

Elements of Accountable Communities for Health

A Review of the Literature

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ABSTRACT | Accountable health initiatives, most commonly referred to as accountable communities for health (ACHs), have been implemented nationwide in response to or as a result of contributions from state innovation model grants and community transformation grants, through collaborations with state Medicaid programs, or through other policy and financial incentives. The Center for Medicare & Medicaid Innovation has announced its own Accountable Health Communities Model, which has a \$157 million budget over five years [1]. ACHs are best known for their cross-sector approach to addressing population health disparities. These cross-sector interventions are carried out with financial, technical, and planning support from health care delivery systems; philanthropic organizations; local, regional, and state-based public health departments; community-based organizations; consumers of health care; and others. This review of the literature seeks to understand the fundamentals of ACHs including common characteristics, major challenges, and variations in stakeholder engagement to address identified community needs.

Methods

In conducting a systematic review of the literature, we identified peer-reviewed, published articles and gray literature as sources that illuminated elements of accountable health initiatives. Sources describing health care planning and federal initiatives that existed before 2010 (and therefore before the implementation of the Patient Protection and Affordable Care Act of 2010 [ACA]) were not included. However, sources predating the ACA that describe collective impact models and those that describe other intervention elements that are now present in accountable communities for health (ACHs) were included, as reflected in the literature, from sources published as early as 2008. Articles centered upon interventions focused on health care delivery systems, with less emphasis on community engagement (such as sources relating only to accountable care organizations [ACOs]), were excluded. Interventions from sectors outside of the health realm that remain relevant with ACHs were included. Government sources, issue briefs from nonprofit and advocacy or-

ganizations, and ACH memos were all included. To be included in the search, sources did not have to explicitly mention “accountable health” or “accountable communities for health,” though those were search terms. Other searches included “collective impact,” “community engagement,” and “cross-sector collaboration.” The search continued until the results reached saturation—that is, new information was no longer able to be gathered from the varied sources. In total, 56 pieces were recognized as appropriate for inclusion in the review of the literature.

Background

The ACA put value-based payment models at the forefront of health care delivery system reform. The Centers for Medicare & Medicaid Services (CMS), through the Center for Medicare & Medicaid Innovation, were tasked with piloting variations of value-based payment models and were offered grants for initiatives ranging from primary care overhaul models (such as patient-centered medical homes, health homes, and

comprehensive primary care) to accountable care initiatives (including ACOs). Most of these interventions are created in accordance with the Triple Aim: the belief that to achieve health care delivery system reform, interventions must focus on reduction of health care costs, improvement of patient-centered health care experiences (including quality of care), and improvement in population health [2].

There is a growing body of evidence suggesting that the success of value-based payment models will be closely tied to efforts addressing the behavioral, social, economic, and environmental determinants that play a key role in health inequities and poor health outcomes [3]. In some instances, behavioral and social determinants may exceed genetic factors in terms of predetermining health [4]. Thus, there is growing recognition of the need to address the underlying root causes of poor health outcomes, rather than simply providing treatment [3]. To improve the health of communities, health care delivery systems, public health departments, and community organizations have begun to create cross-sector alignments, embracing “accountable health.”

Accountable health initiatives fundamentally embrace the concept that there is a shared responsibility for the health of a community or patient population across sectors. By focusing on the alignment of clinical and community-based organizations, they offer an integrated approach to health, health care, and social needs of individuals and communities to achieve equity, better population health outcomes, reach a higher quality of health care, and reduce costs [5]. In looking across sectors and aspiring to share accountability, accountable health initiatives differ from ACOs, which hold providers responsible for better management of clinical conditions in a patient population. The term “accountable health” encompasses programs that are sometimes referred to as “accountable communities for health,” “accountable care communities,” “coordinated care organizations,” or “accountable health communities,” among other variations in name. For this review, we will refer to all accountable health initiatives as accountable communities for health, or ACHs. Often, these initiatives are based in a health care delivery system with support from a public health department and are funded through a variety of means, including private, state, and federal grants, as well as a “braiding” or “blending” of community funds and resources. ACHs operate on a continuum,

with programs evolving and adjusting to address fluctuations in community need.

Structure: Multisector Collaboration, Community Engagement, and Governance

Accountable communities for health engage multiple sectors rather than provide interventions based only around a health care delivery system. However, the process by which a health care delivery system or a community embraces a multisector approach to population health varies. ACH interventions have reported financial incentives, changes in patient populations, community interest, catastrophic events, and changing provider responsibilities as catalysts for cross-community collaborative health initiatives [6]. Other common catalysts include collaborative assessments, accreditation, regional planning, and health care delivery system reform initiatives. ACHs are similar to many collective impact [7] initiatives in that they have a centralized infrastructure, common agenda, shared measurement strategies, continuous communication, and mutually reinforcing activities [7]. Additional factors encouraging multisector collaboration include the ability to share data across sectors and the introduction of a new delivery system and payment models [8].

Sectors engaged in ACHs around the country include business, education, health care delivery, public health, finance, housing, transportation, and community-based organizations. The literature provides many examples of the ways in which cross-sector collaboration leads to effective population health interventions. One study finds that the largest scope of population health activities is carried out by governmental public health agencies, with hospitals, community health centers, nonprofit organizations, and other local government agencies following suit [9]. In the study, communities that achieved comprehensive system capital (a dense network of cross-sector community collaboration) also had the largest scope of population health activities. Over a 16-year study period, communities that successfully achieved comprehensive system capital experienced lower mortality rates from preventable conditions, compared to communities without that capital [9]. It is worth noting that in rural communities, or areas that are underresourced, establishing and maintaining collaboration may be notably difficult, due to lack of proximity. In PacificSource Community Solutions, an ACH located in rural Oregon, members within

the governance structure experienced high levels of turnover and burnout, since the heavy lifting of system transformation continually fell upon the same sets of shoulders. However, the ACH sites strong leadership, transparency, and sharing as keys to resilience [10].

The growing burden of chronic disease demands innovative, preventive approaches to address the underlying causes of disease, including those that are social, environmental, and behavioral. Some health care delivery systems have begun to engage the communities that they serve in fostering solutions to population health problems. Community engagement, defined by the Centers for Disease Control and Prevention as “the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their wellbeing” [11], has become one of the cornerstones of ACHs. The literature suggests that coordinating efforts between health care delivery systems and community-based organizations (whether health-related or not) have been effective at improving chronic disease management, especially among populations with high rates of diabetes, asthma, obesity, and hypertension [3]. However, it is not merely enough to engage communities in partnerships; the most successful partnerships are equitable. According to the Clinical and Translational Science Awards Consortium, successful partnerships between communities and health care delivery systems set specific purposes and goals; build trust and establish relationships through working with formal and informal community leadership; encourage community self-determination; respect diversity and recognize cultural influences; provide communities with resources to assist with analysis, decision making, and action; and make long-term commitments regarding technical assistance [11].

In a survey of 237 partnerships across nearly every state, ReThink Health was able to summarize key considerations for funders, policy makers, and others working in ACH-like models. The authors recommend considering developmental phases when crafting and delivering initiatives, engaging in learning to understand trends in the partnership’s development, supporting long-term strategic planning, considering the use of grant funding as a bridge to other financial structures, and emphasizing infrastructure to encourage long-term success in multisector partnerships. Through acknowledging the developmental

nature of partnerships and cross-sector collaborations, emphasis is placed not just on improving results within existing systems, but also on “transforming the structure of the health ecosystem itself” [8].

Importantly, community engagement within the ACH model includes consumer engagement. Most models indicate the necessity of consumer input in a decision-making capacity within a governing or advisory board. Interventions grounded in consumer engagement suggest that it is important, albeit sometimes challenging, to engage consumers and consumer advocates in decision-making capacities. Some notable challenges include ensuring that consumers have an equal voice, providing consumers with the tools to understand conversations within the governance board that contain technical language, and preventing consumer burnout from high expectations of participation [12]. In the Aligning Forces for Quality initiative, funded by the Robert Wood Johnson Foundation, communities made provider quality information available to consumers, while also implementing interventions to help providers improve their quality of care and help them engage consumers in ways that help consumers make informed health care decisions [12]. The literature suggests that it is not enough to make health information and data available to consumers; the information must also be easily understood by consumers [12].

States, private organizations, and other ACH funders often allow ACHs to have the autonomy to determine their own governance structure, with some fundamental guidelines. Often, governance structures must be planned as part of a request for proposals before a community receives funding [2]. Funding entities often include provisions mandating governance structures to reflect multisector engagement [13,14]. Leadership teams, or governing bodies, are established, with representation at the individual and organizational level from ACH partners, to develop a process for collaborative decision making regarding the intervention, evaluation, financial obligations, and conflict management [2]. To build a sound governance structure, the California Accountable Communities for Health Initiative (CACHI) indicate the following key conditions: Effective decision making; accountability to the community; representation of stakeholders’ interest; proper fiduciary, fiscal, and social responsibilities; and control over funding and staff [15]. The governing body and all participating organizations must come to a common

understanding of the community's needs and cultivate a joint approach to addressing priorities through agreed actions [7]. It is also important for the participating organizations to cultivate trust and create a common vocabulary. Regular meetings among stakeholders strengthen relationships and build trust within collective impact and other initiatives [7].

The most successful cross-sector partnerships engage one entity, sometimes the fiduciary agent, as a “backbone organization” (also referred to as the integrator, bridge organization [13], anchor institution, or convener) [16]. Often, the backbone organization is a health department or health care delivery system; however, it is possible for a backbone organization to be a community-based organization, nonprofit, or other participant in the ACH [2]. A backbone organization's key support activities include guiding vision and strategy, supporting aligned activities, sharing measurement practices, building public will, advancing policy, and mobilizing funding [17]. Duties of the backbone organization also may include completing community health needs assessments, developing priorities based on those assessments and other evidence (with input from the rest of the governing board), and ensuring the implementation and evaluation of interventions related to priorities [18]. Joint improvements and collaboration through a backbone organization have been linked to broader engagement of community-based organizations, cohesive development of a shared vision and goals, and overall improvements in health outcomes [2,18].

The backbone organization is responsible for convening and integrating the multisector partners [19]. Multisector partners should convene to establish a shared vision, goals, and an agenda, with all partners in the ACH coming to a consensus on “mission, vision, goals, objectives, and appropriate intervention strategy” [18]. This kind of cross-sector alignment and active engagement of stakeholders may address community health and social needs in a “mutually reinforcing portfolio of interventions” [20], which reaches across sectors to, among other things, deliver high-value health care, reinvest savings, enable healthy behaviors, and expand socioeconomic opportunities. There is some evidence that a mutually reinforcing portfolio of interventions—such as combined investments in health care delivery systems, public health, and community-based initiatives—maximizes health and economic outcomes [21].

Interventions and Return on Investment

Often, public health programs target preventable behavioral risk factors, including smoking, problematic diet, and lack of physical activity [9]. Research suggests that through addressing behavioral risk factors, many inequities in chronic disease that are related to race and geographic disparities can be mitigated, especially in prevention or management of type 2 diabetes and cardiovascular disease [2]. Evidence shows that, in addition to addressing behavioral risk factors, addressing community and individual social needs—including education, housing, food security, and income and employment—can reduce morbidity and mortality of preventable negative health outcomes [22]. Accountable communities for health embrace the need to address health risk factors that exist outside the walls of the clinic. Often, ACHs incorporate a wide spectrum of interventions into their programs, including those that address immediate physical and behavioral health needs and those that involve long-term work in health-related social needs and equity [23]. The interventions are fostered through cross-community and cross-sector networks, with input regarding local health issues coming from community members and relevant key stakeholders [14].

There is a growing expectation on the part of policy makers that investments of any kind show a return on investment (ROI). Investments in population health often require a long-term perspective, with gains in health status accruing over time [9]. This has been one of the biggest challenges for ACHs, as many federal grant programs require progress to be shown in three years [24]. This reflects a debate regarding focus: Should we look to intervene among high-risk, high-cost individuals with a rapid ROI, or should we work to intervene early to prevent someone from becoming high risk, which involves a removed but possibly larger ROI? For example, early childhood interventions have been shown to be effective in improving long-term health outcomes while being cost-effective. However, strategies prioritizing early childhood interventions often receive pushback for their inability to show cost-effectiveness in the short term [25]. Trust for America's Health breaks down the return on investment for various early childhood interventions, finding a range from a \$1.46 return for every \$1 invested for insurers in the Community Asthma Initiative, to a \$25.92 return for every \$1 invested in the Good Behavior Game [26]. The Altarum Institute made various estimations of the economic benefits of greater racial equity in Michigan, including a \$39,000 lifetime economic value

for an “at risk child” achieving school readiness, a 25 percent reduction in spending on state Medicaid and public assistance programs through erasing racial disparity in income, and lower premature death rates [27].

Some public health interventions are able to produce a short-term return on investment. Interventions addressing root causes of disease through social determinant work have demonstrated measurable returns in decreases in emergency department utilization and hospital admissions. For example, at Hennepin Health in Minnesota, the State Innovation Model program provides grant support to link individuals who have been recently released from the county jail or the Adult Corrections Facility to transitional housing and employment supports. Upon analyzing the cohort of Hennepin Health participants, the results showed that between 2012 and 2013, there was a 9.1 percent decrease in emergency department utilization and 3 percent decrease in hospital admissions among participants [28]. In an accountable care community in Summit County, Ohio, a diabetes management intervention that increased participant access to healthy foods and promoted healthy behaviors led to a 10 to 25 percent reduction in per-member per-month costs among participating diabetic members [27].

There is no single prescriptive intervention implemented by ACHs on a large or national scale. Rather, successful ACHs embrace their specific community assets and needs and target interventions to goals that are within reach. Interventions and strategies are created through a shared vision between community and participating partners. Leverage created by coordinated community efforts can improve ACH influence of local policy [29]. Policy-based interventions focusing on social determinants of health—including interventions targeting early childhood development, urban planning, housing, income enhancements, and nutrition—have demonstrated effectiveness at improving long-term health outcomes for disadvantaged neighborhoods [26].

A common concern surrounding the implementation of an ACH intervention is related to community capacity [28]. Resources, not surprisingly, vary across and within communities. Therefore, funders of interventions often bolster capacity-building initiatives. Some interventions employ the use of cross-site learning communities, a technical assistance team, and investments in leadership training. Specialized expertise, rather than generic

support, is important when promoting community capacity building [29].

Often, grants are awarded to ACHs in phases: focusing first on capacity building (including creating the coalition and planning an intervention strategy), followed by actual implementation of the intervention. Funding may also be awarded on a phased-in basis dependent on achievement of specific benchmarks or milestones [29]. To frame an intervention and its processes, iterations, and milestones, some communities employ a theory of change model. Some funders may require theories of change, although many communities create them to illustrate the assumptions, general timelines, goals, and expected outcomes of an intervention. Theories of change are high-level logic models that consider the timetables, resources, and investments needed to guarantee an intervention’s success [30]. In a theory of change model, a physical diagram is created to outline ways in which specific inputs (such as funding, existing infrastructure, personnel) or actions (e.g., “setting the table” for multisector dialogue, initiating an intervention) are related to anticipated outcomes (e.g., improved community health). The relationships among inputs, actions, and outcomes are based in time. As the intervention gets underway, an effective theory of change may provide the framework for the evaluation of the intervention [30].

Data and Evaluation

Prioritizing population health demands cross-sector planning, implementation, and evaluation. This includes the necessity to exchange health and social needs information across sectors where relevant. To characterize the scope and scale of community needs, partners of community-oriented interventions may find it useful to link disparate data sources, such as those from the health care delivery system, social services, and others. Coordinated data is an important first step in understanding the magnitude of health needs and identifying how a community can design targeted interventions [31]. However, data exchange is associated with practical and legal challenges [32]. Data sharing across sectors can be difficult, especially when considering patient privacy protections. The Health Insurance Portability and Accountability Act (HIPAA) and Title 42 of the *Code of Federal Regulations* Part 2 have often been cited by health care providers as barriers to exchanging a patient’s health information and to realizing the full potential of care coordination [33,34]. However, some

ACHs have persevered, creating data warehouses that gather information from multiple, competing health care and social service providers. Hennepin Health has engaged in a HIPAA business associate agreement (the contract a business associate must sign with the covered entity to ensure compliance and assume liabilities associated with violation of the HIPAA Privacy Rule and HIPAA Security Rule [57]). Patients are asked to consent to the sharing of their health information when applying for Medicaid benefits, when receiving medical care, and when receiving social services. It is the direct obtainment of patient consent that allows Hennepin Health to share data freely among partners [35]. The data are then analyzed and used to evaluate the intervention [23,36]. Creating data-sharing agreements among intervention partners, such as a memorandum of understanding, may be a feasible way to share information and protect privacy, while adhering to regulations across sectors. The creation of a data-sharing agreement is often the responsibility of the backbone organization [23].

The Center for Healthcare Organizational and Innovation Research (CHOIR) produced a toolkit designed to give advice on best practices for communities engaged in cross-sector data sharing [37]. The toolkit specifically addresses data sharing within ACHs and stresses a continuum from beginner to advanced. CHOIR describes seven parameters for assessing maturity across this data-sharing continuum. The seven parameters include purpose/aim, relationships/buy-in, funding, governance and privacy, data and data sharing, technical infrastructure, and analytic infrastructure. Within each parameter, CHOIR lists common barriers reported by communities and strategies to overcome those barriers. CHOIR suggests that communities interested in cross-sector data sharing build a common foundation among stakeholders by identifying a purpose or goal surrounding health concerns in the community; building relationships among stakeholders; securing funding; establishing parameters for data governance, specifically data-use agreements; considering the type and content of data needed to answer common goals; and obtaining or building the needed technical and analytical infrastructure [37].

The literature suggests that providers have little guidance for finding ways to add social determinants of health into electronic health records (EHRs). Some

providers capture social and behavioral determinants of health in an EHR within a patient's social history narrative [4]. Population health may be improved through inclusion of social-determinant-related questions into the EHR, which permits greater precision in diagnoses, facilitates shared decision making (among clinical staff, patients, and social workers), promotes prevention (through the identification of social determinant risk factors), promotes intra-ACH referrals (such as from the health care delivery system to social services), and enhances internal review of community-related health risk factors and needs [4]. CMS developed a screening tool for their Accountable Health Communities Model to evaluate the impact of different entities in addressing health-related social needs to improve health. The 10-question screening tool addresses housing instability, food insecurity, transportation needs, utility needs, and interpersonal safety [37]. In 2016, HealthPartners released summary measures comprising three components: current health, sustainability of health, and well-being. These measures may be used by ACHs and ACH-like initiatives to assess conditions that create the greatest impact on the health and well-being of their consumers, thereby guiding their community-directed initiatives [39].

In addition to sharing data about health information, it is also necessary to share data among partners regarding status of intervention outcomes. For example, one intervention created a web-based results database with data from each participating site. With all sectors updating their sites quarterly, each member organization of the intervention was able to stay engaged by setting targets and assessing progress. The web-based tool encouraged site autonomy, and each site had the ability to generate impact reports targeting a specific result area, indicator, strategy, or performance measure [40]. Impact reports present an evidence-based picture of the effects a partnership's efforts have in relation to the direct and indirect costs they incur [16]. Appropriate collection, use, and sharing of data becomes crucial when considering an intervention's evaluation.

Upon creating an evaluation of ACHs (or any other interventions that address social needs through the context of health care delivery services), evaluators may experience barriers such as the need to address many steps along the path of screening for social needs, the need to address potential confounders (such as quality

of social services provided and resolution of problem), and the need to allow for adequate time before evaluating ultimate outcomes [41]. To evaluate the content and dose of social needs interventions, evaluators may track patient referrals, successful connections between consumers and social services, and resolution of social need [41].

In 2014, the Institute of Medicine (now the National Academy of Medicine) published recommendations for measures of evaluating a patient's social determinant needs, which were drawn from validated assessments [42]. These kinds of measures are essential when assessing the cost-effectiveness of an ACH intervention. A cost per quality-adjusted-life-year (QALY) approach for assessing cost-effectiveness may be difficult to apply to upstream interventions [43]. Upstream interventions (for example, an intervention centered upon kindergarten readiness [44]) are complex, with effects that are often not seen for many years and manifest across sectors [43]. Efforts to analyze ACH and population-related efforts often evaluate effects of the intervention across sectors, including unintended benefits and consequences. For example, an effort to evaluate health impacts of a housing program might also assess impacts in residential stability, social networks, access to health and social services, and exposures to new stressors [24].

In *Vital Signs: Core Metrics for Health and Health Care Progress*, the Institute of Medicine identified a core measure set designed to apply across different levels of the health care delivery system. The measures address quality of care, costs of care, and individual engagement in health and health care. However, the authors recognize that data is currently limited in addressing multisector performance on the addressed issues. The core measure focus areas are life expectancy, well-being, obesity, addictive behavior, unintended pregnancy, healthy communities, preventive services, care access, patient safety, evidence-based care, person-centered care, personal spending burden, population spending burden, individual engagement, and community engagement [45]. Some of the aforementioned measures are already collected by health care delivery systems; however, many may require the adoption of survey tools with data collection reliant on consumer consent.

To evaluate population health interventions, it may be effective to categorize measures by level of

multisector engagement. For example, one study created a typology for multisector engagement in population health activities through three sets of measures: the scope of the population health activities contributed by each type of organization (for example, business-related, community, or educational organizations; health care delivery systems; or payers), the density of connections that exist among organizations partaking in the community health effort, and the extent to which organizations play a coordinating role within the network [9]. The Agency for Healthcare Research and Quality has created the clinical–community relations measurement framework, which provides a structure for identifying, categorizing, and understanding basic components of effective relationships between clinical services and community resources. The framework's measurement domains can provide the basis for empirical assessment of structure, processes, and outcomes of relationships at the community level [46]. Across the literature, there is an emphasis on defining and evaluating the capacity of organizations participating in cross-sector collaborations [9,39,46].

During the process of evaluation, evaluators for Making Connections—a multisite, multiyear intervention seeking to improve childhood outcomes through cross-generation and cross-sector improvements and alignment [41]—cultivated high-level research questions to effectively communicate program goals and outcomes. The research questions included ones relevant to overall community conditions and key indicators; explicit changes on an individual level or that of a subgroup; changes in community capacity (including systems of support and opportunity); pursued strategies (e.g., a process-level evaluation); and the sustainability of improved capacities, upward trends, or positive outcomes. Effective evaluation provides a critical bridge to public policy interventions [40]. To influence public policy, community-based initiatives may seek to determine which parts of an intervention are generalizable [30].

The Blue Sky Consulting Group identified six key steps in the optimal approach for evaluating ACH initiatives. Those steps include development of a logic model identifying essential components to achieve desired outcomes, use of specific evidence-based measures that are both quantitative and qualitative, comparison of actual implementation experience to the expectations as presented in the logic model, assessment of multilevel

contextual factors that influence outcomes and implementation experience, continual quality improvement through technical assistance to ACHs in understanding and using data, and finally identification of emerging principles and lessons learned. This optimal approach is flexible enough to be generalized across ACH designs [47].

Financing

Finding entities willing to invest or provide sustainable funding streams can prove difficult for ACHs. The collaborations need start-up funds—support for the initial intervention or implementation stage—and sustainable funding once the approach has been proven effective. Funders may be reluctant to pay for infrastructure and prefer investment in short-term solutions. However, ACHs and other collective impact models challenge funders to move from the position of a one-time funding organization and into the long-term process of enacting social change [7]. Once established, the financing streams of ACHs are diverse. Some are funded through State Innovation Model grants [48]; some, through private philanthropic or nonprofit organizations. Others are coordinated efforts between an ACO and other community programs, while some funding streams come as a result of a hospital's community benefit requirement (implemented under the ACA) [49]. Other initiatives find unique ways to combine various funding streams within the health care delivery system and community [8,14,50]. Additional financing structures, in order of relative dependability, include grants, contracts and prizes, in-kind agreements, loans and investments, dues, sharing agreements, taxes, and credits [51]. Some states envision circumstances in which ACHs will be most financially viable and sustainable through integration with delivery and payment system reform, and funded by both private and public payers [2,23]. The wide variety of available funding streams creates the opportunity for braiding or blending of multiple funding sources when appropriate. However, this patchwork of funding streams comes with strings attached—often in the form of distinct eligibility criteria and implementation requirements (sometimes including requirements for the organizations receiving the grant and the population eligible to enroll in the program) [9]. It may be difficult for ACHs to manage various funding streams, especially in cases involving start-and-stop funding periods. With each distinct funding source, complexity increases. An ACH should designate a financial manager, or funding hub, with the capacity

to identify, apply for, and coordinate funding streams, thereby ensuring sustainability. Occasionally, the funding hub may also serve as the backbone organization; however, selection of an appropriate entity depends on each community's assets, needs, and capacity [52].

Grants might fund the entire ACH operation, but they usually aid with specific activities and infrastructure, including technical assistance, health information technology development, and general start-up grants. Start-up activities funded by an initial grant may include staffing, coordination of community referral systems, and development of plans for data sharing [2]. According to the John Snow Research and Training Institute, there are various pathways to financial sustainability for an ACH. First, ACHs must secure infrastructure funding for programmatic and administrative functions. This start-up funding often comes from philanthropy, hospital community benefit, and government grants. Later, the ACH may explore financial engagement from private and public payers, such as through investments by private insurance or Medicaid [53].

Financial involvement can be incentivized through pooled savings associated with health improvements and reduced health care utilization [53], or improvements in other sectors. Many ACHs recognize the need for a collaborative, cross-sector risk-sharing arrangement, since health may be a side benefit of policy programs across other sectors [51], just as other sectors may generate savings from health-based programs. In fact, cross-sector partnerships and financial agreements may foster willingness by state legislatures to approve funding requests [51]. Successful risk-sharing arrangements align financial incentives with community- and patient-level outcomes, and are agreed upon within the governance structure. For example, an ACH might coordinate social services, public health, and local safety net health providers to engage in a financial partnership [37]. In many cases, the backbone organization plays a leading role in developing risk-sharing arrangements.

The Wellness Trust model provides an example of how to “capture” savings from ACH-supported interventions and catalyze joint investment [53]. As envisioned in the CACHI program, this trust would be jointly governed by community partners to reinvest savings in new or upstream interventions and could also be a vehicle for joint investment by multiple partners [20, 54]. This expands on the Prevention and Wellness Trust Fund concept, originally passed in Massachusetts, which was supported by fees charged to health

insurers and acute care hospitals to support community-based prevention grants in the state [55].

The National Governors Association (NGA) has reported on opportunities for coordinated efforts between communities and health care delivery systems. The NGA acknowledges that whether or not federal funding is available for ACH-like models, states have the autonomy to encourage community-based interventions as a means to increase the effectiveness of their Medicaid and Children's Health Insurance Programs (CHIP). However, the NGA also notes that state governments may find it difficult to promote long-term funding of such measures, unless they are incorporated into tax policy, incentives for public-private partnerships, or other innovations [56]. The NGA recommends various financial strategies to incentivize creation of community-health care delivery system partnerships, including adopting payment policies to reimburse community health workers (for provision of services under Medicaid and CHIP), adding community coordination as a specification for direct contracting arrangements with provider delivery systems, and encouraging the funding of community care team programs by nonprofit entities, private foundations, charitable organizations, and counties through grant making [2].

Conclusion

We are in the early days of accountable health initiatives, focusing on establishing the principle of accountability for a community's health and applying it to the multiple sectors that contribute to health. Within the health sector, ACHs are expanding the concept of accountable care (for individuals or groups of individuals) to accountable health (for a community). ACHs build on experience with multisector, collective impact, and community engagement models within and beyond health [58].

Accountable health initiatives use a variety of approaches in terms of their scale and focus. There is some debate about what measures are appropriate for accountable health—regarding cost-effectiveness, return on investment, and time frame. Best practices for building the data systems that support accountable health are also in the early stages, and long-term financial sustainability for accountable health initiatives has not yet been defined. Given the variety of approaches that fall within the rubric of accountable health,

common approaches to evaluation have also not been defined.

Despite all these uncertainties, there is a common set of principles driving these initiatives relating to the value of improving population and community health through (1) growing investments by public and private funders for pioneering accountable health initiatives [52]; (2) focused dialogue among these investors through the Funders Forum on Accountable Health, to assure that there is cross-initiative learning and coordination; and (3) ongoing movement building through entities such as the National Academies of Sciences, Engineering, and Medicine's Roundtable on Population Health Improvement. Accountable health initiatives may be early in their development, but they are promising in the drive toward achieving the Triple Aim.

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