or collection, data privacy and sharing, and infrastructure can pose barriers to implementation. Because many data efforts, such as health information exchanges and all-payer claims databases, are still too early in their development to serve as a foundation of an ACH's measurement approach, few communities have a comprehensive data infrastructure and platform for sharing at this time.¹⁸

Through SIM, initial regional-level data efforts are underway to bridge these gaps and integrate data from insurers, clinical and behavioral health providers, and social service providers (e.g., housing). Minnesota has formed a data analytics sub-group that includes ACH representatives, which has identified six priority areas and data sources focused on social and environmental determinants of health.¹⁹ The six priority areas include: mental health and substance use; race, ethnicity and language; access to reliable transportation; social services; housing status; and, food security. In Washington, the ACHs are receiving data via regional dashboards through the state's Analytics, Interoperability and Measurement (AIM) strategy. Through AIM, Washington is investing in infrastructure development and analytic capacity to improve whole person care and inform health improvement strategies supported by SIM.²⁰

Finally, ACHs are wrestling with measuring regional impact, such as quantifying short- and intermediate-term outcomes. Given the short time frame of initiatives in some states, along with the other reform efforts occurring simultaneously, it may be difficult to directly attribute long-term health improvements to the ACHs. As states think through their ACH models, it is valuable to consider how to measure the impact of these regional collaborative entities from the outset.

7. Financing and Sustainability

Initial funding for ACH development has largely been supported by SIM grants in all states. The amount of funding for the ACHs varies by state, with Minnesota committing \$5.6 million in SIM funds to 15 ACH projects over two years, and Washington dedicating \$810,000 toward each of its nine ACHs. In California, SIM design funds were used to develop the ACH model, an evaluation framework, and to explore enhancing community data-sharing capacity. In the absence of SIM test funding, private foundations are supporting implementation in six communities for up to three years. In Washington, private and public sector organizations are providing in-kind contributions and grants to specific ACHs to supplement SIM funds. All ACHs are expected to develop plans for financial sustainability to support the backbone organization and ongoing health improvement activities.

While most states are receiving initial SIM support to develop ACHs, ACHs have reported insufficient resources to meet the social and logistical needs of patients as well as concerns that existing funding will not sustain ACHs as their role becomes more central to overall state delivery system reform. All states require ACHs to develop a strategy to be self-sustaining post-SIM award period. ACHs and states are considering a variety of longer-term financing plans, including health plans; federal, state, and local grants; Medicaid waiver demonstrations; social impact bonds; and hospital community benefit programs, among others.²¹ Some states are considering opportunities to link ACHs to emerging value-based payment (VBP) efforts that instead of rewarding for volume, pay for patient outcomes, which is consistent with ACH goals.²² ACHs will need to collect outcomes and cost data in order to measure the return on investment and build the business case for future investment.

Exhibit 2:

Select Key Features of Accountable Communities for Health					
State	Number of ACHs	Geography	Governance/ Backbone Organizations	Priority Focus Areas*	Financing
California	6 ACHs	Regional	<ul style="list-style-type: none"> Public health agencies County health departments Medical centers 501c3 non-profit 	Asthma, violence, obesity, and cardiovascular disease.	\$850,000 per site over three years
Iowa	6 C3s	Regional	<ul style="list-style-type: none"> County health departments Medical center Public health agencies County boards of health 	<ul style="list-style-type: none"> Tobacco use, obesity, and/or diabetes. May also address SIM strategies of medication safety, patient and family engagement, community resource coordination, social determinants of health, hospital acquired infections, and obstetrics. 	\$1,300,000 awarded to 6 C3s from March 2016 to January 2017
Michigan	5 CHIRs	Regional	<ul style="list-style-type: none"> Health systems Community-based organizations 	High ED utilizers, individuals with multiple chronic conditions, and healthy mothers and babies.	Approximately \$500,000 per CHIR
Minnesota	15 ACHs	Regional <i>(can be overlapping)</i>	<ul style="list-style-type: none"> MCOs/ ACOs Community Care Teams Medical centers/clinics Physician groups Integrated health systems Health foundation Non-profit community health board Social service agency Non-profit health plan 	Care coordination for low-income individuals; behavioral health care; diabetes prevention and/or management; linking released correction facilities clients with services; improving health equity; improving capacity to support at-risk youth in crisis; and opioid use in seniors.	\$370,00 per site over two years
Washington	9 ACHs	Statewide	<ul style="list-style-type: none"> Local public health agencies Community-based organizations Non-profit organizations 	Access to care; behavioral health/integrated care; chronic disease prevention and/or management; obesity/diabetes prevention and management; housing; oral health care; substance use disorders; adverse childhood experiences (ACEs); and health equity.	<ul style="list-style-type: none"> \$150,000 for first pilot ACHs, allocated in 2015 through state legislation; \$100,000 to seven ACHs, allocated in 2015 through SIM; and \$810,000 for all nine ACHs, allocated in late 2015 post-designation through 2019.

*Examples of priorities (not a comprehensive list)

State Case Studies

Following are case studies from four SIM states that have developed and are implementing ACH models. California, Michigan, Minnesota, and Washington are using SIM funds to support their programs.

California Accountable Communities for Health Initiative



Through SIM, the Accountable Communities for Health Work Group guided the design of the ACH concept. The work group includes representatives from community clinics, health plans, hospitals, public health, prevention, academia, and philanthropy, as well as the California Department of Public Health. The model is a multi-payer, multi-sector alliance of major health care systems, providers, and health plans, along with public health, key community and social services organizations, schools, and other partners serving a particular geographic area.²³ In July 2016, the California Accountable Communities for Health Initiative (CACHI), a consortium of philanthropic funders and the state, announced three-year \$850,000 awards to six communities throughout the state to “advance common health goals and create a vision for a more expansive, connected, prevention-oriented system.”^{24, 25}

Governance

California’s ACH collaboratives must include health plans, hospitals, private providers or medical groups and community clinics serving the defined geographic area. The CACHI collaboratives must also engage government agencies, including health and human services and public health, as well as community and social service agencies, particularly those representing underserved communities. CACHI efforts must also engage community partners that are most relevant to the selected health issue such as: county and/or city government leadership; behavioral health providers; housing agencies; food systems; labor organizations; faith-based organizations; schools; transportation and land use planning agencies; dental providers; and local advocacy organizations.

Priority Focus Areas

California’s ACHs must support a portfolio of mutually reinforcing interventions within the following broad domains: (1) clinical services; (2) community program and social service programs; (3) community-clinical linkages; (4) environment; and (5) public policy and systems change. Each of the six selected communities and their partners chose a community priority to focus their efforts: asthma, violence, and cardiovascular disease. Each site will also target a specific geographic community of between 100,000 and 200,000

residents. The approach will allow ACHs to target their efforts and better coordinate resources and interventions around a single condition. The CACHI will assess the effectiveness of the ACH model.

Data and Measurement

ACHs must describe how they will share data in support of their population health improvement activities as well as community health, clinical, and cost data to support the goals of the ACH. To assist in data sharing and inform the ACHs, the California Health and Human Services Agency is using funding from its SIM grant to assess data capacity and sharing practices.

Financing and Sustainability

Through the CACHI, the six ACHs will receive a combined \$5.1 million over three years, \$850,000 per local collaborative. Funds will be used to develop the initial infrastructure under a common vision and begin addressing identified gaps. Grantees that have met key milestones will be eligible for two more years of implementation funding. CACHI requires each ACH to develop a “Wellness Fund,” a vehicle for attracting and braiding resources from a variety of organizations and sectors to support the ACH as well as for developing innovative financing mechanisms. For example, it is important to identify savings from improved health and build the case for allocating some portion into the Wellness Fund for reinvestment into prevention or other interventions for which there is limited funding.

Michigan Community Health Innovation Regions



In Michigan, a Community Health Innovation Region (CHIR) is a consortium of community partners, government agencies, business entities, health care providers from Accountable Systems of Care (ASC), and individuals that come together with the common aim to improve population health (ASCs are existing health system, provider organizations, or provider-hospital organizations within each of the CHIR regions).²⁶

In March 2016, the Michigan Department of Health and Human Services announced five pilot CHIRs for its Blueprint for Health Innovation strategic plan, the SIM health innovation plan. The Blueprint for Health proposes to develop and test new multi-payer health care payment and services delivery models using CHIRs as a core component.²⁷ The CHIRs are focused on the entire population living within a defined geographic location, with an emphasis on Medicaid beneficiaries. While the five pilot CHIRs cover only a portion of the state, final geographic boundaries will be determined after partners have worked together to target investments and impact. The overall goal of CHIRs, in partnership with the Michigan Primary Care Transformation and ASCs, is to develop community capacity to improve population health. CHIRs will ultimately be held accountable for reducing health risks in the community related to health inequity, as well as addressing socio-economic and environmental determinants of health.

Governance

Backbone organizations have been identified to provide overall support, facilitate decision-making for the CHIRs, and oversee administration, consensus building among partners, implementation, and data services. Michigan requires cross-sector participation in each CHIR, including the local public health department; the regional ASC; Medicaid health plans; community mental health; other payers; and community members. Other stakeholders encouraged to participate include: human service providers, education institutions, housing, transportation, employers and purchasers, local government, and community and non-profit organizations.

Priority Focus Areas

The CHIRs will target three populations: individuals with frequent ED utilization; individuals with multiple chronic conditions; and healthy mothers and babies. All regions will be required to focus on high ED utilization, but depending on

resources, communities may choose to address one or both of the other target populations. In subsequent years, regions will be required to work on both the high ED utilizers and the second population of choice. The CHIRs will work closely with the ASCs, patient-centered medical homes, Medicaid health plans, and other organizations in their regions to develop a community health needs assessment and define population health goals and initiatives across the medical, behavioral, and social support sectors to reach shared goals.

The state is offering technical assistance to the CHIRs. Michigan has a two-year contract with the Institute for Healthcare Improvement to provide coaching, training, and technical assistance for Michigan Department of Health and Human Services, quality improvement coaches, and ASC and CHIR staff. The state's SIM effort is also supporting a Collaborative Learning Network to catalyze cross-sector collective impact for priority populations.²⁸

Data and Measurement

The CHIRs are required to track a shared set of process and outcome measures based on identified local priorities using an online platform. In addition, a common set of population health core measures that relate to shared priorities across all of the regions will be reported by CHIRs through an online system. Information from Michigan's vital records systems and immunization registry, along with the Behavioral Risk Factor Surveillance System (BRFSS) survey, will be the primary data sources for population health-related monitoring and reporting.²⁹

Financing and Sustainability

The CHIR initiative is intended to be multi-payer, and includes participation from Medicare, Medicaid, commercial health plans, as well as self-insured employers.³⁰ While SIM funding will provide support for administrative oversight through 2019, CHIRs must develop sustainable financing. Per the state's blueprint, "The CHIRs will be required to test new business models that align investments across organizations in order to: (1) sustain the CHIR decision-making body; (2) create sustainable financing for the population health improvement strategies identified in the Community Health Improvement Plan; (3) support the efforts of local public health departments for overall health improvement; and (4) leverage local public health department infrastructure for community development."³¹

Minnesota Accountable Communities for Health



Through SIM, Minnesota awarded grants to 15 entities to serve as ACHs. The ACHs are engaging a broad range of providers, public health, and communities to promote population health and patient-centered coordinated care, with increasing financial accountability for outcomes.³² The demonstration began in February 2015, with all programs initiating care coordination efforts within one year. Each ACH, serving a specific geographic area, is focused on a target population defined by risk-status (high-ED utilizers), individuals with a chronic condition or disability, or an underserved group.

Governance

Leadership for Minnesota's ACHs must be locally based and include providers, community partners, and community members. This leadership structure is responsible for identifying priorities and developing strategies to address the population's health needs. Each ACH is engaged with multiple community partners, including public health, long-term services and supports, behavioral health, and social services. The state required ACHs to include at least one organization participating in, or planning to participate in, an ACO or ACO-like arrangement. The grant requires a fiscal agent and a lead agency. For seven of the ACHs, the fiscal agent is (or is affiliated with) a health care provider.³³ These fiscal agents serve as the backbone organization. In most ACHs, an ACO representative serves on the leadership team and ACO staff play a key role in project management. In some cases, they also provide data analytics and care coordination support.

Priority Focus Areas

Example priority areas and target populations in Minnesota's ACH program include: care coordination for low-income individuals and those living with behavioral health conditions; reducing unmanaged diabetes; linking released correction facilities clients with services; improving health equity; and improving capacity to support at-risk youth in crisis.

Data and Measurement

Through the 2008 state legislature, Minnesota established the Statewide Quality Reporting and Measurement System, which includes measures of patient satisfaction, quality, and costs, to support performance measurement. The state has developed a roadmap for the exchange of clinical data across providers and settings, with a specific action plan for behavioral health, long-term care, and social service providers to support the evolving ACO/ACH coordinated care models. In particular, the state is seeking to incorporate more patient-specific measures, such as those related to complex populations, community engagement, and care integration.³⁴ A SIM analytics subgroup finalized six priority areas focused on social determinants of health, identified data sources, and is making recommendations to state leadership for integrating this data into broader system reform efforts.

Financing and Sustainability

Minnesota's ACHs are supported with approximately 14 percent (\$5.6 million) of the state's SIM funds.³⁵ In 2014, the state solicited applications for ACH grants and by early 2015, Minnesota had awarded approximately \$370,000 to each entity. Three previously funded community care teams received sole-source funding. The National Rural Health Resource Center was awarded approximately \$200,000 to serve as the ACH Learning Community. At the proposal stage of the program and at the end of an award, each of ACH is required to complete Minnesota's Continuum of Accountability Assessment Tool, to assess their capacity related to accountable care models and the Triple Aim.³⁶ Minnesota requires ACHs to be all-payer and to partner with ACO, with ACOs serving as the fiscal agent for seven of the state's ACHs. ACHs are also seeking funding from other sources, such as the Spreading Community Accelerators through Learning and Evaluation grant from the Institute for Healthcare Improvement.³⁷

The Hennepin County Corrections Clients Accountable Community for Health

The Hennepin County Corrections Clients Accountable Community for Health links health care coordination, behavioral health support, employment services, housing, and life skills building for inmates released from the county's adult correctional facility and jail. Individuals interested in care coordination are referred to a vocational counselor. A community health worker provides disease and health education and sets up medical appointments. The care team assists with enrollment in medical benefits and housing placement. The care team's work is dependent on ongoing communication from the time of the initial meeting with the individual through his or her release, integration back into the community, and job placement.³⁸

Healthier Washington



Washington state's ACH, called Healthier Washington, is a multi-agency effort supported in part by SIM funding. Each of the nine ACHs — rolled out in phases and designated by Washington's Health Care Authority (HCA) in 2015 — are aligned with the state's Medicaid purchasing regions. MCOs are active partners within the ACHs, which are designed to support whole person care, including a shift to fully integrate financing of physical and behavioral health care. During the initial year, each ACH conducted a community needs assessment and resource inventory to inform regional health priorities. This past year, each ACH finalized their regional priorities, and identified project area(s) for the upcoming year.

Governance

The state provided flexibility for ACHs to be creative in establishing their governance and engagement structures. Requirements for ACH designation included establishing operations and governance structures, multi-sector and community engagement, regional health improvement plan efforts, and initial sustainability planning. ACHs have governing bodies with participation from key community partners representing systems that influence public health, health care, and the social determinants of health. Some ACHs have additional stakeholder groups at the regional or county level that provide input on priority populations and programs.

Priority Focus Areas

Washington's ACHs were required to identify priority areas (service gaps and/or health priorities) as part of the ongoing development of a regional needs and resource inventory. As of July 2016, all ACHs had established formal priorities that will drive their efforts over several years, which include whole person care (including the integration of behavioral, oral, and physical health care); care coordination, chronic disease prevention/management; obesity prevention/management; housing; oral health care; substance abuse; and ACEs.

Data and Measurement

The impact of Washington's SIM efforts will be assessed using Washington's Common Measure Set, a selection of 52 measures. While the current measures set is focused on access to primary care, prevention, acute care, and chronic care, there is interest in building additional measures that reflect population health and ACHs' community-level focus areas. Data from Medicaid, Public Employee Benefits, and Department of Health surveys are used to inform Washington's delivery system transformation efforts, including supporting ACHs with population health management and community needs assessments.³⁹ Through its new Analytics, Interoperability, and Measurement (AIM) strategy, the state will provide ACHs aggregate, de-identified data at the state, regional or county level.⁴⁰

Financing and Sustainability

State legislation passed in 2014 provided funding for the first two pilot ACH sites. In March 2015, seven additional regions received ACH design grants through SIM.⁴¹ Pilot sites were awarded \$150,000 and design grant regions received \$100,000 for their initial year. While approximately \$220,000 per year (starting in 2016) in SIM funds will be allocated to each ACHs through the end of the award period in 2019, Healthier Washington envisions ACHs continuing their collaboration. In addition to SIM funding, many ACHs are receiving in-kind support, primarily from the backbone organization or ACH participants that are serving as fiscal agents, or providing administrative support as well as additional local grant or philanthropic assistance.

Both ACHs and the state see sustainability a key focus, and the shift to more action-oriented activities will offer ACHs the opportunities to demonstrate their value to regional and state stakeholders. Under DSRIP, ACHs will be required to manage delivery system reform activities at the regional level.⁴²

Washington State's Cascade Pacific Action Alliance

The Cascade Pacific Action Alliance (CPAA) is an ACH serving central western Washington. CPAA includes representation from criminal justice, education, employers, health plans, hospitals, local and state government, long-term care, primary and specialty care providers, public health, and social services. Children with behavioral health challenges are a CPAA priority population, with the CPAA's Youth Behavioral Health Coordination project seeking to decrease the number of youth with unmet behavioral and physical health needs, thereby increasing school attendance and academic achievement.⁴³ Through the use of behavioral health screening tools, treatment resources, and school-based pilots, efforts are focused on intervening as early as possible in both education and health care settings to connect at-risk youth with community-based interventions and treatment.⁴⁴

Other Emerging State Examples

In addition to the above examples, several other SIM states are pursuing ACH-type models. **Delaware** created the Healthy Neighborhoods program, which will provide resources to communities to convene forums of local leaders, align on priority health areas of focus, assess existing resources, facilitate targeted interventions, and track performance. The resources offered to neighborhoods will include a funding pool for interventions, dedicated staff members, and additional centralized support. Healthy Neighborhoods, which will be implemented statewide, is focused on four priority areas: healthy lifestyles; maternal and child health; mental health and addiction; and chronic disease prevention and management.⁴⁵

As of March 2016, **Iowa** has launched its initial six Community Care Coalitions, or C3s, funded by SIM through 2019. Spanning 19 counties throughout the state, the C3s are locally based coalitions of health and social service stakeholders collaborating to promote the coordination of health and social services across care settings and systems of care. The C3s have two primary functions: (1) to address the social determinants of health through care coordination; and (2) to implement broad-based population health interventions related to the Iowa SIM Statewide Strategies.⁴⁶ They are also developing and implementing interventions to address tobacco, obesity, and diabetes (the SIM population health focus areas), and will be encouraged to address other SIM Statewide Strategies and Supplemental Strategies of including medication safety, patient and family engagement, community resource coordination, social determinants of health, hospital acquired infections, and obstetrics.⁴⁷ The communities use CDC's three buckets of prevention as a strategic framework and include both clinical and population-based community-applied initiatives in their interventions. Data, including referral and statewide alert notification system, pharmacy data, and National Quality Forum measures, will be collected by C3s, Iowa Department of Human Services, Iowa Department of Public Health, and Iowa Health Care Collaborative to implement community-based performance improvement strategies.⁴⁸

Virginia used a portion of its SIM Design award funds to develop Accountable Care Communities (ACCs) in five regions that cover the state. ACCs engaged in a planning process to develop a governance infrastructure, identify regional population health priorities, and develop corresponding payment and delivery levers that align with Virginia's Plan for Well-Being and proposed Delivery System Reform Incentive Payment (DSRIP) Waiver.⁴⁹ Participating stakeholders include health systems; local government and health departments; private providers; community services boards; federally qualified health centers; health care and community philanthropy organizations; school systems; colleges and universities; housing agencies; and other social support providers. Since the close of the SIM grant, the state continues to explore funding support for the established ACCs, and has submitted a DSRIP waiver that, if approved, could support select ACC projects focused on Medicaid populations. Pending future funding, the ACCs will develop Regional Transformation Plans, which will include how statewide metrics will be implemented in each region.⁵⁰

Conclusion

As states across the country, and particularly SIM states, move to implement and test delivery system innovations, the focus on broad-based population improvement efforts is at the fore. ACHs seek to better integrate and coordinate care across the spectrum of services and providers in order to address the full range of medical and non-medical factors that influence health for a population. Flexible in nature, ACHs offer innovative prevention initiatives that extend care outside the clinical setting, and also focus on total population or community-wide prevention interventions to transform health. ACHs are intended to compliment broader delivery system transformation efforts, including patient-centered medical homes, behavioral health integration, care coordination efforts, community health teams, initiatives to target high-need, high-risk populations, and Medicaid waiver demonstrations, as well as play a role in the shift toward value-based reimbursement. The key features of ACHs are likely to persist in state approaches to improving population health and clinical-community linkages at the county and regional level.

ABOUT THIS RESOURCE

This resource was produced by the Center for Health Care Strategies (CHCS) with support from Center for Medicare and Medicaid Innovation. CHCS is part of a team led by NORC at the University of Chicago that is serving as the *State Innovation Model Resource Support Contractor*. CHCS is supporting the states and the Innovation Center in designing and testing multi-payer health system transformation approaches, along with NORC and other technical assistance partners, including SHADAC, the National Governors Association, and Manatt Health Solutions.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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